Patient- and family-centred care and efficiency: Complementary aims?

A REPORT ON THE SEVENTH ANNUAL CEO FORUM

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INTRODUCTION

We spend billions each year to provide millions of Canadians with healthcare. We educate and deploy thousands of people to provide that care. We strive to develop cutting-edge technology and breakthrough drugs. And we are woefully bad at using perhaps the most important healthcare tool of all: our ears.

Healthcare providers in Canada, from individuals to institutions, from policy-makers to professions, have consistently failed to listen to the people they serve. Patients and their families have traditionally been allowed to do no more than recite symptoms and complaints. The idea they might be important contributors to shaping and delivering care had no purchase. Care was done to patients, it was done for patients, but it was not done with patients. That view has changed.

Recently, as the importance of caring for the whole person has been recognized, efforts to reform healthcare by making it “patient-centred” have been growing, as have efforts to involve patients and their families in improving healthcare. We at the Canadian Foundation for Healthcare Improvement (CFHI) believe the transformation of healthcare cannot happen unless we demonstrate our commitment by dedicating time, planning and resources to engaging patients in the changes we all need. Redesigning healthcare to meet the needs and values of individuals, rather than treating patients as inputs in a vast healthcare machine, is clearly the right thing to do. But is it practical?

In early February 2013, we convened our seventh annual CEO Forum to explore the question of whether patient- and family-centred care and efficiency are complementary aims. We brought together leading clinicians and administrators to tell their stories of transforming care to make it more patient-centred, and we asked patients for their insights too. This report gives highlights of the Forum, and presents some of the growing body of evidence that patient- and family-centred care actually contributes to a more efficient and effective healthcare system.

A VOICE THAT SPEAKS TO THE NEED FOR CHANGE

There are different terms for the subject of the Forum — patient-centred care, patient engagement — but it comes down to listening. Listening to people who need care, and to their families. Of course, it goes deeper. You have to seek out input, build it into your structure, change your culture so your organization and people respond. But it starts with listening, and the Forum started with one woman telling her story, a story of care that was anything but patient-centred.

Shelley McKay was an elite athlete with a successful career, but domestic abuse left her with post-traumatic stress disorder, which she hid for many years; eventually, however, she attempted suicide, and was hospitalized. Afterwards, however, she faced another challenge: the healthcare system’s bias against mental illness. When she developed seizures, that bias meant security guards were posted by her bed in emergency, and the neurologist thought she was faking; he needed video proof before he would take her complaint seriously. When her daughter, who also suffered the abuse, recently attempted suicide, a hospital social worker told Ms. McKay not to be “pressured” by the girl, and refused to let them see a psychiatrist.

“I share this in hope no other patient has to share these very embarrassing judgments that coloured how I was treated medically and psychologically,” she told the Forum. She urged participants to train doctors to read patients better, to recognize the huge toll mental illness takes on individuals and society and to do a better job of integrating mental illness into the care continuum.
SHIFTING THE FOCUS TO VALUE

Where Ms. McKay challenged her audience to change their approach to people with mental illness, Alberta Minister of Health and Wellness Fred Horne urged a new attitude toward healthcare in general, because its status as an indelible Canadian icon gets in the way of improving a system that is “…very good, but by no means the best.”

We tend to mistake cost for value, Mr. Horne said, and to focus on pilot projects rather than long-term improvement. He also criticized our focus on what he called the “sharing and caring paradigm,” where just getting together to tell each other about improvements in care, as opposed to adopting ideas and making real changes, is considered success. “We need to move to make quantifiable differences,” he said. Just back from Europe, he urged Canadian health leaders to focus on continuous quality improvement, as European healthcare does, instead of looking for magic bullets to fix big problems all at once.

To achieve sustainability, he concluded, means we must start to “look at cost not value, look to primary healthcare to reorganize the delivery of services, and move from an information-sharing culture to focus on meaningful results.”

The issue of cost versus value echoed in a presentation by John Wright, senior Vice President of Ipsos Reid Public Affairs, which undertook a national survey of Canadians, specifically for the CEO Forum. Canadians were asked for their views of our healthcare system, particularly relating to access, care, communication and efficiency. The survey found a mild sense of improvement across the country on most issues, but ultimately, Mr. Wright warned, there was no reason to break out the champagne. Despite the billions of dollars that have been pumped into healthcare since the 2004 health accord (the “fix for a generation”), six out of 10 Canadians see no change in the system. Brenda McGibbon, one of a group of patient representatives invited to the Forum (to ensure that there, at least, patient voices would be heard) said that made her want to cry.

“There seems to be a disconnect between what ordinary people want and what exists, and unless you have patients talking about it and trying to do something about it, I don’t see really any other way to change,” she said.

BEGIN AT PATIENT-CENTRED CARE, ARRIVE AT EFFICIENCY

The goal of the Forum has always been to give healthcare leaders a chance to learn from each other’s strategies, perspectives and experiences and the balance of speakers at the 2013 event were there to talk about how patient-centred initiatives made their organizations more efficient. Here are a few examples:

Palliative and Therapeutic Harmonization (PATH)

Chris Power, CEO of Nova Scotia’s Capital Health Regional Authority, told the Forum about the PATH clinic. It was developed by two specialists in geriatrics concerned that elderly patients with multiple chronic conditions are subjected to too many treatments, but aren’t helped to understand what the impact of those conditions might be. Physicians, too, need to be educated to take a patient’s frailty into consideration when making recommendations for treatment. “We don’t treat the frail elderly well, not because we don’t care but because we don’t know,” Ms. Power said. Staff at the clinic work with patients and families to explain the high risks and often limited benefits of interventions such as heart surgery or dialysis. Ms. Power told the Forum that of the first 150 patients, 71 people were scheduled for a total of 77 different interventions. Seventy-five per cent cancelled surgery when they understood what its impact on health and quality of life would be, and 22 people chose not to undergo dialysis.
Trusting Babies to the People who Care the Most

Dr. Shoo Lee, pediatrician-in-chief at Mount Sinai Hospital in Toronto, imported an idea from Estonia to improve results for neonatal intensive care. On a visit there, he found it was standard practice to leave almost all care of delicate newborns to their parents. Nurses train parents in care, and administer medication and IVs, but parents do everything else, including charting. When Dr. Lee introduced the experiment at Mount Sinai, with some babies cared for by their parents and others by nurses, the results were remarkable: babies looked after by parents gained 25 per cent more weight. They also had no infections while 11.5 per cent of babies cared for by nurses did. Parents made no medication mistakes. Dr. Lee hopes parents will be primary caregivers in every neonatal intensive care unit in Canada within three years.

Telehomecare Keeps Patients Off the Road

The University of Ottawa Heart Institute is the only tertiary cardiac centre serving a wide area of eastern Ontario, Heather Sherrard, Vice President of clinical services told the Forum. Heart failure is the most common reason for admission to the hospital and readmission rates are as high as 25 per cent after one month and 50 per cent within the first year. With careful monitoring, however, readmissions can be reduced. More than 50 per cent of the Heart Institute’s patients come from outside the city, where rates of heart disease are higher. The challenge was to manage their disease remotely. The answer was very low-tech: monitoring devices were sent to clients by Greyhound bus. They are hooked up to the telephone, which typically everyone owns - unlike a computer. A nurse based in Ottawa tracks approximately 100 patients a day. The results were good: 70 per cent of patients had one to two admissions for heart failure in the six months before they got the monitors. That dropped to 15 per cent in the six months after receipt of the monitors.

TRANSFORMING CARE ONE PATIENT-CENTRED IDEA AT A TIME

- The Holland Orthopaedic and Arthritic Centre at Sunnybrook Hospital in Toronto switched to having advanced practice physiotherapists assess potential hip-prosthetic implants, freeing up surgeons to do more operations

- Saskatchewan shortened waits by moving some surgery into private, freestanding clinics to take pressure off in-hospital operating rooms

- C-CHANGE, an initiative that brings together stakeholders in cardiovascular disease, is working to reduce 450 sometimes conflicting guidelines to 30 clear, easy-to-follow directives

- Anndale McTavish, a patient representative, is the first person who speaks to new residents when they arrive at Kingston General Hospital, to tell them patients are their partners. “Hear me, respect me, work with me,” is her key message. And she wants Kingston’s model of patient engagement to spread: “For all of you in the room, start small, start anywhere, just bloody start.”

WHY CAN’T CANADA GET CENTRED ON PATIENT-CENTRED CARE?

Asked why good ideas don’t spread from one region to another in Canada, Nova Scotia’s Chris Power said too many people cling to the notion their organization or province is unique and ideas from elsewhere won’t work. “People often believe if it’s not coming from the ground up, if people in your organization don’t initiate it, it’s not right,” she said, adding “We need to get over ourselves.”
To help us all get over ourselves, here are ideas from the Forum that have made care more patient-centred — ideas that will likely work for you:

**Listen to patients**

Mount Sinai’s pilot project on parental care was designed by parents. Kingston General Hospital has 59 patient representatives, serving on every committee that has anything to do with patient care. “A patient at the table takes the bureaucratese out of the conversation,” said Dr. Mark Wyatt, of Saskatchewan’s Surgical Initiative.

**Give patients options**

In Saskatchewan, patients can choose to switch surgeons for faster care, but didn’t have to. At Sunnybrook, they can step out of the queue for surgery and then come back.

**Make real change**

Efficiency won’t come from tinkering, Sinai’s Shoo Lee said. “What I am talking about is changing the paradigm of care … we shut beds, we cancel surgery, but it doesn’t change the model of care. At the end of the day, we have to understand the model of care has to change.” Leaders have to drive the shift to patient-centred care, said Marie-Dominique Beaulieu, president of the College of Family Physicians of Canada. “Leaders must support quality. You have levers to help professionals to change their practice.”

**Rethink guidelines**

Few guidelines include patient input, patient advocate Dr. Sholom Glouberman said. “Top down guidelines are wrong-headed,” said Dr. Tom Noseworthy, lead on strategic clinical networks for Alberta Health Services. They are training patients to be members of research networks. “I guarantee that will change the dialogue.”

**Think ahead**

Saskatchewan was in a rush, and would have done better to go through a Lean assessment to establish what functions were necessary and what could be made more efficient, before putting money into alleviating waiting lists, Dr. Wyatt said. Never buy technology and then look for a patient to use it on, the University of Ottawa Heart Institute’s Heather Sherrard said. Nova Scotia had to cancel a policy to limit payments for diabetes test strips just four days after introducing it, because they had not done sufficient groundwork to gain support, Peggy Dunbar of the Diabetes Care Program told the Forum.

**Take a chance**

Smaller institutions can be more innovative because they’re willing to try an idea that sounds good, Dr. Lee said. “I’m not saying an evidence base is bad, but you have to be willing to try new things.”