

Listening *for* Direction III

NATIONAL CONSULTATION ON
HEALTH SERVICES AND POLICY ISSUES
► 2007-2010



February 2008 | FINAL REPORT

Canadian Health Services Research Foundation AND
Canadian Institutes of Health Research, Institute of Health Services and Policy Research

IN PARTNERSHIP WITH:

Canadian Agency for Drugs and Technologies in Health
Canadian Healthcare Association
Canadian Institute for Health Information
Canadian Patient Safety Institute
Health Canada
Statistics Canada

Reference as:

Susan Law, Colleen Flood and Diane Gagnon on behalf of the *Listening for Direction III* partners

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SUSAN LAW, COLLEEN FLOOD AND DIANE GAGNON,
ON BEHALF OF THE *LISTENING FOR DIRECTION III* PARTNERS

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LETTER FROM THE PARTNERS – OTTAWA, JANUARY 2008

We are pleased to present the results of *Listening for Direction III* (Lfd III), the third joint national consultation to determine health services and policy research priorities in Canada. For the 2007 exercise, we welcomed three new organizations to the partners group: the Canadian Patient Safety Institute, the Canadian Healthcare Association and Health Canada. Planning for Lfd III began in late 2006. The Lfd III partners built upon the foundations and experience of Lfd I in 2001 and Lfd II in 2004. It was agreed that the format and process would remain broadly the same (a series of workshops with invited healthcare leaders from academic and healthcare institutions, a translation workshop and the production of a final report), with three important differences.

First, the partners agreed to include voluntary health organizations as invited participants. This was inspired by a partnership initiative between the Canadian Institutes of Health Research – Institute of Health Services and Policy Research and the voluntary health sector. Second, although it was felt to be important for participants to consider current health system priorities in light of previous Lfd themes, we agreed to attempt to start with a fresh slate out of concern that, in this third round, participants could be unduly influenced by the appeal and consistency of past themes. Interestingly, important new themes did emerge from the 2007 consultations, yet certain issues and themes are persistent, some recurring with renewed vigour, such as health human resources, albeit with nuances reflecting today's context. There was ample indication that the most challenging issues in health services delivery and organization are neither quick nor simple fixes; the need for creative and collaborative problem-solving between researchers and decision makers is still very much present. The third and most significant difference was that partners agreed it would be ideal to include the territories in this dialogue. Health Canada provided additional funds to permit consultation sessions in Nunavut, the Northwest Territories and the Yukon. Key findings have been incorporated here and a separate Lfd III report on the northern dialogues has been produced as a sister document to this overall report.¹

The reader is reminded that the intent is not to provide an exhaustive listing of all health system issues and the corresponding research priorities, but to identify the broad, compelling priority areas where an infusion of scientific evidence will help to inform decision-making about improvements in the organization and delivery of the healthcare system.

The work of the partners does not end here. We have committed to playing a more rigorous role in evaluating the outputs, relevance and impact of the Lfd process between consultation periods. We hope that this exercise continues to stimulate useful linkages between the academic and decision-making communities across Canada. We welcome feedback on this report.

Collaboratively yours,

- Canadian Health Services Research Foundation
- Canadian Institutes of Health Research – Institute of Health Services and Policy Research
- Canadian Agency for Drugs and Technologies in Health
- Canadian Healthcare Association
- Canadian Institute for Health Information
- Canadian Patient Safety Institute
- Health Canada
- Statistics Canada

1 Canadian Health Services Research Foundation (CHSRF). (2007, October) *Listening for Direction III: Report on the Northern Dialogues*, Final Report to Health Canada. Available on CHSRF and Health Canada web sites: (www.chsrf.ca); (http://hc-sc.gc.ca/sr-sr/part/ngo-ong/index_e.html)



SECTION I: INTRODUCTION AND SUMMARY OF OUTCOMES

This is the report of the third joint national priority-setting exercise to determine health services and policy research themes that are responsive to critical issues in the organization and management of the Canadian healthcare system. The objective is to provide a common road map for national granting and knowledge organizations to help guide investment decisions for research funding and related knowledge exchange activity. This approach – working together at a pan-Canadian level to conduct the exercise, create a common research agenda and collectively monitor the activities of our partner organizations – encourages the co-ordination, collaboration and complementarity of programming among partner agencies, and we believe that it benefits the scientific and decision-making communities. The background, process and results of previous listening exercises are included in Section II.

The number of funding partners has grown in each successive *Listening for Direction* (Lfd) exercise; eight partners participated in Lfd III. In this round, for the first time, we were able to include consultations in the three territories of Canada with funding support provided by Health Canada. In addition, the voluntary health organizations were included as invited participants to the individual sessions (five regional, one national and three territorial). Overall, 202 people attended the Lfd workshops (of the 1,230 individuals invited), including 107 decision makers, 40 researchers and 55 "others." See the list of organizations invited to the workshops in Appendix I.

Eleven research themes emerged from the *Listening for Direction III* consultations; theme descriptions and illustrative questions are presented in Section IV.

RESEARCH THEMES FROM THE 2007 Lfd III PRIORITY-SETTING PROCESS

- Workforce and the work environment
- Change management for improved practice and improved health
- Data, information and knowledge management
- Values-based decision-making and public engagement
- Patient-centred care
- Patient flow and system integration
- Chronic disease prevention and management
- Health system financing and sustainability
- Emerging technologies and drugs
- Quality and patient safety
- Linking population and public health to health services

Many important considerations were tabled as enabling factors to support the process of implementing change through knowledge transfer and exchange mechanisms. Feedback from participants to date indicates that this was considered a useful exercise; the partners received encouragement for more evaluation of the overall value and impact of the process, and suggestions about how to create better linkages in future consultations with the provincial funding agencies in consideration of their priorities and challenges.

SECTION II: OVERVIEW OF THE PROCESS

WHAT IS LISTENING FOR DIRECTION?

Listening for Direction is a process for setting health services research priorities that reflect the needs and concerns of decision makers in the Canadian healthcare system. The primary aim is to identify areas where investments in research are most likely to help to improve system-level decision-making. The process requires the significant involvement of healthcare managers and policy makers in the consultation meetings to identify and prioritize current and longer-term issues. The process also requires the involvement of lead researchers to help translate decision makers' needs for information into researchable questions. *Listening for Direction* is based on the principle of "linkage and exchange" whereby funders, researchers and research users are brought together in the interest of promoting the production of timely, relevant evidence to inform healthcare decision-making.²

WHY LISTEN FOR DIRECTION?

The *Listening for Direction* partnership is composed of national agencies that fund health services and policy research and/or related knowledge transfer activities in Canada. Every three years since 2001, national partners have conducted *Listening for Direction* to help guide their investments in research and related activities. The common bond is a belief in the value and contribution of research evidence to inform decisions about our healthcare system, and in the value of "user" engagement (decision makers and researchers in this case) in terms of ensuring the relevance and potential use of the results.

The partners join forces primarily to enhance co-ordination and collaboration:

- ▶ **Co-ordination** – by partnering, they coordinate efforts and resources to set national priorities and thus reduce the consultation burden (and cost) for partners and the wider academic and health service delivery community.

- ▶ **Collaboration** – once the LfD research themes have been developed following the consultation meetings, the partners meet to determine how best to ensure leadership and coverage for all of the themes, and where opportunities lie for complementary or joint action.

In short, and in economic terms (but not necessarily short economic terms), the partnership aims to maximize both efficiency and effectiveness in setting a common system-relevant research agenda within the partners' collective available resources.

LISTENING FOR DIRECTION I (2001–2004)

The first *Listening for Direction* exercise took place in 2001, and a national health services and policy research agenda was developed for the following two to five years. Five national organizations partnered in the process:

- ▶ Advisory Committee on Health Services of the Conference of Federal/Provincial/Territorial Deputy Ministers of Health
- ▶ Canadian Coordinating Office for Health Technology Assessment (CCOHTA)
- ▶ Canadian Health Services Research Foundation
- ▶ Canadian Institute for Health Information
- ▶ Canadian Institutes of Health Research - Institute of Health Services and Policy Research (CIHR-IHSPR)

This consultation resulted in the identification of 15 priority research themes, divided into primary and secondary themes.

2 Lomas, J. Fulop, N., Gagnon, D. & Allen, P. (2003) On Being a Good Listener: Setting Priorities for Applied Health Services Research. *The Milbank Quarterly*, 81(3), 363–368.

TABLE I: 2001 RESEARCH THEMES

| PRIMARY THEMES |
|---|
| <ul style="list-style-type: none"> ➤ Health human resources ➤ Financing and public expectations ➤ Governance and accountability ➤ Driving and managing system change ➤ Improving quality ➤ Healthcare evaluation and technology assessment ➤ Public advice-seeking in the era of e-health ➤ Improved access for marginalized groups |
| SECONDARY THEMES |
| <ul style="list-style-type: none"> ➤ Primary healthcare ➤ Globalization ➤ Regionalization ➤ Population health ➤ Continuum of care and delivery models ➤ Performance indicators, benchmarks and outcomes ➤ Evolving role of informal and voluntary care |

LISTENING FOR DIRECTION II (2004–2007)

In the second *Listening* exercise, held in 2004, the Canadian Health Services Research Foundation and CIHR-IHSPR were co-strategic leads, in collaboration with the three other LfD I partners. The Health Statistics Division of Statistics Canada joined as the sixth partner for LfD II.

Listening for Direction II distinguished two sorts of researchable questions from the identified priorities: syntheses of existing evidence – where there was felt to be a sufficient body of knowledge which could be synthesized within six to 24 months; and primary research – where new evidence was required which could be produced over the next two to five years.

TABLE II: 2004 RESEARCH THEMES

| |
|--|
| <ul style="list-style-type: none"> ➤ Workforce planning, training and regulation ➤ Management of the healthcare workplace ➤ Timely access to quality care for all ➤ Managing for quality and safety ➤ Understanding and responding to public expectations ➤ Sustainable funding and ethical resource allocation ➤ Governance and accountability ➤ Managing and adapting to change ➤ Linking care across place, time and settings ➤ Linking population and public health to health services |
|--|

FOLLOW-UP: PARTNERS' LfD-RELATED ACTIVITIES

The themes of *Listening for Direction I* and *II* informed several of the partners' investments in research and other activities. Examples of partner activities related to the *Listening for Direction II* themes include:

- The Foundation selected two themes as being central to its activities. Under the "Management of the Healthcare Workplace" theme, it funded two programs through its Research, Exchange and Impact for System Support (REISS) competition. It also commissioned two syntheses and a scoping paper. The Foundation was also involved in several networks related to healthy workplaces. Under the "Managing for Quality and Safety" theme, the Foundation funded three REISS programs (two of which were funded in partnership with the Canadian Patient Safety Institute) and commissioned two syntheses in partnership with the Institute.

- ▶ CIHR-IHSPR adopted *all* of the themes to guide its strategic budget investments (approximately \$8 million per year). For example, the themes were reflected in the Interdisciplinary Capacity Enhancement teams, the Strategic Training Initiatives in Health Research program, and priority announcements around the Operating Grants program. Priority announcements would include funding for research grants, peer reviewed as excellent but not funded under CIHR's general open competition because of resource constraints. These projects funded by CIHR-IHSPR include initiatives funded in partnership with the Canadian Patient Safety Institute. In addition, CIHR used the themes to guide some of its central programs, such as the Partnerships for Health System Improvement research projects competition.
- ▶ The Canadian Agency for Drugs and Technologies in Health (formerly the CCOHTA) conducted activities in six of the 10 theme areas. For example, it developed reports on issues related to "Timely Access to Quality Care for All" (including issues related to radiation, telephone triage and emergency room overcrowding) and to "Linking Population and Public Health to Health Services" (such as vaccine alerts). The Agency also undertook education and training initiatives, such as a course for journalists on "getting it right on new drugs," a component of the "Understanding and Responding to Public Expectations" theme area. As well, the Agency developed knowledge transfer initiatives, such as creating a format for reporting emergency room overcrowding.
- ▶ The Canadian Institute for Health Information used the themes to inform its strategic plan and carried out activities within six of the 10 priority theme areas. It developed reports on research findings concerning the following subjects: the minimum data set for health human resources; surveys on the supply of physicians and nurses; and emergency department use and wait times. The Institute also took part in research activities on topics such as wait times and access to care, quality and safety indicator development, and patient safety in Canadian hospitals.
- ▶ Statistics Canada was active in eight of the 10 theme areas. Through the Canadian Community Health Survey and the National Population Health Survey, Statistics Canada collected information on the health status of Canadians, important health determinants and healthcare services use, including national and provincial measurement of wait times and access to specialist services, non-emergency services and diagnostic tests. These and other data sources were used to publish national and provincial health and performance indicators and research on wait times and access to care; disparities in health, access to care and health outcomes; chronic disease prevalence, impact and outcomes; and micro-simulation models of the potential future impact of treatment and prevention efforts. In partnership with national health organizations, Statistics Canada conducted and reported on the 2005 Survey of the Work and Health of Nurses with the Canadian Institute for Health Information, and the 2006 National Survey of Primary Care Experiences with the Health Council of Canada.
- ▶ Health Canada has used LfD II as an input to its decisions concerning research priority-setting and resource allocation. The resulting research has been used in the department's policy and regulatory decision-making processes. For instance, Health Canada has used LfD II in support of its work on the regulatory policy environment with respect to food and drugs.

SECTION III: LISTENING FOR DIRECTION III PROCESS

In 2007, eight national organizations partnered for the third round of *Listening for Direction*:

- ▶ the Foundation and CIHR-IHSPR, who were the co-strategic leads
- ▶ Canadian Agency for Drugs and Technologies in Health
- ▶ Canadian Healthcare Association
- ▶ Canadian Institute for Health Information
- ▶ Canadian Patient Safety Institute
- ▶ Health Canada
- ▶ Statistics Canada

With additional financial support from Health Canada, the LfD consultations were extended for the first time to include the territories – the Yukon, the Northwest Territories and Nunavut.

For the 2007 *Listening for Direction* process, the objectives were to identify health system priorities for the short term (one to two years) and the longer term (three to 10 years). These results would be analyzed by researchers who would identify questions suitable for syntheses of existing research, and questions that required original and perhaps longer-term research.

Given the partners' concern about steering participants towards the results of the past two rounds of LfD, it was decided to approach the consultation meetings with a relatively "clean slate": *Listening for Direction II* themes were available for reference, but were not used as the basis for preliminary discussions. Despite this different approach, themes from LfD I and II re-emerged in this third round – a direct reflection of those issues that are persistent and perhaps inherent challenges to our healthcare system, such as human resources, quality and safety, and change management.

The 2007 consultations uncovered 11 priority theme areas (listed below). These overlap to some degree (namely, there are research questions that may be relevant to one or more theme areas.) In Section IV of this report, we provide examples of synthesis and research questions relevant to each theme area.

TABLE III: 2007 RESEARCH THEMES

- ▶ Workforce and the work environment
- ▶ Change management for improved practice and improved health
- ▶ Data, information and knowledge management
- ▶ Values-based decision-making and public engagement
- ▶ Patient-centred care
- ▶ Patient flow and system integration
- ▶ Chronic disease prevention and management
- ▶ Health system financing and sustainability
- ▶ Emerging technologies and drugs
- ▶ Quality and patient safety
- ▶ Linking population and public health to health services

THE PROCESS

The *Listening for Direction* model builds on the respective areas of expertise of research funders, researchers and research users. All groups participate in the process with varying degrees of intensity throughout its various phases. Representatives from the partner organizations (primarily research funders whose roles include knowledge transfer and research use) oversee the consultation process, listen to the discussions and, with the aid of expert researchers, use the concerns identified by decision makers and other research users to derive research questions. During the consultation workshops, research users identify priority issues that would benefit from being informed by research. Researchers "translate" those priority issues and concerns into research questions that are likely to provide evidence to help address those issues.

The *Listening for Direction III* process was divided into six phases.

FIGURE I – Timeline and Phases for Listening for Direction III

| |
|---|
| PHASE I |
| BACKGROUND INFORMATION |
| November to February 2006 |
| <ul style="list-style-type: none"> ▀ Environmental scan of health research funders ▀ Survey of health research provincial agencies ▀ Survey of the partners' leaders ▀ Compilation of activities relating to Lfd I & II priorities ▀ Survey of consultation invitees |
| PHASE II |
| CONSULTATION WORKSHOPS |
| February to April 2007 |
| <ul style="list-style-type: none"> ▀ National: Ottawa ▀ Southern regional: <ul style="list-style-type: none"> ▪ Vancouver ▪ Edmonton ▪ Toronto ▪ Montreal ▪ Halifax ▀ Northern regional: <ul style="list-style-type: none"> ▪ Whitehorse ▪ Yellowknife ▪ Iqaluit |
| PHASE III |
| TRANSLATION AND SORTING SESSION |
| April/May 2007 |
| <ul style="list-style-type: none"> ▀ Priorities → research/synthesis themes/questions ▀ Research vs. synthesis |
| PHASE IV |
| FINAL REPORT |
| September 2007 (draft) |
| February 2008 (final) |
| PHASE V |
| VALIDATION |
| March 2008 |
| PHASE VI |
| FOLLOW-UP ACTIVITIES |
| <ul style="list-style-type: none"> ▀ Ongoing |

Phase 1 – Background Information

In Phase 1, the partners gathered background information to support the consultation workshops. This information was provided to participants at the beginning of each of the nine workshops.

Partners carried out an environmental scan of health research funders to uncover other organizations' priorities and priority-setting processes. In addition, interviews were conducted about the value and impact of the *Listening* exercise with the member organizations of the National Alliance of Provincial Health Research Organizations and with the partners themselves. Partners also compiled the activities undertaken in order to begin an assessment of how priorities identified in earlier *Listening* rounds were being used.

In addition, and in recognition that only a portion of those invited to the *Listening* workshops would be able to attend, a pre-consultation survey was sent to everyone invited to the consultation workshops. This allowed more voices to contribute to the *Listening* process. For those able to attend, the survey served to prime them for the day's deliberations. A summary of the pre-consultation survey findings was presented at the beginning of each *Listening for Direction III* consultation meeting. It was also presented to the research experts at the translation workshop, as part of the input for the translation and sorting session.

Phase 2 – Consultation Workshops

Between February and April 2007, nine consultation workshops were held across Canada: one national workshop, five regional workshops in the South, and three northern regional workshops across the territories. Overall, 1,230 individuals were invited and 202 people attended the workshops. Of these, 107 participants were decision makers (including senior hospital and health region managers, clinical leaders, and national and provincial government policy analysts and advisors); 40 were researchers (mid-career and senior academics and researchers in decision-maker settings); and 55 came from a variety of other settings (such as consultants, knowledge brokers, research administrators, healthcare associations and professional associations). A list of the

organizations invited to these workshops is included in Appendix I.

The goal of the workshops was to identify emerging short- and longer-term priority issues from which research and synthesis themes and questions would later be developed. Participants were asked to prioritize immediate, short-, medium- and long-term issues.

Phase 3 – Translation and Sorting Session

A report was prepared for the translation and sorting session which provided a preliminary aggregation of the overall results regarding the health system issues identified at the consultation meetings; the summary results for each of the individual workshops were included for reference. A small number of health services research experts were identified by partner organizations and invited to a one-day meeting held in Ottawa at the end of April. Partner organizations were invited to sit as observers to this phase of the process. The expert panel included representation from across the country, content and research expertise across the broad range of theme areas, and expertise and experience in working with managers and policy makers in the healthcare system. The above documents were sent to the expert panel in advance for their review and reference during the session. The list of issues identified through the consultations were grouped and translated into 11 broad research theme areas at this meeting. A secondary step (which continued beyond the one-day session) was to develop illustrative examples of synthesis and primary research questions for each of the 11 themes that corresponded to the issues and questions raised during the sessions.

Phases 4 & 5 – Final Report and Validation

The partners developed this final report using the results of the translation and sorting session. It will be sent to all invited workshop participants, along with a survey inquiring whether the themes and illustrative research questions reflect their views regarding priorities, and whether they think the research results obtained by addressing these priority areas might be useful in their decision-making processes (see Appendix II).

Phase 6 – Follow-up Activities

The partners will use the final report and the validation survey to inform their respective strategic planning. The Coordinating Committee on Health Services Research – composed of the *Listening for Direction* partners – will continue to meet regularly to share information about activities undertaken to address the different themes (including research and knowledge transfer activities). The committee will take into consideration the capacities of the respective organizations to address specific theme areas and potential areas for collaboration.

The partners have agreed to invest jointly in a more rigorous approach to monitoring and evaluating the following elements: (i) progress on the theme-related activities; and (ii) the impact or value-added of this listening exercise across the themes and the different jurisdictions/regions of Canada, and among partners and the various communities of researchers and decision makers. The Foundation has volunteered to co-ordinate this effort on behalf of the partners as a component of its impact and evaluation portfolio. The partners acknowledge that, despite difficulties in evaluating the impact of previous *Listening for Direction* processes, this step is essential. The committee will determine how this evaluation is best achieved, including the potential involvement of workshop participants and consultation with other interested groups, such as the provincial governments and health services research funding organizations.

SECTION IV: LFD III PRIORITY THEMES (2007–2010)

Eleven research themes emerged as priorities from the nine consultations that took place across Canada from February to April 2007. As in 2001 and 2004, the first theme – the workforce and the work environment – continues to reflect health human resources as the highest priority area of concern to decision makers across Canada. The other themes are not ranked in order and no attempt was made to prioritize them.

For each theme identified below, we outline the scope and meaning as discussed during the workshops. Following each of the theme descriptions, we then provide illustrative questions suitable for synthesis (where sufficient research evidence exists that could be summarized within a shorter timeframe, such as one to two years), and for primary research (where new research is indicated which would require a medium- to longer-term timeframe to complete, such as two to 10 years). It is important to note that the questions listed below are illustrative – this is not a comprehensive or exhaustive list of synthesis and research topics that could be addressed under each theme area. Furthermore, there are aspects of some of the synthesis questions that may also lend themselves to primary research, as would the research topics listed below. These lists are presented as a guide and stimulus for developing research activities relevant to the priorities that emerged from this consultation exercise.

1) Workforce and the Work Environment

The workforce and the work environment continue to top decision makers' concerns, as in previous *Listening for Direction* consultations. Participants thought it imperative to find strategies to address staffing shortages, which are particularly acute in the North. Yet, overall, they felt the solution was not necessarily to train more of the same kinds of providers to do the same kinds of things. Research and strategies are needed to better employ existing providers, to develop new models for staffing (such as new team mixes, including non-traditional health system workers, or substitute providers, such as nurse practitioners for rural and remote areas including the North) and to develop new models

of practice (such as collaborative models of care and self-care). To support this, we need innovative education and training programs to help healthcare providers adapt to these new models and train staff for the future.

The issue of workforce migration, particularly for recruitment and retention, was raised in several regions: outflow (in the East); influx (Alberta); and permanent flux (in the North). Another common theme was the impact on the workforce and workplace of immigration patterns and trends in different parts of the country. Other issues identified included the impact of the aging population on the healthcare workforce (staff aging, the type of workforce/care needed to address the aging population), succession planning, a healthy workplace and safety issues. Finally, in light of the implications for the healthcare system (such as retention and productivity) and patient outcomes (for example, experience of care, mortality and morbidity), participants acknowledged the need to continue to invest in strategies to create and sustain healthy workforces and work environments in all settings and jurisdictions experiencing challenges.

ILLUSTRATIVE SYNTHESIS QUESTIONS:

- i– How do various training and education initiatives affect:
 - a. the quality, safety, cost and timeliness of healthcare services;
 - b. the willingness of providers to engage in team-based care and shared decision-making; and
 - c. job satisfaction and retention in the health care field?
- ii– How does the mental and/or physical health of the workforce impact on service delivery and patient outcomes? What is the impact on quality, safety, productivity and cost?
- iii– How do various remuneration mechanisms for providers, with respect to particular organizational contexts (such as primary care, community-based care, hospitals), affect the type, quantity, quality, safety, cost and timeliness of services delivered by providers? What are the effects on patient outcomes?

- iv– How do various non-financial factors – such as professional governance and health system structure – interact with remuneration mechanisms, and what is the impact on the type, quantity, quality, safety, cost and timeliness of services delivered by providers? Is there an effect on patient outcomes?
- v– What enabling factors and steps have allowed other jurisdictions to change the scope of practice, and what has been the impact on the type, quantity, quality, safety, cost and timeliness of services delivered by providers? What has been the effect on patient outcomes?
- vi– What approaches have been shown to be effective in integrating new kinds of workers – professional, paraprofessional and non-professional – into healthcare teams?

ILLUSTRATIVE RESEARCH QUESTIONS:

- i– What are the barriers (for example, political, economic and/or organizational) to changing the scope of practice of various healthcare professionals to better align human resources capacity with healthcare needs?
- ii– What are the implications of integrated teams and other new models of staffing and practice on patient outcomes?
- iii– What can the different Canadian and international primary care reforms teach us about transition to new team models?
- iv– What are the factors contributing to different regional experiences – including those in the North – with respect to the turnover of health professionals? What motivates professionals to stay or to migrate? Where, and under what conditions, have regions been successful with retention strategies?

2) Change Management for Improved Practice and Improved Health

The need for information and strategies to guide the implementation of evidence-based change was raised as an issue throughout the workshops. In other words, decision makers were looking for

ways to create bridges between the production of scientific evidence and the introduction of evidence into policy and the implementation of change. Participants expressed frustration with situations where sufficient evidence has been produced with results clear enough to drive policy change, but they have insufficient evidence regarding strategies for implementing change in the desired direction. Participants wanted better evidence and tools regarding how to bring about change. This was expressed as the need to uncover best practices, intervention/implementation studies, demonstration projects, impact analyses and evaluations. Decision makers also identified their need to understand how to engage providers (particularly physicians) and other stakeholders in renewal and redesign, and how to embed evidence into decision-making.

ILLUSTRATIVE SYNTHESIS QUESTIONS:

- i– What lessons are available from other sectors that could guide actions in healthcare, in terms of taking local or smaller successes or other positive developments and implementing them more broadly in the healthcare system?
- ii– Are there barriers to system transformation – even in light of clear evidence supporting change – that may be unique to healthcare? Are they amenable to policy influence?
- iii– How can models of evidence-informed promising practices in chronic disease prevention and management be disseminated and implemented across jurisdictions in the Canadian context, and reflect sensitivities related to geography and/or culture?
- iv– How can we better engage healthcare professionals in policy and system change and what factors result in positive participation by professionals in policy change? What strategies are effective in improving healthcare professional leadership and engagement in organizational change? What works under which circumstances? What strategies should be avoided?
- v– What is known from healthcare and other sectors about ways to cease or decommission “old” practices, approaches and policies in favour of new, evidence-informed practices, approaches and policies?

ILLUSTRATIVE RESEARCH QUESTIONS:

- i- What are the pathways and strategies to shift from successful innovative and proven practices in small-scale settings to widespread or large-scale change, such as for emerging or established quality and safety initiatives, or for models of chronic disease prevention and management?
- ii- In communities where change is difficult to achieve or where there are particularly challenging circumstances (for example, change comes at a fairly high cost relative to perceived benefit), what strategies are effective to plan, communicate and implement change for improved health? How do these strategies differ from isolated northern communities to inner-city populations, for example?
- iii- How can integrated information systems and knowledge management support or help to drive change in the right direction? What information do decision makers need at the beginning, throughout and following change in delivery systems to ensure the adequate capture of costs and benefits?
- iv- What are the relative contributions of factors such as power, leadership, resources and professional/organizational culture in supporting or impeding change and knowledge management?

3) Data, Information and Knowledge Management

An important new theme raised by decision makers in 2007 was the need to strengthen current information/data management and infrastructure. There was a concern that decision makers (and researchers) lack the right comparable data, and there is a need to better manage existing data – assess, collect, access and use them – and to find ways to integrate them across silos (organizations, sectors, jurisdictions, etc.). Participants highlighted the importance of having data that are presented in useable and meaningful forms from a decision-maker perspective, and that lend themselves to interpretation and application in particular management, clinical and/or policy contexts. Furthermore, some investment is required to determine effective strategies to enable the translation of existing data

and databases for use by decision makers. In certain jurisdictions of the country, such as the territories, there are substantial gaps in the availability of information and evidence regarding health status, the effectiveness of interventions, and processes of care and/or outcomes, as well as a limited capacity to use this information to inform decision-making. Information systems must be in place that can feed back to clinical practice in a bottom-up process. In addition, issues were also raised concerning the following subjects: creating, implementing and evaluating electronic health records; ensuring the appropriate use of data in electronic health records by decision makers and researchers; ethics; and privacy issues.

ILLUSTRATIVE SYNTHESIS QUESTIONS:

- i- What can we learn from Canadian and international experiences (for example, health maintenance organizations and veterans affairs systems in the United States; e-health strategies in the United Kingdom) regarding the integration of clinical and administrative information needs? Where have there been successful attempts to establish useful, timely, relevant information available for users at all levels of the system including primary healthcare and community care? What are the pathways to and factors that determine success? What are the challenges and barriers?
- ii- How can health information be managed and used to improve the capacity for evidence-informed patient care and decision-making in healthcare settings? How can it be used to improve decision-making, leadership, collaborative care, management and resource allocation processes?
- iii- What are the factors within particular contexts that will influence effective implementation, data input and support of information systems by providers, including user-friendliness, privacy and confidentiality, change management, incentives and training?
- iv- What does international experience reveal about the planning and strategies needed to ensure that decision makers and researchers make effective use of databases and the data residing in electronic health records?

ILLUSTRATIVE RESEARCH QUESTIONS:

- i- Assess and evaluate the development of electronic health records in Canada, particularly with respect to whether systems are being developed that allow a full spectrum of uses, including practitioner usability, clinical relevance, patient access/participation, system reporting, disease/outcomes surveillance and research.
- ii- How valid are health services research measures drawn from existing health databases and emerging electronic health records-based information systems? To what extent are data definitions for specific diseases – such as diabetes, congestive heart failure, asthma, arthritis – and overall morbidity similar across provincial databases?
- iii- What promising practices exist in healthcare and elsewhere (for example, outside the healthcare sector) for the most effective use of information? Where are the gaps in the existing databases and other information sources (for example, patient-reported outcomes)? How do we optimize the use of underutilized databases (such as provincial drug databases)? In what ways, to what extent and for whom are registries valuable?
- iv- How can reliable information systems to collect, analyze and report data about health and healthcare be implemented in areas with limited resources, such as in the North and in rural and remote communities? What limitations and opportunities must be taken into account to ensure respect for cultural norms, ethical guidelines, and existing rules and regulations regarding access to information for particular populations, such as Aboriginal people?

4) Values-Based Decision-Making and Public Engagement

Values-based decision-making and public engagement were raised as issues in many of the nine workshops. They were identified as the most important issues at the eastern workshop held in Halifax. The focus was on the need for ethical decision-making frameworks, public involvement in decision-making and, in particular, strategies for engaging the public in priority-setting (or at least ensuring people understand the difficult trade-offs necessary). This theme area was closely linked to concerns about sustainability and resource allocation, and the need to make trade-offs relative to system design, the medicare basket and access.

ILLUSTRATIVE SYNTHESIS QUESTIONS:

- i- What does Canadian and international experience show about promising practices in terms of models and frameworks for public participation and engagement in priority-setting processes? How is success measured and what evidence is there regarding the impact of different processes on citizen satisfaction with the healthcare system, cost savings, improved decision making, etc.? What barriers prevent more widespread adoption of validated approaches in Canada, and what strategies are required to overcome these barriers?
- ii- What is known from health and other disciplines (such as education, business, social marketing) regarding effective mechanisms for translating facts and evidence about specific services and the healthcare system into a form suitable for the general public?
- iii- What is known about the interplay between the media and health policy? What proven strategies should policy makers adopt to work positively with the media as a form of engagement with the public?

ILLUSTRATIVE RESEARCH QUESTIONS:

- i- What are the various costs and benefits of engaging the public in decisions involving trade-offs in efficiency and/or effectiveness (including factors affecting quality of life) for particular interventions (such as funding for high-cost cancer drugs or the appropriate intensity for end-of-life care)?
- ii- Are the values of individuals working in the healthcare system and/or the public vis-à-vis the healthcare system changing over time? Have changes in governance – such as regionalization – altered the public's sense of ownership and/or participation in the health system? Are there trends or patterns that can be identified and associated with other contextual factors?
- iii- What are the particular challenges for aggregating public preferences and values in healthcare delivery that are unique to Canada, given our jurisdictional boundaries across institutions, regions, provinces and territories, and at the pan-Canadian level?
- iv- Who is the “public” and how do decision makers engage members thereof? How is representativeness determined? How are issues of gender, wealth, culture, class, race and power handled in these cases? What models and approaches for public engagement have been adopted in Canada at a systems level and how should they be assessed in terms of success, outcomes or impact on decision-making?
- v- What strategies can be adopted by healthcare providers, managers and policy makers to better manage, understand and reflect public expectations (for example, related to appropriate access, quality of care and choices about alternative treatments)? To what extent does the public know when and how to complain about poor quality of care, or how to involve themselves in the development of

good care? What mechanisms are effective for communicating standards of care and/or breaches in appropriate or effective care (for example, in the North, where there are persistent problems around communicating and executing the medical travel policy)?

5) Patient-Centred Care

Closely linked to the previous theme was the call for better evidence to underpin patient-centred care policies and practices, and consumer participation in healthcare. Patient-centred care is understood as collaboration between informed, respected patients and their families and a co-ordinated healthcare team to achieve quality healthcare. The focus is on the participation and engagement of the patient, as opposed to the engagement of the public at large. There are two sides to this: what is the patient doing to be more engaged; and what are providers doing to help patients be more engaged? Discussions at workshops related to collaborative care included having patients participate in their own care and in decisions about their care, as well as having providers be more responsive in designing systems around patients' needs. A key need is to implement and improve continuity and co-ordination of care from a patient-centred perspective with a philosophy of care where a trusting, positive relationship between provider and patient/family is a core value. The impact of increasing patient demand on health services was also of concern.

ILLUSTRATIVE SYNTHESIS QUESTIONS:

- i- What is meant by patient-centred care? Is there a common definition suitable for the Canadian context?
- ii- What outcomes are observed or achievable through patient-centred care approaches, including costs and benefits to patients and the healthcare system?

- iii– How can the electronic health record be a vehicle for supporting patient-centred care? What are the costs and benefits, and how does the implementation of electronic health records need to be adapted to support this type of care?
- iv– What evidence and promising practices exist for involving patients in the design of programs of care and the development of more optimal quality of care? What are the implications for evolving provider-patient partnerships, models of "shared" care, and clinical practice?
- v– How, and under what conditions, can families and informal care providers be optimally involved in supporting patient-centred care?

ILLUSTRATIVE RESEARCH QUESTIONS:

- i– What is the effect of different components of patient-centred care (for example, attention to cultural sensitivity, literacy, etc.) on immediate and longer-term outcomes?
- ii– When and how do patient perspectives differ from public and provider perspectives about appropriate care and the organization of services?
- iii– How can patients be involved in meaningful ways in the design and re-design of healthcare services? What are the objectives and consequences of their involvement? What happens in cases where the input is rejected or inconsistent with other health system objectives?

6) Patient Flow and System Integration

The issue of wait times was raised in a number of sessions. Concerns were raised that addressing wait times by way of disease silos has failed to recognize the common determinants of many conditions (co-morbidities) and has also failed to acknowledge other pressing health priorities, such as mental health. Participants spoke of the need for more of a systems approach to wait time issues. Themes that

emerged in this regard included the following: the need to consider the system as a continuum and as a whole; the need for navigational aids for patients and families; the desire to move away from an acute-care focus towards primary healthcare and population/public health models (this would include the adoption of lessons learned from the projects funded by the national Primary Health Care Transition Fund³); consideration of both public and private elements of the health system; the need for related governance and accountability structures; and ensuring that the needs of vulnerable populations are not lost in a systems approach.

ILLUSTRATIVE SYNTHESIS QUESTIONS:

- i– What does international and Canadian experience demonstrate in terms of the costs and benefits of different approaches or models of promoting integrated patient care across the healthcare system, for example, care pathways, patient navigators or care co-coordinators? What navigational tools exist?
- ii– How do we systematically measure and evaluate service integration, access and patient flow at different levels of the healthcare system? What does integrated care mean from a patient perspective?
- iii– What are promising practices and solutions regarding the challenges associated with access and health service integration for vulnerable groups, including Aboriginal peoples, rural/remote populations and immigrants?
- iv– What evidence supports promising practices for managers and clinicians to effectively manage waiting lists and times?

ILLUSTRATIVE RESEARCH QUESTIONS:

- i– What interventions work to promote the integration of primary healthcare (including community care and mental health) with the rest of the healthcare delivery system?

3 This \$800-million fund was established by the federal government in 2000 to stimulate research and evaluation of the primary healthcare reform initiatives across the country; it was wound down in March 2006. See: <http://www.hc-sc.gc.ca/hcs-sss/prim/phctf-fassp/index_e.html>. Priorities for Applied Health Services Research. *The Milbank Quarterly*, 81(3), 363-368.

- ii- How and where are services for Aboriginal groups integrated (or not) with the rest of the healthcare system at policy and practice levels? Where are there opportunities for improved integration that would contribute to better health and healthcare?
- iii- What is known about the current quality and pattern of healthcare provided to populations living in the North? What alternative arrangements for providing healthcare for northern populations would enhance the access to and quality of services – from professional, government/institutional and patient/population perspectives? What are the costs, benefits and risks associated with changes in existing service delivery given the impact of these changes on southern providers of care to northern populations, and on northern recipients of care (whether this care is provided in the North or the South)? Under what conditions is it appropriate and effective to import “southern models” of care provision to the North?
- iv- What is the impact on health and healthcare of the forms of regionalization in various jurisdictions? Is it possible to generalize lessons from the Canadian experience regarding governance and accountability mechanisms that promote or enable improvements in services and health outcomes?
- v- What is the impact of various funding mechanisms on patient flow in terms of facilitating or impeding access to appropriate care, such as coverage for workplace compensation, private insurance and out-of-pocket payments? Are there gaps or duplications hindering high-quality care?
- vi- How can access and integrated care for vulnerable groups be improved?
- vii- What approaches and interventions, from within Canada or internationally, are successful in reducing wait times and what are the effects (intended and unintended) of attempts (both

successful and otherwise) to reduce wait times and improve access for particular services across Canada and internationally?

7) Chronic Disease Prevention and Management

Participants indicated that there was a need for new approaches to the prevention and management of chronic diseases, including mental disorders, diabetes, arthritis, stroke and obesity. Such approaches must incorporate strategies for prevention that extend beyond healthcare to include the contributions of other sectors and relevant non-healthcare professionals. Concerns included the rising complexity and burden of chronic illness, the impact of these trends on funding the healthcare system and the need for new ways to deliver care. The incidence and prevalence of early-onset chronic disease was a particular concern in the North, where mental health and diabetes have become significant problems and populations experience high rates of preventable disease. Discussions across the country focused on the need to move away from acute-care models and to avoid current silos. Chronic disease management and interventions need to be functionally based (from the patient’s and family’s perspectives) rather than disease-based.

Models of care should be flexible and contextualized, taking into account co-morbidities and paying particular attention to vulnerable, at-risk populations. Also of concern is the aging population at increased risk of chronic illness. Participants agreed that innovative models of care spanning prevention and management are needed to address this complex area. Questions were also raised about the effectiveness of different models/approaches and various combinations of interventions, and the implications for quality of care and providers’ roles. It was stated during the consultation sessions that we have “islands of good practice related to chronic disease management in a sea of disinterest.”

ILLUSTRATIVE SYNTHESIS QUESTIONS:

- i- What are promising practices, nationally and internationally, for funding and delivery models for chronic disease prevention and management across different settings? Are innovations in other countries or jurisdictions relevant to our geographic and resource contexts? To what extent do different models address the need to integrate health and social care for certain chronic diseases?
- ii- Which strategies for chronic disease management contribute to improvements in health outcomes and/or experience of care and/or performance of the healthcare system in terms of efficiencies or effectiveness?
- iii- In what ways and at what cost are various primary healthcare and community-based providers effectively involved in chronic disease prevention and management?
- iv- How should chronic disease services (such as those for diabetes and mental health) be organized and delivered in the Canadian context to maximize the effectiveness of proven interventions? Under what conditions are patients/groups with complex or multiple diseases best managed?

ILLUSTRATIVE RESEARCH QUESTIONS:

- i- Evaluate the existing and emerging alternate funding models for supporting chronic disease management in Canada. How do they vary across disease groups and jurisdictions (geographic, socio-economic and urban/rural)?
- ii- What methods and tools should be adopted for chronic disease surveillance to enable the assessment of processes and outcomes of care over time and over the disease trajectory? How can these approaches accommodate the complexities associated with patients or groups who have multiple and changing chronic disease portfolios?

- iii- What are the costs and benefits of disease-specific registries that include administrative and clinical information – from the perspective of research, audit, surveillance and decision-making about the organization and delivery of health services?
- iv- In what ways can patients play a more active role in preventing chronic disease and engage to a greater extent in self-help or self-management to improve health outcomes? What are the implications for the healthcare delivery system and professional practice?

8) Health System Financing and Sustainability

The financing and sustainability of the healthcare system continues to be an issue for decision makers. Concerns include the balance and interplay between public and private financing and the balancing of accessibility, quality, choice, innovation and cost-control. Other concerns include the impact of different funding and remuneration/incentive models on the supply and price of human resources, the quality and cost of care provided, and the economy of scales across different institutions, settings and jurisdictions. With respect to sustainability, it was commonly thought that an even greater shift from the current hospital-centric model to a community- and preventive-based approach would come with time. The problem of rising costs related to pharmaceuticals and an aging population was raised in all workshops. Also, there is a need for new decision-making structures to adequately consider appropriate resource and service allocations. (This is closely linked to the values-based decision-making and public engagement theme.)

ILLUSTRATIVE SYNTHESIS QUESTIONS:

- i- How can our healthcare system be described such that the different components and the degree to which they are sustainable are revealed? What are the threats and supports to a sustainable healthcare system in Canada (considering factors on both the demand and supply sides)? How can decision makers and the public be effectively engaged in determining solutions?

- ii- What is the role for private financing/delivery in Canadian healthcare? What is the role for different forms of private delivery in Canadian healthcare? What are the limits, values, models and regulatory interventions that might apply in ensuring an appropriate balance between private interests and public objectives and constraints?
- iii- What are the national and international promising practices and models with respect to providing end-of-life care?

ILLUSTRATIVE RESEARCH QUESTIONS:

- i- How can the healthcare system adapt to an aging population and what models are required for change?
- ii- What are the options for financing community-based models of care, such as home care, continuing care and long-term care? What is the impact in this sector of different schemes that involve co-payments, cost-sharing or deductibles, for example?
- iii- How can values, costs, dignity, choice and effectiveness be balanced in end-of-life policy choices, and how can and should this inform clinical practice?

9) Emerging Technologies and Drugs

Decision makers were concerned about the impact on the health system of new technologies such as genetics, genomics, nanotechnology and reproductive technologies, and they articulated the need not only for modelling and forecasting, but also for developing practice standards and ethical frameworks. The focus was also on the need to adapt to new technologies, such as electronic health records, to develop standards and to assess their real value. A lot of interest was also expressed in the following issues: management of and ethical decision-making regarding pharmaceuticals and the adoption of new drugs; financing and access to new drugs; resource allocation vis-à-vis drugs; and the safety and effectiveness of new drugs brought to the market. These concerns were linked to issues of sustainability,

financing, safety, access and appropriateness. Also, there was an expressed need to develop capital and technological infrastructure to its full potential.

This theme of emerging technologies and drugs was also linked to the need for greater patient, public and provider involvement in policy formulation.

ILLUSTRATIVE SYNTHESIS QUESTIONS:

- i- What is the impact of various models and policies for financing prescription drugs and managing drug programs across the country, in terms of access to necessary medicines and equity within and between jurisdictions? What does international experience reveal regarding access, equity and financing of prescription drugs, as well as the management of drug programs at national or regional levels? How and to what extent are these experiences relevant to Canada?
- ii- What has been learned to date about different approaches to evaluating the costs and benefits of new drugs and technologies prior to their entry on the market and in terms of post-market surveillance?
- iii- Are there models, tools or techniques for harmonizing policies across jurisdictions?
- iv- What evidence exists to support promising practices for adopting and excluding new technologies?
- v- What are effective strategies for engaging members of the public and broadening their knowledge about the trade-offs and options considered in decisions about the inclusion or exclusion of drugs and technologies within a publicly funded system?

ILLUSTRATIVE RESEARCH QUESTIONS:

- i- How do decision makers access and apply evidence about the effectiveness of new drugs and technologies? What strategies are effective for integrating evidence about the effectiveness and efficiency of new drugs and technologies into decision-making?

- ii– What approaches and ethical considerations are applied to decisions about coverage for drugs to treat rare diseases? What are the implications for funding?
- iii– By what criteria are drugs and technologies covered, reassessed or decommissioned by insurance programs across jurisdictions? What are the ethical issues surrounding decisions and the implications for funding? What are the implications for managing the public's response and that of the private sector?
- iv– What are the costs, benefits and ethical considerations in designing a post-marketing surveillance program in Canada?

10) Quality and Patient Safety

Concerns focused on the need for improvements in the quality of care (including patient safety) throughout the healthcare system. Participants felt that cultural change was required to better involve providers upfront in the "quality strategy" through different mechanisms, such as making quality a key component of their tasks, using the right incentives and having a system that can integrate innovation. There was also concern regarding quality in chronic disease management, focused at the intersection of disease groups. Also mentioned was the need to continue to focus on patient safety related to adverse event management, particularly in long-term and homecare settings, and with respect to the post-marketing surveillance of pharmaceuticals. Questions were also raised about performance indicators – their use and misuse, the need to focus on clinical results as well as on outcomes important to patients, the need to understand data gaps, and the need for shared standards allowing for comparative analyses.

ILLUSTRATIVE SYNTHESIS QUESTIONS:

- i– What are the methods and measures for assessing patient safety outside acute care environments? This work should build on the

World Health Organization and other syntheses on this topic to include comparative evidence for the Canadian context.

- ii– What are the effective interventions for improving safety in non-acute environments?
- iii– What research strategies and study designs are appropriate for the assessment of quality and safety under different circumstances (for example, across different settings, jurisdictions and types of health problems or client groups)?
- iv– How can decision makers and clinical leaders access and use effective information about safety and quality at different levels of the healthcare system?

ILLUSTRATIVE RESEARCH QUESTIONS:

- i– How can patients and families be engaged in supporting delivery to improve quality and safety and/or system redesign (particularly in situations where people were or may have been harmed)?
- ii– How do the public and patients understand quality and safety? How do they assess and seek out care that is safe and of high quality?
- iii– What strategies are effective to enhance leadership and governance for quality and safety in the healthcare system? By what means, and to whom, are institutional boards and senior executive teams held accountable for safety and quality improvement?
- iv– What are the costs and risks to health and the healthcare system for failing to address concerns of safety and quality?
- v– What are the information strategies needed to support the reporting and delivery of safe, high-quality care at the organizational and system-wide levels?

11) Linking Population and Public Health to Health Services

This is an area that was also considered a priority in the *Listening for Direction II* report. During the LfD III consultations, participants continued to acknowledge that the healthcare system cannot possibly cope with future demands if greater attention is not paid to disease prevention and health promotion. It was clear that this issue crosses many sectors that involve population and public health more broadly – including housing, employment, education and the environment – as well as the specific efforts of population and public health providers and their organizations. There are inter-sectoral challenges that must be addressed for certain vulnerable populations, such as people in the North and new immigrants, where literacy, health education and geography are variables in attempts to promote healthy lifestyles and behaviours. There is a need to ensure that such efforts work in tandem with the healthcare delivery system and that there is effective collaboration at the interface between these sectors. Emphasis was placed on the need for system-level interventions that aim to improve overall health across sectors and address health status disparity. Questions were raised about the influence of the political/governance structure on health outcomes, and about decision-making concerning public health policy issues (such as access to vaccines) with respect to the ethical and practical implications for health services. Also of concern were specific issues related to the environment – the impact of global warming and other environmental changes on health and healthcare – and to

globalization, such as medical tourism, migration of healthcare professionals and pandemic management. Such issues are of particular concern to northern populations, where environmental and cultural changes have had dramatic effects on health and quality of life within single generations.

ILLUSTRATIVE SYNTHESIS QUESTIONS:

- i– Where and in what ways does the public health system interface with healthcare services? Where are the opportunities to make improvements in health and healthcare through coordinated action at the organizational-systems level?
- ii– Where, in what ways and with what effects has the healthcare sector effectively partnered with non-health sectors/government (for example, environment, transportation, housing) to improve the health status of disadvantaged groups?
- iii– What evidence is available to support the design of a healthcare system that is more responsive to communities, such as Aboriginal people, who face particular challenges in their socio-economic and physical environment?
- iv– How does the healthcare system help to mitigate the effects of social disadvantage?
- v– What methods and measures have been used to consider both upstream prevention efforts and downstream treatment interventions to improve health outcomes?

ILLUSTRATIVE RESEARCH QUESTIONS:

- i- How can the healthcare system optimally assess its readiness (for example, planning, resources, human and institutional capacity) to respond to potential pandemics?
- ii- To what extent does the healthcare system function to address the healthcare needs of disadvantaged groups?
- iii- What types of accountability and governance models and structures are needed across public health and the healthcare system to address the broader determinants of health?
- iv- What is the actual and potential impact of changes in the environment, such as those produced by global warming, on healthcare systems?
- v- In what areas do non-medical determinants of health have an effect on the need for and cost of healthcare services and what are those effects, for example, the relationship between the quality and type of housing and the provision of emergency care?
- vi- How can traditional knowledge (specific to different cultures across Canada) work alongside other types of knowledge in managing or preventing injury and illness?
- vii- What risk factors, or combinations of risk factors, have the greatest impact on disease burden and cost to the healthcare system? What interventions – either upstream or downstream – would be most effective at modifying these risk factors and thereby improving health outcomes?

SECTION V: ADDITIONAL ACTION ON PRIORITIES

At the end of each consultation workshop, participants were asked to identify any other resources, evidence or investments that might help address the issues raised in the previous sessions. Most of the discussions were closely related to the theme area of change management for improved practice and improved health. People discussed the need for more investment and investigation into how research can inform change and knowledge transfer and uptake. It was suggested that partners adopt an investment perspective of “best bang for the buck” in this regard.

There was a call to create and institutionalize learning environments. Organizations need to set in place structures and processes for using research. People were looking for means that would encourage the use of research and show its usefulness. Some suggested there was a need for more investment in demonstration and pilot projects and greater focus on evaluating interventions. Decision makers are interested in learning from others’ experiences and in finding out how these lessons learned can be adapted to their specific contexts. Database improvements were considered core to this process, including mechanisms to enhance the use of existing data and to develop new databases with appropriate, sharable information.

There was also a call for more research, particularly on the best means of disseminating and implementing research. In terms of research and the decision-making process, more needs to be known about the different mechanisms and processes required to get research into the hands of politicians, managers and decision makers. What are their respective knowledge needs?

Some of the workshop participants suggested some tools and mechanisms to facilitate the uptake of research. For example, several proposed the creation of forums where researchers and decision makers either share their knowledge and experience on specific best practices or discuss how to implement certain research results in a specific context. Others proposed the creation of an inventory or virtual network that would house research results and a list of researchers linked to their areas of interest. Various types of training sessions for decision makers were also suggested, ranging from targeted courses on specific content areas to longer-term training programs. Finally, all agreed on the usefulness of syntheses of existing evidence in forms useable by decision makers.

Another topic of concern was related to research capacity. In most of the workshops, people agreed on the need for developing greater innovation and capacity in evaluation research. Some regions discussed the need to increase and better develop their overall research capacity. This was a concern especially for eastern provinces and the northern regions.

SECTION VI: ACKNOWLEDGEMENTS

Listening for Direction III would not have been possible without the much appreciated contribution of several professional and dedicated people and their organizations. The partners wish to express their sincere thanks to these individuals for their commitment, their support for this process, and the quality of their input.

First and foremost, our gratitude goes to all those who generously agreed to share their insights and knowledge by taking part in one of the consultation workshops and/or by answering our surveys.

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APPENDIX I – LIST OF ORGANIZATIONS INVITED TO THE WORKSHOPS

Vancouver

Aboriginal Health
 BC Association for Community Living
 BC Cancer Agency
 BC Injury Research and Prevention Unit
 BC Provincial Health Services Authority
 British Columbia Academic Health Council
 British Columbia Children's Hospital
 British Columbia Ministry of Health
 British Columbia Women's Hospital
 Canadian Institutes of Health Research
 Centre de santé de la Haute-Saint-Charles
 Centre for Health Services and Policy Research
 Centre for Native Policy and Research
 Children's and Women's Health Centre of British Columbia
 Creston Valley Hospital
 Fraser Health Authority
 Health Canada
 Health Council of Canada
 Health Employers Association of British Columbia
 Hollander Analytical Services Ltd.
 Infant Development Program of British Columbia
 Interior Health Authority
 Michael Smith Foundation for Health Research
 Ministry of Children & Family Development
 British Columbia Ministry of Health
 Northern Health Authority
 Praxis Management Inc.
 Provincial Health Services Authority of British Columbia
 Simon Fraser University
 St. Joseph's General Hospital – Comox
 St. Paul's Hospital
 Thompson Cariboo Health Services Area
 University of British Columbia
 University of Northern British Columbia
 University of Victoria
 Vancouver Coastal Health Authority
 Vancouver General Hospital
 Vancouver Hospital & Health Sciences Centre
 Vancouver Island Health Authority

Edmonton

Alberta Association of Registered Nurses
 Alberta Bone & Joint Institute
 Alberta Heritage Foundation for Health Research
 Alberta Medical Association
 Alberta Ministry of Health & Wellness
 Aspen Regional Health Authority
 Calgary Health Region
 Canadian Patient Safety Institute
 Capital Health Authority
 Chinook Health Region
 College and Association of Registered Nurses of Alberta
 David Thompson Regional Health Authority
 East Central Health
 HBA Services
 Health Law Institute
 Health Quality Council of Alberta
 Howard Research and Management Consulting Inc.
 Killam General Hospital
 KMB Consulting
 Northern Lights Health Region
 Palliser Health Region
 Peace Country Health
 Royal Alexandra Hospital
 Shepherd's Care Foundation
 St. Mary's Hospital – Camrose
 Taber Associate Medical Centre
 University of Alberta
 University of Calgary
 University of Calgary Medical Clinic
 University of Lethbridge

Halifax

Acadia University
Annapolis Valley District Health Authority
Atlantic Health Sciences Corporation
Avalon Health Care Institutions Board
Beauséjour Regional Health Authority
Business New Brunswick
Cape Breton District Health Authority
Capital District Health Authority
Central East Health Care Institutions Board
Central Regional Community Health Board
Colchester East Hants Health Authority
College of Licensed Practical Nurses of Nova Scotia
Community Hospitals and Continuing Care Division, Department of Health
Cumberland Health Authority
Dalhousie University
Department of Health and Community Services
Eastern Health
Eastern Regional Integrated Health Authority
Essex, Kent & Lambton DHC
Government of New Brunswick
Government of Newfoundland & Labrador
Government of Prince Edward Island
Guysborough Antigonish Strait Health Authority
Health Association of PEI
Health Law Institute
IWK Grace Health Centre
King Regional Rehabilitation Centre
Kings Country Memorial Hospital
Labrador-Grenfell Health
Medical Programs Division, Department of Health
Memorial University of Newfoundland
Miramichi Regional Health Authority
New Brunswick Dept. of Health & Wellness
New Brunswick Healthcare Association
New Brunswick Innovation Foundation
Newfoundland & Labrador Centre for Applied Health Research
Newfoundland & Labrador Dept. of Health & Community Services
Newfoundland and Labrador Centre for Health Information
Newfoundland and Labrador Health Boards Association
Nova Scotia Association of Health Organizations
Nova Scotia Department of Health
Nova Scotia Health Promotion
Nova Scotia Health Research Foundation
PEI Health Research Institute
Pictou County District Health Authority
Premier's Health Quality Council of New Brunswick

Prince County Hospital
 Prince Edward Home
 Prince Edward Island Dept. of Health & Social Services
 Queen Elizabeth Hospital
 Queen Elizabeth II Health Sciences Centre
 Régie de la santé Acadie-Bathurst
 Regional Health Authority #4
 Regional Health Authority #6
 Registered Nurses' Association of Nova Scotia
 Restigouche Health Authority (Regional Health Authority 5)
 River Valley Health (Regional Health Authority 3)
 Souris Hospital
 South Shore District Health Authority
 South West Nova District Health Authority
 South-East Regional Health Authority
 Stewart Memorial Hospital
 University of Prince Edward Island
 University of New Brunswick
 University of PEI, School of Nursing
 Wayfinder Consulting Incorporated
 Western Health Care Corporation
 Western Hospital
 Western Regional Integrated Health Authority

Manitoba (Invited to Edmonton Workshop)

Assiniboine Regional Health Authority
 Brandon Regional Health Authority Inc.
 Burntwood Regional Health Authority Inc.
 Churchill Regional Health Authority
 Concordia Hospital
 Interlake Regional Health Authority
 Manitoba Health
 Manitoba Health Research Council
 Manitoba Institute for Patient Safety
 NOR-MAN Regional Health Authority
 North Eastman Health Association Inc.
 Parkland Regional Health Authority
 Public Health Agency of Canada
 Regional Health Authority – Central Manitoba Inc.
 South Eastman Regional Health Authority
 St. Boniface General Hospital
 Ste. Rose General Hospital
 Swan River Valley Hospital
 University of Manitoba
 Veterans Affairs Canada
 Wade and Wade Consulting
 Winnipeg Regional Health Authority

Montreal

ADRLSSSS de la Baie-James
ADRLSSSS de la Baie-James (Conseil Cri)
ADRLSSSS de la Capitale nationale
ADRLSSSS de la Côte-Nord
ADRLSSSS de la Gaspésie-Îles-de-la-Madeleine
ADRLSSSS de Laval
ADRLSSSS de l'Estrie
ADRLSSSS des Laurentides
ADRLSSSS du Bas-Saint-Laurent
AETMIS
ADRLSSS de Montréal
Agence de services de santé et de services sociaux de la Mauricie et du Centre du Québec
ADRLSSS de Lanaudière
Association des CLSC et des CHSLD du Québec
Association des conseils des médecins, dentistes et pharmaciens du Québec
Association québécoise des établissements de santé et de services sociaux
Centre de réadaptation Lucie-Bruneau
Centre de santé de la Haute-Saint-Charles
Centre de santé de l'Université McGill
Centre de santé et de services du sud de Lanaudière
Centre de santé et de services sociaux de Sorel-Tracy
Centre de santé et de services sociaux des Sommets
Centre de santé et de services sociaux Haut-Richelieu/Rouville
Centre de santé et de services sociaux Jeanne Mance
Centre hospitalier affilié universitaire de Québec
Centre hospitalier de l'Université de Montréal
Centre hospitalier universitaire de Québec
Centre régional de santé et de services sociaux de la Baie-James
CLSC-CHSLD Haute-Ville-des-Rivières
CLSC-CHSLD Sainte-Rose de Laval
Complexe hospitalier Sagamie
Conseil d'administration du CSSS de Sorel-Tracy
Cree Board of Health and Social Services of James Bay
CSSS de Bordeaux-Cartierville – Saint-Laurent
CSSS de la Côte de Gaspé
CSSS Vaudreuil-Soulanges
Direction de la santé publique de Montréal Centre
Director of the School of Public Policy, Montreal
Douglas Hospital
École nationale d'administration publique
Fédération des médecins omnipraticiens du Québec
Fonds de la recherche en santé du Québec
Fonds québécois de la recherche sur la société et culture
Groupe Santé Sedna Inc.
Hôpital Charles LeMoine
Hôpital des enfants de Montréal
Hôpital de réadaptation Lindsay
Hôpital du Sacré-Coeur de Montréal
Hôpital Maisonneuve-Rosemont
Hôpital Sainte-Justine
Human Resources Development Canada
IAB & IHSPR
Institut de réadaptation de Montréal
Institut national de santé publique du Québec
McGill University
McGill University Health Centre
McGill University - Law
Ministère de la Culture et Communication du Québec
Ministère de la Recherche, de la Science et de la Technologie du Québec
Ministère de la Santé et des Services sociaux du Québec
Montreal General Hospital Research Institute
National Public Health Institute of Quebec
Régie régionale de la santé 4
Régie régionale de la santé et des services sociaux de Chaudières-Appalaches
Régie régionale de la santé et des services sociaux de la Montérégie
Régie régionale de la santé et des services sociaux de l'Abitibi-Témiscamingue
Régie régionale de la santé et des services sociaux de l'Outaouais
Régie régionale de la santé et des services sociaux du Nunavik
Régie régionale de la santé et des services sociaux du Saguenay-Lac-Saint-Jean
SMBD - Jewish General Hospital
The Kidney Foundation of Canada
Université de Montréal
Université de Sherbrooke
Université Laval

Nunavut

Arctic Health Research Network
 Baffin Regional Hospital
 Deh Cho Health & Social Services Authority
 Dogrib Community Services Board
 Fort Smith Health and Social Services Authority
 Government of Nunavut
 Hay River Health and Social Services Authority
 Nunavut Dept. of Health & Social Services
 Sahtu Health & Social Services Authority
 Yellowknife Health and Social Services Authority

Saskatchewan (Invited to Edmonton Workshop)

Access Consulting
 Athabasca Health Authority
 Cypress Regional Health Authority
 Five Hills Regional Health Authority
 Health Quality Council of Saskatchewan
 Heartland Regional Authority
 Keewatin Yatthé Regional Health Authority
 Kelsey Trail Health Region
 Laurence Thompson Strategic Consulting
 Mamawetan Churchill River Regional Health Authority
 Member of the Legislative Assembly
 North Central Health District
 Northern Health Authority
 Population Health – Northern Health Authorities
 Prairie North Regional Health Authority
 Prince Albert Parkland Health Region
 Regina Qu'appelle Regional Health Authority
 Saskatchewan Association of Health Organizations
 Saskatchewan Health
 Saskatchewan Health Research Foundation
 Saskatoon Health Region
 St. Elizabeth's Hospital
 Sun Country Health Region
 Sunrise Health Region
 University of Regina
 University of Saskatchewan

Toronto

Alexandra Marine Et General Hospital
Association of Ontario Health Centres
Baycrest Centre for Geriatric Care
Bloorview MacMillan Children's Centre
Brant Community Healthcare System
BridgePoint Health
Canadian Cancer Society
Canadian Institute for Health Information
Canadian Institutes of Health Research
Canadian Memorial Chiropractic College
Canadian Mental Health Association
Canadian Psychiatric Research Foundation
Canadian Psychological Association
Cancer Care Ontario
Central East Local Health Integration Network (LHIN)
Central LHIN
Central West LHIN
Centre for Addiction & Mental Health
Centre for Bioethics
Champlain District Health Council
City of Toronto
College of Dietitians of Ontario
College of Family Physicians of Canada
Community Care Access Centre of Waterloo Region
COI Network
Dalhousie University
Elizabeth Bruyère Research Institute
Erie-St. Clair LHIN
Government of Ontario
Grand River District Health Council
Grand River Hospital
Grey Bruce Health Services
Halton-Peel DHC
Hamilton District Health Council
Hamilton Health Sciences
Hamilton Niagara Haldimand Brant LHIN
Hamilton Regional Cancer Centre
Headwaters Health Care System
Health Canada
Health Council of Canada
Home Care
Hospital for Sick Children
Humber College
IAB & IHSPR
Institute for Clinical Evaluative Sciences
Institute for Work & Health
Juvenile Diabetes Research Foundation
Kingston General Hospital – University Hospitals Kingston
Kitchener-Waterloo Health Centre – Grand River Hospital
Lakeridge Health Corporation
Laurentian University
Lawrence Decter Investment Counsel Inc.
Leamington District Memorial Hospital
Li Ka Shing Knowledge Institute
London Health Sciences Centre Research Inc.
Lupus Canada
McMaster University
McMaster University Evidence Based Practice Centre
Mississauga Halton LHIN
Mount Sinai Hospital
Muscular Dystrophy of Canada
Niagara District Health Council
North East LHIN
North Simcoe Muskoka LHIN
North West LHIN
North York General Hospital
Northern Ontario School of Medicine
Ontario Association for Non-Profit Homes and Services for Seniors
Ontario Association of Community Care Access Centres
Ontario College of Family Physicians
Ontario Community Support Association
Ontario Health Quality Council
Ontario Hospital Association
Ontario Medical Association
Ontario Ministry of Health and Long-Term Care
Ontario Neurotrauma Foundation
Ontario Seniors Secretariat
Osteoporosis Canada
Peterborough Regional Health Centre
Providence Continuing Care Centre - Mental Health Services
Public Health Agency of Canada
Queen's University
Queen's University Centre for Health Services and Policy Research
Royal Victoria Hospital
Safe Communities Foundation
Safe Kids Canada

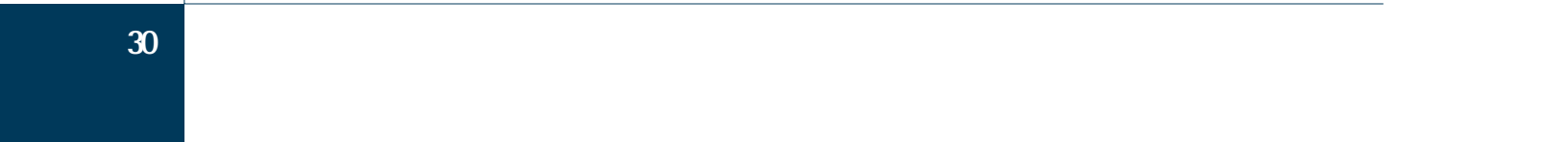
Saint Elizabeth Health Care
 Schizophrenia Society of Canada
 Simcoe York District Health Council
 SMARTRISK
 Somerset West Community Health Centre
 South Bruce Grey Health Centre – Walkerton
 South East LHIN
 South West LHIN
 St Michael's Hospital
 St. John's Rehabilitation Hospital
 St. Joseph Health Centre Foundation
 St. Joseph's Health Centre
 St. Joseph's Healthcare
 St. Joseph's Healthcare Hamilton
 Sunnybrook & Women's College Health Sciences Centre
 Suzanne Lawson and Associates
 Thames Valley District Health Council
 The ALS Society of Canada
 The Arthritis Society
 The Canadian National Institute for the Blind
 The Change Foundation
 The Hospital for Sick Children
 The Royal Victoria Hospital
 ThinkFirst Foundation of Canada
 Thunder Bay Regional Health Sciences Centre
 Toronto Central LHIN
 Toronto East General
 Toronto LHIN
 Toronto Public Health
 Toronto Rehabilitation Institute
 United Way of Greater Toronto
 University Health Network
 University of Toronto
 University of Waterloo
 University of Western Ontario
 VON Canada
 Waterloo Region-Wellington-Dufferin District Health Council
 Waterloo Wellington CCAC
 Waterloo Wellington LHIN
 World Health Organization
 York University

Yellowknife

Arctic Health Research Network
 Aurora College
 Deh Cho Health & Social Services Board
 Dogrib Community Services Board
 Fort Smith Health & Social Services Authority
 Hay River Health & Social Services Authority
 Inuvik Regional Health and Social Services Authority
 Northwest Territories Dept. of Health & Social Services
 Sahtu Health & Social Services Authority
 Stanton Hospital
 Stanton Territorial Health Authority
 Yellowknife Health & Social Services Authority

Whitehorse

Arctic Health Research Network – Yukon
 Council of Yukon First Nations
 Government of Yukon
 Kwanlin Dun First Nation
 Northern Secretariat Office
 Whitehorse General Hospital
 Yukon Dept. of Health & Social Services
 Yukon Francophone Association
 Yukon Medical Association



APPENDIX II – VALIDATION SURVEY

A SUMMARY OF THE FEEDBACK RECEIVED IN RESPONSE TO THIS SURVEY WILL BE COLLATED BY THE FOUNDATION AND DISCUSSED WITH PARTNERS.

Your Participation

1. a. To your knowledge, were you invited to any of the *Listening for Direction III* consultation workshops held in Vancouver, Edmonton, Toronto, Ottawa, Montreal, Halifax, Whitehorse, Yellowknife and Iqaluit between February and April 2007?

YES

NO

If yes, which one? _____

b. Did you participate in any of the *Listening for Direction III* consultation workshops?

About You

2. Which of the following do you feel best describes your current role in the Canadian health system?

Decision maker (policy maker, manager, clinician or association representative)

Researcher (researcher or research funding agency representative)

Other: _____

Relevance of *Listening for Direction III* themes

3. Research themes

Workforce and the Work Environment

Change Management for Improved Practice and Improved Health

Data, Information and Knowledge Management

Values-Based Decision-Making and Public Engagement

Patient-Centred Care

Patient Flow and System Integration

Chronic Disease Prevention and Management

Health System Financing and Sustainability

Emerging Technologies and Drugs

Quality and Patient Safety

Linking Population and Public Health to Health Services

As a decision maker, do you feel your main priority issues for the next five years would be addressed through this list of research themes?

Strongly Agree

Agree

Disagree

Strongly Disagree

No Opinion

4. For *Listening for Direction III* consultation workshop participants only:

From your recollection, do the themes reasonably reflect what emerged from your workshop?

Strongly Agree

Agree

Disagree

Strongly Disagree

No Opinion

5. Other comments/suggestions: _____

Please complete this survey before June 30, 2008 and return it to the CHR SF

Fax: 613-728-3527

