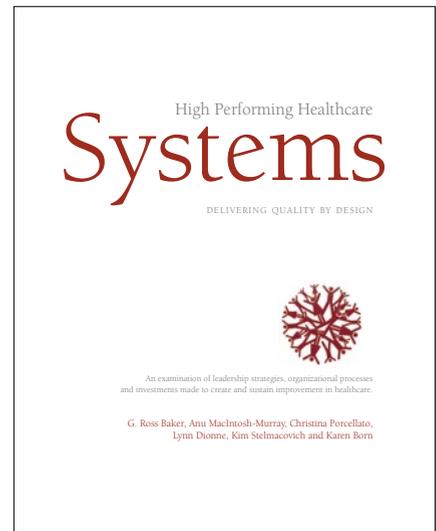


High Performing Healthcare Systems

DELIVERING QUALITY BY DESIGN

Chapter 3 Commentary



Citation Information

Levine, D. 2008. "Commentary: Veterans Affairs New England Healthcare System (VISN 1)." *High Performing Healthcare Systems: Delivering Quality by Design*. 115–120. Toronto: Longwoods Publishing.

To view more please visit:

<http://www.highperforminghealthcaresystems.com>

Commentary: Veterans Affairs New England Healthcare System (VISN 1)

David Levine, President and Chief Executive Officer
Montreal Health and Social Service Agency

Introduction

As president and chief executive officer of the Montreal Health and Social Service Agency (the agency), I am responsible for ensuring that health and social services on the island of Montreal are safe, efficient and meet the needs of the population. Quebec's minister of health and social services has charged me with planning healthcare services, signing performance contracts with all centres that receive funding from the agency and ensuring that performance targets are met. Many of my colleagues in similar positions across Canada have the same mandate, and some are responsible for the direct operations of their organizations.

My main approach to improving performance involves developing integrated networks. I was therefore very interested to read about the success of the Veterans Affairs New England Healthcare System (VISN 1). I have reviewed the case study from the point of view of a health systems manager and I have considered how VISN 1's experience can be adapted to the Quebec and Canadian contexts.

In 2005, the Quebec government established 12 integrated health services networks to serve Montreal's 1.8 million people. Prior to these mergers, each institution had a

specific mandate, was preoccupied with its own growth and functioned largely in a silo. Each of the new networks was formed through the merger of a community hospital, rehabilitation centre, long-term care centres, home care organizations and primary care institutions into a new body responsible for the care of the population in a designated area. The networks have three principal objectives:

- To develop multidisciplinary primary care teams
- To monitor and improve the health of their populations
- To ensure timely access to care

The first two years following the mergers were mainly dedicated to creating the new institutions' administrative and organizational structures and protocols. The focus now is on the implementation of integrated services along clinical lines. The challenges facing this task are enormous because professionals are being asked to work in ways that differ markedly from how they have performed their roles for most of their careers.

The VISN 1 example allows us to look at 10 years of experience and at what has worked and not worked in New England. It is important to take into account the differences between our jurisdictions' care models in order to understand more clearly what can be applied in the Quebec and Canadian contexts.

Developing service lines

The organization of services along clinical service lines and support service lines is an excellent approach to managed care that can ensure the smooth, continuous flow of patients through a healthcare system. Optimal patient flow can be achieved more easily in an integrated model in which all services fall under one central authority. It is not impossible when there is a multitude of different providers, but certainly it is far more difficult. The key elements of standardization and systemization are much more difficult to implement in a non-integrated network. In an integrated network, meanwhile, the use of clinical protocols is simplified and it is much easier to get consensus among physicians in the same organization.

One major distinction must be made between VISN 1 and the Canadian system. In Canada almost all physicians are not employees of their organizations. They are paid by government bodies on a fee-for-service basis and have privileges to work in their various institutions. Primary care physicians do not belong to any institutions and they work out of private offices on a fee-for-service basis. The greatest challenges facing Canada's healthcare system are how to connect the primary care physicians with the rest of the system and how to develop multidisciplinary primary care teams that collaborate with other providers in a seamless care process.

Performance measurement and accountability

The performance contract used in VISN 1 as a basis for measuring and tracking patient care and each organization's clinical and administrative performance has clearly been demonstrated as the tool of choice in an integrated network. VISN 1's commitment to performance measurement and the strong support from all levels of management are essential to implementation and adherence both by clinicians and staff members.

Once again, the fact that Canadian physicians are independent, autonomous professionals adds many challenges to developing standardized clinical performance measures. There is a growing consensus that the increasing availability of clinical data will make it easier to track the provision of care and its outcomes. As a result, it stands to reason that clinicians will be drawn to a more evidence-based approach and to using more standardized protocols.

VISN 1's development of standardized staffing and productivity models for physicians has had a positive impact on that network's physicians and should be introduced into the Canadian system. In Montreal we are setting up network clinics and must decide on panel size and physician support so that appropriate funding can be provided to the primary care teams. This approach has already produced some positive results; for instance, 40 clinics have signed contracts with the island's 12 local networks and are providing greater accessibility as well as more continuous care. Each clinic has also been provided with support resources and at least two nurses to begin helping physicians manage their patients.

Electronic medical records

VISN 1's implementation over a 10-year period of a home-grown electronic medical record system has been a key ingredient in the network's success. The Canadian system is certainly lagging behind in this area. However, a combined federal and provincial effort has recently been set in motion aimed at creating the data warehouse necessary to provide clinicians throughout regions and provinces with the data they need to treat their patients. Organizing the electronic medical records at the local institutional level has been left to each province or region to implement.

Realizing the importance of a more uniform and standardized approach in Montreal, the 12 CEOs and the non-integrated teaching hospitals decided to piggyback on the electronic record that the city's two major teaching hospitals chose for their institutions. This approach means that all physicians and other professionals in their institutions or private offices will eventually be using the same software to generate and maintain their patients' medical records. This standardization will allow for much easier transfer of patient data and offer a common way of viewing records and reading files.

Performance measurement at the national level

The Veterans Health Administration (VHA) has developed nationwide standards. Each of the system's networks, however, has the opportunity to develop its own strategies and implementation processes.

In Canada the development of sets of performance measures, either clinical or administrative, should be mandated to a national organization. The measures should then be validated and provided to the provinces and territories for adaptation to each jurisdiction's unique needs. The Canadian Institute for Health Information (CIHI) would be an ideal organization for carrying out this mandate because the agency already collects healthcare data across the country. VISN 1's experience has shown that performance comparison and transparency are critical for driving change. CIHI has the knowledge and credibility in Canada to carry out this vital work.

Levers of change and the importance of leadership in a performance culture

The VA Boston Healthcare System (VA Boston) realized that money was not the only – and in most cases, not the most important – lever for ensuring high-quality performance. Culture and pride in performing well became the key catalysts for change.

VA Boston's success demonstrates that implementing change is crucial to improving performance. How should we implement such cultural changes in the Canadian context? The use of clinical care indicators and individual physician and team performance have been shown to be the most effective drivers of change. Leadership, especially medical leadership, is a factor of prime consideration, and developing clinical leadership must be part of the process.

VA Boston's experience shows that ongoing training of service chiefs and senior leaders supports cultural change and that the involvement of organizations in the Institute for Healthcare Improvement (IHI) Breakthrough Series provides the structures and processes to bring about positive change. Improving access to primary or specialized care, managing emergency departments more efficiently and effectively, redesigning the use of operating rooms and implementing managed care models are all helped by implementing processes that have demonstrated positive results. Establishing a Canadian collaborative in a more structured form than is presently the case could greatly assist our emerging networks.

The case study documenting VISN 1's transformation illuminates the importance of the actors involved – in particular, their leadership, insight and commitment to a culture of performance. This is the same message that emerges from a study of the Kaiser managed

care model in California. The need to be the best and to be recognized as the leader in a field is a powerful driver in cultural change. The question, therefore, is how to instill the desire to be the best.

First, as VISN 1's experience suggests, it is important to stop finding excuses. This involves an attitude change that is led by people who believe in themselves and their capabilities – people who are driven to excellence because they believe excellence is possible. Leaders must be able to show this possibility to their teams through their personal beliefs, knowledge and commitment to the services being offered.

Leaders must infuse throughout their organizations the belief that “We sell health and ours is the best product on the market.” It's the Ken Kizer in each of us that we need to bring out if we want to introduce a high-performing culture. Systematized processes, along with clear, measurable goals and rigorous feedback processes are essential tools; however, their users must also be believers. In Montreal, as in much of the rest of Canada, we are now at the interface between the science and art of management. I am convinced that the art must come first.

Conclusion

The VISN 1 case study offers an excellent description of what was done in the VA model of healthcare and allows us to glimpse some of the strategies we can adopt in the Canadian healthcare system. I have highlighted some of the differences between the two systems, but the essential issues that led to the success of the VA model are highly pertinent to our own experience. Standardizing processes and performance measurement are the key ingredients to creating a high-performing system. It takes, however, the right leadership to make it happen.