

Submission to Advisory Panel on Healthcare Innovation

December 8, 2014

A healthy population and a vibrant medical
profession

Une population en santé et une profession
médicale dynamique

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is helping physicians care for patients. The CMA will be the leader in engaging and serving physicians and be the national voice for the highest standards for health and health care.

On behalf of its more than 80,000 members and the Canadian public, CMA performs a wide variety of functions. Key functions include advocating for health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 60 national medical organizations.



Introduction

Since 2010, the Canadian Medical Association (CMA) has been calling for health care transformation in Canada to better meet the needs of Canadians. A high performing health care system must be able to respond to the changing nature of its population's health needs.

The CMA believes that seniors care is the paramount health care issue of our time. Our older population will double over the next 20 years, while the 85 and older group is set to quadruple. Currently, we spend almost half of all our health care dollars on seniors. Improving seniors' care will go a long way to fixing our health care system; this is because strategies to address the needs of this population can be leveraged to address the needs of other population groups. That is why CMA has called for the development of a Pan-Canadian Seniors Strategy as a necessary first step.

The CMA welcomes the creation of the Advisory Panel on Healthcare Innovation to better prepare health systems across the country for the above challenges and to contribute toward the sustainability of Canada's public finances and social programs. This brief identifies five important innovations that will not only benefit Canada's growing seniors population but the broader Canadian population as well.

Five Innovations to Improve our Health Care System

1. Supportive living models and palliative care

Canada suffers from a lack of integrated community/residential supports and palliative care models, contributing to poor patient outcomes, significant inappropriate use of health care resources, and higher health care costs. An obvious sign of this gap is the significant number of alternate-level-of care (ALC) patients—most of whom are seniors—languishing in hospitals across Canada. ALC patients are those inpatients that no longer require acute care and are waiting for placement in a more appropriate setting. According to a 2009 Canadian Institute for Health Information (CIHI) report, dementia accounted for

almost one-quarter of ALC hospitalizations and more than one-third of ALC days.ⁱ Dementia is the leading cause of dependency and disability among older persons. The Wait Time Alliance (WTA) has stated that the most important action to improve timely access to specialty care for all Canadians is by addressing the issue of alternate-level-of-care (ALC) patients.ⁱⁱ

The creation of supportive and integrated living models particularly for the frail elderly and those with dementia would lead to improved health outcomes for these patients as well as savings to the health care system.

- Supportive living models can involve providing technology and human resources to support seniors to stay in their home. It has been estimated that tele-homecare could yield an annual reduction in approximately \$540 million in inpatient costs and \$23 million in emergency department visit costs.ⁱⁱⁱ
- For others, particularly those with dementia, residential care models are required that can properly support their needs and provide the highest quality of life possible. A few such models are already in existence but more are required. Models include the Bruyère Village in Ottawa (<http://www.bruyere.org/bruyere-village>) and Saskatoon's Sherbrooke Community Centre (<http://www.sherbrookecommunitycentre.ca/>). CMA recommends that federal and provincial infrastructure programs allow for innovative residential care options to be eligible for funding.
- Despite the vast majority (96%) of Canadians supporting the use of palliative and hospice care in end-of-life care, only 16-30% of Canadians who are dying have access to or receive hospice, palliative and end-of-life services^{iv}. This issue must be addressed immediately across the country. Currently, there is no standard palliative and hospice care model in Canada. However, there are some innovative programs around the country that are leading the way to higher quality palliative care (e.g., West Island Palliative Care Residence in Quebec). The CMA is currently preparing a report to inform health care decision makers including physicians on tools to integrate palliative and hospice care services in their respective communities. But assistance is required to implement innovative practice models across the country.

2. Integrated strategies for high-users of health care and at-risk populations

It is now recognized that a targeted approach is necessary to make substantive change to improve the health status of populations; including reducing health inequities and ensuring more appropriate access to health care resources by those citizens who have a range of socio-economic needs.

Approximately five percent of patients account for two-thirds (66 percent) of provincial health expenditures—many of whom are elderly. This picture is consistent across the country.^v This high use is often due to systemic issues, such as poor integration or lack of access, rather than the choices of these patients. There is general agreement that multi-sectoral approaches are necessary that involve the integration of clinical and social care as well as other sectors to best address this population group that often has polymorbidities.

Programs are being implemented in a few provinces at the regional or provider level to try and accommodate the needs of the high-users population by coordinating and integrating care for the benefit of the patient and the family. Examples include Health Links in Ontario and the Regional Integrated Complex Patient Care Planning (RICP2) program at Vancouver Coastal Health Authority. However, funding models—particularly for inter-sectoral approaches—to support the wide-spread adoption of these approaches are rare.

In addition to the high-users are those populations that feature a high burden of illness. Hundreds of research papers have confirmed that people in the lowest socio-economic groups carry the greatest burden of illness.^{vi} Those within the lowest socio-economic status are 1.4 times more likely to have a chronic disease, and 1.9 times more likely to be hospitalized for care of that disease.^{vii}

As with the high-user group, a multi-sectoral approach is required to address the social determinants of health. While it is important for society to strive to eliminate poverty and provide adequate housing and food security, the health care sector can also contribute. Some innovative programs have been put in place such as the Well North program in the United Kingdom that is targeted at improving the health of the poorest fastest, reducing premature mortality and reducing worklessness.^{viii} In Canada, the St. Michael's family health team has an income security specialist on their multi-disciplinary team. This individual helps patients to navigate the government's social services system, will help patients reduce expenses, complete their taxes, set up bank accounts, access free

programs, budget and save for emergencies. These patients are identified through screening conducted by family physicians on the team.

There are innovative approaches being developed to address the needs of high-volume users as well as at-risk populations. As many of these innovations involve greater integration between health and the community sector and attention to issues not traditionally funded through health care payment systems, there is a need to provide access to funds to enable these innovations to continue and be spread across the country.

A targeted, integrated approach to identify communities in need is required and this must be based on reliable community data (i.e., meaningful use of patient data) which can be used to integrate resources to improve health status. The Canadian Primary Care Sentinel Surveillance Network (CPCSSN) is Canada's first multi-disease electronic medical records (EMR) surveillance and research system that allows family physicians, epidemiologists and researchers from across the country to better understand and manage chronic care conditions for their patients. Health information is collected from EMRs in the offices of participating primary care providers (e.g. family physicians) for the purposes of improving the quality of care for Canadians suffering from chronic and mental health conditions and three neurologic conditions including Alzheimer's and related dementias. CPCSSN makes it possible to securely collect and report on vital information from Canadians' health records to improve the way these chronic diseases and neurologic conditions are managed (<http://cpcssn.ca/>). Despite this innovative approach to sharing information to better manage chronic care conditions, its five-year federal funding terminates in 2015. The estimated cost of continuing the project is approximately \$3 million per year.

3. Optimal prescribing

Poor prescribing can lead to poor patient outcomes and unnecessary costs to the health care system (e.g., fractured hips from falls). The evidence is clear that many seniors in Canada are exposed to inappropriate drug therapy. Data from European countries such as Denmark, , show that inappropriate prescribing can be controlled with only 5.8% of elderly patients using an inappropriate medication in a four month period in 2001. In Canada, CIHI studied senior's drug claims from public programs in four provinces from 2000 to 2006 and found that

the rate of inappropriate drug use in 2005-06 varied from 25.2% in Manitoba to 31.3% in New Brunswick. The rate of regular use of such medications ranged from 12.9% in Alberta to 18.8 % in New Brunswick.

E-prescribing decreases the likelihood of adverse drug events or interactions, and provides tools to monitor both patient adherence and practitioner prescribing patterns. One component of an optimal prescribing strategy would be to provide support to provincial/territorial ministries of health to complete the implementation of drug information systems and regional e-prescribing solutions, and/or to develop an agenda to accomplish the enhanced use of electronic medical records.

A second component of an optimal prescribing initiative would be the development of a collaboration of content experts and professional associations to raise awareness of inappropriate prescribing among physicians and other health professionals and then to develop online educational courses and practice tools to assist at the point of care. Initially the focus might be on prescribing for seniors, but subsequently could expand to cover other priority topics such as inappropriate antibiotic use or the use of narcotics for non-cancer pain.

4. Choosing Wisely Canada - Reducing the provision of low value care

A disconcerting proportion of health care, estimated in the United States to be as much as 30%, confers little or no benefit on patients and may, through exposure to excess radiation, drug reactions, adverse events during procedures, or the worry associated with false positive tests, actually cause harm. This represents both sub-optimal quality of care and poor stewardship of scarce health care resources.

The provision of unnecessary care is driven by many elements including physician habit, lack of up-to-date clinician knowledge, patient demand, and structural or financial incentives in the health system. To counter these diverse influences the CMA partnered with the University of Toronto to launch Choosing Wisely Canada, a campaign to facilitate evidence-informed conversations between physicians and patients about the necessity of tests and treatment about low-value tests and treatment. As of October 2014, 102 recommendations have been developed by national specialty societies about clinical activities that generally should be avoided. For example, the Canadian Geriatrics Society advises physicians and patients against the use of antipsychotics as a first choice to treat behavioural and psychological symptoms of dementia as well as

against the use of benzodiazepines or other sedative-hypnotics in older adults as a first choice for insomnia, agitation or delirium.

Within its first year of operation the campaign enlisted over 30 national specialty societies, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, all provincial and territorial medical associations, and six large citizen groups. To date the campaign has been resourced by seed funding from the Ontario government, direct contribution from the CMA, and a modest contribution agreement from Health Canada.

If the early success of Choosing Wisely Canada is to be sustained, secure long-term funding is essential. Such resources are necessary to support the development and dissemination of materials to raise physician awareness, provide educational opportunities, make available point-of-care tools, assist with implementation at the practice level, and contribute to data collection for evaluation. The medical professional has clearly stepped forward to take ownership of the low value care challenge; they deserve federal support to ensure a successful long-term outcome.

5. National Health Care Guidance Institute

Clinical practice guidelines (CPGs) have a unique ability to enhance quality of care. The peer-reviewed literature provides robust evidence that guideline use is associated with a positive impact on both processes of care and patient outcomes. Additionally, a number of studies have reported that the application of specific CPGs result in cost-effective care, including, for example, those used in the treatment of community-acquired pneumonia, stroke prevention in primary care, traumatic brain injury, and the use of lipid-lowering drugs. Conditions such as these gain particular significance in the face of an aging population: what is the out-patient antibiotic of choice in an elderly patient with pneumonia?; in an older patient with a cardiac arrhythmia what are the comparative risks of treatment with anticoagulants versus possible cerebrovascular accident?; at what age is it no longer helpful to treat hyperlipidemia? CPGs available at the point of care provide evidence-based answers to such questions.

Internationally, national governments have recognized the value of CPGs and taken a leadership role in ensuring their quality and making them available to practitioners. Three among many examples are: United States (Agency for

Healthcare Research and Quality, National Guideline Clearinghouse); United Kingdom (National Institute for Health and Clinical Excellence); and Australia (National Health and Medical Research Council, National Institute of Clinical Studies).

The challenge is that CPGs are not uniformly utilized across Canada nor do we possess a national body or systematic approach to CPG development and dissemination. There are various models that can be implemented to execute this function (e.g., full function agency, collaborative virtual agency) to perform such key functions as prioritizing areas for guideline development, maintaining a national repository and driving active dissemination. The key is having a dedicated agency that can oversee the development and dissemination of CPGs at a pan-Canadian level to improve the quality of care that Canadians receive.

Federal mechanisms to support health innovation

All health systems in Canada and elsewhere are facing the challenge to better meet the needs of their seniors' population. National governments can provide necessary direction and support. The federal government must play a leadership role on seniors care and supporting health care innovation in concert with the provinces and territories and as a system manager itself for those patients falling under federal jurisdiction (e.g., armed forces). This can begin with a First Ministers' Conference as part of the development of a Pan-Canadian Seniors Strategy.

CMA recognizes there are elements of transformation already taking place in the country across the continuum of care that are being supported by technological innovation or clinical innovation (e.g., Choosing Wisely Canada). However, in many cases, there is little funding available to fund projects beyond pilot project status or bring them up to scale, and there is very little cross-country awareness of these "pockets of excellence" due to the absence of mechanisms to share best practices.

Accordingly, CMA recommends the establishment of a National Health System Innovation Fund targeted to provinces and territories to support the adoption of health system innovations including those identified in this brief. Funding criteria should be designed to not only support the development of these innovations but to incent their adoption on a scaled-up basis.

Finally, recognizing the relationship of the social determinants of health on the demands of the health care system, the federal government should implement a requirement for all cabinet decision-making to include a health-in-all policies approach whereby all policies from tax, to transportation, to trade would undergo a health lens to ensure that negative health impacts were minimized/eliminated and positive health outcomes were supported or expanded. This would help to minimize the often unintended health consequences that arise from policies outside of the health sector.

Conclusion

This brief identifies five opportunities for innovating Canada's health care system by improving seniors care—the paramount health care issue of our time. Our proposed innovations would not only improve the efficient delivery of health care but more importantly the quality of care provided to all Canadians. These innovation initiatives require medical leadership at the point of care level in tandem with change at the broader system level with federal support. Together, these innovations can further contribute to the transformation of Canada's health care system—one that better meets the needs of Canadians today and into the future.

ⁱ Canadian Institute for Health Information. Alternate level of care in Canada. Ottawa (ON): The Institute; 2009. Available: https://secure.cihi.ca/free_products/ALC_AIB_FINAL.pdf

ⁱⁱ Wait Time Alliance, *Shedding light on Canadians' total wait for care*. Report card on wait times in Canada. June 2012.

ⁱⁱⁱ *Telehealth Benefits and Adoption: Connecting People and Providers Across Canada*. Praxia and Gartner. May, 30, 2011.

^{iv} Canadian Hospice Palliative Care Association. 2014. Fact sheet: hospice palliative care in Canada. [Accessed 11 November 2014]. Available from http://www.chpca.net/media/330558/Fact_Sheet_HPC_in_Canada%20Spring%202014%20Final.pdf

^v Canadian Institute for Health Information. Pan-Canadian forum on high users of health care—Summary report. The Institute: 2014.

^{vi} Dunn, James R. (2002) *The Health Determinants Partnership Making Connections Project: Are Widening Income Inequalities Making Canada Less Healthy?* Available at: http://www.opho.on.ca/our_voice/collaborations/makeconnxn/HDP-proj-full.pdf

^{vii} CIHI/CPHI (2012) *Disparities in Primary Health Care Experiences Among Canadians with Ambulatory Care Sensitive Conditions*. http://secure.cihi.ca/cihiweb/products/PHC_Experiences_AiB2012_E.pdf

^{viii} <http://www.healthscotland.com/uploads/documents/12107-WhatsWellNorth.pdf>