



“Top 10” Motions - 2017 Great Canadian Healthcare Debate

Debate Exclusive Sponsor: 

Brief descriptions of the “top 10” motions can be found below. Full Issue Briefs will be prepared for the “top 5” motions. They will be shared with NHLC delegates prior to the conference and in conference packages.

National strategy and standards for technologies of choice

Resolved, that the Federal Government commit to a national 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 identification and risk evaluation of barriers, strategies to remove barriers, and will engage the public for input on identified strategies. Technology options may include historical technologies such as email, texting and videoconferencing as well as dynamic technologies not yet developed.

Information and communication flow between care teams, patients and families is essential to quality care. The disincentives for healthcare organizations, providers and patients to utilize common technologies to support this communication leads to ineffective, absent or delayed care, and compromises patient safety; multiple studies show that communication errors account for and are the root cause of medical errors. Further, these disincentives stifle innovation. The balance between institutional and individual risk tolerance requires national debate on privacy along with leadership and standards that both unlock and underpin true innovation and thus, patient satisfaction. It is the determination to look at individual care cases, evaluate system flaws and devise strategies to enshrine the rights of Canadians that will lead provinces to craft legislation and incentivize providers and access.

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.

The Canadian healthcare system is overwhelmed with older people waiting in hospitals for more appropriate levels of care and long waiting lists for long term care. Two of the largest barriers to addressing these factors are affordability of housing and the human need for socialization. The World Health Organization states that there are many determinants that impact health; one of them is housing. Providing affordable and supportive housing is highly cost effective. Acute care costs \$1000/day whereas home care costs \$50/day. In addition, studies by J. Patrick show that provision of alternate care in the community would cut wait times at lower cost. This approach also supports dignity, autonomy, mental and physical health. Keeping and supporting seniors in the community for as long as possible before they must rely on institutional care is of utmost importance. A national strategy facilitated by the funding envelopes that have been announced around affordable housing, and put into action by the provinces needs to be ready by June 2018.

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.

One of the most significant challenges facing Canada's health care system is the misalignment of health care resources, clinical practices and care options for the more than 1.1 million Canadians deemed to be frail – a distinct health state characterized by debility, the presence of multiple, chronic health conditions, and higher risk of poor health care outcomes including death. The Canadian Frailty Network proposes systematic frailty screening of high risk populations who come into contact with the health care system. Earlier recognition and assessment of frailty will allow for appropriate care planning and the widespread integration of holistic models of care that will lead to measurable, significant improvements in health outcomes for Canada's most vulnerable citizens.

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.

The notion of ‘family presence’ views family members not as ‘visitors’ but rather as partners in care who have around-the-clock access to their loved ones. Policies around family presence seek to change restrictive visiting hours, respecting the role that loved ones have as part of the circle of care, involved in information sharing and decision-making processes. Healthcare institutions that embark on the process of changing their visiting policies and practices enable the input of patients, families and other care partners into care planning. With Canada’s aging population, there is a growing number of people relying on the healthcare system. For those admitted to hospital, restricting family access to patients at their most vulnerable times from the people who know them best places patients at risk for medical error, emotional harm, inconsistent care, and unnecessary procedures. Studies indicate that having access to family and loved ones provides a calming influence, reducing complications and stress, improves the patient’s experience of care in hospital, and results in better decisions. Leading hospitals, such as Kingston General in Ontario and Alberta Health Services (South Campus), and healthcare jurisdictions like the province of Saskatchewan have supported family presence policies, working together with patients and families in their development and implementation.

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.

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. Dementia also disproportionately affects women both as patients and caregivers. Canada is one of only two G7 nations that do not have a strategy in place. 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. To create a national dementia strategy, the Alzheimer Society of Canada has proposed that the federal government fund the Canadian Alzheimer’s Disease and Dementia Partnership (CADDP). The partnership would bring together a pan-Canadian network of dementia experts, government, researchers, health-care providers, key NGOs, industry, people living with dementia and their families to develop and implement a comprehensive national strategy through collaborative and coordinated system-level

change. The CADDP would have a formal structure with an independent, stand-alone model of governance. It will support and respect provincial and territorial jurisdiction over health and will not impose programs and services.

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.

A robust framework within the new health accord's long-term funding agreement will improve health outcomes for all Canadians by:

- Showing causal relationships between inputs, activities and population health outcomes;
- Including reports on a comprehensive set of indicators and outcome measures derived from existing national data sources; and
- Linking health and social outcomes data.

This approach would lead to greater transparency for expenditures by monitoring and reporting on the use of federal health dollars under respective bilateral agreements. It would also ensure that federal funding ultimately improves access to equitable, high-quality, publicly funded home- and community-based care, while optimizing technologies such as telehealth, to deliver services that include primary care, mental health care and palliative care. Provincial and territorial governments would be required to report to the federal government annually. Reports in plain language would be made available to the public via Health Canada's website and social media platforms.

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.

The Canadian Patient Safety Institute (2005) conducted an environmental scan of several health curricula to understand the gaps in patient safety content in the education of healthcare professionals. The scan confirmed that education focusing on patient safety was nearly absent, or misunderstood, within the sampled faculties and schools of medicine, nursing and pharmacy; there was no well-established body of knowledge in Canada dedicated to patient safety content with an interprofessional perspective embedded in the curricula, though many health disciplines had incorporated related topics.

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. Patient safety and quality improvement must become more than words on a page. We 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 in 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. The necessary patient safety curricula to achieve this exists. Stakeholders must work together to ensure that these curricula are embedded in health profession education across Canada.

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.

In 2005, the Supreme Court of Canada overturned the prohibition against private health insurance in the province of Quebec via the Chaoulli-Zeliotis case. Canada is the only country in the industrialized world to limit the role of private health insurance exclusively to the coverage of services not insured by the public system; this makes it an anomaly in the industrialized world. Private-for-profit models would move Canadian hospitals closer to the more efficient universal systems of Europe and Australia. Access to a waiting list is not access to health care.

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.

The way we die needs to change. The importance of palliative care is currently front and centre for Canadians, including in the context of discussions and debate on the complex issue of medical assistance in dying. 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.

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.”

The rate of suicide within the healthcare system in Canada (approximately 3700 people per year die by suicide) has not changed appreciably in over 15 years despite all of the advances of modern mental health care (medication, psychotherapy, etc.). Reducing this rate represents a commitment to patient safety, the most fundamental responsibility of health care. Zero Suicide is a commitment to suicide prevention in health care systems that relies on a system-wide approach to improve outcomes and close gaps. Its core propositions are that suicide deaths for people under care are preventable, and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The programmatic approach to Zero Suicide is based on the realization that suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted health care system and on the premise that a systematic approach to quality improvement is necessary. The approach builds on work done in many international health care organizations and incorporates both best and promising practices in quality improvement and evidence-based care. It has demonstrated stunning results in the Henry Ford Health System (HFHS) in Michigan, which experienced an 80% reduction in the suicide rate among health plan members. Zero Suicide is a call to relentlessly pursue a reduction in suicide for those who come to us for care. It is about purposefully aiming for a higher level of performance by designing for zero.