SEVEN YEARS IN…

A FORWARD-LOOKING REVIEW OF PROGRESS ON ACCESS & WAIT TIMES AS WE LOOK TO A 2014 HEALTH ACCORD

A SUBMISSION TO
THE STANDING SENATE COMMITTEE
ON SOCIAL AFFAIRS, SCIENCE & TECHNOLOGY
SEPTEMBER 2011

SUBMISSION TO THE STANDING SENATE COMMITTEE ON SCIENCE, TECHNOLOGY & SOCIETY
ASSOCIATION OF CANADIAN ACADEMIC HEALTHCARE ORGANIZATIONS
SEPTEMBER 29, 2011

WHO WE ARE...

- ACAHO is the national voice of Research Hospitals, academic Regional Health Authorities and their Research Institutes. The Association represents more than 40 organizations, with members ranging from single hospitals to multi-site regional facilities.
- Members of ACAHO are the leaders of innovative and transformational organizations who have overall responsibility for: (1) provision of timely access to a range of specialized and some primary health care services; (2) training the next generation of health providers; and (3) are leaders in research discovery and the early adoption of innovation in the health system.
- There are no other organizations in the health system which provide the unique integration of patient care, teaching, and research & innovation that our members do. Our members are vital "hubs" in the health system - in addition to being a national resource.
- The mandate of ACAHO is provide national *leadership*, *advocacy* and *policy representation* when it comes to the role of the federal government improving the performance of the health system; and advancing the impacts of health research and innovation in the delivery of health care to all Canadians.

OUR VISION & MISSION…

Vision*: To advance patient care and the health & well-being of Canadians through research discovery and innovation.*

Mission*: To create an environment in which research discovery, innovation and learning benefit patients, populations, health systems and the economy.*

ACAHO BY THE NUMBERS....

- Total operating budgets of ACAHO members was over $24 Billion (2008/09)
- Received close to 15 million outpatient visits (2010)
- Treated 5.5 million visits to their emergency departments (2010)
- Had 1.4 million hospital admissions (2010)
- Trained more than 55,000 health providers (2007)
- Employ more than 350,000 Canadians (2008/09)
- Enjoy the support of more than 53,00 volunteers (2008/09)
- Total research budgets stood at $1.8 Billion (2009)
- Are the primary affiliation for more than 2,700 scientists (2007/08)
- More than 11,000 peer-reviewed publications (2007/08)
- $5 million in license income from research discoveries was generated (2003/06)
- 312 patents were issued (2007/08)
- 65 spin-off companies were created (2007/08)
- Over 200 licenses were issued (2007/08)
- 415 disclosures were made (2007/08)

Importantly, ACAHO members are the organizations that provide a range of procedures that are exceptionally complex & rare – such as organ transplants, care for trauma patients, and life-saving surgery for neonatal infants. Members also care for a greater proportion of patients who have complex and severe illnesses.

For more information on the activities of the Association, please visit our website at *www.acaho.org*.

EXECUTIVE SUMMARY

ACAHO remains supportive of the 10-year plan which recognizes many of the dynamic and complex components of the health system. Given the breadth of policy issues covered in the 2004 Accord – of which there are ten – it is fair to say that seven years in, the Agreement has not been an unqualified success nor an unmitigated failure. Rather, we are of the view that the Accord has contributed to different rates of progress across the country depending on the policy issue in question.

When it comes to issues of access and wait times, ACAHO believes that while important progress has been achieved, and is outlined in the Association's three *Wait Watchers'* Reports, there is more work that needs to be done to improve access and wait times, overall system performance and its measurement. In addition, as the country's academic healthcare organizations, we believe that there is an important opportunity to make a significant difference in the health and wealth of Canadians by taking what we have learned to date from the 2004 Accord and applying this knowledge to the future.

In specific terms, this Brief highlights innovative approaches that ACAHO members have generated and adopted to improve patient flow in the system. These extend beyond the five priority areas to across the continuum of care. These case studies demonstrated how with focused attention and the use of applied research and innovation we: save more lives by addressing emergencies quickly and correctly; serve more patients within the same resources and physical constraints; reduce unnecessary days from the length of hospital stay for patients; and improve patient and family satisfaction and participation in the care process.

The breadth of applied health system innovations that were used to achieve these improvements included: (1) process mapping; (2) the implementation of new staffing roles; (3) the generation and use of best practices and care pathways; (4) communication tools and new protocols; (5) collaboration between different sectors, segments of the care continuum, and organizations within the health system; and (6) the active and deliberate involvement of patients and families in the care process.

These real-time innovations occurring at the local level across the continuum of care are playing an important role in improving the manner in which patients are *prioritized*, the *speed* in which they move through the system, and underscore how different parts of the system need to be *aligned*.

Furthermore, the clear and consistent theme is that wait times are improved only through the management of access in the context of quality and appropriateness. Increasing access is not simply about seeing more people in a fixed amount of time; it's about ensuring that the right people are seen by the right practitioner, in the right place, at the right time and with the best possible health outcomes.

Looking beyond the areas of progress and the areas of priority focus in this Brief, we also identify a series of remaining challenges that need to be addressed head-on if we are to further improve access and wait times. These include: (1) improve access to appropriate post-acute care capacity so that it meets the needs of those who are aging, have chronic disease or who have mental health needs; (2) integrate primary health care and supportive care services into the full continuum of care; (3) target and invest in select public health, health promotion and illness prevention areas; (4) modernize physical space and health delivery infrastructure; (5) increase availability of health practitioners and mentors in hospital and community-based settings; (6) leverage the impact of health information technologies on improving access; (7) generate and use data and research to guide decision-making and stimulate applied system innovation; and (8) invest in change management strategies.

As we move towards a 2014 Health Accord, the key policy question is what is the role of the federal government and how can it invest close to an additional $2.0 Billion in a way that maximizes their return-on-investment and the health of Canadians? Furthermore, what kind of accountability framework should be in place so that we can effectively link *sources* of funding with their *uses*, and report to the public on *outcomes*?

Considering the nature of the access and wait time issues that need to be further addressed, we believe that the eight challenges require focused efforts in identifying and applying the mechanisms to stimulate integration and the application of innovation.

To advance the public policy dialogue, ACAHO is initially offering 5 recommendations that focus on the potential role of the federal government in the context of 2014. In addition to the equal per capita cash that will be invested across all provinces and territories, three of these are for time-limited, issue-specific, strategically-targeted Funds designed to accelerate renewal in key areas of the system.

When it comes to improving accountability and system performance, ACAHO believes "*That the federal, provincial & territorial governments continue to develop comparable national health indicators and benchmarks for all priority areas related to access and wait times, and that they be publicly reported on an ongoing basis."* **Recommendation #1.**

The Association also proposes that we need to re-frame the performance of the health system away from issues solely related to its "sustainability", and focus on how we can improve quality and overall system performance. In this regard, the Association recommends *"That the federal, provincial & territorial governments extend the development of comparable national health indicators and benchmarks across the continuum of care focused on the dimensions of quality."* **Recommendation #2.**

While we talk about reducing the impact of over-crowded emergency departments, this is only the symptom. The real issue is the lack of capacity to move people appropriately through the continuum of care because of problematic post-acute care resources and poor attention to preventative and supportive measures. Can the 2014 Health Accord act as a catalyst to ensure post-acute care, supportive, and preventative care strategies, facilitate integration of primary health care with the rest of the health care system, and enable change from older to newer models of care? Is their an opportunity to move forward with new models of primary health care that directs patients to their primary care provider and away from the emergency department?

Given that close to 1 in 5 hospital beds are being occupied by those who do not require hospital care (known as ALC patients), we must find innovative solutions so that the 20% of hospital beds occupied by ALC patients can be used more effectively. To do so, we need to ensure that they are discharged into the appropriate setting be it their own home, a long-term care facility, a nursing home, rehabilitation institute, or chronic care facility, with the appropriate supports and with the intention of preventing readmissions. In the context of academic health sciences centres, it is in part for this reason that the report of the National Task Force on the Future of Canada's Academic Health Sciences Centres ("*Three Missions...One Future*") recommended a movement to “academic health sciences networks”. These networks will provide integration structures for both care processes and future training and research. In addition to the structures however, resources are needed.

ACAHO therefore recommends *"That the federal government, in close consultation with the provinces & territories, create a Team-Based Primary Health Care Fund"* (**Recommendation #3**) and *"That the federal government, in close consultation with the provinces & territories, create a Community-Based Health Infrastructure Fund"* (**Recommendation #4**).

These may be issue-specific, strategically-targeted funds designed to move beyond pilot projects and accelerate the creation of primary health care teams, and the creation of an infrastructure fund to assist in the development of post-acute care capacity, coupled with tax policies designed to defray expenses associated with home care.

Finally, as we discuss, we have more capacity for the generation and use of research and innovation in this country, than we are currently leveraging. We recognize that there are a significant number of "pockets of excellence" when it comes to innovative ways in which high-quality, cost-effective care is delivered to Canadians. That said, one of our ongoing challenges is to find more effective ways in which we can share these applied health system innovations from coast-to-coast-to-coast in real time. In other words, these innovations need to be driven *horizontally* across the country.

One way to do so is to consider establishing a "*National Health Innovation Fund*" (**Recommendation #5**), of which one of its stated objectives would be to promote the sharing of applied health system innovations across the country with the goal of improving the delivery of quality health services. To support this, Canada has academic healthcare organizations with tripartite mandates of patient care, training and research that are prepared and mandated to facilitate the generation and use of research and innovation for improving patient care, health system performance, and the overall health of Canadians. This concept could be closely aligned with the work of the Canadian Institutes of Health Research in developing a Strategy on Patient-Oriented Research (SPOR).

Combined, we believe our recommendations, taken together, focus on strengthening the *structure* of the health system, the *process* by which we improve the cost-effectiveness of delivering care, and improving overall health *outcomes* by focusing on system performance through the prism of quality.

Furthermore, our recommendations are designed to articulate a practical and effective leadership role for the federal government as we move towards 2014 with a specific strategic focus on accountability, value-for-money and system performance.

INTRODUCTION

When preparation meets opportunity, great things can happen. ACAHO commends the Senate Standing Committee on Social Affairs, Science Technology for taking the opportunity to hear evidence in assessing the progress of the 2004 Health Accord and in preparation for the 2014 discussions. We believe that the 2014 Health Accord is yet another opportunity to make a significant difference in the health and wealth of Canadians. As such, ACAHO is pleased to respond to the Senate Committee's invitation to present our future-oriented views of access and wait times and to present some preliminary thoughts on what elements could form part of the 2014 Health Accord.

In the first part of our Brief, we focus on a discussion of access and wait times. We present a brief discussion of what we know about wait times and where progress is being made; with a specific focus on three major groupings of activity we identify and discuss some important policy challenges that we need to address if we are to move the next level of excellence; and offer our thoughts where the federal government can take action in the areas of access, wait times and overall system performance in lead-up to the discussions to a 2014 Health Accord.

SETTING THE CONTEXT

When the 2004 Health Accord was agreed to, it is important to recall it was not only supported by all First Ministers, but all three National Political Parties in this country. In other words, there was no "policy daylight" at the federal level regarding the merits, focus and structure of the Accord and its potential to drive health system renewal. At the time, it was an important statement of intent in terms of what the federal, provincial and territorial governments could agree on a range of priority issues that needed to be addressed over the life of the Agreement.[1]

Equally important, the Accord clarified the federal government's roles and responsibilities vis-à-vis the health system not only as a *steward*, but as a *funder* and an *enabler* of innovation. It also set out important timelines and deliverables to be achieved at the provincial and territorial level. Furthermore, the time-honoured principles of transparency, public accountability and value-for-money are explicitly weaved throughout the Accord.

ACAHO remains supportive of the 10-year plan which recognizes many of the dynamic and complex components of the health system. Given the breadth of policy issues covered in the 2004 Accord – of which there are ten – it is fair to say that seven years in, the Agreement has not been an unqualified success nor an unmitigated failure. Rather, we are of the view that the Accord has contributed to different rates of progress across the country depending on the policy issue in question.

When it comes to issues of access and wait times, ACAHO believes that while important progress has been achieved, and is outlined in the Association's three *Wait Watchers'* Reports, there is more work that needs to be done to improve access and wait times, overall system performance and its measurement. [2] [3]

1. A LAY OF THE LAND ON ACCESS & WAIT TIMES

Of all of the strategic policy issues that are part of the discussion around the future of the health system (e.g., sustainable funding, adequate number of health providers, scope-of-practice issues, patient safety and quality of care, innovative delivery models, public-private interface, to name a few) the public reporting of wait times is the most important barometer by which Canadians perceive the performance of the system. This is expected given that it is an easily understood indicator that speaks to the most important concern facing Canadians in relation to the health system; having timely access to a range of quality health services in times of need.

However, as much as we focus on wait times as an important performance indicator, we know that it is an output measure that is dependent on at least three categories of inputs within the system, these include: (1) the capacity or supply of services and resources in the system; (2) the need and demand for these services; and (3) the many factors that fit in between such as prevention and promotion, social determinants, appropriate discharge protocols and transition of patients into the right setting, eliminating inefficiencies, and engaging families in decision-making.[4]

Within and across these three areas there are a number of common, but diverse approaches that have been evolving. Many of these innovations across the country are outlined in ACAHO's *Wait Watcher I, II, and III* reports[5] and have resulted in some of the progress seen in the priority areas of the 2004 Health Accord.

Notwithstanding the variation in strategies, the clear and consistent theme is that wait times are improved only through the management of access in the context of quality and appropriateness. Increasing access is not simply about seeing more people in a fixed amount of time; it's about ensuring that the right people are seen by the right practitioner, in the right place, at the right time and with the best possible health outcomes.[6]

In the next section we will discuss some of these strategies and successes.[7]

Progress Where We Measure, Manage, Focus & Invest

Data from a number of sources suggest that Canada's choice to select and focus on improving access to care in a number of priority areas has made a positive difference.[8] In December 2005, Health Ministers issued wait time benchmarks of 26 weeks for hip and knee replacements, surgical repair of hip fracture within 48 hours, surgery to remove cataract within 16 weeks for patients of high risk, cardiac bypass surgery within 2 to 26 weeks depending on the urgency of care, and radiation therapy to treat cancer within four weeks of patients being ready for treatment.[9]

The Canadian Institute for Health Information's (CIHI) recent report, *Wait Times in Canada*, a province-by-province comparison concluded that 8 out of 10 patients across Canada received these priority procedures within the identified benchmarks. That includes 83% of cataract patients, 84% of hip fracture patients, 79% percent of patients needing knee replacements, 78% of patients needing surgery for a hip fracture; 98% of patients needing radiation treatment and 99% of patients needing bypass surgery.[10]

As noted by the Health Council of Canada, this is a good start.[11] It suggests that we have made important progress; that we have improved our capacity to measure and monitor access, and that a large majority of patients in these areas are getting care where and when they need it. It also tells us that the involvement of the federal government, not necessarily in prescribing the changes, but in incenting and providing strategic focus, is important. As we move forward, it will be important to review and improve the benchmarks, find news areas of strategic focus and improve our capacity to understand variation across provinces and territories.[12]

Innovations in Patient Flow Improve Access to Care & System Performance

While the federal government has provided leadership in five critical areas – ACAHO member organizations have worked diligently with their respective provincial and territorial governments to make the most of these opportunities – our responsibilities go beyond the priority areas.[13] As academic healthcare organizations, with a mandate and vision of *generating* and *using* research and innovation to improve care and health outcomes, we are deliberate about finding new ways to ensure quality, appropriateness and access for all of our patients.[14]

In 2009, ACAHO's 42 member organizations provided descriptions of 45 measurable improvements and innovations in patient flow that helped to improve timely access to care.[15] These case studies demonstrated how with focused attention and the use of applied research and innovation we could: save more lives by addressing emergencies quickly and correctly; serve more patients within the same resources and physical constraints; reduce unnecessary days from the length of hospital stay for patients; and improve patient and family satisfaction and participation in the care process. The breadth of applied health system innovations that were used to achieve these improvements included:

1. process mapping;
2. the implementation of new staffing roles;
3. the use of best practices and care pathways;
4. communication tools and new protocols;
5. collaboration between different sectors and organizations within the health system; and
6. the active and deliberate involvement of patients and families in the care process.

These innovations were captured and posted on the ACAHO web-site so that we could share best practices across the country; describe how to replicate them; and demonstrate progress and accountability.[16] Detailed quantitative and qualitative measures of the outcomes are provided in ACAHO's *Wait Watcher III* report **("***Order & Speed, Improving Access to Care Through Innovations in Patient Flow***")** and in the cases themselves, but they may be summarized broadly as relating the following areas:

- ***Ensuring access to primary care*** by improving access to clinics and developing a broad-based system level change in the way specialized medical care is accessed. Sample outcomes included: (1) better integration between physicians and specialists; (2) the ability to see more patients; and (3) better disease screening and better prevention.[17]
- ***Preventing more emergencies where and when we can*** by facilitating access to screening and assessment within an emergency department and in community settings using nurse practitioners. Sample outcomes included: (1) the reduction or avoidance of emergency department visits and hospital re-admissions; (2) better pain and risk management; and (3) more appropriate utilization of resources.[18]
- ***Helping to get patients from 911 to the Emergency Department*** by ensuring that ambulances reach hospitals that have sufficient institutional capacity to take patients and by providing expedited treatment protocols. Sample outcomes included: (1) a reduction in the number of times an ambulance is re-directed to another hospital; and (2) faster ambulance offload times to hospital.[19]
- ***Moving patients through the emergency department*** by rethinking physical space, mapping processes and making improvements. Sample outcomes included: (1) an increase in the number of patients that can be seen per month; (2) length of time it takes to attend to each patient, the percentage of patients that are seen within a specific target among other improvements.[20]
- ***Addressing emergencies that occur elsewhere in hospital*** by reducing the time needed to complete urgent consults and improving the flow of patients into and out of the Intensive Care Unit (ICU), sample outcomes included: (1) the ability to safely care for patients in need of ICU services; and (2) faster times for the completion of urgent consults.[21]
- ***Taking a system-wide approach to improving access/discharge planning*** by improving communication, coordinating the journey and the support services required, implementing new staffing roles, facilitating inter-organizational collaborations and measuring and monitoring critical indicators. Sample outcomes included: (1) the reduction of alternate level of care (ALC) days; (2) a reduction in paperwork; and (3) better coordination through the health care system.[22] [23]
- ***Taking a condition-specific approach*** to patient flow by setting benchmarks, developing care-pathways and protocols for paediatric surgery, mental health, cancer, cardiac services, bariatric clinics, and musculoskeletal services. Sample outcomes included: (1) more appropriate utilization; (2) better screening; (3) improved patient and family participation; and (4) increased capacity.[24]

These real-time innovations that are occurring at the local level across the continuum of care are playing an important role in improving the manner in which patients are *prioritized*, the *speed* in which they move through the system, and underscore how different parts of the system need to be *aligned*.

The *Generation* of Research & *Applied* Innovation

Between January and June of 2011, the Canada Health Reference Guide and the Globe & Mail ran close to 160 success stories featuring the impact of health research and innovation from ACAHO's 42 member organizations.[25] These innovations highlight the unique role that academic healthcare organizations play in terms of generating and applying new ways in which to improve access to care, health outcomes and system performance.[26]

These successes informed the public of health risks, identified public health issues, provided prevention strategies, described trends in the health system, and offered information on more effective health practices or innovative ways to diagnose and/or treat disease. In some cases, they identified a breakthrough product, service, or spin-off company; discussed a human interest story; or showed major philanthropic support for a research endeavour. In all cases, they have made an important contribution to advancing the health and well-being of Canadians.[27]

How does the breadth of these innovations impact access and wait times? Considering the three inputs that we have identified earlier, managing access means not only increasing capacity through an injection of resources, it means preventing need or reducing demand, better utilizing supply and available capacity, and ultimately delivering access in the context of quality and appropriateness. The end result is not only improved access and care for the individual, but it is also cost-effective for the system.

2. WHAT FACTORS ARE CRITICAL TO BUILD ON OUR PROGRESS?

While ACAHO members have demonstrated progress in a number of areas related to access to care and wait times, there remain a number of ongoing policy challenges that need to be addressed if we are to move to the next level of excellence. In reality, there are a series of "moving parts" across the full continuum of care that need to be effectively *aligned* if we are to treat those who require acute care in a timely fashion, and for those who can be discharged from a hospital and transferred to the appropriate post-acute care setting. They are grouped under the policy headers of *Community-Based & Primary Health Care*, *Health System Capacity* and *Research & Applied Health System Innovation.*

In 2009, we asked members across the country who had demonstrated progress in improving access to care, what they saw as the major challenges to achieving the next level of excellence.[28] These are broadly stated in terms of care in the community, bed and staffing capacity, health information technologies, data and evidence, physical plant infrastructure, and the alignment of incentives.

COMMUNITY-BASED & PRIMARY HEALTH CARE

1. Increase post-acute care capacity specific to aging, chronic disease and mental health needs

Alternate Level of Care (ALC) patients are hospitalized patients who do not need acute care services, but who remain in acute care beds because they are either waiting to be placed in another type of services or the type of service they need.[29] While there is no diagnosis of ALC in the International Classification of Diseases, this system-based problem can result in devastating effects for the health of the ALC patient as well as those who await entry into the acute care system. To illustrate the magnitude of this problem, Ontario's Expert Panel report on ALC issues provided the following example: if, the average length of hospital stay is 3 days, one

person placed in an ALC bed for 300 days, will delay 100 patients from receiving what they need in acute care.[30]

The ALC issue is a consequence of wait times for services that we need more of and a consequence of trying to find makeshift solutions for services that we simply don't have.[31] ALC patients typically have two types of needs – they need high intensity care (e.g., dialysis or ventilation) and/or they have severe behavioral, cognitive or mental health issues.[32] A recent study by CIHI, showed that of all ALC patients for which there is data across this country, 30% have mental health disorders while the remaining 70% of patients fall into neurological, respiratory, circulatory, nervous system, and other conditions groups. About 10% of ALC patients die in acute care institutions. Of the remaining 90%, 43% percent of these patients are waiting for long-term care, 27% wait to go home, 12% wait for rehabilitation, and 5% are there for other reasons.[33]

Given the statistics, should we not build more long-term care beds and more home care capacity? The answer is a qualified yes. It's not only about more. It's about more, *different*, *flexible* and *integrated*. For example, as seen in the data, ALC patients are not all the same. Patients at risk of wandering, who have cognitive impairments, behavioural issues, or dementia have very different needs from cognitively intact patients on ventilators or on kidney dialysis. In addition, when we discharge people from hospital without proper post-acute care support, 10% will come back to the emergency department within 7 days, approximately 22% will come back within 30 days and nearly 15% will then be readmitted to acute care within a month of their original discharge. This highlights the need for a more responsive and integrated post-acute care system. This would reduce readmissions, free up acute care beds, place patients appropriately in the right setting, result in better outcomes, and ultimately increase flow through the system.[34]

2. Integrate primary health care & supportive care services into the full continuum of care

The term "medically necessary services" is a sad irony as it pertains to the care of elderly individuals and individuals with advanced chronic disease. In many cases, this is the expensive component of care that we pay for when we fail to help people maintain independence in their home. It is what happens when instead of putting in place a series of risk assessment, preventative, and supportive measures, the elderly or severely disabled or ill individuals fail in the direct and indirect activities of daily living. These measures would cost a fraction of the medically necessary services that result when they are neglected.

When people who require supportive services are neglected, they fall or become more ill, they end up with a serious encounter with the healthcare system, they become more vulnerable to infection, disorientation, and dementia, they may loose their independence and autonomy, they may become institutionalized, and this may even be the condition in which they experience death and dying.[35] [36] [37]

Yet, there are known strategies that could be put in place for all aging Canadians.[38] These include: (1) using novel social programs, technologies or support for informal caregivers to ensure that individuals with chronic disease, aging or mental health issues are not isolated or neglected;[39] [40] (2) If these individuals are admitted to the emergency department for any reason, we need to use this encounter as an opportunity to prevent further decline. For example, Canada has developed and tested internationally accepted scales that allow us to reliably assess every elderly individual appearing in our emergency departments for risk of readmission or loss of independence. If we identified these individuals, we could then put in place home assessments and implement preventative measures as is currently occurring in at least one Canadian academic healthcare organization;[41] (3) we need to make sure that all of our elderly and individuals with chronic disease or mental health issues have access to primary care services and that their primary care practitioner is linked into the rest of the system both for the exchange of information and for the coordination of care;[42] (4) if they require hospitalization, it needs to be senior friendly or appropriate to the needs of individuals with chronic disease and mental health needs;[43] (5) it also needs to allow the system to benefit from and support whatever assistance family and informal caregivers

can offer, without compromising the health of the caregiver him or herself; (6) if the person wants to return home, we need to have sufficient flexibility in resource allocation to put in place the supports needed to avoid further institutionalization and hospitalization; and (7) when the time comes, we need to help them through the death and dying process in a compassionate, respectful and dignified way.[44] Denmark is a recent example that has been written about extensively because every one of its seniors currently has access to necessary home care services and assessment for increased support at the age of 75.[45]

3. Target & invest in select public health, health promotion & illness prevention areas

Part of managing access and wait times is preventing need or reducing demand involves going beyond philosophical acknowledgements of the determinants of health. We need to focus on a regular, repeated, and monitored basis, in a number of strategically-targeted areas – for example, concussions, obesity, depression and suicide,[46] or diabetes management, among others.[47] [48] [49] [50] [51]

To achieve this, the public health community and the service delivery community need to collaborate. To do so, appropriate leadership and resources need to be put in place. Unless we do this, what may appear as social choice issues, will show up with devastating and expensive human, social and economic impacts on our health care system. If we are successful, we can free-up capacity, reduce need and demand, and ultimately create a healthier population.

HEALTH SYSTEM CAPACITY BUILDING

4. Modernize physical space and health delivery infrastructure

In many instances across the country, health delivery infrastructure has either exceeded its lifespan (and needs to be renovated or rebuilt), and/or we need to consider building additional capacity that reflects the continuum of care and the changing health care needs of Canadians.[52] In addition to the obvious implications of more physical space in accommodating more patients and therefore improving access, modernized physical plant infrastructure has been associated with better ability to utilize resources, achieve clinical outcomes, reduce infection control issues, implement new models of care, and attract leading clinicians.[53]

In ACAHO's 2012 Pre-Budget Brief to the House of Commons Standing Committee on Finance, we recommended an issue-specific, time-limited, strategic investment in physical plant infrastructure.[54] Building, repairing, and expanding health infrastructure – in all parts of the health system and across the range of settings, from hospitals to long-term care homes, community-based clinics, and others – creates short-term jobs and builds "legacy institutions" that can be sources of pride and social cohesion in communities. It also accelerates the transformation of the health system to meet tomorrow's needs.

5. Increase availability of practitioners & mentors in hospitals & community-based settings[55]

The health needs of Canadians are becoming more complex as a result of chronic disease and an aging population. [56] [57] [58] At the same time, intensified global competition for talent, heavy workloads, and a retiring workforce challenge the supply of health providers.[59] [60] [61] [62] [63] [64] [65]

The consequences of these trends range from limited or inaccessible services for which there are inappropriate wait times or insufficient funding, to adverse affects on health status and health outcomes, compromised safety, sub-optimal utilization of health care resources and stress and strain on patients, families, and providers.[66] [67] [68] These issues and trends were also identified in the recent study by the Standing Committee on Health.[69]

We recognize that it is incumbent on the health provider community to look at new ways – such as inter-professional collaboration – to organize and deliver a range of health care services in an efficient and cost-effective manner. These new models of care can improve the effectiveness and efficiency of the health system by making better use of resources and ensuring a supply of highly trained professionals into the future.

However, they also require that we pay attention to how incoming professionals are being trained and to ensuring the appropriate infrastructure or support necessary – particularly when collaboration is required across disciplines, settings and sectors of service. As we do this, we must also ensure that we monitor our progress and forecast future needs in these areas.

Since 2007, the Health Action Lobby (HEAL) – of which ACAHO is a member – has recommended the creation of a *National Health Human Resource Infrastructure Fund* that would bolster support for the direct and indirect costs of health human resource training, including support for mentors and training facilities, and build databases that would allow for the capacity to monitor and forecast needs.[70]

6. Leverage the impact of health information technologies on improving access[71]

Information technologies play an important role in the management of wait times and access. Telehealth, smartphones, i-phones, electronic health records, the internet and other digital components, are playing transformative roles in: (1) helping us to better utilize new and innovative care delivery models and care settings; (2) helping providers access information at the point-of-care within and across care settings and sectors; (3) improving patient safety and helping to avert clinical errors and adverse events; (4) empowering patients and families to access health information and supportive resources monitoring outcomes at all levels – from the individual client/patient to the system and population; and (5) predicting, monitoring, and averting pandemics and other critical and significant health-related events.[72]

For example, telehealth technologies can enable access to care, support consultations and rehabilitation for individuals who are home-bound or in rural and remote areas. They can facilitate the 'hospital-at-home' for patients with needs like, haemodialysis, in a manner that significantly improves quality of life and reduces the risk of hospital acquired infection. Other health information technologies can support individuals to self manage chronic conditions and to overcome diseases or disabilities; and provide essential information to patients, caregivers and communities.[73]

There are multiple returns-on-investment in such health information technologies – in addition to the important human and health system benefits – there are also the jobs, products and services generated in order to develop and deliver these technologies, and cost savings accrued through the efficiencies gained in their use in health systems. As it pertains to access and wait times, they help us to better utilize existing capacity and in so doing, accommodate more people within the resources that we have.

To this end, ACAHO has supported HEAL's recommendation as part of its 2012 Pre-Budget submission to the House of Commons Standing Committee on Finance to explore linkage between Canada's Digital Strategy, Health system transformation, and the implementation of electronic health records through Canada Health Infoway.[74]

RESEARCH & APPLIED HEALTH SYSTEM INNOVATION

7. Use of data & research evidence to guide decision-making & stimulate applied system innovation

It is commonly known that what we measure; we manage and where we focus and invest; we see progress. An important success factor is the collection of data and information that can facilitate decision-making, the

identification of root causes, and form an evidence base for more innovations. As academic healthcare organizations, the *translation* of research to practice is a key part of our mission.

These ideas have proven true in the areas of access and wait times, where the effect of the federal government's leadership in identifying, establishing and encouraging benchmarks has had an impact on health and health care. Research, data, and evidence, combined with the intent of translation as per the role of academic healthcare organizations, hold levers for future success in ensuring timely access to care. They can also help us in leveraging the 2014 Health Accord to continue to improve the health and economic well-being of all.

8. Investing in change management strategies

There are many areas of care in which best practices are known or established. These are often distributed in care pathways, guidelines, discussed in journal groups, and presented at conferences. If implemented, they could improve access to care and wait times and the quality of care by allowing for better utilization, shortening lengths-of-stay, and improving outcomes in shorter periods of time.[75] Canada's internationally accepted best practice guidelines for nursing care in areas ranging from pain management, dementia care, pressure ulcers, wound management, among others; Ottawa ankle rules, the surgical checklist, the Bone & Joint Health Network's national model of hip fracture care funded by Health Canada, and the Canadian Stroke Network protocols are just a few of the many examples of what can be done when we combine innovation with a deliberate, focused and funded implementation and change management strategy.[76]

How can we more effectively leverage these applied system innovations? Change in large and high stake environments like acute care settings is complex.[77] For example, implementing a protocol as simple as ensuring that every elderly patient in the emergency department is given water at regular intervals to avoid dehydration and delirium requires communication and operational changes that span multiple shifts, multiple workers, supplies and equipment.[78] When we move beyond drinking water and into the realm of addictive substances, state-of-the-art medical equipment, and patient consent, these changes require skilled managerial expertise and funds through which to implement changes. Education and moral suasion are not enough when you want to make operational changes in large, complex and fast-paced environments.

The 8 policy challenges that we identified as necessary in achieving the next level of excellence in access and wait times present opportunities for both federal, provincial and territorial governments. In the next section we identify some policy options where the federal government could play a leadership role as we move closer to what a 2014 Health Accord might hold.

3. LOOKING TOWARDS 2014…

As much as we have focused on assessing the role and impact of the 2004 Health Accord in relation to access and wait times, we know that its expiration is around the corner; only 19 months away.

While this may seem like a long time, we applaud the Standing Senate Committee for initiating a public conversation to consider an array of policy issues that need to be explored and could serve as the basis of an emerging consensus about what are the roles and responsibilities of the federal, provincial and territorial governments in renewing our health system.

While the Association's views on what a 2014 Health Accord are still forming, there are several issues we would like to put before you in the context of improving access to care and wait times, and overall system performance. Our views build on the recent statements by the Prime Minister and Minister of Health who both underscored the need for increased accountability for what is invested in health and health care, and improved system performance in terms of value-for-money.[79]

A key strategic policy consideration is how to invest federal dollars – estimated to be close to an additional $2.0 Billion in 2014 – in a way that maximizes their return-on-investment? How can we ensure that federal funding will facilitate system renewal and meet the changing health and health care needs of Canadians? Furthermore, what kind of accountability framework should be in place so that we can effectively link *sources* of funding with their *uses*, and report to the public on *outcomes*?

Are there different ways in which the federal government can invest resources into the health system that incent and promote change? For example, should the federal government provide the provinces and territories with an equal per capita cash transfer with no conditions, and/or should it look at different ways in which it can create issue-specific, time-limited strategically targeted Funds designed to accelerate renewal? At the same time, should it also look at how it can leverage the tax system (e.g., tax credits, deductions, reimbursement) to support the changing health needs of Canadians? Finally, what kind of accountability/performance framework should be put in place so that all levels of government can speak directly to Canadians about the progress they are making?

While the Association's views are not fully formed and will be discussed by all members in the very near future, we have identified a slate of policy options where the federal government can play an integral leadership role in working with the provinces and territories in facilitating renewal in the health system.

IMPROVING ACCOUNTABILITY & SYSTEM PERFORMANCE

As noted earlier in the Brief, the 2004 Health Accord has acted as a catalyst for shining a light on a number of defined priorities related to wait times in Canada, and ACAHO members have responded with a series of innovative measures in these and other areas across the continuum of care. The Accord not only identified the need for a series of comparable national health indicators but also to take the next step in terms of implementing comparable evidence-based benchmarks. Combined, these developments have allowed governments, patients and the public to have a clearer sense of how the system is performing.

While progress has been made since 2004, we need to continue to build on this momentum. In our view it is important to advance the ongoing dialogue around comparable national health indicators for wait times and benchmarks across all jurisdictions and that public reporting on all defined priority areas occur.[80] At the same time, it is likely that a broader dialogue should unfold in other areas of the system (e.g., mental health, paediatric care, to name a few).

Recommendation #1 – *"That the federal, provincial & territorial governments continue to development comparable national health indicators and benchmarks for all priority areas related to access and wait times, and that they be publicly reported on an ongoing basis."*

MOVING FROM "SUSTAINABILITY" TO THE QUALITY AGENDA

While issues of public reporting on the indicators and benchmarks related to wait times is essential, it is also important to consider how operationalize the principles of accountability and value-for-money when it comes to the broader question of overall health system performance. While no one would "tilt against" these principles, the critical question is what kind of framework should be in place?

For most of the last decade-and-a-half, the public discussion on the future of the health system has been framed as a "sustainability" issue; that is, focused on the amount of funding that was needed, with the federal government acting as a banker of last resort.[81] Increasingly, however, the strategic focus of the national policy

conversation has moved away from "financial inputs" to "health and system outcomes"; that is, focusing on value-for-money and overall cost-effectiveness and performance of the system.[82]

At the same time, issues of health system performance have largely been framed in terms of the access agenda (i.e., wait times). While important progress has been made in relation to wait times, our view is that it is time to re-frame issues of health system performance largely in the context of *quality*; of which access to care is a crucial component. Seven dimensions of quality are identified as follows:[83]

1. *Accessibility* – how easy is it for patients to obtain care?
2. *Effectiveness* – Are you doing the "right" things right?
3. *Safety* – How safe is your service from hazard and danger?
4. *Efficiency* – Does your service perform with a minimum of effort, expense or waste?
5. *Appropriateness* – Are you doing the "right" things?
6. *Provider Competence* – Do you and your staff have the necessary knowledge, skills and personal qualities to provide competent care or service?
7. *Acceptability* – Does your care meet patient expectations?

Closely related, is the matter of accountability; the need to develop one set of national quality-based health indicators and possibly benchmarks across the continuum of care. While we recognize that this will take time, there is an opportunity for the 2014 Health Accord to act as a catalyst for this discussion.

Given the important work that has been advanced at the provincial and territorial levels by a number of health quality councils, there is an opportunity to consider how we can develop a set of national quality-based health indicators that are comparable across all jurisdictions.

To contribute to this conversation, there are a number of federally-funded agencies that focus on different elements of quality in health that can make a difference (e.g., Canadian Patient Safety Institute; Canadian Agency on Drugs and Technology in Health; Canada Health Infoway; Health Council of Canada; Canadian Health Services Research Foundation; Quality Work Life Quality Health Care Collaborative). We would also envision the Canadian Institute for Health Information and the Canadian Institutes of Health Research having a crucial role to play in terms of data capture and its reporting, and the translation of research to practice.

Given our proposed focus on a set of national quality indicators and benchmarks, now is the time for a more in-depth inter-agency strategic discussion about developing an integrated agenda and framework that will improve quality and system performance. In the extreme, perhaps this means there needs to be a re-think about what kind of national governance structure could be in place that focuses on quality and health system performance.

Recommendation #2 – *"That the federal, provincial & territorial governments extend the development of comparable national health indicators and benchmarks across the continuum of care focused on the dimensions of quality."*

For example, the Collaborative for Excellence in Healthcare Quality (CEHQ) – comprised of 11 Academic Health Sciences Centres across the country – is working closely with the Canadian Institute of Health Information to identify a range of quality indicators across a number of dimensions that will be made publicly available in the near future.[84] This is an important if not unique development that speaks to the power of partnerships that need to be leveraged across the country that focus on quality and overall system performance.

OTHER TARGETED FEDERAL INVESTMENTS TO IMPROVE ACCESS TO CARE & WAIT TIMES

While it is likely that the 2014 Health Accord will include unearmarked equal per capita cash to assist the provinces and territories in running their health systems, consideration could be given as to what is the role of the federal government in specific policy areas? Is their an opportunity to work collaboratively with the provinces and territories so that they can address specific policy challenges, such as access to care and wait times, and system performance?

While we talk about reducing the impact of over-crowded emergency departments, this is only the symptom. The real issue is the lack of capacity to move people appropriately through the continuum of care because of problematic post-acute care resources and poor attention to preventative and supportive measures. Can the 2014 Health Accord act as a catalyst to ensure post acute care, supportive, and preventative care strategies, facilitate integration of primary care with the rest of the health care system, and enable change from older to newer models of care? Is their an opportunity to move forward with new models of primary health care that directs patients to their primary care provider and away from the emergency department?

Given that close to 1 in 5 hospital beds are being occupied by those who do not require hospital care (ALC patients) (see Section 2.1 of the Brief), we must find innovative solutions so that the 20% of hospital beds occupied by ALC patients can be used more effectively. To do so, we need to ensure that they are discharged into the appropriate setting be it their own home, a long-term care facility, a nursing home, rehabilitation institute, or chronic care facility, with the appropriate supports and with the intention of preventing readmissions. In the context of academic health sciences centres, it is in part for this reason that the report of the National Task Force on the Future of Canada's Academic Health Sciences Centres ("*Three Missions...One Future*") recommended a movement to "academic health sciences networks". These networks will provide integration structures for both care processes and future training and research. In addition to the structures however, resources are needed.[85]

Recommendation #3 – *"That the federal government, in close consultation with the provinces & territories, create a Team-Based Primary Health Care Fund."*

Recommendation #4 – *"That the federal government, in close consultation with the provinces & territories, create a Community-Based Health Infrastructure Fund."*

These may be issue-specific, strategically-targeted funds designed to move beyond pilot projects and accelerate the creation of primary health care teams, and the creation of an infrastructure fund to assist in the development of post-acute care capacity, coupled with tax policies designed to defray expenses associated with home care.

Another challenge that has been addressed earlier in our Brief (see Section 2.8), is the recognition that there are a significant number of "pockets of excellence" when it comes to innovative ways in which high-quality, cost-effective care is delivered to Canadians. That said, one of our ongoing challenges is to find more effective ways in which we can share these applied health system innovations from coast-to-coast-to-coast in real time. In other words, these innovations need to be driven *horizontally* across the country.

One way to do so is to consider establishing a "*National Health Innovation Fund*", of which one of its stated objectives would be to promote the sharing of applied health system innovations across the country with the goal of improving the delivery of quality health services. This concept would be closely aligned with the work of the Canadian Institutes of Health Research in developing a Strategy on Patient-Oriented Research (SPOR).[86]

This would also enable Canada to better leverage the role of academic health sciences centres and networks, in their capacity to generate and use research and innovation to improve patient care and population health. A recent National Task Force (NTF) report funded by Health Canada, discusses the unique role of academic health sciences centres in providing the structure, culture, governance resources, and partnerships necessary to facilitate the generation of applicable and important research and innovation to drive health system improvements.[87] To this effect, the NTF has also made a series of recommendations that would help link the generation of research to its use in practice. These outcomes hold important potential for a future Health Accord, and are supported by many academic, policy, and research leaders in Canada.[88]

To identify the potential initiatives that could have human and economic benefit when expanded across the country, we recommend that the federal government issue a call for innovations from Canada's academic healthcare organizations. The call would allow these organizations to feature their proposals for transformative change and economic benefit to the health system and Canadians. The government could then select those innovations that that align with its own objectives, fund and monitor their implementation, and link funding to outcomes and public reporting.

We believe that through the deliberate linkage of health research and applied innovation to human health and health system performance, that we can accelerate the adoption of transformative change with improvement in access and wait times across the country. For example, recently, the Vice Presidents of Health Research from across Canada's academic healthcare organizations, presented for the time to the public, their top 3 current research priorities. These priorities are linked to the patient care and population health mandates of their affiliated academic healthcare organizations**.**[89]

What we need is the national leadership, coordinating mechanisms, and infrastructure support to initiate and leverage a pathway through which innovations can either be brought to market or to practice – not just locally and provincially, but right across the country.[90] This national effort will mean real changes in the health of Canadians, and costs savings for funders.

Recommendation #5 – *"That the federal government, in close consultation with the provinces & territories, create a National Health Innovation Fund."*

Combined, we believe our recommendations, taken together, focus on strengthening the *structure* of the health system, the *process* by which we improve the cost-effectiveness of delivering care, and improving overall health *outcomes* by focusing on system performance through the prism of quality.

Furthermore, our recommendations are designed to articulate a practical and effective leadership role for the federal government as we move towards 2014 with a specific strategic focus on accountability, value-for-money and system performance.

IN CLOSING

These are our preliminary thoughts as we move closer to 2014. We hope that they will contribute to the policy thinking about what is the role of the federal government when it comes to health and health care, and more importantly, look to focus the discussion on what is needed to ensure that Canada is a high performing system, with an unshakeable focus on quality improvement.

While we have identified five policy areas in which we believe there is a role for the federal government in the context of 2014, there are other important policy issues that clearly warrant attention and consideration as to how they could fit within the structure of a Health Accord, and include: (1) public health; (2) health promotion and illness prevention; (3) mental health; (4) health human resources; (5) health research; (6) aboriginal health; (7) pharmaceutical coverage; (8) electronic health records; (9) leadership development; and (10) medical equipment. In our view, more public discussion is required within and outside of government as to how these issues can be addressed.

Finally, this Brief is about Canada-building in the 21st Century, and seizing an opportunity for the federal government to work arm-in-arm with the provinces and territories and members of ACAHO in re-shaping our health system to meet the challenges of a growing and aging population.

ENDNOTES

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[14] The collective *vision* of ACAHO members is to advance patient care and the health & well-being of Canadians through research discovery and innovation. The *mission* is to create an environment in which research discovery, innovation and learning benefit patients, populations, health systems and the economy.
[15] ACAHO, 2009.
[16] The cases as prepared by the authors are available at: http://www.acaho.org/?document&id=132. The Health Council of Canada also undertook a podcast program with ACAHO's President & CEO which offers a podcasted discussion of the Cases, also available at: http://www.acaho.org/?policy_2009
[17] See"*Ensuring access to primary care"*, cases by Alberta Health Services available: http://www.acaho.org/?document&id=132
[18] See *"Preventing Emergencies Where and When we Can"* cases by Alberta Health Services Board, Centre hospitalier universitaire de Sherbrooke, The Ottawa Hospital. http://www.acaho.org/?document&id=132.
[19] See *"Getting from 911 to the Emergency Department"*, cases by Alberta Health Services, London Health Sciences available: http://www.acaho.org/?document&id=132
[20] See *"Getting through the Emergency Department"* cases by Alberta Health Services Board, Vancouver General Hospital, Alberta Children's Hospital, Toronto Rehabilitation Institute, Bloorview Kids, The Ottawa Hospital, Hamilton Health Sciences Centre.
[21] See *"Emergencies that occur elsewhere in Hospital"* cases by Horizon Health Network, Alberta Health Services http://www.acaho.org/?document&id=132
[22] See *"Whole system/hospital wide approach to improving access"*, cases by St. Joseph's Healthcare Hamilton, St. Michael's Hospital, London Health Sciences Centre, Horizon Health Network, Alberta Health Services, Hamilton Health Sciences Centre. Available at : http://www.acaho.org/?document&id=132
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[27] ACAHO is working with its member organizations to develop a consolidated web portal access point for the research successes that run in the Globe & Mail and in the Canada Health Reference Guide. It will be made available to the public upon completion. It currently contains close to 160 stories from January to June 2011. The page will be updated quarterly.
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[85] National Task Force on the Future of Canada's Academic Health Sciences Centres, 2010. *Three Missions…One Future – Optimizing the Performance of Canada;s Academic Health Sciences Centres*. Available at: www.acaho.org
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[87] National Task Force on the Future of Canada's Academic Health Sciences Centres, 2010. *Three Missions...One Future – Optimizing the Role of Canada's Academic Health Sciences Centres.* Available at: www.acaho.org
[88] The National Task Force on the Future of Canada's Academic Health Sciences Centres was funded by Health Canada. The result of this initiative included a literature review, case studies, a website with hundreds of resources, a final report and a consensus session of over 100 of Canada's top leaders in the area to discuss the recommendations. The results are available at: www.ahsc-ntf.org
[89] ACAHO, 2011. A forthcoming report will discuss and contextualize the top three research priorities of Canada's academic healthcare organizations. A list of the research priorities is available publicly. See: Saryeddine, T. 2011. Hospital News Special Report: *What are the research priorities of Canada's Academic Healthcare Organizations*? Available at: www.acaho.org
[90] A possible example of this type of approach is illustrated by the Council of Academic Hospitals of Ontario through their ARTIC project in which they have chosen a few projects intended to induce positive health system changes. More details are available at: http://www.chrgonline.com/news_detail.asp?ID=158965.