Health System of Tomorrow: Report of the 2015 CLPNA Think Tank
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CLPNA Think Tank: The Health System of Tomorrow

Overview

Imagine the health system of tomorrow. What role will hospitals play? What about home care? How will the work of Licensed Practical Nurses (LPNs) and other professionals be impacted?

Part of the CLPNAs mission is to provide leadership within the profession and support the evolution of a quality health system for Albertans. The think tanks are one way that Council provides a learning opportunity for LPNs and their partners and stakeholders.

For the third year, the College of Licensed Practical Nurses of Alberta (CLPNA) took an in-depth look at the changing health landscape and the role of LPNs. Attendees heard from local, national and international leaders on care that enriches people’s lives and draws on everyone’s energy and talents.

The day was moderated by Steven Lewis, who introduced the speakers for the day:

- Dr. Samir Sinha, Director of Geriatrics, Mount Sinai Hospital and Provincial Lead, Ontario’s Seniors Strategy
- Nancy Lefebre, Chief Clinical Executive and Senior Vice President Knowledge and Practice, St. Elizabeth Health Centre
- Eva Pedersen, (Retired) Head of Aged Policy Department, Ministry of Children, Equality, Integration and Social Affairs, Government of Denmark
- Carol Anderson, Executive Director, Continuing Care, Edmonton Zone, Alberta Health Services
- Penny Reynolds, Administrator, Capital Care Norwood
- Mike Hindmarsh, Consultant, Center for Collaboration, Motivations and Innovation (CCMI) Canada/USA
- Sergie Pekh, Audit Principal, Auditor General’s Office, Alberta
- Doug McKenzie, Audit Consultant, Auditor General’s Office, Alberta

Carl Amrhein, Deputy Minister, Alberta Health and Linda Demptster, Vice President, Collaborative Practice, Nursing and Health Professions, Alberta Health Services joined the panel discussion on Creating Alberta’s Ideal Health System, along with Dr. Sinda, Lefebre and Pederson. An additional panel on the LPNs of tomorrow was held with the following LPNs:

- Tammy Tarnowski, Site Leader, Two Hills Health Centre
- Quintin Martin, Staff Nurse, Acute Care Cardiology, Royal Alexandra Hospital
- Chloe Kilkenny, General Manager, AgeCare Communities of Wellness, Osteoporosis Canada, Educator Alberta
- Ashley Holloway, Practical Nurse Educator, Bow Valley College
- Teresa Bateman, Director of Practice and Communication, CLPNA

The Honourable Sarah Hoffman, Alberta Minister of Health and Seniors, closed the day.
Themes

Previous think tanks looked at the impacts of an aging population and compassionate person-centered care. The 2015 think tank built on these and addressed the big challenge: We know what needs to be done. Now we need to figure out how to affect real change that takes the system where it needs to go.

As professionals working as leaders, at the bedside and in the community, the role of LPNs has evolved. Throughout the day, speakers spoke to the system’s need for LPNs to champion the patient and help people articulate and realize their own goals for care. LPNs are well-positioned to know what needs to occur to make the system function more efficiently. They need to put forward their ideas on how to better monitor and declutter the system so that energy and resources can be freed up for direct care. When it comes to supporting people in living as well as they can, LPNs can take on the role of coach as well as care provider.

Involving the person in setting care goals and helping them retain function is key to maintaining and improving quality of life. The way professionals practice needs to be continuously rethought; for example, paramedics can deliver care in the community and emergency departments can identify who of the elderly coming to emergency would benefit from more home support. The challenge is to look around and use every encounter between the elderly and the health system to assess their state of well-being and ensure they have the resources they need. That requires better tools, including mobile apps to make assessment easier and information systems that alert other providers that one of their patients may be at risk.

It isn’t new to say that the system needs to be better integrated. What is new is how efforts are being made across the country to do better. Programs focused on integrating hospitals into the continuum of care. Rethinking the emergency room so that it doesn’t become the beginning of hospital induced deterioration – more washrooms, chairs that the elderly can sit in so they aren’t immobilized on stretchers, giving nurses the authority to remove catheters and get patients up to use the bathroom – the fixes aren’t dramatic in and of themselves, but their impact is profound in terms of improved outcomes and reduced hospital stay. Ambulatory services, emergency rooms, home care and inpatient care all need to be seen as steps in a journey that’s focused on the person’s own goals, whether that’s staying home, transitioning into another care setting or deciding that their life is at its end.

LPNs and other providers need to be leaders, disruptive when the status quo isn’t delivering the results it should, and unafraid to adapt as circumstances change and opportunities present themselves. System leaders need to engage staff in decision making and listen to their ideas on how to change policies and procedures so they better meet the goals of care. As one speaker said, we need to not only adopt new practices, we need to give up old ones.

At the end of the day, health is a team sport, said Steven Lewis. It’s not how much you spend, but it’s whether you are getting value for the money. The people on the inside know where the system is broken and we need to have respectful discussions about fixing it.
Hospital of Tomorrow
Dr. Samir Sinha
Director of Geriatrics, Mount Sinai Hospital
Provincial Lead, Ontario’s Seniors Strategy

The day began with a presentation by Dr. Samir K Sinha, a gerontologist with a reputation for broad level thinking on to improve the system. He opened by describing licensed practical nursing as the fastest growing, most important and least appreciated part of nursing. “Your work is at the forefront of where Canada needs to go and the future of nursing.”

Long term care is the fastest growing area of care in Canada. Older patients represent 60% of hospital bed days across Canada. Rather than focusing on the hospital stay, the emphasis needs to be placed on primary care and ensuring that hospital stays support the return of people to their home. Home-based primary care can reduce the elderly’s reliance on hospitals, increase quality of life and reduce costs.

The American Longitudinal Study on Aging found that consistently high users of the system had chronic diseases that require hospitalization without good community care. High users are medically complex patients, have functional impairments (inability to do one or more of the following: transfer from lying to standing, walk to bathroom, toilet, wash, dress and eat something), and are socially frail i.e. don’t have family or a friend who can help them with basic tasks. We need to think about all these issues at the same time in order to help people stay healthy and remain self-reliant.

Sinha outlined five barriers to integrating care for older adults:

- We do little to empower patients and caregivers with information they need to navigate the system
- We don’t require current and future health or social care professionals to learn about caring for the elderly
- We don’t talk to each other well within and between sectors and professions
- We work in silos and not as a system
- We plan for today and not tomorrow with regards to understanding the mix of services we should invest in to support sustainability

The cost of these barriers is high. The most complex 10% of older adults account for 60% of Ontario’s spending; the least complex 50% account for 6% of collective health care spending. Change will require a shift in how we think about acute care and redesigning or establishing sustainable approaches. We need to look for who needs interventions in order to maintain their independence. Dr. Sinha spoke about the Mount Sinai Hospital Geriatric Continuum of Care Model that integrates ambulatory, community, emergency and inpatient care. The model ensures that every senior who comes into emergency is assessed with a focus on getting them back home. We can’t just focus on the four walls of the hospital,
said Sinha. Every aspect of our care walls touching upon other care. We can’t just talk about the hospital of the future; we have to think about care systems.

Dr. Sinha outlined several programs that are showing benefits. For example, Ontario has launched a Hospital At Home model, where care such as an IV is brought to the person’s home. It costs less, the risk of complications is lower, mortality at the end of six months is lower and patients are more satisfied. Other programs are changing the role of paramedics, who often see frail older adults in their own homes in pre-emergent situations. In a community paramedicine model, paramedics are empowered to provide referrals and assessments. Assigning a home care coordinator with responsibility for a reduced number of clients can benefit elders with the most complex issues by focusing on their needs.

Dr. Sinha is also working with hospital designers to improve the care provided in emergency for elderly patients, including more bathrooms with easier access and ensuring they aren’t catheterized. Space is also provided for chairs so people don’t have to be on stretchers.

Geriatric Emergency Case Management is being introduced in Ontario that focuses on improving care in emergency to the elderly. Alert systems send geriatricians and other providers an email when one of their clients is in hospital and the virtual team can readily consult with each other.

Once hospitalized, proactive inpatient consultations teams and acute care units for elders have developed that include patient-centered care, frequent medication review, prepared environments and comprehensive discharge plans. The care model didn’t require additional resources. Rather, it involved the reallocation of resources and increased training. Home care agencies become a key partner with the unit. Nurses take the lead on many care aspects and are empowered to take steps to ensure that patients are on a trajectory that will see older patients returning to home and improving their health status. For example, the “Holy Moley, my patient has a Foley” strategy gives nurses the ability to remove catheters when the patient can get up to go to the bathroom.

Key Takeaways:
- The hospital of the future has to be seamlessly integrated into the continuum of care.
- We need to look at how professional’s skills are engaged. Alberta LPNs have mandatory training in geriatrics and dementia care – the first in Canada.
- LPNs need to take a leadership role:
  - Ensure leaders understand the contributions of LPNS
  - Establish nursing led models of care
  - Encourage best practices
- Geri-EM.com is a free training site that can be used to provide training in the principles of geriatric care.
Are You Ready for the Future of Home Care?

Nancy Lefebre, Chief Clinical Executive and Senior Vice President Knowledge and Practice
Saint Elizabeth Health Centre

Saint Elizabeth describes itself as a health care provider, pioneer and social innovator with a goal to empower people to understand, manage and own their health care. The not-for-profit social enterprise organization has focused on innovation, programs diversity and knowledge and training and believes that short of surgery everything can be delivered in the home and that surgery may be next.

Lefebre said that to understand the future of home care, we need to understand the future of the world. We have to stop looking at home care as a silo and look at the system. We also need to look at people receiving care as unique individuals. The key drivers for the future are:

- Saving our world by addressing climate change through individual actions such as recycling/reducing/reusing and mindful energy use. Less driving, for example, will drive better use of virtual health, tele-home monitoring and smart device use. We will change from “The doctor will see you now,” to “I will see the doctor now.” We will use fewer diagnostics, fewer people and get back to the basics as we move forward. Disposable products will cease to exist and people will manage their own health, their own health records and engagement with the system. This will mean health care providers will need to be leaders, adaptive and disruptors of the status quo.

- Everything. Everybody. Everywhere: The construct of geography and borders, Lefebre said, is becoming irrelevant in a connected world. We need to redefine the home as less about the four walls of the home and more about the context. What does home mean and how do we create the meaning of home regardless of where we are?

  Everything, everybody, everywhere also applies to who has information and who has knowledge. People can readily gather information and be in a very different place when it comes to determining their care. Providers will need to be flexible and learn along with their clients and patients.

  Health care workers will need to be knowledge workers, educated and able to learn. Research will be faster and iterative; we will use new information as we gather it. It will be done in the community and providers will need to be able to work with community based knowledge generation and research.

- People are the third driver. Lefebre believes the most important information is found within us. People like to monitor and have a say in their own health and advanced electronic services can give people more options. New data can give people increased opportunities to impact their health. For example, by giving people information on their genetic makeup, they can make lifestyle decisions that will better impact their health.

  Our behaviours in the system will be driven by what people want. We need to move from nursing to health promotion. People going to hospital will go home sicker and quicker or will
remain in their home. The future will not have the person at its centre but instead, people will move in and out as they choose.

Saint Elizabeth has developed an online community of care called Tyze which can be personalized and used to engage the individual with his or her caregivers and support network. They are also reimagining virtual care, remote engagement and mHealth. They’re working on mobile applications that help teens monitor blood sugars and diabetes care, for example.

Key Takeaways

- Health care providers will need to be leaders, adaptive and disruptors of the status quo.
- We need to move beyond the traditional four walls definition of home and think instead of a home-like context for home care.
- Funding models aren’t keeping up with the changes. As we move forward, people will push for new models of care and that should drive changes to funding.

A New Practice for the Health System of Tomorrow: Restorative Care and Wellness Strategy

The Denmark Example

Eva Pedersen, (Retired) Head of Aged Policy Department, Ministry of Children, Equality, Integration and Social Affairs, Government of Denmark

Denmark is a leader in deinstitutionalizing people and care. Denmark now has a ministry of Health and Elderly and Pederson described it as a signal for how we must proceed; it sends a strong message of the importance of integration.

Pedersen began by talking about how when we look ahead, we should look at where we came from. One hundred years ago, people didn’t live long after retirement, so when the welfare state decided that retired people should live comfortably, support was envisioned for two or three years, not the 20 to 30 years people they live beyond retirement now. The need to provide better elder care in Denmark is also driven by fewer people with time to care for family members. In Denmark, female labour participation rates edge toward 100% and women are not available to look after parents and grandparents.

The Danish system provides universal access to services and basic old age pension with no or limited copayment. Services are tax financed and private providers play a minor role. Municipalities deliver, pay for and plan home care services. They are able to set local standards and determine how to meet them.

Denmark focuses on restorative care. The underlying premise of restorative care is that you take the person into consideration and do things with the elderly, rather than for the elderly. If it saves money, fine, but the focus is on improving care. Restorative care isn’t about what professionals think is best for the person, but instead includes them in the conversation about what they believe will be best for themselves. People may be frail and impaired physically, but have a clear sense of what they would like. If we don’t ask them, we won’t learn what they would like.
Pederson gave the example of a 90 year old who had done errands for others on his scooter and lived an engaged life until a fall. The fall turned him from being an asset to his community to being dependent.

There were two ways of meeting his needs going forward: supply a full package of care or investigate ways of improving his condition through physical training and assistive technology.

The choice made depends very much on your attitude towards the elderly. This gentleman wanted to be able to drive his scooter and be part of his community again. He didn’t care about cleaning his own house anymore, however. The gentleman received training in relearning to walk and ride his scooter, along with more home supports. He was very happy to be given the opportunity to focus on mobility and his social life.

If you’re content with your social life, Pedersen pointed out, you are more likely to participate and care for yourself. In this instance, the restorative care paid off in quality of life and the quality of the community around the person.

**Key Takeaways**

- In the future, in order to ensure adequate care that meets the needs of the individual, we need better gatekeepers who have improved screening and assessment tools. As well, we need improved cooperation between sectors and improved training.
- We need to engage the elderly in discussions about what their goals are and focus on what makes their life meaningful.

**Restorative Care: The Edmonton Example**

Carol Anderson, Executive Director, Continuing Care, Edmonton Zone, Alberta Health Services

Penny Reynolds, Administrator, Capital Care Norwood

The question facing health systems world-wide is how best to meet the needs of people looking to live at home and live well. To that end, AHS is reframing the continuum of care and ensuring that the right care is provided in the right place with the right team.

In one restorative care project, AHS looked at people assessed as needing long term care or supportive living and found many could be supported at home. An Edmonton Zone Rehabilitation and Restorative Care Committee was established and tasked with developing a model to apply restorative care principles focused on maximizing client outcomes and functional abilities. The strategy was aligned with the Zone’s 2030 Plan, Alberta Health’s Dementia Strategy, CoAct, Destination Home and Elder Friendly Care.

Hospitalization is hard on the elderly. AHS worked on introducing restorative care into the hospital system with the goal of discharging people to the lowest level of care and having them back in their homes when making decisions about where to go next. This meant putting people and their family at the centre of the care team, better evaluating the individual’s ability to participate in their own care,
setting individualized goals within 24-48 hours and doing a baseline measure of functional status on admission and discharge.

A restorative care centre was established at Capital Care Norwood. When people come into the program, goals are established within the first two days. These goals and plans for reaching them are written down on a whiteboard by the bedside. That allows everyone to easily see and participate in achieving those goals. The potential discharge date is also set when the goals were established and noted on the white board.

Services are provided seven days a week, including rehabilitation, which had previously been available only on weekdays. Staff were asked to be active participants in program design. Changes being proposed were supported by evidence and staff were involved in the thinking around why the changes were being made. Education was provided to staff and they were involved in developing staffing models, rotations and information packages. The model evolved and fine-tuning and changes were part of the process; things were not set in stone.

In addition to staff, the individuals in the program are involved in determining how best to meet their goals. As Reynolds said, “We try to get people to the point of the best that they can be.” She added that “LPN knowledge and problem solving skills are an integral part of the team.”

People participating in the program on average are 80 years old with complex care requirements. Through their participation, 88% improved their functional abilities, 49% returned home, 21% were admitted to supported living and 17% returned to acute care. Staff identify the work as very rewarding. Next steps will include looking how to avoid people going to acute care and whether working with home care can help identify people who would benefit by restorative care without entering into acute care.

Key Takeaways

- Involving staff in program design and being open to adjusting as new ways of doing things are discovered improves program quality and staff morale.
- We can do better and LPNs can lead the way. LPNs are learners, leaders and mentors, trusted by clients and families.
- LPNs can identify opportunities to help people reach their goals.
- LPNs need to share stories of successes and provide people with new visions of what they can achieve.

Up to 65% of people over 65 who are independently able to walk will lose that ability during a hospital stay.
Panel Discussion: Creating Alberta’s Ideal Health System of Tomorrow

Dr. Samir K. Sinha, Mount Sinai Hospital
Nancy Lefebre, Saint Elizabeth Health Centre
Eva Pedersen, (Retired), Government of Denmark
Carl Amrhein, Deputy Minister, Alberta Health
Linda Dempster, Vice President, Collaborative Practice, Nursing and Health Professions, Alberta Health Services

Panel members were asked to address what should be done in order to move from where we are to where we ought to be.

- Eva Pedersen: The way we see the elderly has to change. We tend not to recognize their potential and forget that they have wishes, dreams and potential, regardless of their age. The most important thing is to recognize this in your daily work. There are many categories of the elderly: the young old, the old old, the frail old, etc. They have the same ideas and personality as they did before. While people with dementia will need more attention, we still have to recognize that they have wishes and desires.

- Nancy Lefebre: Our financial and incentive models need to catch up with new delivery models. We need to look at the three Ps:
  
  o People: Start with looking at people in their own homes as vibrant individuals in the community and engage them on what they see their goals are. Our metrics can be misaligned: people may value the social benefits of care more than the medical goals.
  
  o Paradox: We look to the system for answers that reside with the individual. We look at system experiences when we should look at what the experience is for individuals. We bring lots of people to the table but don’t look at how we can co-create a system. We have to move from a system focused on the sick and move to one focused on the well.
  
  o Politics: We need to park the politics and focus on doing the right thing.

- Dr. Sinha: You have to take an optimistic view in geriatrics. It’s tough but there is a lot of joy in our later years. Alberta needs to figure out on what few things it needs to do in order to move forward. People have changed but the system isn’t moving forward with them. When you look at the opportunities, they are significant. If we take a wellness approach, we start to ask what we need to do in order to be healthy and well. For example, Ontario created free fall prevention and exercise programs. It cost $10 million, but $750 million is spent each year responding to falls. The program also reduces social isolation. In Ontario, caregiver stress has doubled in the past five years, which says home and primary care are not doing enough to meet family needs.

- Linda Dempster: We need to recognize the incredible strengths seniors have and ask them for their participation in care. We need to look outside of health care for innovative ideas. We need to be co-creative with others outside of health care. For example, we have a project with art and

If we get the system right for the elderly, we will get it right for everyone. Dr. Sinha
design students and are discovering new and innovative ways of doing things. Barbara Anne D’Anna says that “Most nurses would probably be very surprised at the amount of leverage, steering capacity, autonomy and decision-making power that resides in their hands.” In Alberta, we are working together with all parts of the nursing profession to develop a vision that will work well for the province and the profession.

- Carl Amrhein: Our minister talks about the four Rs: Right care at the right time at the right place delivered by the right health profession. I also add the 5 R: the right information necessary to deliver on the other Rs. When someone is already a patient, you are already part of the system and not really outside it. We need person-centered care that looks at the needs of people outside the context of the system. We also need to define what home-centered health care looks like.

We need you to work with us to define the concepts that will shape the future. We need to use professions at the full scope of practice, yet not all are able to work at their full scope. If we are going to bend the cost curve down, then we have to use everyone’s skills appropriately. There are a lot of beaver dams around the system which stop the flow of people; we need to identify and remove them. We need to move on this in the next 18 months. Send me your perspective on where the barriers lie and what can be done at carl.amrhein@gov.ab.ca.

With regard to emergency room backlog, we should not be surprised because we send people to the emergency as their first fall back option. If we can better align the primary health care/primary care system with the acute care system, we will be able to do better for the people of Alberta. We need to organize and better identify what primary care is within primary health care. Our solution will have to be a solution customized to Alberta. We can learn a lot from different jurisdictions, but solutions will need to be modified if they are to succeed in Alberta.

Comments during Question and Answer Session

- It’s important that there is buy-in to whatever policy is implemented.
- There needs to be integration between social and health systems. We could use resources more efficiently and get better results by better integrating and investing in social services.
- A population that is aging healthier and living longer is a measure of success as a society. We need to think about the journey that seniors are on and every step of it, similar to the work that was done in Alberta a few years ago as part of the cardiac access continuum.
- Pilot projects are good ways to test new ideas and approaches. The opportunities for success lie in understanding ‘demonstration projects’ and asking how it fits within the overall story. How does it enable us moving towards our overall goals? For example, Ontario is looking at increasing flu vaccination not just by having the vaccine available in pharmacies but also as part
of the expanded use of paramedical services. Figure out the vision and then build the vehicles for delivering on it.

- We need to not only adopt new ways of doing things, we need to give up old practices.
- It isn’t just full scope of practice, it is full scope of health care and place of practice. We need to ask who needs to be where.
- We need to focus on ‘releasing time to care’ and streamline processes. There are great examples about how to do that, for example, a ‘residents first’ initiative where staff got together and talked about what they needed to do. In one small care home, they were able to release 12,000 hours of time and refocus it at the bedside by decluttering the paperwork. Staff are saying to us: “I can champion things, but I’m drowning in policies and paperwork.”
- Government is looking at the policies around placement and housing. Home care and housing are policy areas involving more than seniors. Balancing the needs of a system, the rights of an individual and the capacity needs of the system is very difficult.

An Auditor’s Perspective on Health Care in Alberta
Sergie Pekh, Audit Principal, Auditor General’s Office, Alberta
Doug McKenzie, Audit Consultant, Auditor General’s Office, Alberta

The Auditor General of Alberta (AGA) looks into programs wherever provincial dollars go. It does financial audits as well as systems or value for money audits. It asks what the Government of Alberta gets for the money it puts into the health system and what is the outcome for individuals receiving care and services from the system. Areas of health care that have been audited include chronic disease management (CDM), mental health services and seniors care.

The AGA concluded that there’s an incontrovertible case for managing chronic like a business, putting in systems and information technology, linking people with care teams, and planning and evaluating programs. Dramatic action needs to be taken now: Chronic disease is very widespread. In 2013, it cost 4.5 billion in Alberta to treat the chronic diseases of approximately 735,000 people. People with poorly controlled chronic diseases account for 75% of the costs.

CDM involves continuity of care, a care plan and a care team; good information systems; and patient engagement. From what the AGA has observed, change is driven from the ground up. LPNs are key providers and can be catalysts to support efforts to provide outcomes. If LPNs can put forward a business case that shows that LPNs are making a difference in care, it will help ensure that investment flows into providing their services.

The AGA’s findings indicate that there is a lot of system work that needs to be done in primary care. There aren’t good accountability and tracking systems. Optimal team composition hasn’t been established and physicians aren’t practising in optimally-sized teams. Albertans don’t understand
There is a ratio of about one multidisciplinary provider to every four doctors in a primary care network and the ratio should actually be reversed. There are big information sharing gaps between primary care offices and the rest of the system. Patients are not involved in their care and as yet don’t have access to their information, although the plan is that by 2016 people will have access to the Alberta health portal.

On mental health, the Auditor General found coordination at the front line level is weak or non-existent, with multiple uncoordinated care plans and little or no shared information. If information is not available at the point of contact, the health care system is acting like the individual is not their patient. There is no integrated case management and the system is still running in siloes. For example, people in AADAC still don’t have access to medical records, yet half of people with mental health issues have addiction issues. When coordination in the community fails, people with a mental illness show up in emergency and it ends up being AHS’s cost and issue. Therefore, AHS has a role in the coordination of care in the community.

With regard to long term care, the AGA found that there is little accountability for carrying out care plans and ensuring that there is the right complement of people in care. Facility oversight is fragmented and complex; while there are many eyes, there is little coordination or sharing. Nobody in the health system is going into long term care and assessing whether overall performance is acceptable and it’s difficult to identify high risk facilities.

The AGA has seen a lot of good practices and innovations. Somebody needs to make a call on how things need to be done and move forward. Leadership and action is needed at the system level.

**Key Takeaways**

- Making a difference in chronic disease will come one patient at a time.
- We’re enjoying longer life spans but not more years of good health.
- We need to set clear expectations and hold providers accountable for outcomes.
- LPNs can make the case for being effective members of the primary care team.
- Because we don’t coordinate information about patients, the system acts like the individual is not their patient. This is wrong. The first and ultimate question that needs to be asked is will information sharing benefit the patient or individual? When people say that there is a privacy issue, is it truly a matter of privacy or is resistance to change and to accountability?
- There isn’t a great deal of coordination between different care plans. People can have pharmacist care plans, physician care plans, and physiotherapy care plans, for example, but no overall care plan.
Improving Chronic Disease Outcomes through Self-Management Support

Mike Hindmarsh, Consultant
Center for Collaboration, Motivations and Innovation (CCMI) Canada/USA

Hindmarsh commented that many people receive multiple points of care that aren’t integrated and where the person is never really cared for in the way they need to be cared for. The acute care system does a good job of acute situations but doesn’t handle chronic disease management well at all. Lack of education on how to use the system is part of the problem. People know how to use the bank, the grocery store, but aren’t educated about how the health system works. The answer isn’t more projects; there is a lot of research and data available. We need to figure out how to change our system while we continue to operate it.

We need to use evidence based outcomes, we need a quality improvement strategy, we need to implement a chronic care model and we need a way for people to learn how to do this. The Chronic Care Model or Wagner model is a synthesis of what the research says is needed. With that you will get an informed activated patient interacting with a proactive care team.

You also need to have an action oriented learning strategy – when you give people tools to try things, you get more change occurring. Use the Plan Do Study Act model to test out quality improvement, not pilot projects.

Self-management support is critical and needs to be provided by the practice team at every encounter. This doesn’t mean issuing threats because they don’t work. The patient’s goals are paramount. Patients need to feel confident and effective in their care. They need to see success. Building confidence will take time, but if people understand self-management and the provider’s role, they will be able to pick themselves up and move forward. The old model is telling patients what to do, but it’s about guiding people versus directing them. It’s about coaching; it’s like dancing with a patient instead of wrestling them down.

Providers need CAPE: Compassion. Acceptance and seeing the person as worthy. Partnership. And Evocation - Eliciting wisdom or insight, finding these things within and drawing them out from the person, rather than imparting them to the person.

Another tool is brief action planning, a highly structured patient centered approach. It isn’t about a lengthy plan. It starts by asking the patient what they would like to do in the next week or two to improve their health. Then it sets out SMART: Specific goal, measureable, achievable, relevant and timed. Patients are asked for a commitment statement that the provider repeats back to them. Follow up with the patient is done in a week or two to see how they’re doing.

Self-management is “the individual’s ability to manage the symptoms, treatment, physical and social consequences and lifestyle changes inherent in living with a chronic condition.” Barlow et al, Patient Educ Coun 2002; 48: 177
Hindmarsh also recommended taking a look at the role of health coach and whether that can be part of your team. This is a role ideally suited LPNs working in the community. A health coach is a care and self-management supporter who assesses health status, helps patients set agendas for the clinician visit and makes sure patients understand what the clinician wants them to do. They also determine whether patients agree with their care plans and provide support in improving medication understanding and adherence. The health coach acts as a culture bridge, point of access and supports their patients. 


Key Takeaways
- We have to think about quality improvement as something that everybody does on a daily basis.
- While everyone on the team needs to provide self-management support at every encounter, someone on the team needs to be assigned the role of self-management support lead. Otherwise it’s everyone’s responsibility but no-one is accountable.
- Confidence changes chronic disease conditions.
- Respect the autonomy of the patient. They actually don’t have to change.
- Effective teams don’t work in silos. The team assesses delivery of care, provides proactive planned care each visit and self-management support systems are integrated into clinical care.

LPN Panel on LPNs of Tomorrow
Tammy Tarnowski, Site Leader, Two Hills Health Centre
Quintin Martin, Staff Nurse, Acute Care Cardiology, Royal Alexandra Hospital
Chloe Kilkenny, General Manager, AgeCare Communities of Wellness, Osteoporosis Canada, Educator Alberta
Ashley Holloway, Practical Nurse Educator, Bow Valley College
Teresa Bateman, Director of Practice and Communication, CLPNA

- Tammy Tarnowski: You need integrity, professionalism, the ability to lead a team and think outside the box. All professionals need to work together and LPNs need to transform the system. LPNs need to continue to hone their skills by diversifying their skills and empowering themselves to be the best you can be.
- Quintin Martin: As an LPN, I have the ability to work to my full scope of practice. I can take actions that save lives. Collaboration with an interdisciplinary team is critical, but so is being able to work independently. Education is one of the most important tools. The skills, knowledge and ability to think critically will influence nursing and the system in a positive direction.
- Chloe Kilkenny: LPNs are well equipped to contribute their competencies to the health system and increasingly complex health care needs. They provide diverse skill sets and can work with the full care team and relieve pressure on urgent care sites. One of the challenges is that employers aren’t always aware of the contribution that LPNs can make and this slows the ability of LPNs to contribute to their full scope of practice. I have had the opportunity to work with private and public organizations, Ronald MacDonald House and Masterpiece in Calgary to coordinate care with other disciplines to develop strategies of care.
• Ashley Holloway: I’ve had a varied career, largely due to employers who have supported me. I started in acute care and couldn’t see being other than at the bedside, yet decided to move into education. Multi-disciplinary collaboration is a theme that has been heard today, but we are trained in silos and those need to be bridged so that people know how to work together. I’ve been an LPN for ten years and in the military for about the same amount of time. I work in patient simulation and am enrolled in a Master’s program in health administration. We do some pretty amazing things and it doesn’t get recognized enough.

• Teresa Bateman: I’m excited to be part of the CLPNA and am excited for the future. As a regulator we are focused on competence development, advanced education, and excellence. Next year is the 30th anniversary of LPNs being self-regulated. The mandatory education upgrade in the 90s has transformed the way the profession thinks of itself. We can keep well-grounded as LPNs and grow in our profession. We are focused on the needs of the consumer of health services for tomorrow. We are looking at a more modern regulation that will meet the needs of the profession today and tomorrow. We have a goal to engage and empower the LPN to influence policy development. The goal is empowered professionalism and helping LPNs reach forward with education.

Partnerships are important, for example with practical nurse educators, with the new competency profile, geriatric care, community health and mental health and addictions. Employers are increasingly on board with the enhanced competency profiles. LPNs are seeing doors opening into management and team leadership; assignments are being based on competence, not credentials. This means that we are placing the right person into the right place at the right time. LPNs are embracing the change and demanding the opportunities in every corner. We are all focused on patient focused care. It’s exciting to be an LPN today.

Key Takeaways
• Because the LPN scope has restricted activities and continuing competencies, LPNs are part of a continuous education process from the beginning of practice. LPNs have good insight into their role and are always engaging in education to keep up with the system.
• Teamwork has evolved greatly. There is less differentiation between RNs and LPNs and more collaboration and working together.
• There is an education difference that between LPNs and RNs that LPNs need to honour. We should be proud to be LPNs and focus on our role in the team. The team includes porters, unit clerks, health care aides and RNs. Recognize the need to hand off care to the higher level.
• Focus less on the money and more on giving the right care to the right person at the right time with the right resources. It can’t be all about the money. There has to be passion.
• When we look at scope of practice, health care aides are getting much the same education as LPNs did 26 years ago. Growth is mandatory and not an option. We speak to fourth year RNs about scope of practice and in those discussion today’s registered nurse is a very different thinker than yesterday’s RN. This is as true as it is for today’s LPN vs yesterday’s.
Many organizations recognize LPNs as the right team leader and that they can’t afford to waste your resources. As an RN, I’m very impressed by the calibre of LPN clinical skills and professionalism.

LPNs are managing SL4 level units in supportive living. We are getting better at supporting LPNs in those roles, and they have made a huge difference in the care environment.

How have you moved through the barriers?
- My successes are attributed to the mentors I have had. My coaches have been incredible, as has the support of the CLPNA.
- Clinical nurse educators and others on the same line have been very supportive.
- I’ve had employers recognize that “I’m your sustainability.”
- Full scope looks different in different settings. There is variation.

What is the one message you would give?
- Have confidence in your skills.
- Never stop learning and recognize that there is a lot to be done within the role of LPN.
- Keep advocating for the profession. Never stop.
- Never lose your passion for being an LPN and always have confidence.
- Be you. Be authentic. Connect to your nursing self and wear white on the inside. Show up as the professional you are.

What is the one next body of knowledge we need to know more about?
- Alternative complementary medicine
- Dementia care
- Primary care – we need to know more about PCNs
- Professionalism. Stand firmly under the umbrella of your regulatory framework and represent LPN practice through your own professionalism.

Observations on the Day
Steven Lewis, Health Policy Consultant and Think Tank Moderator

At the end of the day, this is a team sport, said Steven Lewis. It’s not how much you spend, but it’s whether you are getting value for the money. The people on the inside know where the system is broken and we need to have respectful discussions about fixing it.

There is a vast untrodden terrain out there: how are we going to take care of the long goodbye, the end of life. This is where the biggest gains are going to come and where the unglamorous demand is going to be. This is the frontier and the system will live or die on the basis of whether we make that better. It’s slightly more important than primary care and highly specialized care, where the complexity may outweigh the benefits of medical wizardry.

I hope, said Lewis, that you will acquire the competencies you need: the attitude, the ability to listen, the professionalism, your leadership. Use your voice. There can never be enough advocates for the public interest and the public good. We can’t focus all our resources on the glamour parts of health care. As social activists, you have a tremendous role to play. LPNs are prototype Canadians. Professions that require long arduous education journeys are not accessible to many Canadians. Your profession is an important pathway for many into the health system. We need you.
Sarah Hoffman, Minister of Health and Seniors

Linda Stanger, Executive Director, CLPNA, introduced Minister Hoffman as a person who is compassionate, a doer, a mover, a shaker and a listener. The Minister spoke to how honored she was to be asked by the Premier to be health and seniors minister. All of us as Albertans have stories about the care that we have received personally and as a family, she said. It’s about the value of the individual and supporting people in caring for themselves and loved ones so people can live their lives with respect and dignity. “We were elected to provide stable front line care and to do my job well, I need you to be able to do your job well.” We know we need to bend the cost curve, said Hoffman, adding, “I won’t be part of a government that balances its budget on the backs of teachers and nurses.”

Questions, Answers and Input to the Minister

- There seems to be a stigma about private care but often it’s a partnership between private and public care that doesn’t provide a lesser level of care. How do we deal with that?
  - I would aspire to treat my staff to treat my staff with the same respect as they would find in public care. Use the family councils. Encourage participation. It provides confidence in the people who use the services.
- Working with LPNs and RNs is almost seamless. It is frustrating to go to an adult unit and use more of my scope there than in pediatrics. It’s a management choice, not a competency issue. Using LPNs to full scope of practice in pediatrics would save money.
- There is a lot of frustration in rural, isolated Alberta that it isn’t getting the same level of resources. A lot of care gets delivered elsewhere and it’s a burden on the population.
  - Equal isn’t always fair and sometimes there needs to be more effort put into ensuring the right care is being provided. One of my drivers is putting more money into the front line in the zones.
- We need to talk more about prevention, like giving free passes to kids to rec centers and encouraging more community gardens. We also need a unified health record.
  - There is a lot of work done in other ministries that focus on wellness, such as FCSS.
  - Hospitals, physician compensation and pharmaceuticals are the big cost drivers in Alberta Health. Anything we can do to keep people out of hospital, away from doctors and not needing drugs is huge.
- What is your opinion on community street nurses?
  - A big piece of improving health is stability. I named a board to ensure that there would be more eyes on the system. Providing care where needed is based on good values.
- How do we get some optimism back into the front line?
  - Respect earns respect. People who enter the health care want to take care of each other. Sometimes we get stuck in a system that doesn’t let us do that.
  - One of the new AHS board committees is going to be focused on community engagement - and community includes staff.
Conclusion

Adapt. Lead. Innovate and above all, involve people in their own care plans and goals.

The 2015 Think Tank focused on the health system of tomorrow, but delivered timely messages to the LPN practicing today. You need integrity, professionalism, the ability to lead a team and think outside the box. Empower yourself to be the best you can be and be able to work independently and as part of team. The goal for LPNs is empowered professionalism. Be the one that insists that the individual’s voice is heard.

The health system of tomorrow will be based on the paradigm shift already underway – an emphasis on community, the person and not the system, teams and not silos. The CLPNA continues to work as a leader in advocating for care that uses the competencies of all professionals to deliver better, more effective and efficient care. LPNs are an important part of the mix of care and increasingly, taking on leadership roles at the bedside, in the community, and in the ranks of health system planners and managers.