Dialogue Summary

Planning Now for the Future of Technology-enabled Healthcare Work in Ontario

7 & 8 March 2023

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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 funder 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 focused on three contributors to kick-start planning now for the future of technology-enabled work:

1) political and technical leadership to drive health-system transformation
2) attention to getting the 'what' right for health-system transformation
3) attention to positioning technology as a key part of the 'how' for health-system transformation.

Participants identified four ways to plan now for the future of technology-enabled healthcare work:

- articulate the vision for system transformation, create the conditions for dedicated and skilled leadership to operationalize the vision, and engage patients and providers in this work (related to element 1 in the evidence brief)
- work towards creating a team-based primary-care home for all Ontarians, ideally through Ontario Health Teams (OHTs) that are accountable for equity-centred quadruple-aim metrics and that use a population-health management approach to continually improve these metrics (related to element 2)
- put in place the right supports for patients, families and caregivers, for providers and for system leaders to ensure that they can benefit from new technologies, and invest in infrastructure to make these benefits possible in all sectors and not just in hospitals (related to element 3)
- adjust HHR planning processes to reflect ongoing shifts in how healthcare work is undertaken as a result of new technologies, which includes the emergence of new cadres of health workers and changing or declining roles for others (related to element 4).

Three key implementation barriers identified by participants were the limited 'bandwidth' among government policymakers and system and organizational leaders to drive change, uneven digital infrastructure across sectors, and ongoing tensions between 'top-down' and 'bottom-up' approaches. Key facilitators included past successes with health-system transformation to learn from (e.g., Health Services Restructuring Commission, Cancer Care Ontario), growing support for digital-health solutions and technology more generally among patients and providers, and ongoing support for the role of OHTs in driving towards a system centred around strong primary care.

Participants identified five potential next steps:

1) double-down on efforts to make team-based primary care the foundation of the system, and develop a 'common ask' by all system stakeholders that is framed around the core 'truths' of primary care, all of which can be enabled by technology (i.e., first contact care, continuity of care, relationship-based care, comprehensive care, coordinated care, community/population centredness)
2) re-position technology as an enabler of other 'tipping-point' changes, given it can be used to level power imbalances and enable patients and citizens to be a force for change (e.g., putting data in the hands of people can help to strengthen democratic accountability)
3) build on the current government's interest in investing in infrastructure to advocate for establishing a digital backbone and infrastructure in all sectors, and particularly in primary care
4) adjust education and training to build digital capacity among providers in a way that is 'vendor agnostic,' through establishing a baseline knowledge of the health technology landscape
5) leverage the forthcoming AMS Healthcare event to build momentum, broaden the conversation to include a greater number of stakeholders, identify areas of convergence on what needs to be done and by whom, and advance actions that can make a difference.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT CONTRIBUTORS TO KICK-START PLANNING NOW FOR THE FUTURE OF TECHNOLOGY-ENABLED WORK

Dialogue participants focused on three contributors to kick-start planning now:

1) political and technical leadership to drive health-system transformation
2) attention to getting the 'what' right for health-system transformation
3) attention to positioning technology as a key part of the 'how' for health-system transformation.

While much of the deliberation followed the approach used in the evidence brief – identifying contributors to why we are not planning now – we emphasize the positive framing in the subsection headers below.

Political and technical leadership to drive health-system transformation

During discussions about the political and technical leadership needed to drive health-system transformations, participants focused on three specific issues. The first issue raised by many participants was that we are not consistently seeing the type of dedicated and skilled leadership driving health-system transformation that we have seen in the past with hospital-sector and cancer-care restructuring. While most participants broadly agreed with this point, two related points were raised for consideration:

- we have not learned from past successes – such as the Health Services Restructuring Commission or the improvements in the cancer-care system and later the renal-care system – about the right constellation of political leadership and of technical-leadership structures needed to drive health-system transformation, both of which likely need to involve key players outside of government (but with the appropriate transparency and democratic and public accountability measures in place)
- we have yet to strike the right balance between emphasizing 'top-down' leadership from the Ministry of Health and Ontario Health and 'bottom-up' leadership from Ontario Health Teams (OHTs), which are vehicles for driving transformation locally (although one participant noted that leadership capacity among OHTs will vary given OHTs are at different stages in their development).

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 a problem, including (where possible) how it affects particular groups
3) it focused on four elements of a potentially 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"
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 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.

The second issue raised by participants related to the articulation of a vision for health-system transformation. When discussing this, participants diverged in whether they considered there to be the political will needed to articulate a vision for transformation and to create the conditions for dedicated and skilled leaders to operationalize the vision. Many participants reiterated that, regardless of whether there was political will, more needed to be done to ensure that patient, family and caregiver voices, as well as provider voices, are represented in efforts to articulate and operationalize such a vision.

The third issue raised related to whether organizational structures are conducive to supporting health-system transformation. In particular, some participants cited reporting relationships within the Ministry of Health and Ontario Health (e.g., primary care and OHT leads are 'buried' low down within organizational charts) as an indication of an insufficient commitment to execute health-system transformation in areas that are essential vehicles for widespread change in the province. Another participant suggested a different framing, stating that the structures themselves ought not to be viewed as a reflection of insufficient commitment, but instead as barriers to adaptation and to moving forward with plans for health-system transformation – even if political will exists.

Attention to getting the 'what' right for health-system transformation

Participants noted that there was insufficient attention paid to getting the 'what' right for health-system transformation. In discussing this contributor, participants focused on the aspects of health-system transformation that should be prioritized.

- Many participants agreed that priority should be given to continuing on a path towards creating a primary care 'home' for every Ontarian and getting primary-care practices and other health organizations working across silos and using a population-health management approach, and holding them accountable – as practices/organizations and as a collective within their OHT – for equity-centred quadruple-aim metrics.
- Participants diverged in whether they see OHTs advancing fast enough or with the right institutional form (e.g., sufficient scale and sufficient primary-care leadership) to be the centrepiece of health-system transformation, although many participants did agree that they could serve as an important driver of system integration.
- One participant noted how important it will be to work explicitly through the trade-offs that any transformation will entail, given that wins and losses will be experienced differently in different sectors and professions, while another participant suggested that Ontarians should be engaged in helping to make decisions about trade-offs and, at minimum, to be able to watch them being made in public forums.
- Several participants noted that messaging to Ontarians about the 'what' should focus on what they most care about, which could be having a primary-care home and – for those with complex conditions – having good care coordination, or improving access and quality using an equity perspective.
- One participant noted that improving continuity of care is also critical, either alone or as a dimension of quality; otherwise, the participant suggested, we will see the proliferation of 'band-aid' solutions, such as virtual 'walk-in clinics' that are not integrated into a more comprehensive and coordinated continuum of care.
- Several participants suggested that the focus for health providers like primary-care practices needs to be improving care processes, which means that the broader health system needs to strengthen the change-management supports needed to enable such process improvements.
- Several participants noted that existing supports tend to be concentrated in hospitals and insufficient in primary care where they are needed most.

Attention to positioning technology as a key part of the 'how' for health-system transformation

The third contributor to the problem discussed by participants was that there has been insufficient attention paid to positioning technology as a key part of the 'how' for health-system transformation. Within this discussion, participants suggested ways to position and build the case for investments in technology within broader health-system transformation initiatives.

- Many participants agreed that system-wide digital solutions – and not more practice- and organization-specific solutions – are needed to enable the type of transformation considered during discussions about the 'what.'
- Several participants noted that a strong business case is needed for the government to make system-wide investments, with one participant suggesting that it is important for health-system leaders to be clear about how technology can support the achievement of goals at different levels of the health system (e.g., access and quality at the micro level, accountability at the meso and macro level, and population-health improvement at the macro level), and another suggesting that investments need to be justified by anticipated improvements in patient and provider experiences and in health outcomes (and not by cost savings alone).

Participants spoke at length about improving both the procurement of mature technologies and fostering a pipeline of emerging technologies in ways that support health-system transformation.

- Some participants noted that it is important to leverage the power that governments have as a 'single payer' in procuring technologies and implementing them at scale.
- One participant noted that an overhaul of procurement rules is needed if the authority to make such investments remains rooted in individual practices and organizations.
- A few participants noted that it is important to consider how we balance the need to invest in technologies that meet established standards, that can be used at scale and that leave room for ongoing innovation (e.g., large companies leaving 'doors open' for adaptation through APIs) while supporting start-ups (which can introduce new innovations that may have tremendous benefit for Ontarians).
- Several participants suggested that more attention should be given to how the technology needs in the health system – which should be seen as 'public goods' that patients, providers and leaders depend on – can be better aligned to a pipeline of new technologies being created in the innovation system.

Participants also spoke to other ways to position technology as part of the 'how.'

- Several participants noted that the funding of organizations and remuneration of providers – or the future funding of OHTs – needs to be adjusted to support the appropriate adoption and use of the full array of technologies being discussed (the full list of which was included on page 10 of the evidence brief)
- Several participants suggested that more attention needs to be given to the connection between health workers' roles and their professional identity, as well as to new technologies in training programs
- Participants framed the issue of equity, diversity and inclusion (EDI) differently, with some suggesting that those with the greatest needs may be at the greatest risk of being left behind by a 'digital first' approach, and others suggesting that if EDI is foregrounded along with access and quality then we will find ways to ensure that equity-deserving groups can get what they need
- One participant also noted that the appropriate 'receptor capacity' for these new technologies needs to be enhanced (particularly outside of hospital settings) through efforts to strengthen digital infrastructure in all sectors of the health system, and through efforts to bring providers 'on board' (e.g., by engaging them in designing technologies that are of value to them in their work, and by supporting them to be the drivers of adoption and change).

DELIBERATION ABOUT ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH

Element 1 - Defining the role of health-system stakeholders (including government) in enabling compassionate, technology-enabled healthcare

In discussing element 1, participants first focused on who ought to be involved in enabling compassionate, technology-enabled healthcare, with an emphasis on the role of government. Many participants agreed that there are at least four things that no entity other than the Ministry of Health can do:

1) articulate a vision for transformation
2) create the conditions for dedicated and skilled leaders to operationalize the vision
3) support these leaders as they work explicitly through the trade-offs that any transformation will entail and as they engage Ontarians (especially equity-deserving groups) and health providers in helping to make these trade-offs and in understanding why they are being made
4) invest in system-wide digital solutions, overhaul procurement rules, and adjust how organizations are funded and providers remunerated.

On the topic of whether government – and in particular the Ministry of Health – should renew its commitment to existing integration-oriented entities such as the Ontario Health regions and OHTs, participants diverged, with some raising the question about whether it is a shift in thinking about these and other entities that is needed.

Participants also discussed the role of other stakeholders during discussions about element 1. With respect to Ontarians and their providers, participants agreed that they, alone and alongside their health providers, can themselves make decisions about what mix of face-to-face and virtual care options are right for them at any given time. Participants also noted that such patient preferences for different options (i.e., virtual versus face-to-face versus hybrid) should be a top priority in any effort to support technology-enabled healthcare. With respect to insurers and employers, several participants noted these groups are now also key drivers of technology-enabled healthcare and that they need to be factored into decision-making and implementation going forward.

Element 2 - Planning for a future health system where clinical encounters in all sectors and settings are less constrained by the geographical location of providers and patients

In discussing element 2, participants focused on accountability and funding as well as the use of 'non-local' solutions. With respect to accountability and funding, participants agreed that:

1) accountability for equity-centred quadruple-aim metrics should remain with the primary-care home and broader OHT of which each is a part (i.e., with 'bricks and mortar' providers)
2) funding needs to be a driver of accountability and an incentive to adopt technology-enabled improvements to care processes (e.g., nudging providers away from older technologies like fax machines towards newer technologies that are being invested in across the health system and that would be optimized if all providers 'bought in' to them)
3) leaders in these organizations should be able to use their funding to design and implement local solutions to address access and other challenges (e.g., paramedics-supported triage and assessment centres to help unattached patients as long-term solutions are put in place).

With respect to 'non-local' solutions, participants generally agreed that leaders in the organizations who are accountable for equity-centred quadruple-aim metrics (i.e., primary-care 'homes' and the broader OHT) should support 'non-local' solutions that improve access and quality using an EDI perspective (e.g., transgender care, pre-exposure prophylaxis for HIV), including both digital-only solutions and partnered 'bricks and mortar' and digital-only care provision. While some participants offered a divergent point of view, citing the potential downsides of a shift towards more virtual care models that could potentially further fragment care and undermine broader system-transformation efforts, most agreed that there are significant

benefits to be gained when considering virtual options as one component of a full continuum of care (particularly given patients often prefer to have a virtual option).

Within these discussions, several participants also flagged that in the context of a future in which clinical encounters are not bound by geography, the Ministry of Health and Ontario Health need to avoiding 'carve-out' programs (e.g., stand-alone virtual care for people with mental health and substance-use problems), as they can contribute to further fragmentation and weaken accountability.

Element 3 - Planning for a future health system with more digitally supported care

In discussing element 3, participants focused on three groups that are particularly important when considering how to plan for a future health system with more technology-enabled care: 1) patients, families and caregivers; 2) providers; and 3) system leaders. During this discussion, participants mostly considered the types of digital supports needed for each of these groups.

When discussing patients, families and caregivers, participants agreed that digital supports should:

- use off-the-shelf solutions (e.g., FaceTime) whenever possible, rather than require them to learn how to use 'niche' products
- be accompanied by EDI-promoting supports (e.g., digital therapeutics professionals) and not be put aside for equity-deserving groups on the assumption that they can't or won't use them
- be enabled by a culture among providers that supports digitally empowered patients
- ensure that they promote a better understanding of privacy, consent and data sharing
- give significant attention to cyber-security concerns, while recognizing that such concerns would be dramatically lessened with system-wide rather than organization-specific digital solutions.

When discussing providers, participants agreed that digital supports for this group must:

- focus on improving care processes (not simply the digitization of existing processes)
- ensure new technologies offer providers solutions, rather than create more work, with one participant noting that bad technologies simply won't be taken up if they don't save time and/or add value to their work
- be accompanied by significant investment in change-management supports, especially in primary care, and including targeted incentives where needed
- be accompanied by ongoing adjustments to the competencies to be addressed in education and training programs (e.g., as the CanMEDS Framework will now do).

Finally, when discussing digital supports for system leaders, several participants suggested that digital supports should focus on enabling local, cross-organizational decision-making related to using a population-health management approach to achieving equity-centred quadruple-aim metrics. One participant noted – and several agreed – that while technology for population-health management was essential, it is also important for other areas of management, including financial management, quality management, risk management, and health-workforce management.

As part of the discussion about digital supports for each of the groups, a number of participants also noted that there are system-wide supports required more generally. One participant suggested there needs to be focused efforts to build the appropriate digital infrastructure in areas that have traditionally lacked it (e.g., outside of hospital settings), which is key to enabling more widespread digitally supported care across all sectors, and by all of the groups discussed.

Element 4 - Engaging in health human resources (HHR) planning processes that align the workforce to health-system needs

While participants spent less time discussing the fourth element, some important areas of agreement emerged during discussions. First, many participants acknowledged that we need to support the emergence of new categories of health workers (e.g., digital therapeutics professionals) alongside shifts in the roles of existing categories of health workers (e.g., frontline providers becoming more engaged in emerging models of digital care when they are appropriate). Most participants agreed that these new and shifting roles must be included as a key component of HHR planning processes. One participant raised the point that, despite the importance of planning for these new and shifting roles, they are not sufficient in and of themselves, and should be paired with ongoing efforts to build and develop leadership and research skills among providers and organizational and system leaders to ensure that transitions to new technologies are always underpinned by 'what works' for patients.

A second area of focus among participants during the discussion of element 4 was the importance of adjusting professional education and training curricula to ensure that providers are not only adept at using new innovations as they are introduced into the system, but have the capacity to engage in the design, development and implementation of new and emergent technologies, including the establishment of the value proposition and supporting the system's 'digital maturation.'

Considering the full array of approach elements

In considering the four approach elements, during discussions participants emphasized the importance of:

- the Ministry of Heath's role in articulating the vision for system transformation and creating the conditions for dedicated and skilled leadership to operationalize the vision
- working towards creating a team-based primary-care home for all Ontarians, ideally through OHTs that are accountable for equity-centred quadruple-aim metrics and that use a population-health management approach to continually improve these metrics
- putting in place the right supports for patients, families and caregivers, for providers and for system leaders to ensure that they can benefit from new technologies, and investing in infrastructure to make these benefits possible in all sectors and not just in hospitals
- adjusting HHR planning processes to reflect ongoing shifts in how healthcare work is undertaken as a result of new technologies, which includes the emergence of new cadres of health workers and changing or declining roles for others.

Several participants also suggested the addition of a fifth stand-alone element – a counterpart to the first element – that focuses on partnership with users of the system (i.e., patients, families and caregivers) in helping to set a direction for the future. One participant suggested that the fifth element (or adjusted first element) should also emphasize the role of care providers and the importance of their perspectives. This same participant stated that the rationale for this is that it would help to balance the 'vision from the top' emphasis of element 1 by ensuring patient and provider experiences are driving the approach. In discussing a possible fifth element (or adjusted first element), one participant offered a different perspective, noting the need to be realistic about what can be achieved, stating that it is better to be realistic and scaled back in how much emphasis is placed on engaging patients, families and caregivers, than to 'overdo the patient-centredness' of the approach.

Finally, many participants agreed that not all transformations require technology, and that we need to remain focused on ensuring access and quality for patients, while establishing a health system that provides value by achieving equity-centred quadruple-aim metrics, with leaders held accountable for this.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

While participants didn't spend a great deal of focused time discussing implementation considerations, a number of barriers to implementing the options, as well as potential facilitators, were raised throughout the other deliberations. With respect to barriers, participants emphasized:

- limited 'bandwidth' among government policymakers and system and organizational leaders to 'execute' a vision for widespread health-system transformation, even if there is political will to do so
- an uneven landscape in terms of digital infrastructure and capacity for adopting new technologies across sectors in the health system, with hospitals having the most and primary- and community-care settings having the least
- ongoing tensions between 'top-down', government-led approaches for investing in and supporting the adoption of new technologies as a 'public good,' and the need to nurture patient- and provider-driven solutions as well as a healthy market for technological innovations.

The most important facilitators identified by participants included:

- past successes with health-system transformation to learn from
- growing support from patients and providers for digital health solutions, especially when they're one element of a comprehensive continuum of care and when patient preferences can be respected (with existing 'pockets of innovation' providing 'proof of concept' for this approach)
- ongoing efforts to strengthen OHTs, with an emphasis on moving towards a population-health management approach that is anchored by a strong primary-care system, which can provide a platform for health-system transformation efforts.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

Participants identified five potential next steps:

1) double-down on efforts to make team-based primary care the foundation of the system, and develop a 'common ask' by all system stakeholders that is framed around the core 'truths' of primary care, all of which can be enabled by technology (i.e., first-contact care, continuity of care, relationship-based care, comprehensive care, coordinated care, community/population centredness)
2) re-position technology as an enabler of other 'tipping-point' changes, given it can be used to level power imbalances and enable patients and citizens to be a force for change (e.g., putting data in the hands of people can help to strengthen democratic accountability)
3) build on the current government's interest in investing in infrastructure to advocate for establishing a digital backbone and infrastructure in all sectors, and particularly in primary care
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