



Phase 0: Enhancing clinical trial accrual and EDI in Canadian blood cancer research

REPORT BY

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Executive summary

Emerging therapies in blood cancers, along with barriers related to equity, diversity, and inclusion (EDI), are making clinical trial accrual and participation more complex. Clinical research is expanding at an exponential rate, creating intense global competition. If we don't adapt, Canada risks falling behind. Although we remain a G7 leader in clinical trial productivity, the number of clinical trials initiated in Canada decreased by 19% from 2022 to 2023, adding to the 37% decrease seen from 2021 to 2022.

When research quality, patient population, and eligibility are not the issues, what is? Barriers in EDI and increased burden on patients are negatively impacting trial costs, accrual, and introducing biases. Operationalizing EDI in Canadian clinical trials is paramount for improving trial efficiencies, attracting more trials to Canada, and positioning Canada as a future leader in blood cancer clinical research.

PHASE 0 workshop meeting objectives

- **Position Canada as a leader** in inclusive clinical trials by adopting forward-thinking pre-trial practices that enhance competitiveness and advance patient-centered research in blood cancer.
- **Develop a patient-centric** pre-trial navigation service framework that identifies and addresses common barriers to trial participation, providing tailored support to enhance access and engagement.
- **Embed EDI principles** into pre-trial design by developing practical strategies integral to the accrual process from the outset.
- **Define collaborative roles** among research teams, clinicians, patient advocates, and trial sponsors to ensure a coordinated and efficient approach to trial preparation and recruitment.
- **Explore scalable**, nationally adoptable systems for delivering navigation services.



1. Innovation, Science and Economic Development Canada. (2025, April). Clinical trials environment in Canada. Government of Canada. <https://ised-isde.canada.ca/site/canadian-life-science-industries/en/biopharmaceuticals-and-pharmaceuticals/clinical-trials-environment-canada>

2. Innovative Medicines Canada. (2024, May). Clinical trials in Canada: A research note on global competitiveness. https://innovativemedicines.ca/wp-content/uploads/2024/05/6588_IMC_2024ResearchNote_ClinicalTrialsCanada_v2-1.pdf

Introduction & background

Why this matters

Efforts to improve equity, diversity, and inclusion (EDI) in clinical trials have gained momentum in recent years, both for health equity and for scientific reasons; however, impactful system-level change remains elusive. Persistent barriers, ranging from geographic distance and financial burden to language access and medical mistrust, continue to restrict participation and skew representation. From a systems design lens, these are not just logistical hurdles, but design gaps in how clinical trials are conceived, communicated, and implemented.

While countless initiatives have attempted to address EDI by modifying eligibility criteria or recruitment language (which bear importance) during trial design, it is virtually impossible to accurately predict what the exact individual-level barriers will be during a trial. Although improving trial design and protocol is crucial piece, understanding a person's challenges (that may not be addressed in the protocol) prior to trial screening is paramount to addressing this gap.

To shift from awareness to meaningful action, Canada must adopt practical, sustainable models that embed equitable, patient-centred practices at every stage of trial accrual, preventing progress from stalling in utopian ideals. This transformation begins upstream: equipping and supporting patients and their care teams well before clinical trial participation is even on the table.



Setting the stage: Health eMatters IMPACT workshop 2024

To explore this opportunity, Myeloma Canada convened the Health eMatters IMPACT Workshop in April 2024. This national, multi-stakeholder event focused on operationalizing EDI in clinical trial accrual using a systems-level and human-centered design (HCD) approach.

Participants worked through case-based design exercises rooted in real-world experience. Despite working on distinct scenarios, most groups independently arrived at a similar solution: the concept of a pre-trial navigation support service to help identify and address non-medical barriers prior to formal screening.

This concept provided the foundation for the Phase 0 workshop. [Click here to read the full report.](#)

Phase 0: A platform to move from idea to implementation for blood cancer trials

Building on the shared concept developed in 2024, Myeloma Canada convened a follow-up meeting in March 2025: Phase 0 workshop. The goal was to refine the proposed service model into a sustainable, patient-centered, and scalable service that meets patient needs, enhances trial efficiencies and participation, and prioritizes equitable access to care across real-world Canadian healthcare settings.

Once again, the workshop followed the HCD approach. Participants revisited refined versions of the original four personas from the 2024 session, which were now focused on blood cancer clinical trials. The refined personas incorporated additional layers of complexity, with the objective of pressure-testing and translating the proposed solution into actionable design features that could work within existing healthcare structures without changing trial protocols or sites.

Phase 0 workshop participants & representation

Who was in the room

The strength of the workshop lay not only in its methodology but in the people who shaped it. Myeloma Canada intentionally convened a cross-functional, cross-sector group representing the full clinical trial ecosystem, including:

- **Patients** and patient partners
- **Researchers** and academic trial leads
- **Clinical trial nurses**, coordinators, and contractors
- **CRO representatives** and trial sponsors
- **Social workers** and drug access navigators
- **Indigenous health professionals** and community leaders
- **Patient Support Program (PSP) specialists** and health policy stakeholders
- **Representatives** from advocacy organizations
- **Representatives** from research ethics boards
- **Government**

Participants represented a range of geographies, from major urban centres to remote communities, and a wide array of healthcare settings, from large academic centres to smaller regional hospitals.

About half had participated in the 2024 Health eMatters IMPACT workshop, bringing continuity and context. The other half were new to the dialogue, ensuring fresh thinking and expanded reach.

Why representation mattered

Representation in the Phase 0 workshop was not only demographic. Participants brought a wide range of expertise and lived realities to the meeting: from those who design and manage clinical trials, to those who navigate them as patients, caregivers, or access coordinators. The steering committee members also represented a broad spectrum of backgrounds and expertise.

This diversity of backgrounds and experiences enriched discussion, helped challenge assumptions, and exposed blind spots. It ensured that solutions were stress-tested across multiple lived experiences. The presence of Indigenous health leaders, newcomers to Canada, individuals from historically marginalized communities, and frontline navigators, as well as diverse gender identities, socio-economic backgrounds, and urban and rural perspectives, helped ensure the work remained grounded in equity, cultural humility, and real-world complexity.

Crucially, the workshop demonstrated that inclusive co-design is not a symbolic gesture—it is a design requirement. Embedding diverse perspectives into the design process from the outset made the resulting model more responsive, scalable, and implementable across settings.



Phase 0 workshop design & methodology

The meeting unfolded over two carefully designed days intentionally designed to move from shared understanding to actionable innovation. The format blended storytelling, systems insight, and iterative solution design.

- **Day 1 was a collective intake process.** Its goal was to explore models and tools from areas such as PSPs, drug access navigation, social work, and community engagement to spark creative thinking and support the transference of skills, programs, and common frameworks into the clinical trial navigation space.
- **Day 2 was a facilitated design sprint.** Cross-sector teams used HCD thinking to prototype a pre-trial navigation service that addressed real-world challenges.

This structure mattered. Participants came from vastly different geographies, institutions, and lived experiences. Without a common frame, any solution risked being biased, siloed, or blind to systemic friction. The two-day arc ensured that solutions were grounded in insight, not assumption and that design was informed by those who live and work closest to the problems.

Day 1: Collective intake & thematic mapping

Through a mix of plenaries, panels, and facilitated dialogue, participants explored the non-medical barriers that often go unaddressed in clinical trial planning. These discussions were not meant to generate solutions, but to surface tensions, challenge assumptions, and reveal the underlying complexity that any effective model would need to navigate.

Interconnected themes emerged throughout the day:

- **Relational trauma and medical mistrust:** Participants acknowledged the deep-rooted mistrust in medical systems, often stemming from historical experiences of discrimination, which disproportionately affects marginalized communities. This mistrust creates significant barriers for patient engagement in clinical trials.

- **Logistical, financial, and linguistic access barriers:** These barriers continue to affect diverse populations, particularly those facing economic hardship, language differences, or geographic isolation. The lack of tailored support for these individuals exacerbates their challenges in accessing trials.
- **Limited awareness and fragmentation of support systems:** While there may be several resources available for patients, they are often challenging to navigate within the context of clinical trials. The absence of a coordinated service structure leaves patients struggling to access the full spectrum of support potentially available to them, leading to confusion and missed opportunities for care and trial participation.
- **The evolving role of digital tools, including artificial intelligence (AI), in advancing equity:** A growing recognition of the potential of digital tools was explored to support patient navigation, enhance trial matching, and reduce access disparities. The conversation also highlighted the need for these tools to be designed with equity in mind to avoid exacerbating existing inequities.

The day ended with a shared realization:

There are many programs, resources and services that are already in place and available for patients to access, yet awareness and dissemination of the information is lacking and disjointed. What is missing is a lynch pin to pull it all together in a centralized hub and navigate options for healthcare teams and patients.

This foundational insight set the tone for Day 2.

Day 2: structured co-design sprint

Day 2 translated shared insights into structured design work. Participants were intentionally placed into 12 small, cross-sector teams and assigned personas to design a pre-trial navigation service to address non-medical trial access barriers and improves pre-screening readiness.

Teams weren't just asked to be creative, they were also asked to work within current healthcare realities. The central design constraint was clear: teams could not change the trial protocols, healthcare infrastructure, or treatment design. This grounded the work in system-aware thinking, ensuring that all proposals would be feasible within current constraints, and could be implemented in the short term.

Your Mission: Make Clinical Trials Accessible
Build a Real-World Solution

Your Assignment:

- You have been hired as a consultant to design a **Pre-Trial Support Service** that ensures patients can access clinical trials.
- This service will help patients and healthcare teams navigate and overcome barriers before trial enrollment.

Your service must be:

- Realistic** – It must work in real-world settings by identifying and addressing key barriers preventing access.
- Scalable** – It must function across all healthcare environments in Canada, in both urban and rural settings.
- Fundable** – It must have a viable & sustainable financial model.

Constraints:

- You cannot change clinical trial eligibility, protocols, or site locations.
- Your solution must work within the existing healthcare system.

⚡ Your proposal will be evaluated—can it hold up to real-world scrutiny?

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Figure 1 - Phase 0 design constraints & requirements



The personas and settings: designing from lived barriers

At the centre of Day 2 were the four fictional personas, deliberately constructed to reflect real-world barriers in blood cancer care, without confining participants to overly specific narratives.

Each persona was developed with four core design principles:

- 1. Comprehensive, not just diagnostic:** The focus was on logistical, emotional, and systemic barriers and also took into account the medical needs and treatment options related to different blood cancers. The emphasis was on understanding the broader context, such as where people live, how they work, what support systems they have, not just their medical status.
- 2. Intentionally open identity:** Identity markers such as age, ethnicity, language, gender, and geography were deliberately left vague. This choice encouraged projection from multiple perspectives while minimizing unconscious bias. It also opened space to imagine how structural barriers recur across diverse lived realities.
- 3. Pattern-oriented, not representative:** These personas were not meant to represent specific communities. Instead, they surfaced recurring patterns that cut across many identities, such as financial strain, logistical hurdles, systemic mistrust. They were design catalysts.
- 4. Starting with the seed:** Inclusive design doesn't start by mapping every intersectional factor across every variable. That would generate millions of potential combinations and paralyze early-stage creativity. Instead, these personas served as carefully tended seeds—a common starting point with the potential to branch into deeper, community-driven, culturally contextualized design in future phases.

To understand the complexity of the personas, it's important to consider the diversity of healthcare settings in which they receive care. Each setting presents its own set of challenges and opportunities in accessing clinical trials, influencing how patients interact with the healthcare system and their ability to participate in research. A brief overview of each persona is included (Table 1). For full persona descriptions, reference Appendix.

Persona	Healthcare setting	Personal challenges	Systemic challenges
CASEY	Small community cancer centre	<ul style="list-style-type: none"> • Geography/travel to treatment • Financial toxicity • Limited support system 	<ul style="list-style-type: none"> • Limited trial resources and support services • Complex logistics coordination • No contact with research centre support services • Complex trial protocol requirements
ROBIN	Suburban cancer centre	<ul style="list-style-type: none"> • Trust/Fear • Historic cultural / community injustices and inequities 	<ul style="list-style-type: none"> • Few trial support resources • Limited cultural/community competencies • Complex logistics coordination • No contact with research centre's support services
SAM	Mid-size cancer centre	<ul style="list-style-type: none"> • Language • Cultural background and community • Fear • Lack of support 	<ul style="list-style-type: none"> • Limited trial support services • Limited resources in language supports and cultural competencies
DREW	Large urban cancer centre	<ul style="list-style-type: none"> • Financial toxicity • No support system • Work requirements 	<ul style="list-style-type: none"> • Traditional business working hours • Scheduling of multiple appointments in various departments • Complex trial protocol requirements • Located in a costly metropolis

The three rounds of co-design

The co-design sprint unfolded over three structured rounds, which were sequenced to move teams from ideation to pressure-testing to synthesis, using progressive constraints and facilitated reflection. Each round built upon the one before it, following a modified HCD approach that prioritized equity, patient experience, and real-world feasibility. The 12 multi-disciplinary teams were supported by tailored worksheets time-boxed design windows, and on-site facilitators who posed provocative questions to sharpen thinking and surface blind spots (Appendix).

- **Round 1 (grounded design):** Each team was assigned one persona to design their solution.
- **Round 2 (stress testing):** Each team was assigned a second persona to determine whether their proposed solution could work for the second persona.
- **Round 3 (integration and final synthesis):** The process shifted towards refinement, convergence, and system-readiness. The 12 teams were merged into six larger groups to synthesize their solutions into a single, unified pre-trial navigation support service for all four of the personas.

This final form was submitted for presentation during the Proposal Showdown.

The proposal showdown: pitching for impact

Each of the six newly formed teams were invited to present their unified pre-trial navigation support service to the full cohort of workshop participants. The tone was intentionally high-stakes, designed to simulate a real-world pitch to a policymaker, hospital CEO, or trial sponsor.

Participants were asked to vote not for their own team, but for the proposal they believed was most ready to move forward in a real-world context. Before voting, participants were reminded of the three mandatory criteria that every solution had to meet:

- **Realistic:** Works within the current healthcare ecosystem.
- **Scalable:** Adaptable across provinces, care settings, and patient realities.
- **Sustainable:** Has a credible pathway to financial sustainability.

Outcomes and refined proposals

In the Phase 0 workshop, participants worked across six different teams, each developing their own proposal to address barriers to clinical trial participation. While each team worked with different personas and starting points, their proposals reflected clear areas of convergence, highlighting a shared understanding of the practical changes needed to improve equity and participation in clinical trials.

Rather than theoretical concepts, the proposals offered realistic, models grounded in patient experience, healthcare constraints, and operational feasibility.

Core components proposed across teams

Human-centred navigation roles

Each team proposed a dedicated human support role, such as a navigator, peer guide, or social worker to assist healthcare teams and their patients before, during, and after trial screening. These individuals were proposed as trusted points of contact to:

- **Act as a centralized resource** for healthcare teams to assist with solution-driven resource navigation.
- **Identify available options** to address barriers and tailor each solution per individual need.
- **Coordinate and leverage access** to existing supports (e.g., transportation, lodging, financial aid, patient partners, translation services, etc.).

Technology to enhance support

Technology was positioned as a companion tool to improve efficiency and consistency, not as a replacement for human care. Proposed digital supports included:

- **Checklists and timelines** to help patients understand what to expect.
- **A search tool and library** for region-specific resource directories for navigators to reference and update.
- **Scheduling, reminder, and coordination tools** to streamline support delivery.

Importantly, these tools were proposed for use by navigators, not as standalone patient apps (however a patient-facing component could be a possibility). Several teams emphasized the need for low-tech access options as well, such as phone-based navigation or printable materials.

In addition, multiple teams proposed using AI or digital tools to curate and streamline access to existing supports, such as transportation programs, financial aid, translation services, and caregiver supports. Rather than creating new systems from scratch, these tools would integrate fragmented services into a centralized hub for a comprehensive and user-friendly workflow. The goal would be to leverage AI to reduce redundancy, improve consistency, and ensure that patients and the staff supporting them would not be left to navigate siloed systems alone.

Sustainability and scalability within current systems

Not only did the proposed service solutions have to work within the current healthcare landscape, each team was also given instructions to ensure financial sustainability and scalability of the model framework. Teams were not allowed to modify trial protocols nor trial sites to identify feasible paths forward.

In terms of scalability, common implementation approaches included:

- **Re-deploying existing staff** (e.g., social workers, PSP representatives, navigators, patient partners) with targeted training.
- **Coordinating services** through a shared hub platform with national oversight but local flexibility.
- **Develop regional/territorial-based service** options to ensure coordination between all centres.

As for financial sustainability, several teams emphasized the need for external funding models, such as a establishing a distinct non-profit organization receiving blended support from trial sponsors, provincial health authorities, non-profit partners, and foundations. This approach would allow navigation services to operate flexibly across centres and regions, without being constrained by hospital operating budgets.

Conclusion

The Phase 0 workshop, hosted by Myeloma Canada, represents a focused step toward improving EDI in clinical trial participation through adaptive service innovation, while working within current healthcare confines and limitations.

Despite starting from different patient personas and care contexts, each team arrived at strikingly similar conclusions, highlighting the need for externally centralized pre-trial navigation service roles operated by humans and supported by technology aids, that are scalable and transferable across the current healthcare structures, while tailoring solutions to suit the need of the individual patient.

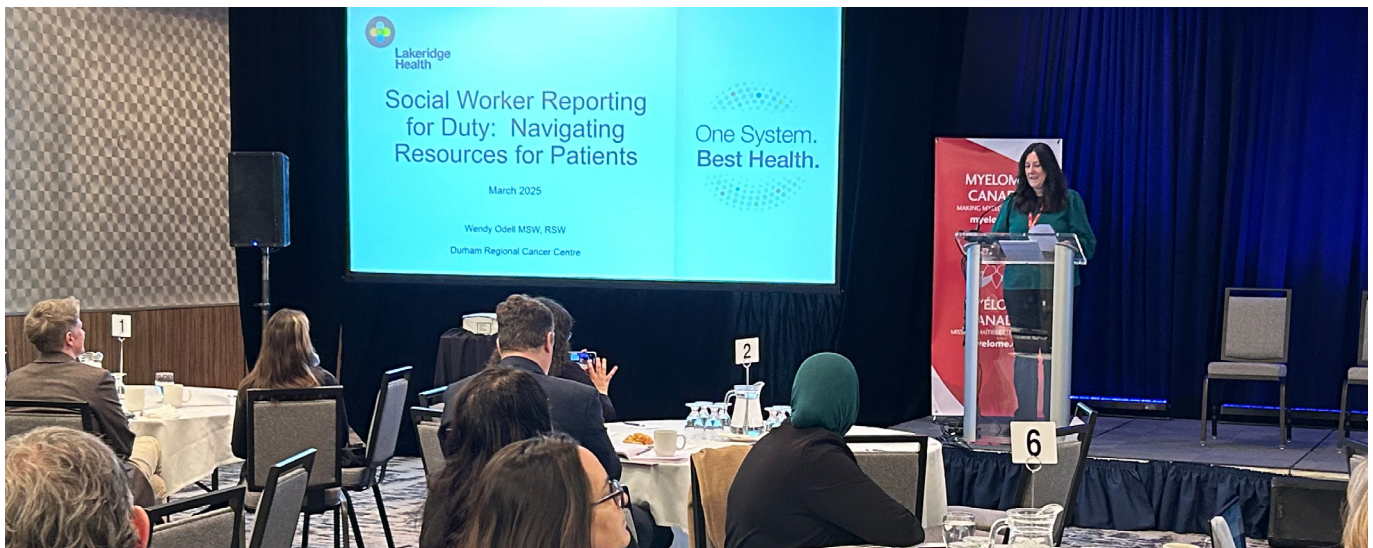
In addition, central to every proposal was the recognition that while many support programs and services already exist, they remain underutilized due to fragmented access and poor awareness. What is clearly missing is a comprehensive, system to tie everything together, providing both patients and healthcare teams with a centralized, trusted point of navigation support. Technology was positioned not as a standalone solution but as a set of tools to strengthen this human connection, streamlining workflows, consolidating fragmented resources, and enabling consistency across care settings. This service model entity (possibly a non-profit) would be funded by a blend of public, private, and philanthropic sources to operate flexibly across regions and beyond the limits of hospital budgets.

The level of convergence across proposals suggests that trial navigation services, if appropriately structured and supported can be delivered in ways that are both feasible and scalable within Canada's healthcare system.

The outputs of this workshop now provide a credible foundation for next-phase planning that will begin by defining the scope of the proposed navigation model, outlining its core functions, service components, and key points of service delivery. This will be followed by the establishment of working partnerships with trial sponsors, research organizations, trial coordinators, healthcare teams, and hospital administrators to support implementation within a micro-environment and ensure smooth integration between clinical sites and the navigation service.

A feasibility analysis will be conducted to assess site readiness, operational alignment, and stakeholder engagement. In parallel, the team will scope and develop the necessary technology tools to support navigators in their roles. Finally, a real-world pilot will be launched to test the model in practice and identify opportunities for refinement and broader application.

These steps will be further defined and led by Myeloma Canada and its partners, in alignment with strategic priorities, available resources, and collaborative input. The ultimate goal of the next phase is to demonstrate feasibility, value, and adaptability across diverse healthcare settings in the real-world, laying the foundation for broader, sustainable integration into the Canadian healthcare system.



Persona and setting



Sam from Emerald City Cancer Centre

Sam's setting

Emerald City Cancer Centre is **mid-sized** and serves a population from an array of different cultural backgrounds and beliefs, with varying degrees of second language understanding. Often, patients have **limited community support** and/or comprehension difficulties, leading to increased anxiety and fear. Although the **centre offers some clinical trials, support resources are finite.**

Sam's story

Sam moved to Canada with family 1 year ago to settle down in Emerald City. Being new to the country, Sam is learning a new language. Although mostly conversational, there is a **struggle to understand complex terms.**

A few weeks ago, Sam was diagnosed with a blood cancer, and was referred to a specialist for follow up. With limited understanding of the second language, comprehension of the disease and treatment options are challenging, not to mention the **increased anxiety of navigating the healthcare system in a new country**, with no community or supports.

Sam's doctor would like to propose a new bispecific antibody clinical trial that has just become available at the centre; however, not only is Sam **leery of taking part in an experimental study**, but **culturally, discussions around cancer are often taboo** (stemming from stigma and fears of misfortune, which limit open dialogue and support-seeking) in Sam's community.

Systemic challenges

- Mid-size Centre with fewer support services
- Limited resources in language supports and cultural competencies

Sam's challenges

- Language
- Cultural background and community
- Fear
- Lack of support

Where can Sam and the healthcare team turn to for support and resources?

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Robin from The 'Burb

Robin's setting

The hospital in The 'Burb is a **decent size cancer centre with good supports** in place; however, **clinical trial offerings are somewhat limited** at the centre. Trust with the healthcare team is an important factor in patient care and the fear of the unknown can pose a challenge for patients considering a trial.

Robin's story

Robin, from The 'Burb, was recently diagnosed with an incurable blood cancer with limited treatment options. Robin's doctor recommends a new CAR-T clinical trial that has just opened; however, **Robin's community has not had good experiences with the medical system** and experimental treatments make them nervous. Many do not feel in a safe space at the hospital, and often feel discriminated against by the system. Generally speaking, there is a **large lack of understanding and disconnect between the healthcare system and the needs/beliefs of the community.**

Although Robin and their doctor have built a good relationship, the trial being proposed is not available in The 'Burb. This means, the **treatment would be given at another centre**, and healthcare would be provided by someone new while on trial. Robin feels powerless and vulnerable, starting over in an unfamiliar setting under the care of someone new.

Systemic challenges

- Smaller centre with fewer support resources
- Limited cultural/community competencies
- Complex logistics coordination with another research centre and team
- No contact with research centre's support services

Robin's challenges

- Trust/Fear
- Historic cultural/community injustices and inequities

Where can Robin and the healthcare team turn to for support and resources?

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Persona and setting



Drew from Greater Metropolis Area



Drew's setting

A **large cancer centre** in the Greater Metropolitan Area (GMA) **offers various clinical trials**. Complex trial protocols and frequent visits to the hospital, for patients facing financial toxicity or have limited support, can be challenging.

Drew's story

Drew lives in the GMA, **does not have any caregivers or supports**, and does rotational shift work for a living. Currently treated for blood cancer at the large cancer centre, Metropolis General Hospital (MGH) and up until this point, the treatment plan has been an all-oral regimen with quarterly follow ups at the hospital for bloodwork.

Managing treatments and medical appointments have been doable to date, and Drew has been able to keep working, earning just enough to support the rising cost of living, which has been a struggle as of late. **Frequent medical appointments are difficult due to unpaid time off** and cost of traveling to the centre.

With cancer numbers progressing, Drew's doctor is exploring bispecific antibody clinical trial options at MGH, and although the trial sounds hopeful, **frequent visits during traditional business hours, transit costs and increased living costs are just not possible**.

Systemic challenges

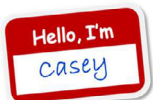
- Complex trial protocol requirements
- Traditional business working hours for staff
- Scheduling many appointments with various departments
- Located in an expensive Metropolis (parking/transit costs are elevated)

Drew's challenges

- Financial toxicity
- No support system
- Work requirements

Where can Drew and the healthcare team turn to for support and resources?

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Casey from Never Never Land



Casey's setting

A **small community cancer centre** in Never Never Land treats patients for various diseases, however it **does not offer clinical trials locally**. Being a small centre with very limited resources, the centre can refer patients to larger centres if/when clinical trials become an option, but it's often too cumbersome for patients to partake.

Casey's story

Casey lives Never Never Land, with a partner and young children, and is the sole breadwinner of the family. Diagnosed with a blood cancer, Casey has been receiving ongoing treatment at the local cancer centre. Although cumbersome, visits to the hospital and treatment schedules have been mostly manageable.

Recently, Casey's doctor, has noticed some signs of disease progression and is evaluating the next course of action. A new and promising CAR-T clinical trial is available but would **require Casey to travel to Atlantis to receive treatment** over an extended period (i.e., one month) and **the protocol also requires a full-time caregiver** throughout this duration. The process also requires frequent blood work in Atlantis, periodic scans, and ongoing follow up.

Taking a long-term leave from work or retiring is not an option. Moving to Atlantis is not an option and travel to treatment would require Casey to take off work, along with a caregiver. The healthcare team are willing to do what they can to help with the limited resources they have.

Systemic challenges

- Small community centre with limited resources
- Limited support services
- Complex logistics coordination (research centre and team)
- No contact with research centre support services
- Complex trial protocol requirements

Casey's challenges

- Geography/travel to treatment
- Financial toxicity
- Limited support system

Where can Casey and the healthcare team turn to for support and resources?

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Detailed methodology for rounds 1 to 3

Round 1 – Grounded design (build Your solution)

Materials used: form 1 (ideation template, not collected)

In the first round, each team was assigned a single persona (e.g., large urban hospital, rural clinic, regional cancer centre). Teams were tasked with designing a pre-trial navigation support service that would address non-medical barriers impeding trial access for that persona, all while operating within existing healthcare system constraints.

The explicit constraints were:

- No changes to trial eligibility, protocols, or site infrastructure.
- Solutions must be realistic, fundable, and executable within current healthcare workflows.

Teams were prompted to consider:

- What barriers is this patient persona facing logistically, emotionally, and financially?
- What forms of upstream support would meaningfully reduce those barriers?
- Who in the healthcare ecosystem (e.g., social workers, navigators, PSP reps) could deliver the intervention?
- What resources, tools, or partnerships would make this work?
- How could this service fit into existing care pathways without duplicating efforts?
- What might a sustainable funding model look like?

Facilitators played an active role in guiding teams beyond surface-level solutions. They asked targeted questions to help teams avoid defaulting to familiar strategies or narrowly clinical fixes. The aim was to anchor innovation in lived experience and systemic realities, not in theoretical idealism.

Outcomes of this round included early-stage service models, described in terms of:

- Patient flow and engagement strategy.
- Types of support offered (e.g., logistical, emotional, financial).
- Touchpoints across the patient journey.
- Roles and responsibilities of implementing staff.
- Assumptions requiring validation in later stages.

Teams worked on large-format worksheets but were not asked to submit their designs at this stage. The focus was on creativity, feasibility, and patient-centered logic.



Round 2 – Stress testing (apply your model to a new persona)

Materials used: form 2 (assessment form, submitted)

In Round 2, each team was assigned a second persona. The objective was to test the adaptability and inclusivity of their Round 1 solution. Teams had to determine whether their proposed navigation model could hold up when applied to a different patient profile with distinct barriers, contexts, and priorities.

Evaluation criteria included:

- **Relevance:** What elements of the original design still work?
- **Gaps:** What aspects no longer serve the needs of this new patient?
- **Adaptability:** What would need to be modified or expanded?
- **Scalability:** Can the model stretch across multiple patient types and care environments?
- **Equity impact:** Does the solution unintentionally exclude anyone?

Facilitators introduced new reflective prompts to push deeper thinking:

- “What happens to your model in a low-resource or remote setting?”
- “If your patient doesn’t speak English or French, does the design still function?”
- “How might trauma or cultural mistrust shape this patient’s response to the service?”

This round emphasized systems-awareness and inclusivity over ingenuity. Teams were challenged to view their models through multiple lenses, not just of the patient, but of institutional readiness, policy friction, and frontline implementation.

Each team completed Form 2, a structured evaluation worksheet. These forms were collected and analyzed to surface common stress points across models, contributing to synthesis later in the day.

Introducing the taskforce: a deliberate disruption

Following Rounds 1 and 2, and just as teams returned from the lunch break to begin final refinements, they were presented with detailed written feedback from a so-called “Taskforce”. The identity of this group was intentionally withheld until after all final proposals were submitted.

In reality, the Taskforce was ChatGPT 4.5, a large language model developed by OpenAI. Prior to the workshop, the platform was pre-loaded with the design brief, workshop objectives, and evaluation criteria. Once all teams completed their worksheets, these materials were uploaded into ChatGPT, which was used to assess alignment, surface potential gaps, and generate prompts for reflection on feasibility, scalability, and equity.

AI’s role: grounding, not generating

Unlike typical applications where AI is prompted to ideate, its use was limited to helping teams stay aligned with the original design criteria.

The AI taskforce assessed:

- How well the solution addressed non-medical barriers.
- Alignment with the assigned healthcare setting and persona.
- System feasibility and service-level specificity.
- Readiness for adaptation across diverse contexts.

The objective was protecting integrity, ensuring that teams stayed true to their challenge brief and persona realities.

What the AI taskforce was asked not to do:

- It did not generate solutions or creative content.
- It did not intervene in team dynamics or decisions.
- It did not simulate human roles or relationships.

Instead, it helped surface blind spots, pushed for coherence, and reminded teams to ground their designs in real constraints.

The teams were not told who comprised the Taskforce or how it was analyzing their work, and the ambiguity was intentional. The goal was to protect the creative integrity and psychological safety of the teams during ideation, while still introducing external friction, which is a necessary condition for testing whether ideas could stand under scrutiny.

The Taskforce feedback focused on:

- **Structural Weaknesses:** Where the model might break down under stress.
- **Equity Blind Spots:** Who might be unintentionally excluded or underserved.
- **Feasibility Concerns:** Which design elements might be unrealistic within current systems.
- **Overlooked Trade-offs:** Unintended consequences of well-meaning choices.

This process revealed which teams had designed with system-wide resilience in mind and which had unconsciously recreated known patterns of exclusion or inefficiency.



Round 3 – integration & final synthesis

Materials used: form 3 (final proposal form, submitted)

Structure: Teams merged into 6 new groups

In Round 3, the original 12 teams were merged into 6 larger, multidisciplinary groups, with each new team now integrating:

- All four patient personas (and their full barrier profiles).
- Two preliminary service designs from Round 1.
- Two Round 2 stress tests.
- Taskforce feedback.

Each merged team was asked to synthesize these inputs into a single, unified pre-trial navigation support service that could address the needs of all four personas and function across multiple healthcare environments. The focus was shifted towards refinement, convergence, and system-readiness.

Teams were guided to:

- Compare and contrast their two service models.
- Identify overlapping principles or irreconcilable elements.
- Make deliberate trade-offs between complexity and clarity.
- Develop a logic model or delivery pathway that was both scalable and sustainable.
- Ensure the proposed solution maintained core equity commitments and patient-centered logic.

The final deliverable was captured in Form 3, which structured each team's submission around the following questions:

- What is the specific problem your model addresses?
- What does your support service consist of (roles, timing, delivery)?
- How does it solve the barriers faced by both assigned personas?
- How it is fundable, scalable, and ready for real-world testing?

PHASE 2

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