Code Gridlock: Why Canada needs a national seniors strategy

Address to the Canadian Club of Ottawa
By Dr. Christopher Simpson
President, Canadian Medical Association
Nov. 18, 2014

Check against delivery

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

Good day everybody.
Bonjour.

The topic listed for my speech is *Why Canada needs a national seniors strategy to make our health system work again.* I am reminded of this topic every time I see or hear the words "Code Gridlock" at Kingston General Hospital where I am on staff.

Please bear with me while I explain because Code Gridlock and the need for a national seniors strategy are very intricately linked.

Code Gridlock is every bit as ominous as it sounds. When a hospital reaches and exceeds its capacity, these two words go out on pagers and smart phones to physicians, administrators, nurses and support staff in hospitals all over Canada, or over the PA system as is the case at my hospital.

Code Gridlock means that the hospital is so full that patients can't move. Patients in emergency can't go upstairs to a bed because the beds are full. Sometimes ambulances can't offload patients into ER because it is packed - even in the hallways. Elective surgeries are cancelled. Transfers from the region are put on hold.

Patient flow, as we call it, has ground to a halt.

To those outside the medical world, the two words probably won't be heard over the white noise of a busy hospital. But to everybody else in the building they work like a dog whistle — start freeing up beds immediately.

That means housekeeping has to be called to start cleaning
rooms as soon as beds are vacated. The physios accelerate their work getting patients mobilized so they can safely get around on their own.

The home care folks go into overdrive to try to get already-stretched services into place for patients nearing discharge. The social workers call in favours to try to get long-term care facilities to squeeze in one or two more people.

All hospitals in the region are told that we can't take any patients other than "life and limb" problems. All physicians, nurses and other health care professionals are urged to do whatever they can to expedite discharges.

And every manager, director, the Chief of Staff, and VPs focus on patient movement - they work at the micro level to decongest the system one patient at a time.

Now that seems sensible, right? An "all hands on deck" approach to a problem that has essentially shut the system down.

But here's the problem: despite our efficiencies that compare favourably to best in class - including length of stay and other measures that help to define optimal capacity - despite judiciously balancing our shrinking budget - despite getting as lean and efficient as I think we can possibly get - we are increasingly in gridlock.

In October, KGH spent 18 days in gridlock.

And today, we are on day 25 of gridlock — 25 consecutive days.

As we struggle, patients are waiting in the ER. Outside of hospitals, other patients' wait times – already months and sometimes years, for elective surgery like hip replacement – just got longer. Patients waiting at one of the community hospitals in our region waiting to be transferred for specialized care just have to keep on waiting.

Unfortunately, the Canadian Health Information Institute doesn't publish figures on Code Gridlocks. But as my hospital's in-house publication noted, they are "a troublesome trend that has continued."

The situation has become chronic at many hospitals. Last February, Thunder Bay Regional Health Sciences Centre won the dubious distinction of shattering all records in the country. It was in gridlock for more than seven straight weeks. That's right weeks. Not hours. Not days.

In 2013 there was a 105-per-cent increase in the number of gridlock days at this hospital in Thunder Bay. The Ontario government came up with $14 million to relieve the problem after the hospital was hit with a fire violation because the hospital was forced to put patients in hallway alcoves.

We call those "overcapacity beds". But what they really are, are windowless nooks, crannies and broom closets - anywhere we can squeeze in a stretcher or a bed.

Code Gridlock may sound shocking to most people. It was developed to deal with the inevitable surges in activity we see — a way to raise awareness acutely and thereby squeeze extraordinary performance out of the system for a few days in order to overcome the congestion.

But increasingly, Gridlock is becoming the norm.

Cependant, de plus en plus, le « Code Gridlock » est en train de devenir la norme.

So what does Code Gridlock have to do with seniors care?

Well, in the hospital world we have another code - ALC. It stands for *alternate level care* (as opposed to acute care).

These are patients who no longer require acute care and for all intents and purposes are able to leave the hospital. More to the point – they *should* be leaving the hospital – not only because the beds are needed by others but because the hospital is, frankly, a toxic environment for patients who have chronic but not acute disease.

Hospitals are not set up to look after people with chronic diseases. Patients get deconditioned, they fall, they suffer hospital-acquired infections. They don't get the care they need and deserve.

ALC patients are almost always seniors who should be in long-term care or at home with assistance from home care, or with community-based solutions.

At KGH during this most recent gridlock, between 60 and 70 patients are designated as ALC. They are trapped. We are warehousing them. We do the best we can. But it's not anywhere near good enough.

About 15 per cent of the acute care hospital beds in this country are filled with ALC patients, about a third of them suffering from dementia.

As a society, we need to step up investment in long-term care and invest much, much more in services for home and community care.

Comme société, nous devons augmenter les investissements dans les soins de longue durée et investir beaucoup, beaucoup plus dans les services de soins à domicile et de soins communautaires.

Why should we do this? Because these patients are in a place where they shouldn't be. We put them to bed – because that's what we do in hospitals: we put patients to bed. Instead of lifting them up, and restoring them, and helping them live dignified lives.

Unfortunately, ALC patients are rudely tagged by frustrated health professionals as "bed blockers," which is so unfair. These are patients who are in this situation through no fault of their own.

If anything it is the fault of our hospital-centric system for quietly conducting an internal debate among ourselves using obscure lexicon like ALC when we should have let our patients in on this dirty little secret.

It's our fault for devising workarounds to keep a broken system afloat…..complicit in the knowledge that doctors and nurses and others, in sincere efforts to do their very best for patients, too often accomplish excellence despite the system rather than because of it.

Our system has been neglected. Our health care professionals have kept it afloat. But increasingly, spectacular system failures like gridlock are becoming the norm.

Policy makers need to wear a big chunk of this problem. Our health care system was set up 50 years ago when the average age of a Canadian was 27. The health care landscape was one of acute disease. So we built hospitals. And we made the health care system about hospitals and doctors.

Today the average age is 47. And the landscape is now one of chronic disease. Like diabetes and dementia. Like chronic obstructive lung disease and heart failure. Like arthritis.

Yet the system hasn't changed much.

We are now warehousing seniors in hospitals at $1,000 a day. Long-term care costs $130 a day. Home care $55. The CMA believes about $2.3 billion a year could be better spent in the health care system with some strategic thinking and investing.

So I am not talking about throwing a lot of money to update the health care system. That's not practical. We need to spend smarter.

Je ne parle donc pas d'injecter des sommes énormes dans le système de santé pour le mettre à jour. Ce ne serait pas sensé. Il faut dépenser plus intelligemment.

In other words, we need a national seniors strategy involving all levels of government, and with Ottawa taking a leadership role. We see this as a much more positive alternative to quarreling over who is in charge of what and who should pay for what.

To use a tangible analogy, 30 years ago provincial transport ministers collectively admitted the Trans-Canada Highway system was neglected to the point of being unsafe. There was one section of the Trans-Canada in my native New Brunswick known as Death Alley.

But the two senior levels of government argued over responsibility and money until the situation was no longer tenable. The Feds said roads are a provincial responsibility. Today the same is said about health.

Finally, 10 years ago Ottawa could ignore the situation no longer and began pouring millions into the Trans-Canada system in partnership with the provinces over the next decade.

I hope we don't have to wait for that to happen in health care.

Canada's 5.2 million seniors represent almost 15 per cent of the population but account for almost half of all health costs.

By 2036, the 65-plus group will account for a quarter of the population, and those over 85 will quadruple.

If nothing changes in our health system, seniors will account for 59 per cent of our health costs in 2031.

Can our universal health care system remain sustainable? It won't unless we start rethinking seniors care and how it affects the overall system.

For starters, I think it is time to dehospitalize the system.

A hospital-centred health care system was developed in the early part of the 20th Century when the average Canadian life expectancy was just over 50 years. Today Canadian life expectancy is 81 and we have been slowly evolving into a patient-centred system.

This is largely because of extraordinary gains in acute care.

In some ways we are victims of our own success. The challenge now is how we deal with chronic conditions.

D'une certaine façon, nous sommes victimes de notre propre succès. Le défi maintenant consiste à traiter les maladies chroniques.

Today, a 65-year-old Canadian in good health can realistically expect to live another 20 years with 17 of those years – or so - in reasonably good shape.

Yet our system is dependent on institutions that were designed to put people to bed until they either died or were cured. The hospital was also designed in an era when aging might as well have been classed as a disease instead of the success that it has become.

As my friend, Dr. Samir Sinha has said, "*Aging is not a disease; it is a triumph."*

You may be asking that if aging is not a disease then how come the 65-plus group accounts for almost half the health costs? Well, the answer is because we don't know how to deal with chronic care efficiently, effectively, and with high quality.

Let's look at some figures from the Canadian Institute for Health Information.

In each of the age groups (65 to 74, 75 to 84, and 85 and older), seniors with three or more reported chronic conditions had nearly three times the number of health care visits than seniors with no reported chronic conditions.

Seniors with three or more reported chronic conditions accounted for 40 per cent of reported health care use among seniors, even though they comprised only 24 per cent of all seniors.

This shows a pattern in which seniors with chronic conditions account for most of what is attributed to seniors overall in health care costs.

I know that you have likely heard about the grey tsunami that is coming like a plague of locusts. But I really think the era we are now in may be remembered as the dawn of healthy and active aging. People in their 50s and 60s will be compared to those in their 40s in previous generations.

Unfortunately, there is also a danger of this era being remembered as the age of staggering health costs. Fear of the great tsunami is probably what is making politicians reluctant to talk about the aging population just as it is human nature not to want to look forward to oral surgery.

But there is a way out of a sustainability crisis while giving all Canadians the health care they need, including those with chronic conditions — if we start thinking differently and strategically.

I am very glad the ambassador of Denmark, His Excellency Niels Abrahamsen, is here with us today because I am going to point to the Danish health care system as one we should consider emulating.

Denmark avoided building any new long-term beds over two decades and actually closed thousands of hospital beds by strategically investing more in home and community care services.

Unfortunately, we are nowhere near our friends from Denmark. Before sending people home, we need to ensure the programs and the system are there to support our patients and their families.

Until then, we need to reinvest in our long-term care capacity. This is why the CMA recommends Ottawa deliver $2.3 billion in funding to help the provinces invest in construction, renovation and retrofitting of long-term care facilities.

The latest study of the health care systems of 11 countries by the Commonwealth Fund had Canada and the U.S. in a race for the bottom. And we only did better than the Americans on costs.

Others can show us how to provide better care to patients for less if we are prepared to study and emulate them.

The European Commission takes independent living seriously enough to have the SILVER project. That stands for Supporting Independent Living for the Elderly Through Robotics. That's right, robotics.

But in an age of wearable technology we are now thinking what used to be the unthinkable. Google Glass has developed a contact lens that reads glucose levels from tear duct emissions. It is now possible to monitor blood pressure through a bandage.

Think of how much more viable home care would be with emerging technology like a sensor a patient can just touch to pass on vital information to a community clinic.

Instead of worrying about what we are going to do with all the old people, we should be joining those whose policy priority is ***aging well.***

All this is doable if our governments are prepared to sit down and develop a national strategy dedicated to the principle of aging well and quality care for all.

No longer should just 16 per cent of Canadians have access to palliative care. No longer should seniors have to choose between buying food and paying for prescription drugs.
And no longer should Canadians believe that long wait times are the price they must pay for a universal health care system. Because it's <u>not true.</u>

Instead of waiting to rewrite health policy, we should look at how an aging population is rewriting reality.

The Canadian Association of Radiologists says an aging population will require more imaging resources across the board and support staff. There is already a lag in supply of such resources, meaning wait times will be difficult to address.

The Canadian Ophthalmological Society says aging is the major single factor driving a crisis in vision loss in Canada. The annual cost of vision loss in Canada is $15.8 billion and that number will double by 2032.

Almost every area of specialized medicine is being affected by the aging population.

In August, I made a pledge that the CMA will work with any government of any political stripe that commits to a comprehensive national seniors care strategy. That pledge stands.

En août, j'ai promis que l'AMC travaillera avec tout gouvernement, de toute allégeance politique, qui s'engagera envers une stratégie nationale exhaustive sur les soins aux aînés. Cette promesse tient toujours.

The CMA continues to believe a committed federal government is a necessary ingredient for a successful seniors strategy. This is why there is the Canada Health Act.

We are seeking support from physicians, stakeholder groups like the Royal Canadian Legion, forward-thinking institutions like Bruyere Continuing Care, media and public officials willing to listen.

This is why I am so glad to have Bernie Blais, President and CEO of Bruyere Continuing Care, and a policy expert like David Dodge with me at the head table.

Fifty years ago Tommy Douglas showed us a better way.

That is the kind of national vision we need now. We must act.

Thank you. Merci!