

Public Private Partnership for Effective Client-Centred Chronic Care Service Delivery

“Public private partnerships are a key part of British Columbia’s strategy to provide affordable infrastructure that meets public needs.”

Partnership BC, June 2003

“The government has been introducing ambitious and wide ranging health system reforms. The innovations and improvements associated with these reforms reflect the government’s desire to create a publicly-funded health services system that:

- is patient-centred;
- provides accessible, high quality services;
- results in improved health and wellness; and
- is sustainable and affordable over the long term.”

Ministry of Health Planning
2003/04 – 2005/06 Service Plan

Introduction

Through the Ministries of Health Services and Health Planning, the provincial government is undertaking to build a more effective and sustainable health service system for the future of British Columbia. Two key components of a revitalized provincial health system are improvements to the method and manner of health care for the chronically ill and the introduction of public private partnerships for the delivery of many client health services and infrastructure support services.

This white paper appraises the opportunities and benefits of shifting the delivery of health services for the chronically ill from publicly managed facilities to community-based private-sector service providers. We also consider the recent and ongoing transition from the contentious medical model for supportive service management to a variety of more patient-centred support models. As an integral part of this shift in health service delivery, we begin our discussion with a review of the options for client-centred health care, the implementation of client-centric service models in the health services workplace and the integration of client-centric service delivery into the health system’s private-sector service partners.

Chronic care client populations

In our recent work within the health service system, we have been struck by the similarities in chronic care service requirements, no matter which chronic care group is being examined. Important similarities also exist in the challenges facing the service providers for each chronic care group. For this discussion, we have considered four groups – mental health, stroke recovery, acquired brain injury and geriatric care. However, we believe the requirements and challenges of service delivery apply to all chronic care groups, not only these four. Suffice it to say that providing patient-centred, accessible, high quality, sustainable and affordable services to chronic care clients presents both challenges and opportunities for the health service system in British Columbia.

Mental disorder client group: Over 2.6 million Canadians have suffered from a measured mental disorder, including major depression, mania disorder, panic disorder or phobia, or a substance dependence in the past 12-months. One in five British Columbians has or will develop some form of mental disorder in his lifetime. 80,000 people in BC today require some measure of long-term mental health care. 4% of all general hospital admissions are due to some form of mental disorder, and an even greater percentage of emergency room visits are due to mental disorder. Meanwhile, over 20% of those suffering a mental disorder report not receiving help for their disorder.

Fortunately the majority of those experiencing mental illness, with self-directed and professional treatment, are able to reduce symptoms and continue to enjoy fulfilling lives. For those individuals with more acute forms of mental illness, it is not always possible to achieve this level of recovery. A wide variety of residential and day programs is required to support individuals with mental illness. The economic impact of mental disorder in Canada was recently estimated at over \$14 billion annually, and the impact on victims and their families is untold. Expansion of private-sector mental health services and the integration of client-centric service models will work to lessen the impact of mental illness on victims, their families and the community as a whole.

Stroke recovery client group: Over 50,000 people a year in Canada suffer a stroke. More than 8,600 of these strokes occur in British Columbia. Over 20% of stroke victims die within a few days of the onset and 25% make a complete recovery, but the remaining 55% suffer some form of long-term impairment, half having minor impairment and the balance moderate to major impairment. There are presently over 300,000 stroke survivors within Canada. Stroke is the third largest killer annually in BC, and the largest disabler of adults

While stroke more often impacts people as they age, stroke does not just attack seniors. 18% of stroke victims are younger than 55. On an annual basis, incidents of stroke represent up to 75% of neurological events requiring hospitalization. The impact of stroke on survivors and their families can be overwhelming. Client-centric response to the health care needs of stroke survivors provides survivors and their families with support, encouragement and the opportunity to participate meaningfully in the stabilization and recovery process.

Acquired brain injury survivor client group: It is only been within the past 50-years that the many forms of brain injury have come to be recognized and identified as acquired brain injuries. Acquired brain injury (ABI) not only occurs as a result of an external (traumatic) head injury, but also results from stroke, surgical insult, prolonged oxygen deprivation and other non-traumatic events. 34,000 people annually in Canada are admitted to hospital with a traumatic brain injury. There are 6,000 traumatic brain injuries in British Columbia each year, contributing to an ABI survivor population in excess of 180,000 in the province. These are individuals with injuries of sufficient severity to need long-term rehabilitative or supportive maintenance services.

Each acquired brain injury is understood to be unique, including its disruptive impact on the ABI survivor's functioning. The individuality of injury removes the opportunity for precision in predicting the degree of completeness of recovery for the more severely injured. Mild injuries have more predictability for recovery although minor cognitive deficits may linger indefinitely. Acquired brain injury and the resulting lifelong impact on the lives of ABI survivors and their families has created a great and growing demand for client-centric therapeutic and rehabilitative service delivery.

Geriatric care client group: In British Columbia today, there are 530,000 senior citizens, representing 13% of the population. In less than 15 years, current projections suggest there will be more senior citizens in BC than persons aged 19 and under. By 2040, seniors will approach 25% of the provincial population. As is the case across Canada, seniors in BC are increasingly significant users of health services. Upwards of 10% of seniors require full-time care at any one time. In addition, 83% of seniors still living independently recently reported having at least one significant chronic health condition.

Led by the provincial government, there are many initiatives underway to create progressive assisted-living residential facilities, geriatric health service facilities and the community infrastructure needed to serve the fast-growing geriatric population. Seniors today are a knowledgeable consumer of health services, and will become more knowledgeable as well as becoming more numerous over time. Whether living independently with minimal health issues or residing in a 24-hour professional care facility, senior citizens expect and deserve quality client-centred health care.

Putting the client first

Health service delivery has begun the process of effectively embracing a client-centric service model. Whatever the circumstance, in emergency rooms, surgical theaters or rehabilitation facilities, every individual seeking and receiving therapeutic care is first and foremost a client – a customer – of the health service system. We are entering a new and challenging era in health care provision, with rapidly advancing health care procedural techniques and with equally rapid growth in the community of informed clients demanding access to the latest and best in quality health care from their respective health service systems.

In this white paper, we discuss the delivery of client-centric service to chronic-care client groups. However, the changing paradigm of health service delivery is affecting all aspects of health care. We believe our recommendations for developing client-centred chronic care models through public private partnerships have ready application for a wide range of other health service disciplines.

What is client-centric health service delivery? As with most aspects of health care, the delivery of services for chronic-care clients has generally followed the established medical model. The service delivery focus has been to treat the affliction, not the person. This focus has too often resulted in a cloud of frustration and sense of failure. In most chronic-care circumstances, treating the affliction will not return the client to her/his previous life circumstances. Focusing on the client and not just the affliction gives powerful support to the client as she/he builds a fulfilling life post-injury or post-illness.

Client-centric service recognizes that clients are customers, not just patients. Client-centric service holistically meets the client's needs. Client-centric service recognizes that clients have opportunities, not just problems. Client-centric service respects the dignity of the client as a whole person and not simply as defined by her/his afflictions. Client-centric service assists the client to achieve maximum independence and minimum dependence within the client's therapeutic circumstances. Client-centric service empowers and does not control the client. Client-centric service has no tolerance for expressions of frustration, anger or blame by care workers at any time in the delivery of service to the client.

There are a number of alternative therapeutic models in use today, each designed in part to supplant the traditional medical model for service delivery. These include the integrated model, the social model, the psychosocial model, the holistic model and the traditional model. To varying degrees, common to each of these alternative service delivery models, the client is engaged holistically at the center of her/his personal therapeutic program. These alternative therapeutic models demonstrate the growing recognition of the importance in providing client-centred focus whatever the service delivery system.

Creating a culture of client-centred service: In our view, there are two primary components for maintaining a successful client-centric therapeutic model in any health service workplace and for any chronic-care community. Whether a walk-in clinic, long-term residence or acute care hospital, the first component is for the health service unit to adopt and nurture a workplace culture of client-centred service. This includes ongoing staff training in client-centric service delivery, pre-employment screening for service aptitude, regular and routine management participation in client-centric service initiatives, and performance measurement and incentive rewards based on excellence in client-centric service achievement.

These initiatives, intended to foster a culture of client-centric service delivery, can readily conform to whatever therapeutic model is currently being practiced by the service unit. This includes a modified medical model bridging the dual perspective of ailment and client. While modified as appropriate for service to health care clients, many of the procedures necessary to establish and sustain a client-centric workplace culture readily borrow from best-practice customer service initiatives developed and long practiced in other service sectors.

The client-centric service plan: The second primary component for successful client-centric service delivery is for the health service unit to establish and maintain a standard process comprehensive enough in scope to create individual client-centric rehabilitative or supportive maintenance service plans. Every chronic care client, in every service setting, must have the opportunity to participate as fully as possible in the development, implementation and ongoing refinement of his personal service plan.

In our view, consistent with the objectives of client-centred health service delivery, development of a client service plan must include:

- Initiation of a client support team, likely including one or more family members, one or more care workers from the client's service delivery unit and one or more other participants in the client's ongoing custody and care, e.g. case manager, personal physician, personal advocate, trustee.
- Negotiation of the client's service plan, with all participants working collaboratively. The client and her/his support team set out the client's personal goals and life experience expectations. The service professionals identify physical, emotional or cognitive limitations and service and support options that maximize the potential for personal goal achievement.
- Establishing life experience expectations. Life experience expectations are the basis for setting goals. This is equally true whether the client is in supportive maintenance or rehabilitative circumstances. For clients in rehabilitation, setting rehabilitative goals follows the chronicling of the client's life experience expectations. For supportive maintenance clients, expectations for quality of care are goals in themselves.
- Setting rehabilitation goals that are realistic, risk-managed and incrementally delineated. As with any goals-based management system, creating multiple incremental steps, each

having a specified time frame and each modest in scope, improves the likelihood of achieving the desired rehabilitation outcomes.

- Regularly scheduled meetings to review of the client's service plan. Are goals and expectations being met? Do the goals and expectations need to be updated to reflect changes in the client's therapeutic circumstances? The frequency of review meetings is determined by the client's circumstances. For example, aggressive rehabilitation goals would suggest quarterly meetings to assess issues around the client's rehabilitative progress and to confirm the next series of steps toward reaching the client's goals.

Imperatives of the client-centric service model: As outlined above, the most important aspect of the client-centric service model is acknowledging and respecting the life experience expectations of the client. What were her/his expectations pre-illness or injury? Are aspects of prior expectations still achievable? What new expectations are possible? Whatever the medical reasons for the client to now require chronic care, the client retains precious associations with her/his life experience pre-injury or pre-illness. Understanding the client's life experience expectations and her/his need for psychosocial continuity is fundamental to serving the client, not simply treating an ailment.

A second important imperative is the identification of the client's support team. Frequently, chronic care clients are limited in their ability to articulate clearly and forcefully their life experience expectations. The client's support team has a critical responsibility to advocate for the client throughout his period of care. Where ready outside support is not available, the health service unit needs to assist the client in recruiting a support team. The service unit may also find it advantageous to appoint an ombudsman, and empower the ombudsman with sufficient authority to exclusively represent the client's interests in the client's relationship with the service unit.

Finally, whether or not the client's family members are active participants in the client's support team, successful client-centric service recognizes that the client's family members are in fact "secondary" clients for the health service unit. Family members must be kept fully involved in the client's rehabilitative or supportive maintenance circumstances whenever that involvement has future repercussions for the family or benefits the client. Families encounter significant disruption to family expectations and family routines when a family member is in chronic care. The fall-out from this disruption needs to be taken into account by the health service unit when engaging with the client's family. (See the section on Issues, Challenges and Opportunities for other considerations of the family in the client-centric service model.)

Measuring client-centred service excellence: Effective measurement of service outcomes provides critical feedback for a health service unit wanting to achieve superior client-centric service delivery. The goals and expectations set out in client service plans provide opportunity to measure both the success of the health service unit in managing the service plan process and the success of the service unit in assisting clients to achieve their goals and expectations. Specific performance and outcome metrics selected by each health service unit will vary depending on the types of services being provided and the types of clients receiving the services.

In recent years, we have been encouraged by the widespread adoption of the balanced scorecard as a basic performance measurement in the health service system. The balanced scorecard is a cornerstone of the client-centric service model. In our experience, the key to effective use of the balanced scorecard is to develop well defined operational and, in this

instance, client service objectives on the non-financial side of the scorecard. The objectives need to be unambiguous and readily measurable. The client-centric service plan process helps guide meaningful objective setting and conclusive performance measurement. Integrating the balanced scorecard to the client service plan ensures that measurement of client and client support team satisfaction with service delivery is incorporated as additional input in scorecard tabulations.

The balanced scorecard typically provides a summary of performance results within the client-centred workplace over monthly, quarterly or annual operating periods. It is equally important that service unit management and team members work collaboratively to develop a comprehensive set of key performance indicators to measure performance in specific service areas, on an immediate basis. Performance indicators can be used to measure weekly or monthly results as well as longer timeframe results. Performance indicators can generally be expressed as ratios of input and outcome. Feedback from well-developed key performance indicators will assist the service unit team to better manage service delivery.

Public private partnership opportunities

Social entrepreneurship is quickly becoming a cornerstone for the evolving health service model. The social entrepreneur brings the passion and innovation of a commercial entrepreneur to the business of delivering social services. Within health services today, social and physician entrepreneurs are already engaged in laboratory services, medical transport services, walk-in clinic services, long-term residential facilities and personal and occupational therapeutic services. Physician entrepreneurs also deliver cosmetic surgical services and other elective medical services.

Private service providers are well suited to deliver most chronic care therapeutic services as partners with the provincial health system. By building these partnerships, the health system is able to better manage cost. Positioning chronic care clients with appropriate client-centred, privately delivered service and support helps to alleviate excessive demand on the publicly operated critical care system.

Current and future private service provider opportunities include:

- **Residential services:** The health system already has relationships with a number of private residential service providers. As the demand for residential chronic care increases, particularly for the geriatric client group, there will be significant new opportunities for private service providers to expand their facilities and increase their service levels.
- **Day-program services:** Many chronic care clients do not require full-time residential service but benefit from day program services offered at convenient local facilities. Day programs include personal and occupational therapy, life-skills compensatory strategies, other rehabilitative services and all-important psychosocial interaction for oftentimes socially isolated chronic care clients. Day program service delivery is currently in high demand and is well suited to fulfillment by qualified private service providers.
- **Home-care support services:** Home-care support services range from day program type services for chronic care shut-ins to intensive therapeutic care for clients recently released from a primary care facility. Home-care support services are in as equally high demand as are day program services. Both offer opportunity for chronic care clients to enjoy client-centred support within the reassuring familiarity of the client's home or neighborhood.

- **Rehabilitation services:** Across the various chronic care groups, there is a wide variety of rehabilitation services in continual demand. As discussed above, rehabilitation services can be provided through a day-program facility or through home-support. There is also growing opportunity for private service providers to operate community-based programs specifically for the delivery of rehabilitation services.
- **Respite services:** Our research indicates there is a much greater demand for family respite services than there are services available. The future model for family respite will be in-home respite services provided by qualified service providers. There are two immediate advantages to the in-home respite approach. Firstly the chronic care client does not have to suffer the anxiety and stress of being relocated to an unfamiliar environment. Secondly, the service provider does not have to dedicate facility space to intermittent and therefore less cost-effective use.
- **Ombudsman services:** The health system currently offers ombudsman-type services through social workers, case managers and other community outreach programs. Given the large numbers of chronic care clients in the community at large, we believe that there is compelling reason to establish ombudsman service availability within the private service provider cluster. As discussed previously, responsible service providers can empower ombudsmen within their own organizations. Alternatively, qualified ombudsman services can be offered through supportive community-level associations.
- **Other services:** The above list highlights only some of the general services that are readily deliverable by private service providers. Each chronic care sector has other, more specialized services that over time will also be deliverable through well-structured public private partnerships.

Building a successful partnership

A real partnership can only exist when both partners share the risks and rewards that arise from the partners' joint initiatives. In our view, the basis for building a successful public private partnership must include both the public agency and the private service provider recognizing and responding to the business requirements of the private partner. This is as true in health service delivery as in any other service delivery area under review by Partnerships BC.

Whether the private service provider operates as a for-profit enterprise or as a not-for-profit chartered society, the private provider must manage to a financial bottom line. As we occasionally remind our clients, the only difference between operating as a for-profit and as a not-for-profit is the modest percentage of revenue that is termed a profit, but which is most often reinvested for further development of the enterprise. Private service providers cannot operate at a deficit, whether operating as for-profit or not-for-profit. In all respects, for-profit and not-for-profit service providers need to employ the same fiscal disciplines in their respective operations.

The business plan: To begin the public private partnership process, the private service provider must have or develop a detailed business plan. The plan needs to set out clearly in both narrative and financial detail the intended operations of the service provider. Critical to the plan is the projection for revenue including, if applicable, the projection for public agency funding. Without a proper grasp on revenue (funding) projected to flow into the organization, operating and capital expense projections are of little value. We encourage the public partner entering into the partnership to review at least an executive-level summary of the private partner's plan. Particularly when the public partner is expected to be a significant funding source for the private partner, it is imperative that the public partner be sufficiently well informed

to be able to give the private partner at least a conditional acknowledgement that the funding projections are reasonable.

Service delivery planning: Once a business plan for the service provider has been completed and vetted, the service provider needs to document the specifics of the intended service delivery model. Specifics include details on services to be offered, including limits on service capacity, care staff skill-sets, staffing levels, in particular care staff levels, and other details important for high-value and measurable service delivery. Central to service delivery planning is the details of the client-centric service plan process. It is our recommendation that the public agency partner maintain an active interest in the private partner's service delivery including, where appropriate, associating the availability of future funding to negotiated, measurable performance objectives and results.

Reporting between the partners: Two metaphors describe the relationship between the public agency partner and the service provider partner in a public private partnership. The first is the view of the public agency as a large-volume customer for the provider's services or goods. The second is the view of the public agency as the financing agency, the "bank," for the provider partner. Both metaphors apply, although in differing ratios, for every public private partnership. The public agency partner has both fiduciary and regulatory responsibility to stay well informed about the operating and service performance of the agency's private service provider partner. An arrangement for regular reporting between the partners needs to be agreed when the partnership is first established.

Service performance review: Private service providers are accountable to two performance review processes. The first is the traditional financial review required of any for-profit or not-for-profit enterprise. The service provider's board of directors and management team conduct this review. The second is the service performance review, appropriately a collaborative undertaking between the service provider partner and the public agency partner. To be actionable, service performance reviews must present performance results in both quantitative and qualitative terms. How many, how often, better or worse are questions that demand quantitative answers. In this regard, balanced scorecard and key performance indicator results are useful quantitative measures. Qualitative narrative is most useful when accompanied by quantitative details. Otherwise qualitative reporting is at risk to drift from fact to fiction.

Incentive-aligned service delivery: As the original altruistic industry, the health services sector has not had significant prior experience with incentive-aligned service delivery. With continuing expansion of the role of private partners in the delivery of health services, performance incentives will become an increasingly noticeable factor supporting high-quality health service delivery. This need not become a cause for alarm. The balanced scorecard is one example of a performance measurement that ensures incentives are based on the holistic client experience, not the least-expensive client experience.

Client turnover as successful outcome: In most commercial sectors customer service excellence is measured by the organization's ability to retain a customer. By comparison, client-centred health services are generally most successful when the service provider is able to discharge a client, having assisted the client to achieve a level of rehabilitation beyond the provider's defined service agenda. We recommend that where applicable the service provider be given incentives for successfully completing client rehabilitation goals leading to the discharge of the client. Disincentives for recidivism need to be factored into client turnover incentive arrangements.

Issues, challenges and opportunities

The pursuit of public private partnerships between the provincial health services system and private service providers will not be without its challenges. The following are among the issues, challenges and opportunities that will need to be addressed for the successful implementation of these partnerships and for the system-wide adoption of client-centred health service delivery.

Privatization: There is a tendency in the public to confuse private service delivery with privatization, or with the American health care model. This confusion can lead to resistance on the part of some individuals who, while very concerned with the financial and operational issues facing the Canadian health system today, do not want to abandon the principle of universal health care. Continuing to inform the public discussion about the fundamental and critical differences between privatization and public/private service delivery will assist greatly in reducing the community's confusion and anxiety.

Funding distribution: As the total dollar value of health services delivered in the province shifts from being primarily through public service delivery to a balance of public and private delivery, and conceivably, over time, to primarily private service delivery, there will be a need for new funding models to be implemented. Private service providers cannot operate at a deficit. Their service offerings have to maintain adequate and relatively constant levels of utilization. In some instances, public agency partners should plan for "pre-buying" services in anticipation of need rather than expecting private providers to expand and contract facility and service availability in response to fluctuating demand.

Expected rapid growth in client groups: This white paper provides a brief overview of the population size and diversity of only four chronic care client groups. There are others. Total demand for chronic care services today includes tens of thousand of clients across the province. With further improvements in emergency and critical care techniques and equipment for treating serious injury and sudden illness, and with the fast coming growth in our senior population, the number of chronic care clients in the province will multiply quickly. To handle this increased demand, today's chronic care service infrastructure will need to be significantly expanded over the next 15-years. We view public partnership with private service providers as fundamental to meeting the ever-increasing demand for chronic care facilities and services.

Quality assurance: As health services increasingly are delivered by private service providers, the public health system is taking on new responsibilities for detailing standards of service and for quality assurance monitoring of private service providers. Implementation of client-centred service models and performance self-monitoring by qualified service providers will provide public agencies with important performance details to assist in the quality assurance monitoring process.

Family involvement: The client-centred service model places great importance on the inclusion of the client's family in the service delivery process for the client. This includes, in particular, the family's participation in the development of the client's individual service plan. Regrettably in some circumstances, the client has no family involved in her/his chronic care arrangements or the client family's participation is counterproductive to the client's achieving her/his life experience expectations. In these circumstances, the service provider and the other members of the client's support team must act in the best interests of the client, notwithstanding contrary family interest. Engaging with a recognized ombudsman may be helpful. Admittedly, absent or contrary family involvement is an unwelcome complication, but a committed client-centred service environment will keep the client's service delivery on track.

Implications of the medical model: There is an increasingly popular view within the health system that the medical service delivery model is in conflict with client-centric service delivery. We do not believe this conflict needs to exist or is without remedy. Yes, the medical model means acting on the patient's symptoms not the client's whole person. In acute care circumstances, the symptoms must be acted on, perhaps urgently; however this does not preclude the introduction of the client-centred care process, starting with the identification of the client support team. Where the will exists in the medical practitioners, medical model service delivery can be accomplished in a client-centric manner.

Private-sector contributions: Private-sector enterprises, from the largest corporation to local businesses are important contributors to the community at large. This support has included and will continue to include contributions, both financial and otherwise, to the health system. Public private health service partnerships can benefit from the support of private-sector sponsors. While financial donations for facility improvements and for enhanced care delivery are always welcome, sponsors can be equally helpful in raising community awareness about chronic care issues and the causes and prevention of the injuries and illnesses that lead to chronic ailments. Corporate sponsors are also generally pleased to promote and support volunteerism from their employee and business communities and from the community at large.

In conclusion

We believe strongly in the value and the viability of the client-centred service model as a formative principle of private service delivery within the health system's public private partnership program. Client-centred health service has a sound theoretical under-pinning but, more importantly, the model continues to be proven successful in use within the health system today. Widely implementing the client-centred model for the delivery of health services will require patience and understanding. Objections will undoubtedly arise, some of them legitimate, some not. Nonetheless, we believe the client-centric model holds out great promise for the delivery of therapeutic services to chronic care clients across the province.

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