

Ken Tremblay's interview with Health Canada's new deputy minister, Simon Kennedy, opens a window onto the complex nature of an organization tasked with regulatory, policy-making and operational functions (all while seeking elusive federal-provincial cooperation). This brief glimpse inside Health Canada's plethora of roles and responsibilities makes a superb entry portal for the first Healthcare Quarterly issue of 2015, which similarly ranges across a wide field of critical concerns.

Funding Reform

Where there is public healthcare there is also talk of funding reform. Anne Wojtak and Dipti Purbhoo take us deep inside that topic in their discussion of "bundled reimbursements," which, advocates argue, raise care quality while lowering costs. Focusing primarily on Ontario's home care system, Wojtak and Purbhoo note that challenges and uncertainties associated with bundled payment increase when one moves from a single diagnosis to complex, chronic conditions. Fascinating, therefore, is their contention that, in the case of home care, a "practical and necessary place to start is with bundling care" rather than payments. The example they provide of an integrated palliative care team brings that point home.

Our next article looks at reforms affecting long-term care (LTC) funding in Alberta. Trafford Clamp, Nadya Repin and Jason Sutherland focus on that province's patient-care-based funding (PCBF) model, which ties the complexity and care needs of LTC residents to the payment LTC providers receive – specifically asking, "Does PCBF support Alberta's goals for providing transparent, stable and equitable funding to LTC providers across the province?" While the authors say that more time is needed to discern the policy's full impact, two clear

"positive strides" have been made: standardizing LTC residents' assessment and reporting, and linking payments to care plans and staffing requirements. But what, they also ask, will be the consequences as LTC providers seek to lower costs below the government's funding level?

Leadership Development

The Canadian Interprofessional Health Leadership Collaborative (CIHLC) recently completed extensive research on collaborative leadership in healthcare. In their article, Matthew Gertler et al. built on this work by developing an inventory of health leadership education programs in Canada, and then analyzing the availability and nature of leadership education to specific health professionals. While they found "many opportunities" for such training, amongst their most discoveries was that continuing education and executive courses had the "highest instances of having evidence of collaborative leadership attributes."

On a related topic, Isser Dubinsky and his two co-authors asked, beyond clinical excellence or mere rotation of roles, what are the ingredients of "truly effective physician leadership" and how can those elements be nurtured? Many physicians have the "traits" leaders require (e.g., integrity, passion, judgment), but "few possess the requisite competencies and technical skills" necessary for optimizing quality, fund raising and other functions. In their article, Dubinsky et al. take readers through a physician leadership skills matrix and implementation toolkit they developed based on seven key competencies (e.g., network development and relationship building, strategic planning and thinking).

Using Technology

“Downtime preparedness” – this was a new term to many of us. However, for Michael Caesar and Scott McIntaggart, it signifies a “culture” that needs to be developed throughout the increasingly digitized healthcare world. The basic premise, the authors explain, is that work needs to continue even when an information technology (IT) system is offline, but preparing for and dealing with clinical system outages requires an “enterprise-wide response.” It’s not just the folks in IT who own the problem. Taking Toronto’s University Health Network as their model, Caesar and McIntaggart’s offer a transferable list of “lessons learned” – including shared accountability, standardization and prioritizing applications and user groups.

Healthcare teaching through simulation is widespread in Canada and elsewhere. Not a lot is known, though, about using simulation to effect organizational change. Darlene Hubley and her colleagues present findings from Holland Bloorview Kids Rehabilitation Hospital in Toronto, which employed a simulation event to support the rollout of an outpatient electronic health record (HER) and a corresponding point-of-care documentation system. The authors extrapolate from their particular example to generate five key lessons – such as clear communication, staging in small and larger groups, supporting active learning – that other organizations will find useful for their change-focused efforts.

Patient Safety

Accreditation is another ubiquitous practice throughout modern healthcare, but, in LTC homes, does it lead to better safety processes and outcomes for residents? And do the characteristics of individual LTC facilities influence whether they seek accreditation? Shawna McDonald, Laura Wagner and Andrea Gruneir provide this issue’s second look at the LTC space

through a tour of their research into these important policy- and finance-related issues (via 587 homes in Ontario). Readers will likely be surprised that, with regard to the first question, only a decreased incidence of falls – 8% lower – correlated with accreditation (as the authors note, accreditation in itself is not a guarantee of better care; only “appropriate implementation and execution” can further that goal). Meantime, the researchers found that for-profit ownership, belonging to a chain and an urban location were predictive of accreditation. Based on these results, it is clear that policymakers “may need to consider new initiatives that reduce barriers for facilities that lack sufficient resources” to pursue accreditation.

Primary Care

Timely access to primary care: it would be hard to find a Canadian who did not wholeheartedly endorse that objective. In this issue’s final essay, Jennifer Fournier et al. introduce us to an “advanced access scheduling system” aimed at bringing about primary care access within 48 hours (we recommend reading this article in conjunction with the ICES report on using primary care practice reports to guide quality improvement in primary care). Implemented at a nurse practitioner (NP)-led clinic in northern Ontario, the results were primarily positive, and included outcomes such as decreased pressure on NPs, enhanced quality of documentation, improved patient safety, fewer missed appointments and heightened patient satisfaction. Even clerical staff, it seems, benefitted, reporting reduced confrontation with clients and greater job satisfaction.

– The Editors

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