Consensus Development Conference: Promoting Access to Quality Palliative Care in Canada

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Abstract

Objective: This article outlines the development and implementation of a consensus development conference (CDC).

Background: As a rapid method for data synthesis, a CDC affords a timely and methodic means of evaluating data to effect change in healthcare policy.

Methods: The CDC methodology was adopted for the Palliative Care Matters initiative due to its engagement with the public, scientific community, and palliative care stakeholders.

Results: It requires the involvement of seven key groups/roles to successfully effect change: a manager, steering committee, scientific expert panel, public lay panel, a lay-panel facilitator, a public audience, and the media for dissemination.

Discussion: This article also details the background information and guiding principles on which the Palliative Care Matters initiative was formed. A Canadian Reference Working Group was formed to develop the Palliative Care Matters guiding principles into six scientific questions. The scientific articles in this supplemental issue each present evidence and expert recommendations that speak to one of the Palliative Care Matters scientific questions.

Keywords: Consensus Development Conference; palliative care; Palliative Care Matters; public engagement

Background

THE COVENANT HEALTH PALLIATIVE INSTITUTE posits that a consensus development conference (CDC) constitutes a foundation for a strong public engagement plan. Developed in Denmark and first implemented in 1987, the CDC is a tool intended to bridge the gap between the general public, scientific experts, and politicians. The intended audience for a CDC is government, administrators, and other decision makers, in addition to the public. A CDC results in a document reflecting the evidence, opinions, and recommendations on an issue. In partnership with Canada's leading healthcare organizations, the Covenant Health Palliative Institute is undertaking a three-phase national CDC on palliative care. The objective of the conference is to develop a national consensus statement and recommendations promoting consistent and timely access to high-quality, coordinated, and integrated palliative and end-of-life care. The purpose of this article, and indeed this issue, is to document the key decisions and learnings from this project.

A CDC is a stylized method which includes a rapid data synthesis of evidence. As such, the review is not intended to generate new scientific data and therefore cannot solve or contribute to a solution.¹ New interpretations and evaluation

of the data, however, are facilitated when evidence is synthesized (in our case, for review by the Canadian public).

"The participants may formulate the best current judgment of a given technology in relation to the healthcare service requirements, the patients' desires, and the demands of the society."

Suitable topics are topical, not too abstract, contain conflicts, call for clarification of objectives and attitudes, depend on expert contribution for clarification, and require availability of knowledge and expertise. The following criteria for the selection of our topic have been proposed²:

1. The issue should have public importance;
2. There should be controversy over scientific aspects of the issue;
3. There should be available evidence upon which to base evaluation of the issue; and
4. The issue should be amenable to clarification on technical grounds."

Guidance for the clear and unambiguous wording of questions has been established. Careful and precise definition of the questions to be addressed is required to investigate the topic efficiently³ to maximize the opportunity for a valid evaluation

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and to avoid a predetermined conclusion.⁴ Poorly worded questions can result in ambiguous or overly generalized recommendations.⁵ The questions will be used by IPSOS and the scientific panel to gather qualitative and quantitative evidence.

Framework

Excellence within healthcare is typically isolated and unknown to the system. The introduction and evolution of palliative care in Canada can best be described as opportunistic, relying on advocacy from local champions. The result of this patchwork approach is unequal access to palliative care. Performance standards are in their infancy which makes it difficult to evaluate the quality of services available. Standardization of high-quality palliative care first requires identification of best practices, their evidence, and quality measures across organizations. We propose to use the Institute for Healthcare Improvement (IHI) Trip AIM framework to ensure quality is assessed through (1) improving the health of the defined population, (2) enhancing the patient care experience (including quality, access, and reliability), and (3) reducing, or at least controlling, the per capita cost of care. A primary objective of the CDC is to engage the public and identify practices which satisfy these three criteria.

Second, closing the gap of best and usual practice entails a mechanism and process to spread innovative practices. Barriers which inhibit the diffusion of innovative practices include “the characteristics of the innovation itself; the willingness or ability of those making the adoption to try the new ideas; and characteristics of the culture and infrastructure of the organization to support change.” In response, IHI initiated a process to facilitate and accelerate change resulting in the development of a framework in 2006.⁶ The process includes three steps: prepare for spread; establish an aim for spread; and develop, execute, and refine a spread plan. A secondary objective of the CDC is to engage all Canadians and to provide dying Canadians and their families with the necessary knowledge to advocate for appropriate change.

Approach

This initiative consists of two stages. Engagement, building consensus, and the development of recommendations comprise the first stage. A change management plan however is required to ensure uptake of recommendations arising from the first phase.

CDCs require public engagement. Intuitively the validity and representativeness of resulting recommendations require an appropriate depth and breadth of the consultation process. We propose a three-stage model intended to optimize the number, selection, and preparation of citizens.

Although 12 citizens are typically described, ideally it is intuitive that engaging more is better. Demographic representation is challenging when age, education, and geography play such important roles. As the number of citizens engaged however increase, the need to identify and synthesize input becomes more difficult, especially when considering qualitative data.

Selection of citizens is an important consideration. Random selection criteria, for example, are used in gathering input from public polls. This method is appropriate when the issues are not complex and easily understood. Discussion of physician assisted dying has moreover polarized the

public and increased the probability of introducing bias if selection criteria are not monitored carefully. In particular, personal experience with death of a loved one will need to be considered. Cross-examination of potential jurors is required in complex and controversial legal cases. The need for clear criteria and management of costs are factors in citizen selection.

Finally, preparation of citizens is classically described as a two weekend process. Longer and more intensive education are offset by time and costs. Preparation can also be offset through the selection of appropriate jurors.

We propose two stages and the following steps which take into account these considerations.

Stage I: Engagement and identification of best practices

Phase 1

Quantitative and qualitative survey. The development of an online survey is to collect quantitative data. These methods allow for a large number of citizens to provide feedback. This phase was conducted by IPSOS (see Roulstan, this issue). Polls are anonymous which encourage truthful feedback. A final question will be provided asking interested participants to participate in a qualitative survey.

Analysis of qualitative data requires greater analytic resources and thereby limits the number of participants. A quantitative survey therefore serves as a filter to select knowledgeable and interested individuals. A qualitative survey probes more deeply and identifies broad feedback. Again, this stage can be used to vet candidates for participation in a CDC. Participation in both quantitative and qualitative survey processes requires sufficient education and interest in the topic. Participation will also stimulate discussions and self-education. Again, a final question asking interested participants for willingness to participate in a CDC will be included.

Phase 2

CDC proper. Selection of citizens from the nomination of interested individuals will ensure a more representative and better informed pool of candidates. A synthesis of data gathered by IPSOS and the scientific panel provide the basis for the CDC. A background article, plain language version of the evidence summaries, and a series of questions guide a dialogue between a citizen and scientific panel. The dialogue takes the form of a jury trial over several days, with a judge represented by the lay-panel facilitator. Including the chair, 12 members of a citizen panel required two preparatory conference calls and review of documentation. A resulting consensus statement was produced on the final day of the conference making reference to the deliberations, recommendations, and consensus statement. The statement can be found in its entirety at www.palliativecarematters.ca

Grundhal⁷ describes in detail a process and roles for key players, including suggested committee and panel sizes.

Manager (and administrative assistant).

- “Formulating proposals to put before the steering committee.
- Recruiting the lay-panel facilitator.
- Managing the hearing of interested parties.

- Advertising for, and short-listing, the lay-panel members and replying to all correspondence.
- Contacting potential scientific experts and following up the final selection once the program has been established.
- Managing the project finances.
- Dealing with the media.
- Providing practical assistance in the production of the final document.
- Preparation and publication of the final document.
- Ensuring that the final document is disseminated and arranging follow-up, such as written material or organizing debates.

In addition, the project manager coordinates meetings and takes minutes; deals with letters and telephone enquiries; distributes material; books accommodation; checks technical equipment for the conference (microphones, etc.); advertises the conference; and delegates practical tasks. A constant service needs to be supplied to the lay panel, the steering committee, and the facilitator.”⁷

Steering committee (6 individuals). At its first meeting the steering committee discusses the project from a general point of view. The project manager must communicate the motivation for selecting a consensus conference as a method for this project, the basic concept of the process, roles, strengths, and weaknesses, etc.

The role of the steering committee should be made especially clear. The time schedule will be presented by the project manager for approval. A list of interested parties in the field must be established. In addition, the steering committee must be informed of the Secretariat’s selection of the lay-panel facilitator.

Finally, the steering committee sets up the framework of the introductory material, which will familiarize the lay panel with the topic of the conference. Such a briefing article may be compiled by the project manager on the basis of existing literature or it may be produced (externally) in the form of a separate article of 15–20 pages by a journalist or another appropriate person. The article will present the subject in general terms and describe the status, development, trends, attitudes, conflicts, etc. in the field. The writing must be unbiased: controversial attitudes should only be reported—objectivity is the aim.

When the introductory material is ready, it is approved by the steering committee (possibly by correspondence rather than a meeting) before it is distributed to the lay panel.

Lay-panel facilitator (like a judge in a jury trial).

- “• Making lay people feel comfortable and persuading them to work together.
- Managing the preparatory weekends, including the work of formulating the key questions.
- Chairing and managing the conference.
- Assisting and steering the lay panel’s production of the final document.
- Focusing the lay panel’s attention on key questions to be answered (so that conclusions in the final document are relevant to the debate and not on aspects that have not been discussed at the conference).
- Working closely with the project manager throughout the process.”⁷

Scientific panel (6 individuals).

- Being abreast of the latest knowledge. Having a good overview of the topic.
- Having good communication skills.
- Being receptive in debates.

Lay panel (10–14 individuals).⁷

- Gain some basic knowledge of the subject in advance by reading the introductory material and participating in the preparatory weekends.
- Draw up the key and sub-questions of the conference.
- Formulate a proposal for the composition of the scientific panel on the basis of their own discussions and the comprehensive list of scientific experts prepared by the steering committee.
- Question the scientific panel at the conference.
- Evaluate the received information and agree on attitudes and any recommendations in relation to the key questions of the conference on the basis of the presentations by the scientific panel and the debate at the conference.
- Write the final document of the conference.

Audience. A high profile lay facilitator supported by a communication strategy can be expected to draw an audience. An appropriate venue and process are required to accommodate the audience.

Media and dissemination strategy.

- printed reports
- journal articles
- stakeholder advisories
- press conferences
- news releases
- TV/radio broadcasts
- video products

Phase 3

The consensus statement is at the heart of a road map for Canada. The Conference Board of Canada was commissioned to write a report outlining potential policy options and implementation plans to guide governments, healthcare organizations, professionals, and other stakeholders. This step is an important step in the policy development cycle. A formal roadmap and action plan would be the next logical steps in this journey.

Framework to Guide Selection of Topics and Formation of Questions

During the last two decades, numerous organizations have engaged Canadians on the topic of palliative and end-of-life care. Table 1 lists the reports which contain, in whole or in part, recommendations to improve the quality of care received by dying Canadians and their families. Only organizations/reports which are national in scope have been included. Advance care planning is included while topics related to withholding and withdrawal of life-sustaining treatment, plus medical assistance in dying, are excluded.

A comprehensive review resulted in the identification of the 19 Canadian reports that identified a total of 192 unique recommendations on palliative and end-of-life care. Together,

TABLE 1. OVERVIEW OF NATIONAL REPORTS

Date	Title	Link
1. June 1995	Of Life and Death. Final report of the special senate committee on euthanasia and Assisted suicide. senate of canada, the honourable senator Joan Neiman, chair.	www.parl.gc.ca/content/sen/committee/351/euth/rep/lad-ic-e.htm
2. June 2000	Quality End-of-Life Care: The Right of Every Canadian Final report of the subcommittee to update of life and death of the standing senate committee on social Affairs, science and technology. senate of canada, the honourable senator Sharon Carstairs, chair.	www.parl.gc.ca/Content/SEN/Committee/362/upda/rep/repfinjun00-e.htm
3. March 2002	Discussion Paper on End of Life. Palliative Care for Aboriginal Peoples. National Aboriginal Health Organization	www.naho.ca/documents/naho/english/publications/ReB_palliative_care.pdf
4. October 2002	The Health of Canadians—The Federal Role volume six: recommendations for reform. Final report of the standing senate committee on social Affairs, science and technology. senate of canada, the honourable senator Michael J.I. Kirby, chair.	www.parl.gc.ca/content/sen/committee/372/soci/rep/repoct02vol6-e.htm
5. November 2002	Building on Values: The Future of Healthcare in Canada Final report of the royal commission on the Future of healthcare in canada. government of canada. roy J. Romanow, qc, commissioner.	http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf
6. June 2004	Dying for Care, Quality End-of-Life Care Coalition of Canada.	www.chpca.net/media/7883/Still_Not_There_June_2005.pdf
7. June 2005	Still Not There. Quality End-of-Life Care: A Progress Report senate of canada. the honourable sharon Carstairs, P.C. Author	www.chpca.net/media/7652/Gold_Standards_Palliative_Home_Care.pdf
8. December 2006	The Pan-Canadian Gold Standard for Palliative Home Care: Toward Equitable Access to High Quality Hospice Palliative and End-of-life Care at Home, The Canadian Hospice Palliative Care Association and the Canadian Home Care Association	http://nshpca.ca/wp-content/uploads/2014/03/Moving-Forward.pdf
9. March 2007	Moving Forward by Building on Strengths, A Discussion Document on Aboriginal Hospice Palliative Care in Canada. Canadian Hospice Palliative Care Association (CHPCA)	www.qelccc.ca/media/3839/qelccc_pan_cdn_partnership_2007.pdf
10. August 2007	A Pan Canadian Partnership for Palliative and End-of-Life Care, Quality End-of-Life Care Coalition of Canada	www.chpca.net/media/7607/ENG_progress_report_2010.pdf
11. May 2008	Hospice Palliative Home Care in Canada: A Progress Report, Quality End-of-Life Care Coalition of Canada	www.parl.gc.ca/content/sen/committee/402/agei/rep/agingfinalreport-e.pdf
12. April 2009	Canada's Aging Population: Seizing the Opportunity Final report of the special senate committee on Aging. senate of canada. the honourable sharon Carstairs, P.C. Chair	www.qelccc.ca/media/3743/blueprint_for_action_2010_to_2020_april_2010.pdf
13. January 2010	Blueprint for action. 2010 to 2020 Progress Report. QELCCC	www.chpca.net/media/7859/Raising_the_Bar_June_2010.pdf
14. June 2010	Raising the Bar: A Roadmap for the Future of Palliative Care in Canada senate of canada. the honourable sharon Carstairs, P.C., Author	www.advancereplanning.ca/wp-content/uploads/2015/09/acp_framework_nov2010_dec16_final_en.pdf
15. November 2010	Advance Care Planning in Canada. National Framework for Consultation. CHPCA	www.mcgill.ca/palliativecare/files/palliativecare/parliamentary_report_eng_dec_2011.pdf
16. November 2011	Not to Be Forgotten: Care of Vulnerable Canadians Final report of the <i>ad hoc</i> Parliamentary committee on Palliative and compassionate care house of commons. Harold Albrecht MP, co-chair Joseph Comartin MP, co-chair Frank Valeriote MP, co-chair	www.parl.gc.ca/content/sen/committee/411/soci/rep/rep07mar12-e.pdf
17. March 2012	Time for Transformative Change: A Review of the 2004 Health Accord Final report of the standing senate committee on social Affairs, science and technology the honourable Kelvin Kenneth Ogilvie, chair	www.cma.ca/Assets/assets-library/document/en/advocacy/end-of-life-care-report-e.pdf
18. June 2014	End of life care. A national Dialogue. CMA	www.hpcintegration.ca/media/60044/TWFF-framework-doc-Eng-2015-final-April1.pdf
19. March 2015	The Way Forward National Framework. A roadmap for an integrated palliative approach to care. CHPCA/QELCCC	

QELCCC, quality end-of-life care coalition of Canada.

TABLE 2. QUESTIONS AND SCOPING NOTES

<i>Number</i>	<i>Question</i>	<i>Issue</i>	<i>Scoping notes</i>
1	What are the essential elements of an integrated and coordinated palliative care program that will help improve access to quality palliative care in Canada?	Despite two decades and a growing evidence base, the majority of Canadians do not have access to the benefits of a regional, comprehensive, coordinated, and integrated program. The model is purportedly efficient and person centered, yet barriers to implementation remain. What Canadians reasonably expect from our universal healthcare model needs to be taken into account, when improving access to an identified set of core services.	A review of this question requires a definition of coordinated and integrated care, including the scope of services included. If available, environmental scans which identify the extent of that care across Canada should be included. The review will evaluate all statements deeming essential services. A survey will invite the public to describe what they consider as essential and what should be included in the healthcare insurance plan of every jurisdiction in the country. A summary of barriers and facilitators will provide insight into the variable adoption of this programmatic approach. The review should include Canada, Australia, Spain, and any other country which has formally acknowledged the need for coordinated and integrated care.
2	Do public health awareness campaigns effectively improve the awareness and quality of palliative care?	Public health awareness campaigns require significant funding yet not all are effective.	Public health awareness campaigns across Canada have been reviewed. A summary of these would provide baseline knowledge relevant to the Canadian healthcare system. The review will include a description and assessment of which elements of a campaign are effective. An international review of national palliative awareness campaigns would result in an inventory of approaches. A survey will ask Canadians what they need to know and how this will help them to access better care. The survey will include the manner in which information is available, including print, visual, Internet, and social media. The synthesis should include an assessment of all outcome measures with a recommendation of what constitutes success or quality.
3	What are the essential components of quality palliative home care services for all Canadians?	Palliative home care is not covered under the Canada Health Act. As a result, providing care in the home is not standardized across Canada. What provinces pay and the resulting financial burden on patients and families varies across the country.	Home care is a broad concept and will begin with a clear definition. A document review of selected programs could include referral criteria, standards, guidelines, and a description of their components. The review of the literature should provide insight into the effectiveness of each of the identified components of home care in the Canadian context. These include 24/7 access to nurses, the role of physicians, and the use of Telehealth. The review should identify variations in services paid for within different provinces. A survey of Canadians will help clarify the experiences, expectations, and unmet needs of care provided in the home. Finally, all arguments for inclusion under the Canada Health Act should be assimilated into one resource.
4	What resources are required to ensure adequate education, training, and mentorship for all healthcare providers and caregivers of Canadians experiencing a life-limiting illness and their families?	Competency frameworks exist for many but not all disciplines caring for dying Canadians and their families. There is an overabundance of educational materials and platforms which are designed to address knowledge gaps in the provision of adequate care. Evidence evaluating the effectiveness of these educational, training, and mentorship tactics, however, is rare. Even more important is the lack of evidence regarding the number of healthcare providers and informal	A brief review of competency frameworks, educational approaches, and platforms is essential. A review of educational need assessments would help to identify the gaps. Note that informal caregivers include volunteers, as well as family members. A survey will help identify the expectations of caregivers and the training they require. The survey will include not only the type of information required but also the channels through which information should be made available (i.e., print, visual, Internet, and social media). Evidence should be gathered which clarifies which resources are required to address the identified barriers and gaps. The review will address whether or not the number

(continued)

TABLE 2. (CONTINUED)

<i>Number</i>	<i>Question</i>	<i>Issue</i>	<i>Scoping notes</i>
5	What have strategic frameworks and plans accomplished for palliative care when adopted by countries?	<p>caregivers with formal training. Support of volunteers and family caregivers exists but it has not been formally evaluated. In recent years, there has been significant effort made to incorporate palliative content into undergraduate education and to adopt a palliative approach for both primary and specialized care.</p> <p>Laswell and colleagues⁸ have described a policy cycle which encompasses the spectrum of strategic planning and policy activities undertaken by organizations and governments. Essential elements of the cycle include: agenda setting, policy formulation, decision making, implementation, and evaluation. To date, close to 100 framework documents have been created to promote and guide palliative care in English speaking countries. Researchers have recently begun to evaluate the impact of these frameworks.</p>	<p>of academic palliative care programs is sufficient. Finally, the review should address what is meant by adequate. In other words, how is the quality of education, training, and mentorship measured? Primary and specialized healthcare providers should be addressed separately.</p> <p>Approximately 20 of these frameworks exist at the national, provincial, and regional levels within Canada. A content analysis would help inform the components and intended outcomes for such frameworks. Specifically, what components of such strategies are helpful to the advancement of palliative care? A global review of frameworks and their outcomes could help identify, in particular, the timing and resources necessary for improving the quality of care. A review of what constitutes quality and success is integral to this review. A public survey will explore the expectations of Canadians, specifically on what they would like to see their frameworks and plans accomplish.</p>
6	Does measurement of indicators that address desired outcomes, including patient/family reported outcomes and experience, improve the quality of and access to palliative care?	<p>Much evidence exists to inform the desired outcome measures. Systematic review of outcomes and expert and consensus-driven approaches have resulted in a myriad of performance measures. The review will include an assessment of which indicators are associated with improvements to the access and quality of care. Implementation of measures, however, is more limited as a result of the practical limitations in data availability and methods. Even fewer evaluations of the effect indicators have on the delivery of palliative care exist.</p>	<p>An environmental scan and review of frameworks, indicators, implementation, and evaluation are required. Advance care planning should be included. A review of the barriers to measurement should be included. Emphasis on the need for patient-reported outcome measures is required. The role of qualitative data will be considered. A survey will address what Canadians need to know about their healthcare system.</p>

these reports and recommendations represent a vast consultation with Canadians. We wish to honor all the individuals and organizations by acknowledging and building on work that they have already completed. Not all recommendations, however, are relevant. Many are duplicated, others are dated and most importantly, many have already been implemented.

Guiding principles

The following principles apply to all questions.

1. Questions should generate evidence that is person centered. Patients and/or families must be included in the process at every level, contributing to design and delivery and providing ongoing feedback about how well the system is working.
2. Questions are applicable to all Canadians. When possible, evidence supporting the following populations of interest should be addressed: rural, remote, and indigenous.
3. Quality of palliative care includes the six Institute of Medicine dimensions: safe, effective, efficient, timely, person centered, and equitable.
4. Definition of Palliative Care (Adapted from A Model to Guide Hospice Palliative Care © Canadian Hospice Palliative Care Association, Ottawa, Canada, 2002.)

Palliative care strives to help patients and families:

- address physical, psychological, social, spiritual, and practical issues and their associated expectations, needs, hopes, and fears
- prepare for and manage self-determined life closure and the dying process
- cope with loss and grief during the illness and bereavement

Palliative care aims to:

- treat all active issues
- prevent new issues from occurring
- promote opportunities for meaningful and valuable experiences, personal and spiritual growth, and self-actualization.

Palliative care is appropriate for any patient and/or family living with, or at risk of developing, a life-threatening illness due to any diagnosis, with any prognosis, regardless of age, and at any time they have unmet expectations and/or needs, and are prepared to accept care.

Palliative care may complement and enhance disease-modifying therapy or it may become the total focus of care.

Palliative care is most effectively delivered by an interdisciplinary team of healthcare providers who are both knowledgeable and skilled in all aspects of the caring process related to their discipline of practice. These providers are typically trained by schools or organizations that are governed by educational standards. Once licensed, providers are accountable to standards of professional conduct that are set by licensing bodies and/or professional associations.

Canadian Reference Working Group

A Canadian Reference Working Group (CRWG), representing the Canadian public and major stakeholders, was convened on June 15, 2016, and a nominal group technique was used to facilitate the meeting to choose the recommen-

dations which have the greatest likelihood to improve the quality of palliative care for all Canadians. The CRWG reached consensus on the identification and wording of six questions. A face-to-face meeting was followed by four rounds of editing to arrive at the final questions and scoping notes. A committee of 16 represented a balance of expert, stakeholder, and public representatives. The questions are designed to help gather the evidence which addresses significant national recommendations. Evidence will be gathered from qualitative and quantitative inquiry of public alongside scientific expert review of the academic and gray literature. Where practical, we will ask for stakeholder insights into an analysis of the current state.

All questions align with one or more recommendations from national reports on palliative care. Nominal group technique was used to elicit those recommendations which were deemed to have greatest impact. The content and order of the six questions therefore reflect the priorities of the CRWG. The questions struck an important balance in scope—neither too narrow to be useful nor too broad to weigh down the evidence gathering process. A description of the issues and scoping notes is meant to develop a common language and understanding of why the questions are important. These also serve to guide a scientific panel tasked with collection of evidence addressing the respective questions. The final questions and scoping notes are provided in Table 2.

Stage II: Change management, policy implementation, spread

Financing and delivery of healthcare fall within provincial jurisdiction. A report summarizing the recommendations informed by scientific experts and citizens is a powerful and necessary first step. Gaining the attention of health ministers, establishing the urgency for change, sequestering sufficient resources, and developing appropriate policy and procedures will require a plan. Three steps are contemplated.

- Step 1: Prepare for spread
- Step 2: Establish an aim for spread
- Step 3: Develop, execute, and refine a spread plan

Author Disclosure Statement

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References

1. Scherstén T: Topic and scope of consensus development conferences: Criteria and approach for selection of topics and properties for assessment. In: Goodman C, Baratz SR (eds): *Improving Consensus Development for Health Technology Assessment: An International Perspective*. Washington, D.C.: National Academy Press, 1990.
2. Committee of the Institute of Medicine Council on Health Care Technology. Consensus Development at the NIH: Improving the Program. National Academy Press, Washington, DC. 1990.
3. Fink A, Koscoff J, Chassin M, Brook RH: Consensus methods: Characteristics and guidelines for use. *Am J Public Health* 1984;74:979–983.
4. Oliver MF: Consensus or nonsensus conferences on coronary heart disease. *Lancet* 1985;1:1087–1089.
5. Lomas J: The consensus process and evidence dissemination. *Can Med Assoc J* 1986;134:1340–1341.

6. Massoud MR, Nielsen GA, Nolan K, et al.: *A Framework for Spread: From Local Improvements to System-Wide Change. IHI Innovation Series White Paper*. Cambridge, MA: Institute for Healthcare Improvement, 2006. www.IHI.org (last accessed June 26, 2017).
7. Grundhal J: The Danish consensus conference model. Public participation in science: The role of consensus conferences in Europe 1995 (pp. 31–40). London: Science Museum.
8. Lasswell HD: The policy orientation. In: Lemer D and Lasswell HD (eds.), *The Policy Sciences*. Stanford University Press, Stanford, CA, 1951.

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