

**APPENDIX E: ENVIRONMENTAL SCAN REPORT AND INTERVIEW GUIDE**

**WCWL ENVIRONMENTAL SCAN SUMMARY**

**Donald P. Schurman  
Helen M. Roman-Smith**

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# WCWL ENVIRONMENTAL SCAN SUMMARY

## **Purpose:**

- To obtain information on the usability, uptake and implementation of the WCWL priority tools in the seven RHAs participating in this project.
- Objectives:
- Describe the current practices of entering patients to a waiting list;
- Describe the acceptability of the point-count measures; and
- Describe attitudes towards and opinions about the implementation of the WCWL priority tools.

## **Study Design:**

- A semi-structured interview administered in-person with key informants.

## **Subjects:**

- Key informants within the seven participating RHAs, which included the Chief Executive Officer, the Chief Medical Officer or alternate(s) and the clinical head, administrative head, and booking clerks for at least each of two services for each RHA.
- Identification of key contacts was facilitated by input by the members of the WCWL Implementation Committee. Additional contacts were gained in an iterative process.

## **Methods:**

- An interview instrument (Appendix 1) was developed by members of the WCWL Steering Committee and the WCWL Implementation Panel.
- Key informants received an introductory letter, the WCWL interim report, and a background paper on point-count measures (Hadorn, 2000) within one week of the appointment.
- The questionnaire was administered in-person in the informant's city by a team of two WCWL interviewers.
- Each question was asked of each respondent.
- The interview was lead by the same interviewer while the second interviewer took written notes and asked questions for clarification.
- The interviews ranged in length from 45-90 minutes.
- All interviews took place in between December 20, 2000 and January 23, 2001.
- The notes were reviewed and themes were extracted and summarized in a final report.

## **Key Findings:**

### **Participation:**

- Thirty-nine interviews were conducted typically with one (n=21) or two (n=14) respondents at a time.
- In total sixty-six respondents participated across the seven urban RHAs in Western Canada.
- Twenty-nine percent (n=19) of the respondents were members of one or more WCWL panels or committees.

- The CEO of each RHA was interviewed in addition to twelve other senior administrators.
- Representatives from three services of cataract surgery, children’s mental health services, general surgery, hip and knee replacement surgery, and MRI scanning were interviewed in each region.
- Roughly half of the respondents were clinicians and the other half were administrative or support staff.

**Current Prioritization Practices:**

This section relates to the responses given to the first six interview questions that summarize the mechanics of waiting list compilation.

- The process of prioritization is highly variable. In most cases, judgements of urgency for planned surgeries and imaging services are classified in two to four categories (e.g., urgent and elective; urgent, semi-urgent and elective; ASAP, urgent, non-urgent; 1, 2, and 3; urgent 1, 2, 3 and elective) by the surgeon or referring clinician. Prioritization classifications are generally not structured and based intuitively.
- The priority codes are typically reported on the procedure booking form but are not transferred to the patient’s medical record.
- Cancer patients are frequently routed through the system as a separate level of urgency with established benchmarks for service ranging from seven to 28 days. In the case of children's mental health services when a referral is made to a program the intake worker (generally a non-clinician) tends to use an informal three level classification system, which is denoted in the patient’s medical record.
- Judgements of urgency are transferred to a position on a waiting list once the referral letter, booking form, or intake information is received. Chronological order is then maintained. Surgical services are most often scheduled from a single waiting list kept by individual surgeon. Medical imaging and children’s mental health services use merged lists by facility or program.
- Patients are booked for service by priority, case mix, chronology, and therapy modality. Occasionally the teaching value of the patient, or the “squeaky wheel” would impact the order.
- Waiting lists were equally managed by paper and computerized databases.
- Surgical patients who required emergent services were typically triaged into four categories and were accommodated either in a dedicated emergency operating room or by bumping another elective patient or by being added to the end of the slate that day. Children and adolescents requiring emergent mental health services are diverted to appropriate crisis intervention programs. Emergent MRI cases are either squeezed in, result in bumping or are added at the end of the day.
- Changes in the patient’s clinical condition, or social and economic factors or availability could change their position on the waiting list. Sometimes a change in position results from a cascade of system events such as a patient being bumped to accommodate a more urgent patient or equipment failure. A patient may be removed from a waiting list if the patient is no longer medically fit for the procedure, if the patient’s condition has resolved, if he or she has chosen to no longer have the procedure, or if the patient accessed another service higher in intensity.

### **Acceptability of Point-Score Measures:**

The following section addresses the responses given to the interview questions seven and eight.

- Implementation of the prioritization tool was considered feasible and beneficial for surgeon specific waiting lists and for use in a common waiting list with centralized booking such as a roster. Either by single or merged lists the additions of benchmarks for acceptable or maximum wait times was considered necessary to implementation.
- Some practitioners felt that to some degree they were already using a prioritization system that organized patients by urgency. They felt that prioritization within three to four categories adequately and fairly managed their caseload and that the application of points would not substantially change the order of their patients. Other practitioners believed that beyond establishing the highest degrees of urgency that chronological order was the fairest process to use when scheduling “true electives.” Some practitioners were not convinced that a prioritization tool could adequately capture the multitude of variables taken into consideration required when prioritizing patients.
- Advantages of using the point-count measures were improvements in patient care, transparency, fairness, and the protection of access to services for those most at need. Given that the tools were reliable and valid their use was considered more objective, consistent, measurable and auditable in the stratification of patients. The tools could aid in the efficient collection of standardized comprehensive data and that the data collected could be used in utilization predictions, outcome research, making comparisons (e.g., between practices, and urban centres), and the identification and communication of gaps in resources. With the development of acceptable wait time benchmarks the tools could help improve system accountability.
- Disadvantages include the need for education to increase the theoretical acceptance of point-count measures as being able to model the multi-variable process of patient prioritization, and training for its consistent use. A point-score system is believed to be more resource intensive and may require a more highly trained individual to administer the tool. Despite the increase in objectivity of the tools, they remain subjective and vulnerable to gaming and to “score creep” if tied to resource allocation. Regular independent aggregate monitoring would be required. Use of the point-count system could decrease professional autonomy, and jeopardize personal income. Lastly, the lack of a point-count measure for every service could lead to an uneven playing field.

### **Implementation Issues:**

The following section addresses the responses given to the remaining interview questions.

- The surgeons, physicians, and practitioners were consistently identified as the key players whose buy-in is important for successful implementation. Other key players identified were administrators, managers, technicians, the ministries of health and the professional associations/colleges. The patients, relatives, and the public were also included as needing to buy-in.
- The willingness to participate by all the key players and to support the process is seen as the greatest potential barrier to successful implementation of the point-count measures. A paradigm shift in practice philosophy, the acceptance of another form to complete, and the time to complete the tools is sizeable barriers to the successful implementation and consistent use of the point-count measures by the practitioners. A commitment for

additional infrastructure resources, such as personnel and IT to maintain the system is required.

- The acceptance of point-count measures to compare urgency of different conditions or procedures within the service was varied and dependent upon the service. Making comparisons across conditions is inherent in the children's mental health tool, the MRI tool and the general surgery tool, although there is debate as to the appropriateness of including cancer within the general surgery tool. Interest exists in the development of a tool that could be used across different imaging modalities and across orthopaedic surgeries.
- The comparison of urgency between services was considered unrealistic since “you would be comparing apples to oranges.” It was felt that certain procedures would always fall to the bottom of the list, such as hernia and varicose vein surgery and never get done.
- Point-count measures should definitely be applied in a standard manner within the region and ultimately across the province. It was viewed as advantageous if it could be more broadly applied in a standard manner across Western Provinces.

### **Limitations:**

- Approximately 30% of the respondents had been associated with the project prior to the interviews. There may be a selection bias as one can assume that project participants were more informed about the project than non-participants. However, the responses of participants and non-participants were not compared.
- This qualitative study did not sample a representative population of potential respondents. In turn, the opinions offered are those of the individual and cannot be generalized beyond the group interviewed.

### **Discussion - Critical Success Factors:**

The successful implementation of the WCWL priority tools will rely on a number of critical success factors, which include:

#### **Change management:**

- Adoption of the point-count measures system is a change in the “social contract” between physicians, “their” patients, and the system. In order for a new system to work, there must be a change not only in the technology available, but a change in the minds of those who, in effect, manage the wait lists. Physicians must be “enrolled” in this new way of doing business. Clearly, there must be something in it for them. But this does not imply direct financial gain. Rather they must be convinced it is better for their patients without any additional burden being placed on the physician’s office.
- Accordingly, for the implementation of the point-count measures to occur a change management strategy would need to be developed and widely adopted to garner acceptance of this approach. The change management strategies need to address the tendency to remain at status quo and the desire to game systems that are not individually endorsed.

#### **Refine tools, implement, and adjust:**

- The WCWL priority tools are still in the process of being refined. For some of those interviewed, the MRI tool lacks face validity. But while it is clear that the tools require further development, their effectiveness can only be tested in actual practice in a number

of jurisdictions. If at all possible these tool development and implementation efforts should include national professional societies.

**Implementation Logistics:**

- The logistics of implementation are complex. Implementation should proceed step-wise tackling areas prone to success first. If possible, implementation should also occur in multiple jurisdictions and the funding of this initiative should primarily be assumed by Provincial Health Departments across Western Canada. Clearly, most participants felt the tools must be applied consistently across a province.

**References:**

- Hadorn DC and the Steering Committee of the Western Canada Waiting List. Setting priorities for waiting lists: defining our terms. CMAJ 2000 vol 163(7):857-60.

**Appendix 1:**

**Semi-structured Interview Guide for the WCWL Environmental Scan**

1. How are judgements of urgency denoted or codified in the medical record?
2. How are these judgements transferred into a position on the waiting list?
3. How are services scheduled, exactly (including single/merged lists)?
4. What form does the waiting list take (e.g. paper logbook, computerized spreadsheet)?
5. When booking elective services, how is allowance made for emergencies?
6. What factors determine changes in position on waiting lists?
7. How might point-score measures of urgency fit into the current system in the RHA?
8. What advantages and disadvantages would be associated with point-count measures in your system
9. Who are the key players whose buy-in is important for success of point-count measures?
10. What are the major potential obstacles to implementing point-count measures in your system?
11. To what extent do you feel that point-count measures should be used to compare the urgency of different conditions or procedures?
12. Do you think that point-count measures should be applied in a standard manner for a service (same tool) across hospitals or facilities within your RHA?
13. Are there any issues that should have been discussed regarding the use of the WCWL point-count measures of urgency for elective procedures?