The creativity to do more with less in a constrained health care system

As doctors, we hear about and feel the daily challenges of a constrained health care system—the lack of adequate doctors, nurses, operating rooms, hospital beds, CT, and MRI, and the list goes on. How do we improve access for patients amid these ongoing challenges? How do we accomplish the difficult task of providing patients with the quality care they need when they need it?

In the words of former Lego CEO Jørgen Vig Knudstorp: "Many creative people are finding that creativity doesn't grow in abundance, it grows from scarcity—the more Lego bricks you have doesn't mean you're going to be more creative; you can be very creative with very few Lego bricks." What lessons have *we* learned from years of scarce resources in hospital-based and specialty care? How have we been creative in addressing a constrained system? And what actually works to increase patient access and reduce wait lists?

It has long been known in queuing theory that a single-entry model, where the first patient in line is directed to the first available physician, is the most efficient model to keep wait times as short as possible.[1] Multiple studies show that the key barrier to implementing this model revolves around the potential unwillingness of physicians to engage in this kind of practice and their ability to standardize their practices. Yet, the benefits are clear: reduced wait times for both consultation and surgery, high provider satisfaction, and, from an equity perspective, better outcomes for patients and physicians.

Understanding this, in 2018, the Specialist Services Committee, a partnership between Doctors of BC and the Ministry of Health, launched the Enhancing Access Initiative, which supports interested groups of specialists to implement a single-entry model that strengthens patient access to specialist services by prioritizing patients to see the first available physician. Today, 34 specialist groups have implemented pooled referral models by working with local communities of practice, holding engagement sessions with referring partners, and establishing true multidisciplinary clinics. In a thorough evaluation, it was noted that groups who underwent this process were able to decrease wait times by almost 70%, or 75 days![2]

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The Specialist Services Committee also created new fee structures in 2011 to support nurses in practice with rheumatologists. This was in response to significant data that showed multidisciplinary care reduces patient wait times, improves patient self-management, and leads to improved emotional and psychological well-being.[3] More than a decade later, this has led to a 15% increase in the number of patients seen by rheumatologists across the province.

Inspired by this, the Specialist Services Committee rolled out a specialist team collaborative in 2022, in which more than 10 different specialist groups embarked on a process to integrate multidisciplinary team members in complex specialist practices. Despite the specialists being spread across the province in both rural and urban locations and across the spectrum from procedural and nonprocedural specialties, the outcomes again demonstrated success across all metrics. For these specialist groups, the capacity to see patients increased by more than 50%!

In my last President's Comment, I spoke about the necessary work to increase health human resources and infrastructure. Far too many patients remain on wait lists, uncertain when they'll be seen by a physician or when their diagnostic test or surgery will take place. While we wait for those increases in resources and infrastructure to be realized, we cannot afford to stand still. By listening to physicians across BC and leaning on their successes, we can reduce wait times for patients and improve their experience of care in times of scarcity, if we are willing to be creative. Single-entry models and multidisciplinary team-based care are two examples of evidence-based interventions that can help increase capacity in a constrained system.

In scarce times, we need to rely on our innovation, motivation, and ability to be strategic with our resources so we can do more with less. Doctors of BC, by way of

Continued on page 149

Continued from page 147

were viewed by all participants on a big screen in the main lecture hall.

The transformation of CME has begun with new and innovative methods to promote physician wellness throughout medical education. Having a sense of community among health care providers is crucial for listening, sharing ideas, and feeling supported and valued.

This was the start of what I call CME 2.0. Medical education and conferences are more than academics. These concepts are crucial to support and develop a thriving family doctor. I can't wait for CME 3.0 in 2024. I want to change physician burnout to physician ignite!

—Daniel Y. Dodek, MD, CCFP, FCFP
St. Paul's Hospital CME Conference for Primary Care Physicians, Physician Lead Wellness

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Re: The general surgery workforce versus population growth in BC

In the article "Chasing a moving train: The general surgery workforce versus population growth in British Columbia, 2012–2022" [*BCMJ* 2024;66:46-50], the authors recognize that "[c]ancer care is a resource-intensive area of medicine, requiring not only operating rooms but also oncologists, chemotherapy nurses, and radiation treatment infrastructure." However, pathology is also critical to cancer care, providing the link between general surgeons and oncologists. Diagnostic imaging is critical as well. Pathology infrastructure is resource-intensive, including physical laboratory resources (space, equipment, reagents, etc.) and skilled professionals (pathologists, pathologist assistants, medical laboratory technologists, cytotechnologists, medical laboratory assistants, and others).

The pathology workforce is also chasing a moving train.

—Valerie Taylor, MD, FRCPC, DRCPSC
Kelowna

PRESIDENT'S COMMENT

Continued from page 148

the Joint Collaborative Committees, engagement partners and regional advisors and advocates based within the boundaries of each health authority, and several Doctors of BC departments, fully supports this work by prioritizing the physician voice and leaning in on collaborative care because we can all truly do better, together. ■

—Ahmer A. Karimuddin, MD, FRCSC
Doctors of BC President

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