CAHO | CATALYST

Making the Connection

Dr. Barry McLellan
Chair, CAHO
President & CEO
Sunnybrook Health Sciences Centre

The 2012 Ontario Budget provides our first glance at how the Ontario Government plans to address the current fiscal situation. The health sector is expected to receive an increase of 2.1 per cent annually over the next three years, and our hospitals will not receive any increase in base operating funds.

The budget also proposes changes to the Ontario Research Fund (ORF) by proposing a cap to the funding and requiring institutions to spend their funds within the given fiscal year or risk losing their allocation. The budget also proposes funding reductions to Clinical Education. CAHO will continue to work with the government on both these fronts to discuss the impact of these changes on the CAHO community.

Undoubtedly, the next couple of years will be challenging for our sector. We need to remain focused on the levers that will continue to strengthen the health research sector. Initiatives like:

- The creation of a Health Research and Innovation Council. Ontario lacks an overarching health research strategy and this council would bring together all stakeholders to create an effective strategy to ensure the best health research translates into the best health care delivery.
- Clinical Trials Ontario (CTO) which has the opportunity to positively effect and grow Ontario's market share and make it the preferred location for global clinical trials. CAHO would like to ensure previous support for CTO's multi-year funding is honoured. This funding is vital to the development of a more attractive environment for clinical trials and will facilitate a more robust health research enterprise in Ontario.
- The Ontario Government recognizes ARTIC as a great example of collaboration and applauds CAHO for its leadership and commitment to improving the health care system. CAHO wants to ensure the province continues provide on-going support for the ARTIC Program to develop a provincial pathway for evidence adoption. The government's budget proposes to accelerate the evidence-based approach to care by building on the mandate of Health Quality Ontario (HQO) to provide recommendations to direct funding to where evidence shows the greatest value.

CAHO member hospitals are innovators and contributors to a knowledge-based economy. We want to ensure our hospitals have the right environment to operate and thrive in. As the budget is implemented, CAHO will continue to work with government officials to understand the implications on the CAHO community and share our ideas to ensure the health care environment is one that supports research, innovation and a continued focus on patients.

In the Spotlight

Dr. Andrew Morris
Associate Professor, Division of Infectious Diseases, Department of Medicine, Mount Sinai Hospital, University Health Network and University of Toronto

CAHO Antimicrobial Stewardship Program (ASP) in Intensive Care Units (ICU) ARTIC Project Lead

Dr. Andrew Morris (MD SM FRCPC) obtained his medical degree at the University of Toronto in 1994, where he subsequently obtained specialty certification in Internal Medicine and subspecialty certification in Infectious Diseases. While undergoing a Canadian Infectious Diseases Society research fellowship under the supervision of Dr. Allison McGeer, Dr. Morris completed a Masters Degree in Epidemiology from the Harvard School of Public Health in 2000.

In 2000, he accepted a position at McMaster University and Hamilton Health Sciences, where he worked as a clinician-teacher for 6 years. He held numerous leadership and administrative roles there, including Chair of the Pharmacy and Therapeutics Committee, Physician Lead for Drug Utilization, and Director of the Infectious Diseases Residency Training Program.

In 2007, he was lured back to Toronto, where he currently holds a clinician-educator appointment as Associate Professor in the Department of Medicine, Division of Infectious Diseases, at Mount Sinai Hospital (MSH) and University Health Network (UHN). He is the Director of the MSH-UHN Antimicrobial Stewardship Program (ASP), working collaboratively with a variety of health-care professionals to optimize antimicrobial use in patients. Dr. Morris is the incoming Chair, Specialty Committee on Infectious Diseases, Royal College of Physicians and Surgeons of Canada. He is regularly invited to speak on antimicrobial stewardship-related issues.

CAHO Catalyst recently sat down with Andrew and asked him to reflect on the CAHO ASP Project and his research at Mount Sinai.

1. Can you briefly described to our readers what the CAHO ASP Project is and what inspired the research and development of this program?

Antimicrobial stewardship is, simply put, making sure patients get the right antibiotics (antimicrobials) when they need them and only when they need them. Although this sounds fairly straightforward, it is quite a complicated task, especially when it involves patients in the intensive care unit (ICU), where the stakes are amongst the highest in health care and the patients are very complex. Our project involves working collaboratively with individual hospitals to help them either establish or optimize their own ASP to set them up for success working in the ICU. Antimicrobial stewardship is inspired by several facts: our current approach to antimicrobial-resistant organisms is inadequate, patients can be harmed by unnecessary antimicrobials and the antimicrobial pipeline (whereby new drugs are developed) is rapidly drying up.

2. Can you share with us what the objective of the ASP Project is and what your team and CAHO is trying to achieve?

Our team and CAHO are trying to reduce unnecessary antimicrobials in ICUs, reduce complications of unnecessary antimicrobial use and develop a system for hospitals to compare their results. Our hope is that this will develop best practices that will lead change throughout the health-care system.

3. Can you share with us a preview of some of the early learnings from the CAHO ASP Project?

So far, we have learned that antimicrobial stewardship is truly in its infancy, with most hospitals having either no or only a rather small antimicrobial stewardship program. Additionally, we have also learned that there is a ready appetite for developing this kind of program: health-care providers want to do the right thing. In our experience, multidisciplinary collaboration with the ICU team not only results in improving antimicrobial use, but it results in reduced antimicrobial costs, and reduced drug-resistance in the ICU.

4. Can you describe to our readers research you and your team are working on in addition to the CAHO ASP Project at Mount Sinai?

We are interested in learning how to use antimicrobials best in order to help patients. This includes understanding common infections (such as skin infections and pneumonia), and less common but more potentially severe infections (such as staphylococcal bloodstream infections and sepsis). As time goes on, we realize that it is important for us to understand that doctors will only change how they prescribe antimicrobials if we improve how we diagnose infections: our research is starting to focus on this aspect of patient care.

5. When you are not working at Mount Sinai, what do you like to do in your spare time?

Probably the wrong question: You should have asked, "When you are not coaching your daughters, or playing and studying basketball, what do you like to do in your spare time?" Answer: Helping improve antimicrobial use while working at Mount Sinai Hospital (and University Health Network). I also spend family time up at our cottage, stay fit, and (very occasionally) enjoy scotch—one of the early antimicrobials!

CAHO News

Ontario Budget Proposes Strong Action for Ontario

On March 27, the Ontario Government laid out its roadmap for a stronger Ontario with the release of the 2012 Ontario Budget. The government maintains it is on track to eliminate the deficit by 2017-18 as planned. Despite a budget focused on reduced spending, the Ontario Government maintains its commitment to protect health care and education.

Much of the focus for the budget has been on introducing changes to public service compensation and public sector pension funds – key expenses that currently consume more than 50 cents for every dollar spent by the Ontario government. Overall, there were no major surprises with respect to health care and health research. Many of the reforms that are proposed in the budget have been previously announced by the government in Ontario's *Action Plan for Health Care*.

There are several proposed changes that CAHO will be working with the government on as they move forward with adoption. These include:

Ontario Research Fund - The government is proposing to cap the funding under the operating and capital components of the ORF. Essentially this would require recipients to spend their funding according to the agreed allocation. The Budget states that "a cap on the ORF program would not yield savings but would provide greater flexibility to continue matching federal awards to invest in research infrastructure and ensure the continuation of the program. This would allow the government to continue funding large-scale, transformational research at Ontario's universities, hospitals and research institutes."

Reduced Funding for Clinical Education - The government plans to achieve savings by reducing the per-resident funding to medical schools to reflect the amount required to support quality health outcomes from new professionals. Funding for indirect teaching costs will also be reduced. The government plans to reduce funding by $13.5M in 2012-13, $14.2M in 2012-14 and $15M in 2014-15 for total 3 year savings of $42.8M. Ministry of Health and Long-Term Care (MOHLTC) officials indicated this is not intended to reduce the number of residents but rather indirect costs of teaching including things like Faculty Development, and general overhead as an example. They also indicated the government would be consulting with hospitals and medical schools regarding the funding changes.

Hospital Funding - The government is proposing holding growth for hospitals' overall operating base to zero per cent in 2012-13 while continuing to increase investment in the community sector to an average of four per cent. Total hospital operating funding will grow by two per cent in 2012-13 due to ongoing support for key services such as wait times initiatives and priority treatments, including chronic kidney disease and transplants. And finally, the budget confirms the government's commitment to patient-centered funding which will be phased in over three years and will be based on the types and volume of services and treatments that are delivered, at a price that reflects the best practice and complexity of patients and procedures, while encouraging efficiency. Government also reiterated their commitment to activity-based funding.

Evidence-Based Health Care – Through the budget, the government is proposing to accelerate the evidence-based approach to care by building on the mandate of Health Quality Ontario (HQO) to provide recommendations to direct funding to where evidence shows the greatest value. CAHO will continue to work with the MOHLTC and HQO to support this vision through the CAHO Adopting Research to Improve Care (ARTIC) Program.

Moving forward, CAHO will continue to work with the Ontario Government as it implements its changes to the health care system and understand its impact on the CAHO community. Working with stakeholders, CAHO will ensure health research and innovation remains at the forefront of the health care system, and that patients continue to receive the best care possible as they access the system.

CAHO News

Canadian Study Shows Hospitals That Spend More Get Better Results

A new Canadian health care study released in the March 2012 issue of the Journal of the American Medical Association (JAMA), and led by Dr. Therese Stukel from the Institute for Clinical Evaluative Sciences (ICES), suggests that patients admitted with high-risk, care-sensitive conditions treated in Ontario hospitals do better at hospitals that have more nurses and where inpatients have more access to specialists and specialized procedures. The study followed approximately 390,000 adults with a first admission for heart attacks, congestive heart failure, hip fractures or colon cancer with surgical resection between 1998 and 2008.

The objective of this study was to assess whether patients admitted to hospitals that spend more to treat patients more intensively, at a higher cost, also have lower mortality and readmission rates and higher quality of care. The study measures medical intensity as 'the quantity of medical care provided overall to similarly ill patients and is a marker of a hospital's tendency to treat similarly ill patients more (or less) intensively.'

"Higher-spending hospitals were higher-volume teaching or community hospitals with high-volume or specialist attending physicians and having specialized programs, such as regional cancer centres, and specialized services, such as on-site cardiac catheterization, cardiac surgery, and diagnostic imaging facilities," Dr. Stukel stated in the report.

She continues by stating, "We found that higher hospital spending intensity was associated with better survival, lower readmission rates, and better quality of care for seriously ill, hospitalized patients in Ontario in a universal health care system with more selective access to medical technology."

Higher-spending hospitals were more likely to have a greater use of evidence-based care, skilled nursing and critical care staff, more intensive inpatient services, and high use of technology. In addition, patients admitted to these hospitals had longer stays, were less likely to be admitted to an intensive care unit, and had more medical specialist visits during their episode.

Cardiac patients were more likely to receive cardiac interventions and evidence-based discharge medications. They were also more likely to experience collaborative ambulatory care within four weeks and see a cardiologist within a year. Patients with hip fractures were more likely to receive inpatient rehabilitation and those with colon cancer were more likely to have a preoperative consultation with a surgeon and undergo computed tomography for preoperative staging.

CAHO member hospitals treat the most critical and complex patients and in many cases this care is provided at higher costs than other institutions because they are providing more expensive specialized services that result in better outcomes. This study provides valuable information on how the cost of care can impact the quality of patient care. CAHO member hospitals continue to improve the health care system with a focus on evidence-based research and bringing research into practice.

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