Dialogue Summary

Supporting Rapid Learning and Improvement for Select Conditions in Canada

20 February 2020

McMaster University | HEALTH FORUM

EVIDENCE >> INSIGHT >> ACTION

McMaster Health Forum

Dialogue Summary:
Supporting Rapid Learning and Improvement for Select Conditions in Canada

McMaster Health Forum

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

Authors

Kaelan, Moat, PhD, Managing Director, McMaster Health Forum

Aunima R. Bhuiya, M.Sc. Candidate, Co-Lead Evidence Synthesis, McMaster Health Forum

Paula Voorheis, Co-Lead Evidence Synthesis, McMaster Health Forum

Funding

The funding for the stakeholder dialogue (and the evidence brief that informed it) was provided by IMAGINE SPOR Network, which receives funding from the Canadian Institutes of Health Research (CIHR). In-kind support has been provided by the Chronic Pain Network and the Child-Bright Network, both of which receive funds from CIHR as part of Canada's Strategy for Patient-Oriented Research. The McMaster Health Forum receives both financial and in-kind support from McMaster University. The views expressed in the dialogue summary are the views of the dialogue participants and should not be taken to represent the views of IMAGINE SPOR Network, McMaster University or the authors of the dialogue summary.

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.

Acknowledgments

The authors wish to thank the staff of the McMaster Health Forum for assistance with organizing the stakeholder dialogue.

Citation

Moat KA, Bhuiya AR, Voorheis P. Dialogue summary: Supporting rapid learning and improvement for select conditions in Canada. Hamilton: McMaster Health Forum, 20 February 2020.

Dialogue

The stakeholder dialogue about supporting rapid learning and improvement for select conditions in Canada was held on 20 February 2020 at the McMaster Health Forum in Hamilton, Ontario, Canada.

Product registration numbers

ISSN 1925-2234 (online)

Table of Contents

SUMMARY OF THE DIALOGUE

Participants generally agreed that the four aspects of the problem outlined in the evidence brief captured important aspects of the challenges inherent in establishing rapid-learning health systems (i.e., opportunities exist but aren't always acted on, some problems (or conditions) may not be prioritized or resourced centrally, other system initiatives can detract focus from a particular problem, and not all assets are in place or well connected). However, participants raised additional challenges related to each of the seven characteristics of a rapid-learning health system that are just as important, but weren't highlighted to the same extent in the brief:

1) patients feel disenfranchised from their health system, making it a challenge to engage them in the numerous ways required (in relation to the first characteristic of 'engaging patients');
2) there is a lack of consensus around what ought to be measured, which can hamper efforts to collect, analyze, link and share data that matters (in relation to the second characteristic of digital capture, linkage and timely sharing of relevant data);
3) research systems have many characteristics that make it difficult to do things 'rapidly', including ethics boards, long timeframes for follow-up and researchers' attitudes (in relation to the third characteristic of timely production of research evidence);
4) patients struggle to find the information they need, while decision-makers at all levels are often working with incomplete data, or evidence that doesn't directly meet their needs (in relation to the fourth characteristic of appropriate decision supports);
5) health systems are complex and fragmented, with many stakeholders focused on protecting their 'turf', making it difficult to 'link assets' (in relation to the fifth characteristic of aligned health-system arrangements);
6) many health-system policymakers and stakeholders suffer from 'change fatigue,' and there is a culture of risk mitigation that impedes innovation and leads to a lack of willingness among key organizations to be early adopters of new approaches to care (in relation to the sixth characteristic of culture of rapid learning and improvement); and
7) policymakers, stakeholders and researchers lack the bandwidth to build and retain the capacities required to support rapid learning and improvement (in relation to the seventh characteristic of competencies for rapid learning and improvement).

Participants voiced their support for the elements presented in the evidence brief, but emphasized the need for additional components within each. For Element 1 – identify existing assets and gaps in the characteristics needed for rapid learning and improvement for specific conditions – several participants suggested, and many agreed, that the first steps in the process of identifying assets and gaps needed to be bringing the right individuals and organizations together to help create a cohesive vision, establish shared goals that can ensure realistic priorities, and focus on building relationships before 'linking' assets. For Element 2 – establish supports and integrate characteristics of a rapid-learning health system into a condition-specific programmatic approach – many participants emphasized the need to strategically choose which focal points within condition-specific approaches offer the best opportunities to move ahead quickly, get results and gain traction. For Element 3 – prioritize targets and establish accountabilities for rapid learning and improvement – participants emphasized the need to establish roles for government (such as system stewardship and strategic direction), and for other key actors in the system (such as clarifying how to proceed with shared accountability while recognizing comparative advantages). When discussing implementation considerations, most participants acknowledged that a healthcare culture resistant to large-scale change, and challenges with succinctly describing the core components of a rapid-learning health system are important barriers that need to be overcome. In terms of opportunities, existing approaches that embody the rapid-learning approach in Canada (e.g., Alberta's Strategic Clinical Networks) can provide a road map for those interested in pursuing it in various settings across the country.

Participants suggested three next steps: 1) develop a succinct and compelling 'elevator pitch' to engage key stakeholders; 2) build networks and an approach for developing the next generation of champions; and 3) use existing success stories as a platform upon which to move ahead with additional efforts across Canada.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Participants generally agreed that the four aspects of the problem outlined in the evidence brief captured important aspects of the challenges inherent in establishing rapid-learning health systems (i.e., opportunities exist but aren't always acted on, some problems (or conditions) may not be prioritized or resourced centrally, other system initiatives can detract focus from a particular problem, and not all assets are in place or well connected). However, participants raised several additional challenges related to each of the seven characteristics of a rapid-learning health system that are just as important, but weren't highlighted to the same extent in the brief:

1) patients feel disenfranchised from their health system, making it a challenge to engage them in the numerous ways required (in relation to the first characteristic of engaging patients);
2) there is a lack of consensus around what ought to be measured, which can hamper efforts to collect, analyze, link and share data that matters (in relation to the second characteristic of digital capture, linkage and timely sharing of relevant data);
3) research systems have many characteristics that make it difficult to do things 'rapidly', including ethics boards, long timeframes for follow-up and researchers' attitudes (in relation to the third characteristic of timely production of research evidence);
4) patients struggle to find the information they need, while decision-makers at all levels are often working with incomplete data, or evidence that doesn't directly meet their needs (in relation to the fourth characteristic of appropriate decision supports);
5) health systems are complex and fragmented, with many stakeholders focused on protecting their 'turf', making it difficult to 'link assets' (in relation to the fifth characteristic of aligned health-system arrangements);
6) many health-system policymakers and stakeholders suffer from 'change fatigue,' and there is a culture of risk mitigation that impedes innovation and leads to a lack of willingness among key organizations to be early adopters of new approaches to care (in relation to the sixth characteristic of culture of rapid learning and improvement); and
7) policymakers, stakeholders and researchers lack the bandwidth to build and retain the capacities required to support rapid learning and improvement (in relation to the seventh characteristic of competencies for rapid learning and improvement).

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 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 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.

Below, we describe each of these challenges in turn.

Regarding the disenfranchisement of patients from their health system (which was raised in relation to the first characteristic of engaging patients), several participants discussed that there is currently a lot of patient engagement "waste" in the form of duplication, false promises, missed targets and let downs. Patients are often surveyed repeatedly without any knowledge of how their contribution will have an impact on the research being produced or the subsequent outcomes regarding their care. Several participants commented that engagement is an active process that hinges on relationships, where a lack of trust can diminish meaningful progress. Participants suggested that patients often engage in healthcare in their own ways, which may not align with the way in which providers or researchers wish to engage them. For example, participants brought up that patients may be actively searching the internet for information, using social media or talking to their friends and family, even if they seem "disengaged" in clinical contexts. A lack of consistency in information provision and a lack transparency about evolving evidence hinders patient understanding. Many participants stated that these issues, and other related examples, have collectively created a culture of patient engagement in Canada that may not be well aligned with the needs of engaging patients in the myriad ways needed to support the establishment of rapid-learning health systems.

When considering the lack of consensus around what ought to be measured, which can hamper efforts to collect, analyze, link and share data that matters (in relation to the second characteristic of a rapid-learning health system), several participants agreed that the notion of evidence-driven improvement starts to 'break down' when we don't know which outcomes demonstrate significant progress. Participants agreed that evidence can facilitate buy-in among stakeholders, but they debated the usefulness of process-indicator targets versus outcome targets. One participant suggested that patient satisfaction can be entirely independent of quality of care and that measures showing we are "moving along a continuum" do not necessarily show progress towards the desired final outcome. Other participants clarified that there was a difference between setting targets for achieving a rapid-learning health system versus setting targets for a practice change that you're using the rapid-learning health system for. Most participants agreed that there was a lack of focus on economic benefits, cost-effectiveness data and clinical-outcome measures, but that practitioners may often be hesitant about what the data might show. Finally, several participants emphasized that a lack of consensus on how to utilize and share data was just as problematic as the confusion around producing data in the first place. Overall, participants generally agreed that the barriers currently inhibiting adequate digital capture, linkage and timely sharing of relevant data would make it difficult to construct a rapid-learning health system.

Concerning the issue that research systems have many characteristics which make it difficult to do things 'rapidly', such as ethics boards, long timeframes for follow-up and researchers' attitudes (in relation to the third characteristic of timely production of research evidence), one participant summarized that a rapid-learning health system may be like trying to get a "super tanker to do a slalom course." Participants suggested that there first has to be recognition that there is a problem to begin with. Chronic pain, for example, can often get "lost" because it is not a "hot topic". Participants also discussed that it is difficult to rapidly mobilize researchers to create enough capacity in the research system; there is often a lack of alignment with the incentives researchers have and no rewards from shifting focus. In addition, there is often a lengthy follow-up time for trials which aim to examine issues such as chronic pain. Slow information generation and dissemination within the research community can lead to a cycle of "reinventing the wheel", which can create further gaps. Generally, participants felt that the current 'slowness' of the research system, especially pertaining to chronic conditions, creates an environment that may not be conducive to the timely production of research evidence needed to support continuous improvement.

When taking into consideration the struggle patients face to find the information they need, while decision-makers at all levels are often working with incomplete data that doesn't directly meet their needs (in relation to the fourth characteristic of appropriate decision supports), participants emphasized that it may often be too easy to get the wrong information. As mentioned above, there is a lot of "reinventing the wheel," making trustworthy, comprehensive and accurate summaries hard to find. When thinking about patients, one participant suggested that the inaccessibility of academic information and the time restraints clinicians are

under to deliver comprehensive information are significant barriers to patient understanding. Another participant added that patients also often don't possess a "passport" of their own healthcare information, further increasing information inconsistency. Participants agreed that facilitating informed decision-making at all levels with appropriate data and evidence would be a challenge.

Regarding complex and fragmented health systems, with many stakeholders focused on protecting their 'turf' making it difficult to 'link assets' (in relation to the fifth characteristic of aligned health-system arrangements), one participant summarized that "culture eats strategy for breakfast," where a lack of trust between pieces of the system and a lack of willingness to change make it difficult to effectively collaborate. Participants agreed that there was often a lack of clarity around the different values that matter to diverse stakeholders, as well as a lack of effort to identify any shared priorities. Although 'turf wars' were suggested by one participant as being good for spurring competition and driving innovation, there was also acknowledgment that too many sources of 'truth' could make it difficult to align processes and people. Participants agreed that there was no standard of care across Canada, and patients have diverse experiences across different settings and among different care providers. Additionally, participants pointed out that there are many rural and remote communities in Canada that face challenges in 'keeping up' with iterative change, even if they were willing to 'link assets.' Overall, many participants were concerned about the challenges faced in developing a coordinated effort to adopt a rapid-learning health system approach, especially considering the need for continuous adaptation to fill gaps and align support.

When participants considered health-system policymakers and stakeholders suffering from 'change fatigue' in a culture of risk mitigation that impedes innovation (in relation to the sixth characteristic of culture of rapid learning and improvement), they generally agreed that culture change is difficult, especially when there are such diverse cultures within political, research, patient, clinical and other stakeholder groups. Participants agreed that risk is always going to occur with a rapid-learning approach; there will be operational risk, reputational risk, and financial risk. Participants emphasized the reputational risk experienced when setting new targets, especially in medicine, may especially exacerbate slow adoption. Many participants agreed that without strong 'champions' committed to promoting a culture of teamwork, collaboration and adaptability, creating support for a rapid-learning health system might be difficult.

Finally, regarding the lack of bandwidth among policymakers, stakeholders and researchers to build and retain the capacities required to support rapid-learning and improvement (in relation to the seventh characteristic of competencies for rapid learning and improvement), participants agreed that a lack of resources and incentive to build capacity were key issues. One participant emphasized that when looking to build capacity for a rapid-learning health system, we presume that there "is a system, not a swamp." Participants agreed that scaling and spreading is expensive and complex, especially when taking into consideration rural and remote settings. One participant emphasized that focusing on moving information and not people would be beneficial, but that a lack of stewardship for this type of approach may also be a limitation. Generally, participants felt that achieving consistency in capacity, expertise and infrastructure across the health system may be difficult, inhibiting the 'scaling-up' and rapid-learning and improvement approaches.

DELIBERATION ABOUT ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH

Participants voiced their support for the three elements presented in the evidence brief: 1) identify existing assets and gaps in the characteristics needed for rapid learning and improvement for specific conditions; 2) establish supports and integrate characteristics of a rapid-learning health system into a condition-specific programmatic approach; and 3) prioritize targets and establish accountabilities for rapid learning and improvement. However, despite most participants expressing that they agreed the three elements are important parts of a potentially comprehensive approach, they emphasized the need for additional components and considerations for each, which are described in the sections that follow.

Element 1 – Identify existing assets and gaps in the characteristics needed for rapid learning and improvement for specific conditions

As framed in the evidence brief, element 1 focuses on potential processes to identify existing assets and key gaps in the characteristics needed for rapid learning and improvement, which could be tailored to specific conditions, with the intention of:

- engaging in processes to map assets and any existing connections (e.g., using existing frameworks, asset-based approaches, gap analysis); and
- identifying political windows of opportunity with respect to problem-focused initiatives.

Many participants expressed that this framing needs to emphasize the importance of a preliminary step that wasn't included in the brief before element 1 was possible. Specifically, a number of participants explained that in order to identify assets and gaps, a well-thought-out process of identifying and bringing together the right individuals and organizations was essential. This would help to create a cohesive vision for what the rapid-learning and improvement approach would look like in the short, medium and longer term, as well as establish shared goals that can ensure realistic and collectively agreed-upon priorities that would drive the first stages of mapping assets and filling gaps. One participant suggested that it wasn't possible to know what could be considered assets (or gaps) unless this shared vision was created through broad stakeholder engagement, and that the focus of element 1 should be first and foremost about building relationships before 'linking' available assets.

In supporting this approach, participants specifically identified the following four steps:

1) identify a neutral and trusted facilitator for the process;
2) create spaces and structures to convene;
3) clarify where there may be conflicts of interest, and whether the approach could exacerbate competition for limited resources, and ensure these threats are mitigated; and
4) identify mutually beneficial arrangements and 'win-win' opportunities when establishing shared goals.

Element 2 – Establish supports and integrate characteristics of a rapid-learning health system into a condition-specific programmatic approach

Element 2 was framed in the evidence brief as focusing on establishing supports and integrating characteristics of a rapid-learning health system at a programmatic level, noting that the programmatic approach may vary based on the resources and capacity available amongst those working to address problems for a specific condition (e.g., technology, infrastructure, personnel, data-sharing agreements). The element could include choosing strategies that can help strengthen existing assets and fill gaps based on some of the characteristics of a rapid-learning health system. However, despite most participants stating that they felt this was appropriate, many emphasized the need to strategically choose which focal points within condition-specific approaches offer the best opportunities to move ahead quickly, get results, and gain traction. Many participants stated that the additional components flagged as being vital during deliberations regarding the

first element – and particularly the need to build relationships and establish shared goals – would be essential in helping to achieve this, given the identification of focal points for action would require a prioritization process. When considering what a prioritization process could look like, most participants expressed support for the identification of a priority population (or populations) based on available data, clarifying their most pressing needs, designing care pathways or programs to address those needs, and evaluating to learn about whether and how these pathways and programs are contributing to improved patient care and experiences.

In addition to the processes described above, participants also weighed in on how to move forward with a programmatic approach and overcome some of the key challenges related to particular characteristics of a rapid-learning health system that emerged during deliberations about the problem. For engaging patients (the first characteristic), efforts could be strengthened by ensuring transparency about what is known from research evidence, establishing a trusted source for citizens and patients to access this information, and clarifying for them the role(s) they can play as well as the benefits that will result from their continued engagement. To address the lack of consensus around what ought to be measured (the second characteristic), participants suggested focusing on 'quick returns,' celebrating small wins, finding the most relevant 'carrot' for each stakeholder, and more consistently incorporating economic outcomes. Regarding research systems that make it difficult to do things 'rapidly' (the third characteristic), concentrating on less complex health issues to begin with as well as using regionalization to 'spread and scale' were suggested as more viable starting points. To support patients and decision-makers in finding comprehensive and relevant information (the fourth characteristic), participants discussed the important role of empowerment - providing mentorship, resources and education to stimulate a more connected network of expertise and information among patients and decision-makers. To overcome system fragmentation with many stakeholders focused on protecting their own 'turf' (the fifth characteristic), participants suggested that facilitators, leaders and spaces need to be assigned to actually bring people together. In addition, identifying the relevant 'carrots' to support groups letting go of their 'turf' would be essential. To help health-system policymakers and stakeholders suffering from 'change fatigue' in a culture of risk mitigation (the sixth characteristic), one participant proposed that terminology may be especially important, and emphasizing the concept of 'learning' could make the process a lot less scary than emphasizing 'change' and 'transformation'. Furthermore, many participants noted that it will be essential to support the shift towards a culture that views patients as partners in the care process, rather than seeing health professionals as 'fixers'. Finally, regarding the lack of bandwidth to build and retain the capacities required to support rapid learning and improvement, participants discussed that 'bigger' organizations can create the platforms on which 'smaller' organizations can do their work. Finding the balance between large and small would be key.

Element 3 – Prioritize targets and establish accountabilities for rapid learning and improvement

In the evidence brief, element 3 was framed as focusing on choosing measures to evaluate progress towards improving patient care and experience for a specific condition as a result of the implementation of a rapid-learning and improvement approach, as well as identifying ways to assess the extent to which each of the seven characteristics of a rapid-learning health system had been established. In addition, a key piece of this element was framed as establishing who (i.e., what individual or organization) will ultimately be held accountable for ensuring efforts are made towards rapid learning and improvement across each of the seven characteristics, with sub-elements including:

- prioritizing performance targets to evaluate the development and implementation of rapid learning and improvement (both with respect to each condition overall and in terms of the level of maturity of each of the seven characteristics of a rapid-learning health system); and
- assigning accountability for performance targets and rapid-learning efforts.

As with elements 1 and 2, participants were supportive of the element as framed in the brief. However, when discussing element 3 participants also emphasized the need to establish roles for government (such as system stewardship and strategic direction), and for other key actors in the system (such as clarifying how to proceed with shared accountability while recognizing comparative advantages) in order to facilitate the prioritization

of targets and establishment of accountability. A number of participants reiterated the importance of ensuring shared goals are established early as part of element 1, which would be the only way to clarify what the overarching goals were in terms of establishing a rapid-learning approach for the conditions they focused on. One participant suggested, and many agreed, that without the groundwork laid for shared understanding of goals earlier, it would be impossible to collectively agree on targets, and probably not feasible politically to assign accountabilities for achieving targets.

In considering this, participants specifically discussed the following issues that need to be incorporated in efforts to prioritize targets and set accountabilities for rapid learning and improvement:

1) stewards need to be clearly established early in the process, with support from all relevant actors (especially physicians, who need to be engaged often);
2) comparative advantages need to be identified and used to drive considerations around setting targets and assigning accountabilities (e.g., large organizations can do certain things smaller groups cannot);
3) tasks, targets and accountabilities need to be considered through a sustainability lens to ensure improvements can continue over time (this can be supported through mandates from government);
4) targets need to be vetted for financial, technical and political feasibility, at the level of patients, providers and organizations (distinguishing between setting targets for achieving a rapid-learning health system versus setting targets for a practice change that you're using the rapid-learning health system for); and
5) examples can and should be used as a jumping-off point about how to approach setting targets and accountabilities, such as the return-on-investment studies conducted as part of an evaluation of Alberta's Strategic Clinical Networks.

Considering the full array of approach elements

Taken together, the deliberations about the elements indicated that participants generally agreed with how they were framed in the evidence brief, with a number expressing that they were important parts of a potentially comprehensive approach. However, participants also emphasized the need for additional components and considerations for each element. For element 1, a well-thought-out process of identifying and bringing together the right individuals and organizations was an essential consideration that was necessary early on. For element 2, participants suggested strategically choosing which focal points within condition-specific approaches offer the best opportunities to 'rapidly' improve and gain traction. In doing so, selecting priority populations based on available data, clarifying their most pressing needs, and designing and evaluating care pathways or programs to address those needs would be crucial. For element 3, participants emphasized the need to establish a system of stewardship and clarify the process of shared accountability while recognizing comparative advantages. Without the groundwork laid for shared understanding of goals, participants agreed it would be impossible to collectively set targets. There were also a number of important implementation considerations (and in particular barriers) identified by participants with respect to the elements, which are detailed in the section below.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

When discussing implementation considerations, most participants acknowledged two major barriers to moving forward with the rapid-learning health-system approach. The first major barrier raised by participants was that healthcare culture tends to be resistant to large-scale change, and this is the case at all levels of the system (i.e., at the level of patients, providers organizations, and across the system more generally). Some aspects contributing to a resistant culture raised by participants included variations across different settings in ability, and in some cases openness to change. In particular, some participants noted that there will be some patients, providers, organizations and system elements that are amenable to the new approach, but others that aren't, and this varies across contexts. As such, some participants highlighted that because culture change to support rapid learning and improvement requires widespread 'buy in' across the system and a willingness to move away from the status quo, these variations might make achieving this particularly difficult.

The second major barrier raised by participants was that it was a challenge to succinctly explain the core components of a rapid-learning health system to the range of stakeholders who would need to embrace the approach in order to make it a reality. Participants noted that different audiences at various levels of the system would likely need to be engaged in different kinds of conversations related to rapid learning and improvement, so there was a need to tailor existing frameworks – and each of the seven characteristics – in ways that ensure they can be communicated effectively to patients, providers, and organizational and system leaders. Some participants suggested that without efforts to overcome this barrier, the value of rapid learning and improvement may not be fully understood.

Participants also mentioned a number of other potential barriers that need to be considered, including challenges securing funding and resources to support the approach (which could negatively influence the sustainability of rapid-learning health systems), a lack of competencies across systems to support each of the seven characteristics, collective action problems, and misaligned priorities in both health and research systems.

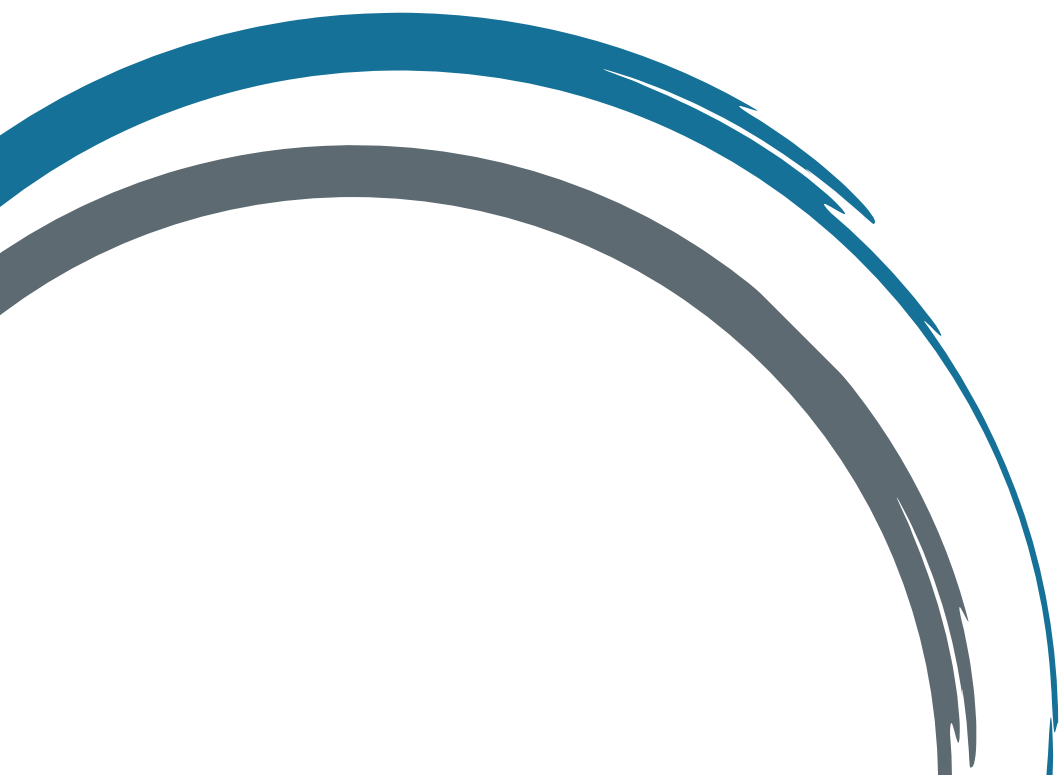
In terms of opportunities, participants mostly emphasized how existing approaches that embody the rapid-learning approach in Canada (e.g., Alberta's Strategic Clinical Networks) can provide a road map for those interested in pursuing it in settings across the country. Participants also identified a number of strategies that could help to facilitate faster adoption and scale-up of the rapid-learning and improvement approach for select conditions, including:

- expanding upon existing patient-engagement initiatives to create more opportunities for patients to engage in priority setting, service planning, monitoring and evaluation;
- creating peer-to-peer mentorship and coaching to help support strengthening rapid-learning assets across systems, and to aid in the development of competencies and cultures conducive to rapid learning and improvement;
- establishing condition-specific 'one-stop shops' that curate and make accessible the best available data and research evidence for use by patients and providers, as well as by organizational and system leaders;
- establishing common goals, standards and accountabilities for rapid learning and improvement that could be embraced within and across health systems for any condition; and
- using collaborative governance as a way to strike the right balance between 'top-down' and 'bottom-up' approaches.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

While many participants admitted that the scope of work involved in pushing forward efforts to establish a rapid-learning health system could be intimidating, most stated that they had ideas about tangible actions that could be taken to help create momentum for the approach in relation to the particular conditions they focus on in their work. Specifically, participants' suggested next steps fell into three broad areas:

1) develop a succinct and compelling 'elevator pitch' to engage key stakeholders;
2) build networks and an approach for developing the next generation of champions; and
3) use existing success stories as a platform upon which to move ahead with additional efforts across Canada.



McMaster University | HEALTH FORUM

>> Contact us

1280 Main St. West, MML-417
Hamilton, ON, Canada L8S 4L6
+1.905.525.9140 x 22121
forum@mcmaster.ca

>> Find and follow us

mcmasterforum.org
healthsystemsevidence.org
socialsystemsevidence.org
mcmasteroptimalaging.org
mcmasterforum

FORUM+ | McMaster University