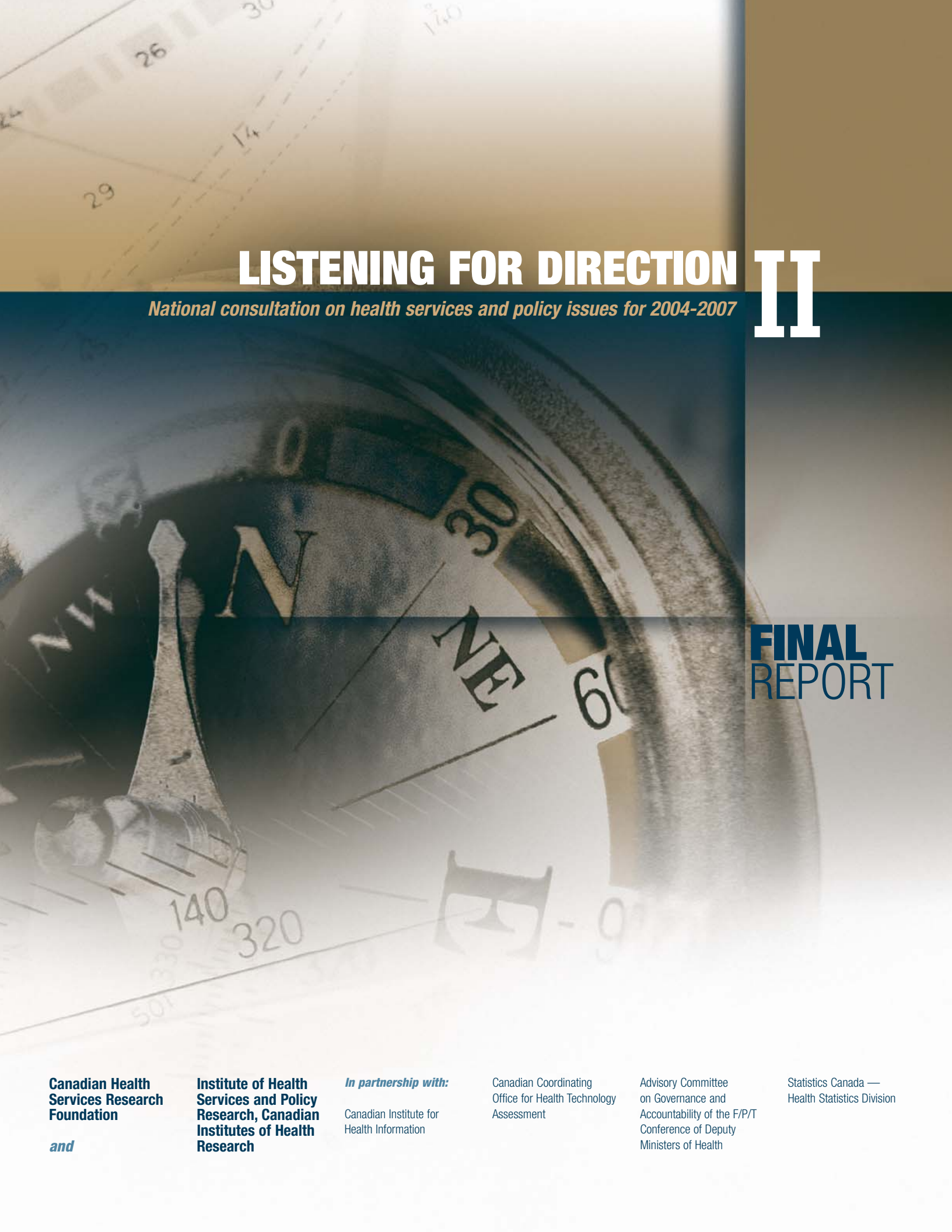

LISTENING FOR DIRECTION II

National consultation on health services and policy issues for 2004-2007

FINAL REPORT

Canadian Health Services Research Foundation

and

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

In partnership with:

Canadian Institute for Health Information

Canadian Coordinating Office for Health Technology Assessment

Advisory Committee on Governance and Accountability of the F/P/T Conference of Deputy Ministers of Health

Statistics Canada — Health Statistics Division

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on behalf of the *Listening for Direction II* partners

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Letter from the partners

Ottawa, August 2004

We are pleased to present the results of *Listening for Direction II*, the second joint national consultation on health services and policy issues in Canada.

Listening for Direction II started in late 2003, with the partners interested in examining our then-current research priorities. We decided to build on the positive experience of our first joint priority consultation in 2001, particularly because it had made information-gathering efficient and minimized consultation overload and respondent fatigue. We were also pleased to bring on board the Health Statistics Division of Statistics Canada as an additional partner.

This time around, we decided to use the previous *Listening for Direction* report as a point of departure. Our confidence in the approach has been bolstered by seeing the process adopted in whole or in part by a number of other agencies, inside Canada and beyond, or seeing other agencies simply take the outcomes of the process as the basis for their own priority-setting.

In August 2004, the Coordinating Committee on Health Services Research, which includes all of the *Listening for Direction* partner organizations, will meet to discuss how the organizations will ensure collaboration on the themes reported here.

We hope that the growing interest in *Listening for Direction* will continue to provide useful linkages between the decision-making and research communities for years to come. As always, we welcome your feedback on the findings identified in this report.

- Canadian Health Services Research Foundation
- Institute of Health Services and Policy Research, Canadian Institutes of Health Research
- Canadian Institute for Health Information
- Canadian Coordinating Office for Health Technology Assessment
- Advisory Committee on Governance and Accountability of the Federal/Provincial/Territorial Conference of Deputy Ministers of Health
- Health Statistics Division, Statistics Canada

SECTION I
Introduction and summary of outcomes

In the beginning… *Listening for Direction I*

In 2001, five organizations partnered to develop a national health services/policy research agenda by consulting with a broad (geographic, disciplinary, and 'role') representation of key healthcare system decision makers and researchers. The five organizations were the Advisory Committee on Health Services of the Conference of Federal/Provincial/Territorial Deputy Ministers of Health (ACHS); the Canadian Coordinating Office for Health Technology Assessment (CCOHTA); the Canadian Health Services Research Foundation (CHSRF); the Canadian Institute for Health Information (CIHI); and the (just-established) Institute of Health Services and Policy Research (IHSPR) from the Canadian Institutes of Health Research (CIHR). This broad consultation process resulted in the ***Listening for Direction I*** report, which was widely disseminated throughout Canada and used in a variety of ways, not only by these five partners but by other key research organizations in the country. Fifteen priority research themes were identified and divided into primary and secondary themes:

Research themes from 2001 priority-setting process

Primary Themes

- 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

- Primary healthcare
- Globalization
- Regionalization
- Population health
- Continuum of care and delivery models
- Performance indicators, benchmarks, and outcomes
- Evolving role of informal and voluntary care

In the three years that followed, partners focused their activities around these themes. Some examples of impact activities include:

- the Canadian Health Services Research Foundation published an international report on **"Planning human resources in healthcare: Towards an economic approach,"**[1] which generated numerous downloads from its web site;
- the Canadian Institute for Health Information and Statistics Canada released a report on **"Health Indicators 2003."**[2] This is one of the most frequently downloaded reports from the Canadian Institute for Health Information's web site and is the most frequently accessed free data on the Statistics Canada web site;
- the Canadian Institute for Health Information and the Canadian Institutes of Health Research jointly supported a major research project, the results of which have just been released, on the incidence of "adverse events" in Canadian hospitals;
- the Institute of Health Services and Policy Research collaborated with a number of other CIHR institutes to support 12 new research projects focusing on improving access to appropriate healthcare services for a variety of "marginalized" groups; and
- the Canadian Coordinating Office for Health Technology Assessment published more than 140 assessments of health technologies of national significance.

The priority-setting process used in 2001 has been applied, in whole or in part, by a number of other agencies.

The priority-setting process used in 2001 has been applied, in whole or in part, by a number of other agencies. The CIHR Institute of Population and Public Health and CIHR's cross-cutting injury research initiative both employed similar processes. A number of provincial health research funding agencies used the outcomes of the process to refine research priorities (for example, Alberta Heritage Foundation for Medical Research; Nova Scotia Health Research Foundation). Other countries and agencies have also adopted this priority-setting process (such as Australia's National Health and Medical Research Council; the Colorado Health Foundation, Denver). A detailed description of the process and a similar process used by the U.K.'s Service Delivery and Organization Research and Development Programme were published in the international journal *The Milbank Quarterly* in 2003.[3]

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1 Bloor, K and Maynard, A. (2003) *Planning human resources in healthcare: Towards an economic approach*, Ottawa: Canadian Health Services Research Foundation.

2 Canadian Institute for Health Information and Statistics Canada. (2003) *Health Indicators*, Ottawa: Canadian Institute for Health Information.

3 Lomas, J, Fulop, N, Gagnon, D, and Allen, P. (2003) *On Being a Good Listener: Setting Priorities for Applied Health Services Research*. The Milbank Quarterly; 81(3): 363-388.

Three years on… *Listening for Direction II*

In November 2003, the Canadian Health Services Research Foundation, CIHR's Institute of Health Services and Policy Research, and their partners (Canadian Institute for Health Information, Canadian Coordinating Office for Health Technology Assessment, Advisory Committee on Governance and Accountability of the Federal/Provincial/Territorial Conference of Deputy Ministers of Health, and the Health Statistics Division of Statistics Canada) embarked on a second round of national consultations on health services priorities — ***Listening for Direction II***.

This time around, the "listening" exercise was intended to establish both a primary research agenda that would address issues identified as likely to be preoccupations two to five years from now (reflecting the time required by the research granting and execution processes) and a research synthesis agenda to address priority issues over the next six to 24 months, in recognition of the more immediate needs of policy makers, managers, and the public for accessible summaries of research evidence in the shorter term. Once again, the six organizations partnered on this process because they were all at a stage where they were interested in refreshing their own priorities, they wished to make information-gathering as efficient as possible, and they wished to minimize respondent overload and fatigue. This partnered process was also intended to result in an agreement on sharing of responsibility across the identified priority areas, in order to minimize overlap.

For this set of consultations, the *Listening for Direction I* themes were used as points of departure for the research themes discussion. The results of the consultations suggested that the themes identified as priorities in 2001 continued to be priorities, though participants in the 2004 discussions offered some very useful suggestions for consolidation, repackaging, and more detail and definition. Two of the 2001 themes were viewed as being of lower current priority than three years ago — "globalization" and "public advice-seeking in the era of e-health." However, these issues were retained through being embedded in other 2004 priorities. Emerging new priorities included public health issues, particularly preparedness for emergencies, and patient safety.

One thing that did not change was the high priority given to "health human resources" — this general area was the top priority in 2001 and again in 2004, reflecting not only the importance of health human resources in a service-intensive industry, but also the seeming intractability of many of the key health human resources issues with which policy makers and managers in our healthcare system continue to grapple. In fact, health human resources issues were the

One thing that did not change was the high priority given to "health human resources" — this general area was the top priority in 2001 and again in 2004.

only issues that were viewed as a top priority at every workshop. What was different in 2004 was that there was widespread acknowledgement that "health human resources" casts a net too wide, and that it would be useful, in the process of channelling research to where it was needed most, to distinguish envelopes within that broad theme. The key sub-priorities within the health human resources theme were a) issues related to training, planning, and regulation of the workforce; and b) issues related to the characteristics and quality of healthcare workplaces.

The 2004 consultations generated the following top 10 priorities for the next five years. More details on each of these themes, including examples of research questions falling within each, can be found in Section III of this report.

Research themes from 2004 priority-setting process

- 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 public health to health services

SECTION II
Overview of process

What we did…

There is, of course, no single correct way to identify research priorities. The model employed in 2001 was based on the principle of linkage and exchange between research funders, researchers, and users of research.[4] The process is designed to ensure that the research priorities that emerge are feasible from a research perspective and that they respond to decision makers' needs. This is done by facilitating a dialogue involving researchers and research users, by focusing on research "issues" rather than research questions at the consultation/dialogue phase, and by having leading researchers then "translate" those priority issues into questions that are likely to provide evidence that would address those issues. The process is thus designed to maximize the likelihood that the research funded as a result of the "listening" process produces timely and relevant evidence and information that is likely to be used by those responsible for developing policy and managing the healthcare system.

The considerable positive feedback and the observation that a number of other agencies inside Canada and beyond had adopted the process, in whole or in part, or had simply taken the outcomes of the process as the basis for their own priority-setting gave the 2004 partners confidence that a similar process would meet their collective objectives and needs. The *Listening for Direction II* process was divided into six phases.

PHASE 1	PHASE 2	PHASE 3	PHASE 4	PHASE 5	PHASE 6	
Background Information • Survey and workshop at the IHSPR symposium • Activities relating to LfDI priorities November to January	**Consultation Workshops** • National: Ottawa • Regional: – Toronto – Edmonton – Vancouver – Québec City – Fredricton • Meeting of ACGA Mid-January to Mid-February	**Translation and sorting session** • Priorities – research/ synthesis themes/ questions • Research versus synthesis Mid-March	**Preparation of draft and validation through a web survey** End of April to Early May	**Validation with partners** End of May	**Final Report** Summer 2004	**Follow-up activities** Fall 2004

[4] Lomas, J, Fulop, N, Gagnon, D, and Allen, P. (2003) *On Being a Good Listener: Setting Priorities for Applied Health Services Research*. The Milbank Quarterly; 81(3): 363-388.

Phase 1 included gathering background information to help the parners determine the best way to conduct the consultation workshops. A survey was sent to registrants for the national symposium *Strengthening the Foundations: Health Services and Policy Research — Canadian Health Care*, hosted by the Institute of Health Services and Policy Research in Montreal, November 22-24th 2003. The results of that survey were then used as the basis for in-depth discussion during a structured workshop during the symposium. The outcomes of that workshop pointed to the continued relevance of most, if not all, of the 2001 themes, but also to a need for more clarity and to the possibility of some repackaging. On the basis of the outcomes of this Phase 1 consultation, the partners agreed that the smaller-group regional consultation workshops could make best use of the workshop time by taking the 2001 themes as the basis from which to begin the conversations.

The outcomes of that workshop pointed to the continued relevance of most, if not all, of the 2001 themes, but also to a need for more clarity and to the possibility of some repackaging.

The national and five regional workshops were held between January and March 2004. More than 850 people were invited to participate in the workshops. In total, 161 individuals participated (65 percent decision makers and 35 percent researchers). Decision-maker participants represented a variety of healthcare organizations and responsibilities, including the federal government, provincial and territorial governments, regional health districts/authorities, professional associations, and community care and other ambulatory care associations. Researchers represented a wide range of disciplines, departments, faculties, and institutes from universities and affiliated academic units across the country. During these workshops, individuals were asked to brainstorm on specific health services issues that Canada will face within the short (six to 24 months) and medium to long terms (two to five years). They were asked to prioritize these issues and determine their top five priorities. Participants were also asked to reflect on key priority issues related to data and data access and to capacity building. An end-of-day period was devoted to the development of strategies to help the partners better track the impact of *Listening for Direction II*.

During Phase 3, a small number of health services research experts were invited to help the partners by translating the key issues identified during the workshops for the immediate (six to 24 months) and longer terms (two to five years) into concrete priority themes, and by identifying some prototypical research and synthesis questions within each theme. Key immediate and longer-term priority issues were regrouped under 10 common research themes for which specific questions were developed for synthesis and research purposes.

Following the translation and sorting workshop, a draft report was developed and posted on the Canadian Health Services Research Foundation's web site. All invitees to the consultation workshops (including those unable to attend the workshops) received an e-mail asking

them to participate in a validation survey. The purpose of this survey (which can be found in the appendix) was to provide the partners with feedback from a broad set of experts on whether the themes, and the partners' articulation of key research questions within each theme, accurately reflected their views regarding priorities. A total of 116 individuals responded to the survey (56 percent decision makers, 34 percent researchers, 10 percent others). Of the respondents, 68 percent had participated in one of the consultation workshops. Results indicated that 92 percent of respondents agreed or strongly agreed that the 10 proposed themes would address the priority issues in health services for the next two to five years. More than 92 percent of participants from the workshops agreed or strongly agreed that the proposed themes reflected the priorities that had emerged during the workshops.

The release of this final report represents an important milestone for *Listening for Direction II* but not the end of the process. The partners will be meeting later this year to discuss how best to ensure that these priorities receive the attention of the research community over the next few years. Our discussions will be intended to map out a strategy for collaborative progress on all the themes and to identify areas where agencies are prepared to take a lead role.

The release of this final report represents an important milestone for Listening for Direction II *but not the end of the process.*

SECTION III
Priority research themes

As noted in Section I, 10 research themes emerged from the issues identified as a result of the consultation process described in Section II. As in 2001, health human resources was the only issue that was proposed at every workshop as being one of the top five priorities. Ranking of other themes/issues varied across workshops; although they are numbered in this section, that numbering is not intended to imply ranked importance. As noted in Section I, these 10 priority themes were viewed by participants, on balance, as being the most pressing priorities in both the short and longer terms. The specific questions within each theme differ; for example, the longer-term questions reflect a collective view that there is insufficient current evidence to address those questions.

The description for each theme starts with a brief outline of the context and content identified during the consultation process. The key questions for short-term (next six to 24 months) summary and synthesis of existing research and illustrative questions for longer-term (two to five years) prospective research are then specified under each theme. In all cases, the topics and scope for the short-term synthesis of existing research are more clearly specified and circumscribed than are the illustrative questions for the prospective research intended to address longer-term aspects of each issue.

As in 2001, health human resources was the only issue that was proposed at every workshop as being one of the top five priorities.

1 Workforce planning, training, and regulation

As in 2001, health human resources was viewed as a top priority issue. However, a clear separation of workforce and workplace issues emerged from the 2004 consultations. Workforce planning, training, and regulation is particularly focused on providing information and evidence to inform the actions and policies of governments and educational and professional bodies. It encompasses issues regarding planning (such as future required ***numbers and mix*** of healthcare personnel, ***surplus/shortage***, and ***recruitment/retention***), training of healthcare workers (such as ***new credential requirements, ways to facilitate inter-professional team-work***, and ***cross-disciplinary approaches***), as well as the regulation of scope of practice and entry to practice (such as ***redefinition of roles, international workforce migration,*** and ***use of foreign-trained graduates to address Canada's needs***).

In addition to an expressed desire to see the development of robust, flexible, and reliable ***integrated forecasting models***, concern was expressed about being able to understand the timing and impact of changing workforce demographics (such as aging and change in gender mix), as well as the effect of the aspirations and attitudes/expectations of younger entrants on the future workforce. National and regional data to monitor and evaluate the impact of these changes were identified as a priority. Significant challenges were seen in creating and sustaining training

for ***interdisciplinary and inter-professional teamwork*** and adapting the regulation of ***scopes of practice***, particularly as they relate to primary healthcare and non-acute settings. The lack of evidence supporting claims about the value of increased ***educational preparation*** (sometimes called "creeping credentialism") was questioned by many participants in the consultations. Some also pointed to the potential relationship between the increased educational preparation time being demanded in some professions and the ***shortages in the healthcare workforce***, as well as to the relationship between shortages and concerns about the system's quality of care and patient access.

Key synthesis questions (next six to 24 months)

A) **Value of inter-professional team care in different settings**
What are the models of team care? What, if any, are the differences between inter-professional and inter-disciplinary team care? What aspects of change management might facilitate implementation of inter-professional care? Does team-based care work in Canada under current regulatory and funding conditions, and what can be learned from other jurisdictions regarding the potential of policy and regulatory changes for facilitating improved team-based care? Why should we do/use team-based care? What are the implications for costs, training, planning, and regulation?

B) **Forecasting models**
What are the criteria for accepting or rejecting different models as valid under specific circumstances or exercises, and what are the conclusions from applying these criteria to the models that are now in widespread use in Canada? What major influences over the supply and demand factors should be incorporated into forecasting models? How reliable/useful have health human resources forecasting models been, historically and in Canadian (and other) jurisdictions? What are the critical success factors that distinguish relatively accurate from other such models?

C) **Scopes of practice and health professional regulation**
What is the extent of overlapping scopes of capability across the healthcare professions in Canada today? What is known from other jurisdictions about the more cost-effective use of healthcare personnel through closer alignment of scopes of capability and scopes of practice? What are the key regulatory, political, and educational barriers to improving the precision with which healthcare professionals are used in ways that take advantage of their full scopes of training/expertise, and what can we learn from other jurisdictions in terms of breaking down these barriers?

D) **Relationship between extent/nature of training and health outcomes**
What do we know about the relationship between different levels/lengths of training (such as for nurses) and impacts on the health improvement/quality of care for patients? What variations exist internationally in curricular content and length/nature of training of particular health professions, and is there evidence of related international variation in the nature and quality of care provided?

Illustrative research questions/areas (two to five years)

I. Does increased specialization improve health outcomes? What, if any, are the differences in health outcomes from an increasingly specialized versus a more generic healthcare workforce?

II. Evaluation of different mixes of healthcare services and professionals in specialized centres on costs, quality, patient safety, and patient satisfaction.

III. Development and/or evaluation of alternative models of education and training for inter-professional practice.

IV. Evaluation of the impact of extended training on quality/outcomes of care and on patient satisfaction. What is the value/cost of upgrading qualifications within professional groups?

V. Development and appraisal of new integrated health human resource forecasting models, including appraisal of national or regional surplus/shortage situations for selected healthcare professional groups.

VI. Evaluation of alternative approaches to improving recruitment and retention of healthcare professionals to underserved communities.

VII. Evaluation of the impact of changing expectations regarding work/life balance on future workforce supply, training requirements, and recruitment and retention, particularly to rural and northern communities.

2 Management of the healthcare workplace

This priority issue includes issues that relate to ***improvement of the workplace, appropriate workloads*** for all workers, and ***improvements in quality of work-life***. It is particularly intended to focus on the actions and approaches of employers, unions, and professional associations. Effective ***teamwork and interdisciplinary collaboration*** also came up in this context, but with more of a focus on the role of occupational hierarchies, organizational structures, and management practices and approaches and their effects on workplace productivity, stress, absenteeism, and so on. In addition, attention focused on the need to nurture the next generation of ***professional leaders*** and to provide more substantive opportunities for ***professional development***. Concern was expressed about the emerging generational gap in which newer members of the workforce had higher expectations for ***balance between home and work lives***. There was a desire to identify the role of workplace characteristics, circumstances, and environments on ***recruitment and retention***, especially for ***rural and remote*** communities.

Key synthesis questions (next six to 24 months)

A) **How changing demographics are leading to changing expectations in the workplace**
What are the gender, cultural, and generational factors that are influencing the work experiences and expectations of healthcare professionals? What, if any, is the influence of changing expectations regarding the balance of home and work life, expressed by more recently trained healthcare professionals, on the nature of the workplace?

B) **Factors generating organizational commitment and productivity by healthcare professionals**
What lessons can healthcare learn from other sectors for creating commitment to the workplace and high levels of productivity among those working in healthcare settings? What can be learned from other sectors with a human service focus or from the general human resources literature, and how generalizable are these findings to healthcare?

C) **Identification of leaders in healthcare**
What are the key characteristics of effective leaders in sectors outside healthcare? Are there specific leadership skills needed in healthcare? What are the most effective training/experiential foundations for nurturing the next generation of leaders for healthcare in Canada?

Illustrative research questions/areas (two to five years)

I. What are the roles of work life/home life balance, and what attributes of the workplace are key to improving recruitment and retention of healthcare professionals to rural and remote communities?

II. What are the major threats to safe and healthy healthcare workplaces (such as lengths of shifts, job stress, management practices, lack of independence or opportunity to use skills, and physical attributes of workplaces)?

III. Evaluation of alternative approaches to improving the quality of healthcare workplaces.

IV. Evaluation of the impact of a healthy workplace on patient outcomes.

V. What are the key attributes of healthcare workplaces that either encourage retention or contribute to excessively high turnover and burnout?

VI. What are the key attributes of outstanding leaders, in and outside of healthcare? Development and/or evaluation of alternative approaches to creating and nurturing future healthcare leaders. How can we incorporate the necessary skills into professional education?

3 Timely access to quality care for all

This was a significant and recurring theme that encompassed all aspects of timely access to care at all levels of the healthcare system. The overarcing interest was in improving the timeliness of access to publicly funded necessary and appropriate healthcare services. Better analysis of ***waiting times and waiting lists*** and of their relationship to system capacity was brought forward. Effective techniques for ***waiting list management*** and approaches to their governance were viewed as key issues that could potentially be informed by research. ***Inconsistencies in access***, especially for rural and remote communities and for minority groups, was also a key component. Finally, improved methods for ***assessing population needs*** were linked to potentially improving access and quality for minority groups with many unmet needs.

Key synthesis questions (next six to 24 months)

A) **Waiting time management for specialized and diagnostic services**
What are the most effective governance and management models, and policy approaches for ensuring waiting times do not undermine the provision of high quality care?

What are the technical challenges in measuring and managing waiting times, and how can they be overcome? What lessons about waiting list/time management are there for Canada from other countries? What are the differences that matter in waiting list management for emergent, urgent, and elective specialized and diagnostic services?

B) **Timely access to primary and community care**
What are the most effective governance and management models, and policy approaches for ensuring waiting times do not undermine the provision of high quality care? What lessons about primary and community care waiting list/time management are there for Canada from other countries? Do approaches such as open booking systems improve access, are there other proven approaches for doing so, and what are the barriers (if any) to uptake/implementation in Canada?

C) **Improving access for rural and remote communities and for minority and vulnerable groups**
What are the major barriers to access for these communities and groups, and what do we know from other jurisdictions or Canadian best practices about what can be done to reduce them?

Illustrative research questions/areas (two to five years)

I. Development and evaluation of policy or management approaches to improving access to quality care for minority and vulnerable groups, such as those with mental health problems or addictions, aboriginal peoples, ethnic groups, official language minority communities, and the poor.

II. Development and evaluation of new approaches to waiting time management for procedures or conditions that are identified as being particularly problematic in terms of threats to health of patients while waiting for services.

III. Development, testing, and evaluation of models for assessing the relative urgency of patients awaiting access to common resources.

IV. Evaluation of the impact of alternative models of primary care on access to necessary services for those living in rural, northern, and other remote communities.

V. Evaluation of e-health approaches to improving access to services for those living in rural, northern, and other remote communities. What human resource, technology, and transportation initiatives can improve access to specialty services for small, rural, and remote communities?

VI. Evaluation of the relative impact of alternative approaches (such as additional funding versus common waiting list management versus patient guarantees) on reducing waiting times for specific services.

VII. Evaluation of relationships between waiting times and outcomes, and development of related guidelines regarding acceptable waiting times for specific procedures/services.

4 Managing for quality and safety

This theme relates to the need to identify effective ***quality management*** strategies to ensure safe delivery of high-quality services. During national consultations, there was an expressed interest in research designed to identify and widely

disseminate proven strategies to improve quality. The importance of learning from best practice approaches was expressed, as was the need to better understand how to use knowledge gained from research to improve the quality of care. There was a great deal of interest in the potential of ***performance indicators***, population-based and institution-specific ***evaluation of patient outcomes***, and ***technology assessment*** as tools to improve the quality of care. ***Improving patient safety*** was identified as an area of particular concern, with the focus being on exposing ameliorable "***system***" sources of adverse events.

Key synthesis questions (next six to 24 months)

A) **Improving quality**
What are the most effective ways to promote evidence-based changes in clinical behaviour to improve quality of care? What are the barriers to and enablers of the development, dissemination, and uptake of clinical best practices?

B) **Improving patient safety**
What are the most effective routes to improved patient safety, including physical, procedural, behavioural, and system innovations? What are the most effective ways to change behaviours to improve patient safety? What are the barriers to and enablers of the implementation of effective adverse-event reduction systems in healthcare workplaces?

Illustrative research questions/areas (two to five years)

I. Development and evaluation of alternative system- and institution-level approaches to reducing the incidence and impact of institution-based adverse events.

II. Assessment of the extent of healthcare adverse events outside hospitals and other institutional settings.

III. Development and assessment of the foundations for, validity and reliability of, and impact on quality of care of system-, institution-, and provider-level performance indicators.

IV. Evaluation of the impact of technology assessment as a tool for improving the quality of healthcare.

5 Understanding and responding to public expectations

Although issues raised under this theme in consultations were often linked to sustainability (see number six below), the theme was deemed worthy of separate consideration because many aspects of it that are unrelated to system sustainability were raised. At one end, there were concerns about demand creation as a result of ***increasing marketing and entrepreneurship*** in the health sector. Among examples of issues here were the impact of ***direct-to-consumer advertising*** for prescription pharmaceuticals and direct-to-provider promotion of tests and treatments for which there was not always supporting evidence. A need was identified for support of ***evidence-based decision-making by patients*** and the public, and for greater use of ***public and community engagement*** as a communication and values-assessment tool, as well as a way to ***get the public involved in system-level decision-making***. The role of ***government as a guarantor of information*** was raised, as was the ***media's role in influencing public opinion*** and the lack of ***research literacy*** of the media and public for interpreting research results. Finally, the need to find ways to communicate effectively with the public

about the relative importance of individual- and community-level determinants of health beyond healthcare was emphasized.

Key synthesis questions (next six to 24 months)

A) **Impact of market-driven influences on patients, on care-seeking, and on the provision, quality, and costs of that care**
What are the key sources of influence in patients' decisions to seek care? To what extent are patients involved in clinical decisions and where do they get their information? How much influence do direct marketing efforts such as direct-to-consumer advertising, toll-free lines, patient forums and patient support groups have on care-seeking?

B) **Interpersonal, attitudinal, cognitive, and risk-perception influences on patient and consumer choice of health and related services**
How do patients make the decision to seek care or to undergo treatment? How do patients and the public perceive and assess risk? What are the roles of social networks and social support in patients' assessment of risks and decision-making about health services?

C) **Role of the media in influencing public attitudes and public expectations of health services**
What role do media sources play in patients' decisions about whether and when to seek care, and in their understanding of treatment choices and their likely effects? What is the relative importance of different media as sources of influence on patients and prospective patients? How do the media choose and train reporters and editors who work the healthcare beat?

D) **Effectiveness of alternative approaches to public engagement**
What is known from Canadian and international experience about alternative approaches to understanding the public's interests and expectations and to engaging them meaningfully in healthcare policy decisions?

Illustrative research questions/areas (two to five years)

I. Evaluation of the extent and influence of "demand creation" influences, and of entrepreneurial arrangements such as provider-owners, on one or more of health services utilization, costs, access, and quality.

II. Assessment of the levels of familiarity among the public with well-understood evidence-based facts about the effectiveness and cost-effectiveness of healthcare alternatives.

III. Appraisal of the sources used by the public to gain understanding of potential threats and approaches to improving personal health.

IV. Appraisal of the sources used by, and levels of understanding of research evidence among, healthcare professionals, policy makers, managers, and the media.

V. What are the key determinants of patient care-seeking and treatment decisions, including the role of such things as risk perception, rationality, stigma, and media and professional influence?

VI. Development and evaluation of alternative ways to engage the public and communities in effective and informed decision-making about health services financing, organization, regulation, and provision.

6 Sustainable funding and ethical resource allocation

Concern focused on ***raising adequate revenue*** as well as ***defining the services to be covered*** by public funding. Specific concerns here included the increasing prevalence of public-private partnerships and confusion about whether these represented solutions or threats to sustainability challenges. There was interest in ethical processes involving ***public engagement*** to make tough allocation choices, in particular ***processes that elicit public values*** at national, regional, and local levels to determine public coverage. There was also concern for ***institution-level ethics***, especially in decisions affecting the healthcare workforce or access to the system for minority groups. There was some suggestion that the key to future sustainability lay in better exploration of its links to ***primary healthcare reform***, better ***chronic disease management***, and ***policies to improve the use of pharmaceuticals*** in the system. There was an overall interest in assessing on a routine basis whether we are getting ***value for money*** in the healthcare system.

Key synthesis questions (next six to 24 months)

A) **Ethical framework for resource allocation**
What are the different ethical bases, if any, in methods used for allocating resources for the care of populations and for the care of individuals?

B) **Models for institution-level resource allocation**
What is known about the ethical and values foundations of institution-level resource allocation decisions within the healthcare sector? What roles do various sources of input (such as the public, employees, unions, other affected staff, other interests, and research evidence) have in such decisions?

C) **Evidence on system efficiencies and resource redeployment**
Claims about the cost savings associated with improving efficiency are as old as debates about healthcare funding. What is known, from Canadian and international evidence, about critical success factors in extracting and redeploying real resources as a result of efficiency gains? Are there best practices in this respect, and what are the keys to their generalizability? What can current evidence tell us about the scope for potential efficiencies within Canadian healthcare to reduce the need for additional new funding in the short and longer terms?

D) **Effects and effectiveness of public-private partnerships**
So-called public-private partnerships are gaining increasing prominence in discussions about sustainability. What is known, from Canadian and international experience, about the effects of these partnerships on access, quality, costs, and outcomes of care?

Illustrative research questions/areas (two to five years)

I. What is meant by "sustainability?" How is the term used by different interests?

II. What is the relationship in Canada between arguments about sustainable financing, tax policy, and sector-specific healthcare costs? How can information on these relationships be most effectively communicated to a Canadian public concerned about whether publicly funded healthcare will be available when they need it most?

III. How can policy makers most effectively inform and then engage the public in discussions and decision-making processes related to the financing of healthcare and to the allocation of resources both across and within healthcare sub-sectors?

IV. Evaluations of the impact of primary care reform models and new models of chronic disease management on the costs of Canadian healthcare.

V. What has been the impact on health outcomes and healthcare costs of different provincial drug programs and formularies?

VI. Evaluation of the cost implications of selected efficiency-improving innovations in Canadian healthcare and of the likely practical barriers to extraction or re-deployment of "saved" real resources.

7 Governance and accountability

There was strong interest expressed in a comprehensive set of routinely created and reported and easily understood ***performance indicators***, which would provide a valid basis for evaluating system performance at all levels, from individual practitioners through institutions on to regions, and across accountability loci — regional authorities, provincial governments, and the federal government. The need for much-improved ***performance assessment outside institutional settings*** was highlighted, particularly for primary healthcare and other forms of community-based care, with calls as well for more attention to ***population-based assessments of health***. There was keen interest in finding ways to harness Canada's rich healthcare system data resources to develop more meaningful performance indicators, while at the same time respecting ***privacy concerns for data use***. The increasing role and complexity of ***public-private partnerships*** was seen to need a commensurate increase in the sophistication and extent of performance assessment for monitoring and compliance purposes. This was related to better evaluation of the appropriate ***governance and overall value of public-private partnerships***. On the governance level, there was also continued interest in exploring issues of ***regionalization***, such as the appropriate size and structure of regional health authorities, and the value of ***regional networks*** and other forms of regional system integration and co-ordination.

Key synthesis questions (next six to 24 months)

A) **Selection, role, and use of individual performance indicators**
What are the characteristics of effective performance indicators for accountability versus those for effective quality improvement? Which indicators are most appropriate for which roles/levels?

B) **Current organizational frameworks for using performance indicators**
What are the organizational frameworks or models for performance accountability that are currently being used?

C) **The link between population-based funding and accountability**
What forms of population- and needs-based funding enhance accountability for population health, service accessibility, equity, and effectiveness?

D) **Implications of foreign experiences of public-private partnerships for Canada**
What can Canada learn about governance and accountability

best practices from the experiences of other countries that have implemented public-private partnerships to address their needs for healthcare capital, management, or service delivery?

E) **Intelligence from regionalization experiences**
What have we learned from Canada's extensive experimentation with models of regional governance and accountability? What lessons, if any, are there from experiences outside Canada? Is there evidence pointing to optimal catchment population or geographic sizes for best governance/accountability practices that address the trade-off between community responsiveness and operational cost-effectiveness?

Illustrative research questions/areas (two to five years)

I. What is the overall effectiveness of performance indicators in improving the accountability of providers, institutions, organizations, networks, and governments (for example, the influence of report cards on organizational change)?

II. Evaluation of effectiveness of alternative approaches to performance indicator reporting, in terms of public understanding and acceptability.

III. Evaluation of Canadian and international approaches to addressing privacy concerns in the research uses of large population databases. Where is the public in terms of its understanding of and comfort with uses of personal-level data for health services/systems research purposes? What are the best (Canadian and international) practices in terms of managing/minimizing the risks of privacy breaches associated with research uses of individual-level health and health services data?

IV. Analysis of governance and accountability challenges associated with the emergence of new public-private partnerships in healthcare.

V. Evaluation of alternative governance structures for public-private partnerships.

VI. Evaluation of alternative regionalization models in terms of best governance/accountability practices with respect to community responsiveness and operational efficiency.

8 Managing and adapting to change

This issue focused on the need for better tools to bring about change at the system level, particularly in ***breaking down the organizational and professional silos*** that characterize healthcare. Also, the difficulty ***in adapting the system to external forces*** was noted, both for short-term issues such as ***health emergencies*** and long-term changes such as ***demographics and disease patterns.*** A lot of interest was expressed in the development and more widespread use of ***tools for evidence-based decision-making***, such as ***information systems, technology assessment***, models of ***risk management***, sharing of information and ***best practices***, and the development of networks and other research and ***knowledge translation*** mechanisms.

Key synthesis questions (next six to 24 months)

A) **Models and mechanisms of knowledge translation**
What are the most effective ways of translating evidence into practice, for different types of knowledge being

transferred and for different implementation settings or targets (for example, professional groups)? What do we know about the effectiveness of current practices in knowledge translation and the mechanisms by which they work? What are the organizational structures and processes needed to implement evidence-based change?

B) **Intra-organizational management structures**
What are the lessons learned from other industries for effective intra-organizational management structures that can break down inter-professional or inter-organizational silos to improve organizational and system effectiveness?

Illustrative research questions/areas (two to five years)

I. What circumstances and/or processes encourage system-level or organization-level policy or managerial innovation?

II. Evaluation of information-system innovations in effecting significant organizational, professional, or other policy change.

III. What are the most effective ways to package and communicate technology assessments, healthcare evaluations, and other types of research evidence to encourage use by the public, managers, policy-makers, and providers in the healthcare system?

IV. Evaluation of effectiveness and applicability of "change management" success stories from other sectors (in Canada and internationally) for Canadian healthcare.

9 Linking care across place, time, and settings

The dominant focus in this issue was the need to significantly improve ***chronic disease management*** and the potential of alternative ways of organizing ***primary healthcare*** as the vehicle to achieve this. There was interest in the creation of ***new models of integrated service delivery*** and in evidence and information on the relationship between ownership (that is, public-only, private-only, or public-private partnerships) and cost-effective service integration. There was also interest in the consequences for ***caregiver burden*** of adopting different service delivery models and in better documentation on the ***evolving role of informal and voluntary care***. Potentially valuable initiatives in need of detailed scrutiny and evaluation included new ***home- and community-based technology***, such as home health monitors, and social programs, such as ***caregiver support***. The need for ***new models for rural areas***, different ***socio-economic groups***, and ***different cultures***, not just on models for traditional urban areas, was emphasized. Finally, the links between this theme and theme number one were noted. In particular, the success of any new models for care integration and co-ordination will be dependent on the availability of appropriately trained personnel to increase the capacity for this kind of service delivery.

Key synthesis questions (next six to 24 months)

A) **Improving chronic disease management**
How effective and efficient are current chronic disease management models in Canada? What are the key factors that contribute to effective chronic disease management in the context of primary healthcare? What is the value of inter-professional team care in different contexts and settings?

B) **Caregiver support and informal and voluntary care**
What is known about the effectiveness of interventions to provide caregiver support? What is known about the impact of recent policy changes in Canada on shifting burden of care to informal and voluntary caregivers? How can we reduce caregiver burden?

C) **Technology and chronic disease management**
What is known about new technologically-based innovations in improving continuity of care, particularly for the management of chronic diseases?

Illustrative research questions/areas (two to five years)

I. Evaluation of the impact of new and recent policy changes on the distribution of care burden, particularly with respect to the care of chronically ill patients, and with a particular focus on the informal and voluntary care sectors.

II. Evaluation of the effectiveness of different interventions to support caregivers.

III. Evaluation of the effectiveness and cost-effectiveness of new or current chronic care management models in Canada.

IV. Development, analysis, and/or evaluation of funding and organizational mechanisms for improving the co-ordination of informal and voluntary caregivers with the formal care system.

V. What is the influence of changing demographic and cultural factors on the capacity for informal and voluntary care? How can home- and community-based technologies contribute to more effective care, particularly for patients suffering from chronic diseases?

VI. How could patient safety be improved at the transition points of care, such as transfer from hospital to community, or referral from generalist to specialist and back?

VII. Evaluation of alternative approaches to service integration, particularly with application to chronic disease management.

10 Linking public health to health services

Besides the obvious link between ***public health emergencies*** and the ***consequent surge capacity*** needed from healthcare services, issues were raised about the links between public health initiatives broadly conceived and core healthcare services. Particular note was made of the relationship, for example, between effective ***disease prevention*** and ***health promotion*** and the demands for curative care. The impact of ***complementary and alternative medicines*** on the population's health was raised as a burgeoning issue. Finally, the public health workforce and issues related to theme number one (workforce planning) were seen as central to any efforts to improve linkages and promote closer integration. Questions were raised about the best approaches to improve ***professional and organizational alignment*** so as to incorporate public health professionals as key members of the healthcare team. Particular emphasis was put on the impact of the lack of public health-healthcare system integration on the health of disadvantaged and minority groups.

Key synthesis questions (next six to 24 months)

A) **Surge capacity: How to organize health services to cope with emergencies?**
What is Canada's organizational, infrastructure, and human resources capacity to respond to public health emergencies? How does it compare with that of other countries? Are there "best practice" models from elsewhere that it would be useful to emulate in Canada?

B) **Relationship between specific disease prevention or health promotion products or services on need for traditional healthcare services**
Syntheses of state of knowledge on the actual or likely impacts of particular health promotion or disease prevention approaches (including, for example, natural health products) on the costs, quality, access, and distribution of traditional healthcare services.

C) **Public health threats and the need for healthcare and public health professionals**
Does Canada train sufficient public health expertise? What public health training do front-line healthcare workers receive? How does this compare with training models elsewhere?

Illustrative research questions/areas (two to five years)

I. Evaluation of alternative approaches to training, not only for public health professionals but for healthcare system front-line workers on public health and healthcare system preparedness for public health threats.

II. Evaluation of alternative approaches to integrating public health personnel, systems, and services within healthcare service delivery, organization, regulation, and funding.

III. Evaluation of alternative approaches to the integration of effective health promotion and disease prevention into public health and healthcare services.

IV. Analyses of relative contributions of interventions outside healthcare (for example, housing for those with mental health problems, early childhood education, or programs for disadvantaged youth) compared to traditional healthcare interventions in improving the health of defined groups?

V. Analysis of alternative structures, processes, and organizational models for facilitating inter-sectoral collaboration on the broad social determinants of health.

VI. Modelling future health human resource requirements for dedicated public health personnel under alternative training/integration scenarios.

SECTION IV
Follow-up activities

What next… communication and evaluation

During the consultation workshops, participants were asked to bring suggestions to the partners as to what types of follow-up activities would contribute most to the effective dissemination of information regarding partners' actions relating to the different research themes. One of the most common suggestions was to provide regular progress reports, through e-mails, web postings, or hard copies, to interested individuals working in the Canadian health services arena (and covering all sectors and roles, such as in government, health authorities, professional associations, the voluntary sector, universities, etc.). These reports would include information relating to different activities under each theme, such as calls for applications, results of research competitions, links to published research articles or reports arising out of funded research, and so on. Another suggestion was that subsets of the partners periodically host workshops focusing on a particular theme (as IHSPR did in 2003 on the "financing and public expectations" theme and the foundation did more recently for "primary health-care"). These workshops would have a number of possible purposes, including the facilitation of network-building, particularly involving interaction between researchers and decision makers. Participants also felt that calls for research proposals or syntheses should be clearly linked back to *Listening for Direction II* themes. This would allow people to understand why particular research themes or topics were being prioritized. In summary, participants expressed a keen interest in more transparency and more frequent updates about the activities stemming from the *Listening for Direction* process.

In August 2004, the Coordinating Committee on Health Services Research, which includes all of the *Listening for Direction* partner organizations, will meet to discuss how the organizations will ensure collaboration on the themes. The outcome of this meeting will be posted on the partners' web sites in the fall of 2004.

One of the comments that was received during Phase 1 of *Listening for Direction II*, from the workshop participants at the IHSPR November 2003 symposium, was that it was difficult to evaluate the success and impact of *Listening for Direction I*. The lack of information from the partner organizations relating to the various activities under each theme (noted above), and the absence of any formal impact assessment plan, were highlighted as particular issues. In order

One of the most common suggestions was to provide regular progress reports, through e-mails, web postings, or hard copies, to interested individuals working in the Canadian health services arena.

to address this during this second consultation process, we asked participants of the workshops to suggest how partners might most usefully evaluate the impact of *Listening for Direction II*. Suggestions included the tracking of and reporting to interested parties on all new initiatives related to each theme. This would include information on the creation of new networks, teams, or consortia, what has actually been funded or what activities have been conducted by the partner organizations, and their impact on decision-making and policy. All six partner organizations have agreed to collect and disseminate such evaluative information as it becomes available over the period between now and the next *Listening for Direction* exercise.

SECTION V
Acknowledgements

The *Listening for Direction II* partners wish to express their sincere appreciation for the invaluable dedication and the high-quality work of the many individuals who made this national consultation process not only possible but successful. Most importantly, we wish to thank those many individuals who took the time away from their own busy lives to provide the partners with the benefit of their wisdom during one or more workshops. We wish to recognize a number of individuals who played essential roles during the consultation process or in the preparation of this report. And we apologize in advance if we have inadvertently left anyone off this list. Special gratitude goes to a number of workshop participants who willingly volunteered to act as facilitators:

Morris Barer, Lillian Bayne, Sally Brown, David Clements, Krista Connell, Mylène Dault, Geoffrey Gurd, Bob Hinings, Brian Hutchison, Denise Kouri, Jonathan Lomas, Anne McFarlane, Hélène Morais, Marcel Saulnier, Pierre Sauvé, Lynn Stevenson, Gail Tomblin Murphy, Pierre Tousignant, and Diane Watson.

The *Listening for Direction II* report depends critically on the difficult task of scribing small-group and plenary interactions during these consultations. These individuals represented each partner organization in this important task:

Stella Andriopoulos, Beaudelaire Augustin, Sue Beardall, Gisele Carriere, David Clements, Katherine Fafard, Michelle Gagnon, Kim Gaudreau, Jeanie Lacroix, Louise Lapierre, Craig Larsen, Kira Leeb, Sarah Lenz, Anne McFarlane, Jasmine Neeson, Michele O'Rourke, Claudia Sanmartin, Margot Shields, Mike Tjepkema, Greg Webster, and Paula Wollam.

The sorting and translation workshop is an essential phase in the *Listening for Direction* process; we wish to acknowledge the very important contributions of those who volunteered to help the partners convert what we heard during the workshop consultations into research themes and sample questions. A special thank you to François Champagne, Vicki Foerster, Pierre-Gerlier Forest, Paula Goering, Brian Hutchison, and Laurence Thompson.

And finally, we offer a special acknowledgement to Jasmine Neeson, who ensured that the entire process was as seamless as humanly possible, and who attended all of the workshops.

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Appendix *(Sample only – do not complete)*

Validation Survey

Listening for Direction II Draft Report

1 a) To your knowledge, were you invited to any of the *Listening for Direction II* consultation workshops held in Ottawa, Toronto, Edmonton, Vancouver, Québec, and Fredericton in January and February 2004?

☐ Yes ☐ No

If yes, which one? _____

b) Did you participate in any of the *Listening for Direction II* consultation workshops?

☐ Yes ☐ No

If yes, which one? _____

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: _____

3 **Research themes**

- 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 public health to health services

a) 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?

OR

As a researcher, do you feel this list of research themes would form a reasonable agenda for synthesis activities and applied research in health services and policy over the next two to five years?

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ No opinion

For Listening for Direction II consultation workshop participants only:

b) Do you feel the themes reasonably reflect the proceeding of your workshop?

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ No opinion

4 a) Based on the list of research themes, what do you feel should be the top theme for the next six to 24 months?

b) Based on the list of research themes, what do you feel should be the top theme for the next two to five years?

Optional questions to be answered after reading the draft report:

http://www.chsrf.ca/other_documents/listening/pdf/lfd2_draft_report_e.pdf

5 Do you agree with the research/synthesis questions classification?

☐ Yes ☐ No

If not, what would you change?

6 **Other comments/suggestions:**