Dialogue Summary

Ensuring That the Health-related Decisions Affecting Canadian Military Personnel, Veterans, and Their Families are Informed by the Best Available Evidence

16 October 2022

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McMaster Health Forum

The McMaster Health Forum's goal is to generate action on the pressing health and social issues of our time. We do this based on the best available research evidence, as well as experiences and insights from citizens, professionals, organizational leaders, and government policymakers. We undertake some of our work under the Forum banner, and other work in our role as secretariat for Rapid-Improvement Support and Exchange, COVID-19 Evidence Network to support Decision-making (COVID-END), and the Global Commission on Evidence to Address Societal Challenges.

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Conflict of interest

The author declares that he has no professional or commercial interests relevant to the dialogue summary. The funder reviewed a draft dialogue summary, but the author 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 didn't dispute that there are many missed opportunities to ensure that health-related decisions affecting Canadian military personnel, Veterans, and their families are informed by the best available evidence. Some dialogue participants drew attention to key features of the context for the problem, including that evidence is just one input among many to the advice that public servants provide to elected officials. Dialogue participants tended to: 1) agree with two of the challenges on the evidence-demand side (unevenly distributed capacity and insufficient enablers) and less so with a third challenge that had been identified in other parts of government (an unevenly supportive culture); 2) agree that there were fragmented (or few) requests and fragmented responses at the interface between the evidence-demand and evidence-supply sides; and 3) agree with the challenges related to the mix of standards and insufficient public sharing on the evidence-supply side.

Dialogue participants gave the most attention to an approach – a new cross-department (i.e., cross DND/CAF and VAC) evidence-support unit (or 'hub') – that draws on one part of what was described as element 1 in the evidence brief (leveraging existing capacity) and on element 2 (formalizing and strengthening the 'interface' between the evidence-demand side and the evidence-supply side). Such a unit would build on what worked well with the COVID-19-focused Fusion unit and on what is working well in other units, such as DGMPRA's focus on making connections to strategy development and other internal processes, and on adjusting priorities in an agile way. This approach could involve applying a structural 'solution' (a cross-department task force) that has been shown to work well with the Transition Group. Participants also supported the development of standards for evidence products and processes, which was described as element 3 in the evidence brief.

Several dialogue participants indicated that COVID-19 has created a window of opportunity for implementing a new approach. No important barriers to implementation were identified.

While there was insufficient time for dialogue participants to discuss next steps in any detail, the two broad directions for moving forward are:

1) DND/CAF and VAC to discuss whether and how to jointly design an internal health evidence-support unit that leverages capabilities across internal units and that shares evidence needs with and integrates responses from evidence-support partners domestically and peers in the Five Eyes (e.g., U.K.'s OVA) and possibly NATO); and
2) their key evidence-support partners (Atlas, CIMVHR and CPCoE), alone or with representatives from DND/CAF and VAC, to develop standards for evidence products and evidence-related processes (for their own use and for use in calls for new work by other external partners), to propose a workable mechanism for sharing requests and responses, and to develop a 'theory of change' and related monitoring and evaluation framework for the broader working of DND/CAF's and VAC's health evidence-support system and their parts in it.

List of acronyms used in this dialogue summary:

- Atlas: Atlas Institute for Veterans and Families
- CADTH: Canadian Agency for Drugs and Technologies in Health
- CAF: Canadian Armed Forces
- CIMVHR: Canadian Institute for Military and Veterans Health Research
- CPCoE: Chronic Pain Centre of Excellence
- DGMPRA: Director General Military Personnel Research and Analysis (a unit within DND)
- DND: Department of National Defence
- NATO: North Atlantic Treaty Organization
- OVA: Office of Veterans' Affairs (a unit within the U.K. Cabinet Office)
- VAC: Veterans Affairs Canada

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Dialogue participants didn't dispute that there are many missed opportunities to ensure that health-related decisions affecting Canadian military personnel, Veterans, and their families are informed by the best available evidence.

Some dialogue participants drew attention to two key features of the **context for the problem**:

1) evidence is just one input among many to the advice that public servants provide to elected officials; and
2) public servants spend a great deal of time: a) trying to communicate evidence effectively to politicians and their staff (and, related to the subject matter of this dialogue, how the health system works and why an evidence base needs to be built before health treatments can be safely and effectively used on a widespread basis), b) responding to their requests for evidence when decisions have already been made or to fulfil a (often meaningless) reporting requirement, c) responding to their requests for a 'buffet' of everything known on a topic (without the context to know how to contextualize the evidence in ways that make it actionable), and d) complementing the 'one bit of evidence' they may have identified with the many forms of evidence needed to make and implement key decisions.

One dialogue participant noted that public servants also spend time explaining to researchers why decisions may be made based on many factors, not just evidence.

Participants didn't suggest additions to or changes to: 1) the many domains and types of decisions for which evidence is needed in DND and VAC (see Table 1 in the evidence brief); or 2) the four aspects of the broader current context highlighted in the Evidence Commission report, namely the lessons learned from what did not go well in the COVID-19 evidence response, innovations that emerged as part of the COVID-19 evidence response, growing recognition of the need to formalize and strengthen evidence-support systems, and emerging understanding about what an evidence-support system needs to be able to do.

One participant singled out a highly valued innovation that emerged as part of DND/CAF's COVID-19 evidence response: an evidence-support unit (called Fusion) that fed many forms of evidence to the Surgeon

Box 1: Background to the stakeholder dialogue

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

1) it addressed an issue currently being faced in Canada;
2) it focused on different features of the problem, including (where possible) how it affects particular groups;
3) it focused on three elements of a potentially comprehensive approach for addressing the 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 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.

One important point to note is that this dialogue was convened over a three-hour period instead of the usual seven-or-so hour period, so not all points could be probed by the facilitator, with the result that this dialogue summary sometimes includes observations that no one spoke to particular issues.

General in a timely, demand-driven and context-sensitive way. Later in the deliberations, participants returned to the idea of building on this experience.

Moving from the context to the **framing of the problem**, dialogue participants:

1) agreed with two of the challenges on the evidence-demand side (unevenly distributed capacity and insufficient enablers) and less so with a third challenge that had been identified in other parts of government (an unevenly supportive culture);
2) agreed that there were fragmented (or no) requests and fragmented responses at the interface between the evidence-demand and evidence-supply sides; and
3) agreed with the challenges related to the mix of standards and insufficient public sharing on the evidence-supply side.

Regarding the **challenges on the demand side**, participants noted that the unevenly distributed capacity manifests itself:

1) on the one hand, as few staff with the combination of policy capacity and the authority to request the needed forms of evidence (with 'few' compared to the breadth of decision-making being supported and given the departments are 'built for service, not for integrating evidence into decisions about services'), and few staff with skills in evidence integration (into existing processes) and communication (to politicians and public servants), and with an awareness of the many recent developments that can help them to use evidence in their policy and program work (e.g., turning to one-stop shops of pre-appraised evidence syntheses and to 'living' evidence syntheses rather than always commissioning new research), as well as no fit-for-purpose capacity-building programs in the Canada School of Public Service and the Defence Learning Network; and
2) on the other hand, as several key areas of strength that can be systematized or scaled up, including those listed in Table 3, such as DGMPRA's agile prioritization process, Statistics Canada's high-quality data analytics and modeling support, and CADTH's timely provision of technology assessments for key drugs and devices.

Participants also noted there are also downsides to some of the cross-government enablers for evidence use (listed in Table 2 of the evidence briefly), including the burden arising from so much low-value data collection and reporting, and that mandate letters can sometimes introduce priorities and initiatives that have not been subjected to rigorous analysis. A few participants agreed that a barrier to evidence use can be fixed policy and program objectives and five-year evaluation cycles, which inhibit ongoing evidence-driven learning and improvement, while one participant noted that DND/CAF's electronic health record does not support timely data analytics. Participants tended to describe a culture in both DND/CAF and VAC that is very open to using evidence, as well as a willingness to systematize or scale up what's going well and to address gaps. One participant noted that DND/CAF and VAC have a structural advantage that other decision-makers in health systems don't have: they can direct service providers to deliver the treatments we already know are the best treatments and do so in a way that also reflects the best available evidence (e.g., funding multi- and inter-disciplinary chronic pain management). One participant's experiences during COVID-19 – with the Fusion unit – had shown him that evidence support <u>can</u> now work with the same speed as policy processes (i.e., a team can 'triage evidence and make it digestible for decision-makers'). He noted that while the staffing model (selecting key people and allowing them to focus exclusively on this role) was not felt to be sustainable after the worst of the pandemic was over, he could imagine a staffing model that draws staff from multiple units to address a wide variety of health issues. No one explicitly spoke to a key finding from other parts of government – that a lack of commitment to transparency in the evidence provided as inputs to advisory and decision-making processes contributed significantly to a lack of focus on using evidence – although one participant noted that 'it's important to leverage the Ombudsperson and Surgeon General who can put [evidence] into the public sphere.' One participant noted a related problem, namely that VAC tends to 'make quick decisions on slow problems' (e.g., cannabis use among Veterans) and has no accountability mechanism or operational processes in place to ensure that policies and programs evolve as the state and understanding of the evidence evolves. Another participant expanded on this, noting that 'evidence can be inconvenient to the

political narrative… and the result is bad public policy and bad medical policy. There's a race against time to get evidence early enough to correct bad policy.'

Turning to **challenges at the interface** between those needing evidence to inform their decisions and those responding to these needs, those speaking up tended to be from the evidence-supply side (i.e., Atlas, CIMVHR and CPCoE). They noted that they are often not being asked for evidence to inform decisions (e.g., 'we're under-utilized… and poised to be leveraged' and 'we don't get any [requests] for evidence support'), and consequently they rely more on the input from their advisory groups or the interests of researchers. Those on the evidence-demand side noted that VAC's agreements with entities like Atlas, CIMVHR and CPCoE preclude them giving explicit direction to these units. One participant on the evidence-supply side noted that 'the procurement arrangement needs to change in order for them to re-structure so they can provide evidence according to demand.' Later in the deliberations, participants returned to this topic, noting that these entities would value input about where and how they can most add value, and that they would benefit from the coordination of requests and responses. They also acknowledged that there is nothing in their current agreements that precludes them from providing an evidence-support service. Participants from the evidence-demand side (i.e., DND/CAF and VAC) did not explicitly address a few topics mentioned in the evidence brief, such as the little leveraging of stocks of existing evidence or the lack of government standards for science advice and for expert or stakeholder panels, although they did mention that they do often benefit from evidence products and evidence-related processes involving the Five Eyes or NATO.

In terms of **challenges on the evidence-supply side**, dialogue participants tended to agree that these included: 1) mix of or lack of standards for decision-relevant forms of evidence, such as evidence syntheses and guidelines; and 2) mix of or lack of standards for what is included in different types of responses to requests from decision-makers (e.g., evidence scan, jurisdictional scan, horizon scan, key-informant interviews, and deliberative processes). A few participants from the evidence-supply side noted that they engaged advisory and reference groups comprising Veterans and their families in helping to set priorities. One participant noted the potential for conflict between the priorities of government and those of Veterans and their families, another noted there is likely to be a fair degree of alignment between the two, and a third noted that they are often two or more complementary perspectives on the same topic (e.g., Veterans may care about accessing a potential new treatment, health providers may care about whether and how they should provide it, and government may care about whether they should reimburse providers for it). A participant from the evidence-demand side noted the disconnect between policy/program and research timelines, with research reports on prioritized topics often coming in long after policy and program staff have had to 'move on.' Another participant from the evidence-demand side noted how unhelpful it is to have the 'need for more research' called out in every research report (to which a participant on the evidence-supply side agreed and added that while 'we may not need more research, we do need better coordination of the research that is being undertaken'). A few participants on the evidence-supply side spoke to their organization's lack of a 'theory of change' and suggested work was underway to fill in the 'black box' between processes (research partnerships, completed projects, and disseminated projects) and outcomes (improved Veterans' well-being). Another participant on the evidence-supply side suggested that documenting the impacts of evidence explicitly along the way 'is a dream.' One participant emphasized the importance of consistent public sharing of responses so 'we don't sit on knowledge,' while another noted that there are a 'classification barrier' and legal aspects to public sharing that need to be considered. Participants didn't speak explicitly to the possible challenges arising from the absence of a roster of service-oriented evidence-support providers meeting explicit standards, absence of a common approach to describing and adjudicating calls for evidence support, or incomplete coverage of all forms of evidence (e.g., behavioural/implementation research – although one participant did mention insufficient near-real time data analytics prepared by 'data miners' who can 'put the data into an easy picture'). One participant noted that a major part of DND/CAF's research infrastructure is focused on long-term research discoveries and innovations (not evidence support), with perhaps about two-fifths of it likely to be actionable, and that this infrastructure needs long-term commitments to deliver and cannot pivot every six months based on 'whims.'

DELIBERATION ABOUT THREE ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH FOR ADDRESSING THE PROBLEM

Dialogue participants gave the most attention to an approach – **a new cross-department** (i.e., cross DND/CAF and VAC) **evidence-support unit** – that draws on one part of what was described as element 1 in the evidence brief (leveraging existing capacity) and on element 2 (formalizing and strengthening the 'interface' between the evidence-demand side and the evidence-supply side). As noted previously, such a unit would build on what worked well with the COVID-19-focused Fusion unit and on what is working well in other units, such as DGMPRA's focus on making connections to strategy development and other internal processes, and on adjusting priorities in an agile way (and its growing focus on building partnerships with evidence-support partners, integrating across forms of evidence, and advocating for feedback loops so they can keep their evidence support 'green'). This approach could involve applying a structural 'solution' (a cross-department task force) that has been shown to work well with the Transition Group). Participants also supported the development of standards for evidence products and processes, which was described as element 3 in the evidence brief.

Element 1 – DND/VAC, alone and in collaboration with central agencies, to build capacity, address the culture, and leverage enablers for evidence use in government

Many participants noted that capacity for 'evidence integration' and evidence use exists in a number of 'pockets' of DND/CAF (e.g., DGMPRA and Transition Group) and VAC (e.g., Policy and Research division), as well as in their counterparts in the Five Eyes (e.g., U.S. Veterans Affairs' Evidence Synthesis Program) and NATO, and that this capacity can be more effectively leveraged by DND/CAF and VAC in providing evidence support that works with the same speed as policy processes. A few participants suggested that such a 'hub' would benefit from leadership 'on both sides of a Veteran's transition' (i.e., from DND/CAF and VAC). One participant noted that this would leverage a key area of Canada's comparative strength on the evidence-demand side, namely DND/CAF's and VAC's agility, while another participant noted that it would also leverage a key area of Canada's comparative strength on the evidence-supply side, namely evidence synthesis and support. Another participant noted that such a 'hub' is about the 'how' but that more work needs to be done to flesh out the 'what.'

While it was noted that any initiative led by central agencies like the Privy Council Office, such as improving transparency in the evidence provided as inputs to advisory and decision-making processes, could accelerate improvements in evidence use, a change in the culture of evidence use was not seen as a critical component of any way forward.

Element 2 – DND/VAC and CIMVHR/Atlas/CPCoE to formalize and strengthen the 'interface' between the evidence-demand side and the evidence-supply side

Several dialogue participants indicated that they saw value in transitioning to the potential future system depicted in Figure 2, and that the proposed cross-department evidence-support unit could help to achieve this value. The unit could: 1) coordinate among the requesters (i.e., those on the evidence-demand side), including horizon scanning and prioritization of questions, and oversee a one-window request process; and 2) enable coordination among those responding to requests (if not direct such coordination given the nature of existing agreements with Atlas, CIMVHR and CPCoE). The unit could also share a list of areas of policy and program 'interest' where 'anticipatory' evidence support could be planned for, as well as help the evidence-support partners to understand the internal processes into which their evidence needs to 'land.' One participant noted that it would be important to keep in mind 'human psychology' and that politicians may worry about the political damage that could come from people being able to point to evidence that was provided and that did not align with the advice they were given or the decision they ultimately made. Another participant expressed concern that such a request-and-response system could become too transactional, with evidence-support partners only responding to 'knocks on the door' and not engaging in more anticipatory work. Several

participants noted that 'horizon scanning' could help to provide balance in a portfolio of work being undertaken.

Element 3 – CIMVHR/Atlas/CPCoE to develop and implement standards for key forms of evidence, key types of evidence products and processes, and their public sharing

Several participants drawn from the evidence-supply side noted that they saw value in common standards, although one noted that the 'devil is in the details.' Participants did not address explicitly what might constitute appropriate public sharing of responses, such as an anonymized list of requests among eligible requesters and of the evidence response without attribution to the original requester.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Earlier deliberations had clarified that many of the potential barriers to implementing the elements of an approach for addressing the problem did not apply in the context now being discussed, especially among those in leadership positions on the evidence-supply and evidence-demand side. Participants did not speak explicitly to whether there may be resistance among health providers (who may need to change their service mix) or among military personnel, Veterans and their families (who may appreciate the value accorded to lived experiences in high-quality evidence-related processes, but who may resist the incorporation of evidence in stakeholder-engagement processes).

Several dialogue participants indicated that COVID-19 has created a window of opportunity for systematically implementing a new approach, which one participant called 'standing capability' for evidence support. One dialogue participant noted that it would be important to develop a 'business case' in order to take advantage of this window of opportunity. Another noted that her organization's work on 'evidence literacy' (e.g., helping Veterans and their families make sense of news that there's a new 'cure all') would complement what is being discussed.

One participant noted that some unresolved broader issues could continue to create the same difficulties for new ways of doing things as exist for current ways of doing this, such as: 1) whether VAC's focus is ill and injured Veterans or all Veterans; and 2) and whether VAC's key decision criterion is need or entitlement.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

While there was insufficient time for dialogue participants to discuss next steps in any detail, the two broad directions for quickly moving forward are:

1) DND/CAF and VAC to discuss whether and how to jointly design an internal health evidence-support unit that leverages capabilities across internal units, and that shares evidence needs with and integrates responses from evidence-support partners domestically and peers in the Five Eyes (e.g., U.K.'s OVA) and possibly NATO; and
2) their key evidence-support partners (Atlas, CIMVHR and CPCoE), alone or with representatives from DND/CAF and VAC, to develop standards for evidence products and evidence-related processes (for their own use and for use in calls for new work by other external partners), to propose a workable mechanism for sharing requests and responses, and to develop a 'theory of change' and related monitoring and evaluation framework for the broader working of DND/CAF's and VAC's health evidence-support system and their parts in it.

A dialogue participant concluded the deliberations by reminding fellow participants that: 1) we're talking about evidence that can save lives and have a huge impact on military personnel, Veterans and their families; 2) we need to be able to put this evidence in a format and language that senior leaders can digest and use in decision-making; and 3) the 'hub' idea is about refining and coordinating what people are already doing – not creating entirely new capabilities – and it must include the Five Eyes.

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