Transcript – Improving Health Systems with Strategic Clinical Networks™ (CMAJ Podcast)

Interview with
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BM: Braden Manns, Associate Chief Medical Officer, Strategic Clinical Networks

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AL: Hi, I'm Andreas Lapacas, Editor in Chief of the Canadian Medical Association Journal, and today I'm speaking with Braden Manns and Tracy Wasylak, who are here to tell us about an initiative by Alberta Health Services called Strategic Clinical Networks. And I've reached them both in Braden's office in Calgary. So welcome to both of you.
TW and BM: Thank you.

AL: Let's just start with a quick description of who you are. So Tracy, can we start with you?

TW: Sure. My position is Chief Program Officer for the Strategic Clinical Networks at Alberta Health Services and I've been involved in this initiative since its inception in 2011, and I also hold an adjunct professor position at the University of Calgary Faculty of Nursing.

AL: And were you a nurse before Tracy?

TW: I was. I was a practicing ICU nurse for many years.

AL: Awesome. Braden?

BM: So I'm a kidney specialist in Calgary and I work at the University of Calgary in the Departments of Medicine and Health Economics, and I'm the Associate Chief Medical Officer for Alberta's Strategic Clinical Networks.

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AL: So why don't we sort of jump right in and have you tell listeners in 60 seconds or less why should Canadians and Canadian physicians care about Strategic Clinical Networks?

BM: So, good question Andreas. So you know this, but international surveys tell us that our health system is one of the most expensive in the world. Fortunately the US is always slightly behind us in these metrics, but aside from that we're a very expensive health system. We get average or below-average outcomes in terms of quality. We know that there's gaps in care and health outcomes are not as good as they could be, and we know from the Naylor report that there's lots of good examples about how to get over these gaps, how to address them, but we really in provinces have had a real problem scaling up solutions that work to overcome these gaps. So networks are really about how do we get evidence into care. So, for instance, anti-psychotic [drug] use in long-term care facilities was quite high and that was idetnified as an important gap by Alberta Health Services. So in the Alberta health system, we borrowed an idea from the Manitoba area that had successfully reduced the inapprpriate use of anti-psychotics. We think that's important because it's associated with strokes in elderly patients with dementia. And so we implemented a solution that worked elsewhere. We spread it across the province – initially to all of the long-term care, but now also the supportive-living environments, and we've taken our anti-psychotic use from about 28% down to 17%. So we've sort of gone from having some of the worst numbers in the country to having some of the best numbers in the country. So that's just an example of what networks can do. They can work across stakeholders, across regions to push good ideas up provincially.

AL: One of the things I really like about that example is that you got the intervention from Manitoba. Cause my sense is in Canada, we tend not - to feel like we can't take things that other folks have found to be effective, so congratulations on that.

TW: Yeah, I was just going to say that where we got that from was the EXTRA program that's sponsored by the Canadian Medical Association, the Canadian Nurses Association and the Canadian Foundation for Health Care Improvement. And this was a small long-term care facility just outside of Winnipeg that published their small project and this idea that we can share innovation across the country and not have to reinvent it…is I think something that the networks feel is something we should be doing a lot more of.

AL: Let's try to make this sort of more granular and real and use that example of the anti-psychotic prescriptions in long-term care facilities. So, I can't imagine folks in Alberta didn't know before the SCNs existed that that was probably an issue and probably want to address it. So tell us a bit about which Strategic Clinical Network took this on and what exactly was it about the SCN that allowed you to do this that didn't allow you to do it before?

TW: When we started the networks, Andreas you may have recalled this, that we asked every SCN to look at areas in health where we were either causing harm, or by virtue of what we were

doing, we weren't actually adding value. So the Addiction and Mental Health and the Seniors Health SCNs took it upon themselves to reassess sort of that poly-pharmacy in long-term care. And even though we had indicators that are benchmarked nationally, actually because so much of long-term care is in the private sector and not owned and operated by AHS, this really wasn't on anyone's radar screen until we were able to pull the data provincially and start to look at it, and then start to compare ourselves to other provinces. So I think one of the things the networks do a really good job of is they have the time and space to actually pull the right data and do the analytics on it to say yes, there's variation, is it apporpriate or inappropriate? And then, ok, if it's inappropriate, scan the world to say, ok, who's doing this well? And then try and take what they're doing and customize it to an Alberta context. The other thing about long-term care that I wanted to point out is: it's not well-resourced. The funding models across the provinces are quite different, and so their ability to do a lot of quality improvement is hampered by some of those barriers. So the network was able to be the change management and do the train-the-trainer and support a lot of private sector long-term care facilities.

AL: So you mentioned two strategic networks – Mental Health and Addiction [and Seniors Health] – so tell us a bit about like what makes a Strategic Clinical Network. Who's leading these and frankly, what's their budget? How many resources are at the disposal of these two Strategic Clinical Network?

TW: So the governance model for the network is we have a part-time senior medical director who has expertise in the field of that network, we have an administrative director, and we've also worked with the universities to have a part-time scientific director. So it's a small staff but dedicated to each network. And then in order to get a broad view from across the province, we actually have created these core committees and on the committees we bring patient and families, we have policy makers, we have the operational leaders and managers, and then 50% of the network committee is actual practicing clinicians – not just physicians, but nurses, allied health professionals – with the idea that we get a broad spectrum of voices at the table to think about where are the vexing problems and how might we solve them? And so there's a small cost for the infrastructure Andreas that goes into supporting that small team. And then AHS – we've either resourced their projects through innovation funding that's been awarded to us through our health authority or we've brought in grants from outside agencies to help do the pilot testing, to be able to do the proof of concept and show our funders that this is something of value that would be worth spreading and scaling.

AL: So maybe just to push it more, you're talking about three people being responsible for running the network – a clinician, a manager, and a scientist. It sounds like the clinician is part-time. Is there then a core group – because you mentioned before that one of the advantages of the network is that you're able to analyze data, etc., so who does that?

BM: Yeah, so there is a full-time executive director and a full-time assistant scientific director. You know, we didn't start clinical networks. We didn't invent these things. They were going in the UK, Scotland, and New South Wales in Australia for about 20 years. I guess where our networks look a slight bit different is Cy Frank, Tom Noseworthy and Tracy realized that if we're going to embed ourselves using data to inform changes in care, then we need a strong scientific arm. So we do have the executive director and an assistant scientific director who are full-time staff as well. I would say one of the things we've become really cognizant of is that we're not just a network that is hived off, away from operations and away from the rest of the organization. We're supporting operational priorities, and those people aren't just sending emails throughout the day. They're working on the projects that the network is working on with our operational partners, and our zones and our provincial programs. So one of the challenges we've had – and we can talk more about costs later - is that when you think about the projects that the networks are leading and the projects start, as Tracy said, when you identify a gap, you get an idea, you test it locally, you see if that works using data, and if it does, you spread it out provincially. So there's sort of a pipeline with each network. The executive director spends some time on one project – it might be at the pilot stage – they're spending some time on projects moving provincially. If we've been approved to move something provincially, there's resources that get added on. It might be coordinators. And so it's a bit of a matrix where they're supporting some of the core SCN, which is identifying those gaps, getting everyone to agree on which ones are the priorities, starting to develop the ideas, vet those, pilot them and then move them provincially. So all the networks when they start are at a different place, and then obviously now the goal, is now that you've spread something provincially, it seems to work, let's pass it off to operations and let's just get that sustained as usual practice within the system.

TW: Andreas, I'll just add that we do support a little bit of a business intelligence unit around the SCNs. Not every SCN has their own, but our analytics department has deployed some of our major analysts to the networks, we have a health economist who helps with doing the whole cost-effectiveness and determining the whole value proposition, and we have access to a full-time implementation scientist and others. That business intelligence unit really is core to all the SCNs.

AL: If you took all the resources that are going into the SCNs now in Alberta – and we'll talk about cost savings in a sec – but how much is that approximately per year?

BM: I mean, roughly speaking, and Tracy can add in the decimal points, but roughly speaking, a network is about a million dollars to run, but again, some of that [resources] is around supporting projects and things. So for every network you add, it costs roughly about a million dollars, but we know from return on investment that we're getting, we're extracting more out of the health care system than it costs, but it does take a couple years as Tracy would say to squeeze some juice from the lemon. You've got to get people together, you've got to agree on

what you're going to work on, so there's an upfront investment and you don't expect money back for a couple of years.

AL: And just for listeners, there's about four million people in Alberta, is that about right?

BM: 4.3 million, yep.

AL: So what are the key ingredients for success? You're obviously thinking this is a successful initiative. What are the key ingredients?

BM: So Andreas, when I started we actually did a bit of a review of the existing system-wide clinical networks to try to understand that. And actually, one of the things we were asked to do was actually - Verna Yiu, our CEO, challenged us and said you know SCNs have done some good things, but we think they can do better. So we did a lot of listening to stakeholders across the province and created a Roadmap out of that. Actually it's interesting that what we heard from our stakeholders was very similar to what the experience of other countries was. Successful networks have great leaders, they communicate well – they communicate and they engage so it's two-way communication. They have adequate resources and funding – because if you're going to bring everybody together, you need some ability to then take priority projects forward, otherwise you just frustrate people. You need access to health data and well-designed projects that are strategically aligned with other health partners. And you need effective partnerships. And you need to be embedded in the health care system. You can't sort of sit on the outside, and that's easier if you've got a province-wide health system like we've got with Alberta Health Services. Although, as you know, primary care still sits outside Alberta Health Services. We've been really fortunate to have supportive leadership as well with our current AHS CEO, our Board, and our old AHS CEO. Those I think are the successful ingredients.

BM: To use an example, the organization identified that the experience and outcomes for women with abnormal mammograms and possible breast cancer was not optimal. Patients felt their experience, the information they received, and the wait times – so a patient goes for a mammogram, it's noted to be abnormal, the process was ok, you go back to your family doctor who now tells you about that result, they organize a biopsy, you wait for that biopsy. That biopsy is done now, the biopsy result goes back to the family doctor, the family doctor books another visit. The woman obviously is pretty concerned by this point. The family doctor, who as you know, they have to know something about everything across the entire breadth, and now they're interpreting the biopsy, they're arranging a visit to – is it surgery or oncology? What happens then? Ok, maybe it's the surgeon in this case. So that process was taking a long time. The network just got all the stakeholders together in the room – the diagnostic imaging, primary care, the surgical programs, oncology – and said, how can we smooth this process and just move it efficiently along? So now a woman with an abnormal mammogram…the radiologist speaks to the woman and they book the biopsy, they notify the family doctor, the biopsy's done,

based on the result, a referral automatically goes into surgery. Again, the family doctor is kept in the loop, and then we've been able to take that time from a woman going from an abnormal mammogram to a referral to surgery down from about 25 days down to about 9-10 days, something like that. You know, this was not rocket science. It just got people together and smoothed out some of those inefficiencies. They also created educational tools and some information for patients. They have some navigators to help the women understand the process. And at the same time, they tagged along…well, we're only doing 5% of surgeries as same-day mastectomies in Alberta, but actually some provinces were doing more than 50%. So they tagged on that initiative and now we're doing over 50% of mastectomies as same-day mastectomies. So that just gives the sense of…again, it's not that we've developed some new cure for cancer. We're just getting patients to the treatment more quickly, with better information, and we've shown that that has improved patient experience. We've shown it reduces the time to get the treatment that patients they need, and it's reduced the number of hospital days people are in hospital so it's saved money.

AL: And has that been truly spread across the whole province?

BM: Yeah, so that's been spread across the entire province, across all of the surgical sites that are doing mastectomies.

AL: Clinicians within the health care system – and administrators within the system – are I think all feeling incredibly busy and stressed, so how did you get this to be top of their priority to make these changes given that they have all of these competing priorities?

TW: Well, I think one of the things that has been a really important way for us to get priorities is to demonstrate the burning platform has been important because, as you know, a lot of administrators are buys doing a lot of different things, and they don't have the time and attention to get into the detail. But the other really important part of this has been patients. Patients have come to us and said, this is really important. So on the breast health example, we had patients who were part of the network who said this is a priority. They also went to the Ministry, so the Ministry was concerned about it and said, can we work together to fix this? So it was helping to align the expectations of Albertans and the Ministry and the health system. And so when it all came together, the operators said if you can get the clinicians and everyone together, we will support the recommendations. So we actually got a provincial group to come together and actually talk about this. Because, as you know, a lot of the diagnostic imaging work that goes on actually is done in the community in private facilities, so I think one of the things the networks do is try to bring all of the partners from across the system regardless of who the funder to make sure we can build the continuum from primary care all the way across the system. And that is seen as a value-add from the operators perspective because they just don't have time. They're

busy running the system every day, and this is redesign work that takes a little bit of thinking and planning with everyone's voice at the table.

AL: So I think you're raising a really important point cause when I think of Alberta Health Services as I mentioned before, I think I'm right that primary care is not part of AHS and you said before that many of the long-term care facilities are private. But your AHS-funded Strategic Clinical Networks are willing to engage and even spend money, it sounds like, to help key stakeholders that aren't part of AHS to all work together as a team.

TW: Absolutely, and a really good example of that is…we had a home care nurse talk to the Diabetes, Obesity and Nutrition SCN about the fact that wound care in the community and diabetic foot ulcers weren't being treated properly, and she was concerned that that was leading to a higher incidence of premature amputations. So the network took a look at our amputation rates in comparison to other provinces, and we realized that we could do something about reducing that and helping the primary care networks do better screening earlier on. And this isn't the family doc doing the screening – this is actually nurses and other people so that when a diabetic patient comes to a family doctor visit, they could actually do some extra screening. And so that Diabetic Foot Pathway we've actually been able to train and implement it in…we have 42 primary care networks in Alberta, and 35 of them have now been trained in and are applying this screening. And we're seeing some really significant improvements in diabetic foot care in Alberta.

TW: And the other thing that we've been able to influence, Andreas, is policy. So one of the things we found out was that patients who were diabetic can't get any aids for their foot care until they show up with a diabetic ulcer. And we've been able to show our policy makers that giving them the foot care products before the ulcer shows up in high-risk patients will actually prevent the diabetic foot ulcer from occurring. So now we're starting to think about policy changes at the government level. So that just speaks to the breadth of, again, designing the pathways based on what the patients' journey is and working with everybody who touches that patient along the continuum.

BM: Just one thing to add there: this has worked the best in zones where there's an effector arm, so a family physician identifies a high-risk foot or maybe there's an ulcer developing. In the zones that have been able to mobilize their podiatry teams and their vascular surgery teams, and again, as SCNs, we enable things, but vascular surgery and podiatry really got together and when they receive a patient, they're really aggressive at limb-sparing surgeries and really carefully managing these patients. And so that's been great because, you know, one of the things we say sometimes is primary care, this is yours to fix, yours to fix, but they need somewhere to send people often. And so we didn't own that vascular surgery piece. They really stepped up to the plate and evaluations have shown that in zones that have been able to

organize their services that way, people spend less time in hospital as a result of amputations and we believe that's because there's more toe and forefoot amputations versus those larger, below-knee amputations or above-knee amputations that land people in hospital for more time.

AL: And zones are a term that you folks use for regions right?

TW: Yes.

AL: So one of you – I think Braden – mentioned that at a certain point, you spread something across the province, it's integrated and then you move it, I think, into the Alberta Health Services routine budget and it no longer becomes something the SCNs are worried about because they're moving on to something new. Do I sort of have that right? Is there any worry that if you take your eye off the ball with the long-term care example or the diabetic foot ulcers that things will just go back to the way they were before?

TW: Yes, that is a common issue post any project, and I know in every province in Canada we suffer from that. What we've tried to do, Andreas, when it comes to sustainability is we've built a bit of a dashboard on the key metrics of improvement and we don't drop it altogether, but we periodically take the dashboard to our clinical operations executive team to help show the gain. The other thing we've done is in the zones where we've put resources in to sustain the work, we've built an accountability agreement with those zones. And I'll give you an example: When we did the rural stroke action plan, we actually built a new model of early supported discharge and rehabilitation where the teams would go out to the patients' homes to give them their post-stroke rehab instead of patients waiting in hospital for long periods of time to get a rehab visit. And to do that, we added a bit of resource in rural Alberta. And so we built an accountability agreement with the administrators of those zones that they had to maintain the gains – the improvements in morbidity and mortality for stroke in their zone. We give them a quarterly report and they're then accountable to ensure those resources are spent on the stroke program in their area. And we implemented that five years ago and we're still holding the gains that we started five years ago. So we think that this periodic monitoring and really clear accountability on what outcomes we all hold for Albertans is a bit of the secret sauce for making that stick.

AL: You mentioned that women's poor experience with breast biopsies was one of the factors that led to focusing on that particular topic. How were women involved in the actual Strategic Clinical Network? How do you involve patients?

TW: So in the breast health, we actually had a group of very motivated obviously cancer survivors who wanted to help co-design that pathway. So we have them at the table. We obviously have patients and families at our core committees, but for every project, we mobilize patients and families to be part of the co-design of the pathway development or the project itself. And so there's over 150 advisors connected to the networks. And where do we get our advisors

from? There's lots of patients groups. Probably every province has lots of patient groups. And we draw upon those folks to get involved with us so it's 'Nothing about us without us.' Where we've done that, we've had much greater success and much better improvement.

AL: And you talk in this supplement that's coming out in the CMAJ, you talk quite a bit about innovation. What do you mean by that and how have Strategic Clinical Networks fostered innovation in health care in Alberta?

TW: So for us in Alberta, we defined innovation as not just a new, fancy, shiny gadget. Be we really thought it really relies on any kind of…innovation is about trying out new and novel things. It could be a new model of care, a new process, but again, it's really trying to respond to gaps and problems and trying to solve those in an innovative way with things that matter to patients and families. And that's where our research arm has been really, really helpful to us, Andreas, because they've been able to help us study innovative ways, build a robust evaluation around that, so when we think of spreading and scaling it, we have the evidence to suggest that it's cost-effective, it improves quality, and it improves the experience. We're trying to inspire innovation both from the grassroots – because there's lots of good ideas out there – and we're also trying to work with other provinces around some of the innovation that they're doing that we can draw into our own province.

AL: Now I'm sure everything hasn't gone smoothly as you've rolled these out over the last few years. What are a few of the lessons learned from things that just haven't worked?

BM: No, everything's gone perfectly smoothly Andreas [laughs]. Well, I think we intimated this and you sort of hit the nail on the head. The operational partners – they are swamped. These people are not working seven hours a day. They're busy. They're dealing with patients waiting in the hallways in emergency rooms and in hospital wards, they're dealing with capacity issues. They're dealing with overtime and with sick calls. So it doesn't leave a lot of room to be thinking about spreading and scaling things that are working really well on one unit. So what the networks have done is provide a bit of capacity to move those good ideas forward, but where there's been challenges with the networks I think would be…when we reached out to stakeholders, we had hundreds of pages of comments – things that were going well and weren't going well. And probably two-thirds of those pages were on communication Andreas. And just the feeling that sometimes the networks didn't communicate early enough around their priorities. And then at the end of the day, where we ran into challenges were priorities that came forward often from patients and on-the-ground clinicians and they didn't – operations, who controls the budget, they didn't feel that these were entirely aligned with their priorities. They didn't deal with the most burning priorities for them. So often times, operations is being asked to provide resources. We're asking them to change the way nurses or physicians in their program work. So when they don't feel like these priorities are the most important to them, that can be alienating.

So one of the things we've really focused on over the last couple years is on aligning things together. And because we're in a similar situation in some ways to what I understand is going on in Ontario with cutbacks in health, so these operational teams don't have extra resources, and if we go to them with ten initiatives, their eyes can glaze over a bit even if they think these are important gaps and we agree that this is important, they just don't have the resources. So we're really focusing on aligning the work we're doing with what the Alberta Health Ministry is sending out to the province asking them to do, and bundling things together. So I'd say that's one area where we've learned the importance of – really, the clinical networks are in some ways 'bottom-up'. It's the ideas on the ground that come from the clinicians and the patients, but it works best when we align that with the 'top-down', with the people who hold the budgets and the people who make the decisions. When we align those projects, those priorities and ideas together, that's when it works really well.

TW: I think the other thing we've really learned over these last few years is you know, we talk about patient engagement, and it's kind of a buzzword in a lot of places, but how do you effectively engage patients in a way that's not tokenistic? And we have learned the hard way where we've done it well and where we haven't done it well. And we have created a Best Practice Guide on how do you actually effectively engage patients so they are co-designing with you instead of we're just telling them that we're fixing the problem for them. And that's tough to do because we've actually had to train our folks on what does co-design really mean, and how do you effectively do it? And when we get these big projects and we've got clinicians in the room, not everyone feels comfortable having the patient sitting there when you're airing your dirty laundry about what's not working at a unit level. So we spend a lot of time now training our clinicians on how to feel comfortable having a patient in the room when you're starting to figure this out.

AL: And I'm assuming often there's more than one patient in the room. Am I right?

TW: Yeah, we usually have groups of patients. One of the things we've learned is to actually, you know, level out the power differential that often occurs, we have four or five patients in the room at any given time. That does two things: one, you get a breadth of understanding from a lot of different people, and more importantly, if one advisor can't be there, they know there's others there to carry on with the work. A lot of our advisors are actually patients who have the diseases and conditions that we're trying to work on. So, for example, our dialysis group: we have a lot of dialysis patients that are working really hard on the work we're doing around Living Donor Transplant. Well, they can be quite sick, so we have to also be really careful that we're respectful of their capacity.

AL: I think I'm going to wrap it up here, but would just ask if either of you have a burning, brief thing to say at the end. Tracy?

TW: Well, one of the points I just want to reemphasize, Andreas, that that the networks have done a really good job on is really looking at where there's huge variation – even across hospitals – that people don't necessarily have the time or not taking the attention to look at those things. That's where we've been really successful in bringing operators to show the big variation that's occurring, even in our own province. That in and of it sefl is a real mobilizer of oh, we've got to do something about this.

AL: Great, Braden?

BM: I guess the only thing I'd say is that we've really talked about, and the examples we've used, have been very illness focused. And the networks really started out being very illness focused, but we've been asked to also focus on prevention and maintaining health. And so a couple of the new networks that we've brought on over the past couple of years – one is in primary care and it's really building those bridges around access and transitions out into primary care, but population, public and Indigenous heath is another network that focuses on Indigenous health and they've been doing a lot of great work linking with Indigenous communities, and population and public health has been doing stuff around prevention and they're working across all of the networks and trying to link patients. You know, there's hundreds of thousands of contacts that happen with the health care system everyday. Can we link people if they're smokers to effective smoking cessation programs? If people have risky drinking, can we link them to brief intervention programs? So we're trying to embed prevention into network activities as well.

AL: Thanks a lot.

BM: Thanks Andreas.

TW: Thanks Andreas.

AL: So I'd like to thank Braden Manns and Tracy Wasylak who have been talking to me from Calgary. Braden is the Associate Chief Medical Officer for Alberta Health Services Strategic Clinical Networks and Tracy is the Chief Program Officer of the Strategic Clinical Networks with Alberta Health Services. To read the series of articles about the Strategic Clinical Networks, please visit cmaj.ca and don't forget to subscribe to the CMAJ podcasts on Soundcloud, Apple podcasts, or any podcast app. And let us know how we're doing with our podcasts by leaving a rating. I'm Andreas Laupacis, Editor in Chief with the CMAJ and thanks for listening.