

The Actionable Innovation Day (AID) Approach: An Option for Driving Healthcare Innovation

Brett N. Hryciw, Cecilia Tran, Rashi Ramchandani, Cameron Love, Christine Caron, Aimee Sarti, Annelise Miller, Suzanne Madore, Michael Chasse, Andy Pan, Simon Didcote, Scott Millington, Heather Galley, Kwadwo Kyeremanteng, Andrew Seely

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Abstract

Background: Innovation is essential to address healthcare challenges like resource limitations, overcrowded emergency departments, healthcare provider burnout, and more. Implementing innovation in healthcare faces barriers, including resistance to change, lack of multidisciplinary communication and alignment, resource constraints and more. The Actionable Innovation Day (AID) approach was developed to address these barriers, creating a model for distilling multidisciplinary, immediately applicable, consensus-based recommendations for actionable change.

Objective: To evaluate the Actionable Innovation Day (AID) model as a structured approach for fostering multidisciplinary collaboration and generating actionable, system-level healthcare innovations.

To assess the feasibility and impact of the AID model in identifying and prioritizing practical, low-cost solutions for improving critical care coordination, patient-centered care, and AI integration.

Methods: Stakeholders, including multidisciplinary healthcare workers, administrators, patient partners, and industry participants within the Eastern Ontario region were invited to a first regional AID event focussed on acute and critical care. Conducted both in-person and virtually, AID featured (1) morning presentations from individual presenters offering recommendations, and (2) afternoon problem-oriented small-group breakout sessions to explore regional critical care solutions. Actionable recommendations were generated, and later rated with a 5-point agreement Likert scale (with email follow-up survey).

Results: The regional AID event had 57 participants, including 16 multidisciplinary leaders offering a total of 42 recommendations. Each small group generated 5-8 recommendation, synthesized in discussion and analysis, leading to 28 recommendations were generated across four domains: Innovation in Healthcare, Regionalized Care, Critical Care Practices, and AI in Healthcare. 49 (86%) participants responded to the post-event survey, rating their level of agreement. 23 (82%) recommendations had a score > 4. Top recommendations included fostering partnerships between research, industry, and

healthcare (Rating: 4.50/5), involving families in patient physical therapy in ICU and in home rehabilitation (4.46), and establishing centralized critical care coordination (4.44).

Conclusions: The AID approach emphasizes multidisciplinary and multilevel input, incremental and sustainable change, and practical, low-cost solutions, aligning with the Agile Innovation framework. This approach provides an optional model for coordinating meeting to catalyze innovation.

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Original Manuscript

The Actionable Innovation Day (AID) Approach: An Option for Driving Healthcare Innovation

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Abstract:

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Discussion: The AID approach emphasizes multidisciplinary and multilevel input, incremental and sustainable change, and practical, low-cost solutions, aligning with the Agile Innovation framework. This approach provides an optional model for coordinating meeting to catalyze innovation.

Introduction

Innovation is foundational to the advancement of any discipline, particularly healthcare. It encompasses technological advancements, process improvements, and cultural and organizational shifts, all of which enhance the quality, efficiency, and accessibility of healthcare services¹. As healthcare systems face challenges related to resource limitations and increased demand leading to burnout amongst healthcare providers, innovative thinking becomes essential to ensure sustainability and progress^{2,3}.

In healthcare, innovation acts as a catalyst for improving patient outcomes, optimizing workflows, and enhancing patient experiences⁴. The acute care system in Canada has acknowledged the need to address overcrowded emergency departments, prolonged wait times, and healthcare provider burnout^{3,5,6}. These issues underscore the need for practical innovation to improve both patient care and operational efficiency. However, healthcare innovation often faces significant barriers, including organizational resistance to change, the complexities of evaluating multiple stakeholder opinions for idea validation, and resource limitations for implementation⁷.

The regional Actionable Innovation Day (AID) was conceived to help address these barriers. It serves as a structured model to bring together diverse healthcare stakeholders to propose actionable changes within a local health authority. The regional AID event aimed to establish a shared understanding of healthcare priorities and develop practical solutions that can be scaled across regions to drive healthcare transformation.

Methods

Invitations to AID were disseminated to ICU and ED healthcare workers, including physicians, nurses, respiratory therapists, and administrators from hospitals within the Champlain Local Health Integration Network (LHIN). Patient partners, government representatives, and industry participants were invited to ensure broad, multidisciplinary perspectives. The event was held both in person and virtually to mitigate geographical barriers to participation. It focused on coordinating expedient patient transfers when necessary to provide timely access to appropriate levels of care while minimizing unwarranted risks and expenses of unnecessary patient transfers.

Figure 1 describes the agenda of the regional AID. The event began with a series of morning presentations from multidisciplinary clinician, industry and health care administration leaders and patient representatives to provide relevant context, identify opportunities for present and future innovation, and offer 'actionable recommendations' to address immediate problems in healthcare technology and innovation. Over two 90-minute periods, 16 speakers each gave a 7-8-minute presentation, followed by 3-4 minutes of questions & Answers. Speakers were multidisciplinary, including senior hospital administrators, physicians, nurses, as well as respiratory therapy, social worker, and patient presenters, all who identified unsolved challenges and proposed actionable recommendations. Each speaker offered 1-3 recommendations at the conclusion of their talk. All recommendations were systematically documented by designated recorders (CT, RR) during the AID. Following the presentations during the morning, participants joined one of three 90-minute small-group breakout sessions in the afternoon to explore recommendations to address the key theme of "how to optimize regional critical care delivery?". Moderators facilitated these sessions, helping attendees identify actionable recommendations and items related to the key theme. Recommendations from the breakout sessions were then presented by a small-group speaker for further whole group discussion and organized into summary consensus recommendations.

At the end of the day, all recommendations were summarized. A follow-up survey using MentiMeter (Stockholm, Sweden) immediate audience polling allowed attendees to anonymously rate their level of agreement with the suggested recommendations using a 5-point Likert scale. Items with high agreement were prioritized for future implementation.

Results

Participant Demographics

Fifty-seven participants attended the regional AID conference. A follow-up survey was sent to all attendees, and responses were received from 49 (86%). Respondents ranged in age from 23 to 65 years, with a median age of 47 years [IQR 37–55]. The participants included 6 physicians, 2 registered nurses, 1 respiratory therapist, 17 industry partners, 4 allied healthcare providers, 7 research staff, 5 administrative staff, 5 leadership staff, and 2 patient partners. Gender distribution was 42.9% female and 57.1% male, and 81.6% identified as Caucasian. Experience levels ranged from individuals in training to those with over 25 years of experience (see Table 1).

Generated Insights

The conference featured 16 presentations from various professional backgrounds, including physicians, a registered nurse, a respiratory therapist, a social worker, administrators, and patient partners. Presentations covered future innovations in healthcare, patient-centered care, critical care advancements, nursing and respiratory therapy improvements, and innovations in urban and resource-limited settings. Topics also included the integration of AI, predictive monitoring, effective inter-hospital transfers, social work innovations, and enhancing partnerships between academia, industry, and healthcare. Presenters focused on using existing resources to enact meaningful change within the Champlain LHIN, and their recommendations were recorded (see Table 2).

Small group discussions then provided a multidisciplinary platform for further exploring these as well as additional solutions to improve the efficiency and effectiveness of regionalized acute care. Four themes emerged: (i) coordination and communication, (ii) resource management, (iii) education, and (iv) family and patient engagement (see Figure 2). Coordination and communication focused on establishing centralized critical care coordination, real-time data dashboards, and repatriation protocols for optimizing patient transfers. Resource management emphasized ICU utilization, severity, predictive monitoring pilots, and ensuring adequate community resources. Education was highlighted as vital for fostering collaboration among stakeholders, including community members, academic institutions, and healthcare providers. Family and patient engagement included strategies like promoting journaling and home-based rehabilitation to enhance patient recovery. All recommendations from the presentation and small group sessions were then synthesized into a comprehensive list of recommendations generated from the event.

Actionable Recommendations

16 speakers provided a total of 42 actionable recommendations during individual presentations in the morning of the AID, followed by discussion and questions after each. Second, an afternoon set of parallel small group sessions came up with recommendations to address improved regional coordination of critical care. Subsequently, a total of 28 actionable recommendations emerged from a synthesis of the individual presenters and discussion by participants during the day (see Appendix Figure A), as prepared by two independent observers present and recording all events of the day (CT and RR). They summarized the recommendations and discussion into four key domains: (i) Innovation in Healthcare, (ii) Innovation in Regionalized Care, (iii) Critical Care Practices, and (iv)

Use of AI in Healthcare. No pre-existing framework was utilized for classification. A follow-up email survey was sent to all showed broad support for these recommendations, with agreement ratings ranging from 3.66 to 4.50 on a 5-point Likert scale (see Appendix Figure A). Of the 28 recommendations, 23 of which ranked >4 , and 13 recommendations were ranked >4.25 . These highly ranked recommendations are included in Table 3.

In the domain of 'Innovation in Healthcare,' participants emphasized fostering partnerships between research, industry, and healthcare institutions as a key driver of innovation (Rating: 4.50). Embedding innovation into organizational strategies received strong support, with a focus on recognizing local innovation efforts and sharing practical tools with related areas to enhance broader applicability. For 'Innovation in Regionalized Care,' mentoring early-career investigators and promoting regional critical care research were prioritized, with participants stressing the importance of developing future researchers (Ratings: 4.31 and 4.26, respectively). Another key recommendation was to review policies, protocols, and medical directives annually to identify and move forward with 1-3 innovation priorities (Rating: 4.25). In 'Critical Care Practices,' involving families in patient physical therapy and home rehabilitation was highlighted as an important strategy for enhancing patient outcomes (Rating: 4.46). Establishing centralized regional critical care coordination to optimize care and bed occupancy also received strong support (Rating: 4.44). Additional recommendations included implementing Lung Safe Ventilation protocols, initiating a pilot program for wearable monitors, and reducing noise exposure in the ICU by using headphones (Ratings: 4.43, 4.42, and 4.41, respectively). In the 'Use of AI in Healthcare' domain, participants highlighted the importance of using device-agnostic platforms to prevent vendor lock-in and promote cohesive data analytics (Rating: 4.32). Participants also supported improving data capture and using predictive clinical decision support tools to extract more value from monitoring (Rating: 4.30, 4.30). Emphasizing the human element by identifying and retaining tasks best suited to humans rather than AI was also considered critical (Rating: 4.27).

Discussion

Redefining Innovation in Healthcare

Healthcare innovation is frequently reduced to a radical process that yields disruptive, revolutionary outcomes. In contrast, incremental innovation can represent disciplined, user-centered improvements that address practical challenges⁸. The optimal approach to a sustainable innovative culture may therefore be achieved incrementally through regular, collaborative assessment of real problems faced by healthcare providers, patients, and institutions⁹. The regional AID event embodies this definition of innovation, focusing on low-cost, actionable improvements designed to enhance patient outcomes and healthcare system efficiency.

Furthermore, AID's participatory model promotes easily implemented ideas that are subsequently positioned for rapid iteration and validation based on real-world feedback. By centering on the immediate needs of stakeholders, the AID event moves away from the often imagined "lightbulb moment" of innovation and toward a collaborative, methodical approach that balances creativity with practical implementation. Nonetheless, it is recognized that subsequent implementation is a significantly greater barrier.

Building on the Agile Innovation Framework

The regional AID event shares many parallels with the principles of Agile Innovation, which emphasizes iterative cycles of planning, execution, and adaptation¹⁰. In the outlined AID approach, stakeholder engagement was the first critical component. By involving individuals from multiple

disciplines, including those who control resources and those directly affected by care, the AID approach ensured that the identified problem had practical and systemic significance. Furthermore, local experts' presentations provided the necessary context and highlighted the nuances of specific challenges within their domains. These expert-driven insights were crucial in framing the problems effectively and in proposing potential solutions tailored to real needs. Following the problem identification phase, group breakout sessions facilitated further ideation as well as evaluation and refinement of proposed solutions. These sessions provided a multidisciplinary platform for the exploration of innovative approaches and assessment of the feasibility of each idea. The collective prioritization of actionable recommendations allowed the AID contributors to establish a foundation for subsequent development and validation phases of the Agile Innovation framework.

Beyond its direct impact on critical care, the AID approach has broader relevance given the pressing challenges of an aging population and rising healthcare expenditures. With the projected increase in chronic diseases and long-term care needs, healthcare systems require structured, multidisciplinary approaches that can rapidly identify and implement cost-effective, sustainable solutions. The iterative nature of AID allows for practical, system-level interventions that can be adapted to various domains, from geriatrics to community-based preventive health programs.

Overcoming Conventional Barriers to Innovation

Systemic barriers often impede healthcare innovation¹¹. The AID approach deliberately addressed these barriers by incorporating specific strategies designed to facilitate a conducive environment to implement change. One significant barrier to healthcare innovation is the misalignment between administrative priorities and the adaptive, rapid changes required for practical innovation. Policymakers and administrators may be reluctant to embrace such changes due to concerns about potential risks, costs, or disruptions to established processes. AID actively involved administrative leaders throughout the event to align innovation priorities with organizational goals, enabling smoother adoption and increasing the likelihood of long-term integration. Furthermore, the intention to promote incremental innovation, as opposed to radical invention, ensures that the implementation process can be more readily navigated. A second substantial barrier involves the limited availability of financial and infrastructural resources⁷. High-cost innovations can be particularly challenging to implement in resource-constrained environments such as Canadian healthcare. AID addressed this challenge by emphasizing low-cost, high-impact solutions that required minimal resource investment. This approach not only made the proposed innovations more feasible for a wide range of institutions but also reduced barriers related to resource allocation, thereby promoting more equitable innovation. Third, the diffusion of innovation is another critical aspect of sustainable healthcare change^{12,13}. The Actionable Innovation Day approach promoted the diffusion of recommendations in several ways. The recommendations are naturally distributed throughout the health authority by involving innovators and early adopters across most disciplines and from sites across the region. Similarly, because of the collaborative approach to developing the recommendations, those involved are more likely to appreciate the relevance and alignment of the proposed solutions to the specific context of their local community. Finally, by inviting administrators, we hope to promote a cultural shift that promotes innovation from those in leadership roles. Leaders who actively participate in and advocate for innovative initiatives set a positive example, foster a supportive culture, and help embed innovation as an organizational value¹⁴. Cultural barriers, particularly resistance to change, often hinder the adoption of new practices. This resistance can be exacerbated by fears that new innovations will add to the workload of already overburdened healthcare teams. AID sought to counter these concerns by focusing on innovations designed to streamline workflows and reduce unnecessary burdens. By ensuring that solutions aimed to simplify processes and enhance efficiency, AID helped foster a positive perception of innovation, encouraging broader acceptance and adoption.

Next Steps in the Agile Innovation Framework

The Agile Innovation framework provides a pathway for advancing the actionable recommendations from the regional AID event beyond early development to institutional or regional integration. While the AID approach successfully established initial concepts and actionable solutions, the subsequent steps involve continuous iteration, refinement, and early implementation plans. The Agile Innovation framework advocates for development sprints that iterate rapidly on solutions, incorporating ongoing feedback to prepare innovations for broader evaluation and deployment¹⁰. For these next steps, ongoing communication and collaboration among AID participants would be a cornerstone to success. This will ensure the development of practical, context-specific solutions that can move forward effectively. The AID model can also be conducted at regular intervals to maintain momentum and evaluate progress. Future iterations of the event can facilitate follow-up discussions on implementation progress, allowing for both synchronous and asynchronous advancement of innovations.

Limitations

One of the challenges during a communal collegial effort to distil consensus recommendations is the need to summarize information during a discussion process into a summary list of recommendations. This is variably facilitated by a chair and therefore lacks standardization. This would be a limitation of this work and the method in general. In addition, synthesis of recommendations also may be subject to typically unconscious bias. Nonetheless, there are recognized best practice means to amalgamate and synthesize information which would benefit this type of single day collaborative educational event designed to generate consensus recommendations.

Conclusion

The AID process represents a possible organizational format for a meeting to engage healthcare leaders on the topic and process of innovation, supporting the generation of consensus recommendations and hopefully serving as a catalyst for innovation that improves care. The design is aimed to create a participatory model that engages multidisciplinary and multilevel stakeholders. By aligning with the Agile Innovation framework, a structured, practical approach is provided to advancing critical care focused on low-cost, scalable solutions, aiming that the innovations developed are both impactful and sustainable. Next steps require refining techniques of synthesis. We appreciate however that the next steps are to follow through on the recommendations, as that is where recommendations are turned into action, and is the admittedly more challenging next step Implementation.

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Table 1: Summary of demographic characteristics of RAID survey respondents (n=49)

Demographic Factor	N (%)
Gender	
Male	31 (63.3%)
Female	18 (36.7%)
Age (years)	
< 20	4 (8.2%)
20-30	11 (22.4%)
30-40	15 (30.6%)
40-50	12 (24.5%)
> 50	4 (8.2%)
No response	3 (6.1%)
Years of Experience	
Less than 1 year	3 (6.1%)
0-5 years	4 (8.2%)
5-10 years	4 (8.2%)
11-15 years	6 (12.2%)
16-20 years	6 (12.2%)
21-25 years	12 (24.5%)
> 25 years	11 (22.4%)
Ethnicity	
Canadian	40 (81.6%)
South Asian	3 (6.1%)
East/Southeast Asian	4 (8.2%)
Black	1 (2.0%)
Other	1 (2.0%)
Occupations	
Student	6 (12.2%)
Registered Nurse	3 (6.1%)
Registered Therapist	1 (2.0%)
Allied Healthcare	4 (8.2%)
Industry Doctors	17 (34.7%)
Research Staff	7 (14.3%)
Administration staff	5 (10.2%)
Leadership Staff	5 (10.2%)
Patient Doctors	3 (6.1%)

Abbreviations: N - number of participants

Table 2: Summary of key points and actionable recommendations from presentations of healthcare professionals of innovation in healthcare

Speaker	Title	Recommendation Summary
Cameron Love (Hospital CEO)	Future of Innovation at TOH	1. Communicate and instill a sense of pride and importance of discovery within your teams 2. Create strong program structure and process that incorporates Discovery into everything we do and talk about 3. Identify 3 innovation priorities annually to move forward with.
Kwadwo Kyeremanteng Chair, Dept Critical Care)	Future of Innovation in Critical Care	1. Pilot program for wearable monitors in hospitals 2. Pilot of adopting AI-based early warning system
Christine Caron (Patient representative)	Patient Centered Innovation	1. Alleviate delirium and PTSD in critical care patients through: a. ICU diary (communicates discharge management with diagrams about steps/risks) b. Sounds (headphone and sunlamp): headphone halo from patients to be protected from sounds in ICU (spa music for physiotherapy, brown noise, pink noise) c. Physical therapy: Teach families OT or PT exercises to perform during their ICU stay to mitigate physical impairments or disabilities (ex. ICU cycle, yoga bands)
Annelise Miller (ER MD)	Innovation in Resource- Limited Community/Rural ED	1. Understand the context (who/what/where/why/how) with your community partners a. Clearly define providers, materials, time, geographic distance, physical space 2. Foster innovation (support local teams/local management, ensure it facilitates timely action and builds inter-institutional relationship) 3. Innovation should occur alongside advocacy
Suzanne Madore (Hospital COO & VP)	Innovation in TOH Nursing	1. Foster a culture of innovation with support from leadership 2. Embed innovation into strategy and comprehend the essence of innovation 3. Recognize and reward innovation
Lauralynn McIntyre (ICU Dept. Research Lead)	Research Innovation	1. Monitor and aim to increase number of patients enrolled in critical care studies at TOH 2. Promotion of critical care research at TOH 3. Training to develop future innovation researchers a. Early career investigator support for innovation researchers
Matt Bromwich (Surgeon, CEO, Hospital Innovation Lead)	Innovation in Scientific Academic Industry Partnerships	1. Innovation should be subtractive (one solution replaces 9 other tasks) 2. Have a team around you (to speak the language and fill in the gaps)
Pierre Cardinal	Innovation in Documentation	1. Post innovation work and findings on free forums such as Google Firebase Community

(Intensivist, Educator)	& Education	
Frank Fiorenza (Respiratory Therapist, CEO)	Innovation in Respiratory Therapy	1. Review mechanical ventilation policy and add a minimum of 1 new solution annually 2. Identify if ventilation protocols are lung safe or Lung Protective. Implement Lung Safe. 3. Review critical patient transport protocols and add a minimum of 1 solution annually. 4. Do you have an idea for a new device or way to improve patient care - bring it forward 5. Have you been presented with an innovation recently? Is it viable at your facility? Take on a minimum of 1 new project annually - be the champion
Michael Chasse (Intensivist Scientist)	Where is AI in Critical Care	1. AI tools should learn to use data "as is": Tools should use unstandardized data inputs to improve their adaptability and effectiveness in real-world settings. 2. Healthcare practitioners should prepare for the inevitable partial replacement by AI in specific tasks, embracing the shift as part of the ongoing evolution of medical practice. 3. Anticipate and decide on non-replaceable tasks: Identify and prioritize the tasks that humans should retain, even if AI could perform them more efficiently and/or better.
Andrew Seely (Surgeon, Intensivist, Scientist, CEO)	Monitoring-Based Predictive Decision Support	1. Implement extubation advisor at TOH in a multidisciplinary quality improvement project focused on reducing extubation failure 2. Continue to seek to get more value from monitoring, by implementation and evaluation of predict clinical decision support tools
Scott Millington (Intensivist, VCC Lead)	Virtual Critical Care	1. Hub-and-spoke model for other specialties that deals with any acute patients a. Use VCC workflow and technology to take responsibility for region
Heather Galley (Critical Care SW)	Innovation in Social Work	1. Admission checklist → automatic social work referral 2. Review Critical Care Family Assistance Program criteria and implement updates
Alexandre Tran (Surgeon Intensivist Scientist)	Predicting & Preventing Ward Deterioration	1. Improve data capture and analysis to personalize prediction of critical events 2. Capitalize on the human element to maximize technology effectiveness
Andy Pan (Intensivist, Regional Transport Lead)	Improving Inter-Hospital Critical Care Transfers	1. Involve the transport physician early on and determine best means of transfer 2. Pre-transfer optimization and minimize transition points
Andrew Kramer (Data Scientist) Simon Didcote (Developer, CEO)	Continuous Predictive Monitoring	1. Implement continuous non-invasive monitoring outside ICU combined with suitable regulated analytics such as VSI - especially for high-risk patients 2. Consider investigating use of regulated EWS like ViSIG in ICU to improve outcomes 3. Use a device agnostic platform to tie analytics together to avoid vendor lock in.

Abbreviations: ICU - Intensive Care Unit; PTSD - Post-Traumatic Stress Disorder; OT - Occupational Therapy; PT - Physical Therapy; SW - Social Work; TOH - The Ottawa Hospital; AI - Artificial Intelligence; VCC - Virtual Critical Care; VSI - Visensia Safety Index; EWS - Early Warning System

Table 3: Summary of highly ranked actionable recommendations for critical care innovation

Key Domains	Recommendation ¹	Rating ²
Innovation in Healthcare	Innovation must be fostered through inter-institutional relationships as well as partnerships between research, industry, and healthcare.	4.50
Innovation in Regionalized Care	We need to train and mentor early career investigators to develop future innovation researchers	4.31
	We need to promote critical care research in the region	4.26
	We need to review policies, protocols and medical directives to identify 1-3 innovation priorities annually to move forward with	4.25
Critical Care Practices	Involve families in patient physical therapy in ICU and in home rehabilitation	4.46
	Implement centralized regional critical care coordination to optimize specialized care and bed occupancy	4.44
	Implement Lung Safe Ventilation and follow evidence-based guideline recommendations	4.43
	Implement a pilot program for wearable monitors in the region	4.42
	Protect patients from sounds in the ICU with use of headphones/ halo	4.41
Use of AI in Healthcare	To avoid vendor lock in device agnostic platforms must be used to tie analytics together	4.32
	We must continue to seek to get more value from monitoring, by implementation and evaluation of predictive clinical decision support tools	4.30
	We must improve data capture and availability to personalize critical event prediction	4.30
	We must identify and prioritize the tasks that humans should retain; we need to capitalize on the human element to maximize effectiveness	4.27

¹ Recommendations with an overall Likert rating of ≥ 4.25 were included in the table

² Rating was evaluated on a 5-point Likert scale

Time	Session
0700 – 0815	Coffee/Registration
0815 – 0830	Welcome Address
0830 – 1000	Speaker Presentations: Future Innovation
1000 – 1030	Networking
1030 – 1200	Speaker Presentations: Present Innovation
1200 – 1300	Networking/Lunch
1300 – 1415	Small Break-out Groups Discussion: Innovation in Critical Care Regionalization
1415 – 1430	Networking/Coffee break
1430 – 1545	Summary of Small Group Discussions
1545 – 1645	Summary and Rating of Recommendations
1645 – 1700	Closing Remarks

Figure 1: The regional AID conference agenda.

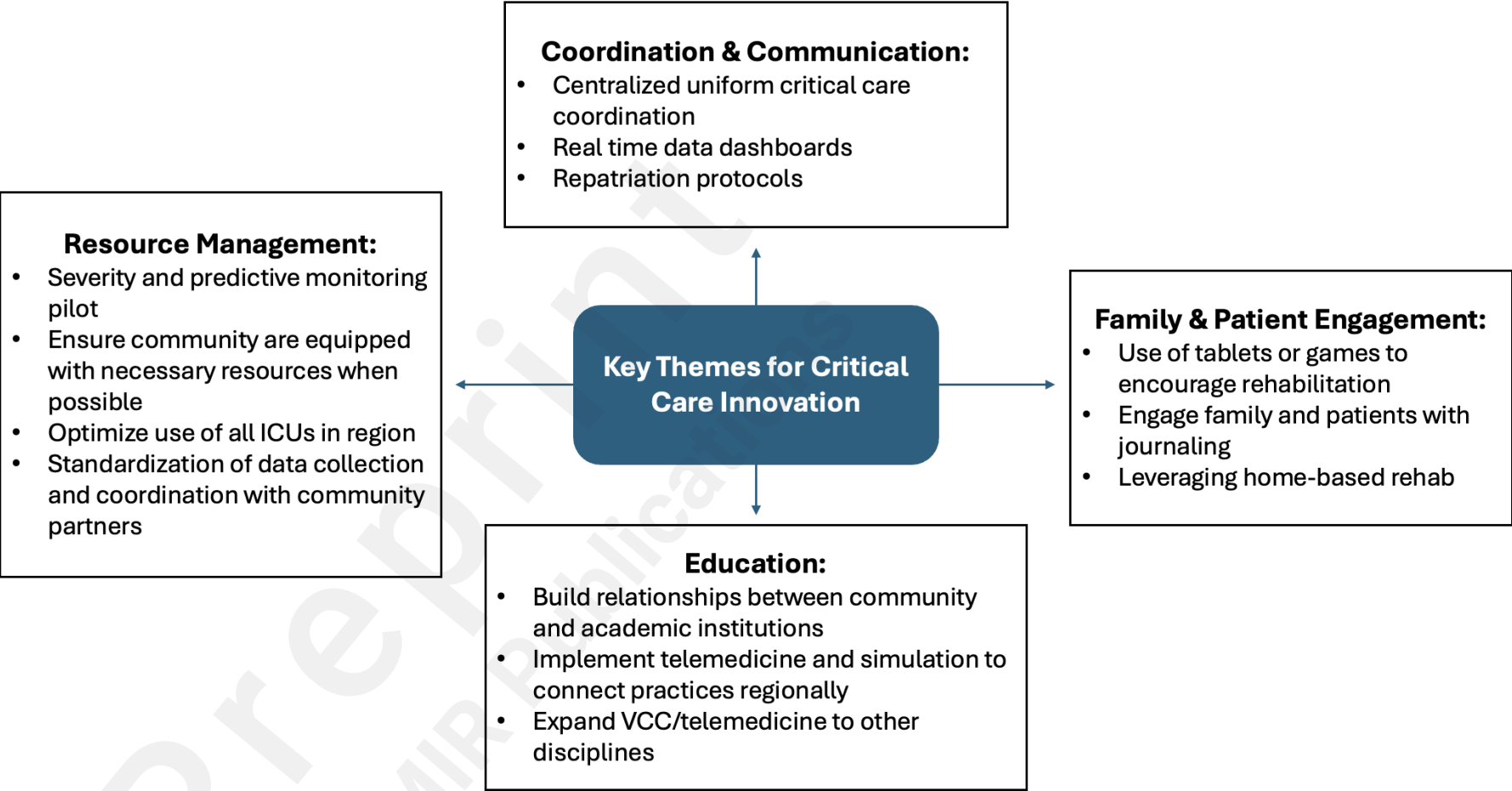
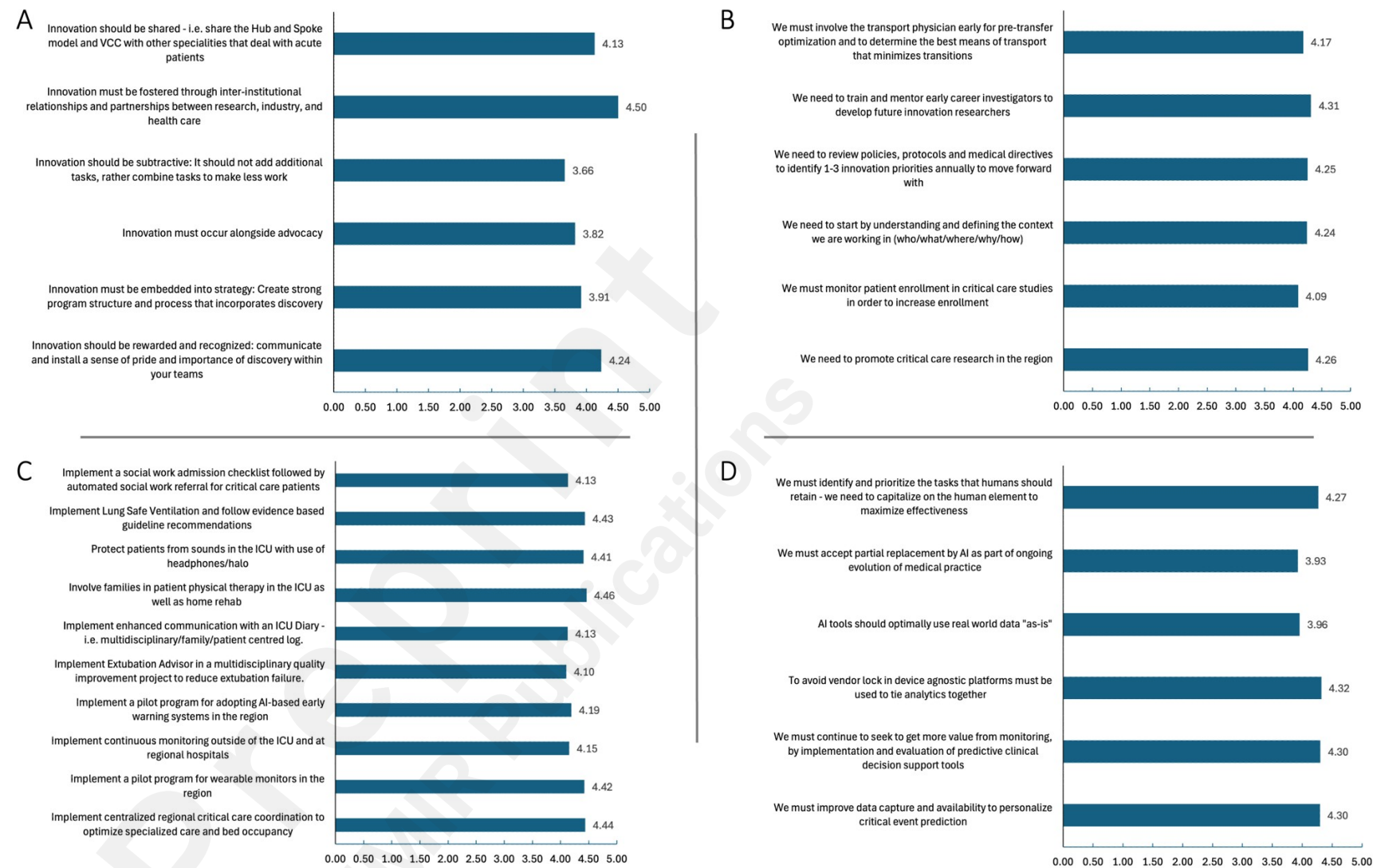


Figure 2: Summary of actionable recommendations to optimize regionalization of critical care for a Local Health Integration Network (LHIN) in Ontario, Canada generated from small group discussion organized by key themes.



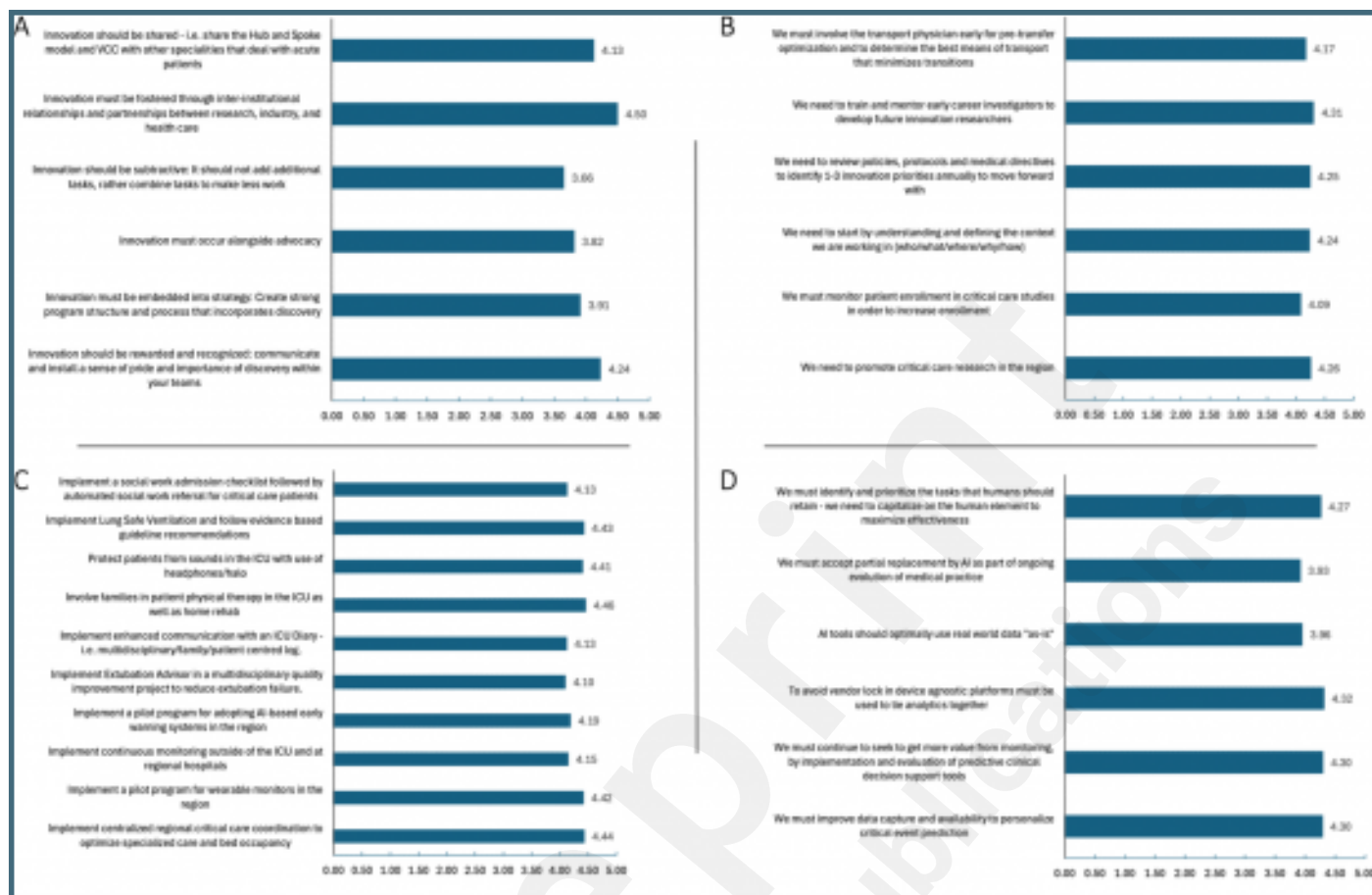
Appendix Figure A: Attendee agreement ratings for recommendations related to a) Innovation in Healthcare b) Innovation in Regionalized Care c) Critical Care Practices d) Use of AI in Healthcare. Agreement was rated on a Likert Scale (0=No agreement; <https://preprints.jmir.org/preprint/73614>

[unpublished, non-peer-reviewed preprint]

5=Strong agreement)

Supplementary Files

Untitled.



Figures

The regional AID conference agenda.

Time	Session
0700 – 0815	Coffee/Registration
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1645 – 1700	Closing Remarks

Summary of actionable recommendations to optimize regionalization of critical care for a Local Health Integration Network (LHIN) in Ontario, Canada generated from small group discussion organized by key themes.

