October 27, 2011

Health Quality Council of Alberta releases second interim progress report on independent review

*(Calgary, AB)…*The Health Quality Council of Alberta (HQCA) today released its second interim report related to its independent review of the quality of care and safety of patients requiring access to emergency department (ED) care and cancer surgery and the role and process of physician advocacy.

The HQCA review team has been pleased with the number of individuals who have participated in the review. "Nearly all the people with whom we wanted to speak have come forward, as well as others who requested to meet with us, and they have been forthcoming and sincere with their comments," said Dr. John Cowell, Chief Executive Officer of the HQCA.

"Given the scope of the review and the need for a full understanding of the issues, it would be premature to make any recommendations until our work is complete," said Dr. Cowell, adding there are interviews left to conduct and more data to gather and analyze.

Quality of Care and Safety of Patients Requiring Emergency Department Care and Cancer Surgery

Based on the patient charts analyzed to date, the review has confirmed that severe crowding and extremely long wait times as identified by the University of Alberta Hospital (UAH) Emergency Department (ED) physicians were an issue for patients at the UAH ED in 2008. This in turn put at risk the quality of care these patients received. "On the basis of the patient charts analyzed to date, we have not seen any evidence that lives were lost at the UAH ED as a result of prolonged ED wait times in 2008," said Dr. Cowell. "What we have seen is that once patients received care, it was appropriate, but was often provided in challenging and very difficult conditions."

An important example of how the safety margin of the care for patients in the UAH ED was eroded is illustrated by the following experience of a person who went to the ED and left without being seen after approximately a five-hour wait. The patient returned to the ED the following day, still feeling ill, and within a short period of time required life-sustaining therapy. The patient survived, was admitted to the hospital and subsequently discharged home. According to the severity of the patient's condition when the patient first went to the ED, Canadian guidelines recommend that such patients wait no longer than 30 minutes before being assessed by a physician.

Dr. Cowell adds, "Based on the analysis of provincial ED wait time data for 2008, there is no reason to believe that ED crowding and long wait times were unique to the UAH or to only EDs in Edmonton."

In contrast to the data available on the ED issues, information related to the wait times for cancer surgery (focus on lung cancer surgery) has been more difficult to find. Regarding the reference in the Alberta legislature on February 28, 2011 to a 1,200-person waitlist related to lung surgery, including 250 patients who died while on that list, the HQCA has not seen evidence to date that a waitlist of this size exists or existed. Work on this issue is ongoing. Furthermore, to date no evidence has been found to link physicians advocating for additional thoracic surgery resources with subsequent decisions to curtail physician practice opportunities.

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Role and Process of Physician Advocacy in Patient Safety and Health Service Quality

Dr. Cowell says that during the course of the review, the team has learned that physicians are expected and encouraged to advocate for individual patients, groups of patients and the health needs of the community as a whole. It appears, however, that the process for physicians to follow is not obvious or defined. “We have learned that physicians we have spoken with have received little, if any, education or coaching on how to advocate effectively. We have also heard that in the healthcare system, administrators, clinicians, government officials and politicians are often uncertain how to handle or react to physician advocacy.”

A number of physicians have described disturbing life- and career-changing outcomes that they attribute to their advocacy efforts. These include having hospital privileges affected, feeling ostracized by peers, and having contracts for services being altered or cancelled, which in some cases, limited their options for remaining in the province. Some have elected to leave the province to seek work elsewhere. “During the course of the interviews it came to light that since 2008, the lack of stability in organizational structure, leadership and reporting relationships within Alberta Health Services has impacted physicians’ willingness and ability to advocate for their patients,” adds Dr. Cowell.

To date, no evidence has been discovered that inappropriate financial payments have been made to any physician to muzzle their attempts to advocate on behalf of patients.

Process

Every practicing physician in Alberta has been mailed a survey within the past week asking about their knowledge and experience related to advocacy in Alberta and the extent to which advocacy for patient care is influenced by healthcare provider organizations, government, professional colleges and others. It is expected that this survey, which is supported by the Alberta Medical Association and the College of Physicians & Surgeons of Alberta, will reveal the extent of issues and concerns related to physicians’ experiences advocating for their patients.

“The timeframe of this review goes back to 1998, spanning more than a decade during which the province’s healthcare system experienced many significant structural changes. We expect that when the review is done, we will have a more complete understanding of ED crowding, wait times for lung cancer surgery and physician advocacy issues,” said Dr. Cowell. “As with any review the HQCA conducts, our goal is to make system-wide recommendations and identify opportunities for improvement as a result of the findings.” The review is due to be completed in February 2012.

The HQCA’s second interim report on the *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* follows.

The HQCA gathers and analyzes information and collaborates with Alberta Health and Wellness, Alberta Health Services, health professions, academia and other stakeholders to translate that knowledge into practical improvements to health service quality and patient safety in the healthcare system. The HQCA is a provincial health board created in 2006 by the Health Quality Council of Alberta Regulation under the Regional Health Authorities Act.

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The Health Quality Council of Alberta's Second Interim Report on the *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy*

Progress to Date

- Over 70 interviews averaging two hours in length were completed by October 26, 2011.
- Over 600 patient charts from the University of Alberta Hospital (UAH) have been analyzed including all those identified by the UAH Emergency Department (ED) physicians.
- Acquiring all the data to support the analysis of ED wait times and crowding has been difficult. To gain a good perspective on wait times and crowding since pre-2008, data are needed from 10 years ago to present. However, in some cases data were incomplete or non-existent.
- The review team continues to gather many documents from interviewees and through a formal request to Alberta Health Services.
- A systematic literature review is underway to highlight effective intervention strategies that address the issue of ED crowding and to determine the concept, scope and practice of effective physician advocacy. This will be completed in mid-December 2011 and included in the final report.
- Beginning October 18, 2011, every practicing physician in Alberta was mailed a survey asking about their knowledge and experience related to advocacy in Alberta and the extent to which advocacy for patient care is influenced by healthcare provider organizations, government, professional colleges and others. Both the Alberta Medical Association and the College of Physicians & Surgeons of Alberta have provided their support for the survey. Preliminary data will be available in mid-December 2011 and complete results will be included in the HQCA's final report early next year. It is expected that this survey will reveal the extent of issues and concerns related to physicians' experiences advocating for their patients.

Findings to Date

Quality of Care and Safety of Patients Requiring Emergency Department Care and Cancer Surgery

Emergency Department Care

The University of Alberta Hospital emergency room physicians identified patients in 2008 (and a few in 2010) as examples of patients whose care could have been compromised by ED crowding issues. The review team has analyzed all of the charts of the patients identified by the UAH ED physicians and, in addition, analyzed charts of other ED patients in 2008 to look for other possible cases where negative clinical outcomes might be related to excessive wait times. Charts of ED patients seen in 2008 who met specified criteria and died in the UAH ED, died

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within 72 hours of admission to hospital, or required care in an intensive care unit are still under review and analysis is ongoing.

Results

- Of the patients identified by the UAH ED physicians, two patients died neither of whom were determined to be related to excessive ED wait times. However, the review has confirmed that severe crowding and extremely long wait times as identified by the UAH ED physicians were an issue for many of the these patients. The average wait time for an initial assessment by a physician in the ED was 3.1 and 4.9 hours for patients whose condition was classified as emergent (CTAS II[1]) or urgent (CTAS III) respectively. Canadian guidelines recommend that patients wait no longer than 15 minutes if they are classified as CTAS II and 30 minutes if classified as CTAS III. Over 50% of these patients were admitted to hospital. The average time the admitted patients spent in the ED was 18.5 hours. However, 20% of these patients waited more than 48 hours to be moved to an inpatient hospital bed.

- Excessive ED wait times put the quality of care these patients received at risk, in part by reducing the safety margin of the care that was able to be provided in the ED. An important example of this was the experience of a patient who went to the ED and left without being seen after approximately a five-hour wait. The patient returned the following day and within a short period of time required life-sustaining therapy. The patient survived, was admitted to hospital and subsequently discharged home. If the patient had been seen close to the 30-minute Canadian guideline for how this patient's condition was classified (urgent), the review team believes the patient would not have required urgent life-sustaining therapy the following day.

- Although the review team has serious concerns about the length of time it took these patients to access an ED bed and be assessed by the physician, once this occurred, the team had no concerns about the quality of care provided to patients notwithstanding the crowded environment where the care was delivered.

- The review team has completed its analysis of all patients who died in the UAH ED in 2008 who spent longer than four hours in the ED and whose age was between 18 and 85; none of these deaths could be attributed to excessive ED waits.

- Charts of patients admitted to the UAH ED in 2008 who subsequently required intensive care unit care are still being reviewed.

Analysis of Provincial Emergency Department Wait Times

Preliminary analysis of this data that is available from 2005 to present strongly suggests that ED crowding and long wait times are a phenomenon experienced by patients across Alberta.

- Based on comparable ED data, the Edmonton and Calgary sites have consistently had longer wait times than other sites in Alberta.

[1] CTAS stands for the Canadian Triage and Acuity Scale and is an ED-assigned urgency score with CTAS I being the most urgent and CTAS V the least.

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- In Calgary and Edmonton, from 2005 until late 2010, there was an upward trend in the average time patients spent in EDs and in the percentage of patients who left without being seen.

- There had been some improvement in ED performance over the four quarters beginning October 1, 2010 and ending September 30, 2011.

Cancer Surgery Care

The availability of data and information regarding cancer surgery care (with a focus on lung surgery) has been limited. Through interviews, the review team has concluded that there likely have been issues with delays in accessing thoracic surgery at the University of Alberta Hospital.

- To date, the review team has been unable to confirm a waitlist of 1,200 patients, including 250 patients who died while on that list.

- Given the number of patients who were alleged to have died while on the wait list for lung surgery, some of whom had lung cancer, the expectation is that these deaths would be reflected in differences in lung cancer survival rates between Calgary and Edmonton. However, when the data relevant to this time period were analyzed, there was no significant difference in the five-year cancer survival rates between the two cities.

- To date, the review team has not found evidence to suggest a link between physicians advocating for additional thoracic surgery resources and subsequent decisions to curtail practice opportunities.

Role and Process of Physician Advocacy in Patient Safety and Health Service Quality

- Interviews are being conducted with individuals who have had direct experience advocating for patient care or who have had administrative or other (e.g., governance) experience with physician advocacy.

- A qualitative approach is being used to conduct and analyze these interviews to identify themes/issues about the historical and current experiences of physician advocacy in Alberta's health system.

- Emerging themes/issues related to physician advocacy include:

    - Physicians are expected and encouraged to advocate for individual patients, groups of patients and the health needs of the community as a whole.

        - Physicians we have spoken with have had little, if any, coaching or education on how to advocate effectively.

        - Due to the lack of stability in organizational structures, leadership and reporting relationships within Alberta Health Services and some of the former health regions, it was often not clear to physicians who was responsible for dealing with a particular advocacy issue (i.e., with whom they should speak and when).

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- A number of physicians have come forward to describe their challenges when advocating for their patients. For many, these experiences resulted in tense, difficult or stressful circumstances that were life and career changing and included actions such as having hospital privileges affected, feeling ostracized by peers, and contracts for services being altered or cancelled, which in some cases limited their options for remaining in the province. Some elected to leave the province to seek work elsewhere.

    - The review findings to date indicate that in many cases the process that was followed in the health system by administrators, clinicians, government officials and politicians in dealing with physicians and their advocacy efforts was not obvious, was poorly defined, and was inconsistent.

- Boundaries of authority, accountability and responsibility between the Alberta government (i.e., premier, cabinet, health minister, MLAs and government ministries), Alberta Health Services (i.e., governance, administrators and clinical operations) and the regulatory bodies (including physicians) were blurred, confusing and inconsistent.

- To date, no evidence has been discovered that inappropriate financial payments have been made to any physician to muzzle their attempts to advocate on behalf of patients.

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