

*WHY HELL SHOULD FREEZE OVER:  
INTERPROFESSIONAL COLLABORATION AND INTEGRATED CARE*

**KEYNOTE LUNCHEON SPEECH**

**by**

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**2<sup>nd</sup> annual Triprofessional Conference: Ontario Pharmacists,  
Physicians and Nurse Practitioners: A Call for Collaboration,**

**Tuesday, October 27, 2009**

- Thank you for the introduction and the invitation to speak to you today on behalf of The Change Foundation. I'm particularly pleased to participate in this program because it provides real accounts of how nurse practitioners, pharmacists and physicians are collaborating to improve patient care in communities across Ontario. I take that as a sign of progress, since a decade ago there likely wouldn't have been enough examples to fill the bill.
- I applaud the impulse driving this conference and salute the sponsoring organizations for participating in it. Henry Ford wrote that: "Coming together is a beginning. Keeping together is progress. Working together is success." So, congratulations on the coming together and the keeping together. Now for the tough stuff -- working together.
- As the title of my speech – *Why hell should freeze over: Interprofessional Collaboration and Integrated Care* – not so subtly suggests, this call for collaboration among health-care professionals demands a bit of a seismic shift – that is, changing our health-care system from still a largely siloed, provider-centric series of health-care interactions into an integrated health-care system built around the patient and the public. That kind of shift doesn't occur quickly, or without controversy. Witness the recent rounds of news releases and dueling exchanges about Bill 179 from and among the heads of health professions. It seems that relations are still sometimes more internecine than interdisciplinary!

- That aside, you heard this morning – and will hear later this afternoon - about some of the changes in practice, culture and education that are happening on the ground in communities across Ontario and how different health-care professionals are coming together in new ways – and with patients -- to address chronic health conditions like diabetes or cardiovascular disease. These are, as I said earlier, signs of progress, and signs of hard-earned investments in family health teams and nurse practitioner-led clinics paying off. There are also promising programs in pharmacy and primary care such as TIPPs and IMPACT. But to widen and increase these collaborative efforts – to make them less incidental and more institutional - more like the natural way of working – will require system change on many fronts.
- The historic failure to provide better collaborative care for patients – the failure to connect with others around the needs of patients -- is a system failure fueled by human nature, complacency, scarcity, myopia, timidity, and self interest (among other things) and it is shared by many: funders, planners, employers, provider associations and unions, practitioners, regulators, educational institutions, even the public in its adherence to the status quo.
- To turn that failure around, many of those same players will have to be brought on side – and once on board, there are many factors required for shared care -- and a long check list to succeed. For instance, health professions will need to develop different competencies (and in some cases, principles), employers will face more complicated labor relations, and regulators will have to think about implications of team and shared

accountability. The government, for its part, will need to make new arrangements around funding models and IT and provide policy and legislative support as it implements its blueprint for action in Ontario under increasingly constrained financial circumstance.

- I come at multidisciplinary collaboration this morning from a system and patient experience perspective, paying particular attention to the essential contribution that team-based care can make to integrated health systems. An integrated health-care system not for its own sake, but as a means to delivering quality care and positive experiences and health outcomes for patients as they travel across the continuum of care. A system that is coherent from a patient's perspective.
- That has been the focus of much of The Change Foundation's work since it got out of the grant-giving business and into the think tank business back in 2007. We are a health policy think tank that generates research, analysis and informed discussion about health system integration and quality improvement in home and community care in Ontario. The advent of Local Health Integration Networks and the putative push for a more integrated health system wrapped around patients and populations helped convince The Change Foundation Board to redirect its resources to health integration and quality improvement in Ontario.
- I'd like to share just a little of what The Change Foundation's research has turned up on patient perspectives on integration and their experiences with interdisciplinary care -- and the connection between

the two. I will highlight a few statistics to provide an indication – though admittedly it may not reflect today’s reality -- of how far Ontario has gone in implementing interprofessional care in relation to other jurisdictions. And I will end with some thoughts on areas where the Foundation and the TriProfessionals may find common cause.

- Though this audience is made up of knowledgeable champions of collaborative care, let’s just remind ourselves why it’s good for you: It provides increased access to care; reduced errors; improved outcomes for people with chronic disease; better use of resources; and increased employee and professional satisfaction.
- It is also a key element in any integrated health system. Early on in the Foundation’s evolution as a think tank, we produced a jurisdictional review of integration efforts internationally and in Canada. We identified 11 common elements as success factors in all jurisdictions, and not surprisingly, interprofessional teams are among them. The review cites the development of interprofessional teams (with clinicians in the tent as employees or through contract) as the best use of resources. A noteworthy finding, given last week’s Economic Statement.
- The review recognizes that there are a lot of barriers -- particularly around alignment of financial incentives – and stresses the need for role clarity, and an understanding of the decision authority for patient care; if not clear, it can result in much slower care processes and can inhibit real integration.

- The Change Foundation chose to focus its first health integration report on patient and caregiver perspectives on navigating health services in Ontario. The report is called *Who is the Puzzle maker?* and its title came directly from one of the patients who participated in the focus groups we held across the province in 2008.
- Why a focus on patient and caregiver views? A high performing health system understands, measures and responds to patient experience. Quality Improvement frameworks incorporate the patient experience and views directly into improvement methodologies. Ontario has created a relatively new governance structure (LHINs) to plan and integrate care at the local level at the same time as regionalizing priority programs like cancer. Case management functions for community care (home and LTC) are under a different organization (CCAC). Physician services remain independent. So what is the patient experience related to how well integrated care is in Ontario?
- We undertook three separate research projects on patient perspectives: (1) a literature review on patient and family views on navigating the system; (2) a general population survey about information flow and communication across transition points; and (3) 10 focus groups with regular users of the health-care system and caregivers.
- One of the themes that emerged was the difficulty patients were having navigating the system, with patients and caregivers wondering if anybody is joining the dots. Our literature review revealed that patients receiving care in clinics featuring multi-disciplinary teams reported

- To quote Phyllis from Ottawa: "...the delivery of care at those community health centers is just phenomenal...you get the medical attention; you get the follow-up if you're diagnosed with diabetes. ..when I was diagnosed with my heart problem I was immediately referred to the Ottawa Heart Institute..I was part of the health-care team. I got to see a physio. I got to see dietitians. I got to see a cardiologist. I got to see a psychologist. I got to see a social worker. Instead of being left alone to figure it out."
- At the same time, our general population survey in Ontario found that only 27% of people in the survey reported that they sometimes received instructions from a health-care provider about where to seek further care if needed while 32 per cent reported they occasionally, seldom or never received such instruction.
- Another theme that emerged from our research was that perceptions of coordination are directly linked to perceptions of the extent of communication between providers. The professionals themselves are highly valued but patients believe they are not communicating well with each other. Evidence suggests that this directly affects care and patient outcomes: "Quality of care and patient safety can be jeopardized due to

- Focus group participants reported a lack of communication between providers. To quote Krista from Kingston: “Trying to organize it to get them all to work together was next to impossible. Nobody knows what the left hand is doing kind of thing.”
- You can read the full report on our website – [www.changefoundation.com](http://www.changefoundation.com) -- where you can also hear what some of the other patients and caregivers had to say.
- The Change Foundation will be conducting a second survey in 2010 – this time with health-care providers to gauge their perceptions of how integrated the system is.
- And now, a quick look at some statistics that suggest where we are in Ontario today on moving along collaborative care. First, though, to place Canada within the international community: In a 2006 Commonwealth Fund Survey of six nations, Canada was second last in the percentage (32) of physicians who reported practicing in interdisciplinary teams and dead last (22 per cent) on the use of non-MD clinicians. That same year, Canada also came last in the percentage of practices that routinely use non-physicians to provide primary care services – 25 per cent. And within Canada, in a Health Council of

Canada survey from 2006, Ontario was last among the provinces in the percentage of the population – 13 per cent -- served by primary care teams.

- The 2006 Health Care in Canada survey reported that 88 per cent of nurses strongly or somewhat supported a requirement that health professionals work in teams; 83 per cent for pharmacists; and 47 per cent for doctors. If you pull out indications of strong support only, the gaps are even wider: 59 per cent of nurses; 54 per cent of pharmacists; and 18 per cent of doctors.
- Another source – taken from the National Physician Survey, CFPC, CMA, and RCPSC – shows the percentage of family physicians who reported they do NOT collaborate with other health professionals. In Ontario in 2007, 43.6 % of family physicians in Ontario reported they didn't collaborate with nurse practitioners and 19.2 per cent reported they didn't collaborate with other nurses. Interestingly, only 8.6 % say they don't collaborate with pharmacists – but it's not clear from the data who is initiating the collaboration (or whether it's about calls to decipher handwriting!)
- The public appetite for collaborative care, according to a 2006 Pollara surveys, is strong. Almost 60 per cent of the Canadian public either strongly or somewhat supported the increased use of non-physician providers. Seventy-six percent of Canadian public is either strongly or somewhat supportive of requiring health professionals to work in teams.

And only 18 percent of doctors strongly supported that notion, while 54 per cent of pharmacists and 59 percent of nurses strongly supported it.

- You get the drift. The less-than-dizzying pace of change in Ontario is no doubt tied in part to the fact that primary health care reform is not a top government priority. The Change Foundation thinks this issue is foundational, so we dedicated our second *Meeting of the Minds* – called First Things First: Fostering accountable, connected, and quality primary care – to the issue. And we will be co-sponsoring a Policy Exchange on Primary Care with the highly regarded Commonwealth Fund in the spring of 2010. I would encourage you to watch the Foundation website for news on both. We have heard today that there is increased use of interprofessional teams within facilities and in the primary care setting – can the TriProfessionals and The Change Foundation talk about what might be done to link them?
- Over my 30 years in health care – whether working with the Primary Health Care Transition Fund, the Mental Health Collaborative, in Ontario hospitals, in District Health planning, or most recently with the Alzheimers Society of Canada – I have seen the need to break down this abiding barrier to better health care -- or to use the conference's more positive language – to open more doors.
- You are doing that, and I commend you for it. May I take this opportunity to formally thank The Medical Post and Pharmacy Practice for facilitating this conference and to recognize the leadership of the groups who came together to make it happen: the Ontario Pharmacy Association, the

Ontario Medical Association, the Ontario College of Family Physicians, the Nurse Practitioners Association of Ontario and the Association of Family Health Teams of Ontario.

- I wish you great success in the coming year, and look forward to the third annual conference – which I hope will expand the number of health professions with whom you are collaborating. And if hell hasn't quite frozen over by next year, maybe we can aim for a goodly drop in degrees. That seems to be how we do it in Canadian health care – by degrees, usually going in the right direction, with a cautious, but collective commitment to improve the health and the care of our patient partners.
- I will end with a reminder to sign up for our e-newsletter called *Top of Mind* – our latest issue is out this week, featuring several new reports and commentaries from The Change Foundation.
- Thank you again for the invitation and for hearing me out this morning. And now I would be happy to take any questions, comments, or push-backs in the time that remains. Thank you.