

# CANADIAN PAEDIATRIC SURGICAL WAIT TIMES (CPSWT) PROJECT



**Editor's Summary:** The *Canadian Paediatric Surgical Wait Times* project was the first project to use standardized national access targets to measure and manage wait times for children and youth waiting for surgery across Canada. The project is an unprecedented collaborative venture of 16 children's hospitals in eight provinces. The initiative was funded by Health Canada and resulted in national benchmarking, best practice sharing and improved access to care at participating hospitals. The project achievements were based on both consensus and the use of comparable data. The establishment of national standards and accompanying strategies for managing wait times are the foundation for significant future improvements.

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**Participants:**

B.C. Children's Hospital			Stollery Children's Hospital
The Hospital for Sick Children			Saskatoon Health Region
Alberta Children's Hospital			Winnipeg Children's Hospital
CHU Sainte-Justine			Kingston General Hospital
Centre hospitalier universitaire de Sherbrooke			Children's Hospital of Western Ontario
McMaster Children's Hospital			Janeway children's Health and Rehabilitation Centre
IWK Health Centre			Children's Hospital of Eastern Ontario
Montreal Children's Hospital			IBM Canada Limited
Centre hospitalier universitaire de Quebec			

<b>Purpose:</b>	Before the onset of this project, most wait times initiatives were focused on adult procedures. There was a lack of information on paediatric surgical wait times, inconsistent methods of prioritizing paediatric patients, and little knowledge-sharing across Canada's Paediatric Academic Health Sciences Centres (PAHSCs). The goal of this project is to collect and measure wait times using a central database and national standardized access targets, to enable benchmarking by participating hospitals and national comparison.
<b>Context:</b>	Unlike provincial wait time initiatives, participation in this project is voluntary. Led by the Surgeon-in-Chief of each of the Paediatric Academic Health Sciences Centres, it is a very large, unprecedented, collaborative venture, and to the best of our knowledge, the only project of its kind in the world.
<b>Resources:</b>	Operating \$: ___2.6m Stage I + 9.8m Stage II_____ FTEs: ___ 26 Stage I (16 Sites), 67 Stage II (32 Sites)_____
<b>Source of resource:</b>	<input checked="" type="checkbox"/> <i>In kind</i> contributions from the organization <input type="checkbox"/> Dedicated internal funding <input checked="" type="checkbox"/> External funding (example grant, Ministry etc.)
<b>Population group:</b>	Paediatric patients waiting for elective surgery.
<b>Patient flow entry and end points:</b>	Surgeon decides to treat and family consents (entry point). Surgery performed (end point).
<b>Description/ approach:</b>	<p>Diagnosis-based access targets were adopted because:</p> <ol style="list-style-type: none"> <li>1. The ability to produce standardized data, as each patient with a given diagnosis defaults to the same priority level. This allows for National and local analyses, comparisons and benchmarking. This also prevents potential practice variance or "gaming" by clinicians.</li> <li>2. Patients are referred based on a diagnosis; so Wait 1 and Wait 2 can be captured using the same target description.</li> <li>3. Procedure names are not standardized across different institutions, provinces, and regions.</li> </ol> <p>Project Approach:</p> <ol style="list-style-type: none"> <li>1. Surveyed current clinical pathways for patients that did not meet access targets.</li> <li>2. Determined percentages of completed cases exceeding access targets.</li> <li>3. Measured and assessed how well participating hospitals met access targets through analysis of submitted data.</li> <li>4. Developed a standard Clinical Pathway Guideline to expedite cancer cases exceeding access targets.</li> </ol>

<b>Tools and tactics:</b>	<p>The Paediatric Canadian Access Targets for Surgery (P-CATS) are national standardized access targets. The priority is defaulted by diagnosis; once the diagnosis is selected by the surgeon the access target is automatically assigned to the case. The list of P-CATS diagnoses (with associated access target) was developed by over 100 paediatric surgeons in 11 subspecialty expert panels, representing the highest levels of paediatric expertise from across Canada. P-CATS use 7 priorities (from 24 hours to 12 months) across all surgical subspecialties.</p> <p>The Clinical Pathway Guideline is a compilation of best practices used at Paediatric Academic Health Sciences Centres to expedite cancer cases exceeding access targets through internal reallocation (99.95% of cases); rarely by transfer within region or province (0.05% of cases).</p>
<b>Measurement approach:</b>	<p>Wait time data collection using national standardized access targets started in September 2007 and is ongoing. Over 1400 monthly reporting packages included percentages of cases waiting out of window, completed out of window in each of six surgical areas. Data was reported anonymously, enabling participants to benchmark themselves with peers or comparable volumes across Canada.</p> <p>Data collection on patients using the Clinical Pathway Guideline, started on January 1, 2008 and is ongoing. Participating hospitals are required to record whether or not the Clinical Pathway Guideline was used for each Cancer Surgery case reported.</p>
<b>Impact/evaluation:</b>	<p>Many paediatric patients across Canada exceeded their access targets (“out of window”). The clinical pathway guideline, developed and implemented for patients waiting for cancer surgery, proved to be an effective strategy for reducing wait times.</p> <p>Participating hospitals reported internal benefits from participating in the project, such as: prompted process changes to improve operational efficiencies, informed resource re-allocations, active management of wait lists and decreased number of cases out of window, best practice sharing with peers, benchmarking with peers (of comparable size) from across Canada.</p>
<b>Observation/ Discussion:</b>	<ul style="list-style-type: none"> <li>•“Collecting data on this Project confirmed for me that standardized, diagnosis-based targets are a much better system for children. [It] allowed us make finer priority discriminations based on acuity, enabling us to prioritize some cases before others.”</li> <li>•“Without additional resources it is difficult to reduce wait times overall, but this data makes it possible to redistribute OR time more equitably, based on case acuity.”</li> <li>•“We’ve learned how to become excellent when you’re good. Our ability to do the right cases at the right time has increased.”</li> <li>•“I’ve learned that wait lists and wait times are two different things. You can have long wait lists but short wait times, and vice versa. This knowledge helps you to make the right decisions.”</li> </ul>

<p><b>Critical success factors/ lessons:</b></p>	<ol style="list-style-type: none"> <li>1. Both CEO and Surgeon-In-Chief for each hospital signed Participation Agreement; bridging surgical and operational arms of each Site</li> <li>2. Project funding for participants</li> <li>3. Strong governance structure to manage project included: qualified experienced project manager, Leadership Committee, Project Steering Committee</li> <li>4. Strong stakeholder engagement and collaboration strategy. Consensus reached on requirements through weekly calls with participants. Site Coordinator in frequent contact with participants to address specific needs</li> <li>5. Communications with provincial authorities and leveraging provincial requirements (where existing)</li> <li>6. IT: including collaboration website, Wait Time Data Collection Tool to minimize participants' workload</li> </ol>
<p><b>Limiting factors:</b></p>	<p>Stage II of this project is currently addressing some such factors:</p> <ol style="list-style-type: none"> <li>1.Capacity Analysis study to better understand the relationship between capacity and demand for surgery.</li> <li>2.Gather and share best practices in OR Performance Improvement to enable participating hospitals to understand and measure their efficiency</li> <li>3.Standardizing minor differences in data definitions across jurisdictions</li> <li>4.Develop Surgical Indications for one surgical procedure to ensure appropriate candidates for surgery be contained on surgical wait lists.</li> </ol>