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[00:00:22]

Dana Riley: Good morning and good afternoon, everyone. This is Dana at the CIHI office in Ottawa and we're going to go ahead and get started. Before we do that, I'm going to just let you all know that you're — the teleconference line is currently in lecture mode, which means that all of the participants' lines are muted. A couple of technical issues to address: the web content is available through Adobe Connect — if you've not already done so, please click the Adobe Connect link in the web conference invitation that you received; and please note that today's web conference will be recorded. For the first portion of the web conference, the teleconference line will be in lecture mode, which means that all of your participant lines are muted. If you have questions during this time, I want you to please type them in the discussion chat box towards the bottom right-hand side of your screen. I'm going to keep track of these questions throughout the presentation and then we will address those during the question and answer period at the end of the web conference. Once the presentations are complete, I will open the teleconference line for discussion. During that discussion period, we will kindly ask you all to be responsible for controlling your own phone's mute function by either using your mute button or by dialing *6. We ask you not to place the call on hold, as the hold music will be heard over the conference line. If you would like to make a comment or ask a question during the discussion, please use the Raise Hand function in Adobe. The Raise Hand function is near the top of your screen; let's all practise that. If you can hear me, please raise your hand in Adobe. Great, perfect, now let's all lower our hands. Awesome. So, if you raise your hand during the discussion, I will call on you by name and prompt you to un-mute your line and proceed with your comment or question. So that takes care of the technical business and we will go ahead and get started. Like I said earlier, good morning and good afternoon to all of our participants who are joining us from across the country. Welcome to today's web conference about *Improving Health System Efficiency in Canada: Perspectives of Decision-Makers*. My name is Dana Riley, and I'm a senior analyst with the Canadian Population Health Initiative at CIHI; I'm facilitating today's

discussion. We also have on the line a few of my colleagues from the project team at CIHI. In the room with me I have Jean Harvey, the director of the Canadian Population Health Initiative. We also have Sara Allin on the line, our senior researcher in Toronto, and I have Janice Zhang, the senior analyst with CPHI, in the room with me too. We are also very pleased to welcome Susan Brown, the vice president and chief operating officer for Hospitals and Communities for Interior Health, British Columbia, and Janet Knox, the president and CEO of the Nova Scotia Health Authority. Finally, we have a diverse audience from across Canada on the line today who have all — all have a shared interest in health system efficiency and our recent CIHI report. So just to give you a sense of how the discussion will proceed today, we will start with some welcoming remarks and a brief overview of CIHI's health system efficiency work, then I will invite each of our guest speakers to reflect on the report findings in the context of their respective settings. After that, we will open the telephone lines for discussion among all participants. As a reminder, if you have any questions or comments during these presentations, please write them in a chat box and we will address them during the discussion session following the presentation. I will now call on Sara Allin to start the presentation.

Sara Allin: Thanks, Dana. I'm very excited to have this opportunity to discuss the results of our short report on health system efficiency. It's now available on our website, so please visit cihi.ca if you haven't already seen it. So as we can see on slide 4, the aim of today's session is to present the results of our study that summarizes what we heard from senior leaders in B.C. and Nova Scotia and hear how these findings resonate with you — with all of you. And we are thrilled that you've joined us today, and we are especially delighted that 2 system executives participated in this study, as Dana mentioned, have agreed to provide some of their reflections on the report's findings. Across Canada and internationally, governments are introducing changes to their system to improve efficiency — in other words to get better value from the money they spend — and CIHI has made a commitment in its recent strategic plan, as you can see here on slide 5, to support jurisdictions in their efforts to improve the health of Canadians and to improve the performance of their health systems. We've identified priority themes and populations to focus on over the next 5 years, of which one is to improve value for money. This report is just one of several initiatives and products that aim to fill some of the information gaps in this important dimension of health system performance. Today's presentation will be on the third report of a multi-phase project that began with a series of consultations to define health system efficiency — in other words, what is the objective that we should be measuring? Measuring efficiency against and through this work, the definition of efficiency was the effectiveness of systems that are able to convert spending into improved access to timely and effective health care. We then applied the definition of efficiency to CIHI and Stats Can data to estimate efficiency at the health region level across Canada and uncover some of the factors that are

associated with variations, and much of the variations could not be explained with the available data, so we did — we undertook the Phase 3 study, which is qualitative in nature, in order to gain a more in-depth understanding of the facilitators and barriers to improving efficiency in 2 provinces in particular and I'm — we will now turn it over to my colleague Janice Zhang to present findings from this qualitative study. Over to you.

Janice Zhang: Thank you, Sara. So, first I'm going to give you a brief overview of the methodology of our study. So this was a multiple case study, and what this meant is that our qualitative study focused on 2 provinces — British Columbia and Nova Scotia — and 2 regions within each province that had varying levels of efficiency according to Phase 2 of our analyses. So, in Nova Scotia, each of our — as you can see from the schematic — each of our regions combined 2 district health authorities, and so this approach is consistent with previous Statistics Canada and CIHI analyses. We selected cases from each province that were roughly compare — comparable, which means that they didn't include a major urban centre and they had comparable population characteristics. In total, we interviewed 42 senior health system decision-makers at the provincial and regional levels from 2014 to 2015, and we are very pleased that some of you could join us on the line today. So at the time of our interviews, as you can see, these district health authorities no longer exist. Nova Scotia was in the process of consolidating its district health authorities into now what is 1 Nova Scotia Health Authority; we asked key informant in our interviews to reflect on their roles in the previous district health authorities, but this reorganization is an important context for our work. Throughout all stages of this project, we worked closely with an expert advisory group that included representatives from the ministries of health in Nova Scotia and British Columbia, qualitative researchers and content area experts.

So, this slide is the conceptual framework that we — that we developed through analyzing our interview data. And this conceptual framework for improving health system efficiency illustrates that in the context of strong leadership and challenges in the external environment, action to improve health system efficiency can occur along 5 dimensions. So these are performance monitoring for accountability and decision-making, system-level integration in governance and care delivery, partnerships outside the health sector to improve population health, physician engagement and remuneration, and flexible funding. So each of the — for the next couple of slides, I'm going to describe our findings regarding each of these dimensions and sort of illustrate what they mean, and that's going to be illustrated with quotes from key informants.

So, firstly, key informants in both British Columbia and Nova Scotia cited the importance of formalized accountability agreements between ministry — the ministry of health and health authorities to set expectations and standards

for funding and service delivery as a facilitator for improving efficiency. In B.C., these agreements have been in place since 2001, when the current health authority structure was created. Nova Scotia has established this more recently with the 2015 reorganization. Overall, B.C. key informants describe their province as having strong analytical capacity for performance monitoring, [00:10:00] including examples like in this quote from the B.C. key informant. [Inserted quote: A manager dashboard shows our operating managers their unit's performance, but also the performance of their peers and this gives them an opportunity to . . . ask questions . . . it encourages a dialogue.] Nova Scotia key informants largely noted the need for improved capacity for performance monitoring, such as analytical capacity, reporting mechanisms and the availability of data to support decision-making as challenges to improving efficiency. So, next, many key informants described the importance of system-level integration to improving efficiency both in terms of governance and care delivery. Our interview participants from British Columbia cited the integrated governance structure of the health authorities as a key facilitator for efficiency, while Nova Scotia key informants reflected that there were many challenges with integration between sectors, levels of governance, regions, etc., with the previous structure of district health authorities, and were hopeful that amalgamation would improve integration. In terms of care delivery, respondents from B.C. mentioned that integration between acute and community care and within the community care sector was a top priority. In particular, in the report, we highlight the example of the primary care home, which key informants pointed to as a model wrapping primary care services around the patient. The use of an integrated electronic medical record is a key component to improving efficiency in the primary care home, so this quote from the B.C. key informant illustrates this link between patient-centred care and efficiency. [Inserted quote: We'll have succeeded when people don't have to tell their story 20 times.]

In both provinces, our interview participants recognize that addressing the social determinants of health could improve health system efficiency. In order to do this, they noted that strong partnerships are needed across sectors, as many of the levers for action on the determinants of health fall outside of the direct control of the health system. This quote from a Nova Scotia key informant illustrates this idea. [Inserted quote: The relationships with the policy, with emergency, with community services . . . those relationships are so important to getting through the silos, and from where I sit, it has a huge impact on efficiency.] So, our interview participants noted that health authorities play a variety of roles in this partnership; so that could include sharing information, working collaboratively on joint initiatives or taking leadership to bring disparate groups together around the common issue. In several interviews, we heard from participants in these more rural regions that the rural — because of the rural geography of their region, strong informal ties facilitate intersectoral partnership at the community level.

Interview participants from both provinces mentioned that the system changes to improving efficiency can't be made without engaging with physicians. For example, the Doctors of BC created the Divisions of Family Practice, through which health authorities can engage with family physicians as a collective through these physician-led organizations to help promote health authority–physician collaboration and partnership in decision-making. This quote from a B.C. key informant describes how physician engagement takes work to build and the need to prioritize that relationship. [Inserted quote: It's not an established habit of physicians to work closely with health authorities in that manner. So, it's taken time to develop the trust and confidence that allows us to do this and there's still a long way to go.] In several interviews, we also heard that physician payment is a potential lever to improving health system efficiency. For example, key informants described a range of possible alternatives to the dominant fee-for-service model, from changes to fee codes to salary models as possible ways of aligning service delivery with system-level goals in order to improve efficiency.

So, the final of the 5 key dimensions for action to improving health system efficiency is flexible funding. Interview participants from both provinces reflected that it was challenging to make changes for efficiency by shifting health care investments upstream or investing in partnerships with other sectors because of the need to maintain funding for patients already in acute care. This quote from the Nova Scotia key informant describes such a change as a "leap of faith." [Inserted quote: It's going to take a huge leap of faith to invest more in . . . primary [health care] and prevention and . . . education and still maintain the funding for the acute care and the people who are sick in the system.] Of note, key informants in Northern Health identified that the flexibility of the health authority funding structure in B.C. was a key to improving efficiency. We also heard about the many challenges to improving health system efficiency that system managers face. They identified that rural and remote geography and the population characteristics of the regions that they serve — so specifically an aging population in Nova Scotia and a larger Aboriginal population in the regions that we focused on in B.C. — are important contextual challenges for their efforts to improving efficiency. Cultural resistance to change was also a theme underlying many of the challenges to improving efficiency that we heard in our interviews. For example, several key informants mentioned that public expectations of health care can conflict with the goals of efficiency, so that system change requires public engagement and support. Finally, key informants stressed the importance of leadership to provide vision and act as champions within the system to affect meaningful change, as this B.C. key informant describes. So, finally, by comparing the experiences of health system leaders in 2 provinces at different stages of health system transformation, our report identified a variety of different actions across 5 key dimensions along with health — which health system efficiency can be improved.

Dana Riley: Thank you, Janice, for providing that informative overview of CIHI recent health system efficiency report. I will now invite Janet Knox, the president and CEO of the Nova Scotia Health Authority, to say a few words. Janet Knox is an accomplished health executive and leader with a passion for improving the health of Nova Scotians. She is committed to engaging Nova Scotians in conversations that will shape the future of health and the health system in the province, and she believes in managing Nova Scotia resources effectively for the sake of better health outcomes. Janet please un-mute your line and go ahead.

Janet Knox: Thank you very much and hello everyone. It's a — it's wonderful to have this opportunity to provide a reflection on this report. I thought I would start by talking about Nova Scotia Health Authority, because as you have heard the study was done at a time before we were Nova Scotia Health Authority. We began as a new organization on April 1, 2015, with a mandate to govern, manage and provide health services to all Nova Scotians with our partner organization, the IWK Health Centre, and to implement the strategic direction set out in the provincial health plan. So really, as the previous speaker has said, Nova Scotia Health Authority is an amalgamation of our 9 previous district health authorities, and these authorities were of varying size with varying responsibilities for service provision, and all charged to develop an integrated community-based health system, and 4 of those previous DHAs were subject to this review.

The first year of this organization has been focused upon building a foundation for a new organization focused on all Nova Scotians and our support to Atlantic Canada. And so governance and accountability, structures and processes have been central to our work: building the relationships so that collaboration, partnership and engagement can happen and must happen; setting the priorities for the development and evaluating our progress; and creating the foundation in relation to working as 1 organization — expectations for the outcomes we were to achieve, developing our strategic plan, and creating early wins, so that our physicians, employees and volunteers who work with us every day could be hopeful that the massive change that we are undergoing in this province really will produce the results that we need to create together. So I just wanted to set that context in all of this as we continue to provide the services that Nova Scotians expect to receive and truly value. So an opportunity to talk about the report itself. One thing I would like to say at the beginning: I do appreciate that the report is concise and provides an efficient way to understand the research that was done and what the findings have been. And I think it's written in a way that we will enhance people to access it and to think about how they can use it. Given that our system is undergoing immense change in each of our provinces, it is a snapshot of a point in time and — and there is a time lag that some people could say would be a challenge. For me, I would just like to explain this: the data used for this efficiency review is now 7 to 9 years old;

however, we have learned or we should have learned a great deal about our systems and our impacts on our population in that time and how we must marshal change. In Nova Scotia, the last 7 years have been a very different conversation and discussion that has led to a change in overall structure of our health system. This change began as a sustainability plan, and the leaders in the system insistent that it must be about that as well as a focus on better health outcomes for our people.

Managing change takes focus and purposeful time and energy. Our health system is valued by our population, and change in that is feared often by local communities because it often sees change as having negative outcomes for their system. So I do appreciate and see value in this project as it further supports the work that we are doing in this province with evidence. Also, I think it's really helpful for us in Canada to be evaluating our system, and — and having a comparison [00:20:00] with British Columbia really creates that opportunity for dialogue and learning from each other. And I would want to say to my Canadian colleagues that here in Nova Scotia, we had found that our colleagues across Canada are more than willing to talk about challenges and successes and the lessons learned as we move on our journey to create a better health system for our people.

I also want to comment on the qualitative content of this — this project — this 3-phase project. We are learning as we use our data that they — we have to have a qualitative approach as we move into communities and talk about the lived experience in the community. The data is one thing — the quantitative data. The qualitative data added to that is rich in terms of how we learn about what will be useful and helpful in helping move our services to the place that will be focused on how we help people to be healthy and stay healthy. I believe we need more of that, and I thank the Canadian Institute for Health Information for promoting such dialogue and subsequent learning. A few comments on the framework, and I thought I would use some examples because we — I — I'm not going to talk about what was learned about the previous parts of our organization, but how — what we are doing now in Nova Scotia Health Authority that reflects this framework. And I would like to say that the very important part of — of really monitoring our efficiency is to really understand what our goals are — what the goals of our system are and what is our accountability to achieve that. So here in Nova Scotia, we have begun Nova Scotia Health Authority just over a year ago with a first-time-ever accountability agreement in this province, and we have defined the roles for the Department of Health and Wellness and the minister and what are the subsequent roles for the Nova Scotia Health Authority and the IWK Health Centre, and that is a very important start.

We are consolidating and building our performance management system, and we know we have a lot of work to do to create the appropriate information management systems that will help us to make efficient decisions. That said,

I believe that we don't wait until — that everything is perfect; that we need to use the information that we have to the very best of our ability. So as we began merging these — these organizations, we targeted 3 specific areas of service delivery to address wait times for service. And I know that in this report it was reported by our participants that we had a lack of data in continuing care; what we found is that we — we needed to find ways to use the data available for all parts of the journey of our citizens who moved through our services and really to understand that journey for our patients and for their families and the communities we serve. And I'll use the example of long-term care and home care, where we had unbelievable wait lists. Great long ALC in our hospitals, and over the course of the first 14 months, we have reduced the wait time in people waiting for — the number of people waiting for long-term care and the number of people waiting for home care by 70%. And that really was achieved by using our data to truly understand all parts of the journey and then being able to use best practices, such as home first philosophy, to really change our work together and then scale it right across our province. The first time ever we have eliminated wait times for home care. Using a similar process of understanding our data, we have been able to reduce access to MRIs by 12% across our province. One of our big areas was wait times for orthopedic surgery, and we have had an ability to increase our cases by more than 700, but really using our data helped us understand that we needed to focus on the journey and of the process through accessing this service, and we focused on the longest waiters. So I'm just using those examples to show that we need to not wait till we have perfect data, but ask ourselves how can we be accountable by using the data that we have? System-level integration in governance and care delivery is central to the work that we are doing in Nova Scotia, and I would say that this report really supports why we moved to 1 health authority working in collaboration with our partners. And we have learned in the first year that the spread of best practices can be easier when your system is integrated and you function as 1 system and that the solution-finding to challenges is quicker and the expectation to work as one serves many outcomes.

We remind ourselves constantly that the population served moves through our system and we need to function in an integrated way to serve them in that way. Then we are focused on them, on the population and not on ourselves. So our planning takes into account this continuum of the perspective from prevention to palliation and requires collaboration, planning, implementation and evaluation of our outcomes all across the system. We believe community-based, interdisciplinary collaborative care teams focused on primary health care is the foundation, and the integration must be full collaboration across the continuum, so we are very supportive of that. The issue around partnerships and collaboration, what we have found and what we are moving to help us all understand, is that the focus on the health of the population requires the health system to be a good partner and a collaborator, and our focus needs to be on building coalitions of leadership in what is

needed because the silos must come down. Physician engagement in all aspects of this work is key. It is challenging and important work, and what we have chosen to do is to say that co-leadership with physicians is really, really important, and that becomes very much part of our work. What I would add in here, though, that we would say that engagement of all players of all of our practitioners in the health system is key to ensure the success and make sure that we are not assuming that any one group is ready for all of these changes. We would agree with the conversation about the payment approaches; we have old models of payments, particularly for our physicians, that renovation is really needed, and that's going to take a great deal of collaboration.

In terms of flexible funding, I very much agree and am very interested to hear of the work that happens in other parts of our country. In Nova Scotia we, like others — it has been easier just to increase the spending in acute care and I'm a registered nurse and I know — I have been in the system for a long time and we've really educated our communities to understand that if we have hospitals, we had health system. And so we really are working hard to help people understand what services need to happen and to change the mindset and focus on the value for — for all parts of the system and really focusing on the outcome. So, as an example in Nova Scotia, we have community health boards. They are volunteer boards that would help us focus on the local health needs of the community — they are very wellness oriented; and we have in our first year restored the funding for wellness initiative grants because we needed to signal in the community that that kind of work is very, very important. So, in summary, I think the framework can be used by our organization to discuss efficiency. I would say that a key strategy that is missing perhaps for us is that meaningful public engagement; I think that needs to be part of the framework. Change management is key to creating the need to focus for our system, engaging the public in open direct conversation about the challenges, the goals — and strategy is key to creating the needed change, and this takes immense focus and indeed considerable resources, helping the people of our province and all of us who govern it and work in the system understand the need for change is key to be able to reorient our work and to achieve better population health outcomes.

So to that end, Nova Scotia Health Authority in October 2015 initiated a program that we call Talk About Health, which is focused on Nova Scotians and our health status and to have a real conversation about our facts and what is our health status in our first step in creating this imperative for change. And to date 1,000 people have participated in 42 face-to-face conversations around our province and just under 10,000 have engaged in conversations over our website to talk about health of our population. The directions are pretty clear; they are overwhelmingly clear. Nova Scotians are telling us we need to focus on health of our population. We knew that, but we know that — we felt quite certain that the evidence was showing us that in terms of our

expenditures and our health status, but the first step really needs to be that we have to have the need for change. This work is continuing with the next step beginning in the fall, where with our province we will create a [00:30:00] common vision for what that means for us and move on then to talk about what we need to do. We are hopeful that this approach will create an opportunity for us to let go of some of the things that we have done in the past and embrace community-based health homes as one example of real change. We need our citizens and our communities to value and be part of needed change, and this report talks about the political reality of health care. We believe that working on the ground in local communities — this creates a supportive external environment. So I hope that some of my examples have helped to show that we believe that this report has created a framework that creates an opportunity for reflection and learning, and I believe this is what we need in our province and indeed in our country. Thank you.

Dana Riley: Great, thank you very much, Janet, for providing that rich and informative reflection on health system efficiency from Nova Scotia's perspective. Janet, for now you can please go ahead and mute your line? I will now invite Susan Brown, the vice president and chief operating officer for Hospitals and Communities, Interior Health, British Columbia, to join us on the line. Susan Brown joined Interior Health in 2011 and assumed her current position in 2015. In her current role, Susan Brown brings leadership to acute home and community services, as well as allied health and patient transport, with the goal of enhancing integration, accountability and transparency across these service delivery streams. Susan please un-mute your line and go ahead.

Susan Brown: Thanks very much. Janet, I think you made my job a lot easier — you did a fantastic job of summarizing a lot of the sentiments I had as well, and so it's a great opportunity to read the report and in fact give the reflections publicly. Just a little bit about Interior Health: we do have a large geography — we are 215,000 square kilometres, which is a bit larger than Scotland and England put together — and I think our neighbours and colleagues from Northern Health might be on the line and they in fact have a significant issue as well with delivering great service across a very large geography with a dispersed population. We also are part of 5 regional health authorities in British Columbia as well as 1 provincial health authority. And also most recently in 2013, we have First Nations Health Authority, who are starting out their journey by focusing on community and primary care right now and most effort put on those on-reserve First Nations population. So, the report certainly does give us opportunity to — to look at where those pieces that we need to focus on and it does indeed cover subject matter that is lacking in the literature. So I will try not to duplicate what Janet said, but I did have 4 points that I wanted to raise. Health system efficiency as I read the report is not all attributable of course to the health system per se; so much can be influenced by social policy, which of course can drive reform. In British Columbia, we really benefit from the provision of a wide variety of social

services and programs; however, we still face many challenges. When I think of changes that have occurred over the past decade, 2 decades, that have really significantly altered what we see in emergency rooms or hospitals or in fact may still make change for the future, I can think of a few things that really influenced that. Now our policy on smoking, bicycle helmets, seatbelts, all those things make a difference to — to what we see in day to day, and now I think even in the U.S. and New York, as they are making policy around sugary drinks, which of course influence so much of health. And all the ministries — not just the health ministry — have an impact on health and well-being of our population — thinking of education, social development, environment, Ministry of Children and Families . . . in fact, the list goes on, and you can think of many populations that cover several of the ministries (for example, mental health).

The second point that I would like to make is that health care spending comes from a fixed budget, and we are all encouraged to be innovative and ensure that when we are spending we are doing that in the most efficient way possible. And by efficient, I mean delivering high or higher quality of care for the same or less amount of money. The challenges with innovation is when it is the absolutely right thing to do for the patient and it can reduce length of stay, but it can increase our throughput throughout our hospitals. For an example, a great thing that we implemented in Interior Health was enhanced recovery after colorectal surgery. We started that initiative about 4 years ago and it spread through 8 of our larger hospitals that do this type of surgery. I mean, we have reduced our length of stay so significantly that for every 1 patient that we used to put through for that type of surgery, we can put 2 to 3 through in the same amount of time. And as everybody knows, the first and second day of your journey in — in the hospital is the most expensive, so we have the challenge of really getting our teams and our staff to think about innovation and quality, but sometimes we can actually increase cost by doing that if, in fact, we are not able to shut down service at the back end. So that's one thing where I was — we talk about innovation a lot in health care and it's one thing that I would be interested in more is how do you do that innovation, where — where great ideas and curtail those costs at the same time? The other piece related to that particular example is the technology related to it also costs us money.

The third point is B.C. is quite integrated. It provides a lot of benefits, as noticed in the report. The challenge to being so integrated becomes the inability to be nimble; for everything you touch, it has a ripple effect and an impact elsewhere in the system. That being said, the integration is allowing us as a province to put effort on the same initiative, which results, I think, in a more significant change. We are focusing on developing the primary care sector into a more robust service with the goal of reducing hospital utilization and, in fact, the whole reliance on our hospitals, particularly our emergency rooms. As any of you can imagine, that takes significant effort, but we can

learn from each other and work together, which I think is the beauty of the integration. Within the report, there was a quote from our colleagues in the South Shore, which really captures our journey in B.C. It was related to the leap of faith, which I think they talked about at the start in the introduction of today's WebEx, and I think in B.C. we are in the thick of things now, and there are no new dollars going to the acute care services. All the investments are in the community, so we are taking that leap of faith and we are into that journey now and have another 2 years within that mandate to re-reshape the community services.

The fourth point that I wanted to make: yes, very aging population. We in Interior Health, I think, have probably the highest number of people over the age of 85 in our jurisdiction per capita. And that, as you know, is where some of the bend starts to happen for that population, so really trying to come up with different ways of delivering the care with less reliance on the facility-based services. So looking at telehealth, home health monitoring and again that robust wrap-around in the primary care area. And we do have to engage our physician colleagues. I have worked in a dyad or co-leadership model in B.C. for the last 20 years, which I think is essential. Operations can't go out ahead of physicians, and when the physicians have great ideas they need operations to come in behind them. One thing that I was left wanting more on the report was related to the physician engagement and the remuneration. I would like to see more analysis on that and what that does to really help us achieve our goals. Also, the other piece that I thought to enhance the report or potentially the opportunity for a future phase was the appropriateness of the services we deliver. One of the things, and I heard Janet talk about surgery, was when we see higher utilization of some services, we're heavily reliant on our surgeons to advise on whether that's appropriate or not, so some work in that area may benefit us in the future.

We also — as mentioned, we do have accountability within our system. We have a mandate letter each year from government, which in the health authorities, we have to live to and fulfill [00:40:00]. And additionally, I heard Janet speak about the engagement of the community and the stakeholders, and we started down that journey with our healthy living plans, which really involved, you know, police, local governments, schools, not-for-profit organizations and the community at large. And as we move forward with our rural planning in the health authorities, there will be more engagement of that and of the rural health system at large. So I'd just like to thank you for the opportunity to reflect on this paper, and I think it is something that we — will be meaningful for us as we move forward in B.C.

Dana Riley: Great, thank you, Susan, for sharing your perspective with regard to the health system efficiency. I'm now going to un-mute the participants' line.

IVR: [The conference is no longer in lecture mode].

[Irrelevant conversation]

Dana Riley: So, I will give a reminder to all participants please mute — mute your telephone lines using the mute button or by dialing *6 to cut down on the background noise.

[Irrelevant conversation]

Dana Riley: And you can press *6 or you can use your phone's mute button to mute your lines.

[Irrelevant conversation]

Dana Riley: Okay and — so then, if you would like to make a comment or ask a question, please use the Raise Hand function in Adobe. I'll call on you by name and prompt you to un-mute your line and put comment or question. We — we didn't receive any questions yet in the discussion forum text box, so perhaps one of our presenters would like to get the discussion started. Okay, Joanna, please go ahead with your question. Please un-mute your line using *6 and go ahead. It's Joanna from Manitoba. Great, thank you, Joanna.

Joanna: I had a question for Ms. Knox and I'm — I may not have heard you correctly, but I noted here that I believe you made a comment related to the need to focus on the patient and not on ourselves, and then later you commented about the silos needing to come down. And I — I would really appreciate if you could elaborate on that.

Janet Knox: Thank you for that question. My comments really are about the — we really need to focus on population health and we really need to understand the journey of our citizens, our residents through the health system. And really understand what their experience is when we are looking at efficiency of service provision. We really need to hear from them. And I think my comment about — I wanted to raise the issue of the qualitative perspective. We have experience of going into communities, we have — we have for us now what we call a profile of each of our communities and then of clusters of communities, and when we go into the community and talk to either groups about what we are seeing and what we understand and then talk to them about their lived experience in that community, you come out with — together — perhaps a different plan in terms of what we understand to be really important. So one of the things might be the issues around transportation — who are the people and how did they access the services? If we truly just look at "this is the population, their demographics, just how many of them there are," [inaudible] so that was what I was referring to. We really need to be focused on our population and what is their reality.

Joanna: Thank you for your comments. I don't know if you're comfortable speaking a bit about "instead of focusing on ourselves."

Janet Knox: Sorry.

Joanna: And some of the potential barriers that we need to be aware of in that regard.

Janet Knox: Okay.

Dana Riley: And sorry, before you go ahead, this is Dana from CIHI in Ottawa. I just want to ask people please not to use the hold button on your phone; there is some hold beeps coming to — over the teleconference line and it's very distracting. So please don't use the hold function on your phone; you can use *6 to mute your line, *6 to un-mute your line or your hold button on your phone.

Janet Knox: Okay, is it okay —

Janet Knox: This is Janet Knox again, so thank you for that question about ourselves. What I was referring to is the whole concept around collaboration and partnership and breaking down silos and really being able to move in from a leadership perspective in seeing ourselves as the health system. How do we become collaborative leaders, how do we purposely build partnerships and networks, so that we can be focused on our population together? So I'm talking in particular about disciplines or that kind of thing. It's about the system, our organizations moving in and being able to be the partner, that sometimes takes the lead, sometimes is — is working and walking with other organizations because, as Susan Brown has said, it is not just — If we're talking about the broad population health, the health of our people, the health system is only one part of the solution for that, and so we need to see ourselves as really collaborative — a collaborative organization building partnerships purposefully, and then acting as partners, than cannot always be in the lead.

Joanna: Thank you.

Dana Riley: Great, thank you for providing that response, Janet. Is there anyone out here who has another question for either Janet Knox or Susan Brown?

[Irrelevant conversation]

Dana Riley: Okay, well perhaps I can get to — get us discussing things here and I'm — So either Janet or Susan or Sara on behalf of CIHI, which of the dimensions summarized in our CIHI framework for improving health system efficiency most resonate with your region's strategies for performance improvement that you're implementing?

Susan Brown: It's Susan. Maybe I will start off and others can join me. I think the pieces that really resonated for me was performance monitoring and accountability. It really helps us drive our decision-making. A lot of work has gone into a — a dashboard or a matrix for the province in B.C., which get all of our boards

focusing on the same thing. And there is a nice blend of the matrix in that performance monitoring, which covered quality, costs and many other things, but I think the key to that piece is not having so many indicators — but it becomes almost impossible to monitor them all. So I think the province has done a great job at getting focused on what is key to — to running the system, which really helps drive the senior executives in the province around their decision-making and how to monitor and match up to those key deliverables, which really gets to the next piece about the governance and the care delivery. One really does merge with the other there and the — the governance and the care delivery pieces, we had mentioned with the integration, we are really all focusing on the same initiative, which should allow for a more significant shift in the province with regards to our outcomes in specific areas, primarily primary care in this instance, and we've got some other major files that all the health authorities are working on here, which really gets back to the integration and the governance and much of their all being dealt with in separate files right now. They are — really all do dovetail together — so, for example, seniors care, mental health, rural care, primary care — and we — we also are looking at surgical wait times within the province, that they really all are about robust primary care and access to care in the system.

Janet Knox: I'd agree with Susan on those comments, and I would say that the performance monitoring for accountability and decision-making sets us up [00:50:00] that we are focused on what it is that we need to do to provide an appropriate system to support our citizens, and how do we know that we are achieving that. However, I personally can't separate that out from really the rest of the factors, because just monitoring and deciding on ourselves, as the system alone, what is it that we need to do won't work either. But if we don't really focus on the performance monitoring and really being accountable and transparent we won't get there. So it is very, very important. The other parts are how you create a system so that you can do that appropriately. That's how I would see it.

Dana Riley: Great, thank you both. And is there anyone else who has some other experiences that they would like share with regards to performance monitoring or how it's implemented in your region? And I'll just remind people that if you'd like to ask a question through the teleconference, please use the Adobe function and raise your hand. It can be related to the questions that we've already started, or if you have new questions that you'd like to post to either of our panellists, please go ahead. I will remind you that in about 10 minutes Susan Brown will have to leave the line, so if you some final questions for Susan please go ahead and raise your hand on Adobe and we'll address those first.

[Irrelevant conversation]

Dana Riley: Okay, so for others, Susan or Janet, can you tell us a little bit more or elaborate on how your region partners with other sectors to improve population health? So some of the ways that you're doing unique interventions to address population health issues?

Janet Knox: So, it's Janet. As Susan — maybe I'll start — no maybe you should start, Susan, if you have to leave in 6 minutes. Sorry.

Susan Brown: That's good, go for it and I'll wait till you're finished.

Janet Knox: I will be really quick and say, really, the partnerships, that in our approach in our previous 9 organizations to moving forward with the — with the combined amalgamated one. It is really to think about who the population is that we are serving with any given issue and who are the key partners that we need to bring together around the table. So in our Mental Health and Addictions, we have some wonderful examples of partnerships with the police, the Department of Community Service, local communities, local support groups, that kind of thing. And one of the things that we've learned in our past is that we really need to define what are we trying to achieve together and — and put the common roles — goals out on the table and agree to them, and then talk about who takes the lead on what and put in a purposeful evaluation of our progress together. Another example to give you, too, would be how we support children and youth in their school environments and how do we bring the health system participants and professionals into the school environment and work together with the school to provide that support for ongoing health and wellness support in schools. That would be some examples.

Susan Brown: Thanks, Janet, and it's Susan. Much like Janet has said, similar types of approaches here, working closely with the police around mental health clients to ensure their safety and well-being until they come into our care or get to areas. We have been given some grants on other mental health not-for-profit organizations that are managed in the community to try and be more responsive to patients when they self-identify that they need assistance that may not need to come to the emergency department. We also have partnered heavily with our hospice societies around our hospice and palliation needs, and also within the community living sector, where we have worked out in local areas with local government and many people sitting around that table. Those plans have resulted in grants in local communities around assistance to seniors and also working with school areas and different areas just around healthy living aspects, whether they be local gardens for food and different opportunities for seniors around adult day programming. Thank you.

Dana Riley: Great, thank you both very much. We do have a question coming through on the chat function. It's from RCHS, and they are asking what resources did you invest in or obtain in a way of change management?

Susan Brown: It's Susan, maybe I'll jump in there first. With regards to the 5–6 files that we are focusing on in the province, we did invest — well, we didn't invest, we re-aligned our team to support actual functional teams under each of those files to drive the change. So each file will have a strategy lead, a project manager and all the other pieces that you would consider that you would need for any type of change — HR, finance, our business support people, our office people — but have we made sure that there is dedicated teams. We seconded them out of their normal jobs to really focus on those 5 initiatives to help drive them.

Janet Knox: It's Janet here. That would be very similar here; at the beginning of Nova Scotia Health Authority, we created a transformation office with an executive leader, and so change management, project management, human resource support, financial support as we move our projects through are very much — project what we need to do.

Susan Brown: The one other thing that I was remiss in mentioning — it's Susan — we — we do have a patient voices network here in B.C., and they work with residents within our jurisdiction to help them become prepared to sit at tables with health professionals, and really that is about patient-centred care and they are — we are using their voices at several of our tables and — and at our actual strategy development table [inaudible] to improve the system through the lens of the patient.

Janet Knox: It's Janet. Thank you very much, Susan, for bringing that up. And I also was remiss in terms of our planning. The experience and the input of patients, individual families and communities is part of the plan in terms of really understanding their experience, but also hearing their suggestion as we plan our services provincially to meet their needs, so thank you for raising that.

Dana Riley: Thank you for both of those perspectives. I have a question here from Melina that is relevant to what we are just talking about, and she is asking if we would also speak to how the civil society role and value to strengthening the health system and how to engage charities and not-profit sector partners into these conversations. Susan are you still — do you want to take that first? I know your time is —

Susan Brown: Okay, thank you. So absolutely, it sort of gets to people being accountable for their own health to some degree, and I think really that social policy piece comes into place in the amount of education that is done for the general public around diet, exercise, healthy living, and then secondly the not-for-profit organizations can play a significant part in what we do. I think of Heart and Stroke, and the amount of advertising and great education they do with the public around really being keenly aware of what to avoid, and then if you do have symptoms how quickly to get to service. And then we have partnered quite heavily with not-for-profits in the Interior in the mental health sector around specifically, most recently, in child and youth mental health, really

trying to target that service in a way that is meaningful for youth to receive it, which is a bit more unconventional from what the traditional health care system would offer. And then again, really thinking about hospice-type care. Many of us knows its [01:00:00] — that relaxed atmosphere, that will allow people to come and go when they please and not have that very institutionalized feel to it. And having food whenever they want it, and just provide the different environment from a hospital or institutionalized feel to it. So that's some examples, thank you.

Janet Knox: From Nova Scotia Health Authority perspective, we have a new strategic plan as a relatively new organization. It has for the next 3 years just 3 major areas, and the one of them is engagement with Nova Scotians to create a healthier future. And our commitment is that we will engage Nova Scotians to promote and support our shared accountability for health and improvement in health status. And so when we go out and talk about health, we partner with community councils, local government, community health boards, schools, chambers of commerce, those kinds of groups, the African Nova Scotia Health Coalition, the Réseau Santé, which is our Acadian group. So we are engaging with others so that we are showing that this is about all of us, and this is about talking about the people of Nova Scotia with the people of Nova Scotia. And so really trying to change that we are not here to tell you what's needed, we are here to learn together about what we need to do together to get to a preferred future. And we've had great success in terms of really engaging the non-profit sector, and we've had 14 years in this province with district health authorities that were charged with developing an integrated community-based system. So we have a lot of history in that and they expect to be engaged. So it is — we are really starting at a very good point in time. And we have, through Accreditation Canada, processes for years now, focused very much on the health of the population in every discussion, and it helped our folks really — the physicians, employees and volunteers who work in our system — really to be focused on population health. And we know that to be the case because with every survey, we're told that there has been something happening here that we really have been having this conversation. So it is really, how do we engage people in their own health? And this work that we must never lose sight of.

Susan Brown: It's Susan again here. I have one last comment and then I have to leave the call unfortunately, but the other piece that's helping us: we have 54 First Nations bands within our geography in Interior Health and 7 nations, which we have letters of understanding with. And that is really helping us to form our health care that really supports excellent health care to those populations in a way that is culturally sensitive. I think that's one significant difference that I really noticed in the health care system over the last 5 years, is really driving that partnership with First Nations, to ensure we are being culturally sensitive in delivering care in a way that they feel welcomed in our system.

Thanks, and it's been a pleasure working with you to reflect on your report and we look forward to future things. Thank you very much.

Dana Riley: Great, thank you, Susan, for joining us today. It's — has been really great that you have been able to take the time to share experiences with us. So, thanks again. For the remaining participants, we do still have Janet Knox on the line and I — we have a question asking for the name of the strategy that Janet Knox referred to. I believe they are looking for your Talk About Health strategy.

Janet Knox: That's correct.

Dana Riley: And is that document publicly available?

Janet Knox: If you go on our website, engageforhealth.ca, you can read all about it.

Dana Riley: Wonderful, thank you. I am going to go back to an earlier question that was posted, and it was in regards to cultural resistance and public expectations. And RCHS is asking in what ways would public expectation not be aligned with your plan?

Janet Knox: Thank you for that. What we would say is that our plan is being developed with public engagement and so, as Nova Scotia Health Authority was created, it was created to amalgamate the service provision and to focus on the health of the population. That being said, as many of us experienced, there is a lot of traction and attachment to local facilities and local services and in communities, and so we have a commitment to work with the citizens of this province in terms of planning the system together. So as I said earlier, as we plan our services there is a component built in which is the engagement of the practitioners who work in the program to plan, and the recipients of the service, and the communities in which the service resides. So that's work that we are beginning to undertake now.

Dana Riley: Thank you, Janet.

Female: (Inaudible) Do you have any questions or anything?

Male: No, I am good.

Dana Riley: Just to reminder to everyone that if you're not contributing to the discussion to please mute your line by using your mute button or *6. So if you have some more questions, you can either raise your hands in Adobe or type them in the discussion text box. Are there any members of our expert advisory group on the line? Do you have any specific questions related to the project that you would like to ask right now? Okay, to some of the participants on the line, how do you successfully engage physicians in some of these conversations about the health system efficiency changes? Or what challenges do you face in successfully engaging physicians in order to bring

about system changes to improve health system efficiency? Does anybody have any specific examples about how you successfully engage physicians in your region? I see a group on the line from Northern Health — would you like to share any comments or perspectives with regard to the report or how you engage physicians in your region? If you would like to comment, please go ahead and un-mute your line by using *6 and — Sara Guilcher. Sara, would you please you to un-mute your line and go ahead. Sarah Guilcher, please go ahead and un-mute your line and go ahead with your question. We have a question coming through from Sara on the chat function, so we will let her type it out and then we will be able to get it over the line.

Catherine Gaulton: Hi, it's – it's Catherine Gaulton, I go to called out for a minute. You were asking the question about examples [01:10:00] around how we would engage physicians in this work. And I'm from Nova Scotia, from Janet's neck of the woods, and I think one of the things that we found is most crucial is actually to have the conversation be about the quality and safety of the service that we are providing to our communities. And that's an immediate opening for our conversations with physicians. That and the data that actually speaks to practice. And when we say that, we mean practice that is very close to the interface with physicians, not the highest-level system data, where you might use that to drill down, but when you do that it is an immediate in with physicians that stays the course. So that's been our experience. Lots of specific around that of course, but I don't want to take everybody's time on the call but just wanted to add that.

Dana Riley: Great, thank you, Catherine. I will go ahead with the question from Sara Guilcher. She is asking the question — it's for you, Janet — regarding the Talk About Health and what are the differences amongst community members as to what are the priorities?

Janet Knox: Thank you very much, Sara. So we have — we have done a content analysis of all of the conversations, and there is pretty good agreement, and I just remind you that the first phase of the conversation was really about what is the health status of Nova Scotians, why might that be the case. So what's the evidence showing us, and what do we think is important in terms of promoting health? And the conversation came back to — that as a province we need to learn how to live well. So as citizens, so that individual accountability, we need to create systems or supports in our community level, but also from a prevention sort of perspective that supports people living well. So that got to policy direction in terms of are we doing an assessment of policies that really impacts, like the health impact assessment? We talked a lot about the silos in terms of service delivery and that — now we came from a past here about 2 and a half years ago of having a commission go around our province and really talk about economic prosperity of this province, and one of the comments that came out of that report is that we are so small that we should not be competing with each other, community to community, that

we really needed to be more collaborative. We said that in this discussion around the province, we have the 3 Cs: cooperate, collaborate and coordinate our efforts together, so that we are maximizing every effort. And really, that whole focus about how do we really help Nova Scotians understand what we need to do. And we talked a lot about and heard from them of having the courage to do things differently and how do we engage others so that we can progress there. So it was overwhelming, I have to tell you for us, in terms of saying "wow, when you really talk to Nova Scotians, they're kind of ahead of us." We worry about having "this is what people want," and those of us who work in the system know all of our experiences — when we try to change things in a community and you had to have, say, 700 people at a meetings and those kinds of things, so it causes us to reflect on how do you bring people along and together we create this reality. So we are saying to Nova Scotians, we need to do this well and we need to take the time to do it. And while we are doing that, we are still making sure that we are focusing on efficiency and talking about what Catherine has said — how do we need to engage all in terms of this work — but it's astounding in terms of the common response from Nova Scotians.

Dana Riley: Great, thank you, Janet, for providing your perspective on that. Okay, so do we have any other questions for Janet Knox from our participants, specifically related to health system efficiency or regarding some of the key dimensions reflected in the report?

Dana Riley: Okay, I have a question and it's regarding the flexibility of funding: So to what extent does your region have the flexibility to reallocate funding from acute to community or preventative care? And this question can be for some of the participant across the country who are listening or for you Janet with regards to reallocation of funding.

Janet Knox: Well, maybe I'll start. It's Janet. We have — in our accountability agreement we are required or asked to have a no-surprises perspective, and so if we change service delivery then there is a process by which we do that. That being said, when you talk from a population perspective — so if you are offering services for people who have chronic obstructive pulmonary disease and you're looking at how do you use the resources across the continuum of support, we have the opportunity to move those resources around. It's still the same program, and so perhaps some of those services need to be up front into the community or, for instance, in our "home first" philosophy with the focus on support for people who perhaps needs — who at one time would have been destined for long-term care, when we changed the perspective of how we support them to go home and be supported in their home, we just have to be open and okay and courageous and say this is how we need to do our work. And engage our funder in the conversation, and we can do that and we need to see that's what must be done. It is a challenge because it's — the costs of providing acute care services are very high, and there is a lot of

investment that we have made that is very appropriate and — and important; however, we just had one, I will give an example, one of our community hospitals reoriented the whole process of how they support seniors to the point where we actually flipped units, one unit became the acute care unit at a smaller number of patients and another unit became the community transition unit with a focus to home support and we changed the number — we dramatically reduced the number of people who were classified as ALC — alternate level of care — and staying in the hospital in that area, reduced the wait list for home support and home care and in that service delivery, reduced the cost of the programming by $500,000 a year and it was all by — this is the population, this is who we are serving, how do we use our resources in the best way to have the best outcomes for the population. So it's how you approach your work.

Dana Riley: Great, thank you, Janet. Do any participants have any other examples that they would like to add to that? Okay, if you have any questions, you can go ahead and ask them now or you can use the chat function, but we are going to start to wrap things up for today. So, if you have any final questions, now it's the time. Otherwise, we will get things wrapped up. Okay, in that case, I am going to invite Sara Allin to make a few closing remarks with regards to this discussion.

Sara Allin: Thanks, Dana, and thanks everyone for joining us in this web conference. I have been taking notes extensively listening to Susan Brown and Janet Knox [01:20:00] sharing their thoughts on how the findings resonate with them and what we need to consider in some future work. And in particular, I heard that we need to know more about how to innovate, how to make the changes that we need to do to improve efficiency, but then contain costs or then keep within the confines of our fixed annual budget. And that's a challenge that we heard today and something we need to think about a bit more in our work. We also need to think about measures of appropriateness and how to identify services that aren't needed or clinically valuable, and that reminds me of some work that we are doing also within this theme of value for money at CIHI, of how we're just partnering with Choosing Wisely Canada to identify these little-value services that we shouldn't be doing and we should report on them, so we were — we are working with them as a partner in this.

I also heard that we need to know more about how to effectively engage physicians and other providers, but also how the changes to their remuneration might influence efficiency. We heard that a lot in our key informant interviews, but we could do more to draw on the evidence of what might work and what revisions to remuneration might be effective there. So thank you for all those comments, and thank you for spending your time today emphasizing what's going on in Nova Scotia. It's very interesting to hear about the public engagement work in particular, and we would like to also acknowledge all 42 of our key informants who have provided us such a

rich and thoughtful insights from Interior Health, from Northern Health, from B.C. ministry and from Nova Scotia. Our expert advisory group, many of whom are on the line today, we're very grateful to all of your help along the way and support. For example, Martha Burd from B.C. and Sara Guilcher from University of Toronto, and our peer reviewers, including John Abbott who was on the line, as well as Catherine Gaulton. Thanks to our project team; Jean Harvey, our director; and our VP, Research and Analysis, Kathleen Morris, for supporting and contributing to this work. So in closing, I guess as I mentioned earlier, CIHI is committed to improving our understanding of value for money, and this is just one part of a broader program of work that is under way now. And many other projects, we can look forward to their release; one of them in an indicator study of the widely used Cost of the Standard Hospital Stay indicator. Another project looking at efficiency of the inpatient acute care sector and, as I mentioned, the project with Choosing Wisely Canada to identify these low-value clinical services. So, we welcome any other comments or questions that this report or our work may have sparked and please email us at cphi@cihi.ca. And we would be delighted to continue having this conversation. And so thank you and have a great day.

Participants: Thank you, everyone. Thank you. Thanks.