



Collaboration in Healthcare— A View from the Field



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*This Report draws on the “Collaboration in Healthcare” Executive Roundtable held in Toronto on December 7th, 2006. The Roundtable was sponsored by **R3D Consulting Inc**, a management and technology consulting firm that has been part of various initiatives with Infoway, the Quebec Ministry of Health as well as Regional Health Agencies in other parts of Canada.*

R3D Consulting invited a cross section of Health Care practitioners to the Roundtable to obtain valuable input from the field as part of R3D’s contribution to the urgent debate on how best to improve healthcare service delivery in Ontario.

***Alan Kay**, the Glasgow Group, is an expert in Roundtable best practices discussions and change management implementation and led the Roundtable session. **Robert Angel**, The Gilford Group, is a subject matter expert in customer marketing strategies, performance management, culture change, and organizational development, and wrote this report.*



Summary Findings-

The Executive Roundtable identified that significant progress is being made in collaboration in Healthcare. From the participants' perspective, there are three key areas that require further work:

1. Clarify the implementation framework

The field sees many of the current changes as ad hoc - piecemeal projects that integrate only partially with unclear milestones and desired end state. This seems to leave participants with insufficient sense of progress, meaning not tangible enough indicators of how well we are doing and what we need to do next to stay on target.

2. Evolve the consultation and collaboration model

The healthcare system is working to have programs designed better for users (and working better as well). Collaborating more with the field would help set communications priorities more effectively both in project design collaboration and ongoing as an operating principle.

3. Accelerate use of electronic communication

Current systems development is generating data that is already being used for improving the quality, speed and effectiveness of patient diagnostics and care and reducing time constraints. As noted above, there are good opportunities to improve effectiveness in this regards.

The following report details the discussion shared at the Roundtable. It is provided to offer an insight as to what is happening and a 'snapshot' of opportunity for Health Care Management to further explore.



Collaborating to Improve Ontario Healthcare Service Delivery – A View from the Field

1. Introduction – Communication and Collaboration Models

The Ministry of Health and Long Term Care has put The Local Health System Integration Act in place, with 14 Local Health Integration Networks – and 54 Community Health Centres – as a fundamental component of Ontario’s health care system. LHINs are aimed at improving the health care people are receiving and creating a strong system for delivery as the goals. Movement is occurring on three fronts:

- Keeping Ontarians healthier
- Improving access to doctors and nurses
- Reducing Wait Times

Massive transformation is in the works – a complex process for all healthcare institutions, emphasizing the need for collaboration among agencies and providers.

In this context, R3D Consulting brought together front line healthcare practitioners to discuss how the healthcare collaboration and communication model is unfolding and how to increase service delivery under the regional healthcare structure. This Report draws on Roundtable comments which can be summarized as follows:

- 1. Communication and collaboration models appear not well developed yet, creating disconnects in how goals are communicated and actions prioritized*
- 2. The discussion suggested a number of practical steps to get LHINs moving forward – clarified milestones, better user consultation, and performance benchmarks*
- 3. There is some consensus in the field on improved healthcare decision making – but still some gaping operational holes, e.g. not enough trained technicians for equipment like MRIs, and a looming nursing shortage*



2. Signs of Communication Progress

The Ontario healthcare system has recognized for some time that it must look beyond traditional process approaches. Collaboration and communication have made a good start, judging by healthcare providers' anecdotes about what one person called "small victories". Front line staff speak of improvements they are experiencing on their own – and call for many more such improvements.

The speed of technology adoption

"We believe investing in e-Health...will do the most to improve all the attributes of a high-performing health system".

- Ontario Health Quality Council Report, April 6, 2006

Investing in e-health is flagged as a priority in Ontario. However, time constraints of front line staff urgently call for process improvements and technology adoption that reduce these time pressures.

For example, *Diagnostic imaging technology* has been an early success in using advanced technology to streamline process and speed up diagnostics. It has also helped get doctors sufficiently interested in technology and to adopt technology more readily.

Nonetheless, front line staff still see doctors resistant to using computers. This holds back basic communication improvements such as email and patient data sharing, as well as more sophisticated collaboration and workflow applications. Doctors are increasingly being pulled into greater technology use by patients, who are demanding technology from doctors and expect doctors to become more technology aware now that they can look up many medical topics on the web themselves.

Technology adoption is often generational, for example microsurgery is being advanced more by younger surgeons, implying that the next generation will understand technology use in medicine much better than the current one.



The business case for electronic patient records

The patient is recognized as the focal point of the healthcare system. Medical practitioners can improve patient care significantly by applying more collaborative knowledge. An example is laparoscopic surgery using collaborative techniques to bring together specialist knowledge and treatment, coordinating the diagnosis and treatment cycle, and eliminating overlaps. This is seen as a break through in *a teamwork and knowledge-based approach* to patient care and how specialists can expand their roles.

Emergency departments are going more digital, implementing patient tracking systems. This benefits the doctor who can now expect results faster. The shorter time makes the entire hospital more efficient. It attracts attention to the need to *articulate benefits*, rather than just buying more technology. None the less, front line staff still see too much resistance from doctors who say “I can go on the floor and write my orders easier on paper”, despite the time saved in not having to go back to the nursing desk to transfer information.

**“...many hospitals
in the GTA are
frustrated by slow
progress towards
electronic health
records...”**

*- Toronto Star,
November 2005*

A traditionally strong community focus is now being reinforced by attention to refining communication with home care providers, working with technology partners and community programs. In one collaborative environment, if the patient has a fall there is more data and better access to it to help decide whether the patient should be brought to the hospital or additional emergency care provided in the home. This significantly speeds up patient care, lessens demand for facilities, and reduces costs.

Such advances in data and communication feed back into emergency room planning, illustrating how complex situations are being improved by collaboration mechanisms – bringing in partners and fostering community interaction. Although support systems still have a long way to go, patient entry into the emergency system can now be said to initiate a comprehensive program of communication and collaboration.



The impending shortage of qualified nursing staff

Changing demographics mean a definite shortage of nurses as the demographic bulge works its way out of the hospital system. Nursing retirement will accelerate in the rest of this decade as baby boom nurses reach 20-25 year service levels (or more). Demographics also mean a shrinking supply of newly trained nurses with requisite skills and experience.

The Roundtable participants believe too little is being done, and call for more intense knowledge transfer – mentoring programs, reducing training in a school setting in favor of more partnering of new graduates with nurses near retirement, and giving more responsibility to nursing staff especially in remote areas where resources are more dispersed. An improving collaborative climate may help by encouraging soon-to-retire nurses to stay on temporarily, as well as bring back retired nurses for part time work or specific needs.

Building and using collaboration tools

“Building blocks and data mean that such situations can be rationalized to just the procedures needed.”

- Roundtable participant

It was noted that knowledge transfer starts with electronic communication, e.g. reporting data at the point of care or consistent reporting on pathology. A participant described how a “lot of thinking about how to use tools” is progressing in his institution to address tests being repeated as the patient goes to several different specialists. It will take time to resolve this because of a severe lack of resources, and in any case it takes time to build tools with an intelligent framework. In his facility only some parts are in place so far and not all components are heading in the right direction. There have been many studies, he says, and big infusions of cash are being made now. His institution is trying to integrate more data more quickly, but “the complexity is huge – there is a lot of policy collaboration at top, but change in the field is slow”.



“The Naylor Report (November 2003) advised on Healthcare collaboration, cooperation, communication and clarity and the difference between health and health care (i.e. less of the latter, and more of when former).... Canada needs change – more adaptability, more collaboration, and above all more performance mind sets

*- Dr. Caroline Bennett, former Minister of State for Public Health
Speaking at SAS Advisory Council, November 2006*

Now that the roles in the healthcare system have been clarified – MOHLTC as steward, LHIN deciding what to do, and hospitals deciding how to do it – there will hopefully be more of a “take charge” approach to bringing about change.



3. Messages from the Front Line

Field healthcare staff say communication and collaboration challenges complicate day-to-day performance as front line healthcare managers. Such comments are significant not just to the LHINs, expected to address these issues, but to players right across the healthcare system.

It was pointed out at the roundtable that overwhelming workloads get in the way of collaborative intentions, e.g. better linkage between CHCs and LHINs. This is a well known challenge, regarding which several component issues have been identified which might help in resolving the larger linkage need.

Translating policy into collaboration in the field

Policy affects implementation, a participant pointed out. The Roundtable discussion reinforced that people in the field lack a clear understanding about government's desired outcomes. The field sees a chronic lack of resources holding back communication and collaboration infrastructure in the community.

Hospital specialization, e.g. 3 hospitals doing orthopedic surgery not 5, is seen as still requiring more time to see real results, with the perception of continuing strong doctor resistance. While the new legislation has encouraged going down to the local level where actual medical conversations and decisions take place, it is not clear that the regional local organizations have taken sufficient responsibility yet for carrying this forward. As a Roundtable participant noted, "it is no longer for government to say this is how to do it - but, the LHINs are just starting up and have no funding yet – perhaps, in another year they will have a stronger role, so it may be too early to say how things will evolve." Notwithstanding, "understanding policy and how it translates into field action will continue to be a major challenge at the grassroots level needing to be fixed".



Many innovative ideas are in conceptual development. However, moving from a planning policy at the high level to action on the ground will be a challenge. Silos are widespread, meaning at the human level there are still so many entities delivering services that health care personnel are left to doing a lot on their own.

The expectation is that the system will not fix anything until collaboration is resolved.

- Roundtable participant

To further complicate the situation, a participant added that surgeons are medical experts and should be able to rely on communities of practice bringing them together along with standards of care. Understandably, surgeons view effectiveness rather than efficiency as the goal, often the reverse of the hospitals' view. In addition, "the wait times focus needs everyone to be working together – it is not possible to shorten wait times just by increasing surgeon time since there is a finite supply of surgeon time".

The Field view is that policy is introducing a voluntary approach that can't be enforced or explained easily. This does not imply a desire for a more rigid and non-discretionary system but for more clarity of outcome.

Elevating knowledge communication

As reported earlier, nursing shortages and greater complexity call for mentoring of nursing staff. There is a desire for mentoring that can lead people through implementation based on agreement as to what needs to be achieved in a non-threatening manner. Mentoring applies not just to medical staff but extends to patients. One of the participants admitted that lack of time often prevents mentoring from happening- despite good intentions.

Given our increasingly diverse society, participants would like medical staff to speak the patient's language. Language availability is rarely a feature in emergency where the



need for communication is often urgent, leaving patients and relatives struggling to find some one to talk to so they can understand the treatment.

Communication and culture change

The perception seems to be that more money is being made available through government but it is not being targeted to all the right priorities.

The wait time issue already mentioned is seen as a roadblock to other tasks being tackled. This was described as being “more than just a surgeon doing the job properly – there are not enough surgeons meaning a superficial understanding of each medical situation and no apparent long term plan”. In fact, “the community at large sees statistics (like wait times) but lacks an understanding of what lies behind them.”

A participant said that wait time data is a great asset, but lack of prioritization in implementing components prevents a workable solution. For example, one hospital has put in a system for MRI but cannot operate it more than 8 hours day because of operating funds and resource constraints. The hospital is training more people, and looking at collaboration between processes, but has not been able to close the resource gap completely. Because resource constraints were not thought through at the outset, application has been much more difficult than envisaged.

Field staff are apprehensive about how under the LHIN model “5 or 7 hospitals will work together to consolidate hospital and human resource issues”. The concern seems to be about the degree of consultation – which has so far not been seen as extensive enough. There is particular concern in smaller institutions, who say they are not often consulted, especially around chronic disease and sickness prevention.



Adoption of electronic tools

As noted above, electronic tools are already streamlining process and communication, and are essential for increasing collaboration on a wide range of activities. More leadership is seen to be needed, for example holding workshops with key opinion leaders to help the slow adopters to pay more attention by engaging practitioners.

Data exchange and reporting would be much easier if all surgeons have access to email.

As a symptom of the problem, it was stated that vital performance data is not being produced by scorecards. For example, we do not know how many cancer surgeries are being conducted in Ontario with what results. This is critical when procedures are competing for resources with all kinds of treatments.

Providing partnership assistance

There was considerable discussion about how suppliers can help remove barriers. The expectation in the field is that pent up demand for health care technology will soon turn into a call for more help. Given expectations that LHINs will pool their resources to boost buying power requiring more computer system standardization, collaboration will certainly need to increase in future.

Consultation with users makes sense, enabling directors with more time to deal day to day with staff limitations and efficiencies beyond medical treatment related. The front line's task is to test product and make recommendations. However, the decision maker for operating and collaboration tools is usually at the director or executive team level, not the staff level, according to the panel. As the LHINs develop, closer collaboration with technology and service partners will be essential for progress.

The emphasis so far has tended to be on point solutions, meaning that sharing data is harder when only some components of the solution are being changed. A Roundtable participant describes a messaging system project now in production phase but still experiencing difficulty flowing information between systems and sending data to home



care providers. This project started as being CCAC funded, until MOHLTC saw and recognized its value. Today, a LHIN director sits on its council and champions the project. It is expected to be one of top priorities along with patient portal when the LHIN policy is announced in January '07. This project “did not benefit from setting an agenda but rather just emerged”.

It would help for LHINs to share best practices and build that into their plans. There are perceived to be overlaps between LHINs that go unrecognized, so that opportunities to allocate funds more effectively go unnoticed.

Outside suppliers can be helpful in providing resources that highlight ease of use or help the decision maker get buy in.

The message from the front line is that the goal must be kept in mind, defined by the group as better patient satisfaction. Better communication will help keep policies behind the goal understood, and collaboration will help get the right priorities set. In the next section, we look at some suggestions that may contribute to this.



4. Collaboration Dealing with Complexity

The Field view is that more systematic filling of gaps in processes, more acceptance of change, and more trust are all urgently needed. These communication and collaboration suggestions lead to three themes arising from the discussion.

Clarify the implementation framework

The field sees many of the current changes as ad hoc with unclear milestones and desired end state. There are not tangible enough indicators of how well we are doing and what we need to do next to stay on target.

Evolve the consultation and collaboration model

Collaborating more with the field would help set communications priorities more effectively both in project design collaboration and ongoing as an operating principle.

Accelerate use of electronic communication

Current systems development is generating data that is already being used for improving healthcare, there are good opportunities to improve effectiveness in this regards.

Much has been written about innovation in healthcare. The collaboration model must be aimed not just at doing existing practices better but also at finding completely new things to do that for example, prevent illness at much less cost than treating it, or change treatment methodologies to lower cost approaches that make healthcare more widely accessible.

While work is also proceeding on administrative systems, we suggest heightened communications of management decisions – in support of applications such as those



that: prioritize projects, aid performance assessment and decisioning, improve hands-on management of professional staff, set and meet new staff development and retention objectives, etc.

Selectively, more electronic data will help. For example, one participant suggested an optical system might help her job, while another suggested better nursing care would be promoted by better communication at the bedside with the patient. Another participant sees the immediate need is to have electronic communication more web based, getting doctors on line, having hospitals send out more information to the community, enabling the public to find out about programs, accessing information for scheduling, creating client management internally, setting up bed registries, communicating on best practices, disseminating pandemic information, etc. It was suggested that hospital quality assessment might be based more on hard fact, perhaps measured on cost per case for funding.

The suggestion is for a “systems thinking” approach in the Regions that starts by creating a clearer framework for short term results and the longer term, with a more prioritized approach to deal succinctly with complexity, aligning systems from one LHIN to another. The goal is to emphasize innovation, critical path, and progressive outcomes.



5. Conclusion

The Roundtable participants delivered some clear messages about significant gaps still in concept execution and the relationship between direction and doing. The front line people feel they are making progress, for example in piloting electronic patient records, using mentoring for personal development, and working with patients at home not in hospital. Electronic collaboration can help free up time, vital as a looming talent shortage gets closer.

To create a more satisfactory environment, they see key decision makers needing to collaborate more to design and evolve consultation models and collaboration on programs that work better for users. More collaboration will automatically bring about more communication.

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We would like to thank the participants and everybody else who provided input to the Roundtable and made it a worthwhile discussion.

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