Challenge Address
Health Provider Summit: Continuum of Care
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Summits, Principles, Continuum of Care and Health Care Transformation: Why and Why Now…

Healthcare communities have long been talking about the need for evidence-based and collaborative care in the service of better outcomes for health systems and ultimately for patients …

Even with improvements in efficiency and effectiveness, the status quo may not be sustainable.

http://www.cdhowe.org/pdf/Commentary_327.pdf

It would appear that clinical and economic perspectives converge… change is not an option for Canada's health but a requirement.

Our options, although easier said than done, are not that complicated

…spend more now and less later or distribute what we spend now differently…or both

The cost of illness, particularly chronic disease, extends far and deep…beyond the usual terms of governments, beyond the capacity of one intervention or one health provider, beyond one patient, and beyond one sector.

Unprevented, untreated or poorly treated health problems affect families, the workplace, communities, as well as health systems – qualitatively and economically. For example, the cost of mental illness is estimated at $51 billion dollars annually in Canada.

http://www.phac-aspc.gc.ca/publicat/cdic-mcbc/pdf/cdic283-eng.pdf

By definition, prevented or well treated or serviced health problems allow for better quality of life, better participation in life's roles, and greater

health cost offset.

Staying healthy and managing disease is determined by multiple factors. Social, psychological and biological factors keep people well and contribute to the development and management of disease.

Health and illness are not dichotomous. We all live in variable states of health and illness. Health promotion and illness prevention – and these often about social and behavioural factors – are as relevant to someone who is ill as they are to someone who is well.

Just as health and illness are not simply or singly determined, people do not live simply. We bring our health and illness with us home, to school, to work, to communities and in jail. Health doesn't, and arguably systems shouldn't, start and stop at the doctor's door.

Canadian Academy of Health Sciences. Smarter Caring for a Healthier Canada: Embracing System Innovation. September 2011.

Brian Golden (Clayton and Christensen): three types of medical interventions:

- Intuitive (e.g. depression)
- Empirical (e.g. myocardial infarction)
- Precision (e.g. strep throat)

Does this suggest that the only things we can do with precision are those that are simply determined? Much of what costs patients, families, employers and the health system (e.g. chronic disease, mental health) are not.

There is no single health care service, support, piece of information or health provider that can categorically ensure health, prevent illness or manage chronic disease.

The problem is that we do not have a health system that resources collaborative approaches to care…especially in primary care and at transition points from one kind or venue of care to another

The gaps in care cost…

Multiple providers doing the same or similar things serially and uncollaboratively and taking time to do it, costs money for systems and taxpayers, creates frustration for providers and enhances rather than relieves patient's illness and distress.

Collaboration and integration reduces them…

Care is coordinated, responsive, efficient, takes less time, relieves rather than enhances patient distress and makes for more successful providers.

So lets assume that we have come to a place where we have good collaborative intentions. Further, we have principles, strategies, and guidelines, and all in support of continuous and collaborative care. How do we take them to the street?

We likely all agree on better health, better care, better value but not likely on what constitutes better health, better care, better value.

We have a system that pays designated providers to deliver designated services. How do we take a system that is provider and service-based and make it needs-based?

How do we take what is essentially a medical system and make it a health system?

How do we ensure access to needed care and not just access to the care we have traditionally funded and made available through our public systems?

If we truly want to be evidence-based, providing the right care to the right person at the right time in the right place, then we need to make that care, that provider, that service accessible.

Publicly-funded, single-payor care is an historic Canadian value – for consumers, decision-makers, funders and providers.

It would appear that providers elsewhere might agree on its value proposition…

Forbes, April 2012: Why Do So Many Doctors Regret Their Job Choice?

A U.S. survey of 24,000 physicians revealed "…only 54% said they would choose medicine again as a career…the lack of a single payer system is responsible for much of the frustration."

Whatever our solution (or solutions) for a transformed health care system, its design and implementation, like service delivery must be collaborative.

The responsibility and accountability must be borne by those who administer systems, those who fund them, those who provide care within them and those who use them.

This means that there must be leadership but also empowerment – together the stakeholders in Canada's health and health system(s) must have the agency to affect change.

At a Chronic Pain Summit in Ottawa a couple of weeks ago, NDP Health Critic Libby Davies reminded us that Tommy Douglas' vision of a public health care system was not a static one. It was intended and needs to evolve over time.

That time has come.

Some things to think about as we go into today's work…

1. Think like the health care provider you are, the health care provider sitting next to you, a consumer, a decision-maker, a funder, a family member…chances are you have or will wear many of these hats.

2. Don’t think about physicians, nurses and allied health providers. There is nothing allied about the health care provided by the 100,000 occupational therapists, physiotherapists, pharmacists, dietitians, psychologists, social workers, speech language pathologists and audiologists…we are all health providers.

3. Rather than seeing collaborative care as amplifying liability for your colleagues' work, consider that it might reduce risk. More people putting their minds to a problem, each with different expertise and perspective, are likely to do a better job than just one – that includes patients and families as well as the range of health providers.

4. Providers with whom you collaborate have expertise that may be different but is of equal value.

5. Understanding doesn’t require agreement but agreement has to be negotiated.

6. Accepting change in principle is necessary but real change will depend on your accepting it in practice.


STOP
Collaborate
and Listen