~~Don't~~ Sweat the Small Stuff

A new chapter each week – a 4 minute read!

Chapter 4 – Front Door for You – Back Door for Me!

Small Thing # 3 - The "Back Door"

The "back door" of health care. I hate to call this a small thing because it really is quite pervasive and as the system becomes more stressed due to demand it represents a clear indication of a system that does not meet needs equally. I worked at the Group Health Centre in Sault Ste Marie over 20 years ago and it was an integrated model that should have been replicated but the Ministry had other plans for the model and it is merely a shadow of its former self. At the time the centre was the only organization to win four successive national best practice awards as well as the Tommy Douglas Inaugural Award for Excellence in Primary Care. Roy Romanow the Commissioner appointed by the Prime Minister to lead the Royal Commission on the Future of Health Care in Canada called the Group Health Centre the "jewel in the crown of Medicare". A lot has changed.

It was Lucy Fronzi the head of the booking department who explained the concept of the "front door" and "back door" of the health care system. My entire experience with health care was the small town I grew up in and in retrospect I realize that it had its own form of "manipulated" access. At the Group Health Centre we had over 100 providers and there was a centralized call centre with a staff of 12 who used a customized computerized system for booking appointments. We were booking over 400,000 appointments each year. The centralized system allowed for efficient booking of appointments and allowed us to arrange multiple appointments for those who travelled in from outlying areas. You could arrange to see your GP, a physio therapist and an optometrist all in one visit to the centre. Sounds great BUT, most providers blocked parts of their schedule that only their nurses or receptionists could book, so we had a situation where the system was defeating itself. The patients who knew the extension of their physician's nurse would by-pass the appointment centre and gain preferred access to their provider. This was the proverbial back door. Those who dutifully went through the "front door" waited longer for their appointments. This reinforced the preferred choice of using the back door when you needed care and made our million dollar call centre far less effective.

As much as I wish the system did not rely on the "back door" Carol and I happily used the back door to access the system. We reached out to our own radiologist who provided us with more timely information and advice throughout our journey. We connected with a nurse from the cancer centre who helped arrange and facilitate our care. We gained access to our oncologist at Princess Margaret through an associate. I used my contacts to get expedited surgical and homecare services. There is no doubt in my mind that our journey and outcome was positively impacted by our relationships and knowledge of the system. I would not hesitate to do it again because this truly was a matter of life and death.

As mentioned in the last chapter the system used a back door to admit Carol so she could access diagnostics and even using the back door Carol spent eight days as an inpatient getting scans and a biopsy that all could have been done on an outpatient basis. I added up the entire time of these procedures we tied up a bed for almost 180 hours to access about 8 hours of care.

The back door and special relationships are not in and of themselves bad – it is only when they disadvantage others that they have a negative impact on the system in that they provide preferential access to some while others have their access delayed. (The Canadian version of a "two tiered" system!) I have been asked to help people access care and do so willingly. I often think if we arranged the system correctly someone should not have to call me to assist in accessing the system. The A- ha moment came for me when I realized that the "back door" was simply another workaround to provide timely "access" to care. We have set up a system to provide care without considering the access dynamic. We have left access to occur naturally or as a byproduct of system design instead of being a component we should plan for in the delivery of care.

We have failed quite miserably at making access a key component of our delivery system and we tend to fail just as badly when access becomes an issue. We tend to revert to "MOTS" – "more of the same" – i.e. we will simply provide more – more beds, more machines, more hours, more locations. These may improve access but at times they will take months or years to bring on-line and may be cost prohibitive. This is the approach that we tend to take as it allows the politicians to demonstrate they are doing something to deal with a current crisis. The problem with this approach is that it does not really analyze why access is failing. It assumes the way in which we provide the care currently is the best or only way we should deliver care. We seem oblivious to the other factors that impact access such as: how we pay providers, where we locate services, scope of practice and legacy regulatory issues, turf protection, mythologies that drive decision making and the inability to see potentially different approaches to providing care (think virtual and artificial intelligence). It is time to think long and hard about access and be willing to look at all system components to improve access in primary care, emergency care, diagnostics and surgeries. If we find ways to reward better access we will find a system that will improve access organically – my experience is that incentives do work.

We cannot lose site of the fact that for certain conditions much of the time the system does respond effectively and quickly. From Carol's first visit to the ED until her first chemotherapy treatment it was only 12 days (covering 2 weekends and eight days as an inpatient). This allowed for the necessary testing, diagnostics, referral to and meeting with an oncologist who would set up her care plan and keep us up to date with her progress. The pathology showed that Carol had Large B Cell Non-Hodgkins Lymphoma. (This was accurate at the time but not complete.) Overall this was incredibly quick and the systems' ability to respond so quickly was encouraging and demonstrated that the cancer centre in Thunder Bay managed access in a very proactive way. We started an 18 week journey where there would be six cycles of chemotherapy with each session lasting all day and happening once every three weeks. The drugs used were Cyclophosphamide, Hydroxydaunomycin, Oncovin, Prednisone and Rituximab – better known as CHOP-R. The cancer centre had a special feel about it and the staff there were great – they seemed to get that "newbies" were frightened, uncertain and somewhat in shock. There approach made the journey better. They deserve our thanks.

Next Week – Welcome to the Cancer Club