Dialogue Summary

Supporting Rapid Learning and Improvement Across Ontario's Health System

28 March 2019

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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.

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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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Table of Contents

SUMMARY OF THE DIALOGUE

Dialogue participants generally agreed about the need to adopt a rapid-learning health-system approach. Participants repeatedly emphasized the need to capitalize on the proposed changes to Ontario's health system and to 'get it right' from the beginning. Participants emphasized three challenges related to supporting rapid learning and improvement that build on those described in the evidence brief: 1) parts of the provincial health system are dated and no longer fit for purpose; 2) significant gaps exist in the characteristics of a rapid-learning health system; and 3) silos in the health system limit the extent to which connections can be made among assets that support rapid learning and improvement.

Dialogue participants generally agreed in principle that a rapid-learning health-system approach could be used to drive targeted improvements in the system. Participants most strongly agreed with the third element described in the evidence brief, and specifically the idea of a platform to coordinate efforts to support rapid learning and improvement across the province. Participants also agreed with pursuing the second element – supporting local area-focused rapid learning and improvement, specifically as a mechanism to support the transition towards Ontario Health Teams. However, the lack of detail regarding how these teams will take shape hindered participants' ability to deliberate on the sub-elements presented in the brief. Finally, despite most rapid learning and improvement in the province occurring at the level of 'problem-focused initiatives' (the first element), participants varied in their perspectives about how to best support such initiatives across the system.

When considering what next steps different constituencies could take to help move forward with rapid learning and improvement, participants identified four areas for action: 1) spreading awareness about the frameworks for and concepts related to a rapid-learning health system as well as current (or emerging) assets in Ontario's health and research system that could be better leveraged and connected (e.g., the Strategy for Patient-Oriented Research 2.0); 2) promote an elevated role for patient perspectives across the system; 3) work with collaborators to develop tools and resources that can be used consistently across Ontario Health Teams; and 4) ensure that Ontario Health Teams are designed and implemented with evaluation in mind.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Dialogue participants generally agreed about the need to adopt a rapid-learning health-system approach and with the three challenges identified in the problem section of the evidence brief. Throughout the deliberations, dialogue participants repeatedly emphasized the need to capitalize on the proposed changes to Ontario's health system and to 'get it right' – meaning support rapid learning and improvement – from the beginning. Several participants identified that the introduction of *The People's Health Care Act* (Bill 74), which will trigger the consolidation of the province's six arm's-length agencies (i.e., Cancer Care Ontario, eHealth Ontario, HealthForce Ontario Marketing and Recruitment Agency, Health Quality Ontario, Health Shared Services Ontario, and Trillium Gift of Life Network) and the 14 Local Health Integration Networks into a single agency (Ontario Health; as well as the creation of Ontario Health Teams) that will effectively operate as accountable-care organizations providing care to a defined population, offered a unique opportunity to embed the rapid-learning health-system approach right from the start (or to 'bake it in').

Participants emphasized three challenges related to supporting rapid learning and improvement that build on those described in the evidence brief:

1) parts of the provincial health system are dated and no longer fit for purpose;
2) significant gaps exist in the characteristics of a rapid-learning health system; and
3) silos in the health system limit the extent to which connections can be made among assets that support rapid learning and improvement.

Parts of the provincial health system are dated and no longer fit for purpose

Dialogue participants began deliberations by describing how Ontario's health system was not designed to meet current challenges and required a fundamental overhaul (as opposed to strictly leveraging and connecting assets in the health and research systems). Participants agreed that a rapid-learning health system could enable such an overhaul, however, a number of participants also explained that they thought we needed first to "create an actual system" before we could embed rapid learning and improvement in it.

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 potentially 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 potentially comprehensive approach to address 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 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.

The dialogue 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 about 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.

Given the system's emphasis on hospital-based and physician-provided care, several participants acknowledged that the system was not designed to 'produce health' (e.g., by bridging healthcare and public health and addressing the social determinants of health) or to be responsive to the evolving needs of the population. As one participant said: "Our system is dated. It was set up for a different set of demographics." While another participant went further: "Our system was designed to produce the very results we have." A third participant illustrated that the system was outdated using the mental health sub-system as an example: "We have a mental health system that continues to reflect the old stigma, despite the change in how mental health is now publicly seen."

Significant gaps exist in the characteristics of a rapid-learning health system

While a number of gaps were highlighted in the problem section of the evidence brief, participants signaled what they considered to be the four most important gaps among the seven characteristics of the rapid-learning health system, namely gaps in: 1) engaging patients; 2) digital capture, linkage and timely-sharing of relevant data; 3) aligned governance, financial and delivery arrangements; and 4) culture of rapid learning and improvement.

The first gap that was highlighted by participants throughout deliberations about the problem was the inconsistent level of patient partnership across the system. While all dialogue participants agreed that there has been progress made in engaging patients and the public in the health system, most participants suggested that there was more work to done. In particular, one participant noted that patients were still being engaged in a tokenistic way and described feeling as though patients were consulted to check off a step in a process rather than to provide meaningful input that will be acted upon. Another participant noted that while the Minister's Patient and Family Advisory Council is a positive step forward, there remain many 'tables' where patients do not have a seat, and that these are often the places where important decisions are being made. Participants indicated that patients can do much more. Patients were referred to as "champions of cultural and systemic change," as well as 'connectors' that could help to bridge silos in the system. Participants called for more meaningful patient engagement to ensure that patients are driving the cultural changes necessary to achieve a rapid-learning health system.

The second gap in the characteristics of a rapid-learning health system where participants saw significant need for improvement is the digital capture, linkage and timely sharing of relevant data. Building on the first point above, participants noted that the data used to inform decisions in the health system are not patient-centred. One participant described how few of the data assets in the province are being co-designed with patients. They noted, for example, that patients are not being actively engaged in designing satisfaction surveys or in determining process and outcome measures for health services. Dialogue participants also identified a number of other challenges relating to the capture, linkage and sharing of data, including the limited capacity to link data, to analyze data, and to share data in ways that can improve patient care.

The third gap in the characteristics that participants emphasized was the misalignment of governance, financial and delivery arrangements with efforts to pursue rapid learning and improvement. For governance arrangements, participants identified how past reforms in the system have repeatedly delegated authority to progressively lower levels. Participants noted that a lack of central leadership may challenge the widespread adoption of a rapid-learning health system. One participant described this by stating, "we delegate the responsibilities down and down and down; just do it and we trust you." The involvement of a central organization (whether this is the ministry or the new Ontario Health) is critical to get health-system leaders, stakeholders (including patients) and researchers to work together to achieve a rapid-learning health system. With regards to financial arrangements, participants suggested that to date efforts to make significant changes to the way in which the health system operates have failed because financial arrangements have not been adapted alongside changes to delivery arrangements. Participants focused on the lack of incentives in place for stakeholders, in particular health providers, to engage in rapid-learning and improvement efforts. Finally, for delivery arrangements, participants focused largely on monitoring and evaluation, noting unclear system

(and reform) objectives, lack of a common data platform, and slow-to-respond researchers. As one participant said: "Most of our [health-system] initiatives roll out with vague objectives, making them hard to evaluate." Other participants identified the Institute of Clinical and Evaluative Sciences (ICES) as a key asset in the system, but noted that it still did not include all necessary types of data and is not sufficiently engaged in supporting improvements to care experiences and health outcomes. One participant gave as an example of slow-to-respond research: "We tried to embed economic evaluations into trials and it took us five years."

Finally, participants highlighted the lack of a culture of rapid learning and improvement. In particular, participants noted an enduring focus on the wrong priorities, self-interest of stakeholders, and the political nature of our health system. Several dialogue participants noted the continued focus on hospital-based care, and not on the full range of settings where care is or can be provided. Other participants emphasized the difficulty of adopting a rapid-learning health-system perspective given the self interest of many stakeholders and their reticence to work with the full range of partners needed. As one participant said: "There are sacred cows and incentives that are difficult to change … there is a lot self-interest in how the system is designed." Finally, some participants identified how the political nature of our health system, which makes it very difficult to admit to any type of failure, fostered a culture that was not conducive to rapid learning and improvement.

Silos in the health system limit the extent to which connections can be made among assets that support rapid learning and improvement

Dialogue participants agreed with the third feature of the problem as described in the evidence brief, which focused on the lack of connections among assets in the system. Participants described how policy legacies, interests and politics have created silos in the system that limit the extent to which connections can be made between assets. As one participant said: "Many groups are in silos and are happy to be in silos; they don't want to change." This resonated with another participant, who explained how silos were not conducive to trust and collaboration in the system: "Silos are factions. I learned that the LHINs are the enemy. Everybody was more interested in their own well-being. How do you work when everyone is your enemy?"

While all participants agreed that the health system could benefit from rapid learning and improvement, many described the framework as being difficult to explain and were grappling with many of the nuances in the related concepts. Participants emphasized that until the framework and tangible examples could be easily described in an 'elevator pitch,' it would be difficult to get the type of traction required to get buy-in across silos. Further, some participants suggested that the lack of a compelling pitch could lead some to not appreciate its potential, and others to feel threatened by the changes.

DELIBERATION ABOUT ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH

In deliberating about how to support rapid learning and improvement across Ontario's health system, participants examined several strategies described in the evidence brief. These included: strategies to support problem-focused rapid learning and improvement (element 1); strategies to support local area-focused rapid learning and improvement (element 2); and strategies to coordinate efforts to support rapid learning and improvement across the province (element 3). In general, participants most agreed with element 3, suggesting that there is a need for a central leadership platform able to steward rapid learning and improvement from the top. Next, participants generally agreed with the implementation of element 2, specifically as a mechanism to support the transition towards Ontario Health Teams. However, the lack of detail regarding how these teams would take shape, hindered participants' ability to deliberate on the sub-elements presented in the brief. Finally, despite most rapid learning and improvement in the province occurring at the level of 'problem-focused initiatives,' participants varied in their perspectives about how to best support such initiatives across the system (element 1). A summary of the deliberation about each element is presented below.

Element 1 - Support problem-focused rapid learning and improvement

The deliberation on element 1 focused on supporting 'problem-focused initiatives' or initiatives addressing recent or current health-system priorities. Participants generally agreed that it is important to continue to support complementary problem-focused rapid learning and improvement, particularly the ones that currently exist (e.g., in the cancer sector) and encourage them to intersect with other parts of the health system and with population-focused initiatives.

However, participants had mixed views about the sub-elements included in the evidence brief to adopt a common model and language for problem-focused initiatives across Ontario's health system. While one sub-element involved starting with a model that could bring all professionals together and then using the model to support spread across the province, several participants saw the value of having a diversity of models, mentioning the ARTIC (Adopting Research to Improve Care) model used in specialty care, the Strategic Clinical Networks in Alberta and New Brunswick, the Primary Care Networks in British Colombia, and ones that could be adapted such as the collaboratives supported by the Canadian Foundation for Healthcare Improvement.

One participant supported a "let a thousand flowers bloom" approach, instead of focusing on a single common model. The participant indicated that significant efforts have been spent shifting from one structural model to another structural model, and therefore, emphasized the need to promote the concept of a rapid-learning health system in the hope that it will take root in different sectors. In encouraging a diversity of models to 'bloom,' the participant suggested that it could enable the heath system and its stakeholders to experiment and compare different models. "We need a rapid-learning health-system approach to build a rapid-learning health system in the province."

Other participants indicated that we should be guided by the principle of 'form follows function,' whereby each model should primarily relate to its intended function or purpose (and be aligned with the needs of different populations). Instead of starting with a pre-determined model that would be spread across the province, we should define the problem, identify the solution, then implement, evaluate and learn. One participant pointed out that using ARTIC as a standard model started with a solution rather than with a problem.

Element 2 - Support local area-focused rapid learning and improvement

The deliberation about element 2 focused on supporting organizations to work together with their local area, such as the recently announced Ontario Health Teams. Participants generally agreed on the need to ensure that Ontario Health Teams are created in ways that move us towards a more integrated system. At the time of the dialogue, there was still significant uncertainty about how the creation of Ontario Health Teams will take shape. Therefore, many participants expressed some hesitation in deliberating about the sub-elements included in the brief.

However, participants did deliberate at length about when to embed a rapid-learning approach. Several participants questioned the need to embed the rapid-learning health-system approach from the beginning of the Ontario Health Teams (or to 'bake it in'), emphasizing the need to gradually introduce rapid learning and improvement as these Ontario Health Teams mature, and to support them with a learning platform. For these participants, it was crucial to have a well-functioning system before embedding a rapid-learning health-system approach. As one participant said: "We don't have a system. [The creation of the Ontario Health Teams] is an opportunity to build the system, and then build the learning." A second participant referred to the experience of Kaiser Permanente which is often mentioned as an exemplar of a rapid-learning health system: "Before [Kaiser Permanente] became a learning system, it was a health system … Once you have the health system in place, then you learn."

When turning to the learning platform, several participants emphasized the need to leverage academic health centres, to establish learning collaboratives, and to engage key entities that could provide tangible supports. But again, several participants indicated that the learning needs of these Ontario Health Teams will vary (as well as the resources available). Therefore, the learning platform will need to be responsive to a wide range of needs.

Element 3 - Coordinate efforts to support rapid learning and improvement across the province

Finally, as mentioned above, element 3 gained the most traction among dialogue participants. Participants agreed about the importance of championing efforts to support rapid learning and improvement in the ministry and at Ontario Health. Participants emphasized three key themes: 1) prioritize purposeful changes; 2) enable culture change across all levels of the health system; and 3) support the development of one or more learning platforms to operate across the system.

For the first theme, prioritize purposeful changes, participants highlighted the importance of establishing clear and measurable objectives for rapid learning and improvement. They discussed that too often health-system reforms are made without adequate consideration for how to meet the goals of the reform. To avoid similar challenges, participants suggested investing time in determining objectives, getting the input and experience of a wide range of stakeholders, and establishing clear communications about rapid learning and improvement. Participants noted that this should be spearheaded by the ministry or another central organization, such as the soon-to-be-created Ontario Health.

Second, participants agreed on the need to support a culture change across all levels of the health system. They stressed that such an approach should start with the widespread engagement of patients/citizens and providers. Further, they highlighted that a cultural change could also be fostered by creating financial incentives within the system to reward rapid-learning and improvement outcomes and providing flexibility in how they are achieved. While participants saw the need to have efforts at the provincial level to support rapid learning and improvement, they wanted to balance these alongside fostering bottom-up approaches. As one participant said: "We want to create coherence, but don't want to squash innovation." A second participant echoed the need to have efforts to achieve some coherence and cohesion. "We'll be throwing a lot at people and [shouldn't just] hope they can work cohesively."

Finally, at the provincial level, participants supported the development of one or more learning platforms to operate across the system. In particular, they emphasized that such a platform should include the many needed research-related supports to learning and improvement across the first four characteristics of the framework (i.e., patient and public engagement; data analysis and sharing; timely research; and contextualized decision support) to enable rapid learning and improvement at the provincial level, regional (Ontario Health Team) level, and problem-focused level. Some dialogue participants indicated that a brokering function to point people to the right supports and to regularly ask whether the right supports are being provided at the right levels would be helpful to ensure the effective use of resources. Participants suggested that these research supports will need to be complemented by other types of supports across the remaining three characteristics of the rapid-learning framework (i.e., aligning governance, financial and delivery arrangements; creating a culture of rapid learning and improvement; developing the competencies for rapid learning and improvement), including establishing clear lines of accountability and encouraging the development of communities of practice that operate within and across populations and problems. Referring to financial arrangements, one participant provided the example of the United Kingdom where healthcare organizations were required to earmark 2% of their budgets for evaluation. While this 2% was an aspirational goal, it was seen as a promising approach to support applied research and create geographic equity across regions.

Considering the full array of elements

Overall, while dialogue participants agreed in principle that a rapid-learning health-system approach could be used to improve the health system, participants were reticent to articulate ways forward that differed substantially from the status quo. That said, there was significant consensus on element 3 in moving forward with a province-wide approach and embedding a rapid-learning framework in the development of Ontario Health and Ontario Health Teams. Throughout the deliberations on all three elements participants consistently emphasized three of the seven characteristics of a rapid-learning health system: improving patient engagement at all levels of the system; better availability and use of data; and establishing a culture of rapid learning and improvement.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Dialogue participants identified four implementation barriers during their deliberations. First, they expressed concern about the existing silos in the health system, which may prevent us from moving toward a rapid-learning health-system approach. Second, the lack of valid and reliable metrics that could help monitor progress towards (and reward engagement) in rapid-learning health system. Third, several participants indicated that the research system "is in flux right now" (e.g., with uncertainties around the renewal of the Strategy for Patient-Oriented Research, new leadership in key research-funding agencies, and changes to provincial funding models for university research). Fourth, a few participants highlighted the lack of distributed research-ethics infrastructure that can support the timely production of research evidence. As one participant said, we need a "far more responsive and rapid system of ethics" if we want to achieve a rapid-learning health system.

Having discussed barriers, participants identified two features of the current landscape that could (alone or together) create a window of opportunity to support rapid learning and improvement. First, there are technological opportunities to leverage, particularly to strengthen patient partnership, with participants particularly emphasizing the potential to rapidly develop and put in place patient portals to give patients access to their own health information. One participant warned, however, that vendors tend to resist the deployment of interoperable systems, which are key to a rapid-learning health system. Second, participants discuss the need to look creatively at what types of money could be available. The federal government's Strategic Innovation Fund, which provides investments in infrastructure across the full spectrum of research, was identified as a promising funding source for supporting the development of a rapid-learning health system.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

In the deliberations about next steps, participants described what they would bring back to their respective constituencies and how their suggestions could work to advance the 'way forward' being discussed. Together, participants prioritized four actions to support rapid learning and improvement across Ontario's health system:

1) spreading awareness about the framework for and concepts related to a rapid-learning health system as well as about current (or emerging) assets in Ontario's health and research system that could be better leveraged and connected (e.g., SPOR 2.0);
2) promote an elevated role for patient partners across the heath system;
3) work with collaboratives to develop tools and resources that can be used consistently across Ontario Health Teams; and
4) ensure that Ontario Health Teams are designed and implemented with evaluation in mind.

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