

INTEGRATION: A NEW DIRECTION FOR CANADIAN HEALTH CARE

A Report on the Health Provider Summit Process



Prepared in collaboration with



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TERMINOLOGY

The following terms are specifically defined in this document.

- Family — In keeping with a number of texts,¹ the term “family” refers to two or more individuals who depend on one another for emotional, physical, and/or financial support. Members of a family are self-defined.
- Patients — While recognizing various preferences for describing individuals who want to access the health-care system (e.g., patients, clients, users, consumers, persons), for simplicity, the document uses the term “patients” throughout.
- Primary care — The primary care system refers to the “first line” of clinical services that provides an entry point to the health-care system. Primary care teams include family physicians, nurse practitioners (NPs), registered nurses (RNs), and other health-care professionals working side by side as partners. Such teams produce better health outcomes, improve access to services, ensure the most efficient use of resources and create greater satisfaction for both patients and providers.
- Interprofessional care — This document uses the term “interprofessional care” just as the World Health Organization defines “collaborative practice”: as occurring “when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, caregivers and communities to deliver the highest quality of care across settings.”²

ACRONYMS

CMA	Canadian Medical Association
CNA	Canadian Nurses Association
CPP	Canada Pension Plan
HEAL	Health Action Lobby
IHI	Institute for Healthcare Improvement
NP	nurse practitioner
RN	registered nurse

¹ See, e.g., Stamler, L. L., & Yiu, L. (2011). *Community health nursing: A Canadian perspective* (3rd ed.). Toronto: Pearson Prentice Hall; Stanhope, M., Lancaster, J., Jessup-Falcioni, H., & Viverais-Dresler, G. (2011). *Community health nursing in Canada* (2nd ed.). Toronto: Pearson Canada.

² (World Health Organization, 2010, p. 13)

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PART 1: THE HEALTH PROVIDER SUMMIT PROCESS

A growing number of health providers in Canada share the vision that, “by 2025, Canadians will have the best health and health care in the world.”³ With stable, predictable funding in place, and a robust pan-Canadian effort, this goal is both realistic and achievable.

Early in 2012, CNA and CMA formed a steering committee⁴ of volunteers, whose purpose was to initiate a summit process that would focus on transforming the Canadian health-care system. The case for change was clearly outlined in the subsequent discussions through widespread agreement on the following points:

- Patient care in Canada is designed from the point of view of the provider, whether this provider is a hospital, clinic or individual. To improve, the system needs to be redesigned to support patient-centred care.
- Variations occur in quality and access to care, both across the country geographically and across socioeconomic groups.
- Canada’s multiple health-care systems are (1) complex, (2) difficult to access, (3) involve many levels of care, practitioners and delivery mechanisms, and (4) a challenge for patients and families to navigate:
 - Canadian care providers are not integrated horizontally or vertically. Care delivery occurs in silos.
 - Barriers exist in accessing the system.
 - Transitions between providers are difficult for patients and family members.
- Interprofessional collaborative teams could be designed to deliver more and better care.
- Canadian health care is not the best in the world; the status quo is unacceptable.

In addition to these issues, international comparisons indicate that Canada’s performance lags behind many other industrialized countries on the quality of health services received for the price paid. The Conference Board of Canada gives Canada’s health system a “B” grade and places us 10th out of 17 peer countries.

One in four Canadians now say that developing a long-term action plan to improve the performance of our health-care system should be the top priority for the federal government⁵ (second only to improving conditions for the most vulnerable Canadians, at 29 per cent).

Guiding Health-Care Transformation in Canada

Initial guidance to the project steering committee stemmed from *Principles to Guide Health Care Transformation in Canada* (CMA & CNA, 2011)⁶ and the Institute for Healthcare Improvement’s (IHI) “triple-aim” framework (2013).⁷ Both initiatives also served as a starting point for the provider summit process.

³ (CMA, 2011, p. 3)

⁴ See Appendix A for steering committee members.

⁵ Adapted from a Nanos national representative online survey.

⁶ See Appendix D.

⁷ See <http://www.ihl.org/offerings/Initiatives/TripleAim/Pages/default.aspx> for further information.

The joint CMA-CNA report offers six principles to guide the transformation of Canada's health-care system:

- a. Patient-centred care that is seamless along the continuum of care
- b. Quality services appropriate for patient needs
- c. Health promotion and illness prevention
- d. Equitable access to quality care and multi-sectoral policies to address the social determinants of health
- e. Sustainability based on universal access to quality health services
- f. Accountability by stakeholders — the public/patients/families, providers and funders — for ensuring the system is effective

As of September 2013, 131 Canadian health organizations had endorsed these principles.

The IHI “triple-aim” framework offers an approach to optimizing health-system performance, based on the idea that new designs must pursue the following three goals:

- Better Care — improving the patient experience of care (including quality and satisfaction)
- Better Health — improving the health of populations
- Better Value — reducing the per capita cost of health care

Taking Action

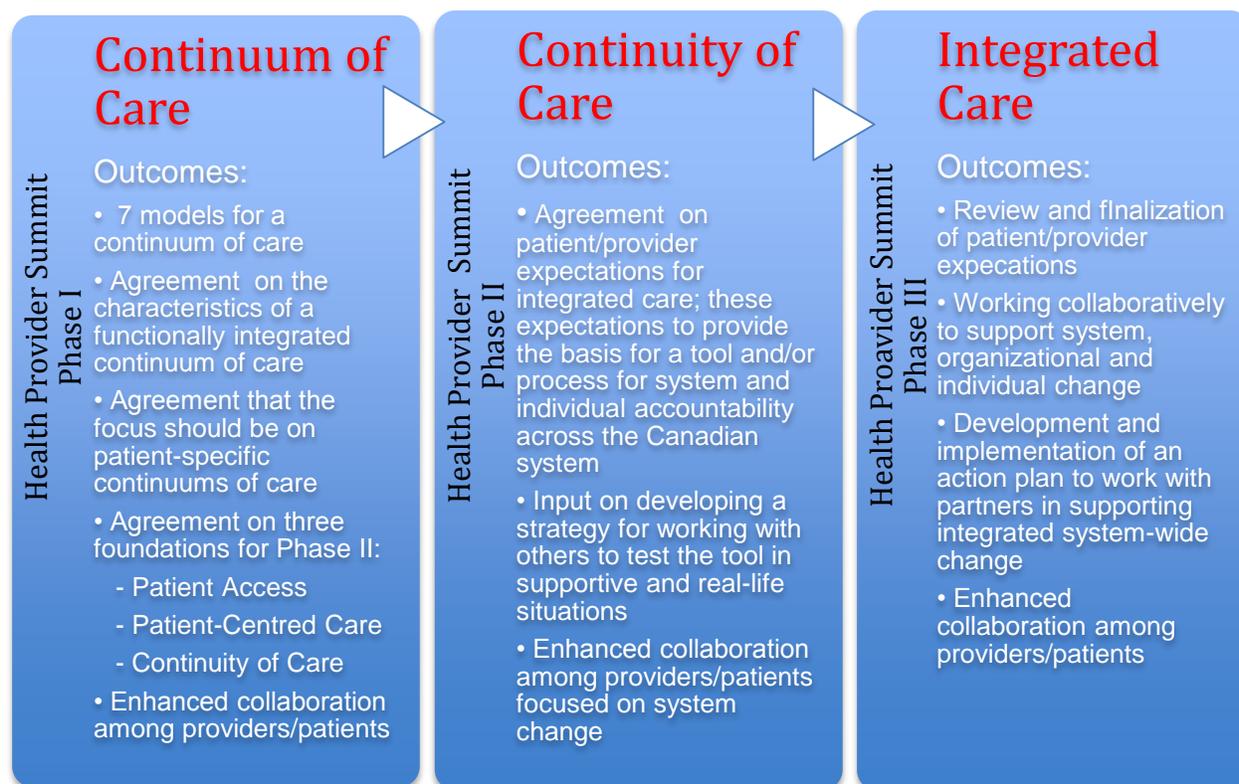
When CNA and CMA began discussing how to help Canadians secure the best health and health care in the world by 2025, they concluded that a functionally integrated health system along the full continuum of care was essential. Such a system would require interprofessional collaborative teams to ensure patients receive the right provider, at the right time, in the right place, for the right care. In addition, the two organizations agreed that governments by themselves could not achieve the necessary change — leadership from physicians, nurses, pharmacists and other health providers would also be needed to support a more fully integrated and patient-friendly health system.

For this type of large-scale change to succeed, Canadians must have a long-term relationship with their primary health care team. For such relationships, we must help Canadians navigate more smoothly through the system while addressing the social determinants of health, the promotion of health and the prevention of disease.

When HEAL⁸ joined the steering committee, its members developed a three-phase process. Phase I and II involved national summit workshops (May 2012, February 2013); Phase III was used to develop an action plan (summer 2013). The workshops engaged providers and the public in discussions while developing recommendations on integrated care. Before and after each workshop the steering committee reviewed outcomes and developed next steps.

⁸ See Appendix C for the list of HEAL members.

THREE PHASES



Phase I: The Continuum of Care

In the Phase I summit workshop (Ottawa, May 7, 2012), CNA, CMA and HEAL hosted representatives from health-provider groups and the public to initiate discussions on creating Canada's first functionally integrated continuum of care.

After identifying the characteristics of an ideal continuum,⁹ workshop participants created seven functionally integrated continuums of care,¹⁰ along with possible visual concepts, based on three high-impact chronic disease areas: hypertension, mental health and diabetes. Each continuum represented ways that the system could be rearranged to better support users.¹¹

⁹ See Appendix F: Report of the Health Provider Summit, Phase I — Continuum of Care Workshop.

¹⁰ Ibid.

¹¹ Ibid.

Phase II: Continuity of Care

After the Phase I summit, the steering committee reviewed the seven proposed models for continuums of care to determine the elements of a functionally integrated system that would be common to all personal pathways through care. As a result, the Phase II summit workshop (February 2013) built upon Phase I from the perspective of individuals' needs.

The objectives for Phase II were to

- a. develop a draft tool that Canadians can use to support their travel along the continuum of care (this tool would also gather data and function as a report card for use by health-care decision-makers to help change the health-care system in support of seamless continuity of care);
- b. provide input on developing a strategy for pilot testing the tool in real-life situations; and
- c. continue to build effective, collaborative relationships with colleagues and patients in support of excellence in continuity of care as we strive to achieve the best health and health care for Canadians by 2025.

Phase II summit participants outlined the expectations regarding this tool based on five scenarios:

- Aboriginal people with diabetes
- Adults with chronic obstructive lung disease
- Children with obesity
- Seniors with dementia
- Youth with mental health concerns

Each scenario was discussed using five foundations identified after the Phase I summit: (1) patient access, (2) patient-centred care, (3) informational continuity of care, (4) management continuity of care, and (5) relational continuity of care. Participants agreed that better health, better care and better value for Canadians would result when these five foundations are supporting integrated care (these foundations are further explained in Part 2, below).

Phase III: Advancing Toward Integrated Care

Phase III effectively started in a debriefing meeting after the Phase II summit, when steering committee members reviewed the second summit outcomes and began laying a foundation for the final phase: how to move into action.

This discussion sought ways of bringing the system and individual approaches from the first two phases together for practical action in support of integrated care. To do so, summit participants validated the Phase II expectations and created a final basis for a tool that Canadians could use to support their passage along the continuum of care. The next step was to prepare and circulate this report (and a final briefing note) to workshop participants and other interested parties and to encourage them to disseminate the report further.

The steering committee then decided to share the final list of summit foundations and expectations with other groups and organizations¹² (engaged in creating similar information, tools and mechanisms) to encourage their use for developing health indicators and outcomes to benchmark integrated care in the future.

In addition to this wider dissemination, CMA, CNA and HEAL are integrating the summit results into their current work with the Council of the Federation to advance the principles of health-care transformation. They are also supporting initiatives on community-based interprofessional collaborative teams and incorporating this report's foundations and expectations into health-in-all-policies initiatives.

Additional results are provided in the Phase I report (Appendix F).

¹² For example, the Conference Board of Canada, Canadian Institute for Health Information, Statistics Canada, Accreditation Canada, Canadian Health Services Research Foundation and the Canadian Alliance for Sustainable Health Care.

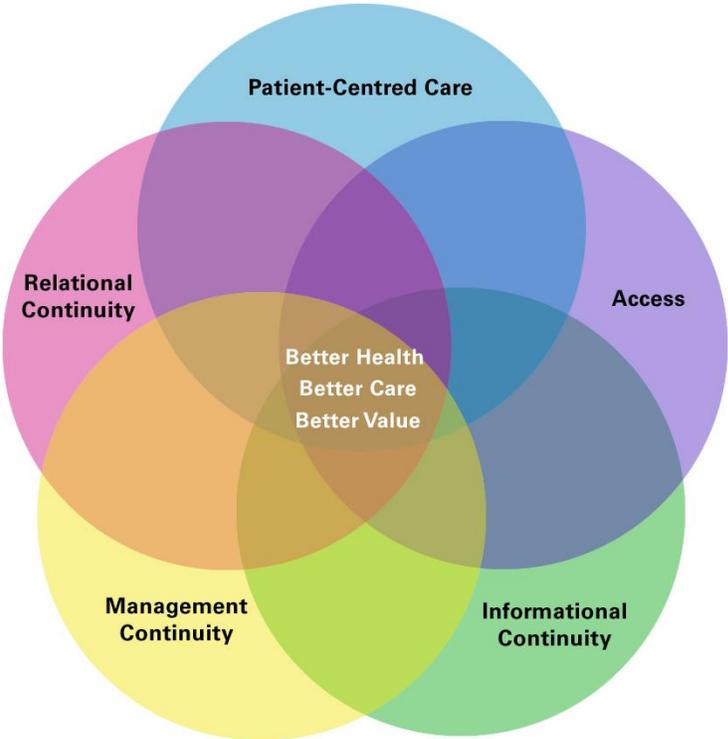
PART 2: OUTCOMES

Five Foundations for Integrated Care: Patient/Provider Expectations

Ideally, integrated care provides seamless care pathways along and within each patient’s continuum of care. Success in integrated care includes addressing the factors that determine and maintain health along these pathways. A strong primary health-care foundation as well as collaboration and communication within and between different health professionals are essential for achieving functionally integrated care.

As a result of the Phase I and II summit workshops and related steering committee meetings, expectations for each of the five foundations for integrated care emerged and were confirmed by summit participants: (1) patient access, (2) patient-centred care, (3) informational continuity of care, (4) management continuity of care, and (5) relational continuity of care.¹³

When the expectations that follow are in place to support these five foundations of integrated care, the result is better health, better care and better value for Canadians.



¹³ Expectations for each of the five foundations were created using five scenarios (aboriginals with diabetes, adults with COPD, children with obesity, seniors with dementia and youth with mental health concerns).

a. Patient Access

All Canadians benefit from access to a comprehensive, publicly funded health-care system. Canadians have a right to equitable access to quality health care, and they expect accountability and sustainability from their health-care system. Many portals of entry exist for accessing health care.

Expectations

- Distributed access to care, regardless of geographic location; for example, that
 - access to specialized care via interprofessional teams is immediate, flexible, and timely;
 - a primary care health screening tool is available for children and youth (either in schools or other community centres);
 - care moves to the patient, rather than the patient to the care — specifically, access to care occurs where it is best provided, not where it has been traditionally funded;
 - every youth with a chronic mental health problem has access to a case manager;
 - need and expertise drive care, not funding models;
 - telehealth is available in rural and remote communities; and
 - there is workplace accommodation and access to appropriate exercise programs.
- Access to care tailored to patients' needs; for example, that
 - information is culturally relevant and patient-centred;
 - more learning opportunities are provided in communities and in educational settings;
 - patients can access their own charts;
 - patients have access to education in a credible and consumable format with clear descriptions of warning signs and outcomes; and
 - patients can choose from an inventory of program and service options.
- Equitable access to affordable choices for prevention and health promotion irrespective of mobility or financial status; for example, that
 - accessible and affordable medication is in place;
 - care service and support are accessible and provided when needed;
 - financial incentives are in place for healthy and affordable food choices;
 - social services are available to support management and recovery (housing);
 - there is an emphasis on health infrastructure in communities, e.g., centres to access recreation as well as affordable, guided and effective physical activity (both structured and unstructured); and
 - there are similar advantages and disadvantages for publicly funded and private care.
- Better food labeling is developed (in plain language), along with education to help patients make healthy food choices.
- Funding and access disparities related to mental health are identified and addressed.
- Funding is flexible to ensure a safety net for care, e.g., a health-care funding model similar to the Canada Pension Plan (CPP). (Client-based funding supports autonomy.)

- Mental health and mental health care are integrated into health care at the primary care level, including in the workplace. Patients are engaged in care decisions and are comfortable bringing mental health problems to primary care settings. Clinical practice guidelines (CPGs) exist that include integration of mental health care-providers and consultants on primary care teams.
- Supports are in place to advocate for individuals who are without formal or informal caregivers.
- The norm is active evaluation that identifies and acts on barriers to access based on the social determinants of health.
- There is greater access to culturally appropriate care throughout the lifespan that is easily accessible locally, both on reserve and off (e.g., access to midwifery, expanded scopes of practice).

b. Patient-Centred Care

Patient-centred care recognizes that the patient is the most important consideration in health care. “Patient-centred care is seamless access to the continuum of care in a timely manner, based on need and not the ability to pay, that takes into consideration the individual needs and preferences of the patient and his/her family, and treats the patient with respect and dignity.”¹⁴ “Improving the patient experience and [responding to the health needs] of Canadians must be at the heart of any reforms.”¹⁵

Expectations

- Customized care provides an integrated approach to the specific needs of a patient; for example, that
 - appropriate education entails patients understanding their condition or disease process;
 - ‘client-centric’ means more patient empowerment for decision-making;
 - health providers are more accountable for the delivery of quality care;
 - since patient ‘non-compliance’ is usually more about side effects and not being comfortable with a diagnosis/treatment, we need to understand what these factors are, including identifying the right professionals and appropriate interventions, to address these challenges;
 - performance indicators align with patient outcomes; and
 - the patient has a holistic plan — developed from an interprofessional health-care-team perspective — that meets their needs.
- The patient is a proactive leader and manager of individual care needs; for example, that
 - patients are able to book appointments with the necessary providers;

¹⁴ (CMA, 2010, p. 6)

¹⁵ (CMA & CNA, 2011, p. 2)

- patients are accountable for the therapeutic plan, and health goals are established at the front end of disease management with a focus on optimizing wellness;
 - patients are integrated into all phases of the treatment process at their highest levels of contribution; and
 - patients' goals are at the centre of health-care planning, with the system respecting the preferences individuals have for care.
- Aging with dignity is a priority while ensuring the best clinical or evidence-based care. End-of-life strategies bring both the family and medical team on board as the patient's wishes are followed and respected.
 - Care responds to need rather than defining it; that is, individualized care plans change, as do team leads, based on the needs of the individual. If it is a child, the lead may be a parent, educator or nurse.
 - Ethical considerations are addressed regarding any requirement of partnership between provider and patient, e.g., with respect to weight management.
 - Patients' social needs are met, e.g., with respect to isolation.
 - Societal and cultural changes for the prevention of disease and promotion of health are included in public health policies to help establish an environment of societal sensitivity to chronic disease.
 - Traditional and cultural ways of knowing (traditional knowledge and medicine) are woven into the delivery of services/resources and education. Traditional activities (e.g., hunting, berry picking, ice fishing) are part of the health infrastructure.
 - Culturally appropriate modalities of care form part of the team approach. This includes elders and traditional healers ("unregulated practitioners") in the circle of care.

c. Informational Continuity

Informational continuity links care from one provider or event to another by ensuring that data follows the patient. Information can be disease- or person-focused. Documented information tends to focus on the health condition, but knowledge about the patient's preferences, values and context is equally important for bridging separate care events and ensuring that services are responsive to needs. This type of knowledge is usually accumulated in the 'memory' of providers who interact with the patient.

Expectations

- Global electronic health records/medical records (EHR/EMR) are accessible to multiple stakeholders across jurisdictions; for example, that
 - electronic health records support safe, secure and accurate patient information and prevent duplicate conversations with different health-care providers;
 - information is updated and transferred from practitioners and institutions in real time;
 - information on the patient's progress is available to all members of the team, even when the patient has not informed all team members;
 - seamless sharing of electronic health records across the continuum is a norm;
 - test results are available to patients and providers in a timely manner;

- the onus is on providers, not the individual, to communicate/share information; and
- the patient understands, manages and retains his/her own health records (in either EMR or hard copy) and determines when others can have access to them.
- Patients receive consistent information and direction; for example, that
 - all relevant information, social and functional, is integrated into information resources easily accessed by patients;
 - information is available about healthy eating and the benefits of regular physical activity, and expert guidance is provided by health professionals with expertise in managing therapeutic diets and physical rehabilitation;
 - information is available through telehealth;
 - patients get “push” electronic notifications of followup appointments and reminders of elements of their care plan; and
 - patients understand their care plan and the consequences of not following it.
- Medication management is in place and is easy to use.

d. Management Continuity

Management continuity refers to the delivery of services in a complementary and timely manner. This is especially important in chronic or complex clinical diseases that require management from several providers who could potentially work at cross-purposes. Shared management plans or care protocols facilitate management continuity, providing a sense of predictability and security in future care for both patients and providers.

In the case of chronic or persistent health conditions and disease (e.g., mental disorders, diabetes, heart disease), continuity of contact (expressed as access) embodies the notion that regular contact is needed to ensure that management goals are adapted and met and that providers must often facilitate access to a broad range of services. Flexibility in adapting care to changes in an individual’s needs and circumstances is an important aspect of management continuity. When care is long term, both consistency and flexibility are critical for management continuity.

Expectations

- Care, service and support is coordinated across sectors and geographic areas; for example, that,
 - patients have ongoing care regardless of their age, such as when a young person is moving from a pediatric to an adult specialist;
 - information exchange and collaboration occurs no matter what the state of communication is with respect to system integration;
 - there is a long-term relationship with a primary care team that proactively considers (anticipates) potential health risks — that is, when prevention, early intervention and health promotion can yield the greatest benefits;
 - patients are able to rely on an integrated, interprofessional primary care model;
 - funding structures are reviewed to support the coordination and continuity of care;
 - there are no delays between seeing one provider and the next; and
 - there is continuity in case management.

- Care teams collaborate with patients to advocate for change.
- Every patient designates an advocate who can easily navigate the system. If a family needs help, then a navigation coordinator is available to followup.
- Patients are provided with the resources (or navigator/role model) to improve overall health and well-being. (Ultimately, the system's need for navigators will change, such that patients are empowered and able to make decisions.)
- Patients maintain wellness through regularly assessed and adjusted proactive health plans. Individualized care in care plans (e.g., through technology/apps) is able to flag changes (in care/health status/gaps in reporting) to prevent adverse events or potential risks.
- The right outcomes are used to evaluate performance (quality of care, cost of care). Measurement metrics align to prevent unintended consequences (funding models, incentives and disincentives, etc.).
- There is seamless transition in the availability of services, both on reserve and off, with no jurisdictional fighting over who is paying for a service (Jordan's Principles).

e. Relational Continuity

Relational continuity provides a bridge from past to current and future care. This continuity is often most valued in primary and mental health care. Even in contexts where there is little expectation of establishing ongoing relationships with multiple caregivers, such as inpatient and nursing home care services, a consistent core of staff provide patients with a sense of predictability and coherence.

Expectations

- There is better coordination among all providers and systems; for example, that
 - an integrated primary care model is in place (patients need to be able to rely on an interprofessional approach);
 - discharge planning is based on an integrated team approach;
 - expert informal caregivers and personal care workers are recognized as part of the team in their own right;
 - optimal use of communication modalities supports efficient communication with patients and teams; and
 - providers have an excellent understanding of each team member's roles, skill levels and related boundaries.
- Direct relationships with child patients are a priority. More communication occurs with children and providers, not just with parents.
- Health training includes emotional intelligence and cultural competence, not just grades and aptitude tests (i.e., the measures of admittance to professional training need to change and be more inclusive).
- Professionals work in or are educated in their own community to provide more permanence. Practitioner transience is limited to bring a continuity of knowledge among community-based practitioners.
- Improvements in cultural competency improve service delivery and build trust.

- Patients have the ability to enter and exit a patient-friendly system that helps foster patient autonomy.
- Patients maintain regular contact with providers so that care also exists outside of acute episodes.
- Providers are familiar with services in their communities (other than those with registered health-care providers) that could be of benefit to the health and well-being of their patients (e.g., recreation centres, exercise classes, walking programs).

SYSTEM IMPLICATIONS FOR INTEGRATED CARE

Those involved throughout the summit workshops and steering committee meetings based their discussions on key assumptions related to how an ideal, functionally integrated system would need to operate. The following assumptions were confirmed throughout the process, as noted below.

- Keep the patient perspective front and center —
 - Empower and support patients to care for themselves. Remember all patient-care settings, e.g., urban, rural and remote.
 - “Patient” may be defined as a person, community or population.
 - The continuum has to fit patients, not the other way around. The answer for the system is having individual and flexible patient continuums.
 - The focus on the patient has to be the new framework for problem solving.
- Keep health providers engaged —
 - All providers need to see their individual roles and have them validated.
 - Build trust and relationships. Communication is key.
 - Providers must agree to support change, starting with the patient.
 - Providers understand that working collaboratively with patients is the solution. The desire to work together is exceptionally important.
 - Respect among providers, as well as between providers and the public, is essential.
- Identify and act on the social determinants of health¹⁶ —
 - These are the societal conditions in which people are born, grow, live, work and age, including the health system. Address the biological, social and psychological factors that maintain health, determine illness and impact the management of care, e.g., poverty, housing, transportation, and family and emotional support. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels and are an essential factor in health-system design.
- Address system challenges —
 - Build the infrastructure necessary to support collaboration. Include accountability and ongoing evaluation with patients, the public, providers and systems.

¹⁶ See http://www.who.int/social_determinants/en/for_further_information_from_the_World_Health_Organization.

- Look at cost through the evidence of patient outcomes. Make the tough decisions around feasibility and trade-offs.
- The professions have to be willing to make system change a reality.
- The transition points between elements of care are currently not very functional (e.g., between acute care and rehabilitation).
- There is a tremendous opportunity to leverage technology and innovations.
- Take a whole-system approach —
 - Avoid focusing on one aspect of care such as chronic disease management. Make the system work for all aspects of care.
 - Think holistically about patients in the system as a whole.
 - Think long term, anticipating future priorities and system inputs for prevention, promotion and care.

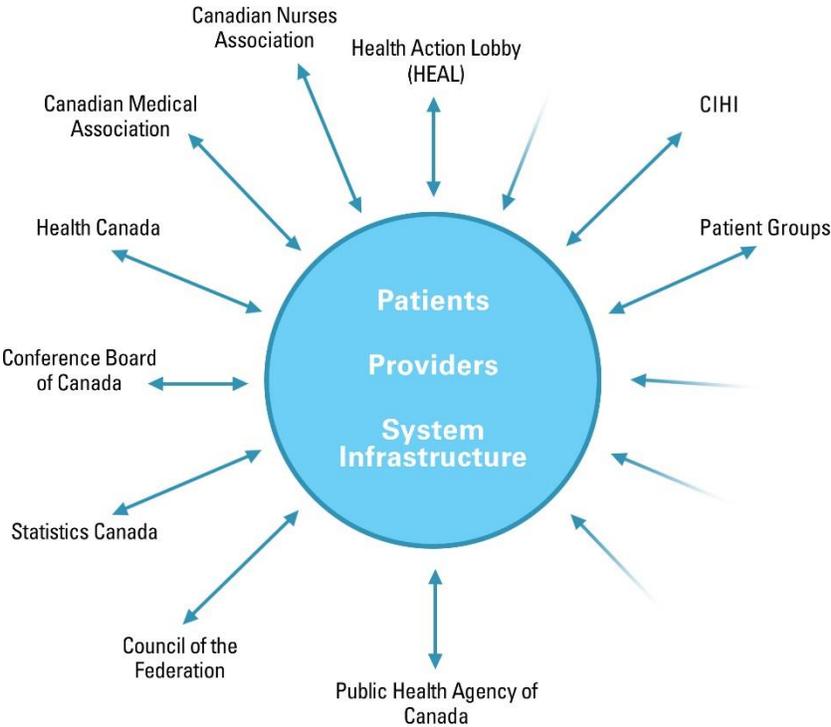
PART 3: IN CONCLUSION — STAKEHOLDER ENGAGEMENT

Next Steps

From the initial meeting, this project focused on concrete deliverables that would benefit the patient, challenge the health-system status quo and engage health providers (and others) committed to acting on a new, integrated vision for health-system care for 2025. The outcomes described in Part 2 of this report address this challenge from individual and system perspectives.

At the conclusion of the second summit, steering committee members recognized that leadership for this work would need to come through collaboration with health providers, patients, organizational representatives, others involved in parallel initiatives and provincial/territorial health leaders. The following graphic includes those groups and organizations that share such an interest. Arrows without names are there to recognize the need for additional stakeholders in this work.

The expectations of patients and providers noted during this summit process will be validated with patient groups and distributed to the system partners identified in the graphic below, that is, organizations that are already invested in parallel initiatives on health-care indicators and outcomes. Through collaboration with such partners, these expectations will contribute to research and development in quality measures and accountability.



CNA, CMA and HEAL recognize that giving Canadians the best health and health care in the world by 2025 requires the creation of a functionally integrated health system along the full continuum of care — a system based on interprofessional collaborative teams that ensure the right provider, at the right time, in the right place, for the right care. The health provider summit process was one important step in this direction.

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Appendices

A. Project Steering Committee

Havelin Anand	Canadian Association of Occupational Therapists
Lisa Ashley	Canadian Nurses Association
Joanne Charlebois	Canadian Association of Speech-Language Pathologists and Audiologists
Karen Cohen	Canadian Psychological Association/HEAL
Christiane Ménard	Canadian Society of Respiratory Therapists
Jeff Morrison	Canadian Pharmacists Association
Kate Rexe	Canadian Association of Occupational Therapists
Martin Vogel	Canadian Medical Association
June Webber	Canadian Nurses Association
Eleanor White	Canadian Chiropractic Association (formerly)

B. Phase I and II Summit Workshop Participants

LAST NAME	FIRST NAME	ORGANIZATION
Alleyne	Julia	Bone and Joint Canada
Anderson	Susan	Canadian Healthcare Association
Ashley	Lisa	Canadian Nurses Association
Autio	Heather	Canadian Society for Medical Laboratory Science
Badiuk	Brenda	Canadian Association of Medical Radiation Technologists
Bard	Rachel	Canadian Nurses Association
Baxter	Sharon	Canadian Hospice Palliative Care Association
Beaulieu	Marie-Dominique	College of Family Physicians of Canada
Bonang	Lisa	Canadian Medical Association
Brennan	Michael	Canadian Physiotherapy Association
Brimacombe	Glenn	Health Action Lobby/Association of Canadian Academic Healthcare Organizations
Brunet	Robert	Canadian Association of Physician Assistants
Charlebois	Joanne	Canadian Association of Speech-Language Pathologists and Audiologists
Chauvin	Jim	Canadian Public Health Association
Clarke	Carol	Ottawa Community Immigrant Services (formerly)
Cloutier	Paul-Émile	Canadian Medical Association
Cohen	Karen	Canadian Psychological Association
Collins	Mary	B.C. Healthy Living Alliance
Cooper	Dana	Canadian Association of Optometrists
Coxe	Angela	Canadian Society of Respiratory Therapists
Denny	Keith	Canadian Healthcare Association
Dick	Bev	Canadian Federation of Nurses Unions (Alberta)
Dietrich	Linda	Dietitians of Canada
Dolgowicz	Christina	Canadian Society of Respiratory Therapists
Doucette	Kevin	Canadian Medical Association

Duncan	James	Canadian Chiropractic Association
Eisener-Parsche	Pamela	Canadian Society of Physician Executives
Florizone	Dan	Ministry of Health, Saskatchewan
Fréchette	Danielle	Royal College of Physicians and Surgeons
Freiheit	Deirdre	Health Charities Coalition of Canada
Gervais	Rachel	Canadian Association of Occupational Therapists
Gold	Irving	Association of Faculties of Medicine of Canada
Green	Maggie	Canadian Physiotherapy Association
Haggie	John	Canadian Medical Association
Hatch	Meagan	Canadian Psychological Association
Heitshu	Michael	Canadian Chiropractic Association
Henningsen	Nadine	Canadian Home Care Association
Irving	Karen	Conference Publishers
Keenan	Dirk	Canadian Chiropractic Association
Kilroy	Katrina	Canadian Association of Midwives
Lamoureux	Eric	Alzheimer Society Canada
Larsen	Craig	Chronic Disease Prevention Alliance of Canada
Lemire	Francine	College of Family Physicians of Canada
Love	Ondina	Canadian Dental Hygienists Association
Lynch	Bridget	Canadian Association of Midwives
MacCallum	Barbara	Canadian Counselling and Psychotherapy Association
Mang	Eric	College of Family Physicians of Canada
Mann	Ann	Canadian Council for Practical Nurse Regulators
Martell	Cal	Martell Consulting
Martin	Lorna	Canadian Counselling and Psychotherapy Association
Masotti	Kelly	Canadian Psychiatric Association
Maynard	Michelle	Canadian Society of Respiratory Therapists
Mayne	Michael	Department of Health and Wellness, Prince Edward Island

McGibbon Lammi	Brenda	Alzheimer Society Ottawa and Renfrew County/Canadian Association of Occupational Therapists
McGlasson	Rhona	Arthritis Alliance of Canada
McGregor	Jane	Aboriginal Nurses Association of Canada
McVey	Lynne	Mental Health Commission of Canada
Ménard	Christiane	Canadian Society of Respiratory Therapists
Miller	Carol	Canadian Physiotherapy Association
Morrison	Jeff	Canadian Pharmacists Association
Nielsen	Christine	Canadian Society for Medical Laboratory Science
O'Callaghan-O'Brien	Leacy	Canadian Association of Medical Radiation Technologists
Occhionero	Tonia	Canadian Association of Midwives
Paul	Mariam	Canadian Home Care Association
Phelps	Fred	Canadian Association of Social Workers
Poston	Jeff	Canadian Pharmacists Association
Racine	Hélène	Douglas Mental Health University Institute
Ralph	Tim	Canadian Association of Physician Assistants
Reid	Anna	Canadian Medical Association
Reid-Haughian	Cheryl	ParaMed Home Health Care
Rexe	Kate	Canadian Association of Occupational Therapists
Reynolds	Stuart	Canadian Dermatology Association
Riley	Johnathan	Arthritis Alliance of Canada
Roye	Charmaine	Canadian Medical Association
Roy-Pilon	Josée	Canadian Association of Radiologists
Rozefort	Willine	McGill University, Douglas Hall
Saryeddine	Tina	Association of Canadian Academic Healthcare Organizations
Saunders	Alex	Canadian Psychiatric Association
Shamian	Judith	Canadian Nurses Association
Sherry	Vanessa	Canadian Hospice Palliative Care Association
Shkrobot	Jody	Canadian Pharmacists Association

Silas	Linda	Canadian Federation of Nurses Unions
St-Pierre Ellis	Lyne	Department of Health, New Brunswick
Strachan	Dorothy	Strachan-Tomlinson
Tomlinson	Mike	Strachan-Tomlinson
VanDenakker	Tricia	Canadian Society for Medical Laboratory Science
Vanderkooy	Pat	Dietitians of Canada
Vogel	Martin	Canadian Medical Association
von Zweck	Claudia	Canadian Association of Occupational Therapists
Watkins	Todd	Canadian Medical Association
Webber	June	Canadian Nurses Association
White	Eleanor	Canadian Chiropractic Association
Wilson	Anne	Canadian Association of Midwives
Wright	Ann	Canadian Dental Hygienists Association
Yale	Janet	Arthritis Society
Zummer	Michel	Arthritis Alliance of Canada

C. Health Action Lobby (HEAL) Members

More information about the Health Action Lobby (HEAL) can be found at <http://healthactionlobby.ca/>

Members:

Alzheimer Society Canada
Association of Canadian Academic Healthcare Organizations
Association of Faculties of Medicine of Canada
Canadian AIDS Society
Canadian Association of Community Health Centres
Canadian Association of Medical Radiation Technologists
Canadian Association of Midwives
Canadian Association of Occupational Therapists
Canadian Association of Optometrists
Canadian Association of Physician Assistants
Canadian Association of Radiologists
Canadian Association of Social Workers
Canadian Association of Speech-Language Pathologists and Audiologists
Canadian Chiropractic Association
Canadian College of Health Leaders
Canadian Counselling and Psychotherapy Association
Canadian Dental Association
Canadian Dental Hygienists Association
Canadian Dermatology Association
Canadian Healthcare Association
Canadian Home Care Association
Canadian Hospice Palliative Care Association
Canadian Medical Association
Canadian Mental Health Association
Canadian Nurses Association
Canadian Orthopaedic Association
Canadian Pharmacists Association
Canadian Physiotherapy Association
Canadian Podiatric Medical Association
Canadian Psychiatric Association
Canadian Psychological Association
Canadian Public Health Association
Canadian Society for Medical Laboratory Science
Canadian Society of Nutrition Management
Canadian Society of Respiratory Therapists
Catholic Health Alliance of Canada
College of Family Physicians of Canada
Dietitians of Canada
Paramedic Association of Canada
Royal College of Physicians and Surgeons of Canada

D. Principles to Guide Health Care Transformation in Canada

This document is available at:

http://www2.cna-aicc.ca/CNA/documents/pdf/publications/Guiding_Principles_HC_e.pdf

E. Mapping of the Health Provider Summit Process

In the table below, the themes in the two left-hand columns show key concepts in the health provider summit process in relation to other initiatives, currently underway, that support it.

Foundations for Phase II of the Health Provider Summit	From the Health Provider Summit Phase I Workshop (May 2012)	WHO — Principles of Primary Health Care*	CMA & CNA — Principles to Guide Health Care Transformation in Canada†	“Towards a Canadian Model of Integrated Healthcare”‡ —
<p>Patient Access</p> <p>All Canadians benefit from access to a comprehensive, publicly funded health-care system. Canadians have a right to equitable access to quality health care, and they expect accountability and sustainability from their health-care system. Many portals of entry exist for accessing health care.</p>	<p>An ideal integrated continuum of care must</p> <ol style="list-style-type: none"> (1) have the appropriate allocation of resources; and (2) be driven by communication, coordination, collaboration and access. <p>Patient satisfaction isn't enough. We need good service, safe outcomes without waits and delays, and high quality care. If something doesn't make a tangible difference for patients, it isn't an improvement.</p>	<p>Accessibility means a continuing and organized supply of essential health services is available to all people, with no unreasonable geographic or financial barriers.</p>	<p>Sustainable health care requires universal access to quality health services that are adequately resourced and delivered along the full continuum in a timely and cost-effective manner.</p>	<p>How will patients know when an integrated healthcare system exists?</p> <p>When they don't have to wait at one level of care because of incapacity at another level of care.</p> <p>When they can make an appointment for a visit to a clinician, a diagnostic test or a treatment with one phone call.</p> <p>When they have a wide choice of primary care providers who are able to give them the time they need.</p>

* World Health Organization. (2008). *Primary health care (now more than ever)*. Retrieved from <http://www.who.int/whr/2008/en/>

† CMA, CNA. (2011). *Principles to Guide Health Care Transformation in Canada*. Available from the CMA website: <http://www.cma.ca/advocacy/hctprinciples>

‡ Leatt, P., Pink, G. H., & Guerriere, M. (2000). *Towards a Canadian Model of integrated healthcare* [HealthcarePapers], 1(2), 13-35. Available from Longwoods: <http://www.longwoods.com/content/17216>

Foundations for Phase II of the Health Provider Summit	From the Health Provider Summit Phase I Workshop (May 2012)	WHO — Principles of Primary Health Care	CMA & CNA — <i>Principles to Guide Health Care Transformation in Canada</i>	“Towards a Canadian Model of Integrated Healthcare” —
<p>Patient-Centered Care</p> <p>The patient as client/consumer/user must be at the centre of health care.</p> <p>Improving the patient experience and responding to the health needs of Canadians must be at the heart of any reforms.</p>	<p>An ideal integrated continuum of care must start with a patient- centered approach (in which a patient may be defined as person, community or population).</p>	<p>Public participation means individuals and communities have the right and responsibility to be active partners in making decisions about their health care and the health of their communities.</p>	<p>The patient must be at the centre of health care.</p> <p>A strong primary health-care foundation as well as collaboration and communication within and between health professional disciplines along the continuum are essential to achieving patient-centered care.</p>	<p>When they do not have to repeat their health history for each provider encounter.</p> <p>When they do not have to undergo the same test multiple times for different providers.</p> <p>When they are not the medium for informing their health-care provider that they have been hospitalized/ undergone treatment procedures/been prescribed drugs/not filled a previous prescription/been referred for followup care.</p> <p>When they have easy-to-understand information about quality of care and clinical outcomes in order to make informed choices about providers and treatment options.</p>
<p>Continuity of Care</p> <p>Ideally, integrated care provides seamless care pathways, along and within the continuum of care, that ensure the right provider, at the right time, in the right place.</p>	<p>An ideal integrated continuum of care must have more of a focus on public health. Prevention and promotion happen at many levels and in a broad range of circumstances.</p>	<p>Health promotion is the process of enabling people to improve and increase control over their health.</p> <p>Intersectoral cooperation, the commitment from all sectors</p>	<p>Canadians deserve quality services that are appropriate for their needs, respect individual choice and are delivered in a timely, safe and effective manner according to the most currently</p>	<p>When they have 24-hour access to a primary care provider.</p> <p>With chronic disease, they are routinely contacted to have tests that identify problems before they occur, provided with education about their disease</p>

<p>Continuity of care[§] is the degree to which a series of discrete health-care events is experienced as coherent, connected and consistent with a patient's health needs and personal context.</p> <p>Three types of continuity exist in all settings: informational, management, and relational. Each type differs according to the setting, the providers, and the context of care, and each can be viewed from either a person- or disease-focused perspective.</p>	<p>Build the infrastructure necessary to support collaboration. Include accountability and ongoing evaluation to patients, the public, providers and systems.</p> <p>There is tremendous opportunity to leverage technology and innovations.</p>	<p>(government, community and health), is essential for meaningful action on health determinants.</p> <p>Appropriate technology includes methods of care, service delivery, procedures and equipment that are socially acceptable and affordable.</p>	<p>available scientific knowledge.</p> <p>Multisectoral policies address the social determinants of health.</p> <p>The health system must support Canadians in the prevention of illness and the enhancement of their well-being.</p>	<p>process and provided with in-home assistance and training in self-care to maximize their autonomy.</p>
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[§] Adapted from Haggerty, J. L., Reid, R. J., Freeman, G. K., Starfield, B. H., Adair, C. E., & McKendry, R. (2003). Continuity of care: A multidisciplinary review. *BMJ*, 327, 1219-1221. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC274066/>

F. Report of the Health Provider Summit —

Phase I: Continuum of Care Workshop

CANADIAN
NURSES
ASSOCIATION



ASSOCIATION DES
INFIRMIÈRES ET
INFIRMIERS DU CANADA

ASSOCIATION
MÉDICALE
CANADIENNE



CANADIAN
MEDICAL
ASSOCIATION

Health Provider Summit

Phase 1:

Continuum of Care Workshop

May 7th, 2012

Ottawa

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INTRODUCTION

In Ottawa on May 7th, 2012, representatives of health-provider groups participated in the first phase of a multi-phase process to develop a functionally integrated continuum of care for Canada. This workshop was focused on taking an initial step: mapping out options for a continuum of care, using a chronic disease prevention and management framework, for three high-impact areas: mental health, hypertension and diabetes.*

The workshop's objectives were to

1. listen to participants' perspectives and contributions about achieving the Phase I purpose;
2. identify horizontal and vertical segments along the continuum of care (in a functionally integrated health system) and define these segments of care in the context of achieving "best-in-the-world" health care;
3. consider barriers to access along the continuum and variations in care;
4. reflect on the need for clinical practice guidelines and for optimizing collaborative care teams and the scopes of practice for individual provider groups;
5. embed a care-centred approach in discussions and recommendations; and
6. continue building effective, collaborative relationships among the provinces and territories to support the 2025 vision and guiding principles focused on "best-in-the-world" health care.

Opening Remarks

Rachel Bard, CNA's CEO, and Dr. John Haggie, CMA president, opened this first ever Canadian workshop on an integrated continuum of care.

After welcoming the participants, Ms. Bard acknowledged the planning committee's work, responsible for bringing this process forward. She then emphasized the need to think big — to focus on the health-care providers who can contribute to achieving the world's best health and health care for Canada by 2025 — and noted that a system based on interprofessional teams that enhance access along the continuum of care is a realistic and achievable goal. Ms. Bard also asked participants to address the need for smooth transitions for patients as they navigate through a system supported by stable and consistent funding.

Dr. Haggie urged those in attendance to use their imaginations when thinking about a potentially improved system and continuum of care, asking "how health care in Canada can accomplish the [IHI] 'triple aim' of lower cost, improved health for all and improved patient experience?" While pointing out that health care today is not patient centred, he also stressed the importance of having patient representatives at the table, noting that "there is no help for patients to navigate health care, the most complex essential service in our society." In closing, Dr. Haggie reminded participants that the tools and levers to make a lasting and constructive change were in their hands.

* Based on "Selecting Initial Topics for Shared Clinical Practice Guidelines," Advice in response to a request from the Council of the Federation to the Canadian Medical Association and the Canadian Nurses Association (February, 2012).

Workshop Process

Throughout the workshop participants' engaged in interprofessional discussions focused on exploring, creating, illustrating and testing options for an integrated continuum of care. In fact, the workshop itself modeled how such a continuum would function: through a process in which a range of providers work together and collaborate to make the continuum function at its best.

After identifying the characteristics of an ideal continuum, participants worked in seven mixed-provider groups to create separate conceptions of a functionally integrated continuum of care for Canada. Each group then presented their continuum to the full assembly, reviewing each other's work and enhancing their proposals based on mutual learning. Further refinements helped each group test their continuum against mental health, hypertension or diabetes scenarios.

The following report presents further details of the Phase I workshop, including the characteristics of an ideal continuum, the seven proposed continuums and key plenary discussion points related to each group's conception.[†]

Challenge Address

In the challenge address for this initial phase, Canadian Psychological Association CEO Karen Cohen prompted participants to ask themselves what they could do to ensure practical access to the health-care system for all Canadians. In doing so, she challenged all stakeholders in care (i.e., the providers, consumers, funders and agencies that deliver care) to think about the changes that are necessary to deliver care differently. Currently, the publicly funded system supports siloed care (delivered by designated providers in designated venues) rather than collaborative and accessible care across the continuum when and where people need it. While the task of changing this may not be easy, Ms. Cohen emphasized how necessary it is, pointing out that, "even with improvements in efficiency and effectiveness, the status quo may not be sustainable. Change is not an option for Canadian health care — it is a requirement."

The status quo, she noted, which gives us "multiple providers doing the same or similar things serially and in silos and taking time to do it, costs money for systems and taxpayers, creates frustration for providers and intensifies rather than relieves a patient's illness and distress. When care is coordinated, it is responsive, efficient, takes less time, eases patient distress and makes for more successful providers." To illustrate, Ms. Cohen compared a personal, clinical anecdote describing the impact of a failure in health professional collaboration against a second, more successful example.

Challenging participants themselves to work collaboratively in sharing their perspectives and experiences as health providers, she urged them to identify differences and focus on common ground as they moved toward developing a seamless continuum of care. Recognizing that this perspective begins with the best interests of patients, Ms. Cohen noted the extraordinary efforts required of providers for its success and emphasized that optimal health outcomes will demand collaboration among all stakeholders: health providers, funders of care, agencies that deliver care and all of us (who are consumers of care). In closing, Ms. Cohen said: "Accepting change in principle is necessary, but real change will depend on your accepting it in practice. The time for this change has come."

[†] Conflicting statements reflect these proposed continuums and represent differences in participants' perspectives.

CONTINUUM CHARACTERISTICS

Participants worked in small groups to respond to the following question:

“This meeting is an initial step in creating the best health-care continuum possible for health promotion and chronic disease prevention and management in Canada. What characteristics should this continuum have to make it meaningful for health-care providers?”

Example responses were considered from the perspectives of (1) patient/care, (2) provider engagement, (3) system challenges, (4) communication and collaboration, and (5) other factors.

Perspectives:

Patient/Care

- Canadians have already paid for their care — we have to remember this is about them. We can't lose sight of Canadians when talking about provider needs.
- Empower patients to care for themselves. A patient with a chronic disease will spend more time caring for themselves than a provider will.
- Patients want a system they and their families can navigate. We don't need to add expensive staff to do that for them.
- Put customer service for patients at the heart of this. We need to have the right person at the right time looking out for patients — while keeping one step ahead.
- Remember all patient-care settings, e.g., urban, rural and remote.
- The continuum has to fit patients, not the other way around. We aren't a homogenous society and different groups have different models, e.g., the Hmong, Innu and Inuit.
- This focus on the patient has to be the new framework for problem solving.
- Use the words person or health-centered care — avoid 'patient'. We need to be focused on the bigger picture of health — not health care.

Provider Engagement

- All providers need to see their role and have it validated.
- People need to be connected to the services they need, without having to return to a provider. We need commitment and connectivity from a service provider perspective.
- Providers must agree to make a change — starting with the patient and working from there.
- Providers understand that working together collaboratively is the solution.

- Research-provider interactions to enable working together, e.g., interprofessional scheduling, care plans, mechanisms for referral, funding models. Simply putting everyone together in the same building isn't the solution. Collaboration and teamwork will have to be built into the schedule.
- There are many providers who work outside of the hospital who need to be a part of this, e.g., in schools, the criminal justice system, etc.

Patient Navigators

- In a fully functional and integrated system, navigators won't be needed. It will be simple for people to access systems and functions.
- Navigators can't be confined to their local health network.
- While navigators shouldn't be necessary, patients will need a "most responsible" provider to go to, someone who will advise them given their context. Patients ask for someone to help them.

System Challenges

- Build in accountability to patients, the public, providers, systems.
- Build the infrastructure necessary to support collaboration.
- Include ongoing evaluation as part of the process. The entire care provision has to be built on best practice and best evidence.
- Look at cost through the evidence of patient outcomes. Governments tend to look at the short-term bottom line, which often ends up costing more in the long run. Make the tough decisions around feasibility and trade-offs.
- The current reality is one of tightening budgets, with all providers competing for funding. Governments have to be committed to this initiative, and cutbacks need to be shared equally by all providers. We are a team.
- The transition points between elements of care aren't very functional right now, e.g., between acute care and rehabilitation.
- There must be easy access to the appropriate level of high-quality care, 24 hours a day.
- There is tremendous opportunity in leveraging technology and innovations.
- We need to look as much at keeping people out of chronic care and emergency rooms as we do at treating them.

Communication and Collaboration

- Ways to build trust and relationships:
 - Support good communication at the clinician level
 - Making time for communication is critical
 - Teamwork means respect and fairness. Respect among providers and with the public are essential.
 - The desire to work together is exceptionally important. Being aware of others' scopes of practice will reinforce the right message to patients.

Other Factors

- Are we capable of change? The professions have to be willing to make this a reality.
- Are we falling into the same old trap of creating bins of people? The new way of thinking has to be much broader.
- Our continuum must reflect Canadian values and the IHI "triple aim." Our value is in finding the balance.
- The journey to health and through the health system may be conceived as more cyclical rather than as a continuum. Patients go through this journey.

CONTINUUMS OF CARE

After reviewing a list of draft continuum elements at each of the seven tables, participants agreed on a list of contributing factors and access points for an ideal, full continuum of care in Canada.

Contributing Factors

- Access points are representative but do not include all access points.
- Access is both direct (e.g., walk-in) and indirect (e.g., at the points of the continuum).
- Access to the system is available 24 hours a day, seven days a week, and is individual-driven rather than system-driven. The system is accessible from anywhere.
- The continuum allows for multiple fixed entry points, which may not be defined as access points.
- The continuum is outcome oriented.
- The social determinants of health have two dimensions: health-service use and barriers to access.
- The system is driven by communication, coordination, collaboration and access.

Access points

- Chronic disease management
- Convalescence/Rehabilitation/Ambulatory
- Diagnostics
- Disease prevention
- Enablers: family, information, technology, funding, case management, discharge planning, accessibility, case pathways
- Health promotion
- Home care
- Long term care
- Oral health
- Peer supports
- Personal health-care information/record/public health
- Personal health-care team
- Primary health care
- Public health (e.g., promotion/prevention, schools, shopping centres, self-care)
- Secondary care including acute/hospital/medical specialties

- Self-care (information, diagnosis, treatment)
- Type of care, type of provider, location of care
- Unregulated health/service providers (counsellors, therapists, etc.)
- Voluntary community care

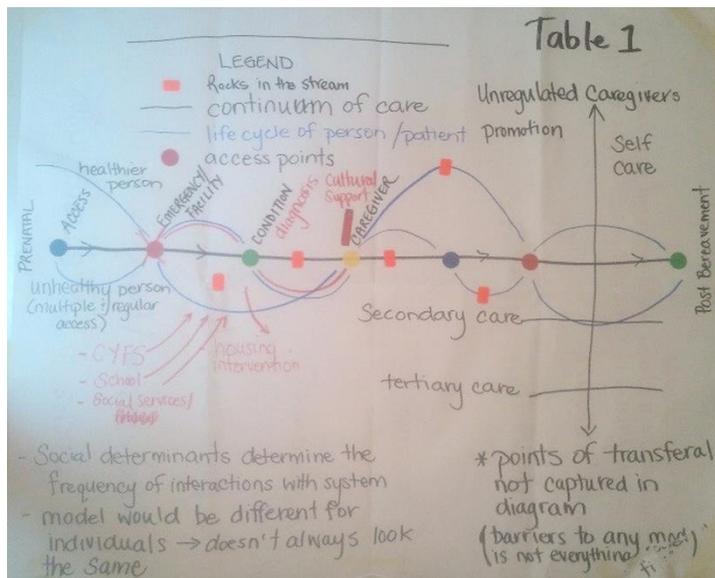
Participants then illustrated their group's access points on an continuum, which included key aspects of the interfaces between these points as well as any parallel continuums or overarching elements. The main focus of the exercise was on "what works on the ground."

Seven proposed continuums were created:

1. Braided River
2. Circles of Health
3. Flywheel
4. Hub and Spoke
5. Music/Sine Wave
6. Parallel Tracks
7. Web

These continuums are provided below in alphabetical order. Following each are key plenary discussion points using, where possible, participants' own words.

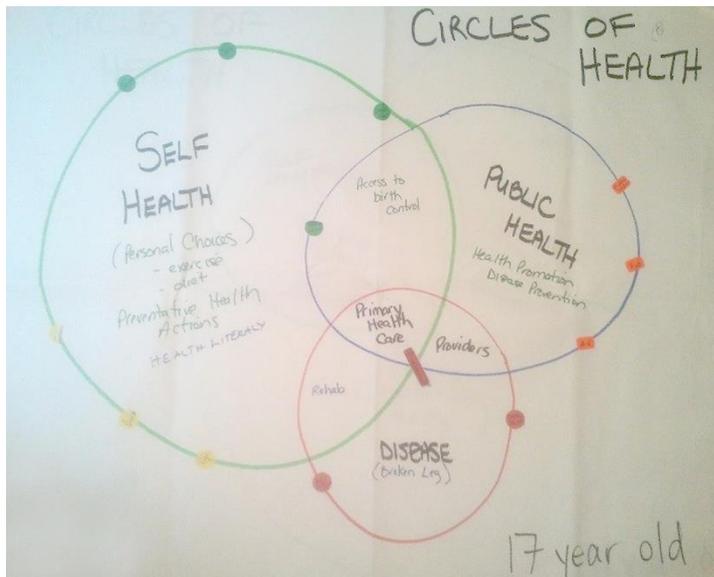
1. Braided River



Discussion Highlights

- Along the points of access there are different professionals and different methods of accessing the system.
- Immunization would be an access point along the continuum. Not all public health is actually an intervention within a more formal system.
- Limitations — the points of transfer aren't captured here: legislation, political influences, third-party payers, systemic and personal factors, geographic barriers.
- Non-regulated health professionals weren't included, but they may be part of self-care.
- Public health seems to move away from this model, but public health can cross into difficult-to-describe aspects, e.g., clean water, safety, etc.
- Self-care and prevention are below primary care. Social determinants determine the interactions with the system. This model will change depending on the patient.

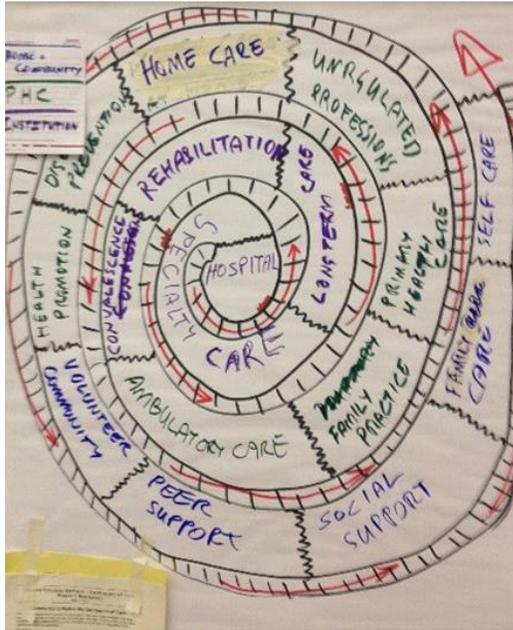
2. Circles of Health



Discussion Highlights

- The circles can be used to predict the use of health-care providers and resources. What is the optimal funding model? Which provider is used when? How will we manage moving a patient over time? How will we allocate resources to each circle?
- The key is the flexibility of the model. Any access point gets the patient the help they need, depending on the situation. The intersection points between providers will also change based on what is required. This model focuses on the future, where there will be more focus on public health and eventually on moving the patient toward self-care. The key is to remove barriers that prevent an individual from moving from one side to the other.
- These models need multi-dimensional modelling to come alive.
- This is not a continuum. Patients may enter and leave at any point. The circles are flexible: moving, rotating, expanding and contracting as patients access the system.
- Time could be added as a fourth dimension.

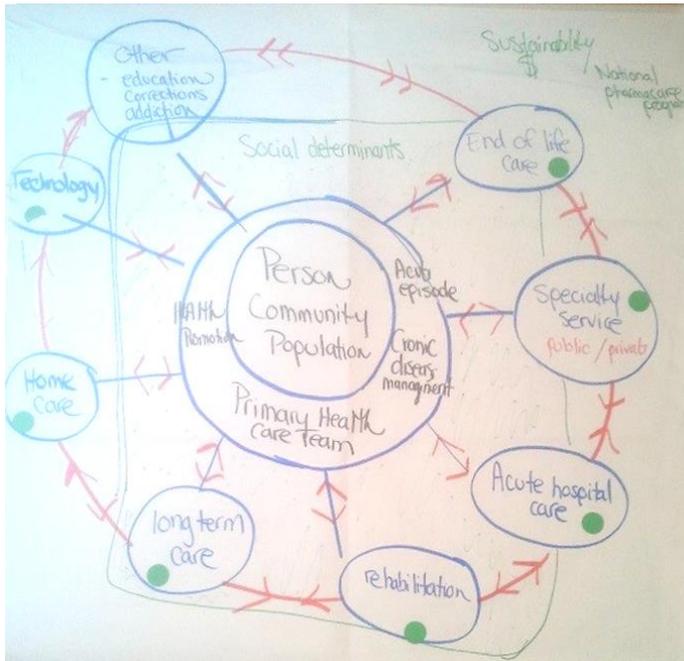
3. Flywheel



Discussion Highlights

- The flywheel uses elements from along the continuum of care to try and map the intensity levels of intervention. The lower the intensity required to care for a patient, the greater the success of the system. Entering the system at any point, the idea is to move them one way without having them spiral backwards.
- As the largest cost driver, having hospitals at the center might lead to more pressure on the system.
- Prevention and promotion happen at many levels of care. The model isn't trying to indicate that a particular piece happens here or there.
- The primary health care team is the access point.
- The system has to be adequately resourced, functionally integrated and shared. Mental health has to be accounted for.
- This is a patient-centred model. Centrifugal force moves you out from the centre, with decreasing intensity of care. The provider team works to move the patient, either to the next level down or to the most appropriate and least intensive level of care required. The primary care team will be kept apprised of the care being delivered.

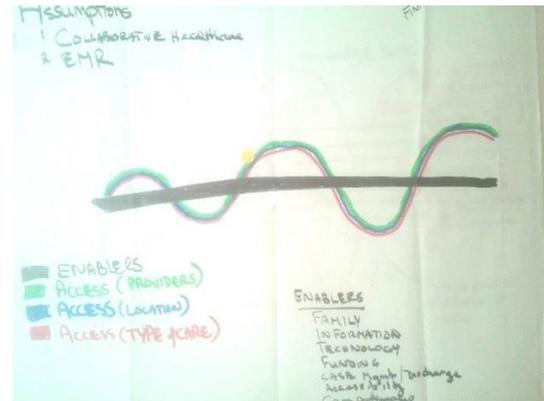
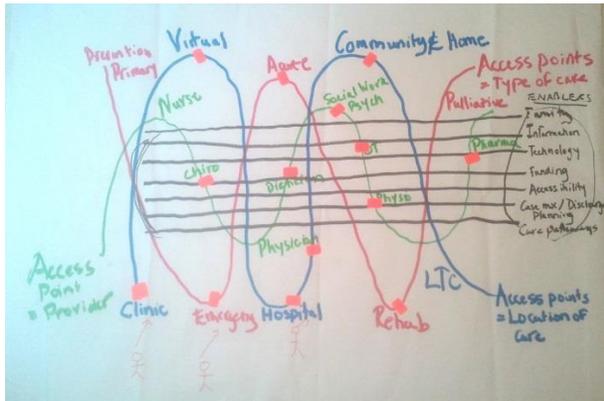
4. Hub and Spoke



Discussion Highlights

- At the centre of this model is the person, community or population. Around its core are health services.
- Providers would all collaborate to meet patient needs.
- Sustainability in terms of cost is important, as is the cost of drugs.
- Technology is an access point — patients should be able to book their own appointments.
- The presence of a national pharmacare program is a key assumption.
- There are a range of access points to the system.

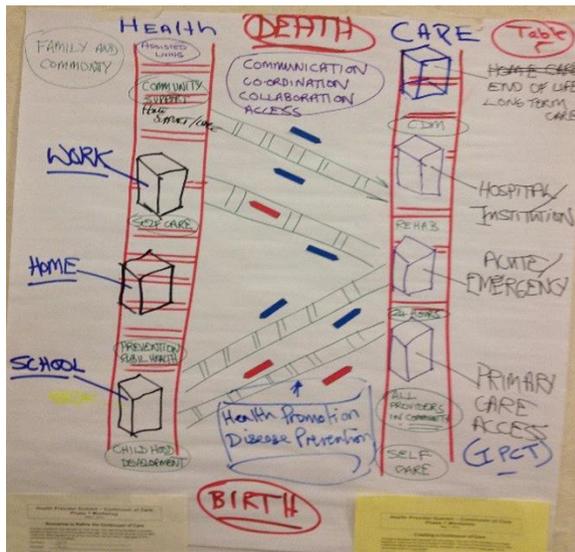
5. Music/Sine Wave



Discussion Highlights

- At the centre of this model is a patient with a family physician who refers that patient for care, e.g., to a wound specialist, to a respirologist, or into diabetes management. Everything is interconnected, and there is a team of enablers supporting the patient.
- It is a lot to ask the patient to get to all these appointments and manage all this care on their own.
- Part of what we created was ideal. When we added the elements of access, it elaborated some aspects of the ideal system.
- The assumption is that there is access to other points of care along the continuum. An ideal system would have multiple points of entry: child, youth and family services; schools; social workers; shelters; psychological assessment, etc. Individuals with no support network can access some kind of support outside of the family.
- The context of the first point of contact is important, e.g., police, ambulance, emergency room. For ease of discussion, this model assumes an urban context of access to care.

6. Tracks



Discussion Highlights

- At the heart of this model is the continuum of life rather than the continuum of care.
- There are passive and active moments along the health route, e.g., nutrition programs. There are some factors that will help to dictate the frequency of interactions.
- The idea is for the patients' health needs to stay on track. Those needs could include the need for primary care.

Process Observations

Dan Florizone, Saskatchewan's deputy minister of health, provided some process observations about this initial workshop, emphasizing current opportunities in health care. Mr. Florizone noted that the Council of the Federation has asked that health providers be engaged in health-system design. Practicality and creativity, as well as small changes that can be incorporated and tested immediately, will be part of moving forward. Forming teams and changing the patient experience are essential to this progress: the continuum of care has to be defined and measured at every step in the patient's journey, and any waiting or waste has to be removed. "Examining the health system from the perspective of the patient will never lead us astray," Mr. Florizone said.

Discussion Highlights

- 20 per cent of primary care is provided through interdisciplinary teams. Raising that percentage will take time, as will new perspectives, e.g., medical students, who now expect to work collaboratively.
- Avoid 'death by a thousand improvements'. If it doesn't make a tangible difference for patients, it isn't an improvement.
- Interdisciplinary models require new models of funding. What are the risks?
- Patient satisfaction isn't enough. There has to be good service, safe outcomes without waits and delays, and high-quality care.
- Taking a "whole-problem" approach allows for a better understanding of patients. We must always look at the problem from the perspective of the patient.
- An emergency room in the U.S. has a door-to-disposition time of 45 minutes. The team comes to the patient as soon as they walk through the door. How can we apply this to Canada?
- We have to do things differently for patients, and to do that we have to work together to prototype and spread new ideas.

CONCLUSION

Jeff Morrison (Canadian Pharmacists Association) closed the workshop by complimenting participants on their significant achievements over such a short period of time. Regarding next steps, he explained that a brief communiqué would be sent to participants and encouraged all to share this information with colleagues. Once the planning committee finalizes and distributes the workshop report, it will convene to explore how to follow through on this initial phase of the summit process.

Mr. Morrison encouraged everyone to keep thinking and talking with colleagues over the coming months about a functionally integrated continuum for Canada and its benefits for both patients and providers.