Driving Innovation: Reinventing Ambulatory and Community Care

Report on the Sixth Annual CEO Forum

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The story of healthcare in Canada today is one of growing numbers of chronically ill patients poorly served by a system designed for acute, episodic care. Changing that story is essential. But is it possible? And how?

The solution, it’s generally agreed, lies in community-based, multidisciplinary teams dedicated to the care of chronically ill people who face multiple health challenges but respond to well-managed, co-ordinated care. Integrated care delivered by teams with a patient-centred focus that emphasizes self-management is the key to keeping the chronically ill from the recurrent crises that send them back to hospital. But how can that world be created?

This was the subject of the 2012 CEO Forum, organized by the Canadian Health Services Research Foundation in partnership with the Canadian Institute for Health Information, the Canadian Nurses Association, the Canadian Medical Association, and the Association of Canadian Academic Healthcare Organizations. Each year, the forum brings together health leaders from across the country to share strategies for improving healthcare.

At the 2012 forum, a number of clinical leaders shared their views about how to ensure high-quality ambulatory and community care for people with complex chronic conditions. The result was glimpses into several effective projects, a long list of barriers to change, and some better understanding of how to make progress — along with warnings that the process will be slow and that producing sweeping change isn’t easy.

The statistics are familiar but grim. One per cent of patients account for one-quarter of healthcare costs, 5% of patients use up half the healthcare budget, and 81% of Canadians over 65 years of age have at least one chronic condition. The people represented by those numbers are in and out of hospital, with everything from congestive heart failure and chronic obstructive pulmonary disease to mental health problems.

Too often, after admission and stabilization, people with serious chronic diseases are “discharged to nothing,” as speaker Irfan Dhalla of St. Michael’s Hospital in Toronto put it. “There’s a high-voltage drop in intensity of care after discharge,” he said, quoting a U.S. study that found 21% of Medicare patients were back in hospital within 30 days of discharge — and in 50% of those cases, the patient did not see a physician before being readmitted to hospital. The situation is not much different in many parts of Canada.

That collapse of care between hospital and community, forum participants agreed, should never be allowed to happen. In B.C., the HomeVIVE program (Home Visits to Vancouver’s Elders) supports the frail elderly at home, through a team of caregivers who believe that sending the very old into emergency is akin to dropping something fragile from a great height. In Toronto, a group of downtown hospitals transfers vulnerable patients from inpatient wards to a “virtual ward” on the day they’re discharged, and care continues at home supported by a multidisciplinary team. In Montreal, CSSS de la Pointe-de-l’île is testing Telehomecare. The program puts high-tech monitors into the homes of newly-discharged chronically ill patients, who enter their health data on a screen. One nurse oversees results from 80 patients at once, but there’s also homecare backup and patients can call for support any time.

1 Jencks et al, NEJM 2009; 360: 1418-28
DEVELOPING OPTIMAL CARE

Further afield, accountable care organizations (ACOs) are being introduced in the U.S. Designed to provide care to Medicare patients, ACOs are groups of doctors, other providers and hospitals who benefit financially (or share the risk) if they meet certain standards for high-quality, co-ordinated care. Adalsteinn Brown of the University of Toronto told the forum that ACOs are organized around patients, not hospitals or political boundaries. But he cautioned that Canadian healthcare’s preoccupation with trying to create structures, rather than developing patient-centred care, may get in the way of developing ACO-style organizations here.

Robert Howard, president and CEO of St. Michael’s Hospital in Toronto, said that true accountable care organizations are built around a funding model not used in Canada. Here, where hospitals operate on annual budgets set in advance, each patient costs them money, essentially discouraging treatment, while for physicians who are paid fees for service, every treatment is rewarded. That disconnect does not encourage co-operation. In a system with ACOs, funding is attached to the patient, to encourage physicians and institutions to work together. It’s supposed to lead to more integrated care, Howard said, although it’s also possible it leads to unnecessary treatments. One thing’s certain: it’s a big change. “For me, the big challenge will be moving the funding model,” he said.

Shirlee Sharkey, president and CEO of Saint Elizabeth Health Care, said changes have to go far beyond how funding is organized. She told the forum about a program Saint Elizabeth set up in a Toronto hospital to divert mental health patients from the emergency department. The mental health workers assigned to the job had broad knowledge of the resources available in the community for people suffering mental health crises. The program reduced return visits to emergency within 28 days by 57% and helped change community care as well. “You need to go beyond diverting money and resources and divert thinking as well,” Sharkey said.
ACCOUNTABLE LEADERSHIP

The need to reshape thinking has to start at the top, said David Levine, president and chief executive officer of the Montreal Regional Health and Social Services Agency. If plans for restructuring care are bogging down, it is always a question of leadership, and not doing enough to engage staff in the project. “Leadership is risk averse,” he said, and resistance to change is widespread among health professionals. As a result, nothing much happens. Several speakers agreed that expectations of teamwork should begin in school, with multidisciplinary training. Others said health professionals need to move on from medicine’s traditional reactive mode. “We have to teach them not to wait for problems to occur, but to prevent them,” said Alain Larouche, of the Groupe conseil santé Concerto in Montreal.

MOVING FORWARD: PERSON-CENTERED CARE

Thomas Lee, network president of the Partners Healthcare System (attached to Brigham and Women’s and Massachusetts General hospitals in Boston), told the forum that the way people work together, rather than structure, is what matters in building integrated care systems. The key to bringing professionals and organizations together is to focus on an overarching goal — which for his group is “to increase value for patients.” That translates, among other things, into asking patients what their health goals are. The answers often differ from the process goals that institutions aim for. “I would make yourselves the world leaders in measuring outcomes that matter to patients,” he told the forum.

The system’s failure to adapt to what chronically ill people need from community-based care was a recurring theme at the forum. “Every large system pays attention to its biggest customers, but healthcare doesn’t do that,” observed John Abbott, CEO of the Health Council of Canada.
One participant wanted to know if size matters — specifically, whether only institutions like those in Boston can operate effective ACOs. Lee said smaller places have some advantages in connecting with community care, but added that patients should be willing to travel for good care. Brown said geography will always be a factor in Canadian healthcare, but it should not prevent the development of better care in the community. “I don’t believe density determines the model...don’t decide what the structure is. Different cities need different ways of dealing with patients.”

The forum focused on efforts to manage chronic disease linked to hospitals and institutions. That focus was intended to show that the barriers keeping general internal medicine doctors (who for the most part work in hospitals) from caring for patients in the community can be overcome. Those barriers are perpetuated by organizational and funding structures, as well as the need to do a better job training people to work in teams.

The institutional focus is a mistake, said Canadian Nurses Association CEO Rachel Bard. “If we want a revolution...we need to change our frame of reference,” she said, calling for community care that would keep people from going into hospitals in the first place. Sharkey added, “The broader issue is not the hospital/community/home care divide: it’s person-centred care.”

**CONCLUSION**

Kaveh Shojania, director of the Centre for Patient Safety at the University of Toronto, told the forum he was getting the message that change by baby steps was more likely than revolution. “I think we are all saying change begins locally,” he said.

On the evidence, that’s true — but is it enough? No. Incrementalism has not delivered the healthcare system needed in 2012 and it is not helping the people who most depend on healthcare. More needs to be done to move away from solo general practice and towards integrating general internal medicine with community and primary care. Healthcare providers need to be trained and paid as team workers from the beginning. If this requires the system to ditch rules and practices that are barriers to better care, so be it. Perhaps motivated professional teams can push what policy-makers find hard to advance.