

OUR CHALLENGE TO YOU

THE GREAT CANADIAN
HEALTHCARE DEBATE

ISSUE BRIEFS TOP 6 MOTIONS

THIRD EDITION | 2017

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Tuesday, June 13, 2017
8:45 to 10:30 am

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The Great Canadian Healthcare Debate offers health leaders a unique opportunity to debate and advance policy resolutions that reflect the current Canadian health system context and address the most pressing issues facing the healthcare system and health leaders today. Chosen by an esteemed Policy Resolution Committee and early bird registered delegates, these are the six motions (in random order) from which conference delegates will select the three motions that will be debated this year.

- A. Patients and families as partners in health** page 3
 Resolved, that Canadian healthcare leaders fully embrace ‘patients and families as partners in health’ to enhance the patient experience, safety, and quality of care, by committing within the next two years to adopt a policy in their institutions for ‘family presence’, allowing patients to designate a loved one(s) as a member of the care team with around-the-clock access.
 SPONSOR: Carol Fancott, Director of Patient Engagement, Canadian Foundation for Healthcare Improvement
- B. National Affordable and Supportive Housing Strategy for Seniors** page 6
 Resolved, that the federal Ministry of Health and the Ministry of Infrastructure and Communities in partnership with the provinces and territories jointly develop an affordable and supportive housing strategy for seniors focused on community living. This action would be achieved through the implementation of research and best practice. The strategy should be ready by June 2018, to be put into action by the provinces.
 SPONSOR: Amy Porteous, VP, Public Affairs, Planning and Family Medicine, Bruyère Continuing Care
- C. National Dementia Strategy** page 9
 Resolved, that in order to address the growing social and economic impacts of dementia, governments in Canada must commit to working with a unified partnership of stakeholders, supported by the Alzheimer’s Society of Canada, to ensure that Canada has a national dementia strategy and Action Plan by 2019.
 SPONSOR: Mimi Lowi-Young, former CEO of Alzheimer Society of Canada, Health Systems Policy and Governance Advisor
- D. National strategy and standards for technologies of choice** page 12
 Resolved, that the Federal Government commit to a national patient technology strategy by 2020 whereby patients and families are able to interact with the healthcare system through technology options of their choice. This strategy will be developed through the identification and risk evaluation of various technologies, and will engage the public for input. Technology options may include historical technologies such as email, texting and videoconferencing as well as technologies not yet developed.
 SPONSOR: Trina Diner, Manager, Palliative Care and Telemedicine, Thunder Bay Regional Health Sciences Centre
- E. Embedding patient safety and quality improvement as core curriculum** page 15
 Resolved, that provincial and territorial Ministries of Advanced Education, in partnership with the regulatory, accrediting, and certifying bodies, commit to patient safety by requiring that all educational institutions in Canada embed patient safety and quality improvement as core curriculum in health profession education programs. Every healthcare provider should enter practice with the ability to provide safe, high quality care, and policy, legislative, regulatory and accrediting bodies should enable practice standards and environments that foster a safety culture and are committed to continuous learning and improvement.
 SPONSORS: Sandi Kossey, Senior Director, Strategic Partnerships & Priorities, Canadian Patient Safety Institute and Maryanne D’Arpino, Senior Director, Safety Improvement and Capability Building, Canadian Patient Safety Institute
- F. Palliative care first approach** page 19
 Resolved, that recognizing that medical assistance in dying (MAID) is a complex and important issue for Canadians, health care leaders support a ‘palliative care first’ philosophy for individuals with life-limiting illness. This philosophy will reinforce the delivery of a consistent, high-quality integrated palliative approach to care by planning for and funding an appropriately skilled and adequately sized health care workforce with knowledge in the palliative approach to care and access to palliative care specialists.
 SPONSOR: Quality End-of-Life Care Coalition of Canada

Prepare to Debate!



We are very pleased to present to you the issue briefs for the top 6 motions going forward to the 2017 Great Canadian Healthcare Debate!

These 6 issue briefs are the result of a process that began in late 2016 when the Call for Motions for the Great Canadian Healthcare Debate was issued. In all, more than 30 motions were considered. The Policy Resolution Committee, whose mandate is to oversee the process and to recommend the top motions that go forward, had the challenging task of identifying the top motions using the criteria significance, impact, interest and ability to action. The process resulted in a list of the top 10 motions, each of which is a strong motion that identifies an important issue in our healthcare system today. You will find them listed in the back of this booklet. Congratulations to each of the top 10 motion sponsors!

This year, conference delegates who had registered by the early-bird deadline were invited to participate in the process of selecting the top 5 motions by telling us their priorities in an online survey. We heard from over 150 delegates! If you were one of the early-bird registrants who completed the survey we hope you enjoyed being engaged in the process. Based on the early bird survey results - the rankings of the motions were very close in some cases - and additional deliberations, the Policy Resolution Committee decided to increase, to 6, the number of motions that will go forward. This decision reflects the sheer number of critical issues facing Canadian health leaders.

On Monday, June 12th, you will be given another important opportunity to engage in this year's Debate. You will be asked to vote on the top 3 motions that will be debated. Your vote will set the stage for an exciting morning on **Tuesday, June 13th**, when the sponsors of the top 3 motions make the case for why theirs is the number one priority.

So, come prepared to debate and make this a dynamic discussion! Conference delegates will have an opportunity to make their voices heard. Read these issue briefs carefully; each sets out very thorough information about an important issue that health leaders are facing today. Formulate some questions and/or comments that you can share. Prepare to support your top motion. Explain why it is your top priority. Tell us how you or your organization can contribute to moving any or all of these motions forward.

Thank you for being part of the Debate!

Tony Dagnone
Chair, NHLC Policy Resolution Committee

A. Patients and families as partners in health

Resolved, that Canadian healthcare leaders fully embrace ‘patients and families as partners in health’ to enhance the patient experience, safety, and quality of care, by committing within the next two years to adopt a policy in their institutions for ‘family presence’, enabling patients to designate a loved one(s) as a member of the care team with around-the-clock access.

SPONSOR: Carol Fancott, Director of Patient Engagement, Canadian Foundation for Healthcare Improvement

ISSUE:

Patient and family-centred care is a key dimension of healthcare quality, and is noted in mission statements, visions and strategic plans of healthcare organizations world-wide. Engaging with patients and families and involving them in care fosters partnerships with providers, focusing care on the needs and preferences of patients. Yet despite the aspirational desire to develop such partnerships, obstacles continue to persist, including structural barriers imposed by institutions when visiting hour policies separate families and other loved ones during hospital stays. Isolating patients at their most vulnerable time from the people who know them best places them at risk for medical error, emotional harm, inconsistencies in care, lack of preparedness for the transitions of care, and unnecessary costs^{1,2}.

Restrictive visiting policies perpetuate historical patterns of paternalistic healthcare, where ‘professionals/providers know best’. Families are not visitors in the lives of patients. Families are partners in care, and are the eyes, ears and voice for the patient at their most vulnerable moments, providing the necessary support that is essential to patients’ health and well-being. Family presence policies enable patients, if they choose, to designate family members or other caregivers to have unrestricted access to them while they are in hospitals. Open access allows family members to be present to participate and communicate with providers during activities such as team rounds, shift reports at the bedside, discharge planning, and during transitions in care. Family presence allows us to gain allies for improved quality, safety, and patient experience of care. Implementing such policies is a practical step to make care more patient and family-centred, although it can be a huge cultural shift for many organizations. Over 90% of Canadians are supportive of family presence policies, yet a 2015 study showed that less than one third of large Canadian acute care hospitals had accommodating visiting policies.³

BACKGROUND:

Healthcare facilities have long held beliefs that the presence and participation of families interferes with care, exhausts the patient, places undue burden upon families, or spreads infection. However, there is no current evidence to support those beliefs.^{4,5} Rather, at these times when patients are most vulnerable and in some cases incapacitated due to acute cognitive or physical decline⁶ and unable to participate in care, the need for family presence becomes more imperative, as family members and other loved ones may be more keenly aware of changes in the patient’s status, and therefore become a valuable resource during hospitalization.

In fact, emerging evidence supports the adoption of family presence policies in institutions. The participation of families brings benefits for patients, healthcare providers, and the family members themselves. For patients and family members, there is evidence that supportive family presence policies can decrease patient and family anxiety⁷, improve experience and satisfaction with care⁸, and help maintain cognitive function among elderly patients⁶. Such policies may also militate against medication errors promote improved medication adherence, and lower the risk of falls⁹ and other accidents. Nurses have noted their assessments and care planning were better informed with the input of family members.¹⁰⁻¹² At an organizational level, evidence suggests readmission rates can decline by as much as 25% when family members are actively involved in discharge planning¹³. Benefits can also include reduced lengths of stay and emergency department visits¹⁴, improved coordination of care¹⁵, and improved organizational culture.

Engaging with patients and families has been considered “the blockbuster drug of the century”.¹⁶ The Federal Advisory Panel on Healthcare Innovation identified patient engagement and empowerment as one of the five most promising areas of innovation with the potential to sustainably reduce growth in healthcare spending while leading to improvements in the quality and accessibility of care.¹⁷ Evidence is mounting to indicate that indeed, partnerships with patients and families improve the quality, safety, and experience of care, and the introduction of family presence policies supports such partnerships.

CONSIDERATIONS:

The move to family presence is not about downloading responsibility to families. Rather, it is about considering families as partners in care. To make this shift requires the engagement of patients and families in the process of change together with providers, and it requires adequate resources to deal with this change. What started as a grassroots movement in patient and family-centred healthcare organizations such as Kingston General Hospital and Alberta South Health Campus is now sweeping the country. The provinces of Saskatchewan, New Brunswick, and Prince Edward Island have instituted family presence policies in all their hospitals, partnering with patients, families, and providers as they have implemented these changes. The Canadian Foundation for Healthcare Improvement (CFHI) has supported many organizations since 2014, when it launched the 'Better Together Campaign' in partnership with the US-based Institute for Patient and Family Centered Care (IPFCC), to encourage healthcare organizations to adopt and implement family presence policies.

In Canada, the campaign is supported by thirteen leading organizations including Accreditation Canada, Patients Canada, the Academy of Canadian Executive Nurses, the Canadian College of Health Leaders and four provincial quality councils. Over 50 organizations, including the provinces of Saskatchewan, Prince Edward Island, and New Brunswick, have now taken the pledge. CFHI has resources available to support organizations that want to make this change. The momentum continues to grow as more and more organizations join this movement, but there is still more work to do. The ability of designated loved ones to have open access to patients while in hospital should be readily available to all, regardless of where one is admitted across the country. Family presence policies are an innovation that can have a profound impact on the culture of organizations delivery in health services and can catalyze patient and family-centred care.

NEXT STEPS:

The adoption of family presence policies represents a culture change for many healthcare organizations and is a practical step toward delivering more patient and family-centred care. The desire for change needs to be articulated from all stakeholders – including governments and healthcare leaders, providers, patients and families. As a pan-Canadian organization, CFHI is committed to sharing its resources, and encouraging dialogue among provinces, territories, and health regions in support of this move to family presence. Organizations interested in publicly demonstrating their commitment are encouraged to take the 'Better Together Pledge', which indicates a commitment to at least one of the following, in partnership with patients, families, clinicians, and other staff: (1) A review of their organization's current visiting hour policies and website; (2) the development of a family presence policy; and (3) the implementation of this policy and monitoring of its impacts. Canadians across the country need to start the conversation about family presence within their own hospitals or healthcare organizations, and if they are able to identify a loved one to stay by their side around the clock in their time of need if they so choose. The momentum is building...the time for change is now.

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This brief was prepared in collaboration with the Canadian Foundation for Healthcare Improvement.

B. National Affordable and Supportive Housing Strategy for Seniors

Resolved, that the federal Ministry of Health and the Ministry of Infrastructure and Communities, in partnership with the provinces and territories, jointly develop an affordable and supportive housing strategy for seniors focused on community living. This action would be achieved through the implementation of research and best practices in collaboration with all levels of government and the health and housing sectors. Furthermore, the strategy should be ready by June 2019, to be actioned by the provinces and municipalities.

SPONSOR: Amy Porteous, Vice President, Public Affairs, Planning and Family Medicine, Bruyère Continuing Care

ISSUE:

National and provincial leadership is needed to create and implement affordable community-based living models for seniors. Keeping and supporting seniors in the community for as long as possible before they have to rely on institutional care should be a top priority for many reasons. Community-based living refers to a full continuum of options including independent living, assisted living, congregate living, long term care or retirement living and community supports on one site. Research and practice shows that community-based living supports dignity, autonomy, mental and physical health. It also makes a lot of sense economically. Simply stated, in Ontario, acute care costs approx. \$1000/day whereas assisted living costs approx. \$55/day. Many people are waiting in hospital for an alternate level of care (ALC), which could be provided at a much lower cost within a community setting. This would allow for acute care to be provided to people who need it plus Canadians would be happier at home or in the community than in hospital or institutional living, while also maintaining or even improving functionality. Finally, there are examples of this already working in seniors' communities all across the country, which we could learn from to develop a framework for all.

BACKGROUND:

This motion tackles some of the alarming trends associated with the aging population: rising rates of chronic disease and disability, homelessness among seniors in Canada, ALC and quality of life; and proposes a new way of looking at the issues and solutions through an affordable and supportive community living model. The statistics are staggering and something has to be done to address this or else our health system, that we so value, will no longer be sustainable. The case is complex and multi-faceted.

For the first time in Canada's history, there are now more people over the age of 65 than there are under the age of 15, according to Statistics Canada. The cohort of people over the age of 65 is large and growing faster than the rest of the age cohorts. The population growth rate for people over 65 increased by 3.5 percent; four times faster than the population at large. Many people over the age of 65 are living healthy for the majority of their lives. However, statistics also show that the older we get, the more likely we will be managing a chronic disease and the more likely that we will need some degree of support - either in the home or in an institutional setting. Statistics Canada data shows that the prevalence of disability increases steadily with age: 2.3 million working-age Canadians (15 to 64) or 10.1%, reported having a disability in 2012, compared to 33.2% of Canadian seniors – those aged 65 or older. This is, therefore, a trend we must pay attention to.

Another important factor we need to look at is housing and homelessness among Canada's seniors. The World Health Organization states that there are many determinants that impact health; one of them is housing. In fact, "evidence of health impacts focus on improvements in housing and improved mental health and general health". The National Shelter Study showed that 8.3% of residents of shelters are 55 and over. This study also documents the reasons that seniors can become homeless, including the lack of income to pay for housing (low government assistance, insufficient pensions, low wages and/or savings), the shortage of affordable and secure housing and deteriorating physical and mental health. A national affordable and supportive housing strategy focused on community living would address each of these areas and would cost the system less in the long run.

Another major issue in Canada is high rates of ALC; 7,500 or 14% of acute care hospital beds are inappropriately used across Canada each day. Over a single year, the use of acute hospital beds by ALC patients exceeds 2.4 million days. The Canadian Institute for Health Information (CIHI) defines ALC as 'patients in acute care hospitals who no longer need acute services, but are waiting to be discharged to a setting more appropriate to their needs'⁷. While ALC patients are waiting for a number of destinations, long term care (LTC) is consistently the one with the longest wait times. Data suggests that to place all seniors

already on the waiting list for LTC, more than 130,000 beds will be required by 2021 - an almost 75% leap in bed capacity. Costa et al., demonstrate that in Ontario, most of the ALC patients who are waiting for LTC placement may be more appropriately cared for in the community setting given adequate community resources. In fact, across Canada, an estimated 30-50% of ALC patients could benefit from supportive home care and be discharged from hospital. In addition, waiting in hospital is not the best place for people due to deconditioning, increased exposure to infection and lack of socialization and engagement, to name a few. To this end, in 2012, the Drummond Report was released and stresses that when we keep seniors over the age of 80 years inactive and immobile for more than 5 days, we remove their ability to be active for the rest of their lives. The report concludes that the best care for seniors is care provided as close to home as possible and recommends more resources be allocated to community-based care. So why aren't we looking at this?

Another barrier to transition back to community living is affordability. I challenge you to sit down with a room full of discharge planners and social workers for hospitals. Due to lack of affordable living options, people are being placed on waiting lists for LTC. Unlike private retirement homes, LTC home beds across Canada are publicly subsidized based on income. A recent study by Dr. Peter Tanuseputro looked at the neighbourhood income of people who enter LTC in Ontario and stated "there is definitely a gradient – overall, those living in poorer neighbourhoods (a proxy for individual income) end up in LTC much more often than those in the richest neighbourhood (22.9% versus 14.8%, respectively of those who enter LTC)". This makes a lot of sense. There are plenty of options for people who have the ability to pay. If you look at the retirement industry in Ottawa alone, rental rates are, on average, \$4000/month for basic services. Our housing system has also provided options for affordable housing for the lowest income earners through affordable housing programs (albeit still in high demand) but what about the rest of Canadians? What are they to do?

There is also an economic case to be considered. In Ontario, the average cost for care within an acute care hospital is approx. \$1000/day, compared to chronic/rehab care at \$550-750/day, long term care at \$155-170/day and assisted living at \$55-70/day. Studies by Jonathan Patrick PhD show that provision of alternate care in the community would cut wait times at a lower cost.¹³ The math is simple. Diversion from hospital has the potential to save the system millions. But how do we do this?

The final and most powerful argument around the need to develop an affordable and supportive community living framework is that it supports dignity, autonomy, mental health and physical health. People do not want to be waiting in hospital or taken care of in LTC unless they absolutely have to. With support for the activities of daily living, many people can remain in their homes. It is even better if they can do this in a community living environment where they can stay active, engaged and socialized.

I believe that these alarming trends can all be addressed through a national affordable and supportive housing strategy. We do not need to look at how we can better support people after their acute care visit but instead focus on keeping people as healthy and as well as possible and in the community for as long as possible. We need to think differently. What I'm advocating to do is to create the necessary supports before people require acute care, which includes a continuum of care and services (e.g. affordable and supportive housing, community support programs, LTC, congregate living) in a community setting. The need for socialization and engagement is great and contributes to one's overall health. This cannot be forgotten in any national strategy for housing and supports.

CONSIDERATIONS:

Based on the evidence above, we cannot do more of the same and expect to get a different result. Where government and health care leaders need to invest their time and energies is to learn from the models that are currently working in the field, get buy in from all levels of government and sectors - namely health and housing - and roll out a national framework to help facilitate these affordable and supportive community living models.

There are thriving seniors' communities across Canada that demonstrate this innovative approach – both in the for-profit and not-for-profit sectors. Seniors are living within a continuum where they can get varying levels of care and services depending on need. Many of these communities allow people to remain autonomous for as long as possible. They also allow for couples requiring different levels of support to remain living in the same setting e.g. one in independent living and one in LTC on the same site. The key differentiating factor is that they need to be affordable or available on a sliding scale, depending on income.

The Bruyère Village and the Perley and Rideau Veterans Health Centre are excellent examples of this model in action. Both are not-for-profit organizations that provide different levels of housing (independent living, assisted living and LTC on one site) with affordable housing built within the model along with community support programs available onsite for tenants and for the

surrounding community. It is economically sustainable insofar as there are different rents available based on the ability to pay. Other continuums worth studying include Christie Gardens in Toronto.

Finally, a national affordable and supportive housing strategy for seniors can address rising costs associated with aging while meeting the basic human needs by emphasizing quality of life in a community living model with appropriate supports. The evidence is already out there. All that is required is to put it into a framework that can be actioned. It really does take a village to care for our seniors.

NEXT STEPS:

In order for this to strategy to work, the Ministry of Health and the Ministry of Infrastructure and Communities must jointly develop an affordable and supportive housing strategy for seniors focused on community living. This strategy would need to be developed through engagement of federal, provincial and municipal governments and the health and housing communities through the implementation of research and best practices. Furthermore, the strategy needs to be ready by June 2019 to be actioned by the provinces and municipalities, facilitated by the funding envelopes that have already been announced around affordable housing for seniors.

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This brief was prepared in collaboration with Bruyère Continuing Care.

C. National Dementia Strategy

Resolved, that in order to address the growing social and economic impacts of dementia, governments in Canada must commit to working with a unified partnership of stakeholders, supported by the Alzheimer's Society of Canada, to ensure that Canada has a national dementia strategy and Action Plan by 2019.

SPONSOR: Mimi Lowi-Young, former CEO of Alzheimer Society of Canada, Health Systems Policy and Governance Advisor

ISSUE:

Every three seconds, someone in the world will be diagnosed with dementia. In fact, 3 out of 4 Canadians know someone with dementia. More than a half million Canadians currently have dementia and that number will double in less than 15 years. There are currently no effective pharmacological treatments for dementia. Dementia has far reaching impact on the social fabric, the economy, and health system of Canada; \$10 billion a year is spent on direct and indirect care. Recently-released 2016 census data by Statistics Canada shows that seniors now outnumber young people in Canada and more people will be living beyond 80 - the risk of dementia doubles every five years over the age of 65. Dementia carries substantial stigma which prevents individuals with the condition and their families receiving timely diagnosis, care and support. Available resources are exceptionally limited and Canada has no plan to deal with escalating numbers of people with dementia. Twenty-nine countries have a national dementia strategy or plan – including the United States and the United Kingdom. Canada is one of only two G7 nations that do not have a strategy in place. The time has come for the federal government to act quickly and decisively.

BACKGROUND:

According to Alzheimer Disease International, a dementia plan or strategy is the single most powerful tool to transform care and support. These strategies elevate dementia as a national priority and provide a framework for addressing this growing public health problem. The experiences of countries that have dementia strategies show that coordinated and targeted action at the national level delivers results.

Rising Tide, a report commissioned by the Alzheimer Society of Canada in 2010 with input from key subject matter experts, initiated a national conversation that discussed the impact on Canadian Society. It produced data for the first time regarding the prevalence, incidence and economic burden of dementia. It also described best practices for models of care and prevention strategies.

Also In 2010, the federal government funded the *National Population Health Study on Neurologic Diseases* at a cost of \$15 million dollars. In 2014, the report resulting from the study, "*Mapping Connections*", was released. It had minimal impact because no action was taken by the federal government in response to the recommendations in the report.

Again in 2014, a case statement and framework for a national dementia strategy was prepared and presented by the Alzheimer Society of Canada to the federal government, asking for a commitment of resources. This proposal was based on the Canadian government's commitment at the G8 dementia summit. The government signed a resolution to find a disease-modifying therapy by 2025 and to establish national dementia strategies.

In October 2014, provincial and federal ministers of health agreed to establish a national dementia plan. This was a significant milestone. However, there was no follow-through.

In October 2015, country representatives of the Pan American Health Organization (PAHO) voted unanimously in favour of a Regional Plan of Action on Dementia. The Regional Plan of Action obliges countries to develop national action plans. Canada was a signatory to this document. According to a news release by Alzheimer's Disease International directly after this meeting, "National dementia plans remain the single most powerful tool to transform national dementia care and prepare for the global dementia epidemic." Among PAHO member countries, dementia plans are in place in Costa Rica, Mexico, Argentina and the U.S., with Chile expected to announce their plan soon.

The Senate of Canada has also demonstrated how serious the matter of dementia is for Canada by publishing a report based on the interview of over 100 subject matter experts and individuals with dementia. *Dementia in Canada: a national strategy for dementia-friendly communities* (2016) articulates what actions are required with 29 recommendations including direction to establish a National Dementia Strategy and Action Plan.

The World Health Organization has now recognized that dementia is a public health crisis. This has become a Declaration proclaimed by the WHO providing direction to member states regarding planning for dementia strategies and plans.

The actions related to Alzheimer disease and dementia by the federal government has been extremely limited. The Canadian Consortium on Neurodegeneration and Aging (CCNA) was created by providing funding of \$23 million for 350 researchers. Other affiliated charities and the private sector have contributed to research. Extensive leading edge research is being undertaken in Canada, for example by the Krembil Institute (UHN) and CCNA. Although these organizations have provided excellence in research, there is limited coordination, knowledge translation and exchange is somewhat rare and the impact on change in clinical practice and service delivery is minimal.

The consequences of the lack of action by government are devastating. Examples of this impact are: overcrowding in emergency departments; 70% of residents in long term care have Alzheimer's Disease or other dementias and are receiving inadequate care; limited home and community care to support caregivers; and lack of skills and training of the health profession in dementia care.

All of the relevant data indicates that government action must occur NOW before the inaction causes disarray to the social fabric of Canada. As a country, we will never be able to build enough long term care beds or have adequate community services to accommodate those who will need this care, unless alternative models of care are implemented, additional support is available to care givers, and extensive research for disease modifying therapy are not actively pursued now.

Other countries have implemented national dementia strategies with commitment to research, models of care, stigma reduction and timely, early diagnosis. Countries that have excelled in research include the U.S., which has allocated close to \$300 million for research, and the U.K., which is also committing large sums to research programs as well as creating dementia friendly communities. The Netherlands has also implemented many strategies focused on care and research.

Understanding that urgent action is needed, on February 3rd, 2017, Bill C-233, "An Act respecting a national strategy for Alzheimer Disease and other dementias" (a Private Member's Bill introduced by Conservative MP, the Honourable Rob Nicholson), received third and final reading in Parliament. This is an important but small step forward.

CONSIDERATIONS:

Alzheimer's Disease and other dementias have devastating and far-reaching health, social and economic consequences. These neurologic conditions continue to impose a significant burden on thousands of Canadian families. According to the Organization for Economic Cooperation and Development (OECD) (2015), "Dementia receives the worst care in the developed world." There exists no option for Canada but to create a national dementia strategy and action plan by building a coalition of provinces and federal governments to agree on the allocation of dollars from the designated \$3 billion for home and palliative care. This funding would be allocated to care for people with dementia as well as substantially increasing funding for research (revamp CCNA) and impact training and education of health professionals through a national standard to focus on screening and early diagnosis. The government needs to acknowledge that the data is clear and conclusive and that action is required now. Here are some of the considerations;

- Dementia starts 15 – 20 years before the first symptoms appear.
- Canada has an aging population; the risk of getting the disease increases with age.
- The economic impact is now over \$8 billion per year and is expected to double in less than 15 years.
- The number of people with the disease is expected to double in less than 15 years.
- The number of visits by individuals with dementia to emergency rooms will result in more overcrowding due to lack of necessary and appropriate care in the community.
- There are over 335 types of dementia with Alzheimer's Disease being the most common (approx. 60%).
- Dementia is a progressive neurodegenerative disease which may last up to 15 years.
- No action in the immediate future will continue to place enormous pressure on the Canadian economy.

- Regardless of potential push back from the provinces, as they feel health care delivery is in their jurisdiction and would view the national dementia strategy as superfluous, the federal government still needs to proceed with the development of a national dementia strategy.
- A National Dementia Strategy will give the federal government an ability to hold the provinces accountable for the allocation of the "home and palliative care" dollars, with a specific portion allocated to the care of and service delivery to individuals with dementia and their families.

NEXT STEPS:

- Royal assent and passage into law of Bill C233, *An Act Respecting a National Strategy for Alzheimer's Disease and Other Dementias*.
- Establish the Canadian Alzheimer's Disease and Dementia Partnership.
- Allocate \$30 M per year for 5 years.
- Identify the necessary leadership to provide action to create a National Dementia Plan and Action Plan
- Convene first meeting of stakeholders to include relevant neurological charities, The College of Family Physicians of Canada, The Canadian Medical Association, The Canadian Nurses Association, The Canadian Consortium on Neurodegeneration and Aging, Representatives from health organizations representing Indigenous communities, appropriate provincial government representatives, representatives from the federal government (Public Health Agency of Canada, Finance, etc.), people living with dementia and their carers, home care and long term care providers.

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- Reports from the Alzheimer Disease International

This brief was prepared in collaboration with Mimi Lowi-Young MHA, Dip.Admin., FACHE, FCCHL, former President and CEO of the Alzheimer Society of Canada.

D. National strategy and standards for technologies of choice

Resolved, that the Federal Government commit to a national patient technology strategy by 2020 whereby patients and families are able to interact with the healthcare system through technology options of their choice. This strategy will be developed through the identification and risk evaluation of various technologies, and will engage the public for input. Technology options may include historical technologies such as email, texting and videoconferencing as well as technologies not yet developed.

SPONSOR: Trina Diner, Manager of Telemedicine, Thunder Bay Regional Health Sciences Centre

PURPOSE:

National debate is needed on the use of technology in healthcare. As one example, email has been used in society for 20 years, yet has not been integrated effectively within healthcare. Citizens should be enabled to interact with the healthcare system by means of their choosing, for example, by scheduling appointments on the web, and by using email or texting. Privacy experts may disagree. However, it should be an individual's choice if and what information can be shared electronically. The barriers to health care using technology need to be thoughtfully weighed against perceived privacy risks. This includes communication tools as well as video technologies.

ISSUE:

Imagine being able to have a five-minute video appointment with your doctor, wherever you are. Your doctor may then order tests and have you connect with them again by video for the results. Your doctor then asks you to make an in-person appointment, which you book on the web. Imagine connecting by video using software you are familiar with using - Facetime or Skype for example - from wherever you are to the doctor when she/he arrives at your mother's bedside at the hospital. Imagine reading a text from the homecare worker who just left your father's house. The text says, "Saw your dad this morning, he is doing well". These options are realistic and available now.

The majority of medical errors are caused by communication breakdowns; 55% of medical errors involve miscommunication between providers and patients. To enable communications between patients and the healthcare system, a national patient technology strategy should be developed. To adopt a patient-centred approach to technology, a mass customization theory should be employed, whereby services are tailored to suit the individual needs of a customer by using flexibility and a user's choices within the process. This will enable providers, patients and families the best access options for communications with each other through technology and risk tolerance of the user. This will enable a tremendous increase in variety and customization without a corresponding increase in costs. The debate should include differentiating between organizational risk and individual risk tolerance for sharing information over electronic media. Leveraging technology can help serve to increase access to care, decrease errors, reduce patient and family stress, and increase patient and provider satisfaction by allowing communication to be used in ways adopted by society at large.

In a Canadian survey released by Newad, over 54% of Canadians have a smartphone, 86% of students text every day and over 92% of students own a laptop computer. In addition to text and email, the 2015 Canadian Telehealth Report published by COACH, Canada's Health Informatics Association, shows that videoconferencing varies widely across the country, with some provinces accessing no video capabilities, and one province, Ontario, conducting hundreds of thousands of appointments per year by videoconferencing. Access to care should not depend on where one lives in Canada.

BACKGROUND:

This issue exists due to multiple factors in modern society including the increased use of internet and cellular technology juxtaposed against privacy laws and healthcare funding models. Solutions developed through this initiative will complement the Canadian government's science and innovation agenda, which is about making things better in ways that benefit everyone. The innovation agenda will support ideas that can be transformed into simple solutions that result in new services. Innovations can create entirely new jobs, markets and industries that never existed before. And they can give existing industries a new lease on life by making them more productive and efficient.

Strong privacy laws were introduced to protect patient information housed by organizations and providers so that it cannot be accessed outside of the direct care of the patient. This has led to varying degrees of usage of technology and software between

clinicians, patients and across provinces. A thoughtful national discourse on what technologies and information can be shared through which mediums will ensure access for all Canadians at a risk level acceptable to Canadians.

Other jurisdictions have found ways to move forward. For example, Kaiser Permanente in northern California reported that 110 million interactions were done using mobile communications in 2016. Over half were via smartphone, videoconferencing, kiosks and other technology tools.

CONSIDERATIONS:

Pros:

- All Canadians would have more accessible healthcare options
- Reduced medical errors
- Increased trust and satisfaction in the healthcare system for patients, families and providers
- Canadians and physicians/clinicians having clear guidelines
- The rights of Canadians to interact with the healthcare system through their own choices
- Economic savings, reduced time taken for appointments for clinicians, patients and families
- Reduced travel (whether rural or urban)

Cons:

- Lack of understanding of risks versus benefits for information and pay structures
- Risk tolerance of organizations and individuals
- Need for change management of healthcare providers

Sustainability will be achieved by leadership guiding this debate and an outcome which incents provincial/territorial governments to adopt a patient technology strategy. This may mean guidelines or legislative changes.

NEXT STEPS:

A committee of individuals seeking to recommend solutions and focused on enabling modern and widely used technologies needs to be struck by the federal government, led jointly by leaders in innovation and health. The group will make recommendations for a patient technology strategy and adoption framework and forward those recommendations to the federal government. Using similar vehicles will influence adoption across provincial/territorial landscapes. Stakeholders should include:

- Passionate health technology leaders;
- Government of Canada;
- Statistician/Expert in risk analysis;
- COACH leadership (specifically regarding telemedicine technologies);
- Privacy Commissioner leadership;
- Canadian Medical Association;
- NHLCC Co-Sponsors - HealthCareCAN and the Canadian College of Health Leaders;
- Provincial/territorial and/or federal governments; and
- The general public.

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This brief was prepared in collaboration with Trina Diner, Manager of Telemedicine, Thunder Bay Regional Health Sciences Centre.

E. Embedding Patient Safety and Quality Improvement as Core Curriculum

Resolved, that provincial and territorial Ministries of Education, in partnership with the regulatory, accrediting, and certifying bodies, commit to patient safety by requiring that all educational institutions in Canada embed patient safety and quality improvement as core curriculum in health profession education programs. Every healthcare provider should enter practice with the ability to provide safe, high quality care, and policy, legislative, regulatory and accrediting bodies should enable practice standards and environments that foster a safety culture and are committed to continuous learning and improvement.

SPONSORS: Sandi Kossey, Senior Director, Strategic Partnerships & Priorities, Canadian Patient Safety Institute and Maryanne D'Arpino, Senior Director, Safety Improvement & Capability Building, Canadian Patient Safety Institute

PURPOSE:

Primum non nocere – First, do no Harm. Patient safety is already embedded in health professional curriculum, thanks to several national health organizations and faculties who have taken on the mantle and inserted patient safety content into their standards and educational outcomes. Work on embedding patient safety and quality improvement (QI) science into curriculum has begun. However, patient safety and QI education is fragmented, and has as many silos as other aspects of healthcare. Conversations have started to happen, but the “tipping point” has not yet been reached to make health professions education the transformational agent it has the potential to be to effect culture change in academia and practice settings, to save lives by making the system even safer for patients. Reducing avoidable harm is why patient safety matters! A sobering reality is that the majority of health professions students graduate ill-prepared to work effectively with other health disciplines to uphold well-known patient safety and QI standards. Yet, most health practitioners will, at some point in their career, unintentionally contribute to harming the patients they are intending to help.

ISSUE:

Patient safety and QI have moved from the periphery to the forefront of healthcare in Canada over the past decade. Every healthcare provider needs to be able to *First, do no Harm*. They need to provide care and to improve care to ensure that patients receive safe, high quality care. Yet, despite a growing recognition of the need to embed patient safety and QI in every aspect of healthcare education, approaches to teaching healthcare students and providers are inconsistent, insufficient, and the effectiveness of the education that is given is still open to debate. Though improvements in patient safety education have been made, our collective wisdom tells us there is much more to be done; we have a long way to go to incorporate patient safety and QI into all health professionals' curricula. This shortfall continues to place patients at risk during their care, e.g. preventable harm in hospitals, home care, etc. Healthcare providers go to work trying to do their very best for the patients they serve, but we will not serve them well if they are not prepared with the basic knowledge and skills to ensure safe care.

Everyone within healthcare is responsible for patient safety and QI, but who is responsible for what gets included in curricula and licensing requirements? Who is assessing whether academia is providing this training? The Canadian Patient Safety Institute believes the key to professional excellence is in mandated standards to get patient safety and QI education firmly established in colleges and universities in the health professions. Any one of a number of levers can be used to push patient safety and QI competencies in the health professions - from regulation, accreditation of programs, professional certification and licensure, to collaboration with provincial and territorial ministries of education (through health professions legislation) and provincial quality councils. Only through a combination of mandated requirements and moral suasion can the effectiveness of education and training in patient safety and QI be measured and ultimately tested. Like seatbelt and bicycle helmet legislation, goodwill can only get you so far.

The challenges of integrating safety content and QI into curricula can at times feel monumental, despite the passion and commitment of academics and clinical educators who are trying to move the patient safety education agenda forward within their institutions. Scarce resources, competing priorities, packed curricula are but a few of the hurdles to integration. When confronting this reality, several important questions arise. There is no shortage of effective patient safety curricula – why is it so hard to influence curricular changes? Do we have enough faculty with the necessary abilities to properly train the next generation of clinicians? Do our learning environments support and reinforce what is taught in the classroom and practice settings about patient-centered care, just culture, interprofessional teamwork, disclosure, transparency and system learning? The answer to these questions, broadly speaking, is...not yet, not consistently, not sufficiently.

BACKGROUND:

Until 2008, at least in Canada, there was no unified understanding of what patient safety meant in terms of competencies required of those in practice or those in training programs. The Canadian Patient Safety Institute, in collaboration with the Royal College of Physicians and Surgeons of Canada, published the *Safety Competencies Framework* that define the concrete skills, behaviours and attitudes required of healthcare professionals to provide safe patient care. Yet, despite substantial uptake by the field, many healthcare professionals, as well as professional bodies, remain unaware that this framework even exists.

Safety Competencies

Contribute to a Culture of Patient Safety
 Work in Teams for Patient Safety
 Communicate Effectively for Patient Safety
 Manage Safety Risks
 Optimize Human and Environmental Factors
 Recognize, Respond to, and Disclose Adverse Events

Several national organizations, important levers for influence and change in the education of health professionals as accrediting, certifying or regulatory bodies, have already taken up the challenge to review their national entry-to-practice standards or educational requirements to align them to a set of patient safety competencies: the Medical Council of Canada, Royal College of Physicians and Surgeons of Canada (*CanMEDS 2015*), Canadian Association of Schools of Nursing, Association of Faculties of Pharmacy of Canada, and National Association of Pharmacy Regulatory Authorities.

Each of these organizations has already determined the extent to which safety competencies are incorporated into their instruments for the assessment of students, to identify gaps in content and address the shortcomings to ensure appropriate emphasis on the teaching and learning of patient safety and QI. In addition, the Canadian Physiotherapy Association and the Canadian Association of Occupational Therapists have each issued position statements in support of including safety competencies into their curricula. These collaborations have supported the integration of safety content into academic programs by influencing the requirements governing certification or entry into professional practice. Expecting programs to be accredited and students to be examined and licensed based on training in patient safety and QI can only contribute to faster and more comprehensive integration of patient safety into curricula.

The BC Patient Safety & Quality Council created a post-secondary academic working group to bridge the gap between healthcare education and practice, to *“Build Quality Care from the Ground Up.”* The Health Quality Council of Alberta (HQCA) has dedicated time and many resources to its Quality and Safety Education Framework (formerly the Blueprint Project) to develop content in patient safety and QI that should be incorporated into educational programs at all levels. In environmental scanning, HQCA found that few programs teach a systems approach to patient safety and QI.

CONSIDERATIONS

Students and new members of the healthcare team have the potential to act as strong positive change agents. Faculty and educators, from the top down, should encourage this potential for generational change as patient safety and QI leaders.

Capacity building is needed to educate the educators with building content, curricula and instructional design with creative delivery methods that will allow educators to more readily uptake this type of training and not have to reinvent the wheel. Educators need tools and resources to assist in teaching patient safety as it is not easy to do without conviction and understanding. Faculty need to understand what “quality” and “safety” mean, and how to teach them. They should have learners doing hands-on QI projects and interacting with harmed patients and their families. However, educators are already dealing with crowded curricula and training programming, so the ability to embed patient safety and QI into existing curricula is key. In fact, patient safety competencies and QI should never be seen as add-ons to curricula. They should be incorporated and overlaid in the most appropriate and useful manner across all relevant learning objectives, and tiered along the novice to expert continuum. The good news is that the current curricula of health professions already have a great deal of patient safety content, by virtue of what it takes to be a health professional. The challenge is to make it more explicit by matching patient safety and QI competencies to current learning objectives and curricula, to identify gaps in coverage and highlight the needs for faculty development. Canada could be among the leaders to demonstrate the importance of using the levers in education to prepare

the next generation of practitioners to become patient safety champions because they consider patient safety and QI content to be a natural part of their curriculum.

NEXT STEPS

The concerted efforts of educators and organizations invested in the education of health professionals will have monumental influence in changing the world of patient safety.

There is no shortage of effective patient safety curricula. So, why is it so hard to influence curricular changes? Clearly, the major challenge is with implementation. Levers of regulation, accreditation and certification must more broadly influence how the training of health professions evolves to meet the 21st century needs of our patients, health providers, and populations. The future does not rest only on building new curricula, or refining the language of existing patient safety educational frameworks. That will lead to incremental change at best. Every healthcare provider should enter practice with the ability to provide safe, high quality care without fear of retribution. The necessary patient safety and QI competencies to achieve this already exist. Stakeholders must work together to ensure that these curricula are embedded in health profession education across Canada and are not undermined in practice settings. That agenda can only move forward with the collaboration and strong leverage of regulators, accreditors, certifying bodies, and provincial/territorial ministries of education who should be pushed to exert their influence on the required content of the curriculum in the various faculties, and within the hospital community where students are training and practicing.

Guiding frameworks, strategies that are discipline specific and locally adapted for implementation, models, and national standards would serve to support faculty as they work to embed patient safety and QI into already packed curricula. Spread and sustainability can be achieved by demonstrating how organizations like the Royal College of Physicians and Surgeons of Canada, the Canadian Association of Schools of Nursing, and the National Association of Pharmacy Regulatory Authorities have been able to influence curriculum for future health practitioners. Integration of content into curricula could also be supported by existing provincial education ministries involving input from schools and professional organizations, and the licensing authorities charged with introducing core curriculum on patient safety and QI. An inter-professional/inter-organizational approach of this nature could end the current patchwork approach, minimize duplication, foster cross-pollination, and demonstrate interprofessional collaboration at the highest levels.

To advance this motion, a concentrated effort is needed by the levers mentioned above within each of the professions - they are the major players and doers. The latter, perhaps encouraged by government funding, as was the case for the integration of interprofessional competencies into curricula, must put in place the essential mechanisms to change practice standards so that they explicitly include patient safety and QI competencies into curricula. Faculty will then be better positioned and supported to develop the mandated content.

There are still many barriers involved such as: the challenge of gaining acceptance from each of the national and provincial/territorial bodies that hold sway, the potential cost in time and complexities of implementation, and the intrinsic resistance to change. However, the role of regulators of self-governed health professions is to promote public safety. If they aren't ensuring safety and QI as standards for accreditation, certification and licensing, they are doing their profession and the public a disservice. Ultimately, success in embedding patient safety education into curricula rests on the willingness of like-minded individuals and organizations with the power and influence to effect change so that future generations of health professionals have a solid foundation in patient safety science and QI at the start of their careers.

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This brief was prepared in collaboration with the Canadian Patient Safety Institute.

F. Palliative care first approach

Resolved, that recognizing that medical assistance in dying (MAID) is a complex and important issue for Canadians, health care leaders support a ‘palliative care first’ philosophy for individuals with life-limiting illness. This philosophy will reinforce the delivery of a consistent, high-quality integrated palliative approach to care by planning for and funding an appropriately skilled and adequately sized health care workforce with knowledge in the palliative approach to care and access to palliative care specialists.

SPONSOR: Quality End-of-Life Care Coalition of Canada (QELCCC)

PURPOSE

The way we die needs to change. The importance of hospice palliative care is currently front and centre for Canada’s aging population, including in the context of discussions and debate on the complex issue of medical assistance in dying (MAID) following the passage and implementation of legislation at the federal, provincial and territorial levels.

ISSUE

Across Canada, we are seeing a wave of change in care for people of all ages faced with frailty and/or chronic life-threatening illnesses and choices at end of life. Palliative care services – once only offered in the last days or weeks of life to people designated as dying – need to be better integrated with treatment services to enhance people’s quality of life throughout the course of their illness or the process of aging. Despite the fact that most Canadians would prefer to die at home and that only a small proportion need intense tertiary care in the last days or weeks of life, most (67%) still die in hospital. It is crucial that a palliative approach to care is delivered by inter-professional teams with access to specialists as needed and supported with the skills, knowledge and confidence to meet the wishes of individuals and their families to live well until dying - whether at home, in long-term care settings, in residential hospices or hospitals. Everyone has the potential to benefit from the growing willingness to acknowledge that dying is part of living, and that people deserve and should receive the integrated palliative approach to care at all stages along their illness trajectory and in all settings of care.

BACKGROUND

An “integrated palliative approach to care” requires thinking differently about care for people of all ages living with life-limiting illnesses and near the end of life based on a number of relevant issues. Those issues include:

1. **Significant changes in illness trajectories.** Canadians are now more likely to survive heart attack or a cancer diagnosis, and to live for several years with chronic illnesses or increasing frailty. With advances in medical technology, children are now surviving with complex illnesses and experience life threatening illness for their entire lives. Although *when* people will die is less predictable, they will still experience the same losses throughout their illness trajectory (e.g. pain, loss of mobility and other functions, physical and mental limitations, loss of roles and relationships). They and their families would benefit from palliative care services such as psychosocial support and pain and symptom management that can enhance quality of life. Being diagnosed as “close to death” should no longer be the trigger for Canadians to receive these services. Bereavement services may be difficult to find in many areas of the country.
2. **The cost of “futile” treatments at end of life.** Growing data on the cost of health care services show that our health systems spend a significant amount on procedures in the last days or weeks of a person’s life that offer little benefit and sometimes increase the person’s discomfort. A closer look at these interventions has shown that many occurred simply because many people did not have advance care plans and health care providers were hesitant to have open transparent conversations with individuals and families about the prognosis or the benefits and risks of those interventions.
3. **Increasing health care costs and pressure to manage them.** Faced with rising health care costs and pressure to manage and control budget increases, health care systems are making concerted efforts to reduce the use of costly hospital services and provide more care in the community. This disconnect between the care that people want and need and the care that they actually receive is due largely to a shortage of community providers who are skilled in the palliative approach to care and the lack of supports for family caregivers who – given changing illness trajectories – are often providing care for a loved one for years.

4. **Consumer advocacy.** As our population ages, more people are speaking out about the kind of care they want as they near end of life. They are advocating for services that focus on quality of life as well as options that allow them to die “at home” wherever that may be.
5. **A growing focus on advance care planning.** Over the past few years, a number of Canadian jurisdictions have actively promoted advance care planning – encouraging primary care providers to talk to their patients about the kind of care they want. However, the process itself raises expectations that the home- and community-based care people want will be available as they age – which is currently not the case in many parts of Canada. Those expectations are another pressure for change.

To address these issues, the QELCCC (made up of 39 national associations and organizations) and the Canadian Hospice Palliative Care Association (CHPCA) advocated and received funding from the Government of Canada to create *The Way Forward*. This national initiative worked with federal/provincial/territorial governments, the non-profit and charitable sector and communities to move beyond the politics of health care by leveraging existing networks of agencies and organizations to develop a national framework for action.

CONSIDERATIONS

The Way Forward developed practical and implementable tools and resources to help policy makers, health planners and service providers make changes and make them more quickly, including:

- a clear definition of the integrated palliative approach to care;
- a policy paper that explained the concept and the rationale for the integrated palliative approach;
- a summary of the literature;
- descriptions of innovative models of the integrated palliative approach to care already in place and working around the world;
- analyses demonstrating the cost-effectiveness of the palliative approach to care;
- surveys of Canadians, family physicians and nurses working in primary care to understand their attitudes and perspectives; and
- a framework or roadmap to implementing the integrated palliative approach to care with clear action steps for sectors, health care settings and providers.

The national framework or roadmap was structured in a way that had three key strengths.

1. The framework was developed as a draft and then used as the basis for consultation with people at all levels in the health care system – provincial/territorial ministries, regional health planners, health professional associations, local service providers and consumer groups. Not only did it provide a roadmap for implementing the integrated palliative approach to care, it became the way to engage people in the conversation.
2. The framework included sector specific actions. It laid out the steps that each sector could take to shift the system to an integrated palliative care approach. We were able to check with people working in all sectors and ask key questions such as: does this make sense to you? Does this reflect your reality? Will this work in your sector? Is anything missing?
3. The framework reinforced that change is organic and can start anywhere. It doesn’t need to wait for provincial policy or the kind of province-wide initiative launched by Alberta. It can begin in a primary care practice, a home care service or a long-term care home. The goal of the framework was to empower people throughout the health care system and give them the tools to be able to start where they are and act now.

NEXT STEPS

- CHPCA and the QELCCC members will continue to be a catalyst for change. Until all Canadians of all ages, with all diagnoses have access to the integrated palliative approach to care including bereavement across settings and people are comfortable having conversations about the kind of care they want towards the end of life, these organizations will keep pushing.
- Federal, provincial, territorial governments and regional health organizations and professional colleges/associations need to continue to support health-care providers through the change management process and culture shift.
- There also needs to be much closer integration between two inter-related initiatives: the integrated palliative approach to care and advance care planning. Each needs the other to actually meet Canadians’

expectations that they will have the kind of care they want and need when faced with a life-threatening chronic disease or frailty, and each needs to be fully and effectively engaged in by Canadian citizens and professionals.

- The integrated palliative approach can start anywhere in the system. Organizations can begin this process through multiple actions:
 - Developing policies that help shape organizational culture and help promote the integrated palliative approach to care and advance care planning.
 - Establishing a shared vision and goal.
 - Setting clear expectations for all providers and staff, including ongoing education.
 - Developing tools and guidelines that help providers integrate the palliative approach to care – including those related to advance care planning.
 - Forging strong relationships with other services and settings to help deliver palliative care.
 - Communicating clearly with the health care providers, the public and patients about the palliative approach to care.

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This brief was prepared in collaboration with the Quality End-of-Life Care Coalition of Canada.

“Top 10” Motions - 2017 Great Canadian Healthcare Debate

(in random order)

National strategy and standards for technologies of choice

Resolved, that the Federal Government commit to a national patient technology strategy by 2020 whereby patients and families are able to interact with the healthcare system through technology options of their choice. This strategy will be developed through the identification and risk evaluation of various technologies, and will engage the public for input. Technology options may include historical technologies such as email, texting and videoconferencing as well as technologies not yet developed.

National Affordable and Supportive Housing Strategy for Seniors

Resolved, that the federal Ministry of Health and the Ministry of Infrastructure and Communities in partnership with the provinces and territories jointly develop an affordable and supportive housing strategy for seniors focused on community living. This action would be achieved through the implementation of research and best practice. The strategy should be ready by June 2018, to be put into action by the provinces.

Frailty Screening

Resolved, that healthcare leaders transform the care of frail Canadians through systematic frailty screening of high risk populations, implementation of care plans appropriate for the degree of frailty, and public reporting of quality of care indicators for those who are frail.

Patient and families as partners in health

Resolved, that Canadian healthcare leaders fully embrace ‘patients and families as partners in health’ to enhance the patient experience, safety, and quality of care, by committing within the next two years to adopt a policy in their institutions for ‘family presence’, allowing patients to designate a loved one(s) as a member of the care team with around-the-clock access.

National Dementia Strategy

Resolved, that in order to address the growing social and economic impacts of dementia, governments in Canada must commit to working with a unified partnership of stakeholders, supported by the Alzheimer’s Society of Canada, to ensure that Canada has a national dementia strategy and Action Plan by 2019.

Public accountability for federal home and community care investments

Resolved, that to ensure the intended goal of universal access to high-quality, national, publicly-funded home- and community-based care is achieved, the federal government develop and implement an accountability framework linked to strategic home care funding by December 2017.

Embedding patient safety and quality improvement as core curriculum

Resolved, that provincial and territorial Ministries of Advanced Education, in partnership with the regulatory, accrediting, and certifying bodies, commit to patient safety by requiring that all educational institutions in Canada embed patient safety and quality improvement as core curriculum in health profession education programs. Every healthcare provider should enter practice with the ability to provide safe, high quality care, and policy, legislative, regulatory and accrediting bodies should enable practice standards and environments that foster a safety culture and are committed to continuous learning and improvement.

Private pay health care systems to co-exist with the universal health care system

Resolved, that the Federal Government commit to allowing provinces and territories to improve health care outcomes by allowing private pay health care systems to co-exist, legally, in parallel with our universal health care system.

Palliative care first approach

Resolved, that recognizing that medical assistance in dying (MAID) is a complex and important issue for Canadians, health care leaders support a ‘palliative care first’ philosophy for individuals with life-limiting illness. This philosophy will reinforce the delivery of a consistent, high-quality integrated palliative approach to care by planning for and funding an appropriately skilled and adequately sized health care workforce with knowledge in the palliative approach to care and access to palliative care specialists.

Make suicide a “never event”

Resolved, that over the next 5 years, health care leaders across the country will articulate and infuse the fundamental tenet throughout their workforces that a suicide death is an unacceptable outcome of its care, and build a culture that strives to make suicide a “never event.”

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