Going far together: Healthcare collaborations for innovation and improvement in Canada

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Abstract

Healthcare in Canada, as elsewhere, must adapt in order to better meet the needs of the chronically ill. Such adaptations are happening locally, but healthcare decision- and policy-makers require channels and mechanisms for sharing project outcomes and spreading or scaling up successful approaches. Without formal mechanisms, there is a risk of losing the rich knowledge produced by improvement projects; of compromising the efficient use of healthcare resources; and of negatively impacting the further distribution of potential outcomes and impacts. This paper profiles three Canadian collaborations, supported by the Canadian Foundation for Healthcare Improvement (CFHI), which supports healthcare leaders in working together to develop, share, implement, and sustain evidence-informed and systems solutions. The collaborations are team based and particularly relevant to patient engagement and chronic disease care. They illustrate early lessons on how collaborative partnerships, with a shared vision and ownership, can co-address multiple components, conditions and communities, using evidence-based approaches and embedding performance measurement and evaluation. They also demonstrate the role organizations such as CFHI can play in facilitating a collaborative approach to accelerating healthcare improvement within and across organizations or systems.

Keywords: Disease management, Chronic disease, Evidence-based, Healthcare improvement, Health services, Interdisciplinary teams, Patient Engagement, Spread

> 'If you want to go fast, go alone. If you want to go far, go together.'

In healthcare improvement and innovation, this African proverb holds especially true. Globally, there are many examples of 'going it alone' and this is true of the Canadian experience as well.

Canada has earned a reputation in public health, population health, and healthcare for its multiple experiments, across provinces and territories, in how systems are financed, organized, managed,

and delivered. This approach feasibly affords Canadians an opportunity for cross-system comparisons. Arguably, though, there are too few channels or mechanisms for sharing improvement project outcomes and spreading or scaling up successful approaches.[1,2]

Spread may be defined as the process through which new working methods developed in one setting are adopted, perhaps with appropriate modifications, in other organizational or system contexts.[3] The opposite of spread is containment, which occurs when changes at one site are not adapted and adopted by others.[3] Scale up may be defined as the process through which new methods developed in one setting (e.g. a single hospital department) are diffused more expansively across that setting (e.g. to all hospital departments).

This paper presents an approach to collaborative healthcare improvement in Canada that aims to amplify and accelerate opportunities for spread and scale up. The approach is illustrated through a description of three health improvement collaborations, which are in different stages of progress, involve interdisciplinary teams working within or across healthcare systems and include methods and channels for knowledge sharing. Each collaboration is supported by the Canadian Foundation for Healthcare Improvement (CFHI), an agency dedicated to accelerating healthcare improvement for Canadians. CFHI works shoulder to shoulder with policy-makers, managers, front-line providers, patients, and families to provide the analysis, processes, tools, learning systems, and leadership development needed to accelerate change. This paper addresses the following objectives:

- To explore how healthcare leaders are collaborating to develop, share, implement and sustain evidence-informed and systems solutions, with particular emphasis on chronic disease care and patient engagement strategies in the Canadian context;
- To identify strategies for enhancing a collaborative approach for health systems improvement, e.g. through jointly identifying health priorities, introducing integrated evaluation and performance management plans, and formalizing in-person and e-learning platforms and strategies; and
- To identify early and common lessons for driving effective and sustainable systems improvements at scale (multiple systems, contexts, regions) and pace using a team-based, collaborative approach that aims to develop local capacity for improvement.

From nation of pilot projects to sustainable improvement initiatives

When it comes to spreading healthcare improvements across Canada, one former federal Minister of Health, Dr Monique Bégin, popularly described this nation as a 'country of perpetual pilot projects', arguing there was scarce evidence of moving proven projects into stable, funded programs, and rare occasions of transferring the outcomes of pilot projects across jurisdictions.[1] More recently, a Canadian health economist observed, 'there are plenty of innovative projects going on, but these are typically small-scale, often region-specific, and can suffer from not having clear plans for permanence if what is tried proves successful'.[2] According to Bégin *et al.*,[1] this phenomenon has multiple underlying root causes (see Table 1). Many of these root causes relate to what one health services and policy research expert referred to as 'perpetual uniqueness syndrome' in healthcare – the idea that each jurisdiction is so unique that what is grown and works there cannot possibly take root and develop here.[4]

In early 2012, Canada's provincial and territorial premiers created a pan-Canadian Healthcare Innovation Working Group, recognizing that when it comes to improving healthcare for Canadians, 'more can be done together',[5] and have since released their first report which captures areas where they have started working together.[6] This interest in collaborative strategies is promising but until formal mechanisms for sharing best practices and discussing pilot outcomes become the norm, each new pilot project and the knowledge it produces can neither lead to efficient use of resources nor maximize potential outcomes and impacts. Consider such waste in the context of Dr Donald Berwick's profile of efficiency (or the reduction of waste) as 'the quality dimension of our time'. In a recent speech, Berwick speculated:

> … for the next three to five years at least, the credibility and leverage of the quality movement will rise or fall on its success in reducing the cost of healthcare – and, harder, returning that money to other uses – while improving patient experience. 'Value' improvement won't be enough. It will take cost reduction to capture the flag.[7]

In Canada, as the United States and elsewhere, healthcare costs are rising at a rate faster than revenue growth, even as changing demographics

Table 1: Dr Monique Bégin's five reasons why healthcare pilot projects in Canada fail to be scaled up or spread[1]

1. Health services research funders throughout Canada, dating back to the mid-1970s, have – with good intentions – launched thousands of pilot and demonstration projects. When the funds stopped, so too did most of these projects, regardless of their merit.
2. Provincial and territorial governments have limited 'horizontal collaborative mechanisms' to share pilot project experiences. Even in cases where pilots have led to full-scale provincial programs, these programs often fail to develop beyond borders.
3. Governments are often cautious and reluctant to sustain programs that began as pilots because of their innate need to control the bottom line.
4. The knowledge that arises from even the most effective, evaluated projects is neither systematically captured nor shared in a way that allows for generalizability, leading to repeated wheel reinventing across jurisdictions.
5. There is a lack of will to scale up projects and programs that have demonstrated success.

and expectations and the increasing prevalence of chronic illness are testing system limits.[8] New approaches are needed in financing, organizing managing, and delivering healthcare to achieve high-quality, patient- and family-centred, co-ordinated, and efficient care. With its set of 10 provincial and 3 territorial public health insurance plans, and federal care delivery programs for First Nations peoples on reserves, federal police, military personnel and veterans and prisoners incarcerated in federal institutions, Canada offers fertile grounds for experimenting with new approaches in healthcare. The real challenge is not in undertaking the experiments, but in creating formal mechanisms and processes for sharing best practices, disseminating project outcomes regularly, and adapting and adopting successful approaches across the country. It also remains a challenge to undertake collaborative health systems improvement. As Berwick puts it, 'pilots won't suffice, it's time to "flood the zone" (as they say in basketball) or 'start at scale."'[7]

Guiding a pathway for improvement

To support collaborative healthcare improvement, CFHI deploys its unique approach (see Fig. 1),[9] which outlines the process in which health organizations and systems can work with CFHI to animate their improvement journey. CFHI routinely works with policy-makers and those who deliver services as well as an extensive network of expert faculty, improvement coaches, and academic mentors who are senior applied health researchers and practitioners from various domains (clinical, managerial, and policy sectors). This approach draws extensively from CFHI's EXTRA (Executive Training for Research Application) program – a fellowship program for senior healthcare leaders to gain better management and use of evidence for quality and performance improvement.[10]

While the approach is consistent, CFHI customizes its application to meet the needs of health organizations and systems. It includes an internet-based learning platform that provides a shared space for teams involved in collaborations that reach across jurisdictions. It also aims to support a particular improvement initiative, while developing a lasting capacity for delivering improvements. The evaluative function is essential, as it provides results (both successes and failures) in real-time and enables the growth of meaningful collaborations and the generation of measureable results that can be shared broadly. In each of the collaborations presented, CFHI is employing its approach to

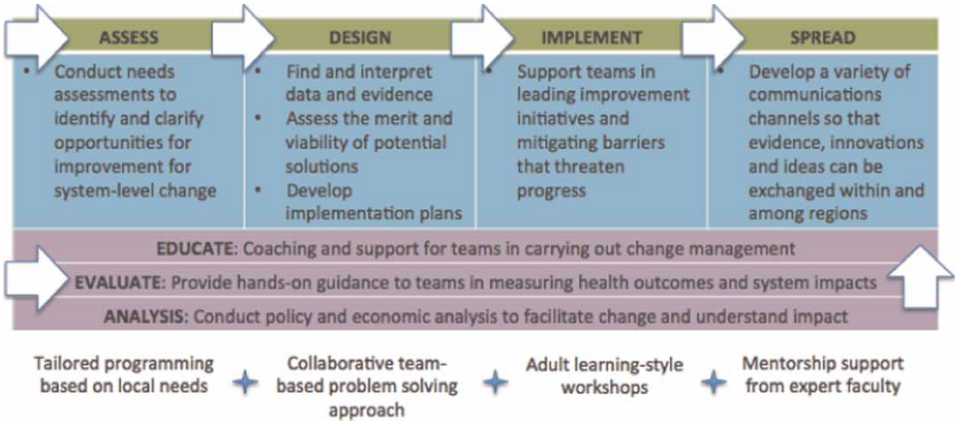

Figure 1: The Canadian Foundation for Healthcare Improvement's Improvement Approach.

support collaborative healthcare improvement in Canada.

Collaboration I. The Integrated Chronic Disease Management Strategy in the Northwest Territories, featuring the work of the Department of Health and Social Services and eight regional health authorities

In its 2011–2016 strategic plan, the Northwest Territories (NWT) Department of Health and Social Services (DHSS) set a priority to 'improve the health status of the population' through the development of an integrated, culturally appropriate chronic disease management (CDM) strategy that tracks system quality outcome measures.[11] The NWT DHSS invited CFHI to carry out a needs assessment in June 2010 to identify and assess the greatest challenges facing those who develop health policy and deliver health services across NWT. Eight regional health authorities (RHAs) with the DHSS deliver health services to 45,000 northerners – a diverse population, facing a range of unique health needs across a sizeable geographical area that includes 33 communities, most with no road access. Staff turnover is extremely high in the NWT, resulting in an above-average number of short-term healthcare providers – often from southern provinces. These factors pose significant challenges to building and sustaining capacity to deliver consistent and quality healthcare across NWT.

The CFHI-led needs assessment raised the profile of population health across NWT, where local data indicate that chronic diseases account for approximately 70% of all deaths and half of all hospital admission days.[12] A full backgrounder of how the NWT collaboration for an Integrated Chronic Disease Management Strategy developed is available[13,14] and its objectives and improvement aims are featured herein (see Table 2). The evidence base for this collaboration was drawn from the Expanded Chronic Care Model (ECCM),[15] which positions a population health promotion lens alongside clinical health services and describes how the two approaches complement one another. The four healthcare components of the ECCM (self-management, health system design, information systems, and decision support) informed the purpose and aims of this collaboration.

What is working?

The NWT collaboration has resulted in a number of early achievements. The evidence-based approach (see Fig. 1) was developed collaboratively – CFHI and DHSS staff worked with Drs François Champagne (lead faculty), Sam Sheps, and Michael Moffatt to adapt elements of CFHI's EXTRA (Executive Training for Research Application) program.[10] This approach is now being applied across CFHI's collaborations. Dr Champagne has further summarized the NWT transformation model as: (i) evidence-based (relying on both scientific evidence and practical, applied knowledge); (ii) participative, with a 'bottom-up' approach that engages the clinical, front-line staff alongside decision- and policy-makers; (iii) aiming to build capacity and skill-up participants in their use of evidence to inform practice and policy; and (iv) rooted in experimentation, allowing for the application of different ways of delivering healthcare.

CFHI has supported the transformation process through its tailored learning approach, consisting of seven workshops delivered over 21/2 years, an 'online hub' where all of the collaboration worksheets and materials are stored, edited, and managed, and access is provided to CFHI faculty and support. This approach provided embedded training to interdisciplinary improvement teams around the design, implementation and evaluation of an 'improvement tracer' methodology through a phased approach of assessing, acquiring, adapting, and applying evidence to inform the tracer projects (in diabetes, mental health, and renal care as per Table 2). As a result, an improved self-reliance on research evidence and optimization of best practices has been established, with increased capacity to inform sustainable and efficient health system decisions, processes, and policy for the NWT health system (see Tables 2 and 3).

The commitment to developing a territory-wide CDM strategy is evident through the NWT's strategic plan, 2011–2016,[11] as well as through participants' commitments to improvement, the majority of which related to increasing the use of evaluative and research evidence in policy and practice (see Table 3). The collaborative contribution of more than 40 participants in the process is a major facilitating factor in this initiative to date. The DHSS and RHA participants include frontline clinical managers, directors and executive staff – all of whom were selected by the DHSS to act as champions for the design of a CDM strategy for the territory. This collaboration brought together individuals who would not normally interact and created a space where ideas could be shared and relationships could develop in order to support broader system improvement goals (see Table 2).

Table 2: Improvement aims of the Northwest Territories Collaboration for an Integrated Chronic Disease Management Strategy[16]

(1) Develop territorial health service delivery models (starting with diabetes, renal, and mental health) maximizing the use of resources and providing care based on evidence and best practices.

Multi-site chronic disease 'tracer' improvements focused on:

I. Diabetes – To build the capacity of primary care teams to provide self-management support to people with type II diabetes. This new capacity aims to improve:

- Appropriateness (of referral/transfer, reduce inappropriate referrals)
- Comprehensiveness

II. Mental health – To standardize processes and procedures for referral and sharing of information in mental health. Theses standardized processes aim to improve:

- Access/ease of referral
- Appropriateness
- Continuity
- Comprehensiveness
- Restructured (referral and information-sharing processes)

III. Renal – To improve and integrate the provision of renal care provided to NWT residents. This integration aims to improve:

- Access/ease of referral
- Appropriateness
- Continuity
- Comprehensiveness

IV. Systems integration

- Alignment of future public policy initiatives to support chronic disease management
- Increased self-management of chronic disease
- Improved data and information collection
- Increased continuity of care for patients with chronic diseases

(2) Enhance capacity and self-reliance for the use of evidence to inform sustainable and efficient health system decisions, processes and policy in Canada's North.

Early results show increased competency development in use of evidence in participants' self-rating, with average scores of 3.5 or higher (on a 5-point Likert scale) in:

- Defining/formulating a health-system problem in their region;
- Searching for and acquiring research evidence;
- Interpreting data;
- Critically assessing the merit and viability of evidence for potential solutions;
- Adapting evidence to local context; and
- Applying evidence to develop implementable solutions.

Table 3: Examples of participants' commitments to improvement (58 in total) as part of the NWT Collaboration for an Integrated Chronic Disease Management Strategy

Area of intended improvement	Examples of participants' commitment statements
Increased use and diffusion of research evidence	'Continue to encourage staff to research and apply evidence to their primary clinical practice' 'Actively use research evidence to support program strategies/ changes within the region'
Increased use of evaluation	'Focusing my own work with administrative data on chronic disease with a view to developing long-term indicators to measure [evaluate] the long-term success [outcomes] in chronic disease management' 'Commit to involving evaluation at the outset of project planning'
Enhanced collaboration and stakeholder engagement	'Incorporate an integrated interdisciplinary working group to identify and define problem areas and build a strategy' 'Continue discussing optimal means of engaging patients with colleagues, nurses, doctors and diabetes educators'
Improved workplace processes	'Create workable protocols for implementation' 'Document patients individual challenges to self-management'
Enhanced reliance on systems design thinking	'A key indicator of success for all of us is that now we think much more in terms of the system and how we're interconnected and how some of the work that goes on here needs to be integrated in the work that we do as individuals. We have really evolved to think of the system as a whole rather than as individuals'

At present, the tracers have achieved the following results:

- Diabetes – Self-management support training has been completed for clinicians at the tracer sites – Norman Wells, Behchoko, and Yellowknife, and baseline and progress measures have been collected.
- Mental Health – A standard referral pathway for mental health services is being implemented between Stanton Territorial Hospital and the communities of Fort Good Hope and Fort Simpson. Flow charts and referral checklists for inpatient and outpatient psychiatry have been designed and produced, and training has been delivered to staff at the tracer sites.
- Renal – NWT Chronic Kidney Disease (CKD) Clinical Practice Guidelines have been developed and approved. These guidelines include disease definitions, classification of stages of CKD, risk assessment criteria, and pre-referral work-up, as well as recommendations for management of renal disease for all primary care clinicians and a clear process for referral of renal clients.

Why is it working?

There are a number of factors facilitating the early-stage achievements of the NWT CDM initiative. First, the partnership between CFHI and the DHSS is a collaborative partnership, with both partners co-funding and developing the initiative; therefore, there is established shared ownership and responsibility to mark milestones, with the partners equally committed to working with the tracer teams to evaluate their results and performance to inform scaling up and spread at the systems level. To show progress, the partners have contributed to a variety of communication products (e.g. written summaries, conference presentations, and videos), which have served as channels for reaching a wider audience both within the territory, across Canada and internationally. Using the NWT transformation model (developed by Dr Champagne), the partners are committed to 'telling the story' of this improvement process in a detailed evaluative case study, which will help in further disseminating the approach taken. Second, the initiative is about starting at scale: (i) it addresses multiple components of system improvement at once (delivery system design, decision support, information systems and self-management), while (ii) focussing on multiple conditions (diabetes, mental health and renal care) and (iii) implementing improvements across multiple communities. Third, the approach incorporates curriculum and learning for participants to develop and refine their skills for effectively interpreting and analyzing data and evaluative results. Related to these skills enhancement is, fourth, that the initiative has engaged and built local champions from within all levels of the health system. Each of these factors contributes to the sustainability of the improvements made so far

as well as to the ongoing development of the NWT CDM strategy.

Collaboration II. The Patient Engagement Projects, featuring one of 17 projects underway across Canada, the feature one based at the McGill University Health Centre in Montréal, Québec

Health system improvement is best achieved collaboratively, recognizing that patients, families, and caregivers are the primary sources of input and, indeed, the drivers to motivate practice and policy transformation. CFHI is working with patient engagement teams across the country to develop and share innovative strategies for achieving patient- and family-centred care, which is a central theme guiding CFHI's work alongside improved efficiency and coordination. Since 2010, CFHI has launched 17 Patient Engagement Projects (PEPs) to uncover lessons and promising practices leading to care that is truly patient and family centred. The PEP initiatives are developed on the basis of three key objectives: (i) to support the development, implementation and evaluation of patient engagement in health services to improve the quality of care; (ii) to enhance organizations' capacity to engage patients and families in the design, delivery, and evaluation of healthcare; and (iii) to increase knowledge and understanding of the effectiveness of promising patient engagement strategies that ensure patients and families are at the core of health services. A full backgrounder on how CFHI and its partners initiated PEP is available.[17,18] For the purposes of this paper, one PEP is explored in detail – the PEP hosted by McGill University Health Centre (MUHC) in Montréal, Québec, that involves a total of five care teams in three hospitals and sets out to engage patients and front-line staff in partnerships to co-create improvements to transform the inpatient care experience and co-design care processes (see Table 4 for an overview of MUHC PEP's improvement aims).[19]

What is working?

The results to date from the MUHC PEP team (see Table 5) show patients transitioning from care recipients to collaborators in care design. One patient representative reported, 'It has been encouraging to see how the staff are really trying to listen to patients. Even though they sometimes have a little trouble understanding why this is important to the patient. But they really are trying. They will listen. And try to see it from the patient's perspective and that is very encouraging.' Equipment relocation, redesigned treatment rooms, and improved admissions processes have increased work efficiency and quality of care. Having patients and professionals partner in redesigning in-patient care systems has had profound impact on those receiving care through the reshaping of care processes to respond to patients' real needs. Aiming to overcome work processes and physical environments that impede the delivery of safe, high-quality care and result in dissatisfied and disengaged patients, care teams have been successful in achieving quality improvement through a number of targeted strategies. Extensive patient experience feedback has been obtained via surveys and post-discharge interviews, while staff and patient representatives have formed hospital patient–staff committees to share in improvement strategies and lessons learned.

These results demonstrate what can be achieved at the project level. At the collaboration level, the CFHI PEP program entails a tailored learning process, with interdisciplinary teams coming together to share challenges and strategies for addressing them. Over a 2-year period, PEP teams participate in four workshops and are

Table 4: Improvement aims of the McGill University Health Centre Patient Engagement Project

(1) Understand the inpatient experience through the eyes of patients and families (or other personal caregivers) and utilize that focus to redesign care processes
Patients and staff co-develop, test, and refine all aspects of inpatient care
(2) Deeply engage patients and families, along with staff, in reshaping care processes that respond to their real needs, thus improving safety, access, and the work environment
Sharing feedback with staff frequently around: • Patient narratives • Focus groups • Quantitative measures
Adequate opportunities for interaction and exchange through: • Three to four patient representatives designated for each of the five tracer units • Engage patients willing to provide narratives
(3) Increase nurse time in direct care by eliminating waste and duplication
Drawn from the Transforming Care at the Bedside [20] initiative, designed to teach front-line teams how to carry out rapid-cycle improvement processes so they can become the owners and leaders of improvements needed to achieve better patient outcomes

Table 5: Preliminary results from the McGill University Health Centre Patient Engagement Project

- Twenty patient representatives moved from being careful observers to active collaborators
- Hospital Consumer Assessment of Healthcare Providers indicated a 30% improvement in responsiveness of caregivers reflecting better patient experiences
- Eight percent increase in nurse time spent in direct care and a 50% reduction in waste activities
- Equipment re-location significantly reduced time spent hunting and gathering
- Quiet zone led to a 50% reduction in interruptions and 60% reduction in medication transcription errors
- Redesigned chemotherapy treatment room shortened the wait to start chemo by 57%
- Improved mental health admission process reduced the admission time from 4.3 hours to 1 hour
- Approximately $3,000 worth of medical supplies per unit was returned for recirculation
- MUHC Patients Committee donated $40,000 for the purchase of whiteboards for bedside 75% communication
- Front-line staff, manager and patient representatives developed new leadership competencies

granted access to an 'online hub' where all of the workshop materials and team reports are stored. Importantly, patients and patient representatives are active participants on the teams and in the workshops. An additional advantage to the teams is access to the CFHI-commissioned PEP research team, led by Dr G. Ross Baker. The purpose of this accompanying research is to determine lessons learned from PEP and to document promising practices in Canada and internationally, with the ultimate goal of providing Canadian healthcare organizations with recommendations on effective ways to engage patients to improve the quality and delivery of care. Dr Baker and colleagues have been active as faculty in the CFHI workshops; indeed, bringing real-time qualitative feedback to the teams on the barriers and facilitators they collectively face in implementing patient- and family-centred care. This participative approach has been helpful in pinpointing areas for attention in the change management process, while at the same time, providing further information back to the research team.

Why is it working?

There are a number of factors contributing to the early-stage achievements of MUHC and the PEP program. First, this collaboration relies on engaging patients and patient representatives as the primary drivers in the transformation process. As the patient is the person present for every step of care, they bring expertise that is beyond what healthcare providers, decision- or policy-makers can offer alone. Patient engagement initiatives represent a growing interest in reorienting systems toward improved care and system design modeled around patient- and family-centred care, and the MUHC PEP demonstrates how much better system design and service care improvements are when patients are engaged in co-creating them.

A second factor that is contributing to 'why this collaboration is working' is the focus on evaluation and performance management. Although engaging patients may seem like an obvious approach, there is a lack of empirical evidence about its effects, which is why it was additionally essential to launch a range of PEPs at once (17 in total).[20] Performance progress markers, an evaluation tool from CFHI, were used by the MUHC PEP team to articulate how to move beyond what is expected, as minimum care requirements, to provide services under an ideal care model to achieve success through improved inpatient care. The participative approach featured a change to bottom-up care design through an increase in patient and front-line work involvement in service design. MUHC's efforts are, in large part, a result of moving beyond what patients expect to see (progress marker set I), such as having patient representatives at Transforming Care at the Bedside meetings, to what they would like to see (set II), like the opportunity to be involved in discussions, to finally what they would love to see (set III) by way of active participation in re-designing care processes and addressing key challenges to design.

CFHI's support (see Fig. 1) – a third factor – provides a 'set sequence' to improved patient engagement, e.g. strategies for engagement were furthered through the workshops coordinated by CFHI, bringing PEP teams together to learn from one another, the PEP research team and key experts in the field of patient engagement. These strategies and lessons learned from across the PEP collaboration are already being disseminated in a variety of ways (e.g. written summaries, conference presentations, videos, and online workshops). CFHI is committed to further 'curating' the PEP results, especially working with the PEP research team, to ensure the lessons reach others across Canada and internationally. This emphasis on shared learning will help to contribute to the further application, adoption, and spread of patient engagement.

Collaboration III. The development of the Atlantic Healthcare Collaboration for Innovation and Improvement in Chronic Disease, featuring the work of 17 RHAs, four provincial Departments of Health and supportive partners across four provinces: New Brunswick, Newfoundland and Labrador, Nova Scotia, and Prince Edward Island

Between 2011 and 2012, CFHI convened RHA CEOs and representatives from the provincial departments of health across four Atlantic provinces to assess health system priorities. An analysis of these priorities, as documented in the organizational strategic plans from all of the RHAs and departments of health, revealed common challenges and aligned priorities, particularly those related to CDM.[21] Opportunity was seized, and the Atlantic Collaboration for Innovation and Improvement was designed, inspiring these provinces to work together to address these priorities collaboratively. In March 2012, CFHI and all 17 RHAs from the four Atlantic provinces (with endorsement from the provincial departments of health) formalized their commitment through a Charter agreement, which sets the goals, objectives, activities, roles, and other features of this collaboration.[22]

The approach draws from the ECCM[15] and involves improvement teams undertaking patient- and family-centred improvement projects related to (i) self-management, (ii) delivery system design, (iii) decision support and information systems, and (iv) strengthening community action.[15] (All of which aim to re-orient healthcare services to effectively address the needs of those living with chronic diseases.) The improvement projects cover a range of healthcare issues, some acute and some community-based, and focus on a variety of disease areas and conditions from Type II diabetes and chronic obstructive pulmonary disease to long-term mental health issues and suicide. The collaboration launched in the fall of 2012 with the overarching goal of 'improving the health of people living with chronic diseases in Atlantic Canada'. (See Table 6 for a summary of the collaboration objectives and initial evaluation questions. These objectives and questions will help to guide the development of an evaluation framework for the collaboration.)

What is working?

At present, a total of 10 interdisciplinary improvement teams have developed as part of the Atlantic collaboration. A full backgrounder on the Atlantic collaboration and these improvement projects are available[23]. In alignment with the ECCM principle of effectively drawing out improved functional and clinical outcomes for clients in multiple areas of chronic disease simultaneously, improvement teams are committed to harnessing the power of a collective effort and building capacity in the Atlantic region. Through the first workshop (November 2012) and follow-up activities (via distance learning), this first cohort of teams are identifying key barriers to improvement and stakeholders to engage for achieving change, as well as setting improvement targets and measurement indicators necessary to monitor and evaluate their progress. A network of chief executives who are responsible for healthcare delivery in the Atlantic region has also been established – this includes the larger group of signatories to the Charter agreement, but also a smaller group of five RHA CEOs, who together with CFHI's President and CEO, form an executive committee which oversees, sets direction for, and monitors the performance of the collaboration. Importantly, the collaboration is endorsed by the policy leaders at each of the four provincial departments of health, which is essential in the context of sustaining, scaling up, and spreading improvements across the Atlantic region.

Table 6: Objectives and initial evaluation questions of the Atlantic Healthcare Collaboration for Innovation and Improvement in Chronic Disease

1. Develop a patient and family-centred approach to CDM
   - What CDM-related improvements in patient-centredness, efficiency, or coordination have resulted from the initiative?
2. Promote the sustainability of the health system
   - What CDM-related improvements in self-management, system design, decisions, and information support or community action have resulted from the initiative?
   - To whom and how effectively have the improvement project (IP) policy-delivery solutions and outcomes of the IPs spread?
3. Build a network of organizational, regional, and provincial teams, which will share evidence-informed, effective, sustainable and system-level solutions and work together to develop and implement IPs
   - To what extent has the collaboration increased linkages and the sharing of information across the Atlantic for the improvement of CDM?
   - What types of new relationships and actions have transpired as a result of the initiative?

Following its improvement approach (see Fig. 1), with workshops and access to an 'online hub,' CFHI is also increasing its capacity to support this large-scale collaboration through the development of a mentorship network, where each team has access to faculty/academic mentors and improvement coaches. Academic mentors assist with problem formulation, methodology, and data requirements, as well as the systematic assessment and application of evidence from research to improvement initiatives. Improvement coaches assist with the change management process and the tactical and strategic approaches to effective implementation of the improvement project. A focus on partnership development, particularly in the Atlantic region, is also crucial for building capacity across the Atlantic to grow, share, and sustain evidence-informed and systems solutions.

Why is it working?

There are a number of areas to monitor in this early phase and throughout the next 3 years of the Atlantic Healthcare Collaboration. First, the partnership between CFHI and all 17 RHAs in Atlantic Canada offers collective responsibility to a common vision of systems improvement in CDM. Supporting this vision is the network of chief executives who provide a governing body to identify health priorities and set outcome and systems improvement targets for their regions. Endorsement from the provincial departments of health is expected to facilitate support and uptake of improvements cross-regionally and provincially. Second, the Atlantic collaboration addresses multiple components of system improvement at once, while focusing on multiple conditions (COPD, diabetes, mental health, etc.) and implementing improvements across multiple regions. Third, connecting the improvement teams through the CFHI approach (Fig. 1), with workshops that focus on assessment, design, implementation, and evaluation is helping to further co-ownership in and responsibility for a common vision of system improvement for people living with chronic diseases.

Realizing the value of true collaboration

In healthcare, true collaboration is about more than likeminded people working together. It happens when healthcare professionals from across jurisdictions and disciplines bring to bear their unique knowledge, skills, and experiences to resolve persistent challenges, perform vital functions and tackle common problems – together. CFHI's improvement approach (Fig. 1) is tailored to offer this support, in person and virtually, to health system leaders who are committed to improvement. As CFHI's collaborations demonstrate success, these results will be shared as widely as possible so that all healthcare decision makers, administrators and providers can benefit. With a growing political will to create efficient, coordinated, and patient- and family-centred care and the commitment of provincial and territorial premiers to innovation in healthcare,[5,6] there is opportunity for Canada to shed its reputation as a *nation of pilot projects*.

The cases here, although at different stages and tackling different health system challenges, share a truly collaborative approach. They offer glimpses into how improvements can be made in partnership with colleagues across jurisdictions when they are formally supported. They make considerations for sustainability and spread at the outset of improvement efforts, including embedding evaluative strategies to learn about how the improvements were undertaken so that they can be shared within, across, and beyond. Although still at an early stage in their life cycle, they can provide examples of the future of healthcare in Canada, serving as a model for other healthcare systems realizing the power of true collaboration.

In short, they can provide examples of going far, together.

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References

1. Bégin M, Eggertson L, Macdonald N. A country of perpetual pilot projects. Can Med Assoc J. 2009; 180(12):1185.

2. McGrail K. Canada a nation of health care 'pilot projects'. 2012, March 5 [cited 2012 Nov 26]. Available from: Troy Media. http://www.troymedia.com/blog/2012/03/05/canada-a-nation-of-health-care-pilot-projects
3. Buchanan D, Fitzgerald L, Ketley D. The sustainability and spread of organizational change. London: Routledge; 2007.
4. Lomas J. Personal communication; 2007, no date.
5. The Council of the Federation. Premiers announce health care innovation working group. Victoria: The Council of the Federation; 2012.
6. The Council of the Federation. From innovation to action: The first report of the Health Care Innovation Working Group. Victoria: The Council of the Federation; 2012.
7. Berwick D. 'The Moral Test' Speech to the 23rd Institute for Healthcare Improvement National Forum in Orlando [document on the internet]. 2011, Dec 7 [cited 2012 Nov 26]. Available from: http://pickerinstitute.org/wp-content/uploads/2011/12/Dr.-Don-Berwick-The-Moral-Test1.pdf
8. Constant A, Petersen S, Mallory CD, Major J. Research synthesis on cost drivers in the health sector and proposed options. 2011 [cited 2012 Nov 26]. Available from: http://www.chsrf.ca/Libraries/Hospital_Funding_docs/CHSRConstantSynthesisCostDriversENG_1.sflb.ashx
9. Canadian Foundation for Healthcare Improvement. Our proven approach to collaboration [Internet]. Ottawa: CFHI; 2012 Nov [cited 2013 Jan 31]. Available from: http://www.cfhi-fcass.ca/WhatWeDo/Collaborations/OurApproach.aspx
10. Canadian Foundation for Healthcare Improvement. Executive training for research application [Internet]. Ottawa: CFHI; 2009 Oct [cited 2012 Nov 26]. Available from: http://www.cfhi-fcass.ca/WhatWeDo/EducationandTraining/EXTRA.aspx
11. Northwest Territories Health and Social Services. Building on our foundation 2011–2016: a strategic plan for the NWT health and social services system [Internet]. Yellowknife: Government of Northwest Territories; 2011 [cited 2012 Nov 26]. Available from: http://www.hlthss.gov.nt.ca/pdf/reports/health_care_system/2011/english/building_on_our_ foundation.pdf
12. Northwest Territories Health and Social Services. Northwest Territories Health Status Report [Internet]. Yellowknife: Government of Northwest Territories; 2011 [cited 2012 Nov 26]. Available from: http://www.hss.gov.nt.ca/health/slides/nwt-health-status-report.
13. Leith E, Kirvan C, Verma JY, Lewis K, Roberston S. Re-imagining Healthcare: The Northwest Territories transitions to an integrated chronic disease management strategy. Healthc Q 2012;15(1):19–21.
14. Canadian Foundation for Healthcare Improvement. The Northwest Territories collaboration for an integrated chronic disease management strategy [Internet]. Ottawa: CFHI; 2012 Oct [cited 2013 Jan 31]. Available from: http://www.cfhifcass.ca/WhatWeDo/Collaborations/NorthwestTerritories.aspx
15. Barr VJ, Robinson S, Marin-Link B, Underhill L, Dotts A, Ravensdale D, et al. The Expanded Chronic Care Model: an integration of concepts and strategies from population health promotion and the Chronic Care Model. Hosp Q 2003;7(1):73–82.
16. Canadian Foundation for Healthcare Improvement. Integrated chronic disease management in the Northwest Territorites [poster]. Ottawa: CFHI; 2012.
17. Brosseau M, Verma J. Engaging patients to improve quality. Healthc Q 2011;14(3):16–18.
18. Patient Engagement [Internet]. Ottawa: CFHI; 2010 Aug [cited 2013 Jan 31]. Available from: http://www.cfhifcass.ca/WhatWeDo/Collaborations/PatientEngagement.aspx
19. Canadian Foundation for Healthcare Improvement. Patient engagement: a key ingredient for transformation [poster]. Ottawa: CFHI; 2011.
20. Rutherford P, Lee B, Greiner A. Transforming care at the bedside. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2004.
21. Akunov N, Leith E. 2012. An Analysis of Health System Priorities in Atlantic Canada: An Environmental Scan (Unpublished). Ottawa: CFHI. 2012.
22. Canadian Foundation for Healthcare Improvement. Atlantic Healthcare Collaboration for Innovation and Improvement in Chronic Disease Charter [Internet]. Ottawa: CFHI; 2012 Mar [cited 2013 Jan 31]. Available from: http://www.cfhi-fcass.ca/Libraries/Collaborations/AtlanticCharter-March12–2012-E.sflb.ashx
23. Canadian Foundation for Healthcare Improvement. Atlantic Healthcare Collaboration for Innovation and Improvement in Chronic Disease [Internet]. Ottawa: CFHI; 2012 Nov [cited 2013 Jan 31]. Available from: http://www.cfhifcass.ca/WhatWeDo/Collaborations/AtlanticHealthcare.aspx