DRAFT RECOMMENDATIONS

CAEP | ACMU

1 COORDINATED MISSION

The emergency care system is embedded in the broader healthcare system and its many interdependent subsystems. We should all have a shared purpose, common principles, and a coordinated mission.

2 OPTIMIZE ACCESS POINTS

There must be optimization of the number, distribution, capability, connections, coordination, and workforce of emergency departments and other access points in the emergency care system.

3 ACCOUNTABILITY

Patient care accountability frameworks should be implemented to define program expectations and performance targets, and to hold individuals, programs and organizations to account.

4 DISASTER PREPAREDNESS

The COVID-19 pandemic has highlighted the need for ongoing, validated and adequately funded disaster preparedness, integrated throughout healthcare systems and across jurisdictions.

5 ADAPTATION & EVOLULTION

Emergency care systems must continually improve their approach to knowledge creation, implementation, and integration, within and beyond medicine, to adapt to a changing world.

EM:POWER
The Future of Emergency Care in Canada

CAEP TORONTO 2023

COORDINATED MISSION

The emergency care system is embedded in the broader healthcare system and its many interdependent subsystems. We should all have a shared purpose, common principles, and a coordinated mission.

1. Canadian healthcare leaders, providers, and organizations should adopt the **Quintuple Aim framework** as the overarching goal of health system redesign.

2. Health-system planners should **understand population needs**, determine which services would best meet these needs, and resource them appropriately.

3. Provincial ministries of health should implement **patient care accountability frameworks** that incorporate accountability zones, program expectations and performance targets.

4. Health planning and design should be entrusted to an **independent public entity** at arm's length from government, to reduce the impact of election cycles on health system decisions.

5. Canadian policy-makers should **learn from international health systems** while regulating the delivery of publicly funded health care, to ensure the principles of the Canada Health Act and Quintuple Aim are achieved.

6. Ministries of health and health authorities should assure all Canadians **access to primary care**, prioritizing those in greatest need. Reliable access to primary care will help emergency systems focus on their core mission.

7. Governments must support **unified digital health integration** for patient data access and information-sharing among care providers, researchers, and communities.

8. Principles of **Justice, Equity, Diversity, and Inclusion** (JEDI) should be embedded in health care planning, delivery, and evaluation at all levels.

9. Provincial health ministries should catalyse system redesign by creating adaptive, integrated **clinical care networks** that prioritize patient and population needs.

10. When system factors compromise care, EM must **engage with healthcare leaders** to avoid simplistic responses to complex problems and to encourage system innovation.

OPTIMIZE ACCESS POINTS

There must be optimization of the number, distribution, capability, connections, coordination, and workforce of EDs and other access points in the emergency system.

1. Provincial health ministries should establish **Emergency Care Clinical Networks** (ECCNs) to **coordinate** clinical service and HR planning, operational guidance, and quality improvement-patient safety initiatives.

2. ECCNs should oversee **categorization, standardization** (facilities, equipment, required competencies) and **integration** of EDs and other emergency care access points.

3. ECCNs should establish and support **team-based care**, creating complementary roles and responsibilities in service of patient needs. Health ministries and authorities should provide the necessary **funding for team-building**, including regional simulation programs.

4. Emergency care systems should work with EMS agencies to implement and evaluate **pre-hospital coordination centres** and “expanded scope” EMS concepts.

5. Provincial governments should implement a needs-based, behaviourally influenced, iteratively updated **physician resource planning model** (e.g., Savage model).

EM:POWER
The Future of Emergency Care in Canada

CAEP | ACMU

ACCOUNTABILITY

Patient care accountability frameworks should be implemented to define program expectations and performance targets, and to hold individuals, programs and organizations to account.

1. Healthcare leaders should implement accountability measurement and reporting systems, monitor care gaps and use defined performance measures to determine whether these are best addressed through **new capacity, enhanced efficiency, or reallocation of existing resources**. Where the gap/root cause is capacity, they must advocate for new resources. Where it is inefficiency or misallocation, they must facilitate change.

2. Facilities should implement **demand-driven overcapacity protocols** to be activated when pull systems are failing and access block is compromising care delivery. Overcapacity protocols should also bridge the hospital-to-community transition.

3. Provincial governments should immediately invest in **aging-at-home options and alternate level of care (ALC)** transition capacity to expedite hospital outflow, mitigate acute care access block, and improve quality outcomes.

4. Hospitals must **publicly report ED performance** in relation to CAEP ED access and flow targets, as articulated in its 2013 position statement on overcrowding and access block.

5. The minister of health must hold all hospital/health authority CEOs accountable to bed occupancy levels of 85%, on average, to **reduce the use of emergency departments as admitted patient holding units**.

DISASTER PREPAREDNESS

The COVID-19 pandemic has highlighted the need for ongoing, validated and adequately funded disaster preparedness, integrated throughout healthcare systems and across jurisdictions.

1. All health care facilities and agencies must have, as a required organizational practice (ROP), a formally **tested and periodically exercised plan** for all-hazard surge capacity, that includes some level of real (as opposed to virtual) and constant capacity redundancy.

2. Competency in disaster response must be validated though structured **cyclical auditing**, integrated as a critical factor into the existing evaluation processes of the organization and be a requirement for healthcare facility accreditation.

3. Preparedness planning must be integrated at all levels of the health system, be uniform in format and allow for mutual aid between agencies at all levels, from local to national, and across jurisdictions/licensures.

4. Education and training in disaster preparedness should have **dedicated annual funding** to achieve and maintain competency.

5. All disaster planning must consider **vulnerable segments of the population** including those with special needs, challenges and requirements.

EM:POWER
The Future of Emergency Care in Canada

CAEP | ACMU

ADAPTATION & EVOLUTION

Emergency Care Systems must continually improve their approach to knowledge creation, implementation, and integration, within and beyond medicine, to adapt to a changing world.

1. CAEP, in conjunction with university departments and divisions of emergency medicine, should develop a **pan-Canadian EM research network**, to coordinate researchers and facilitate interdisciplinary collaborations that prioritize the most urgent and impactful patient and population healthcare needs.

2. Emergency physicians should embrace **leadership and stewardship roles in digital health**, to ensure that the best innovations are promulgated and that precious public resources are not diverted to non-value-added activities.

3. Emergency physicians, through their national and provincial organizations, must be knowledgeable in the population health effects and health system impacts of **climate change events** (e.g., wildfires, floods), and participate in public and professional education, and advocacy.

4. EM training programs should include public affairs, policy and advocacy in their teaching, as part of a **health systems science (HSS) curriculum**, to advance understanding of the broader context in which EM operates and nurture the next generation of systems change leaders.

5. EM training programs should address the impact of **social identity** in the health care setting and foster opportunities for productive interaction among specialties, to establish **teamwork and shared goals** as integral parts of professional identity development.