Dialogue Summary

Improving Access to Care and Outcomes for Heart Failure in Ontario

30 January 2019

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McMaster Health Forum

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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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Dialogue

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SUMMARY OF THE DIALOGUE

Dialogue participants collectively agreed that the way the problem and its causes were framed in the pre-circulated evidence brief was appropriate, which included: 1) the number of Ontarians with heart failure is increasing, and many will visit the emergency department and be hospitalized; 2) Ontario's health system is not optimized to reduce emergency-department visits and hospitalizations among heart-failure patients; and 3) there is growing pressure to rapidly identify and scale up models of heart failure that will achieve the 'triple aim' of improving the patient experience and population health while keeping the amount spent per person manageable. Deliberations regarding the first and third dimensions of the problems were relatively focused, with the majority of time spent on the second dimension. In particular, dialogue participants raised a number of challenges at each of three levels:

1) individuals, for both patients (e.g., challenges accessing care when it is most needed; sub-optimal education for patients about their condition; and a perceived lack of confidence among patients that their providers were up-to-date about their condition and needs) and providers (e.g., a lack of support for implementing best practices; cognitive biases that make it a challenge for providers to break out of the status quo; and a lack of trust among providers in the community and academic settings, and hospital administrators);
2) organizations (e.g., a lack of coordination and collaborative planning across organizations involved in providing care for heart-failure patients; and inconsistency in organizational capacity and willingness to proceed with adopting new models of care); and
3) system (e.g., inconsistent stewardship for linking innovations related to heart-failure care with planning and service delivery; lack of standardization in how care for heart-failure patients is packaged; emphasis on prioritizing acute procedures rather than the longer-term management; and funding arrangements for heart-failure care that aren't aligned with what is needed to improve access and patient outcomes).

In deliberating about how to improve access to care and outcomes for heart failure, dialogue participants expressed support for drawing on components of the elements of the potentially comprehensive approach presented in the brief: 1) prepare the health system for rapid learning about the promising innovations included in the COACH trial while awaiting the results; 2a) develop a plan for scaling up rapid follow-up clinics if they are shown to be effective in the COACH trial; and 2b) establish an approach for moving forward if promising innovations included in the COACH trial are inconclusive, ineffective or harmful. Dialogue participants provided practical suggestions for how these elements could be implemented, but focused the majority of their deliberations on element 1 and 2a. Dialogue participants identified three cross-cutting themes that should be kept in mind: 1) prepare clear communications about the COACH model targeted to different users; 2) engage with a wide variety of partners within and beyond heart failure; and 3) reflect on how lessons learned throughout the COACH trial can be integrated into a plan moving forward.

With regards to next steps, dialogue participants focused on actions related to elements 1 and 2a, and made a distinction between those that could be accomplished by different constituencies as compared to those that could be pursued by the COACH investigators. The four suggested next steps for different constituencies are: 1) incorporate mentions of and results from the COACH trial (once available) in ongoing work on other upcoming heart-failure initiatives; 2) consider how the right context can be created for the implementation of the COACH model at a regional level, including supporting the dissemination of findings to local organizations; 3) generate increased patient and public awareness about heart failure with the aim of creating a 'burning platform' for change; and 4) reduce the 'fracturing' of patient voices by bringing together existing patient groups to advocate for change. Three next steps specific to the investigators of the COACH trial are: 1) plan for the dissemination of the results through the nine pilot sites and more broadly through 'town hall' meetings targeted at specific stakeholders; 2) consider and begin planning for how flexibility can be built into the COACH model to support widespread adoption and implementation; and 3) engage a health-technology assessment program and apply to Health Quality Ontario's ARTIC program (should they resume accepting applications) to develop a business case and plan for scale-up, respectively.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

At the outset of deliberations about the problem, dialogue participants collectively agreed that the way the problem and its causes were framed in the pre-circulated evidence brief was appropriate. In particular, participants noted that the three overarching dimensions of the problem presented were useful ways to think about the most pressing challenges underpinning access to care and improving outcomes for heart-failure patients in Ontario. These dimensions were:

1) the number of Ontarians with heart failure is increasing, and many will visit the emergency department and be hospitalized;
2) Ontario's health system is not optimized to reduce emergency-department visits and hospitalizations among heart-failure patients; and
3) there is growing pressure to rapidly identify and scale up models of heart-failure care that will achieve the 'triple aim.'

Deliberations regarding the first and third dimensions of the problem were relatively focused, with the majority of time spent on the second dimension. When discussing the first dimension (the number of Ontarians with heart failure increasing), many participants stated they were aware of the magnitude of the problem and there was a need to ensure that innovations such as those tested in the COACH trial could be used to improve the situation. Later in the day, one participant circled back to the indicators included in the evidence brief, and made the case that it was important for the group to consider how they could better leverage these numbers to drive greater awareness to the problem and its magnitude among a wider audience (e.g., the policymakers and stakeholders who need to champion change in heart-failure care, as well as patients and members of the public).

When discussing the third dimension (growing pressure to rapidly identify and scale up models of heart-failure care that will achieve the 'triple aim'), participants stated they felt comfortable with the idea that health systems are increasingly moving towards a rapid-learning orientation. Specific points were made about how the COACH trial fit into this emerging paradigm, with a number of participants agreeing that whether and how the lessons learned from the trial are scaled up across the province present an ideal test case for determining Ontario's readiness for rapid learning and point-of-care improvements.

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 Ontario;
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 policy issue;
4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three approach elements, 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 elements of an approach to 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.

We did not aim for consensus because coming to agreement about commitments to a particular way forward can preclude identifying broad areas of agreement and understanding the reasons for and implications of specific points of disagreement, as well as because even senior health-system leaders typically need to engage elected officials, boards of directors and others on detailed commitments.

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.

Participants spent the majority of time during deliberations about the problem focused on the system-level issues outlined in the second dimension of the problem (Ontario's health system is not optimized to reduce emergency-department visits and hospitalizations among heart-failure patients). There was general agreement among participants about the key challenges related to health-system arrangements that were highlighted in the evidence brief, including:

1) delivery arrangements aren't optimized for supporting heart-failure patients who present to the emergency department, with specific challenges related to:
   a) the lack of widespread decision support to enable accurate risk stratification of heart-failure patients,
   b) little accountability as patients transition between settings, and
   c) sub-optimal integration of care across settings which has negative implications for rapid follow-up and continuity of care for individuals who are discharged;
2) financial arrangements that limit the delivery of services outside of acute-care settings, with specific challenges related to:
   a) hospital funding mechanisms that aren't conducive to incentivizing coordination across sectors and settings,
   b) slow implementation of alternative funding models that could support the remuneration of a wider range of health providers as well as the remote monitoring of discharged patients, and
   c) few resources dedicated to help foster the development, implementation and scale-up of promising innovations; and
3) governance arrangements that can make it difficult for individual health providers, teams or organizations to adopt innovative models of care without support from the Ministry of Health and Long-Term Care or Local Health Integration Networks.

In addition to agreement about these particular systems-level dimensions of the problem as presented in the evidence brief, participants raised a number of related challenges that exist at the level of individuals (i.e., patients and providers), organizations (e.g., hospitals) and the health system in Ontario more broadly. These are addressed in turn below.

Individual-level challenges: Patients

While the key individual-level challenges raised by dialogue participants related to health providers (described below), participants briefly highlighted three important individual-level challenges at the level of heart-failure patients. The first challenge, which was raised by a number of participants and reiterated throughout the deliberation, was that patients aren't currently getting what is most important to them: access to the right care at the right time. Some participants suggested that this can be particularly problematic in the 30 days after discharge, when there is still some uncertainty about a patient's condition. Participants noted that in most cases, Ontarians don't have access to the type of 'rapid clinic' included in the COACH trial, which forces heart-failure patients to resort to visiting emergency departments. The second challenge related to patients that was raised by participants was sub-optimal efforts to educate them about their condition, resulting in patients who don't have the knowledge and skills required to take an active role in managing their condition. The third and final patient-related challenge raised by participants was a perceived lack of confidence among patients that their providers were up-to-date about their condition and needs. This point was closely linked to the discussion about the lack of data access among providers described below, with a number of participants suggesting that this contributed to the problem. In particular, the fact that many providers can't consistently access a comprehensive and consistently updated source of patient-related information at the point of care means that providers frequently ask for the same information multiple times, which does little to reassure patients they are on top of things.

Individual-level challenges: Providers

With respect to providers, participants raised three important challenges that need to be addressed in Ontario if access to care and outcomes for heart failure are going to be improved: 1) a lack of support for implementing best practices; 2) cognitive biases that make it a challenge for providers to break out of the status quo; and 3) a lack of trust among providers working in the community, providers in academic settings, and other system stakeholders such as hospital administrators.

The first challenge raised by participants as being an issue faced by providers was the lack of support for implementing best practices. In discussing this challenge, a number of participants flagged that there was a lack of availability of data to inform clinical decisions, which is an important issue in supporting the delivery of best practices in heart failure. One participant stated that the biggest frustration among cardiologists was in getting patient information where they're providing care, and that currently data doesn't 'travel' across care settings. A number of participants agreed, with some stating that certain types of data such as test results and diagnostic imaging were vital for making informed decisions about care, and that it was difficult to ensure high-quality, patient-centred care in its absence. A number of participants stressed the importance of acknowledging the inefficiencies that a lack of data may lead to, including ordering unnecessary tests that add costs to the system. A few participants also noted that, in addition to data, validated decision-support tools – such as the algorithm tested in the COACH trials – are not as available as they ought to be. Participants also noted that very few providers have consistent access to data about their own performance that can help them adjust how they deliver care to patients in real time. One participant noted that many providers tend to be overly risk averse with healthy, low-risk patients, and in the context of triaging heart-failure patients presenting to the emergency department, the absence of feedback on the appropriateness of their decisions with and without the use of validated risk-stratification tools can result in unnecessary hospital admissions. Participants generally agreed that this could create additional costs to the system and at the same time put patients through unnecessary stress. The same participant who raised the challenge of risk-averse providers suggested that since health providers tend to perceive themselves as performing well, in the absence of performance data suggesting otherwise, they may think they do not need decision supports, even if they would be happy to have them. Finally, one participant noted that regardless of the supports in place to help providers make more accurate assessments of patient risk, the drivers of risk aren't consistent across patients and over time, and this should be acknowledged. In closing the discussion of this dimension of the problem, one participant cautioned the others about the assumption that more decision support was necessarily better, particularly in the context of primary-care settings where a single 'non-specialist' could have to keep up with hundreds of guidelines and other sources of best practices. Most participants agreed that this point had important implications, particularly within any future discussions about how elements of the COACH model could be adapted to be integrated with other sectors that play an important role in non-acute heart-failure management.

The second challenge discussed by participants was that the traditional way of approaching care for heart-failure patients has resulted in the establishment of cognitive biases that make it difficult to move beyond the status quo. As a number of participants stated, care for heart-failure patients in Ontario has most often been provided by individual specialists in acute-care settings. This has created silos, and established approaches that are now entrenched. As such, health providers may be biased (whether knowingly or unknowingly) against new ways of approaching care. The result is that adopting elements of the COACH model, such as engaging with a broader range of providers (e.g., navigator nurses, and potentially primary- and home- and community-care providers) and a broader range of tools (e.g., risk-stratification algorithms and remote-monitoring supports) may be challenging given they're not as standardized. Participants also raised a number of points related to individuals' perceived authority over decision-making and their ability to drive change, which could also help to explain the bias towards inaction. In particular, a few participants stated that, while many providers acknowledge that aspects of their daily clinical practice ought to be done differently in the interest of improving patient care, proposed changes and quality-improvement initiatives are often viewed as unachievable from the perspective of an individual. Some participants suggested that this relates to the many

'moving parts' required to implement new ways of doing things, which at minimum requires effort to coordinate with other individuals, and in most cases hinges on broader system-level changes that involve decision-making across a range of individuals and organizations.

The third challenge facing providers that was raised by participants was a perceived lack of trust among individual providers in the community, providers in academic settings, and other system stakeholders such as hospital administrators. A number of participants agreed with this point, with some stating that such a lack of trust could hamper efforts to plan collaboratively and coordinate better care for heart-failure patients. One participant noted that there were similar trust-related challenges prior to the establishment of the Cardiac Care Network in the early 1990s (which has since combined forces with the Ontario Stroke Network to form CorHealth), when there was need to address the issue of heart-surgery wait times. The participant stated that it was only after establishing trust among the key players – most notably the wide range of providers involved in heart surgery – by engaging them in the decision-making process that they could push forward the initiative. Some participants acknowledged that this point was particularly important in the context of scaling up elements of the COACH trial, given efforts to do so would hinge on collaborative thinking informed by collective access to administrative (e.g., budgetary) and patient data (e.g., test results) among a broad range of individuals who aren't necessarily accustomed to approaching challenges this way.

Organization-level challenges

Participants focused on two important challenges at the organizational level: 1) a lack of coordination and collaborative planning across organizations involved in providing care for heart-failure patients; and 2) inconsistency in organizational capacity and willingness to proceed with adopting new models of care.

The first challenge at the organizational level raised by participants related to the lack of coordination and collaborative planning across organizations involved in providing care for heart-failure patients. Some participants suggested that, similar to the challenges discussed at the individual level, organizations are failing to share information across settings, which may stem from a lack of trust and an engrained culture of competition. Similar negative consequences to those highlighted at the individual provider level were raised by participants in discussing this challenge, and included unnecessary testing, delays in care, and overall system inefficiencies.

The second challenge at the organizational level raised by participants was positioned as a consequence of the first, and related to the inconsistency across organizations in terms of capacity and willingness to proceed with adopting new models of care like those tested in the COACH trial. In particular, some participants noted that a failure to coordinate and collaborate in the planning and delivery of heart-failure services has resulted in varying capacity across sites in the province to move forward with innovations, with some groups of organizations (e.g., teaching hospitals) in a better position than others to orchestrate fundamental changes to service-delivery models more rapidly. Additionally, participants focused on variability in organizations' willingness to move forward with new ways of doing things, with some more likely to take a 'leap of faith' towards implementing new standards when they emerge. One participant stated that organizational culture matters a lot in determining willingness to take on an approach to risk assessment and rapid follow-up similar to what is being tested in the COACH trial, and much of this can be linked to the perspectives of administrators. Participants noted that in most cases, the direct practical implications (including benefits) of a shift towards a new way of operating need to be clear to get administrative leaders on board. Examples could include the potential of a new approach to risk assessment and triage to reduce unnecessary hospital admissions, address an acute bed shortage, and save money. Finally, participants also noted that willingness depends on an organization's ability to have a flexible approach towards adopting and implementing a new model of care – and this too varies across settings. For example, if there are no resources available to hire a nurse navigator, some organizations may have the flexibility to re-purpose the hours of existing employees and move forward with the new model of care, whereas others won't.

System-level challenges

During deliberations about the problem participants focused on four important system-level challenges: 1) inconsistent stewardship for linking innovations related to heart-failure care with planning and service delivery; 2) a lack of standardization in how care for heart-failure patients is packaged; 3) an emphasis on prioritizing acute procedures (e.g., surgery) rather than the longer-term management of heart failure; and 4) funding arrangements for heart-failure care that aren't aligned with what is needed to improve access and patient outcomes.

The first challenge at the level of the health system was framed as an overarching issue of inconsistent stewardship for linking innovations related to heart-failure care with planning and service delivery. Specifically, participants noted that there currently isn't a single entity responsible for the oversight of all the promising initiatives that exist in heart-failure care in Ontario, in the same way that Cancer Care Ontario oversees these same types of initiatives in the realm of cancer care. There was general agreement among the group that one of the downsides of this is that pockets of innovation often tend to be time-limited, one-off initiatives that aren't scaled up or sustained. A number of participants suggested that a key driver of these failures is the absence of a coordinator who can support groups of providers and organizations that could benefit from mutual learning, or could collaborate on pushing for broader system-level changes in support of particularly promising models of care. Some participants also suggested the lack of provincial stewardship for heart failure could be a contributing factor to the lack of sharing and integration of patient data across providers and organizations. When considering what else these challenges meant in the context of the COACH trial, some participants stated that they pose a major risk to ensuring the promising insights emerging about a standard approach to rapid follow-up are shared, adapted to local contexts (and organizational cultures) as needed, and implemented across the province.

The second challenge at the level of the health system was related to the first and centred on a notion put forward by a number of participants that there is currently a lack of standardization in how care for heart-failure patients is 'packaged' in Ontario. Participants noted that this lack of standardization includes inconsistent language used to describe different packages of care, as well as the processes monitored and outcomes evaluated. Some participants noted that this lack of standardization made it difficult to make sure that the right approaches and supportive policy context can be communicated to government to improve patient care.

The third challenge at the level of the health system was an emphasis on prioritizing acute procedures (e.g., surgery) rather than the longer-term management of heart failure. A number of participants noted that this challenge was at least in part underpinned by a disease-specific focus that shapes how much of cardiology – including treatment of heart failure – is approached. In particular, some participants noted that since the management of heart failure may align more with a chronic-care model, requiring understanding and addressing a wide arrange of health and non-health antecedents with both disease and non-disease specific solutions (of which a surgical procedure may be one of many), a purely disease-focused approach is not ideal. Some participants suggested that the biggest implications of this were with respect to how heart-failure care is funded (e.g., paying for episodic care versus longer-term comprehensive packages of care that are tied to a fuller scope of patient needs), while others indicated that it also had important implications for how heart-failure management beyond 30 days should be approached (e.g., integrating it into more generic chronic disease-management models).

The fourth challenge at the level of the health system was related to existing funding arrangements for heart-failure care in Ontario, which aren't aligned with the kinds of innovations that are needed to improve access to care and patient outcomes. This overlapped with the funding-arrangements issues that were raised in the evidence brief and centred on the fact that the bundling of services in existing quality-based procedures (QBPs) isn't necessarily aligned with providing the kinds of services tested in the COACH trial (e.g., new approaches to identifying and stratifying patients according to risk and supporting select patients with rapid

follow-up and nurse navigators). Furthermore, while it wasn't the focus of the evidence brief or the dialogue, some participants noted that existing funding arrangements are also not conducive to better integration of services across specialty care, primary care, and home and community care. One participant highlighted that, despite the promise of something like the 'bundled care' pilots happening across the province – where money is allocated to patients for an entire episode of care that may engage a range of providers across a range of settings – the conversation needed to be more nuanced as this is not an ideal 'end game.' This participant also noted that, given the earlier discussions around longer-term heart-failure management, it could be that funding is arranged with a chronic disease-management approach in mind, in which heart failure is one of many conditions. However, some participants suggested that, politically, there is significant division among key policymakers and stakeholders (including care providers), which would make changing the funding status quo in meaningful ways very difficult. Another participant suggested that it was particularly important to flag that one of the key challenges in the context of the COACH trial is the misalignment between how funding is allocated and the need to incentivize change at the organizational level – which would need to be addressed for the key insights from the trial to be scaled up. In working this through, a number of participants noted that funders often don't have the flexibility with available resources to incentivize change. One participant suggested that a key challenge is not only in how organizations are paid – which was the focus of most of the discussion – but also in how individual providers were remunerated, which need to be viewed as two separate 'baskets.' Regarding the latter, some participants stated that changes to billing codes may have made it less likely for providers to engage in the kind of care included in the COACH trial, although not all participants viewed that to be a significant challenge.

DELIBERATION ABOUT ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH

In deliberating about how to improve access to care and outcomes for heart failure, most dialogue participants expressed support for the following elements: 1) prepare the health system for rapid learning about the promising innovations included in the COACH trial while awaiting the results; 2a) develop a plan for scaling up rapid follow-up clinics if they are shown to be effective in the COACH trial; and 2b) establish an approach for moving forward if innovations included in the COACH trial are inconclusive, ineffective or harmful. However, dialogue participants suggested a range of different approaches that were not presented in the evidence brief, each of which are summarized under their respective element below.

Element 1 - Prepare the health system for rapid learning about the promising innovations included in the COACH trial while awaiting the results

For element 1, dialogue participants emphasized three approaches that could be pursued to prepare the health system for rapid learning about the promising innovations included in the COACH trail while awaiting the results: 1) be prepared to speak to how costs can be kept low or reduced further during scale-up; 2) be prepared to examine how and why the interventions work; and 3) be prepared to speak to the need to prioritize improvements to heart-failure care.

Be prepared to speak to how costs can be kept low or reduced further during scale-up

Dialogue participants described the need for COACH investigators to be able to speak to whether and how the costs of the intervention can be kept low or reduced further during scale-up. In particular, one dialogue participant explained that the current narratives that gain traction for funding at the organizational and provincial level are those that emphasize efficiency, collaboration and improved patient outcomes. Another participant agreed that a business case would be useful in gaining support for the intervention, noting that even having 'back of the envelope' calculations about admission reductions, for example, could help to secure partnerships with organizations. Similarly, other dialogue participants advised that investigators should

consider ways in which the intervention's cost could be reduced, and suggested the possibility of substituting peers in place of the nurse navigators or adding the navigation role to that of an existing care coordinator for another chronic condition.

Be prepared to examine how and why the interventions work

Dialogue participants also encouraged investigators to be prepared to speak to how and why the interventions work, ensuring that they consider when, where and for whom they were most effective. One participant emphasized that such information could inform decisions about the most appropriate places to begin and where additional supports may be needed to achieve equity in the availability of safe and effective heart-failure care. Furthermore, one participant suggested that this information could also help to build flexibility into the intervention and be adaptive to local resources and populations. In particular, the information could help to identify where local changes could be made to better fit existing processes and where these changes may begin to affect the effectiveness of the interventions.

Be prepared to speak to the need to prioritize improvements to heart-failure care

Finally, dialogue participants described how investigators should be prepared to speak to the need to prioritize improvements to heart-failure care (not just procedure-based care), to support the personalization at the community and patient level to achieve impacts, and to support the widespread uptake of 'must do' effective components. One participant underscored this point by suggesting that investigators speak about the intervention as a complement to the heart-failure care pathway rather than as an episode of care, emphasizing that this intervention could help gain additional insights about and personalization of subsequent primary care and home and community care. Other participants commented that another way of demonstrating the need for investment in heart-failure care more broadly would be to consider (and speak to) how this intervention could be embedded within other existing (or planned) initiatives, such as those of CorHealth in Ontario and the Canadian Cardiovascular Society nationally.

Element 2a - Develop a plan for scaling up rapid follow-up clinics if they are shown to be effective in the COACH trial

Most dialogue participants devoted the bulk of their comments to element 2a, with many of the suggestions for element 1 leading into suggestions for element 2a. In particular, deliberations focused on five actions to support scaling up rapid follow-up clinics: 1) develop a communications plan with distinct messages for different groups; 2) use the discipline of the ARTIC application process to draft a proposal for scaling up the intervention(s) across the province; 3) establish partnerships with CorHealth, HQO and other organizations; 4) adjust organizational funding and provider remuneration to incentivize optimal care; and 5) situate the COACH trial as an exemplar in Ontario's transition to a rapid-learning health system.

Develop a communications plan with distinct messages for different user groups

All dialogue participants agreed that the first step in scaling up rapid follow-up clinics would be to develop a communications plan that would serve both to explain the intervention to the broad range of stakeholders involved, as well as to garner some support and buy-in for the eventual scale-up. However, dialogue participants suggested that communication plans should be tailored for each of the different user groups, namely policymakers, regional and organizational leaders, professional and patient leaders, and groups that will be developing guidance on similar or related topics (including other chronic conditions).

For policymakers, this includes messaging about how investing in rapid follow-up clinics will improve patient experiences and outcomes, save money directly, and contribute to reductions in 'hallway medicine' (and the clinics can be supported in whole or in part by discontinuing some related services and re-investing the savings, and the clinics' performance can be tracked using already-identified indicators). The messaging could

also include the potential for rapid follow-up clinics to be a high-impact first step towards establishing a full continuum of care – using a hub-spoke-node model – that will further improve patients' experiences and outcomes (and an important part of capacity planning that will set up the system for future success).

For regional and organizational leaders, dialogue participants suggested focusing on how many of the existing investments at this level are similar innovations (e.g., navigators and rapid follow-up clinics for other chronic conditions) or complementary innovations (e.g., multidisciplinary primary-care teams), and whether these existing innovations could be supported to take on these high-impact heart failure-specific functions.

For professional and patient leaders, dialogue participants suggested messaging that would help these leaders to understand the 'must do' effective components of the interventions stemming from the trial, the components that are effective when supported in particular ways, and where adaptations to the model could be made to suit a given community or patient population.

Finally, participants suggested the development of simple messages stemming from the COACH trial that could be widely disseminated to and used by groups that will be developing guidance on similar or related topics, to provide a consistent narrative from the trial and avoid having different messages coming from different groups.

Use the discipline of the ARTIC application process to draft a proposal for scaling up the intervention(s)

In deliberating about mechanisms that could support the scale-up of the COACH trial, dialogue participants pointed to the potential to apply to HQO's ARTIC program. Given that the application process requires significant preparation in terms of developing a business case, supports for behavior change, and a sustainability plan, participants suggested that the structured process of putting the application together also lends itself well to considering how to frame proposals to the ministry and other potential funders. While one dialogue participant noted that the ARTIC program was not currently accepting applications, there was some consensus across participants that undertaking such a structured process may still be worthwhile. Further, one participant suggested that additional insights about scaling up and sustainability could be drawn from the Canadian Foundation for Healthcare Improvement's approach to learning, spread and scale-up collaboratives, while others advised looking to the research literature on sustainability and to past successful efforts to scale up and sustain pilot projects, such as those used to reduce tobacco consumption.

Establish partnerships with CorHealth, HQO and other organizations

Throughout the deliberations, participants consistently returned to the many organizations whose work is closely aligned to the COACH trial, either more broadly through the scale-up pilot projects or more specifically with regards to heart failure and other chronic conditions. Participants generally agreed that establishing partnerships with these organizations is critical to the scale-up and sustainability of the COACH trial. In the short term, participants suggested leveraging partnerships with CorHealth, HQO and other relevant organizations to promote a smooth transition from the COACH trial, which has raised patient and professional expectations about optimal care, to widespread implementation and regular monitoring to show impacts on patient experiences, health outcomes and healthcare costs. Furthermore, participants suggested working with partners to ensure that organizational funding and provider remuneration at least don't penalize optimal care, and to develop compensable 'packages of care' that are specific to heart-failure care and that complement heart-failure care through the management of common co-morbidities.

In the long run, participants emphasized the need to find partners who could provide sufficient funds at the local level to support the scale-up of innovations like those being studied in the COACH trial, and hence to improve care experiences and health outcomes at manageable per capita costs.

Adjust organizational funding and provider remuneration to incentivize optimal care

Many dialogue participants mentioned how the existing funding and remuneration models do not incentivize optimal care for heart-failure patients and in many cases act as a disincentive for rapid assessment and coordination of care. Participants described needing to work with organizations and with the ministry to adjust organizational funding and provider remuneration to incentivize optimal care. For example, cost savings resulting from optimization could be used to roll out further improvements across the continuum of care. Dialogue participants all recognized that these changes are often difficult to make, but suggested using discretionary funds from regional organizations or re-allocating funding from previously piloted innovations that are no longer meeting community needs, at least in the short term.

Situate the COACH trial as an exemplar in Ontario's transition to a rapid-learning health system

Finally, dialogue participants recognized the opportunity to situate the COACH trial as an example of how the system could support innovative solutions for pressing health-system challenges by rapidly implementing, evaluating and (if successful) scaling up these approaches across the province. Participants spoke about the history of challenges with pilot projects in Ontario and considered how the COACH trial could benefit from a different, more deliberate approach. One idea introduced by participants was to situate the COACH trial within a rapid-learning health-system orientation and position it as a first effort to see whether a similar approach could be applied to other chronic conditions and ultimately to other innovations. Dialogue participants suggested that this approach could be beneficial for both the COACH trial and rapid-learning health-system orientation, building off the momentum for each initiative.

Element 2b - Establish an approach for moving forward if innovations included in the COACH trial are inconclusive, ineffective or harmful

Despite the relatively little time spent during the deliberation on this element, many dialogue participants suggested that having a plan should the innovations included in the COACH trial be inconclusive, ineffective or harmful, was just as important as knowing how to move forward should it be successful. In particular, many participants pointed to a history of ad hoc evaluation and inconsistent learning from pilot projects in the province. Dialogue participants focused on the importance of learning from failures at each level of the intervention (i.e., individual components, the intervention as a whole, the implementation of the intervention, and sustaining the intervention), as well as for specific types of organizations or populations. Participants suggested that these lessons could result in pursuing the implementation or scale-up of select components of the intervention, for specific types of organizations or populations. One participant also suggested that the resulting lessons could shape other interventions outside of the trial, for example shifting the approach taken in the implementation of the hub-spoke-node model.

Finally, one participant mentioned undertaking a cost-benefit analysis if the trial results are inconclusive, noting that innovations that result in similar effects but reduce costs may still be worth pursuing.

Considering the full array of approach elements

Dialogue participants expressed support for drawing on components of the two elements of the potentially comprehensive approach presented in the brief, but noted that it would ultimately depend on the results of the trial. While they provided concrete suggestions about how to move forward with the elements, they also identified three cross-cutting themes that should be kept in mind:

- prepare clear communications about the COACH model targeted to different users;
- engage with a wide variety of partners both within and beyond heart failure; and
- reflect on how lessons learned throughout the COACH trial can be integrated into a plan moving forward.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Overall, dialogue participants agreed that there are opportunities to improve care for heart-failure patients and that there was a significant amount that could be learned from the results of the COACH trial. Dialogue participants identified a range of implementation considerations, including potential barriers and windows of opportunity to move forward with the two elements.

With regards to barriers, one dialogue participant noted the need to 'future proof' the COACH trial results, given the potential for large-scale changes in the health system to over-shadow preparation and dissemination efforts. In light of these potential reforms, another participant described the need to carefully consider who should be targeted in the knowledge-translation strategy, suggesting initial efforts should be focused at the professional and local levels. Finally, dialogue participants described how professional and organizational resistance to change may act as a barrier for generating buy-in for the implementation of the COACH model (or components of the model) following the receipt of the trial results.

Dialogue participants also identified four 'windows of opportunity' that could support the implementation of the elements. The first 'window' is the many initiatives related to heart failure occurring in 2019, and the potential to align the dissemination of the results from the COACH trial (and any subsequent actions) to capitalize on any attention and contribute to a coherent narrative. In particular, participants highlighted the following initiatives: the recent release of the HQO Heart Failure Quality Standard; the upcoming release of the pathway for the hub-spoke-node model from CorHealth; and the release of new Canadian Cardiovascular guidelines, as well as a suite of planned activities (of which the release of the guidelines is one) for the first national 'heart failure week' in May. The second 'window' is existing narrative around 'hallway medicine' in the province, given heart failure is a significant contributor to emergency-department visits and hospital admissions. Third, one participant mentioned how the cardiac leadership at the University Hospital Network in Toronto is interested in heart failure and may be receptive to exploring reforms to how care is provided at a local level. Finally, one participant mentioned how the upcoming federal election could also open additional windows of opportunities, either through the potential reorganization of the pan-Canadian health organizations or the potential development of a national quality indicator specific to cardiac disease (which was recently requested by the Canadian Cardiovascular Society).

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

In deliberating on next steps, dialogue participants made a distinction between next steps for those attending the dialogue and those of the investigators of the COACH trial. Generally, participants focused their suggested actions for next steps on element 1 (prepare the health system for rapid learning about the promising innovations included in the COACH trial while awaiting the results) and element 2a (develop a plan for scaling up rapid follow-up clinics if they are shown to be effective in the COACH trial). Relatively few suggestions were provided for what to do should the trial results be found to be inconclusive, ineffective or harmful (i.e., element 2b).

Dialogue participants identified four specific next steps for different constituencies to lay the ground work for lessons learned from the COACH trial should the results be positive (i.e., element 2a):

- incorporate mentions of and results from the COACH trial (once available) in ongoing work on other upcoming heart-failure initiatives;
- consider how the right context can be created for the implementation of the COACH model at a regional level, including supporting the dissemination of findings to local organizations;
- generate increased patient and public awareness about heart failure with the aim of creating a 'burning platform' for change; and

- reduce the 'fracturing' of patient voices by bringing together existing patient groups to advocate for change.

Suggested next steps specific for the investigators of the COACH trial should the results be positive (i.e., element 2a), include:

- plan for the dissemination of the results through the nine pilot sites and more broadly through 'town hall' meetings targeted at specific stakeholders;
- consider and begin planning for how flexibility can be built into the COACH model to support widespread adoption and implementation; and
- engage a health-technology assessment program and apply to Health Quality Ontario's ARTIC program (should they resume accepting applications) to develop a business case and plan for scale-up, respectively.

Finally, one dialogue participant suggested that the investigators undertake a cost-effectiveness analysis should the results be inconclusive or ineffective, noting that the model (or some of its components) may still be worth pursuing if the cost is lower and level of effectiveness is similar to existing practices. Similarly, another participant suggested a fulsome look at the secondary or tertiary outcomes of the study as well as a sub-analysis of the individual pilot sites, should the primary outcome be found to be inconclusive or ineffective, to determine whether it is worth pursuing the implementation of individual components of the model or under specific contexts.

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