In Conversation with Marilyn Emery

Ken Tremblay

Women's College Hospital (WCH) is not an ordinary place. It is an organization that has reinvented itself and the care it provides – so much so that a cornerstone of its contribution to healthcare delivery includes its Institute for Health System Solutions and Virtual Care. Combined with Women's College Research Institute, the organization is poised to revolutionize the provision of care and management of disease, in Toronto and across the globe. At the helm is president and chief executive officer (CEO) Marilyn Emery, no stranger to transformational change and its cultural underpinnings. With a view that healthcare leaders need to work to keep people out of hospitals, Emery and her team at Women's College are redefining care through innovative technology and community partnerships.

Emery offered her insights to *HQ*'s Ken Tremblay earlier this year.

HQ: One measure of a leader is the ability to take an organization to a destination it would not have selected on its own. How does that describe your success at WCH?

ME: I arrived at Women's College a year after the de-merger. It certainly wanted its independence back, yet that came at a price. How do we take on this mandate

as an independent academic ambulatory hospital while still advancing health for women? Meanwhile, there were no strategies or resources in place.

One of my first goals on arrival was to deeply understand the place. The second was to have a hard look at what it would take to get a clear vision around that destination and to determine what it would take to fulfil it.

The hospital has a 100-year legacy of innovation and extraordinary heritage supporting women in medicine and healthcare leadership. It was a huge need to have that [history] acknowledged, understood and incorporated into any new vision and destination. It took a lot of redefining and broadening [of views] as well as a very clear strategy with action items that would have us deliver on it.

HQ: Women's College Hospital's corporate journey has been anything but traditional. As it "dis-integrated" from Sunnybrook, it "reintegrated" with others, arguably for the better. What is the most remarkable feature of Women's College Hospital today?

ME: The first thing that comes to mind is that we have remarkable leaders, truly delivering on innovation and the hospital of the future. Equally remarkable is our mandate to keep people out of hospital. The third aspect, in keeping people out of hospital, is that we do not operate in the traditional acute in-patient environment or operate entirely in a community environment. We operate in a space that isn't occupied by a lot of folks. You cannot do that without partnering with a myriad of other acute in-patient facilities, the CCAC [community care access centre] and many other agencies. We literally have hundreds of partnerships; we cannot do what we do or be who we are without our partners.

HQ: Your career is synonymous with cultural change. What has the WCH journey been like: specifically, the highs and lows?

ME: Becoming independent again was a huge high for the organization. At the same time, it was at a low because post-merger, we were not resourced or structured in any way to fulfil our mandate. Taking on an organization that had been around for a long time but with a new mandate and few resources and structures, while needing people to align themselves with the needs of that mandate, was very difficult. It required a lot of courage: standing in the face of what worked before, needing to be different in order to go forward. We've gone from that uncertainty to finding new ways to deliver on both our mandate and innovation without going to the government for money. To me, that's real innovation.

We're at a real high right now, some two thirds of the way through our strategy, and we're delivering on it even faster than we had envisaged. Great people attract great people: we have recruited an amazing array of talent, and that is a high point.

HQ: I heard a presentation about your successes with breast reconstruction surgery: through technology, partnerships and by engaging patients, surgeons have been able to discharge post-operative patients the same day, while driving stellar outcomes and patient satisfaction. What were the lessons learned from that approach to care?

ME: That's an amazing story. For quite some time, we have been one of the largest centres in Canada performing breast surgery, and our surgeons have been very innovative in developing new approaches. Canadian length-of-stay data average between four and five and a half days. A couple of years ago, our experience was two to three days, quite ahead of most other centres. About two years ago, Sunnybrook's [in-patient programming] left our site, meaning that surgical beds we had relied upon for our programs were no longer available to us. Frankly, unless we were prepared to transfer this program to another centre – which we were not prepared to do – we had to learn how to perform this surgery safely, delivering high quality and without in-patient beds. That challenge was, in many ways, a tremendous lever for change.

About a year before Sunnybrook was to leave our site, a large team was created to redesign our approach to care. In addition to learning how "no beds" spurs innovation, we learned how to provide better care by front-end loading the process with tons of preparation and education for the patient before she set foot in hospital.

We took on a whole new approach to pain management, a key reason why patients stay in hospital post-operatively. Patients started managing pain before their surgery even began. We also looked at patient care post-discharge and have been able to use technology in an absolutely spectacular way to provide better care. Patients go home with a smart phone, communicating daily with their surgeon in terms of their pain and how they're feeling. They take a photograph of their incision every day and send it off to the surgeon.

When you have surgery, your first post-operative visit is often two to four weeks later; there is this black hole [of information] where the surgeon actually doesn't know what's happening until that visit. In this model, the surgeon can see and access current information from the patient like never before.

There have been many, many lessons learned, including that a care pathway can be applicable to other surgeries. We've applied this concept to thyroid surgery and are about to apply it to vaginal hysterectomy surgery. To our knowledge, no one else is doing that procedure on an overnight-stay basis.

HQ: I imagine the Institute for Health System Solutions and Virtual Care has received some attention from researchers, funders and policy makers. What innovations and early results hold the greatest promise for healthcare in Canada?

ME: We're in deep discussions with the Ministry of Health and Long-Term Care on our X-OR concept, using one of our ORs as an incubation lab [for surgical innovation]. For example, if a surgeon in Thunder Bay wants to assess if a surgical procedure can become a potential overnight stay or be performed on a same-day basis, we can support that evaluation. By working together across larger patient populations, we can determine if the procedure, as performed, can be scaled up in a meaningful way for the system.

We and our partners are very interested in these evaluations as well as sponsoring knowledge transfer. For example, the breast reconstruction process we described has been very successful clinically, has achieved high patient satisfaction scores and has demonstrated high acceptance of smart phone technology. Our surgeons have shared their results; through knowledge transfer, lessons learned are disseminated to other providers where there may be benefits for larger patient populations. That is one area of focus for our institute: the whole issue of scale-up and execution science.

Another aspect we are examining through the institute is appropriateness of care: everything from echocardiography to standardized laboratory tests. When you think about it, there is huge promise for the healthcare system if we can scientifically assess what tests are essential and which are okay to eliminate from the standardized approaches we always use.

HQ: In a recent article, you noted that preventing hospital readmissions cannot be a solo mission. What other healthcare challenges are not a hospital's to solve in isolation?

ME: Probably all of them! This [discussion] is an important piece of keeping people out of hospital. We know that the healthcare challenge for the next number of decades will be managing patients with complex, multiple chronic conditions. These were not the health challenges of the past century. Doing what it takes to manage people in the community requires partnering with primary care, engaging supportive specialists and consultants and working with long-term care providers. Honestly, the most important healthcare challenges are, and it's just dawning on us now, that they are not for hospitals to solve by themselves.

The other thing that is really important to us (and others) is equitable access to care. Again, that's not something that hospitals alone know all about. We don't know enough yet about the barriers affecting equitable access to care. Our institute is doing a lot of research in this area; we are very dependent on, yet unfamiliar with, all our community organizations that serve our populations. We need them to help us to learn what the barriers are so that we can break them down.

HQ: WCH is leading the charge in the use of innovative technologies to reduce system reliance on beds, and that focus includes your Centre for Ambulatory Care Education. How is that program reshaping the clinical experience and curriculum at WCH?

ME: Our centre is significantly reshaping the clinical experience and curriculum at the Faculty of Medicine and beyond; WCH is well positioned to train the health professionals of the future. The main health challenge of the future will be managing populations with multiple, complex chronic conditions. That's not just about healthcare; it's about the social challenges [and determinants] that also impact one's health.

We know that the vast majority of health interventions take place outside of the walls in the acute care hospital. If you think of all the office and clinic visits, the vast majority of healthcare is delivered in community or ambulatory settings. Yet, much of the training of health professionals takes place inside the four walls of a hospital and most in tertiary or quaternary centres. That training is largely episodic.

Our approach to ambulatory care of women, particularly through our centre, is that we provide trainees with a longitudinal experience in ambulatory care versus the episodic nature of traditional in-patient care. Students have a unique opportunity to follow people for as long as they're in the training program, up to a couple of years. One example is our Complex Care Clinic. It's an interdisciplinary clinic supporting patients with multiple complex conditions. So, rather than referring them to a cardiologist, then an endocrinologist or a mental health professional, we work with them in a single setting in one visit while training health professionals – physicians, nurses, social works, therapists and pharmacists – all important lessons around managing these folks longitudinally.

HQ: I note that you offer "virtual wards" in medicine and mental health with area hospitals and the Toronto CCAC. How have those partnerships supported your efforts to create a seamless journey for the patients and clients you serve?

ME: These partnerships have been absolutely fundamental, again emphasizing the notion you cannot operate in this space by yourself. The virtual ward is an interesting partnership located at Women's College. Partners include St. Michael's, UHN [University Health Network], Sunnybrook and the Toronto CCAC. It's multidisciplinary and been designed to avoid multiple visits to the emergency department [ED] and or divert readmissions from hospital.

We have learned many things in the process. First and

foremost, we have learned about what the CCAC sees [with patients in the community] that we don't see. We have learned that the biggest issues that can cause readmission to hospital and/or to an emergency department have to do with under-housing, mental health and addictions. Knowing that has helped us (and our partners) to focus on interventions that really matter.

HQ: Most healthcare leaders are engaging the primary care system as a means to reduce the impact and burden of chronic disease. What have been your success stories and what issues remain as a leadership challenge?

ME: It's been a lesson a long time coming: successful healthcare systems cannot be successful without finding a way to engage the primary care system.

We have several projects under way looking at ways to better support primary care practitioners in the community, like the virtual ward. We're working in partnership with a couple of other hospitals where we have identified the top-30 large, solo family physician practices – most of them along College Street – that have a significant number of frequent users of emergency departments, mostly the Toronto Western site. Rather than taking approach of wrapping services around patients, we are wrapping services around these solo practice practitioners, giving them, for example, a general internist on call 24/7, 365 days per year, to help them sort out what needs to be done.

We have an Acute Ambulatory Care Unit that, where appropriate, can admit a sick patient for quick, short-term interventions so that he or she stays out of an ED or in-patient bed. UHN is the navigation hub for providers who may not know enough about the services and resources available in the community. Again, this can only be done in partnership; meanwhile, we're learning a lot about what's needed to support primary care in the community.

This speaks to engagement. These 30 or so family physicians are absolutely thrilled that we provide this service; in turn, we have greater capacity to address hospital needs. It's figuring out how to help busy practitioners, on their own for 30 years, remember how to access and use these resources. This may be one of our biggest challenges.

HQ: The mission at WCH is to become a world leader in women's health. How does a facility in Canada achieve that objective?

ME: There are so many aspects to this mission. We are very fortunate that we have a research institute and roster of extraordinarily talented clinician scientists who can attract grants supporting [needed] research. We have gender equity in all of the research that we do, ensuring that we promote research that also understands the impact of research on women. It's important to understand research that is important to women. We are the only hospital-based research institute in Canada focused primarily on women. For example, while seniors are an issue with the healthcare system, that group is primarily women: women live longer and have more complex conditions. This research is one of three important pillars of our strategy: advancing health for women.

We also have clinician scientists doing really important work for communities of women around the world, such as in Bangladesh, Poland and the Bahamas. Another is doing important work abroad in HIV/AIDS [human immunodeficiency virus/acquired immunodeficiency syndrome]. Each one of these clinician scientists is bringing that world focus on women to those who live here in Toronto. Frankly others are not paying attention to these communities; by working in partnership with others around the world, they bring that work here, ensuring we pay attention to equity in research and an understanding of what is important to women, beyond just their bodies. Women understand that, and they need us to understand that there is so much more to what impacts their health.

HQ: What do you hope will be your leadership legacy at WCH?

ME: Women's College has an extraordinary and inspiring history. Absolutely, it had to reinvent itself in order to transform that legacy and create [new] meaning and relevance as the health system is challenged by the future. When I leave here, I will know that Women's College is doing work that is not duplicated elsewhere, that it provides care relevant for women worldwide. That will make me feel very good about the time that I spent here. Our capital redevelopment is under way, scheduled for completion in a couple of years. I think my legacy will be building something that was founded on what is important to women. Making sure that WCH is relevant to the health system of the future would make me feel really good.

We did a study with over 1,000 women, asking them what was important to them as they interact with the health system and providers. The outcomes of that study were incorporated into the design of the new facility. What was interesting was that what is really important for women, works for the 30% of our clients who are men. What man wouldn't want to be a partner with the health team in order to determine the priorities for his own healthcare? What man wouldn't want to be heard when talking about his health issues? The crowning [achievement] will be an enduring facility that will support this work.

HQ: Thank you. HQ