Innovation and Efficiency

Ideas around *Innovation and Efficiency* were discussed often in the Conversation on Health. Participants covered topics like service delivery and innovation, best practices, capital planning, and administration and management in their exploration of this topic. Here is a selection of what British Columbians had to say on the subject of *Innovation and Efficiency*.

Service Delivery and Innovation

Participants expressed their frustration that there seems to be a lack of focus on innovation in the health care system. In particular, they explored ways to improve the quality and efficiency of service delivery. Some, for example, pointed to misuse of the helicopter ambulance service, unnecessary testing, inability to track patient misuse of the system, duplication of programs and strategies within and between health authorities, and an apparent inability to set priorities within the system.

Participants encouraged government and health authorities to seek out and implement efficiencies throughout the system. For example, they suggest permitting pharmacists to re-fill prescriptions under limited circumstances. This, they argue, will reduce the need of chronic disease sufferers to see a physician or specialist when a simple refill is all they need. Other suggestions include: doing more regular testing at home with simplified reporting mechanisms so the doctor can see test results without the need for a visit; understanding the costs of individual tests and procedures and comparing these around the system to find the most efficient approaches, and then adopt these approaches everywhere; and centralizing more services, like sterilization.

Some participants believe that the lack of patient input into the system leads to overlooking areas where efficiency, innovation and quality can be achieved. Solutions suggested ranged from a patient bill of rights, to comment cards available to all patients as they leave facilities and a feedback loop to ensure that comments and suggestions are acted upon.

A number of participants talked about their experiences in the system and the apparent lack of coordination of patient care, resulting in duplication of tests, improper diagnoses and waste. Similarly, some believe that there is insufficient rigour in the system to manage patient demands, meaning that treatments, tests and procedures are often undertaken without meeting clear evidence-based criteria.
Some argue that patients will visit a walk-in clinic, the emergency room and their family doctor for the same ailment. Sometimes this is due to a lack of information about where to go, and sometimes it is about patient preferences. Often, participants suggest a provincial overview of service delivery in order to move patients to where there is space for tests or procedures. Similarly, participants recommend good discharge planning, streamlining the coordination of services, and methods to help patients cope with their conditions. Specialized clinics, designed to handle a specific procedure, came up time and again as a way to help move patients with particular conditions through the system quickly. There is general support for more options and smaller settings for procedures and treatment to reduce reliance on hospitals. Similarly, participants raised mobile clinics and diagnostic tests as options for service delivery to rural communities, improving access, ensuring faster testing and diagnosis, and possibly averting serious conditions before they progress and require acute care.

Participants are concerned that there is no funding to pursue and implement innovative ideas. Many feel there are no mechanisms to seek out those ideas and study or test them. There is some support for the Innovation Awards and the Innovation Fund, but participants want to see innovation as part of the ongoing business of health care, and not a special event. Some suggest an external committee or panel of experts who would constantly search out innovative ideas around the world and recommend their application to British Columbia.

> It would be helpful to have an experienced "soccer Mom" scheduling the specialist's time. No one should have to wait two hours in a cast clinic when they have an appointment. Yet everyone does wait, it turns out they book 3 patients for every 15 minute time slot and they get delayed every day as they take ER patients first. If it happens this way everyday why not change the way this is scheduled???? The patient's time is just as valuable as the Doctor's.

- Online Dialogue, Surrey

Evidence-Based Decision-Making and Best Practices

Participants are concerned that the health care system seems unable to consistently study and apply best practices from British Columbia and around the world. They argue the system needs a shift in culture to an environment that embraces change, identifies its needs and finds its solution. Systems need to be implemented that will continuously improve health care delivery and operationalize innovative ideas and practices. Participants argue that we need to seek out and implement best practices, rather than always trying to re-invent everything.
While some participants believe that the current focus on evidence-based practices is suspect because scientific proof sometimes appears fleeting, others argue that a strong foundation in evidence will ensure that health service delivery is always based on the clearest scientific evidence supporting positive health outcomes.

Similarly, there is an ongoing debate about the usefulness of pilot projects. Some believe that pilot projects are an effective way of testing an idea or new approach. Others, however, suggest that we use pilot projects to avoid implementing anything new. They cite examples of successful pilots that ran out of money and were never implemented. For these participants, pilot projects are only useful if there is a commitment to implementation once they are proved to be successful.

*I think that if we’re going to be moving ahead and making major changes in our thinking outside the box, one of the overlays we really want on that is a strong evidence-based scientific evaluation of these things before we bring them in and after they have been brought in,… [and] they should be evaluated to a high standard.*

- Focused Workshop Health Human Resources, Vancouver

**Capital Planning, Infrastructure and Equipment**

Participants are concerned that there is no apparent capital planning to ensure efficient purchase and implementation of facilities and equipment. Participants believe that capital planning is not considering the future demographic trends, nor the most recent advances in facilities planning to guard against infection and ensure the most efficient patient care. Participants understand that the demographic make-up of the province will continuously change, and they encourage planning more flexible facilities to accommodate the consequent shifts in demand.

Participants suggest using other public facilities, such as closed schools or recreation centres, to take the load off of health facilities during busier periods. Some participants suggest more energy efficient practices in hospitals would save in operating costs, and recommend everything from hallway motion switches for lighting to turning off computers, and heat recovery systems. Another common suggestion was to use expensive diagnostic equipment throughout the day and night wherever possible.
Similarly, participants worry that there is little organization around procurement, and the result is that health authorities do not take advantage of their collective purchasing power. There is no provincial-level procurement strategy to ensure cost-savings wherever possible. Procurement of medical technologies was a focus of some participants. They suggest a provincial procurement strategy on medical technologies that would support the purchase of these technologies when they are needed, after studies to determine whether they are the most efficient answer to patient requirements. Similarly, some participants argue that medical technologies should not only be seen as an expense but also as a growth area, and that British Columbia should be investing in the development of medical technology here, for sale elsewhere.

Health care should not be pigeon-holed in people's minds as a 'social issue' or merely 'public spending.' Health care research and innovation has the potential to be more of an economic generator, returning substantial benefits to the community, and reinforcing and enhancing public health care.

- Vancouver General Hospital and University of British Columbia Hospital Foundation, Submission

Administration and Management

Administration was often criticized as being too top-heavy, inefficient and unresponsive to patient and front-line requirements. Participants recommend streamlining health care administration and management, from the Ministry of Health through to the health authorities. They also recommend the elimination of departing executive payouts and reduction in executive salaries.

Administrative practices were often criticized as resulting in duplication, wasted effort and poor patient outcomes. Clerical work required by health care practitioners was viewed as both unnecessary and time-consuming, taking away from good patient care. Some participants suggest business process mapping in order to understand the administrative processes, then eliminating waste and duplication. Some also recommend that we undertake external measures of service quality and efficiency to ensure that we have the most efficient management and administrative systems possible. Centralized administrative services, such as human resources and information technology, were recommended to avoid duplication and waste within and between health authorities. Some recommended turning to private delivery of certain services to avoid costly and inefficient administrative practices.
Participants blamed inefficient scheduling practices for poor morale, over-work and inability to retain good personnel and recommended that new and innovative approaches to scheduling be introduced.

Participants expressed frustration with the lack of transparency and efficiency in scheduling and referring to specialists, diagnostic tests and procedures. Many saw the need to return to a general practitioner in order to get a referral to a specialist, even for chronic disease sufferers who return to the same specialist repeatedly for care, as particularly problematic. Participants recommended province-wide referral systems, objective criteria to manage referrals, different rules around specialist referrals and assigning administrative duties to staff.

A surgery that may go overtime [is] not allowed to start because the hospital would incur extra payment for nurses and support staff. Thus a significant proportion of the operating rooms are not being used efficiently lying idle while patients wait. The private surgical clinics are able to work more efficiently and see patients more quickly because they have no such bizarre restraints.

– Online Dialogue, Vancouver

Conclusion

Participants are frustrated with what they see as inefficient administrative and procurement practices and unnecessarily bureaucratic steps in the overall management and administration of the health care system. They also are concerned that the system does not pay enough attention to best practices and evidence when making decisions and introducing new procedures. Their suggestions ranged from the introduction of external review processes designed to seek out and implement best practices from across the globe, to business process reviews that would investigate specific administrative processes and determine ways to make these more efficient. Participants consistently want to ensure that the health care system is delivering care using the most efficient and innovative practices possible.
Innovation and Efficiency

This chapter includes the following topics:

Service Delivery and Innovation
Evidence-Based Decision-Making and Best Practices
Capital Planning, Infrastructure and Equipment
Administration and Management

Related Electronic Written Submissions

A Vision for 2017
Submitted by the BC College of Family Physicians

Submission to the BC Conversation on Health
Submitted by Society of Specialist Physicians and Surgeons

Physicians Speak Up
Submitted by the British Columbia Medical Association

Submission to the Conversation on Health
Submitted by the BC Cancer Agency

Sunshine Coast Conversations on Health
Submitted by the Women’s Health Advisory Network, the Sunshine Coast Hospital and Health Care Auxiliary and the Seniors Network Advisory Group

Improving Rehabilitation Services for the People of British Columbia
Submitted by the Physician Working Group on Rehabilitation Services

Advancing Healthcare in British Columbia Through Medical Devices and Technologies
Canada’s Medical Device Technology Companies

Advancing Leadership and Innovation In Specialized Health Care in BC
Submitted by the VGH and UBC Hospital Foundation

Recommendations for Better Health Care
Submitted by the British Columbia Optometrists Association

Saving Money By Saving Patients
Submitted by Leta Sinclair

Recommendations for Improvements to Healthcare Services for Seniors
Submitted by Mary McDougall

2020 The Future Without Breast Cancer
Submitted by the Canadian Breast Cancer Foundation
Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Health Care Spending and Patient Safety.

Service Delivery and Innovation

Comments and Concerns

Quality and Efficiency
Coordinating Patient Care
Access and Demand Management
Service and Facility Availability
Innovation
Information

• Comments on quality and efficiency:
  • Change management in Canadian health care over these past twenty years has largely been focused on trying to create a short-term dramatic shift through the intermediary of a crisis, usually based on financial-sustainability pressures.
  • No simple criteria exist for choosing between the competing use of funds, and the effectiveness and efficiency of different health care interventions.
  • Family physicians find many patients checking to confirm the diagnosis or approach after having seen a walk-in provider: a source of waste and re-work.
  • The health system uses a service delivery model designed to meet the needs of service provision, not to meet the needs of individuals seeking health care. While it is recognized that the goal is person-centred care, we aren’t close to achieving it.
  • By opening hospital laundry services to the competitive bidding process starting back in 2002, service levels have increased, quality has improved and costs have been dramatically reduced.
  • No one solution is without complicating issues that most of us likely haven't even considered.
  • The major savings in health care expenditures in the past twenty years have been through providing the same care cheaper. Much of health care twenty five years ago consisted of putting the patient to bed, often in hospital and caring for them. Fewer interventions were performed. The patient either recovered or did not. Frequently they suffered complications as a result. This also maintained high
costs. Over the interim we have learned. We do more investigations. We perform more interventions. Length of stay for many routine diagnoses is shortened. More patients are treated at home. Results are improved. We institute more prophylactic measures. Morbidity is reduced. We save money. This compensates to a large extent for increased numbers of interventions.

- How is it possible to understand the need for head injury services without knowing the incident rate in adults and children across the provinces? This should be determined at the Ministry level, not left up to each health authority, which will result in variations across the province in terms of the care offered, as is the case with hip replacements.

- Funding from the provincial government to health authorities should not be based on their level of operating efficiency and patient outcomes. Many areas are not efficient because they do not have the funds to provide the care. Others are not efficient because they have too many patients and not enough money. Other areas are not efficient because they do not have the space or staff or are isolated. Some areas do not have the doctors to provide the type of care that comes in.

- Managers and human resources departments are unable to deter the abuse of the very liberal system regarding overtime and calling in sick from health professionals.

- The cleanliness is so poor because the cleaning is only being done once a day and everything is left dirty in the meantime. This is part of the reason why contagious diseases are being spread in the hospitals.

- The food is bad and the parking is a racket.

- Private sector involvement in support services is gaining popularity because it does save money and it does improve services.

- Health authorities are trying to get legal arrangements in place to allow families to pray for family members during operations. This can lead to faster recoveries and healing.

- Blanket testing over a certain age is expensive, time consuming, leads to many false positives and is generally useless.

- Using BC Ambulance Service helicopters for routine transfers of patients is a gross waste of money. They should only be used in cases of multi-trauma patients more than one hour from a trauma centre, as they were originally mandated for. Their continued misuse is due to poor management. Land transport should be used in most cases.
• A heart patient may need stents in one or more arteries. The rules require a certain percentage of arterial blockage before insertion can take place. The result is that a patient may get two stents put in on one occasion, but have to return in a short period of time for a third or fourth insertion to be made. This is ridiculous expense, and also bad medicine. It should be stopped.

• Do you think we need to introduce a system of patient accountability? The system is currently abused by many and there is very little incentive for the user to save the system money. So often we hear that health care is free in Canada, so why spend my own money to keep healthy, when I can simply check in at the local clinic if I get sick?

• Lack of competition prevents efficient delivery of services, better quality service and sustainable wage structures.

• There is a concern that some health tests, such as mammograms, may have unintended negative side effects. Similarly, some pharmacological treatments have negative side effects costing the system and the patient in resources and health.

• The health care system must find a way to track the expensive practice of some people who go from doctor to doctor and make repeated appointments, when they do not have illness, chronic or otherwise. A quota system on number of visits annually in this category, perhaps?

• There are four system levels at which change is needed: the experience of patients and communities (True North); the functioning of small units of care delivery-microsystems; the functioning of the organizations that house or otherwise support microsystems; and, the environment of policy, payment, or regulation, and accreditation, and so on.

• Compare health care to the private sector: the big three auto companies are going broke while Europe and Asia are expanding. Why? Because they pay attention to quality, not to lip service. Paying attention to quality results in a decrease in shortages of health professionals and reasonable wait lists.

• If we have a focus on service quality, we will improve Indigenous health. It is a separate and additional pathway to improving Indigenous health. The word under-serving is very close to undeserving, and we need to re-orient health services, especially those that are not Indigenous-based health services, so that they audit themselves to ensure that they provide best practice according to guidelines for the care that they provide to Indigenous clients.

• As there is no TPA treatment (TPA is a thrombolytic or clot buster drug) available in the Province for ischemic stroke victims, a patient living in the Kootenays
should immediately have been transported by air ambulance to Calgary, where the TPA treatment is available. This would be a less costly method of handling a person who has been diagnosed as having had a stroke, rather than all the hospitalization, therapy, counselling, and home assistance costs which are the result of palliative care. If both hemorrhagic and serious ischemic strokes were transported to Calgary, the Computed Axial Tomography (CT or CAT Scan) could be done on arrival in Calgary, therefore avoiding time delays with trips back and forth between Trail, Nelson and the airport.

- Unions prevent volunteer work in the hospital.
- Why are test results not given over the phone? This would save the time required to make another appointment. If the doctor wishes to see the patient again as a result of the test, this could still be done.
- Why is it necessary to space out the test requests? The option of getting them all on the same day could save time off work for some people, and speeds up the doctor’s diagnosis and recommendations.
- Some readmissions may be related to disease progression, but might some of it be related to not dealing with the root cause of the patient’s issues? There is research evidence to suggest that predictors of re-hospitalization include the following: lack of adequate support, premature discharge from hospital, non-adherence to medication and follow up procedures, substance abuse, and delay in seeking treatment. On the same unit, we have also job shadowed nurses. And we found that they were not attending to any of these predictors of re-hospitalization. Nurses are spending minimal time on patient and family coping, social support, and increasing patient self-care capacity.
- There are no standard diagnostic procedures in the Province. In addition, there are too many procedures ordered to test for the same condition.
- Blame is issued with no means for correction. The system becomes reactive and covers problems, but does not correct them.
- Achieving efficiencies is best achieved in an environment sheltered from fluctuations in clinical pressure. Some redundancy must be built into the system.
- We, in healthcare, have not looked at all our processes with anything like the scrutiny that most other industries have, and there is a lot that we are doing that we do not need to do, and which is wasteful. You could probably give higher quality health care at half the cost and give it to everybody on time.
• Richmond's Hip and Knee project has been very successful in reducing the wait times for hip and knee replacements, and has resulted in such efficiency that we are now the provincial if not national benchmark for length of stay and other measures.

• Patients have to stop at a pharmacy on the way home when they are released from the hospital. This is a hardship for single people who do not have help.

• Patients are being discharged too soon and are not able to care for themselves at home.

• What is really jamming the system is that there is a small percentage of people that require a lot of attention and resources. If you can deal with them with a dedicated group of people, that frees up the rest of the doctors and nurses and nurse practitioners to be more efficient, and to deal with the broader population that does not need as much. You then get a specialization in dealing with those people, rather than it being a rare occurrence, so that you are not learning as much as you would in a more specialized setting.

• There is duplication of programs and strategies.

• Visits to the doctor are always necessary for prescription re-fills, even in cases of chronic illness.

• In-patient priority encourages inefficiencies.

• Innovative programs in several provinces have shown that simply organizing hospitals' work better, introducing more specialized facilities (that is, hospitals that only do one type of surgery), and by using technology more effectively, public hospitals can become much more efficient and better at what they do. And these public solutions can drastically cut wait times.

• **Comments on coordinating patient care:**

  • Who speaks for the citizens having problems with the health care system? Patients do not have a collective voice or an ombudsman. Current patient advocates are health authority employees, so they are part of the system and therefore biased.

  • Of the key strategies that have underlined the development approach in Australia, the most significant probably is maximizing Aboriginal participation in policy, planning and delivery.

  • I am of the trans-gender community going through a transition over the next three years. I am appalled that I have no control over my own body in this process. The government mandates onerous counselling sessions that give assessors total control over me. The Province places trans-gendered people in harm’s way with
their unreasonable demands for a two year real life experience (RLE). These are third-world medical practices. If I was a woman looking for an abortion on demand, it would happen, no questions asked. Why the double standard? The government’s policy is overwhelmingly anti-trans-gendered care. We have no voice here.

- The procedure of going into the hospital a day or two prior to surgery for a pre-surgery meeting is flawed. Although they do tests, they know the results will not be available for four or five days, yet the surgery is scheduled in two days.

- After-operation care was very good. Nurses were available as needed and stuck to a timely schedule. The tools they needed to perform their tasks were close at hand. So this was good.

- Unfortunately, the historical emphasis on physician and hospital medical services has resulted in a fragmentation of vision care in British Columbia and other provinces, as services covered and degree of coverage varies depending on the patient and provider. In addition, there has been a disturbing trend towards separating the refractive and health components of eye care, especially as the level of publicly funded coverage for primary eye care services has been eroded, even though there is compelling evidence that considering refractive findings in isolation poses significant public health risks.

- Patients are spending their whole life running back and forth to various clinics to treat specific problems.

- When I make a hair appointment a month in advance, I get a phone call reminding me that I have to turn up tomorrow to my hair cut. Some of these medical procedures, tests and examinations are booked months in advance. There is no phone call to remind you, and there is no penalty if you miss that appointment.

- I pay if I am not there if somebody comes to fix my dishwasher. I think we are missing a huge section here that we need to examine, on how people take it all for granted and they do not feel it is important to turn up to some of these appointments.

- People are forced into the acute care system because the Medical Services Plan does not recognize the value of preventative care and complementary medicine (such as naturopaths or chiropractors).

- Doctors are only hearing one symptom or complaint per visit.

- Individuals are going to three or four professionals to treat one issue.

- Family doctors do not have access to good triage for specific complaints.

- How can we treat better to avoid repeat treatment?
• **Comments on access and demand management:**

- Patient expectations are completely different now than they were before. Patients are much more forward and do not always have the best information, so their demands increase.

- In New Zealand they have very rigorous clinical protocols around surgery. If you want a surgical procedure, you are going to be evaluated against a very clear protocol as to what the expected outcomes are: life expectancy, quality of life, and a whole range of criteria. If at the end of the day a panel has the authority to accept you as a surgical candidate. If you do not meet the criteria, you get a letter saying thank you for your request, and you are referred back to your clinical practitioner for follow-up. The public has come to understand that not everyone is going to get it because they ask for it. Decisions are based on upon very clear, defendable, clinical evidence and protocols.

- The thresholds of illness are changing. For instance, a systolic blood pressure of 140 used to be quite acceptable but now this threshold triggers a diagnosis of hypertension and the prescription of drugs.

- The other side of health disparities is privilege. So whenever we are spending our time looking at inequities, we should spend as much time talking about the problem of non-Indigenous privilege, because if someone is getting not enough of the service, someone else is getting more than enough.

- Access to outpatient rehabilitation services is unacceptably long even in tertiary facilities in Vancouver. There are no standards for rehabilitation services.

- When changes were made to out-patient care and discharges, the workload for both home care and outpatient therapy increased immensely. There is difficulty keeping up with demand. Longer wait lists for rehabilitation mean later intervention and poorer outcomes. Consider and plan for downstream effects of change.

- Why do doctors’ offices charge $100 for the transfer of my file?

- There are different care levels at different health care facilities.

- We need to focus on expediency and timeliness of care. The physicians have been called at three o’clock in the morning for years to ask if the patient can take a laxative. Now that is silly. It is not about professions trying to increase their scope of practice, it is about efficiency and effectiveness of care.

• **Comments on service and facility availability:**

- Walk-in clinics have turned into a non-accountable, stand-alone, limited opening times alternative to family doctors.
• Richmond Hospital has specialized in hip replacement with great success.

• There is not enough patient education offered, nor is there access to technology and terminology.

• Another area worth examining is the provision of intra-cellular X-ray spectroscopy testing in high risk populations to provide reliable quantitative measures of the relationship between specific types of food consumption and magnesium deficiencies in the population. If a significant number of cases of magnesium deficiency could be resolved through simple testing, nutritional counselling and supplementation, a considerable dent could be made in reducing down-stream costs to the publicly funded medical system.

• Research has demonstrated that prenatal ultrasounds are generally unnecessary in normally healthy pregnant women and yet many of these women will undergo at least one or more of these tests.

• Why are we using ultrasounds at a drop of the hat for pregnancy? Babies have been born for centuries without the use of a scan and I know moms with no apparent problem having five.

• One participant had sixteen radiation treatments, but since the hospital would not do it on the weekend, it took a month.

• Clinical practice guidelines are not always adopted or enforced for accessing diagnostic tests.

• A system whose discourse is dominated by interests will end up catering to those interests. Whether it is the pharmaceutical companies or the unions or the doctors or any other group, even though their interests may be legitimate, they are competing among themselves and it becomes a brokerage model. Well you cannot broker the public interest. You cannot broker fairness. If physicians get to practice wherever they want, why would you ever expect rural areas to be served?

• **Comments on innovation:**

  • We are told there is no funding, but then we see it spent elsewhere than on innovative ideas presented.

  • Innovation is not encouraged. When new ideas are presented, there is no funding mechanism to make them happen.

  • Currently, health care does not have discretionary funding to develop new programs.

  • Our systems, whether they are health or social or criminal justice, they are a product of bureaucracy, meaning you incrementally add and develop the system
over time and you rarely go back and fundamentally re-think it. So you are simply layering on top of it and gaining knowledge and improving. But you are never coming back to the big question: would you create a healthcare system based on dealing with the outcomes of the lack of intervention in the front? You would actually do something entirely different if you were going to start from scratch.

- Too often we let a jurisdictional debate stop us from doing the things that we need to do for the people that all of the jurisdictions are supposed to be serving.
- At the core of any concept of a sustainable system is the idea of adaptability. And at the core of the idea of adaptability is the ability to change. How do you recognize what is happening? How do you facilitate the appropriate direction of change? And how do you do so in a way that is actually enduring so that it is not a kind of a one-off flavour of the month.
- The generation that is currently in management is stuck in the nursing model. This creates burn-out and sick days which stresses our budget. Then we cannot afford a healthy workplace to reduce sick days. Management tries but is not successful at developing innovation in care because staff and management are nursing-focused.
- Successful change initiatives in culturally significant organizations are those that recognize the importance of culture and use its forces in the mutual interests of its stakeholders.

- **Comments on information:**
  - There is very limited information available prior to accessing the health care system, so we do not know who to contact.
  - People from different cultural communities will go to their own social contacts to get information in their own language.
  - There are huge cohorts of the population who do not know that they can self-refer to a physiotherapist, a massage therapist, a chiropractor, or any of those professionals. They do not understand that they have a choice and that there are different things that can happen for them when they make that choice. There are lots of people who are not informed consumers.
  - The media has played an education role in what interacting with health care system is like.
  - Health care is delivered broadly by the community and by other ministries as well. However, we are not allowed to know the mental health status of our clients, or share the application form for disability assistance. So we do not know whether the clients need to be treated differently or accommodated.
• I do not know if patients necessarily need more choices because they do not already know what is available. We really asked the larger population if they feel that they need more choices. When we have done some research around patient journeys, they already find the system very complex to navigate, and no one gives them an understanding of the whole system.

• The public tends to be captured by vested interests more than the public interest view, which is government's view. The public is motivated by fear and figures that if the government says one thing and a health care interest group says another, the healthcare interest group gets more credit. Government has lost the public relations communications battle. If you don't have a strategy for capturing the public mind to a different way of doing business and not to fear that change in the face of a predictable backlash from vested interests, then you will not succeed. When, at election time in Saskatchewan, the Nurses' Union puts up billboards that say that it is unsafe to be a patient in Saskatchewan hospitals, this is just fear mongering and hysteria. The government does not fight back. When neurologists in Saskatoon say you should go to Calgary for a neurological exam because you will die here, the system does not actually answer.

• Many of us do not know what our rights are, what our health care insurance pays for, or what we can expect the doctor to do for us. We need to be educated. We need to know how to maximize our time and make the most of our visit with the doctor. We need to know more about how the health care system works.

Ideas and Suggestions

Quality and Efficiency
Coordinating Patient Care
Access and Demand Management
Service and Facility Availability
Innovation
Information

• Ideas about quality and efficiency:

• Turmoil related to negative change management outcomes affecting surgeons or operating room structures and sterile processing support could lead to service gaps and the exacerbation of existing integration challenges and system-culture conflict. More importantly, service gaps inconvenience the patient and introduce avoidable risk. Our duty of care requires that we design and implement changes properly and with due diligence to transition issues.

• Chronic care patients should be able to have prescriptions refilled by pharmacists.
If we can control the small things, the larger vision of healthcare in British Columbia would be more efficient delivery of services.

Group specialists into hospitals. This works well in large population areas.

Savings from contracting out the laundry can go directly to patient care and reducing waitlists.

Eliminate recorded messages. We need a human to talk to.

The Interior Health Authority meal program should be cut out.

Improve emphasis on process-based treatment protocols.

There should be a watch dog committee that oversees the use of medical testing to ensure we are not doing too many tests.

WorkSafe BC gives way more support than does the health plan. This should be corrected so that all the plans offer the same services. There are too many plans out there under different ministries. Why is administration in multiple ministries doing the same jobs and asking for the same information when you could have one program that covers everyone?

Eliminate waste in usage of paper for filling out forms, including unnecessary forms.

Health care should not be pigeon-holed in people’s minds as a social issue or merely about public spending. Health care research and innovation has the potential to be more of an economic generator, returning substantial benefits to the community, and reinforcing and enhancing public health care.

When you have a blood test you should be able to phone your clinic and get the results and if you need a prescription refilled you should be able to phone your doctor and have it refilled by phone.

Pay for diagnostic screening tests to avoid expensive downstream effects of long-term illnesses.

Liaise between facilities to ensure that tests are not duplicated.

If regular blood pressure tests are required for a patient, issue them equipment so the tests can be done in the home. Results can be faxed, phoned or emailed into the doctor’s office.

Cholesterol testing in pharmacies takes the load off physicians and makes mass testing easier.

We have made incredible strides in efficiency especially with home care and shortening hospital stays. There are no more efficiencies to be found.
• X-rays are ordered for fear of lawsuit and to get patients out the door, sometimes multiple times. Because they are free, orders are usually for larger portions of the body than are necessary.

• It is said that we do not know what a procedure costs and how much time it takes. This smacks of a poor management team. So tighten up and streamline making the system more cost efficient.

• In Vancouver most of the hospitals have their own sterilization facility. For all bulk sterilization, one central facility should be established to take care of the needs of all the major hospitals in Vancouver and the surrounding areas. This kind of facility could reduce costs drastically and increase the efficiency while eliminating duplication.

• A waste management and quality control agency should be set up in every hospital to police the amount of waste that takes place in the hospital, and to see that quality control is maintained for all the goods and services that are used. This Agency should also be responsible for any fraud and theft that may prevail in the hospital.

• Issue hospital and physician report cards.

• Avoid discrimination based on risk factors. Instead, the health care system should take responsibility to help individuals change.

• To reduce infection rates, all staff should wear uniforms and be trained in cleaning adequately. Cleaning standards should be returned to the pre-2000 level.

• Free up the ambulance attendants from having to remain at the hospital until the patient is seen by the doctor; then they can attend to the next patient's transport to hospital faster. It may turn out to be more of an emergency.

• We have no capacity for independent oversight of our health care system, and we are one of the few jurisdictions in the world that does not have any. We have no ombudsman, we have no quality health council, we have nothing, and most of the jurisdictions in Canada have got something. We have zero.

• Focus more on quality of care and less on the budget or bottom line. Re-orient to what is important to individuals and their families.

• You can do quite a bit about changing the current system we have within our budgets, and there are a lot of inefficiencies in that system that you can still capitalize on, not necessarily transferring money from one budget to another but in doing it better. So the homeless outreach we are doing we are funding internally because it actually does save some effort in our office. We have long ago given up on the idea that the money tree will grow, but if our success is only
measured by volume, by the number of bodies that are processed through a system and by how large or how small our deficit is, those are the only things we are going to do, and we need to start measuring other things.

- Our health care system has all the resources it needs: it is just that we are very wasteful.

- New technologies will expedite many routine medicals.

- There is a real need for unions and health authorities to sit down and collaborate and talk through what they are doing. We can work things out together and develop processes and procedures to work more efficiently.

- The Ministry of Health should be the program evaluation body. They would oversee the health authorities. The issue of quality would be left to an independent body set up for that purpose.

- We need to actually take some units, whether they are acute care or residential care or community health units, and bring some experts in who understand job re-design and actually say, we are really going to take a look at what the patient population is that comes in here, and we are going to take a look at what those people need and we are going to say on this unit these are the competencies that are required, therefore this is what we need.

- Sell three days' worth of drugs to patients on release from hospital, which would save the patient time and trauma and the cost of having to stop to purchase medications on the way home. This allows the hospitals to earn money from selling the drugs, but three days' worth is not enough to take the business away from the pharmacies. It also allows patients to go directly home.

- Simplify the system so that people do not have to go to so many places for services, tests, and so on. It is too bureaucratic.

- More sittings of the Legislature should be implemented in order to deal with important issues.

- Health care should be removed from political influence and become a permanent infrastructure with funding based on best practices.

- Bring in outside evaluation consultants to re-organize and streamline processes.

- Existing wastes must be located and corrected. Front line professionals can tell you where those wastes are and how they could be corrected.

- Efficiency in operating rooms needs to improve. Start operations on time. Do a time and motion study to monitor physician behaviour.
- Develop a system of routine audits to pin-point inefficiencies and highlight best practices. Report the audit results so that the public, providers and government are equally aware of what is working and what problems exist.

- Maybe we need to close some beds for a week or ten days and get the people on the unit to work with a job re-design expert who will start over rather than trying to fix what is there.

- Core capabilities should be identified within the infrastructure to identify opportunities for improved products, processes and outcomes. Improvements and solutions, however, should be looked for inside and outside of British Columbia.

- Competition will drive choice and efficiencies.

- Create efficiencies in system administration.

- Establish acceptable levels of service by first getting input from front line staff. Administrators need to understand front line jobs. Then take a common sense approach to establishing acceptable levels of service.

- Create quality assurance programs.

- Focus on prevention, partnership, treatment and education.

- Reinforce basic service delivery processes and administration, such as record keeping, continuity of care and complementary support.

- Review delivery of service and financial compensation to find efficiencies in system.

- Develop a screening reminder system like the one used for mammograms. It works well and should be used for other screening.

- Comment cards should be more readily available to patients. All patients should be asked at least once a week how their stay has been. All patients should be given the opportunity to fill out an exit survey.

- There should be a forum in place to ensure that when patients do actually write a letter to health officials expressing concerns, there is at minimum a response acknowledging the letter has been received.

- Have a patient advocate that is not connected to the health system.

- Facilitate the establishment of a good consumer representation process.
• Individual patients should have an information sheet given to them as soon as a diagnosis is mandatory. There should also be a care plan for survivorship and guidelines for health surveillance, and these should be given to the patient, caregiver, and doctor.

• Develop a breast cancer awareness kit, distributed by surgeons.

• The Cancer Agency needs to give patients direction and the ability to research other avenues.

• Create an accountable entity within the provincial health care system with the mandate to provide a vision and strategic plan for rehabilitation services that meets the needs of payers, administrators, service providers and consumers. Develop minimum standards for rehabilitation services at the provincial, regional and community levels. Develop standardized outcome and performance measures for rehabilitation services. Develop a human resources plan for rehabilitation providers.

• Patients and their families should be encouraged to report experiences regarding treatment or services they received while in hospital. These reports would be made directly to a department within the health ministry. Additionally, all front line health care staff should be encouraged to anonymously participate in a yearly survey facilitated by the same department. Who better than patients and front line health care staff to provide information of what is really is going on in the hospitals? Utilizing the data received, government would be in an ideal position to bring forth the concerns (and praises) that have been expressed with the health authorities. This in turn would allow the health authorities to bring these issues to the individual hospitals and give them the opportunity to address them.

• Have a patient bill of rights.

• Draw from the experience of patients.

• We need whistle blower legislation to protect staff and families who push for answers regarding quality of care and patient safety. It needs to be an official and easily accessible avenue of communication.

• Develop an understandable feedback loop to inform doctors, government, the general public, patients, administration, nurses, and so on how to improve the use of our health care system.

• Issue report cards by patients about doctors and emergency care and customer service cards to comment on service.
• **Ideas about coordinating patient care:**
  
  • Undertake a policy review regarding transfers between facilities.
  
  • A ministry dedicated to provide services and healthcare to seniors and committed to ensuring collaboration between branches of the Ministry of Health, the health authorities and community organizations would support greater opportunity for collaboration, an end to duplication, and accountability for funds expended through tax dollars.
  
  • Somebody mentioned that something is initiated and nobody knows what happens. If you go to the Mayo Clinic there is somebody who is put in charge of your file when you walk in the door. Somebody follows your file all the way through. You might only be there two days. But when you are finished, they make sure that you have seen everybody, that all the tests are back, and the consultation note is out.
  
  • We need investigative experts or a team to act as soon as there is a suspicion of cancer.
  
  • There should be a breast cancer diagnosis to plan in one week.
  
  • Adopt over-capacity protocols province-wide so that all hospitals have an organized and effective approach to manage situations where demand exceeds capacity. In addition to increasing the absolute number of acute care beds, inpatient bed capacity should be improved by optimizing bed management such as expedited discharges and discharge processes.
  
  • Direct people to where there is less wait.
  
  • You need continuity from diagnosis to treatment, including coordination between practitioners and improved information flow.
  
  • We need to include a rehabilitation perspective in the emergency room.
  
  • Using community nursing, take groups of patients and walk them through the system.
  
  • Group patients and the types of care to be delivered in a coordinated way.
  
  • Streamline the integration and coordination of services for both seniors and the chronically ill.
  
  • Increase the interaction between hospitals and family doctors.
  
  • Good discharge planning is required.
  
  • Involve more ethnic organizations to help patients cope with language and cultural differences.
• Implement a middle person between the doctor and patient to improve communication. People will organize visits to the doctor, medications, personal care, tests and so on.

• One of our problems is publicizing and then rolling out what is working well. For example, there has been a lab callback program in Kelowna that has been very successful, and it has been in place probably about four years but has not been rolled out to any other labs yet. This is a private lab and they have got all their physicians signed on, and they have got their patients signed on. If you have diabetes, every three months you get a notice to come in and get a A1C test and results get sent to both you and your physician. And if there is a problem, there is a little note that says that you should book an appointment. The patient then needs to call to book an appointment. So it works in terms of managing the secondary prevention piece, that somebody else is actually doing that coordination rather than the physician.

• Merge the Ministries of Health, Social Services and Children and Families because integration leads to communication.

• Flag at-risk and heavy-use patients and provide them with a care co-ordinator.

• Try to combine lab test requests into as few separate visits as possible, thereby aiding in a faster diagnosis.

• Early diagnosis can improve treatment, efficiency and effectiveness.

• An independent panel could review decisions made by specialists and hospitals, investigate conflicts of interest and review manipulation of wait lists.

• Ideas about access and demand management:

  • Go back to addressing the sources and causes of demand through a systems orientation.

  • We should look at innovations that manage demand.

  • Educate people so that their expectations of the medical system are lower.

  • With the pressure on the healthcare system, we are going to have to make sure that whoever gets access to the public purse is providing clinically effective and cost effective treatment.

  • Close acute care beds, stop hangnail surgery, lump and bump removal and all the unnecessary procedures that cost the system so much and contribute so little to health care.

  • Our goal should be to make the best use of all the community resources in the health care system.
• Mobilize laboratory services.
• Create specialized clinics to push through high volume operations and speed up wait lines.
• More mental health clinics are required.
• There should be a colonoscopy program for those over 50 and more screening for skin cancer.

**Ideas about service and facility availability:**

• Provide treatment options and training for physicians to allow treatment to be decentralized.
• Implement a northern regional health centre with specialists.
• Why not let the testing units be used in off-hours by private practitioners, for a fee per hour for the lease of the equipment, to perform tests on people who are prepared to pay.
• Why do we not have mobile screening and testing facilities as they do in Washington?
• More diagnostic facilities should be made available at clinics.
• Utilize specialty medical or surgical centers where equipment and health care people can be more efficient with much improved results.
• Make Medical Resonance Imaging machines (MRIs) available. Have them privately-owned, but the service paid for by public funds.
• It would be helpful to have an experienced soccer Mom scheduling the specialist's time. No one should have to wait two hours in a cast clinic when they have an appointment. Yet everyone does wait. It turns out they book three patients for every 15 minute time slot and they get delayed every day as they take emergency room patients first. If it happens this way everyday why not change the way this is scheduled? The patient's time is just as valuable as the doctor's.
• Implement a leadership role for the G.F. Strong Rehab Centre (or its future replacement) as the Province's main provider of tertiary adult rehabilitation services, including: transparent and equitable access for citizens of all regions in the province based on need and appropriateness; leadership in rehabilitation research, education and professional training; and, support for regions through outreach, education and dissemination of information.
• With regard to the suggestion that walk-in clinics extend hours of operation to 24 hours a day and seven days a week, do we have a sense what the peak times are? Could we adjust hours to accommodate peak demand, rather than jumping to 24 hours a day and seven days a week?

• Health services need to work beyond business hours.

• Increase services and equipment available.

• Look at having surgeries and services working later and on the weekend.

• Implement specialty hospitals or licensed facilities to take care of chronically ill seniors and those near death.

• Make available a direct phone line in emergency departments to the nurse hotline.

• We need more and smaller options for health care rather than hospitals.

• Implement clinics for pap tests, sexually transmitted diseases (STDs), and sexual health. These would be open in the evenings and provide information on options for sexual health.

• Until a fully-staffed, centrally-located regional hospital is built in the West Kootenays, transport the stroke patient by air ambulance to a center that offers TPA (a thrombolytic medication or clot buster) treatment or, arrange for a patient to receive a Computer Axial Tomography (CAT or CT) Scan and necessary examination and treatment in the Kootenay area.

• Put the nurse hotline on the back of CareCards.

• Separate acute care and chronic care facilities.

• Create more global non-profit clinics with a prevention approach.

• Urgent care would have diagnostic facilities located in a hospital with a large and well-organized triage system.

• Implement streamlined emergency clinics operating 24 hours a day and seven days a week for basic services.

• 24 hours a day for clinic operating hours is unnecessary. Four o’clock to ten o’clock in the evening are the peak hours.

• **Ideas about innovation:**

  • Implement start up funds for reengineering systems. Funds should be available for programs with a solid three year payback and ongoing savings. Initiatives should demonstrate the ability to improve outcomes.
• The Ministry’s innovation awards are really good, but not very well publicized. They recognize innovations, but no one is aware of the awards or who receives them.

• Frequent changes in leadership reduce the ability to follow through on working, effective initiatives.

• Implement a rehabilitation secretariat or a health care professional secretariat that provides advice to the minister before money is given out so that nothing is overlooked.

• With regards to improving the system, we need to start small with initiatives that are proven and have been shown to make a difference and begin to utilize those in pockets within the health authorities to influence how people operate differently and change their practice.

• They figured out in the United States, in intensive care units, that if you control the blood sugars, your death rate plummets and the length of stay plummets. With all of these $5,000 a day services, it is amazing how sometimes the simple things will get you such a huge payoff.

• Establish a blue ribbon panel for health care that would be a decision making body that could make recommendations to government. It would be composed of experts from across the health field and also include cross-provincial representation. The panel would report to the Minister of Health. It would address the issue of costs in health care. The notion of having a non-political, but strong evidentiary base of experts to help shape and guide the development and delivery of older adult services for British Columbians is still what we are looking for. You need the ability in that group to analyze everything and to come up with the best case scenario, not just based on feeling or wants, or this is best so we should do that. It has to be a group that can be questioned at any level and be able to substantiate what they recommend.

• What we need to do is have more leadership and strategic direction at the provincial level: some kind of innovations council, a body that has a governance structure that is very broad-based, that has a lot of legitimacy that looks at best practices and evidence, that does teaching that looks at what is really working out there. It would really look at the cost effectiveness issues with a lot more focused attention. This is not happening in the individual health authorities because there are not enough resources.

• The experience of Alberta is a good one. Over the years they have had ongoing blue ribbon panels advising their government around services for seniors. They are not perfect, but they do some things very well. In Alberta long term care,
there was a quality crisis that then caused the Auditor General to come in and do a report on all long-term care facilities in Alberta, which then caused a whole bunch of recommendations. I do not want to have to wait until we have the quality crisis before somebody says we had better do a review of this.

- I think that innovators in hospitals should not be made to feel like they have to creep around the walls of the hospital and be termed a maverick. We have discouraged innovation because we have tried to make people toe the party-line and do the right thing because we are all concerned about safety.

- We need to encourage and resource innovation. That innovation could be as basic as a palm-pilot type of tool that collects information at the point of care, to all kinds of other operational and technological innovations.

- The system has to be prepared for ambiguity and messiness because you are going to have the very traditional stuff that is not going to shift and you do not go there first. Then you have this really engaged group and you have got to be ready to shift parts of the system. That is where the tension starts emerging and it gets complicated to know how far to go while at the same time allowing it to be a voluntary grassroots process.

- Targets, incentives and battles are the determinants of change. In this country, we never set targets and if we do we set them nine years out and we are careful not to define what they mean. It lets people know they can relax, that the change is not serious.

- Create an arm's length group that approves innovative ideas and programs. They could evaluate the data and evidence and encourage sharing of programs and innovations.

- Implement a performance management system that drives behaviours based on client satisfaction and a social model of care (complemented by the traditional and somewhat existing medical monitoring and measures).

- **Ideas about information:**

  - Government should provide a report on where the cut-backs ($2.2 million) benefited the system. For example, how did they benefit home care? Do we have improvements in acute care as a result?
  
  - Develop a directory of services in the phone book and have a general information phone line.
  
  - Generate a central database of services across regions.
  
  - Electronically track patients between services such as walk-in clinics or NurseLine to emergency rooms using tracking identification.
• There are confidentiality issues. If a primary care physician wants to get their data from the hospital, whether their patients were admitted or not, there are hoops to go through as a result of rules around confidentiality.

• Educate the public about available resources.

• Develop a set of standards that must be adhered to regarding the release of information to patients and families.

• Have more communication with the families of patients.

**Evidence-Based Decision Making and Best Practices**

**Comments and Concerns**

*Evidence-Based Programs and Studies*

*Pilot Projects, Best Practices and Implementing Success*

• Comments on evidence-based programs and studies:

  • There is a need to stop the advertising and impressions people get from studies and reports that are so-called scientifically proven. Then a month later another scientifically proven study reports the opposite.

  • There is a lack of Aboriginal mentoring support to develop evidence-based products and increase research report capacity.

  • If we are going to be moving ahead and making major changes in our thinking, one of the overlays we really want on that is a strong evidence-based scientific evaluation before and after we implement ideas. They should be evaluated to a high standard.

  • We talk about evidence-based decision-making as in determining what everybody else has done about a particular problem. But the other type of evidence is needs assessments. We used to examine what were the problems people were having, what were the needs, what were some of the dynamics that were part of it, and then you went to solution-based approaches, looking at the resources that we had. So we addressed those needs with the most effective way to responding to them. And what would be the desired outcome. If it is works, which it does sometimes, then you have your own evidence-base. But there are other models for how you can get at the solution, other than waiting to see what somebody else does.
• **Comments on pilot projects, best practices and implementing success:**

  • I get nervous when people say pilot projects and I will tell you why. This is my jaded side. We have been piloted to death here. We have had more pilots and they never amount to anything even if they are successful. The research has been done out there. The studies have been replicated. I think implementing best practice is what we need to be doing. We have evidence now. What is in the way of implementing? We need to implement the evidence; we do not need more studies or pilot projects.

  • We are a nation that is unable to generalize from success. That is our crippling problem. We are a pilot project country. Take a concrete example of primary healthcare: the model has been well described, but we never get there and the change is actually slowing down. Why is that? Because this is a matter that is negotiated with the Medical Association instead of mandated by public policy. We negotiate everything in Canadian Healthcare with an interest group. We never say, thank you, we have heard you. We understand, but this is the way we are going to do it. And it is not because we want to shove things down your throat, but at some point the public interest is clear and your interest is clear and they do not match. And when they do not match, the public interest prevails, full stop.

  • We have done so many pilots. They put in a million dollars into a whole bunch of community developers last year, and they have evaluated it and demonstrated the results. We have received one-time funding in the BC Healthy Living Alliance. We are going to start up a whole bunch of programs and then what is going to happen in ten years? The intent of pilots is good, but they are almost an unhealthy diversion in the sense that they do not bear fruit in the long-term.

  • There seems to be an inability to take successes from other health care systems (or other systems in general) and apply them. We do not adopt best practices.

  • It will be our responsibility to seek out areas where cooperative research can take place. It is fundamental that this cooperation take place if the professions and the public are to make more educated and informed decisions concerning the most effective form of treatment. Today, the public continues to find itself faced with an overwhelming volume of information, often kept isolated or presented in a way that is far too often conflicting and confusing.

  • Royal Inland Hospital in Kamloops should be examined closely, for I have never encountered a better run or more efficient hospital. Appointments happen on time, there is little waiting. Someone has that hospital very well organized. Perhaps put that person in charge of more hospitals!
• We do an absolutely awful job of collating and pulling together peer-reviewed best practices that can be shared across our country.

• If we keep doing the same things and expect better outcomes and better results, we will be sorely disappointed.

• What is clearly evident is that we do not understand the research that is already out there. We are not distributing or disseminating that information to everybody. We are not applying it very well in the decisions we are making. We are not evaluating what we are doing in the system. And there is, actually, a strong resistance by many professional groups and by government groups to undertaking evaluation.

• These days, you cannot get a project up and running in the developing world unless you have a formal evaluator on your team and formal evaluation processes in place. These are absolutely essential. And yet here we are, the clever developed world, where we rarely include evaluation in most of our policy decisions.

Ideas and Suggestions

Evidence-Based Programs and Studies
Pilot Projects, Best Practices and Implementing Success

• Ideas about evidence-based programs and studies:

  • We need to work towards a system that runs itself by encouraging a creative environment that identifies its own needs and finds solutions.

  • Promote rehabilitation research and training to improve the availability of evidence based, cost effective, and high quality rehabilitation care to citizens of British Columbia. Encourage world class innovation that will bring economic benefits to British Columbia.

  • Create evidence-based and best practice programs.

  • Look at the model in the United Kingdom, namely, delivery councils, which are multi-disciplinary teams that operationalize various initiatives. These councils gather budget from different levels of government to implement initiatives. While one level or delivery arm is the lead, delivery and operations are at the local level.

  • Research needs to be re-focused so it is not just about the current medical model, which is only a pharmacological model. Do not focus on technological solutions. Think outside the box.
• We are committed to the current public health care system and to strengthening it to include evidence-based complementary medicine and preventative medicine.

• Encourage behaviour change research.

• We need more health policy based on health research which is evidence-based.

• Make clinical phase three data public.

• If we have ideas that we want to bring to the table, no matter from what political end you come from, be prepared to come to the table with factual evidence that what you are saying has worked somewhere else.

• Adopt a national best-demonstrated efficiency-sharing symposium and repository.

• **Ideas about pilot projects, best practices and implementing success:**
  
  • Release more information on positive experiences.
  
  • Implement a return to honest, factual scientific integrity to replace present public relations propaganda.
  
  • It is important to focus not only on innovation, but on making innovative ideas available to everyone so it does not need to be re-invented.
  
  • We need to celebrate innovation and success.
  
  • Search out the best practices and have the intestinal fortitude to implement them regardless of vested interests.
  
  • Look carefully at the studies that have been done by the Senate, because the recommendations that have come forth are non-partisan and seek to find solutions, rather than seeking political gain.
  
  • Change the mandate of the Ministry of Health to invest in research that has practical outcomes for health care in the province.
  
  • Academic centres should be assigned responsibility to identify and translate best practices across all health authorities.
  
  • Health authorities could collaborate on evidence-based care, and could be given the mandate to develop best practices in a certain area, and disseminate the information to other health authorities.
  
  • Pay the best ten physicians to travel around the Province to rotate the excellent physicians.
- The Ministry of Health should work with the British Columbia College of Family Physicians and other groups to develop a British Columbia Quality Outcomes Framework, followed by the institution of pilot programs for assessing and recognizing quality in practices, with a view to raising the profile of the elements of quality, acknowledging those who have committed to addressing quality and meeting defined standards, as with accreditation in other health sectors.
- Set deadlines for implementing policies systems-wide based on successful demonstration projects.
- Look in British Columbia first (the world comes to us now).
- Develop innovation around a defined need.
- Assign funding backed up by strong evidence-based information.
- Match demand with access (both the type of care setting and the type of health care provider) across the continuum of services through prevention, resource management, trend analysis (demographic, age, ethnicity, gender, disease and health profile) and collaborative care models.
- Planning about best practices is not the work we do today. We must invest in learning environments and change.
- Make sure it is evidence-based and has a real life application to any ideas for access.
- We need to stop treating the application of new knowledge into the health care system as a project. To be sustainable, ongoing and long-term efforts and focus are required.
- Recognize our best practices and resource them to spread them out in a useable format. Research entities need to be linked, smart, accessible, timely, and funded appropriately.
- Form a centre for best practices. This can be under the Canadian Institute for Health Information, or the Canadian Institute for Health Research.
- Implement specialized surgical services within the public health system.
- Centers of Excellence for certain types of care can work well at the tertiary level.
- Use studies and pilot projects to test new approaches.
Capital Planning, Infrastructure and Equipment

Comments and Concerns

Planning
Facilities and Equipment Management
Procurement

• Comments on planning:
  • There is a lack of accountability in the cost of construction. An evaluation of the actual costing during and at completion of a project should be performed to determine if the actual construction was in line with the proposal.
  • They are building hospitals without kitchens, and trucking in airline food.
  • We need to look to real estate professionals to assist with managing valuable assets. It is possible that the university model for infrastructure management and revenue generation may offer some possibilities.
  • We should encourage increased collaboration provincially and federally in the area of capital asset and infrastructure planning and management. In addition, there should be defined protocols and standards between health authorities.
  • We see that hospitals are built and used with the 98 per cent occupancy rate as guidance for administrators. This is an unrealistic figure when it comes to influenza and other sudden illnesses. Everyone shakes their heads when people are harboured in halls and storage rooms while the administrators shine with a fantastically efficient operation.
  • There are more meeting rooms in hospitals than there are wards.
  • Physical facilities for delivery of rehabilitation services are aging and there has been no capital planning for replacement.
  • Look at models like Australia, where a non-urgent care clinic is included in the hospital. In one case, the emergency room admission and non-urgent care admission were across the hall from each other.

• Comments on facilities and equipment management:
  • Facilities are out-dated.
  • Medical Resonance Imaging scanners (MRIs) are not always needed for diagnosis.
  • It doesn't make sense to me to have empty operating rooms, beds and down time on expensive diagnostic equipment that could be running around the clock but for the fact that we don't have the public funding to staff and operate. Surely with
careful consideration and planning there is a way to utilize our full potential for the betterment of all public access to health care.

- We have no automated lifting. Vancouver Coastal Health needs $30 million to put in more ceiling lifts, and if we do that we will have only just managed to cover our high-risk beds, not our low-risk beds. The City here has just automated garbage collection so that garbage men do not have to lift those big containers. And yet, we have still got ninety pound nurses attempting to lift patients that are over two hundred pounds.

- In terms of the standard of maternity care at Lion's Gate Hospital, the staff is great, but the physical aspect of the department is very poor and can add to the stress of a labouring woman.

- Our health system is very frustrating especially with all of the money that seems to be being wasted in the management end of things. We need to have smart, accountable, innovative, and experienced people running our health system, not people who think it is a good idea to bring in pre-cooked food from another province and reheat it for the patients, or who think it is smart to send our hospital laundry to Alberta.

- I think St. Paul's hospital charging money for Medical Resonance Imaging scanner (MRIs) usage after hours is an excellent idea. If the resources are there, why not use them to bring in badly needed funds.

- Medical Resonance Imaging machines (MRIs) are difficult to access and are not available 24 hours a day and seven days a week.

- There is a legacy of huge hospital complexes that have been shown from a number of points of view to be inefficient, sometimes actually dangerous in concentrating certain pathogens, and rigid in the expression of professional leeway in making medically sound judgments. In short, large hospitals suffer from the same impediments that can be seen in all bureaucracies; moreover, other models exist that provide the same services in a less centralized way, better and cheaper, but this can only be co-ordinated under a public medical care model.

- Hospital administration costs far too much. I have seen a $15,000 fish tank (with a weekly maintenance contract to accumulate more costs) installed at a human resources office to calm the staff.

- **Comments on procurement:**
  - A local private surgery outfitted its recovery room (tables, lamps, care carts, blankets, linens, curtains and so on) and even some of its operating room items (for example, carts and storage bins and the like) with items from IKEA. They did
this at a mere fraction of what the hospitals pay. The hospitals purchase from approved medical companies who charge five and six times the real value of the same items.

- Our daughter, who is an intensive care unit nurse in the United States, told us the hospital she works in does not use dressing packages that are as expensive as the ones we were getting. Half of the items in that dressing package were not used. That seems to be such a waste as those sterile dressing packages must be expensive.

- It is important to provide the market in British Columbia with access to the latest developed technologies and devices, which are more easily adopted and propagated in other jurisdictions. Barriers in British Columbia are mostly due to the current funding structure and actual disincentives that exist around adopting new technology.

- Should we be purchasing costly designer drugs rather than generic ones?

**Ideas and Suggestions**

**Planning**  
**Facilities and Equipment Management**  
**Procurement**

- **Ideas about planning:**
  - Infrastructure should be built for the future, understanding the need for flexibility while still meeting standards. For example, flexible and modular designs may enable health authorities to respond to changing needs and technology using their same infrastructure.
  - Match the needs of patients with the capacity of facilities.
  - Re-visit hospital layouts.
  - The clinic under construction in Lytton could be expanded.
  - The cycle time from planning to occupancy of new facilities should be reduced by half.
  - Minimum care facilities on hospital properties can be connected by tunnels and electric carts can be used to transport patients between buildings.
  - We need to look at both funding and the availability of providers when we are developing capital and operating plans. You could build a $100,000 million hospital but not have anybody to actually delivery service there.
• Develop a long-term plan for capital investment in rehabilitation facilities at the provincial, regional, and community level.

• **Ideas about facilities and equipment management:**

  • Re-use public facilities (such as schools and hospitals) that are closing down for retirement centres and wellness or seniors’ facilities.

  • There should be a centralized record system for medical equipment.

  • Our society tends to focus on what is big, expensive and dramatic, like the latest wonder drug or piece of medical machinery. Often the things that are cheaper and less fancy are more effective.

  • By investing in more cost-efficient, less invasive care, we can not only save lives, but save money.

  • Diagnostics must be controlled within the public system with national guidelines about when it is appropriate to use each kind of diagnostic test or machine, followed by quick access to the specialist so tests will not need to be repeated.

  • We need to take into consideration all the newest research and technologies, and we need to make new treatments and methods available and consistent across Canada.

  • Equipment needs to be standard so all staff know how to work it and it should not be user-specific.

  • Get rid of private food and housekeeping in institutions: it is inefficient.

  • The main focus here is hospitals since they use constant power 24 hours per day, every day of the year. The amount saved could be re-directed to other areas of the healthcare systems including staffing. Use wind power, with electricity from the city grid as the backup. Install motion sensors equipped with bypass switches in rooms or hallways where vacancies could occur. Turn off all computers or set them to sleep mode when they are not in use. Use energy saving washers and dryers. Install heat recovery systems. Explore new telephone systems. Seek volume discounts at couriers.

  • Evidence clearly supports the contention that there is testing equipment sitting idle in hospitals (and would most likely be made available in clinics) that could be made available for those willing to step out of endless cues to purchase testing services. This provides more timely medical service to all concerned.
Currently there are facilities for mammograms. Expand this department to include Pap Tests and other female related tests. This would assist physicians by eliminating these tests from their daily routines, resulting in reduced costs and assisting the doctor’s office to run more efficiently.

Implement specialised services clinics for types of surgery, such as hips, knees, and hearts (similar to cancer treatment centers). These would be co-ordinated by the public health care system.

We need different kinds of health centres, leaving the hospitals for long term care or for major health issues.

Non-urgent care centres, similar to the one at University of British Columbia Hospital, should be installed in walk-in clinics central to each neighbourhood. The key is visibility and the capacity to treat all non-urgent conditions. This will assist people in choosing that option over going to the emergency room. Should their situation require a trip to emergency the Nurse Practitioner or doctor at the walk in clinic can advise this, and call the closest emergency room to smooth the way for the patient.

Get up-to-date equipment in hospitals.

British Columbia has the opportunity to create a regionally based health technology assessment system led by the provincial health region. The individual regions could be the assessment arm for provincial medical device funding decisions.

Implement more efficient utilization of equipment and facilities (24 hours a day).

Undertake a per-use-per-day study on equipment such as X-ray machines and scanners, and on operating rooms in all major hospital facilities in order to maximize usage of public investments.

Move away from tendency to use the equipment just because it is there, and create guidelines for the use of diagnostic equipment.

Train diagnostic equipment operators so the equipment can be made available twenty-four hours a day and seven days a week.

Mobile services could address demand issues:

Instead of using hospitals for care and services, provide suitable services delivered by nurses and technicians in a mobile unit.

Implement mobile units equipped with up-to-date diagnostic tools.

Implement mobile medical services that can provide some non-life threatening, non-emergency services.
I. Ideas about procurement:

- Develop a new $60 million fund, not restricted to major capital purchases, but also used to acquire any medical device technology that would improve the health of British Columbians. Create accountability in monitoring the fund's distribution and the technology assessment that is built into the medical device technology fund. The provincial government would provide templates and frameworks developed by the Canadian Agency for Drugs and Technologies in Health (CADTH). These templates would be used by the clinician to enrol patients in the field study program that measures the effectiveness of the technology over the period of that program. Upon completion of these assessments, the government would have evidence as to the value of the technology and could then determine continued funding. In effect, create conditional reimbursement. The Ministry of Health should establish a consultative process with the MEDEC (Canada’s Medical Device Technology Companies) to develop the parameters for an ongoing program to help British Columbians receive the technologies that they and their healthcare providers have determined as best for them and to maximize the offset to the PharmaCare Program and regional budgets due to use of device technologies. In addition, the fund would alleviate clinicians' concerns and their patient care decisions that are based solely on cost. Finally, the fund would stimulate the home-grown medical device industry in British Columbia.

- There is an opportunity to be more strategic in adopting medical device technologies that would be beneficial to patients in British Columbia through funds made available for technologies that come to market outside of the normal budget cycle.

- Save money and time by purchasing used equipment.

- Technology should be centralized to lower costs.

- Get portable equipment not tied to hospitals.

- Government should be bulk purchasing software programs for people with disabilities.

- Items such as hip protectors, which cost $100 plus per pair when bought in small quantities from medical supply outlets, could probably be purchased in bulk from suppliers at greatly reduced costs so that all residents would then be able to purchase them from the facility at reduced costs.

- British Columbia has the opportunity to create a regionally based health technology assessment system led by the provincial health region. The individual regions could be the assessment arm for provincial medical device funding decisions.
Administration and Management

Comments and Concerns

General System Administration
Administrative Processes
Administrative Personnel
Scheduling and Personnel Management
Referral System

- Comments on general system administration:
  - There are too many jurisdictional layers in the Canadian health care system.
  - I feel that the financial chaos, person-power deficiencies that our medical system has developed to date along with the thrust to privatization is primarily due to political government management and controls set forth to basically protect a system process that is clearly not working to maximize human health, thus facilitating a no-win scenario.
  - There is too much costly administration.
  - Doctors spend time on generic administrative tasks.
  - The focus is on the bureaucracy rather than on service to the public. As a result, there is very little reporting on efficiency in the system.

- Comments on administrative processes:
  - Between five and ten per cent of consumable items that carry a use-by date were wasted due to poor stock control processes. If appropriate logistics (inventory control), stock rotation (first in first out) and moving items appropriately within each department or establishment were used, much of this wastage could be eliminated.
  - The administrative workload is huge. There are six layers from the frontline to the top. Administrators should be supporting the clinicians, but right now it is the other way around.
  - Even the most routine services involve a multitude of steps, forms and people. All of these steps consume valuable staff time, which could be better spent delivering patient care. These steps compromise quality and create opportunities for mistakes.
  - Interior Health uses different lab forms at different locations. Standardize forms at least within health authorities. The different forms are confusing to staff.
Hospital procedures are ridiculous. You have to be interviewed by admissions people a day or so before surgery. Then you have to answer questions when you are admitted. Then someone comes around and asks you the same stuff in the operating room. Then they give you the wrong medications anyway.

After the colonoscopy, my wife was wheeled out in front of that area to wait for a porter to come and return her to the emergency room. We waited for nearly half an hour while porters were paged several times. I asked if I or anyone else could take her, but I was informed that they would get in trouble from the union representing the porters if that happened.

Clinics need to operate differently. You are always treated as a new patient, even you have been there for years. As a result, you are always waiting and signing in.

In the past 15 years we have gone from individual hospital boards to Community Health Councils, to Health Regions, to Health Authorities. Money, time and energy were spent on each re-organization.

There are employers that require medical forms to be filled out by the attending physician every two weeks, even if the doctor has specifically stated that the patient will be off for a month or for an indefinite amount of time pending tests and their results.

When pre-paying MSP billing, a statement is still mailed out. This is a waste of resources and clearly shows the levels of bureaucracy that need to be readjusted.

The amount of clerical work done by nurses needs to be addressed. At the moment, far too much time is taken doing these tasks. This needs to be transferred down to clerical workers.

Resources are being put into making hospital policy and protocols in the name of better patient care that can potentially make simple procedures frustrating for staff and thereby taking time and energy away from the patients.

Because there is no sharing of information between public and private labs, blood test often have to be done twice, double billing the medical plan.

As an undergraduate nurse working in acute care, I find some simple procedures are made extremely complex and time-consuming through hospital procedures. For example, a referral for a patient to see a wound care nurse consists of requisitioning the referral through the computer, calling the wound care specialist on their pager, office and voice mail and then recording that a wound care consult has been requested in the chart, kardex, care plan and various other forms. This takes away the time nurses can spend caring for their patients and contributes to frustration and burn-out of nurses.
• Business process mapping gets everyone who is affected in the room to go through the business process, and then you look for your efficiencies. And by looking through the efficiencies you can re-direct that energy elsewhere. So you actually build capacity in the system because there is no duplication of efforts.

• I have witnessed and prevented many examples of errors in the timing and application of medications which arose from poor quality records, disorganized chains of command, a lack of management supervision and follow-up, clumsy manual record keeping systems and tired frustrated staff.

• Initial contact screening would be assisted by accessible records. Initial contact with a health care professional is currently subject to too many delays and leads to overuse of emergency.

• Tests not utilized or lost is the most unacceptable waste of resources (financial, human and equipment).

• Diagnosing can be inefficient as a result of over-testing, and turf protection and arrogance by health practitioners.

• One of the things that other industries have done is use the business review process. They literally undertake a very detailed review of what gets done, who touches it, how do they touch it, when do they touch it, and why do they touch it. These are all things that need to be reviewed in order to encourage improvement and innovation.

• Regarding prevention of lost or stolen wheelchairs, affix a six-foot pole to the back of the wheelchair. This will make it difficult for citizens to place the wheelchairs in cars, buses or SkyTrains. Also, position volunteers at entrances and exits of the hospital to interact with patients and monitor wheelchairs as they come and go.

• One of the most powerful sessions in the north was in Quesnel when physicians, the diabetes educators, and home care workers got together with some patients. They were led through the patient journey. The service providers could not believe the journey of the patients.

• There is duplication and misuse of health cards.

• The ongoing paperwork for disability, Fair PharmaCare and the Medical Services Plan subsidy is onerous and unnecessary.

• **Comments on administrative personnel:**
  • Administration is top-heavy.
  • There are too many costly golden handshake departures.
  • Administrators are desk-bound.
• There is no transparency or accountability on hiring standards.

• How much of the various health authority budgets are made up of administrative and public relations costs? Surely senior administrative staff could handle the odd public relations assignment or have an assistant do it to save costs.

• There is no one managing on the floors or even the operating rooms. There is no one in charge.

• Management has not signed on to regular report cards on their performance and how they compare with their peers here and in other western countries.

• There is too much management in the system, poor communication and power struggles that cause money being wasted and poor utilization of resources. I have worked in the health system for 30 years and have seen it eroded and made more dysfunctional with administrative changes and managers protecting their turf.

• Administrative personnel drain money from front-line health care.

• Too much time is wasted in meetings, planning sessions and conversations, and not enough time spent in implementing the solutions. The managers are out of touch with what is happening.

• In the business world when problems of this extent occur it is a common practice to change leadership. This means replacing the administration staff starting from the top executives. These people have had plenty of time to resolve the situation, so it is time for new leadership.

• Cars are provided for managers to travel to and from meetings and meals are catered in the meetings. Is this fiscally responsible?

• There have been jobs invented which are not needed. Clinical Nurse Managers do nothing besides sit in their office: they cannot answer questions for you!

• There have been resignations of middle managers due to unrealistic expectations.

• **Comments on scheduling and personnel management:**

  • There is resistance to the introduction of surgical technicians to assist at the table in place of Registered Nurses. For the cost of two Registered Nurses, we would be able to hire three operating room scrub technicians.

  • When receiving pre-operative physiotherapy in a warm water pool, there were only three of us in a pool that was meant for ten. This calls for a more efficient booking system so that the facility can be fully utilized.

  • Doctors or their secretaries should be trained with a program to schedule patients in for future visits. The system should alert the doctor so that they are aware of the
scheduled appointment and if they need to contact the patient, the patient should be contacted.

- You have got to get more staff into the Medical Services Plan office. There is no way we should be out reimbursement money for over eight months. The people who are submitting receipts for reimbursements are the ones who can least afford to be out that money, and shame on you for not doing something about this very serious problem.

- Compare twenty-four hour or even twelve or sixteen hour home care to round the clock acute care bed.

- **Comments on the referral system:**
  - A visit to a general practitioner is required in order to receive a referral to a specialist, even when the visit to the general practitioner may not have been necessary.
  - Patients who visit their optometrist for diagnosis of simple eye diseases, often at the request of a general practitioner, must then be referred back to a physician for further diagnostic tests or a prescription to initiate treatment. This inefficient process delays treatment, inconveniences patients, and is wasteful of health care resources.
  - There are long waits to see family doctors followed by long wait times to get the appropriate laboratory and diagnostic testing and then a long wait to see a specialist.
  - There is no accountability for cancellations, rescheduling, authorisations for appointments or surgical procedures.
  - There is no transparency in the process of referrals between practitioners.
  - Infrastructure and access to facilities is inadequate for specialists to be able to perform surgeries.
  - In addition to an inefficient referral system there is too much bureaucracy in the health authorities resulting in unnecessary travel and additional assessments by new doctors.
  - Patients have to go to a family physician each time they need a referral to a specialist, even when the specialist advises the patient that they must return on an annual basis.
  - It is a waste of time and resources to require a family doctor to write referrals to specialists when the patient knows what is wrong.
  - There is a lack of rehabilitation services post-surgery.
• The pre-requisite to seeing a specialist that has had a patient under their care for a number of years is a recommendation from the patient’s General Practitioner.
• The current system of tracking referrals is very poor.

Ideas and Suggestions

General System Administration
Administrative Processes
Administrative Personnel
Scheduling and Personnel Management
Referral System

• Ideas about general system administration:
  • Use a quality improvement approach to managing the system, thereby improving administrative practices and service delivery.
  • Use energy saving washers and dryers and a lower water temperature. Install heat recovery systems to re-direct lost heat from ducts and boiler exhausts. Install motion sensors equipped with bypass switches in rooms or hallways. One or two ceiling lights can be running constantly, bypassing the sensor, if safety is a concern. Purchase and install wind turbine(s), with the city grid as the backup. If we generate more power than we need, we can sell it!
  • Build in continuous efficiency reviews of the entire health care system.
  • We need to be able to look for those innovations and trust the people charged with implementation to be able to make those innovations happen. Though process like this can help facilitate that, they can also interfere with it. We have to distinguish between governance, management and service delivery. It is worth reminding government that political leadership includes setting direction. They are not being elected to micromanage.
  • We require easier transfer and portability of health records between health authorities.
  • Set up a proper purchasing office in hospitals or provincially.
  • Address the bed shortage by utilizing off-site more appropriate beds and supports.
  • Standardize services offered by walk-in clinics, and improve available information about services offered.
• Look at the BC Cancer agency triage model to see if the template could be applied elsewhere.

• Create a system to refer seniors to available programs.

• Health care professionals need to be provided with the tools that enable them to make proper and quick diagnoses.

• Link existing small programs to increase efficiency.

• A triage person should make the first stage diagnosis. There is no fast tracking happening in emergency and no consistent assessment in emergency. Nurse Practitioners could perform this task in emergency.

• Employ video conference specialists to assess patients and assist with rural care.

• Some clinics are doing triage before sending people to hospital emergencies. This should probably be the rule rather than an exception.

• Ideas about administrative processes:

  • Use a management program such as ISO or Q-Base. This would move the health care system towards addressing non-conformities in employee training, dealing with vendors, dealing with patients and other customers, and putting in a system of continual improvement.

  • Health care is a service business, so it should be administered like one: be efficient, be practical, and meet the goals of the plan and the needs of those who pay for it first and foremost.

  • Offer annual awards for medical workers who offer ideas that result in substantial savings for health care. These workers know the systems the best.

  • We need a more efficient management system to free up funds for health care workers.

  • Legislation should be implemented to limit hospital liability. Nursing staff currently spend more time than necessary checking up on patients, and recording same, in order to protect the hospitals against possible liability.

  • Naturopathic doctors and doctors of chiropractic should be able to order tests.

  • Develop a form for the patient to fill out before visiting a physician that would ask for the medical reason for the visit along with a list of current symptoms. It could either be electronic or on paper (for those without computers). This would assist the doctor and the patient to find the medical problem, and would expedite visits.

  • Establish an on-line system to allow patients to compare time for elective surgery at various hospitals. Patients who are healthy enough, and have adequate
financial resources, can go to facilities where waiting times are less, which would help to balance out the workload of institutions.

- Perhaps Pharmanet or some other information system could be utilized to streamline protocol around the issue of maintenance medications for hospital patients.
- Bring a business focus to health care management.
- We need to create centralized services for non-care support, such as information technology. These services, including technical expertise around human resources, should be provided provincial wide.
- Bulk purchasing of pharmaceuticals. Bulk purchasing of all hospital supplies.
- Stop theft in hospitals.
- Assign case numbers, track doctors recommendations and follow up. Focus on complex care instead of acute care.
- Make health care practitioners accountable for the supplies they use.
- Streamline paperwork in the acute care setting for minor or less severe cases.
- Eliminate translation services in 130 languages and focus on the two official languages.
- Stop reorganizing the administrative framework and focus on patient care.
- Patients should sign an acknowledgement of the receipt of test results, so we will know if they got to where they needed to go.
- Give doctors greater access to diagnostic tests.
- Allow the public to make suggestions for planning and spending. Ensure greater openness as to how decisions have been made.
- Every single health insurance card would have the picture of the cardholder, as well as a computer-readable identification strip.

- **Ideas about administrative personnel:**

  - Re-organize the health ministry under two Assistant Deputy Ministers. One responsible for sick care, which is virtually most things you do now, the other responsible for real health care (promotion, education and legislation). Cap spending on sick care at present levels and target expected budget reductions of one per cent per annum over the next 20 years. As people begin to take more personal responsibility for their own health, demands on the system will be dramatically reduced. State clearly how and where you will re-invest savings.
• Streamline transfer functions so physicians are used for their expertise and others can do more minor functions.

• Senior administrators seem to have just do what they want and when things are not successful, they get pay outs. It is rewarding inefficiency.

• Consider persons trained in hotel management for hospital administrators.

• Reduce bureaucracy, and put more resources into delivering real care for senior members of society.

• Control the bureaucracy in order to fund the system.

• Invest more in management training.

• Decrease the administrative burden in order to lower costs, but ensure that we have better qualified and sensitive administrators.

• Re-organize to eliminate costly top-level administrative positions.

• Develop well-trained, well-mentored, and efficient administration.

• When management is fired, there should be no payouts.

• Hire people that know the job and have pride in their work. That is the bottom line. Stop hiring your friends.

• Managers provide their own vehicles and meals, as is expected of their staff.

• Reduce the numbers of health care managers and then the remaining managers must be given the authority and support to efficiently manage, and that includes the best utilization of workers and resources.

• The Chief Executive Officers of hospitals will be rated and evaluated once a year on efficiency and care delivery.

• No more political patronage jobs for Chief Executive Officers of hospitals.

• Manage hospitals efficiently by hiring independent consulting company to dig out loopholes and inefficient methods.

• **Ideas about scheduling and personnel:**

  • Operating room scheduling could be more efficient and be on time. For example, administer anaesthesia in the holding room to save time. Do not allow empty operating rooms. Have a separate operating room for emergencies.

  • Government and health authorities should expand operating room capacity in public hospitals by: a) designating new Scheduled Procedures Only operating rooms in each health authority for chronic lengthy wait time procedures; b) conducting efficiency reviews of current operating room scheduling and logistics
that include input from all staff (including booking clerks, porters, nurses and surgeons); and, c) where feasible, eliminating hospital corporate days that involve closures of clinics, operating rooms and ward staffing.

- Improve utilisation and scheduling of the existing facilities and services.
- Implement a Radio Frequency Identification (RFID) monitoring system to track missing wheelchairs.
- A surgery that may go overtime is not allowed to start because the hospital would incur extra payment for nurses and support staff. Thus a significant proportion of the operating rooms are not being used efficiently: they are lying idle while patients wait. The private surgical clinics are able to work more efficiently and see patients more quickly because they have no such bizarre restraints.
- If people on long wait lists for tests would agree to go for tests in the middle of the night or early morning it would very much shorten the lists. The medical machinery for all tests is in the hospitals 24 hours a day. All that is required is to hire technicians to work night shifts.
- We need a responsive screening system that anticipates a number of abnormal results and related scheduling needs and develops a fast-track system to access services.

- **Ideas about the referral system:**
  - Create one-stop evaluation and treatment clinics as pioneered in Alberta for orthopaedic and hip replacement procedures.
  - Stop letting specialists waste time by calling patient two weeks before an operation; this duty should be handled by a trained receptionist or licensed practical nurse.
  - We need more efficient protocols for referrals. Revamp the referral system to save money.
  - Implement a graduated referral and treatment regime by using other health care professionals to make referrals to nurses, nurse practitioners and doctors.
  - We need standard of care of specialists to make sure that practicing specialists are staying current and providing a consistent standard of care to patients.
  - Require competency-based evaluations of specialists.
  - Accountability and quality assurance has to be implemented to ensure that the general practitioner and specialist follow through with their assigned responsibilities.
• British Columbia needs a transparent process to provide the public with information regarding treatment options and the risk associated with each option.

• Look at ways of stream-lining the referral system, such as having the family physician less involved once a specialist starts handling a case.

• We need a province-wide referral base that divides patients based on their ability to travel. Are they able to travel anywhere in the Province; can they travel anywhere in the health authority or are they only able to travel locally? Each patient would then be assigned a triage number and the next available appointment would be offered based on the patient’s indicated level of need and ability to travel.

• Establish criteria for some surgeries as we cannot all afford to have a hip replaced.