



UBC CENTRE FOR
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Working Together While Staying Apart

Care Integration in a Brave New World
Conference Summary

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CHSPR 2021 HEALTH POLICY
CONFERENCE

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Working Together While Staying Apart: Care Integration in a Brave New World Conference Summary was produced by:

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About CHSPR

The Centre for Health Services and Policy Research (CHSPR) is an independent research centre based in the School of Population and Public Health at the University of British Columbia (BC). Our mission is to stimulate scientific enquiry into health system performance, equity, and sustainability.

Our faculty are among Canada's leading experts in primary health care, health care funding and financing, variations in health services utilization, health human resources, and pharmaceutical policy. We promote inter-disciplinarity in our research, training, and knowledge translation activities because contemporary problems in health care systems transcend traditional academic boundaries.

We are active participants in various policy-making forums and are regularly called upon to provide policy advice in BC, other provinces, and abroad.

We receive core funding from the University of BC. Our research is primarily funded through competitive, peer-reviewed grants obtained from Canadian and international funding agencies.

For more information about CHSPR, please visit <https://chspr.ubc.ca/>.

CHSPR's Health Policy Conferences

CHSPR's annual health policy conference is an opportunity for those interested in health policy issues to hear about emerging research and participate in interactive dialogues with experts in thematic areas shaping Canada's health system. This long-standing conference draws together leaders, researchers, policy-makers, academics, health care providers, and patients, from universities, governments, industry, health authorities, and national organizations across BC, the rest of Canada, and internationally. This document presents highlights from the 2021 conference. For summaries of past conferences, please visit <http://chspr.ubc.ca/conference/past-conferences/>.



About the Conference

CHSPR held its 33rd annual health policy conference on March 8 and 9, 2021. The conference was held virtually due to the COVID-19 pandemic.

Integrated care systems are shifting the way that health and social care are organized, delivered and paid for. Challenges of medical and social complexity, and a growing percentage of Canadians living in ill health, are creating a population increasingly inadequately served by organizations and providers operating autonomously. The effects of the COVID-19 pandemic brought these problems into stark relief, in particular by exposing the problems that fragmented health and social care systems face in adapting to crises that require urgent and/or collaborative responses. These problems have had particularly pernicious effects on the most acutely affected among us – ethnic minorities, Indigenous populations, seniors living in residential care facilities, those living in rural and remote communities, those living in poverty, and people with the most complex health care issues. Those most in need would see the greatest benefit from a coordinated health and social care capacity and capability.

The 2021 CHSPR Conference brought together research and policy experts, students, patients, and care practitioners from across the health care and social systems, to examine barriers, experiences and evidence from elsewhere, and options and priorities for moving us to a more efficient and effective integrated care system. Key topics included physical and virtual models for integrating care, workforce skill and training requirements, regulatory barriers and solutions, and funding and financing models that are able to align system goals with personal and organizational incentives. The conference was free to attend and all sessions were video recorded and are available to watch at <https://chspr.ubc.ca/conference/program/>.

Supporters and conference organization

This conference would not have been possible without the financial support of generous supporters, including the BC Academic Health Science Network, the BC Ministry of Health, the Canadian Institute for Health Information, the BC Patient Safety & Quality Council, Healthcare Excellence Canada, and the Michael Smith Foundation for Health Research. This report would not have been possible without support from Health Canada.

The program committee was chaired by Dr. Sabrina Wong of CHSPR. The planning committee was led by Dawn Mooney and Joyce Huang of CHSPR. Support was provided by the UBC Faculty of Medicine. We gratefully acknowledge that this conference took place on the traditional and unceded territories of the Coast Salish peoples, and we thank Coast Salish Elder Roberta Price of the Snuneymuxw and Cowichan First Nations for the welcome she provided.



DAY 1 SESSION 1

Can we counter gravity?

A policy perspective on integrated care

Speaker: Pierre-Gerlier Forest, Director, School of Public Policy, University of Calgary

Dr. Forest delivered a keynote presentation, setting the stage by explaining what we mean by integrated care and discussing why it is difficult to create change in healthcare, especially when it comes to integrated care. He focused on eight key areas:

- 1. Perspective: Why is has integrated care not been successful?**
Dr. Forest identified five reasons: limited benefits for patients and providers; options and models proliferate; incentives are confusing; competing needs and priorities; and politics often trumps policy.
- 2. The context: First principles**
Five principles need to be considered when integrating care: innovation, true experimentation, competition, precise measurement, and transparency.
- 3. What can we learn from experimentation: Integrating what?**
Projects aim to integrate clientele, disease, geography, social/cultural contexts, or payers.
- 4. Governance: Who decides?**
Several groups make decisions about healthcare (i.e. patients, clinical leadership, multidisciplinary panels, health authorities, provider organizations, payers). This often creates a problem of accountability—who will be responsible for the success or failure of a project?
- 5. Funding: Paying for integration**
Options for funding include: Accountable Care Organizations, bundled payments, pay for performance, global budgets, and hybrid models.
- 6. Delivery: Teamwork**
People remain interested and engaged by prioritizing incentives, compensation, complexity, decision-making, and stability/retention.
- 7. Outcomes: Is it worth doing?**
Yes, based on five benefits: consistency, equity, moderate savings, enhanced patient experience, and clinical agency.
- 8. Endpoints: The consensus**
In order to achieve an integrated primary healthcare system, we need: strong primary healthcare, an extended range of services and goods, effective care teams, established pathways, shared decision-making, data-informed (not data driven) practice, and outcome driven investments.



Respondent: Coast Salish Elder Roberta Price, Snuneymuxw and Cowichan First Nations

Elder Price's response focused on the need to address equity and patient experience in hopes of improving patient outcomes. She discussed how COVID-19 is highlighting inequities for the most vulnerable people. She provided suggestions: fully funding healthcare workers in long-term care so they don't need to work multiple jobs; more Indigenous healthcare providers; moving funding to rural areas to support families; moving to a more holistic way of being with patients in which decision making includes the patient and their family in addition to the healthcare team; and moving away from an "I know what's best" attitude to value patients' knowledge and experiences. Finally, Elder Price emphasized that work needs to be done to protect patients, and that we need to continue to reflect on our practice.

Respondent: Tess Romain, CEO, Toronto Central Local Health Integration Network

Ms. Romain's response focused on examples of Ontario Health Teams (OHTs) learning from COVID-19. She highlighted that the 14 local health integrated networks (LHINs) across Toronto are responsible for the planning, funding, and integration of local healthcare services. LHINs were established to organize integration within regions; they bring hospitals, home care, and long-term care together. LHINs have provided information to the population about resources in their communities through a population health and equity approach. In 2019, OHTs were created for the purpose of better connecting different parts of the healthcare system and bringing together healthcare teams, patients, families, and communities within defined geographic areas.

Ms. Romain provided examples of integrated care from the COVID-19 response in Toronto:

1. Toronto's response depended on collaboration with OHTs to focus on equity at the local or neighborhood level. There was a need to leverage or build on the trusted relationships that existed within communities.
2. Testing spoke to the connections between government, policy, and local health teams working together.
3. A significant need to establish a cross-sectoral Toronto COVID-19 planning and response table became apparent. This brought together people from different sectors (primary care, acute care, public health) to monitor the COVID-19 response.
4. It became clear that the rates of testing were lower in vulnerable areas/high needs communities, but rates of positivity were higher. OHTs began to reach out to those with trusted relationships in these communities including primary care providers and community agencies.
5. There was increased collaboration with Indigenous peoples in their communities.
6. The team established a recovery hotel, providing shelter to the homeless population. This was a collaboration between various sectors.

Ms. Romain concluded by emphasizing that she saw local teams come together in an integrated fashion because no one provider could take on COVID-19 alone. COVID-19 not only brought to light the problems in healthcare equity but also the need for integrated care and for local teams to collaborate and identify barriers to develop local solutions.

Audience Q&A

How would you define integrated care in one sentence?

Dr. Forest noted that there are many different aspects of integrated care, making it difficult to define. He has read reports that provide multiple definitions of integrated care and then conclude that there is no best way to define the term. It has been defined in relation to different clientele or different contexts, but there is no real consensus.

Elder Price stated that integrated care means respect, reciprocity, equity, and moving away from politics. It means shared decision making with patients and healthcare professionals.

Ms. Romain noted that integrated care should be centered on the person/patient and what their definition of integrated care is. Integrated care encompasses better access, better navigation, and better communication, but the way to get there is complex.

What is the role of the federal government—or inter-provincial/territorial collaboration—on implementing integrated care?

Dr. Forest identified a need to increase capacity at the federal level to achieve desired outcomes, specifically by sending money to provinces. There is also a need to facilitate communication and learning among the provinces and territories. Dr. Forest noted that there is resistance to learning from other provinces or adapting work across provinces due to different contexts.

Elder Price commented that money-saving initiatives are often prioritized instead of what can really help people become well.

Dr. Forest, you note that government won't take risks with pilot projects. What do you think could be done to get them to do so?

Dr. Forest discussed how academics are also guilty—we like to see our projects do well, and we like to publish. Thus, we tend to limit risk when developing projects. Many pilot studies are successful because they were designed not to fail; this implies many constraints that don't allow us to replicate our work in other contexts. Dr. Forest believes we need to accept more risk in our studies.

Ms. Romain, can you talk about creating OHTs in rural and sparsely populated areas? How is it different from urban Ontario?

Ms. Romain emphasized that OHTs in rural areas have more primary care leadership and community partners; whereas, in urban settings the focus is more acute care. Geography makes a difference in that there are different challenges faced by community members, making solutions different as well.

How do you view virtual care in relation to integrated care?

Elder Price has been going into hospitals to see families for eight years but had to move her support to virtual care. She discussed how being on Zoom is difficult, but it does have the benefit of creating more opportunities for integrated care (i.e. less travel, involvement of more providers).

Ms. Romain discussed how virtual care during COVID-19 has exploded and has been mostly an enabler. She referred to a project in long-term care in Toronto where staff were able to access specialists when people couldn't move in and out of long-term care homes. People could also be remotely monitored post discharge from acute care. One issue with virtual care is equity, in that some people aren't able to access it.

Dr. Forest was struck by the ability of the healthcare system to transition to virtual care so quickly. Things that seemed impossible before COVID-19, became possible; obstacles disappeared due to the pressure of the pandemic. He discussed some of the drawbacks of virtual care; specifically, that it doesn't support the social aspect of integrated care, it makes developing relationships difficult, some services require direct health provision which virtual care has made very difficult, and it can't address the full spectrum of patients' problems.

Which outcomes (e.g. population health, patient or provider satisfaction, etc.) are you referring to when you talk about "outcomes driven investments"?

Dr. Forest discussed how "outcomes driven investments" was created as a label to think about the marginal investment in health and social care, and to ask ourselves how to produce the best outcomes in terms of population wellness. Research has shown that investing in social policy, programs, and education is a much better way of investing marginal dollars than having, for example, a new MRI machine in a rural area.

What are appropriate measures of system integration and networking in primary care? How do we know when we are more integrated than before?

Ms. Romain responded by emphasizing that an integrated system means that people are attached, they can get access to providers, and they are happy with services. It is challenging to establish the appropriate measure of outcomes. She discussed how there are factors that are typically easier to measure and tend to be the focus of governments or regions (e.g. attachment rates to primary care, referrals), which are great at an aggregate level, but it's also important to assess patient satisfaction, access, and having needs met beyond primary care.

Elder Price responded that the best way to measure integrated care is by lives saved, patient satisfaction, and by more people being well across the country. In terms of how we know that care is better integrated than before, she discussed decolonization, looking at different ways of knowing, and changing policy around how we welcome more people to show a greater reflection of Indigenous peoples in healthcare.

Dr. Forest pondered how we can integrate information from different providers and how we can ensure that healthcare providers will have a complete understanding of people's contexts. Integrated care requires an integration of information about the person; it is not enough to fix the acute problem, we also need an understanding of the whole person and their community.



DAY I SESSION II

Integration of care: What do we know?

This panel provided international and Canadian examples where an integration of care approach has been successful.

Interdisciplinary clinical care network for post-COVID recovery: A BC example

Speaker: Adeera Levin, Head, Division of Nephrology, University of BC

Dr. Levin described the BC Post-COVID-19 Interdisciplinary Clinical Care Network (PC-ICCN) as a case study of integration of clinical care and research. The PC-ICCN aims to integrate care models and care providers and is patient-centered and patient-informed. Its purpose is to guide the development and maturation of a BC network focused on patients who have recovered from acute COVID-19. Its clinical goals are to improve patient outcomes, enable responsible resource utilization, guide health care professionals and patients based on best evidence, and enhance capacity within primary and specialty care. Systematic collection of information will enable improved understanding of biological consequences and mechanisms, promote responsible ordering of tests for surveillance, diagnosis, and monitoring, and lead to improved management of complex patients through shared learning and collaboration between specialties. A coordinated research (basic, translational, clinical and implementation) effort will reduce burden on patients (e.g. by avoiding duplication of forms and tests) and will increase sharing of results between scientists, clinicians, and policy makers.

Network components

- Clinical programs (within regional health authorities)
- Provincial post COVID-19 helpline (for practitioners)
- Provincial registry of patients
- Provincial guidance and education (with and for primary care providers, patients, and specialists)
- Provincial research activities leveraging existing protocols and funded research

As of March 2021, there are three post COVID-19 recovery clinics in BC, at St Paul's Hospital in Vancouver, Vancouver General Hospital, and Jim Pattison Outpatient Care and Surgery Centre in Surrey. There is ongoing engagement with primary care providers, a Rural Coordination Collaborative, and regional health authorities outside Metro Vancouver. A helpline was established to answer urgent clinical questions. Standardized testing schedules, clinical assessment tools,



referral pathways, and clinical guidelines have been developed. The standardized approach to clinical care provides patients with a coordinated assessment; access to appropriate specialists, investigations, and patient education; and any additional services required for individualized care and long-term monitoring.

Enabling a province-wide approach

Challenges for developing a province-wide approach to care and research include coordinating with multiple clinics and health authorities and different approaches to data privacy and human resources. New clinics will need to implement the standardized approach to data collection, which will add complexity. Qualified investigators within each health authority will have to be identified and recruited as research and clinical leads. Resources for clinical and research support will have to be identified. Solutions to these challenges include stewardship of the data collected at established clinics; collaboration between clinicians and researchers regarding implementation of standard procedures; and health authorities understanding the need for infrastructure support.

The opportunity

Dr. Levin concluded by saying that this network could create truly integrated access to clinical care and research capabilities in the context of a new disease in collaboration with all stakeholders across a province. The network could reduce variation in care, testing, and access and decrease visits to outpatient offices, emergency departments, and walk-in clinics. It may also improve knowledge of long-term impacts of COVID-19 and provide an opportunity to establish sustainable infrastructure for future pandemics and public health emergencies.

International learnings from case studies: Organizational practice combined with jurisdictional practice

Speaker: Walter Wodchis, Senior Scientist, Institute for Better Health, Trillium Health Partners

Dr. Wodchis began by explaining that emphasis should be put on integrating health and social care services to meet the needs of individuals with complex health and social needs in community settings. Ideal models of integrated community-based primary health care are comprehensive, person-oriented, inclusive of carers and family, health promoting, strengths-based, and without a singular disease focus. They also address inequity in health and risk across population sub-groups. He then drew on learning from seven years of international case studies, including:

1. A seven-country study of integrated care programs (c. 2014)
2. Nine case studies of integrated care in Ontario, Quebec and New Zealand (iCOACH study) (c. 2014-2018)
3. 30 programs in 11 countries that address the needs of high-cost, high-need patients (c. 2019)



International learning 1

“Lessons learned” from providing integrated care for older people with complex needs include the need to focus on clinical integration rather than organizational or structural integration. Success appears to be related to good communication and relationships among those receiving care and the professionals and managers involved in delivering care. Effective models employed multidisciplinary teams with well-defined roles and joint responsibility for care.

Integrating care is a bottom-up process that coordinates care at the local level for shared patients. It is enabled by system-level priorities, funding, and technological supports that enable and remove barriers to sharing information and care. This approach takes time, is an ongoing process, expands the horizons of what kinds of care are integrated, and takes the focus from individual to population health.

International learning 2

- **Ontario**
Ontario has fairly comprehensive funding of home and community services. Ontario would seem to have in place all the elements of a broad continuum of primary health care, but these different elements continue to operate relatively independently with no overall coordinating strategy and few mechanisms to integrate client care across providers and settings.
- **Quebec**
In Quebec, there were early aims to integrate health and social services into community health centres. There was delayed promotion of primary care practices in Family Medicine Groups with additional health service providers (e.g. nurses and nurse practitioners). It is important to highlight that structural integration of several components of the continuum of care does not mean that services are well integrated.
- **New Zealand**
In New Zealand twenty District Health Boards (DHB) are responsible for the planning and delivery or contracting of comprehensive health services in geographic regions. DHBs have multiple alliances with the 32 Primary Health Organizations who contract with primary care physicians. The most promising initiatives for integration have been through Maori Whānau Ora initiatives with joint Maori community and institutional providers.

Overall, policy contexts can provide financing and incentivize local providers to collaborate. Policy requirements for shared care planning (as in Quebec) provide a top-down strategy to integrate care. Integration itself is a bottom-up activity built upon trusting relationships enabled through co-design and co-delivery.

International learning 3

- **Program elements**

The three program elements included segmentation (e.g. outreach), eligibility criteria, and recruitment. Coordination included program intake, assessment, planning and coordinating health and social care. Engagement included support for shared decision making, patient self-management, and caregivers.

- **Policy**

Top-down approaches included bundled budgets, revised staffing models, inter-organizational governance and accountability mechanisms, and rigorous external evaluation. Bottom-up approaches included local discretion in spending (e.g. gym memberships, pharmacy debt), local role adaption (e.g. redeployed hospital staff), local partnerships (e.g. local steering committees), and local quality improvement (e.g. monitoring data by local steering committees).

This work recognizes the importance of addressing the agenda of integrated care for populations with complex needs. It is important to provide stimulus through funding or other means to support the development of local initiatives to improve care. Top-down policies that require structural or organizational mergers at the outset slow progress. Barriers that make it more difficult for providers to integrate care, such as differences in financing and eligibility of patients for needed care, should be removed.

Key take-aways

Care integration is realized at the patient and provider level. Improving integration requires resilient and trusting relationships between patients, caregivers, and providers; and among providers; with managerial and leadership support across distinct organizations. Providers and patients can suffer from inertia and require stimulation to break out of existing patterns. Finally, policy priority, resources and supports can act as accelerants.

The role of digital health in integrated care delivery

Speaker: Carolyn Steele Gray, Scientist, Bridgepoint Collaboratory for Research and Innovation, Lunenfeld-Tanenbaum Research Institute

Dr. Steele Gray began by identifying digital health tools and concepts, including:

- eHealth—information communication technologies
- mHealth—mobile devices
- Telehealth/telemedicine/telecare—phone or video care)



- Health records—electronic medical records, electronic health records, personal health records
- Health Information Exchange
- Big data in health
- Artificial Intelligence in health

She then explained that the conceptual framework for digital health in integrated care includes:

- Triple Aim outcomes (cost and utilization, population health, experience of care)
- Micro, meso, and macro level
- Vertical and horizontal integration, whether at the clinical, professional, organizational, or systems level
- Functional (e.g. activities, action, new policies) and normative integration (e.g. values, beliefs, shared aims)
- Technology as a social artifact (shaped by context and has the power to shape context)

Prior to COVID-19, the iCOACH comparative case study (discussed above) of three Ontario, three Quebec, and three New Zealand cases was conducted. The key questions asked were:

- What functionality, use and role does technology play to enable activities of integrated models of community-based primary health care?
- What are the implementation enablers and challenges in adopting technology across different organizational contexts?

Digitally enabled integrated care activities

Overall, Dr. Steele Gray described the use of technology in integrated care as “interesting”. For care coordination, technology was often a static care plan in an electronic medical record where only some members of a care team had writing privileges, making coordination challenging. In clinical decision supports, the use of technology was most often around accessing evidence-based guidelines and did not align with a more holistic approach to care. In quality improvement, technology was valued by leaders in collecting performance measure data; however, not all providers saw that data as important or relevant to integrated care.

Implementation factors

An implementation science lens was used that focused on policy. Factors were explored through implementation narratives focusing specifically on how information sharing to support care

coordination was enabled or hindered by individual, organizational, environmental, and technological factors.

How the policy context shaped implementation

All three jurisdictions (Ontario, Quebec, and New Zealand) have strong legislation and regulations around patient data privacy and security. This is critically important as it shaped how technologies were put into place to support integrated care.

Ontario has a “light-touch” policy environment as well as grassroots interventions. There is some fragmentation in the system. The policy environment and security regulations lead to increased workarounds and multi-step connections.

This is a centralized government initiative in Quebec. There are several centralized digital assets including a regional utilization and home support platforms. The policy environment and security regulations led to increased permission (access) but there are barriers based on professional designation.

In New Zealand, there is a blend of top-down and bottom-up approaches. Integrated models are based on local initiatives. There are centralized digital assets with unique patient identifiers. The policy environment and security regulations are improving but there are still multiple logins and professional restrictions. The policy environment and security regulations in all regions are made more challenging due to organizational and professional inertia.

Effect of COVID-19

Virtual visits increased significantly early in the pandemic but declined later. COVID-19 led to disruption of organizational and provider inertia. Regulatory changes in Ontario during COVID-19 allowed organizations to select their own platforms. Temporary virtual care billing codes were implemented on March 19, 2020. There were also amendments to privacy and security legislation expanding the ability to link data across platforms. Overall, payment mechanisms improved, and an interoperability precedent was set.

The opportunity and the risk

Dr. Steele Gray concluded by identifying the opportunity—that broader adoption of technologies to enable different activities of integrated care supports the normative and functional aspects. She emphasized the importance of keeping the longer-term vision of what are integrated care model could look like in mind. If we lose sight of this vision, a rapidly-changing environment could put technology systems in place that lead to greater fragmentation and increased inequity within our system for different populations, organizations, and teams.

Audience Q&A

The three post-COVID-19 clinics are located in Vancouver—how do they enable equitable access for patients outside the city?

Dr. Levin replied that the bulk of hospitalized patients were in this area, and that although the clinics are in Vancouver, they are accessible to rural populations via a “buddy system” with the Vancouver Island and Interior health regions.

How much of the integration you see elsewhere is possible because of single health systems? Do our provincial systems make this tougher?

Dr. Wodchis replied that across the world, health and social care systems are not integrated (Scotland may be an exception) and they all face barriers. The provincial systems don’t necessarily make integration hard. However, independence of physician budgets from the rest of the health system do. New incentive funds for collaborative model of cares are needed.

We have stumbled for years with electronic medical records and other digital technologies in Canada. How much of a barrier does this represent?

Dr. Steele Gray noted that there are different implementation factors with electronic medical records as they are contextual and varied. There is often an initial barrier, a “J” curve, and then increased uptake. Co-designing with users is important for implementation.

You mentioned fights over data privacy. How have these issues impeded care integration in your examples?

Dr. Levin answered that the COVID “cloud” in BC for administrative data is has been useful. There is a need for complex data sharing agreements to facilitate this. Some challenges include accountability for use. Perhaps start with view access, then commentary, then open flow. There is a need to ask patients and providers themselves what their privacy needs are. This is mostly assumed. The legalistic interpretation of privacy remains a barrier.

How are practitioners working within the pilot project compensated? Were incentives needed and, if not, do you think they would be needed to expand?

Dr. Levin explained that the teams are funded by regional health authorities, and Doctors of BC funds, on a fee for service model.

What does good co-design look like?

Dr. Wodchis replied that good practices in co-design include job shadowing for mutual knowledge and building trust. The answers to our problems lie with those experiencing them. Iterative engagement yields solutions.

If inertia is an issue, what is the best way to get past it—incentives, orders, or something else?

Dr. Steele Gray replied that the best way to surpass inertia is to ask the people involved, and to focus on engagement, building relationships, and a shared aim/vision.

Can you speak to the involvement of patients in different parts of the network?

Dr. Levin replied that patients are involved at all levels including boards, steering committee, and understanding data. There is targeted recruitment and careful attention to who is being engaged for representation of the community and equity. There is involvement at the outset. Mixed methods data are used.

Can you expand on your plans to virtualize the patient journey (ongoing monitoring, experience and outcome reporting, peer supports, visits)?

Dr. Levin replied that patients select virtual vs. in-person visits. There will also be standardization. Reporting will occur when there is enough meaningful information. Materials will be designed with patients.

What processes and mechanisms were used to build essential relationships?

Dr. Wodchis replied that relationships must be based on understanding each other's roles, responsibilities, and capabilities.

Is there any initiative in Ontario to evaluate Ontario Health Teams on use of virtual care? Will there be any indicators looking at virtual care use with funding tied?

Dr. Wodchis responded that there is an indicator for virtual access to care across Ontario Health Teams.

COVID-19 may have disrupted some organizational and political inertia; how can we maintain momentum post-COVID-19?

It is unfortunately already waning. There is a need for accountability to disinvest from status quo. Integrated care is an essential component of population health.



DAY II SESSION I

The do's and don'ts of nurturing local collaborative capacity to support health sector integration: Reflections on recent experiences in New Zealand and beyond

Speaker: Tim Tenbenschel, Associate Professor, School of Population Health, University of Auckland

The keynote on the second day of the conference focused on the importance of policy enablers coupled with collaborative local integration. Dr. Tenbenschel reflected on the conditions necessary (and potentially sufficient) to nurture inter-organizational collaboration to facilitate integrated care over the long term in public health systems. This is critical given that integrated care systems tend to fail when inter-organizational collaboration is weak. He drew on experience in New Zealand and Canada, which share key characteristics, including primarily public funding, decentralized administration, primarily non-government providers, and contemporary issues related to marginalization and colonization.

He drew lessons from four projects:

1. **System level measures framework**
A National New Zealand initiative to stimulate local integration, quality improvement, and equity.
2. **iCoach**
A New Zealand case study (also described above).
3. **Auckland Regional After Hours Network**
A local initiative to make health care more accessible on evenings and weekends.
4. **Ontario Health Links**
Building inter-organizational approaches to integrated care locally.

Structurally, initiatives calling for inter-organizational collaboration often come from middle management in health sector organizations and are thus subject to pressure from above (senior leadership) and below (front line staff) to succeed. In addition, success is contingent on local and contextual factors including policy and health system characteristics. As a deviation from the status quo, collaborative management has barriers to successful implementation, including issues related to costs (in terms of time, resources, and emotional energy), legitimacy (exclusions from



collaboration, diffusion of accountability), power (often entrenching existing power relations), and complexity (in selecting scope and focus of collaboration).

At the local level, threats to inter-organizational collaboration include: lack of support or pressure to produce results too soon from senior management; conflict between senior leadership of organizations; exhaustion and burnout among those responsible for fostering inter-organizational collaboration; insufficient resourcing for collaboration or competition for/lack of dedicated resources; staff turnover and lack of continuity; and potential stakeholders viewing collaborations as a threat or lacking legitimacy.

In contrast to these threats, necessary conditions for nurturing inter-organizational collaboration include: formalized structures for inter-organizational relationships; trust between senior leadership of organizations; appropriate and secure resourcing for collaboration; provision of constructive feedback (e.g. through sharing data on relevant indicators); and spreading of collaborative load over people and time.

Dr. Tenbenschel also highlighted that while collaboration is often viewed as being inherently equity-enhancing, this actually depends on who is or is not involved (as a collaborator). As such, collaborations can as easily entrench marginalization as address it.

Unfortunately, there are no easily identifiable sufficient conditions for the long-term success of inter-organizational collaboration. Having the necessary conditions does not guarantee that the collaboration will be successful—a certain amount of luck is involved. The goal of future work should be to identify what can be done to increase the chances of collaborations surviving and how to establish more permanent cultures of inter-organizational collaboration.

Respondent: Mary Beaucage, Can-SOLVE Chronic Kidney Disease Network Patient Governance Circle

Ms. Beaucage, of the Nipissing First Nation, reflected on her experiences as a kidney transplant patient and as a partner and advocate of patient-oriented research, as they relate to the challenges of inter-organizational collaboration and integrated care. From an Indigenous perspective, healthcare is supposed to be coordinated between the federal and provincial systems. However, her transplant experience demonstrated a lack of effective coordination, as it took almost a year for the Manitoba, Ontario, and federal governments to resolve payment details. She echoed Dr. Tenbenschel's comment on equity being a product of who is involved in collaboration. In particular, she challenged the idea that people or patients should “stay in their lane” in terms of the socially and historically defined roles and encouraged interdisciplinarity to advance equity in collaborations.

Audience Q&A

How useful are provider incentives in establishing integrated care networks?

Dr. Tenbenschel answered that while there was some application of incentives in primary care, the ability of organizations to offer them is often limited to small scale disbursements from flexible funding pools as larger district health boards lack the ability to allocate funds for discretionary purposes.

What is the role of patients in integrated care?

Ms. Beaucage answered that patients should be their own advocates, not be passive recipients of care, and seek involvement in advocacy organizations to help create an environment where the patient voice is routinely part of the process of care. Dr. Tenbenschel built on these sentiments, identifying a need for patient councils with underrepresented voices in local decision making in New Zealand. Both identified that it is challenging for patients to break out of their traditionally passive roles, and that this is a structural issue in health systems.

What should be sacrificed in order to fund collaboration?

Dr. Tenbenschel answered that this is challenging as funding decisions are often opaque, and noted that acute care (rather than community-based care) tends to be a funding magnet, while not necessarily lending itself to effective integrated care supporting inter-organizational collaboration.

What is the role of evidence in driving leaders to undertake collaboration?

Both Dr. Tenbenschel and Ms. Beaucage identified the challenge of isolating the specific effects of collaborations and how requirements for evidence of an effect, especially early on, can be detrimental. Collaborations are more likely to succeed where the organizational culture is built around trust (as opposed to expectations around returns on investment or contractual obligations).

Are there potential for harms for patients being subject to constant experimentation and changes in care processes?

Ms. Beaucage reflected that patients can be harmed and that often patients are not included in knowledge translation efforts, such as being told the outcome of projects that their health path intersected with or asked about their experience. Patients should be involved from the outset. Dr. Tenbenschel built upon her observations and identified a particular challenge of time to institutionalize organizational change, with attrition becoming more common after 18 months as initial excitement wanes and personnel turnover occurs.

Who is accountable for integrated care, and what is the role of integrated care in rural areas?

Dr. Tenbenschel responded that accountability is based around liability and can run counter to the goals of integrated care, which requires trust between stakeholders. Instead, he advanced the use of the term responsibility, which implies a shared relationship. Ms. Beaucage echoed this idea and said that responsibility implied a process as opposed to discrete obligations. In response to the role of integrated care in rural areas, she voiced that due to resource constraints and the constant need to rely on others and informal connections, rural communities cannot have effective care without it being integrated.



DAY II SESSION II

What is needed to facilitate integration?

This panel provided examples of addressing structural issues and lack of integration from primary care and long-term care in BC, and identified opportunities for research.

Influencing organizational collaboration within BC

Speaker: Morgan Price, University of BC

Dr. Price presented work being done at the University of BC Department of Family Practice's Innovation Support Unit, a three-year-old team funded by the BC Ministry of Health. The group focuses on better collaboration with different groups at different levels. He described three levels of influencing collaboration:

1. **Micro level: Team Mapping**

Team mapping is a facilitated workshop where a primary care team works together to identify how they want to work together. Team mapping is a way to learn about each other's skills, be patient centered, and work through tensions. Due to COVID-19, the workshop is virtual.

2. **Meso level: Primary and Community Care Mapping**

Team mapping at the meso level is focused on teams such as community health centres, primary care networks, or patient medical homes. It looks at how care is delivered across multiple teams within communities to coordinate service for a population. The mapping uses simulated patient cases and asks team members how they might address aspects of care.

3. **Macro level: Team Based Care Advisory**

Team mapping at the macro level involves a diverse group of inter-sectoral stakeholders looking at how primary care team-based care can be moved forward in BC. The Advisory is focused on a series of workshops that looks at: why (what are our goals?), how (provincial collaboration), and what (individual to provincial system).

Dr. Price concluded his presentation by reflecting on 2020. His last conference in person was the 2020 CHSPR conference. He reflected that we do not do virtual as well as we do face to face care, and that we need more processes to help us work together and deal with tensions, especially now.



Long term care: The next chapter

Speaker: Jennifer Baumbusch, University of BC

Dr. Baumbusch began her presentation by emphasizing that long-term care is under-resourced, under-staffed, and under pressure. During COVID-19, resources have been focused on acute care, and much less so on seniors' care. She identified three main issues over the past three years: the evolution of ownership models; the evolution of the built environment; and the evolution of staffing models. She discussed how the focus of long-term care changed over the last year from person-centered care in January 2020, to infection control in March 2020, to having 840 outbreaks in long-term care across Canada in June 2020. There has been a huge impact in a short period of time on a sector that was already under pressure and under-resourced. Dr. Baumbusch then identified three areas of focus for building back long-term care after COVID-19.

1. **Where can we go from here to improve collaboration and integration of care?**

First, we need to design the space and place; campuses of care need to be integrated within the broader community (e.g. onsite medical clinics, dental clinics, pharmacy, labs). Second, we need built environments that support integrated care including best practices from person-centered care (i.e. private rooms and bathrooms, accessible outdoor spaces). Third, we need electronic health records to follow people across the system to enhance the continuum of care.

2. **Designing the workforce**

We need to design the workforce to include on-site nurse practitioners to decrease fragmentation of care. Research has shown that having more nurse practitioners supporting residents and their families decreases hospitalizations and decreases hospital length of stay. We also need to leverage virtual health platforms, evaluate what works best and not entirely go back to how things were pre-COVID-19. We need to promote the full and authentic integration of care aides into all aspects of care.

3. **Person-centered care**

Finally, we need to design around the person, and fund people rather than beds. We need individualized and direct funding models that are rights-based; funding and the care team needs to follow the person. For example, if a person is able to move back home, funding should follow them to allow them to access appropriate services. The Canada Recovery Caregiving Benefit (CRCB) has become a reality during COVID-19, after years of advocacy, in which individuals can receive up to \$500 per week for 38 weeks if they are caring for a dependent person at home. We want people to age where they want to age. People and their caregivers need to have the resources to make this possible.



Accelerating integrated care through research innovation

Speaker: Jessica Nadigel, CIHR Institute of Health Services and Policy Research

Dr. Nadigel began by identifying integrated care as necessary to achieve high quality patient care. Care needs to be integrated across the health sector, and health care needs to be linked to preventative and social care. She discussed how the Canadian Institutes of Health Research (CIHR) can support integration as a research funder.

Research has many impacts, including cultural, economic, environmental, social, and legal impacts; impact on health and well-being; policy influence and change; and technological development. To achieve impact, we need inter-disciplinary multi-jurisdictional teams, such as community-based primary health care innovations teams, with various professions involved. We need meaningful partnerships, engagement, and integrated knowledge translation, in which patients, families, caregivers, decision makers, and healthcare providers co-produce research. We need a direct link to healthcare priorities. We also need researchers to be embedded in health system organizations.

There are significant challenges to assessing the impact of health services and policy research on decision making. Key ingredients that funders look at to support impactful research include: multi-jurisdictional, interdisciplinary, and multi-sectoral teams; patient, provider, and decision-maker involvement; meaningful patient engagement; relevant priorities; integrated knowledge translation; researchers embedded within the system; diversity of funding programs; and the ability to assess impact.

Over the next five years, CIHR aims to accelerate health system transformation through research to achieve the Quadruple Aim and health equity for all. Priorities include:

1. To support and invest in research that leads to better outcomes, with better value, while improving equity and the healthcare experience for patients, families, and healthcare providers.
2. To modernize the healthcare system with digital health solutions and data science.
3. To integrate evidence into health services and policy decisions for improved health system performance and outcomes.
4. To strengthen capacity for evidence informed health system transformation.



Respondent: Kevin Turner, patient partner

Mr. Turner first shared how he became a patient partner after a negative experience with the healthcare system. Many mistakes were made due to a lack of an appropriate system, leading to extensive heart damage for him, and resulting in him consulting the legal system. He thought it would be better to work within the system as a patient partner to influence change.

He reflected on each of the three presentations:

1. In response to Dr. Nadigel's presentation

Meaningful patient engagement stood out as being very important. He emphasized the need to find patient partners who can engage in research rather than complain about the healthcare system. A strong patient voice and positive ideas will result in better outcomes and better value. He also noted that modernizing the healthcare system with digital solutions is the direction forward.

2. In response to Dr. Price's presentation

Mr. Turner reflected on his appreciation of the mapping concept discussed by Dr. Price, specifically how the process allows for learning about one another in a patient-centered way. He discussed how patients are consumers of healthcare and want proper, timely, and correct service. He urged everyone to keep this in mind in their research.

3. In response to Dr. Baumbusch's presentation

Mr. Turner appreciated the focus on patient-centered care. He discussed what he as a patient wants from the system: mutual respect; to be treated as an equal; to be able to collaborate in decision making; and to be involved in decisions that involve him. Finally, he wants no harms as a result of treatment, no errors in treatment, and he doesn't want to be treated as an inconvenience or an invisible person.

Audience Q&A

If you could pick one structural obstacle for provincial policymakers to tackle, what would it be and why?

Dr. Baumbusch focused on the workforce issues in long-term care, specifically how the situation has not improved over the years. She discussed the need to transform long-term care to make it an appealing place to work where there are education programs that prepare people to work with frail older adults. The last year hasn't done anything to improve the situation and there hasn't been any creativity about how to tackle these issues in the future.

Dr. Alex Singer, the session chair, agreed with Dr. Baumbusch about how the last year has made things worse, and asked if there is anything that we have learned in the pandemic that we can take forward. Dr. Baumbusch suggested giving care aides full time jobs and paying them a living wage. She emphasized the need to treat the workforce with more respect.

Dr. Price added that a structural issue is the organizational barriers between members of a circle of care and the need to address these. For example, these members might work across several organizations and even within one team, we might have multiple funding streams, creating fragmentation and barriers.

Dr. Price: Could your mapping work be scaled across large systems? It seems like a lot of local expertise and resources will be needed for expansion.

Dr. Price discussed how team mapping is by nature a bit intimate. Rather than having 1,000 people on a Zoom call talking about how teams work together, intimacy is what makes it valuable. He emphasized that the planning process is often more important than the plan. The Innovation Support Unit has scaled their work by training 235 facilitators across BC and creating both in person (pre-COVID) and virtual facilitator training.

Dr. Price: Can you comment on how the shift to virtual care has (or has not) impacted on relationship building within the teams as they work through this process.

Dr. Price discussed how virtual care has made relationship building much more difficult, as the important unofficial activities are not occurring (e.g. hallway conversations, meetings in the lunchrooms, lunch with friends, connecting with team members). The mapping process he discussed allows for check-ins and team huddles, which have become increasingly important. He also discussed how team mapping needs to be very structured, as we can't assume that everyone will engage in the same way they would if they were in a room. Generally, there are two facilitators for the mapping sessions where one is managing writing on the screen and one is managing the conversation. Both facilitators are overseeing group dynamics and paying attention to people who are disengaged or haven't had the opportunity to speak.

Dr. Nadigel: Is demonstrating impact a tool for seeking more funding, or for deciding who to fund in the future?

Dr. Nadigel responded that impact can be demonstrated at different levels. Impact is not necessarily a tool to seek more funding, but demonstrating the impact of research and using that to show how the work can be adapted to other settings is beneficial.

Mr. Turner: I agree completely that mutual respect is key. The problem is that this isn't emphasized in the training of health care professionals. Any ideas?

Mr. Turner wondered why mutual respect isn't emphasized in healthcare provider training. He provided some suggestions: learning to frame questions in different ways if you're not getting an answer, taking a holistic approach, treating people the way you want to be treated, and being kind to others.

Dr. Baumbusch talked about hard vs. soft skills in nursing and how we culturally value different skills. Students are often anxious and are looking to master hard skills, but there is a need to also foster soft skills such as mutual respect and communication techniques.

How do you evaluate the impact of the efforts or the changes that you are making?

Dr. Price discussed using a continuous quality improvement iterative approach. He noted that the Innovation Support Unit has looked more at program evaluation than at impact. They have gone back to clinics and teams and asked them how things have changed for them and/or whether certain

initiatives have worked. Although they haven't looked at hard outcomes, a lot of their evaluation has been related to quality improvement.

Dr. Nadigel noted that measuring impact is challenging. Often, research funding goes out for four to five years and then CIHR receives an end of grant report. CIHR is shifting away from standardized reports and toward individual reporting for programs to really get at the impact of programs and research.

Dr. Baumbusch drew on the long-term care perspective, noting that there is a need to look at measuring the quality of work-life and the quality of resident care, and how these two can be linked together. She noted that data is often collected on resident outcomes, but we don't always have good ways of using the data.



DAY II SESSION III

Closing

Speaker: Steven Lewis, health policy consultant

Dr. Lewis reflected on the aspects of integrated care that were discussed during the conference. First, he addressed the idea that “care is excellent, but not integrated,” observing that if care is truly excellent, then it must be integrated.

Many people are working on integrated care, but the instinct of most providers is to not want to do it. Why are people reluctant to engage in what they know needs to be done? Integrated care has not spread to many areas; it is complex, relationship-based, difficult to achieve and sustain, and a lot of work. Dr. Lewis pointed out that politics matter and that there is competition for resources. He wondered whether policies are needed to establish a context where integration is more likely to occur by making people more responsible—where people sense an obligation to improve. He wondered why there is a lack of progress when it comes to providing integrated care and what it is about integrated care that healthcare providers don't like. He suggested the fundamental reason for this might be because it implies interdependence, involves being responsible for achieving things beyond typical duties, and involves a lack/loss of control. We're often taught to be autonomous professionals with a domain of practice with deep expertise in an area—this is different than saying “I am a piece of the puzzle.”

Additionally, he discussed how health science education, practice, and accountability is still built largely on a biomechanical model. Person-centered care isn't often prioritized: it is often not about the person at all but rather the focus is on individual biological characteristics leading to increasingly specialized and specific interventions.

Dr. Lewis then provided some suggestions to reframe integrated care:

1. **We need to take a wider view of integration**

We currently see it as the structural and clinical integration of organizations, as financial resources and incentives, as policies, and as a way of ensuring that the well-functioning parts work together to meet someone's needs. But there are more fundamental issues. We really want the person to be at the centre of healthcare and we want to deliver good care from the perspective of the person.

2. **Return to generalism**

If we are really going to focus on integrated care, every specialist and everyone who works in the system needs to have a generalist perspective where holistic care is valued even when providing very specialized care. The whole person's context, values,



environment, and preferences need to be kept in mind. Otherwise, specialization can become a risk factor; specialization is still a fragmented approach to providing care even if it is essential and valuable. We need to restore the fundamental primacy of the relationship with the patient and make sure that is integrated into all aspects of care.

3. **The biggest integration needs to take place within our own minds**

We need to understand the concept of who the person is first, before thinking of integration in a structural way. If providers can think in an integrated way about the person, then the integration that needs to happen across teams and organizations will occur more naturally. We need a fundamental recognition that everything we do needs to relate back to a person as a whole. The focus on social determinants of health needs to be emphasized where multiple approaches and people are working together.

4. **Inter-organizational collaboration and trust**

Maybe there are too many organizations. We still have a very fragmented and structural approach to healthcare. We say we need a system that can be adaptive and flexible enough to meet people's emerging needs, but we don't trust the system to do that. Referring back to Dr. Forest's presentation, Dr. Lewis emphasized that we need to trust experimentation. Projects are often designed to be safe and planned to be successful. If they're too safe, they're not imaginative; we need true experimentation to create change, supported by resources and funding.

Dr. Lewis concluded the conference that by combining generalism, an integrated perspective on the person, and enhanced conditions of trust at the person, organizational, and policy level, we have an opportunity to move forward to improve integration.

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