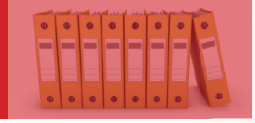

# Knowledge into Practice:
# Two Examples of Health Policy in the Real World

By Karen Laforet, RN, MCISc

Many people dismiss policy as a government responsibility. While macro-scale policies typically do fall under government control, in reality, policies consist of complex interactions that factor into every aspect of human society. Policy examples might include the government's diabetes strategy, community stakeholders lobbying for change in a town's policy for ice-rink hours of operation or an agency's decision on how to implement short-term illness programs.

In the last issue of *Wound Care Canada* (Spring 2015, Volume 13, Number 1), we featured an article that reviewed what policy analysis is: a collection of techniques and tools used to examine the why, how and what of established polices.[1] We introduced frameworks for the development and critique of policy and learned that policy analysis is a technical, political and interpretive exercise. In many ways, policy analysis mirrors wound care; it is both a science and an art that draws on experience and knowledge guided by methodology. The push for health-care reform provides an impetus for health professionals (HPs) to become active participants in health-care reform and increase their "policy savvy".[2,3] Now that the theory has been laid out along with a framework for analysis, this next article will explore how to put this knowledge into practice.

Before proceeding it is important to remember that when using any type of analysis framework, whether it is Collin's[1] or others, all of the steps presented are not required for every problem, nor are the steps linear. What the framework provides is a template for asking a series of questions at the appropriate times in the policy process. There is the risk of using the framework iteratively, which most likely will result in needless frustration. Policy analysis frameworks are, by their nature, a guidance construct. The purpose of this article is to use examples to demonstrate how such analysis may be used for the development of a policy (such as

an organization's need for a policy on conservative sharp wound debridement*) and to evaluate policy implementation (Ontario's Diabetes Strategy). The terms *organization*, *agency* and *company* will be used interchangeably throughout the article.

## Example One: Policy Development for Conservative Sharp Wound Debridement

At the time of this publication, an Ontario provincial policy for health professionals specific to the act of conservative sharp wound debridement (CSWD) is non-existent. Professional regulatory bodies responsible for public safety have put the onus of responsibility onto the HPs, requiring them to use their individual judgement to determine if they have the knowledge, skills and critical thinking to discern the appropriate treatment.[4] While the Canada Health Act (the Act)[5] addresses the scope of practice for nurses within a hospital setting, the policy for reduction of patient harm, clinical competency and risk management is left to the individual organization. The result: a wide variation of training methods, techniques and competencies. How does an organization have the assurance the HP's practice meets quality and risk indicators? What would constitute a strong organizational policy for CSWD?

The policy content for CSWD in a clinical setting needs to address clinical governance, risk mitigation and patient safety.[1]

The search for evidence to determine key CSWD policy features has been made easier thanks to the Canadian Association of Enterostomal Therapists' CSWD recommendations in 2011.[6] The first of their kind in Canada, these recommendations were developed to inform practice for the individual HP as well as the organization. In this policy example, key issues may include: methods of debridement, treatment option decisions, practitioner competence, potential complications—if CSWD is provided or not and independent practitioner action vs. employer-supported procedures.

Conservative sharp wound debridement is an advanced-practice skill. Health professionals who perform advanced procedures are viewed as experts; therefore, it is the responsibility of the organization to ensure quality of care and credibility of the clinicians who offer those services.[7] Given this responsibility, policy options and their considerations would include:

- **Option A:** Provide the infrastructure to provide CSWD to selected patient populations:
  - Clearly defined and designated scope of practice for the individual and within the interdisciplinary team
  - Minimum level of educational preparation and practice-based mentoring
  - Regulatory process for ongoing competency assessment, quality control and management systems
- **Option B:** Choose not to offer CSWD:
  - Economic implications—if the organization is the only one not offering this service will it impact the organization's ability to conduct business
  - Ethical concerns for not providing the service
  - Risk management: what are the legal ramifications if CSWD not offered

The organization exploring CSWD policy would uncover evidence indicating wound debridement is a gold standard. While the data supporting one method of wound debridement over another are inconclusive, there is sufficient evidence that

* The scope of this article focuses on policy development rather than clinical evidence or clinical practice.

CSWD is a necessary intervention that can expedite wound healing.[8,9,10] Since the role of debridement in wound management is established, there is a risk for the HP who doesn't perform the act when necessary to be held in breach of duty of care to the patient. Where the patient suffers harm through either an act or an omission, the HP may be found negligent.[11]

When considering the different policy options it is important to remember that they may not be mutually exclusive.[1] In the example cited here, the organization may determine that their clinical governance framework cannot support the rigour required for Option A and that the number of patients requiring CSWD is insufficient to maintain clinical competence, yet the outcomes presented with Option B are perceived as a high risk. To mitigate that risk, adding a policy action such as partnering with another agency with demonstrated expertise would lessen risk for HPs and the company and provided the needed treatment for the patients.

Thus far, Collins' framework[1] has been utilized in a step-by-step fashion (Table 1). Continuing with the analysis, we'll follow through using the last three steps; examining the evaluative criteria, what the trade-offs might be choosing Option A or B and finally, deciding on a course of action. Collins lists five criteria to use when evaluating the outcomes of the options, four of which are pertinent to this policy:

- **Relevance:** Is CSWD a requirement for the patient population? In this scenario, the answer is yes, based on current practice and available evidence.
- **Effectiveness:** Does the company need to provide it or is it possible to outsource to an agency that has demonstrated expertise? Partnering with an agency would meet the objectives to sustain the business, support HP in their practice and reduce potential for patient harm.
- **Efficiencies:** Partnership would augment existing resources and provide added value to the patients relatively quickly vs. developing an internal program.
- **Impact:** Using a risk management lens for patient care, partnership would improve clinical outcomes and minimized risk for staff and the company.

Weighing the outcomes as presented, the organization decided to explore an agency partnership to provide CSWD (see sidebar page 29). Next steps would include policy implementation. The devil is in the details

**Table 1.** Collins[1] Framework for Health Policy Analysis: Policy for Conservative Sharp Wound Debridement

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|---|
| **Step 1. Define the context**<br>Need for conservative sharp wound debridement in the community. |
| **Step 2. State the problem**<br>Need for an organizational policy on conservative sharp wound debridement. |
| **Step 3. Search for evidence**<br>Wound debridement is gold standard and CSWD is a necessary intervention. Risk of harm to not provide as an option. |
| **Step 4. Consider different policy options**<br>Develop in-house program; do not offer CSWD; partner with agency to provide to patients. |
| **Step 5. Project the outcomes**<br>Reduce risk for patients, HP and organization. |
| **Step 6. Apply evaluative criteria**<br>Partnership model is relevant for patients, efficient, effective, mitigates risk, provides clinical competence for advanced act. |
| **Step 7. Weigh the outcomes**<br>Internal CSWD program vs. partnership model. |
| **Step 8. Make the decision**<br>Explore partnership to outsource CSWD for patient population. |

## Example of a Policy Statement for Conservative Sharp Wound Debridement (CSWD)

Company X will provide CSWD through partnership with a qualified agency as per the following criteria:

- Current and full accreditation
- CSWD qualification program includes: risk management module, infection control, handling of bio-hazardous waste, minimum of 8 hours theory (anatomy and physiology) and demonstrated skills competency using a mentorship process.
- Each qualified health-care professional has good standing with their professional college
- Quality control program includes random routine observational audits (minimum quarterly audits)
- Medical director reviews, approves and signs off on each HP practical skills and knowledge annually as part of an annual requalification program
- Financially viable for the company
- Regional Health Authority approval

with policy implementation and as we'll see in the next example, this is where a significant breach may occur between what is intended and what actually happens.[12]

## Example Two: Ontario Diabetes Strategy

In 2008, the Ontario government announced a four-year, $742 million plan called Ontario Diabetes Strategy (ODS).[13] The policies and their implementations were intended to expand services and improve the health of Ontarians with diabetes. The strategy included an online registry, educational tools and five key elements:

- Improving access to insulin pumps and supplies
- Expanding chronic kidney disease services
- Implementing a strategy to expand access to bariatric surgery
- Education campaigns to prevent diabetes by raising awareness in high-risk populations: Aboriginal and south Asian communities
- Increasing access to team-based care closer to home by mapping prevalence across the province and locating diabetes programs to align services and address service gaps

The five "strategic elements," as they are referred to by Ontario's Ministry of Health and Long-Term Care,[13] will guide the policy analysis—specifically, implementation and achievement of outcomes. Before proceeding with the analysis it is important to step back and look at the national health-care picture to place the ODS into perspective. One of the key policy challenges facing all provinces and territories is the hospital-centric nature of the Canadian health-care system. Put another way, the health-care system has historically been designed to treat acute episodes of illness. The Canada Health Act universal principle is for the provision of "medically necessary care"[5] and since its inception, care has been hospital based. Health promotion, prevention and chronic disease management have been secondary concerns, taking a back seat for program funding. This is the context within which the ODS was developed.

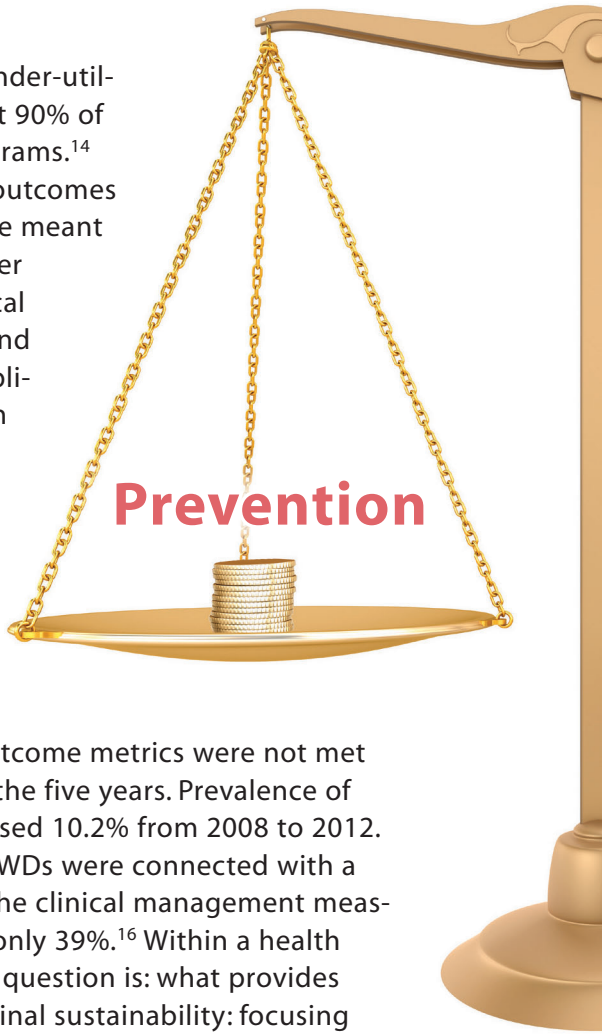
According to Collins,[1] a clear problem statement is the critical first step of analysis. The problem serves as the filter for the policy analysis process to make sure the policy issue has been identified and successfully addressed. The Ontario government defined the health policy problem as how to improve the health and expand services for persons with diabetes (PWDs). The context for the policy was based on the facts that 90% of PWDs have type 2 diabetes[14]

and approximately two million Ontarians will be diagnosed with diabetes by 2020. The complications of this chronic disease are also well documented: approximately 1600 Ontarians have diabetes-related amputations each year. In addition to amputations, the burden of illness includes kidney dialysis, heart attacks, blindness, and/or strokes.[15]

What options are available to address the Ontario government's mandate to improve the health of and expand services for PWDs? As stated earlier, the ODS elected to implement a multi-faceted service-oriented approach combining data capture (via an online registry and baseline data set), education, treatment (chronic renal disease and obesity, insulin pumps and supplies) and improved access (through regional centres). The ODS outcome metrics included:

- Access to care: percentage connected with a primary care physician, regional centres or percentage signed into the registry
- Reducing risk: percentage reduction of inactive persons and percentage of PWDs who are overweight or obese
- Decreasing diabetes burden: percentage prevalence tracking data via a diabetes registry
- Clinical management: percentage who completed an eye exam, LDS-C and HbA1c test within guideline periods
- Complications: percentage of ER visits for glycemic control, renal replacement therapy; hospitalization rates for infections, DFUs or amputations; MIs[15]

In 2013, the Auditor General of Ontario and the MOHLTC issued reports on ODS's progress. Results were mixed. New program offerings increased availability of diabetes care and provided more options for education and support. Diabetes education teams (DETs), consisting of a registered nurse, dietitian and other professionals were added to the existing 152 diabetes education programs (DEPs) for a total of 322. The teams help teach people with diabetes about the disease and how to manage it. Unfortunately, hospitals and family health teams had also set up their own DETs with alternative funding (some from another branch within the MOHLTC), resulting in service overlaps and under-utilization of about 90% of education programs.[14] The projected outcomes of the ODS were meant to provide better access for clinical management and to reduce complications through improved monitoring. Despite an approximately 30% increase in diabetes support services, the outcome metrics were not met within each of the five years. Prevalence of diabetes increased 10.2% from 2008 to 2012. While 80% of PWDs were connected with a family doctor, the clinical management measures averaged only 39%.[16] Within a health policy lens, the question is: what provides better longitudinal sustainability: focusing on treating persons after they become ill or keeping them healthy in the first place? Evidence supports health promotion and prevention. Despite this evidence, the only comprehensive strategy to reduce risk was the cigarette smoking reduction programs.[14]




The noticeable absence of prevention and health promotion within the ODS strategy has been the most widely criticized aspect of the program. Ninety percent of type 2 diabetes can be prevented or managed effectively, with complications reduced through prevention strategies. Yet the ODS allocated only 3% of its total funding to prevention—$19 million out of $742 million. At the same time, the ministry paid out over $24 million for a diabetes registry that never materialized.[14] The Auditor identified that a number of diabetes service providers were underfunded and that these providers believed more funding needed to be directed toward preventive services. Ironically, the MOHLTC cited the burden of illness


for diabetes complications routinely when promoting the ODS, focusing especially on amputation rates, and yet has refused to allocate monetary resources to foot care and offloading—two evidence-based strategies that reduce the risk of foot ulcers and foot complications.

Health-care funding is indicative of the priorities and values of a government. Despite the Diabetes Expert Panel's and the Auditor General's recommendations, the MOHLTC has chosen not to fund foot care strategies such as chiropody, orthotics or offloading devices in their 2012–2016 diabetes strategy.* Policy analysis/review requires illumination at multiple levels, from individual patients to the top decision makers. At every level, persons with diabetes are impacted. The ODS has attempted to expand services and improve the health of Ontarians with diabetes,but our policy analysis shows that much more work needs to be done. To coin a phrase from the Canadian Diabetic Foot Strategy: "Is anybody listening?" Diabetes-related foot amputations can be reduced by 85% with early screening and appropriate footwear.[17] The illness model continues.

## Conclusion

Health-care policy presents unique challenges[18] due to several factors:

- The influence of health-care professionals in the field
- It is difficult to offer patients a choice of services
- Decision making frequently involves life-and-death decisions

Given these challenges, it is important for clinicians to understand how policy can impact the politicized complexity of health-care reform as well as the link between policy and advocacy.[19]

The use of a framework in policy analysis is helpful for clinicians for a number of reasons: it strengthens one's knowledge and understanding of the role policy plays in organization and society; it enables sharing of evidence, common-sense and real-time practice knowledge to decision-makers to effect change in addition to critical assessment of policy decisions; and, most importantly, it provides a basis from which to advocate for our patients.

*"According to the Diabetes Expert Panel established by the Ministry in 2006, 'keeping people well and preventing disease is the most cost-effective, affordable and sustainable strategy for coping with chronic disease. . . . we believe an increased focus on prevention warrants consideration.'"*

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* In 2015, the CAWC, along with the Canadian Diabetes Association, the Registered Nurses' Association of Ontario and the Canadian Association for Enterostomal Therapy, began a process of consultations with the MOHLTC of Ontario to encourage policy changes to support the funding of foot care, orthotics and offloading. At press time, no changes to policy have been announced. The consultations continue.

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