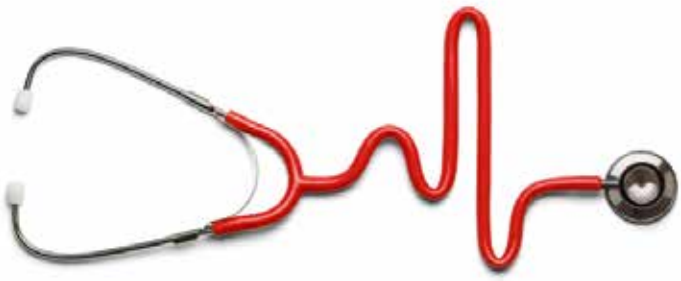
CANADA-US
HEALTH SUMMIT 2015

A Summary Report



Wilson Center

Canada-US Health Summit 2015

November 2-3, 2015
The Wilson Center
Washington, D.C.

A Summary Report

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CANADA-US HEALTH SUMMIT 2015

Wilson Center

Executive Summary

On November 2 and 3, 2015, more than 100 senior healthcare stakeholders—government officials, health professionals, academics, and patient advocates—gathered in Washington, D.C., to participate in the inaugural Canada-U.S. Health Summit, a meeting dedicated to sharing information and building cross-border partnerships around common health priorities.

Hosted by the Canada Institute at the Woodrow Wilson International Center for Scholars, the conference concentrated on the following areas:

- Canadian and American healthcare system trends, challenges, and opportunities for ongoing information-sharing and collaboration;
- Key healthcare topics of interest to audiences from both countries;
- Areas of promise in both countries that provide potential "best practice" case studies; and
- Health care areas where Canada and the United States are working collaboratively as a foundation for further cooperation.

Key topics included health quality metrics; public health and regulatory cooperation; health information technology; health delivery system reform; and public health, research, and health innovation.

The conclusion: both countries face similar obstacles to improving healthcare, including the challenges brought by an aging population and cost pressures on the health system. Healthcare innovation examples from both countries demonstrated the translatable nature of innovation beyond national borders.

A number of areas were identified for future study and collaboration, including:

- Overarching accords in health science research, such as “measurement science” for health quality metrics, “implementation science” for public dissemination of research findings, and the “science of science” to estimate the impact of science;
- Cross-border considerations for privacy and security in health information technology;
- Standards development in patient-reported outcomes;
- Knowledge and data-sharing around patients with complex medical needs;
- Supply chain coordination in healthcare; and
- Deeper collaboration in public health, in surveillance, research and leadership training for public health officials.

Core funding support for the Summit was made possible by the Robert Wood Johnson Foundation.

As a next step, co-organizers of the Summit will continue to promote a health dialogue between Canada and the United States through focused meetings on priority topics such as regulatory cooperation and health information technology.

Introduction

On November 2 and 3, 2015, more than 100 healthcare stakeholders—government officials, health professionals, academics, and patient advocates—participated in the inaugural Canada-U.S. Health Summit, a meeting dedicated to sharing information and building cross-border collaborations around common health priorities.

The main goals of the conference concentrated on the following areas:

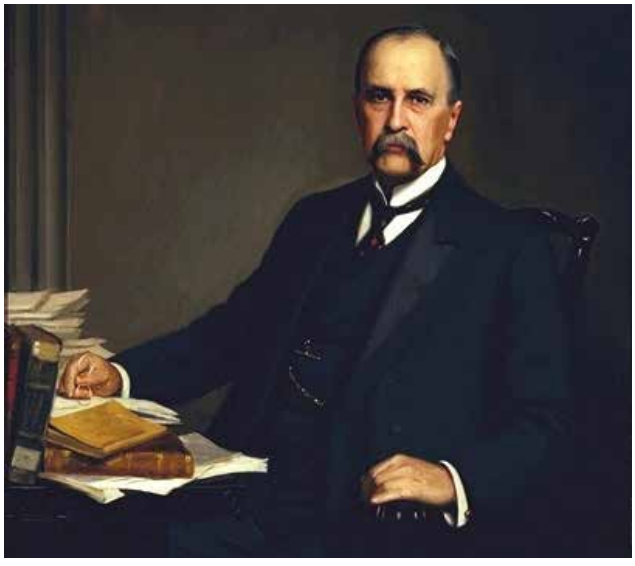
- Examine Canadian and American healthcare system trends, challenges, and opportunities for ongoing information-sharing and collaboration;
- Discuss key healthcare topics of interest to audiences from both countries;
- Highlight areas of promise in both countries that provide potential "best practice" case studies; and
- Showcase areas where Canada and the United States are working collaboratively in health as a foundation for further cooperation.

Why a Canada-US Health Summit?

Canada and the United States enjoy a strong partnership that is unique in the world. Our shared values and entrenched economic linkages have brought peace and prosperity to the Canada-U.S. border. As with other sectors, such as transportation, energy, and border security, Canada and the United States should strive to share best practices in a way that allows health innovation to be adopted rapidly across borders. The time has arrived for Canada and the United States to construct a formal dialogue on health.

Canada and the United States are experiencing transformational change in our respective health systems. We are facing massive challenges, from containing costs to treating chronic conditions, but there are profound opportunities if we look outward for solutions and collaboration. Ten years from now, healthcare delivery and measurement will have evolved significantly in both countries due to technology, utilization of big data, an aging population, and other drivers. Thus, the Health Summit was motivated by a goal: to harness the trusted Canada-U.S. partnership to drive health improvement in both nations.

One of the key barriers to cross-border dialogue has been the perception that the two systems are too distinct to be comparable. Even more damaging, though, to a health dialogue are critics in each country who argue that there is nothing to learn from the other country because its health system is inferior; such criticism leads to citizens of one country hearing only the horror stories about the other. Views on healthcare are often colored by political persuasion, more so in the United States, but anecdotally growing in Canada. There is not enough comparative academic research to counter this perception.



Dr. William Osler, described as the father of modern medicine, is an inspiration for the conference. A Canadian, he is one of the founders of Johns Hopkins in the United States.

Photo credit: https://commons.wikimedia.org/wiki/File:Sir_William_Osler.jpg

The reality is that each nation has its own strengths, but also shares some of the same weaknesses, areas where each country could stand to improve its health outcomes and health system performance. Our opening panel noted that both countries face similar challenges around care coordination, patient satisfaction, outcome measurement, and access to primary care. As will be discussed later in this report, subsequent panels brought up other areas such as the slow rate of innovation adoption in each country.

Data from the Commonwealth Fund demonstrate our need for improvement relative to other G10 nations. In a ranking of 11 industrialized nations, Canada and the United States rank 10th and 11th, respectively, in health system performance. While the dramatic difference in health expenditures between the United States and Canada also requires attention, it is the relatively poor performance of both countries' health systems relative to their G10 counterparts that we hope cross-border collaboration in health can address.

Mirror, Mirror: Rankings of Health System Performance

COUNTRY RANKINGS

Top 2*

Middle

Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2011; World Health Organization; and Organization for Economic Cooperation and Development, OECD Health Data, 2013 (Paris: OECD, Nov. 2013).

Source: The Commonwealth Fund, Mirror, Mirror on the Wall, 2014 Update

Both countries are striving to meet these challenges. In the United States, the Affordable Care Act (ACA) is aimed at addressing key systemic problems such as reducing the large numbers of uninsured Americans, integrating and coordinating care across providers, and making the insurance marketplace more efficient. In Canada, the Health Accord, an agreement between provinces, territories, and the federal government that provides stable funding, is a tool for setting national health standards. Canada's newly elected government has initiated a process of negotiating the Health Accord's renewal with provincial and territorial leaders.

Topic Areas

The following section summarizes key topics covered during the Canada-US Health Summit's panels and breakout sessions.

Health Quality Metrics and Outcomes

FRAMING QUESTIONS

- Which policies are shaping health quality and outcomes measurement? How are these policies evolving in ways that are shaping the direction of health and health care metrics?
- What is the state of patient-reported outcomes in terms of measure development and use? How has this changed, and how will patient-reported outcomes change?
- What is the state of measuring cost and value of investments and the challenges and opportunities?

DISCUSSION POINTS

Both the United States and Canada are undergoing shifts away from fee-for-service models that favor the volume, not quality, of services and toward payments based on value. Within the value shift, Canada and the United States are wrestling with the same goals: assessing the most appropriate outcomes, understanding costs, and determining how to assess cost within the context of quality to assure real value in the health system.

Tara Oakman (farthest left) from the Robert Wood Johnson Foundation leads the quality metrics discussion with the panelists Kathleen Morris, Pierre Yong, Astrid Guttmann, and Helen Burstin.

Panelists discussed measuring cost and quality together as a critical activity that demands tremendous effort. For example, getting these data requires providers to use health IT meaningfully and report information using agreed-upon measures. Financial incentives have helped encourage to make available data that in turn can be used to refine reimbursement: for example, a speaker in a later session noted how the Centers for Medicare and Medicaid Services (CMS) withheld a portion of hospitals' Medicare payments unless they reported on certain measures. Thus, improved reporting utilizing better measures can help payers and providers move away from just looking at the cost of care toward actually measuring value by combining cost and quality data.

Panelists also discussed the role of consumers and patients in measuring quality. There is growing activity in developing patient-reported outcomes measures, and both countries are seeing new innovative initiatives dedicated to moving beyond reporting patient experience and toward reporting specific outcomes relative to services. Canada and the United States are pursuing patient-reported outcomes in areas where large volumes of data can help inform the most appropriate patient-reported outcomes measures.

The panel uncovered that Canadian provinces and American payment initiatives such as accountable care organizations both provide opportunities for measurement within a given population, but quality metrics need to account for variances in geography and social determinants, among other areas.

OPPORTUNITIES FOR CROSS-BORDER INFORMATION SHARING AND COLLABORATION

The panel produced a number of exciting ideas for cross-border collaboration in quality metrics and outcomes. First, panelists agreed both nations—and other nations—should be working collaboratively on the advancement of "measurement science," or the development of quality metrics. Even though payers differ, each nation can take measures that work well—as well as those that should be tabled or re-evaluated—from the other without having to reinvent the proverbial wheel.

Second, given that high volumes of data are necessary to measure quality outcomes, greater standardization of data would allow nations to pool data together. An area of future exploration could include how to leverage cross-border relationships to standardize sources of data from providers, such as electronic health records.

Third, panelists noted the need for greater investment in patient-reported outcomes, including how to encourage greater public engagement while respecting individual privacy. For example, measuring appropriate care for complex patient populations is a concern to both nations, but we now recognize that determining appropriateness

involves not only reporting on clinical outcomes but also reporting from these patients. Both countries can work together to develop efficient metrics to help these patients receive the most appropriate care. Such metrics can be piloted in ways that are context specific, but eventually scaled and standardized across both countries.

Health IT: Solutions for Improving Health Outcomes

FRAMING QUESTIONS

- What are the needs and challenges to achieve regional, national, and cross-border coordination of electronic health records?
- How can our nations better collaborate on health IT initiatives to improve patient safety without compromising privacy?
- Is health IT being utilized in a meaningful way to enhance the relationship between patients and providers?
- What tools do governments have to ensure health IT adoption and utilization is helpful to providers and not furthering a "check the box" mentality?

DISCUSSION POINTS

The role of government in the adoption and utilization of health information technology (IT) served as a major theme of this panel, which featured federal, state, and provincial government officials.

The panel largely focused on the role of government in health IT policy and the different nature of health IT policy decisions at different levels of government. For example, in both the discussion and the questions from the audience, some felt the Canadian federal government's approach is more indirect given the role of the provinces in health policy, whereas the American federal approach is more direct. The federal government in the United States seems more of a driver than its Canadian counterpart, although states do have some role in health IT policies through the Medicaid program. At all levels there are examples of success, but these successes often required community leadership and buy-in.

Another key topic focused on government's role in ensuring that health IT secures value for providers. Once government introduces incentives for providers to adopt, it must ensure health IT is used in a way that is meaningful—and not a burden—to patient care. Otherwise, government efforts could inadvertently push "check the box" attitudes rather than real application of health IT. However, panelists noted the challenges in collecting provider input on what they find useful about health IT and the policy changes needed to improve it; for many providers, responding to regulations means taking away time from patient care.

Finally, panelists wanted to guarantee that utilizing health IT is valuable for patients and consumers as well as for providers. Ensuring that consumers see value in health IT will encourage them to report their own data, something vital to getting a more complete picture of a patient. A panelist asked how one can capture data when consumers are utilizing healthcare services outside the clinic? Others noted that technology in general is giving consumers the opportunity to find health information on their own, helping them to make their own health decisions outside a clinical setting.

OPPORTUNITIES FOR CROSS-BORDER INFORMATION SHARING AND COLLABORATION

Concerns over patient privacy, particularly the effect of the PATRIOT Act in the United States, was raised in the discussion. While there were unresolved questions regarding the impact of the PATRIOT Act on health IT adoption in both countries (and it should be noted that Congress recently amend the act), it is clear that the law has a chilling effect on cross-border exchange of health data, ranging from medical records for "snow birds" to public health and medical research.

Panelists also reiterated the generally-accepted principle that health IT could help harness the power of big data; however, some questioned whether policies are in place that make data collection valuable rather than collecting data for the sake of data. Refining what and how data are collected could be an area of future exploration and have important implications for research and public health.

The discussion only briefly touched on interoperability, a topic that could be explored further.

Health Delivery System Reform

FRAMING QUESTIONS

- How can we improve care coordination across practice settings?
- How are payers using financial incentives to change practice patterns and improve care delivery?
- How are we improving program efficiency to strengthen quality at reduced cost?
- How can social determinants of health be incorporated into delivery system reform?
- How can the United States and Canada leverage our joint efforts on medical education to strengthen delivery system reform efforts in both countries?
- How can delivery systems meet needs of rural populations?

DISCUSSION POINTS

The push toward health delivery system reform in the United States and Canada highlights a common thread between the two counties. Regardless of who pays—the government, private insurers, employers, or individuals paying out of pocket—the payer wants the best value for its healthcare dollar. The panelists described efforts in both nations to achieve greater value. In fact, payers in both countries are using similar tools to push providers toward more value-based, accountable care.

Panelists shared strategies to bring together payers to align reimbursement around goals such as improved reporting on outcomes, increased access to and utilization of primary care, and care coordination across providers. Other speakers echoed the panel's theme of using reimbursement to drive practice change. As noted earlier, CMS pushed hospitals into "voluntary" public reporting by holding back 2 percent of their Medicare reimbursement unless they reported on certain outcomes. Such reporting programs eventually became the basis for further quality and value initiatives.

Panelists also discussed the need for payers to work with providers toward reform. One panelist noted that providers must want reform and believe in it. Additionally, some reform initiatives will not work in certain communities: creating bundled payments might work better in an urban environment with large health systems but not in a rural market dominated by small practices made of a handful of physicians.

Panelists commented that system reform demands a flexible approach and learning from failure as well as success. In the United States, the Affordable Care Act gave CMS new abilities to test alternative payment models at both the provider level and through state Medicaid programs. The recently-passed Medicare Access and CHIP Reauthorization Act will better align different quality incentive programs around delivery-system reform goals and will reduce providers' reporting burdens.

Despite the optimism and excitement, other panelists noted that delivery system reform takes time to create cultural shifts, build infrastructure, and change practice patterns. For example, one success story from the United States took decades to achieve and was begun well before the passage of the ACA. Additionally, evaluations—particularly those that are peer-reviewed—take time to complete, and payers and providers need more information on what is successful and what should be avoided in order to adopt effective, systematic changes in how they deliver healthcare.

Lastly, delivery system reform in both countries is inherently political at all levels. Obviously, both countries will be undergoing political changes, and new political leadership may affect approaches to delivery system reform. But local politics—such

as the relationship between a hospital and area physicians—play just as large a role in the success of these reform efforts. For example, some physicians might resist a primary-care initiative that empowers nurses, but making such a change could free up physicians to see more complex cases and thus improve a practice's efficiency and revenue. Having strong community leadership and the buy-in of all stakeholders is key to ensuring successful reform.

OPPORTUNITIES FOR CROSS-BORDER INFORMATION SHARING AND COLLABORATION

Panelists and audience participants recognized the need for further information-sharing: since both nations have many demographic similarities and limited healthcare dollars, we should learn from each other so that neither country is throwing good money at ideas that haven't been successful. Additionally, both the United States and Canada are still trying to take key elements of what is working at a local or regional level and scale them up to a national level.

The discussion identified several areas that seem ripe for cross-border sharing and further exploration. First, patients with complex medical needs and "super utilizers" pose a challenge to health system performance in both countries. Many of these individuals have additional challenges that are not integrated into the healthcare system, such as behavioral health issues and the need for support services, such as housing and transportation.

Second, how patients and consumers can be part of these efforts needs further exploration as well as something "big" on the horizon. This theme was echoed on other panels: consumers and patients are increasingly using technology to interact with the healthcare system and often make healthcare decisions outside the system that are unknown to payers and providers.

Public Health and Regulatory Cooperation

FRAMING QUESTIONS

- How do Canada and United States serve as strong partners in health?
- What are common regulatory and public health challenges faced by both countries?
- What are the new opportunities and areas for collaboration?

DISCUSSION POINTS

This panel acknowledged that Canada and the United States are trusted partners in regulatory cooperation and public health, and maintain a strong network in information and resource sharing, activity coordination, and regulatory harmonization. Recognizing that infectious diseases and microbes do not know borders, the panelists emphasized the need for deep cross-border coordination in public health, research, and regulatory affairs. Chronic disease, prescription opioid abuse, and aging are public health challenges in both countries, and areas where greater cooperation across borders would be beneficial. Finally, panelists discussed the interconnectivity in today's world that underscores the importance of Canada-U.S. coordination at bilateral and multilateral levels in ways that enhance health and safety of its citizens.

Chief Public Health Officer Gregory Taylor of the Public Health Agency of Canada and Acting Assistant Secretary of Health Karen DeSalvo from the U.S. Department of Health and Human Services discuss potential partnerships and areas where the two agencies already collaborate.

OPPORTUNITIES FOR CROSS-BORDER INFORMATION SHARING AND COLLABORATION

- Surveillance and information-sharing around common health and regulatory objectives are a logical place to collaborate.
- Transport and logistics industries have developed sophisticated methods to monitor the international supply chain. There is the potential to collaborate in order to harness these methods in the health sector.
- Exchange programs for capacity-building and leadership among public health officials are important areas in which to collaborate.

Health Innovation

FRAMING QUESTIONS

- How can we share effective innovations and make those innovations scalable across regions, nations, and across borders?
- How can a standards-based supply chain be an innovation strategy for quality improvement, safety, and health outcomes?
- What are Canada-U.S. collaborative opportunities to streamline supply chain processes to drive economic value and improve outcomes and patient safety?
- Why is innovation a challenge in Canada and the United States, and why has so little progress been achieved?
- What is the capacity of innovation in both nations' health systems and the potential to accelerate system transformation-quality improvement, safety, health outcomes, and economic value?
- How can we capture evidence of impact of innovation and create health system metrics for the future?

DISCUSSION POINTS

Innovative health initiatives and models are being utilized at local or pilot levels on both sides of the border by breaking down traditional barriers, fostering collaboration, encouraging the innovative use of technology, and acknowledging the cost of care to derive greater value to the patient.

Greater value in the health system can be unlocked through scaling innovation across regions, countries, and at the global level. At the same time, scaling innovation cannot be "one-size-fits-all," but must allow for adaptation across different populations to address variances such as social determinants of health.

Technology is fundamental to scaling innovation by serving as a tool to disseminate best practices and encourage patient self-management.. At the same time, while technology that is accessible to consumers has helped scale global innovation in other sectors, such as taxis (Uber) and travel/tourism (Expedia), the same has not held true for health—yet.

Transparency is an important part of innovation: transparency in the ownership of health records, transparency in costs, and transparency in outcomes and across systems. Creating an environment where innovation thrives arguably requires constant evaluation of outcomes and an ability to assess and address failures.

Industry, including manufacturers, suppliers, and distributors, must be critical partners to innovation. Industry proposes solutions to questions around value. For industry, customer demands in Canada and the United States are similar: they want

improved services, better funding, reduced budget pressures, and answers to how they can work with manufacturers and suppliers to be more efficient.

One panelist suggested that the baby-boomer generation can create the demand necessary to scale innovation, particularly at the consumer level. Baby boomers have a desire to be in the "driver's seat" with their health; they have greater access to information and are comfortable with new technology, especially mobile technologies.

OPPORTUNITIES FOR CROSS-BORDER INFORMATION SHARING AND COLLABORATION

The panel highlighted a number of areas for cross-border collaboration.

First, the two countries should work toward common standards that can be utilized to support goals around reduced cost and improved patient outcomes. Standards must be informed by high quality data to be viable. Bilateral networks have already been established for other sectors, such as food supply and transportation, that have enabled these sectors to scale innovation, evaluate outcomes, and inform decisions in ways that can be employed in the healthcare sector to improve patient care.

Second, the United States and Canada could employ bar coding across the supply chain to provide a tool to improve patient safety and outcomes, which would reduce costs and provide better value to the health system in both countries. Barriers to using national and global supply chains for this purpose still exist, but successful case studies in targeted areas can encourage wider adoption across jurisdictions and product areas. Regulators, payers, providers, manufacturers, and suppliers need to be part of the conversation on supply chain and health innovation.

Finally, health professionals in both countries should focus on targeted areas where local innovation can be scaled across borders.

Public Health and Research

FRAMING QUESTIONS

- How can we build upon existing cross-border partnerships in medical research to achieve common goals in health?
- What pressing public health needs must be addressed 5, 10, 20 years from now? How can research help address those needs?
- How can research serve as a tool to improve patient and health system outcomes?

DISCUSSION POINTS

On this panel, speakers discussed the strong institutional ties between Canada and the United States in basic, translational, and patient-oriented research. For example, the Canadian Institutes for Health Research (CIHR) has a partnership with the National Institutes of Health, as well as with the Patient-Centered Outcomes Research Institute (PCORI), which include funding, information sharing, and resource-sharing. However, most Canada-U.S. collaboration in research is scientist-to-scientist, rather than planned research investment on a national level between the two nations.

During her keynote speech, former U.S. Health and Human Services Secretary Kathleen Sebelius discussed how a public health emergency was the first issue she had to address when she was first nominated to the cabinet. She worked closely with her counterparts in Canada and Mexico to address this emergency.

Our panelists described the importance of implementing research, where government-funded research findings are disseminated in a comprehensive way. In both countries, patient-centered research has served as a central priority within nationally-sponsored health research agendas. Panelists noted that patient-centered research can improve patient recruitment for clinical trials as it has a positive impact on trust and meaningful engagement.

Coordination between Canada and the United States has been fundamental to public health emergency preparedness. Both countries have served as active partners in the Global Health Security Initiative, an international partnership among nations to better address global health security risks.

The close coordination between Canada's National Microbiology Lab and the U.S. Centers for Disease Control and Prevention (CDC) has allowed both countries to address public health emergencies such as the H1N1 influenza pandemic and the international Ebola outbreak.

OPPORTUNITIES FOR CROSS-BORDER INFORMATION SHARING AND COLLABORATION

Our panelists commented on the benefit of joint collaboration in "implementation science," promoting methods to disseminate research findings and overcome trust barriers in research.

Discussion in the breakout session also focused on the importance of joint exploration into the "science of science," where Canada and the United States can work together to understand the production of science and qualitative and quantitative methods to estimate the impact of science. Such collaboration requires constant learning from one another in a more coordinated, mission-oriented fashion.

Finally, our panelists agreed that deliberate and more formal cross-border partnerships in health research could achieve broader, joint research goals.

Consumer Engagement

FRAMING QUESTIONS

- How can we encourage consumers and providers to engage in shared decision making, particularly for managing complex or chronic conditions?
- How are providers involving consumers and patients in delivery system reform?
- How can consumers and patients provide input into the relationship between pharmaceutical and medical device companies and government regulators?
- What is the role of employers and insurers in empowering patients and consumers?

DISCUSSION POINTS

This session brought together practitioners, providers, patients, and consumers to discuss how policy can help consumers to have a greater voice in their own care as well as in health system change overall. The panel began with a thoughtful discussion about what the terms "patients" and "consumers" convey. Some felt that "consumer" suggests that healthcare is an ordinary economic good and thus something that individuals can choose to purchase, when in reality, many individuals *must* purchase healthcare out of necessity, not convenience. But others felt that "patient" feels paternalistic and too focused on a disease rather than the individual. While there was no resolution, several discussants recognized that terminology is important because such labels affect how we are treated in the healthcare system and how we look at our own health and confront our own weaknesses.

Additionally, while empowering consumers ultimately may help reduce societal stigma, several discussants noted that at an individual level, stigma remains a significant barrier for individuals when talking about their own health, especially outside the healthcare system. Several discussants noted the need to work with employers, since individuals may fear asking for assistance or accommodations in the workplace.

With respect to reimbursement, discussants indicated that decisions are not always aligned with consumer priorities. One panelist noted that the healthcare system is geared toward individuals asking for care, but many people do not specifically seek care and may not even realize that care is needed. For those with a chronic condition, this disconnect has resulted in a patchwork of services rather than coordinated care. Discussants also noted that many consumers also need access to support services such as housing, job training, or access to healthy food—outside the healthcare system; however, providers traditionally have not been reimbursed for addressing these "social determinants of health."

Despite these challenges, many participants in the session believe that consumer engagement is taking hold in health and healthcare, a feeling that was reflected in other panels throughout the conference. One panelist noted the growing shift among health professionals toward shared decision making and a greater involvement of consumers and patients in quality reporting, delivery-system changes, and other reform initiatives. Several participants also noted that many employers are thinking about how workplaces can be healthier environments because making such "workplace wellness" investments can improve productivity and employee retention.

OPPORTUNITIES FOR CROSS-BORDER INFORMATION SHARING AND COLLABORATION

Several audience members suggested future sessions on either behavioral health or palliative care as good starting points for sharing learning on consumer engagement. Audience members felt that many consumers face challenges accessing behavioral health or palliative care, respectively, because these services are too often fragmented.

Canadian Ambassador to the United States Gary Doer (center) speaks with Victor Dzau, president of the National Academy of Medicine.

Conclusion

The organizers of the Canada-US Health Summit 2015 hope that this gathering will help strengthen the close friendship between Canada and the United States. This relationship has enabled the two countries achieve a vast number of shared goals in areas such as trade, security, and energy, among others. We would like to see health be an area of rich collaboration as well.

We believe there is great promise in establishing a conversation that lasts beyond the Summit itself—to make our countries healthier and our health systems run better. This report not only summarizes top-line findings from the Summit, but also provides us with opportunities for future events that dive deeper into areas of mutual interest. Certainly the report cannot capture the numerous discussions that happened among attendees, connections that may lead to future cross-border collaboration on any of the topics discussed in this report.

Lastly, we recognize that political changes in both the United States and Canada will have effects on health policy and healthcare. A newly elected government in Canada and an election on the horizon in the United States may lead to new dialogue on these important topics. We hope to convene another summit once these political changes are in place.

And perhaps this future summit can report on collaborations that were either made or inspired by the 2015 Summit.

After all, collaborations in health are more than just government to government—they happen between scientists, between communities on and away from the border, between entrepreneurs and industrial giants, and, most importantly, between patients and consumers who are demanding and deserve change.

Case Studies

In addition to summarizing the summit's proceedings, this report showcases innovative health initiatives from speakers and attendees in both countries that carry the potential for translation across borders.

The Arthritis Society (Canada) — *Consumer Engagement*

The Arthritis Society of Canada reminds us that anyone living with arthritis can work at nearly any type of job. With a multidisciplinary approach and the cooperation of various stakeholders including employees and employers, the Arthritis Society developed the *Joint Matters at Work* program to help employers and employees understand how to manage arthritis and protect joints within the workplace.

The program includes

- A screening clinic hosted by an Arthritis Society physiotherapist to promote early recognition and self-management of arthritis;
- Access to health information in the workplace to encourage employee awareness and workplace health (e.g., lunch 'n' learns);
- Access to online health information including workplace exercises, nutrition, and fatigue management.

While employees with arthritis may want to "tough it out," the *Joint Matters at Work* program encourages employees to seek help early through proactive and empowering workplace programs. The program creates a win-win for both employees and employers. Additionally, *Joint Matters at Work* checklists offer a guide for primary care providers, medical specialists, workplace occupational health specialists, physiotherapists, occupational therapists and vocational counselors, psychologists—as well as employers and employees—on how to deal with arthritis and persistent musculoskeletal disorders in the workplace.

For more information about *Joint Matters at Work*, visit the Arthritis Society's web page at www.arthritis.ca.

Ebola Medical Countermeasures Research & Development (Canada and United States) — *Public Health and Research*

Canada-U.S. joint research efforts in Ebola medical countermeasures provide a model for further joint research that invests resources and expertise on both sides of the border.

VSV-EBOV is an experimental Ebola vaccine discovered by researchers at the Public Health Agency of Canada's National Microbiology Laboratory (NML). The discovery of the Ebola vaccine was funded by the Public Health Agency of Canada and the Canadian Safety and Security Program, and required collaboration with government departments, investment by private industry, and importantly, international partnerships that included the U.S. National Institutes of Health and the U.S. Defense Threat Reduction Agency. The vaccine is currently in clinical trials in Canada, the United States, Europe, and Africa.

ZMapp is an Ebola treatment containing three monoclonal antibodies. ZMapp was initially developed by NML, with subsequent support from the Public Health Agency of Canada and the U.S. Biomedical Advanced Development and Research Authority (BARDA).

Canadian Partnership Against Cancer — *Consumer Engagement and Innovation*

For the majority of Canadians, access to basic healthcare is accessible and tailored to meet the needs of its patients; but for First Nation communities, this is not the case. To help make access to health care accessible to all, the Canadian Partnership Against Cancer (CPAC) has teamed up with First Nations, Inuit, and Métis communities to create the *First Nations, Inuit and Métis Action Plan on Cancer Control.* At its heart, the action plan seeks to improve the patient experience, which for many First Nations and Inuit patients means traveling far from their home communities for care. The action plan looks at ways to make transitions in care more culturally sensitive through better understanding of the journey by embedding culturally appropriate practices, offering specialized training for care providers, and brokering dialogues between communities and clinicians.

With the mission to harness the best of what's working well in cancer control and share it broadly with all Canadians, CPAC is taking an unprecedented step towards achieving this goal. CPAC, an independent organization funded by the Canadian federal government, works with partners from across Canada to meet the goals of the Canadian Strategy for Cancer Control. Those goals include reducing the risk of cancer, lessening the likelihood of Canadians dying from cancer, and enhancing quality of life for those affected by cancer.

For more information, visit www.partnershipagainstcancer.ca.

Mercy Health (United States) — *Innovation*

In sectors such as manufacturing, strong linkages in global supply chains enhance both product safety and productivity. The global supply chain in health, however, is comparatively fragmented. Nevertheless, there is great potential to leverage the supply chain to improve health system outcomes and reduce costs, between Canada and the United States, and at the global level.

In the case of Mercy Health, a four-state regional health system headquartered in St. Louis, Missouri, the U.S. Food and Drug Administration (FDA) envisioned strengthening medical device post-market surveillance through the use of electronic health information. The data are gathered in the course of patient care, and the system uses unique device identifiers (UDIs) as keys that enable the linking of disparate systems. To this end, the FDA supported a demonstration performed by Mercy Health that had three aims:

- Implement a coronary stent surveillance system in its electronic health record (EHR),
- Identify the obstacles for creating such a system along with potential solutions, and
- Assess the usefulness of the EHR data in device safety surveillance.

Using GS1 standards, Mercy designed and implemented a system for capturing prototype coronary stent UDIs by means of barcode scanning in its cardiac catheterization laboratories (cath labs) and incorporating the barcodes in its supply chain management, inventory management, billing, and cath lab clinical systems. The UDI was used to link the specific coronary stent with the patient in whom it was implanted. This resulted in the creation of a database that included pertinent UDI-related device information and clinical data obtained from the EHR, thus enabling assessment of coronary stent safety and effectiveness over time.

This “proof of concept” pilot demonstrated that EHR data can be useful in evaluating implanted medical devices in a post-market setting. There are efforts underway to scale the UDI approach for cardiac catheterization to two other health systems in the United States. The next step would be to work with a national device registry to obtain this same information in a de-identified format from multiple health systems in order to assess large numbers of devices nationally and create a clearer picture of device performance and safety in the real world. As a result of the Canada-U.S. Health Summit, discussions are underway regarding UDI program implementation in several Canadian provinces.

More information regarding the Mercy Health UDI initiative can be found at: http://mdepinet.org/unique-device-identifier-udi-implementation-in-the-electronic-information-of-a-single-health-system-an-mdepinet-demonstration/

Institute for Clinical Evaluative Sciences (Canada) — *Quality Metrics and Outcomes*

Population-sourced data can serve as a powerful tool for health providers to better inform efforts aimed at improving care quality. Health providers in Canada and the United States are analyzing data from patient medical records to better understand care improvement for patient populations. In the case of Ontario's Institute for Clinical Evaluative Sciences (ICES), population-sourced data was utilized to support mental health system evaluations.

The Institute for Clinical Evaluative Sciences is a not-for-profit research institute encompassing a community of research, data and clinical experts, and a secure and accessible array of health-related data from the province of Ontario. ICES produced the first comprehensive Canadian report describing the burden of mental health and addictions and service utilization in children and youth, using ICES health administrative data, population-based survey data, and school-level education data. The report included an ongoing commitment to longitudinal child and youth performance measurement through collaboration between the ICES Mental Health and Addictions (MHA) Research Program and the Ontario Ministry of Health and Long Term Care (MOHLTC). In addition, the report led to the development of a data integration plan that in a shared, strategically important initiative between MOHLTC and ICES with early success in bringing in new population-based sources of data.

For more information regarding ICES' mental health of children and youth scorecard, visit: http://www.ices.on.ca/Newsroom/Announcements-and-Events/2015/The-Mental-Health-of-Children-and-Youth-in-Ontario-Report.

Project ECHO (United States and Canada) — *Outcomes*

Sanjeev Arora, MD, a liver disease doctor in Albuquerque, was frustrated that thousands of New Mexicans with hepatitis C could not get the treatment they needed because there were no specialists where they lived. The clinic where he worked was one of only two in the entire state that treated hepatitis C. Arora was determined that all patients in need of treatment should get it, and thus created Project ECHO so that primary care clinicians could treat hepatitis C in their own communities.

Project ECHO (Extension for Community Healthcare Outcomes) has a simple mission: to develop the capacity to safely and effectively treat chronic, common, and complex diseases in rural and underserved areas, and to monitor the outcomes of this treatment. The heart of the ECHO model™ is its hub-and-spoke knowledge-sharing networks, led by expert teams who use multi-point videoconferencing sessions, or teleECHO™ clinics, with community providers. In this way, primary care

doctors, nurses, and other clinicians learn to provide excellent specialty care to patients in their own communities. The ECHO model, originating from the University of New Mexico Health Sciences Center (UNMHSC), has expanded—across diseases and specialties, across urban and rural locales, across different types of delivery services, and even across the globe.

There is great potential to integrate Project ECHO's platform in Canada. Like the United States, Canada confronts challenges in serving rural and underserved areas. ECHO has successfully been used in the Province of Ontario in the area of chronic pain management.

For more information visit Project ECHO at: http://echo.unm.edu/ and ECHO Ontario at: http://www.echoontario.ca/.

Nova Scotia Extended Care Paramedic (ECP) Program (Canada) — *Delivery System Reform*

Both Canada and the United States are exploring models to improve access to care in the home setting to alleviate strains on the broader health system. Such models include expanding the roles of professionals in the health workforce. An important example is the Nova Scotia Extended Care Paramedic Program (ECP), designed to provide enhanced and timely non-emergency and emergency care to residents of nursing homes in the Halifax Regional Municipality in Nova Scotia. Under this ECP program, all potential calls are screened through pre-defined criteria by communications officers at the Provincial Medical Communications Center. Eligible patients are then treated by an Advanced Care Paramedic with an extended scope of practice tailored to the needs of nursing home patients.

The paramedics travel in a non-transport capable SUV to deliver treatment directly at the patient's bedside. Depending on the patient's needs, the paramedic will deliver treatment and work with the on-site professionals to develop a home care plan, or arrange for a "facilitated" transport to hospital at a time when the patient will be seen quickly. If required, ECP staff will also facilitate the immediate provision of emergency care.

Ongoing program evaluations have demonstrated the overwhelming success of the ECP program. The program has also received international awards and inspired multiple research studies garnering interest from across the world.

Medavie EMS played a coordinating role in Nova Scotia. The non-profit organization has since partnered with the Commonwealth Care Alliance in Massachusetts to offer a similar program for low-income patients with complex chronic conditions.

For more ECP information, visit: https://accreditation.ca/long-and-brier-island-community-paramedicine-project.

For more information about Massachusetts' Commonwealth Care Alliance paramedicine program, visit: https://commonwealthcarealliance.wordpress.com/tag/paramedics/.

Value-Driven Outcomes Initiative (Utah) — *Innovation*

Vivian Lee, senior vice president for health sciences at the University of Utah, was struck by a sentence from a journal article on the healthcare cost containment problem: "There is an almost complete lack of understanding of how much it costs to deliver patient care, much less how those costs compare with the outcomes achieved." Spurred by the problem, Lee launched the Value-Driven Outcomes Initiative, a project that brought together leaders from various departments such as quality improvement, biomedical informatics, and IT to create a tool to help their university and other healthcare providers understand the true cost of care. The project team produced the VDO tool, which translates big data into actionable information about true costs on the patient level. The tool won a 2013 Innovator Award in the Health Care's Most Wired Competition.

The VDO tool determines the true cost of healthcare services using an extensive five-step process. It allows users to select a diagnosis, procedure, or diagnosis-related group and produce a chart that compares the variation between various providers side-by-side. One can start at a high level to compare the average cost per case for a group of physicians, and drill into data to see where the variation is coming from, looking at actual cost of labs, pharmaceuticals, and supplies.

The University of Utah has used the VDO tool to craft a standardized care process for cellulitis and build in decision support in the electronic health record system, driving down costs by $1,000 per patient and reducing re-admits by 50 percent. The tool has been used for physical therapy and joint replacements with impressive results.

In addition to working to share their methodology widely, the University of Utah team is focusing on making the tool more advanced. Since releasing the first VDO iteration, the team has been working to integrate quality data including mortality, readmissions, length of stay, bleeding, infection rates, and other patient outcomes.

At the end of the day, the VDO team's focus is ultimately quality, not cost.

For more information on the Value-Driven Outcomes tool, visit these web pages:

- "How Can We Control Our Costs?" Algorithms for Innovation, University of Utah Health Sciences (http://healthsciences.utah.edu/innovation/algorithms/2013/two/index.php#features-wrapper)
- "What Are a Hospital's Costs? Utah System Is Trying to Learn," by Gina Kolata, *New York Times*, September 7, 2015 (http://www.nytimes.com/2015/09/08/health/what-are-a-hospitals-costs-utah-system-is-trying-to-learn.html?_r=0)
- "Value Driven Outcomes—A Patient's Perspective," video by University of Utah Health Care, at https://youtu.be/O77Aj9jvQ90

Registered Nurses Association of Ontario ECCO Model (Ontario) — *Delivery System Reform*

In both Canada and the United States, health delivery system reform includes the deployment of interdisciplinary health teams to improve patient care through prevention at the community level.

In 2012, the Registered Nurses Association of Ontario (RNAO) conceived the Enhancing Community Care for Ontarians (ECCO) model to address improvement in coordinated primary care.

The ECCO model is a whole system strategy that includes enabling primary care to be the foundation and center for care coordination for all Ontarians; fostering full and expanded scope of practice utilization of health professionals within interprofessional teams; improving service integration through one regional planning and funding agency; and advancing structural realignment that makes these objectives possible.

Elements of the ECCO model can be found within the province of Ontario's Health Links initiative (http://www.health.gov.on.ca/en/pro/programs/transformation/community.aspx), which is focused on providing coordinated, efficient, and effective care to patients with complex needs.

The health workforce in Canada and the United States share strong ties based on similar training, education, as well as a cross-border flow of health professionals. There is great potential to leverage the connectivity of the Canada-U.S. health workforce to better promote education and training with respect to coordinated care in interprofessional health teams.

Rise Asset Development (Ontario) — *Consumer Engagement*

In both Canada and the United States, social determinants such as income and social status, social support networks, and employment/working conditions can influence the mental and physical health of populations. In areas such as mental health, support services can operate alongside the health system to address gaps in patient needs that are shaped by social determinants. As a result, such programs are inherently translatable across borders.

Rise is a not-for-profit organization operating across the province of Ontario that employs entrepreneurship as a pathway to better health outcomes and quality of life for people with a history of mental health or addictions challenges. Entrepreneurship support services include low-interest small business loans, free training, and mentorship to people with a history of mental health or addiction challenges, who are unable to access traditional financing. Approximately 65 percent of Rise's serviced population are on some form of social assistance. As part of Rise's loan evaluation process, Rise considers the individuals' commitment to take necessary steps to manage financial goals. Rise has an admirable default rate of less than 7 percent.

Rise's Peer Supported Start-Up program (http://www.riseassetdevelopment.com/programs/group-lending-program/) is targeted at women and men who have educational and experiential gaps that would prevent them from starting a business. Peer Supported Start-Up includes a month-long training sequence that is focused to get each learner to produce a business plan by the end of the program. Lending groups composed of three to six borrowers are formed at the outset of the class. For individuals who wish to move forward with their completed business plan, low interest financing is offered in small amounts to start ($1500 or less). Rise leverages a volunteer Investment Committee (http://www.riseassetdevelopment.com/about-us/investment-committee/) to help make the lending decisions. A Mentorship Program (http://mentorhub.riseassetdevelopment.com/) is designed to provide Rise entrepreneurs with additional support and guidance as they design and implement their business plans and grow their businesses. Rise volunteers are provided with anti-stigma training and mentorship resources via the Mentor Hub.

For more information, visit riseassetdevelopment.com.

Biographies of Speakers

Jane E. Aubin

As chief scientific officer, Jane Aubin, PhD, oversees scientific affairs at the Canadian Institutes of Health Research and provides expert advice on matters relevant to science and technology, potential opportunities, and emerging orientations and trends in the national and international health research community. As vice president of the research, knowledge translation and ethics portfolio, she is also responsible for all aspects of adjudication of grants and awards at CIHR, and finally, as a member of the Science Council, she participates in the development, implementation, and reporting on CIHR's research and knowledge translation strategy.

Deborah Bae

Deborah Bae, MPA, MBA, joined the Robert Wood Johnson Foundation in 2005 as a senior program officer and is interested in discovering and exploring innovative ideas, novel approaches, and new ways of thinking, and then sharing the learnings both within the Foundation and beyond. Previously, Bae worked in the New York City Department of Health Bureau of Informatics and Data Services, helping to implement an electronic disease reporting system for all New York City hospitals and laboratories. She also was a microbiology laboratory research assistant at the University of Pennsylvania.

Robert Bell

Bob Bell, MD, was appointed deputy minister of health and long-term care effective June 2, 2014. Prior to this role, he served as president and chief executive officer of University Health Network for nine years. He was previously the chief operating officer at Princess Margaret Hospital and chair of both Cancer Care Ontario's Clinical Council and the Cancer Quality Council of Ontario.

David N. Biette

David N. Biette is director of the Wilson Center's new Polar Initiative, which convenes and fosters discussion and research on Arctic and Antarctic issues investigating the human, environmental, and geopolitical challenges of the Polar Regions. He also serves as senior advisor to the Center's Canada Institute. Biette has served as executive director of the Association for Canadian Studies in the United States, and as a political-economic officer at the Consulate General of Canada in New York City. He is the author of numerous chapters, policy briefs, and op-eds, and appears regularly in U.S. and Canadian media.

Helen Burstin

Helen Burstin, MD, MPH, FACP, is the chief scientific officer of the National Quality Forum (NQF), a not-for-profit membership organization that works to catalyze healthcare improvement through quality measurement and reporting. Prior to her appointment as chief scientific officer, Burstin served as the senior vice president for performance measurement since joining NQF in 2007. In her role, Burstin provides strategic guidance to all NQF work from the perspective of current and emerging measurement science.

Susan Dentzer

Susan Dentzer is senior policy adviser to the Robert Wood Johnson Foundation, the nation's largest philanthropy focused solely on U.S. health and health care, and is also one of the nation's most respected health care journalists and thought leaders. Dentzer served from 2008 to 2013 as the editor-in-chief of *Health Affairs*, the nation's leading journal of health policy. She also previously led PBS NewsHour's health unit, reporting extensively on-air about health care reform debates from 1998 to 2008.

Karen DeSalvo

Karen DeSalvo, MD, MPH, is the acting assistant secretary for health in the U.S. Department of Health and Human Services. DeSalvo also remains in her role as the national coordinator for health information technology, where she continues to set high level policy and the strategic direction of the office, including efforts related to interoperability. Before joining the U.S. Department of Health and Human Services, she was health commissioner for the City of New Orleans, and senior health policy advisor to New Orleans Mayor Mitchell Landrieu, from 2011 to 2014.

Irfan Dhalla

Irfan Dhalla, BASc, MD, MSc, FRCPC, is Health Quality Ontario's vice president of evidence development and standards. Dhalla continues to practice general internal medicine at St. Michael's Hospital, where he cares for inpatients and teaches medical students and residents. He is also an assistant professor in the Department of Medicine at the University of Toronto, with a cross-appointment to the Institute of Health Policy, Management and Evaluation.

Joseph P. Drozda, Jr.

Joseph P. Drozda, Jr., MD, FACC, is a cardiologist and director of outcomes research at Mercy Health—a four state regional health system headquartered in St. Louis. He is a member of the American College of Cardiology's board of trustees, is a past chair of the American College of Cardiology's Clinical Quality Committee, and is the ACC representative to the National Quality Forum, where he chairs the Health Professionals Council.

Victor J. Dzau

Victor J. Dzau, MD, is president of the National Academy of Medicine. He served nearly 10 years as chancellor for health affairs at Duke University and president and CEO for Duke University Health System. Before that, Dzau held influential posts with Harvard Medical School, Brigham and Women's Hospital, and Stanford University. He is an internationally recognized trailblazer in translational research, health innovation, and global health care strategy and delivery.

Michael M. Engelgau

Michael M. Engelgau, MD, MS, is deputy director of the Center for Translation Research and Implementation Science (CTRIS) at the National Heart, Lung, and Blood Institute, part of the National Institutes of Health. As deputy director of CTRIS, Engelgau helps to lead an integrative, trans-Institute effort to advance the translation of scientific discoveries in heart, lung, and blood diseases research to clinical and public health practice nationally and globally.

Suzanne Ffolkes

Suzanne Ffolkes is the vice president of communications of Research!America, the nation's largest nonprofit alliance working to make research for health a higher national priority. As vice president, Ffolkes oversees internal and external communications and marketing strategies to position Research!America as the substantive, go-to resource for members of the alliance, policymakers, media, and the public.

Jaeson T. Fournier

Jaeson T. Fournier, DC, MPH, is the chief executive officer of West Side Community Health Services. West Side is the largest Federally Qualified Health Center (FQHC) in Minnesota, providing medical, dental, and behavioral health services through 16 locations in Saint Paul and Ramsey County. Fournier is also the board chair of a Medicaid-focused Accountable Care Organization (ACO), known as the Federally Qualified Health Center Urban Health Network (FUHN). FUHN is a consortium of 10 FQHC organizations in the Twin Cities with 40 metro clinics, many of which are involved in multi-disciplinary collaborative care models, including his own.

John H.V. Gilbert

John H.V. Gilbert, PhD has been a seminal leader in the education of health professionals in British Columbia and internationally. In the early part of his career, he pioneered linguistics and psychology as the basis of practice for speech-language pathologists and audiologists. In the latter part of his career, his vision and leadership led to the concept of interprofessional education being developed as a central tenet of team-based collaborative patient-centered practice and care. These concepts are now part of university, college, and institute health sciences training in many places across Canada.

Alan Glaseroff

Alan Glaseroff, MD, is co-director of Stanford Coordinated Care, a service for patients with complex chronic illness. Glaseroff, a member of the Innovation Brain Trust for the UniteHERE Health, currently serves as faculty for the Institute of Healthcare Improvement's "Better Care, Lower Cost" collaborative, and serves as a clinical advisor to the Pacific Business Group on Health "Intensive Outpatient Care Program" CMMI Innovation Grant that completes in June 2015.

Sherry Glied

Sherry Glied, PhD, became dean of New York University's Robert F. Wagner Graduate School of Public Service in August 2013. From 1989 to 2013, she was professor of health policy and management at Columbia University's Mailman School of Public Health. She was chair of the department from 1998 to 2009. On June 22, 2010, Glied was confirmed by the U.S. Senate as assistant secretary for planning and evaluation at the Department of Health and Human Services, and served in that capacity from July 2010 through August 2012.

William E. Golden

William E. Golden, MD, is professor of medicine and public health at the University of Arkansas for Medical Sciences and medical director of Arkansas Medicaid, where he is the clinical lead for the program's multipayer payment reform initiative. Previously, he served as the vice president for clinical quality improvement of the Arkansas Quality Improvement Organizations and designed numerous statewide quality improvement projects.

Michael Green

Michael Green has an international reputation and proven track record of transforming healthcare through the use of digital health. As president and chief executive officer of Canada Health Infoway, he works with Infoway's jurisdictional partners and other key stakeholders to accelerate the development and adoption of digital health in Canada, which will provide clinicians and patients with information they need to support safer care decisions and a more modern and sustainable health care system for all Canadians.

Doris Grinspun

Doris Grinspun, RN, MSN, PhD, is the chief executive officer of the Registered Nurses' Association of Ontario (RNAO), the professional association representing registered nurses, nurse practitioners, and nursing students in the Province of Ontario. RNAO's mandate is to advocate for healthy public policy and for the role of registered nurses and nurse practitioners. Grinspun assumed this position in April 1996.

Astrid Guttmann

Astrid Guttmann, MD, MSc, is chief science officer and senior scientist at the Institute for Clinical Evaluative Sciences, Canada's largest health services and policy research institute. She is a staff physician in the Division of Paediatric Medicine at the Hospital for Sick Children, and an associate professor of paediatrics and health policy, management and evaluation at the University of Toronto. She received her undergraduate degree at Harvard University; a second BA at Oxford University, where she was a Rhodes Scholar; her medical degree from McGill University; and an MSc in epidemiology from McMaster University.

Erika Harding

Erika Harding, MA, received her International Baccalaureate (IB) from the United World College of the American West, a BA in political science from Barnard College, and did her graduate work at the University of New Mexico in Latin American studies. She served as UNM's representative in Mexico, while working as the UNM Latin America Data Base analyst for political and economic issues. She has a long history of work in public education, public health policy, and health education, including working in the areas of reproductive health and melanoma prevention.

Dora Hughes

Dora Hughes, MD, MPH, is a senior medicine and health policy advisor in Sidley Austin's Government Strategies practice. She provides strategic advice to clients across a wide range of issues relating to the implementation of the Affordable Care Act (ACA), including coverage, health care quality, and innovation, and payment policy and reimbursement. Hughes also counsels clients on issues related to biomedical research and clinical trials, regulatory and approval processes for drugs and devices, including molecular diagnostics, health information technology, and population health.

Martha Huston

Martha Huston is president of Cardinal Health Canada, the leading solution provider for Canada healthcare in the acute, long term care, and alternate care markets. Cardinal Health is a $103 billion health care services company headquartered in Dublin, Ohio, that improves the cost effectiveness of healthcare. In her current role, she is responsible for creating, communicating, and implementing Cardinal Health Canada's vision, mission, and overall direction.

Shelly Jamieson

Shelly Jamieson is chief executive officer of the Canadian Partnership Against Cancer (the Partnership), an independent organization funded by Health Canada to accelerate action on cancer control for all Canadians. Jamieson also serves on the board of directors of High Liner Foods, the finance committee of the Toronto 2015 Pan Am/ Parapan Am Games, the board of the Gordon Foundation, the board of Health Quality Ontario, and is chair of the Ontario Public Service's Amethyst Awards Selection Committee.

Simon Kennedy

Simon Kennedy was named deputy minister of health effective January 21, 2015. Previously, he served as the deputy minister of international trade and as Canada's G-20 sherpa. During his tenure, negotiations were successfully concluded on the Canada-European Union Comprehensive Economic and Trade Agreement. Negotiations were also concluded on the Canada-South Korea Free Trade Agreement, Canada's first free trade agreement in Asia, and the treaty was brought into force on January 1, 2015.

Oliver Kim

Oliver Kim brings nearly 15 years of health policy experience at the state and federal level. He is also co-founder of Cross-Border Health, an organization that supports dialogue between the United States and other nations around common health priorities. Prior to Cross-Border Health, Kim served as deputy director for the Senate Aging Committee under Chairman Bill Nelson (D-Florida).

Eileen Mac Donald

Eileen Mac Donald is president of GS1 Canada, a member of GS1, the world's leading supply chain standards organization. Mac Donald is responsible for leading GS1 Canada's strategic direction and growth by driving organizational planning and priorities in conjunction with board directives. In this role, Mac Donald oversees finance, operations, industry and government relations, corporate affairs, and marketing for GS1 Canada, managing business opportunities and challenges.

Cindy McDaniel

Cindy McDaniel is the current senior vice president of consumer health at The Arthritis Foundation. Through her various roles at The Arthritis Foundation, McDaniel has more than three decades of experience understanding, educating, and empowering people with arthritis to live better. She was the founding editor of *Arthritis Today* magazine in 1987 and became publisher in 2001. She also oversees the Foundation's consumer research initiatives and its nationwide health outreach through numerous tools and channels.

Antonia Maioni

Antonia Maioni, PhD, is associate vice-principal, research and international relations, at McGill University. She holds a cross appointment as professor in the Department of Political Science and the Institute for Health and Social Policy at McGill University. She also teaches in Fundamentals of Medicine and Dentistry in the Faculty of Medicine and in the International Masters in Health Leadership program in the Desautels Faculty of Management, and is a member of the Research Group in Health and Law in the Faculty of Law.

Tom Marsden

Tom Marsden is the director for global development and business development at Dun & Bradstreet. Marsden helps federal government public health and safety organizations fulfill their missions through the effective use of D&B's business information and data management capabilities. He is a 16-year veteran of D&B, having spent the past 10 years working in the government solutions unit and held prior roles as executive assistant to the EVP of strategic accounts and leader of the electronic licensing business units.

Thomas A. Mason

Thomas A. Mason, MD, is the chief medical officer and acting director, Office of Programs and Engagement, in the Office of the National Coordinator for Health Information Technology (ONC). Mason leads and champions clinical oversight of ONC programs and clinical coordination within ONC. Mason is a board-certified internist with an emphasis on primary care and preventive medicine with 14 years of clinical experience. Mason also has more than 10 years of additional experience and training in the principles of public health and population medicine.

Paul Messino

Paul Messino, MPP, is the chief of health information technology policy with the Maryland Department of Health and Mental Hygiene. Messino designed and implemented the Medicaid Electronic Health Record (EHR) Incentive Program in Maryland. Since 2010, he has lead teams focused on increasing EHR adoption in Maryland; expanding the functionalities offered to Maryland health care providers by the state's Health Information Exchange; developing an electronic clinical quality measure calculation engine and clinical repository; creating a personal health record for Medicaid recipients in the Long Term Supports Services community; and planning for data-driven decision making within Medicaid.

Kathleen Morris

Kathleen Morris, MBA, is the vice president of research and analysis at the Canadian Institute for Health Information. She provides leadership for an integrated program of health services and population health initiatives, including indicator development, web-based performance reporting, and analytical reports. She also has responsibility for the data standards and quality analysis that underpin CIHI's work. Morris initially worked with CIHI as a consultant for major database renewal and e-strategy development and implementation. In 2009, she joined CIHI as an employee, and she most recently held the position of director of health system analysis and emerging issues.

Tara Oakman

Tara Oakman, PhD, is a senior program officer at the Robert Wood Johnson Foundation, working to improve the value of the foundation's investments in health and health care and also to help ensure that all young children—supported by their families and communities—have the building blocks for lifelong health and well-being. Prior to joining the foundation in 2013, Oakman served as director of the Quality Team in the Exchange Policy and Operations Group at the Center for Consumer Information and Insurance Oversight (CCIIO) in the Centers for Medicare and Medicaid Services (CMS).

Robin Osborn

Robin Osborn, MBA, has been vice president and director of The Commonwealth Fund's International Program in Health Policy and Practice Innovations since 1997. She has responsibility for the Fund's annual international symposium on health policy, annual international health policy surveys, and comparisons of health systems data. She also oversees the Commonwealth Fund–Nuffield Trust international conferences on quality, the Fund's International Working Group on Quality Indicators, the Harkness Fellowships in Health Care Policy and Practice, and the Australian–American Health Policy Fellowships.

Stephen Ostroff

Stephen Ostroff, MD, is the Food and Drug Administration's acting commissioner of food and drugs. As the top official of the FDA, Ostroff is committed to strengthening programs and policies that enable the agency to carry out its mission to protect and promote the public health. Before being named acting commissioner, Ostroff served as the FDA's chief scientist since January 2014. Ostroff joined FDA in 2013 as chief medical officer in the Center for Food Safety and Applied Nutrition and senior public health advisor to FDA's Office of Foods and Veterinary Medicine.

Robert C. Pendleton

Robert C. Pendleton, MD, FACP, is associate professor of medicine (clinical) at the University of Utah. After completing his medical school training at Baylor College of Medicine in 1997 and internal medicine residency at the University of Utah in 2000, he began his career as a full-time hospitalist as one of the University of Utah hospitalist co-founders. As a hospitalist, his clinical interests include caring for acutely ill hospitalized adult patients. In addition to serving as a co-director of the hospitalist group, he has recently been appointed as the chief medical quality officer of University of Utah Hospital and Clinics.

Dani Peters

Dani Peters is president of Magnet Strategy Group, a government affairs consulting firm that manages public affairs strategies in Canada and the United States. Prior to founding Magnet Strategy Group, Peters held senior roles in public affairs firms in the United States and Canada, concentrating on fields that include innovation, health, and life sciences. Peters is also the co-founder of Cross-Border Health, an organization that supports dialogue between Canada, the United States, and other nations around common health priorities.

Hoangmai Pham

Hoangmai (Mai) Pham, MD, MPH, is a general internist and the acting chief innovation officer at the Center for Medicare and Medicaid Innovation, where she has responsibility for overseeing implementation of the Medicare and CHIP Reauthorization Act, and strategic and operational planning for the center. Pham's previous positions at CMMI were as director of the Seamless Care Models Group, where she was responsible for the design and implementation of payment and care delivery models on accountable care organizations and advanced primary care.

Frank Plummer

Frank Plummer, MD, is the chief scientific advisor of the Public Health Agency of Canada, director general of the Centre for Infectious Disease Prevention and Control in Ottawa, and scientific director general of the National Microbiology Laboratory in Winnipeg. He is recognized in Canada and abroad for his work in public health and science, having received numerous honors, including most recently a grant from the Grand Challenges in Global Health of the Gates Foundation for his HIV research, the Rh Institute Award, and many more.

Jeff Richardson

Jeff Richardson, MBA, has served as the executive director of Mosaic Community Services for 20 years and brings more than 30 years of experience in behavioral health. He has been instrumental in Mosaic's growth to become the largest community-based behavioral health service provider in Maryland, serving more than 27,000 people annually.

Stephen Rosenthal

Stephen Rosenthal, MBA, is the senior vice president, population health management, for Montefiore's integrated delivery system, and president of CMO, The Care Management Company, LLC, a wholly owned for-profit subsidiary of the Montefiore Health System. Rosenthal has been a leader in the development of programs and initiatives in care management interventions. These programs and those for the frail and vulnerable populations have supported the growth of Montefiore's Integrated Delivery System, and its 4,900 provider network of physicians, primary care providers, its home health agency, rehabilitation facility, and eight acute care hospitals.

Thomas Scully

Tom Scully is a general partner with Welsh, Carson, Anderson & Stowe, a private equity firm in New York, which is the most active U.S. private equity investor in healthcare. Scully was the administrator of the Centers for Medicare and Medicaid Services from 2001 to 2004. CMS administers Medicare, Medicaid, the Children's Health Insurance Program, and is the largest agency in the U.S. government, spending more than $1 trillion for fiscal year 2015. At CMS, Scully had an instrumental role in designing and passing Medicare reform and Medicare Part D legislation, and in making the vast agency more open and accountable to the public.

Hon. Kathleen Sebelius

The Honorable Kathleen Sebelius is one of America's foremost experts on national and global health issues, human services, and executive leadership. As CEO of Sebelius Resources LLC, she provides strategic advice to private companies, not-for-profit organizations, higher education institutions, and financial investors. Sebelius currently serves as a member of the board of directors of Grand Rounds Inc., Hampton Creek Inc., and Humacyte Inc., and she is a senior advisor to Enhanced Pharma, Out Leadership, and the Aspen Institute, where she co-chairs the Aspen Health Strategy Group.

Lisa Simpson

Lisa Simpson, MB, BCh, MPH, FAAP, is the president and chief executive officer of AcademyHealth. A nationally recognized health policy researcher and pediatrician, she is a passionate advocate for the translation of research into policy and practice. Her research focuses on improving the performance of the health care system and includes studies of the quality and safety of care, health, and health care disparities, and the health policy and system response to childhood obesity.

Jean R. Slutsky

Jean R. Slutsky, PA, MSPH, is the chief engagement and dissemination officer at the Patient-Centered Outcomes Research Institute (PCORI). She leads PCORI's Engagement Program and its growing dissemination and implementation planning efforts. She also serves as director of PCORI's Communication and Dissemination Research Program. Before joining PCORI, Slutsky directed the Center for Outcomes and Evidence at the Agency for Healthcare Research and Quality, where she conceived and implemented the Effective Health Care program.

Anne Snowdon

Anne Snowdon, BScN, MSc, PhD, has dedicated her career to producing research and advancing innovation to improve the health and wellbeing of Canadians. As professor and academic chair of the World Health Innovation Network at the University of Windsor's Odette School of Business, Snowdon leads the work of the first Canadian health innovation center with formal ties to the United States. She works to build collaborative partnerships between the two countries to advance the health of populations, and accelerate health system innovation in both countries to achieve sustainability, economic value, and productivity by providing support for innovators and entrepreneurs to successfully bring their discoveries to the Canadian, U.S., and world markets.

Kathryn Spangler

Kathryn (Katy) Spangler is senior vice president, health policy, for the American Benefits Council. In this role, Spangler directs the development and advocacy of the Council's health policy priorities. Spangler also serves on the advisory board to the University of Michigan Center for Value-Based Insurance Design.

Gregory Taylor

Gregory (Greg) Taylor, MD, CCFP, FRCPC, is Canada's chief public health officer, appointed on September 24, 2014. Taylor obtained his MD from Dalhousie University in Halifax, where he also completed a family medicine residency. After several years in active primary care in Ontario, he completed a fellowship in community medicine at the University of Ottawa and joined Health Canada's Laboratory Centre for Disease Control. His initial responsibilities focused on cardiovascular disease, and he has been involved with a wide range of federal chronic disease activities.

Peter W. Vaughan

Peter W. Vaughan, MD, is deputy minister of the Nova Scotia Department of Health and Wellness. Prior to becoming deputy minister, Vaughan was the president, chief executive officer, and medical director of the South Shore District Health Authority. Vaughan's international clinical medical experience spans several jurisdictions in Canada, the United States, Central America, and Europe.

Dave Williams

Canadian astronaut and physician Dave Williams is the president and CEO of Southlake Regional Heath Centre and assistant professor of surgery at the University of Toronto. Prior to joining Southlake, Williams was the director of the McMaster Centre for Medical Robotics at St. Joseph's Healthcare Hamilton, and professor in the Department of Surgery of the Michael G. DeGroote School of Medicine from 2008 to 2011, and held the position of chief medical officer of quality and safety at St. Joseph's Healthcare Hamilton from 2010 to 2011.

Hal Wolf

Hal Wolf is an internationally respected health care and informatics executive. As director of The Chartis Group, Wolf is a leading authority on integrated care models and mHealth development and implementation, working with international health systems and organizations on end-to-end operations, commissioning, data and architectural design.

Janet Yale

Janet Yale currently serves as president and CEO of The Arthritis Society after years of providing results-oriented leadership in c-suite positions in the private, public, and not-for-profit world. An accomplished senior executive with a long history in the telecommunications sector, Yale previously served as executive vice president at TELUS and president and CEO of the Canadian Cable Television Association. A lawyer and economist by training, she worked early in her career as a director general at the CRTC and as general counsel to the Consumers Association of Canada.

Pierre Yong

Pierre L. Yong, MD, MPH, MS, is the director of quality measurement in the Quality Measurement and Value-Based Incentives Group/Center for Clinical Standards and Quality, at the Centers for Medicare & Medicaid Services (CMS). At CMS, he oversees measure development and analyses for a variety of CMS quality reporting and value-based purchasing programs. Previously, Yong was the director of health care quality and outcomes in the Office of the Assistant Secretary of Planning Evaluation at the U.S. Department of Health and Human Services, where he oversaw projects on value-based purchasing, quality, comparative effectiveness research, and data infrastructure for patient-centered outcomes research.

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Peter Weems	Medical Imaging
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Alison Williams	Office of the Asa Hutchinson, Arkansas
Dave Williams	Southlake Regional Health Centre
Hal Wolf	The Chartis Group
Janet Yale	Arthritis Society
Pierre Yong	Center for Medicare and Medicaid Services
Kim Zimmerman	American Health Care Association
Nancy Zionts	Jewish Healthcare Foundation

Agenda

MONDAY, NOVEMBER 2, 2015

8:00-8:30am

Registration and Breakfast

6th Floor Atrium

8:30-9:00am

Welcome Remarks

6th Floor Joseph H. and Claire Flom Auditorium

- Deborah Bae, Senior Program Officer, Robert Wood Johnson Foundation
- David Biette, Senior Advisor, Canada Institute, Wilson Center
- Dani Peters and Oliver Kim, Co-Organizers, Canada-US Health Summit

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9:00-9:45am

Healthcare in Canada and the United States: Debunking the Myths, Building Constructive Partnerships

6th Floor Joseph H. and Claire Flom Auditorium

Our opening panel will set a foundation for understanding the current and changing nature of both health systems, which is important to fostering a cross-border dialogue on health and healthcare.

- Sherry Glied, PhD, Dean, Robert F. Wagner Graduate School of Public Service, New York University
- Antonia Maioni, PhD, Professor, Institute for Health and Social Policy, McGill University
- Moderator: Dora Hughes, MD, MPH, Senior Policy Advisor, Sidley Austin LLP

9:45-10:45am

Topics in Health Quality and Outcomes Measurement

6th Floor Joseph H. and Claire Flom Auditorium

Metrics are important, but which ones matter most in accounting for health, quality, and value? This panel will discuss lessons learned, future initiatives, and incorporating patient-reported outcomes.

- Helen Burstin, MD, Chief Scientific Officer, National Quality Forum
- Astrid Guttmann, MDCM, MSc, Chief Science Officer, Institute for Clinical Evaluative Sciences, Ontario
- Kathleen Morris, Vice President, Research and Analysis, Canadian Institute for Health Information
- Pierre Yong, MD, Director, Division of Quality Measurement, Centers for Medicare and Medicaid Services
- Moderator: Tara Oakman, Senior Program Officer, Robert Wood Johnson Foundation

11:00am-12:00pm

Health IT: Solutions for Improving Health Outcomes

6th Floor Joseph H. and Claire Flom Auditorium

What are the needs and challenges to achieve national, sub-national, and cross-border coordination of electronic health records?

- Michael Green, CEO, Canada Health Infoway
- Thomas A. Mason, MD, Chief Medical Officer, Office of the National Coordinator for Health IT
- Peter Vaughan, CD, Deputy Minister, Nova Scotia Department of Health and Wellness
- Moderator: Hal Wolf, Senior Healthcare and Informatics Executive, Vice Chair elect, Board of Managers of the Healthcare Information and Management Systems Society

12:00-1:30pm

Lunch

6th Floor Dining Room

Looking Out: Learning Beyond Borders to Inform Decision-Making in Healthcare

- The Hon. Kathleen Sebelius, Former Secretary, U.S. Department of Health and Human Services
- Moderator: Susan Dentzer, Senior Advisor, Robert Wood Johnson Foundation

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1:30-3:00pm

Pathways to Delivery System Reform

6th Floor Joseph H. and Claire Flom Auditorium

Both the United States and Canada are considering how to use delivery system reform models such as coordinated care to improve patient care. Panelists will share examples of lessons learned and overcoming barriers to systemic change.

- Robert Bell, MD, Deputy Minister, Ministry of Health and Long Term Care, Government of Ontario
- William Golden, MD, Medical Director, Arkansas Medicaid
- Hoangmai (Mai) Pham, MD, Acting Chief Innovation Officer, Center for Medicare and Medicaid Innovation (CMMI)
- Stephen Rosenthal, Senior Vice President, Population Health Management, Montefiore Medical Center
- Moderator: Lisa Simpson, MB, President and CEO, AcademyHealth

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3:00-3:15pm

Break

6th Floor Atrium

Hosted by Dun & Bradstreet

3:15-4:15pm

Cross-Border Perspectives in Public Health and Regulatory Cooperation

6th Floor Joseph H. and Claire Flom Auditorium

How can both the United States and Canada collaborate to address public health priorities of mutual interest? How can we build upon existing cross-border partnerships in public health and regulatory cooperation to achieve common goals?

- Karen DeSalvo, MD, Acting Assistant Secretary for Health, U.S. Department of Health and Human Services
- Simon Kennedy, Deputy Minister, Health Canada
- Stephen Ostroff, MD, Acting Commissioner, U.S. Food and Drug Administration
- Gregory Taylor, MD, Chief Public Health Officer, Public Health Agency of Canada
- Moderator: Victor Dzau, MD, President, National Academy of Medicine

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4:15-5:15pm

Topics in Innovation

6th Floor Joseph H. and Claire Flom Auditorium

This panel will cover topics such as: How can we share effective innovations and make those innovations scalable across regions, nations, and borders? What is the current and future role of consumer engagement to better improve health outcomes?

- Erika Harding, Director of Replication Initiatives, University of New Mexico
- Shelly Jamieson, CEO, Canadian Partnership Against Cancer
- Robert Pendleton, MD, Chief Medical Quality Officer, University of Utah Healthcare
- Tom Marsden, Director, Global Development, Business Development, Dun & Bradstreet
- Anne Snowdon, PhD, Chair, Odette World Health Innovation Network, University of Windsor
- Moderator: David Williams, MD, President and CEO, Southlake Hospital

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6:00-8:00pm

Evening Reception

Embassy of Canada
501 Pennsylvania Avenue NW

Hosted by GS1 Canada and the Embassy of Canada

TUESDAY, NOVEMBER 3

8:15-9:00am

Welcome and Breakfast

6th Floor Atrium

9:00-10:15am

Breakout Sessions

Breakout Session 1a

Public Health and Research

6th Floor Moynihan Board Room

- Jane Aubin, PhD, Chief Scientific Officer and Vice-President, Research, Canadian Institutes of Health Research
- Michael Engelgau, Deputy Director, Center for Translation Research and Implementation Science, National Institutes of Health
- Frank Plummer, PhD, Senior Advisor, Public Health Agency of Canada
- Jean Slutsky, Chief Engagement and Dissemination Officer, and Program Director for Communication and Dissemination Research, Patient-Centered Outcomes Research Institute
- Moderator: Suzanne Ffolkes, Vice President of Communications, Research!America
    1. *How can we build upon existing cross-border partnerships in medical research to achieve common goals in health?*
    2. *What pressing public health needs must be addressed 5, 10, 20 years from now? How can research help address those needs?*
    3. *How can research serve as a tool to improve patient and health system outcomes?*

Breakout Session 1b

Innovation Topic: Transforming Canada and U.S. Health Systems by Leveraging Cross-Border Supply Chains

5th Floor Conference Room

- Joseph Drozda, MD, Director of Outcomes Research, Mercy Health

- Martha Huston, President, Cardinal Health Canada
- Eileen Mac Donald, President, GS1 Canada
- Moderator: Anne Snowdon, PhD, Director, Odette World Health Innovation Network
    1. *How can a standards-based supply chain be an innovation strategy for quality improvement, safety, and health outcomes?*
    2. *What are Canada-U.S. collaborative opportunities to streamline supply chain processes to drive economic value and improve outcomes and patient safety?*
    3. *Why is innovation a challenge in Canada and the United States, and why has so little progress been achieved?*
    4. *What is the capacity of innovation in both nations' health systems and the potential to accelerate system transformation-quality improvement, safety, health outcomes, and economic value?*
    5. *How can we capture evidence of impact of innovation and create health system metrics for the future?*

10:30-11:45am
Breakout Sessions

Breakout Session 2a

Consumer Engagement for Health System Improvement

5th Floor Conference Room

- Irfan Dhalla, MD, Vice-President, Evidence Development and Standards, Health Quality Ontario
- Cindy McDaniel, Senior Vice President, Consumer Health, The Arthritis Foundation (United States)
- Jeff Richardson, CEO, Mosaic Community Services (Maryland)
- Janet Yale, President and CEO, The Arthritis Society (Canada)
- Moderator: Kathryn (Katy) Spangler, Senior Vice President, Health Policy, American Benefits Council
    1. *How can we better involve consumers in market access evaluations (pre- and post-market)?*
    2. *How can we empower consumers to improve care and disease management?*

3. *What is the role of large employers, insurers, and government, how can they work together with patients and consumers?*
4. *What are best practices in workplace wellness?*

Breakout Session 2b

Delivery System Reform

6th Floor Moynihan Board Room

- Jaeson T. Fournier, DC, MPH, CEO, West Side Community Health Services
- John H.V. Gilbert, CM, PhD, FCAHS, Co-Chair, Canadian Interprofessional Health Collaborative
- Alan Glaseroff, MD, Co-Director, Stanford Coordinated Care, Stanford University
- Doris Grinspun, RN, PhD, CEO, Registered Nurses Association of Ontario
- Moderator: Robin Osborn, Commonwealth Fund
  1. *How do we improve care coordination across care settings?*
  2. *How are we streamlining payments to incentivize care?*
  3. *How are we improving program efficiency to strengthen quality at reduced cost?*
  4. *Quality standards: How and what to measure now, 10 years from now?*
  5. *How do we consider social determinants of health when measuring quality and health outcomes?*
  6. *How can we leverage our joint efforts on medical education to strengthen delivery system reform efforts in both countries?*
  7. *How can delivery systems meet needs of rural populations?*

11:45am-12:30pm

Closing Remarks

6th Floor Joseph H. and Claire Flom Auditorium

- Thomas Scully, Former Administrator, Centers for Medicare and Medicaid Services, General Partner, Welsh Carson Anderson and Stowe

Index of Acronyms

ACA	Affordable Care Act
ACO	Accountable Care Organization
CCIIO	Center for Consumer Information and Insurance Oversight
CHIP	Children's Health Insurance Program
CIHI	Canadian Institute for Health Information
CIHR	Canadian Institutes of Health Research
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
CRTC	Canadian Radio-television and Telecommunications Commission
ECCO	Enhancing Community Care for Ontarians
Project ECHO	Extension for Community Healthcare Outcomes
ECP	Nova Scotia's Extended Care Paramedic Program
EHR	electronic health record
FACC	Fellow of the American College of Cardiology
FACP	Fellow of the American College of Physicians
FDA	U.S. Food and Drug Administration
FHQC	Federally Qualified Health Center
FUHN	Federally Qualified Health Center Urban Health Network
G10	the Group of 10
Health IT	Healthcare Information Technology
HHS	U.S. Department of Health and Human Services
ICES	Ontario's Institute for Clinical Evaluative Sciences
mHealth	mobile health

MOHLTC	Ontario's Ministry of Health and Long Term Care
NML	National Microbial Laboratory
NQF	National Quality Forum
ONC	Office of the National Coordinator for Health Information Technology
PATRIOT Act	Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism
PCORI	The Patient-Centered Outcomes Research Institute
SUV	sport utility vehicle
UDI	unique device identifier
VDO	value-driven outcomes

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