~~Don't~~ Sweat the Small Stuff

A new chapter each week - A 4 minute read!

Chapter 3 – "Admission of Guilt"

As we sat in the ER just having learned that Carol likely had some form of lymphoma we were in a numb state. We were told that there would need to be more tests and investigations. The doctor indicated that Carol would need to be admitted. This came as a surprise. Carol was in no pain, had been working all week to move her parents and had no physical distress. She wanted to be home in her own bed, but that apparently was not an option. The oncologist indicated that there was an urgency about getting the tests done and they would likely be done on Sunday. What I did not realize at the time was that the oncologist was admitting her because she would access testing far more quickly as an admitted patient instead of as an outpatient. This is apparently a very widespread practice and makes one wonder how many of the people in a hospital bed are simply there because we cannot figure out how to schedule tests effectively!

What made me feel guilty about this admission was the fact that I was very aware of the regional health care system. Thunder Bay Regional not only supports the hospital needs of the 120,000 people who live in Thunder Bay, but also serves as the regional referral centre for northwestern Ontario which has a population of about 250,000 people. Just to compare – Northwestern Ontario covers 440,000 square kilometers - the size of England and Germany combined! Northwestern Ontario has a population of 250,00 – England and Germany have 140 million people – over 500 times as many people. Aside from the demographic extremes Thunder Bay regional was in "gridlock" 310 out of 365 days in that particular year. This means they had more patients than beds on 310 days of the year. One day they had over 450 patients admitted to their 350 bed facility. You can appreciate that beds are at a premium at Thunder Bay Regional.

Carol was admitted after a several hour wait in the ER. We had been made aware in the emergency department that this was serious and that we needed to access the additional tests as quickly as possible, and if they were all going to be done the next day, admission seemed to be the right thing to do. Sunday morning came, and we expected a follow-up CT, a bladder scan, and a biopsy. By Sunday afternoon nothing had happened. We wondered how the sense of urgency that we were given on Saturday had all but evaporated. During the next week Carol got the required tests and biopsies. She was in the hospital for eight days in total. When I add up the actual time for each of the procedures the total for the week is less than 8 hours. Admission time taking up a bed – 192 hours but the actual procedure time was less than 8 hours.

This made little sense to me but even though I had been in health care for 25 years, this was all new territory for me. I knew the CEO of Thunder Bay Regional (Jean Bartkowiak) as we had served on the Ontario Telemedicine Network board together. I asked Jean if this was the best

way for Carol to access the care she needed. He checked with his Chief of Staff and his VP of Medical Affairs (also a physician), and both indicated that this was the best course of action for Carol to get the care she needed

Small Thing #2 – This may not be such a small thing but why can't we seem to make assessing services convenient, easy and cost effective? I find it amazing that I can book a hotel room in Beijing in less than 30 seconds and choose from 50 different hotels. The way we have set up health care is very different, and forces clinicians to do "workarounds" to make the system do what it needs to do. Workarounds are more costly, usually inconvenient, and are a clear indication that we have made a mistake in the way which we (the system administrators!) have organized the care delivery system.

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By Sunday afternoon nothing had happened. We wondered how the sense of urgency that we were given on Saturday had all but evaporated. Later on Sunday I emailed a friend who was a radiologist. She phoned me almost immediately and asked to be put on speaker phone and asked Carol for her permission to look at Carol's images. Carol happily complied. We expressed our concern that things seemed so urgent yesterday but here we were 24 hours later and nothing had happened. Our friend mentioned that she knew one of the nurses in the cancer centre in Thunder Bay and she would touch base with her to help coordinate Carol's care. Early Monday the nurse arrived and introduced herself. From the small world department, it turned out Carol had taught her some 25 years ago at a small school outside of Fort Frances. She was instrumental in getting things arranged and expedited.

When you live in northern Ontario we are five hours due north of the Mayo clinic. It is well known in our area and many who have the financial resources will access diagnostics and care at the world renowned centre. For all of its faults the US system can teach us a lot about all sorts of things as it is constantly changing to meet regulatory, legal challenges, technology, financial and market challenges. While we have many advantages over the US system we should, realize that the US system offers us the opportunity to see in real time many different approaches and decide what works and what doesn't. While our system does not have many of the challenges of the US system, we tend to be slow to adopt innovations that would work well in our system. As an example one area is the way in which Mayo arranges their diagnostic services. If you arrive there you will have your needed tests arranged quickly and efficiently and you will likely have a definitive diagnosis within 2 to 3 days. The default in their system is to do things on an outpatient basis as hospitalizations are horribly expensive. To do this effectively

you need to have adequate diagnostic capacity – which we would consider “over capacity” in the Canadian system.

Minnesota, (home to the main Mayo Clinic) is similar to Ontario in that it has a lot of land (by US standards and a small population - just 6 million people – less than half of Ontario. What is surprising is that Minnesota has more MRIs per capita than the US average and the state of 6 million can boast about 250 MRIs for 6 million people. Ontario has 138 MRIs for 14 million people. To have an equivalent number in Ontario on a per capita basis we would need to have 583 MRIs not 138! I called the Mayo clinic in Rochester and the DI manager informed me that they had 75 MRIs at the single Mayo clinic site in Rochester. – Think about that 138 for all of Ontario vs 75 at one single clinic!

As we hear more about lengthy wait times for diagnostics all across Canada our approach seems to be based on a base strategic planning assumption. We seem to have decided to restrict the access to needed diagnostic services, (a false economy belief that DI capability is “net cost” instead of viewing it as a cost saving tool – i.e. – early diagnosis, avoiding unnecessary investigations and seeking of second and third opinions). Secondly, we have made the system less flexible by locating the majority of DI capacity in hospitals, with their regulatory/union/legal frameworks, that make access poorer and often force unnecessary hospital admissions and increased complexity to access those diagnostics.

Aside from the actual numbers of CTs, MRIs, PET scanners and other diagnostic devices we need to reconsider how we have set up access to services. We should not forget that the diagnostics are the first step in the treatment process and delays at this level put people’s lives at risk. To think that restricting or reducing access to diagnostics is somehow beneficial is foolish. The most cost effective or cheapest care is no care at all – hardly a realistic alternative – especially if you are the one who will die due to the absence of care!

Next week – Front Door for You – Back Door for Me!