

In Conversation with John Cowell

Ken Tremblay

Health quality councils, in this case the Health Quality Council of Alberta (HQCA), in Calgary, have become synonymous with new approaches to quality measurement, system evaluation and consumer satisfaction. As governments reshape and retool Canada's healthcare system as well as relationships with providers, quality councils play a pivotal role in assessing performance and policies that ensure the tenets of safety, quality, sustainability and access to timely care. Commenting on the Alberta experience, HQCA Chief Executive Officer John Cowell spent a few moments with Ken Tremblay.

HQ: What makes the HQCA unique compared with your counterparts in other provinces?

JC: The Health Quality Council of Alberta [its precursor] was a work in progress, starting as the Health Services Utilization Commission and ultimately becoming the Health Quality Council of Alberta. During that process, we became convinced that we needed to take a unique viewpoint to quality and safety. That [perspective] brings policy makers, service providers and the people to the table – through the actual experience of the consumer. When we looked at high-performing health systems, we found that high quality doesn't matter unless it is understood through the experience of consumers.

We learned that the notions of quality and safety were confusing to people; few appreciated that they are measurable and well defined. That led to the creation of the Alberta Quality Matrix for Health. Unless we had a template for discussion and action, the [safety and quality] agenda was not going to move forward or deliver the changes we needed.

When we completed population-based surveys for long-term care and emergency care through the experience of the patient, we cobbled the results in ways that gained the attention of policy makers and service providers. What is unique is that we combine clinical outcomes from the health services database with what people report as their experience and outcome.

HQ: I note that HQCA was established through the province's Regional Health Authorities Act. How do you balance



Dr. John Cowell, CEO, Health Quality Council of Alberta

provincial and regional perspectives when you report health service quality to Albertans?

JC: We do what we call *regional data breakouts*. We have not only looked at aggregate results for the province but parsed these findings by postal code to what were our nine health regions. When we published our results, we were able to show each health region what its citizens said about their experience. We were able to compare and contrast regions with one another. In

this way, regions were able to identify what worked in region 1 as opportunities for region 2. In this way, regions were able to identify what worked in one region compared to another. This was one way to support knowledge transfer.

HQ: In December 2008, your council released its survey results about long-term care and the family experience. How will those results improve service quality by providers? What might be some early wins?

JC: The long-term care survey was the first of its kind in this province. We looked at long-term care from two perspectives, that of the family and that of the resident. The family response was astonishing, a more than 70% response rate, which spoke to

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the incredible importance this issue was given by families. The residents' response rate – mostly because of lesser cognitive skills – wasn't as high. However, we had very rich findings.

The win was that we were able to establish a baseline for every single nursing home in the province. Never before were such rich data available to the individual facility owner or operator, regions or the province. We now have a baseline to compare changes as the system reorganizes and introduces innovation.

Some of the critical findings focus on the human equation: communication between the staff and the resident and family ranked very high and drove satisfaction either positively or negatively. What was fascinating to us was the focus on the human side of the relationship versus clinical and accommodation issues. The win was feedback to the providers and operators. We have had astonishingly positive reaction from providers in that these early wins did not cost a lot of money.

HQ: The council did extensive research into the patient experience within emergency departments. As many provinces wrestle with emergency departments overflowing with primary care clientele, were there any lessons learned?

JC: We studied all 66 emergency departments in the province. We were able to combine patient satisfaction results with clinical outcomes from the emergency database. Number one: people are not as irritated or worried about clinical outcomes. What drives them crazy is [a lack of] communication: "Are you telling me how long I've got to wait?" "Will you see me as soon as you possibly can?" and, "Will you keep me informed?"

The other lesson: A lot of patients could have been seen somewhere else for their primary care. If there had been effective triage to redirect them back to another primary care provider or setting or to enable them to stay at the nursing home, that would

have been an incredibly useful finding. Triage or streaming people into the right pathway kept coming up. This dovetailed nicely with a study on the Calgary region's emergency/urgent care, where we identified that if you could improve primary care in the community, you would relieve the pressure on the emergency system.

We have shared this information with primary care networks, policy makers and service providers. There has been tremendous work done in the past six months in rerouting cases back to primary care settings and away from emergency departments.

HQ: What gains in quality and safety have been the most dramatic for the HQCA? What challenges remain?

JC: We are empowered to conduct inquiries for significant incidents; I don't think other councils were given this power. The minister can request that we look into significant incidents, and a regional health authority can ask for our assistance to help analyze a concern. To date, we have done four: dialysis deaths from a potassium chloride–sodium chloride substitution, a morphine-related death, a death from a pump error and, lastly, an infection prevention failure with flawed cleaning and sterilization techniques.

Each of these reviews uncovered significant findings about quality-of-care practices, and specific provincial actions have resulted. With the latter [incident], improved legislation and standards resulted from our review of infection control practices. We see that [outcome] as a huge quality improvement directly related to our work.

Concurrently, we identified that disclosure of harm to patients and families was not done well or consistently in the province. That led to what we believe to be a first in Canada, a disclosure-of-harm framework for regional health authorities and the professions. We combined that framework with an educational program for service providers, and we have early anecdotal evidence that disclosure practices are dramatically improving. We plan to go into the field to determine if these changes have a measurable impact on outcomes.

We have made dramatic improvements in the way concerns and complaints are handled. We devised concerns and complaints resolution frameworks, which are making a difference. They address specifically our dimensions of quality via acceptability and safety in terms of effectiveness of care.

HQ: Translating "Knowledge to Action" is the mantra of your organization. What new knowledge have you been able to translate into new action?

JC: We released a pamphlet we call *It's Okay to Ask*. We discovered repeatedly that communication breakdown between the user and the system is a huge problem. The pamphlet advises ordinary people using the system: how to organize their thinking, how to prepare for a health services encounter – the questions

they need to ask, what they need to know before they leave, whether they need to come back again and questions for their pharmacist if they've been given medication. We published over 350,000 pamphlets for distribution across the province, and I've been on talk shows to get the word out. We're telling people that they can make their whole health service encounter more efficient, more acceptable, more appropriate and safer. Better than being either intimidated or fearful, take a friend to write it down – do whatever it takes to have a better encounter.

HQ: Managing change successfully lies at the heart of what we do as leaders. What have been the lessons you and the council have learned along the way?

JC: We have paid attention to approaches used by other councils. For example, we learned that you irritate service providers and policy makers if you pretend that you know how to do their business better than they do. We learned very early

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that informed collaborative support is the right way to go. We resisted all efforts to make us an auditor. The success we have enjoyed is because we have taken the position that the provider is the expert and our job is to bring the best information to leverage that expertise for high-quality healthcare.

HQ: How are networks changing the landscape in Alberta?

JC: Perhaps our most important initiative is the Health Quality Network. We have progressed from nine health regions and other [service provider] boards into a single entity. In addition, we have included professional associations, regulatory bodies and academic medicine. To advance the quality and safety agenda, we needed senior people from all these sectors in a room at the same time, identifying issues and interventions together. That collaboration has been incredibly rich. We also have a couple of subordinate networks that focus on single issues, such as medication safety.

Perhaps our most important initiative is the Health Quality Network (HQN). The HQN membership includes senior officers from our former nine health regions, Alberta Cancer Board, Alberta Mental Health Board, Alberta Health and Wellness and the health professions. To advance the quality and safety agenda, we needed senior people from all these sectors in a room at the same time, identifying issues and interventions together. That collaboration has been incredibly rich. The

network will need to change to reflect the new consolidated Alberta Health Services organization, but it will continue. We also have a couple of subordinate networks that focus on single issues, such as medication safety.

HQ: Alberta “blinked” with changes last year with its health authority model. How has that change affected how your organization relates to government? Other stakeholders?

JC: From our perspective, it is business as usual. We will continue to work with the various components that make up the Alberta Health Services organization. We are dealing with the same people. Yes, they have been reorganized into a single, large, integrated organizational entity. Probably the biggest implication for us will be to see how the pieces fit together. So far, there have been no substantive changes in the way we do our work with Alberta Health Services and Alberta Health and Wellness. And, of course, there has been no change in our relationships with the professions and academic medicine and research. Probably the single biggest issue will be, how does the new Alberta Health Services relate to Alberta Health and Wellness at the ministry?

HQ: How has the information age and agencies like the Canadian Institute for Health Information (CIHI) made your work easier?

JC: As you know, we have a mandate to measure, monitor and assess the quality and safety of the health system. Until recently, our internal capacity to analyze health services databases was not there. We have those capabilities now, and we're developing our expertise.

Previously, we were dependent upon data and information from national agencies like CIHI, the Canadian Patient Safety Institute and Accreditation Canada. However, we realized that we needed relevant Alberta data and local interpretation for our policy makers and service providers. We'll see where this goes and how our own analysis lines up with what is available nationally. One of the directions we'll be taking is to trend our own survey information based on the questions that we feel are unique to Alberta.

HQ: If quality healthcare outcomes tend to be linked to critical mass/economies of scale, any thoughts about how large and small jurisdictions should compare?

JC: Large institutions tend to have bigger pools of resources to address reporting systems, supportive technology and teams that can respond to significant events; smaller organizations cannot support infrastructure. So, in many instances, the council can provide that resource to the smaller jurisdictions. I am hopeful that [Alberta's] new organizational structure will supply sufficient critical mass to provide that infrastructure throughout the province.

From a clinical services perspective – such as the example of Shouldice Centre [in Thornhill, Ontario], where they focus on hernia repairs – there can be economies of scale. There are some clinical models developing in Alberta that would focus on orthopedic and gastrointestinal procedures. Would they become highly efficient, appropriate and safe models for providing high-quality, clinical outcomes? Shouldice has proven a model for hernias; I haven't seen similar models emerge in other clinical clusters.

Perhaps the new primary care networks are going to provide economies of scale. Logic would infer that if you have a critical mass, you will become more efficient. But a lot will be determined by the business model supporting the clinical model.

HQ: What has been the best advice you have shared with policy makers? What advice has been the hardest to convey and why?

JC: It comes back to bringing user perceptions and experiences to the table in a way that is believable and credible. Before you make large policy decisions or change health service delivery models, be sure that you understand what the consumers have been telling you about their experience. In the past, policies and service delivery decisions were made from the perspective of what suited the stakeholder. We need to organize around the patient's journey and the patient's satisfaction. That has been our message, and it is being heard in a meaningful, measurable way. But it's going to be some time before we see health systems reorganized around the notion of true patient centredness and consumer feedback.

HQ: How has your training as a physician assisted you in your leadership role at the HQCA?

JC: I am a primary care physician; I did family medicine and emergency medicine in Toronto. Later, I became a specialist in occupational medicine, working with large organizations in terms of workplace health and safety. Both of those backgrounds shaped my current work in quality and safety.

I know what it is like to be in an emergency department or a family practice setting. In terms of the occupational medicine, I

saw how organizations approached the ideas of accident prevention and education and how they approached worker health and safety. This concept isn't just a nice idea – these approaches have a moral imperative and improve their efficiency and bottom line.

There is absolutely no doubt in my mind that if we can get the quality and safety agendas embedded in the “DNA” of health service organizations, efficiency will improve, results will be sustained and we will have a much safer, more appropriate health encounter for individuals.

HQ: Anything else you would like the readers of HQ know about Dr. John Cowell?

JC: In the early 1970s, when I was just starting out in medicine in Toronto, I was one of the first physicians to participate in a multidisciplinary team funded through a capitated model, that is, a salaried physician under an alternative payment plan. We were one of the very first groups to demonstrate that a multidisciplinary approach to primary care really works. We trained some of the first nurse practitioners from McMaster University [in Hamilton]. That clinical model worked beautifully! What killed us was, of course, the absence of an electronic health record and a [sound] business model to support us. We were a tiny island in a sea of fee-for-service, so it didn't survive.

The point that I'm trying to make is that, over 30 years ago, I bought into the idea of multidisciplinary primary care. I still believe it works, and I remain a strong proponent of the model. Back then, we felt that nurse practitioners could do a lot of primary care and work very constructively with a physician partner; this idea has taken root in Ontario and is spreading throughout the country. Combined with a multidisciplinary approach and emerging patterns of practice, it is an idea whose time has come.

On a personal level, I never stop learning. All my life I have had a secret desire to be a bluegrass banjo player. I have been practising my skills and think I'm starting to sound pretty good. Playing gigs in public has turned out to be a lot of fun.

HQ: Thank you. HQ



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