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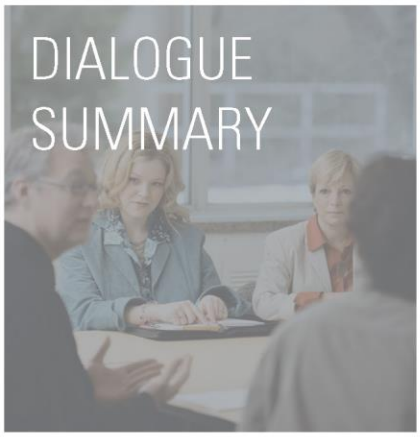
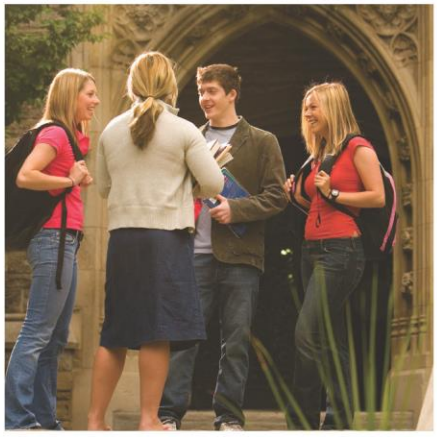



# SUPPORTING OPTIMAL SCREENING APPROACHES IN CANADA

17 OCTOBER 2013

EVIDENCE >> INSIGHT >> ACTION

# Dialogue Summary:
# Supporting Optimal Screening Approaches in Canada

17 October 2013

McMaster Health Forum

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

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Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary, but the authors had final decision-making authority about what appeared in the dialogue summary.

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# SUMMARY OF THE DIALOGUE

Dialogue participants expressed agreement with most aspects of the description of the problem in the evidence brief. This included over enthusiasm towards screening among consumers and providers, the consequences of sub-optimal screening (e.g., over diagnosis and the associated increases in healthcare resources consumed), and the limitations in system-level arrangements that contribute to sub-optimal screening (e.g., the lack of coordination for the delivery of the full spectrum of screening-related care and across sectors and jurisdictions). Participants raised several additional issues, including: 1) lack of emphasis on patient-centred approaches to screening; 2) tensions between organized and opportunistic screening and between 'vertical' program- and primary care-driven screening; 3) absence of a national vision and of approaches to support accountability across sectors and jurisdictions; and 4) limited scale and scope of evidence synthesis and recommendation development to support decision-making and implementation.

Dialogue participants generally agreed that features of each of the elements – coordinated decision-making, coordinated evidence synthesis and recommendation development, and supports for implementation – were needed. Deliberations about how to achieve greater coordination across sectors emphasized the need to strengthen primary care as a key point of contact for screening and to re-frame interactions with patients and providers to ones focused on how screening fits into the patient journey. In considering how to support greater coordination across jurisdictions, dialogue participants emphasized the need to: 1) document and share what is being done well and what could be improved or built upon; 2) adopt common goals and standards; 3) develop and implement processes to ensure accountability for meeting goals and standards; and 4) support collaboration to ensure consistency across jurisdictions. Dialogue participants also indicated that avoiding duplication in conducting syntheses and developing recommendations was important, but any efforts to do so need to support 'local' processes to develop contextualized recommendations where appropriate. Lastly, dialogue participants emphasized the need for supporting quality improvement and accountability (e.g., through the use of performance metrics within and across jurisdictions) as part of broader support for implementation.

Key implementation considerations raised by dialogue participants included the need to build partnerships across sectors and jurisdictions, and to build a sense of urgency about the issue to gain traction in efforts to address it. Possible windows of opportunity that were highlighted by participants include rapid advancements in technology, ongoing efforts towards primary-care reform, and screening being an issue that one or more visible groups might be willing to champion. Lastly, dialogue participants focused on three broad areas that were viewed as essential components of any next steps: 1) strengthening primary care and ensuring linkages to the broader spectrum of care needed for optimal screening; 2) fostering opportunities for exchanging innovations and best practices across sectors and jurisdictions; and 3) supporting a national/collective vision for screening.

# SUMMARIES OF THE FOUR DELIBERATIONS

## DELIBERATION ABOUT THE PROBLEM

Dialogue participants expressed agreement with most aspects of the description of the problem in the evidence brief. Two of these aspects included over enthusiasm towards screening among consumers and providers and the consequences of sub-optimal screening (e.g., over diagnosis and the associated increases in healthcare resources consumed). A key additional aspect is the limitations in system-level arrangements that contribute to sub-optimal screening (e.g., the lack of coordination for the delivery of the full spectrum of screening-related care and across sectors and jurisdictions). As several dialogue participants emphasized, screening is not just about the test, but also timely diagnosis and follow-up care, and support to change the course of the disease for the individual.

Participants built on several of the factors contributing to the problem that were outlined in the evidence brief, and raised additional factors that were not included in the brief, but were considered to be an important part of the problem. These factors included: 1) lack of an emphasis on patient-centred approaches to screening; 2) tensions between organized and opportunistic screening and between 'vertical' program- and primary care-driven screening; 3) absence of a national vision and of approaches to support accountability across sectors and jurisdictions; and 4) limited scale and scope of evidence synthesis and recommendation development to support decision-making and implementation. Each of these four themes is outlined in more detail below.

The lack of emphasis on patient-centred approaches to screening was raised by several participants and in different ways. At the most fundamental level, several participants questioned whether a diseased-focused approach (which was argued to be the dominant approach to screening) is appropriate, rather than an approach focused on a patient's journey that would take into account risk factors (including family history and individual lifestyle) and preferences for what to do after a positive screening test, and recognize logical 'clusters' of screening activities that are likely to be needed at different stages of a patient's broader life trajectory. The issue of patient-centredness in screening was also expressed by dialogue participants in the context of informed consent. For example, one participant noted that there are many potential benefits of screening, but also

**Box 1: Background to the stakeholder dialogue**

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

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

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

potential harms associated with it, and that ensuring informed consent that takes into account an individual's risk factors and preferences is critical. However, as other participants noted, attaining 'true' informed consent is often difficult given that providers typically lack the time to engage with patients both to provide relevant background information and to discuss the implications of screening for them. One participant illustrated this idea with an example from the HIV sector where there is 97% uptake of pre-natal HIV testing, yet informed consent is often not achieved and some patients may not know the test is being done even though it can have profound consequences for them (e.g., stigma-related shunning in some communities).

Several dialogue participants discussed the tensions between organized and opportunistic screening and between 'vertical' program- and primary care-driven screening (and they noted that organized screening has typically been more a hallmark of vertical programs and opportunistic screening than a hallmark of primary care). One participant suggested that the tensions between organized and opportunistic screening are the same as those observed in primary care more generally, and that we continue to face the dilemma as to whether to target investments towards programs that can deliver fast results or to continue supporting the transition to more integrated and patient-centred primary care. One participant questioned the emphasis on delivering screening through organized programs and suggested that primary care was the optimal setting for many forms of screening given providers' familiarity with their patients' unique contexts. While agreeing with the important role of primary care for providing many types of screening, several participants noted that opportunistic screening inherently lacks accountability, whereas organized programs take responsibility for the full care pathway, which includes having accountability measures in place. In addition, one participant highlighted that a potential limitation of organized programs, which has to be addressed, is a lack of linkages back to primary care (and in some instances programs bypassing primary care altogether) where much of the follow-up care and support needs to take place. More generally, one participant cautioned that medical genetics and personalized medicine are going to challenge existing approaches to screening, and both organized programs and primary care will have to become more nimble and responsive to address this development.

The third theme that emerged was the absence of a national vision and of approaches to support accountability across sectors and jurisdictions. As one participant outlined, there is generally a lack of efforts or opportunities to draw on "lessons learned" from other sectors and jurisdictions. Another participant emphasized that the absence of a federal presence in screening policy limits our collective ability to create and realize a vision. Others, in expressing agreement and lamenting the lack of federal engagement in the dialogue, generally noted that there is a need to find a way to get the federal government to play a role. Others noted that such a vision could also be facilitated by groups with a national vision (e.g., the Council of the Federation). Several participants also indicated that a key driver of the absence of an overarching vision for screening in Canada is at least partially due to a lack of accountability. For example, one participant emphasized that inconsistencies across sectors and jurisdictions will endure without efforts to determine how the country is faring overall in screening, and where progress can be made. Another participant stated that knowing who is accountable for delivering results is essential. The same participant further suggested that without evaluative metrics that set standards based on commonly prioritized outcomes, and without evaluative processes to measure progress across the country, there is no way to ensure a standard level of quality and to hold accountable those not meeting standards. Other participants noted that evaluative metrics and processes need to include the tough-to-measure outcomes like informed consent for screening, uptake of screening, time to diagnosis, and appropriateness of care.

The last theme that emerged during the deliberations related to the limited scale and scope of evidence synthesis and recommendation development to support decision-making and implementation. Some participants noted the need for groups such as the Canadian Task Force for Preventive Health Care to produce evidence syntheses and actionable recommendations at a bigger scale. However, these participants also noted the limited prospect for budgets being expanded to accommodate a greater scale of work. The limited scope of evidence synthesis and recommendation development was also highlighted as a challenge. One participant indicated that knowing whether something like a screening test 'works' is insufficient for

decision-making, and that decision-makers also need evidence about how it can be adapted to and implemented in different contexts so that benefits can be maximized, harms minimized and value for money achieved. Participants generally agreed that working through implementation considerations is a critical part of decision-making, yet typically not addressed in the syntheses being prepared and the recommendations developed by groups across the country. Furthermore, one participant lamented the lack of reconciliation of conflicting recommendations, while another participant lamented that both direct costs (i.e., the costs of administering a screening program) and opportunity costs (i.e., the next best use of resources devoted to a screening program) are inconsistently addressed in syntheses and recommendations despite their importance to decision-makers. Lastly, while agreeing with the importance of research evidence to inform decisions about optimal screening approaches, two participants cautioned that there can be a tendency to be paralyzed by the need to find sufficient research evidence, and they underscored the importance of providing additional forms of evidence about implementation considerations when high-quality research evidence is lacking (particularly since issues often emerge quickly and decisions need to be made within short periods of time).

## DELIBERATION ABOUT ELEMENTS OF AN APPROACH TO ADDRESS THE PROBLEM

Much of the deliberation focused on components of the first element of a potentially comprehensive approach to addressing the problem (creating a model to coordinate decision-making about screening across sectors and/or jurisdictions), given that it was the most comprehensive of the three elements outlined in the evidence brief. In addition, it was viewed that the scope of the first element could potentially include efforts to establish a hub to coordinate evidence synthesis and recommendation development (element 2), and to support the optimal implementation of screening approaches (element 3), and therefore much of the deliberation about a model for decision-making touched upon components of these elements.

### Element 1 - Create a model to coordinate decision-making about screening across sectors and/or jurisdictions

In deliberations about achieving greater coordination across sectors, two main themes emerged. First, several dialogue participants raised the notion that fostering coordination across sectors requires strengthening primary care, which is typically the most common point of contact for screening and where ongoing care and support are typically provided after a positive screening result. As noted by several of the dialogue participants, this could include strengthening a variety of supports for primary care, including incorporating mechanisms for measuring primary care providers' performance (as a way of identifying areas for improvement over time), enhancing the use of electronic medical records to support more coordinated care, ensuring remuneration mechanisms are aligned with recommended practices, and ensuring continuity and coordination among the various components of screening (e.g., from primary care to labs to follow-up care).

Second, many dialogue participants supported the idea of re-framing the interactions with patients and providers to ones focused on how screening fits into a patient journey. This type of approach necessitates greater collaboration across sectors because, as one participant noted, "it's not just screening for one disease, but thinking through the full spectrum of possible screening and care that is needed, which would include information and education provision about the full story." In addition, one participant noted that the 'patient journey' approach to care is well accepted by primary-care physicians, given that is how they generally work. Other dialogue participants pointed out that we know people require specific packages of care and support at different life stages (e.g., adding breast cancer screening to the routine package of care for women once they reach 50 years of age) or for different health issues or life events (e.g., pregnancy). As one participant highlighted: "This avoids a 'screening brigade' by instead focusing on knowing what do along a certain point in a patient journey." The individual gave the example of knowing the types of care and support that are needed to support a healthy pregnancy (part of which would relate to supporting informed decisions about screening).

In deliberating about greater coordination across jurisdictions, four interconnected themes emerged that could collectively enhance coordination of screening approaches across the country. First, dialogue participants suggested that a key focus of efforts to foster better coordination across jurisdictions should be on documenting and sharing what is being done well in existing screening programs (i.e., in a highly organized and efficient way), and what could be improved or built upon. Several dialogue participants emphasized the need to undertake this documenting and sharing in a systematic way and avoid basing it on anecdotes. Some participants suggested that this type of exercise would be useful as a way of helping jurisdictions from "being caught out" as possible laggards in screening practice in the country in the short run, and as a way to lay the groundwork for better coordination in the long run.

The second theme related to achieving greater coordination across jurisdictions relates to the need for setting consistent goals (e.g., specific targets for screening uptake vs. 100% informed consent) and standards of care related to screening. Several dialogue participants pointed to the need to set national standards collectively or to adopt international standards. One dialogue participant suggested that setting national goals and standards might be best achieved through a consensus-building approach, and argued that such an approach would be more likely to build acceptance across the system. Another participant emphasized that any approach to setting goals and standards needs to be done in collaboration with consumers and other stakeholders committed to improving the system.

The third theme builds on this and relates to the recognition of many dialogue participants that goals and standards will need to be coupled with some form of accountability or incentive for meeting them. One dialogue participant argued for putting accountability mechanisms in place. Several other participants suggested that performance metrics for the quality and appropriateness of screening would act as a powerful incentive, with one of them noting that, as with setting goals and standards, a consensus-building approach to establishing performance metrics would be optimal. Another dialogue participant suggested that another approach could be to harness the competitive instincts among jurisdictions by celebrating examples in different sectors with the goal of incentivizing or applying peer pressure among provinces to see who can come out best on performance metrics. As part of this discussion, examples from the U.S. were highlighted where performance metrics are used by large payers such as Kaiser Permanente and by the U.S. Office of Personnel Management (which administers health insurance programs for federal employees and members of Congress, and certifies and oversees those issuing health insurance in the country). Groups such as these set the bar for what should be thought of as good quality care, and then use performance evaluations (and their clout as large purchasers of care) to hold accountable payers that do not meet specified standards (e.g., by placing them on 'improvement plans' to get them on track to meet standards and, if quality is not improved, by asking them to leave the group). One dialogue participant cautioned that setting national standards and operationalizing them through performance metrics could be problematic if they are not properly aligned with the goals of screening. Specifically, the participant argued that the most appropriate goal for screening should be achieving 100% informed consent, and that if national standards aim towards a specific target for providing screening tests to specific populations (e.g., 70% uptake) then practices not achieving this level of uptake but still achieving 100% informed consent may be inappropriately penalized. In addition, another dialogue participant further cautioned that it would be problematic to set national standards in Canada given that accountability rests at the level of provinces and territories.

The fourth theme from the deliberations is the recognition from participants that while an approach focused on the patient journey is a way of supporting coordination across sectors (as outlined earlier), it is also an area that some indicated could benefit from greater national collaboration to ensure consistency across jurisdictions. Some participants called for establishing national groups to develop optimal patient journeys. Such groups could identify key stages of the life course for which these patient journeys could be constructed, and the full range of activities (not just screening) that would be optimal in each journey. One participant gave the example of antenatal care where this type of approach already exists.

**Element 2 - Establish a 'hub' to coordinate evidence synthesis and recommendation development to support optimal screening**

Deliberations related to establishing a 'hub' to coordinate evidence synthesis and recommendation development revealed general agreement about the need to avoid unnecessary duplication of efforts across the country. However, while generally acknowledging the need for more coordinated approaches, several dialogue participants expressed concerns about a 'centralized' process for evidence synthesis. These participants suggested that any efforts to improve evidence synthesis and recommendation development should also support 'local' processes to develop contextualized recommendations (where appropriate) and to address the full range of implementation considerations.

Some dialogue participants indicated that it would be critical to leverage existing provincial/territorial and national capacity for evidence synthesis and to build capacity where little exists. However, while leveraging existing capacity was viewed as essential, it was also noted by several participants that this would ideally be accomplished with federal government financial support. Synthesizing research evidence about implementation considerations and making recommendations about implementation was the one key area where current capacity was noted to be limited.

Several dialogue participants emphasized the importance of re-focusing (or expanding the focus of) evidence-synthesis efforts to include the full range of implementation considerations related to screening. It was noted that a focus on what should be done in terms of screening practice (i.e., traditional recommendation development) should be retained, but that it should be completed by supporting implementation through resources such as workbooks that assist with contextualizing the evidence/recommendations at the level of provinces/territories, regions and organizations.

Lastly, several dialogue participants also suggested that there is a need to better target or frame the take-home messages from syntheses and recommendations for both patients and providers, as well as for managers and policymakers. One participant suggested that efforts focusing on patients and providers could focus on framing screening as part of different steps on the patient journey.

**Element 3 - Support optimal implementation of screening approaches**

Deliberations about supporting the optimal implementation of screening approaches generally focused on the need to give much greater attention to closing the evidence-to-practice gap and the evidence-to-policy gap. While this included drawing on the insights from evidence syntheses about implementation and using more appropriate framings for different audiences (e.g., focusing on the patient journey) as was outlined above, dialogue participants emphasized the need for supporting quality improvement and accountability as part of a broader mandate for implementation. Indeed, one dialogue participant indicated that this element should be about "supporting implementation and improvement" rather than just "supporting implementation." In addition, another dialogue participant stated that there is a need for quality improvement to drive the agenda forward, and that without such a forward-looking approach, efforts to support optimal screening approaches remain simply quality-assurance exercises, which lack the ability to support progress over time. Building on these sentiments, another dialogue participant indicated that it is easy to set up a screening program, but what's hard is to convince the government to continue to invest, and this requires real improvements in outcomes. To do this, you need built-in quality-improvement efforts over time.

Three specific themes from the broader focus on quality improvement in screening emerged from the deliberations. First, as outlined earlier in the summary of deliberations about the first element, participants generally agreed that there is a need to continue to push for the use and reporting of metrics that key stakeholders can agree are important to achieve. For example, one participant highlighted that understanding how to move from quality assurance to quality improvement is a poorly understood field but, in general, the

fundamental components are: 1) knowing what should be measured; and 2) using metrics to monitor those outcomes. Another participant emphasized that research evidence is critical for quality improvement, but that there is a need to consider a broad range of evidence in measuring progress. A third participant suggested that metrics could include measures about the full range of activities at each stage of screening (i.e., not just the activities related to the test, but also the follow-up and subsequent care).

Second, several participants emphasized the need to begin to establish accountabilities in primary care given the amount of screening that occurs in primary-care settings. Several participants indicated that accountabilities should include the full spectrum of activities involved in screening in primary care. One participant provided an example where the scope of monitoring was expanded from only documenting the ordering of a test as the relevant outcome to also include the completion of the test and the adjudication of the result. The participant indicated that even though there was a substantial drop in adherence to screening standards after the expansion in scope of measurement, that the benefit was a fuller picture of where to target efforts for improvement in the future.

Third, similar to the deliberations about the 'hub' for evidence synthesis, several dialogue participants emphasized the need to leverage existing capacity for implementation, in this case among national and provincial quality-improvement agencies, and to build capacity where little exists. Examples provided by participants for where there is emerging or existing quality-improvement capacity included the Canadian Foundation for Health Improvement at the national level, with its overall mandate to accelerate healthcare improvement in Canada, and provincial quality councils (e.g., Health Quality Ontario). As one dialogue participant highlighted, the benefits of leveraging the capacity of such groups is that quality councils are seen as "neutral experts" who can be used to help in a situation without bias.

**Considering the full array of options**

Across the deliberations for each of the three elements, several core themes emerged that appear relevant to each. First, there was consistent emphasis on the need for greater coordination across sectors and jurisdictions, not only in terms of decision-making about screening policy and practice (element 1), but also as a component of leveraging existing capacity for evidence synthesis and recommendation development, and for quality improvement. Second, the notion of re-framing screening so it is seen as part of a larger patient journey rather than as being about discrete tests and associated care at one point in time, was discussed as being fundamental to each of the elements (e.g., for recommendation development and for determining outcomes to measure quality improvement). Lastly, participants repeatedly emphasized the need to avoid 'business as usual' in terms of ensuring greater accountability (e.g., through performance metrics), expanding the scope of evidence synthesis and recommendation development (e.g., by focusing on the full range of implementation considerations), and moving towards quality improvement in the true sense of the term.

## DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

The focus of the deliberations about implementation considerations was on what might need to be considered or done to move forward with any or all of the three elements. The need to build partnerships across sectors and jurisdictions was noted on several occasions as a key component of implementation. Related to this, one participant emphasized that the entire health system has to be part of the calculus of implementation to ensure resources are deployed efficiently, and that programs and services are having the intended impact. For example, a number of dialogue participants highlighted several groups involved in evidence synthesis or related work where greater collaboration or partnership building among them would be beneficial. The main groups highlighted include the Canadian Task Force on Preventive Health Care, the Canadian Association for Drugs and Technologies in Health, the Canadian Primary Care Sentinel Surveillance Network (a pan-Canadian multi-disease electronic medical record surveillance system that could support

implementation efforts), and provincial health technology assessment groups. An example provided from the United States was the synergistic relationship between the U.S. Preventive Services Task Force, which develops recommendations, and the Community Preventive Services Task Force, which has a focus on supporting the implementation of recommendations across the country. As one part of building partnerships, public and stakeholder engagement was viewed as critical with one participant stating that "the best you can do is be absolutely clear about your process and include [in it] stakeholder engagement. There will always be disagreement, but using a clear process helps to address this."

Many dialogue participants indicated that a sense of urgency needs to be built about the issue to gain traction in efforts to address it. However, there were mixed views about whether some sense of urgency exists already, with some participants emphasizing the barriers that exist to bring issues related to screening to the forefront of policymakers' agendas, and others highlighting possible windows of opportunity. For example, some participants generally noted that screening is not currently viewed by policymakers as the most pressing challenge as compared to other issues in provincial and territorial health systems. In addition, it was noted by some that screening is not a 'sexy' issue, and by others that screening could benefit from being re-framed in the context of health promotion and disease prevention. Some cautioned against such re-framing given that screening is more than prevention, but they still acknowledged that the issue of screening could be 'massaged' to make it a more appealing issue to the public. Lastly, one participant suggested that bringing the issue of screening up to the surface might be resisted by those who might view efforts at reform as infringing on their autonomy (e.g., primary-care providers) and, as a result, ministries of health may be hesitant to wade into an issue that could spur such a response.

Possible windows of opportunity that were highlighted by participants include rapid advancements in technology, ongoing efforts towards primary-care reform, and screening being an issue that one or more visible groups might be willing to champion. Two examples of technological advances were provided as opportunities to bring a sense of urgency to addressing the issue. First, one participant suggested that rapid advancements in pre-natal screening are creating a mounting sense of urgency to work across jurisdictions to put systems and processes in place to determine how best to incorporate new technologies in practice. Second, another participant raised the issue of the rapid growth of personalized medicine, noting that those offering genetic tests can often bypass the government and deal directly with patients and providers. As a result, the participant suggested that a sense of urgency could be built around the risk that personalized medicine "will get out of control." Broader primary-care reform efforts were also suggested as a potential window of opportunity. For example, efforts towards reforming funding and remuneration systems could be used to negotiate the inclusion of specific incentives, and shifts to different delivery models in primary care (e.g., team-based care) could be used as a mechanism to support the implementation of the 'patient journey' approach to care. Lastly, one participant noted that the lack of focus on healthcare at the federal level has left the Canadian Medical Association struggling to achieve relevance on a national issue, and that screening could be something the association would take on more actively. It was suggested that a natural fit for pursuing this would be through the Choosing Wisely Campaign.

## DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

During the final deliberation, participants were asked what should be prioritized going forward and/or what their organization or group should do differently based on what they learned from the deliberations about the problem, elements of a comprehensive approach to addressing the problem, and key implementation considerations. Responses from participants focused on three broad areas that were viewed as essential components for next steps: 1) strengthening primary care and ensuring linkages to the broader spectrum of care needed for optimal screening; 2) fostering opportunities for exchanging innovations and best practices across sectors and jurisdictions; and 3) supporting a national/collective vision for screening.

Dialogue participants who highlighted 'strengthening primary care' as a priority emphasized their commitment to supporting access to optimal screening. Specifically, participants identified the need to work on creating more entry points to screening within primary care (e.g., by nurses working to their full scope of practice and/or expanding the scope of practice for nurse practitioners), and creating points of access to primary care for those who have no primary-care provider. For example, one participant emphasized that a key issue has been the gap between acute care and primary care and the participant's hope was that ambulatory-care organizations could help fill this gap. Doing so would ensure that when people get a positive screening test, there is someone 'there' to address the issue. Those who highlighted better linkages between primary care and the broader spectrum of care needed for optimal screening emphasized that screening is not just about testing, and that screening "is such a small slice of a larger pie." These participants expressed their commitment to supporting the integration of screening within broader issues (to help foster a greater sense of urgency), and to supporting the development of care pathways that attend to a broader "treatment cascade" (i.e., ensuring access to needed social and community supports).

Dialogue participants who identified the need to foster opportunities for exchanging innovations and best practices across sectors and jurisdictions were generally in alignment with one dialogue participant who stated that "we have limited yet strong expertise in this country, which needs to be pulled together." This participant suggested that there needs to be some sort of supporting, coordinating or linking body for helping to pull this expertise together. Specific examples of next steps that could be taken were to investigate ways to link screening groups and health quality councils. Other participants noted that a key next step is to ensure that innovations from specific provinces are made available to other provinces to learn from. One suggested mechanism was to "put interests aside for one issue" such as newborn/pre-natal screening (given the general sense of urgency around addressing the issue) and "demonstrate how collectively, we can work together to make a difference." Another participant similarly highlighted the "need to crack a 'nut' somewhere", and this could be to facilitate a process to harmonize at least one guideline to demonstrate how this type of activity could be done and the type of impact that it could have. Lastly, a number of participants identified the Choosing Wisely campaign as one way to foster exchanges across sectors and jurisdictions about best practices.

Lastly, participants who emphasized supporting a national or collective screening vision suggested several key steps or requirements to make progress. At the most fundamental level, participants noted the need for the federal government to make a commitment to the issue given its national importance. Such a commitment would need to include funding mechanisms (e.g., towards expanding the scale of evidence synthesis and recommendation development in terms of topics addressed and the scope of such work to include the full range of implementation issues), as well as related supports (e.g., pressing for truly interoperable electronic health records). In addition to this, one participant noted the need for inspirational leadership and highlighted the United Kingdom where such leadership, coupled with robust data about the failure to effectively screen women and public pressure to do better, sparked the commitment to broad-based revisions in screening approaches. Lastly, in speaking to the need to move forward with collective action in the screening sector, one dialogue participant indicated that "there is no place to turn to in times of uncertainty", and that this results in a lack of coordinated approaches. The participant further indicated that "we have the skills, 'know-how' and resources, but for some reason we're not creating the platform and doing something about it".

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