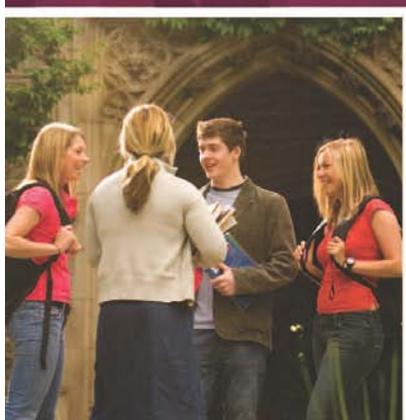




DIALOGUE
SUMMARY



DEVELOPING A RURAL
HEALTH STRATEGY IN
SASKATCHEWAN



17 JUNE 2010

EVIDENCE >> INSIGHT >> ACTION

**Dialogue Summary:
Developing a Rural Health Strategy in Saskatchewan**

17 June 2010

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at the regional/provincial level and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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Conflict of interest

The author declares that he has no professional or commercial interests relevant to the dialogue summary. Select staff of Saskatchewan Health and select Health Regions reviewed a draft dialogue summary, but the author had final decision-making authority about what appeared in the dialogue summary.

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SUMMARY OF THE DIALOGUE

Dialogue participants generally agreed that Saskatchewan does not have an integrated approach to addressing the healthcare challenges faced by those living in rural areas. They also generally agreed with the many features of the problem that were described in the evidence brief. Dialogue participants identified several additional features of the problem, including: 1) silos within government and across levels of government; 2) inadequate education of healthcare professionals in rural communities and in teams; and 3) inconsistent application of scope-of-practice legislation. A number of dialogue participants expressed concern that local community efforts to build healthcare centres often were not sustainable, created an unhelpful competitive dynamic among communities, and left communities with equal needs with very unequal levels of service.

Most dialogue participants were drawn to option 1 (supporting self-management, ‘aging in place,’ and healthcare-related travel), which was seen as a natural extension of “patient first” principles, and option 3 (optimizing the use of healthcare professionals and interprofessional teams), which was seen as the mechanism to get the healthcare system to operationalize these principles. As one dialogue participant commented, “we need to create the will to focus on the patient, and the teamwork that it takes to care for and support each patient effectively.” Dialogue participants introduced two option elements that hadn’t been addressed in the evidence brief: 1) creating sub-regional centres that serve a number of small rural communities in a defined geographic area and from a base located between communities, not within any given one; and 2) continuing to address silos within government and across levels of government and to advocate for more integration in health and human services.

The key implementation considerations identified by dialogue participants included the importance of: 1) taking advantage of the common sense of purpose created among influential doers and thinkers by the Patient First review; 2) building partnerships within and across communities; and 3) engineering a shift from the current crisis-driven culture (among leaders, healthcare providers and communities) to a culture of coordinated and proactive planning that is accompanied by the alignment of resources to those partnerships that can operationalize the resulting plans, and by clear consequences for those partnerships that fail to do so.

Dialogue participants generally agreed that any rural health strategy would have to be developed through a Ministry-led process, but they: 1) emphasized that the motivation for the strategy had to be a “patient first” (or “customer owner”) orientation, which would capitalize on the goodwill created through the Patient First consultations and report, even if the provincial and national economic situation had to be acknowledged as an important backdrop for the strategy; 2) reiterated that the strategy-development process should incorporate citizen engagement and the identification of compelling stories about how rural healthcare can be accessed and delivered more consistently and reliably in a way that meets patient expectations and improves health in a cost-effective manner; 3) highlighted that the strategy mustn’t be the “same old, same old,” but instead should outline bold initiatives that leave room for local flexibility; and 4) suggested that the implementation of the strategy should build and capitalize upon leadership at all levels of the system in order to foster a culture change within the system, support initiatives that are likely to be effective and sustainable and the partnerships that can best deliver them, and counter possible opposition from health system stakeholders and policymakers with a more exclusively ‘acute care’ mindset. Examples of bold initiatives that were proposed included significant emphasis on and supports for self-management; interprofessional and distributed education; geographically defined sub-regional primary healthcare centres with performance-based payment, information technology support, telehealth and flexible specialist outreach supports; and streamlined and coordinated referrals and after-care.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Dialogue participants generally agreed with the general statement of the problem – Saskatchewan does not have an integrated approach to addressing the healthcare challenges faced by those living in rural areas – and with the more detailed description of the multi-faceted nature of the problem as described in the evidence brief. In particular they agreed that: 1) chronic diseases are a significant and growing challenge in the province; 2) effective (and cost-effective) programs and services, such as primary healthcare, chronic disease management, self-management supports and cardiac rehabilitation, are not always reliably and consistently available or accessible to those living in rural areas; and 3) a variety of gaps in existing delivery arrangements (e.g., inequitable distribution of primary healthcare physicians, limited scopes of practices of other types of healthcare providers, and the lack of supports for travel to urban centres for care) and financial arrangements (e.g., significant use of contract labour and overtime compensation and of travel to receive care) likely contribute to effective programs and services not getting to those who need them in rural areas. With regard to chronic care, one dialogue participant noted that “people will travel for episodic care, but for someone requiring ongoing care for chronic renal disease” it’s a different story.

Several dialogue participants lamented that the evidence brief did not focus on the determinants of health, such as poverty and housing. However, over the course of the deliberation about the problem most dialogue participants seemed to accept the argument put forward by one dialogue participant that “if you try to solve it all, you won’t solve anything,” and that “we need to ask what are the first five things to fix in how we allocate healthcare resources” that have or could have an impact on rural health. They also agreed that they would need to keep working with other agencies and ministries to address deep-rooted problems like teenage suicides and tuberculosis, and to keep “thinking outside the system as it’s currently designed.”

Dialogue participants identified several additional features of the problem:

- silos within government (especially for addressing the social determinants of health) and across levels of government (especially for First Nations populations and for initiatives like electronic health records), although some dialogue participants felt that these issues were less significant than they once were;

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

- 1) it addressed an issue currently being faced in Saskatchewan;
- 2) it focused on different features of the problem, including (where possible) how it affects particular groups;
- 3) it focused on three options (among many) for addressing the policy issue;
- 4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three options for addressing the problem, and key implementation considerations;
- 5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible options for addressing it;
- 6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
- 7) it ensured fair representation among policymakers, stakeholders, and researchers;
- 8) it engaged a facilitator to assist with the deliberations;
- 9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: “Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed”; and
- 10) it did not aim for consensus.

Participants’ views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue and by those who review the dialogue summary and the video interviews with dialogue participants.

- inadequate education of healthcare professionals in rural communities and in teams; and
- inconsistent application of scope-of-practice legislation (e.g., emergency medical technicians are not allowed to work to their full scope of practice in some regions that are a long way from a trauma centre).

Regarding teams, one individual noted that the estimate of the current percentage of citizens with access to team-based primary healthcare services that was provided in the evidence brief (31%) is an underestimate.

Dialogue participants held different views about the importance of, on the one hand, acknowledging economic realities and supporting rural populations in getting over “grieving about what was” (e.g., having a local hospital with an emergency room) and, on the other hand, embracing community pride and supporting rural populations in using their own resources for the buildings they would like to see constructed and staffed (i.e., generate “ground up” solutions rather than impose “top down” solutions). A number of dialogue participants expressed concern that local community efforts to build healthcare centres often were not sustainable, created an unhelpful competitive dynamic among communities, and left communities with equal needs with very unequal levels of service. One dialogue participant also emphasized the importance of working through what providing urgent cardiac and stroke care within the “golden hour” meant for large areas in the province.

A few dialogue participants also noted the importance of taking into account the unique challenges faced:

- in remote communities;
- among First Nations and Métis populations; and
- by those living with mental illness and addiction.

One dialogue participant also noted the significant financial burden faced by those who were not from a First Nations population or who didn’t have private healthcare insurance, but who had to travel outside their community to receive care.

DELIBERATION ABOUT POLICY AND PROGRAM OPTIONS

Most dialogue participants were drawn to option 1 (supporting self-management, ‘aging in place,’ and healthcare-related travel), which was seen as a natural extension of “patient first” principles, and option 3 (optimizing the use of healthcare professionals and interprofessional teams), which was seen as the mechanism to get the healthcare system to operationalize these principles. As one dialogue participant commented, “we need to create the will to focus on the patient, and the teamwork that it takes to care for and support each patient effectively.” Several dialogue participants noted that all three options intersect with primary healthcare reform initiatives.

Option 1 – Support self-management, ‘aging in place’, and healthcare-related travel

Dialogue participants were generally strongly in favour of initiatives that support keeping patients at home and within their communities, and that give patients and their families a greater role in their own care and in the healthcare system more generally.

With regard to providing supports for self-management and/or ‘aging in place,’ dialogue participants discussed the need for a much greater emphasis on supporting self-management, continued enhancements to telehealth, and a more flexible approach to specialist outreach services. Many dialogue participants saw great advantages in supporting self-management, but recognized that this would require a cultural shift both among healthcare providers (some of whom were resisting pilot projects) and among patients and their families (some of whom are overly reliant on primary healthcare centres), a significant shift in the training and continuing professional development of healthcare providers, and a significant shift in the resources made available to patients and their families to support self-management (e.g., education by diabetes nurse educators among others, self-monitoring tools, patient flow sheets, and peer support groups). One dialogue

participant lamented that the provincial “health line” had been implemented in a centralized fashion instead of a much more decentralized fashion at the regional or sub-regional level, which the individual argued could have provided more patient-specific and context-sensitive supports for self-management (particularly for chronic conditions).

A number of dialogue participants described the significant impacts that telehealth has been having in their communities (particularly for episodic care), but noted that more work needed to be done to get telehealth capacity into specialists’ offices. They argued that if telehealth could become a more routine part of specialists’ days – a “virtual clinic” that runs alongside or complements their regular clinic – and a more efficient use of their time – with little to no “down time” between patients – there would be a much higher rate of participation by specialists and much less need for “itinerant clinics” in rural communities. These dialogue participants also noted that work needed to continue to ensure that there is always a skilled telehealth facilitator “with the patient at the receiving end of a telehealth appointment” (even if the large number of telehealth units now operating means that this facilitator can no longer be a registered nurse). One dialogue participant noted that the large “bandwidth” needed for telehealth and the lack of information technology (IT) supports remained a problem in a number of rural communities. Another dialogue participant argued for broader efforts to “leverage technology” to improve the patient experience, such as through the enhanced use of email for patient/provider communication, the innovative use of telephones (as Sask Tel has started to do with LifeStat) and social networking sites, and the “opening up” of electronic health records to patients (as has been done by some U.S. healthcare organizations). Another dialogue participant noted that some of these efforts would require a re-examination of how healthcare providers, especially physicians, are paid, given that most reimbursement is based on an in-person visit.

A few dialogue participants argued for a flexible and supported approach to specialist outreach that works both for specialists and for the communities that need them. One dialogue participant provided a number of examples of specialist outreach (a diagnostic CT and MRI program, a midwifery program designed to keep a higher percentage of births closer to the Athabasca basin, and a travelling surgical team) that each needed different forms of local infrastructure and capacity to be in place in order to be successful. A number of dialogue participants argued for enhancing how referral centres support after-care in order to minimize the time spent outside of one’s home community, and to enhance continuity of care. One individual described how community liaison nurses were being used to support cancer-related after-care, and how they were supported centrally and through an annual provincial symposium.

While all of these interventions could support ‘aging in place,’ one dialogue participant singled out a cultural shift as being needed to truly support ‘aging in place.’ This individual described how easy it is for an elderly person with an acute illness or an acute exacerbation of a chronic condition to suddenly move into a trajectory that sees their dependence on others steadily increase. For example, a patient with mild dementia might get dehydrated and more confused, and rapidly become “institutionalized.” This dialogue participant argued that if all healthcare providers kept ‘aging in place’ as a goal with each patient, such trajectories could be avoided in many situations. This individual also argued that greater discussions among patients, families and healthcare providers about end-of-life care could avoid some forms of unwanted “heroic care” that takes patients out of their homes and away from the support of their families. Another dialogue participant argued that greater amounts of home care were sometimes needed in order to avoid patients having to access long-term care facilities when their need for home care couldn’t be met.

There were mixed views about the emphasis that should be accorded to providing supports to rural residents who have to travel to receive care. Most dialogue participants wanted to see greater emphasis on enhancing the services brought into communities (which was the focus of the preceding paragraphs) compared to enhancing the supports available for rural residents who have to travel out of their communities to receive care. A number of dialogue participants worried about the potential for budgets “being eaten away” by ever increasing demands for financial assistance and accommodations for those who have to travel to receive care. One dialogue participant also worried that supporting large volumes of travel out of communities also draws healthcare expertise out of communities and undermines existing and emerging centres of excellence within

communities. This individual argued for keeping and supporting healthcare providers in rural communities, where patients and their families have linguistically and culturally appropriate supports (which they often do not have in referral centres). A number of dialogue participants recognized, however, that there would always be urgent or complicated cases requiring travel outside communities, and that financial assistance, accommodations and linguistic and culturally appropriate supports would need to be maintained for such cases. One individual noted that the targeted use of “patient navigators” might assist with some challenges encountered by patients and their families, but wondered whether they were a “work around for a badly functioning system.” Another individual noted that Health Canada’s First Nations and Inuit Health Branch needed to be at the table for discussions about enhancements to linguistic and culturally appropriate supports. A third individual noted that “cultural navigators” might be particularly helpful for First Nations populations.

While not identified as a component of this option, a number of dialogue participants broadened the notion of self-management to include the greater engagement of patients and citizens, possibly through citizen councils or patient and family councils. One dialogue participant saw such councils as the key first step in any rural health strategy. Another dialogue participant emphasized the importance of paying close attention to “who’s on councils and whether patients feel safe.” A few dialogue participants offered cautions about allowing patients’ voices to drive all elements of the system. One noted that patients are not telling governments that they want health promotion and disease prevention programs in addition to healthcare services. Another noted that patients are pushing their healthcare providers for interventions that are ineffective or harmful. A third dialogue participant reminded others that the focus needs to be on the “embedding of patient voices within the planning and delivery of healthcare services and in decision-making about the healthcare system as a whole.” This individual argued that it’s not about “patient wants,” but about “patient needs and perspectives,” and that such input might help to overcome cultural differences within and across government and health professions.

Option 2 – Increase the breadth and accessibility of chronic disease management programs

Dialogue participants generally agreed that a more programmatic approach to chronic disease management could help to improve rural health, but most did not see this option as providing the single approach that would mobilize patients and providers to improve healthcare in rural communities (and a few worried that it would not address ongoing challenges in responding to acute and episodic care). A number of dialogue participants noted that the Health Quality Council was already doing some of this with their “collaboratives” focused on several prevalent chronic conditions (e.g., diabetes, coronary artery disease, chronic obstructive lung disease, and depression) if not all challenging chronic conditions (e.g., HIV/AIDS), but that the Council was encountering difficulty with “spread [beyond early adopters] and sustainability [beyond a period of intensive activity by the collaborative].”

Of the six elements of the Chronic Care Model – self-management supports, decision support, delivery system design, clinical information systems, health system changes and community resources – dialogue participants addressed self-management supports and clinical information systems (and to a lesser extent, community resources) in the discussion about option 1, they later addressed aspects of decision support and delivery system design in the discussion about option 3, and they addressed select aspects of health system change in both sets of discussions. One dialogue participant argued that these six elements should be the core elements of any “balanced system.” In the discussion of option 2 dialogue participants emphasized points such as: 1) greater support for electronic health records (as one dimension of clinical information systems), as well as greater IT support; 2) greater investments in community resources; and 3) greater consideration of physician-remuneration mechanisms that support performance-based payment for coordinated and proactive chronic disease management (as one element of health system change).

Option 3 – Optimize the use of healthcare professionals and of interprofessional teams

Dialogue participants generally agreed that there needed to be more attention given to encouraging team-based care and, within that context, to using the right providers for the right tasks in the right settings, and to preparing both trainees and international graduates to succeed in these settings. Some dialogue participants saw education as critical to this transition, particularly interprofessional education (to prepare healthcare providers to work in teams) and distributed education (to expose trainees and international graduates to rural communities to which they might or would return, and to develop the broad range of skills and cultural competence needed to work in these communities). Several dialogue participants identified accommodation and information technology as constraints to distributed education (and often to recruitment and retention as well). Circling back to a topic that came up in discussion about option 1, a few dialogue participants also saw education as critical to supporting greater self-management. One dialogue participant said that the system needed to evolve into one in which “it’s clear that patients take ownership of their chronic conditions, the healthcare team services them, and patients and their families know who to go to.”

A few dialogue participants identified additional steps as critical to this transition, including: 1) the consistent application of scope-of-practice legislation (so that all healthcare providers are working to their full scope of practice); 2) greater use of nurse practitioners, licensed practical nurses and “navigators;” 3) creative use of “itinerant” providers and mobile teams (who can be based anywhere) to fill gaps and to allow local healthcare providers to take time off; 4) enhanced use of healthcare provider remuneration as a lever to support change (and of rewards for developing and maintaining specialized skill sets and for performance more generally); 5) more attention to identifying what constitutes the critical mass needed to support anesthesia and surgery (and more generally the key elements of a “hub and spoke” model of care for defined geographic areas); and 6) greater engagement of local clinical leaders and local community leaders to support “different ways of doing things” (including team-based care and partnerships between communities and reserves). One dialogue participant summed up many of these points by saying: “We need to set up a system in a way that expands skill sets, not that contracts them.”

One dialogue participant expressed concern that the evidence brief gave greater attention to physician assistants than to other types of healthcare providers who can play a significant role in primary healthcare. Another dialogue participant argued that family medicine is uniquely positioned to provide “full service” primary healthcare, and expressed concern that health teams have the potential to jeopardize such comprehensive care. Over the course of the deliberation, however, there was less emphasis on interprofessional rivalries and more emphasis on how different health professionals need to work together to best serve their patients. One dialogue participant reminded others that “there are no providers in [some] rural communities” and “the oddity is that the longer the distance, the lower level of training” expected.

Several dialogue participants discussed steps that are already being taken to expand the participation of First Nations and Métis populations in all health professions (including the “representative workforce strategy”), and they emphasized the importance of strengthening math and science education in rural communities (to ensure that students have the basics needed to participate fully in their training), bringing training to rural communities (as described above), recognizing the tremendous diversity within and across these populations, and using cultural safety concepts.

Considering the full array of options

Dialogue participants introduced two option elements that hadn’t been addressed in the evidence brief. The first additional option element involved creating sub-regional centres that serve a number of small rural communities in a defined geographic area and from a base located between communities, not within any given one. One dialogue participant noted that this will require overcoming a small ‘c’ community perspective

and embracing a larger sense of community. The same individual argued that “urban” solutions like emergency medical services and telehealth won’t solve “rural” problems. Another dialogue participant saw such sub-regional centres as a critical component of the “hub and spoke” model mentioned in the discussion of option 3.

The second additional option element involved continuing to address silos within government and (especially for First Nations populations) across levels of government, and (for those outside government) to advocate for more integration in health and human services and more of a patient focus. One dialogue participant noted that while most accountabilities within government continue to be “vertical” rather than “horizontal,” the emerging “enterprise” approach to government is beginning to change this. Another dialogue participant argued that silos exist not only within government, but within the healthcare system. For example, committees are set up to examine some programs and services, but not others. A third dialogue participant noted that some municipalities are also playing an active role in supporting enhancements to rural healthcare, and they need to be engaged in partnerships to improve healthcare at the front line. Several dialogue participants noted that partnerships across levels of government are beginning to emerge, often in ways that are creative yet still attentive to accountability arrangements with funders. These dialogue participants argued that these are long-term developments that will need to be nurtured in order to build the trust and shared understandings that will one day see all healthcare providers working in an integrated way under a single “umbrella.”

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Dialogue participants generally agreed that it would be critically important to take advantage of the common sense of purpose created among influential doers and thinkers by the Patient First review, to engage citizens actively in the development of the rural health strategy and in its operationalization at the individual and community level, to find a way to foster a social movement among the provinces 40,000 healthcare providers so they “own and drive” this “patient first” orientation in all communities (i.e., to “capture their hearts and minds,” in the words of one dialogue participant), and to enlist everyone from healthcare professional leaders to the Premier in providing coordinated leadership that moves everyone beyond self-interest. Dialogue participants also agreed that, while research evidence would need to underpin any actions, compelling stories from other jurisdictions and animating voices from patients, citizens and communities would be essential to making change happen.

A number of dialogue participants noted the current and future importance of building partnerships within and across communities for any initiatives to be successful, but particularly for initiatives in remote communities. Key questions in relation to these partnerships are always who and how. One dialogue participant noted that “there are pockets of excellence in all regions, but everyone is really busy, and there aren’t enough opportunities to share innovative solutions” and to create the collaborations needed to scale up these one-off initiatives to the provincial level. Even province-wide successes in one domain, such as H1N1 vaccinations, are not always built upon in other domains.

One dialogue participant argued that a shift was needed from the current crisis-driven culture (among leaders, healthcare providers and communities) to a culture of coordinated and proactive planning that is accompanied by the alignment of resources to those partnerships that can operationalize the resulting plans, and clear consequences for those partnerships that fail to do so. A few dialogue participants noted that the system “had created a dependency on a certain way of delivering services” and that “doing what we’ve been doing for patients for 30-40 years is not getting us to where we need to be.” One dialogue participant argued that “I don’t think we don’t know what to do. We know the solutions but we’re incapable of delivering those solutions... because of existing structures and cultural mindsets.”

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

Dialogue participants generally agreed that any strategy would have to be developed through a Ministry-led process, but they:

- emphasized that the motivation for the strategy had to be a “patient first” (or “customer owner”) orientation, which would capitalize on the goodwill created through the Patient First consultations and report, even if the provincial and national economic situation had to be acknowledged as an important backdrop for the strategy;
- reiterated that the strategy-development process should incorporate citizen engagement and the identification of compelling stories about how rural healthcare can be accessed and delivered more consistently and reliably in a way that meets patient expectations and improves health in a cost-effective manner;
- highlighted that the strategy mustn’t be the “same old, same old,” but instead should outline bold initiatives that leave room for local flexibility (e.g., significant emphasis on and supports for self-management; interprofessional and distributed education; geographically defined sub-regional primary healthcare centres with performance-based payment, IT support, telehealth and flexible specialist outreach supports; and streamlined and coordinated referrals and after-care); and
- suggested that the implementation of the strategy should build and capitalize upon leadership at all levels of the system in order to foster a culture change within the system, support initiatives that are likely to be effective and sustainable and partnerships that can best deliver them, and counter possible opposition from health system stakeholders and policymakers with a more exclusively ‘acute care’ mindset.