

Delivery of Urgent Cancer Surgery in Saskatchewan within Standardized Timeframes

Final Report

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Terrence Sullivan & Associates



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TERRENCE SULLIVAN PHD

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Executive Summary

For over 10 years, the province of Saskatchewan has been measuring and reporting on cancer surgery wait times. In fact, the province has been a leader in this area within Canada. In March 2013, the Saskatchewan Ministry of Health and the Canadian Foundation for Healthcare Improvement commissioned this report to support policy decisions concerning setting standards, collecting data and reporting on the delivery of urgent surgical cancer care in Saskatchewan. This work supports the Saskatchewan Surgical Initiative and one of the provincial improvement targets related to the delivery of cancer surgery and treatment within consensus timeframes. As an impetus to this work was the fact that the province's historic classification system and target timeframes for urgent cancer surgery were not perceived to be fully supported and would be impacted by the new three-month elective surgery wait time standard. This report and its recommendations will inform any potential changes.

The issue of waiting times continues to be high on Canadians' list of concerns about the health care system. Waiting for care contributes to the anxiety and stress patients experience and is often identified as an issue with publicly funded health care systems.¹

In September 2004 the First Ministers targeted wait list management as a critical concern and the federal government earmarked \$5.5 billion over 10 years through the Wait List Reduction Fund for the reduction in the wait lists for five key health areas including cancer, cardiac care, diagnostic imaging, joint replacements, and sight restoration, while recognizing the different starting points, priorities, and strategies across jurisdictions. While cancer was a priority area, cancer surgery was not among the areas where targets were set, rather excessive and dangerous radiation therapy waits were the priority. Despite that, most provinces (8 of 10) have adopted a process to measure and a few have adopted an explicit approach to manage cancer surgery waiting times.

The policy rationale behind wait list management is that the inclusion of target dates provides benchmarks for provincial/territorial activity around wait list management,¹ thus improving the tracking of time to treatment, improving accountability and reducing wait time. Given that little evidence exists linking the amount of time that is clinically appropriate to wait for a procedure other than the biological aggressiveness of a disease, most targets or benchmarks are consensus based on surgeon experience.²

However, not all delays in obtaining priority-area treatment are directly related to access to care. Factors that may extend the wait include delays in updating wait lists for patients who are receiving pre surgery adjuvant or neo-adjuvant treatment, or a patient's preference to have the surgery postponed. Delays can also be seen where health system capacity and resources are an issue or where processes are not optimized to maximize patient flow and quality of care or – in situations unlikely for cancer – where surgery is inappropriately over utilized.

Most provinces have established a system to assign a priority status that is linked to a particular wait interval band regardless of whether or not a specific target is established. In fact, only a

few provinces (Ontario, Saskatchewan and Manitoba for H&N cancer) actually set targets for the percentage of cases to be completed within these bands. There is variation in the banding, in the priority assignment process and in the approach to data collection, reporting and performance management. There are also variations in the process adopted to support the management of the wait list itself and the flow of patients within the province.

Saskatchewan has a long history of innovation in the delivery of quality care. It was one of the first provinces to initiate a quality program back in 2002 with the launch of the Saskatchewan Surgical Care Network – known at the time as the most comprehensive surgical database in Canada and an inspiration for other provinces. The province has developed many processes to improve their wait time management since 2004. Numerous advancements were made following the launch of the Saskatchewan Surgical Initiative in 2010.^{3,4}

The province has the desire and the will to continue to lead with respect to surgical care and may consider examining a surgical quality initiative to complement the work in access to care. In support of quality leadership, this report finds that there is not sufficient evidence to support specific targets for cancer surgery waiting time. There are a number of practices in other jurisdictions that have been successful to develop cancer surgery waiting time targets and to support the management and delivery in these targets.

Based on the input from a sample of Saskatchewan surgeon advisors, the environmental scan and key informant interviews from other Canadian jurisdictions, a set of recommendations were crafted in support of tying cancer surgical access together with a quality agenda. These recommendations should be discussed and expanded upon within the broader delivery community to build consensus and momentum on next steps. Further development and implementation of the recommendations should follow shortly over the course of the coming weeks to months to maximize the support and initial consensus developing across key stakeholders.

At the heart of the recommendations are three key points; a) provide more flexibility in the assignment of wait time bands; b) establish the infrastructure to continue to lead ongoing measurement and c) improve the quality of cancer surgery. Finally process improvement recommendations must also be implemented in support of these recommendations and they will be essential to achieving wait time targets. Our recommendations follow.

1. Wait Time Intervals: Add new band at 6 weeks in addition to existing bands (3 bands) 3 weeks, 6 weeks, 3 months

- The majority of performance issues lie with patients who fall over the 3 week timeframe but are actually more appropriately matched with a slightly longer wait (i.e. 6 weeks).
- These bands align with the current and future proposed classification for non-cancer surgery and thus support consistency across different procedures.
- As part of this new system, the surgeon's clinical assessment and priority assignment are key drivers of surgical booking. However, in establishing this

new classification system, it is imperative that the Province works with clinicians to establish clear guidelines that support when and why to classify cases within each band. The establishment of vignettes has been a successful tool used in Ontario to support surgeons in making consistent assignment across the province. It is useful to note also that Ontario has benefited from having a surgical lead for the Province with oversight to the assignments and where inconsistency exists, following up with surgeons one-on-one to clarify and support.

2. Develop a Surgical Oncology Quality Program

- Tie the focus on access to support for consistent quality management processes and targets across the province (ex: surgical margin targets for prostate and rectal cancer, reporting performance against guidelines, sentinel node biopsies for appropriate sites, rapid use of emerging evidence).
- Saskatchewan may also wish to consider adoption of surgical synoptic reporting as an approach to data collection to support consistency and quality improvement. Synoptic reporting allows for the collection of key data elements related to the surgical procedure in discrete data fields and supports a standardized “easy to read” report output.
- Identify a Clinical Leader to champion this initiative and establish some distributed leadership as part of the renewal of the surgical oncology program.

3. Eliminate or revise the Priority Assessment Tool

- Given the perceived and actual lack of value of the assessment tool for setting priority in bookings and the fact that most other jurisdictions have opted to not use one due to lack of evidence, we recommend that the tool itself be eliminated.
- Some standard process and associated definitions of priority should be implemented in its place (e.g. assign the band to the patient) and an appropriate approach to the removal of the \$12 fee.

4. Identify process improvement opportunities with operating room booking

- Despite the fact that all surgeons use the same central registry and that there is a central intake process, the process is not optimized and significant human intervention is required to ensure that people are appropriately scheduled regardless of the priority status assigned.
- Consider adding dedicated specific cancer blocks for OR time or allowing flex time for cancer cases (done in BC).

5. Develop consistent provincial policy and process guidance for wait list management

- Work to develop optimal process flows based on several possible pathways (emergent, 3 weeks, 6 weeks, 3 months) and support standard implementation across the province. These processes could be supported with the guidelines and vignettes referred to in recommendation number 1. As a set, these

documents can articulate the expectations clearly for both providers and patients so that there is clarity around the anticipated process flow.

- In addition to having a set of policies and procedures at the Provincial level, identify opportunities and supports to better manage and support wait lists across levels of care (surgeon, facility, booking processes, region).
- Identify how IT systems can support this consistency.

6. Identify new innovation and leadership opportunities such as Wait 1 measurement and work towards measurement of total “cancer treatment wait time” trajectory, including the period from symptom presentation to first consultation to first treatment

- Develop new approach to measuring treatment waiting windows irrespective of modality (surgery, radiation, chemotherapy) in cooperation with Saskatchewan’s cancer agency.
- Examine opportunities to collect data to measure “wait 1” – an important phase of care for patient experience.

This report recommends that Saskatchewan move beyond the addition or changes to wait time intervals or targets. A more effective measure to ensure transparent, consistent and high quality care lies in a holistic approach to creating a quality program in surgical oncology. This Program must be supported by dedicated leadership and allow for collaboration across the Government, clinicians, administrators and patients. Through the Program, these parties can work together to define and design processes, tools to guide practice and mechanisms to collect and report data to measure and manage multiple aspects of quality care.

1. Background

The Saskatchewan Ministry of Health and the Canadian Foundation for Healthcare Improvement have co-sponsored this research report to support policy decisions concerning the setting standards, collecting data and reporting on the delivery of urgent surgical cancer care in Saskatchewan. This work supports the Saskatchewan Surgical Initiative and one of the provincial improvement targets related to the delivery of cancer surgery and treatment within consensus timeframes.

Saskatchewan's historical classification system for non-emergent cancer surgery involves surgeons assigning patients with cancer or suspected cancer to one of the following priority levels based on their clinical assessment of the patient's condition and need. Each priority level has a different target time frame.

- Procedures for proven or suspected invasive cancer. The target time frame is that 95% be completed within 3 weeks. Most cancer surgeries are expected to fall within this category.
- Procedures for slow growing or indolent cancer. The target time frame is that 90% be completed within 3 months. An example might be a slow-growing prostate cancer or early stage thyroid cancer.
- Procedures that are performed for routine screening or as a scheduled follow-up procedure as part of surveillance following cancer removal to be performed within 12 months.

Surgeons, schedulers, patients, and regional health authorities have all expressed difficulties with the existing classification structure. Furthermore, as we achieve a 3 month maximum wait time for surgery, the historical classification scheme for non-urgent cases becomes irrelevant.

In late 2012, it was thought that an interim solution might be to also create a 6-week wait time category. Upon review by select surgeons, the creation of a 6 week wait time category was rejected for the following reasons:

- A 6 week wait time category is not useful from a clinical perspective. This is a system management issue. Similar to Ontario, wait time categories are not meant to drive clinical decisions, they are used to determine system needs and capacity.
- There is no clear published evidence that supports sooner care improves outcomes (although there is anecdotal evidence that suggests that excessive waits in the entire diagnostic to treatment process can upstage lower stage disease influencing both treatment and prognosis), thus there is a possibility that neither the 3-week nor the 6-week wait time categories are correct. There is evidence that suggests longer waits are linked with patient stress, thus a shorter wait time target is preferred to a longer one. Thus, the creation of a 6-week wait time category may add stress to patients, which is not patient centered care.
- More wait time categories are detrimental to wait list management best practices.

Note: Upon consultation with a small sample of thoughtful surgeons on this project it is clear that there was a misinterpretation of this proposal in that the 6 week interval proposed was understood to be proposed *instead of* the 3 week target. The recommendation in this report is that the 6 week interval be added *in addition to* the 3 week and 3 month intervals.

2. Approach to Data Collection

A combined quantitative and qualitative approach was taken for this assignment to develop a current state analysis followed by an assessment of key learning from other jurisdictions and considerations for Saskatchewan with respect to standardized timeframes for cancer surgery. We interviewed a number of informants (see appendix) to gather answers to the following questions to identify how other jurisdictions set and manage wait time targets for cancer surgery, who they worked with, what is working, what is not working and what is the level of satisfaction with the process and results of the wait times management process. Specifically, the current state analysis will answer the following questions:

- What are the timeframe policies in place for cancer surgery in other jurisdictions?
- How are urgent and non-urgent defined?
- Which provinces have set provincial standards? If not provincial, who is setting the standards?
- What processes were used to develop standards? How did jurisdictions overcome the lack of evidence related to deciding appropriate timeframes for cancer care?
- What strategies were used to configure delivery to meet the timeframe standards?
- How effective have these strategies been?
- How supported by key stakeholders have these strategies been?
- What is the patient engagement experience and response to this process?
- If standards exist, how have these standards impacted the delivery of care to patients? Are there any unintended consequences you did not foresee?
- If standards exist, how do you deal with variability among surgeons with similar practices/patient populations? Is there accountability amongst surgeons? Is specialty and/or surgeon level data shared and, if so, how? Are audits performed?

We developed an approach to presenting the analysis in order to address these questions and identify options for Saskatchewan.

3. Evidence Review

While it is clear that more biologically aggressive tumors may be adversely affected by longer waits and cumulative delays in the entire cascade from suspicion of cancer to definitive treatment (including the diagnostic cascade), the current body of evidence is not yet robust enough to provide definitive guidance with respect to maximal wait time intervals for surgery and associated outcomes for a range of cancers. The rapid scan of the literature identified few reviews, and no randomized studies. What has been produced is difficult to compare due to:

- Differences in the time intervals (e.g., time from diagnosis to surgery, time from symptoms to surgery)
- Type of study design (mainly retrospective reviews)
- No adjustment for variables such as prognostic significance
- Small sample size
- Small number of studies

Intervals to progression are dependent both on disease site (e.g. early prostate cancer or thyroid cancer) and biological aggressiveness (e.g. testicular cancer or sarcoma). Evidence suggests that most surgeons implicitly triage with these two considerations in mind. There is a growing body of literature with respect to active surveillance which in time may be of relevance to the wait time discussion in future. Absent definitive data, provinces in Canada have taken two approaches – establish consensus-based targets and aim to meet those targets, or to report on the actual number of days patients wait for surgery and aim to reduce those waits.

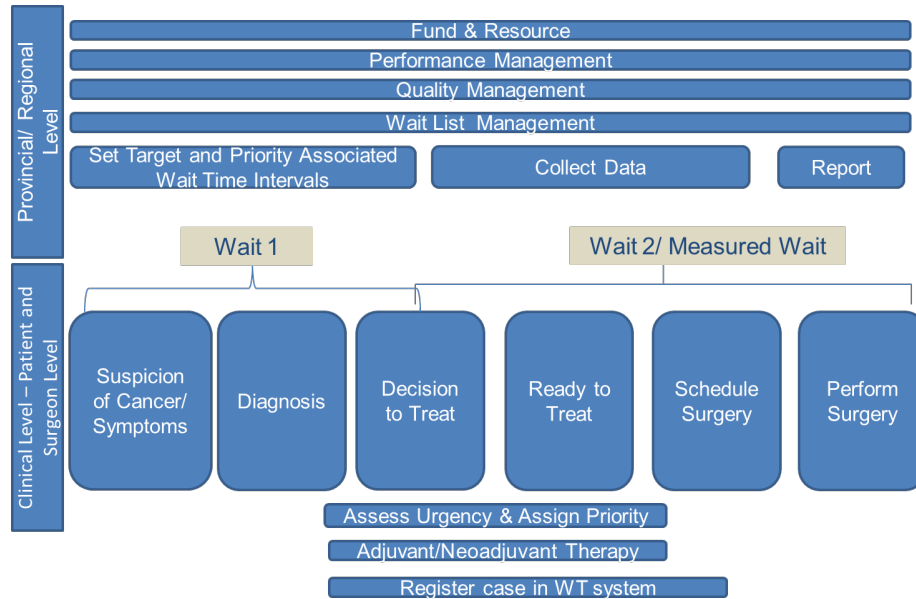
Waits for cancer surgery need to be considered within context of the current and future capacity of the health care system to meet targets, managing other delays in the patient journey such as diagnostic delay, potential incentives for stimulating reductions, and the impact on the broader system, e.g., surgeries other than cancer.²

The current state of evidence in the literature does not support linking specific wait times and adverse outcomes and should not be a key factor informing Saskatchewan's decision making at this time. Practices in other jurisdictions provide more significant information for this purpose.

4. Findings

The following outlines the factors involved in cancer surgery wait time management. Each of these processes is important when considering factors involved in improving the access to quality care. As such, analysis and recommendations apply to a variety of these elements.

Figure 1: A Process View of Wait Times for Cancer Surgery



4.1 Pan Canadian Findings

The picture of wait time management for cancer surgery across the country looks different depending on the process. Most provinces measure and report cancer surgery wait times. Few provinces have set targets for cancer surgery wait times (Ontario, Saskatchewan, Manitoba). Fewer provinces have effectively implemented performance measurement and management systems to support these targets (Ontario, Saskatchewan). Where there has been success, it has been credited to a combination of political will along with achieving and aligning clinical and administrative consensus.

For the most part, the key factor in the success of wait time initiatives in Canada is not determined by the appropriateness of the interval or target but rather the way in which targets, measures, reports and manages performance to create a transparent high quality surgical care system.

While the Ontario example is far from perfect, the experiences in this province inform a number of observations within a broader surgical oncology quality mandate. The evolution of the cancer surgery wait times program in Ontario took place within the development of a broader surgical

oncology program for the province along with the growth and development of the provincial wait times information program (later the “Access to Care” program), each of which reinforced the other.

In 2005, the provincial Cancer Surgery Expert Panel released its report outlining a six point strategy for providing “equitable access to quality cancer surgery in a timely and appropriate manner”.⁵ Key features of this plan included:

1. Best Practice Targets and Approaches to Support Standardization

The report recommended the development of standards, guidelines and best practices to promote the quality, safety and efficiency of cancer surgery. Following from this, CCO developed quality standards and guidelines for cancer surgery and began to implement quality surgical practice indicators to monitor whether these and other standards and guidelines are being used in clinical practice. CCO and the Regional Vice Presidents began to use these standards and guidelines to determine which hospitals should receive additional cases, and where programs need to be developed. CCO also developed Communities of Practice as a vehicle to promote surgical quality within and across LHINs and to strengthen the link between quality initiatives and funding. The establishment of consensus based wait time targets for surgical priority levels was part of this initiative.

2. Information to Monitor Performance and Support Quality Improvements

The Cancer Quality Council of Ontario is a major vehicle to monitor performance and support ongoing quality improvements in Ontario’s cancer system. Both the Council’s first report (2003) and CCO’s *Ontario Cancer Plan* (2004) noted that there were few published, well-developed quality indicators for cancer surgery by which to measure access and appropriateness. CCO has since increased its focus on developing information to monitor surgical performance and support quality improvements. The data collected as part of the wait times information system was used to support reporting at local and provincial levels.

3. Human Resources

Recognizing the need to improve the efficient and effective use of skilled surgeons, this Panel recommended training for more cancer surgeons to meet the growing demand for this specialty as well as provincial funding support for post-residency surgical oncology fellowship positions.

4. Technology

The report identified the important role of information systems to support standardized practice and data collection and reporting for quality management. Technology recommendations also included investment in health technology supports for surgery.

5. Funding

The report emphasized the importance of quality based funding and tying additional surgical case funding to quality outcomes and adherence of institutions and their surgical leaders to participation in a surgical quality program. This lever is an important component as is the investment in health technologies to support surgical investment (but may be less important in areas of Saskatchewan where there are fewer market pressures between institutions because of low population density).

6. The Organization of Services to Meet Quality Standards and Future Needs

The report identified the need for the appropriate provincial, regional and local infrastructure to support management of these initiatives and collaboration on future planning.

In 2006 a subsequent updated report, targets for cancer surgery wait times were published that built on the 2005 report and identified priority levels and targets for cancer surgery wait times using a consensus based process.⁶ These are the targets in use today. The infrastructure that evolved to support these foundational works included the development and implementation of the Wait Times Information System, the establishment of a provincial lead for cancer surgery wait times and a provincial program team to support data collection, process and practice improvement and performance management. The levers of additional quality based funding and public reporting originally identified in the 2005 CCO report have served to support the overall program. While the profile of this program has lessened over time, the primary tenants and learning are still relevant today –a multi-faceted, multi-level approach is required.

The following table summarizes the pan-Canadian findings by province. Details of the specific targets and reports can be found in the Appendix of this report.

Province	Targets for Cancer Surgery Wait Times	Measure Cancer Surgery Wait Times	Publicly report cancer surgery wait times	Tool for assessment of urgency	Unique Features/ Notes
Ontario	✓	✓	✓	×	Clinical Lead/ Clinical Expert Panels/ Perf. Mgmt
Saskatchewan	✓	✓	✓	✓	Regional Perf. Mgmt
Manitoba	✓ Head/neck only	✓	✓	✓	
Quebec*	×	✓	✓	Unknown	Supportive of wait 1 measure
Alberta	×	×	×	×	Cancer surgery not in AHS mandate
British Columbia	×	✓	✓	Unknown	Report waits publicly at surgeon level
Newfoundland and Labrador	×	✓	✓	Unknown	
Nova Scotia	×	✓	✓	×	Rejected assessment. tool due to lack of evidence
New Brunswick	×	✓	✓	Unknown	

Province	Targets for Cancer Surgery Wait Times	Measure Cancer Surgery Wait Times	Publicly report cancer surgery wait times	Tool for assessment of urgency	Unique Features/ Notes
Prince Edward Island	x	x	x	Unknown	

*Note: Over the past month, Quebec has removed its original target of 4 weeks for cancer surgery from its web site. This change is reflected above.

4.2 Saskatchewan Findings

Based on interviews with a small sample of thoughtful Saskatchewan surgeons for this project, followed by a discussion with surgeons in Regina (June 12th, 2013) and in Saskatoon (June 13th, 2013), there appears to be a base of support the existing intervals of 3 weeks and 3 months and some mixed support for the introduction of a 6 week priority band.

4.2.1 Observations from Regina Surgeons

In an onsite exchange with a good sampling of cancer surgeons in Regina, the following items were raised in a lively exchange. Some of the surgeons questioned the availability (constraints) of surgical suite time as the principal explanation for wait time challenges in Regina region. Others believe that there has been gaming by some subspecialty surgeons to get to a 3 week window for all their patients, regardless of biological aggressiveness of the disease. Others believe that the introduction of a 6 week window would allow for some reduction in the imperative to get the procedures done as quickly as possible, providing some false relief from the pressure in cancer surgery. The surgeons expressed belief in the value in trying to advance a quality program, provided there was better access to surgical suite time. There was also some commentary that the creation of dedicated blocks for cancer surgery would be a useful step in the right direction, along with more active management of the booking schedule by the booking team. There was some discussion of the need for better cooperation with the cancer agency clinicians in scheduling procedures and working together on multidisciplinary care planning. The booking team described challenges of getting surgeons to book in when short term availability presented itself because of unforeseeable cancellations. In Regina there was particular support for process improvement focussed on booking and simplification and notification within the booking sequence.

4.2.2. Observations from the Saskatoon Surgeons

The Saskatoon surgeons indicated that access to surgical suite time was not a major issue. They did identify the challenge of effectively using the 6 week window for conditions which were either provisional or more indolent and could imagine a relatively manageable process to produce some vignettes on which patients might fit the 6 week window, based on some simple guidance, particularly for some breast cancer cases (DCIS) and possibly others. They also were enthusiastic regarding doing work on the diagnostic cascade. There was a strong view that the booking surgeon should be in a primary role to drive the diagnostic processes before surgery in a timely fashion and that this protocol should be worked out with the diagnostic areas. There were views that the patient should actually be booked when they are ready for the procedure, as opposed to a pre-emptive reservation in the system without regard to urgency. There was reference to the challenge of managing the program without a head of surgery within the region, and the aspiration to have confirmed leadership.

Taken together, it is fair to say that surgeons were supportive of the aspiration to complete most surgeries 3 months. However, there appears to be a discrepancy around the 95% priority 1 within 3 weeks as there are some surgeries that should be completed BEFORE the 3 weeks and others that can be completed AFTER 3 weeks but before 3 months. The surgeons did not feel that there was a need to have a special status for emergent cases and these should not be within the scope of the wait list. Given the consistently poor performance in the 2 regions these surgeons represent and the general support for the banding as it is (with our without additions as there was not consensus on this point), this speaks to process improvement in booking and managing waits and capacity related issues that are at the root of the current performance issues rather than the inappropriateness of the bands and targets themselves.

It was noted that capacity issues largely associated with OR nursing staff are an issue in the Regina region working against meeting targets and that capacity related to the diagnostic, adjuvant or neo adjuvant activities is an issue that has affected most regions to some extent. The surgeon teams noted that they have begun to take into account the adjuvant/neoadjuvant cases, but this does not appear to be done uniformly across the province yet.

While evidence exists that waiting longer in general increases patient anxiety, the reliability of a still appropriate but slightly longer waiting time, and the ability of the system to deliver on that commitment may be more important than a single shorter waiting time.

The following are the key process issues highlighted by informants that reflect the challenges:

- Lack of flexibility in assignment of wait time based on urgency. A number of informants felt that the two bands alone were insufficient to address the range of patient needs. Additional bands would be more appropriate – particularly between 3 weeks and 3 months.
- The patient assessment tool is not deemed to be particularly useful in determining or assigning priority and is time consuming for physicians. In Nova Scotia, for example, the province assessed the option to implement an assessment tool and decided not to pursue it due to lack of evidence and clinical support.
- Long wait times reporting may be linked to inaccurate capture and documentation of built in waits for adjuvant or neo adjuvant treatment – radiation or treatment to occur in advance of surgery. Surgeons report they are now building this in as a patient related delay and booking the surgery accordingly but it appears the current process is not consistently set to accommodate this case
- Delays occur when attempting to flow patients between regions to reduce wait time. The example provided was around the referral of patients from Regina to Saskatoon where the surgery (reason unclear) ultimately occurs in the same timeframe as it could have been completed locally. It is also worth noting that surgical referral patterns often flow

east-west as opposed to north-south and that surgeries performed out of province in Manitoba or Alberta may not be accurately (if at all) captured in the wait times data.

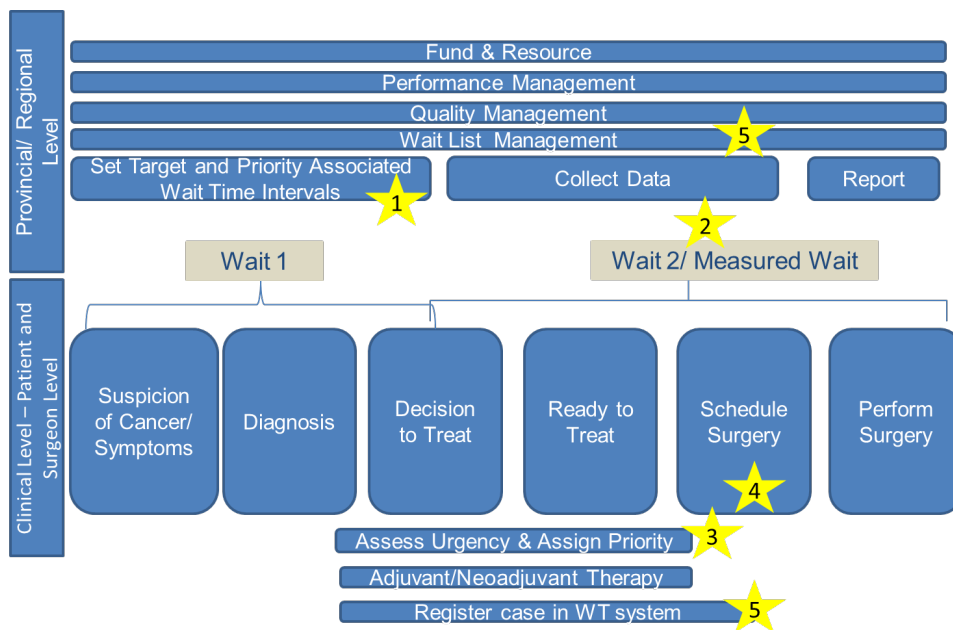
- Availability and flexibility of OR time is an issue as there are no blocks for cancer care and surgeons need to prioritize around their general block schedules (this is particularly an area of concern in Regina). The ability to designate space and time blocks for cancer surgery specifically – even if on a more ad-hoc basis – may be a consideration as is the practice in the Vancouver area.
- Inability to consistently monitor the list (unclear who is on my list) and manage to meet targets (active wait list management vs. wait list tracking and reporting functions). This could be linked to the variation in process and practice within each region or centre within each region as well as the IT system and people resources used to support this function. Often, surgeons are working to manually intervene to ensure certain patients are seen in time intervals more specific and narrow than the 3 weeks and 3 months based on their assessment of need and priority.
- From a patient experience perspective, the waits for the diagnostic interventions required in advance of cancer surgery are often long. The “wait 1” diagnostic phase and its impact on the overall patient experience and possibly on outcomes, is a factor to consider as part of a broader analysis, as was argued originally by Quebec when it originally established its 4 week waiting time target (the definition was ultimately not determined to be “time of suspicion or symptoms” but rather “date of decision to treat” largely due to the feasibility of data collection).
- Also from a holistic perspective, focus on waiting for “cancer treatment” or “first definitive treatment” may be a better way to look at wait times. From a patient perspective, this may be more reflective of their experience and may better capture the current practice patterns across all treatment modalities. For example, one informant suggested that current practice may lean inappropriately to surgery as the first definitive treatment reflecting the history of long waits for radiation oncology and medication oncology in Saskatchewan.
- Lastly, the issue of waiting times and access as a measure of quality is important but so are measures of the quality of care and surgical treatment which for at least some surgeons may outweigh what are viewed as simple access guidance. Measurement of re-operation rates, the presence of surgical margins and protocols against guideline may be important measures to include as part of the overall analysis.

5. Recommendations

Based on the initial input from the Saskatchewan surgeon advisors, meetings with a group of surgeons in Regina and Saskatoon, taken together with the environmental scan and key informant interviews across the country, a set of recommendations are presented in support of advancing the cancer treatment access and quality agenda. These recommendations should be discussed and expanded upon within the broader delivery community. Further development and implementation of the recommendations should follow shortly over the course of the coming months to maximize the support and initial consensus developing across key stakeholders.

At the heart of the recommendations are a move to create more flexibility in the assignment of wait time bands and the requirement to establish the infrastructure to continue to lead ongoing measurement and improvement in the quality of cancer surgery care. However, it is also clear that modification to the bands alone will be insufficient to address the issue of inconsistency across the province today. Process improvement recommendations **must** also be implemented in support of these recommendations and they will be essential to achieving the wait time target.

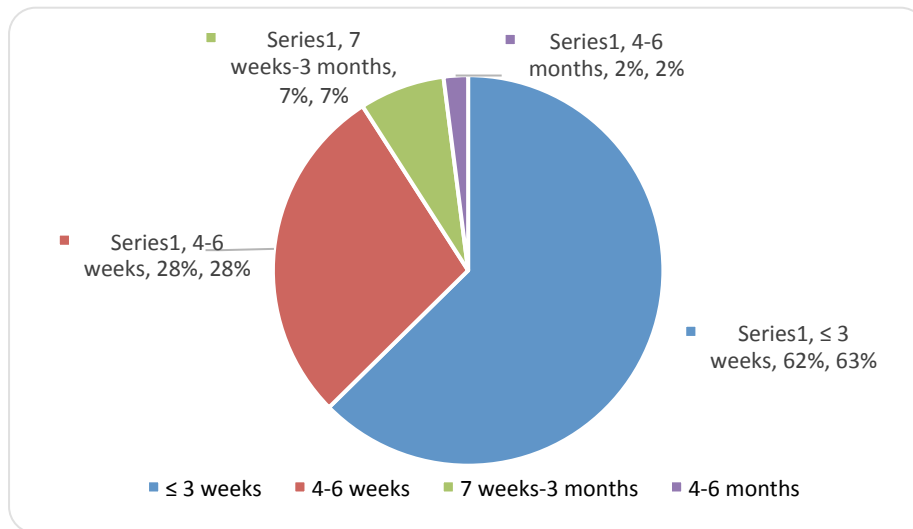
Figure 2: Focus of Recommendations in Process for Cancer Surgery Waits



1. Add New Priority Band at 6 Weeks

One of the issues that served as an impetus for this report was the understanding that the historic wait time intervals and targets were not broadly supported across the province. However, upon further examination through consultation with the Project's surgeon expert panel and other provincial informants, there appears to be a higher than expected level of consensus that a 3 week and 3 month interval make sense. However, the 3 week and 3 month intervals alone are insufficient as some cancers need to be seen "sooner" than 3 weeks and some "not as soon". Given that the wait list management process is dependent on the appropriate assignment of priority, it makes sense to create additional priority levels for those cases that are less urgent than the 3 week interval allows but should not wait 3 months. A 6 week band was endorsed as an addition to the 3 week and 3 month bands with the possible designation of vignettes to identify patient populations who would be most suitable for the early, middle and late band. While it is clear that modifications to the wait time intervals and associated targets are insufficient to address the breadth of issues facing the surgical cancer care community, there is an indication that the addition of the 6 week band aligns well with the observed distribution of data today. Figure 3 reflects the current distribution of cases by target times.

Figure 3: Surgery for cancer or suspected cancer (invasive cancers with a target time frame of 3 weeks)



Source: Data from Saskatchewan Surgical Initiative: Available from: http://www.sasksurgery.ca/pdf/Cancer_Overall.pdf
Actual Patient Waits for Procedures Performed 01-Sep-2012 to 28-Feb-2013, Saskatchewan Surgical Registry

Surgeons identified the practice of intervening to schedule surgeries specifically based on their assessment of relative need of their patients and the fact that some required care sooner than 3 months. The entire process of managing surgical bookings, establishing the target surgical date, and rebooking based on urgency seem to be challenging in both Regina and Saskatoon. This speaks to the importance of the ability to assign a priority status of less than 3 months provided that the system responds in order to support surgical booking and alignment of resources accordingly. It seems that there is a manual surgeon-specific set of activity that is currently taking place to adjust the patient flow to move patients to specific surgical dates as the current bands are not specific enough. The formalization of the new band, assignment of targets and some process enhancements to align to these bands are desirable considerations. The addition of the 6 week band should be supported by the development of detailed vignettes or guidelines to support the assessment and assignment of patients to each of the wait time intervals.

Ontario has worked to develop clinical decision making guidelines which articulate the features of patients to be assigned to each of the wait time bands. A set of supporting vignettes for each serves to illuminate these guidelines and oversight is provided to ensure consistency of practice. In cases where persistent variation is noted, a designated provincial surgical lead reaches out to those surgeons on an individual basis to provide support. The set of guidelines for priority setting should be part of a group of policies and procedures that effectively outline and support consistent processes across the wait time continuum and could take place under the auspices of a provincial surgical oncology quality program described in recommendation number 2 below.

2. Develop a Surgical Oncology Quality Program

Strong surgical leadership is required to support the next phase of improvement in cancer treatment in Saskatchewan. Serious consideration should be given to limiting the number of centres where the most complex care is delivered. It would be important to tie access to surgery with support for consistent quality management processes led by surgeons, with targets across the province (surgical margin targets, performance against guidelines, sentinel node biopsy, use of emerging evidence etc). Initiatives such as surgical synoptic reporting should be strongly considered to support consistency in practice and to enable measurement of clinical quality indicators, as well as patient perspective and ultimate decision making. As the Province considers its next steps following this work, identifying surgical leadership will be an important success factor to mobilize support and build consensus on a number of the interrelated measurement and improvement initiatives. The Saskatchewan Cancer Agency is an obvious partner in this regard and has indicated in discussion that it is prepared to support build better quality measurement and reporting as part of the broader cancer mandate within Saskatchewan.

3. Eliminate Priority Assessment Tool

Given the perceived and actual lack of value of the assessment tool for prioritizing bookings, and the fact that most other jurisdictions have opted to not use one due to lack of evidence, we

recommend that the tool itself be eliminated. Some standard process and associated definitions of priority should be implemented in its place. The new process must take into account the requirement to add a cancer flag and the impact process redesign will have on other disease sites.

4. Identify process improvement opportunities with OR booking

Despite the fact that all surgeons use the same central registry and that there is a central intake process, it still seems as though the process is not optimized and that significant human intervention is required to ensure that people are assigned appropriately regardless of the priority status assigned. Moreover there appear to be issues when sudden cancellations occur and opportunities for rapid cycle booking appear. Saskatchewan should consider improvement opportunities with its OR booking processes. As part of this, regions may consider adding specific cancer blocks for OR time or allowing flex-time for cancer cases (done in BC). Regina has already implemented blocks designated for cancer patients (as opposed to surgeon specific blocks).

5. Develop consistent provincial policy and process for wait list management

As noted earlier, the concerns with the historic 3 week and 3 month targets are more likely symptoms of a great issue concerning the lack of clear and standard processes around the assignment of wait list priority and wait list management. The theme of lack of clarity and consistency came up throughout discussions with a range of informants. As such, the development of a set of detailed provincial policies supported by processes flows and decision making guidelines around the assignment of surgical priority, surgical booking and wait list management is required. This effort would include mapping a sub-set of the processes outlined in Figures 1 and 2 above (Assess urgency and assign priority, Register case in wait time system, Schedule surgery).

Through process re-design, development of supporting guidelines and associated communication, the Province can start to be able understand and manage the flow of patients. As part of the surgical quality program, the Province should work with surgeons, administrators and other leaders to develop optimal processes based on several possible pathways and support standard implementation across the province. Through this activity, opportunities to better manage and support integrated management across levels of care and geography will emerge. IT systems can support this consistency.

6. Consider a move to measure “cancer treatment wait time”

Consider a move to measure “cancer treatment wait time” where the measurement reflects the patient experience from initial symptoms through the diagnostic phase to decision to treat inclusive of all treatment modalities. This will require some integration of hospital and cancer agency encounter data in a common window. Wait time could reflect the delivery of the first definitive treatment. The province can examine opportunities to collect data to measure “wait 1” – an important phase of care for patient experience and is already looking at new GP referral billing codes and other electronic options that may support this.

6. Summary and Next Steps

The objective of this report was to provide an overview of cancer surgery wait time programs across Canada and to put the Saskatchewan experience in a pan-Canadian perspective and identify options for new wait time intervals/ targets. However, the issue of wait time targets extends beyond the targets themselves and must be approached from a system perspective in order to ensure alignment of clinical and performance management objectives with evidence and patient experience. This report has provided an overview of a set of recommendations that should be discussed more broadly with the clinical and administrative communities in the province. However, the decision to add the new interval at 6 weeks and to initiate a surgical quality program and identify leadership should be taken immediately to both signal the intent to renew the process and the commitment to address the issues holistically and in collaboration. A consultation on the how might follow with a broad surgical and administrative engagement to ensure successful implementation and buy in.

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9. Appendix

Summary of Pan-Canadian Wait Times Targets and Intervals

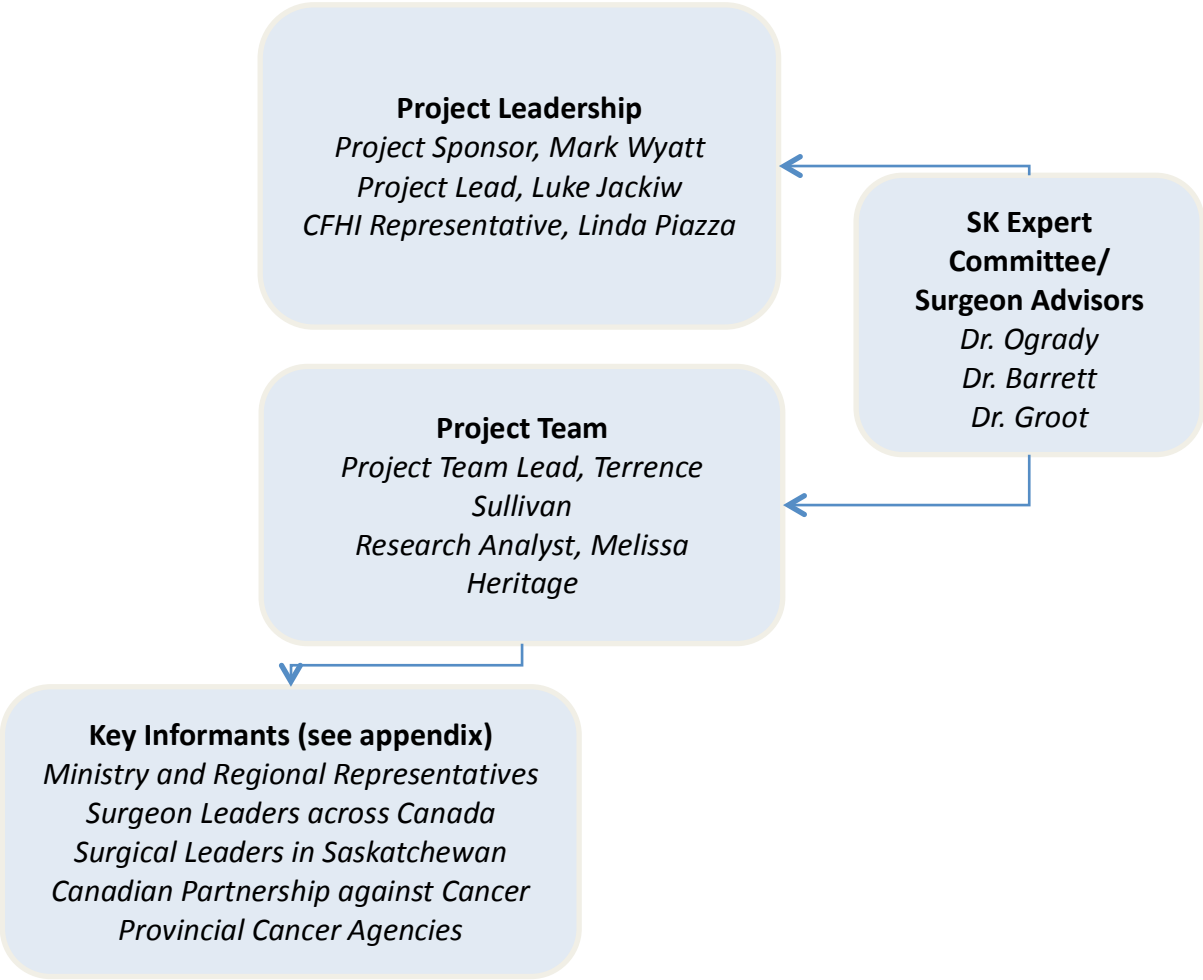
Ontario	
Targets / Intervals	<p>The target is to treat 90% of patients within the timeframes specified by priority levels I-IV.</p> <p>PI: Immediate: Patients requiring surgery to remove known or suspected cancers that have immediately life threatening conditions (airway obstructions, haemorrhage, neurological compromise).</p> <p>PII: 2 weeks (14 days): Patients diagnosed with very aggressive tumours, such as central nervous system (CNS) cancer.</p> <p>PIII: 4 weeks (28 days): All patients with known or suspected invasive cancer that does not meet the criteria for urgency categories II or IV.</p> <p>PIV: 12 weeks (84 days): Patients diagnosed with indolent cancer.</p>
Wait Times Reported	<p>Ontario reports wait times for the following cancer surgeries as 90th percentile: bone, joint and muscle cancer, breast cancer, eye cancer, gastrointestinal cancer, genitourinary cancer, gynaecological cancer, head and neck cancer, liver and pancreatic cancer, lung cancer, neurological cancer, prostate cancer, thyroid and endocrine cancer.</p> <p>Data for the cancer surgery summary is reported as average, median and 90th percentile for priority levels II-IV for each hospital and the province.</p> <p>Latest available data: Feb - Apr 2013</p>
Saskatchewan	
Targets / Intervals	<ul style="list-style-type: none"> • Level 1: 95% of patients completed within 3 weeks. Procedures for proven or suspected cancer. • Level 2: 90% of patients completed within 3 months. Procedure for slow growing or indolent cancer. • Level 3: within 12 months. Procedures that are performed for routine screening or as a scheduled follow-up procedure for cancer detection.
Wait Times Reported	<p>Data is provided by the Saskatchewan's Surgical Patient Registry and is reported as 90th percentile and as percentage of patients completed within 3 weeks, 4-6 weeks, 7 weeks-3 months, 4-6 months and longer than 6 months. Saskatchewan reports wait times for individual health regions and the following cancer surgeries: resection of bladder; radical prostatectomy; mastectomy; lymph node dissection; thyroidectomy; resection bowel, colon or rectum; hysterectomy; thoracotomy; nephrectomy; breast biopsy. Latest available data: Oct – Mar 2013</p>

Manitoba	
Targets / Intervals	Head and neck cancer surgery intervals: <ul style="list-style-type: none"> • Priority Level 1 Urgent: < 6 weeks • Priority Level 2 Semi-urgent: < 12 weeks • Priority Level 3 Elective < 24 weeks
Wait Times Reported	Data is reported for the province as median. Manitoba reports cancer surgery wait times only for head and neck cancer. Latest available data: April 2013
Québec	
Targets / Intervals	None
Wait Times Reported	Data is presented as the percentage of people operated on within intervals of 28 days, 29-56 days and 57+ days per region since April 1 st 2013.
Alberta	
Targets / Intervals	None
Wait Times Reported	None
British Columbia	
Targets / Intervals	None
Wait Times Reported	Data is provided by the Surgical Patient Registry (SPR) and presented as median and 90 th percentile. BC reports surgery data in 3 categories: <ol style="list-style-type: none"> 1. cancer suspected (≥5% suspected of having cancer) 2. cancer not suspected (≤5% suspected of having cancer) 3. all Wait time data can be searched by surgeon, facility, procedure, age and health authority. This search tool provides data for all surgery, not only for cancer surgery. Latest available data: Feb – Apr 2013
Newfoundland and Labrador	
Targets / Intervals	None
Wait Times Reported	Data is provided by regional health authorities for individual hospitals and reported as median and 90 th percentile. Newfoundland and Labrador reports wait times by disease site: bladder cancer surgery, breast cancer surgery, lung cancer surgery, colorectal cancer surgery, prostate cancer surgery. Latest available data: Oct - Dec 2012
Nova Scotia	
Targets / Intervals	None
Wait Times Reported	Data is provided for each community, hospital/clinic and the province and presented as median and 90 th percentile. Nova Scotia reports wait time by disease site: bladder cancer, breast cancer, colorectal cancer, lung cancer and prostate cancer. Latest available data: Oct - Dec 2012

New Brunswick	
Targets / Intervals	None
Wait Times Reported	<p>Data is provided by the Surgical Access Registry for communities, hospitals and the province and presented as median and 90th percentile.</p> <p>New Brunswick reports wait time in 2 categories:</p> <ol style="list-style-type: none"> 1. All surgeries (including cancer related surgeries) 2. Cancer related surgeries only <p>Reported surgery types include the following cancer related surgeries: general surgery, gynecology surgery, neurosurgery surgery, orthopaedic surgery, otolaryngology surgery, thoracic surgery, urology surgery, gynaecology surgery</p> <p>Latest available data: Jan-Mar 2013</p>
Prince Edward Island	
Targets/ Intervals	None
Wait Times Reported	None

Project Governance

The following outlines the governance structure for this engagement.



Project Key Informants

Name	Role
Dr. Peter Barrett	Project Surgeon Expert Advisor, Urologist, Saskatoon Physician leader with the Saskatchewan Surgical Initiative
Dr. Gary Groot	Project Surgeon Expert Advisor, Urologist, Saskatoon Director of Research and Graduate Studies, University of Saskatchewan College of Medicine
Special meeting of the Cancer Surgeons in Saskatoon Hosted by Dr. Richard Bigsby	Reviewers of recommendations
Dr. Mark Ogrady	Project Surgeon Expert Advisor Ear Nose and Throat Surgeon, Regina
Scott Livingston and Dr. Monica Biel, Saskatchewan Cancer Agency	Reviewers of recommendations
Special meeting of the Cancer Surgeons in Regina Chaired by Dr Mark O'Grady	Reviewers of recommendations
Luke Jackiw	Project Manager , Saskatchewan Ministry of Health Acute and Emergency Services Branch
Patrick O'Byrne	Director, Acute and Emergency Services Branch Saskatchewan Ministry of Health
Mark Wyatt	Executive Director, Saskatchewan Surgical Initiative
Jenny Bartsch	Director, Surgery Services Saskatoon Health Region
Dr. Jon Irish	Chief of the Department of Surgical Oncology at Princess Margaret Hospital/University Health Network and Mt. Sinai Hospital, Toronto. Professor of Otolaryngology-Head and Neck Surgery at the University of Toronto
Paul Grundy	Senior Vice President and Senior Medical Director of Cancer Care AHS
Dr. Antoine Loutfi	Surgeon and Former Head, Quebec Lutte Contre le Cancer
Dr. Geoff Porter	CPAC Surgical Lead, Nova Scotia Surgeon
Janet Martin	Cancer Waits Facilitator, Cancer Care Manitoba
Dr. Ryan Patterson	BC Surgeon informant, Director Surgical Administration VGH

Name	Role
Tracy Johnson	Manager of Emerging Issues, CIHI Cancer Surgery Wait Times Indicator
Mary Argent- Katwala	Director, Diagnosis and Clinical Care, Canadian Partnership against Cancer

Provincial Wait Times Data References

Provincial Wait Time Postings	
1. Ontario	Source: http://www.waittimes.net/Surgerydi/en/Service_Data.aspx?View=0&Type=0&Modality=5&ModalityString=5&ModalityType=9&ModalityTypeString=9&LHIN=&city=toronto&pc=&dist=0&hosptID=0&str=&period=0
2. Saskatchewan	Source: http://www.sasksurgery.ca/sksi/cancersurgery.html
3. Manitoba	Source: http://www.gov.mb.ca/health/waittime/cancer/surgery/neck.html
4. Quebec	Source: http://wpp01.msss.gouv.qc.ca/appl/g74web/Oncologie.asp
5. Alberta	Source: http://waittimes.alberta.ca/CancerServices.jsp?rhalD=All&loctnType=All&doSearch=N
6. British Columbia	Source: http://www.health.gov.bc.ca/swt/faces/Search.jsp
7. Newfoundland and Labrador	Source: http://www.health.gov.nl.ca/health/wait_times/cancer_wait_times.html
8. Nova Scotia	Source: http://waittimes.novascotia.ca/categories-procedures/all
9. New Brunswick	Source: http://www1.gnb.ca/0217/SurgicalWaitTimes/Reports/Index-e.aspx?tab=2#anchorWaitTime
10. Prince Edward Island	Source: http://www.healthpei.ca/index.php3?number=1037887&lang=E