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Canadian Physiotherapy Association

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Exploring Quality in Physiotherapy

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Quality care: safe, effective, patient-centred, timely, efficient, and equitable

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Measuring Quality in Health Care

As the saying goes... "*show me your budget and I will tell you what your priorities are*!" The fact that almost half of our provincial budgets are spent on health care suggests that health care is still a core Canadian value. As Canadians, isn't access to publicly funded health care sufficient? Do we really need to focus on quality?

The answer to this question is that quality drives efficiency which drives cost. So, measuring quality is fundamental to building a sustainable health care system. A good place to start is with the "Triple Aims Framework" which is often referred to as the impossible triad of "quality, accessibility, and affordability". Achieving the balance of delivering high quality health care that is accessible and affordable requires evidence to continuously evaluate and improve the health system using cycles of plan, do, study, act (PDSA). Local health care teams each develop their own quality indicators that fit within a quality framework that is generally established by provincial health quality councils and agreed upon by all stakeholders. The most common quality framework includes the following six dimensions of quality: appropriateness, accessibility, acceptability, safety, efficiency, and effectiveness.

The evidence required to evaluate the health care system includes routine collection of "key performance indicators" (KPIs). These measures are reported on a regular basis to provide relevant and actionable information about the performance of the health system. The Canadian Institute for Health Information (CIHI) collects, analyzes and reports on the performance of the Canadian health care system at the national, provincial and local level. An example of a KPI is wait times for access to care, such as surgery. While important, KPIs are not the same as clinical outcome measures, and thus are limited in their use to inform individual patient decisions. What we need to build is an integrated system that includes both KPIs to inform decision makers, and clinical outcome measures on which to base individual patient decisions. Clinical outcome measures that can be used to inform individual patient care and then, in an aggregate form, also serve as KPIs for stakeholders would be ideal. This would provide incentive for clinicians to collect good data that can serve a dual purpose. More important than collecting the data is analyzing it and sharing the results back to the front line care providers so that they can use the information to improve care delivery. There are excellent examples of the use of balanced score card reporting to achieve this type of impact.[1]

Unfortunately, measuring health quality is currently mostly focused on care that is delivered within hospitals. Few systems have been developed to evaluate quality of care delivered in the community. Over the next decade, as we transition health service delivery from acute care hospitals to the community, we will be faced with the challenge of how to measure the impact of that transition. As physiotherapists who work across the full continuum of care—in the public and private sector—in acute care, long term care and the community—we need to challenge ourselves and our profession to lead the way in establishing KPIs and integrated systems to collect data that will address these current gaps. Are we ready for this challenge? Who should be leading this work? The health care system, employers, your association, regulators? While there are advantages and disadvantages to each, the most effective systems are those in which the data are collected, analyzed by a third party at arm's length to the health care system and its regulation, and reported back at the individual provider level.

The shift from acute care hospitals to integrated care in the community, while necessary, will not be an easy transition. Among the challenges will be developing an integrated system for communication and data collection. At present, there are very few mechanisms by which primary care practitioners can communicate to insure continuity of care delivery. The majority of spending and focus is on delivery of hospital care. There is a notable lack of planning for care delivery in the community, the place where the majority of physiotherapists now work. Not only is there a lack of focus on integrated community health service delivery, but the focus on rehabilitation in the public sector is also lacking. Since we cannot change or improve upon that which we cannot measure, what are we doing as a profession to address this gap? Measuring quality in health care isn't just "nice" to do, it is "necessary" to do – hence, the focus of this issue of Physiotherapy Practice.

On behalf of the Board and staff of CPA, enjoy reading this issue all about quality of physiotherapy service delivery and we look forward to seeing you at Congress in Victoria for a high quality program!

Linda Woodhouse
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Patients No Longer Expect Good Physiotherapy

Chantal Lauzon, PT, CPA Senior Practice Manager, CPA Member since 1995

Have you ever wondered whether your patients can tell the difference between good physiotherapy and shoddy practices?

The short answer is yes. But that's not all.

Educated consumers are influencing the current health care environment. Word of mouth is being eclipsed by online reviews. As the public becomes more engaged, there is more attention paid to value for money and proven outcomes. With more eyes on us, advocating for the role of the profession can be heavily influenced by the actions of the profession—good or bad.

It is clear that patients no longer expect *good* physiotherapy. They expect *quality* physiotherapy.

CPA has embarked on a Quality Physiotherapy campaign. In order to reach a larger audience, our blog series is being re-published in this magazine and we will be bringing the QualityPT campaign to you through all of our communication channels. If you haven't already liked us on Facebook, or aren't following us on Twitter (@PhysioCan), now is a good time to try something new to stay up to date on the conversation. You can even join in! We want to hear your stories.

The CPA Code of Ethics was revised in 2014 to reflect some of the changes in the health care consumer landscape. As a profession, and as individual practitioners, we adhere to the principles of our Code of Ethics and those of the regulatory bodies in each province. Here are examples of how physiotherapists do this:

- The patient's/client's course of treatment is a partnership between the therapist and the patient/client. Work closely as a team to reach the best possible outcome.
- Take time to conduct a thorough assessment, determining how the condition or injury has affected the patient/client, and understanding the patient's psychosocial history before proposing a course of treatment.
- Consider the patient's/client's values, needs/goals and readiness for change when setting the treatment goals. Continually review subjective and objective progression of goal attainment using outcome measures.
- Educate the patient/client (and in some cases, the caregiver) on the condition and empowering them with relevant self-management strategies thus avoiding forming a therapeutic relationship built on dependence.
- Refer the patient to a colleague if the treatment needed is not within the skillset of the therapist or the scope of practice.
- Explain the proposed treatment, the risks and benefits. Answer any questions before, during and after the treatment to ensure informed consent is obtained.
- Strive for excellence by continually reflecting on the care provided and how to improve. Continue to learn new skills. Use critical thought to decide when to change practice, based on current evidence.
- Stay connected and engage with your profession through colleagues, communities of practice, mentors, and your professional association—through a Division, at the level of the local district, the provincial branch or the national office of the CPA).

Quality care is safe, effective, patient-centred, timely, efficient, and equitable

Need to know

Along with adhering to the CPA Code of Ethics, physiotherapists and physiotherapist assistants strive to provide quality physiotherapy care (#QualityPT). What does this mean in real terms?

Quality was defined by the Institute of Medicine (IOM) in 1990 as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[1]

In 2001, IOM identified conceptual components of quality. Quality care is safe, effective, patient-centred, timely, efficient, and equitable.[2]

1. Safe
2. Effective
3. Patient-Centred
4. Timely
7. Efficient
6. Equitable

CPA proposes adding a seventh dimension: **Cost-effective**.

Are we missing something?

In this issue of Physiotherapy Practice, we explore these dimensions of quality. Do they speak to the quality care that patients/clients expect to receive from physiotherapy? Do we need to focus on other indicators? How should the CPA define quality care in physiotherapy? CPA's QualityPT committee will look at defining quality for our profession as well as looking at how each physiotherapy practice, be it in a hospital setting, a chain of clinics or a sole practitioner, can implement quality improvement.

Most physiotherapists take the commitment to their patients/clients very seriously. We know that physiotherapists are involved in practice reflection. They're motivated to learn and provide the best possible care. Physiotherapists are squarely positioned as an evidence-based profession, continuously evaluating and evolving our practice against the latest scientific data.

These are the strengths that will allow us to meet the needs of increasing demand, changing demographics, and an evolving health system. Our ongoing attention to our strengths means that physiotherapy will continue to be a highly-respected, highly-sought service for rehabilitation, health promotion and prevention.

The vast majority of physiotherapists are highly trained, dedicated to continuous learning and improvement, and passionate about providing excellent care to their patients and clients. Some have been doing continuous quality improvement for their entire careers. Some have used informal self-reflection and patient outcomes to improve their practice.

Many health care institutions are adopting some form of the IOM dimensions of quality. In order to ensure that we are all speaking the same language, we invite you to explore the six dimensions as well as ways that quality is being measured and improved throughout this issue of Physiotherapy Practice.

By being aware of quality indicators that can be measured and steps to take to ensure that the practice is continually improving, each and every PT and PTA can help to elevate the whole profession. Together, we can make our profession stronger.

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Here's Why Patient Safety is Important

Sandi N. Kossey, PT, BScPT, MHA, Senior Director, Canadian Patient Safety Institute
CPA Leadership Division Executive Committee Member since 2014, CPA Member since 1998

Although it has been almost 15 years since I worked in a clinical setting, I can remember the face, name, and diagnosis of every patient I have ever inadvertently harmed.

Don't get me wrong, I was not a bad therapist, I was an EXTREMELY GOOD therapist. I am no different than you. But I will tell you that you can, and likely will, contribute in some way to unsafe care for the patients, clients, and residents for whom you intend to do your very best.

There was Mrs. M, the sweet (86-years-young) woman who was admitted from her assisted living facility to the inpatient internal medicine unit where I worked. She had a diagnosis of community-acquired pneumonia. Despite my best efforts to document and communicate her transfer and positioning needs to other members of the care team, she sustained a fall during an unsupported transfer and fractured her hip. Surgery and an unfortunate prolonged period of bed rest contributed to a stage four sacral pressure ulcer and ultimate sepsis, which were major factors in her death.

Mr. J was a spirited 54-year-old gentleman who resided in a men's shelter and was frequently re-admitted to our unit with congestive heart failure or complications related to his diabetes. On one of his admissions (his last), I was asked to assist with his mobility and endurance to prepare for discharge. This time, he complained of worsening discomfort in his leg and I strongly suspected venous thromboembolism. I documented my assessment and communicated my recommendations to Mr. J's nurse, as well as the charge nurse, who immediately paged the resident.

When checking in on my patient list the next morning, I noted nothing had yet been done to investigate. I immediately spoke to the student intern on the unit and even left a written note in the physician's section of the patient chart (which broke the rules in those days!). The medical team was not able to do patient rounds that day until the afternoon. They had been busy attempting Mr. J's futile resuscitation.

I was privileged to work with some exceptional therapy assistants in both inpatient and outpatient settings, and wow, we were such a cohesive team! But so many unfortunate factors were at play one day, when somehow the assistant to whom I had delegated a patient's treatment provided the care plan to the wrong patient. Mr. K, who was to be non-weight bearing, only took a few steps before the identity error was noted and reported. But Mr. K experienced such significant pain after this incident that his family was very distraught and requested he be moved to a different unit. Our sincere apologies did not take away the sleepless nights and suffering for the patient, his wife, and his daughter. I, too, felt so bad that I can't say I slept much either. Thank goodness we

could talk openly about this as a supportive team.

I also loved working with students in their clinical placements—I feel like sometimes I learned as much from them as they learned from me. In the last week of one final placement, one of my exemplary students was treating a patient in his inpatient room while a new patient was transferred from the ICU and left to settle in to the neighbouring bed. The student kindly granted the young man's request and passed him the jug of ice water he could not reach.

The patient, newly decannulated after a prolonged intubation and with cognitive deficits and impulsivity following an anoxic brain injury, was a very high aspiration risk. His chart had actually been flagged and a sign placed on his room door to note this. That jug of water should never have been in his room. Thankfully, this near-miss harm was averted and a lesson learned.

I would be remiss if I didn't acknowledge that I was a part of a wonderful interdisciplinary team. We truly cared for the many patients that were admitted and subsequently discharged (sometimes all too often without my knowledge or against my professional advice) from the hospital I worked in to the community—the great abyss where I could only hope that the care plans were implemented, the services started, the equipment installed correctly. I am not naïve; I know my idealistic plans were often lost or not appropriate and the safety of these individuals was compromised and at risk. But my hands were tied. What more could I do?

Oh, and since that last one felt like a confession, I also haven't even mentioned the countless individuals I treated without wearing gloves or appropriately cleaning my hands. But please know, those were the days before we, as frontline care providers, knew anything about "superbugs", health care-associated infections, and hand sanitizer. I know much better now.

What you need to know about patient safety

It is absolutely fitting that the first quality dimension for the QualityPT Campaign is safety. Simply put, safety is a precursor for quality. You cannot have quality care if that care is not safe, and Quality Physiotherapy (#QualityPT) is not exempt. As care providers we have a legal, moral, and ethical obligation to do no harm. Patients deserve no less.

Patient safety is not medical error. It is not professional incompetence. It is not someone else's problem.

Patient safety can be defined as "the pursuit of the reduction and mitigation of unsafe acts within the health care system, as well as the use of best practices shown to lead to optimal patient outcomes."

Like so many authored reports, publications, and presentations about patient safety (even my own), I could have begun this article by providing you with data about the incidence and magnitude of harm here in Canadian health care settings. But these would be faceless statistics. My personal examples can help paint the picture for you as fellow therapy professionals. And, even after I left frontline clinical roles and moved into leadership positions within and outside the physiotherapy profession, I knew I still had an influence and accountability for safe care.

Common challenges associated with patient safety

Health care is incredibly complex. As an individual or as a profession, we can acknowledge our accountability and be equipped with the best knowledge, skills, and attitudes for safety. Yet our systems do not always support safe practice environments or foster a just safety culture of learning and improvement from when things go wrong. We work within an imperfect system.

As rehabilitation care providers, our own professional values are sometimes at odds with the essential tenets of patient safety and quality. Our role is to optimize the health, well-being, and quality of life of the patients, clients, and residents we serve. Yet sometimes our best care, our #QualityPT, is to support a patient's right to live at risk. Safety is not always within our control.

Patient safety can be defined as "the pursuit of the reduction and mitigation of unsafe acts within the health care system, as well as the use of best practices shown to lead to optimal patient outcomes."

This year's Canadian Patient Safety Week theme is ***Ask. Listen. Talk.***

When things go wrong… potential consequences

I have shared with you only some of the experiences and insights I have carried with me in my career path as a Senior Director with the Canadian Patient Safety Institute. Now I have the privilege to work with and learn from an extraordinarily passionate team and an expansive network of inspired individuals at all levels and facets of the health care system that are making health care safer across Canada.

Perhaps most importantly, the patients and families that motivate me these days are just some of the names and faces that have been harmed themselves or who have lost loved ones to harm from health care, and now generously and selflessly volunteer their time to contribute to Patients for Patient Safety Canada. Their stories, while incredibly heart-wrenching, have a message of hope and encouragement – our attentions and even our smallest efforts to optimize safe, high quality health care *are* important.

You carry (with you) your own experiences as a health care provider, leader, and as patient and family member yourself. We all deserve safe care and we all have a role to play in patient safety.

Three things you can do right now in your practice

What can and should you do? First, let me reiterate my earlier point – safety is paramount for quality. You cannot provide #QualityPT if you are not contributing to safe care. I can advise you to ensure you are using best clinical evidence, optimizing your care environments, equipping yourself and your staff teams with skills and knowledge, speaking up and reporting safety concerns, and contributing to quality improvement efforts. No matter what your role is, you can start by keeping patient safety top of mind and making it a priority in your everyday practice.

These are all the things I did to help me, my teams, and my organization to prevent, manage, and learn from these incidents in our efforts to improve patient safety and quality, amidst so many competing priorities (and sometimes chaos) we experience in our day to day work. But I was asked to share with you three things you can do *today*.

The Canadian Patient Safety Institute believes that every patient experience should be safe and that it is important for everybody to contribute to and celebrate safe care. Every year, we are proud to host Canadian Patient Safety Week where we can all encourage everyone to *Ask. Listen. Talk.* (#asklistentalk) and raise awareness of patient safety issues and solutions. Here is your first opportunity – what are you doing to celebrate this year?

This year's Canadian Patient Safety Week (October 24–28, 2016) theme is *Ask. Listen. Talk.* Health care providers, leaders, patients, and their families are encouraged to ask questions, listen to answers, and talk about concerns and ways of improving safety. Free promotional packages will be available and will include patient safety tools, magazines and many other promotional materials to celebrate Canadian Patient Safety Week. Check out asklistentalk.ca to learn more about the campaign and check back in the coming months to order your package. If you look back to my examples—communication was a contributing factor in all of these patient safety incidents. Continue the conversations—**Ask. Listen. Talk.**—to help keep patients safe.

Last year, for the first time, we examined safety from the provider's perspective. When harm occurs, providers are also impacted, and like me, you will be too. Just like our previous patient stories, five provider videos were filmed and are now available on our website. And now for your second opportunity—I encourage you to view the videos and share them with your colleagues and students. Spark a conversation with your team about your experiences and your understanding of patient safety. Doing this may seem insignificant to some, but it may feel overwhelming and take courage for others. Support each other, strengthen your teamwork, and openly communicate about when things have gone well and when things have gone wrong. You will ignite the culture shift needed for learning and patient safety improvement.

Finally, the third thing you can do right now: Stop! Clean your hands.

About Sandi Kossey: Sandi is Senior Director with the Canadian Patient Safety Institute and leads strategic national initiatives with the health system, governments, providers, and patients and families to make health care safer. Sandi started her career as a practicing physiotherapist in acute care and since then has worked in leadership roles in occupational health and safety, regional and provincial stroke services, and organizational health for a provincial health and welfare trust. She is an Executive Committee member of the Leadership Division of the Canadian Physiotherapy Association and also instructs patient safety curricula for graduate students at the Faculty of Rehabilitation Medicine, University of Alberta. Contact Sandi at skossey@cpsi-icsp.ca or follow her on Twitter @ptsafety_sandi

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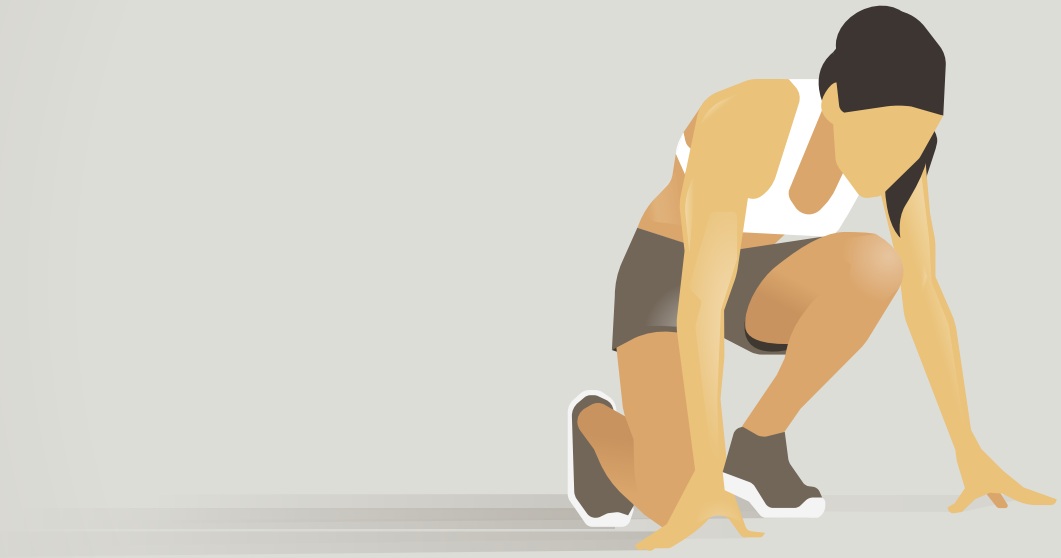

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Is Your Treatment Effective?

Mark Werneke, PT, MS, Dip MDT

How do you know if what you are doing is working? You don't want to waste your time, or your patients' time and money. Physiotherapy is supposed to add value to the health system, not be a drain on it. After decades of collecting outcomes during routine clinical practice, I would like to share with you my clinical thoughts on ways to achieve efficient and effective patient outcomes.

Here's why being effective is important

Decades of discussion have gone into what makes a physiotherapist "effective". Some believe in further education, while others (like myself) have found research suggesting that years of clinical experience, continuing education courses, and specialty certification(s) may not be as important as traditionally thought.

To me, being effective means adding value to patient care. That means being able to measure what you've done so that you can use that information and learn from it.

My focal area of clinical interest lies in managing patients with cervical and lumbar impairments from a biopsychosocially-informed perspective. In that realm, I share an unrelenting passion for collecting data and multi-domain outcomes. I do this by using psychometrically sound measures during everyday clinical practice to guide patient management.

How you can learn from what you've measured

Evidence suggests for clinicians and instructors to learn from their clinical experience and years of training, they must be provided with *optimal patient feedback* about what they are doing right or wrong at the patient's bedside. Optimal patient feedback is:

- Patient self-report objective assessments
- Performed serially throughout patient's episode of care
- Risk-adjusted to improve the meaningfulness of your interpretation of that feedback
- A helpful compass for establishing patient rehabilitation prognosis
- A guide for clinical decisions regarding optimal treatment strategies

It is fascinating to see how the patient's self-report outcome data tells a story. I love being able to know whether I should confirm or change a patient's intervention based on serial and optimal patient feedback assessments.

Decades of discussion have gone into what makes a physiotherapist "effective". Some believe in further education, while others have found research suggesting that years of clinical experience, continuing education courses, and specialty certification may not be as important as traditionally thought.

Unexpected results

Mr. B was a 55-year-old computer analyst with complaints of intermittent low back and left leg pains to the mid-calf. Mr. B loved to exercise in his home gym; physical activity appeared to make him feel better. But his pain pattern persisted, especially with prolonged standing and walking.

If you are thinking unilateral stenosis, then you are correct. To me, Mr. B's problem appeared to be a straightforward biomechanical case. However, my baseline psychosocial screening results were unexpected.

While the patient appeared to be managing his pain fairly well, his StarT (Subgroups for Targeted Treatment Back Screening Tool) classification was high. Furthermore, his intake self-efficacy measurement scores for coping and managing pain were very low.

Based on these baseline screening results, I added cognitive behavioral training (CBT) to my treatment plan. Education, specific functional training, and problem solving are a few key components of CBT.

At discharge, Mr. B had fewer visits and higher functional status than originally predicted. His psychosocial screening results were now good. If I had not thoroughly screened Mr. B's biopsychosocial status at intake, my outcome results may not have been as efficient or as effective.

What you need to know about being effective

So, being effective means being able to measure what you've done so that you can use that information to learn from it. The functional status scores from patient self-report outcome measures that physiotherapists typically collect during routine care are observational data.

These measures can be either paper or computer administered. You can use questionnaires like the Oswestry or computer adaptive testing (CAT) driven surveys, such as the FOTO lumbar CAT measure.

When you're choosing your outcome measurement system, there are a few things you should consider, including:

1. A large national patient database.
2. Robust, risk adjusted models to predict expected functional status and number of visits that similar patients should achieve by discharge.
3. Functional status computer adaptive testing (CAT) measures (which are more efficient than traditional tools).
4. Benchmarking reports to judge how a clinician is performing compared to other physiotherapists treating similar patients.

Our research group specifically chose FOTO as our outcome system because it met all of these needs. I think it is fair to disclose that I am a member of FOTO's Research Advisory Board (for the past three years). With that said, I have been using FOTO data for over two decades to manage my patients on an everyday basis.

Common challenges associated with being effective

Differences in outcomes between your patients and other providers may be due to the fact that your patients received superior treatment. It may also be simply due to the differences in the characteristics of the patients you are managing.

The majority of physiotherapists do not have the capability to apply sophisticated risk adjusted analytical methods to strengthen the validity and interpretation of their patient outcomes. We chose FOTO to manage and risk-adjust our outcomes; this allows us to compare apples to apples.

Another challenge our research group learned from using observational data for improvement was that it takes time to understand how to integrate patient self-report data into daily practice. Analyses of providers' performance using FOTO data between 2010-2014 taught us that it takes about one to three years of practice to enhance your outcome performance skills.

The point is: don't be discouraged when you first start to systematically incorporate patient outcome data into your practice.

The short version of not using objective patient self-report data in your practice is that you won't be as an effective physiotherapist as you could be.

Potential consequences of not using effectiveness in your practice

The short version of not using objective patient self-report data in your practice is that you won't be as an effective physiotherapist as you could be.

That applies to both choosing the observational data you will collect and how you analyze it.

What risk-adjusted analytics can tell you about performance

I collect outcomes data with eight other physiotherapists who work across the US. As a group, we've standardized our data and patient self-report outcome collection process.

One of our clinicians (we'll call him Rob) was always getting better functional outcomes for patients with lumbar impairments using unadjusted or raw data, compared to another clinician (we'll call her Sara). Both had received the same training and had similar clinical reasoning and manual skills.

However, when we applied risk-adjustment to interpret our outcome data, we found that there were many *other factors not related to the clinician's treatment*.

Sara was seeing older patients with more chronic pain conditions. More of her patients had:

- Lumbar surgery
- More medical comorbidities
- A higher caseload of worker's compensation and litigating patients

All of these factors can negatively influence a clinician's functional status outcomes.

What was fascinating was that after advanced risk adjustment analyses to control for patient case-mix, Sara's outcome performance was better than Rob's. It should be noted that Rob and Sara's data are encrypted, so no one knows which physiotherapist was which. There are limitations of unadjusted observational data.

The science of risk-adjusting observational outcome data is relatively new in physiotherapy practice. The best published physiotherapy risk-adjusted models have an accuracy of about 35-40%.

That means that 60% of the time, we cannot precisely identify all unmeasured or potential confounders which may also influence our outcomes. However, with that said, if you aren't using risk-adjusted data, then you can't compare results.

Three things you can do right now to make your clinical practice more effective and efficient

1. **Understand how to integrate these data to guide your patient management.** I don't believe this concept is emphasized enough at university or postgraduate educational levels. Can you remember an instance when a clinical instructor shared their patient self-report outcome data to support the value of interventions being touted as evidence-based?
2. **Choose efficient measures.** When getting started, using efficient measures means a reduced time for patients to complete and physiotherapists to score. Saving time during fast-paced and often hectic outpatient environments is a strong clinical advantage for collecting data at the patient's bedside.
3. **Make a plan to incorporate observational data into your practice today.** Start with small steps and within a few weeks, you'll start to have valuable data to improve your patient care.

Mark Werneke is a full-time clinician working at a suburban hospital-based outpatient clinic; he is also a clinical scientist. Mark is interested in outcome-guided patient management and has been collecting data at the patient's bedside for the past three decades. He is a cofounder of a research group examining the associations between McKenzie methods and multi-domain patient outcomes. This group has been fortunate to publish clinical observations and results in multiple peer-reviewed journals. Mark has also presented internationally and nationally on topics related to the biopsychosocial management of patients with low back pain.

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If You Want to Deliver Real, Evidence-Based Medicine, Read This

Trisha Parsons, PT, PHD, Associate Professor, Queen's University, AMS Phoenix Fellow, CPA Member 1996

When I was first asked to write about patient-centred care, I thought of this story to tell: After the birth of my first son, I was in hospital for an unprecedented six days post-delivery. Suffice it to say, I had a number of complications.

He was born a week before Christmas, and I quickly recognized that this meant we would experience a continual turnover in staff, many of whom were not native to the obstetric floor. Every eight hours, there was a new nurse to greet me.

Amongst the complications I faced was my son's inability to breast feed. He didn't latch properly. He was losing weight. So I had a number of consultations with the lactation expert, who developed a plan that I initially agreed to. I was charged with pumping breast milk for an hour. I would then use a store of previously pumped breast milk that would be rigged up in a tubing contraption and I would finger feed my son for an hour.

Once his "finger feeding" was finished, I would pump again for an hour. This cycle would repeat, five or six times a day, and at least twice during the night. I don't remember much, except making a joke about having a deep empathetic connection with a dairy cow. By the fourth day, my son was still losing weight. My other complications were no better and I had forgotten how to sleep.

My confidence as a new mother was fading fast. If breastfeeding was natural, and I couldn't feed my son, what did this make me? I was near the brink. I wanted to revise the feeding plan. Each time they'd roll the medieval-looking breast pump into my room, I would ask, "Can't we just feed him some formula, just this one time?" The response back was routinely the same, "*Breast is Best*."

Now, this isn't just a catchy slogan. It was a philosophy based on prevailing research evidence, a few systematic reviews, which demonstrated better outcomes for babies who were breast fed. I do truly believe that those who were helping me and my son were interested in ensuring the best outcome for him. It's just that, with each passing day, that was looking less and less probable. I was sleep-deprived, and my decision-making was poor. My son continued to lose weight and I was not well.

That was when Jean arrived. Well, I call her Jean. I'm not 100% sure what her name was, I'm sad to say. With everything that was happening, my memory was shot. While the details are fuzzy, this is what I remember. Jean arrived on an afternoon shift. She came directly in to speak with me. She explained that she was a nurse, there to help me and my son. She asked a number of questions: what I was finding challenging, what would help me the most. I have forgotten most of what she said to me, but I remember how she made me feel. *Listened to. Seen.*

"So, talk to me about your breastfeeding routine."

I described the routine to her, and she thoughtfully said, "How is that working for you?"

I said that I was exhausted, that I needed sleep.

"What do you think if we tried this: You pump, and I'll feed him? You'll get to sleep faster."

Within 24 hours I was home.

A few years later, I came up against the slogan, "*Breast is Best*", a second time. I was pregnant again, and, in a routine pre-natal checkup, was being interviewed by an obstetrical resident about my birth plan. She eventually made her way to the topic of breastfeeding.

"So, you plan to breastfeed," she said. Her eyes fixed on my chart.

I shrugged my shoulders and said, "I plan on trying, but last time it was very difficult and was hard on both of us. If I have those problems again, I'm going to bottle feed him."

You would have thought I had hit her.

...patient-centred care matters not only for instrumental reasons (such as, better patient satisfaction, improved health outcomes, more cost-effective care provision, and greater equity in health care delivery) but for moral reasons: it is the right thing to do.

"What? No, that's really not a good idea. You care about your baby's health, don't you?"

"Yes, and in my judgement, that's what's best for him."

"But, '*Breast is Best*'."

"I understand why you think that, but I don't share that opinion."

She quickly left the room, and I could hear her talking in the hallway with my obstetrician. I was being ratted out. After five minutes they returned together. Her arms were crossed in front of her chest and she stood with her feet planted firmly.

John*, my obstetrician, sat down on a stool, placing himself below me.

"So, I hear that you're thinking about not breastfeeding your baby, do I understand that correctly?" John asked.

"Yes, because of my experiences last time. I'll try, but if I have the same problems, I'm going to bottle feed him. I'm not trying to be difficult, or some type of anti-breastfeeding crusader; I just want to be honest about my plans, and what feels right for us."

"I understand. I know that Caitlin* here, was telling you about the research on breastfeeding."

"Yes, I've read some studies. There are some issues with the quality of those reports."

John nodded, smiling, "Systematic reviews really are only as good as the evidence used to make them, and may not generalize to your case."

"I know I'm not an expert in the research, but that's what I was thinking, too," I said.

"I think Dr. Parsons has a good grasp on the situation; she knows what's in the best interest for herself and her baby."

Not one to be shaken from her belief for long, Caitlin repeated, "But, '*Breast is Best*.'"

"Yes. I understand your point of view, but ultimately, you need to consider the whole picture, not just the research," John said, "A good doctor uses all of the information available to them."

What you need to know about patient-centred care

What my doctor was describing is in fact what Dr. Trisha Greenhalgh has coined as "Real EBM". In her talk on the subject, she speaks of how she fell into the best practice algorithm trap that has permeated health care. That we have failed to recognize that evidence-based practice is not only the application of research evidence, but is a phenomenon that emerges from the interaction between research evidence, clinical experiences, and patient experience.

Dr. Greenhalgh's message is simple, if you want to deliver *real* evidence-based medicine, you need to "focus on a deep understanding of your patient."

Common challenges associated with patient-centred care

As an AMS Phoenix Fellow, I've spent a lot of time thinking about patient-centred care: what it is, where it lives, and what it does. One of the outcomes of this activity has been the development of a series of narrative practice seminars, which I run as part of a course that I teach in the entry-level physiotherapy program at Queen's University. Narrative competence, the ability to elicit, attend to, and be moved by stories of illness, has a number of benefits as they relate to our practice as physiotherapists and the delivery of patient-centred care.

One of the activities I ask of our students is to write a reflection on a personal experience with patient-centred care. It never ceases to amaze me how rich and profound these reflections are. Some students

There is a collective culture that supports the environment in which patient-centred care is allowed to emerge

focus on the theoretical aspects of patient centred-care, offering variants of the IOM's definition that patient-centred care is care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.[1]

Other students write stories about good examples of patient-centred care, where the health team was able to work collaboratively with the patient and the patient's family to bring about an optimal outcome that aligned with the patient's values and needs. The majority however, relay stories which demonstrate failure in the delivery of patient-centred care. In thinking about patient-centred care, it's often easiest to recall examples when it didn't happen. Many of their experiences resonated with my own, and called me to reflect on the times in my practice and life when the priority was not the patient; but on some other metric or system-focused issue.

I've found narrative practice to be a helpful key with which to unlock both clinician experience and patient experience; that through the cyclic process of close reading and reflective writing I've become more attuned with myself, my personal and professional experiences, and by better eliciting and attending to the stories of others, patient's experiences. I wish I could say, that as a physiotherapist, I was always like John; but when I reflect back on my practice I see a disheartening number of times when I was more like Caitlin. That what mattered most was what the research said, or what the policy said, or what the care map said; not what the patient said. That when under pressure and in austere times, the outcomes mattered most, and that I didn't focus on outcomes that mattered.

How you can provide patient-centred care

In contrast, however, when I reflect back on those moments in my practice where patient-centred care lived, I realize that many of those experiences existed in environments where the leadership valued it too. To adhere to a principle of patient-centred care fundamentally means that you believe in the value of a single person, their autonomy. For as much as an individual can believe that, it is far easier to operationalize when you work in environments that believe it too.

There is a collective culture that supports the environment in which patient-centred care is allowed to emerge.

How do we build these environments? How is policy crafted with the belief that patient-centred care matters? Further, that patient-centred care matters not only for instrumental reasons (such as better patient satisfaction, improved health outcomes, more cost-effective care provision, and greater equity in health care delivery) but for a moral reason: it is the right thing to do. One of the organizational vision statements which reflect a culture of patient-centred care comes from the Ottawa Hospital. The vision was born out of the failure to deliver patient-centred care. Hospital representatives read a letter written by a family member who recounted a harrowing experience of their loved one in the hospital.

The sort of thing that was almost too fantastical to believe... that you hope would never happen. The vision that rose from the ashes of that horrifying experience was simple:

"To provide each patient with the world-class care, exceptional service and compassionthat we would want for our loved ones."

That we would provide the type of care that we would want for our loved ones in an ideal that is at the heart of providing quality physiotherapy service.

Trisha Parsons is a physiotherapist, scientist, and faculty member at Queen's University in Kingston, ON. Her work is in the field of Renal Rehabilitation. As an AMS Phoenix Fellow she is evaluating strategies to develop and sustain narrative competence in physiotherapists in order to support the delivery of patient-centered care for persons with complex health conditions.

Follow her on Twitter: @TLParsons @AMSPhoenix @QueensSRT

Related reading:
Dr. Trisha Greenhalgh: "Real EBM" www.youtube.com/watch?v=qYvdhA697jI

1 Crossing The Quality Chasm: A New Health System For The 21St Century http://bit.ly/1frypus

Using your waitlist to measure demand for your service? Think again: remove it!

Cathy Hoyles, BScPT, MHM, CHE, CPA Member since 1992

How long have you been waiting to hear those words? Most outpatient physiotherapists in publicly funded health care have been waiting a long time. This is our story.

Here's what you need to know about being *Timely*

Eastern Health is a regional health authority in Newfoundland and Labrador. We have eight ambulatory sites with 20 physiotherapists that deliver adult musculoskeletal services.

Our biggest problem, the *energy sucker*, was the waitlist for routine clients. While we did a good job getting patients with urgent problems in within two weeks, people who had problems we classified as "routine" often waited eight months to a year. The number who waited was large; often in the hundreds.

Sound familiar?

Common challenges associated with not using timeliness

At one of our smallest sites, the staff had had enough. The large waitlist was not helping:

- With maximizing our resources in these budget-restrained times;
- With staff morale: They just couldn't get out in front of this issue and morale was low;
- Our efficiency: we spent significant time "managing" this waitlist by calling patients, leaving messages, sending letters, scheduling and rescheduling. All of this wasn't addressing the problem – not to mention the frustration of clients not showing up for appointments.

There was nothing left to do but to imagine a future without this problem, and bring that reality to life.

Led by senior frontline physiotherapists and assistants who *knew* that this would work the best: Create a system that allowed people to come to us when they were ready.

Let them choose the time, date, or even if they wanted to come at all.

No. More. Waitlists.

No more calling people with appointments that they may or may not show up for.

It sounded impossible, but it wasn't.

We removed the waitlist by sending all those referrals back to the client (not the referral source – the client) with a letter of instruction; when you are ready to come to physiotherapy, call us the week before at a dedicated time to get an appointment. We put in a phone line for this purpose to make sure this was the only "work" happening on that line. If you're familiar with Lean management, we used the concept of "client pull", or the client triggering or pulling the service to *them* at a time that works for *them*.

Here's why using timeliness is important

What happened was amazing and challenged all the assumptions we had about those routine people sitting on the waitlist: only 40% of the people out there with referrals returned.

Most people were able to get an appointment with one or two calls to the appointment line, and the wait time (defined as the time you first tried to contact us to when we saw you) was less than 15 days.

I know what you're thinking – what about all those people that did not come back? What about them? Well, we were worried about those people too, so we *called them all*.

- We found over 50% of that sample *did not want to come to physiotherapy and had no intention of making an appointment* even though their primary provider had sent a referral.
- We found 8% that had tried to make an appointment and couldn't get through, and less than 10% who were confused by the process.

Our big worries were reduced:

- Were the majority of people trying to call for appointments and couldn't get through? *No.*
- Were people confused by this process? *No.*
- Could the people who wanted our service get to us? *Yes.*

Significantly, our time "managing waitlists" went from four hours a week to one hour, which allowed more service recipient time.

The time lost due to "no shows" was drastically reduced, which made it easier for the service to meet performance targets.

Everyone that was scheduled for an appointment actually showed up.

A time-sensitive service

Our lessons were powerful—half of those people on the waitlist did not want to come to physiotherapy. Using the waitlist as a measure of demand was artificial; most who called for an appointment did it within six weeks of getting a referral from their primary care provider. If a person didn't return by then, the likelihood of ever reaching out for physiotherapy was miniscule.

We know now that physiotherapy is a time-sensitive service—people want it when their problem is urgent to them, and the service needs to be available to fit their life to make it possible.

When we have a system that allows access at a time that is right for them, we become a more valued part of managing a client's health.

Simple.

What you can do right now to incorporate timeliness in your practice

Our story continues—we've removed waitlists in four other sites since this pilot, and the data is holding true to the trend we first saw. Better access and higher efficiency in the service.

We have more work to do, and more lessons to learn. We look forward to sharing that story with you as we go along, but, what can you do right now?

Two significant things:

1. Understand what a true client orientation, or client pull, would look like for you. Anything that makes your service more accessible to the client *at a time that works for them* will move you in the direction of client orientation.

   It can be hard for people to give up their bias towards a service that is set up around the clinician, but the results are worth it for everyone.
2. Understand your waste. Specifically, how much time to you spend per week managing your waitlist? What is the rate of no-shows? This lost time can be converted back into service recipient time when you change your access process, and you have a baseline to measure against.

A full webinar on this topic was presented through the Canadian College of Health Leaders in January 2016. Please contact the College at info@cchl-ccls.ca to obtain your copy.

No. More. Waitlists.

No more calling people with appointments that they may or may not show up for.

Why is the "E-word" a bad word?

Chantal Lauzon, PT, CPA Senior Practice Manager, CPA Member since 1995

Why do people shut down when the word "efficiency" is used? Is there so much negative connotation that we can no longer see the benefits? I reached out to five different people in the #QualityPT world and no one wanted to tackle this one!

What you need to know about the "E-word"

I recently left an academic health science centre where many of us cringed whenever we heard the "E-word". To us, "efficiency" meant job cuts. And because of funding issues, there *were* reductions. After each round of layoffs, all in the name of "efficiency", we had to learn how to do more with less. So to me, the "E-word" conjured images of my smaller team.

The term was not used lightly.

But was it all bad? Yeah... that part really was. As professionals, we still had to provide the best quality of care to our patients with the resources that we had.

Because of the smaller team, we finally gave in and adopted a version of electronic charting (typing into a Microsoft Word form, which is uploaded as an attachment to an electronic chart.) For some, this process increased efficiency. One physiotherapist reported that when working on the weekend, moving from one unit to the next, her time was wasted when her patients were not ready to see her. She had to find something to do while she waited. Now, she could sit down at any computer and document patient care provided to patients throughout the hospital.

That was a good change, although for PTs who still type with two fingers, this change certainly slowed them down.

During my Lean Green Belt certification, I tackled a project that I had been avoiding: equipment management. Having moved to program management over a decade ago, we had absolutely no control over purchasing, servicing, tagging, inventory management or storage. After speaking up at the right meeting, at the right time, and to the right person, the stars aligned. An inventory controller was hired for six months to declutter hospital units. I quickly attached myself to the project and convinced them to use Lean tools to complete the physiotherapy equipment project.

Before the decluttering, a lot of time was wasted looking for the right piece of equipment for each patient. There were "have" units and "have-not" units, depending of the level of support and

available budget held by each unit manager.

Some physiotherapist assistants (PTAs) had to spend 20 minutes taking everything out of the equipment room in order to reach that one piece that always seemed to be buried at the back (only to stuff everything back in again!).

After trial and error, measurement, standardized tagging, pooling and redistribution of equipment, most patients now have access to the equipment they need and less time is wasted.

Efficiency win?

Yes.

Here's why being efficient is important

The Institute of Medicine defines being efficient as: avoiding waste, including waste of equipment, supplies, ideas, and energy. Efficiency is often equated with layoffs. However, efficiency is really about avoiding waste.

By avoiding waste, we save money, time, and energy; all of which can be used elsewhere.

All of these things can increase efficiency thus save money/time/energy:

- Are PTAs being assigned tasks that do not require the specialized skills of a physiotherapist, thus freeing up the PT's time to assess and analyse the complex patient?
- Is the right number of supplies used for each patient?
- Are your patients being asked to fill out electronic patient reported outcome measures, such as FOTO, in the waiting room?
- Is your equipment well organized and easy to access?

What you need to know about efficiency

In order to be efficient, the first step is to identify waste. Once you've figured out where your waste is, talk to the people actually doing the work to come up with solutions.

You can use a Plan/Do/Study/Act (PDSA) cycle of quality improvement to implement and evaluate changes. Or you can use a process like Lean.

The result should be increased time for PTs and/or PTAs to do the things they need to do.

One example that we came across was the need to fax documents.

Waste was identified: PTs type up the patient's discharge summary, print it, fax it to the institution the patient is being transferred/referred to.

Why can't they just push a button from the electronic medical record (EMR) to send it? Well, because "the system wasn't designed that way."

Hmm. I left before we fixed that one.

It's not that hard to identify waste. Usually, I come across something and think "that's dumb, why are we doing it that way?"

Others may refer to this as cautionary. Staff is your best source to identify waste, unless it has become so ingrained because "it has always been done that way." Hopefully not.

If you've experienced the "stay the course" kind of response, a great idea is to seek external advice: ask your patients/clients or other outside person.

Think about all the time you've spent sitting in a waiting room. Did you find that an efficient use of your time?

In order to be efficient, the first step is to identify waste. Once you've figured out where your waste is, talk to the people actually doing the work to come up with solutions.

Common challenges associated with efficiency

1. It can be difficult to get *staff buy-in*, especially if they're living in fear of being laid off. If they aren't involved from the beginning, and through the implementation, change management can be that much more difficult.
2. Another common challenge is being *stuck in your way of thinking*. If it's difficult to find solutions to your "waste", try using one of these tools to get your team thinking outside the box.
2. *Making changes is difficult*. Finding time to address efficiency when you are run off your feet, have no time to reflect and think through from problems to solutions, can make the process even more difficult.

Potential consequences associated with inefficiency

A repercussion of being inefficient is that your patients might not receive the level of quality physiotherapy that they require. Many things are beyond our control in an imperfect health care system.

The great thing about efficiency is that there are many things within your reach to fix, you just have to start with one problem at a time.

Three things you can do right now in your practice:

- Look around you right now. Is there any part of your practice that's not efficient? What can you list right now? If you can't think of any, ask your patients.
- Use the PDSA cycle of quality improvement. Break the problem up into small chunks; learn more about efficiency, and consider getting your yellow or green belt in Lean methodology certification.
- Create an environment where your staff can bring ideas forward; empower them to make changes. At your next team meeting, throw out the question "what can we be doing better?" If you're a clinic or team manager, start asking your staff "what can we be doing better?"

Don't ignore that caution light... trust your gut. Stop. Reflect. Act!

Here's why EQUITABLE physiotherapy is important -

Common challenges associated with equitable physiotherapy

Sarah Wojkowski, PT, CPA Member since 2004

On November 4th, 2015, Prime Minister Justin Trudeau was asked why having a gender balanced cabinet was so important. His response was simple: "Because it is 2015".[1]

This succinct answer made me pause to reflect on my own career as a physiotherapist. Could I provide such a pointed answer if someone were to ask me if my practice has been *equitable?*

What affects being equitable?

My initial thought was "of course". When I practiced clinically, I provided the best care that I could to each and every client I had the privilege of working with.

But after some reflection, I realized that it was the *people who needed* physiotherapy (PT) services, but could not access them that affected equitability.

It could be because of:

- Where they live
- When the services were available
- The languages I did not speak; or
- Responsibilities like child care

While I might provide the best care possible to those who came to me, what about those who couldn't? If I had to answer whether I had an equitable practice, I realized that I couldn't be as confident as our Prime Minister.

Are you confident that your practice is equitable?

In an effort to move past my disappointment in the realization of my own answer, I have mulled over the fact that I am part of a larger group of individuals, a profession who provides services across Canada.

So I began to ponder: "Can we, as a physiotherapy profession, confidently say that we provide Canadians with equitable care—regardless of where they live, their race or gender?"

Unfortunately my reflection on this question was not any more positive. I don't think we can. In fact, I think we have substantial work to do if we want to be able to provide an answer that is firm and confident when asked if all Canadians have equitable physiotherapy services.

Here's why being equitable is important

To illustrate why our work is cut out for us, let's consider "Sharon". Sharon is 38, has three children under the age of eight and works part-time as an administrative assistant. Sharon's husband travels regularly for work. They have just enough money to make ends meet each month. The family lives in Northern

Ontario and does not have extended family close by.

If Sharon hurt her back while picking up one of her children at home, could we as a profession be confident that she could have the same access to physiotherapy as other Canadians?

To answer this question we would need to consider a number of things:

1. Is there a PT in her community?

A. If there is a PT:

- Are services available when Sharon is not working so she doesn't have to take unpaid time away from work?
- Are there options for affordable childcare or do the treatment rooms and clinic space allow her to bring her children with her?
- Do they speak a language that Sharon can understand?

B. If there is not a PT:

- Is there a PT in another community, and can Sharon drive to or access this provider through public transportation?

2. Do Sharon or her husband have health care benefits that can assist them in paying for these services?

- If yes, do the benefits provide 100% coverage for all required treatment, or is only a portion of the fee covered to a maximum – and can they afford to pay the remaining fees out of pocket?

3. Can Sharon and her husband cover the indirect costs associated with accessing physiotherapy services (like cost of transportation, child care, time away from family responsibilities)?

- If they can't, do Sharon and her husband believe that the care that they would receive from a PT outweighs the other sacrifices that they would have to make to be able to pay for the services?

Now, let's change the scenario. Sharon lives in downtown Vancouver, she and her husband have full-time, permanent jobs with extended health benefits. They also have extended family close for support and childcare assistance. Would the answers to the questions above change?

I would argue they do.

As a result, "Sharon" highlights the challenges associated with achieving equitable physiotherapy in Canada.

What you need to know about equitable health care

In Canada, we are fortunate to practice in health care systems that are imperfect, but have an underlying premise that Canadians should receive necessary care based on need, and not ability, to pay.[2] Unfortunately, many of us can provide specific examples of when individuals could not, and still can't, receive needed physiotherapy services for a number of reasons.

Equitable care means that we physiotherapists provide care that does not vary because of personal characteristics like gender, ethnicity, geographic location and socioeconomic status.[3]

It is important to remember that equitable care *does not mean* that every patient receives the same care, or has the same level of health.[3]

Health disparities arise from unfair social systems such as low quality education – while differences in health are related to biological causes such as age.[3]

Common Challenges Associated with Equitable Physiotherapy

In Canada, there are populations who are more likely to report an unmet need for health care in general.

These groups include:[4-8]

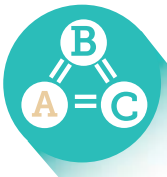
- Women
- Aboriginal peoples
- People in worse health
- Persons less than 69 years of age
- Persons with higher education
- Persons with lower income
- Persons without prescription drug coverage

However, there is a lack of evidence available that specifically identifies who needs, but does not, or cannot access, physiotherapy in Canada.

We also don't know how many Canadians have third-party benefits that could cover the cost of physiotherapy services (in part or whole) . This lack of information makes it difficult to identify specific actions that can be taken to ensure equitable physiotherapy services are available for all Canadians (#QualityPT).

Here's what we do know:

- Individuals who live in rural communities across Canada have greater challenges associated with accessing physiotherapy services.[9]
- There are gaps in service provision, challenges with delivery mechanisms and funding models associated with the delivery of rehabilitation services, include physiotherapy, for Aboriginal peoples who live in Canada.[8]
- Individuals with chronic conditions have increased difficulty accessing community based physiotherapy services in Canada compared to individuals without a chronic condition.[9]



Achieving equitable physiotherapy will be a challenge. Across the country, systemic changes are required to facilitate equitable physiotherapy that reflect evidence-informed practice.

But there are other important facts to consider. For example:

- Secure employment (jobs that provide a full range of benefits and have a possible career path) is declining and fewer Canadians may have the disposable income and/or health benefits that provide the financial means to pay for PT services.[10]
- New Canadians are more likely to work in insecure employment and lack health benefits.[10]
- Access to child care is a barrier, and limits access to good employment and both parent's ability to work for pay.[10]
- Regardless of educational attainment, women were still less likely than men to be employed in Canada in 2009.[11]

Potential consequences of not being equitable

Concern about inequitable health care is mounting. Studies have linked insecure work with deteriorating social outcomes[12] and translated low income into poorer health and diminished quality of life.[13]

In some areas, life expectancy in Canada is equivalent to lifespans in Third World countries.[13] In addition, intra-city life expectancy differences have been noted to be up to 21 years less in low income vs. high income neighbourhoods.[13]

Physiotherapy is effective in reducing acute and chronic pain, while limiting the risk of increased disability and chronic conditions.[14] A lack of physiotherapy services could result in *increased health system costs, delayed or reduced functional recovery for patients, and decreased quality of life.*

Three things you can do right now in your practice to be more equitable

Achieving equitable physiotherapy will be a challenge. Across the country, systemic changes are required to facilitate *equitable* physiotherapy that reflect evidence-informed practice.

These can include:

- Revising provincial funding models to integrate more physiotherapists into publicly funded, primary care roles
- Modifying existing third-party payers plans to increase total coverage

However, these major changes require thoughtful and persistent advocacy from the CPA, provincial associations and professionals like you and I.

But we can start small. Here are three simple tasks that you can start with today.

1. **Learn more about equitable care.** Many organizations across Canada support the goal of achieving quality health care. In Ontario, Health Quality Ontario (HQO) provides resources for health care providers to support quality improvement initiatives. Do you know if there is an organization is supporting the quality care movement in your province/territory?
2. **Become involved.** To "advocate" is an essential competency for Canadian physiotherapists.[15] PTs are well positioned to identify local, provincial and national opportunities to ensure equitable health care services. CPA continues to share a number of initiatives that will focus on achieving #QualityPT—will you participate?
3. **Pause and reflect.** Take a few minutes and think about your current practice. Can you identify opportunities to facilitate *equitable* physiotherapy?
   - Does your clinic have a space that encourages children to accompany parents to appointments?
   - Can you use technology for patient care (i.e. could you call a patient versus have the patient drive a distance for an appointment)?

If each of us makes one small change, as a profession we can take a large step forward in achieving *equitable* care.

After reading this post, if you are still asking yourself why *equitable* physiotherapy is something that you should be concerned about, I say "because it is 2016."

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The Health Quality Movement of the 21st Century

Did We Take a Wrong Turn Somewhere?

Allan Macdonald, PT, MBA, CPA Member since 2002

I recently reviewed some interesting passages from a book where the main purpose was simple, menacing, and genius, all wrapped into a bound set of 592 pages. *This Idea Must Die: Scientific Theories That Are Blocking Progress,* edited by John Brockman, is a collection of essays where the authors have been challenged to examine "infallible" ideas, and make an argument to set aside, re-frame, and/or re-examine the seemingly infallible in order to make room for new ideas to advance. For example, Nina Jablonski argues to rid ourselves of the concept of race, and Hans Ulrich Obrist warns against the framing of unlimited economic growth—certainly an interesting essay for the homeowners among us in Toronto and Vancouver!

Some of the essays are brilliantly executed and based on evidence, while others sound more like an author airing his/her grievances to the scientific world. The book can be read as a pop intellectual celebration with marginal net new contribution, or it can be seen as setting the stage for asking interesting questions about ideas that have long been framed as a "given". It got me thinking. What ideas are impeding progress in the physical rehabilitation world?

This article is written from an "ideas must die" perspective, and I would ask readers to consider it as it is intended—a challenge to a seemingly infallible idea! I submit that the "quality movement", which by and large has reduced and separated the client experience into manageable functions and specialties—quality, safety, client experience, performance measurement—has established conditions which are suboptimal for creating an excellent client/clinician therapeutic relationship, thus resulting in unsafe and suboptimal health outcomes. You may have heard a collective thud as the cadre of consultants, administrators and bureaucrats who have built healthy careers on building out "high quality health care" fell off their chairs after reading the above statement!

Since the Institute of Medicine (IOM) published its seminal treatise on the sorry state of health care in the United States—Crossing the Quality Chasm—in 2001[1], it has been obvious that something had to change in the way that health care services were organized, delivered, and monitored. It was no different in the Canadian context. A 2004 report outlined how 185,000 Canadian patients suffered unintended harm while in hospital.[2]

No less than a revolution was launched in the health care world as professionals across the globe latched onto the seemingly infallible idea that the health care experience could be reduced, quantified, measured, and reported, launching a "quality movement" which most assumed would eventually lead to improved health outcomes for clients and families seeking out care.[3]

It is likely complete heresy to many to consider the fact that, despite pouring billions of dollars into a focused and reductionist approach to building out quality and safety in health care, we have seen little appreciable change. However, this is the case. Acknowledging isolated success at centres like Virginia Mason in Seattle[4], some writers have questioned the effectiveness of said "quality movement".[5-8]

Is this something to be concerned about? Could it be argued that "change takes time", and that many positive steps have been taken as we plod towards improved quality? Or is the lack of success of the "quality movement" a canary in the coal mine that reveals a deeper failure in transforming what is at the core of helping people live healthy and productive lives—the client/clinician relationship?

The client/clinician relationship is a complex entity and the methodologies, approaches, philosophical underpinnings, and orientation are different for nurturing trust and fostering health behavior change vs. improving highly measurable and transactional interactions that occur every day as a client seeks assistance from health care providers. Have we missed the boat? Have we poured time and resources into building a highly fragmented management system that can monitor quality of care while focusing less on the mechanisms and processes that create trust, empathy, and teamwork in the client/clinician relationship?

There are several important missing pieces of evidence that could further inform the "quality movement" discussion. Does a healthy, high-quality therapeutic relationship improve health outcomes for clients/families? What are the components of a healthy, high-quality therapeutic relationship, and how could they be improved? To what degree, if at all, does a quality improvement system with a heavily reduced set of functions and roles, set inside a fragmented set of microsystems, contribute to improved health outcomes? Has the focus on the transactional aspect of the health care spectrum resulted in improved health outcomes? Would a focus on the evolving client/clinician therapeutic relationship, and its primary success components, be the way to a safer, more reliable and affordable health care experience?

The client/clinician relationship is at the core of the overall objective of most health care professionals—helping people understand how to improve their health in an effective, convenient and affordable manner. Could it be that the mechanistic, reductionist, and dare I say it, scientifically oriented evidence-based approach could be getting in the way of a high-quality a safe health care-related experience?!

These are just some of the considerations that leaders, clinicians, and researchers firmly embedded in the seemingly infallible "quality movement" could ponder as they continue their noble work of contributing to effective, high quality experiences every time a client asks for help.

PATIENT ENGAGEMENT:

What does it mean to physiotherapy practice and quality improvement?

Maria Judd, BScPT MSc. Senior Director, The Canadian Foundation for Healthcare Improvement
Carol Fancott, BScPT MSc, PhD, Clinical Research Leader, Collaborative Academic Practice University Health Network
Jennifer Rees, BScPT, Lead Engagement and Patient Experience, Alberta Health Services

Consider the scenario of Mrs. Atwal: Mrs. Atwal is a 72-year-old retired teacher, who recently suffered a hip fracture. After treatment in acute care, she was discharged home, where she lives with her husband and two dogs.

Mrs. Atwal is likely to receive care from physiotherapists at many points across the continuum of her care. As a patient/client-focused profession, physiotherapists are strong collaborators within the health care team, and engage with their patients in many facets of care including setting goals, determining treatment plans, and making decisions regarding discharge. Physiotherapists consider each patient holistically, as a person within the context of their communities. Building effective partnerships and better understanding the patient experience of their disease or illness can lead to improved patient outcomes and improved health over time.[1] Increasing attention directed toward *patients' experiences of care* has shown great promise in not only improving patient outcomes, but also improving the quality of care and design of health systems.[2] In times of fiscal constraints, focus on chronic disease management, and the "aging tsunami", engaging patients to transform the health system has become a prominent strategy to pursue better care, better health and better value for money.

What is 'patient engagement'? Patient engagement is intricately linked to the concept of patient and family-centred care. Patient-centred care has been defined as "care that is respectful of and responsive to individual patient preferences, needs and values, and that patient values guide all clinical decisions".[2] The Institute for Patient and Family Centred Care[A] outlines four key principles that should guide all encounters with patients and families: respect and dignity, information sharing, collaboration, and partnership. These principles underpin meaningful patient engagement efforts at all levels of the health system.

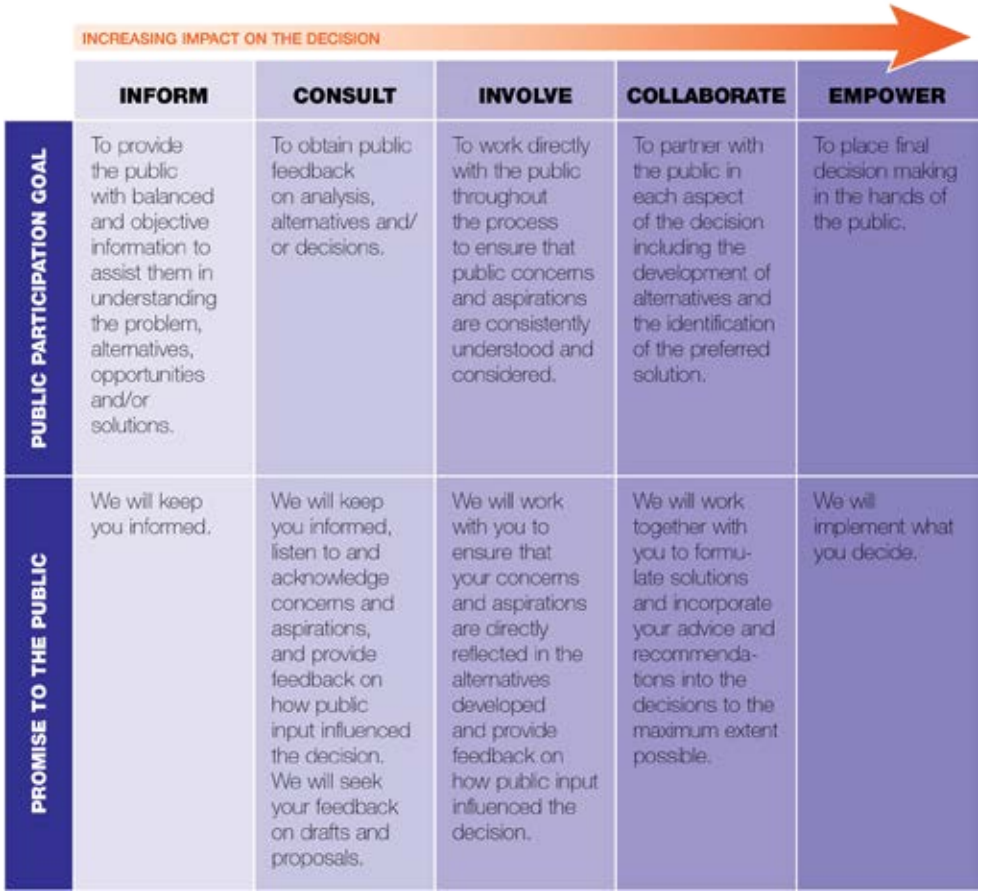
Engaging with patients is not a new idea, particularly within health care practice. Consider Mrs. Atwal above; physiotherapists providing care would involve Mrs. Atwal (and her family) in discussions regarding goals, treatment, and discharge, considering the context of her life, and the impact this hip fracture has now had. However, the recent enthusiasm for patient engagement has taken on many different meanings across the health spectrum. For the purposes of this article, we define patient engagement as "the involvement of patients and/or family members in decision-making and active participation in a range of activities (e.g. planning, evaluation, care, research, training, and recruitment). Starting from the premise of expertise by experience, patient engagement involves collaboration and partnership with professionals".[4]

Many frameworks for patient engagement and patient involvement have begun to surface in the literature and in practice. The framework presented by the International Association for Public Participation[B] is commonly referenced as it elucidates a continuum of engagement for how patients/the public may be involved to inform, consult, involve, collaborate, and empower, with increasing influence of decision-making across this continuum (see figure 1). Similarly, the framework presented by Carmen et al.[5] highlights this continuum of involvement, but importantly also add the components of *levels* of engagement in health care, drawing our attention to how patients may be involved at levels including, but not limited to, *direct level of care (e.g. shared clinical decision making)*, to influence the health system at *organization/program levels (e.g. patient advisors on quality committees)*, as well as at the *policy level (e.g. members on resource allocation agency committee)*.

The specific purpose and goal of engagement will help to determine the type of engagement that occurs and at what level. Returning to Mrs. Atwal, we see how, as physiotherapists, we partner and encourage strong involvement at the individual level of care, gaining greater insights into their experiences of disease and illness, tailoring treatments and decision-making that aligns with Mrs. Atwal's values and fit the context of her life. For example, as a new patient in our care, we may provide Mrs. Atwal with information about her condition and trajectory for recovery so that together we can set goals. If we further explore Mrs. Atwal's experiences of care, these unique patient perspectives can help us to better understand potential issues such as those related to transitions and coordination of care as she moves through the health system. Engagement efforts might include involving Mrs. Atwal (and her family) to partner with us in a quality improvement initiative that examines processes related to transitions, and gain valuable insights from the patient perspective as new processes are designed and implemented.

Linking patient engagement to quality improvement The literature points to patient insights as an under-developed resource for improving health services, as patients may offer differing perspectives and experiences, and have unique knowledge that

Figure 1: *IAP2 framework*
©2007 International Association for Public Participation www.iap2.org



only they can have as recipients or users of the services within a highly complex system.[6,7] The experiences of patients (or users of the health system) are central to improvement efforts.[8]

Efforts and initiatives to ensure the experience of patients and their families drive improvements in the design, delivery and evaluation of health services are growing across Canada. One such example is the CFHI's Partnering with Patients and Families for Quality Improvement Collaborative,[C] created to enhance the capacity of organizations across Canada to partner with patients and families to improve care (see figure 3). Preliminary results from the 22 projects in CFHI's collaborative suggest that meaningful patient and family engagement in quality improvement can lead to changes in models of service delivery/models of care. The example below illustrates how one team engaged patients and families to improve the transition from hospital to home for patients with hip fractures (Image 1).

Research at two hospitals in British Columbia revealed that patients/families lacked basic information and resources on how to manage their care needs and stay safe at home after a hip fracture. A joint team (core members included a Physiotherapy Practice Coordinator, a Clinical Nurse Specialist and a Patient and Family Advisor) was formed from Vancouver Coastal Health and Fraser Health to engage patients, caregivers and staff in a care redesign project.

The project's aim was to improve the patient experience of the transition home after a hip fracture by determining the optimal tools and processes to support patient/family self-management, confidence and competence. An interdisciplinary team developed The FReSH START Toolkit: Fracture Recovery for Seniors at Home :A Hip Fracture Guide for Patients and Families (FS)[D,8] using best evidence and "words of wisdom" from older adults who had sustained a hip fracture, and orthopaedic clinicians.

Further improvement opportunities were also generated from patient experience data (using the Canadian Patient Experience Survey (CPES-IC),[E] transitions subset), surveys of patients and health care professionals, interviews and focus groups, helped to identify priority improvement themes then tested using PDSA methodology.[F] Key improvement ideas identified and implemented included a) the introduction of a formal discharge briefing meeting with a patient and their caregiver and b) the introduction of pharmacist bedside coaching, while in hospital, and a pharmacist follow up call to the home after discharge. Patient experience data improved (20% from baseline) after introduction of the pre-discharge briefings with patients and caregivers and the pharmacist follow up post discharge. Several of the clinical recommendations from this initiative are being implemented throughout the province of British Columbia's 28 hospitals through the BC Hip Fracture Redesign Initiative. Patient and family experiences were at the heart of their improvement efforts.

How can you engage with your patients across the continuum and at all levels of care? Many methods of engagement exist across the spectrum, and to reiterate, depending on purpose of engagement, different strategies will exist across the continuum. Here are a few ideas for engaging patients and families:

At the direct level of care:

- At the end of a clinical visit ask your patient/client "How could your appointment have been better today?" Listen and learn from the patient experience.
- Use shared decision-making aids to help ensure treatment decisions are made based on patient preferences, medical evidence and clinical judgment patient.[G]

At the organizational level:

- Use structured methods to gather patient experience data (e.g. through surveys, focus groups, storytelling methods) and generate opportunities for improvement
- Partner with patients on change initiatives, to ensure that changes meet patients' needs. Over 100 tools to engage patients and families in improving health and health care can be found.[H]

At the policy level**:**

- Provide opportunities to work together with patients and families to consider changes in your facility policies. For example, form a team at your organization and take the CFHI's Better Together Pledge[I] and commit to reviewing your visiting hour policy with staff, patients and families and ensuring your policy supports family presence and participation. CFHI's Better Together campaign[J] has resources that can help in implementing family presence policies that enable families to be present 24/7 and participate in care.

Conclusion Patients and families play key roles across all levels of the health system. By recognizing their 'expertise by experience', their insights can move us toward a more patient and family focused system that enhances their experience of care, outcomes and value for money spent in health care.

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Figure 2: *Carmen framework*
Source: Carman, K. L., P. Dardess, M. Maurer, S. Sofaer, K. Adams, C. Bechtel and J. Sweeney (2013). "Patient And Family Engagement: A Framework For Understanding The Elements And Developing Interventions And Policies." Health Affairs 32(2): 223-231. Adapted with permission.

A Multidimensional Framework for Patient and Family Engagement in Health and Health Care

Continuum of engagement

LEVELS OF ENGAGMENT	CONSULTATION	INVOLVEMENT	PARTNERSHIP AND SHARED LEADERSHIP
Direct Care	Patients receive information about a diagnosis	Patients are asked about their preferences in treatment plan	Treatment decisions are made based on patients' preferences, medical evidence, and clinical judgment
Organizational design and governance	Organization surveys patients about their care experiences	Hospital involves patients as advisors or advisory council members	Patients co-lead hospital safety and quality improvement committees
Policy making	Public agency conducts focus groups with patients to ask opinions about a health care issue	Patients' recommendations about research priorities are used by public agency to make funding decisions	Patients have equal representation on agency committee that makes decisions about how to allocate resources to health programs

Factors influencing engagement:
- **Patient** (beliefs about patient role, health literacy, education)
- **Organization** (policies and practices, culture)
- **Society** (social norms, regulations, policy)

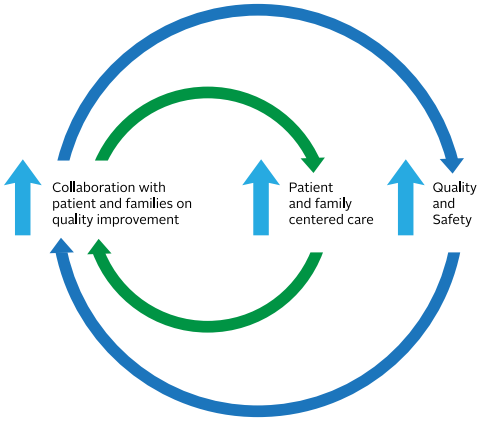

Figure 3: *Linking Patient and Family Engagement, PFCC and Quality Improvement*
Source: CFHI's Partnering with Patients and Families for Quality Improvement Collaborative curriculum. Accessed at http://www.cfhi-fcass.ca/WhatWeDo/partnering-with-patients-and-families-collaborative

Image 1: *Dolores Langford, Physiotherapy Practice Coordinator, Coastal Community of Care, Vancouver Coastal Health and Kathleen Jackson, patient, 'Good to Go' hip project.*

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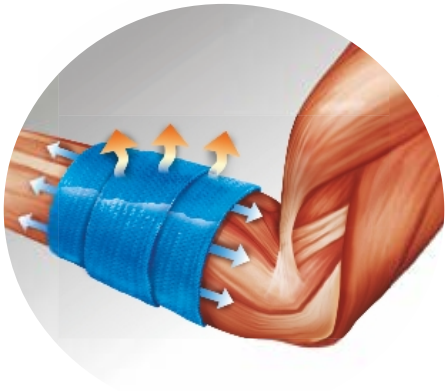

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Safety Alert/Stop the Line:

Saskatchewan uses lean tools to improve patient and staff safety

Kate Fast, BSc. PT, M.A. Health Leadership

Across Canada, an estimated 7% of patients admitted to hospitals experience adverse events.[1] In Saskatchewan, over 190 patients experienced critical incidents in 2014/15 and over 2400 staff had accepted insurance claims for work place injuries.[2] While other industries, such as aviation, have reduced risks to near zero, Dr. Ross Baker recently observed that many Canadian health care organizations still struggle to address key patient safety issues.[3]

Saskatchewan is using Lean management tools to make health care environments safer for everyone. This is our story.

Provincial Context

In 2012, system leaders recognized this strategic priority by establishing a provincial 'Safety Outcome'. This outcome aligned the work in 13 health regions to achieve a provincial goal of zero preventable harm to patients and staff by 2020. The Safety Alert/Stop the Line (SA STL) is one of the key strategies within the Outcome and is intended to strengthen the culture of safety and increase the capabilities of regions to continuously and systematically reduce the risk of harm. The province has a target of implementing the SA STL in all regional health authorities by March, 2018.[4]

The SA STL work began in 2012, and was designed through a provincial 3P (production preparation process) that included internal and external stakeholders and patients. The result was a conceptual 'future state' process map that envisioned stop the line, response, and reporting processes to address potential and actual safety risks identified by patients, staff and physicians. The SA STL was based on two guiding principles: a commitment to patient-centred care and to building safe health care environments for everyone (patients and staff).

While the concept of 'stop the line' is understood in general, the specifics and scope of the SA STL are being defined as the work evolves. An operational definition of the SA STL that is clear, objective and measurable is needed in order to assess progress towards implementation. Seventeen key processes, policies and activities have been identified that collectively constitute the foundational elements of the SA STL.

SA STL Defined as a Lean Process Improvement

The SA STL can also be viewed as a process improvement in the flow of safety information (see SA STL Current State Process Map, Fig 1). Since not all processes within health care can be engineered to prevent defects (*judoka*), the next most effective approach to error detection is inspection at every step. This prevents defects from being passed along, that may result in errors and possible harm. The SA STL imperative is that everyone becomes a safety inspector and that they stop care processes if a defect is detected.

When a defect is detected, staff and providers are expected, if possible, to fix it in the moment, before being passed on. 'Stop the Line' is the signal, or *andon*, used to communicate that a defect has been detected (or error has occurred). By March, 2018 all regions will have a 'stop the line' *andon* and standard processes for bringing in additional resources to restore safety when needed.

A real 'stop the line' example, shared by Saskatoon in December 2015, showed how this works.[5] A child was in recovery following surgery. The mom noticed that the child was becoming distressed and short of breath and called for their nurse. The nurse quickly examined the child and the IVs and recognized that the medication in the IV was the wrong concentration for a child. Recognizing the seriousness of the situation, she immediately called out a 'stopped the line,' which brought others in to assist. The surgeon quickly came to the bedside and the team stabilized the child's condition. A member of the family called the 24/7 telephone number, dedicated to intake of safety incident reports. Because there was a potential for imminent and serious harm, the vice president on call was immediately notified. She spoke to the family member who reported the incident and then came to the unit to provide support to the family and the care team. Errors do happen in health care, but the 'stop the line' processes enabled staff to stop and get the immediate help needed to restore safety. Prior to the SA STL, it was unlikely for staff and patients to have the support of senior leaders at the time when it was needed the most.

Lean management relies on data to track performance, assess improvement and set priorities. The SA STL includes process improvements aimed at making safety incident reporting easy, encouraged and celebrated. At the unit level, safety incident reports contribute to locally meaningful safety indicators that are reviewed through daily huddles and visual management (DVM). For example, at Saskatoon City Hospital, nurses, physical and occupational therapists and care coordinators on the Orthopedic Unit huddle every morning at 7:30. They use a standard agenda to review patient or staff safety concerns from the night before and to identify any potential safety issues for that day. This is the venue for interdisciplinary collaboration and troubleshooting, such as how to implement the actions resulting from a post-fall huddle. They may also use this time to look at progress on safety indicators (DVM), such as the number of falls or number of staff injuries related to patient lift/repositions. Creating opportunity and formalizing time for these interdisciplinary quality improvement discussions ensures that everyone on the unit is engaged in improvement and safety.

At the organizational level, the SA STL includes provincial work standards that make reporting of organizational safety outcomes routine. Regions are expected to have standard work to ensure that safety incident data is used

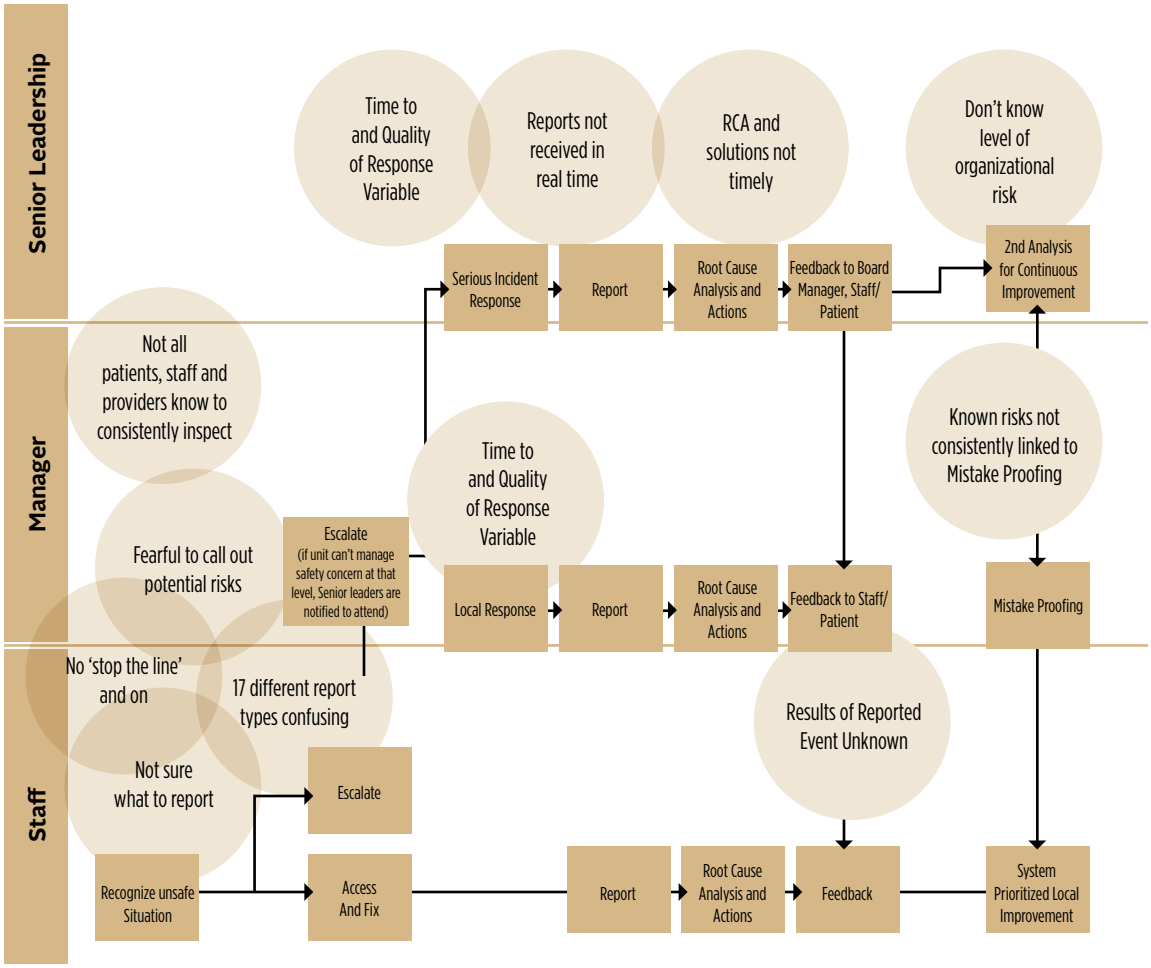

***Fig 1**. Current State Process Map for the Flow of Safety Information*

This process map is a generalization and is a compilation of regional safety information flows.

to inform investments in harm reduction (at a minimum through occupational health committee and mistake-proofing). Senior leaders are expected to review unit safety performance data with managers and staff on a routine basis. This process is known as a wall walk.

Daily visual safety management and the utilization of safety data represent feedback loops. These are a characteristic of learning organizations and are prerequisite for continuous improvement.[6] The SA STL processes include multiple feedback loops. One of the most important is the expectation that leaders connect directly with those who report serious or critical safety incidents. Work standards also exist to ensure that staff that report have a mechanism to learn what follow up actions have avbeen taken. These feedback loops are powerful positive reinforcements to staff, physicians and patients.

The process changes listed above are expected to have secondary positive impacts on the culture of safety within organizations. The SA STL initiative includes a commitment by regions to train senior leaders in root cause analysis (RCA). Work standards for leaders include the expectation that leaders coach staff and providers to investigate safety issues using RCA principles. Additional process improvements, such as making reporting easy, making safety more transparent and talked about, are also expected to positively influence the safety culture.

Current State of Safety Alert/Stop the Line in Saskatchewan

The SA STL initiative is underway in all regions. Daily visual management (DVM), introduced as a lean management tool in 2013, is used in the majority of acute and ambulatory settings and includes safety as a specific indicator. Most organizations are using safety information to improve performance, although efforts are focused primarily on response to safety incidents rather than prevention and systematic harm reduction.

Within regions, there have been measureable improvements. Saskatoon Health Region introduced the SA STL process improvements in 2014 and the processes have spread to three acute care hospitals and related ambulatory settings. An internal evaluation completed in January, 2016 documented several improvements:

- The number of voluntary safety incidents reported has increased 100% over baseline.
- 90% of the reported incidents were addressed on units by staff/leaders at the local level. This shows that SHR is moving towards the goal of zero harm to patients and staff.
- The time it takes to address safety concerns (lead time) has decreased. Serious safety incidents that which resulted in severe or immediate risk to patients and staff were mitigated at the vice president level within 40 minutes. Safety risks that resulted in moderate harm to patients or staff were mitigated at the director level within 4 hours, 50 minutes. This is notable because the response time is now known and rapid.

Using Lean tools and systems has provided a framework for improving safety for patients and staff in Saskatchewan. They have also enabled the health system to create data sets that help inform and guide improvement. While we are early in the journey, the learnings have been rich and there is evidence that our system is moving in a safer direction.

Spotlight

What does Leadership mean to you?

Leadership Division
Canadian Physiotherapy Association

Leadership is a choice, not a position. – Stephen Covey

"As long as we make leadership something bigger than us... as long as we keep leadership beyond us... as long as we make it about changing the world... we give ourselves an excuse not to expect it from ourselves and from each other". ~ Drew Dudley

"It is our light and not our darkness that frightens us." ~ Drew Dudley

Leadership roles exist in all aspects of our profession. Issues around leadership are relevant whether you are a clinician, student, assistant, manager, supervisor, practice leader, researcher, professor, or administrator. Wherever you are, whatever you do, leadership is essential to your work, your profession, and yourself.

The CPA Leadership Division exists to help you develop your own leadership skills as well as those of your colleagues. We provide a variety of venues by which Division members are able to network with other physiotherapists across Canada who deal with similar issues. Much of this networking is encouraged through our member newsletter, ***The Leading Edge***, issued four times each year. We also issue weekly ***eBlasts,*** sharing TED Talks and other inspirational resources with our members;, we also welcome discussion on our Facebook page and Twitter feed. Members are eligible for ***funding and recognition opportunities*** offered by the Leadership Division.

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To learn more about where we came from, who we are, and where we're headed, read former Leadership Division Chair and Newsletter Editor, Carol Damp Lowery's wonderfully written article in our latest newsletter.

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fisiocrem is a topical solution containing natural herbal active ingredients which are traditionally used in Herbal Medicine to help relieve aches and pains and inflammation in muscles and joints caused by sprains, strains, bumps and bruises.

fisiocrem provides relief from aches and pains of muscles and joints in cases of simple backache, arthritis, strains and sprains involving muscles, tendons and ligaments.

And now it's available in Canada!

The easy & FREE way to test fisiocrem

We're convinced that once you see for yourself how well it works for patients and feel the clean and non-greasy aspects, then you'll love it like so many others.

Try fisiocrem now and see why it's the natural choice for the dedicated professional.

fisiocrem T.M.

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