

DEVELOPMENTS IN GENERATIVE A.I. AND MACHINE LEARNING – PAGE 20

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PHOTO: JERRY ZEIDENBERG

Time for made-in-Canada EHR solutions?

Panelists at the recent AI in Hospitals conference, in Toronto, lamented that Canadians have invented or co-developed a variety of technologies, but companies in foreign countries have taken them further and benefited. They said Canada's expertise in AI presents a similar opportunity, one that shouldn't be squandered. It could even be used to create and share a home-grown EHR. Pictured are John Vail, CAN Health Network; Justin Hartlen, Virtual Hallway; Andrea McKnight, St. Joseph's Healthcare Hamilton; Joe Cafazzo, UHN. **SEE STORY ON PAGE 20**

Scarborough and Lakeridge join elite EMRAM 7 group

BY NORM TOLLINSKY

Two Ontario hospital systems – Scarborough Health Network (SHN) and Lakeridge Health – have joined an exclusive group of Canadian hospitals that have achieved Stage 7 of the Electronic Medical Record Adoption Model (EMRAM), a ranking from the Healthcare Information and Management Systems Society (HIMSS) earned by only six other Canadian hospitals.

Scarborough Health serves a population of 850,000 in Toronto from three sites: Scarborough General, Birchmount Hospital and Centenary Hospital. Lakeridge Health provides care for 750,000 Ontarians in Oshawa, Ajax-Pickering, Bowmanville, Port Perry and Whitby.

The two hospital systems went live in December 2021 with a shared instance of an Epic electronic health record that includes five other hospital organizations and a total of 14 sites in Ontario's Central East region, providing care teams at each location with real-time access to patient health information from any other participating site.

> **Both hospital systems achieved a 95% rate for using barcode medication administration.**

Among the accomplishments qualifying Scarborough and Lakeridge for Stage 7 EMRAM designation was a 95 percent rate for using barcode medication administration (BCMA). "This means every medication administration we have is electronically supported through physician order entry, pharmacist verification, and bedside barcode scanning," said Rachel Howe, Lakeridge Health's clinical practice leader.

"Our nurses will scan the patient wristband and the medication before administration and that helps to ensure the patient receives the right medication, the right dose, the right route and at the right time.

"We started with BCMA when we went live with Epic in 2021 and we have been continuously refining the process and optimizing it ever since. It was a huge change management focus for our organization."

Other hospitals have access to the same

CONTINUED ON PAGE 2

Scarborough Health Network and Lakeridge Health achieve EMRAM 7

CONTINUED FROM PAGE 1

technology but have varying levels of BCMA usage, noted Dr. Larry Nijmeh, emergency physician and Lakeridge's chief medical officer. Achieving a 95 percent rate requires an organization-wide commitment, especially in a busy emergency department where medication often must be administered quickly, he noted. "Stage 6 EMRAM requires a 50 percent rate for BCMA, so it's a big jump to 95 percent and Stage 7."

Scarborough Health made the same commitment to achieving 95 percent BCMA usage, said Kevin Chung, vice-president, digital health. "A lot of the credit goes to our clinical community who have since 2021 really bought in to leveraging our tools and the investment the organization has made. Everyone at Scarborough Health was aligned from the CEO down to the clinicians and the digital technology staff."

Optimizing the use of Scarborough Health's digital tools was a key part of the hospital system's focus on improving patient care, he added.

Chung cited the hospital system's use of its MyChart patient portal as another digital technology application contributing to its Stage 7 EMRAM designation. "At SHN we have over 340,000 MyChart users and had over 500,000 pre-and post-appointment self-completed questionnaires just from January to April this year."

As part of its HIMSS assessment, SHN highlighted its use of patient messaging through MyChart. Following an encounter at one of SHN's clinics, patients can reach out to their care team with any questions.

"It's another example of how embedded digital technology is as part of our practice," said Chung. Patients can also see test results, discharge summaries and future appointments. SHN plans to continue to leverage its use of MyChart both to get people onboard and expand its functionality.

A creative use of SHN's electronic health record has had a positive impact on patients with sickle cell disease, an inherited blood disorder that causes red blood cells to become hard, sticky and misshapen. "Sickle cell is a condition with a high prevalence in the Scarborough community, so this is a good example of leveraging digital technology tools to support the population in our community," said Chung.



Kevin Chung, VP digital health, Scarborough Health

"One of the things about patients with sickle cell disease is that their pain is so significant that the faster we treat them, the better the outcome, so we made it a priority to develop a flag in Epic for sickle cell patients."

When sickle cell patients show up in the ED, they are immediately identified and prioritized for care. The system automatically displays an order set and best practices to relieve their pain, resulting in an initial consult in less than 15 minutes from the time of arrival. "That's a high bar and a standard for Ontario," said Chung. "In the past, the time to initial assessment could be over 120 minutes."

Contributing to Lakeridge Health's achievement of Stage 7 EMRAM was the organization's use of clinical decision support for improved patient outcomes. Clinicians receive decision support alerts directly in the electronic health record, providing them with evidence-based guidance at the point-of-care.

For example, the system generates a contraindication warning when a patient is allergic to a medication that's ordered. It also alerts a nurse if a drug is administered at the wrong time.

"We also have Our Practice Advisory alerts that guide our clinicians on following best practices," said Howe. They also prompt escalation pathways, help identify risks and implement strategies for prevention. "We have active alerts that interrupt a clinician during the workflow with a pop-up on their desktop or mobile device as well as passive alerts or advisories that appear in the patient chart," she added.

Other alerts will advise a nurse who has conducted a positive Morse falls risk assessment on a patient to add the falls care plan to their chart or warn that a patient may be deteriorating based on recently entered vital signs.

Lakeridge Health also used its electronic medical record system to cope with a 2024 global shortage of bottles used to collect blood culture samples. "We were at risk of running out of these bottles and impacting our ability to diagnose blood stream infections, so we used the data in Epic and a practice advisory to alert clinicians to unnecessary tests," said Dr. Nijmeh.

Another practice advisory prompts clinicians to evaluate the necessity of urinary catheterization over a period of time to decrease the incidence of infections, and to get patients moving and discharged sooner.

Using digital technologies to access patient information from other sites has also contributed to improved patient care. "When I started in practice, I couldn't see a lot of patient information," said Dr. Nijmeh. "I wouldn't know what happened at a previous visit at another organization. I had to ask someone to call LifeLabs and wait for a fax or I'd call a family doctor and find out they were away for lunch."

Now, clinicians at both Lakeridge and Scarborough Health Network can view patient records from seven hospital systems, including hospitals in Campbellford, Haliburton, Cobourg, Peterborough and Lindsay, a total of 14 sites sharing the same instance of Epic in the Central East region of Ontario.



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Beyond the clinic: An AI-enabled digital platform for type 2 diabetes

BY AMENEH MADJD, PhD

VANCOUVER – In a three-month BC Ministry of Health-supported pilot that tested D2Type, a platform for prediabetics and patients with type 2 diabetes, participants with type 2 diabetes showed improvements in glycemic control, weight and lifestyle behaviours. Mean HbA1c fell by 0.9 percentage points, and half lost at least five percent of their body weight.

The findings were published in Diabetes and presented at the American Diabetes Association Scientific Sessions in 2025.

Building on that pilot, D2Type is now moving toward routine care at greater scale. With support from Innovate BC, the company is working with the Jim Pattison Centre for Health System Learning and Innovation and Interior Health on implementation in community and primary care settings, preparing for broader adoption in British Columbia.

D2Type is a platform consisting of three connected tools that deliver lifestyle-first care: guiding patients, surfacing risk early, and keeping clinicians aligned between visits.

• D2Type Companion is a patient-friendly app that seamlessly tracks lifestyle metrics and delivers timely, coach-supported guidance to keep members on track. The app may tell the patient, "Great to see your blood glucose drop this week!"

• D2Type Beacon, an AI signal and triage layer detecting risk early and recommending next-best actions, so care reaches the right person at the right time. Observing the patient's movements, it might note: "Let's add a little more physical activity this week."

• D2Type Hub, a shared dashboard enabling coaches and clinicians to monitor progress and adjust care between visits, without added team burden. Clinicians, for example, can view charts showing the patient's improvement or decline over time.

D2Type is designed to help alleviate the growth of diabetes in Canada by assisting both patients and caregivers.

Nearly 12 million people in Canada are living with diabetes or prediabetes. For a healthcare system under pressure, the challenge is not simply diagnosis and treatment. Much of diabetes care happens after the appointment ends.

A person may see a healthcare professional only a handful of times a year. Between those visits, they make hundreds of small decisions every day – what to eat, whether to be active, how well to sleep, how to manage stress and what to do when glucose or weight changes. Over time, those decisions shape not only diabetes control, but broader cardiometabolic health.

Clinicians understand this, but primary care teams are already stretched. Where resources are available, patients may receive education and follow-up from diabetes nurses, dietitians and other professionals. Even then, most day-to-day decisions happen between appointments, outside the care team's view. Clinicians cannot realistically review every meal, activity pattern, sleep change or glucose reading, nor do they want another dashboard added to a busy workflow.

That is the care gap Vancouver-based D2Type Health is trying to address.

D2Type is a digital care platform for people with prediabetes and type 2 diabetes, built with a broader cardiometabolic view. Because diabetes often sits alongside



issues such as excess weight, blood pressure and lipid abnormalities, the platform looks beyond glucose alone.

For patients, D2Type brings together information on nutrition, physical activity, sleep, stress, weight, glucose, medications and engagement. The aim is not simply to collect data, but to turn it into practical next actions that fit real life.

Those actions change at different time horizons. In the moment, the platform can help someone make a better choice around food or activity. At the end of the day, it can highlight a pattern worth noticing. Each week, it can narrow many possible goals into a small number of personalized priorities.

Over longer periods, it can show whether those changes are being sustained and whether the plan needs to adapt.

Artificial intelligence supports this process in the background. Rather than giving everyone the same advice, the system looks at patterns across different data streams and how an individual responds over time.

If a suggestion is followed and appears useful, the platform can build on it. If it is difficult to sustain or no longer relevant, the next action can change.

This creates a more adaptive approach to behaviour change. Two people with similar HbA1c levels may need different support because their patterns, barriers and previous responses are different. The intent is to keep recommendations personal and dynamic rather than static or generic. Human coaches can review and adjust weekly plans, while clinical decisions remain with healthcare professionals.

D2Type is not designed around a physician or nurse monitoring every daily data point. Instead, it summarizes longer-term trends and brings forward selected information that may deserve attention. This can help care teams see who is progressing, who may be disengaging and who may benefit from earlier follow-up.

D2Type tries to connect two parts of care that are often separated: the everyday decisions people make outside the clinic and the limited time healthcare professionals have to support them.

If digital platforms can make the weeks and months between appointments more visible, personalized and actionable, cardiometabolic care could become more continuous – extending support beyond the clinic walls without asking clinicians to do more of everything.

Ameneh Madjd, PhD is co-founder & COO of D2Type Health Inc.

Ontario partners aim to transform wound care with AI technology

BY REBECCA BROOKHAM

Advances in artificial intelligence are rapidly reshaping healthcare delivery, creating new opportunities to improve access, efficiency and patient outcomes. For rural communities, where access to specialized care and clinical resources can be limited, AI-enabled technologies offer promising new ways to support patients closer to home.

At Brightshores Health System, within Ontario's Grey and Bruce counties, digital innovation is being used to enhance care by addressing one of healthcare's most persistent and costly challenges: chronic wounds.

Through its Office of Research and Innovation, Brightshores is leading the regional implementation of an AI-enabled wound assessment platform developed by Swift Medical. Supported by funding from DIGITAL, Canada's Global Innovation Cluster, Brightshores first introduced the technology across its six hospital sites before expanding implementation to healthcare partners throughout Grey and Bruce counties.

"Modernizing how care is delivered by reducing barriers and building better ways of working is an important part of improving healthcare for the communities we serve," said Ann Ford, president and CEO of Brightshores Health System. "Through initiatives like this, Brightshores is demonstrating how rural health systems can lead the adoption of innovative solutions that expand access to specialized care and improve the experience of patients across the region."

The technology is now used across multiple care settings, including South Bruce Grey Health Centre's four hospital sites, Hanover & District Hospital, CarePartners community clinics, and during home care visits.

This is creating a more connected and consistent approach to wound management across the region.

Wound assessment reimagined: Chronic wounds affect thousands of Canadians and have a significant impact on patients, providers and healthcare systems. Research published in Wound Care Canada estimated that one in 500 Canadians will develop a non-healing wound during their lifetime, while annual direct wound care costs exceed $3.9 billion nationally (Canadian Institute for Health Information, National Health Expenditure Trends, 1975 to 2011).

Historically, wound assessment has relied on manual tools such as paper rulers and cotton-tipped applicators to estimate wound size and depth. These approaches can be time-consuming, inconsistent and uncomfortable for patients. The Swift Medical platform replaces subjective measurement methods with AI-assisted image analysis.



Rebecca Brookham

"Swift Medical's AI technology has promising opportunities to streamline wound assessments, improve consistency in wound documentation, and support nurses in monitoring patients' healing progress over time," said Stephanie Lefebvre, professional practice and education coordinator at South Bruce Grey Health Centre. "This technology will enhance our clinical workflows while supporting more consistent, informed wound care across our teams."

Using a mobile device, the technology automatically measures wound dimensions, estimates depth, and identifies tissue characteristics associated with different stages of healing. The platform also tracks wound progression over time, enabling clinicians and patients to monitor healing, identify concerns earlier, and make more informed treatment decisions.

"We've seen meaningful improvements in patient engagement and confidence in their care, along with significant reductions in wound-related emergency department visits among patients with diabetic foot ulcers," said Rebecca Johnson, Brightshores research project manager.

The standardized documentation also facilitates communication between healthcare professionals working across a variety of settings.

"By being able to visually share improvements over time, we can help patients better understand their healing journey and provide encouragement and hope throughout their recovery,"

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CONNECTING DATA. EMPOWERING CARE.

Mackenzie Health's RFID in the OR improves medication management

In the operating room, medications move quickly. Anesthesia providers need medications immediately. Multiple clinicians may need to access the same inventory during a procedure. For pharmacy teams, keeping track of what was used, what remains, and what needs to be replaced has traditionally relied on manual barcode scanning and drug reconciliation after each procedure.

For Mackenzie Health in Ontario, those processes were becoming challenging to manage as surgical volumes increased and perioperative workflows grew more complex.

More than a decade ago, Mackenzie Health Richmond Hill introduced RFID into its inpatient pharmacy, becoming an early adopter of the technology in Canada.

In 2014, the pharmacy team implemented Intelliguard's Mira Prep Pharmacy Station to manage medications in 40 crash carts.

Before RFID, checking expirations across all 40 crash carts was a largely manual and time-consuming process. Introducing RFID streamlined this work, saving the pharmacy team roughly a day of staff time each month.

Mira Prep identifies, validates, and tracks every RFID-tagged medication at the item level. In a single 10-second scan, it accurately reads hundreds of medications, replacing manual lot number logging and expiration checks while making crash cart restocking faster. Over the years, RFID has given pharmacy leaders at Mackenzie Health a clearer picture of medication inventory and utilization, helping them make informed decisions based on actual usage rather than estimates.

"It's a no-brainer in terms of workflow," said Susan Simao, director of pharmacy and medication management at Mackenzie Health. "It brought our pharmacy team a new sense of safety and reliability."

Real-time visibility is especially valuable during medication shortages, when pharmacy staff can use RFID data to understand how much medication is on hand and how quickly it is being used. Having this understanding enables pharmacists to adjust inventory levels based on actual utilization, reducing the guesswork involved in managing supply.

As the organization reviewed medication workflows, the leadership team recognized the opportunity to bring the same visibility into one of the hospital's fastest-moving, high-stakes clinical environments: the operating room.

In 2026, the Richmond Hill hospital began using Intelliguard's Mira Care Medication Workstations across all 18 operating rooms and procedural areas. The change gives clinicians quick access to medications without adding more documentation to an already demanding workflow, while giving pharmacy the information it needs to proactively manage inventory.

Instead of manually documenting each medication removed during a procedure, the RFID-enabled workstations automatically capture medication movement.

"Now that RFID is a reality for us, it is a wonderful way for the anesthesia department to proceed in the operating room," said Dr. Jerod Gollant, chief of the department of anesthesia. "With RFID in the OR, anesthesia providers don't have to document what they're taking out during a procedure. We just go into the drawer, take what we need, and we know that the Mira Care Workstation is documenting it."



For pharmacy, automated capture provides visibility that was difficult to achieve through manual processes. Medication movement is recorded at the item level, while expiration and utilization information can be monitored in real-time rather than reconciled later.

Accurate utilization data helps clinicians identify medications being used at higher rates and adjust periodic automatic replenishment (PAR) levels to help maintain availability across procedural areas.

The system also alerts the pharmacy when medications reach critical PAR levels, helping staff respond quickly.

Pharmacy, anesthesia, IT, clinical informatics, operations, and frontline staff worked together to redesign the workflow around the new system. A cross-functional team met weekly for six months before the official launch, working through workflows, testing, and the physical layout of the workstations.

"First and foremost, I give credit to our team – the pharmacy team and our anesthesia assistants – who worked really vigorously on getting all of the workflows established, testing everything, and even designing the layouts of the machines," Dr. Gollant said.

Mackenzie Health worked closely with Intelliguard's implementation and client support teams to map future-state workflows, including narcotic reconciliation after surgery, ensuring a smooth transition.

"Working with Intelliguard was extremely beneficial. After go-live, having Adriana from Intelliguard on-site was irreplaceable because it allowed our team to experience a higher level of support and service," Dr. Gollant asserted. With this successful rollout, Mackenzie Health plans to extend RFID automation to other sites, including Cortellucci Vaughan Hospital, its sister facility in Vaughan, Ont. Consistent technology and simplified workflows could also support anesthesia providers who work across multiple locations.

More broadly, the Mackenzie Health experience points toward a shift in medication inventory management. Rather than relying primarily on manual counts and retrospective reconciliation, RFID gives pharmacy teams a real-time view of medication movement and utilization.

UHN builds platform to enable future advanced analytics

TORONTO – As Canada's largest research and teaching hospital, University Health Network (UHN) operates within a uniquely complex data landscape. Its three mission-aligned data domains of clinical, research and education, together with the enterprise corporate data domain, generate significant volumes and varieties of data.

UHN's challenge is not a lack of data, but the ability to integrate and transform it into trusted, reusable assets that strengthen decision-making today and power advanced analytics for better clinical care and more effective operations tomorrow.

"Reducing data fragmentation is critical to building a trusted enterprise foundation that enables consistent decision-making, scalable insights and innovation across UHN, while ensuring that patients remain at the center of every decision," said Kevin Smith, president and CEO of UHN.

Many of UHN's data platforms and reporting environments were originally developed to meet local and departmental needs. While effective for their intended purposes, this model can make it difficult to integrate information across data domains, reuse data products and scale new capabilities across the organization.

At the same time, UHN's data needs are evolving rapidly, so has the need to provide proactive data governance to ensure access, use and sharing of data for novel use cases.

This necessitates scalability and practicality in managing hundreds of data assets, ensuring robust data stewardship, measuring and monitoring data quality, and applicability of data standards and policies to meet regulatory and institutional requirements.

The Enterprise Intelligence Platform (EIP), developed by UHN's data & analytics department, addresses these challenges by creating a common enterprise-wide foundation for integrating, processing, governing and using data.

The foundation of this platform is critical to UHN's data strategy. It provides a scalable environment for bringing together data from multiple enterprise systems and transforming it into trusted, reusable information products. Through a medallion architecture and Master Data Management (MDM) capabilities, data can be progressively standardized, validated, linked and prepared for broader enterprise use.

Technology alone, however, does not create trusted data. Data users also need to understand what the data means, where it came from, how it was transformed, who is accountable for it and whether it meets established quality standards.

The EIP therefore incorporates enterprise data governance and data management capabilities, including data cataloguing, business glossaries, metadata and lineage, data quality, stewardship and certification.



Members of UHN's data & analytics department

Furthermore, the platform provides strong data governance and data management capabilities as UHN increasingly connects information across clinical, research, education and corporate domains.

Common definitions, ownership, quality controls and traceability help meet integrated organizational demands without creating new inconsistencies or silos.

These capabilities are also foundational to trustworthy AI and agentic workflows. AI models and agents depend on information that is reliable, contextualized, appropriately governed and traceable to its source. Without that foundation, automation can amplify inconsistent definitions or poor-quality data.

"The EIP isn't just a technology upgrade, it's how UHN turns data into a trusted, reusable asset. Once you have that foundation, you can build advanced analytics and AI on top of it with confidence, instead of starting from scratch every time," said Michael Caesar, chief data and analytics officer at UHN.

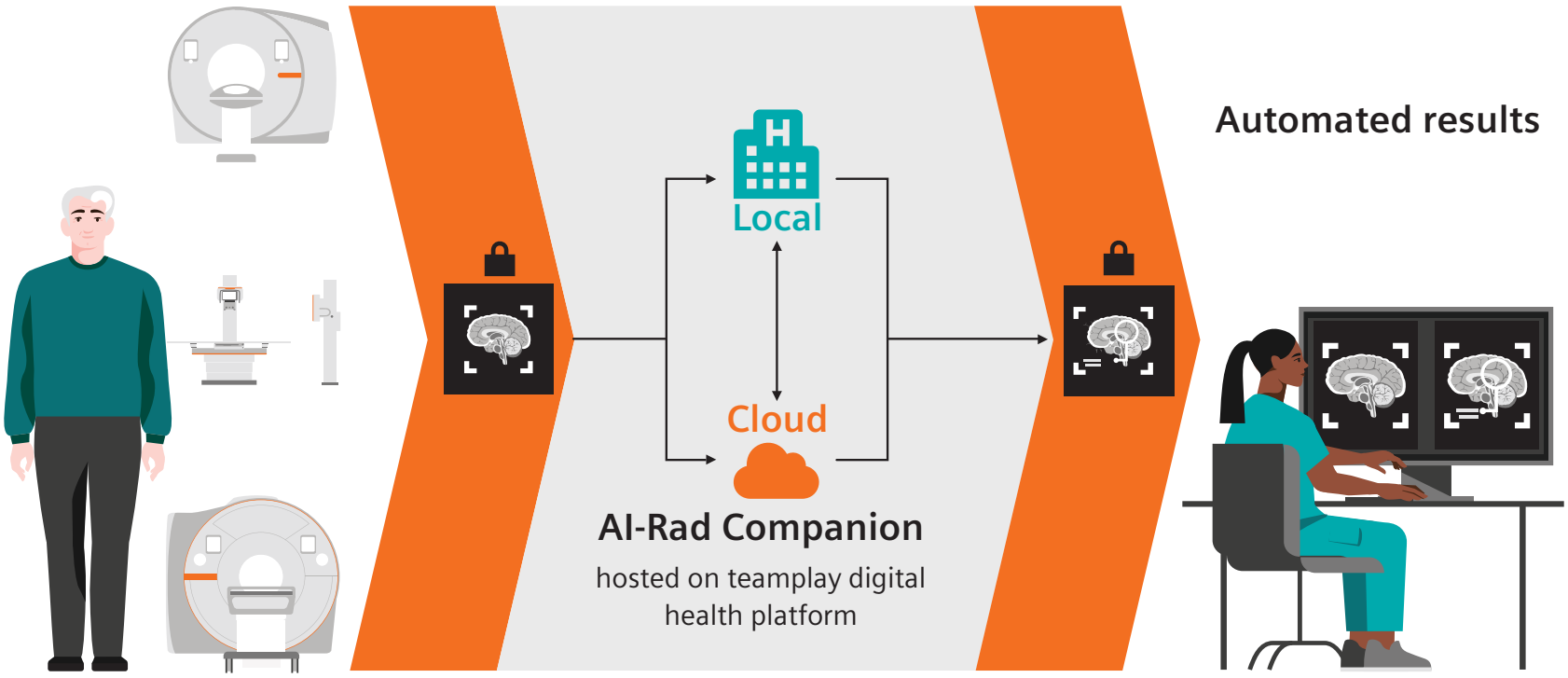
A UHN-led enterprise capability: The EIP extends well beyond modernizing reporting. It is creating an enterprise data ecosystem that can evolve with UHN's needs, supporting traditional analytics today while providing the scalability, interoperability and governance required for predictive analytics,

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[1] *AI-Rad Companion consists of several products that are (medical) devices in their own right, and products under development. AI-Rad Companion is not commercially available in all countries. Future availability cannot be ensured*

SIEMENS Healthineers

Mohawk Medbuy is helping to build a smarter health care supply chain

BY ROXANE BELANGER

Artificial intelligence may dominate conversations about the future of health care, but supply chain leaders are increasingly recognizing that AI is only as valuable as the information that feeds it. In Canada's health care sector, where product shortages, rising costs and operational pressures continue to challenge providers, high-quality data is becoming a strategic asset.

Few organizations illustrate this evolution better than Mohawk Medbuy (MMC), a national not-for-profit shared services organization that supports hundreds of hospitals and health care providers across Canada. MMC describes itself as the "digital backbone" of Canada's health care supply chain, leveraging extensive data resources, automation and AI to improve visibility, resilience and decision-making for its members.

The organization's experience offers a glimpse into how Canadian health care supply chains can move beyond simple automation toward more sophisticated, intelligence-driven operations.

The foundation for this is data rather than AI. For health system leaders, the excitement surrounding AI often obscures a fundamental requirement: a strong data foundation.

"Everything is built on data," said Cameron Love, president and CEO of The Ottawa Hospital. "The one nice thing about having a body like MMC that manages a broad supply chain system is you can create standards for what you need for data, you can create standards for what you need for supply delivery, and you can also start to use that data to inform positioning on what you do strategically."

Love emphasized that AI should be viewed as an enabler rather than the goal itself.

"When you introduce AI, AI doesn't drive what we're trying to do from a model of supply chain delivery, it enables it."

That perspective aligns with broader Canadian discussions about health care supply chain modernization. Data fragmentation has been cited as one of the sector's biggest vulnerabilities, particularly since the COVID-19 pandemic exposed weaknesses in visibility across procurement and distribution networks. During the pandemic, MMC stepped up, bringing together vital data insights to support the sector.

At the heart of MMC's AI strategy is a sophisticated data ecosystem that captures more than $7.4 billion in annual hospital spend data. "The real magic behind MMC's digital strategy is our industry-leading data repository," according to MMC's chief financial and digital officer, Tom Warner. "We put a tremendous amount of work into building and maintaining this repository."

Combining vendor and manufacturer information, this repository also includes contract data and member procurement records that have been cleansed and normalized into a consistent structure.

The scale of that effort is substantial. According to Wisley Chen, data analysis & reporting strategy analyst, MMC manages more than 600,000 items in its Item Master, adds approximately 4,000 new items each month and updates roughly 8,000 existing records monthly.

To manage that significant and growing volume of data, MMC has been deploying AI agents to automate tasks that were previously labour-intensive.

"Our goal was to increase efficiency while maintaining the same amount of resources," said Chen.

The results have been dramatic. Tasks that previously required up to eight minutes to clean and validate a single item record now take approximately nine seconds using AI-powered agents.

Beyond efficiency, the benefits extend to patient care. "We automated these fields specifically because they're essential on both sides," Chen explained. "They're central for us to have reliable master data, but they're also extremely useful for the Members for patient safety as well as compliance."

The value of AI becomes clearer when applied to real-world health care challenges.

Drug shortages are a persistent concern across Canada. According to Health Canada, more than 2,500 drug shortages were reported during the 2024-2025 fiscal



Cameron Love, CEO of The Ottawa Hospital

year – disruptions that can impact care options and continuity of treatment.

MMC is applying AI-driven tools to help anticipate these disruptions before they affect patient care. "Drug shortages are no longer isolated events," said Ally Dhalla, senior vice-president, pharmacy, government and clinical services. "They're very much systemic. They are increasing in frequency, and they're more complex."

Dhalla pointed to MaaTRx, an AI-supported pharmaceutical risk assessment tool, as an example. "The key thing for us is to leverage AI, tools and technology that will facilitate predictive data-driven decision making," he said.

During a recent cyclophosphamide backorder, MaaTRx identified both high clinical importance and supply vulnerability associated with the drug. MMC then worked proactively with international suppliers to help secure importation from other countries before shortages became more severe. "This is truly the focus and the future of MMC – being proactive, being coordinated and intelligence-driven," Dhalla said.

AI's benefits are also being felt throughout MMC's internal operations and service delivery functions. MMC's finance team receives nearly 1,000 vendor reports each quarter containing contract spend information used to validate member hospital rebates.

Historically, processing these files involved extensive manual effort because suppliers submitted data in different formats and structures.

According to senior vice-president of finance, Kyle Watts and director, financial planning & analysis and business transformation Betty Duan, AI now helps standardize and structure incoming data regardless of format.

"It used to take anywhere up to three months for our team to be able to process that data," they explained. "And now we can estimate about six weeks of savings per person in a given fiscal year." The result is faster reporting and distribution of rebates to member organizations – and more time for staff to focus on analysis, collaboration and strategic activities.

MMC has also implemented ServiceNow as a centralized platform through which members can submit and track requests across service lines. Within the first six weeks following rollout, the platform processed more than 1,500 member inquiries, creating a more consistent and transparent experience.

Elsewhere, MMC continues to support the modernization of technology platforms for its Members. It recently completed a large-scale deployment of cloud-based SAP environments for seven Greater Toronto Area hospitals.

It's also implementing QwantifyP2P, an integrated procure-to-pay solution. These initiatives are positioning member organizations to take advantage of future AI capabilities while improving operational resilience.

In preparing people for an AI-enabled future, it's clear technology alone is not enough to drive transformation. Technology alone is not enough to drive transformation.

Recognizing this, MMC has invested heavily in workforce readiness. Chief people officer Tricia McGrath said the organization developed a comprehensive training framework to ensure employees possess the skills and confidence needed to use AI effectively.

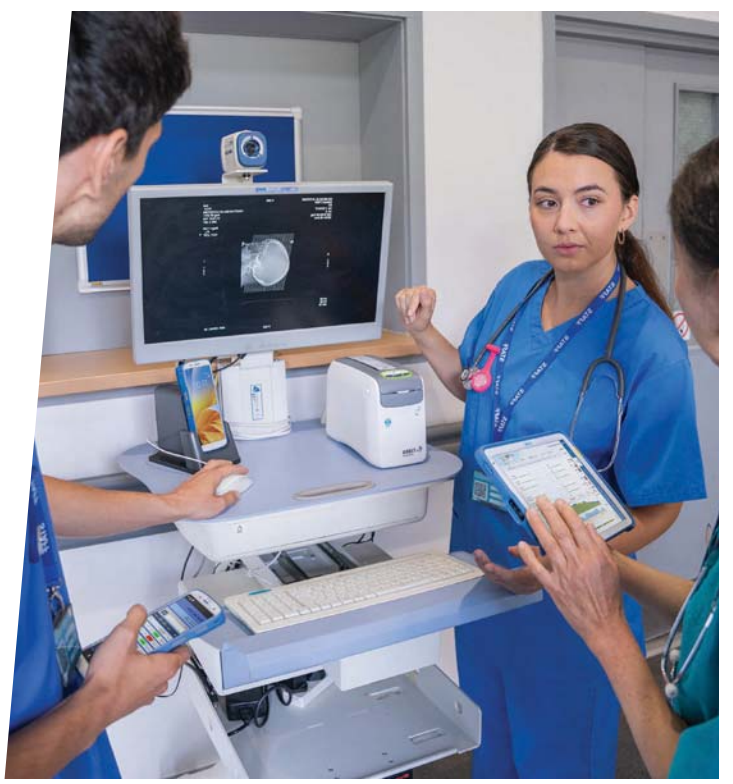
"We launched it earlier this year, and over 98 percent of our staff have actually completed that training to date," McGrath said. The initiative includes practical learning opportunities that help employees apply AI tools to actual MMC business scenarios, ensuring adoption is grounded in real-world value rather than experimentation for its own sake.

Roxane Belanger is a communications specialist with Mohawk Medbuy.

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August 2026 JB01659CA

Hypercare connects Mount Sinai Hospital and SickKids paediatrics

TORONTO – To improve collaboration between Mount Sinai Hospital's Neonatal Intensive Care Unit (NICU) and paediatric specialists at The Hospital for Sick Children (SickKids), the two organizations implemented a secure communication workflow by partnering with Hypercare.

Today, nurse practitioners and physicians at Mount Sinai can connect directly with on-call specialists across multiple paediatric subspecialties at SickKids, helping streamline consultations, reduce communication delays, and support timely clinical decision-making.

The challenge: Mount Sinai's NICU frequently collaborates with specialists at SickKids. While many NICU patients remain under Mount Sinai's care, clinicians often require expert input from paediatric subspecialists in areas such as cardiology, gastroenterology, endocrinology, genetics, plastic surgery, and general surgery.

These consultations occur daily and are an essential part of delivering comprehensive neonatal care. Historically, accessing that expertise was cumbersome and inefficient.

When a consult was required, Mount Sinai's nurse practitioners would contact SickKids' switchboard, request the appropriate on-call specialist, wait for their call to be returned, and often repeat the process if the initial contact was unavailable.

At SickKids, physicians using physical pagers would know the nature of the call. Communicating clinical details, particularly images in a secure manner, added another layer of complexity. Staff were left juggling phone calls, emails, paging systems, and privacy considerations while trying to care for patients.

Dr. Yenge Diambomba, neonatologist and chief medical information officer (CMIO) at Sinai Health, said "the challenge wasn't simply reaching another hospital, it was reaching the right specialist quickly and securely".



Dr. Yenge Diambomba

The solution: To modernize this workflow, Mount Sinai and SickKids established a shared communication process using Hypercare.

Following the completion of a data-sharing agreement and cross-organizational onboarding, Mount Sinai's NICU nurse practitioners received access to the SickKids' Hypercare instance, allowing them to message on-call paediatric specialists directly rather than relying on switchboards.

Instead of waiting for callbacks, clinicians at Mount Sinai can immediately identify the appropriate on-call specialist at SickKids, initiate secure conversations, share clinical information and photos where needed, and continue caring for patients while waiting on a response.

SickKids clinicians would immediately be aware of the nature of the call and respond as clinically necessary using asynchronous communication.

For busy clinicians at both hospitals, the mobility that this solution has provided has been transformative.

"Hypercare has changed the way we communicate. We can reach the right specialist immediately, without being tied to a phone or waiting for a callback, meaning we can continue caring for our patients," said Reem Beshay, paediatric nurse practitioner, Mount Sinai Hospital.

The impact: Rather than navigating multiple communication steps, clinicians now connect directly with the right specialist when they need guidance. The result is faster consultations, more efficient care planning, and fewer delays in decisions

CONTINUED ON PAGE 27



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Reimagining intraoperative imaging for the modern operating room

Canada's healthcare system continues to face pressure from staffing shortages, rising procedural demand and the need to improve efficiency without compromising the quality of patient care. Nowhere is this pressure more visible than in the operating room, where every minute depends on highly coordinated teams, specialized expertise and reliable technology.

For surgical leaders, the question is no longer whether healthcare workforce shortages will affect clinical operations. They already are. The challenge now is identifying technologies capable of helping teams do more with limited resources while maintaining quality and safety.

CIARTIC Move, a robotic mobile 3D C-arm from Siemens Healthineers, introduces a new model for intraoperative imaging: one that brings automation, remote operation and self-driving movement into the surgical suite.

The World Health Organization projects a global shortfall of approximately 10 million healthcare workers by 2030. The impact is expected to be felt across healthcare settings, including operating rooms where highly specialized personnel are often required to support imaging-intensive procedures.

In many minimally invasive orthopaedic, trauma and spine procedures, mobile C-arms play a critical role in providing real-time imaging guidance. Yet positioning these systems often requires close coordination between surgeons and imaging technologists.

Delays, communication challenges and workflow interruptions can arise when staff are unavailable, inexperienced, or stretched across multiple responsibilities. The result is lost time at precisely the moment when efficiency matters most.

A new class of robotic – C-arm: CIARTIC Move is designed as a fully motorized robotic C-arm, from the C-arm itself down to its holonomic wheels. This design enables automated intraoperative imaging workflows, allowing the system to move, position and return to saved views with less manual effort.

For surgical teams accustomed to repeated C-arm repositioning during procedures, this represents an important shift from manual handling toward standardized, technology-enabled workflow support.

Another distinguishing feature of CIARTIC Move is its ability to operate remotely. Through Smart Control, trained users can position and maneuver the system from within the sterile field, eliminating the need to repeatedly step away from the procedure or rely on verbal instructions to non-sterile staff.

This capability has the potential to streamline communication, reduce workflow interruptions and provide greater control over intraoperative imaging.

Key features include Smart Control, which allows trained users to operate core system functions remotely, including from within the sterile field; Position Assist, which can save and recall procedure-specific 2D or 3D C-arm positions and corresponding imaging parameters; Park Assist, which can move the system away from the operating table and return it when needed; and motor-assisted steering supported by touch-sense handles. Together, these capabilities are designed to reduce idle time, simplify repeated positioning and support more predictable imaging workflows.



In one study, use of CIARTIC Move reduced intraoperative imaging time by approximately 55 percent.

A recent pre-clinical human-specimen study evaluated CIARTIC Move in simulated pelvic, spine and distal radius procedures, comparing it with a conventional mobile 3D C-arm. Researchers measured intraoperative imaging time, defined as the time required to perform procedure-related imaging tasks.

The findings were striking.

Across the procedures evaluated, use of CIARTIC Move reduced intraoperative imaging time by approximately 50 percent, with statistically significant results. Pelvic imaging workflows showed a reduction of approximately 55 percent, while spine and distal radius procedures demonstrated reductions of roughly 50 percent. Researchers reported time savings in the range of three to four minutes per procedure.

These may appear to be modest gains in isolation. However, in operating environments where schedules are tightly managed and delays cascade throughout the day, even small workflow improvements can have meaningful downstream effects.

More than time savings: The significance of CIARTIC Move extends beyond measured time savings. Its greater potential lies in helping surgical teams standardize imaging workflows and reduce reliance on manual positioning tasks that can be affected by staff availability, experience and communication demands.

During all procedures performed with CIARTIC Move in the study, surgeons completed imaging-related tasks independently from within the sterile field, including positioning, saving projections and recalling imaging views as needed. Researchers reported 100 percent autonomous operation by surgeons during the study procedures.

> **Its greater potential lies in helping surgical teams standardize imaging workflows and reduce manual positioning.**

For hospitals facing workforce constraints, this capability could have broader implications than procedural efficiency alone.

By reducing the need for imaging personnel to perform routine positioning tasks, CIARTIC Move may help hospitals make better use of scarce expertise within the operating room.

The goal is not to replace clinical skill, but to extend it: enabling trained professionals to focus more of their attention on patient-centred responsibilities while the technology supports repetitive, time-sensitive workflow steps.



Through Smart Control, trained users can position and maneuver the system from within the sterile field.

The system's automated movement capabilities may also contribute to a more ergonomic OR environment. Motorized steering and touch-sense handles are designed to reduce the physical effort associated with moving and positioning the C-arm, while active sensing technology supports collision protection when the system is in motion.

In busy surgical departments, these practical design elements matter because workflow innovation must also fit safely and smoothly into the realities of daily clinical practice.

The Canadian context: For Canadian hospitals, the relevance is clear.

Healthcare organizations across Canada continue to pursue strategies that improve operating room productivity while addressing workforce challenges. Digital operating rooms, AI-enabled clinical tools and automated imaging systems are increasingly being evaluated not simply for their technological sophistication, but for their ability to solve practical operational problems: reducing delays, supporting consistency and helping teams do more with constrained resources.

For Canadian surgical innovation leaders, CIARTIC Move raises an important question: can workflow automation help create more resilient operating room environments? In imaging-intensive orthopaedic, trauma and spine procedures, where procedural efficiency and communication are critical, a robotic C-arm that can automate recurring movements and enable sterile-field operation may offer a meaningful step forward.

Research has long shown that communication breakdowns contribute to inefficiencies, delays and workflow interruptions during surgery. Technologies that reduce repetitive operational tasks and simplify communication pathways may therefore offer benefits extending beyond imaging alone.

Looking ahead: As hospitals increasingly seek ways to maximize resources, improve throughput and support overstretched clinical teams, automation is moving from aspiration to application. CIARTIC Move illustrates how robotic imaging technology may help address operational challenges in the OR by combining self-driving movement, automated positioning, sterile-field control and 3D imaging support in one mobile C-arm platform.

The future of surgical imaging may not be defined solely by sharper images. It may be defined by intelligent, automated workflows that help surgical teams work with greater confidence, consistency and efficiency.

Based on findings from the pre-clinical human-specimen study, "Saving Intraoperative Imaging Time with the Robotic 3D C-arm CIARTIC Move," Siemens Healthineers AG, 2025, and Siemens Healthineers product information on CIARTIC Move. Results were obtained in a controlled research environment and further clinical validation is required. Product availability may vary by country and is subject to applicable regulatory requirements.

SECTRA

The Path to Digital Pathology Starts Here

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Medtronic Canada receives licence for Affera system, Sphere-9 catheter

BRAMPTON, ONT. – Medtronic Canada announced Health Canada license of the Affera™ Integrated Mapping System and Affera Ablation System with Sphere-9™ Catheter, 1

At a presentation in Toronto, Dr. Jason Andrade, director of electrophysiology at the Vancouver General Hospital, observed that cardiac ablation has been shown to be a far better solution to treating atrial fibrillation than medication.

While ablation effectively targets the cause of cardiac fibrillation and restores the heart to regular rhythms, medication only addresses the symptoms. "Medications don't change the trajectory of the disease, and the condition of the heart gets worse," said Dr. Andrade.

Meanwhile, the wait lists for cardiac ablation continue to grow and the costs are rising. "In Canada, over $1 billion [annually] is spent on managing atrial fibrillation," he noted. "Over 50 percent of that cost is hospitalization."

That's why, he said, it's best to conduct cardiac ablation as early in the course of the disease as possible. By waiting, the disease progresses and the patient only gets worse – often leading to hospitalization.

As Dr. Andrade noted, those wait lists are not good for patients. "The disease is festering while patients should be getting treatment," he asserted.

The benefit of Medtronic's Affera system is that it enables physicians to treat different types of arrythmias using the same catheter. That allows them to perform their work faster – they don't have to stop and start over using a different catheter.

It's also less expensive, as they're using one catheter for the procedure instead of two.

Vancouver General is the first site to use the Affera system in Canada. Dr. Andrade noted that it has recently been used in the US and Europe, and now Canadian hospitals – and patients – will obtain the benefits.

"The Affera system represents an important advancement for the treatment of atrial fibrillation and atrial flutter," said Dr. Allan Skanes, director of Western University Heart Rhythm Program, London Health Sciences Centre, in a Medtronic news release.

"By combining high-density mapping and dual-energy ablation in a single catheter, this technology provides physicians with a versatile tool that can streamline procedures while maintaining strong safety and efficacy outcomes for patients."

The Sphere-9 catheter features a novel lattice-tip design that enables both pulsed field and radiofrequency energy delivery and is fully integrated with the Affera Mapping and Ablation System.

This integration supports procedural efficiency by enabling a single transseptal, zero-fluoroscopy, and zero-exchange workflow, allowing physicians to map and ablate with one catheter.

"The Affera system was designed to address key procedural challenges faced by the electrophysiology community while maintaining a high standard of safety and efficacy for patients," said Doron Harlev, vice president of engineering for Cardiac Ablation Solutions at Medtronic and founder of Affera. "Its ability to integrate mapping and ablation technologies and offer both pulsed field and radiofrequency energy provides physicians with meaningful flexibility in treating complex arrhythmias."



Dr. Jason Andrade

The license is supported by results from the SPHERE Per-AF study, which evaluated the Sphere-9 catheter with the Affera Mapping and Ablation System compared with a conventional radiofrequency ablation catheter and mapping system. The Affera system received CE Mark in March 2023, FDA in October 2024, and has also been approved in other international markets.

"At Medtronic Canada, we are committed to bringing meaningful innovation to physicians and patients," said Rob Clifton, president Medtronic Canada. "With the license of the Affera system in our country, we are excited to expand access to a novel mapping and ablation solution that can help physicians treat atrial fibrillation more safely, effectively, and efficiently."

Atrial fibrillation (AFib) is one of the most common heart rhythm disorders worldwide, affecting more than 60 million people globally. In Canada, it is the most common sustained heart rhythm disorder, affecting about 3 percent of the general population – or more than 1 million Canadians, according to the Canadian Cardiovascular Society.

AFib prevalence heavily scales with age. While it affects around 1 percent of people under 50, that number rises to approximately 4 percent at 65 and jumps to 10-15 percent for those 80 and older. Similarly, as the disease advances, the risk of serious complications such as heart failure, stroke, and death increases.

Sectra Digital Pathology has manifold benefits for Michigan Medicine

In 2024, Michigan Medicine, an academic medical centre in Ann Arbor, Michigan, went live with the Sectra module for digital pathology, joining the institution's previously deployed Sectra enterprise imaging solution, dramatically reimagining the pathology workflow. Also under way is a planned transition to Sectra One Cloud early next year.

"About 20 percent of the large academic centres in the U.S. are moving to digital adoption for pathology," estimated Dr. Mustafa Yousif, Michigan Medicine's medical director of digital pathology, associate director of pathology informatics and associate chief medical information officer (ACMIO) for pathology. "It's still not at the same pace as radiology, but we're getting there," he said.

Dr. Yousif said the field is now moving from early adopters to the early majority. The COVID-19 pandemic, which made remote sign-out a necessity, was the first major catalyst; today, artificial intelligence is the main driver. "Without digital pathology, you simply cannot deploy predictive or diagnostic AI tools," he said.

Genomic and other ancillary results can take days, if not weeks, to come back, while an algorithm run on a digital slide can return a result within hours or even minutes, allowing oncologists to begin planning treatment sooner. Many private practices, he added, are already fully digital, with no physical slide distribution at all.

But the biggest shift, according to Dr. Yousif, is in how pathology thinks about its workflow. Most laboratory information systems (LIS) were never designed for digital pathology, which was typically bolted on as an add-on, and many still struggle to orchestrate a digital workflow.

Michigan Medicine took a hybrid approach instead, adopting the enterprise imaging model and building on two decades of experience in radiology.

Ordering, billing and reporting remain in the LIS, while the case itself follows the pixels: a PACS-driven, image-centred workflow. "LIS vendors are often uncomfortable with the term 'PACS-driven,' worried that pathologists will leave their environment. I don't see it that way," he said. "The LIS remains the system of record, but the workflow should follow the image."

The result, he said, has transformed how pathologists approach each case, giving them the flexibility, efficiency and orchestration that drove high adoption among faculty. It has also made it far easier to add new AI and digital image analysis tools into the workflow.

Since 2021, Dr. Yousif has led the digital transformation of Michigan Medicine's Department of Pathology – one of the largest implementations of its kind at a U.S. academic medical centre. Today, nearly one million slides per year are digitized and routed through the pathology imaging environment he designed.

By integrating pathology into Michigan Medicine's Sectra enterprise imaging platform alongside radiology, cardiology, obstetrics and gynecology, and other specialties, he was instrumental in helping to establish a unified, health system-wide diagnostic imaging ecosystem.

Hospitals planning to adopt a digital imaging solution for pathology can choose a standalone, siloed system, but that didn't make sense for Michigan Medicine, given that it already had a Sectra PACS for all other specialties.

Using AI has allowed savings of between 11.5 and 24 hours of scan tech working time every day.

Michigan Medicine knew the limits of the siloed approach first-hand. The department had used whole slide imaging since about 2012, but only in a standalone system for research, education, archiving and consultations. "It lived only inside pathology," said Dr. Yousif. "We could not exchange those images with radiology, oncology or clinicians, and it was never meant for primary diagnosis. It was a decade of fragmented, siloed growth."

"All we needed to do was upscale our environment and make it ready for digital pathology," said Dr. Yousif. The enterprise solution allowed pathology to share storage, security, disaster recovery, and support while also cutting 18 months of implementation time. The enterprise decision was also less costly.

Digital pathology eliminates the onerous logistics of distributing, transporting, and retrieving glass slides. Instead, they're scanned using one of the 15 scanning devices used by Michigan Medicine, uploaded to the Sectra PACS, and instantly accessible for consultations and tumor boards through the integration of Sectra with the hospital's EHR.

Having easily accessible images when a case is ready for review saves anywhere from 30 minutes to an hour that it used to take to look for a slide, said Dr. Yousif.

The department handles roughly 3,500 slides a day, including 500 to 1,000 received for outside consultation. Before digitization, close to 10,000 staff hours a year went into collating, transporting and retrieving glass slides, and administrative staff spent about four hours a day on slide logistics alone.

Using AI has allowed Michigan Medicine to report savings of between 11.5 and 24 hours of scan tech working time every day.



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AI super users: Making MS Copilot agents at Amplify Care

Many health organizations already have some access to Copilot. Amplify Care is a trailblazer in this area.

BY WILL FALK (WITH AI ASSISTANCE)

This is the first article in a monthly series on Canadian AI Healthcare Super Users: people inside health organizations who build with AI rather than wait for it. Each piece looks at one person's stack and the agents they have built. We start with Stewart McKendry, director of AI at Amplify Care, a not-for-profit digital health organization. Most health organizations have Microsoft Copilot because they already run on Microsoft 365. I asked Stewart what it takes to make it useful. Our conversation has been edited for length and clarity. (W.F.)

Access is not adoption: Most Canadian healthcare and public-sector organizations I have worked with run on Microsoft. Employee accounts, email, documents and collaboration all sit in Microsoft 365, so IT can approve Copilot using the contracts, access rules and administrative controls already in place. For most employees, "Copilot" means Copilot Chat, Microsoft's general-purpose chat application. It runs in a browser, as a desktop app, and inside Teams.

Approval is not the same as use. Ontario's Auditor General found that Copilot Chat accounted for about 6 percent of the Ontario Public Service's tracked use of popular generative AI websites from April to August 2025, even though it was the only one approved.

Other services accounted for 94 percent. Those figures describe tracked website traffic. The report did not establish how many employees rejected Copilot, or why. But they match what I see: a large gap between what the tools can do and what employees know how to do with them. People need examples from their own work and help applying the tool to a real task. Handing out access leaves that learning to each employee.

Will: Stewart, where do agents come in?

Stewart: OpenAI and Anthropic each put conversation, research and software creation in one desktop application. Microsoft splits comparable work across Copilot Chat, Cowork, Copilot Studio and GitHub Copilot. An employee who wants to build a custom agent must find and learn another Microsoft product. That may be changing.

On September 25, Microsoft announced a new Copilot that brings Chat and Cowork together in one place. It adds Code, which builds apps and workflows from a plain-language description, and Autopilot, an agent that keeps working in the background. It is rolling out first to Microsoft's early-access Frontier program. Whether it delivers remains to be seen.

Will: Which product do you use, and what do you mean by an agent?

Stewart: At Amplify Care, that product is Copilot Studio. It is now our preferred way to build and deploy agents for our own teams in a secure environment. By "agent," I mean an AI tool configured for a particular job:

- The model generates responses.
- Instructions define the job.
- Knowledge supplies Amplify Care's own information.
- Tools let the agent read or update applications such as SharePoint, Outlook, Salesforce or Asana.



Stewart McKendry, director of AI at Amplify Care.

An employee comes back to a tool that already knows its job, the information it can use, and what it is allowed to do.

Will: What does building one look like?

Stewart: Copilot Studio gives us a visual workspace. I also use Claude Code and ChatGPT for the actual writing of the agents. We describe the job, choose from the models approved for our environment, and add the knowledge and tools. We test the agent, see where it fails, adjust it and publish a new version, often without writing custom software. It works especially well for internal agents because our employees already have Microsoft accounts and belong to organizational groups.

We share an agent the way we would share any other Microsoft 365 resource. An agent that uses the signed-in employee's identity applies that person's existing access. Other enterprise AI platforms support similar controls, with more setup.

Five agents and AI tools at Amplify Care

- **Deployment Copilot:** Connects Asana, Salesforce, Outlook and public information to keep onboarding records current and identify the next follow-up.
- **Healthmap AI Assistant:** Turns plain-language questions into eReferral Healthmap searches, so teams can compare eReferral receivers, save a shortlist and export it.
- **Knowledge Translation & Evaluation Agent:** Finds sourced results in Amplify Care case studies and evidence briefs, for use in conversations with clinicians and partners.
- **French Translation Agent:** Drafts Canadian French versions of Amplify Care resources and creates approved Word documents after bilingual review.
- **Amplify Portfolio Status:** Combines Salesforce opportunities and Asana delivery updates, so leaders can find the projects, risks and decisions that need attention.

Will: Can you give me a real example?

Stewart: Amplify Care's deployment teams help with the adoption of technology. Each adoption process is a project that moves through several stages before the individual goes live. Our teams manage thousands of these projects across Salesforce, Asana, email, calendars and other records.

Without an agent, a deployment specialist may have to reconstruct a project's history from a Salesforce record, Asana tasks, meeting notes and email. The information already exists. The employee has to find it and keep every system current, and that repeated coordination is what we are trying to reduce.

Our Deployment Copilot securely gathers the current state of a deployment, helps maintain its records, identifies the next step, and shows who needs a follow-up. We can then measure whether staff use it and whether it cuts the record-keeping around each project.

Will: What happens when Copilot Studio can't do the job?

Stewart: When an agent needs code, a custom connection or its own interface, we use Microsoft Foundry and Azure. Foundry lets us deploy an approved model in a region and deployment type suited to our data requirements. It can also index documents so an agent can search by meaning, retrieve relevant passages and cite them. Azure hosts the application and provides its storage, identity and APIs.

Will: What have you built that way?

Stewart: For Salesforce, we wrote a custom tool on Azure that defines exactly which records an agent can read or update. It securely exposes the fields and actions deployment work needs, without giving the agent broader access to our data. For our Knowledge Translation and Evaluation team, we indexed published research, so a change management specialist can ask what evidence supports an approach such as central intake and get findings tied to their sources.

Will: Who writes the code?

Stewart: I write much of this software with Codex. I keep each task in its own conversation, tied to a version-controlled repository, and review the changes before they are merged. The code lives in Azure DevOps and runs on Azure. Some of these applications expose their functions to Copilot agents as custom tools.

Will: Who does this work, and what do you call the role?

Stewart: We call this work AI enablement. The person doing it is often called a forward deployed engineer (FDE). At Amplify Care, that means learning how a team works, finding a repeated task, and turning it into a tool the team can test. The engineer defines what the agent may read or change and revises it with the people using it. Employees supply the details that a general AI tool cannot know: a missing Salesforce field, an irrelevant evidence result, a follow-up the agent should have suggested.

Will Falk is a retired management consulting partner who spends his time with start-ups and as a fellow at four institutions. He is a contributing editor at Canadian Healthcare Technology magazine.

We need to educate our staff and our patients to use AI properly

BY MICHAEL MARTINEAU

I have lost count. Over the past year, in conference sessions, webinars, working group meetings, and posts from people I respect, I have heard the same sentence delivered with real conviction.

We need to educate our staff and our patients to use artificial intelligence properly.

Heads nod. The agenda moves on. Two questions go unasked, and I have spent a year waiting for someone to raise either one.

Who does the educating? How do they do it?

The concern is real: Shaili Gupta, an associate professor of medicine at the Yale School of Medicine, described what happens when a patient arrives at an appointment having already consulted a chatbot. Some patients come better informed, asking sharper follow-up questions than before.

Others arrive convinced the chatbot has already found the answer. Gupta characterized the resulting visit as an exercise in trying to "educate, redirect, and cancel out the misinformation."

Adam Rodman, a general internist at Beth Israel Deaconess Medical Center and an assistant professor at Harvard Medical School, was blunter when the subject turned asking chatbots about treatment decisions. "I tell my patients, just don't do it."

Neither physician opposes the tools. Both run artificial intelligence programs at their own institutions. Two clinicians who understand the technology well are describing, from inside practice, a problem they encounter weekly.

The concern is real. Gupta recounted a patient with chest pain who became convinced of a cardiac cause after consulting a chatbot, and who held the conviction through testing that pointed elsewhere. A single patient is an anecdote. In February the Canadian Medical Association published its Health and Media Tracking Survey, conducted by Abacus Data among 5,000 Canadians, which found that people who followed health advice from an AI platform were five times more likely to report harm than those who did not.

Developers have trained these systems to surface the urgent explanation first, and to shape answers around what a user appears to want. Anyone who has typed a symptom into a chatbot at midnight understands the pull of a confident reply.

From the evidence follows the remedy, sincerely offered and widely repeated. Educate patients before they use these tools. The sentence has the shape of a plan and the substance of a slogan.

Who? I have read a good deal of the advice since, and I have yet to find the teacher named in any of it. Consider who the candidates might be.

Gupta is the obvious first answer, and she is already doing the work. The difficulty is where the work has to happen.

Robert Shpiner, a clinical professor of pulmonary and critical care at the David Geffen School of Medicine at UCLA, named the problem in a commentary published in Annals of Internal Medicine.

Patients choose chatbots because the tools answer immediately, Shpiner argued, while the ordinary routes into care do not.

A tracking poll by KFF, the American health policy research organization, found in early March that roughly a third of American adults had consulted an AI chatbot about health within the past year. Asking clinicians to teach patients about artificial intelligence asks them to do it inside the appointment those patients could not get.

In Canada the difficulty sharpens. The same CMA survey found that 57 percent of Canadians turned to the internet only after failing to reach a family doctor or another health professional. Margot Burnell, the former CMA president and a medical oncologist in New Brunswick, observed that Canadians struggling to access care have little choice about where to turn.

A Liaison Strategies poll in May measured the scale. Forty-six percent of Canadians had asked a chatbot for medical advice within the past year. The people most likely to consult a chatbot are the people least likely to have a physician. Assigning the teaching to clinicians assigns it to someone the student cannot reach.

Health systems are the second candidate. Jeffrey Flaks, president and chief executive of Hartford HealthCare, explained in May why his organization built a patient-facing chatbot rather than warning patients away from the ones they already use.

Epic has deployed a similar assistant inside its patient portal. Both decisions are defensible. Neither amounts to education. A health system that builds its own chatbot has made a product decision, and the literacy produced runs one tool deep.

The third candidate goes unmentioned everywhere. OpenAI reported in January that more than 40 million people consult ChatGPT for health information every day, and that seven in 10 of those conversations happen outside ordinary clinical hours.

The companies hold the only classroom that reaches patients at the moment a question occurs to them. Nobody proposes handing them the curriculum, for the obvious reason that a vendor writing its own safety manual invites suspicion.

Every proposal assumes a teacher standing just outside the frame. I have been a patient for some years now, through appointments, portal messages, and lab results opened late at night, and no one has offered to teach me anything about artificial intelligence. I would not know where to enrol.

What to give patients: Three suggestions follow, offered in the spirit of the advice I am criticizing. Each one names who acts and what they do.

First, give patients their data in portable form. Much of what gets diagnosed as a literacy gap is an access gap, because a chatbot knows nothing about the person typing.

> **Clinicians should now determine whether patients are using the Internet and AI when they come in for appointments.**

Bill S-5, the Connected Care for Canadians Act, would require vendors to make health information technology interoperable, defined as letting a user access their electronic health information and exchange it with other health information technologies.

Second, put Rodman's stoplight in front of patients at the point of care. Rodman tells patients not to ask a chatbot about treatment decisions, and Rodman also wrote the clearest guidance any patient has been handed.

Green means go. General questions, diet, appointment preparation, and making sense of your own lab results and visit notes. Yellow means proceed with care.

New symptoms belong here, and Rodman suggests asking the chatbot to interview you the way a physician would rather than reciting a list, so the tool probes for what you do not have.

Red means stop. Treatment decisions belong with a clinician who can examine you.

A national organization should settle the wording and the format once, rather than leaving every hospital and health authority to invent its own. Healthcare Excellence Canada exists to turn a proven approach into something others can adopt locally.

Third, ask patients what they are already using. Add a question to the intake form and to the history. Have you looked into this concern with an AI tool, and what did it tell you?

The question costs one line and surfaces the belief a clinician would otherwise spend the visit discovering by accident. Gupta is describing the discovery happening the hard way, in the middle of an appointment, when a patient arrives already convinced. Asking at the start turns the interruption into information.

We are not waiting: Asking whether patients should be taught before they use artificial intelligence is asking whether to permit something already well underway. The useful question is what gets handed to the people already learning.

Michael "Mike" Martineau is a Canadian technology entrepreneur and Internet pioneer who then became a digital health executive overseeing large-scale EMR deployments across Canadian hospital systems.

Ontario partners aim to transform wound care in with AI

CONTINUED FROM PAGE 4

said Saskia MacMillan, vice president, patient care service & CNE, Hanover & District Hospital.

Building a regional model for innovation: While AI technologies are often associated with large academic health centres, Brightshores and its partners are demonstrating that rural health systems can play a leading role in evaluating and implementing emerging technologies.

Collaboration is key for rural communities exploring the utility of these innovations. Grey Bruce represents a unique rural ecosystem with a close-knit network of healthcare organizations who are willing to test new approaches, generate real-world evidence, and collaborate to scale successful innovations across the region and beyond.

"Partnerships are essential to delivering strong, sustainable health care in small rural communities," said Cara Singh, vice president of clinical services and chief nursing executive at South Bruce Grey Health Centre. "We have opportunities to bring resources and innovative solutions to our small hospital sites that no one organization could provide on its own."

Recognizing that wound care extends across multiple healthcare sectors, Brightshores and its partners established the Grey Bruce Wound Care Community of Practice. The group brings together clinicians and organizations from acute care, home and community care, long-term care, and primary care settings to share knowledge and practices.

This collaborative model has accelerated adoption of the technology, while supporting consistency in wound assessment and management between healthcare providers.

> **Collaboration is key for rural communities exploring the utility of these digital innovations.**

Evidence needed: The future of AI in healthcare: As healthcare organizations increasingly adopt AI-enabled tools, there is growing recognition that implementation alone is not enough. Gathering evidence and evaluating AI technologies in real-world settings is critical to building the healthcare system of the future.

The initiative is looking at broader questions about the role of AI in community-based care:

- How can these technologies enhance decision-making?
- Where do they create efficiencies?
- What supports are needed to sustain adoption?
- How can successful models be scaled to other rural regions?

By pursuing answers to these questions, the Grey Bruce partnership is contributing to a growing body of knowledge about the practical application of AI in healthcare.

At the heart of this work is the patient journey. Through evaluation, we can better understand how these innovations improve outcomes and experiences to support more equitable access to care for rural populations.

As AI continues to evolve, initiatives like this demonstrate that rural communities can do more than adopt new technology – they can innovate and help shape its future.

Rebecca Brookham is the director of research & innovation at Brightshores Health System.

VIEWPOINT

BridgeHead brings HealthStore to Canada as hospitals tackle data fragmentation

Enhances application retirement, enterprise imaging, interoperability and access to patient information.

BY NORM TOLLINSKY

BridgeHead Software, a UK-based healthcare data management company with an established Canadian presence supporting Meditech hospitals, is expanding its offering in Canada with its HealthStore® Clinical Data Repository. HealthStore consolidates patient and clinical information across multiple healthcare systems and makes it available to clinicians and applications, often through the EHR. Use cases include application retirement, Enterprise Imaging, interoperability and authorized secondary use of clinical data.

Canada has achieved widespread healthcare digitization, but challenges remain in connecting information across systems. Statistics Canada reported that 92 percent of healthcare providers had access to a digital health system in 2024, while only 52 percent used one to electronically share clinical information outside their primary setting. Among providers needing to share information, 50 percent cited insufficient integration between systems as a barrier.

Hospitals upgrading to a new hospital information system inevitably confront the question of how much data to move over. "Do you take all the data across from the old EHR to the new one?" asks BridgeHead president and CEO Jim Beagle.

"You'd think that would be the logical thing to do, but that's not what happens in practice. Data quality can be an issue and some older patient information may have less immediate clinical relevance. Migrating data can also be complicated and expensive, so vendors typically bring across only one to two years of data into the new EHR.

"The question then is what do you do with the rest?" he asked. Hospitals often continue to maintain access to their legacy EHR, incurring licensing, maintenance, infrastructure and support costs to keep a superseded system available to provide access to historical patient information.



Jim Beagle, BridgeHead president and CEO



John McCann, BridgeHead VP, global marketing

Instead, hospitals can consolidate and preserve historical data in HealthStore. "This ensures that the data lives beyond the life of the system that created it," said Beagle.

"We have the ability for the clinician to be within their new EHR and have a context-aware link to our HealthStore CDR," he explained. The link launches HealthStore in patient context without requiring a separate login, allowing clinicians to access test results, images, reports or documents. "One of the important differences in our approach is that we consolidate a comprehensive array of clinical data types and link it all to the patient," said Beagle. This avoids the need for clinicians to search across separate legacy archives.

HealthStore can also underpin an Enterprise Imaging strategy by consolidating live and historical medical images and associated information across a hospital or health system, independently of individual PACS and departmental imaging applications. It integrates with the PACS and can ingest copies of imaging data as it is created.

"This can remove the need to repeatedly migrate the historical imaging archive every time a PACS is replaced because the retained data already resides independently in the CDR," explained John McCann, BridgeHead's vice president, global marketing. "It also means the CDR can support business continuity should the PACS be subject to planned or unplanned downtime," he added.

Using BridgeHead's diagnostic-quality imaging viewer, radiologists can access imaging data held in HealthStore even if the PACS is down. "We've had numerous examples of this recently where hospitals have upgraded to a new radiology system but experienced unplanned downtime, with HealthStore used to continue clinical service that would otherwise have ground to a halt," said Beagle.

Interoperability is also a national priority in Canada, with initiatives intended to reduce data silos and enable information to move more consistently between healthcare systems and organizations. Using industry-standard protocols, HealthStore can make patient information available to other authorized systems and organizations where the appropriate exchange infrastructure and governance are in place. "If you're a patient living in Ontario, but you've had an accident and been hospitalized across the country, the goal should be for the clinicians treating you to be able to access the relevant information digitally," said Beagle. "We demonstrated this recently at a HIMSS event, transferring health information from HealthStore to Epic and Oracle Health EHR environments."

Beagle cited one hospital that sent printed CT reports with patients transferring between facilities because the information could not be shared digitally.

Access to reports and images from another hospital can also help reduce unnecessary repeat imaging, saving money and avoiding additional patient exposure to ionizing radiation where applicable.

HealthStore launched in 2012 and is used by thirty customers across the U.K. and the U.S. With Canadian healthcare increasingly focused on interoperability, modernization and productivity, BridgeHead has identified Canada as the next strategic market for HealthStore and has engaged Tectonic Advisory Services, led by president and CEO Glenn Lanteigne, to support its market development and engagement with Canadian healthcare organizations.

HealthStore can be deployed on-premise, in the cloud or in hybrid environments, with BridgeHead's RAPid™ Data Protection solution available to provide backup and recovery where required. BridgeHead is not entering Canada from a standing start. Its RAPid Data Protection solution has been deployed in Canada since 2005, with early adopters including Fraser Health in British Columbia and Humber River Health in Toronto. RAPid is deployed across 10 Canadian hospitals, including Guelph General, Bluewater Health in Sarnia, Stratford General, and Cambridge Memorial in Ontario.

"We're the market leader for the protection of Meditech systems and have been a partner of Meditech for 25 years, so we have a great relationship with them," said Beagle. "We've done a lot of work in terms of optimizing the integration with Meditech systems and we support every generation of their product from Meditech Magic to the latest deployment of Meditech Expanse."

Retiring aging or unsupported applications can reduce cyber-security exposure. Legacy systems can become difficult to maintain and patch where vendors no longer provide full support.

HealthStore is not itself a cyber-security product, but extracting required clinical information from obsolete systems can enable healthcare organizations to retire legacy applications and their supporting infrastructure while preserving access to the clinical data they contain.

Protecting active clinical systems and data from cyberattack, operational failure and other disruption is the role of BridgeHead's RAPid Data Protection solution. "It's vital that hospitals run proper backup tests and keep multiple, truly independent copies of backups stored in different places, both in the cloud and onsite, especially as cybercriminals increasingly target backups," advised Beagle. He noted renewed use of tape backups as a means to create an air gap from network-connected systems. This is especially important as cybercriminals increasingly target and compromise backups. One defensive approach seeing renewed interest is to retain backup data on tape, maintaining an air gap between the backup copy and network-connected systems, he noted.

Following a wave of cyberattacks targeting hospitals in Arizona several years ago, BridgeHead restored one RAPid customer to operation in a matter of days, while other hospitals remained down for weeks, he recalled.

BridgeHead's Platinum Maintenance for RAPid customers is a managed service providing proactive monitoring, backup management and recovery support. It helps reduce the operational burden on IT teams, particularly where specialist backup expertise is difficult to recruit and retain. Approximately 100 RAPid customers across the U.K., U.S. and Canada use the service.

"RAPid is designed to protect healthcare data not only from cyber incidents, but also from operational failures, human error, deliberate misuse and physical disruption, such as natural disasters," said McCann.

While BridgeHead's Canadian footprint is concentrated among Meditech hospitals using RAPid, HealthStore is EHR-agnostic across Meditech, Epic and Oracle Health. As Canadian health systems modernize applications, consolidate systems and pursue greater interoperability, the challenge is ensuring clinical data is accessible and useful regardless of which applications come and go.

Understanding healthcare ROI measurement for funding decisions

BY SUZANNE SCHELL AND SHIRLEY FENTON

Return on Investment in healthcare: ROI in medical settings usually means "release of information." However, a more general meaning for ROI, "Return on Investment", is an increasingly important method used to assess healthcare programs and initiatives.

Linking ROI to stronger funding decisions: ROI measurement is simply a structured way to compare what we invest in programs, people, and improvement initiatives with the value we get back for patients, staff, the organization, and the healthcare system. In hospitals and provincial health systems, that means linking spending on specific programs to clear, measurable results.

When ROI is defined this way, funding decisions become easier to explain and defend.

Leaders across Canada are working within tight budgets, competing priorities, and increasing accountability expectations from boards, ministries, and the public. Every new digital tool, staffing initiative, AI initiative or quality improvement project is competing for limited dollars. Without a common way to show value, discussions quickly become subjective and political.



Shirley Fenton



Suzanne Schell

ROI measurement changes that conversation. When we have comparable evidence about costs and benefits, we can move from opinion-driven debates to transparent choices. Funding decisions become grounded in data, objectives are visible, and everyone can see how a decision supports patient care, staff well-being, and system performance.

What ROI measurement really means: When we talk about value, impact, and ROI, we are not only talking about cutting costs. The real question is whether an investment improves value across the dimensions that matter in healthcare organizations and in the Canadian health systems, such as:

- Quality and safety of care
- Patient and family outcomes and experience
- Staff engagement, retention, and wellbeing
- Clinical risk and organizational risk reduction
- Flow, access, and overall system performance

The Phillips ROI Methodology (https://roiinstitutecanada.com/roi-methodology/), used around the world, incorporates the financial ROI as one part of a broader value success story. The methodology provides a step-by-step logic that connects:

- Identified needs in the organization or system
- Clear objectives at different levels of impact – intangible and tangible
- Practical data collection plans
- Analysis that separates signal from noise
- Reporting that decision-makers can act on

An example of taking an initiative from an idea to reality using Return on Investment occurred in a hospital in British Columbia.

An anesthesiologist worked in the hospital as a specialist in colon cancer surgery. He read about a new process in the UK involving a change in the preparation and aftercare of patients.

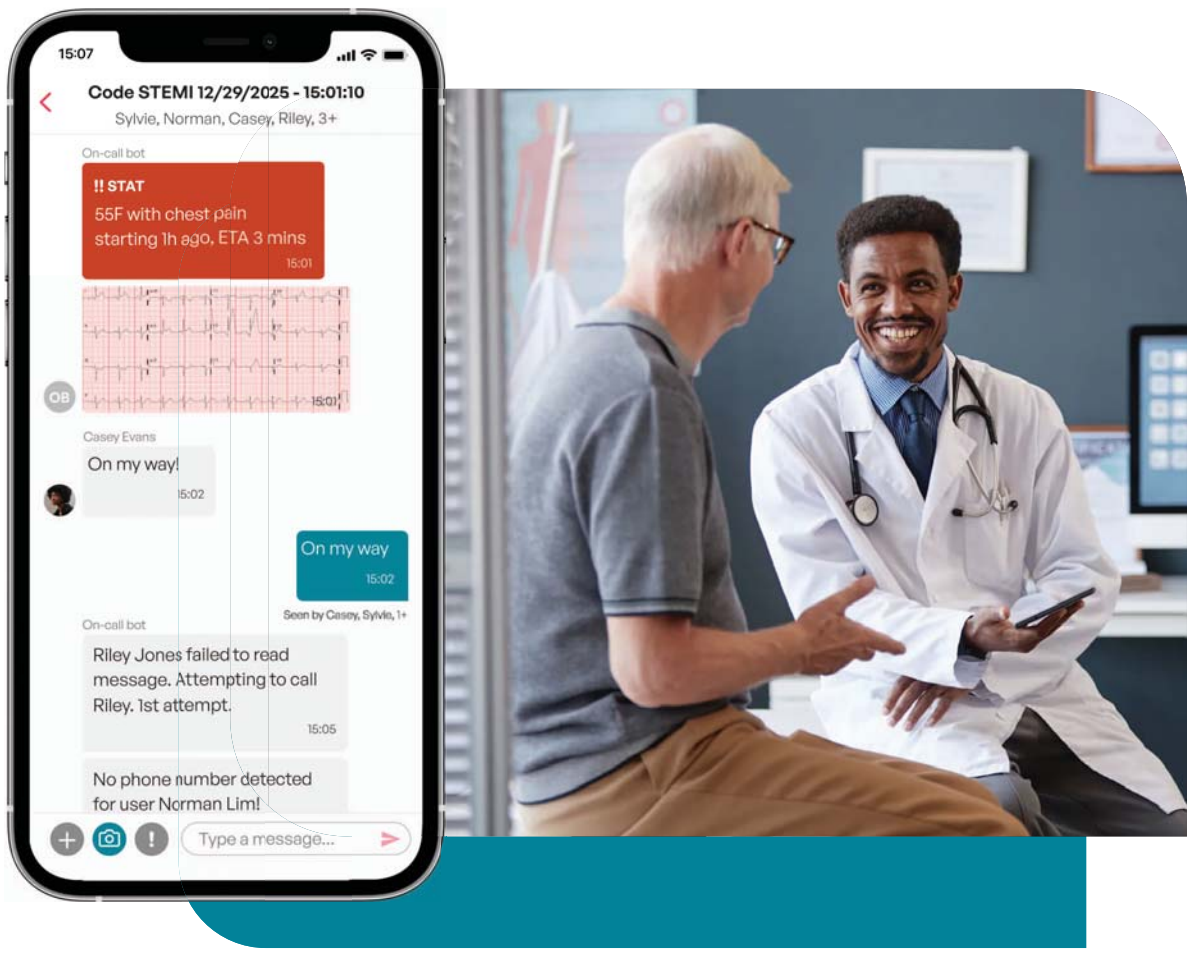
The new process had specific objectives: reduced infections and readmissions and reduced length of stay. He knew it was an opportunity worth pursuing. The funding

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Is the time right for a made-in-Canada EHR, using the latest AI technologies?

Some believe we have the home-grown expertise to deploy a new generation of AI-powered e-records.

BY JERRY ZEIDENBERG

An odd thing happened at the AI in Hospitals Conference, held in Toronto the last week of September. There were the expected presentations of advances in AI in healthcare, and management advice for handling its surging presence.

But unexpectedly, a lively discussion was set off when one of the speakers noted that Canada's expertise in AI provides an amazing opportunity to replace foreign-made healthcare IT systems with newer and better Canadian technology.

Joe Cafazzo, executive director of bioengineering at UHN, asserted that Canada is at the forefront of AI development, and now has a superb opportunity to foster and deploy Canadian-made AI solutions throughout the healthcare sector.

In fact, he opined that leading-edge companies like Cohere could even supplant traditional vendors of EHRs, as the nature of patient records is quickly changing. Said Cafazzo: "In the next few years, EHRs will become obsolete, and natural language will become the interface for all software."

Canada shouldn't lose out on the AI opportunity as it did in so many other healthcare technologies, he said, pointing to the discovery of insulin to treat diabetes and GLP-1 receptor agonists for weight loss. The production of insulin was transferred to US and British pharma companies, and GLP-1 discovery has been commercialized most successfully by Denmark's Novo Nordisk. "We don't want to see this happen again in AI," said Cafazzo.

Justin Hartlen, co-founder of Virtual Hallway, a Halifax company that produced a platform enabling quick consults with specialists, outlined the difficulties of growing a new system in Canada. The platform is used by 10,000 physicians across the country, a significant number, but Hartlen noted there are 100,000 physicians in Canada and reaching them poses difficulties for a small firm. Marketing to the far bigger, international market is even more challenging.

Clearly, entrepreneurial startups need help – especially as they scale-up to reach a sizeable customer base. Predictably, the same thing would happen to an AI company creating a new EHR – unless it was already giant-sized and had deep pockets.

When it comes to giving these smaller companies a boost, Canadian hospitals, with their sizable I.T. budgets, could play a role.

That will require a culture change in hospitals, however, as Canada's hospitals are largely risk averse and tend to avoid buying from small suppliers. Many a Canadian start-up has complained that hospitals here won't even look at them until they've made sales in the U.S. and abroad.

Andrea McKnight, transformation healthcare leader at St. Joseph's Healthcare Hamilton, asserted that Canadian hospitals and health organizations should use their buying power to promote Canada's technology companies whenever possible. She said more hospital executives will need to get on board with this idea, stating that very few currently have this mindset.

Cafazzo observed that nurturing and strengthening Canadian companies is not only important for economic reasons, but for strategic ones. The current US president has shown he's ready and willing to turn off the tech taps with countries like China and even Denmark when the mood strikes him.

It's not unreasonable, he said, to think it could be done to Canada – as he has done in various areas during the trade war. For that reason, it's better to have home-grown sources of technology, especially since Canadians have shown an ability to create breakthrough technologies.

The idea of a made-in-Canada, AI-enabled EHR isn't as far-fetched as it may sound. In the next session, Kathy Malas, chief of AI and innovation at the Jewish General Hospital, in Montreal, discussed how her organization has created a new kind of EHR in partnership with Harris Arc Health; it will be rolled out in the Spring.

Malas described how the JGH aims to become Canada's first AI-integrated hospital. The Electronic Health Record system is part of the plan. Not only will it contain AI abilities, but it will also integrate with its wider community of hospitals and health centres to create a comprehensive, longitudinal patient record. It's doing this because none of the major EHR vendors offers this approach.



Zach Kilburn, chief digital officer Horizon Health


Kathy Malas, chief of AI at the Jewish General

On the AI front, it has a high-powered platform that can support artificial intelligence applications – which consume a great deal of computing power.

It has also created an AI lab that will train staff, develop and test new systems before further testing in the hospital and community – what it calls its 'living lab'. The goal is to solve the healthcare system's pressing problems, such as the severe nursing shortage and too many ALC patients – all in a climate of a funding shortage.

To support innovation and AI, the hospital is redesigning its strategy, operations and services, so that AI is at the core and not bolted on. "It's to improve value, quality, equity and efficiency," she said.

Moreover, the Jewish General intends to share its solutions with others in Quebec and across the country. "We're going to become an AI-first organization," said Malas.

Most hospitals are investigating AI-based solutions and adopting them – some quickly, some more slowly. The question for all of them is, what area should they invest in first?

For its part, Trillium Health Partners, in Mississauga, Ont., is planning a big push into artificial intelligence. Last year, it announced a $25 million fundraising initiative in support of its AI for Better Health program, which aims to accelerate the development of new artificial intelligence tools.

But the issue remains, where to spend the money?

In a presentation at the AI in Hospitals conference, Dr. Laura Rosella, chief scientist at Trillium Health Partners, cautioned that simply implementing AI doesn't automatically translate into value.

What's more, she observed, AI isn't 'plug-and-play' and often calls for a redesign of processes.

Part of the impetus for understanding and investing in AI at Trillium is to prepare for the opening of its new hospital site in 2030 – and what will become Canada's largest hospital.

Nevertheless, Dr. Rosella said the giant hospital will still be filled to overcapacity "unless we do something significant." That includes leveraging new technologies, like AI, to provide care more efficiently than ever before. She explained the hospital is using the quintuple aim of healthcare to determine where to start deploying AI, and where it could make the most impact. Dr. Rosella observed that there are often trade-offs to be made – that if the patient experience is improved by technology, another part of the quintuple aim sometimes actually deteriorates.

As such, it's important to measure AI's impact on each area of the quintuple aim – patient experience, provider wellbeing, cost, population health and health equity.

She noted that like all areas of Canada, the Mississauga region is expected to experience rapid growth in the next 15 years, and with an aging population, a 70 percent increase in major illnesses is forecast.

A priority will be to treat patients at home and in the community whenever possible, and the hospital has already established a command centre in preparation for monitoring patients.

In planning its AI strategy, it seemed like caring for the frail and elderly at home would get the best bang for the buck and would be the natural area to target first. However, Dr. Rosella said the care pathways for its palliative care program were better developed and appeared to be more AI-ready. As such, it created an AI-driven solution for palliative care.

Even so, when the system was applied, it was discovered that some areas still needed improvement. "The patient experience was missed, and our clinicians were having a hard time," she commented.

The team went back to the vendor for improvements. "The framework allows us to make adjustments, and it works much better now," she said.

Meanwhile, the hospital is revising its patient

pathways for community care and AI, and the experience it gained in palliative care was invaluable. The expertise will be applied to community care and running the new, 2.8 million-square-foot Peter Gilgan Mississauga Hospital.

In downtown Toronto, St. Michael's Hospital, part of Unity Health Toronto, has been one of the most active proponents of AI, and its success shows the depth of talent and expertise that's here in Canada. One of St. Mike's success stories is ChartWatch, an early warning system that monitors patients in real-time and can predict if they're going to crash. Through real-time early warnings, it has reduced the unexpected death rate by 26 percent.

The hospital has also produced an automated AI system for ED patients, checking head CTs to see if patients have suffered trauma to the brain or brain bleeds.

Most recently, St. Mike's announced its leadership of VITAL, a project that will invest in infrastructure to connect 160 hospitals in three provinces – to begin with – and to make anonymized data available to researchers. VITAL is also sponsoring leading-edge clinical research projects, such as analyzing various types of drug use patterns across Canada's hospitals to help determine best practices.

The VITAL network is operating under the leadership of two physicians from St. Mike's, Dr. Fahad Razak and Dr. Amol Verma. It has attracted $210 million in funding from various levels of government, including an award of $100 million from Ottawa earlier this year.

AI thrives on large sets of data with a variety of patient populations, and VITAL's shared data will provide just that. The aim is to improve healthcare delivery and to bring further research into Canada, such as drug trials.

Damian Jankowicz, PhD, Unity Health Toronto's executive VP and CIO, spoke at the AI in Hospitals conference and described several leading-edge projects in AI. He also offered lessons from 10 years of work in this area. He said producing AI solutions not only requires data scientists, but also governance, integration and workplace transformation, too.

And it requires product management: "People don't interact with AI, they interact with products," he said. "So, the AI is only a small part of the whole solution."

Most recently, St. Michael's has been working on automating end-of-shift patient summaries for clinicians. These notes are particularly useful when patients are being moved to a different site or level of care – such as a nursing home or home care. If the notes are not available, the new caregivers may have trouble providing the right kind of care, which can lead to mistakes being made.

"Transitions of care can lead to errors when you don't have the data you need," said Dr. Jankowicz. The new project, he said, uses a Large Language Model (LLM) to scour all the patient's nursing notes, labs, imaging reports and other documents to produce a report that's available for the handoff.

The system also promises to be a big time-saver for physicians. "Normally, it takes doctors a long time to generate these notes," said Dr. Jankowicz. "It slows down their work in the hospital." By automating the process, doctors will have a lighter administrative load and more time for patients.

Zach Kilburn, chief digital officer at Horizon Health, in New Brunswick, had some advice for hospitals on when to start – and when to stop AI pilots.

While teams have lots of ideas about AI pilots, and hospitals are eager to launch them, you must know when to end them, too. "Not everything is going to work," said Kilburn, adding that ending projects is not all bad. "Killing something that's not working frees up capacity. Thankfully it doesn't happen too often."

So, how do you determine when to grow the project and when to kill it? Kilburn said you should scale up when: outcomes are improved; adoption is real; costs are understood; and operations can sustain it.

On the other hand, it's time to pull the plug when: the problem changed; the workflow rejected it; value did not materialize; and the risk outweighs the benefit.

Kilburn gave examples of successful AI projects built in-house, including its pharmacy agent, to support medication and pharmacy workflows; a nursing agent, for answers to policy, practice and workflow questions; and the Horizon assistant, for faster access to organizational knowledge.

Heidi

PROCUREMENT NOTICE

REQUEST FOR PARTNERS (RFP)

Reference: RFP-HH-2026-CANADA
Issued: By Heidi
Subject: Bringing relief to Canadian clinicians
Closing date: December 31, 2026

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1.1	**Data Residency & Security:** Patient health information for Canadian deployments is stored exclusively in Canada. Built to support compliance with PIPEDA and applicable provincial privacy and health-information laws, including PHIPA and HIA.	The Issuer (Heidi)	**[IN PLACE]**
1.2	**Clinician Wellbeing:** A formalized belief that 5:00 PM is a perfectly reasonable time for doctors to go home.	The Proponent (CA Healthcare)	**[MUTUAL PRIORITY]**
1.3	**Innovation Mandate:** Desire to be the facility that others look to as the gold standard for clinical AI adoption.	The Proponent (CA Healthcare)	**[OPEN TO LEADERS]**
1.4	**Strategic Action:** Organization is prepared to safely pilot AI and give their doctors their time back without a 12-month delay.	The Proponent (CA Healthcare)	**[FAST-TRACK READY]**

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Q&A: Scaling generative AI and agentic AI without sacrificing trust

We sat down with Dr. Lorne Rothman, Principal, Data Sciences, Canada Healthcare Lead for SAS, to peel through the second annual Data and AI Impact Report: The New Economics of Trust through a healthcare lens.

The research shows that across all industries, Canada has made significant progress in building the foundations for trustworthy AI, but most organizations are still waiting to see meaningful business results from those investments.

Q: Canada's AI trust scores are rising, yet organizations still aren't seeing corresponding gains in business impact or ROI. In healthcare, do you think the issue is that we're being too cautious with AI, or that we're still measuring success using the wrong metrics?

A: The survey didn't specifically target healthcare, so it's worth keeping that in mind. For Canada, results show that the Trustworthiness Index is rising, while Perceived Trust actually declined, so when we say AI trust scores are rising in Canada, we're referring to the Trustworthiness Index, not Perceived Trust.

Focusing on generative AI and the move to more autonomous, agentic AI, I wouldn't say healthcare is being too cautious, but it is cautious. There are lags between when a technology shows it can address a problem, when the regulatory and governance requirements are in place (trustworthiness), and when healthcare organizations are willing to test and implement it (trust).

I think a lot of healthcare AI is still in that experimentation and testing stage in Canada rather than in production.

Some of the gap between improving trustworthiness and measurable impact may simply reflect the time it takes to move from experimentation to production and gaining the necessary trust, particularly with the fairly abrupt and transformational emergence of agentic AI, before realizing benefits at scale. And in healthcare those lags may be longer than in other industries.

We also need to be careful about how business impact or ROI is defined in Canadian healthcare. The return may not be primarily financial savings. It may be freeing up clinician time, reducing administrative work, shortening wait times, improving access and quality of care, or allowing the same resources to serve more patients.

Q: The research shows people often override AI recommendations because they don't understand how the model reached its conclusion. In a clinical setting, how much explainability is enough before a physician or care team can confidently act on an AI-driven recommendation?

A: Let's first be clear about what we mean by explainability, because it means different things depending on the type of AI. With traditional predictive machine learning models using tabular data (columns, rows, and numbers), we're generally talking about understanding what factors drove a prediction, both overall and for an individual patient. There are now standard approaches and algorithms for doing that.

With generative and agentic AI, explainability can mean something quite different. If an LLM or agent reaches a conclusion based on a patient's record or other documents, I would want the clinician to be able to ask what evidence it relied on, where in the patient's record that evidence came from, and ideally go back to the actual source patient records. If an agent takes actions, there also needs to be a record of what it did and why.

And if a predictive model is being used somewhere within that process, then the traditional forms of model explainability still apply to that component.

I don't think there's a single level of explainability that's enough. It depends on what the AI is doing and what happens if it gets it wrong. As the consequences and degree of autonomy increase, I'd expect the requirements for explanation, traceability and human oversight to increase as well.

Regardless, this brings up an important point: we're not simply letting agents loose on everything and allowing them to make fully autonomous decisions. Their access can be restricted to specific subsets of patient data, and consequential actions should require human review.

Q: The report suggests organizations are shifting focus from model development to data quality and governance. In healthcare, are we at a stage where the biggest barrier to better AI outcomes isn't the sophistication of the algorithm, but the quality and accessibility of the underlying patient and operational data?

A: From what I've seen, the data can certainly be a bigger challenge than the sophistication of the algorithm. We have good predictive modelling and AI techniques, and increasingly sophisticated ways of governing them.

The harder problem in healthcare is often the data. Is the data complete and reliable? Is it representative of the population where the model will actually be used? Can we access it? And can we bring together information that may be sitting in different systems or different organizations?



Dr. Lorne Rothman

That's particularly important in healthcare because there is so much fragmentation. You can have very good data, but if it's sitting in separate clinical, laboratory, pharmacy and operational systems, it may still be difficult to use effectively. And you can also have data across silos that isn't standardized (different terminology, units of measurement, ways of expressing dosages, etc.).

I think the shift toward data quality and governance makes sense. Better algorithms can't necessarily compensate for missing or unreliable data. Interestingly, generative AI may actually help address some of the other data problems, particularly non-standardization and information that is difficult to use because it's buried in unstructured (text) records.

So, getting the data foundation right remains important, but AI itself may also become part of the solution to some of these data challenges. In fact, we're already seeing interest in using generative AI to help deal with some of these data standardization problems.

Q: Healthcare is one of the most regulated sectors in Canada, and compliance concerns are rising across organizations. How can healthcare leaders strike the right balance between patient safety and regulatory oversight without creating so much friction that promising AI initiatives never make it into practice?

A: I don't think the answer is less regulation. Patient safety, privacy and oversight have to come first in healthcare. But we also don't want the process to become so difficult that useful applications remain stuck in pilot projects.

Part of the answer is taking a risk-based approach. Not every use of AI presents the same level of risk. An AI application helping schedule appointments is very different from one influencing a diagnosis or treatment decision, or one that surfaces highly sensitive patient data. The level of oversight should reflect that.

And governance doesn't always mean adding another layer of committees and approvals. Some of it can be built directly into the technology: controlling what data an AI can access, what actions it can take, where human approval is required, while keeping a record of what it did.

I don't see safety and innovation as opposing objectives. Good governance should allow lower-risk applications to move relatively quickly while applying greater scrutiny where AI could directly affect patient care or privacy.

Q: The report suggests organizations are slowing their adoption of more autonomous,

CONTINUED ON PAGE 27

Are healthcare organizations and consumers using AI responsibly?

BY NEIL ZEIDENBERG

TORONTO – A session called "Scaling AI Responsibly in the Public Sector," held in September at the SAS Innovate on Tour conference, posed several questions we should ask ourselves prior to using and trusting AI.

Speakers included Saad Rais, a senior manager of health data science at the Ontario Ministry of Health.

Asked, 'What does responsible AI mean to you, and to whom are you responsible?', Rais first noted that before allowing AI to access patient data, we should ask ourselves: "How will a patient's information be used, and what exactly will be disclosed? Is the information being used to create models that train AI? How and where will that information be going – will it be staying in Canada, or will it end up in another country? Finally, how will that information be used by others?"

He asserted that before you can trust in AI, you need to safeguard the data and specify who is responsible for protecting it. That's where governance comes in – it's about managing the data through defined or set policies, roles and standards and determining who's responsible for the data.

Rais added, a common concern people have is accuracy of AI. "In a recent KPMG survey, two out of three people have adopted AI, but 46 percent of those people didn't trust the AI. And that number varied across different demographics. "People need to first trust the AI and what it's doing before they're truly comfortable using it."

> **Many users of AI worry less about the accuracy of the technology in exchange for expedience.**

Those with higher adoption had higher trust in AI; those with lower adoption had lower trust.

At the same time, a group of users adopted AI without considering accuracy and 56-percent of them experienced errors in their work. Many of these users worry less about the accuracy of AI in exchange for expedience."

Speakers agreed there needs to be a governance structure put into place – creating the rules of engagement and determining who is responsible for the data. Ideally, the data should have predictive powers, demonstrate value through better outcomes and you should have to prove the case prior to a major launch.

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How connected care can solve ED congestion and improve healthcare

BY CINDY CARVALHO

Emergency departments have become one of the clearest windows into the health of Canada's broader care system. Not because they're the problem, but because they're the most prominent reflection of the challenges facing care providers and settings across the country.

To better support emergency departments and their providers, we need to manage capacity across the full continuum of care.

Recent data from the Canadian Institute for Health Information (CIHI) found that emergency department wait times reflect pressures across the continuum of care, including access to primary and home care and capacity within acute and long-term care. CIHI recorded 15.6 million emergency department visits across Canada. But what happens inside those departments tells only part of the story.

When primary care is inaccessible, patients often turn to the emergency department. When inpatient beds are unavailable, patients remain there longer. When community, home, or long-term care can't accommodate someone ready to leave the hospital, those pressures work their way back to the ED.

The waiting room may be in the emergency department, but those waits are driven by many pressures across the health system.

Finding the capacity we already have: There's no question that Canada needs additional healthcare capacity.

Only 82.6 percent of Canadian adults reported having access to a regular health provider in 2024, according to CIHI. Growing and aging populations are simultaneously increasing demand for many healthcare services.

But creating new capacity and making better use of existing capacity are two different challenges. Health systems are tasked with making faster, more meaningful progress on both as demand increases.

The challenge is not simply the number of healthcare professionals available. In 2024, Canada had approximately 47,500 family physicians, 9,900 nurse practitioners and 48,500 pharmacists. Yet millions of Canadians still lacked regular access to primary care.

International comparisons reinforce the gap: a 2023 Commonwealth Fund survey found Canada among the lowest of 10 high-income countries for adults reporting a regular doctor or place of care, despite at least 86 percent reporting one in every country studied.

That suggests capacity is not only a question of supply. How effectively we organize, connect and make that capacity accessible matters too.

CIHI found that 15 percent of Canadian ED visits between April 2023 and March 2024 were for conditions that could potentially have been managed in primary care. Nine percent were for conditions that potentially could have been managed virtually.

This doesn't mean these patients are the primary cause of ED overcrowding. CIHI explicitly cautions against that interpretation. Instead, their presence provides another signal of gaps elsewhere in the system.

Navigation needs to mean more than a referral: Traditionally, navigation has meant giving patients information about another service or referring them to another provider. But a referral isn't the same thing as access.

Patients ultimately need more than referrals. They need care.

Modern navigation needs to answer several questions: What does this patient need? Which services are appropriate? How close are they to the patient? Is the patient eligible? Does the provider have capacity? And can we connect the patient directly to that care?

Consider someone arriving at an ED with a need that could appropriately be addressed elsewhere. A list of nearby clinics helps. A confirmed appointment at an appropriate clinic changes the patient's journey. It turns a passive referral into a clear, actionable next step.



Cindy Carvalho

The distinction is important. A referral still leaves the patient responsible for completing the connection. An appointment provides a clear destination, time, and next step.

The same principle applies elsewhere. Someone speaking with a pharmacist may require primary care. A family physician may need to connect a patient with specialist or mental health support. Another patient may begin their journey virtually.

The future of patient navigation is clear orchestration of a complex healthcare system where available care options become actionable next steps.

From individual resources to network capacity: The opportunity becomes larger when we stop thinking about these settings individually.

A health region contains hundreds or even thousands of healthcare resources. Yet when information about services, eligibility, and capacity remains fragmented, those resources don't function as one network.

Technology provides an opportunity to create a connective layer across those environments without requiring health systems to replace every EHR, EMR, booking platform, or workflow already in place.

But technology alone isn't enough. Successful coordination also requires health-system policy, participation from providers and rules that determine how patients should move between services.

Moving beyond the emergency department: In Quebec, hundreds of points of care are connected through the Petal Patient Hub, helping eligible patients move from emergency departments toward available primary care. More than one million ED visits have now been avoided or redirected through the initiative.

Petal's economic analysis estimates that avoided and redirected ED visits have generated $339 million in cumulative economic value since 2022. In a tightly constrained healthcare system, that demonstrates how better patient journeys and more sustainable use of resources reinforce each other. Petal's analysis also reports more than 850 clinics sharing live availability across the network.

The next opportunity is to extend that principle beyond emergency departments and primary care.

Schedules, patient information, clinical expertise and available services already live across different systems and organizations. Interoperable technology helps connect those environments while allowing providers to continue using the systems and workflows that already support them.

That creates an opportunity to connect primary care, pharmacies, specialists, mental health services, diagnostics, virtual care, hospitals, and other services as parts of a broader network.

Cindy Carvalho is executive vice-president, Petal Health.

Stronger data capture can support more dependable digital workflows

BY STEVE OBLIN

Artificial intelligence is beginning to transform healthcare across Canada. From streamlining administrative workflows and supporting clinical decision-making to improving service delivery, healthcare organizations are exploring AI to increase efficiency and meet rising demands despite ongoing staffing constraints.

Yet the effectiveness of any AI initiative depends heavily on one foundational factor: the quality of the data it receives.

Across the healthcare continuum, organizations generate enormous volumes of information every day. Patient intake forms, referrals, laboratory reports, consent forms, insurance documentation, diagnostic reports, and historical medical records all contribute to a complex information ecosystem spanning departments, systems, and stages of care.

As healthcare organizations invest in AI, analytics, and digital transformation, the need for accurate, complete, and accessible information has never been greater.

Conversations about AI in healthcare often focus on algorithms, software platforms, and predictive capabilities. Less attention is often given to the quality of the information used to train, inform, and operate these systems. In many cases, data-quality problems originate well before information reaches an AI application.

Incomplete records, duplicate entries, inconsistent formatting, and inaccurate data extraction can create additional work, interrupt workflows, and reduce confidence in AI-enabled processes. Whether AI is being used for document classification, coding assistance, patient-flow support, workflow automation, or operational analytics, the reliability of its results depends in part on the accuracy and consistency of the underlying information.

While much of today's healthcare information is created digitally, paper documents and faxed records continue to play a role in referral, intake, consent, and records-management workflows. Before AI systems can analyze their content, these documents must be digitized and converted into machine-readable data using technologies such as optical character recognition.

This conversion is an important stage in the healthcare information lifecycle. If



AI depends on the accuracy of its sources.

information is captured incorrectly at the start, errors may carry over into downstream systems and workflows.

The quality of a source image strongly affects the accuracy of Optical Character Recognition (OCR). Blurred images, poor contrast, background artifacts, skewed pages, faded text, and other image-quality issues can reduce extraction accuracy. When incorrect information enters an EMR, EHR, or analytics platform, it may be difficult and costly to identify and correct.

Healthcare organizations evaluating document-capture technology should consider its ability to produce consistent source images across a wide range of document types and conditions. Ricoh document scanners support this requirement through image-enhancement technologies such as Clear Image Capture. The technology is designed to produce clear, sharp source images and address visual issues, including colour shift and line distortion, that can affect OCR performance.

Medical records often contain varied document types, including patient forms, printed clinical notes, referrals, laboratory reports, and legacy records affected by age, print quality, or handling. Better source-image quality can help OCR software extract printed information more consistently across these materials.

Steve Oblin is director of marketing at PFU Canada Inc., a Ricoh company.

Three healthcare AI trends transforming care for patients and clinicians

BY JOHN LEE-BARTLETT

Healthcare has spent the better part of the last decade discussing the potential of artificial intelligence. Early conversations focused on futuristic possibilities such as autonomous diagnosis, predictive medicine and fully automated clinical workflows. While those advancements remain important, healthcare leaders are increasingly asking a more practical question: Which AI innovations are delivering measurable value today?

The answer is becoming clearer across health systems in Canada and around the world. Organizations are realizing the real value from AI and moving beyond standalone technology initiatives and integrating practical capabilities into clinical workflows, governance frameworks and patient engagement strategies.

Their aim is to address persistent healthcare pressures, including clinician burnout, workforce shortages, administrative complexity and rising patient expectations.

Three trends stand out as having the greatest impact on care delivery today.

1. AI is restoring time for human care: For decades, healthcare organizations have invested heavily in technology designed to improve quality, safety and access to information. Yet many clinicians would argue that technology has also increased administrative burden. Physicians and nurses routinely spend hours documenting encounters, entering data, navigating electronic health records and managing non-clinical tasks. The result has often been less time with patients and higher rates of burnout.

This is where AI is beginning to deliver tangible value.

Ambient listening technologies, intelligent documentation tools, conversational interfaces and generative AI assistants are helping reduce the time clinicians spend behind a keyboard. Rather than requiring providers to manually capture every detail of a patient interaction, AI can listen, summarize, structure and prepare documentation for review.

The impact is about far more than efficiency. It is about restoring human connection with patients.

Reducing documentation time can expand clinical capacity without requiring an equivalent increase in staffing. It can also reduce after-hours charting, improve continuity of attention during encounters and create a more sustainable working environment for clinicians.

Importantly, healthcare is redefining how AI success is measured. The first wave of AI focused on what machines could do, while the current wave focuses on what clinicians no longer need to do.

Forward-thinking organizations are increasingly evaluating AI investments based on measures such as reduced documentation time, lower levels of burnout, fewer hours spent charting after shift, improved clinician satisfaction and better patient experiences. These outcomes align much more closely with the realities facing healthcare organizations today.

Healthcare executives should recognize that the most transformative AI implementation may not be the most sophisticated. It may simply be the one that gives clinicians an hour of their day back.

2. Trust has become the new competitive advantage: As AI becomes more embedded within healthcare workflows, the industry's focus is shifting from capability to trust. Healthcare leaders are no longer asking whether AI can generate a summary, identify a trend, or automate a process. They are asking far more important questions:

- Can we explain how the answer was generated?
- Can we validate the recommendation?
- Can clinicians trust it?
- Can regulators trust it?
- Can patients trust it?

These questions are especially relevant in Canada, where public trust is foundational to healthcare delivery and privacy expectations remain among the highest in the world.

Organizations that rush AI deployment without addressing transparency, governance and accountability risk creating solutions that clinicians simply will not adopt. Healthcare is fundamentally different from many other industries. An AI-generated recommendation may influence a treatment decision, a care pathway or a patient outcome. The tolerance for error is understandably low.

As a result, responsible healthcare AI increasingly includes three foundational principles.

First, governance must be built into the architecture from the beginning.

> **Trust is becoming the new competitive advantage in AI. Can the system explain how it generated its answer?**

Leading organizations are embedding privacy controls, auditability, data lineage, access management and clinical oversight directly into their AI platforms rather than attempting to add safeguards after deployment.

Second, explainability matters. Clinicians must understand how an AI system reached a conclusion. The future of trusted healthcare AI is not a black box. It is an assistant capable of showing the evidence, context and rationale supporting a recommendation.

Third, human oversight remains essential. Successful organizations view AI as a support tool rather than an autonomous decisionmaker. AI may summarize information, identify gaps, or suggest recommendations, but clinical judgment remains firmly in human hands.

For healthcare executives, trust determines whether an AI initiative can move beyond a pilot. Without credible safeguards and clinical confidence, even technically capable solutions will struggle to achieve adoption or scale.

The organizations that can demonstrate safety, transparency, accountability and governance will be best positioned to scale AI initiatives, satisfy Health Canada medical device regulatory requirements where applicable and earn clinician confidence.

In healthcare, trust is not a barrier to innovation. It is the foundation that makes innovation possible.

3. AI is evolving from tool to clinical intelligent partner: Perhaps the most significant trend emerging today is the evolution of AI from simple automation into an intelligent collaborator.

Historically, healthcare technology required clinicians to adapt to software. Users learned interfaces, memorized workflows and navigated increasingly complex systems to retrieve information.

This change replaces user interface-driven navigation with conversational access to clinical information, allowing technology to respond more directly to a clinician's intent.



John Lee-Bartlett

Instead of clinicians learning how to use software, software is learning how to support clinicians.

This shift is evident in the rise of AI companions, clinical copilots, intelligent search capabilities and agent-based workflows.

Imagine a physician asking:

"Show me all cardiac-related admissions for this patient over the past two years."

"Summarize the significant changes since the last visit."

"Identify potential gaps in preventive care."

"Recommend applicable screening guidelines based on current evidence."

Rather than searching through multiple applications and dozens of screens, the clinician receives contextual, evidence-based answers in seconds based on security rights and patient consent.

This transformation extends beyond physicians.

Patients are increasingly using AI-powered tools before entering the healthcare system. Many now arrive at appointments with information, assumptions and questions generated by conversational AI platforms. Their healthcare journey often begins long before they interact with a physician.

This creates both opportunities and challenges. More informed patients can become active participants in their care, ask better questions and engage in richer conversations with clinicians. However, misinformation, incomplete understanding and misplaced confidence in AI-generated guidance also create risks.

Healthcare organizations therefore have a new responsibility: helping patients interpret, validate and apply information appropriately.

The future healthcare experience will increasingly involve three partners: the patient, the clinician and the AI assistant.

Success will depend on ensuring each participant contributes appropriately.

What this means for Canadian healthcare leaders: For Canadian healthcare leaders, the immediate priority is to develop AI solutions that solve care delivery challenges: workforce shortages, financial constraints, increasing clinical complexity and rising patient expectations. AI will not resolve these systemic challenges on its own, but it can reduce documentation burden, improve access to information, strengthen clinical decision support and help patients participate more actively in their care.

The leadership task is therefore not to replace clinicians, but to remove friction from the healthcare experience.

The real opportunity lies not in deploying the most advanced algorithms, but in thoughtfully integrating AI into clinical and operational workflows in ways that make work easier for clinicians and healthcare teams. As organizations move beyond pilots and experimentation, the focus is shifting toward implementing AI responsibly, with strong governance, transparency and trust at the core. Healthcare leaders who prioritize these principles will be better positioned to earn clinician adoption, maintain public confidence and scale innovation effectively.

Ultimately, the organizations that realize the greatest value from AI will be those that use it to enhance human connection rather than diminish it. By giving clinicians more time with their patients and helping them navigate increasingly complex healthcare journeys and simplifying the delivery of care, AI can contribute to a more sustainable and patient-centered healthcare system.

Canada's healthcare transformation is already underway, and the leaders who focus on restoring humanity to care, building trusted AI ecosystems and fostering intelligent partnerships between people and technology will help define the next generation of healthcare delivery.

The future of AI assisted healthcare: The defining healthcare AI opportunity in 2027 is not machine autonomy, but stronger human performance. By reducing administrative burden, embedding responsible governance and delivering relevant information at the point of care, AI can help clinicians practise at the top of their profession while preserving human judgment.

For Canadian healthcare organizations, success will depend less on the volume of AI deployed than on the discipline used to select, govern and integrate it. Leaders should prioritize initiatives that return time to clinicians, earn trust through transparency and oversight and measurably improve the patient experience. That focus will distinguish meaningful transformation from technology adoption alone.

Learn more about Altera Digital Health Canada and AI transformations for clinical EHR's and Interoperability at Canada Health Infoway Partnership Conference, Nov 16-18 in Vancouver. Contact via email: Canada@alterahealth.com

John Lee-Bartlett is EVP, Altera Canada.

Patient access: the AI opportunity Canadian healthcare is missing

BY COLETTE LEPINE

Canadian healthcare has spent three years pointing artificial intelligence at the clinical record, and it is starting to work. Canada Health Infoway's AI Scribe Program has enrolled more than 12,000 primary care clinicians, with roughly 70 percent reporting reduced administrative burden and more than an hour saved each week.

Clinical capacity challenges still remain, but these tools undeniably increase clinician efficiency and can help decrease clinician burnout.

Patient access has not improved alongside these gains. Roughly 5.9 million Canadian adults still lack reliable access to a regular primary care provider, according to the Canadian Medical Association.

In 2024, Statistics Canada found 4.5 million Canadians >45 years had difficulty reaching specialist care, and CIHI reported this summer that both emergency department waits and patient acuity are rising.

Much of what patients experience as a health system wait is administrative: a phone line that closes at 5pm, an intake form collecting information the organization already holds, a faxed referral that goes missing.

This is the patient access layer, where the next generation of AI tools, AI agents, have the clearest near-term role for healthcare.

The difference between an AI scribe and an AI agent is the difference between generating content and completing tasks. A scribe produces a note. An AI agent is given a goal, draws on trusted data, follows defined rules, and takes authorized actions across several steps.

Consider a patient asking the status of their referral. A chatbot that explains the referral process or says whom to call has digitized the dead end.

An AI agent orchestrating the workflow can check whether the referral was received, identify what is missing, start the follow-up, schedule appointments, and escalate to a human when judgment is required.

Canadians are ready to trust AI with the details that keep them healthy. Salesforce's 2026 Connected Health Consumer Report found that Canadian patients are comfortable handing AI some of their health information in exchange for safer, more proactive care:

- 73 percent say they would trust AI to flag potential drug interactions before picking up a new prescription
- 63 percent say automatic reminders would help them take their medicine
- 66 percent say an AI agent that suggests necessary preventative screenings would help them stick to their treatment plan
- 54 percent agree that AI agents from their own healthcare provider, offering health tips, would make them feel more secure in that care

And Canada is starting to see working examples of agentic AI in action in healthcare:

- Quebec's Info-Santé 811 routes influenza and gastroenteritis calls to non-clinical human agents equipped with an AI-powered application to help ease nurses' workloads and get patients answers sooner. According to Santé Quebec, between February and June of this year, 5,000 of 17,366 of these calls were handled without a nurse, with wait times falling from close to an hour to about 15 minutes.
- At North Bay Regional Health Centre (NBRHC), surgical patients use an AI assistant grounded only in the hospital's clinician-approved library. Every answer cites its source; anything outside it goes to the care team, and according to NBRHC, >92 percent of users reported satisfaction.

Patient access AI carries less risk than diagnostic or clinical AI, but it isn't low risk. It touches personal health information and influences whether and how patients receive the care they need. Here are three considerations to ensure AI efforts at the patient access layer are successful:



Colette Lepine

1. Document what the AI agent will NOT do first. Define the exclusions before the capabilities, build compliance into the requirements, and give the agent an escalation path that hands a human the full patient context rather than starting over.
2. Focus on logistics. Canadians have drawn this line themselves: polling this year from Liaison Strategies found 68 percent would rather wait two weeks for a human doctor than get an immediate AI diagnosis, and only 13 percent are comfortable with AI diagnosing and prescribing unsupervised. Booking, intake, triage routing, and reminders sit inside public tolerance.
3. Define rules when the answer has to be exact. Provider availability, eligibility, triage thresholds, and locations should come from deterministic logic and the system of record, never an AI's probabilistic judgment.

Two international deployments highlighted at Salesforce's Dreamforce conference in September show these preparations at scale:

- UCLA Health built a patient-facing AI agent grounded on 4,000 pages of content, at a time when its phone lines carried average holds of 17 minutes. It has handled more than 75,000 interactions, 40 percent of which led to faster care.
- CVS Caremark took the five highest-volume reasons members call, deployed them to AI chat agents in 90 days, then reapplied the same reasoning to AI voice agents in six weeks, reporting that over 50 percent of these conversations never had to escalate to a human. This concept could be applied to a provincial government or health authority running many sites: build once, govern once, deploy across channels.

None of this is groundbreaking. Speech recognition, record retrieval, and workflow orchestration have been available for years. What is new is that they can now be rapidly assembled into something that does not depend on staff being at a desk, so a patient can get information and access whenever they need it.

Measurement of the patient access gap is difficult. Canada publishes emergency and surgical wait times in detail, but tracks very little about the patient access layer; a patient who calls at 8pm, hears nothing, and gives up never appears in any dataset. The attempt leaves no record, so the demand looks like it was never there.

That is what makes AI so powerful. An integrated, always-on patient access layer does two things at once. It improves the patient experience while navigating care, letting them get an answer and take the next step on their own schedule rather than the organization's.

Colette Lepine is vice president, health and higher education at Salesforce Canada.

How "Physical AI" is quietly rescuing the hospital floor

BY KASSAUNDRA MCKNIGHT-YOUNG

Every hospital is a complex, living ecosystem. For a single patient to receive a medication or undergo a routine scan, a massive web of non-clinical, administrative, and auxiliary tasks must be executed perfectly. Yet, these are often the very areas where operational friction builds:

- The Hunt for Equipment: Caregivers and support staff lose valuable time every day simply searching for critical physical equipment: telemetry monitors, IV pumps, or wheelchairs.
- Manual Inventory and Audits: Auxiliary staff spend significant portions of their shifts manually counting inventory, verifying supply dates, and tracking down materials.
- Fragmented Communication: Nonstop alerts and unprioritized notifications bombard staff devices, creating cognitive overload and delaying critical tasks.

When an auxiliary staff member is bogged down by manual tracking, or when a porter spends 20 minutes locating a clean wheelchair, the entire care delivery chain slows down. By automating and bringing intelligence to these exact, day-to-day workflows, we can remove the friction that pulls staff away from their primary missions.

According to the newly released Oxford Economics study on Hospital Workflows commissioned by Zebra Technologies, hospitals that have made meaningful improvements to their clinical and operational workflows reported an average 20 percent reduction in emergency department length of stay. Furthermore, in critical day-to-day tasks like medication administration, 73 percent of hospitals that improved this workflow reported a tangible reduction in medication errors, proving that eliminating mundane administrative friction directly bolsters patient safety.

Bringing AI to the Frontline: How does AI transform these "hospital floor" tasks from chaotic to controlled? It does so by embedding machine intelligence directly into the physical devices, scanners, and workflow engines that auxiliary and clinical staff use every day.

- Intelligent Visibility, RFID, and Asset Orchestration: Connecting AI with advanced physical tracking technologies like Radio Frequency Identification (RFID) and Real-Time Location Systems (RTLS) produces incredible operational results. Instead of staff executing manual, room-by-row searches, a Physical AI engine constantly monitors and analyzes the movement patterns of critical hospital assets.

If a specialized pump is misplaced, the system does not just display a set of coordinate dots on an IT map; it intelligently routes a notification to the closest support staff member, identifying the exact device that is clean and ready for use.



Ms. McKnight-Young

This deep integration of RFID and Physical AI is already proving its value on a massive scale. For example, Texas Children's Hospital co-developed an RFID-powered solution with Zebra and its partner Tecsys to conquer a $40 million gap in unaccounted-for inventory. By tagging high-value medications and scanning them via hybrid RFID scanners and mobile sleds, the pharmacy achieved 99.99 percent inventory accuracy in their cabinets.

This tracking goes far beyond simple quantities. Physical AI provides real-time visibility into medication expiration dates and days-to-expiration, allowing the hospital to proactively redistribute stock to high-usage areas before they spoil. As a result, the hospital dramatically reduced expired drug waste from $3 million down to less than $200,000, while avoiding $14 million in unnecessary procurement costs.

Beyond tracking high-value items, Physical AI turns the hospital supply chain from a reactive system into a proactive shield. By analyzing historical consumption rates, ward transfer patterns, and seasonal patient volumes, predictive algorithms can forecast potential stockouts of essential auxiliary materials before the clinical team even notices a low shelf.

Kassaundra McKnight-Young is CNIO, healthcare industry principal North America & Canada at Zebra Technologies.

UHN builds platform

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real-time intelligence, generative AI and agent-based solutions in the future.

The EIP is a UHN-led enterprise capability built through multi-faceted collaboration. Data & Analytics department works closely with clinical programs and enterprise corporate teams to understand strategic priorities, operational needs and the decisions that Data & Analytics need to support.The department also partners with Privacy, Security, and Digital teams to align with UHN standards for technology, information protection, and security.

Technology vendors contribute to the underlying platforms, and specialized product expertise, while Data & Analytics department remains accountable for the overall data architecture, data products, governance, use-case design and how intelligence is integrated into day-to-day clinical and operational work.

The platform is already delivering measurable improvements in UHN's data engineering capabilities. The EIP has achieved a 25 percent improvement in data engineering productivity, driven in part by a 90 percent reduction in time spent searching for, integrating and debugging data.

Beyond accelerating data engineering, the EIP is strengthening how data quality is managed at scale. Automated data profiling, cleansing, standardization and real-time observability provide greater visibility into data quality throughout the lifecycle.

Data quality dashboards have already been developed for patient experience and patient safety data, with plans to extend this capability across additional mission-aligned and enterprise data domains.

Planning around priorities, not technology: To ensure the platform addresses meaningful problems rather than simply showcasing technology, every use case begins with a clearly defined clinical or operational question. Multidisciplinary teams, including subject-matter experts, clinical and operational leaders, analysts and developers, data stewards and, where appropriate, Patient Partners, work together to define the decision that needs to improve, the intended users, the current workflow, the available data and how success will be measured.

Candidate use cases are prioritized based on strategic alignment, expected value, feasibility, data readiness, privacy and security requirements and reuse potential. Grounded in UHN's Data & Analytics Strategic Action Plan, this process also provides important guardrails for responsible AI and advanced analytics.

Early AI use cases show the potential: With a trusted data foundation in place, early initiatives are beginning to demonstrate what the EIP can enable for clinical programs. Advanced Survey Analytics for People (ASAP) helps UHN understand the patient voice at scale by applying machine learning, explainable AI, natural language processing and large language models to thousands of free-text comments generated by patient experience surveys.

> **Digital dashboards have been developed for effectively measuring the patient experience and patient safety.**

All patient data is de-identified and anonymous throughout this initiative. In the meantime, predictive models help identify the factors most strongly associated with patient experience outcomes, while text analytics surface emerging themes, sentiment and changing priorities that would be difficult and time-consuming to identify manually.

When these insights are combined with quantitative measures such as Net Promoter Score (NPS), clinical programs gain a more complete picture of the patient experience, from enterprise-wide trends to specific opportunities for improvement.

For clinical leaders, the value is the ability to move more quickly from data to action. Rather than relying primarily on high-level scores or manually reviewing large volumes of comments, programs can better understand what is driving changes in patient experience, identify issues that may require attention and focus improvement efforts where they can have the greatest impact.

Scaling generative AI and agentic AI without sacrifices

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agentic AI until stronger governance is in place. Looking ahead three to five years, what healthcare workflow would you be comfortable handing over to an AI agent first, and which decisions should always remain in human hands?

A: I would start with workflows that are relatively low risk and where an error can be easily identified and corrected. Scheduling, routing referrals, following up on missing information and coordinating routine administrative processes are obvious candidates.

But I wouldn't simply divide this into administrative versus clinical workflows. The risk can vary considerably depending on the use case. De-identification is a good example. It may sound like a relatively straightforward data-processing task, but an LLM has to work with identifiable patient information, and missing something could expose that information downstream. On the other hand, a seemingly higher-risk use of an LLM might be acceptable with the right human oversight.

> **A seemingly higher-risk use of an LLM or AI agent might be acceptable with the right human oversight.**

An LLM might flag a patient record as indicating a particular medical condition. But if the record has first been de-identified so it no longer contains personally identifiable information, and a physician reviews the case before clinical action is taken, risk can be reduced.

I think we need to look at risk across the entire workflow: what data an AI agent has access to, what systems it can interact with, what actions it is allowed to take, and how easily an error can be detected. Governance of agentic AI isn't just policies and committees. It can also be built directly into the technology, for example through decision flows (a branching structure that combines deterministic rules, predictive models, LLMs and AI agents, with different decisions or actions taken depending on the patient's path through the flow).

You can restrict what data and tools an agent can access, constrain what actions it can take, control the prompts used within an agentic decision flow so the LLM is given specific, predefined tasks and instructions, build human approval points into the decision flow, log the agent's actions, and put guardrails around which patients can be assessed, which data can be reviewed, and where and how AI-generated conclusions can influence subsequent decisions and actions.

Understanding ROI measurement for funding decisions

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required for implementing the new process would be $500,000. He knew he would be turned down.

ROI Institute Canada was approached to assist. Together they secured enough funds to evaluate the new procedure on a small patient group of 16 through to impact and ROI. A critical step in the process compared the 16-patient group to another 16 patient group that followed the traditional process of preparation and aftercare.

They proved that new approach would save enough funds to overcome the cost of implementing it beyond the 16 patient pilot group. The results were dramatic. Applying the ROI process resulted in converting the improvements, zero infections, zero readmissions and reduced length of stay to monetary values.

The monetary value of the improvements were compared to the fully loaded costs resulting in a positive ROI. The CEO and CFO of the hospital were presented with the results, together with the full ROI success story and approved funding for the new process.

Driving better healthcare decisions: Organizations often look to build internal capability to use the ROI methodology. What does that mean? Start with specific objectives, a consistent process, compare costs to monetary benefits. ROI findings and intangible benefits will influence decisions.

Next steps: NIHI offers two courses, "Return on Investment Thinking in Health Care" and "Return on Investment (ROI) Fundamentals in Health Care," both instructed by Suzanne Schell using the Phillips ROI Methodology. These courses detail the thinking, the knowledge and the skills needed to measure value, impact, and ROI in healthcare improvement initiatives. For more information, see www.nihi.ca.

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Hypercare connects

CONTINUED FROM PAGE 10

such as diagnostic testing, treatment recommendations, and discharge planning.

More efficient clinician workflows: By eliminating unnecessary phone calls and reducing time spent locating specialists, clinicians can remain focused on patient care instead of managing administrative coordination. The ability to communicate from a mobile device also means providers no longer need to remain beside a desk phone while waiting for callbacks, allowing them to continue caring for patients throughout their shift.

Secure communication: The implementation also addressed an important operational need – providing a secure way to exchange clinical information between organizations. Rather than relying on fragmented communication methods, clinicians now have a platform that supports secure messaging while meeting the privacy expectations of both institutions.

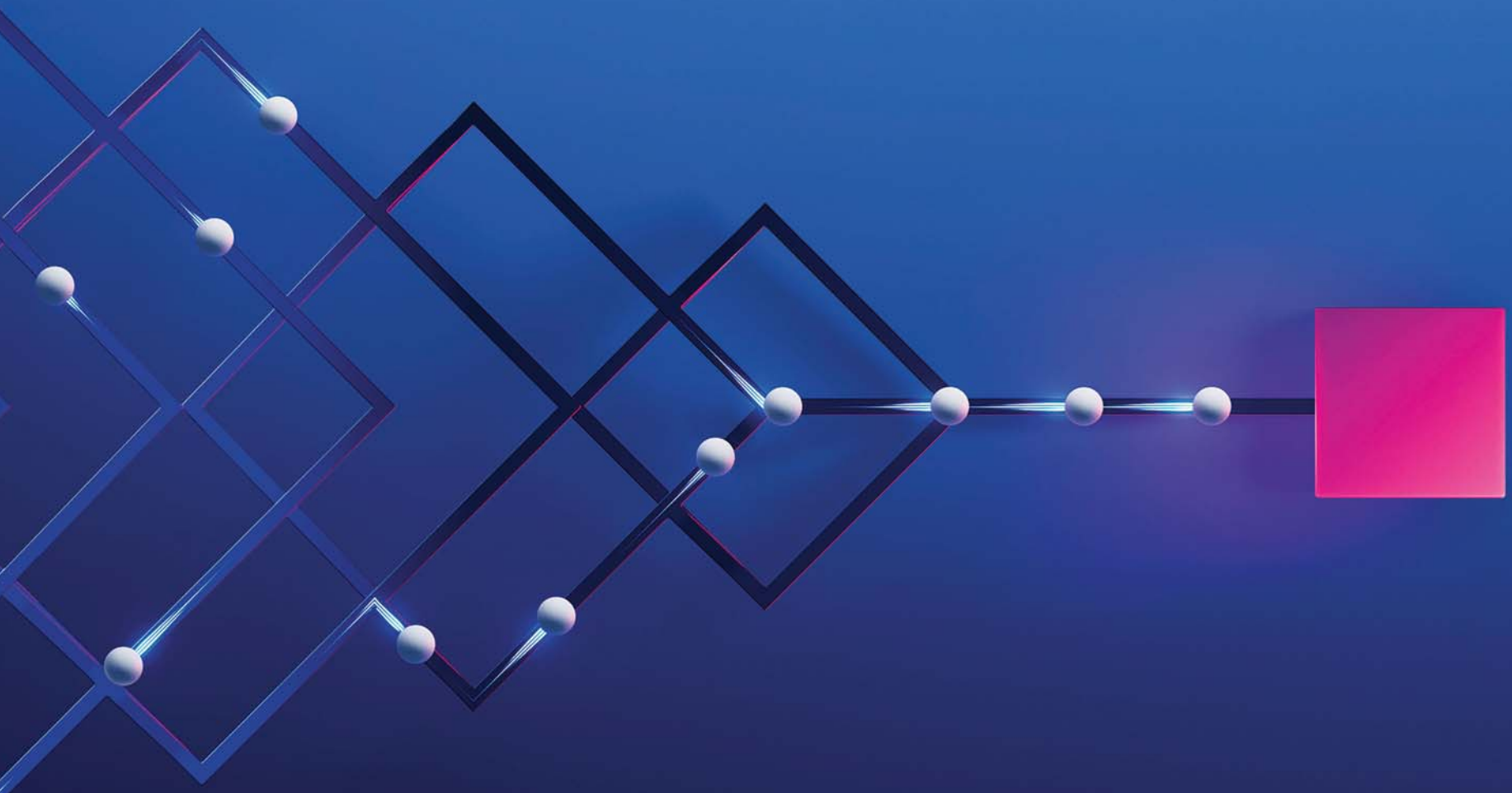
Supporting better patient flow: By implementing Hypercare, teams have gained faster access to specialist advice, often meaning that care can move forward more efficiently. Timely consultations have supported discharge decisions, enabled care planning over weekends, and reduced unnecessary delays caused by communication bottlenecks. The ability to securely share clinical images has also improved the efficiency of consultations that previously required less secure or more fragmented communication methods.

> **The implementation also addressed an important need: providing secure exchange of information.**

Looking ahead: The teams continue to evolve the workflow, with opportunities to further improve continuity as specialists rotate on and off-call. One area under consideration is expanding team-based communication workflows to preserve clinical context during handoffs and reduce the need to repeat information.

For both organizations, however, the value of the collaboration is already clear.

As Dr. Diambomba summarized, "Time and patients are both incredibly precious. Anything that gives clinicians more of one without compromising the other is invaluable. Hypercare has been life changing because it allows us to communicate quickly, securely, and effectively with our colleagues at SickKids, so we can stay focused on caring for our patients."



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