A commentary on access to cardiovascular services: Nursing roles and initiatives

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The Canadian Council of Cardiovascular Nurses (CCCN) applauds the work done by the Canadian Cardiovascular Society in setting benchmarks for wait times. The Canadian Cardiovascular Society is to be commended for developing the benchmark documents, as well as for establishing strategies for systematic dissemination to increase awareness, advocacy and implementation of the benchmarks across Canada. Quality nursing care, as defined within the CCCN framework, includes working with health teams to ensure that patients have timely access to specialized personnel, tests and procedures as required to prevent disease, promote health, address acute and episodic interventions, and to provide rehabilitative and palliative services, depending on patient need. To extend the access to care discussion, the CCCN suggests that further engagement of all stakeholders, especially clients/patients, is needed to find solutions to wait times and define benchmarks. In addition, preventing heart disease and promoting 'health care' should be recognized and acted on as central to reducing wait times for cardiovascular care. Finally, access to cardiovascular services will be more efficient when the first point of care is broadened to include nurses and other health care professionals. Nurses occupy creative, cost-effective roles directly aimed at reducing wait times and improving care while patients wait. The expanded role of interprofessional education and health care teams, as well as the inclusion of patients and families in program improvement, are solutions that the CCCN suggests may contribute to improved access to cardiovascular care and a sustainable health care system in Canada.

Key Words: *Health services accessibility; Interprofessional care; Nursing roles; Patient-centred care; Wait lists*

Observations sur l'accès aux services cardiovasculaires : Rôles et initiatives du personnel infirmier

Le Conseil canadien des infirmières(iers) en nursing cardiovasculaire félicite la Société canadienne de cardiologie pour son travail réalisé dans l'établissement de points de repère pour les temps d'attente. En effet, la Société doit être louée pour avoir élaboré les documents relatifs aux points de repère, de même que les stratégies de mise en œuvre visant une diffusion systématique afin d'en faire la promotion et d'en favoriser l'application partout au pays. La prestation de soins infirmiers de qualité, telle que l'entend le Conseil, englobe la collaboration avec les équipes de soins afin de permettre aux patients d'avoir accès, en temps opportun, aux spécialistes ainsi qu'aux examens et aux interventions dont ils ont besoin pour prévenir les maladies; de faire la promotion de la santé; de traiter les interventions urgentes ou épisodiques ou de fournir des soins de réadaptation ou des soins palliatifs selon le cas. Afin d'élargir les discussions sur l'accès aux soins, le Conseil suggère que toutes les parties intéressées, notamment les médecins et les patients, poussent plus loin leur engagement afin de trouver des solutions aux temps d'attente et de définir des points de repère. De plus, il faudrait reconnaître que la réduction des temps d'attente en cardiologie passe par la prévention des maladies cardiaques et la promotion des soins de santé, et agir en conséquence. Enfin, l'accès aux services cardiovasculaires sera facilité lorsque le premier point de prestation des soins fera une place au personnel infirmier et aux autres professionnels de la santé. Les infirmières et infirmiers prennent des initiatives originales et rentables, qui visent directement la réduction des temps d'attente et l'amélioration des soins pendant l'attente. L'élargissement du rôle de la formation interprofessionnelle et des équipes de soins ainsi que la participation des patients et des familles à l'amélioration des programmes, solutions proposées par le Conseil, pourraient améliorer l'accès aux soins cardiovasculaires et favoriser le maintien d'un système de soins de santé viable au Canada.

THE ISSUE

Access to health care services has been identified as a prominent issue for Canadians (1), and the Canadian Community Health Survey (2) identified waiting for care as the number one barrier to access. As our population ages, the concomitant increase in cardiovascular disease will increase the demand for cardiovascular health care services. Quality patient care is compromised when medically necessary services are not accessible in a timely fashion.

Accessibility, as a guiding principle within the Canada Health Act, is intended to ensure access to medically necessary services that are affordable for the insured member, without discrimination based on age, health status or financial circumstances (3,4). Accessibility is determined by the volume of patients requiring the services, the scope of the facilities, the number of health care personnel and the efficiency

of the health teams that oversee the movement of the patients through the system.

In a joint discussion paper, the Canadian Medical Association (CMA) and the Canadian Nurses Association (CNA) proposed a 10-point plan (5) to address access to care barriers. Areas for development included consultation, transparent communication, development of standards for wait times, gaps in health human resources and system capacity, information technology infrastructure, best practice guidelines and investing in the continuum of care. In the same year (2004), the first ministers of Canada established a 10-year action plan. The agreement included directives to each province and territory to establish timelines to improve access to care by 2005. All provinces and territories were to define acceptable benchmarks for five procedure-related groups, one being cardiac care. The Canadian Cardiovascular Society

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(CCS) established an Access to Care Working Group in 2004 and have published several commentaries devoted to treating the right patient at the right time (6). Each commentary has addressed targets and acceptable wait times for various aspects of cardiovascular care, including specialist consultation and noninvasive testing, echocardiography, rehabilitation, electrophysiology, heart failure, percutaneous coronary intervention and cardiac surgery (6-15).

In response to the first ministers' plan, the CNA encouraged nurses to work with political leaders and health care teams to "reduce wait times; increase the supply of nurses, doctors, pharmacists and other health care providers; expand the continuum of care; and provide sufficient, ongoing and predictable funding" (16). The current mandate of cardiovascular nurses is to identify barriers to achieving heart health and to partner with the health care team and the client/patient to address these barriers. Client advocacy through political action and the creation of innovative practice strategies are key factors in this goal.

As the voice of cardiovascular nursing in Canada, the Canadian Council of Cardiovascular Nurses (CCCN) has been invited to contribute to the access to care dialogue. The CCCN standards for cardiovascular nursing are based on three concepts: caring, partnership and quality of life across all domains of cardiovascular care, from health promotion to palliation. Quality nursing care, as defined within the framework, includes working with health teams to ensure that patients have timely access to specialized personnel, tests and procedures as required to prevent disease, promote health or address acute and episodic interventions, as well as to provide rehabilitative or palliative services, depending on patient need.

THE CCCN'S PERSPECTIVE ON THE ACCESS TO CARE DISCUSSION

The CCCN applauds the work done by the CCS in setting benchmarks for wait times. Cardiovascular nurses across Canada use the commentaries as frameworks on which to build and evaluate programs. The CCS is to be commended for developing the benchmark documents and for establishing strategies for the systematic dissemination to increase awareness, advocacy and implementation of the benchmarks across Canada. Currently, members of CCS are encouraged to work toward meeting the wait time benchmarks, as well as to work with various levels of government to resolve wait time bottlenecks. The CCCN also supports the efforts of the CCS to advocate for creative funding strategies to enhance individual and regional incentives for improvement.

The benchmarks set for reasonable wait times by the CCS were based on a consensus of cardiologists while considering international standards and medical practice guidelines. The CCS created detailed, severity-based wait time benchmarks that account for complex care delivery systems composed of variable models for funding, personnel and facilities. Although what is considered reasonable remains somewhat subjective and may vary from the perspective of the stakeholder (patient, family, nurse, physician or health care administrator), these benchmarks provide a starting point from which to plan and evaluate cardiovascular care. The benchmarks delineate the upper limit of an acceptable wait time and provide a framework for nurses and physicians in triaging clients/patients based on the level of predicted risk.

The final report of the Wait Time Alliance for Timely Access to Health Care outlines a number of 'first principles' to guide the development of wait time benchmarks (17). These principles include the need to develop benchmarks from a patient perspective, involvement of patients in the development of wait time benchmarks, and the implementation of benchmarks with the input of front-line health care workers. The list of 'first principles' in this report, which, for the most part, the CCCN strongly supports, is followed by a discussion of the new cardiac care benchmarks that were developed concurrently with the work of the Wait Time Alliance. A review of the team members who developed these benchmarks (found in the appendix of the report) revealed few nonphysician team members and no

representatives of the consumer or the patient sector. In addition, the Wait Time Alliance is composed of organizations representing physicians. Explicit inclusion of patients and other members of the health care team would provide a more collaborative and comprehensive approach to improving access to cardiovascular health care services.

The CCS states that access to primary care for risk factor modification must be considered, together with access to tertiary and quaternary care, and that all pressure points in the care continuum deserve equal consideration (6). The first 'M' of the 4-M toolbox of strategies suggested in the final report of the Wait Time Alliance is the mitigation of the need for wait lists by disease prevention and health promotion (17). This is a task that necessitates the engagement of all health care professionals, along with consumers. The CMA/CNA discussion paper entitled "The Taming of the Queue" (5) used a framework focused on 'medical care' to illustrate the moments in the system during which wait time decisions are made. Framing discussions about access in terms of 'health care' rather than 'medical care' includes broader viewpoints. Medical care and health care are not synonymous, and the differences in the meanings of these terms have implications for the way in which we regard our health care system and the solutions we propose to health care access in Canada.

The Oxford English Dictionary defines 'health care' as "care for the general health of a person, community, etc., esp. that provided by an organized health service" (18), whereas medical care generally refers to individual services provided by physicians. The 1974 report entitled "A new perspective on the health of Canadians" (19), more commonly known as the Lalonde report, was the first Canadian health report to acknowledge that medical care was not solely responsible for individual well-being or population-level improvements in health status. Although this report prompted some initiatives by the World Health Organization, the majority of its recommendations have not been realized, but neither have they been discounted as strategies to improve health and decrease the use of medical care services. Real change and improved access to care are most likely to occur when health care providers and policy makers take a broader perspective and start thinking in terms of 'health care'.

While the final report by the Wait Time Alliance does not specifically discuss the role of the physician as gatekeeper (17), O'Neill et al (6) state that physicians are increasingly being asked to fill the role of gatekeepers to health care services, and further recommend that "physicians should be empowered to make care delivery decisions at the individual patient level". The CMA's most recent release on wait times (20) continues to discuss "autonomous decision-making within the patient-physician relationship" as the need for physicians to be free to advocate for their patients. The potential solutions to managing wait lists by reducing demand or increasing and/or controlling supply may be limited without the inclusion of other members of the health care team. The solution must involve all members of the health care team, a key member of which is the patient. This conclusion was also reached in the Romanow report (4) on the future of health care in Canada:

In the past, physicians have traditionally played this 'gatekeeper' role, deciding what types of services a patient needs and where those services should be provided. Not surprisingly, nurses have suggested that this is a role they could play, and in reality, nurses and nurse practitioners often coordinate care in Heart Failure Clinics, acting as 'gate-keepers'. However, case managers do not have to be either doctors or nurses, provided that they are in a position to coordinate care and ensure timely access to the care people need.

An important element of the wait time and access issue is the ability to accurately and consistently track wait times. There is a need for a pan-Canadian approach to define and capture common data elements to allow comparisons among sectors and provinces. The measurement of wait times must meet the needs of multiple constituents – government, provider and patient; thus, a broad approach

to development and implementation needs to be undertaken to ensure a credible system. Nurses often lead teams to create and oversee the quality of databases for wait time tracking. Only with accurate tracking of wait times can the sources of delays be identified at the organizational or system-wide level for appropriate action.

The CCS has elegantly crafted benchmark documents, accompanied by strategies for their implementation. To further the discussion, real engagement of all stakeholders, especially clients/patients, is needed to find solutions to wait times and to set benchmarks. Furthermore, heart disease prevention and 'health care' promotion should be recognized and acted on as central ways to reduce wait times for cardiovascular care. This cannot be done without addressing the determinants of health, such as income and social status, support networks, education and culture. As cardiovascular nurses, we see three ways to extend the present discussion about wait times for patients with cardiovascular disease: acknowledgement of the existing and potential roles of nurses in reducing wait times and improving patient care, expanded roles for interprofessional teams, and inclusion of patients and families in program improvement.

THE ROLE OF CARDIOVASCULAR NURSES IN DECREASING WAIT TIMES

Nurses constitute the largest health care-related professional workforce in Canada, and nursing as a profession is being increasingly held accountable for providing high-quality care that is safe and cost-effective (21,22). More than one-quarter million registered nurses were employed in nursing in Canada in 2005 (23). A four-year bachelor's degree in nursing is now the minimum requirement for entry to practice in Canada in all but two provinces. A relatively new and expanding area of nursing is advanced practice nursing. An advanced practice nurse is a nurse trained to the Master's or PhD level whose practice is based on in-depth knowledge of nursing and other disciplines. The two most common advanced practice roles are those of the clinical nurse specialist (CNS) and the nurse practitioner (NP). Nurses with advanced educational preparation in the roles of NPs or CNSs have the skills and knowledge to contribute to "improving access to care, managing chronic disease, addressing the shortage of health-care professionals, and improving patient safety" (24).

Nurses are vital to patient access and must retain and strengthen their roles in "coordinating care, delivering direct services, and helping patients to understand options and navigate the health system" (25). Nurses functioning at each of these levels and in all these roles can improve access to care, decrease wait times and improve the care of patients while they wait, decrease the demand for care through health promotion and prevention, monitor access indicators, and contribute to the growing body of knowledge of the issues related to health care access. Experienced and advanced practice nurses provide critical leadership, high-level skills and the human resources to collaboratively enhance patient access with creative programs.

Improving processes of care to reduce wait lists

Rapid assessment, diagnosis and treatment are essential when patients experience what may be serious cardiovascular symptoms. A systematic review of 36 papers on the impact of NPs on emergency department wait times (26) found that the engagement of NPs in this care sector decreases emergency room wait times, and can improve both quality of care and patient satisfaction. Nurses may safely perform some of the more routine cardiac procedures that are typically performed by cardiologists or cardiac surgeons. For example, one unit in the United Kingdom (27) has studied nurse-led electrical cardioversion as a solution to its shortages in physicians, wait times and acute care beds and concluded that elective electrical cardioversion under general anesthesia can safely be performed by nurses working in a day surgery unit.

There are a number of successful Canadian programs that involve cardiovascular nurses in increasing access to care. The first formal program to show the successful use of registered nurses in managing access

to care was implemented by the Cardiac Care Network of Ontario. Twenty years ago, Ontario designed a system that used an individual patient urgency rating score to determine an appropriate recommended individualized wait time for cardiac procedures. Registered nurses known as regional cardiac care coordinators work with each cardiac facility to triage patients based on urgency. During the waiting period, they are available to patients and providers, should there be a change in patient condition or a requirement to move the procedure date forward. They also provide education and support to patients. These nurses play a crucial role in helping the patient and their family navigate the complexities of today's health care system. In addition to the direct delivery of care, the coordinators have developed best practice guidelines for access to care (28) that have had a direct impact on wait times. Fundamental to the role of access is the redistribution of patients based on capacity. Ontario seeks to reduce disparities between health regions by using the network of regional coordinators to facilitate movement of patients to facilities with availability. Over a three-year period, focused attention by the coordinators in matching patient need with capacity resulted in a 50% overall reduction in regional variations in wait times (60 days to 30 days) for coronary artery bypass graft surgery and a 60% reduction in wait time (70 days to 20 days) for elective cardiac catheterization (29).

In Edmonton, Alberta, NPs and cardiologists have worked together to implement an outpatient clinic that provides prompt access to specialized cardiovascular care called the Cardiac EASE Clinic (30). To enhance coordination and the ability to triage patients, referrals for a cardiac evaluation are sent to a central office. Patients are scheduled with NPs, who complete a cardiovascular history and physical assessment and order diagnostic testing. The NPs also see the patients during follow-up visits to maintain ongoing efficiency with shared management. When the preliminary assessment and testing suggest a low risk of cardiovascular origin, the patient is referred back to the referring physician for monitoring. This program has reduced wait times for cardiology consultation.

In the early 2000s, the New Brunswick Heart Centre (St John, New Brunswick) was challenged to address wait times for inpatient and outpatient cardiac catheterization and percutaneous cardiac intervention procedures. The nursing role of the access coordinator evolved, and a physician and nurse team established a cardiac triage process. Cardiovascular nurse champions act as single gatekeepers through whom all interventional cardiology referrals must pass, regardless of their origin. Two processes are used to evaluate the patient's urgency: the use of three objective medical scoring tools and a mini-decision analysis. The nurses perform the decision analysis for each referral by considering the person's clinical evidence, health and environment. The referring physician and the patient are informed of the planned procedure date and are expected to notify the access team of changes in health status. As a result of this program, there has been marked improvement in the proportion of urgent, semiurgent and elective cardiac catheterization procedures, which are performed within recommended maximum wait times, from an average of 73% in 2005 to 99% in the first quarter of 2007 (31).

The Queen Elizabeth II Health Sciences Centre in Halifax, Nova Scotia, has developed three novel nurse-coordinated clinics to improve access to care for cardiac patients. Experienced cardiovascular nurses at the cardiac Emergency Liaison Clinic provide care to patients who are seen in the emergency department with chest pain, atrial fibrillation, syncope and other diagnoses but are considered to be stable and at low risk for a cardiac event. The patients are telephoned by nurses within 24 h and seen at the clinic within one week for necessary tests, risk factor stratification and assessment. They receive timely diagnoses, education and treatment for their health problems. This clinic reduces the number of unnecessary admissions to hospital and is believed to be a more cost-effective method of delivering service. The Urgent Referral Clinic provides family practice physicians the opportunity to refer patients to a cardiologist for urgent assessment. The nursing role is paramount in these clinics; nurses

provide telephone assessment and triage, risk factor education, support and referrals to other health care professionals. Within these clinics, cardiac education takes place in a supportive environment; patients are encouraged to take ownership of their health and risk factors, which empowers them to make necessary changes. The third clinic at the Queen Elizabeth II Health Sciences Centre, the Early Discharge Clinic, was developed to facilitate discharge from hospital for patients who are stable but waiting for cardiac tests. Patients return for urgent testing, and are assessed and treated in a timely fashion. This clinic helps to reduce patient anxiety and makes bed space accessible to more acute patients.

Improving care of patients on wait lists

Given the relationship between stress and cardiac symptoms, nurses and other health care professionals are concerned about the psychosocial well-being of patients. Wait lists for cardiac surgery and other types of cardiac care are the norm across Canada. Patients on these wait lists report continued health concerns such as chest pain and anxiety related to their health concerns and impending surgery (32,33). Only 41% of patients awaiting coronary artery bypass graft surgery are satisfied with the support they receive from their health care institution (34). Inadequate communication, longer wait time than promised for surgery and short notice to operation were the problems mentioned most frequently. Waiting for cardiac catheterization also increases patient anxiety and decreases quality of life (35).

Simple interventions by nurses, including education and support, have the potential to improve the experience of waiting when provided at the beginning of the waiting period (35). An innovative project to improve care for patients on cancer care wait lists was undertaken in Nova Scotia; this project was initiated and has been run by nurses (36). A staff nurse and a CNS working with cancer patients in an ambulatory care setting make telephone contact with patients waiting for an outpatient consultation. Calls and patient concerns are documented to improve consistency of follow-up, and a teaching plan is followed. Most patients who participated in a pilot of this program (93%) found the telephone follow-up to be helpful. It let them know what to expect and/or reduced their anxiety; they also felt that they had a contact in the 'system'. This program has been continued based on the evaluation of the pilot project. Programs such as this may provide similar benefits and outcomes for cardiac patients. Similar support is provided for cardiovascular patients in the examples of Canada-wide programs profiled in the previous section.

Nurse-led shared-care programs that consist of monthly health education and motivational interviewing reduce anxiety and depression in patients awaiting coronary artery bypass graft surgery, and can have a significant impact in decreasing cardiovascular risk (smoking cessation, weight loss and blood pressure lowering) (37). Whether researching the wait list experience to better address needs or providing information to alleviate some anxiety, nurses recognize the stress and potential cardiovascular implications of waiting.

Decreasing demand for care

Three areas of policy approaches to wait lists are generally discussed: the supply side, the demand side and the specific policies such as setting benchmarks. Most of the energy directed at improving access and decreasing wait lists has focused on the supply side. Although these supply side strategies have been successful in reducing wait times in some areas, they are not sufficient on their own (38). Policies related to the demand side include setting clinical priorities for certain types of health care and managing patient expectations. Another approach to altering demand is more long-term and is only briefly alluded to in various reports; it consists of illness prevention, health promotion and chronic disease management. A number of provinces have implemented chronic disease management programs and made revisions in primary care that have resulted in the reduction of wait times (38).

Inherent in managing chronic disease is the need to ensure that patients adhere to known best practice guidelines. Improved adherence

reduces readmissions and the need for new or repeat procedures, and has an overall positive impact on wait times. A new approach to following acute coronary syndrome patients with a nurse-managed automated calling system at the University of Ottawa Heart Institute (Ottawa, Ontario) improves follow-up care to patients and works with primary care physicians to support patient adherence to medications and self-care practices as promoted in the best practice guidelines (39).

Cardiac rehabilitation programs focus on disease prevention to reduce acute care demand and have existed for many years across Canada. They provide excellent examples of multidisciplinary evidence-based practice. Nurses, physicians, exercise physiologists, dietitians and behaviour specialists effectively work together to promote self-monitoring and cardiac risk reduction to prevent recurrent cardiovascular events.

Although all nurses are trained to promote health, the practice of primary care NPs emphasizes health promotion and illness prevention (40). The Ottawa Heart Institute's programs for prevention of heart disease are just one example: "the Institute has launched a novel and highly successful smoking cessation program that is individualized for treatment, counselling and support. The program is so effective that 50 per cent of the participants remain smoke-free for six months or more" (41).

Also leading the way in cardiovascular health promotion is the Canadian Lipid Nurse Network (CLNN) (42). The activities of the CLNN include promoting standards for dyslipidemia management in Canada; promoting standards for management of all cardiovascular risk factors; providing education about lipid metabolism and dyslipidemia to health care professionals; providing resources on cardiovascular risk factor management to health care professionals; and partnering in programs to raise awareness of dyslipidemia as a cardiovascular risk factor. Nurses within the CLNN incorporate their experience in cardiovascular nursing and specialized education into their clinical care, and they bring their knowledge and expertise to the public arena. These nurses, working under protocols (or more independently, in the case of NPs), provide education, monitoring and medication adjustment to prevent or reduce dyslipidemia within a multidisciplinary environment (or in collaborative practice).

Like most other health systems in the world, Canada is experiencing nursing shortages, which are forecast to worsen over the next decade. In a discussion of expanding nursing roles, the problem of shortages (present and future) cannot be ignored. Access to care also means a safe nurse-to-patient ratio. It is not possible to increase the number of patient beds and procedures without increasing nursing staff. Provincial governments have increased funding to increase the number of seats available at university schools of nursing, support the education of more nurses at the graduate level and increase the number of NPs graduating over the coming years. Increasing the efficiency of nurses by increasing the use of electronic health records also requires provincial support. According to the Romanow report (4), nurses spend 30% of their time managing paper records, and even a 5% increase in efficiency can affect a significant number of nursing positions. The Romanow report (4) also states that:

While much of the focus is on immediate and looming shortages of some health care providers, especially nurses, the deeper and more complex issues relate to their changing roles, the need to re-examine traditional scopes of practice, and the challenge of getting the right mix of skills from an integrated team of health care providers to deliver the comprehensive approaches to health care that Canadians expect.

MAKING INTERPROFESSIONAL CARE A REALITY

Nurses, including registered nurses and licensed practical nurses, account for 43% of the health care workforce, while physicians represent 9%. The remaining 48% includes a range of health care providers

such as physiotherapists, dentists, medical radiation technologists and social workers (43). In 2006, the CNA developed a vision for the future of nursing in "Toward 2020: Visions for nursing" (25). To improve access to care, the CNA identified the need for a range of health professionals that would provide "gateways to primary care, and access to specialist and the broader primary health care system". Villeneuve and MacDonald (25) of the CNA state that "we have not fundamentally changed our 1960's-style system. People still say they can't get health care because they 'don't have a doctor' as if that is the only route to health". The report of the Romanow Commission on the future of health care in Canada (4) has also highlighted the need to change the scopes and patterns of practice of health care providers to reflect changes in how health care services are delivered. Primary health care reform based on interdisciplinary teamwork would permit earlier access and risk stratification. Smith (7) urges the adoption of multidisciplinary care models with integrated health care human resource plans as a national strategy.

Interprofessional education may provide one mechanism for the enhancement of interprofessional care. Interprofessional education involves joint and interactive learning involving students within several health professions. Health Canada includes interprofessional education as a component of the Pan-Canadian Health Human Resource Strategy, with the aim of improving collaborative patient-centred practice (44). Universities across Canada are implementing interprofessional modules and courses aimed at enhancing shared problem solving and developing a mutual understanding and respect for each profession's contributions to complex care situations.

There has been more support for multidisciplinary models in chronic disease management, such as heart failure management. Disease management programs, most often developed and managed by CNSs or NPs, position nurses as part of an interdisciplinary team to improve access to treatment; their goal is to prevent admissions and encourage earlier discharge with careful outpatient follow-up. This approach to care decreases mortality, does not increase the economic burden to the health care system and improves quality of life (15). Multidisciplinary outpatient strategies are associated with reduced hospital admissions caused by heart failure. When heart failure disease management programs are available, patients who have traditionally stayed in hospital for as many as 10 to 15 days may safely be discharged earlier with careful outpatient follow-up, thus freeing up beds for acute patients (45).

PATIENT-CENTRED CARE

The concept of patient-centred care has been understood and discussed for decades but is not as widely accepted or practised as some recent reports on health care issues suggest. In part, this may be because the concept is poorly understood by most health care professionals and, possibly, by the patients themselves. At the same time, when patients in one academic health centre were asked what their priority for change in their medical care was, their most frequent responses were information and increased autonomy (46). The

Registered Nurses' Association of Ontario has published a best practices guidelines document on client-centred care, in which it defines client or patient-centred care as "an approach in which clients are viewed as whole; it is not merely about delivering services where the client is located. Client-centred care involves advocacy, empowerment, and respecting the client's autonomy, voice, self-determination, and participation in decision-making" (47,48). Although the guidelines of the Registered Nurses' Association of Ontario include recommendations to increase the patient-centred aspect of care, they do not recommend strongly enough the inclusion of patients and consumers in decision making around practice and policy within the health care system.

There is increasing recognition that management of chronic diseases improves when patients are supported in developing self-management skills. An Expanded Chronic Care Model has been developed in an effort to reduce the overall burden of chronic disease. This framework integrates health promotion with the prevention and management of chronic disease to support health in individuals and communities and reduce the impact and burden on those who already have the disease (49). New strategies such as telehealth and telehome care are now empowering patients by helping them better understand their disease and promoting self-care (50,51).

The Romanow report (4) called for shaping the direction of Canada's health care system around the health needs of patients and consumers, and made it clear that in the present system, patients have limited control over their own care. As O'Neill and Simpson (page 113 in this issue of the *Journal*) state on the politicization of the wait time issue, "all you need to do is to remember one thing: it's not about doctors, nurses, hospitals, politicians, taxpayers, or money, or winners and losers. It's about patients".

By working together, we can enhance patient-centred care and involvement of consumers in shaping our health care system. The CCS has made a good start by outlining the 10 'first principles' for guiding the development of benchmarks (17). The CCCN invites its health care colleagues to continue to collaborate in finding creative ways to ensure patient-centred care.

CONCLUSIONS

The CCCN advocates building on the recommendations made by the CCS working group on access to care. Explicit inclusion of all stakeholders, including nurses, members of other health disciplines and, most importantly, the consumers of health care, is needed to find solutions to the wait list issue. The plan for change should focus on health care in developing and implementing a vision for sustainable cardiovascular health services in this country. Improved access for all Canadians needs to incorporate a population health, client-centred viewpoint with accurate data tracking systems to evaluate progress. By considering the expanded roles of nurses and teams to assess, treat and follow cardiovascular patients, universal access and efficiency can be maintained and improved without the need for privatizing services to decrease wait times.

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