CONSENSUS CREATES EFFECTIVE PROGRAMS

"Quick Response Service" Project Reveals Importance of Stakeholders' Input

BY LESLIE STARR & SUE VANDERBENT

Healthcare providers in Ontario, Canada, like those in the United States, are working to deliver services more efficiently while maintaining a high level of quality. To encourage efficiency, the Ontario Ministry of Health in 1994-95 allocated $7.8 million toward "Quick Response Service" (QRS) pilot projects throughout the province. The goal of the QRS projects—each of which involved collaboration among a given area's healthcare providers—was to prevent or at least shorten hospital stays.

One pilot project was organized in the province's Hamilton-Wentworth area, which has a population of about 453,000. The project's cosponsors, three local acute care hospitals and a community home care program, were awarded $502,717 by the ministry to:

- Reduce admissions among senior citizens who are often hospitalized so that they can receive healthcare and social services, even though they do not require acute care
- Reduce emergency room visits among senior citizens

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The project's leaders hoped to achieve these aims by providing senior citizens with increased care in their homes (see **Box**). Between April 1995 and April 1997 the QRS project averted 70 emergency room visits and 342 hospital admissions at an estimated savings of more than $3 million.

Summary In the Hamilton-Wentworth area of Ontario, Canada, three acute care hospitals and a home care program joined together to try to reduce local senior citizens' admissions to hospitals and visits to emergency rooms. They hoped to achieve this by providing seniors with care in their homes.

Realizing that the project would have to employ collaborative decision making, its cosponsors selected participants from both the hospitals (for example, administrators and physicians) and the community (for example, consumers and family physicians).

The cosponsors chose cochairpersons from the hospital sector and the community sector. The project was complex because it involved so many stakeholders, but the cochairpersons gave it both its stability and its driving force.

Decision making was done through consensus, a process that can be tedious and frustrating, especially when based on systemic evaluation, a process in which a group analyzes a full range of advantages and disadvantages to a course of action. Nevertheless, the cosponsors found the process vital to the project's success.

By the end of the project, 342 hospital admissions and 70 emergency room visits had been averted. The cosponsors had discovered that because collaborative decision making can facilitate efficiency and "buy-in," it saves both money and time in the long run.

The Project's Organizational Structure

The leaders realized that they would have to employ collaborative decision making for the project to be successful. A comprehensive organizational structure that would involve all key stakeholders and ensure effective communications among them was essential. To that end, the leaders selected participants according to their group skills, functional involvement, and the organizations they represented in the hope that the participants would soon develop a sense of shared ownership in the project and seek the common good rather than that of their particular organization.[1]

In the Hamilton-Wentworth project, participating stakeholders from hospitals included administrators, physicians, and multidisciplinary team members. Participants from the community included consumers; family physicians; and representatives of the local home care program, nursing and homemaking agencies, and long-term care facilities.

The leaders later found that problems arising in the project's implementation phase had originated in the organizational phase. For example, many family physicians reacted adversely because they thought they had not been assigned a large enough role. On reflection, the project's leaders decided that although they had involved some family physicians as individuals, they had done too little to involve them as a group.

The leaders now believe they should have worked harder at communicating with the family physicians—perhaps through family practice rounds, focus groups, or a survey. Family physicians will be key stakeholders in any community healthcare project, and planners of such projects must make persistent efforts to ensure their participation.

Leadership

Leadership is a vital component in creating an environment in which key stakeholders can temporarily set aside their individual concerns and pursue a goal that is important to the community.[2] Good leaders will make sure that all participants contribute their views on the issues involved. To do that, leaders must have a sophisticated understanding of group dynamics, group process, communication styles, negotiation skills, and dispute resolution skills.

The leaders of the Hamilton-Wentworth project decided that, since the project involved both the acute care hospital and community sectors, it should be led by cochairpersons. The shared role visibly symbolized the importance of both the hospital and community sectors. The cochairpersons were responsible for the project's overall strategic direction, design, development, and financial viability. Each cochairperson then hired a QRS implementation coordinator for that sector. The coordinator was responsible for developing a referral package, protocols, community education, and status reports.

From the beginning, the two cochairpersons gave the project both its stability and its driving force. The Hamilton-Wentworth QRS was a complex project, partly because it involved so many stakeholders. Nevertheless, the cochairpersons motivated participants and facilitated consensus-style decision making among them. They were especially good at "reframing" tough challenges as opportunities rather than problems. In addition, the cochairpersons' ability to stay both positively focused on the task and attentive to participants' sensitivities contributed to the project's success.

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Decision by Consensus

An essential element in collaborative decision making is "ownership" of the process by those who make the decisions.[3] Group members who have little influence over a decision are unlikely to contribute resources toward it or to support its implementation.[4] Decisions reached through consensus—also known as "synergistic" decisions—are both more likely to be implemented and usually of higher quality.[5]

In the Hamilton-Wentworth project, the most obvious example of consensus decision making was that used to develop the referral process and the assessment tool. Indeed, because there was a good deal of feedback from both the hospital and community sectors, these items were revised so often that some participants found the process tedious and frustrating. It was thus necessary for the two implementation coordinators, who directed the process, to bring to it a good deal of open-mindedness, patience, and flexibility. Evidence of their success in doing so can be seen in the final QRS document, which, although different from the original plan, was readily implemented by all stakeholders.

QRS HOME CARE SERVICES

To reduce hospital admissions and emergency room visits, the Hamilton-Wentworth Quick Response Service provides area senior citizens with certain services on a home care basis.

Services available within 24 hours of request are nursing, personal care/homemaking, equipment, medical supplies, medication, occupational therapy, physiotherapy, social work, and transitional beds in a retirement home.

Nutritional and speech pathology services are also available, though with a longer waiting period.

Systematic Evaluation

Systematic evaluation—a procedure in which decision makers analyze the advantages and disadvantages of a full range of alternative courses of action—is the best way to reach a decision.[6] But not all decision makers feel they can afford to take the time required for it.

For example, the leaders of the Hamilton-Wentworth project did not use systematic evaluation in their initial planning for a "transition bed option." This option was a formal agreement with a retirement home for emergency respite and home care (paid for by QRS) when a caregiver was temporarily absent or in other short-term acute situations. Rather than examining alternatives, the leaders decided on an option that met the needs of emergency department physicians. Several community groups reacted adversely to that decision. Fortunately, the leaders had by then established their credibility, and this helped them to make peace in the community. Still, they realized that even if their decision on the option had been a good one, their way of making it was flawed.

Systemic evaluation may be frustrating for a leader who is unfamiliar with group process and accustomed to working independently. To be effective at it, a leader must be willing to endure sometimes humbling and discomforting feedback from stakeholders. Because it helps ensure "buy-in," such feedback facilitates collaborative decision making. Systemic evaluation is, moreover, a sometimes slow and time-consuming process. But it is beneficial to a community that is collaborating to design something new.

Consumer Input

Consumer activism has risen over the past two decades, underlining the need for increased consumer participation in development of services that affect healthcare delivery.[7]

Today's consumers are no longer willing to have healthcare decisions made for them—especially when those decisions involve them as members of a community. They want to be part of community healthcare projects from the beginning.[8] And they should be, because if healthcare leaders truly value collaborative decision making, they will certainly want to take the needs and opinions of consumers into account.

Consumers were involved from the start of the Hamilton-Wentworth project. To obtain their participation, the project's implementation coordinators conducted surveys, paper pilots, and focus groups. From these studies the project's leaders learned, for instance, that:

- Senior citizens preferred to be called "patients"—rather than "clients"—even when they received their care outside a hospital or physician's office.
- Eighty percent of seniors preferred to get healthcare services in their homes, rather than in a hospital.
- Contrary to expectation, consumers were not able to complete the QRS referral tool without the help of a physician.

Communities may discover that, because collaborative decision making facilitates efficiency and "buy-in," it can save them both money and time in the long run.

Drawbacks and Benefits of Collaboration

Communities sometimes reject collaborative decision making because it is unorthodox, time-consuming, and expensive, since it involves so many people. However, they may discover that, because collaborative decision making facilitates efficiency and "buy-in," it can save them both money and time in the long run.[9]

The same is true of collaborative decision making's unorthodox nature. Healthcare decisions have traditionally been made by top leaders. But collaborative decision making, because it involves so many stakeholders, is more likely to be implemented.

The success of the Hamilton-Wentworth QRS project shows that involving the community can result in a healthcare system that uses resources effectively and meets the needs of all stakeholders. □

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NOTES

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