Enabling patient-centred policy for electronic consultations: A qualitative analysis of discussions from a stakeholder meeting

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Abstract

Introduction: To support the expansion of a successful regional electronic consultation (eConsult) service, we hosted a full-day national eConsult Policy Think Tank, connecting health-services researchers, clinicians, patients and policy-makers to discuss policy considerations related to eConsult. In this paper, we assess the discussion arising from the Think Tank to identify and understand the policy enablers and barriers to the national spread and scale of eConsult services across Canada.

Methods: We conducted a constant comparative thematic analysis of stakeholder discussions captured during the Think Tank held in Ottawa, Canada, on 5 December 2016. Forty-seven participants attended and debated the following topic areas: (a) delivery of services and standards; (b) payment considerations; and (c) equitable access. The meeting was recorded, and verbatim transcripts were analysed using qualitative approaches.

Results: We identified four themes affecting spread and scale of eConsult innovation from a policy perspective: (a) patient-centredness; (b) value; (c) regulation; and (d) considerations for spread and scale. Patient-centredness was viewed as a foundational principle upon which policy shifts should be guided. Active participation of patient partners transitioned the discussions and resulting recommendations from provider-centred to patient-centred thinking around the relevant policy issues, explicitly demonstrating the importance of patient involvement in healthcare policy decision making.

Discussion: eConsult was viewed as a high-value, disruptive innovation with great potential to transform access to specialists in Canada. A patient-centred approach to policy change (and not just healthcare delivery) was identified as a novel yet critical enabler to the scale and spread of eConsult across Canada.

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Introduction

The Champlain BASE™ (Building Access to Specialists through eConsultation) eConsult service improves access to specialist care by allowing primary care providers (PCPs) to submit a patient-specific question to a specialty service via a web-based portal.[1] The case is assigned to a specialist, who receives an email prompting them to respond within one week via the secure site. Specialists can reply to the question, request

additional information, or recommend a referral. PCPs then decide how to apply the specialist's suggestion(s) for their patient and when the case can be closed. First launched as a small proof-of-concept, eConsult has grown to a fully implemented regional service via collaboration with regional partners. There is now a growing demand for eConsult's expansion to other provinces/territories.

However, adopting new healthcare innovations on a large scale is highly complex and requires systematic approaches, which must include addressing the policies that underlie health systems and health services.[2] This is especially true of eHealth technologies, which are typically introduced into a complex system in a turbulent and contested policy context.[3] Further complicating the issue, the Canadian policy context is full of hurdles resulting from the country's 13 unique provincial and territorial jurisdictions, creating a 'complex labyrinth' of priorities, privacy legislation, provider organizations, centralization models and intake and procurement systems that can be difficult to navigate.[4] For instance, a system like eConsult that facilitates communication between healthcare providers could not function at an interprovincial level, regardless of financial investment or provider engagement, if privacy legislation from one of those provinces prohibited interprovincial communication. In order to expand eConsult at a national level, careful consideration of these factors is needed to identify and overcome barriers, a task only possible through legislation.[5]

In previous publications, our team had explored some of the barriers affecting eConsult's spread and scale, such as ensuring patient privacy, standardizing payment models, clarifying the role of the specialist and defining duty of care.[6,7] Our next step was to build on our assessment in order to identify potential solutions and develop a strategy for spread and scale. To this end, we hosted a meeting in Ottawa where we gathered a group of Canadian health-services researchers, clinicians, patients and policymakers to discuss policy considerations related to eConsult.[8] We employed a co-design approach to facilitate a meaningful engagement of these stakeholder groups, with a particular focus on inclusion of patient partners. Including patient voice in such discussions is critical and it has been said that no policy should be reached without full participation of patients as stakeholders.[9] With the growing emphasis on patient-centred care, there is a need to foster a culture of patient-centredness through policies that can help the healthcare system realize the promise of quality and greater value.[10]

The objective of this paper is to build on our previous work to identify and understand the policy enablers and barriers to the national spread and scale of eConsult services across Canada through a qualitative analysis of discussions arising from this meeting. As many other jurisdictions within Canada – but also in the USA and other countries – are implementing their own eConsult services, our findings will be relevant for others who want to foster policy to support eConsult programme development on a lasting basis.

Materials and methods

Setting

The national eConsult Policy Think Tank meeting (hereafter referred to as the Think Tank) was a full-day meeting held in Ottawa, Canada, on 5 December 2016.[8]

The meeting began with a morning plenary session, which set the stage for small working group discussions that followed (see Supplemental material for a meeting agenda). The stakeholder groups met for one and a half hours in the morning to discuss and debate one of the following topic areas, which had been pre-identified in advance of the meeting by a provider-led working group: (a) delivery of services and standards; (b) payment considerations; and (c) equitable access. Participants were able to join any group based on their interest in the topic area. Small group discussions were facilitated by senior team members using a facilitator guide. In the early afternoon, each group met for another 30 minutes to summarize their recommendations using a format outlined on a report back form. The form had three sections: (a) what did your group identify as existing policies that enable the spread of eConsult; (b) what are your key recommendations; and (c) who else needs to be involved in the conversation?

An afternoon plenary session followed, with individual presentations from each working group describing the results of their discussions to the larger group of attendees, accompanied by questions from the audience. The meeting finished with patient participants' reflections on the day.

Participants

We invited a convenience sample of 101 individuals to participate in the Think Tank via email, of whom 47 attended. The participants included representatives from provincial and territorial governments, national organizations, healthcare providers, researchers and patients. Collectively, they represented a total of 24 institutes/organizations from seven provinces, and one individual from the USA, described in more detail in our earlier publication.[8] Our aim was to engage a range of stakeholders to ensure a sufficient breadth of perspectives and experiences. We did not look for a representative sample. Instead, we looked

for participants that had the ability to influence policy and could ensure that we had sufficient information to address policy enablers and facilitators. As such, the participants represented the key stakeholder groups with an interest in eConsult from the health system, provider, patient and policymaker level.

Data collection

All plenary and small working group sessions were audio-recorded with prior consent. Sessions yielded a total of 14 recordings (12 small group sessions and two plenary sessions), all of which were transcribed verbatim and imported into NVivo™ software for coding.

Data analysis

We conducted a constant comparative thematic analysis using Carney's Ladder of Analytical Abstraction[11] to identify common themes that arose from Think Tank discussions, including unique or complex ideas and perspectives surrounding eConsult policy issues, enablers and barriers. The key steps of this approach, described below, involved a progression from coding of the data, to identifying themes and trends that were associated with our research question, to finally developing and testing propositions to construct an explanatory framework.

Step 1: summarizing and packaging the data. We selected three transcripts, one from each of the three pre-identified policy areas (delivery of services and standards, payment and equitable access), and used them to form an initial coding framework. Two coders (JH, IM) reviewed the transcripts separately using axial coding, which is the process of relating codes to each other using a combination of inductive and deductive thinking, and the constant comparative strategy, whereby each interpretation and finding is compared with existing findings as it emerges from the data analysis. The coders include one individual who attended the Think Tank (IM) and one who did not, and each developed an initial framework independently in order to minimize the risk of Think Tank attendance biasing the themes. The coders worked to organize the data into themes, which were captured as 'nodes' using NVivo™ software. These theme nodes represented a collection of references about a specific theme, topic, concept, or idea. All references to the themes were gathered by coding sources at the nodes. The coders met regularly with members of the research team (LC and CL) to discuss areas of agreement and disagreement and achieve consensus.

Step 2: repackaging and aggregating the data. Nine individuals – seven who attended the Think Tank (CK, DT, DS, EK, KKB, TH, IM) and two who did not (JH, LO) – formed a working group to support qualitative analysis. Participants came from diverse disciplinary backgrounds, including public-policy research, business, medical doctors, representatives of regulatory colleges and patient partners which helped strengthen credibility of the data analysis. The working group met on three separate occasions for two-hour long working group sessions conducted via teleconference. During the first meeting, participants evaluated how well the initial nodes represented the Think Tank discussions. The discussion led to the identification of new nodes, from which the coding framework was remodelled with four categories: patient-centredness, value, regulation and implementation. This revised framework was used to code the remaining transcripts.

Step 3: developing and testing propositions to construct an explanatory framework. After JH and IM coded the remaining transcripts, the working group reconvened to cross-check the findings with respect to the new coding framework, complete a matrix analysis of major themes in the data by condensing the data into simpler categories, and synthesize the findings. Participants also confirmed that thematic saturation was reached. A final meeting of the working group was held to review these documents for internal consistency and to obtain feedback for improvement. Member checks and debriefing via email were done after every meeting and throughout the process of manuscript preparation to ensure internal consistency and accuracy of interpretation.

To ensure qualitative methodological rigor and trustworthiness, we took measures to maximize achieving credibility, confirmability, dependability and transferability.[12] For example, to achieve credibility, two members of the research team conducted the initial coding, with input from others in the central research team. Once initial codes were established, to achieve confirmability, members of the working group with diverse disciplinary backgrounds reviewed the data and the themes in relation to the codes, theorized about them, worked together to clarify meanings and verify team members' interpretations of the data, leading to a few rounds of revisions until consensus was reached with respect to the final interpretation of the meaning of the data. Dependability was achieved through robust documentation of the analysis process and participant feedback, which informed the final synthesis of the data. Transferability of the findings was achieved through 'thick description' of the participants and the research process to enable the reader to make

the transferability judgement as to whether our findings are transferable to their own setting(s).

Findings

Four primary themes were identified through the qualitative analysis: (a) patient-centredness; (b) value; (c) regulation; and (d) scale and spread.

Patient-centredness

Patient-centredness is defined by the Institute of Medicine as 'care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions'.[13] Participants identified the need to shift the focus of system-level change from providers to patients. This was viewed as a fundamental change from the way health services are currently conceptualized and delivered. While participants noted that some individuals may take a patient-centred approach, they agreed that the larger system is still designed with service providers in mind: 'We all say it's about the patient. But if you look at the movement of information through systems, it's service-centric.'

Trust, equitable access and continuity of care were emphasized by all types of stakeholders as essential components of a patient-centred service. Participants described the essential element of trust that patients must have in eConsult in order for the service to function. Patients need to feel confident in their primary care provider's ability to seek care on their behalf, the quality of the specialist's response, and the effectiveness of the healthcare system overall.

Ensuring equitable access to specialists was also a key consideration, particularly for patients in rural and remote regions and those from vulnerable groups (e.g. lower socio-economic status). As one participant described:

> We heard lots of stories from British Columbia where [...] somebody who's living on one [of] the islands will have to take two days off work., take almost a hundred-dollar ferry ride, an overnight hotel [...] often for a 10-minute visit. And so [eConsult] sort of fundamentally changes that.

Participants expressed contrasting views when discussing eConsult's impact on continuity of care. Some stated that eConsult enables greater continuity of care by allowing better connection between providers, while others feared that expanding eConsult could result in providers being less able to build relationships between one another, as the specialists answering their cases would not necessarily be from their region.

> A lot of healthcare is relational. [...] Those relationships [between eConsult primary care providers and specialists] will improve the quality of care that the patient is given. So as you build a distributed thing and consults go to a whole variety of people, it threatens [...] a potential loss of relationships.

In general, participants acknowledged the importance of continuity of care for improving relationships between patients and providers, and emphasized the need to ensure that it is preserved with eConsult expansion:

> I think the geographic issue is potentially a really important one. And I say that because, you know, it impacts on the whole notion of continuity of care, of trust, of using – for an econsultation, the same group or the same individual that I might use for a face-to-face consultation. And that's a pretty powerful concept.

Value

Participants discussed the best way to measure eConsult's value. They noted that the service has distinct benefits for patients, providers and the healthcare system. For patients, eConsult offers a myriad of practical benefits as well as cost savings. In words of one of the patients:

> Seeing it from a patient point of view, there's, you know, lots of savings. If we think [...] in terms of patients travelling long distances, patients and family members having to take days off work and travel as well. And in a lot of cases, I know in our province we have overnight stays, children have to be taken out of school to go along. These are all costs, you know. And so I think looking at that side of it is important as well.

For primary care providers, eConsult 'elevates their level of care' by providing prompt access to specialist advice. For specialists, eConsult's value lay in its ability to supply feedback from primary care providers. One participant, a specialist physician, described eConsult's advantage over traditional face-to-face referrals:

> The primary care doctor sends back an evaluation [...] he'll say, 'that was a great response, thank you so much. I'm going to spread this word to all my colleagues so we don't [send this question] to you again.' So for me it makes me feel so good.

Participants also noted eConsult's value to the healthcare system, which lay in its ability to reduce costs. However, they emphasized that 'the true value of eConsult is its value to patients' and its ability to improve care for patients. As one provider noted: 'Cost savings should be irrelevant. It is important that eConsult provides better, faster care.'

Regulation

Licensing, liability and privacy barriers emerged as recurring sub-themes in conversations regarding the implementation of eConsult across Canada, highlighting the need for definitive regulatory guidelines. To address these issues, participants noted that the service should clearly define who is ultimately delivering care. As one participant asked: 'is the specialist actually delivering care? Or is it the interprofessional conversation and it is, in fact, the primary care provider for the patient who's in the same jurisdiction, the one who's delivering care?'

While these issues are complex, particularly when considering how to deliver a service across multiple provinces with different legislation enacted, participants 'didn't really see eConsult as anything different than existing models of care delivery'. As such, many policies already in place for existing models of care could apply to eConsult as well. As one participant described:

A lot of times in healthcare, especially around technology, we want to try and reinvent the wheel. Rather we should probably look as much as we can at what existing policies are out there and then try and extend them, expand them as necessary rather than really starting over at square one.

Other factors for consideration involved quality monitoring and specialist competencies. Participants agreed that professional licensing bodies can provide oversight, but also noted that individual providers were accountable as well. One participant familiar with the College of Physicians and Surgeons of Ontario's policy on telemedicine explained that it expects its practitioners to comply with its licensing requirements regardless of the patient's jurisdiction, and that any concerns that a provider, irrespective of geographical location, is failing to meet these standards should be reported to the appropriate regulatory authority.

Participants valued eConsult's capacity for quality monitoring, particularly its ability to allow primary care providers to leave comments for specialists:

I think what's special in eConsult that isn't in the face-to-face, is that that primary care doctor is allowed to pay back to you (the specialist) their experience [...] And I don't get that from a face-to-face consult, quite honestly.

However, while participants saw the value of quality monitoring for eConsult, they also noted that no equivalent structure exists for face-to-face referrals, and as such eConsult may be facing a disproportionate level of scrutiny:

[It] is a false double standard to force us to evaluate the eConsult, whereas we're not evaluating the face-to-face. [...] I fear that we're putting extra requirements that may not be necessary, especially as we're getting things off the ground.

Though regulation is ultimately necessary to ensure eConsult runs effectively, some participants stressed the need for maintaining flexibility in the health-system's response in order to support the new demands arising from a service that disrupts the traditional way of managing specialty referrals. For instance, payment mechanisms should be flexible enough to enable access for uninsured or inadequately insured patients as well as to cover patients crossing provincial boundaries. One participant advised leveraging 'existing interjurisdictional funding agreements that govern how regular face-to-face care takes place. [...] Whatever it is that allows people to seamlessly go from Ontario to Quebec or Alberta to BC. We could build on those.'

Scale and spread

When discussing policies to support the spread and scale of eConsult, participants again noted the importance of maintaining a patient-centred approach 'at every level of decision making, not just in the consultation role'. This included healthcare visits themselves, where practitioners using eConsult should incorporate shared decision making. One participant suggested that, upon deciding to initiate an eConsult, practitioners should ask themselves 'does the patient have a question that they want to ask the specialist?'

Participants stressed the importance of maintaining local connections among generalists and specialists and ownership within the national service. Regional ownership was seen as essential to ensuring equitable access for all Canadians and addressing the unique needs of individual communities. As one participant explained: 'equity looks different in a southern, urban context than it does in a northern, remote context'. One recommendation involved tailoring resources to fit the profiles of individual communities, which could include access to allied and non-traditional health providers.

As part of the expansion effort, participants described a need to 'normalize non-face-to-face contact as an expectation', and clarify how eConsult fits into the broader referral–consultation process. Participants recommended leveraging local champions to support spread and knowledge sharing, and to integrate eConsult into medical training programmes so that the next generation of physicians will think of it as a normal part of their scope of practice.

Discussion

The process of expanding eConsult beyond current provincial borders requires thoughtful deliberation about a number of things including policy considerations surrounding the delivery of virtual care. Our analysis of a full day Think Tank revealed four main themes that could guide the alignment and establishment of enabling policy to support eConsult's implementation across Canada: (a) patient-centredness; (b) value; (c) regulation; and (d) considerations for scale and spread.

Patient-centredness emerged as a foundational and unifying lens upon which to develop policy recommendations related to eConsult. It has not only challenged but shaped all other discussions. For example, while acknowledging the costs, the value of eConsult was seen first and foremost in improved patient care. With respect to regulation, the message was to leverage existing interjurisdictional policies and agreements that govern regular face-to-face care to enable people to receive the care they need seamlessly regardless of where they are located. The considerations for scale and spread also focused on patient engagement and incorporating the patient in the design process to ensure the service actually reflects patient rather than system needs. All in all, the analysis revealed that the discussions within each theme captured the three core values of patient-centredness identified by Epstein et al.: (a) considering patients' needs, wants, perspectives, and individual experiences; (b) offering opportunities for patients to provide input and participate in their care; (c) enhancing partnership and understanding in the patient–physician relationship.[14]

Patient-centred care has been identified as central to the mission of healthcare at large, though it has been noted that traditionally, the patients/public have not had the power to shape the services they utilize (and pay for), or to define the value of these services.[15] Consequently, many patients describe their experiences with existing healthcare services as difficult to navigate, disempowering, burdensome and 'seemingly designed to frustrate'.[16] Through the deliberate inclusion of patient participants in our meeting, after we had identified this as a significant gap in our approach, we see an important shift in the conversation. The themes identified here were quite different from the topic areas before the patient partners joined the discussions and reflect a transition from provider-centred to patient-centred thinking around the policy issues affecting the spread and scale of eConsult innovation (Figure 1).

Patient-centred care is not a new concept and there has been growing recognition that it is associated with quality of care.[17] The US Institute of Medicine listed patient-centred care as one the six aims for improvement in its 2001 report *Crossing the Quality Chasm* and defined it as care that respects and responds to the individual patient's preferences, needs and values and ensures that clinical decision incorporates patients' values.[13] Patient-centred care has been associated with numerous benefits including quicker recovery, better emotional health, the need for fewer diagnostic tests and lower diagnostic costs, improved communication, appropriate intervention, enhanced satisfaction and patient-reported outcomes, and biomedical outcomes.[10,18–20] The concept of patient-centred care has been embraced by healthcare organizations,
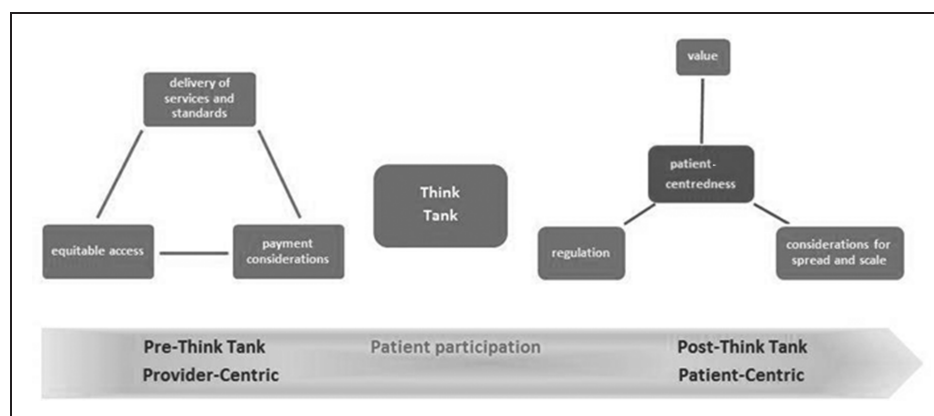
Figure 1. Model reflecting transition from a provider-centred to a patient-centred approach.

researchers and decision-makers.[9,21–23] The challenges of overcoming the inertia and paternalism of our traditional healthcare systems where patient-centredness is concerned still remain. There are, however, growing efforts to integrate patients in broader ways, including co-design approaches to improvement/redesign of service delivery, incorporating patient and caregiver experiences, and making use of outcome measures that patients identify as important.[24–27] The importance of these efforts came out strongly in the patient-centredness theme.

Along with patient-centredness, value in healthcare has emerged as a prominent concept in the last decade, stimulated by the growing need for finding better ways to ensure that the limited resources are used in a way which provides the greatest value to patients.[28,29] When defining the concept of value in healthcare, Porter challenged the healthcare system to emphasize patients' outcomes, their survival and health status as the benchmark against which the expenditure of resources are judged.[28,29] In general, the literature supports the growing importance of providing value, as opposed to just cost-effectiveness, effectiveness or efficiency and the need for appropriate outcomes in terms of what is meaningful and valuable to the individual patient.[30–32] However, finding a mutually acceptable agreement among the views expressed by patients, providers, economists and payers is a complex undertaking. Our analysis revealed that value was viewed differently at the patient, provider and system levels, though better care was consistently viewed as more important than cost savings. In alignment with patient-centred care and Porter's idea of value being expressed as the best health outcomes achieved per dollar spent,[29] it becomes clear that the outcomes achieved must be driven by patient preferences and needs for the delivery of high-value care. These ideas were certainly echoed by the Think Tank participants in our study. New technologies, such as eConsult, are changing the healthcare landscape and provide new opportunities to 'harness the energy, insight and expertise of patients, carers, and the communities that support them to help drive change'.[15]

Our study has several strengths, including a broad representation of different stakeholders involved in the data analysis. Integration of multiple perspectives strengthens the quality of the analysis and interpretation necessary to drive the desired policy change. It also enabled examination of the issues and interpretation in great detail and depth. The chosen framework for analysis utilized a well-respected, stepwise approach based on the Carney's Ladder of Analytical Abstraction, with qualitative methodological rigour achieved through assessments of credibility, confirmability, dependability and transferability.

At the same time, a number of limitations characteristic to qualitative research must be acknowledged. The discussions examined in this paper took place several years prior to its publication, and therefore may not capture the most up-to-date possible picture of the policy landscape. Despite a broad representation of various stakeholders, generalizability is limited in the vast Canadian healthcare context, and the fact that attendees were largely very supportive of eConsult. We were also not able to consistently determine the origin of specific quotations in terms of the type of participant (e.g. patient, researcher, manager, etc.). Most of the study authors participated in the discussions that formed the dataset, which introduces the potential for bias in interpretations. Authors attempted to mitigate this issue by including individuals who did not attend the forum, including one of the two initial coders, who assessed the transcripts for themes without any foreknowledge of the Think Tank or its conclusions. Additionally, the majority of attendees were required to pay travel costs for the meeting themselves or via their institutions, which may have influenced which groups chose to attend.

Post-Think Tank developments

Deliverables from this process include a suite of policy briefs addressing payment, privacy, quality assurance, interjurisdictional licensing and regulation, which aim to inform stakeholders of policy issues pertaining to eConsult, and clarify the stance we and other Think Tank participants have taken on these issues.[8] We have begun sharing these briefs with other regions interested in implementing eConsult, and have solicited feedback through a follow-up to the Think Tank meeting held in December 2017 with the core objective of developing and endorsing knowledge tools (including the previously developed policy briefs) to facilitate eConsult's national expansion. To date, eConsult services have been implemented and are spreading within Alberta (AB), Manitoba (MB), Quebec (QC), Newfoundland and Labrador (NL), and New Brunswick. The implementation strategy and scope for each province varied based on the needs of their respective populations and the infrastructure already in place.

Conclusion

Our in-depth analysis of the policy discussions surrounding eConsult from this Think Tank revealed that participating stakeholders viewed this service as a high-value, disruptive innovation with great potential to transform access to specialists in Canada. Through the feedback obtained, we identified that a patient-centred approach to policy change was one of the

critical factors to enabling the scale and spread of eConsult across Canada. Though the discussions emerging from the Think Tank reflect a local Canadian experience, international readers may be able to apply the study's themes to their own jurisdictions.

Authorship

CL, KE, and LC contributed to the study design, data collection and analysis, and manuscript preparation. JH and IM oversaw the data analysis and led the initial drafting of the manuscript. CK, KKB, TH, DT, LO, and DS contributed to the study design, participated in Think Tank discussion, and assisted with data coding, analysis, and manuscript drafting. All authors read and approved the final draft of the manuscript. None of the authors have any conflict of interest, real or perceived, with regard to the paper.

Declaration of conflicting interests

The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: CL and EK are co-executive directors of the Ontario eConsult Centre of Excellence, funded by the Ontario Ministry of Health and Long-Term Care. They co-founded the Champlain BASE^{TM} (Building Access to Specialists through eConsultation) eConsult service but do not retain any proprietary rights. EK answers eConsults through the service, less than one per month.

Ethics

The Ottawa Health Science Network Research Ethics Board (20120894-01H) and the Bruyère Continuing Care Research Ethics Board (M16-12-052) provided ethics approval for this study.

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Supplemental material

Supplemental material for this article is available online.

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