



Improving Access to Cancer Services: Wait Time Targets for Cancer Treatment

Report of the Wait Times Project 05/06

Executive Summary

BACKGROUND

In recent years, Ontario has seen wait times become longer as the demand for some services increases without a proportionate increase in available resources. Without coordinated action, these waits will likely continue to increase as a result of the growing incidence of cancer and Ontario's expanding and aging population. While there has been some improvement in access to essential cancer services such as radiation and breast screening, more must be done to ensure that high quality services are available when and where they are needed most.

A recent catalyst for wait time focused initiatives was the commitment by Canada's First Ministers to improve access to care by reducing wait times for key services. The commitment called for the development of evidence-based benchmarks for medically acceptable wait times.

Shortly after the First Ministers' announcement, Ontario's Ministry of Health and Long-Term Care (the Ministry) announced Ontario's Wait Time Strategy. The Ministry, through its Health Results Team, asked Cancer Care Ontario (CCO) to provide advice on wait time benchmarks for cancer surgery. CCO coordinated its response through a Wait Times Steering Committee (the Committee).

MANDATE

The Committee's mandate was to:

1. Review current practices for reporting wait times for radiation, surgery and systemic therapy in the cancer system.
2. Establish or confirm relevant, consistent definitions for wait time(s).
3. Develop effective, accurate, consistent, timely, usable measures for monitoring the wait times for radiation, systemic and surgery services, including the development of Target Wait Times (TWTs) for cancer treatment.
4. Identify appropriate mechanism(s) for reporting wait times to all stakeholders (e.g., the Ministry, cancer system, health care providers, public).

The Committee recognized that wait times are only one element of the broader access to care issue, which includes demand, capacity and other factors. The Committee proposed a framework to guide CCO's work on access to care beyond wait times. However, the mandate for the Committee was focused on wait times as a starting point for addressing these issues. The scope was further limited to three treatment modalities: cancer surgery, radiation treatment and systemic therapy.

APPROACH

The development of TWTs was delegated to three subcommittees representing the three treatment modalities. Each subcommittee was given a mandate to review and make recommendations on the measurement of wait times and to establish system performance targets. Specifically, they were asked to recommend:

- Appropriate wait time intervals to provide a foundation for measuring and monitoring wait times as one element of system performance
- Priority categories
- TWTs for each interval and priority category

Each subcommittee included members from across Ontario and from CCO. The subcommittees worked with the Program in Evidence-based Care (PEBC) and a panel of experts to develop benchmarks and targets for cancer treatment in Ontario. These multidisciplinary panels included clinicians, managers, administrators, social and behavioural scientists, and health research methodologists. Subsequent to this consultation, some modifications to the targets were made to ensure consistency with Ministry direction.

THE ACCESS TO CARE FRAMEWORK

The Committee defined 'access to care' as "*equitable and timely access to appropriate care when needed.*"

This definition acknowledges that access to care is much broader than simply timely access (i.e., wait times). Although wait times, especially wait times for treatment, are receiving much attention by policy makers and the media, other dimensions of care are also important to understand and manage.

To illuminate the relationship between wait times and other key factors that influence access, the Committee proposed a framework for understanding the various elements of access to care. The goal was to introduce a mechanism to encourage ongoing thinking about access to care in a broader context.

The access to care framework is based on the identification of three discrete patient populations and the processes and infrastructure that tie these populations together. The three populations are defined as follows:

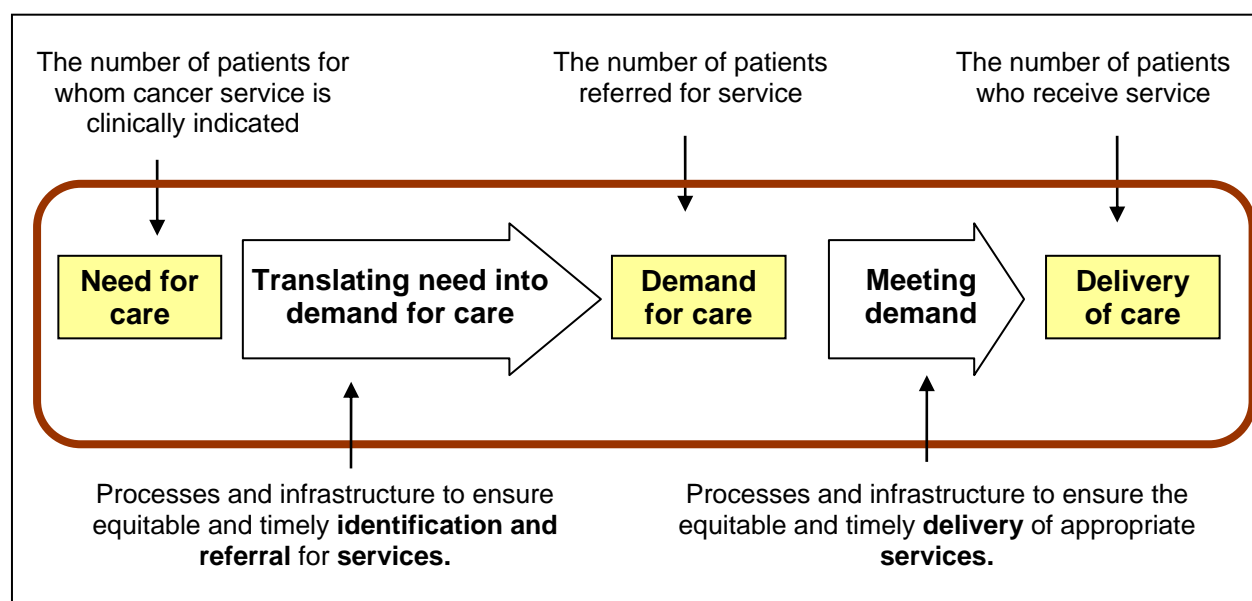
- Those needing care ("Need for Care"): This population is the number of people for whom cancer services are clinically indicated.
- Those referred for care ("Demand for Care"): This population comprises those patients that have been identified as requiring service and have been referred for service.
- Those receiving care ("Delivery of Care"): This population includes patients identified as requiring care and actually receiving the service.

The processes and infrastructure that move people from one population to the next have been defined as:

- Translating need into demand for service: The system must be able to ensure equitable and timely identification of patients for referral to appropriate services.
- Meeting the demand for service: The system must also be able to ensure the timely and equitable delivery of appropriate services.

These populations and the transition from need to demand to delivery of care are shown graphically in Figure 1.

Figure 1: The Access to Care Framework - System Components



COMMON DEFINITIONS

CCO has been reporting wait times for both radiation treatment and systemic therapy for some time. However, in its review of the current state of wait time reporting, the Committee realized that key event dates had different terminology, definitions and application between the three modalities of care. Accordingly, the Committee standardized the wait time event terminology and definitions across the modalities. The resulting discrete events are provided in Figure 2.

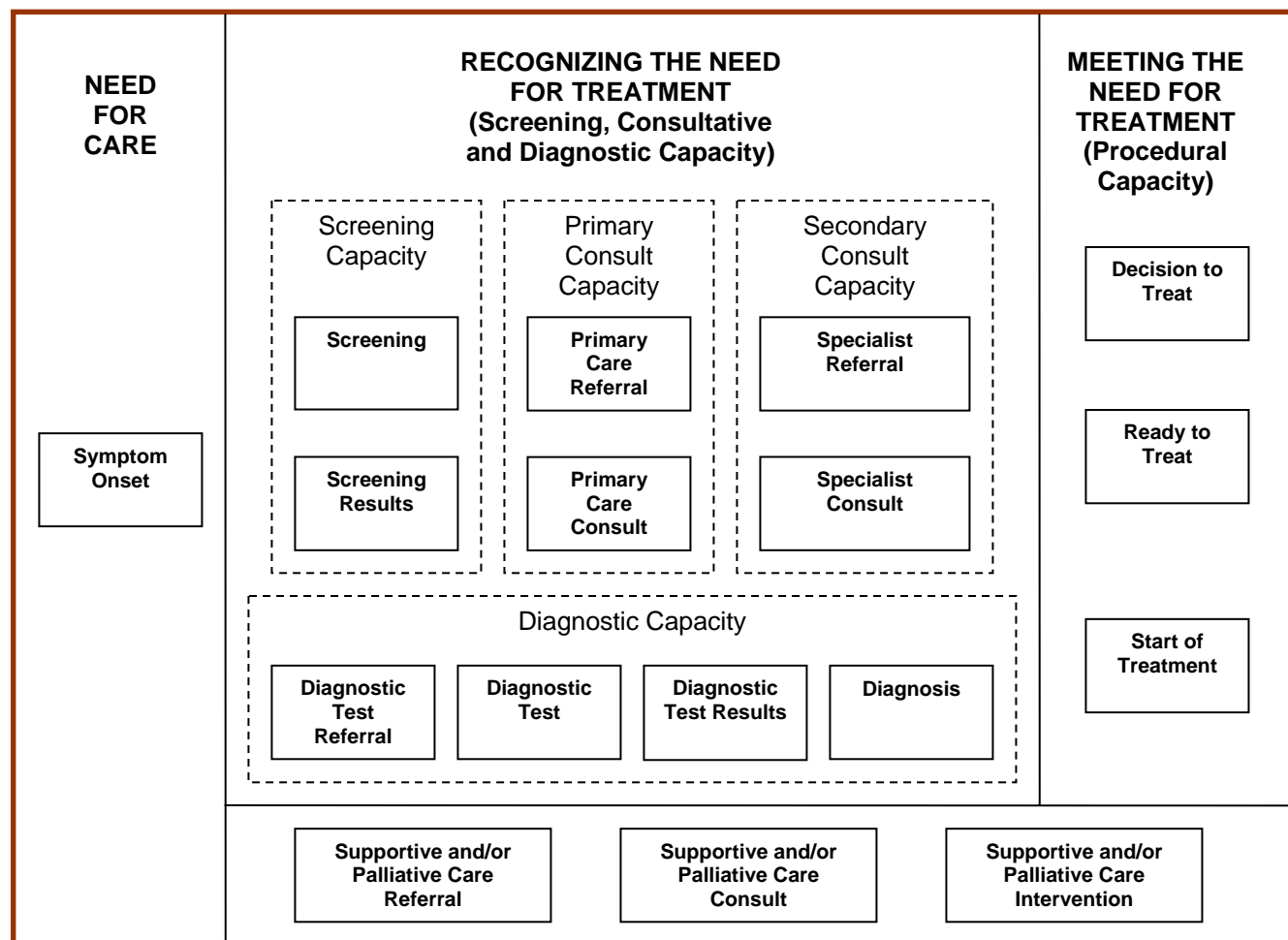
Most of the definitions are revised only slightly from current practice among the centres that submit wait time data. Only one newly defined event is expected to result in a significant change to data collection and reporting: the ready-to-treat (RTT) date. This newly defined event is the date on which any planned wait is over, and the patient is ready to begin treatment from both a social/personal and medical perspective.

The RTT date is the same as the decision-to-treat (DTT) date unless there is a planned wait. The Committee further defined a planned wait, which is any delay that cannot be attributed to a system access issue and includes delays due to:

- Other cancer treatment first.
- Patient choice (e.g., vacation or other personal business).
- Physician choice (e.g., for medical reasons).

The introduction of these standardized definitions will provide a common basis for the measurement and evaluation of wait times across the province, regardless of modality. The implementation of a ready-to-treat date to address planned waits will also provide more meaningful wait time information for system managers.

Figure 2: The Access to Care Framework - Events in the Cancer Care Continuum



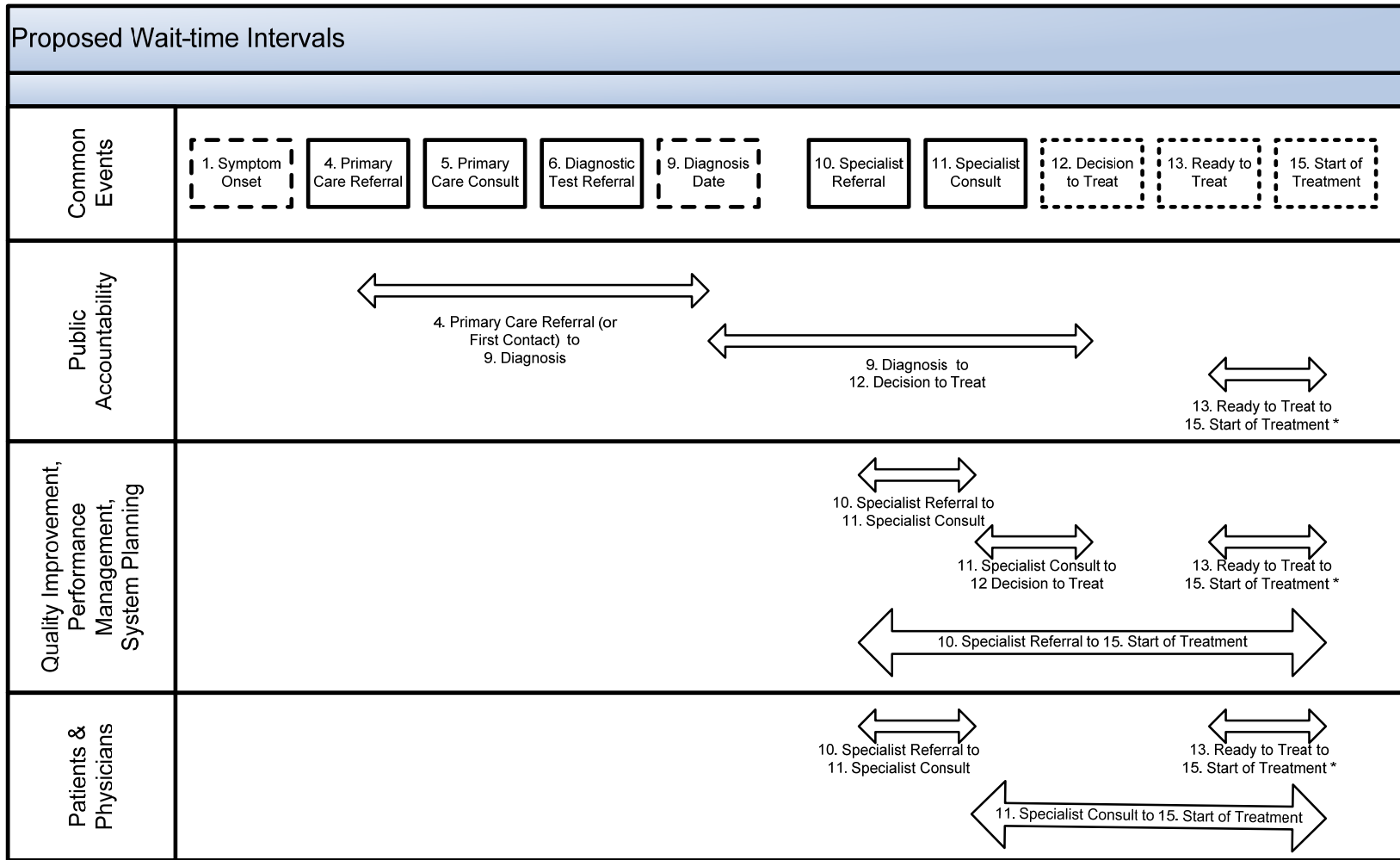
WAIT TIME INDICATORS

The Committee recommended different wait time indicators for different audiences:

- To monitor **accountability for public resources**, the Committee identified three overarching wait time intervals intended to provide the “big picture” of how the system is performing. Collectively, these three intervals span the time from the first contact with the cancer care system to the start of treatment (excluding planned waits).
- For **system administrators and managers**, the Committee (given limited scope/mandate) focused on access to treatment and recommended three intermediate intervals and one comprehensive interval.
- For **patients and their physicians**, the Committee recommended intervals focusing on the patient’s needs once referred to a specialist.

The proposed wait time intervals are shown graphically in Figure 3.

Figure 3: Proposed Wait Time Indicators



Note: Events are not necessarily in sequence. For example, the diagnosis date may precede or follow the specialist referral and consult.

All patients will have this date

Treated patients only will have this date

* = assumes the gap between Decision to Treat and Ready to Treat is attributable to planned delays (e.g., adjuvant therapy) and not system issues.

The Ministry's Health Results Team concurrently developed its own approach to monitoring, measuring and reporting wait times for surgeries, including cancer surgery. It was revealed during the latter part of the project that there are some discrepancies between the two approaches in defining the interval for surgical delay. Both measures are intended to address the same underlying issue, namely how to eliminate the distortion introduced by planned waits, while still capturing any waits attributable to the cancer care system (e.g., timely completion of diagnostic tests, timely acceptance of referred patients). However, the concept of ready to treat does not exist in the Ministry's Wait Time Information System (WTIS) data model, although this date can be inferred from the information collected (i.e., the final date the patient becomes available for treatment).

The potential impact of this difference in methodology cannot be quantified at this time. Further, the added value of collecting detailed "off-list" information (WTIS "unavailable dates") is not known, although it has been suggested that the data collection effort required will be significant.

The impact of the different approaches to measuring planned waits is important because the Committee has endorsed the principle of being as closely aligned as possible with the Ministry's Wait Times strategy, as well as the principle of having a consistent approach to the measurement and reporting of wait time information across the three treatment modalities. To remain true to these principles, the Committee recommended the following:

- That CCO adopt the RTT data point and introduce its collection for radiation and systemic in 2006/07 as part of this transition strategy.
- That CCO make recommendations regarding the use of the RTT date to the WTIS Project Team.
- That CCO work with the Ministry and the first five WTIS hospitals to understand the impacts on data capture and reporting for cancer surgery and incorporate this information into future planning.

Three additional changes to the committees' recommendations were agreed to by committee chairs, subsequent to broad consultation, but prior to publication of the final report. In order to better align with Ministry direction and prevent confusion:

1. "Target maximum wait times", the term originally selected and agreed to by all sub-committees, was replaced with "target wait times".
2. The goal of 95% of patients seen within the target time was reduced to 90%.
3. The term "urgency" was replaced with "priority".

TARGET WAIT TIMES

Each subcommittee was asked to develop TWTs that could be used to monitor and evaluate the relationship between system capacity and the demand for treatment and to plan for appropriate capacity. These targets will be used as a system management tool to identify resources required to meet the implied service levels and to direct resources where they are needed most urgently to meet these service commitments. These targets will allow planners and administrators to know how and when to intervene at a system level to improve cancer care for patients.

The TWTs are not intended to guide clinical decisions about the urgency of the need for treatment for an individual patient. They are designed to measure how quickly services are provided to patients relative to how quickly the treating physician believes the services are

needed. Treating oncologists will continue to have the flexibility to assign a longer or shorter wait time for individual patients as they do now.

The development of a consensus opinion on priority categories and TWTs was based on the literature review, as well as existing standards. Because of the limited available evidence on appropriate wait time intervals for the treatment of cancer, the consensus discussions of the subcommittee members, based on their collective clinical experience and expertise, played a vital role in framing the details of the recommendations.

The recommended TWTs for each of the three treatment modalities are presented by priority category in Table 1.

Table 1: Summary of Recommended Target Wait Times for Cancer Surgery, Radiation Treatment and Systemic Therapy

Priority Category	Target Wait Time (calendar days)		
	Referral to Consult	Consult to DTT	RTT to Treatment
CANCER SURGERY			
1	NS	Immediate	Immediate
2	NS	14	14
3	NS	14	28
4	NS	14	84
RADIATION TREATMENT			
1	Immediate	Immediate	Immediate
2	7	NS	7
3	14	NS	14
SYSTEMIC THERAPY			
1	Immediate	Immediate	Immediate
2	7	NS	7
3	14	NS	14

DTT = Decision to treat date RTT = Ready to treat date NS = Not specified
 All modalities recommend that 90% of cases be completed within the TWT.

It was recognized that these targets could not be achieved overnight and would have to be phased in over time. Annual targets will be determined through consultation between CCO and the hospitals and will take into account local resource limitations and current operating efficiencies.

The development of TWTs is a dynamic process. As the system gains experience with the implementation of the targets, evaluates its performance and the impact on patient outcomes and quality of care, the targets can be refined to reflect this new knowledge. Over time, new literature will be published to provide a better understanding of the science supporting targets and clinical practice patterns will change, resulting in refinements to the original targets. The TWTs in this report are not an end point for the system, but rather a starting point for ongoing continuous quality improvement.

WAIT TIME ACCOUNTABILITY FRAMEWORK

The wait time vision was articulated from two perspectives:

- From the patients' perspective, all cancer patients in Ontario will receive appropriate cancer services within the TWTs as close to home as possible.

- For the providers' perspective, all institutions that provide surgery, radiation and systemic therapy for cancer patients in Ontario will deliver services within the TWTs.

Common definitions, indicators and TWTs alone cannot reduce wait times. To drive improvement and reduce wait times, the cancer care system needs a coordinated approach for using these tools to reduce wait times for cancer surgery, radiation treatment and systemic therapy within a clearly communicated accountability framework. The Committee established five guiding principles for the development of such a framework:

- Responsibility to reduce wait times is shared by the Government of Ontario (the Ministry of Health and Long-Term Care and the Ministry of Education Development and Training), CCO, clinicians and administrators. All stakeholders need to work together to drive improvement.
- All parties will have clear roles in the timely generation, use and evaluation of high quality wait time data. All parties will be held accountable to fulfill these obligations.
- Deviations from the targets will be addressed immediately through a clearly defined process that will include root cause analysis and concrete action plans that are implemented in a timely fashion to improve wait time performance.
- TWTs will be updated regularly to reflect the most recent evidence and clinical consensus available.
- The system must provide appropriate incentives and disincentives to drive needed behaviour to reduce wait times.

As part of the accountability framework, the Committee identified five different stakeholder groups with accountabilities at local hospitals, at a regional level, and at the provincial level. Each of these players has unique responsibilities at each step in the wait time improvement cycle, as summarized in Table 2.

Table 2: Areas of Direct Responsibility for Each Stakeholder

Stakeholder	Areas of Direct Responsibility
Clinician	Deliver service, record data, implement improvement plans, communicate with individual patients
Hospital	Allocate resources to meet targets, implement improvement plans. Collect and report hospital data. Hold clinicians accountable.
CCO-RVP	Monitor data, oversee root cause analysis, develop action plan for local and regional issues. Broker knowledge and champion solutions regionally.
LHIN	To be determined.
CCO-Provincial Team	Support inter-regional knowledge brokering Set and maintain provincial targets. Collect and report provincial data. Report to the public (shared with government) Develop action plans for system-wide issues. (Includes advising government on policy and resource allocation through the Ontario Cancer Plan) Offer advice, consultation and direction regarding individual and regional improvement plans. Enforce relevant contractual obligations. Engage in performance management responsibilities to ensure performance expectations are being met per various agreements at the system, regional and organizational levels.
Government	Set system priorities and make resource allocations (Operating, capital and human resources). Hold CCO accountable. Public reporting (shared with CCO).

SUMMARY

This document is intended to guide CCO, the regional cancer programs and other partners in improving access to cancer services. Working together in the context of this framework, will lead to better information for patients, providers and system managers and ultimately, improved access to cancer services for patients.