Tomorrow's Challenges – Today's Realities
Making the Leap

2002 Ryley-Jeffs Memorial Lecture

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Abstract/Résumé

The premise of the presentation is a challenge to health care providers to examine the quality of services currently provided in health care facilities across the country. While the Canadian health care system is under scrutiny with numerous reviews and commissions, the underlying question is: are the structural changes making a difference? We need to consider the recommendations in the latest report from the Institute of Medicine, *Crossing the Quality Chasm*. The report calls for a sweeping redesign and suggests a set of ten new rules to guide patient/clinician relationships. Dietitians must take the lead on implementation of systematic changes, model the way and get involved in the necessary changes. As the report suggests, the gap between where we are and where we need to go in providing quality health care services is not just a crack; it is in fact a chasm.
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L'auteure fait reposer son exposé sur un défi lancé aux dispensateurs de soins de santé d'examiner la qualité des services fournis actuellement dans les établissements de soins du pays. Au moment où le système canadien de soins de santé fait l'objet d'un examen rigoureux par de nombreux comités et commissions, il faut se poser la question suivante : les changements structurels donnent-ils des résultats? Nous devrions tenir compte des recommandations du dernier rapport de l'Institute of Medicine des États-Unis intitulé *Crossing the Quality Chasm*. Ce rapport appelle à une refonte profonde et propose 10 nouvelles règles pour guider les relations patient-clinicien. Les diététistes doivent prendre l'initiative quant à l'implantation des changements systématiques. Comme l'indique le rapport, l'écart entre la situation actuelle et le but à atteindre dans la prestation de services de soins de santé de haute qualité n'est pas une simple crevasse mais plutôt un gouffre.
(Rev can prat rech diétét 2002; 63:134-139)

INTRODUCTION

At no time in the history of health care has the growth in knowledge and technologies been so profound.

And yet the performance of our health care system varies considerably despite the dedicated talented professionals and leaders who work in the system. Despite the mergers and affiliations that have occurred within health care services, little change has occurred in the way health care is delivered and the impact it has on the health status of Canadians.

What will be the future direction for health care, you might ask? Or, what should we as professionals expect? How can we play a role? What shall our role be to help to ensure a health care system that is both sustainable and effective?

Health care has been subjected to much scrutiny of late through the various reviews and commissions – Fyke (1), Mazankowski (2), Kirby (3), Romanow (4), and The Premier's Review in New Brunswick (5). In its current form, current habits, and current environment, the Canadian health care system is in serious trouble.

There are no silver bullets for a major overhaul and subsequent cure, but the premise for how we might build a better system comes from recommendations discussed in a recently released report from the Institute of Medicine, *Crossing the Quality Chasm* (6). I believe that we can learn a great deal from this report, which gave me a real sense of hope.

Many of you might be feeling that our industry is incapable of doing its job properly. Even more important, with health care prominently featured in the media, you might possibly wonder just how confident the public is about the quality of health care it is now receiving.

In fact, the latest poll released by Pollara (7) stated that while seven Canadians in ten are satisfied with the quality of health care they receive, their overall confidence in the system is falling. Their major concern is with accessibility to health care services. Waiting lists are far too commonplace in our system today. These waiting lists are for diagnostic procedures, treatments, and dietetic counselling, to name just a few.

If we believe what some of the pundits suggest, that by infusing more cash to the system, things will be fine, we can easily mislead the public and ourselves as well.

Table 1(8) highlights the discrepancy between dollars spent on health care and one of the measures of health status, life expectancy. While the U.S. spends more per capita

Table 1
Health expenditures and life expectancy in selected OECD countries
(OECD Health Data 2002)

Country	Health-care expenditures per capita – approx. (U.S. $)	Rank	Total health expenditures % of GDP	Rank	Life expectancy (years)	Rank
U.S.A.	$4,600	1	13 %	1	76.6	7
Germany	$2,700	2	10.6 %	2	77.7	5
Canada	$2,500	3	9.1 %	4	79	2
France	$2,400	4	9.5 %	3	78.8	3
Australia	$2,300	5	8.3 %	5	79	2
Japan	$2,100	6	7.8 %	7	80.5	1
U.K.	$1,700	7	7.3 %	8	77.4	6
New Zealand	$1,400	8	8.0 %	6	78.2	4

than most other OECD countries do, their life expectancy is the lowest. Japan, on the other hand, spends less than half of what the U.S. spends on health care and considerably less than what Canada spends, and yet their life expectancy is the highest. Why? If more dollars aren't the solution to what ails our health care system, what is?

Over the past five to ten years, there have been some major redesigns of health care systems in Canada. While the mantra for change has been the need to be more "customer centred" and more efficient with taxpayer dollars, the impact of these changes has yet to be measured.

Notwithstanding the Pollara results, if we look at the changes from our customer's perspective, we see that all is not so rosy.

Have the changes made an improvement?

In a recent article by Peggy Leatt et al. (9) from the University of Toronto, looking at integrated health care in Canada, the authors suggest we do not yet have an integrated health system. In most of the provinces and territories, we are making structural changes to simplify how we deliver health care and the integration of organizations through regionalization has moved that agenda along. For example, we now have a single food service department in a region where we used to have several. We are standardizing processes to improve efficiencies through the development and implementation of clinical pathways, for example, but are we making a difference for our patients?

After close examination, Leatt suggests that Canada has a series of disconnected parts, a hodge-podge patchwork comprising hospitals, doctors' offices, group practices, community agencies, private sector organizations, public health departments and so on.

Clients who have experienced our current health care system told the authors that they will know our health system is truly integrated when they:

- don't have to repeat their health history for each provider encounter. They say when a patient is admitted to a hospital, within the first 24 hours 35-40 people ask the same questions – name, physician, health number, etc.
- do not have to undergo the same test several times for different providers.
- do not have to wait at one level of care because of incapacity at another level of care
- have 24-hour access to a primary care provider.
- have easy-to-understand information about quality of care and clinical outcomes in order to make informed choices about providers and treatment options.
- can make an appointment for a visit to a clinician, diagnostic tests or a treatment with one phone call.

Kevin (10), aged 15, suffers from what is called "short bowel syndrome" i.e. he has too little bowel to sustain his own growth and health, so he is fed partly by a catheter that stays in his veins, pumping in calories through special fluids. Any of you who work in pediatrics know the challenges that Kevin faces. He has had numerous hospital admissions and is in fact an expert in our customer services. When asked after his tenth admission about the quality of care, or more specifically, "When things go great, what is it like for you?" and "When we fail, how do we fail?", this was his response:

> "Care is best when you tell me what's going on right away, when I get the same answer from everyone and when you don't scare me. Care is worse when they keep me waiting and when they don't listen to what you say (even when sometimes you know better) and when they do everything twice instead of once."
>
> He goes on to say:
>
> "Do you think you could ask me the same questions once or maybe twice, but not over and over and over again, as if you had no memory at all? Don't you ever talk to each other? Don't you ever meet?"

And so for us here today and for our colleagues who work alongside us in health care across this country, how do we make it better for our patients, for their families, for our funders and for our workforce?

I want to now share with you some of the suggestions made in the 2001 report *Crossing the Quality Chasm*.

The report presents a formula for raising the level of the health care quality. The report was released by the Institute of Medicine (IOM), which is one of three bodies that make up the U.S. National Academy of Sciences. The Institute of Medicine has a distinguished history of publishing weighty

Table 2
Simple rules for the health care system in the 21st century

Current approach	New rule
Care based primarily on visits	Care is based on continuous healing relationships
Professional autonomy drives variability	Care is customized according to patient needs and values
Professionals control care	Patient/client is the source of control
Information is a record	Knowledge is shared and information flows freely
Decision-making based on training & experience	Decision-making is evidence-based
'Do no harm' is an individual responsibility	Safety is a system property
Secrecy is necessary	Transparency is necessary
The system reacts to needs	Needs are anticipated
Cost reduction is sought	Waste is continuously decreased
Preference is given to professionals rather than the system	Cooperation among clinicians is a priority

reports on important subjects. It is putting forth a credible challenge to all of us who work in health care.

While this report has been developed and authored by leaders in the U.S., I suggest we need to take a very close look at what the report proposes. I suggest that the learnings from the report have application for health care practices here in Canada and more specifically dietitians in Canada.

The report puts forth recommendations, principles and case studies on how the future could be. It calls for a sweeping redesign and recommends a set of ten new rules to guide patient/clinician relationships (see Table 2).

A word about rules: they are interrelated and intended to build on each other, while the report focused on the health system as a system. I'm asking you as you read these ten rules and to think about how they relate to your own practice – be it as an acute care dietitian, a public health nutritionist, an administrator in a long-term care facility and as a patient yourself.

The ten rules

1. Care is based on continuous healing relationships

The old rule suggests that care is based primarily on visits to the professionals. The new rule suggests that we don't need face-to-face relationships. In fact, "the face-to-face act is a dinosaur" or so the *Wall Street Journal* (11) tells us.

The new rule states that care needs to be based on healing relationships that emphasize mutual trust between clinician and patient.

To establish a relationship, we all know that we need to have a human-to-human interaction. Think about important relationships that you have with your colleagues, your staff members, your patients – chances are you developed those relationships through face-to-face encounters. Now, when you need to connect with your colleagues, you can pick up a phone, send an e-mail and get your message across or ask a favour. The relationship is built on trust and respect.

Under the new rules, care would be available through many new modes of communication and would be accessible to patients exactly when they need it, any day at any time, not just between 9 am to 5 pm on weekdays. While e-mail may not work for some, it will work for many.

Through appropriate use of electronic communication, it may even provide the opportunity to have longer and more meaningful face-to-face visits when they do occur.

It's a fact that Canadians are more web-savvy than many other countries and the fastest growing segment of the population to use e-mail and the Internet are seniors! These numbers are growing.

2. Customization is based on patient needs and values

Today, we see far too much variation in practice in the name of practitioner autonomy and it happens across the system – surgeons, pediatricians, physiotherapists, nurses and, I dare say, dietitians.

It can be said that a system that holds this value fails to make the best use of scientific knowledge. Asking a practitioner to rely on his or her memory to store and retrieve all facts relevant to patient care is like asking a travel agent to memorize airline schedules. We need to deliver care based on best practices.

While patients/clients need to be assured of the standard of care they receive, whether they live in Montreal or Moncton, Saskatoon or Swift Current, they also need to be responsive to individual needs and respectful of their choices. The new rules imply that patient values should drive variability.

3. The patient is the source of control

To me, this is the essence of the report and presents the biggest challenge to our current practice. It has been said that our current health system is paternalistic; we know what's best, we'll do it to you and you will like it. Control over decisions, access and information is typically in the hands of the providers. The new rule asserts that, except in unusual circumstances, control should rest with patients.

A community developer once told me that the underlying principle of working in the community is "Nothing

about us without us". In other words, don't make any decisions about me without involving me. I suggest we need to practice the same guiding principle when working with our clients. While we say we do, the actions and processes that we use everyday contradict this value.

The research (12) shows that in fact the more information patients have, the better informed they are about their choices, the better the outcomes, the lower the costs and the higher their functional status, compared to those patients who tend to be more passive about their care.

Typically, health care professionals underestimate the extent to which patients want information about their care. Not all patients want to be involved, but they should be given the choice and clearly, patients vary in the extent to which they want to be involved in decision-making.

We all say we are client-centred, that our customers drive our practice. If that's the case, why don't we have late night counselling when patients and their families are able to coordinate their time?

A litmus test of how patient/client centred you are is to go back and look at your department meeting minutes – how often do you see the words patient/client/family mentioned?

The transfer of information, both scientific and personal, is a key form of care.

4. Share knowledge and information

The old way suggests that information is a record, often driven by the needs of our risk managers and legal counsel rather than by the sharing of knowledge.

The transfer of information, both scientific and personal, is a key form of care. This rule is all about patients/clients having unfettered access to their own health record and to clinical knowledge.

With the advent of web-based applications, it's possible for health records to be held physically or digitally in a variety of locations and to be accessed wholly or partly by the patient or anyone to whom she/he grants permission.

Our patients should have, indeed deserve to have, as much information as they can get, in order to decide what course of treatment is best for them and their family.

5. Decision making is evidence-based

A considerable body of research called evidence-based medicine has come about as a result of the awareness of the gap between the findings of research and practice. The basic tenet of evidence-based decision making is that what works is what matters most.

The findings of evidence-based medicine show up in three areas:

- **Overuse**, when we use procedures that can't help a condition. There are far too many examples of where we continue to use procedures and tests when we know they have little or no impact. For example: we know that 50% of x-rays for back pain are unnecessary and yet the procedure is still ordered. Another example is the mergers and restructuring in health care that have taken considerable time, energy and media attention in the 90s. While almost every province in the country has seemed to jumped on the restructuring bandwagon, the jury is still out on whether or not restructuring has had any impact at all – either on overall efficiency and/or on the health status of our population.
- **Underuse**, when we know something works and yet we don't seem able to effect change in practice. For example, 50% of the elderly do not get flu immunizations and yet we know they have a positive impact on illness. And we know that the replacement of certain physician functions with other practitioners – nurse practitioners, for example – is the right thing to do but we hesitate to implement such actions.
- **Misuse**, when the evidence is mixed: we're not sure who, when and where to use certain procedures and/or where there are errors in executing procedures. We know that 7% of hospital patients experience an error in their care.

The recent announcement (13) by Dietitians of Canada that they have joined the Cochrane Network is a step in the right direction. The Cochrane Collaboration is an international organization that aims to support health care professionals make well-informed decisions about health care by using the evidence to make decision.

6. Safety is a system property

In 1999 a report entitled *To err is human: building a safer health system* (14) was released. This report stated that 60,000-100,000 people die annually in U.S. hospitals as a result of error – more than all deaths combined of those who die from motor vehicle accidents, breast cancer and AIDS.

We have no reason to believe the situation is any different here in Canada. In fact, estimates (15), suggest that 10,000 Canadians die every year as a result of preventable mistakes in hospital or adverse events as they are often called; that's about 3% of our patients. The Canadian Institute for Health Information (CIHI) and the Canadian Institutes of Health Research (CIHR) jointly announced and appointed a National Steering Committee on Patient Safety, chaired by Ross Baker from the University of Toronto whose mandate it is to:

1. Provide strong clear and visible attention to safety
2. Implement non-punitive systems for reporting and analyzing errors with organizations
3. Incorporate well-understood safety principles such as standardizing and simplifying equipment, supplies and processes

Accountability that relies on blaming individuals stands little or no chance of achieving significant improvements. New systems must move the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm.

In most cases, the problems come from poor systems, not bad people. *Bad systems make good people look bad.*

7. The need for transparency

Health care should be uncompromising in its defense of patient confidentiality, a matter of great concern to all of us. But the pursuit of confidentiality is not a reason for hiding the system's performance from those who depend on the system for care. The old way was to keep information from patients.

In the future, the rule should be: *have no secrets*. Ensure that anyone involved in the system, including patients and their families, can make the most informed choices and know at any time whatever facts may be relevant to a patient's decision making. We owe it to our customers and to our funders to show them the results of our work.

8. Anticipation of needs

Why are we surprised and even cranky when sick people show up at our doors? Not only are we surprised, we are currently in a reactive mode. The new system suggests that we need to organize health care to predict and anticipate needs based on knowledge of patients, local conditions and a thorough knowledge of the natural history of illness.

The latest report (16) on the rising incidence of obesity in Canada will have a significant impact on the practice of dietetics. What are we doing as a profession to work with our partners in health care to stem this tide of unhealthy citizens?

9. Continuous decrease in waste

The old way of achieving this is often a 2% reduction across an organization's budget and we know that's not an effective or equitable solution.

The new rule suggests that asking our workforce to work harder, faster and longer will not solve the problems, nor will taking out 2% from budgets.

Rather, increased value will come from systematically developed strategies that focus on the aims of the health care system including:

- effectiveness,
- timeliness,
- patient-centredness,
- efficiency,
- equity and
- safety.

We know that waste can take many shapes and forms including:

- **Overuse of services**, e.g. – prescription of antibiotics for the common cold. Almost all colds are caused by viruses for which antibiotics are not effective treatment and yet the utilization patterns show that in 40-60% of encounters with the health system for the common cold, patients had prescriptions filled for antibiotics.
- **Transportation.** Patients who are transferred from one floor to another or from one building to another are often a signal of waste. All too often I have walked through a door at one of our health care institutions while a patient (often elderly) is being wheeled in on a stretcher, coming from another facility. It is expensive moving the patient rather than the practitioner, and also extremely unsettling for the patient to have an ambulance ride, be transported through a public area, and ride in an elevator.

10. Cooperation among clinicians

The current system of licensure that protects the scope of practice in fact shows too little cooperation and teamwork. Patients suffer through lost continuity and redundancy when we don't respect each other's notes and findings. Remember Kevin – "Don't you ever talk to each other?"

The new rule focuses on good communication among team members, using all the expertise and knowledge. The rule of thumb needs to be "I have this information, who else needs it?"

The underlying theme of these ten new rules is systems thinking; we can no longer correct the system in pieces or fix pieces of it independently.

The challenge

I would like to introduce you to Don Berwick. He is one of those extraordinary human beings who have a passion for people, health care and quality. He is a pediatrician in inner city Boston and over the past ten years raised the consciousness of health care providers about the quality of care we provide. He has also presented a challenge to us as health care providers to improve the quality of health care not only in the U.S. but also Canada, Great Britain and elsewhere. He is the founder and CEO of the Institute of Health Care Improvement (IHI) (17).

Dr. Berwick was instrumental in producing the Chasm report and at a recent conference where the report received considerable attention, he shared with us how these ten rules could be translated into action.

[A short video was shown that demonstrated how to put the ten rules into action. For information on how to obtain a copy of the tape, please contact the author.]

The tape illustrated some humorous incidents that reveal resistance to and reliance on current systems, using the characters of Dr Newway and Dr Olderway. The skit effectively reveals to us how dietitians might also be reliant on current systems and challenges us to rethink them.

So what's the message for dietitians?

Clearly, many of these new rules involve systems change and we alone can't make that happen. However, I believe that dietitians are equipped with the skills and talents to take the lead on many of these changes, to model the way and to get involved in system changes. Over the years, we have seen where dietitians have been instrumental in sparking changes within health care organizations across this country and in the words of Margaret Mead:

"Never doubt that a small group of committed citizens can change the world. Indeed, it is the only thing that ever has".

As the report suggests, the gap between where we are and where we need to go is not just a crack; it is in fact a chasm. Are you ready to make the leap?

In the words of Arthur Ashe,

"Start where you are
Use what you have and
Do what you can."

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