Root Cause Analysis of Barriers to Integrated Care

Collaborative Workshop

Summary of Findings

Workforce Research and Evaluation

Alberta Health Services

April 2013
[Updated May 2013]
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Meeting Overview – February 14th 2013, Calgary, Alberta

Host
Workforce Research and Evaluation, Alberta Health Services (AHS)

Objectives
- Present results of a research project related to barriers to delivery of integrated care.
- Support stakeholders in recognizing and understanding the root causes of barriers to integrated care.
- Identify linkages to pertinent AHS initiatives and recommend priorities in order to leverage existing work and opportunities.
- Create an opportunity for stakeholders from across the province to network and discuss strategies to improve integrate care.

This document provides a summary of the event. More specifically, it provides highlights from the research presentation as well as summaries of the discussions.

Funding
This event was funded by Alberta Health as part of the “Root Cause Analysis of Barriers to Delivery of Integrated Care” project grant.

In Attendance
Thirty-four participants from Alberta Health Services attended, representing the following areas:

- Access/Discharge Planning
- Seniors
- Children’s
- Mental Health
- Zone Executive
- Strategic Clinical Networks (SCNs)
- Patient Experience

In addition, there were patient participant representatives as well as delegates from Alberta Health and the Health Quality Council of Alberta.

Facilitator
Kate Campbell, Senior Planner
Integrated Service Planning, Priorities and Performance, Alberta Health Services

Acknowledgements
We wish to express our gratitude to all of our interview participants for taking the time to share their experience and knowledge with us, as well as to our workshop attendees for contributing their time and ideas to this project. Finally, we would like to thank our research funder Alberta Health, as this project and workshop would not be possible without their support.
Initiative Background

2010 System Wide Case Management Steering Committee
Patient Navigation as a means to improving access to health services for Albertans has been identified by Alberta Health for a number of years as a priority, with case management identified as one of the strategies for achieving integration. A series of workshops titled Supporting Systems Integration through Case Management, presented by McMaster University Centre for Continuing Education, were conducted across the province late in 2008. These workshops were attended by continuing care and primary care staff and were funded by Alberta Health.

When AHS became one, the opportunity emerged to look at integration across all health service sectors. To that end the System Wide Case Management Steering Committee was formed, co-chaired by the Seniors Health and Primary Care provincial portfolios. The steering committee consisted of representation from across the whole continuum of care, to work with Alberta Health in developing a Health System Navigation Policy and all of the requisite processes, policies and education to accompany.

In April of 2010, we had our one and only face-to-face meeting for visioning and planning, starting the day with a presentation from a mother who described the health care system from her perspective as she tried to coordinate services over the years for her then 13 year old son with cerebral palsy. It was so powerful, that that was when the idea for this research was born – when we as a group realized that this work could not be done until we better understood the lived experience of both clients and front line caregivers in the health care system. Initiated by Jeanne Besner and then followed up by Ester Suter and their teams, the Barriers to Integrated Care research project was funded by the Alberta Government in December of 2011.

Health System Navigation Model
In the meantime, Alberta Health hired consultants to develop a Health System Navigation Conceptual Model and business case, and the committee worked closely with them on the creation of a navigation model, which is essentially a road map for integrating health care services through the use of navigational supports, all the way through from self- to system wide navigation.

Once that was done, we used the model and business case to develop and submit to Alberta Health a Health System Navigation Grant Proposal. This would allow us to operationally test the conceptual model by looking at screening tools and trialing a complete system change in how health care professionals collaborate and work as a team, including incorporating a designated team lead, and the use of an integrated care plan.

Through it all, we brought to the table and leveraged all of the things that were happening in AHS around system integration, including Access initiatives, the Continuing Care Case Management Competency Framework and Skills Education, Chronic Disease Management initiatives (especially the Self Management Model), Addiction and Mental Health integration, Primary Health Care Reform and Family Care Clinics, and the Cancer Care Navigator program to name but a few. All of this brought us to today, unveiling the results of the research idea that was born almost three years ago, to help us on our journey of integrated care.
Research and Analysis

In an effort to better understand the root causes of challenges faced by patients in accessing integrated health care services across the continuum of care, 15 patients/families and 13 of their corresponding providers were interviewed to obtain first-hand accounts of their journey through the health system. To ensure the representation of different viewpoints, participants were selected from three cohorts: adults with mental health issues, seniors, and children with special needs. As well, both urban and rural settings were targeted. A key take-away from the interviews was that participants were genuinely excited to be part of this project and felt valued and honoured that the researchers were interested in their opinions and stories.

One major success reported across cohorts was the support and advocacy received by patients from at least one provider, which was identified as key to accessing services. Many patients acknowledged that were it not for this level of support, they would not have been able to access much needed services and programs. Most providers stated that patient engagement in and ownership of their care is important; several patients expressed a desire for increased access to information to enable informed decision making. It should be noted, however, that patients varied in their expectations of involvement in their health plans, with the more senior patients generally preferring that their providers take full charge of their care, while younger patients shared a desire to be more proactive and to play a bigger role in developing their care plans.

Participants reported several key barriers to access, one of which was the rigid admission criteria held by many programs/services that restrict access particularly for complex patients who may not meet every requirement perfectly, but still require service. Long wait times, both to access services, and upon arriving in the providers’ offices, also presents a challenge for many. When wait times become excessive, providers sometimes feel that they are left with no option but to refer their patients to an external provider/program in order to get them seen in a timely fashion. Both patients and providers shared that they find the health care system at times “confusing” and “very difficult to navigate”, particularly for those with complex care needs, as it is at times impossible to find information that pertains specifically to their health concerns. One person noted that since the merging of the former health regions into Alberta Health Services, the public website has become much more difficult to navigate, and that it is now very hard to find contact information for care providers.

Overall, patients perceived a disconnect between physicians, hospitals, and community services, and feel that they would be better served if providers were aware of other resources around them. When questioned, providers were generally unaware of their patients’ interactions with other providers, and integrated care plans for patients seldom existed, although many providers acknowledge their benefits. Furthermore, both patients and providers reported a lack of information sharing among health professionals, which often results in patients being the conveyors of their own health information. While a few patients felt comfortable relaying their health information, most reported that they did not feel they possessed the medical know-how to accurately communicate information about their care to their various providers. Another issue reported by many was the need for greater focus on the other issues (i.e. social determinants of health) and how they impact patient health, for example, a patient being...
unable to work while awaiting surgery, or a patient without transportation needing to travel from one
town to the next to access health services.

In an effort to remedy some of the issues outlined above, many participants recommended the
introduction of a nurse-coordinator position to improve care coordination, provider-to-provider
communication and patient access issues. They also felt that electronic medical records that were
accessible between providers and across programs/services were a good strategy for improving
communication among providers and awareness of patient information, and supported their continued
implementation. Complementing the general findings outlined above, following are findings that
emerged unique to each cohort:

Mental Health
While there was a call to better integrate care planning from the wider group, there was some
disagreement within the mental health cohort as to how care plans should be handled. Some
participants felt that mental health care should remain distinct from physical care, while others desired
a more holistic approach to care, where mental health concerns would be addressed alongside physical
care planning. It was also noted by providers that there is a need to ensure that not only clinical
providers, but all staff who interact with mental health patients be trained on appropriate behaviour
and service provision, as each person that a patient encounters has the ability to impact his/her health.
Providers also recommended strengthening the ties between hospital and community facilities, as the
two working in partnership is essential to establishing appropriate services for this cohort.

Children with Special Needs
A key message emanating from this group was the tremendous role that parents play in coordinating
services on behalf of their children, through persistence and strong advocacy. Many patients and
providers alike remarked that were it not for the extraordinary efforts of their parents, many of these
children would not have access to the services they need. Having to take on the role of care coordinator
can be overwhelming for these parents, and the ability to access quality information quickly and
conveniently is especially important for this group. Other issues having major impact on this cohort are
the lack of communication and collaboration among providers, which is particularly taxing on these
children, who frequently undergo multiple procedures with multiple providers, and the lack of
appropriate facilities for children with complex needs who do not fit neatly into one clinical “box”. Both
patients and providers reported that efforts are underway in some circumstances to improve
communication gaps through family conferences involving the parents and care providers of the child in
question. These are reported as quite successful thus far, and have been shown to improve
collaboration and integrated planning among providers.

Seniors
Patients and some providers reported reluctance among some health care providers to add geriatric
patients to their caseload, making it difficult for patients in this cohort to access in particular, primary
care. As previously mentioned, senior patients tended to prefer that their care providers have control
over their care decisions, although they do appreciate when providers take the time to explain clearly
what they are doing and what patients can expect from their treatment. A key concern for this group
was the lack of appropriate long-term care facilities for seniors with acute mental health issues, as they are often housed in facilities with staff that are simply not trained to deal with their mental illness, resulting in isolation and inappropriate care for the patient. Another issue reported was the need for improvement in hospital services, particularly relating to patient-centred care during stays and discharge procedures, as several patients reported inappropriate and disrespectful care while in the hospital.

Root Cause Analysis
In order to better ascertain the underlying causes of the challenges reported by participants, the research team used a root cause analysis methodology called Change Analysis, which had been modified to better suit the data. The research team reviewed the interview data for specific challenges/barriers encountered by both patients and providers in attempting to access integrated health care services. In order to prepare the data for the change analysis, individual events were extracted and compiled into two case studies, such that each reflected actual incidents captured in the data (see Appendix 4 for case study descriptions). Each case study was then put through the modified change analysis process outlined in Figure 1 below.

Figure 1. Modified Change Analysis process used to analyze data.

The change analysis of case study no.1 revealed 15 major deviations (i.e. differences between the ideal and actual cases), which were then mapped to 10 root causes and 9 corresponding opportunities for corrective actions. Analysis of case study no.2 revealed 18 major deviations, which mapped to 6 root causes and 5 corrective action areas. Following the change analysis, the corrective actions were grouped under the following individual themes:

- Primary Care, Clinical Care Pathways, and Central Waiting Lists
- Holistic Care
- Community, Remote, and Transition Health Services
- Patient Engagement and Information Sharing
Although eight themes emerged from the data, the last two were omitted from the workshop agenda, as they were deemed to be areas beyond the scope of the workshop, thus resulting in six themes for discussion.

**Strategy Prioritization and Action Plan Development**

Before breaking for lunch, all participants were invited to contribute their ideas to each corrective action theme in what was termed a World Café. The results of this brainstorming session are detailed in Appendix 3. Participants were then requested to select any one of the six corrective themes identified from the research and as a group develop a focused action plan during the second part of the workshop.

To assist each group with the process a facilitator was assigned to the group. The following guiding questions were used to develop each action plan:

I. What is the Strategy? – Describe the strategy in as much detail as possible.
II. What are we trying to achieve with the strategy?
   - Why is the strategy important?
   - What does success of the strategy look like?
   - What are the desired outcomes that can be expected if the strategy was implemented?
III. How are we going to do it?
   - What actions or activities are required to implement the plan?
   - Are there any initiatives/programs currently underway that this plan would align nicely with?
IV. How will we know when the plan has been successful?
V. What are the risks (and associated mitigation strategies) to implementing this action plan?

**Action Plans**

At the end of the discussion group period, each facilitator reported back to all attendees on the plans for their respective groups. Following are the action plans that emerged from those discussions.

**1. Primary Care, Clinical Care Pathways and Central Waiting Lists**

The intent of this strategy is to build a collaborative partnership between AHS and primary care, acknowledging that both are integral to building a sustainable health care system. Involvement of primary care providers in care pathway development, increasing access to Primary Care Networks and Family Care Clinics and developing central and standard wait lists can facilitate continuity of care, transitions between providers/services and reduce service variation.
Activities
The following steps were recommended to translate the strategy into action:
- Define roles/responsibilities (accountability) for providers and patients
- Continue to build partnerships with primary care
- Involve primary care and funding support in pathway development
- Include communication standards when developing pathways
- Provide data/information to inform practice
- Use information technology as an enabler for care provision e.g. Primary Care Networks V.2.0
- Work collaboratively with general practitioners in acute care consultations and long term care
- Involve funding support in consultations
- Develop/strengthen referral systems
- Identify appropriate metrics
- Build on Primary Care Networks patient engagement experience
- Implement Family Care Clinics as Quality Improvement/Plan Do Study Act

Alignment with AHS Initiatives
The following were identified as possible linkages within AHS:
- Path to Home
- Integrated Health Home
- Health System Navigation
- Family Care Clinics
- Collaborative Practice
- Primary Care Networks i.e. patient engagement
- Closed Loop Referral Management Program

Stakeholders
The following were identified to have expertise/resources/interest to significantly influence the implementation of the strategy:
- Patients
- Primary Care i.e. medical home
- Home Care i.e. transition services
- Mental Health

Anticipated Outcomes
- Reduced variation in practice
- Smooth transitions
- Standardize wait time e.g. from care pathway

Indicators of Success
- Improved patient and provider satisfaction
- Improved value for money
- Improved attachment/continuity of care
- Decreased readmission rates, ambulatory care sensitive conditions, Tier 1’s and patient-reported quality of life health outcomes
Risks and Mitigation Strategies

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Primary care providers may not feel comfortable being asked to represent beyond their clinic, i.e. all of primary care</td>
<td>▪ Ensure clear governance structures are in place and that all areas of primary care are represented (e.g. the Primary Care Alliance)</td>
</tr>
<tr>
<td>▪ Lack of integrated information systems (both within primary care networks and with AHS and other systems)</td>
<td>▪ Develop a shared health record and/or integrated care plan(s)</td>
</tr>
<tr>
<td>▪ Difficult for primary care providers to obtain funding for integrated/complex care</td>
<td>▪ Implement new funding mechanisms to address complex care</td>
</tr>
</tbody>
</table>

2. Holistic Care

The aim of this strategy is to promote and sustain person centred care approaches to planning and care delivery which directly impact efficient, equitable, effective, safe and timely delivery of care. A health care delivery system that focuses on these elements is more likely to deliver care that is not fragmented (Institute of Medicine, 2001).

Activities

The following actions were recognised as essential to implementing the strategy:

▪ Adopt interdisciplinary approach to care (every one’s job) e.g. patient identified need determines the best provider for the patient
▪ Promote provider – patient conversations based on the following key questions:  
  ▪ What is most troubling you?  
  ▪ How is it impacting your life?  
  ▪ What have you tried?  
  ▪ How can I be helpful? / What would help?  
▪ Support staff to adopt a person centred care approach to care delivery e.g. education  
▪ Educate providers on the referral pathways  
▪ Gain leadership support

Alignment with AHS initiatives

The following were identified as initiatives that could potentially align with this strategy:

▪ Cancer Care Navigation (national initiative looking at outcomes and system integration)  
▪ Continuing Care Case Management Framework and Education (promotes and provides guidance for delivering person centred care)

Anticipated Outcomes

✔ Delivering person centered care will impact other elements of quality care:  
  ▷ Aligning what is meaningful to a person (patient) translates into more appropriate service utilization
Designing a health care system that responds to what is meaningful to the patient/person and not to the provider or disease

**Indicators of Success**
- Increased patient and staff satisfaction
- Improved understanding of systems for both staff and patients
- Improved interdisciplinary team collaboration
- Decreased utilization
- Increased cost savings

**Risks and Mitigation Strategies**
The following risks and suggested mitigation strategies were identified:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ More resources required to support staff during the initial stages of implementation</td>
<td>▪ Gain leadership support (short term cost for long term gains)</td>
</tr>
<tr>
<td>▪ Adopting a person centred approach to care delivery may not translate into decreased utilization</td>
<td>▪ Use of feedback loops and CQI processes (continuous quality improvement) in designing system integration</td>
</tr>
<tr>
<td>▪ Involve patients in the process</td>
<td>▪ Involve patients in the process</td>
</tr>
</tbody>
</table>

3. Community, Remote & Transition Health Services

This strategy aims to understand and identify the needs of our patient population, by looking at present data available from relevant groups and/or initiatives and utilizing provider knowledge to identify gaps and areas of greatest variation.

**Activities**
The following steps were identified as necessary action items:
- Identify pressure points and ideal state
- Support informed service planning based on identified gaps
- Match population needs to available service areas: Prevention, Promotion, Primary Care, Acute Care, Addictions and Mental Health, Seniors Health and Chronic Disease Management

**Alignment with AHS initiatives**
This plan links to the following initiatives within AHS:
- Addiction and Mental Health Strategy (to include telehealth)
- Primary Care Networks
- Possible programs and/or initiatives in Community Rural Health Service Delivery (CRHSD)

**Anticipated Outcomes**
It is expected that this plan will achieve the following:
- Equitable service to reduce variation in health outcomes/status
- Minimum variation
- Access to speciality services
- A system in which the right provider/service is at the right place, at the right time
**Indicators of Success**

Success will be measured through the following:

- Improved patient experience
- Improved health outcomes
- Improved utilization across continuum

**Risks and Mitigation Strategies**

The following risks and suggested mitigation strategies were identified:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>No data on population access</td>
<td>AHS leadership support and buy-in to support leaders (formal and informal)</td>
</tr>
<tr>
<td>Limited integration of data</td>
<td>Empowerment</td>
</tr>
<tr>
<td>Public expectation</td>
<td>Accountability</td>
</tr>
<tr>
<td>Change acceptance</td>
<td>Dedicated resources to strategy – not off side of desk</td>
</tr>
<tr>
<td>Cultural approaches</td>
<td></td>
</tr>
</tbody>
</table>

**4. Patient Engagement and Information Sharing**

The purpose of this strategy is to put the patient voice at all levels of care i.e. patients own their own care. The key to this transformation is the patient driving the health care system: “my need, my path, my accountability and my partners.”

**Activities**

The following actions were identified as essential to implementing the strategy:

- Design systems to change the paradigm e.g. patients start their own assessment via social media or is incorporated into a care pathway. Patients lead the way with our support
- Develop a burning platform to drive the change e.g. service contracts that have clauses showing how patients and families are connected with their deliverables
- Standardize care by developing guidelines, principles and a single plan of care
- Support patients to make informed choices
- Deliver a flexible, consistent and equitable service

**Alignment with AHS initiatives**

The strategy could potentially be aligned with the following initiatives:

- Workforce Model Transformation Initiative
- Provincial Advisory Council for Addiction and Mental Health

**Anticipated Outcomes**

- AHS becomes the employer of choice
- Standardized care and reduction in variation
- Care is holistic, timely and delivered by the right provider
- Reduction in transition errors
Indicators of Success

- Increased public confidence
- Increased opportunity to address other needs (social determinants)
- Improved accountability to teamwork
- Increased safety
- Improved communication

Risks and Mitigation Strategies

The following risks and suggested mitigation strategies were identified:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of skill set in behavioural skills</td>
<td>Patient coaching facilitation</td>
</tr>
<tr>
<td>Patients with multiplicity of chronicity</td>
<td>Support providers to acquire and integrate partnering skills in care delivery – there may be a need to provide partnering skills training</td>
</tr>
<tr>
<td>Bounded risks by condition, population and individual. Health providers give up on this as they don’t want to negotiate (negative decision making)</td>
<td>Measure risk tolerance/risk change</td>
</tr>
<tr>
<td>Partners will change external/internal</td>
<td>Tools/resources that staff can use to assist them put patients at the centre of care</td>
</tr>
<tr>
<td></td>
<td>Allow patients and families not the organization to determine the temperature they can handle within reason of appropriate use of public funds</td>
</tr>
</tbody>
</table>

5. Workforce and Staffing Model

This strategy addresses the development of a staffing model based on population needs, which includes not only physical health needs, but also takes into account the social determinants of health and their impact on the patient. Building on AHS’ population health mandate, it proposes using social and material indices to determine what improvements will reduce disparities and thereby improve health the most, and then matching these results to appropriate staff mix.

Another key issue to be addressed is the question of the need for a designated health care coordinator. That is, what patient populations require a designated health care coordinator versus what can/should we expect from every provider in terms of facilitating coordinated care?

It is anticipated that this strategic plan will improve patient experience and outcomes by addressing root cause(s) of their health concerns, however, a significant culture shift will be necessary to successfully implement these changes.

Activities

The following are the action items necessary to implement this strategy:

- Develop a progressive strategy to move us from our current approach of developing a staffing model to an approach that includes consideration of social determinants of health
- Identify social and material indices that can guide identification of appropriate staff mix, and be open to considering alternative providers where applicable
- Attend to staff learning and development needs and clarify expected role accountabilities related to social determinants of health and facilitation of coordinated care
- Develop tools (e.g. care pathways) that address social determinants of health as well as care coordination
- Identify appropriate metrics
- Attend to strategies that will facilitate a shift in culture

**Alignment with AHS initiatives**
The following were identified as potential linkages within AHS:
- Workforce Model Transformation initiative
- South Health Campus staffing rotations
- Clinical Strategic Workforce Plan
- Build on AHS’ population health mandate

**Anticipated Outcomes**
- A staffing model that is built on an understanding of the social determinants of health
- Improved patient experience and outcomes
- Provider skills sets actually meet the needs of the patients
- Care plans are tailored to patient needs and include plans to address any issues related to social determinants of health
- All tools, communication mechanisms, etc (e.g., plan of care) explicitly address the social context of care as well as the bio-medical and are integrated across providers and programs
- Decreased health care expenditure because we are actually addressing root causes

**Risks and Mitigation Strategies**
The following risks and suggested mitigation strategies were identified:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff ignore or poorly attend to all expected role accountabilities</td>
<td>Performance management</td>
</tr>
<tr>
<td>Resistance to alternative staffing models</td>
<td>Leadership development (so that they can then provide support)</td>
</tr>
</tbody>
</table>

**6. Collaborative Practice and Communication**
This strategy addresses two key areas of collaborative practice and communication: information sharing and collaboration among providers and leadership.

**Activities**
The following actions have been identified to move this strategy along:

1. *Information/Collaboration*
2. Leadership

- Develop KT strategy for collaboration
- Develop change management strategies
- Showcase successful examples (including patient viewpoint)
- Utilize different communication channels, i.e. separate mechanisms for internal AHS vs. external public messaging

Alignment with AHS initiatives

Opportunities exist to leverage the following:

- AHS has a Clinical Workforce Strategic Plan where collaborative practice is a key strategy for creating a sustainable workforce
- A Collaborative Practice repository of tools and information is being compiled for the Workforce Model Transformation initiative; this could be made available more broadly
- Two years ago, Health Profession Strategy and Practice hosted a Collaborative Practice workshop. The report from this workshop includes an environmental scan on successful strategies for collaboration
- Collaborative Practice and Education Steering Committee (CPESC) has a work plan that will be implemented in the next year, which presents a good opportunity for alignment
- Operationalize through FCCs/SCNs and use them as champions

Anticipated/Target Outcomes

- Improved patient experience and outcomes
- Increased staff experience, recruitment and retention
- Increased provider knowledge of what’s happening with their patients
- Greater opportunities for quality improvement
- More integrated care

Indicators of Success

- Positive patient feedback on collaboration
- Alaska seems to have a well-developed integrated system that could be examined for additional success factors that could be applied to Alberta
### Risks and Mitigation Strategies

The following risks and suggested mitigation strategies were identified:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pockets of resistance</td>
<td>Performance management</td>
</tr>
<tr>
<td>Lack of buy-in</td>
<td>Consider it as a long-term strategy</td>
</tr>
<tr>
<td>It’s not seen as a priority</td>
<td>Collaboration not end goal ➜ continuum</td>
</tr>
<tr>
<td></td>
<td>Make it attractive – focus on what’s in it for providers</td>
</tr>
</tbody>
</table>

### Summary of Alignment with AHS Initiatives

Below is a summary of AHS initiatives that could be aligned with each of the action plans. These initiatives have already been noted in the above action plans.

<table>
<thead>
<tr>
<th>Action Plan</th>
<th>Alignment with AHS Initiative</th>
</tr>
</thead>
</table>
| 1. Primary Care, Clinical Care Pathway and Central Waiting Lists | **Path to Home**  
**Integrated Health Home**  
**Health System Navigation**  
**Family Care Clinics**  
**Collaborative Practice**  
**Primary Care Networks i.e. patient engagement**  
**Closed Loop Referral Management Program** |
| 2. Holistic Care                                  | **Cancer Care Navigation** (national initiative looking at outcomes and system integration)  
**Continuing Care Case Management Framework and Education** |
| 3. Community, Remote & Transition Health Services | **Addiction and Mental Health Strategy** (to include telehealth)  
**Primary Care Networks**  
**Possible programs and/or initiatives in Community Rural Health Service Delivery (CRHSD)** |
| 4. Patient Engagement and Information Sharing    | **Workforce Model Transformation Initiative**  
**Provincial Advisory Council for Addiction and Mental Health** |
| 5. Workforce and Staffing Model                  | **Workforce Model Transformation Initiative**  
**South Health Campus Staffing Rotations**  
**Clinical Workforce Strategic Plan**  
**Build on AHS’ population health mandate** |
| 6. Collaborative Practice and Communication      | **Clinical Workforce Strategic Plan**  
**Workforce Model Transformation Initiative** (i.e. Collaborative Practice repository of tools and information)  
**Collaborative Practice Workshop Report by Health Professions Strategy and Practice** (i.e. Section on environmental scan on successful strategies for collaboration)  
**Collaborative Practice and Education Steering Committee Work Plan**  
**Operationalize through FCCs/SCNs and use them as champions** |
Next Steps

The support of internal AHS stakeholders will play a pivotal role in moving this work forward. The following departments and their respective leaders have pledged their commitment to the next phase of this project:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Action Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allison Bichel</td>
<td>Executive Director, Provincial Access Team AHS</td>
<td>Promote transparent and equitable access to services and supports</td>
</tr>
<tr>
<td>Bev Rhodes (tentative)</td>
<td>Clinical Design Lead, Seniors Health AHS</td>
<td>Promote providers and staff awareness of information systems that can inform care delivery</td>
</tr>
<tr>
<td>Caroline McAuley</td>
<td>Director, Primary Care Integration AHS</td>
<td>Promote structures and processes within FCCs to support collaborative practice</td>
</tr>
<tr>
<td>Corrine Schalm</td>
<td>Director, Access and Quality, Continuing Care Branch Alberta Health</td>
<td>Promote co-ordination and standards for continuing care</td>
</tr>
<tr>
<td>Cotton Chou</td>
<td>Manager, Quality Improvement, Primary Health Care Division Alberta Health</td>
<td>Promote an interdisciplinary and collaborative approach to primary health care</td>
</tr>
<tr>
<td>Jennifer Rees</td>
<td>Executive Director, Patient Experience AHS</td>
<td>Advocate for person-centred care approaches to care delivery for providers and patients</td>
</tr>
<tr>
<td>Noreen Linton</td>
<td>Associate Chief Nursing Officer, Health Professions Strategy And Practice AHS</td>
<td>Encourage and support inter-professional education and practice</td>
</tr>
<tr>
<td>Tim Cooke</td>
<td>Senior Health System Analytical Lead HQCA</td>
<td>Leverage these research findings to further HCQA’s efforts to measure and address care integration and coordination</td>
</tr>
<tr>
<td>Tracy Wasylak</td>
<td>Vice President, Strategic Clinical Networks and Clinical Care Pathways AHS</td>
<td>Encourage the use of research findings to ensure that key strategies are integrated in ongoing and future SCN work</td>
</tr>
</tbody>
</table>

Although these departments have been assigned specific roles, it is hoped that all workshop participants will take responsibility for integrating the findings of this project into their work and that they will be champions for moving it along. To that end, the project team will follow-up with all attendees beginning May 2013 to gain feedback on how participants have made use of these proceedings. The project team will also be available in the interim to present/discuss the proceedings from this workshop with all interested stakeholders.

Looking further ahead, it is anticipated that the findings from this project will inform other initiatives within AHS (e.g. the System Wide Case Management project). A full project report will be released in Summer 2013, and this will be disseminated broadly.
Appendices

Appendix 1: Barriers to Integrated Care Workshop Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00 – 10:10 AM</td>
<td>Welcome/Introductions</td>
</tr>
<tr>
<td>10:10 – 10:20 AM</td>
<td>Background</td>
</tr>
<tr>
<td>10:15 – 11:00 AM</td>
<td>Review Research and Findings</td>
</tr>
<tr>
<td>11:00 – 11:45 AM</td>
<td>World Cafe</td>
</tr>
<tr>
<td>11:45 – 12:00 PM</td>
<td>Report Out</td>
</tr>
<tr>
<td>12:00 – 12:45 PM</td>
<td>Lunch</td>
</tr>
<tr>
<td>12:45 – 2:15 PM</td>
<td>Strategy Prioritization and Action Plan Development</td>
</tr>
<tr>
<td>2:15 – 2:45 PM</td>
<td>Report Out</td>
</tr>
<tr>
<td>2:45 – 2:55 PM</td>
<td>Gallery Walk &amp; Voting</td>
</tr>
<tr>
<td>2:55 – 3:00 PM</td>
<td>Next Steps/Wrap-up</td>
</tr>
</tbody>
</table>
Appendix 2: Barriers to Integrated Care Workshop PowerPoint Presentation

Root Cause Analysis of Barriers to Integrated Care

Collaborative Workshop

Hosted by the Workforce Research & Evaluation Team
February 14th 2013
Calgary, AB

Purpose of the Meeting

✓ INFORM:
  – To present the results of a research project related to the barriers to delivery of integrated care.
  – Support stakeholders in recognizing and understanding the root causes of barriers to integrated care.

✓ CONSULT:
  – To create opportunity for stakeholders from across the province to network and discuss strategies to improve integrated care.
  – Identify linkages to pertinent AHS initiatives and recommend priorities in order to leverage existing work and opportunities.
Setting the Context for Today

2010: System Wide Case Management Steering Committee

2011: Health System Navigation Conceptual Model

2012: Research Initiative

Research Team

- Karen Jackson, Senior Research and Evaluation Consultant
- Nicole Wallace, Research and Evaluation Consultant
- Omenaa Boakye, Research and Evaluation Consultant
- Paola Charland, Research and Evaluation Consultant
Project Summary

**Aim:** To explore the root cause of challenges faced by patients in accessing integrated health services and to identify actionable strategies to address these gaps.

**Population:** Mental health, seniors, and children with special needs. N=15 patients/families and 11 corresponding providers.

**Study Design:** Data collected through semi-structured interviews. Analysis using case study methodology combined with root cause analysis (RCA).

Data Analysis - Themes

- Access
- Support (to patients)
- Communication – between providers and with patients, provider awareness of patient activities
- Person-Centred Care
- Care Coordination
- Collaboration Between Providers
Key Findings - General

- Participants were genuinely excited to be part of this project and felt valued because we were interested in their opinions and stories
- Rigid program criteria is a barrier to access for many complex patients
- Long wait times, sometimes resulting in referrals to external services/programs
- Nearly all patients report support and advocacy from at least one provider, and this support has been identified as key to accessing services
- Both patients and providers find the health care system “confusing” and “very difficult to navigate”, particularly for those with complex care needs
- Most providers felt that patient engagement in and ownership of their care is important, and patients expressed a desire for increased access to information to enable informed decision making
- Varying expectations of involvement among patients

Key Findings – General Cont’d

- There is a need to focus more on the social determinants of health and how they impact patient health
- Many participants felt that electronic medical records were a good strategy for improving communication among providers and awareness of patient information
- Patients perceive a disconnect between physicians and community services
- Lack of information sharing among health professionals results in patients being the mediator
- Providers generally unaware of patients’ interactions with other providers
- Integrated care plans seldom exist, although many providers acknowledge their benefits
- Participants feel that a nurse-coordinator position would improve coordination, communication and patient access issues
Key Findings – Mental Health

- Many participants felt that mental health care should remain distinct from physical care
- Partnerships between hospital and community facilities are essential to establishing appropriate services for this cohort
- Provider participants recommend that all staff, not just clinical, be trained on how to provide service to individuals with mental health problems
- Participants cite the importance of holistic care that supports both mental and physical health

Key Findings – Seniors

- Reluctance among health care providers to add geriatric patients to their caseload
- Patients do not always want to make care decisions – many feel that the provider should do this
- Concerns about the lack of appropriate facilities for seniors with acute mental health issues
- Need for improvement in hospital service, particularly with regards to patient-centred care during stays and discharge procedures
Key Findings – Children

- Parents play a key role in ensuring access on behalf of children with special needs through persistence and strong advocacy. Having to take on the role of coordinator can be overwhelming for these parents
- Providers look to improve communication and collaboration through family conferences
- Lack of collaboration is particularly taxing on these children, who frequently undergo multiple procedures with multiple providers
- Lack of appropriate facilities for patients who do not fit neatly into one clinical box

Selected Quotes

- “Like you get to this position in life not by just this very linear path. I mean there’s been stuff going on from the past that’s impacted health. I mean it’s not just I got hit by a bus; you know fix my broken bones. I got hit by a bus ten years ago and then I got my leg broken by a partner and then I got—like there’s just layer upon layer upon layer, upon layer and again, the model that the health services uses is not meant to peel off each layer” – Service Provider
- “On a weekly basis, I probably get about at least 50 to 60 new requests for patients. And so, we are trying to see as many of these kids as we possibly can and so the clinics are very kind of tightly booked. And it is frustrating often that I would like to have more time to spend with the patients, but it’s just not there. And so, from that perspective the demand is just too great at the moment that we can’t book it the way that we would like to and see patients in a timely fashion.” – Service Provider
Selected Quotes (cont’d)

- “I love [my case managers] to death. They are my angels. They were there for me every minute of my nightmares, of my trouble, of my anger. They never gave up on me.” – Patient

- “The system of AHS as a whole is not a productive structure. The staff and employees individually and what everybody does is incredibly successful I would say, but how it is functioning as a whole organization, not so much.” – Service Provider

- “...I’ve done my role and then it just doesn’t occur to them that it’s required to disseminate that information to other healthcare providers. They just sort of look at it from their perspective, not from the patient’s perspective necessarily, and that they need to make sure that everything stays communicating.” – Service Provider

- “I just want to be a parent. Being a caregiver is one thing and of course you’re going to give the best care you can give to your children and you’ll do the best that you can, but I just want to be a mom.” – Patient

Literature Review Findings

Barriers to Integrated Care
- Access to services
- Workforce capacity
- Duplication of services
- Financial investment
- Collaboration/communication between providers
- Navigating the health care system
- Patient engagement
- Provider remuneration for collaborative/coordination activities
- Ingrained separation between services, provider training and approaches to care

Strategies to Improve Integrated Care
- Support to coordinate care
- Workforce development
- Enhance patient involvement
- Integrated data systems
- Performance measurement
- Reviewing provider reimbursement models
- Co-location of providers and use of telemedicine
- Holistic, evidenced based, multidisciplinary approach to care
Change Analysis Overview

Ideal Case
- What?
- When?
- Where?
- How?
- Who?

Actual Case
- Respond to each question by identifying how the situation should have occurred.

Analyse Each Line to Determine Whether or Not That Particular Action Had an Effect on the Overall Outcome
- Ask Why to drill down to underlying cause of deviation.

Corrective Action
- For each action that altered the outcome, identify a corrective action recommendation to prevent reoccurrence.

CASE STUDY ANALYSIS

Case studies were derived from aggregated patient and provider data. All events were reported in the data, however, they do not represent the experience of any one patient.
Case Study No. 1: Hospital referral, in-patient stay, discharge and follow-up care coordination

- Patient is added to several other waiting lists at different facilities
- Patient is unable to continue working while waiting and experiences financial strain
- Asked by each provider to repeat full medical history
- During the hospital stay, experiences several inconsistencies and lack of person-centred care
- Sent home, despite feeling that it was too early to be discharged, and subsequently developed a post-op infection
- Multiple visits to the doctor’s office, only to be told at each visit by a different physician to “come back if it gets worse”. Ultimately re-admitted to the hospital for three and a half weeks.
- Post-surgery, patient remains on other waiting lists, taking up an unnecessary spot in the queue

Case Study No. 1 – Analysis Summary

10 Root Causes were derived

Mapped to 9 corrective action areas
Case Study No. 2: Patient engagement and information sharing and understanding during routine care and referrals

- Patient unable to gather the information she seeks
- Not empowered to make decisions around the next steps in her care
- Given the lack of a dedicated health care coordinator, pertinent information is not transferred among care providers in a timely fashion
- Additional health care providers are not brought into the discussion.
- Mrs. X is given a new treatment plan, which possibly contradicts her current care routine
- Information is not communicated back to her primary care provider
- Left on her own with a new care plan, without any follow-up support or anticipatory guidance
- Left to communicate the new care plan to her other health care providers and risks improper adherence to her treatment plan, or worse yet, ignoring it altogether

Case Study No. 2 – Analysis Summary

6 Root Causes were derived

Mapped to 5 corrective action areas
Summary of Corrective Actions

- Primary Care, Clinical Care Pathways & Central Waiting Lists
- Holistic Care
- Community, Remote & Transition Health Services
- Patient Engagement and Information Sharing
- Workforce and Staffing Model
- Collaborative Practice & Communication

Ten Key Principles for Successful Health Systems Integration¹

- I. Comprehensive services across the care continuum
- II. Patient focus
- III. Geographic coverage and rostering
- IV. Standardized care delivery through interprofessional teams
- V. Performance management
- VI. Information systems
- VII. Organizational culture and leadership
- VIII. Physician integration
- IX. Governance structure
- X. Financial management

## Summary of Case Study Analysis

<table>
<thead>
<tr>
<th>Corrective Actions</th>
<th>Mapping to Integration Principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Primary Care, Clinical Care Pathways &amp; Central Waiting Lists</td>
<td>I. Comprehensive services across the care continuum</td>
</tr>
<tr>
<td>2. Holistic Care</td>
<td>I. Comprehensive services across the care continuum</td>
</tr>
<tr>
<td>3. Community, Remote &amp; Transition Health Services</td>
<td>I. Comprehensive services across the care continuum</td>
</tr>
<tr>
<td></td>
<td>III. Geographic coverage and rostering</td>
</tr>
</tbody>
</table>

## Summary of Case Study Analysis Cont’d

<table>
<thead>
<tr>
<th>Corrective Actions</th>
<th>Mapping to Integration Principles</th>
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</thead>
<tbody>
<tr>
<td>4. Patient Engagement and Information Sharing</td>
<td>II. Patient focus</td>
</tr>
<tr>
<td>5. Workforce and Staffing Model</td>
<td>IV. Standardized care delivery through interprofessional teams</td>
</tr>
<tr>
<td>6. Collaborative Practice &amp; Communication</td>
<td>IV. Standardized care delivery through interprofessional teams</td>
</tr>
<tr>
<td></td>
<td>VI. Information systems</td>
</tr>
</tbody>
</table>
Thank You!

We wish to express our gratitude to all of our interview participants for taking the time to share their experience and knowledge with us.

We also acknowledge and thank our working group for their collaboration throughout this project:

- Signe Swanson
- Peggy Riches
- Doug Vincent
- Nancy Aspenes
- Jennifer Rees
- Esther Suter
- Rebecca Carter
- Cotton Chou
- Sara Ghotbi
- Jennifer Anderson
- Lesley Podruzny

Finally, we would like to thank our research funder Alberta Health, as this project and workshop would not be possible without their support.

World Cafe (50 min)

There are six (6) stations set up around the room with the following key questions:

<table>
<thead>
<tr>
<th>Corrective Action Brainstorm Question</th>
<th>Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Primary Care, Clinical Care Pathways &amp; Central Waiting Lists: How can AHS optimize current resources</td>
<td>Peggy Riches</td>
</tr>
<tr>
<td>and leverage existing initiatives to facilitate well defined standards of care and wait times?</td>
<td></td>
</tr>
<tr>
<td>2) Holistic Care: How can AHS optimize current resources (and leverage existing initiatives) to promote</td>
<td>Signe Swanson</td>
</tr>
<tr>
<td>an approach to care that considers all potential factors affecting a patient’s health (i.e. key</td>
<td></td>
</tr>
<tr>
<td>determinants of health)?</td>
<td></td>
</tr>
<tr>
<td>3) Community, Remote &amp; Transition Health Services - How can AHS optimize current resources (and</td>
<td>Nancy Aspenes</td>
</tr>
<tr>
<td>leverage existing initiatives) to ensure that patients in rural and remote communities have access to</td>
<td></td>
</tr>
<tr>
<td>comprehensive health services?</td>
<td></td>
</tr>
<tr>
<td>4) Patient Engagement and Information Sharing: How can AHS optimize current resources (and</td>
<td>Jennifer Rees</td>
</tr>
<tr>
<td>leverage existing initiatives) to create an environment (a health care system?) in which patients are</td>
<td></td>
</tr>
<tr>
<td>fully included in their care plans and decisions?</td>
<td></td>
</tr>
<tr>
<td>5) Workforce and Staffing Model: How can AHS optimize current resources (and leverage existing</td>
<td>Karen Jackson</td>
</tr>
<tr>
<td>initiatives) to ensure workforce and staffing models facilitate care that is coordinated and</td>
<td></td>
</tr>
<tr>
<td>integrated?</td>
<td></td>
</tr>
<tr>
<td>6) Collaborative Practice and Communication: How can AHS optimize current resources (and</td>
<td>Esther Suter</td>
</tr>
<tr>
<td>leverage existing initiatives) to support providers to work collaboratively and communicate</td>
<td></td>
</tr>
<tr>
<td>effectively with other providers?</td>
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</table>
World Cafe Example

**Community, Remote & Transition Health Services**: How can AHS optimize current resources (and leverage existing initiatives) to ensure that patients in rural and remote communities have access to comprehensive health services?

- Expand the use of Telehealth to deliver service to patients living in rural and remote locations and for staff education.
- Mobile services (labs, diagnostics, clinics, etc.).
- Utilize remote monitoring technology.
- Encourage the use of Inform Alberta as a service directory and communication tool for people in rural and remote communities to understand the services available to them in their local community.

World Cafe Instructions:

1. Ensure you have a pen and pad of stickies.
2. Move to the station you would like to start at. Please try to disperse evenly amongst the topics.
3. A bell will ring to start the session and every 7 minutes thereafter. The bell is a reminder to ensure you rotate through all six stations.
4. Please move **clockwise** through the stations.
5. Read the question on the flip chart and write down ideas to the question on the stickies – ONE per sticky and please write legibly.
6. Place your stickies on the flip chart under the question. The facilitators may ask for clarification if required.
7. At the end of the session, each facilitator will do a brief summary of the ideas generated during the world cafe.
**Action Plan Development (1.25h)**

**Purpose:** As a small group, prioritize Top 2 Strategies under each corrective action category and together, develop an action plan by answering the following 5 questions:

1. **What is the Strategy?** – Describe the strategy in as much detail as possible.
2. **What are we trying to achieve with the strategy?**
   a) Why is the strategy important?
   b) What does success of the strategy look like?
   c) What are the desired outcomes that can be expected if the strategy was implemented?
3. **How are we going to do it?**
   a) What actions or activities are required to implement the strategy?
   b) Are there any initiatives/programs currently underway that this strategy would align nicely with?
4. **How will we know when the strategy has been successful?**
5. **What are the risks (and associated mitigation strategies) to implementing this strategy?**

---

The same six (6) stations are set up around the room with the brainstormed ideas.

Please select a table that you would like to spend the afternoon developing a focused action plan. **Note:** If 6 people are already at the table, please move on to your second choice.

As a group, you will prioritize the Top 2 Strategies:
- Each person will be provided 2 stickers.
- Review the strategies listed and place the stickers on the strategies you feel would have the greatest impact on improving integrated care. Think about:
  - Feasibility – Readiness, Capacity, Ease of implementation
  - Quality – Accessibility, Appropriateness, Acceptability, Effectiveness, Efficiency, Safety

Once the two priorities are decided, work through the questions for each strategy.

Identify someone to report out to the group.
Voting on Top 6 Strategies

Prioritize the Top 6 Strategies:
- Each person will be provided 6 stickers.
- Review the strategies listed and place the stickers on the strategies you feel would have the greatest impact on improving integrated care. Think about:
  - Feasibility – Readiness, Capacity, Ease of implementation
  - Quality – Accessibility, Appropriateness, Acceptability, Effectiveness, Efficiency, Safety

What Happens Next?
- Summary of Strategies will be sent out to all workshop participants by end of March.
- Based on the research findings and ideas generated and prioritized today, a report that will include recommendations for next steps will be prepared for our funders (Alberta Health) and put forward to AHS Senior Leadership.
- A communication/dissemination plan will be developed.
- We encourage you to talk about/adopt strategies discussed today in your day to day work.
Appendix 3: Barriers to Integrated Care Workshop - World Café

During the first half of the workshop, participants were invited to contribute ideas and suggestions for improvement within each of the six areas for corrective action identified in the research. A dedicated facilitator was assigned to each station, and attendees rotated through them in timed (8 minute) rounds. The contributions of all participants were organized into themes and are listed below.

**Primary Care**

- Continue to develop PCNs and FCCs and increase their reach and availability
- Clarify role expectation and performance measurements between the primary care team and other sectors (e.g. home care, acute care, chronic care)
- Develop a more robust system for attaching patients to a primary care provider (include all team members)
- Establish the central role of primary care provider as being a patient navigation coordinator/primary point of contact. The use of Interprofessional teams is necessary to achieve this
- Ensure that clinical care pathways are incorporated for all patients
- Identify where gaps currently exist in primary care access (i.e. basic, enhanced, complex)
- Establish procedures for primary care medication reconciliation
- Create better linkages and ensure information (reports, referral pathways, etc.) flows freely and efficiently between acute care (or continuing care) and Primary Care

**Patients and Families as Partners and Leaders in Care**

- Recognise the patient as a person and a life and create a safe environment for patients to partake in their care planning
- Promote decision making as a conversation between patient and provider, particularly in complex care. Eighty percent of cancer patients identify health care provider conversations as their preferred way of learning
- Look at/develop initiatives to foster self-care of even most vulnerable
- Embed/enforce patient advisors at all levels of care
- Develop performance indicators to measure patient engagement
- Ensure that patients have access to information that is readily understood, and that they are presented with all options for their care. Presenting only the option the provider deems best is not true patient engagement
- Establish a principle that patients own their path and providers contribute to it, and allow patients to be the drivers and co-leaders of their care
- Create a capability to have patients journal their expectations and/or carry a portfolio for use with all providers
- Ensure that the client’s goals/targets are one of the first steps in the care plan development. Understand that these goals may contradict pathways and support that, with the end result of creating care paths that are transparent to the team and resonate with everyone
- Build a health care contract owned by patients
- Educate staff on the importance of understanding patient information needs and role they play in assisting patients
- Build the public’s awareness that as a patient, you have total license to inform the care you receive and incorporate your own values
Draw from the Patient and Family Centred Care Principles of Include, Inform, Respect, Involve and Listen to me

**Services Driven by Population Needs**
- Differentiate between population needs and wants
- When developing care plans, factor in things such as ability to travel, willingness to use alternate methods of access (e.g., email, phone call, telehealth and video), and ability of providers to deliver services
- Develop staffing models that are responsive to socioeconomic status and social health determinants
- Review service availability and identify gaps
- Develop clear and accessible list of what is available
- Base staffing mix and model on patient care needs
- Attend to program context
- Ensure that patients are matched with the most cost effective and appropriate providers
- Consider generations (of staff) when creating models
- Use alternative providers (e.g., kinesiologists as coaches for helping citizens negotiate their care)
- Move staff rotation between services (South Health Campus model)
- Utilize the AHS Promoting Health Equity Framework to identify patient groups with significant and modifiable health inequities whose voices are missing from planning, and include those on HACs/PACs/SCNs/OCNs

**Information Sharing and Communication**
- Eliminate duplication of communication
- Promote open communication between providers through education and culture shift
- Link communities of practice which have the most frequent connections
- Promote interdisciplinary communication through regular team rounds and case conferences
- Provide staff with effective communications tools and make information easily available to allow for coordinated and integrated information for patients and staff
- Encourage and reward the sharing of resources
- Encourage staff to get involved in discussions and communication around care plans in regular and formal/informal meetings as part of performance measurement
- Ensure that staff understand what information can and cannot be shared
- Allow patients to sign off on the sharing of their information among providers to eliminate privacy barriers

**Other Education and Staff Development**
- Teach and train as teams
- Integrate inter-disciplinary education models into both undergraduate and graduate education programming in order to enhance cross discipline learning
- Increase staff education on the stigma faced by addictions and mental health patients
Prevention and Holistic Care

- Ensure that patients in correctional environments have access to necessary health resources
- Promote healthy retirement planning that considers health and wellness alongside financial arrangements
- Ensure that proper arrangements are made for all patients requiring home care; do not assume that the family members can/will replace home care
- Increase focus on wellness prevention and social determinants of health – a healthier population should improve waiting lists
- Align health outcomes to material and social deprivation indices
- Include holistic components in health care contracts
- Build competency tools/processes for all stakeholders to understand and deliver holistic care, and include academic partners to ensure that holistic care is core knowledge of all disciplines
- Encourage more comprehensive patient assessments that go beyond the immediate concerns of the appointment
- Provide more resources upstream to assist children that were exposed to adverse childhood events and are at increased risk of mental and physical health

Culture Shift– Staff and Clients

- Hold staff and providers accountable for improving the patient experience
- Promote patient advisory committees (combination of staff and clients)
- Ensure that patients understand the information provided to them by asking them to repeat it
- Encourage providers to discuss communication preferences with patients and to be open to multiple methods of information sharing (written, verbal, video, audio, pictures)
- Ensure that care options are aligned with and respective of patients’ culture, language and religion
- Conduct a patient centered conversation by asking “What is most troubling to you today? How is that impacting you/family? What have you tried? How can I help today?”
- Recognise informal caregivers as key members of the team
- Consider how to help manage those who may not want or know how to connect - “the unattached”
- Promote a shift towards the recovery approach
- Promote a shift away from a paternalistic culture
- Quit the “turf protection” and the “this is not my job” attitude

Collaborative Practice and Integrated Care

- Utilize current standards (e.g. the Promoting Health Equity Framework) as a starting point and build from there, rather than creating new standards of care
- Promote the inclusion of non-physician driven plans of care
- Increase collaboration between conventional, complimentary and alternative providers to develop a truly holistic integrated model
- Utilize interprofessional teams to engage in comprehensive assessments that include psychosocial variables
- Utilize virtual care models/teams to leverage relevant expertise
- Create more professional opportunities to boost interest in working in rural areas
- Utilize expanded roles in HCP to better respond to patient care needs
- Create a collective AHS environment of collaboration and communication
- Implement shared care plans with signage for other care providers
- Encourage and focus on continuity of care
- Ensure that all staff are clear not only on their individual roles and responsibilities, but those of their team members as well
- Clarify the accountability of providers to provide service that is coordinated and integrated, and determine where it is necessary to implement a dedicated care coordinator role
- Devise an effective workforce model that allows staff to work at their best and allows for patient involvement

**Build on Pockets of Expertise, Evidence & Innovation**
- Learn from and build on the experience of existing programmes:
  - PCNs
  - The collaborative practice framework developed by AH/AHS
  - The AHS Promoting Health Equity Framework can be used to work with zones, SCNs/OCNs to identify ways to address barriers to access in rural and remote areas
- Utilize existing, internal resources within AHS such as DIMR, Workforce Research & Evaluation to develop optimal service delivery models
- Utilize research findings and evidence-based guidelines more strategically in developing and implementing collaborative practice models
- Leverage education resources being developed for collaborative practice by Workforce Model Transformation initiative and others
- Define health requirements and trends for health care, and promote planning for future health resource shortages
- Measure community functional health status rather than system status to drive system change
- Utilize standardized patient reported outcomes to drive system change/program innovation
- Utilize surveillance data to determine future and current health needs
- Change Tier 1 measures

**Leadership**
- Encourage shared leadership
- Establish super ordinate goals, i.e. what do we want to achieve, and develop a common vision on how to address challenges
- Build momentum towards valuing and understanding collaborative practice (leadership support)
- Ensure management’s support for ongoing training and education to make sure all staff are working to their full scope of practice
- Incorporate an understating of health inequities at all levels of AHS, and empower staff and leadership to work together to address these issues starting with the most vulnerable patients

**Funding and Remuneration**
- Reconfigure the budget for workforce planning so that it supports integration/coordinated staff model vs. care streams and silos
- Consider new models for program funding, physician compensation, and billing/remuneration, (e.g. community based case funding for services)
Technology

- Continue support for the Personal Health Portal, and include access integrated care plans and mobile access
- Develop AHS sponsored navigation apps
- Leverage technology, virtual care, self-management to deliver care in meaningful fashion
- Implement decision support tools for all care providers related to managing complex conditions
- Increase phone consultations: before visit (if the service is not appropriate to patients needs → being on wrong wait list), during the time the patient is under treatment (provide information → avoids patients coming back to the facility)
- Improve access to, and encourage use of telehealth or remote monitoring to support care i.e. mental health, specialist consultations and Medicare programs and services
- Implement virtual networks that focus on leveraging successes across geographical communities and delivering meaningful education
- Implement a common EMR between providers that patients can have structured/appropriate access to – consider privacy issues
- Ensure that electronic data is accessible by all sites

Access

- Ensure a central intake (one central point of entry for specialized services) where real time data for waiting and outcomes is housed
- Integrate and align rural acute and primary care delivery models (one stop shop)
- Continue work on central wait lists and standard wait times, and ensure that care providers have access to the most updated wait times so that they can prepare and advise their patients appropriately
- Coordinate policy for access across the zones for transparent and equitable access whenever possible
- Perform assessments to determine locales for additional onsite or mobile services
- Resolve transportation issues/barriers

System Integration, Demand and Time

- Listen to and work with communities on their issues
- Review the allocation of resources to ensure capacity
- Link services within and outside of the health system
- Enhance providers awareness of external/community services available to patients e.g. CASA, FSCD, and other social and financial support resources
- Strengthen the link between PCNs and AHS, and integrate primary care providers into workforce research and planning

Community Resources and Continuing Care

- Implement a volunteer transportation network
- Leverage and mobilize non-AHS community resources e.g. HAC, Lions Club, community pharmacy, peer support, wellness support, not-for-profits, schools and churches, and building assets
- Promote cross learning across communities
• Align service planning with community and rural development and advocate for additional services in rural communities
• Develop community focused initiatives that engage all health care providers in the community and bring them together for wellness talks
• Increase availability of transitional and community care facilities and ensure the effective use of existing ones
• Consider the role of informal care givers in the community and if/how they can be included in the workforce
• Strengthen the connection between primary care and continuing care

Appendix 4: Workshop Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<tbody>
<tr>
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<td>Corrine Truman</td>
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<td>Nicole Wallace</td>
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<tr>
<td>Name</td>
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<td>Signe Swanson</td>
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<td>Stacy Grainger-Schatz</td>
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Appendix 5: Case Studies for Change Analysis

Below are the case studies compiled from the interview data and used in the change analysis. The text in red denotes a deviation from the ideal process.

**Case Study no. 1: Hospital referral, in-patient stay, discharge and follow-up care coordination**

It is determined that Mr. X is in need of surgery, however, due to it being deemed non-urgent, patient is placed on a waiting list. In an effort to speed things up, Mr. X is added to several other waiting lists at different facilities. Although there are no direct physical health effects from having to wait, the patient is unable to continue working while waiting on the procedure and as a result, has experienced a change in financial status. Mr. X has gone from being financially comfortable to now being unable to make ends meet, and at times, even sacrificing meals due to being unable to afford them, and the stress of this situation weighs heavily upon the patient. Upon admission to the hospital for the procedure, Mr. X is asked to repeat a full medical history, including medications, past procedures, and hospital stays.

During the hospital stay, Mr. X experiences several inconsistencies and general lack of person-centred care including a disruption in established care routines (e.g. time of medication administration), nursing call buttons going unanswered, poor assistance with personal hygiene (including being left unattended in the bathroom for long periods of time and not receiving daily showers), and being discharged in a hospital gown in the hallway. Mr. X, who comes from a rural community, was then sent home, despite feeling that it was too early to be discharged, and subsequently developed a post-op infection, which was discovered by the home care nurse. This infection resulted in multiple visits to the doctor’s office, only to be told at each visit by a different physician to” come back if it gets worse”, and ultimately, the patient was re-admitted to the hospital and stayed for three and a half weeks. Prior to re-admission, Mr. X was subjected to multiple trips to neighbouring towns in order to see a doctor (saw a few different doctors as the same doctor was not available) and for routine blood work and follow-up appointments, which by the patient’s admission were very strenuous for someone who had just undergone major surgery. It was also revealed later on that the patient had not been removed from the other waiting lists, and was thus taking up an unnecessary spot in the queue.

**Case Study no.2: Patient engagement and information sharing and understanding during routine care and referrals**

Mrs. X has a health concern and attempts to gather information on her health issue. Due to its complexity, Mrs. X is unable to gather the information she seeks and remains uninformed about her condition. She proceeds to an appointment with her primary care provider, however, given her lack of information, she is unable to partake in a meaningful discussion of her health and is not empowered to make decisions around the next steps in her care. Her primary care provider refers her to a specialist, however, given the lack of a dedicated health care coordinator, pertinent information is not transferred to the specialist in a timely fashion, and Mrs. X’s additional health care providers are not brought into the discussion. The specialist then proceeds to devise a treatment plan, which Mrs. X is
still unable to contribute to, given her lack of information on her condition. Unknown to her other health care providers, Mrs. X is given a new treatment plan, which possibly contradicts her current care routine. Appropriate information is not communicated back to her primary care provider, and Mrs. X is left without any follow-up support or anticipatory guidance. Left on her own with a new care plan, Mrs. X is left to communicate the new care plan to her other health care providers and risks improper adherence to her treatment plan, or worse yet, ignoring it altogether.