Panels Summary

Modernizing the Oversight of the Health Workforce in Ontario

11, 18 and 25 August 2017

McMaster University | McMaster HEALTH FORUM

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McMaster Health Forum

The McMaster Health Forum's goal is to generate action on the pressing health-system issues of our time, based on the best available research evidence and systematically elicited citizen values and stakeholder insights. We aim to strengthen health systems – locally, nationally, and internationally – and get the right programs, services and drugs to the people who need them.

About citizen panels

A citizen panel is an innovative way to seek public input on high-priority issues. Each panel brings together 12-14 citizens from all walks of life. Panel members share their ideas and experiences on an issue, and learn from research evidence and from the views of others. The discussions of a citizen panel can reveal new understandings about an issue and spark insights about how it should be addressed.

About this summary

On 11, 18 and 25 August 2017, the McMaster Health Forum convened three citizen panels on modernizing the oversight of the health workforce in Ontario. The purpose of the panels was to guide the efforts of the Ontario Ministry of Health and Long-Term Care in determining how to modernize the oversight of the health workforce. This summary highlights the views and experiences of panellists about:

- the underlying problem;
- three elements of a potentially comprehensive approach to addressing the problem; and
- potential barriers and facilitators to implement these options.

The citizen panel did not aim for consensus. However, the summary describes areas of common ground and differences of opinions among panellists and (where possible) identifies the values underlying different positions.

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Summary of the panels

Participants across the three panels identified six challenges that warrant modernizing the oversight of the health workforce in Ontario: 1) oversight bodies have not adapted to changes in the delivery of care; 2) having many bodies responsible for the oversight of the health workforce makes navigating the oversight system challenging and may be inefficient; 3) the oversight framework doesn't put enough emphasis on the soft skills and personalization required to provide high-quality patient-centred care; 4) oversight bodies have not been set up in a way that prioritizes the interests of patients; 5) finding information about health workers and their oversight bodies is difficult and there are limited opportunities for patients to contribute to oversight efforts; and 6) risk of harm needs to be identified and addressed across a patient's entire care pathway. While the first five of these challenges relate specifically to oversight, the sixth involves a broader health-system challenge that is made more complex given the current oversight framework.

Panellists generally supported all three elements of a potentially comprehensive approach to modernizing the oversight of the health workforce: 1) use a risk-based approach to oversight; 2) use competencies as the focus of oversight; and 3) employ a performance-measurement and -management system for the health workforce and its oversight bodies. In discussing element 1, panellists stressed the need for equity in assessing risk across all categories of health workers and an efficient use of oversight resources. Panellists emphasized 'soft skills' (e.g., bedside manner, desire to continue to learn, and willingness to collaborate with other health workers) in the competencies required to deliver patient-centred care (element 2), and they called for a greater voice for patients in a performance-measurement and -management system (element 3).

When the deliberations turned to implementation, panellists identified as the key barriers to moving forward the difficulties associated with pursuing health-system change and maintaining political will and momentum, as well as the politics among professional regulatory colleges, professional associations, and other stakeholders. One panellist challenged health-system leaders to "not just [put] in place what is easiest politically, but what will actually make our system better." Panellists noted a number of facilitators that may help to build political will for change, including recent news stories about patient harm and a general appetite among patients to improve the quality of the care they receive.

"As a patient, I didn't know what health workers were allowed and not allowed to do"

Discussing the problem:

What are the most important factors that may warrant modernizing the oversight of the health workforce in Ontario?

Panellists began by reviewing the findings from the pre-circulated citizen brief, which highlighted what is known about the factors that may warrant modernizing the oversight of the health workforce. They focused on six key challenges, which are, in descending order of the importance given to them by panellists:

1) oversight bodies have not adapted to changes in the delivery of care;
2) having many bodies responsible for the oversight of the health workforce makes navigating the oversight system challenging and may be inefficient;
3) the oversight framework doesn't put enough emphasis on the 'soft skills' and personalization required to provide high-quality patient-centred care;
4) oversight bodies have not been set up in a way that prioritizes the interests of patients;

5) finding information about health workers and their oversight bodies is difficult and there are limited opportunities for patients to contribute to oversight efforts; and

6) risk of harm needs to be identified and addressed across a patient's entire care pathway.

While the first five of these challenges relate specifically to oversight, the sixth involves a broader health-system challenge that is made more complex given the current oversight framework. We review each of these challenges in turn below.

Oversight bodies have not adapted to changes in the delivery of care

Many panellists concluded that the oversight of the health workforce had not kept up to changes in how services are delivered in the system. Panellists focused on three types of changes – health workers whose roles or workload have expanded, settings to which care is increasingly being shifted, and contract and employment arrangements that have become more common as the range of categories of health workers and settings in which they provide care have evolved – as well as on the specific populations for which the changes may be most problematic.

Box 1: Key features of the citizen panels

The citizen panels about modernizing the oversight of the health workforce in Ontario had the following 11 features:

1. it addressed a high-priority issue in Ontario;
2. it provided an opportunity to discuss different features of the workforce-oversight problem;
3. it provided an opportunity to discuss three elements of a potentially comprehensive approach to addressing the problem;
4. it provided an opportunity to discuss key implementation considerations (e.g., barriers);
5. it provided an opportunity to talk about who might do what differently;
6. it was informed by a pre-circulated, plain-language brief;
7. it involved a facilitator to assist with the discussions;
8. it brought together citizens affected by the problem or by future decisions related to the problem;
9. it aimed for fair representation among the diversity of citizens involved in or affected by the problem;
10. it aimed for open and frank discussions that will preserve the anonymity of participants; and
11. it aimed to find both common ground and differences of opinions.

The first change – health workers whose roles or workload have expanded – was most commonly discussed in reference to personal-support workers. Some panellists expressed concern about their minimal level of oversight given their rapid role expansion (to a role that some now likened to a registered practical nurse), their lack of consistent training in these new roles, and the increasing volume of work they take on in the home and community care sector. One participant noted: "I know some PSWs who have to be registered with four companies so that they can get enough hours to make a salary… with this pressure it's not possible they can do a good job with every patient they see." Panellists identified paramedics as another category of health workers whose role was perceived to have expanded, and identified nurse practitioners and physicians as categories of health workers whose workload was perceived to have expanded, all seemingly without appropriate oversight provisions.

The second change – settings to which care is increasingly being shifted – was most commonly discussed in relation to home- and community-care and long-term care settings. Panel members were particularly concerned about the insufficient training of, and lack of supervision for, health workers in these two settings. One participant observed: "when they go into people's homes, they don't have the support of their supervisors and they don't know who to call when they are in situations beyond their

Box 2: Profile of panellists

The citizen panels aimed for fair representation among the diversity of citizens likely to be affected by the modernization of workforce oversight. We provide below a brief profile of panellists:

- **How many participants?**
  13 (Hamilton); 12 (Ottawa); and 12 (Sudbury)

- **Where were they from?**
  Region covered by the: Central East Local Health Integration Network (LHIN); Champlain LHIN; Hamilton Niagara Haldimand Brant LHIN; Mississauga Halton LHIN; North East LHIN; and North West LHIN

- **How old were they?**
  18-24 (2), 25-34 (7), 35-49 (7), 50-64 (10), 65+ (12)

- **Were they men, or women?**
  men (20) and women (17)

- **How many panellists had experience receiving health services from a category of health worker that is not regulated by the *Regulated Health Professions Act, 1991*?**
  Yes (8) and no (29)

- **How many panellists had been involved with a complaints process for a professional regulatory college?**
  Yes (5) No (32)

- **What was the income level of participants?**
  six earned less than $20,000, seven between $20,000 and $40,000, seven between $40,000 and $60,000, five between $60,000 and $80,000, and five more than $80,000, while seven preferred not to answer

- **How were they recruited?** Selected based on explicit criteria from the AskingCanadians™ panel

abilities." Another participant expressed that "home and community care [workers] are not overseen in the same way as a hospital… the supports [both human resources and technology] just aren't there." While concerns were greatest for these two increasingly important settings, some panellists expressed concerns about hospitals, where it may be easier to get the support of other categories of health workers, but the more chaotic environment might lead to "cutting corners" in procedures or forgetting about some of the more routine aspects of care, such as changing sheets and bringing meals that adhere to patients' specific dietary restrictions.

The third change – contract and employment arrangements – was illustrated frequently with the example of personal-support workers, the private home- and community-care companies that increasingly employ them, and the Community Care Access Centres that establish the need for them and fund the companies that pay them. Most panellists were not aware of the potential for new lines of accountability to be established as the roles of Community Care Access Centres become more integrated with Local Health Integration Networks under the *Patients First Act, 2016*.

Panellists also voiced concerns for specific populations of patients (refers to both those currently receiving health services and members of the public more generally) who may not be able to advocate for themselves when faced with harms or risk of harms introduced by these changes in the delivery of care. One participant explained that "the focus on complaints is problematic for elderly people and some Indigenous peoples who have a history of non-response." Other panellists highlighted additional populations, including those with dementia and those with physical or intellectual disabilities. Panellists noted that some of these populations (e.g., elderly, and those with dementia or age-related disabilities) are growing rapidly in Ontario, and unreported harms could increase in tandem should a reactive approach to workforce oversight continue to be used.

Unlike participants in the Hamilton and Ottawa panels, participants in the Sudbury panel focused more on the population of Ontarians living in rural areas. A number of these panellists shared their experiences with challenges not faced by their urban counterparts. These challenges include: 1) receiving acute specialty care in settings with a greater risk of harm (e.g., in community settings when a hospital or other specialty care facility would be used in an urban area); 2) receiving care in settings with fewer or no supports when things go wrong (e.g., specialists and medical equipment); and 3) being more readily identified in a small community as "someone who complains" and then having difficulty accessing care or receiving lower-quality care after having lodged a complaint about a health worker.

Having many bodies responsible for the oversight of the health workforce makes navigating the oversight system challenging and may be inefficient

A number of panellists raised a concern about the number of bodies in workforce oversight, both because of the implications for patients navigating these bodies and because of the potential inefficiency. Panellists noted the many types of oversight bodies (e.g., professional regulatory colleges and government), the many types of bodies that play or appear to play some role in oversight (e.g., healthcare organizations and professional associations), and the sheer number of some of these bodies (e.g., 26 professional regulatory bodies).

Some panellists suggested that the lack of clarity about these bodies' roles and the lack of patient education and resources about oversight makes it difficult for patients to know how to navigate the oversight system (e.g., to report a complaint when harm has occurred), and would likely deter many from taking action and make it impossible for others (like the patient populations noted above) to take action. Other panellists expressed concern about inefficiency. More specifically, two panellists expressed frustration with the redundancies created by having 26 professional regulatory colleges, the administration involved in workforce oversight, and how this administrative burden can draw health workers away from patient care.

The oversight framework doesn't put enough emphasis on the 'soft skills' and personalization required to provide high-quality patient-centred care

Some panellists identified a range of concerns about their encounters with health workers that led them to conclude that the existing oversight framework doesn't put enough emphasis on 'soft skills' and personalization. Panellists described health workers' frequent failure to listen to patients' experiences and medical history, use of generalizations in their responses to questions and more generally their provision of 'impersonalized care,' lack of compassion in communicating diagnoses, and unwillingness to explore options outside of their usual practice (including complementary and alternative therapies).

Some panellists identified education and training programs as the source of these problems, particularly the lack of 'soft skills' such as communication, compassion and coordination of care. Others pointed to the health system, and how it can limit the time and resources that health workers can devote to individual patients, and can instil fear about diverging from practice guidelines. Regardless of the source of these problems, panellists felt that a modernized approach to oversight should help to address their concerns.

Oversight bodies have not been set up in a way that prioritizes the interests of patients

Many panellists expressed their concern that oversight bodies, specifically professional regulatory colleges, prioritized the interests of their professional registrants rather than serving the interests of patients (or Ontarians more generally). Panellists attributed their concern in part to their experiences with registering complaints, where they felt that colleges were "protective and defensive of their own professionals." One panellist recounted a particularly difficult experience with a college where they were told "to get a lawyer, if [they] wanted to continue to pursue the [complaint]." Other panellists at each of the three panels lamented how the complaints process is reactive, relying on individual patients to act as advocates for themselves. One panellist described this as "shifting the responsibility onto the patient rather than on the system." However, panellists also attributed their concern to how they saw professional regulatory colleges engaged in 'turf' wars over the delivery of certain services, which to the panellists appeared to be about what was best for their members and not necessarily for their patients.

Finding information about health workers and their oversight bodies is difficult and there are limited opportunities for patients to contribute to oversight efforts

Many panellists described the difficulty they had finding information about health workers and their oversight bodies before participating in the panel, and expressed frustration after reading the citizen brief that this type of information is not available in a central location. One participant suggested that this lack of transparency eroded public trust in the oversight of health workers. Other panellists did not think it was fair to expect patients who experienced harm to locate information about "what health workers were allowed and not

allowed to do," judge whether a health worker has overstepped what they are allowed to do, and then lodge a complaint.

Many panellists also indicated that there are limited opportunities beyond complaints to contribute to oversight efforts, particularly in terms of providing information about health-workers' performance. One panellist observed that "as patients, we are not routinely asked to be part of the oversight, but we are the ones interacting with health workers… you see in universities that students evaluate their professors, but that is something that is really missing from healthcare." Similarly, other panellists noted how other sectors relied heavily on consumers' comments and evaluations (e.g., through platforms like 'Yelp'), and that such input is typically acknowledged and changes are made accordingly.

Risk of harm needs to be identified and addressed across a patient's entire care pathway

Panellists also noted one broader health-system challenge – managing transitions – that is made more complex by the existing oversight framework. Panellists described experiencing gaps in services and a lack of continuity of care (and hence feeling at risk of harm) when transitioning between categories of health workers (e.g., from physician specialists to primary-care practitioners) and across settings of care (e.g., from hospital to home and community). One panellist described actually experiencing harm: "when I was being discharged, no one asked me about where I was going or for information for my family doctor. I know you can self-refer to the Community Care Access Centre so I did that, but was told that it should be my doctor calling… so I eventually ended up back in the hospital with complications and cost the system more money." Panellists indicated that they felt the existing oversight framework did not ensure that health workers have the necessary administrative competencies required to coordinate care effectively with other individuals and organizations in the system, or that health workers are held to account for ensuring successful transitions between health workers and across settings of care.

"As patients we aren't routinely asked to be part of the oversight… but we are the ones interacting with health workers"

Discussing the elements:
How can we address the problem?

After discussing the factors that suggest the need to modernize the oversight of the health workforce, panellists were invited to reflect on three elements of a potentially comprehensive approach to doing so:

1) use a risk-based approach to health workforce oversight;
2) use competencies as the focus of oversight; and
3) employ a performance-measurement and -management system for the health workforce and its oversight bodies.

Several values-related themes emerged during the discussion about these elements. We provide a short description of each element below, and then describe the values-related themes that emerged in relation to each of the three elements.

Element 1 – Use a risk-based approach to health workforce oversight

Element 1 focuses on taking a risk-based approach to health-workforce oversight by using the potential harms that could be caused by health workers, the likelihood of these harms, and the severity of these harms, to guide the type of oversight put in place and how oversight resources are distributed. This could mean pursuing any of the following sub-elements:

- develop a common definition of risk and determine how it should be applied to health workers; and
- use a risk-based approach to:
  - choose categories of health workers for oversight;
  - categorize health workers under a smaller number of regulatory bodies; and
  - allocate resources to regulatory functions (for example, health-worker registration and complaints management).

Four values-related themes – equity, efficiency, collaboration and accountability – emerged during the discussion about using a risk-based approach to health workforce oversight, and more specifically:
1) equity in efforts to assess risk across all categories of health workers;
2) efficient use of oversight resources based on risk;
3) collaboration among the Ministry of Health and Long-Term Care, existing oversight bodies, health workers and patients, in developing routine processes to support a risk-based approach to the oversight of health workers; and
4) clear lines of accountability in the risk-based oversight of health workers.

A summary of how these values-related themes could be applied to this approach element is provided in Box 3 below.

Panellists across all three panels discussed the first values-related theme – equity in efforts to assess risk across all categories of health workers – by highlighting the need to develop a common definition of risk and a standard process for assessing risk that is fairly applied to all categories of health workers and all settings for care. In particular, many panellists discussed standardization as a way to ensure health workers are measured against, and held accountable for, the same definition of risk (e.g., whether the health worker is a physician or personal-support worker or whether care is being provided in urban or rural settings). One participant stated they felt that "putting in place a standardized process and using common language across health [workers] could help to calm the current chaos."

Other panellists noted that a common definition could more easily be communicated to the public and help to improve public confidence in oversight mechanisms. Despite the emphasis on standardization, panellists recognized that in any risk assessment there would need to be some flexibility based on a health worker's sector or setting, noting in particular that they felt community care presented different risks than a hospital setting, as did working in a rural community compared to an urban centre where more resources are available.

> **Box 3: Key messages about using a risk-based approach to health-workforce oversight (element 1)**
>
> **What are the views of panellists regarding this element?**
>
> - Equitably apply a definition of risk and a standard process for assessing risk across all categories of health workers
>
> - Group categories of health workers into a fewer number of professional regulatory colleges and allocate resources according to their level of risk to maximize efficiencies
>
> - Improve the level of collaboration among the Ministry of Health and Long-Term Care, existing oversight bodies, health workers and patients, in developing routine processes to support a risk-based approach to the oversight of health workers
>
> - Create clear lines of accountability by appointing a single body responsible for processing complaints

Panellists advocated the efficient use of oversight resources – the second values-related theme – and more specifically called for increased grouping of categories of health workers into a smaller number of professional regulatory colleges based on a risk-of-harm approach. In grouping categories of health workers, a few panellists suggested possible solutions: 1) create three groups along a continuum of high, medium or low risk; or 2) develop a scoring system to grade categories of health workers between zero and 100 and assign colleges to oversight bodies based on the range (e.g., 80-90) in which they fall.

Turning to the third values-related theme, panellists described the need to improve collaboration among the Ministry of Health and Long-Term Care, existing oversight bodies, health workers and patients. In particular, participants suggested developing routine processes to support a risk-based approach to oversight, and pushed for concerted efforts to improve the partnerships among these groups. Panellists emphasized the need to differentiate between patients and citizens, highlighting that those who are frequent users of the health system may have a different perspective than other citizens, particularly when it comes to determining the risk that a health worker poses. Panellists also emphasized the importance of ongoing collaboration and engagement of the public by meaningfully including both patients and citizens on the boards of any newly developed oversight bodies that are created as a result of the new risk-based approach. At one panel, participants supported a minimum of one-third patient or citizen representation, while another panel thought that a one-half of boards should be patients or citizens.

Finally, panellists felt that there should be greater accountability for addressing patient complaints – the fourth values-related theme – both in terms of ensuring access for patients to register a complaint and for follow-up and complaints management. Panellists felt that creating one standard body responsible for processing complaints could achieve this goal, and also resonate with their previously expressed values of efficient allocation of oversight resources.

Element 2 – Use competencies as the focus of oversight

Element 2 focuses on using competencies rather than scopes of practice and controlled acts to guide health-workforce oversight. This shift in focus could mean pursuing any of the following:

- develop a process to get input from patients, health workers and existing oversight bodies about how to define the core competencies for each category of health worker;
- determine an approach to update the core competencies as the health system evolves;
- expand the use of competencies across all categories of health workers in:
  - o educational programs preparing candidates for entry to the profession,
  - o training programs preparing candidates for entry into a specialty,
  - o training programs involved in preparing health workers for changes to what they are allowed to do,
  - o continuing professional development programs that help ensure that health workers can safely do what they are allowed to do under the existing oversight mechanisms; and
- use competencies – instead of scopes of practice and controlled acts – as the focus of health-workforce oversight, including to evaluate the seriousness of complaints and other investigations.

Three values-related themes – patient-centredness, trustworthiness, and collaboration – emerged in the deliberation about using competencies as the focus for oversight, and more specifically:

1) patient-centredness and the 'soft skills' that enable it as a core competency for all health workers;
2) trustworthiness and the ability to establish trusting relationships with patients and other health workers as a core competency for all health workers; and
3) collaboration among the Ministry of Health and Long-Term Care, existing oversight bodies, health workers and patients in the development and implementation of core competencies.

A summary of how these values-related themes could be applied to this approach element is provided in Box 4 below.

Most panellists agreed on the need for health workers to improve their levels of patient-centredness and the soft skills that enable it, which was the first values-related theme. Panellists at each of the three panels provided examples of the soft skills they felt should be prioritized as core competencies across all categories of health workers, including: having a good bedside manner; desire to continue to learn; willingness to collaborate with other health workers; effective communication and listening skills both with patients and other health workers; and administration and management skills to facilitate better care coordination. Additionally, a number of panellists agreed that the services that health workers are legally allowed to provide should reflect what they are trained to do (e.g., pharmacist prescribing). Panellists made the case that this could contribute to ensuring the most patient-centred, high-quality care was available, given it would remove barriers for certain types of health worker and could improve patients' access to timely care (e.g., getting a prescription without having to first see a primary-care practitioner). Additionally, panellists identified three categories of health workers – nurse practitioners, pharmacists and personal-support workers – who they believed should define and develop new competencies so they could provide additional services.

> **Box 4: Key messages using competencies as the focus of oversight (element 2)**
>
> **What are the views of panellists regarding this element?**
>
> - Establish patient-centredness and the soft skills that enable it as core competencies for all health workers
>
> - Include trustworthiness and the ability to establish trusting relationships with patients and other health workers as a core competency for all health workers
>
> - Foster collaboration between the Ministry of Health and Long-Term Care, existing oversight bodies, health workers and patients in defining and developing core competencies for health workers

Panellists suggested that the second values-related theme – trustworthiness and the ability to establish trusting relationships with patients and with other health workers – also be a required competency for all health workers. One idea about how this could be achieved was to include trustworthiness as an important character quality that is explicitly considered in prospective students' applications to education and training programs.

Panellists emphasized the need for improvements in collaboration among the Ministry of Health and Long-Term Care, existing oversight bodies, health workers and patients – the third values-related theme – as an element of any process used to establish a core set of

competencies for health workers. A handful of panellists across the three panels advocated strongly for the involvement of health workers, stating "they know best what they can and cannot do." Panellists also encouraged a close collaboration with other government ministries, including the Ministry of Advanced Education and Skills Development, to ensure that the education and training being provided matches the core competencies needed in practice. To continue this collaboration throughout the implementation and updating of core competencies, panellists suggested striking a standing committee with members from each of the aforementioned stakeholder groups to review every three to five years the core competencies for each category of health worker.

Element 3 – Employ a performance-measurement and -management system for the health workforce and its oversight bodies

Element 3 focused on employing a performance-measurement and -management system, which may include:

- introducing an independent body to develop and implement a performance-measurement and -management system;
- develop metrics that allow patients and policymakers to judge and, when needed, demand improvements to the performance of the health workforce or its oversight bodies; and
- establishing clear processes for regular audits of the performance of oversight bodies, which would include:
  - clarifying who should be accountable for what parts of the performance -management system,
  - separating out complaints management from professional registration,
  - allocating the licensing and registration of all categories of health workers to one large independent body, and
  - giving an explicit role in the oversight mechanism to key health-system organizations such as Local Health Integration Networks or hospitals.

Four values-related themes – continuous quality improvement, citizen-values driven, accountability, and patient empowerment – emerged throughout the discussion on element 3, and more specifically:

1) continuous quality improvement among health workers as an ethos to be embedded in performance-measurement and -management efforts;
2) citizen's values and preferences driving the selection of indicators to be used in measuring the performance of health workers;
3) accountability for performance being central to the role of oversight bodies; and
4) patient empowerment being supported by information on the performance of health workers and their oversight bodies.

A summary of how these values-related themes could be applied to this approach element is provided in Box 5 below.

Panellists suggested that embedding an ethos of continuous quality improvement in performance-measurement and -management efforts – the first values-related theme of element three – would support a shift towards a culture of continuous learning in the health system, and a move away from a culture in which health workers are punished for any mistake. Panellists also advocated for greater opportunities to evaluate the performance of their health workers, in efforts to provide them with feedback from which to learn.

In discussing improvements that could be made to the performance-measurement and -management system, panellists emphasized that citizens' values and preferences should drive the selection of indicators to be used in measuring the performance of health workers, which was the second values-related theme. One panellist observed that the performance-measurement system should be "measuring what matters most to us."

Panellists suggested that the third values-related theme - accountability

Box 5: Key messages about employing a performance-measurement and -management system for the health workforce and its oversight bodies

What are the views of participants regarding element 3?

- Embed an ethos of continuous quality improvement and continuous learning in performance-measurement and -management systems

- Select performance indicators using patients' values and preferences

- Embed the necessary structures and processes to ensure that accountability for the performance of health workers is central to the role of oversight bodies

- Introduce interprofessional peer oversight to improve collaboration and accountability as well as to reduce the chance that professional self-interest will interfere with oversight processes

- Empower patients with more information on the performance of healthcare workers and their oversight bodies, and provide them with more opportunities to contribute to the evaluation process

for performance - is central to the role of oversight bodies and that these bodies should be accountable for the performance of the health workers under their purview. In particular, this would include these oversight bodies taking proactive efforts to reduce the risk of harm and making clear what changes have been made when patients have been harmed. Some panellists took this further and argued that oversight bodies should introduce

interprofessional peer oversight to improve collaboration among health workers, and to reduce the chance that professional self-interest will interfere with oversight processes.

Finally, building on previous calls to become more involved with oversight processes, panellists emphasized patient empowerment as a fourth values-related theme. Many panellists identified the need to empower patients with information on the performance of health workers and their oversight bodies. A few panellists offered even more concrete recommendations: 1) provide patients with greater opportunities to evaluate the performance of health workers through questionnaires or short interviews; 2) adjust feedback processes to account for patient-provider power differentials; 3) make measurements easily accessible and understandable to the public; and 4) develop an online dashboard to publicly report on the performance of health workers and their oversight bodies.

"The hardest change will be not just putting in place what is easiest politically, but what will actually make our system better"

Discussing the implementation considerations:

What are the potential barriers and facilitators to implement these options?

After discussing the three elements of a potentially comprehensive approach to modernizing the health workforce, panellists examined potential barriers and facilitators for moving forward.

The discussion about barriers generally focused on the difficulties associated with pursuing health-system change and maintaining political will and momentum. Panellists also felt that navigating the politics among professional regulatory colleges, professional associations and other stakeholders would be difficult. One panellist challenged health-system leaders to "not just [put] in place what is easiest politically, but what will actually make our system better."

Panellists also noted a number of facilitators that may help to build political will for change, including recent news stories about patient harm and a general appetite among patients to improve the quality of the care they receive. Panellists had mixed opinions on whether the upcoming provincial election would act as a barrier or facilitator, with some panellists worried the election of a new government could reverse any improvements that are implemented between now and the election. Others believed it could help to provide a mandate for change to whatever political party ended up in power.

Acknowledgments

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