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# Collaborative Partnerships: Managing Increased Healthcare Demand without Increasing Overall System Capacity

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### Abstract

Collaborative partnerships can help improve integration and quality in local healthcare systems. We describe an innovative approach that was implemented following the formation of a tri-provider partnership between homecare and two acute care hospitals. The approach questioned the prevailing thought that the home is always the most appropriate and least costly location to provide services to clients traditionally served by homecare.

The goal was to improve the delivery of healthcare by better integrating patient characteristics with services provided by homecare, hospitals and family physicians. The result was the implementation of a pilot project in which both homecare clients and non-urgent hospital patients could be served in a hospital-based ambulatory nursing care clinic.

### Introduction

Local healthcare systems can improve, despite the existence of conflicting interests and duplication of services among multiple providers. Healthcare has been described as a system comprising a variety of vertical “silos of care” that need to be accessed horizontally by patients (Pincus et al. 2005; Chinnis 2005; Mann 2005). Historically, the healthcare system has

not facilitated the sharing of funds, other resources or information between the different silos. This lack of system-level coordination has contributed to decreased patient and family practitioner satisfaction. It has also diminished the ability to move toward the desired “seamless” healthcare system (Hibberd 1998). Evidence also suggests that fragmented healthcare has a detrimental impact on patient outcomes (Mann 2005; Booi et al. 2003).

Thus, we ask the question: *is it time for more collaborative relationships between providers?* The answer appears to be yes. For example, one of the themes identified in a series of Ontario Ministry of Health and Long-Term Care (MoHLTC) community workshops that addressed the development of Local Health Integration Units was the need to bridge “healthcare delivery from hospitals to community care and support services” (Ontario Ministry of Health and Long-Term Care Bulletin No. 5 2004). In addition, there is a perceived value in local systems having “the flexibility to address unique local population health needs and priorities” (Ontario Ministry of Health and Long-Term Care 2005). Given this, we ask a second question: *could improving local healthcare integration mean bringing community care back to the hospital?*

## Background

A large proportion of care is being provided outside of hospitals. In addition, there is a progressive shift toward providing higher-cost professional services, compared to lower-cost home support services (Hollander 2002). These changes inevitably impact local resources/capacity and will likely increase the need for local system flexibility. (Barnanek et al. 2004) argued that these changes are “fundamentally reshaping” Canadian health policy by both changing how services are funded and delivered and by affecting the dynamics of health policy formulation. However, one constant characteristic is that the cost of illness still impacts local communities, and their ability to deal with this is affected by the overall local-level health system capacity.

The delivery of healthcare in a community (and consequently local system capacity) can be improved by better integrating the services provided by the different stakeholders such as hospitals, homecare agencies (Ontario Health Services Restructuring Commission 2000; Korabek et al. 2004; Stock et al. 2004; Eagar et al. 2005) and family physicians. One way to facilitate improved integration is to implement an approach that combines the strengths, needs, interests and capacities of the key health service providers while also addressing the characteristics and needs of clients served. A reduction in the capacity of even one of the key health service providers inevitably impacts the resources and consequently the capacities of the others. An example of this occurred in Kingston, Ontario in 2001, when a homecare organization, the Community Care Access Centre (CCAC), restricted services and placed homecare clients on waiting lists as a result of budget constraints. This decision had an immediate impact upon the local healthcare system and affected a wide range of patients and providers. This included: (a) family and acute care physician frustration with delays and decreased capacity; (b) decreased patient satisfaction; (c) increased length of stay for some hospital patients; and (d) increased emergency room utilization by non-urgent patients.

Emergency room visits by non-urgent patients is considered a national issue (Canadian Institute for Health Information 2005). Thus, any increases will pose additional unwanted stress on hospitals and will have a negative impact on local healthcare systems. The challenge presented in Kingston was how to manage increased demand with decreased overall system capacity. The Kingston, Frontenac, Lennox & Addington CCAC, Kingston General Hospital (KGH) and the Hotel Dieu Hospital (HDH) were critical in responding to this challenge.

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## The Collaborative Partnership and Developing the ANCC Intervention Overview and History of the Proposed Approach to Addressing Local Needs

In 2003, representatives from the two acute care hospitals and the CCAC came together to address the issue of system-wide capacity and to discuss innovative approaches to improving local integration, patient care/satisfaction, efficiency and utilization. The collaborative efforts resulted in the January 2005 implementation of a pilot project that had the primary aims of: (a) providing patient care through a hospital-based Ambulatory Nursing Care Clinic (ANCC); and (b) demonstrating an ability to increase capacity through a creative collaboration. The rationale for this shift, given the fact that the demand for services continued to exceed available resources, was to ensure that only those requiring acute inpatient care were hospitalized and that primarily homebound clients were treated by the CCAC. In addition, there was the need to ensure access to services that the CCAC or acute care hospital could uniquely offer as opposed to those that could be offered in other settings, such as an ambulatory clinic. The Ontario Health Insurance Act, Regulation 552, Section 13 indicates that homecare services should not be provided to patients who can attend an outpatient facility; consequently, patients who are able to attend an ambulatory clinic are not eligible for CCAC services if the outpatient service is available. However, until the implementation of the ANCC, the Kingston community had no such ambulatory nursing service for patients to access. Thus, although not required to do so, to address this gap the CCAC often provided these services to clients who were not necessarily eligible.

A primary objective in developing the clinic was to serve patients as they transitioned into and out of both acute and homecare settings. The Hotel Dieu Hospital provides most of Kingston’s hospital-based ambulatory care and was initially considered to be the logical location for the clinic. However, it was finally decided to locate the clinic in the Kingston General Hospital. This decision was due to conflicting issues experienced by the developing partnership that were associated with the different hospitals: pressures, needs, timelines and hospital/union specific policies. It was decided to staff the clinic with KGH nurses. However, operating costs during the pilot project were shared and clinic policy was developed with input from decision-makers representing both hospitals and the CCAC.

## Change Management Issues

The parties were brought together as a result of ongoing collaborations in other areas. During the process, problems were being identified by the different partners in which system-wide stressors had negative but often different impacts upon each partner. It also became clear that in some circumstances a single solution could accomplish desired outcomes for all partners.

Early champions of the partnership included the CCAC's Executive Director and the Chief Executive Officer and Chief Nursing Executive from the KGH. The resulting two-party partnership initially formed out of the heightened urgency felt by both the KGH and the CCAC. The founding organizations quickly identified the value of having the designated Ambulatory Centre involved, even though, in this case, the physical space and staff availability suggested the best decision was to locate the ANCC at the KGH site. The HDH executive team also recognized the value of collaborating and soon joined the partnership.

Initial acceptance of the ANCC concept, of providing homecare services in a hospital setting, was mixed and illustrated a preliminary split between healthcare executives and the community. For example, the hospital and CCAC executives were willing to work outside of longstanding and traditional limits. Additional enablers included the partners' agreement on funding and support from key frontline managers in all three organizations for the politically risky but innovative approach. It took a little more time and effort to explain the rationale and objectives and to properly educate direct providers (medical staff and unit staff). Once this was successfully implemented, the benefits became apparent and good support followed. However, the community was less supportive and more likely to perceive the approach as indicating a withdrawal of services or at least as diminished access. The main issue was overcoming perceptions of providing care for an ambulatory community-based population within an acute care setting. For example, community perceptions were captured in a series of articles published in the *Kingston Whig Standard* with the following titles:

- (a) "Home-care services to be provided at hospital: Drastic steps being taking to cut costs" (Lukits 2004);
- (b) "Hospital care isn't home care: Plan would see home-care services offered at Hotel Dieu" (Schliesmann 2004);
- (c) "What is 'home care' coming to?" (D'Aeth 2004); and
- (d) "Isn't home care about keeping people out of hospital?" (Wamboldt 2004).

Barriers to developing and maintaining both the partnership and appropriate clinic policy were associated with both different administrative philosophies and conflicting provider specific policies and procedures. Overall, these barriers were described by one person as an example of "policy over reason", which sometimes made it difficult to implement what was apparently the best solution. Examples of barriers included:

- (i) different philosophies and approaches to staffing models;
- (ii) identification of and agreement on the appropriate location for the clinic, given severe space constraints experienced by all organizations;

- (iii) different organizational senses of urgency resulted in different policy prioritization and subsequently different timelines;
- (iv) the overall assumption that acute care policies would automatically apply to the functioning of the ambulatory/community-based clinic;
- (v) identification of specific issues and the need to provide guidance for medical responsibility as a risk/liability issue;
- (vi) different organizational funding support mechanisms and agreement on specifics of shared funding;
- (vii) deciding whether nursing staff should be paid at acute care or community care rates;
- (viii) providing education that addressed differences between community-based and acute care nursing procedures; and
- (ix) short time frames between decision and clinic implementation created implementation issues relating to the ongoing development of clinic policy/procedures and the need to provide continuous support and education to staff.

### Clinic Characteristics

For the duration of the pilot project, it was decided to operate the clinic on a part-time basis with hours of operation Monday to Friday, between 4:30 p.m. and 8:30 p.m. In developing additional clinic policy, the partners recognized the importance of selecting the appropriate target population and range of services to provide. Logistical issues presented challenges that still need to be completely resolved in order to best serve the target population. However, it was decided the ideal target population would consist of: (a) mobile patients who were independent, with activities of daily living, but still needing nursing care/treatment and unable to manage care independently; and (b) non-urgent hospital patients who presented at the emergency room (Rivoire et al. 2004). ANCC patients could be either current homecare clients or newly referred patients. Current patients who were eligible but were already receiving nursing services at home would not be asked to switch. Examples of newly referred patients included hospital inpatients that were not appropriate for discharge until nursing services could be arranged or patients referred from their family practice physician. Non-urgent hospital patients who arrived at the emergency room could be self-referrals or patients who were redirected by their family practice physicians' offices for reasons that included office hours, timely access issues or non-available nursing services. Examples of services provided in the demonstration clinic included but were not limited to: wound care, teaching self-care, drain care, injection, phlebotomy, infusion and line (central/peripheral) care.

### Preliminary Results

Since opening in January 2005, approximately nine patients per day have been seen in the clinic. Initial patient/client reactions

have been mixed. Newly referred clients, most of whom were unaware of the new policy, were generally satisfied with the referral. However, some former homecare clients voiced disappointment with changes that they believed represented the removal of services they previously received from (and believed fell under the jurisdiction of) homecare.

A comprehensive implementation analysis and economic evaluation have not been conducted on the clinic. Consequently, economic and utilization changes experienced cannot be fully attributed to the clinic, particularly given that the CCAC simultaneously implemented multiple strategies intended to improve quality and reduce costs. Given this, some experiences that indicate the clinic has potential to demonstrate the intended objective of addressing the issue of “managing increased demand with decreased overall system capacity” include: (a) on average, 180 clients per month were served at the clinic; (b) KGH elective surgery beds have not been occupied by patients awaiting discharge to homecare; (c) the CCAC home support wait-list decreased from 270 to 0 between September 2004 and September 2005; and (d) total in-home nursing services decreased (where some of the difference can be attributed to clients served at the clinic).

### Issues Identified

As could be expected, when implementing a new and innovative multi-provider collaboration, the ANCC demonstration has experienced implementation issues such as those resulting from partner agreements and conflicting interorganizational policies and procedures. Specific challenges that need to be addressed before expanding clinic hours and services include:

- (i) increasing community and provider awareness and acceptance;
- (ii) changing patient and family practice physician behaviour patterns;
- (iii) finding nurses with the correct skill set;
- (iv) addressing cultural differences between hospital and homecare nurses (i.e., approaches to interacting with patients);
- (v) identifying the optimal hours of operations that merge homecare and hospital patient needs with hospital/staffing policy issues and also addressing family physicians’ regular office hours;
- (vi) addressing legal issues related to hospital nurses taking orders from community physicians;
- (vii) extension of the ANCC’s care capacity to include “walk-ins” and/or redirection of patients from the emergency room for non-urgent nursing care; and
- (viii) determination of ongoing funding.

### Discussion

Although significant challenges need to be addressed and

resolved, an existing strength is the continued executive-level support from each partner. There is a shared belief in the value of pursuing collaborative partnerships and in evaluating and improving the hospital-based ambulatory nursing care clinic.

An overall goal of the ambulatory nursing care clinic was to implement a more efficient redistribution of resources within the local healthcare system in the context of a multi-provider partnership. This was believed to translate into increased system-wide accessibility for both hospital patients and homecare clients. However, additional benefits that were also expected include: (a) the clinic’s contribution to reducing homecare waiting lists; (b) better coordination of care; (c) improved homecare client satisfaction (particularly given a client’s ability to “walk-in” or set their own appointment schedule, compared to the standard one-to-two-hour flexible time period when the homecare provider is scheduled to arrive and consequently when the client must stay at home to guarantee service on that day); (d) decreased length of stay for some hospital patients; (e) less emergency room utilization by non-urgent patients; and (f) more appropriate physician referrals with decreased delays until nursing services are provided. Some of these benefits have been realized. Thus, the potential to achieve the others in the future appears reasonable, given continued support, enough time and appropriate policy decisions.

Lessons learned from the demonstration project focus on the need for adequate and frequent communication among local healthcare providers. For example, the solution derived from a crisis situation inevitably resulted in quick decisions and limited time for a full discussion and evaluation of policy options that would otherwise have benefited all provider partners, the community and the day-to-day clinic operations. It would help if all key players in a local system were more fully aware of health system problems as they arose and of their impact upon different healthcare providers. A heightened awareness would provide opportunities for stronger partnerships to develop and subsequently result in the identification of more effective solutions. Essentially, the best solutions are more likely to be identified, accepted and implemented when local providers frequently communicate and act more like members of a local healthcare system and less like separate components or “vertical silos of care that need to be accessed horizontally” by members of the community.

Accessing primary-care nursing services in the community continues to be a health policy issue that warrants both local and provincial attention, such as asking the question: could improving local healthcare (access/integration) mean bringing community care back to the hospital? The collaborative hospital-homecare partnership and the subsequent development of the ANCC pilot project represent an innovative local-level approach to addressing this issue in the context of managing increased demand without adding additional resources. One objective of

the pilot project was to allow for the evaluation and potential redesign of ANCC policy. Next steps include conducting a comprehensive implementation analysis and evaluating preliminary indicators of effectiveness. It is too early to reach conclusions about the long-term impact of the ANCC; however, the consensus among key stakeholders is that it has the potential to improve integration, provide benefits for both patients and providers and serve as a model for other communities. 

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