THE UNIVERSITY OF BRITISH COLUMBIA
Office of the Vice-President, Health
UBC Health

BREATHE & WEAVE: TALKING ACROSS SILOS TO ENABLE HEALTH SYSTEM IMPROVEMENT

Report from the BC Health Summit

March 2023

health.ubc.ca

ACKNOWLEDGEMENTS

UBC Health would like to acknowledge its partners and supporters in convening the Breathe and Weave health summit: members of the BC Health Systems Partnership, Rural Coordination Centre of BC, BC Patient Safety and Quality Council, UBC Health Council, UBC Health patient partner Darren Lauscher, and Cheryl Mitchell from the University of Victoria. Event photography was taken by Paul Joseph from UBC Brand and Marketing.

We acknowledge that the two main campuses of the University of British Columbia are located on the traditional, ancestral, and unceded territories of the xʷməθkʷəy̓ əm (Musqueam) and Syilx Okanagan Nation. We also recognize that UBC's activities take place in community on the unceded, ceded, and traditional territories of 203 First Nations and 38 Métis chartered communities. Each possess their own unique traditions and history on the land that we refer to as British Columbia, and we acknowledge the traditional guardians and caretakers of these territories.

INTRODUCTION

The Breathe and Weave: *Talking Across Silos to Enable Health System Improvement* health summit took place over three sessions on January 23, 26 and 30, 2023 to gather people from diverse roles, sectors, and regions across British Columbia to discuss shared priorities for improving BC's health system and how working together could be better enabled across the system.

The sessions aimed to enable people to communicate and coordinate more effectively across organizational boundaries. We can have greater impact collectively when we understand where our interests overlap and how our efforts affect each other.

The health summit was the first opportunity in recent years to meet specifically for intersectoral dialogue about health and healthcare in BC in the broadest sense with such a large scale of people, regions, and sectors participating.

HIGHLIGHTS

201

Participants on Jan 23

156

Participants on Jan 26

146

Participants on Jan 30

54

Facilitators of discussion groups

5

BC Regional Health Authorities represented

PURPOSE OF THE SUMMIT

The summit was a step to heighten common understanding, shared purpose, and collective action. It was not intended to achieve this aim through a standalone event but rather to develop connections that could build through continuing conversations to generate those outcomes.

Furthermore, the summit was not intended to generate recommendations for systemic changes to be achieved by people outside the summit. Rather, the intent was to facilitate dialogue and create opportunities for participants to work with others around the table and increase synergy across organizations, regions, and sectors.

The summit was intended to enable participants to interact with others in ways that could help shape their own actions.

Specifically, the summit aimed to:

1. enable participants to learn from each other about improvement efforts happening in BC;
2. identify areas/aspects of the system where there was potential to expedite and accelerate these efforts overall; and
3. reveal more opportunities for coordination and collaboration to increase positive impact.

A broad range of participants was invited from healthcare policymakers, administrators, providers, community members, academics, and partners from other sectors (such as industry, not-for-profit organizations, and other organizations interested in health), and from many levels of authority (such as leaders from grassroots efforts, clinical care settings, and provincial organizations).

BASED IN PARTNERSHIP

The BC Health Systems Partnership (convened by UBC Health) identified the need to create this space for dialogue to support collaboration across regions and sectors. UBC Health plays a non-partisan convening role to contribute more expansively in sector leadership and advocacy for positive change given the complexity of health systems. UBC Health had convened the BC Health Systems Partnership, which includes policymakers, health authorities, health professionals, researchers, and diverse community partners to identify and determine how to address urgent provincial issues.

> One of the things I've heard in all the discussions so far has been the importance of alignment, and all working together toward a common goal. Focusing on one or a couple of things and having those priorities be shared across networks has been identified as crucially important. I think we saw the power of establishing shared purpose during the pandemic, and it's something that is coming through as continuing to be essential moving forward.

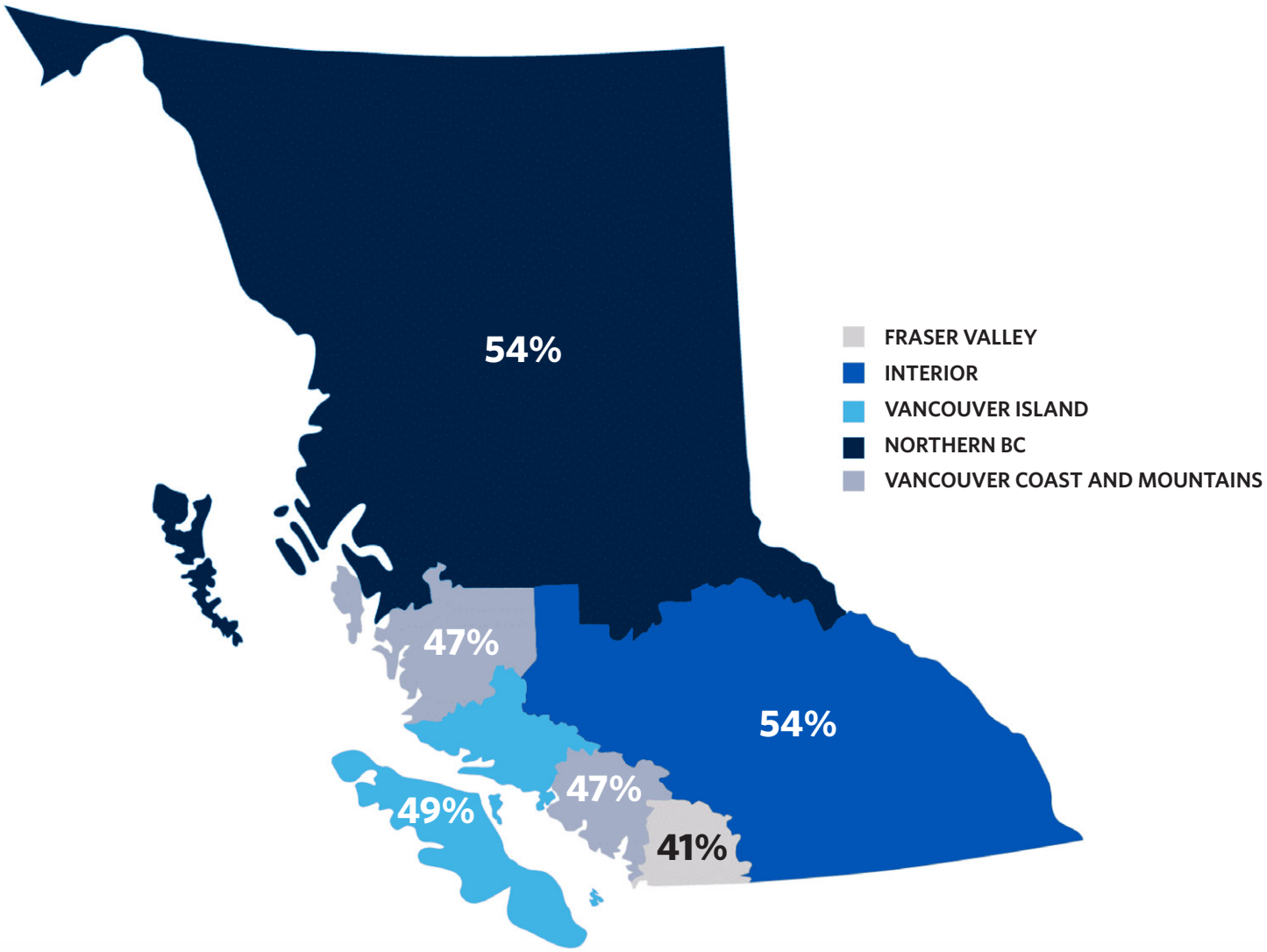
Breah Talan, Director, People & Strategy, BC Patient Safety and Quality Council

WHAT TOOK PLACE IN THE SUMMIT

NUMBER OF PARTICIPANTS

Partnership perspective	Jan. 23	Jan. 26	Jan. 30
Academic	26	20	15
Community Member	18	17	17
Health Administrator	78	59	53
Health Policymaker	22	13	17
Health Provider/Professional	33	26	26
Linked sectors	24	21	18
TOTAL	**201**	**156**	**146**

PARTICIPANTS' REGION(S) OF FOCUS, SHOWN AS % OF ALL PARTICIPANTS



** Participants reported region(s) of focus at registration, and could identify multiple regions

FACILITATORS OF DISCUSSION GROUPS

Discussion groups in the health summit were facilitated by 54 facilitators from a range of backgrounds and organizational affiliations. UBC Health extends sincere gratitude to the BC Patient Safety and Quality Council, Rural Coordination Centre of BC, and health-focused departments at UBC for engaging and supporting facilitators to take on this role at the event.

ORGANIZATIONS PARTICIPATING

AgeCare
AiMHi Association for Community Living
Alberni Clayoquot Health Network
Bayshore Healthcare
BC Association of Kinesiologists
BC Care Providers Association
BC Centre on Substance Use
BC College of Family Physicians
BC Health Care Matters
BC Hepatitis Network
BC Patient Safety and Quality Council
BC Psychological Association
BC Public Service
BC Rural Health Network
BC Society of Laboratory Science
British Columbia Therapeutic Recreation Association
Buron Healthcare
Canadian Association of Midwives
Canadian Association of Occupational Therapists
Cascade Effect Consulting
City of Vancouver
Coast Mental Health
College of New Caledonia
College of Pharmacists of BC
College of Physicians and Surgeons of BC
Comox Valley Counselling
Council of Canadians
Doctors of BC
DSI Strategy & Engagement
Eagle Valley Community Support Society
East Shore Kootenay Lake Community Health Society
EngAge BC
Family Practice Services Committee
Federation of Community Social Services of BC
First Nations Health Authority
Fraser Health
Fraserside Community Services Society
Global Women in STEM
Greater Vancouver Community Services Society
Insight Anti-Racism Coaching Services
Institute for Personalized Therapeutic Nutrition
Interior Health
Island Health
Kamloops Society for Alcohol and Drug Services
KinVillage Association
Louis Brier Home and Hospital
Marineview Housing Society
Metis Nation British Columbia
Michael Smith Health Research BC
Midwives Association of BC
Ministry of Advanced Education and Skills Training
Ministry of Health
Ministry of Post-Secondary Education and Future Skills
Musqueam Indian Band
Northern Lights College
Northern Health
Nurses and Nurse Practitioners of British Columbia
Office of the Seniors Advocate
Pacific Coast Health Services
Patient Voices Network
Physician Health Program
Providence Healthcare
Provincial Health Services Authority
Provincial Infection Control Network of BC
Qathet Division of Family Practice
Resolutions
Rural Coordination Centre of BC
SafeCare BC
Seabird Island
Simon Fraser University
South Island Hospitalists Inc.
Squamish Nation
TLC Pain Management-Vernon
Trillium Communities
Tsow-Tun Le Lum Society
Union of BC Municipalities
University of British Columbia
University of Northern British Columbia
University of Victoria
Vancouver Coastal Health
Village of Lumby
Village of Tahsis

THE SUMMIT'S PROCESS AND THE DISCUSSION GROUPS

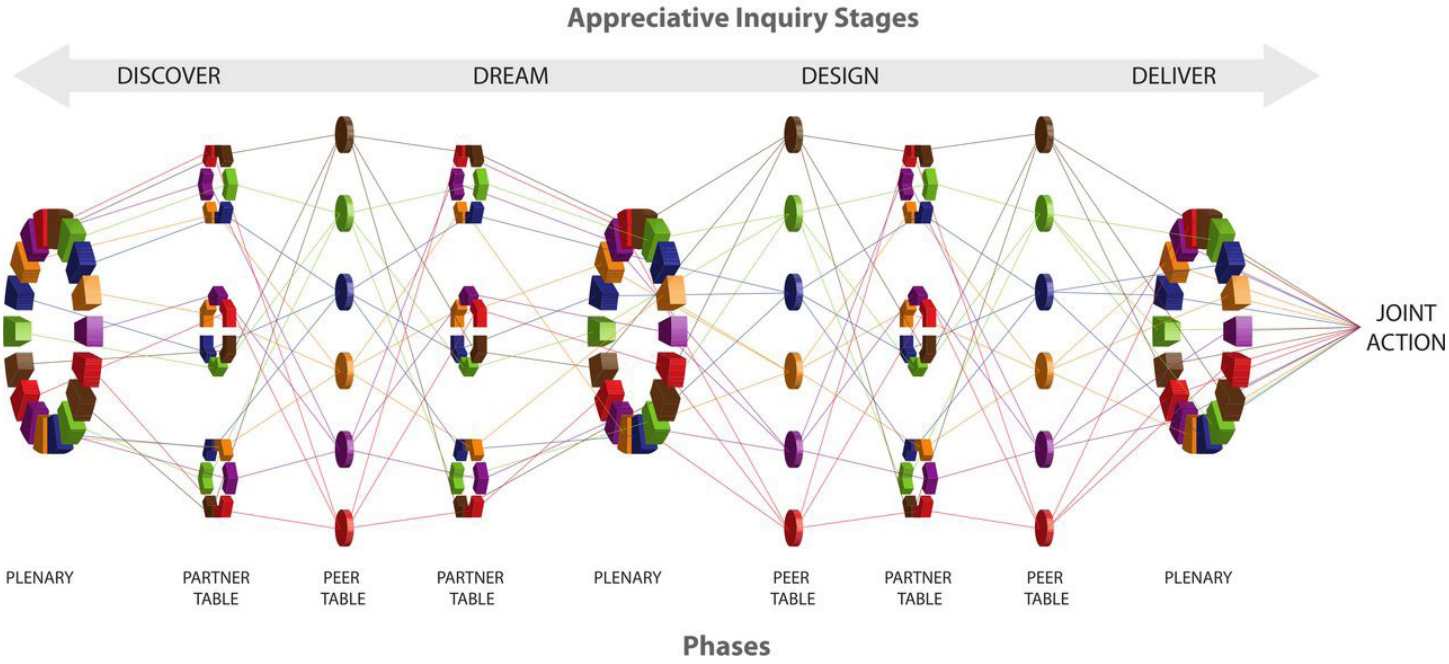
Participants were arranged into discussion groups based on a series of questions. The questions were oriented to develop connection and mutual understanding about perspectives and priorities for health and healthcare in BC and to identify intersecting interests that would enable participants to combine and concentrate their power to make improvements and take more collaborative action. These discussions were interspersed with plenary speakers and panels to stimulate discussion and explore points of greater consensus.

Discussion groups were formed into two configurations over the course of the event:

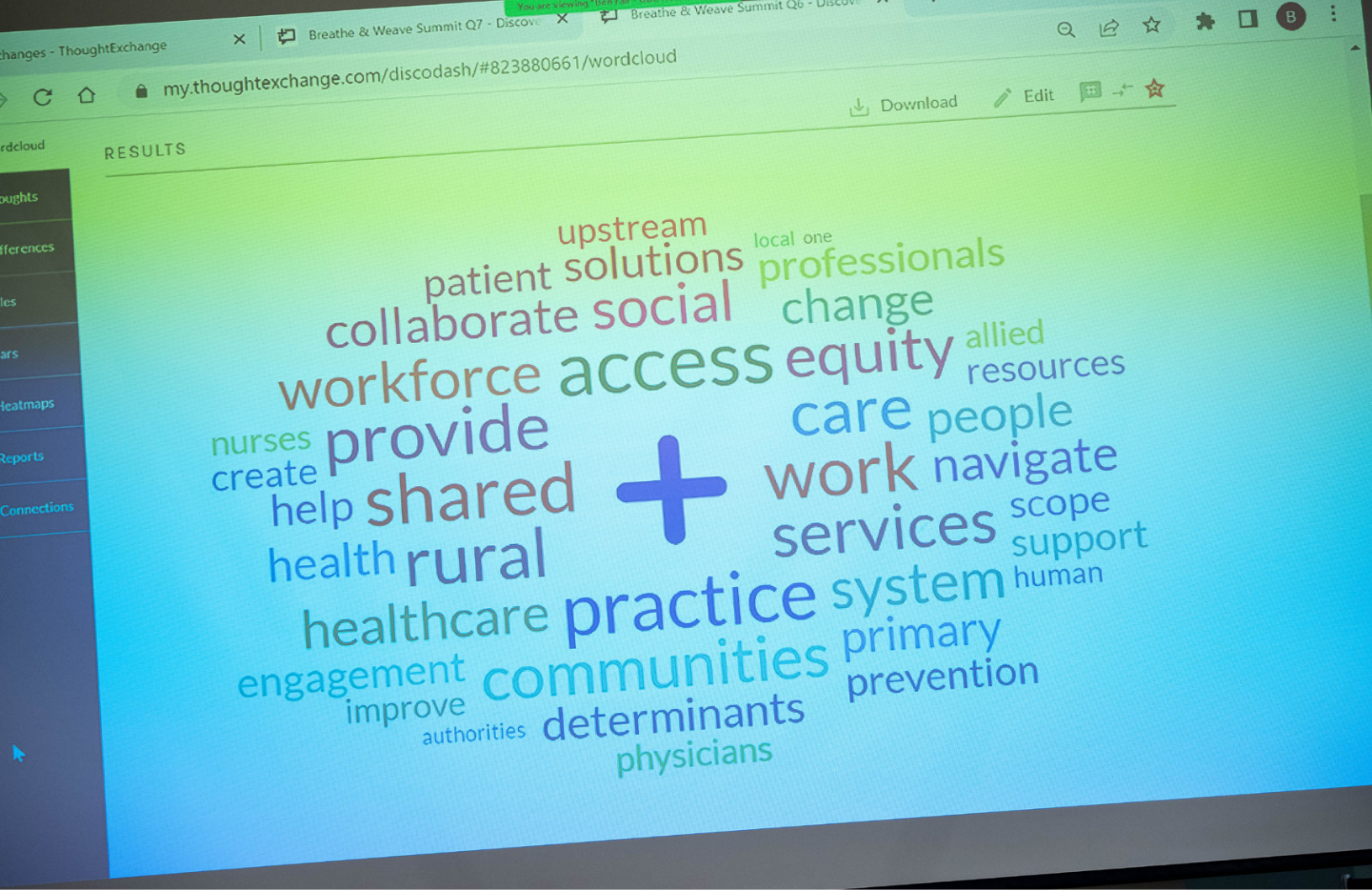
- **Partners** – people from all categories of the Partnership Pentagram Plus
- **Peers** – people from a single category of the Partnership Pentagram Plus

The summit's process was similar but not identical to the dialogue-based process shown in the diagram below.

Breathing & Weaving



** Image used with permission from Rural Coordination Centre of BC



Thoughts from discussion groups were documented in ThoughtExchange, an online engagement platform designed to gather participant thoughts and ideas.

The ThoughtExchange platform enabled participants to:

1. respond anonymously with brief thoughts to the question for discussion;
2. read thoughts shared by other participants and rate how much each one resonated (on a five-star scale); and
3. view the results and explore the thoughts and how they were rated.

After each discussion, participants were invited to add their own thoughts and engage with the thoughts from all discussion groups to identify which thoughts resonated most with participants overall.

THEMES FROM THE DIALOGUE

Discussion groups and individual contribution of thoughts resulted in more than 1,800 statements documented.

Among these thoughts and in the feedback from participants, a prevalent theme was the value for participants of coming together for dialogue with people from different roles, sectors, and regions of BC. Below are a few examples of participants' statements.

ON CONVERGING FOR DIALOGUE: WHAT NEEDS TO CHANGE? WHAT COULD HELP MAKE THE CHANGE? WHAT OPPORTUNITIES WOULD YOU TAKE?

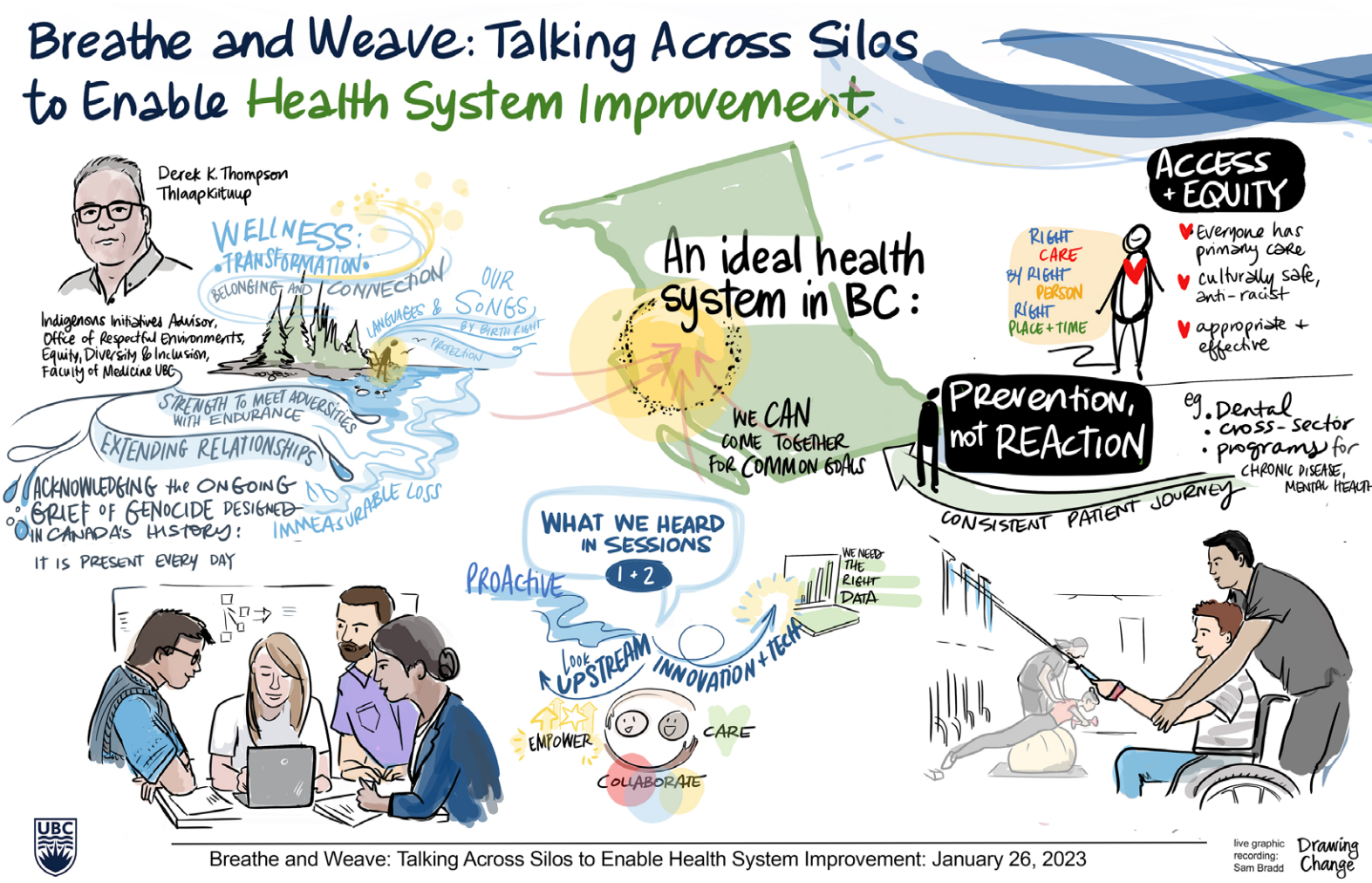
- Networking across silos, collaboration, developing communication, sharing, collaborating.
- Open and honest conversations about the current provision of care and limitations within our existing system. We must first recognize where and when we are not providing optimal care in order to move forward.
- Collaboration and knowledge sharing across Health Authorities at lower levels of the organization. Some innovations can only come from the bottom-up because that is where the rubber hits the road.
- Leaders need the capacity and time to have in-between conversations to have the system moving and facilitate the same across sectors.
- Enable people to share success in their sectors of work, without restrictions of permission, builds effective communities of practice.
- More time and support for networking and collaboration to establish relationships; A better process for collaboration.
- Make relationships a priority so we can work together and move things forward; breaking down silos that prevent people from connecting.
- These types of tables and discussions need to be ongoing, not just one-and-done. There needs to be accountability and commitment to action.
- Connection across sectors to improve care. Connect and learn from each other inside and outside of health.
- Ensuring that we support and help accelerate meaningful dialogue in the health system.
- Share learnings from this summit with colleagues, community and families, to have more conversations like it that lead to hope.
- Continue the conversation and expand the networks that developed during the summit, and call for wider community participation in dialogue like this from across BC.
- Look for opportunities to share innovative projects and lessons learned more broadly across the province.

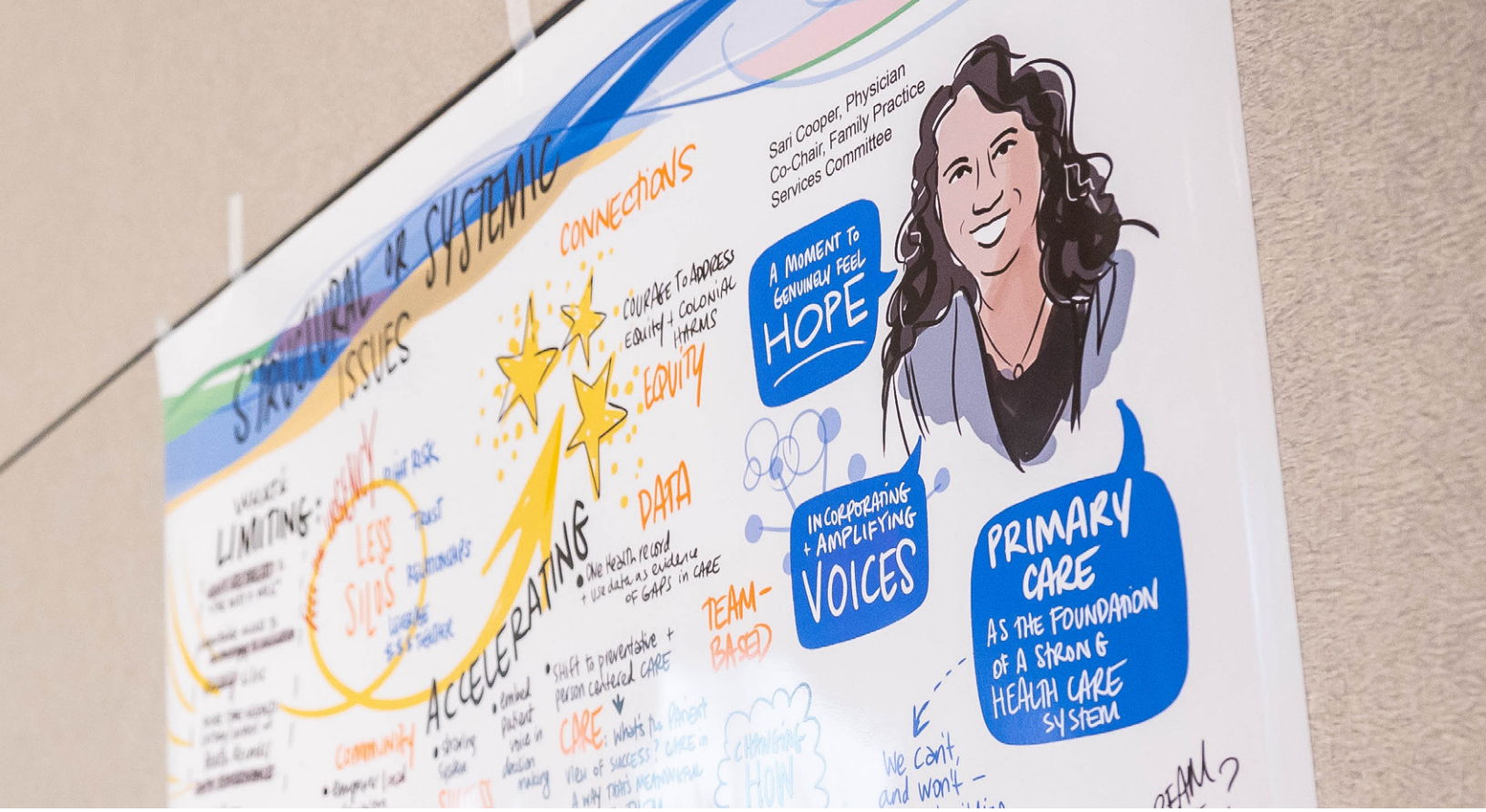
For the last three years, the system has been under a tremendous amount of stress, trying to get through all the challenges of COVID and all the ripple effects. The beautiful part about this conference is to come together in person again and to just pause and think a little more distant into the future. Think a little more at a system level and talk with colleagues that have learned a lot in the last few years.

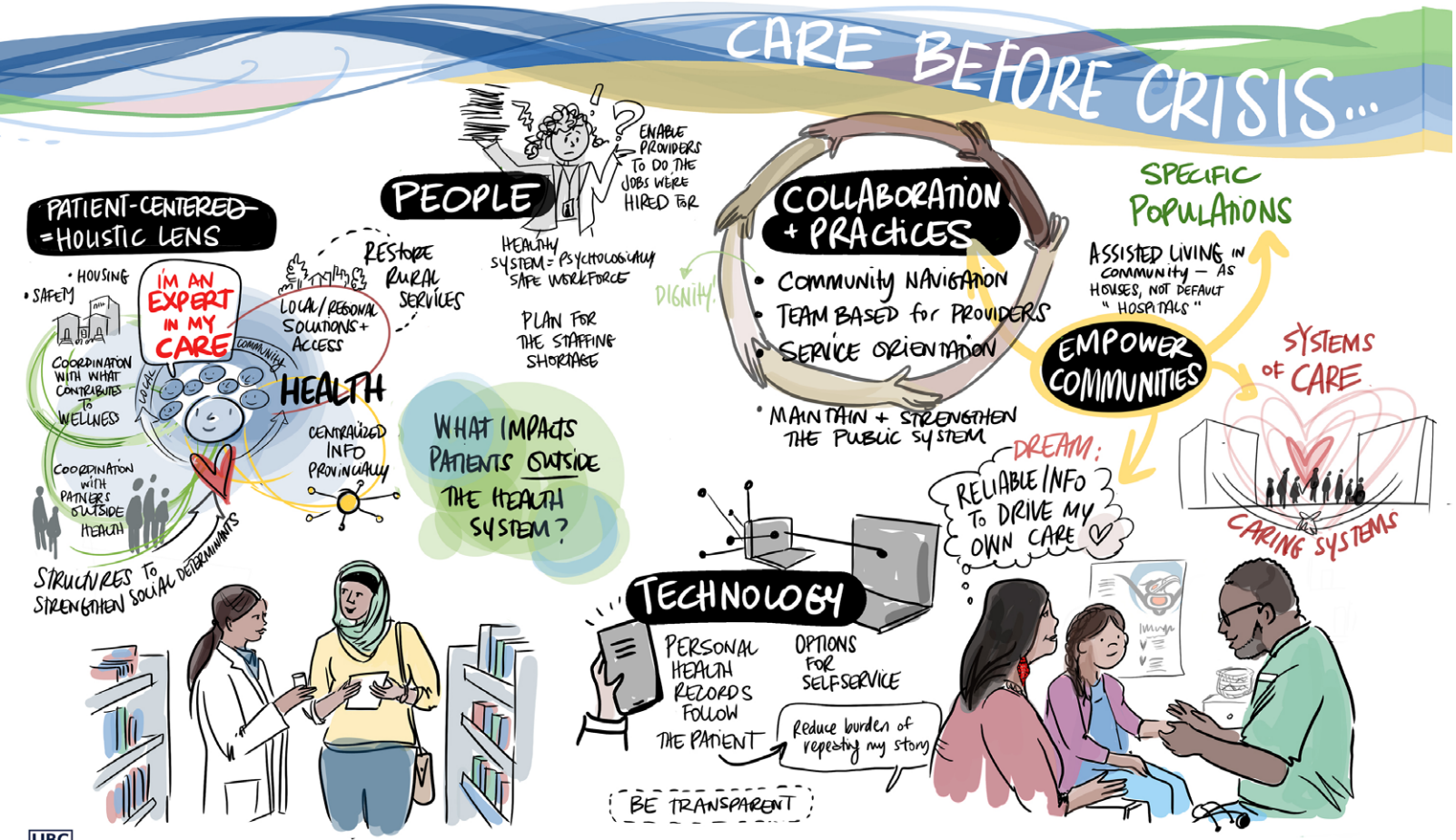
Gregory Marr, Senior Operating Officer, Northern Health

The January 26 session of the summit focused on points of common vision among participants for ideal health and healthcare in BC. A visual reflection was created from those discussions, based on listening to the breakout room dialogue and the notes recorded in all the groups during the session.

GRAPHIC RECORDING OF THE SUMMIT SESSION ON JANUARY 26

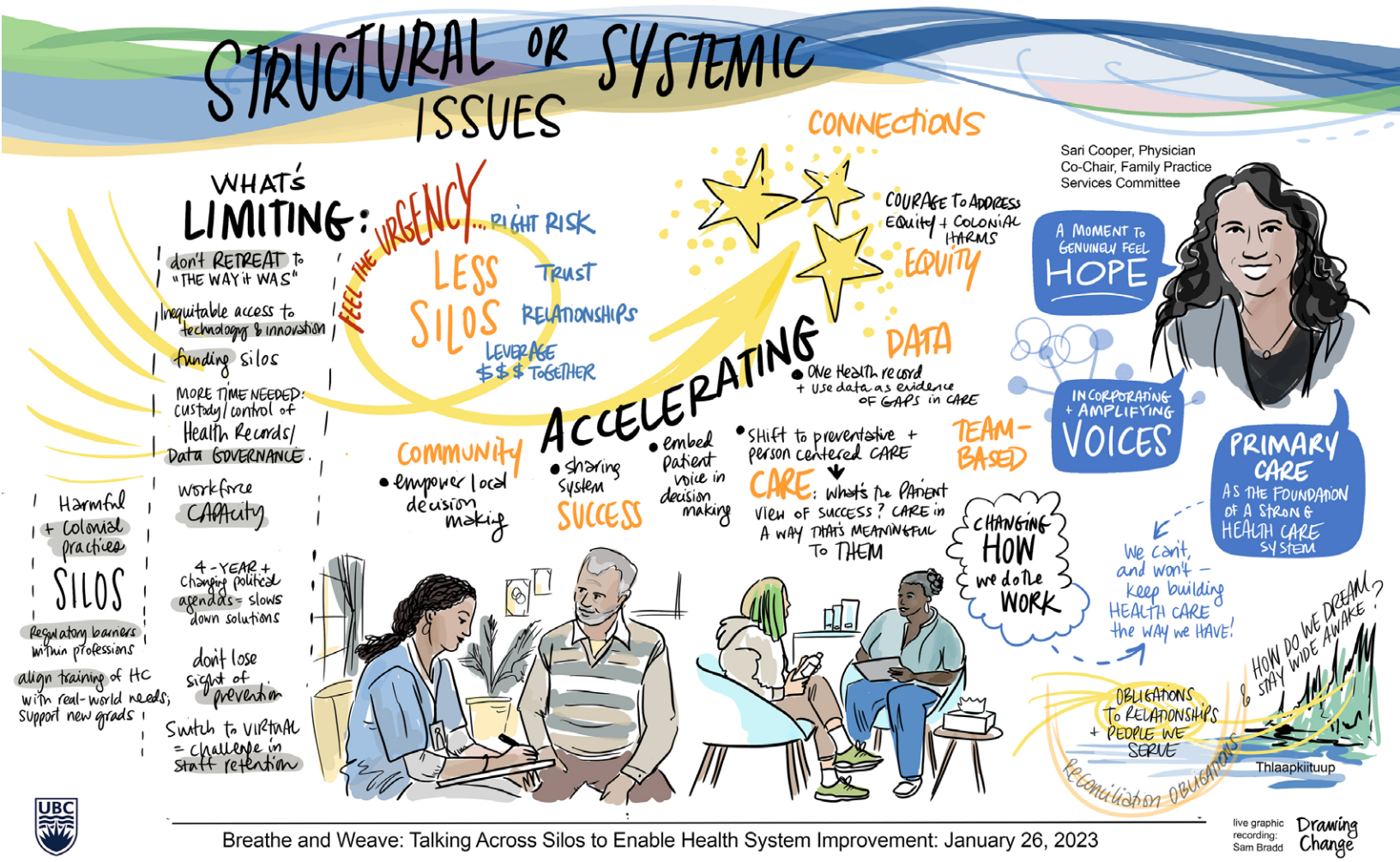






Breathe and Weave: Talking Across Silos to Enable Health System Improvement: January 26, 2023

live graphic recording: Sam Bradd Drawing Change



Relationship could become a prominent theme. People are looking forward to "What can we do in the future?" They see both the short-term and recognize that the relational work takes a long time and may not be seen for five to 10 years. But there are examples that are happening that will take us forward.

Martha MacLeod, Adjunct Professor, University of Northern British Columbia

MOST FREQUENT THEMES

Across all of the summit's sessions of dialogue, the following themes emerged most frequently:

Access	Health and wellbeing of care providers and staff
Accountability	Health beyond healthcare
Community activation	Healthcare teams and working interprofessionally
Digital enablers, technology, and health data	Innovation, risk, and scaling up
Education and training	Recruitment and retention
Equity	Silos and collaboration

Appendix A shows thoughts that were identified as resonating most with participants in each of these areas.

NEXT STEPS

Following up the health summit, UBC Health will continue to advocate for and help to develop capacity for positive change in health by working with health sector partners across BC to enable dialogue, activate assets, and advance policies and innovations to improve health systems at individual and community levels.

UBC Health has identified its own strategic actions related to the following themes arising from the summit:

- Silos and collaboration;
- Healthcare teams and working interprofessionally;
- Education and training;
- Community activation; and
- Equity.

UBC HEALTH WILL UNDERTAKE THE FOLLOWING STRATEGIC ACTIONS:

- Facilitate further discussion among health summit participants around prevalent summit themes to foster understanding and collaborative action.
- Catalyze and support health-focused, interdisciplinary, inter-organizational research collaborations to address the increasingly complex and interconnected health problems facing society and advance interdisciplinary health research and knowledge translation.
- Increase the number of graduate students working to impact health equity within local, national, and global health systems by enabling them to engage in research that extends beyond the academy and traditional disciplinary approaches to impact the public good through collaborative, action-oriented, and creative forms of scholarship
- Provide spaces for community members and health sector partners to connect with UBC researchers.
- Support information-sharing and knowledge generation in team-based care (TBC) by growing the TBC@UBC Network, a dialogue-focused forum for people from diverse sectors and roles to discuss and learn from each other about the on-the-ground needs, opportunities, and challenges regarding TBC design, research/evidence, pedagogy, policy, and integration.
- Integrate team-based training across the health professional programs at UBC to ensure graduates are prepared for evolving models of practice.
- In collaboration with care providers, develop educational tools and resources to support clinicians across BC to deliver practice education to learners in team-based care approaches.
- Support the development of interprofessional teams and clinical spaces dedicated to evaluating and refining models of evidence-informed, interprofessional practice education for team-based primary care.
- Bring patient and community voices into the education of students in health and health-related disciplines to promote a partnership model of healthcare.
- Facilitate patient and community involvement in collaborative health education, research, and systems transformation.
- Develop educational programming focused on pressing health and social challenges facing BC communities, such as the worsening overdose crisis.
- Support training that prepares future healthcare professionals to provide quality, culturally safe care, ultimately leading to improved health outcomes for Indigenous peoples.

To take the conversation further towards more common purpose and collective action on themes from the summit, UBC Health will invite summit participants to identify the themes of greatest interest, and facilitate further discussion on the most requested themes. UBC Health will also ask summit participants to identify on what themes they want further information from the summit documentation, so that UBC Health can compile and circulate the most requested ones.

APPENDICES

UBC HEALTH

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APPENDIX A

MOST RESONATING THOUGHTS IN EACH THEME

Each statement in this table was documented in ThoughtExchange by a discussion group or individual participant during the summit or in the subsequent week. The number shown after each statement gives the score on a 5-point rating of resonance with other participants. After that number, there is a number in parentheses showing how many participants scored it.

In each round of discussion, most of the statements in ThoughtExchange received a similar amount of ratings, because ThoughtExchange evenly distributes the views of the statements among participants.

THEME	WHAT'S HAPPENING IN BC'S HEALTH SYSTEM THAT YOU WANT TO HAPPEN MORE?	WHAT WOULD YOU LIKE TO SEE IN AN IDEAL HEALTH SYSTEM IN BC?	WHAT WOULD NEED TO CHANGE IN THE REAL WORLD TO GET FROM WHERE WE ARE TO WHERE WE WANT TO BE?	WHAT OPPORTUNITIES DO YOU WANT TO TAKE ADVANTAGE OF? HOW WOULD YOU MEASURE SUCCESS?
TOP-RATED THOUGHTS	**Moving beyond an intense focus on acute care/hospital settings.** to move upstream in the system and greater focus on the community, prevention etc. 4.4 (16) **Great longitudinal primary and community care.** Keeps people out of hospital and in their home as long as possible. 4.2 (16) **Collaboration and relationships at many levels of health care** Focus on upstream relationships, community partnerships and prioritizing team based care 4.2 (15)	**Care in the right place by the right person at the right time** 4.3 (15) **Health system where each individual is treated as a valued human being** Respect, dignity and honour 4.2 (15) **Appropriate timely and equitable access to health care** Fundamental idea 4.2 (14)	**Health of our workforce and how we prepare future workforce (training and retaining)** Build mentorship, apprenticeship and practice experience into the program, job descriptions; healthier/more hopeful environments for people to land in 4.3 (10) **Improve public health literacy.** So the public knows where to access appropriate care (i.e., maybe not the ER) 4.2 (12) **Remove barriers of practice for clinicians (regulatory bodies and policy makers/ bylaws)** Encourage scope optimization and care delivery. Providing clinicians the agency to optimize care delivery and practice collaboratively 4.2 (12)	**Focus on cultural safety from an Indigenous perspective** 4.2 (13) **Advocate for Community/ patient advocates on ministry of health policy planning committees** the community and patients know the gaps in care from a unique perspective 4.2 (12) **Community-driven health care solutions in small communities is often innovative because rely on non-ideal resource settings.** Community-driven and bottom-up ideas can then be applied more broadly in the health system. 4.2 (12)

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ACCESS	**Greater access to care, particularly for primary care, and explore alternative approaches to address human health resources** 4.2 (15) **Improved access to primary care** The best entry point to the system 4.0 (16) **Healthcare access for remote nations** It threatens the greater system if we are not able to reduce the gap. 4.0 (15)	**Safe, equitable, timely access to primary health care - including virtual care.** If everyone can have access in a timely way to primary health care, that is safe, it will both improve health outcomes and reduce acute care costs. 4.2 (13) **Access to a primary care provider for all in BC** Currently lack of access to primary care which impacts people's health negatively. 4.1 (14) **Culturally safe, timely access to high level care of all levels for all people no matter what their culture, religion, race or orientation** Currently many people do not feel able and safe to navigate the various levels of our healthcare system 4.1 (14)	**Creating a better and safer working environment to reduce the burnout** Focusing on patient-centered approach to help them navigate on the system to access to resources available and to reduce the duplication 4.0 (11) **The use of technology has helped me as a patient but need more access across boundaries, need to teach more how to navigate technology** Helps me as a patient to have more control over my own health with having access to what is being said, the treatments being used etc 4.0 (10) **Bridge systems to make it easier for patients to access care and for staff to provide it** 3.8 (10)	**Connecting with other professionals to discuss opportunities to ensure patients get the support needed to navigate their healthcare needs** This is a barrier for many people that is taken for granted 4.1 (10) **Health care system navigator for health care providers/rural regional folks on where to go/ who to speak to in the system.** 3.9 (12) **Working together to find solutions to improve better access to healthcare for all Canadians** 3.8 (13)

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ACCOUNTABILITY	**Increased transparency in communication to re-build trust (was impacted greatly during and after pandemic)** We need there to be clearer communication to ensure there is trust between citizens and government, as well as being more aware of available services 3.5 (15) **Courageous leadership** Take into account the picture of the whole system so that we do the right thing 3.3 (1)	**Dream – transparency of policies and procedures so they are not 'discrete' across the province and slightly different (or not) in each HA** would reduce unwarranted variation and increase trust through transparency 3.5 (14) **Collective vision & alignment** Identification of what key health outcomes we are working to are (bringing transparency/ ability to create within that space) 3.5 (13)	**Decision-making should be a bi-directional** process to hear from communities, rather than a top-down approach from health authorities and government 4.1 (11) **Setting priorities, ensuring transparency and accountability.** Being able to believe the systems are fair, equitable, transparent and accountable. 3.7 (12) **Health can't be changed on an election cycle** Health systems cannot be rebuilt in 18 month election cycles and government mandates. 3.6 (3)	**Hold governments accountable for funding allocation, transparency on distribution, and how it was used. 4.1 (13)** **Take advantage of the fact that various levels of policy making government now realize and admit the current healthcare system isn't working.** This is the right place and time to bring about real and lasting change because all parties are finally on the same page and agree the time has come. 4.1 (12) **Transparency leading to accountability.** Our actions need to be able to be held to accountability at all levels from the patient to the CEO of a health authority to the very ministry. 4.0 (11)

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COMMUNITY ACTIVATION	**Rural community driven solutions be truly heard and implemented (when feasible).** It's important rural BC and its citizens be involved in deciding their own healthcare destiny. 4.0 (16) **Increase partnership to develop community care based programs** Successful programs are embedded at the community level 3.9 (15) **Involving patients and communities' members as part of the team, not just clinicians and health care providers.** 3.9 (15)	**Support-lines; support for caregivers; support for primary care providers** Take care of those providing care so the system is sustainable 3.9 (15) **A proactive system that encourages preventive and advocates for patient-centricity and responsibility.** People aka patients have to advocate for their own better health outcomes to bring about a cost effective system. 3.9 (13) **Efficiencies, data driven, team-based, patient and community involvement** patient health, healthier people, population knowledge, participation, and satisfaction, health care worker fulfillment, cost effectiveness, 3.8 (14)	**Rural BC community driven solutions be truly heard and implemented.** Rural BC communities are living their own healthcare and invariably come up with true 'boots on the ground' solutions. 4.1 (12) **Community involvement in system design – engagement to support growth and change** Provide agency to communities to support the changes required 3.9 (12) **Relationships are created at the community-level** Community ownership of their health creates led-responsibility that is sustainable (beyond government policy or funding changes) 3.9 (11)	**Advocate for Community/ patient advocates on ministry of health policy planning committees** the community and patients know the gaps in care from a unique perspective 4.2 (12) **Community-driven health care solutions in small communities is often innovative because rely on non-ideal resource settings.** Community-driven and bottom-up ideas can then be applied more broadly in the health system. 4.2 (12) **Building and leveraging staff and resources to organize community engagement events at the local level** 4.0 (13)

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DIGITAL ENABLERS, TECHNOLOGY AND HEALTH DATA	**Empower people to own their health and health information** 4.1 (16) **Commitment to radical change and system improvements** more technology implementation, human centred design, more flexibility and adaptability 4.0 (15) **Virtual options have created broader access to services/communication tools, have allowed for new ways of sharing information and connecting** Alternate ways of communication, access geographically, more efficient, and allowed us to be able to work together/reach people. Take learning forward. 3.9 (15)	**Health records and other tech systems need to be patient-centered, not provider centered** Records need to accessible by patients and by providers across the province to ensure providers have the necessary information to provide quality care. 3.9 (14) **Easy access and ownership of patient health information** To activate and empower patients and (their care teams) to better manage their care 3.9 (12) **Universal EMR.** So that people don't have to repeat their stories and their medical record is kept in a single instance. 3.8 (14)	**Creating a place where people can call to ask for help and connect with services regardless of whether they have access to digital technology** 4.0 (11) **Better data sharing and capture of data to aid in decision making from a system level to better access to patient level data.** 4.0 (10) **One medical record across the Province** Streamline communications for people as they travel or access care in multiple settings. 3.9 (10)	**Centralized health record system that everyone has access to, including the patient.** This will streamline the system and empower the patient to take ownership of their health. 3.9 (11) **Sharing successes of interventions that have worked** this will be done by first mapping out stakeholders that are relevant for the message and then create partnerships that drive care 3.8 (10) **Patient health empowerment to encourage uptake of self-services. Virtual care is continuing to develop. We need to commit to ensure that virtual services are People-centered to promote people access to health care** 3.5 (6)

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EDUCATION/TRAINING	**Building curriculum about team-based care into education at the academic level. Increase awareness of primary care networks and primary care initiatives.** Increase inter-professional understanding of each other's roles. 4.1 (14) **Connection and collaboration with community partners to fill gaps within our system.** Better meets need, empowers others, educates everyone, builds capacity. 4.0 (15) **Interdisciplinary approach to educate is successful.** Allows to increase the ability to educate quicker and more fully 4.0 (15)	**More public messaging and education** to keep people well and in their home community and out of acute care 3.9 (15) **More collaboration within education and training programs for future health care providers** 3.6 (14) **Upstream - education** How do we engage youth early on? Keep them in rural communities? encourage healthcare as a profession? 3.6 (14)	**Health of our workforce and how we prepare future workforce (training and retaining)** Build mentorship, apprenticeship and practice experience into the program, job descriptions; healthier/more hopeful environments for people to land in 4.3 (10) **Treat the healthcare workforce with care and compassion** This is the most important for sustainability and health of care....our people and the environment to train 3.9 (10) **Set up future rural medical students for success starting with K-12 education (access to appropriate courses for medical school admission)** 3.8 (12)	**Build health literacy into education curriculum starting from elementary school** 4.1 (13) **Change the clerkship and practicum training model towards longitudinal placements where students are spending longer periods of time in community** Early intervention to expose students to community placements 4.0 (12) **Create experiences where students can complete their practicum/residency in a rural community and receive virtual mentorship** If there is not enough mentors in place in rural and remote communities to support student training, we should utilize virtual avenues for placements 4.0 (11)

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EQUITY	**Expansions on supports for Indigenous health** Elevated services and cultural safety to improve upon Indigenous health; cost of not reconciling is the loss of lives, need to be meaningful 4.0 (16) **Increased awareness of the impact of racism on the health care system, the priority that needs to take, and actions articulated in "In Plain Sight"** Awareness is good step, but opportunity now is on operationalizing it across the health system (which has been much slower). 3.9 (15) **Addressing system barriers around stigma and discrimination. System still perpetuates stigma.** 3.8 (16)	**Health system where each individual is treated as a valued human being** Respect, dignity and honour 4.2 (15) **Appropriate timely and equitable access to health care** Fundamental idea 4.2 (14) **Care at the right place by the right person at the right time** So people can equitably access timely and quality care 4.1 (14)	**More access to services in rural areas is required to ensure equity with urban areas in the province** 4.2 (11) **Changes in funding models and service delivery to provide better equity and outcomes for patient care** Huge burden on patients to receive care in rural and remote communities (cost of travel, travel, etc.) 4.1 (10) **Provide transportation for people to and FROM services if they do not have that. Address the on- ramp and off-ramp** To address the SDOH, respect, access, equity, appropriateness. 3.9 (12)	**Focus on cultural safety from an Indigenous perspective** 4.2 (13) **Address disproportionate and inequitable distribution of funding based on outdated criteria such as population density.** 4.1 (13) **Continue to work on building equity by supporting communities at the edge** 4.1 (11)

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HEALTH AND WELLBEING OF CARE PROVIDERS AND STAFF	**Thinking creatively about incentives for recruiting new staff to help address barriers for recruiting health care staff.** Examples: accommodation, daycare, flexible work. Understand why people are choosing casual roles. 4.0 (16) **More taking care of ourselves as care providers so we can help pts. More honesty of burnout and capacity issues.** 4.0 (16) **Better pay, better working conditions (fully staffed, right equipment), better job flexibility and scope or practice)** We need to attract and sustain a strong workforce.... As a platform to build from. (Our people are our business). 3.8 (15)	**Dream – clinicians see themselves as users of the system as well, and not separate from it psychological safety, efficiency, respect** 3.8 (13) **Dream – learning organizations across partners** drives innovation, psychological safety 3.4 (14) **A working environment and payment model that ensures wellness for its workers and enables them to provide the best possible care** Health professionals are feeling burnt out and the current working environment does not support retention of the workforce 3.0 (2)	**Make workforce well so that they can show up when they are needed** 4.0 (12) **Value of those that work within the system** Value people appropriately in order to develop a system that takes care of all 3.9 (9) **We need to create structures that facilitate caring for healthcare workers** Health care workers are challenged to be present for the patients they serve 3.8 (12)	**Support conversations around compassionate leadership for promoting psychological safety** because we need a new vision for leadership that's based in relationship and inquiry 4.1 (12) **Work on psychological safety to work together to achieve a common goal, create connections with others to bridge gaps that exist between services** Encourage active involvement and participation in change, create connections and get grass roots involvement 3.9 (12)

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HEALTH BEYOND HEALTH CARE	**Moving beyond an intense focus on acute care/hospital settings.** to move upstream in the system and greater focus on the community, prevention etc. 4.4 (16) **Integration with other elements of society as a whole, such as housing.** Need a shift/emphasis in focus towards moving upstream in health care. 4.2 (14) **Collaborative work between community health care and service provider teams to help people age in the place of their choice.** Funding dollars need to be more flexible and tailored to person specific needs. Many things impact people's health. 4.0 (16)	**I would like to see more priority in preventing and reversing chronic disease through nutrition and lifestyle.** 80% of current health care dollars goes to treat the symptoms of chronic disease and only 5% of the health budget is used for prevention. 4.2 (13) **Embed prevention and promotion across the system** We must do better at addressing the underlying causes of ill health. 4.1 (14) **People centred, holistic care** because this is what's needed for people to truly thrive 4.1 (14)	**Improve public health literacy.** So the public knows where to access appropriate care (i.e., maybe not the ER) 4.2 (12) **Weave in social determinants of health** Factors like housing, education, social security etc affect the health outcomes of individuals and communities 4.1 (12) **Hospital Act needs to change to reflect the current context of holistic health care and upstream prevention, and empowerment of health care workers** 3.9 (12)	**Better communication of the successes of community health care.** Help foster transparency but also rebuild trust and engagement in the system 4.0 (10) **Supporting virtual community health including having a physician on call to respond where necessary** 3.8 (12) **Setting up our local CSC so that it can genuinely represent the community health care needs** Primary health care is fundamental to the health of the community 3.8 (11)

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HEALTH CARE TEAMS AND WORKING INTERPROFESSIONALLY	**Collaboration and relationships at many levels of health care** Focus on upstream relationships, community partnerships and prioritizing team based care 4.2 (15) **Support team based care** To provide better work environment and wrap services around people, not wrap people around siloed services 4.2 (15) **We need to work together as interdisciplinary groups to make collective commitments in the health care system.** This strengthens the decisions we make and actions we take. 4.2 (15)	**Team based care** to have the right people provide the right care 4.2 (13) **Effective primary care and increased team-based care** 4.0 (15) **Doctors and specialists need to use a more team-based approach (across authorities) & need to communicate patient information and needs w/one another.** This will help patients to not have to consistently be sharing their stories, will save practitioners a lot of time, and better care trajectory 4.0 (14)	**Remove barriers of practice for clinicians (regulatory bodies and policy makers/ bylaws)** Encourage scope optimization and care delivery. Providing clinicians the agency to optimize care delivery and practice collaboratively 4.2 (12) **Investment in primary care** Address shortages of staff – how do we supplement their (those working in those small teams) world 3.9 (12) **Opportunity to enhance health care delivery through the inclusion of various team members to support care.** NPs, Pharmacists' as example. Utilize team-based care to support care delivery. Shift from consults to conversations in transitions of care. Supports autonomy & agency as providers 3.9 (12)	**Team based care with removal of restrictions established by collective agreements** Will provide a team that works together to support the client. All care is everyone's role 4.2 (12) **High functioning team based models of care.** 4.1 (13) **Continuing the Primary Care Networks model, valuing the learning and capacity to problem-solve when implementing this model.** 4.1 (12)

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INNOVATION, RISK AND SCALING UP	**Incorporate and expand other health professionals in delivery of health care. This helps to fill gaps and overlapping of scope of care.** 4.2 (15) **Discussion and exploration, bringing people together to openly discuss and problem-solve issues that have taken years to develop but require solution** because the people who do the work, and the patients who use the system are the best resource to solve the problems 4.2 (15) **Creativity in how we provide care; openness to new ideas/trying things differently (eg. Hospital at home program), borne from challenges that we face** 4.1 (16)	**Need more long term vision and planning this will require different metrics and a different way of thinking that moves beyond the 4 year political cycle.** 4.1 (13) **A reduction in health inequities, understanding the leading determinants of health and wellbeing. change in a way the entire health system and partner silos (other ministries can respond and understand to the unique needs of underserved populations.** 3.9 (14) **Make bolder and innovative changes through collaboration** 3.8 (15)	**Incorporate and embed the indigenous ways of being and knowing in the healthcare system and decision planning.** 4.1 (11) **Citizens working together for benefit of all.** The challenges are bigger than all of us and cannot be solved by any one system, government, or community. 4.1 (9) **Willing to pilot and collaborate beyond health services.** Everyone has a part to play in order to support health and wellness. 3.9 (11)	**Make patient resources more accessible and share what is working well across the province to reduce working in silos.** Spread knowledge and support patients/ community members to have the right resources available to them 4.1 (12) **Policy and legislation have to happen in such a way that provides safe and equitable care** "Right touch regulation" - so policy doesn't get in the way of care 4.1 (12) **Incorporating what we've heard here [at the summit] into organizational strategic plans so these concepts are integrated within workflows from the top levels of the organization** 3.9 (12)

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RETENTION AND RECRUITMENT	**Continue providing psychologically safe work places** To avoid burnout and create supportive learning environments 4.1 (16) **No more normalizing burnout** To further support practitioners, they need to know that burnout is not a symbol of success (we need to facilitate and support work-life balance) 4.0 (16) **Thinking creatively about incentives for recruiting new staff to help address barriers for recruiting health care staff.** Examples: accommodation, daycare, flexible work. Understand why people are choosing casual roles. 4.0 (16)	**Care providers are retained and love coming to work.** 4.0 (15) **Decentralize requirements from primary care providers (offload from doctors onto others who have expertise) to maximize resources and reduce burnout** PCPs currently have lots of responsibilities that could be better served by others (e.g., determining if someone needs physio, writing a sick note) 3.9 (13) **Interventions and systems of support for health care providers** Long-term and thoughtful strategies will support health and retention, and address burnout (not just about $) 3.8 (13)	**Health of our workforce and how we prepare future workforce (training and retaining) Build mentorship, apprenticeship and practice experience into the program, job descriptions; healthier/more hopeful environments for people to land in** 4.3 (10) **Offer adjustments to positions in remote communities to incentive recruitment, e.g., multiple day shifts with accommodation, that meet staff requests** Doesn't feel meaningful when staff travel long distances in to a community and then only have time to see a handful of patients 3.8 (11) **Addressing health human resource shortages** Without the right people, in the right roles, with the right support, nothing else is possible 3.7 (9)	**Measuring success within each community (versus against other communities)** In northern and rural areas, turnover is higher. It reduces community morale when we compare recruitment and retention from an urban city. 4.1 (11) **Recruitment and retention rates should be a measure of success for a sustainable HHR system.** 4.0 (12) **Leadership being visibly supportive of support for the healthcare workforce** Healing and retention 3.9 (12)

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SILOS AND COLLABORATION	**Have an integrative and collaborative collaboration with different stakeholders: Nurses, pharmacists, social workers, doctors, and communities** 4.2 (15) **Starting to see more provincial coordination and collaboration** We need more of this to avoid duplication of work and to build consistency in services and resourcing around common priorities. 4.1 (15) **Willingness to work across silos** This is a complex systems issue 4.1 (15)	**Communication between health care silos Efficient & better for patient** 4.1 (12) **All providers working as partners with shared mutual goals rather than working as isolated parts of the same system.** 4.0 (15) **An ideal system is evidence based and embraces transparency, sharing, and learning together.** There has to be a collective vision and an ability to understand the broader social and economic context. This will include hard conversations. 4.0 (14)	**Collaboration outside of Heath care** Social connections and services are critical elements 4.1 (11) **Build on relationships and collaborate with services outside health care** For example, during flooding a car dealership provided a bus. When people come together, they come up with solutions 4.0 (11) **Improving the flow of information across organizations, communities and hierarchies** There's a lot of good work going on but we don't all know about it, especially the people on the ground. 4.0 (11)	**Reduce bureaucracy and duplication of work and therefore improve efficiency by trusting health care providers and patients on making the best decision** 4.2 (11) **Advocate for collaboration between health authorities to share success/resources** Standardized approach to information so all communities can benefit from local sites doing excellent work to improve health system delivery 4.1 (12) **Engagement with other people who have a part to play in this (community organizations, municipalities) and empowerment to take small piece forward** What can non-clinical people do to help support the system while we're going through change, e.g., Engagement, healthy community partnership tables 4.1 (11)

APPENDIX B

DESCRIPTION OF UBC HEALTH

THE UNIVERSITY OF BRITISH COLUMBIA
Office of the Vice-President, Health
UBC Health

UBC Health

Better health together: Connecting people, ideas, and actions to advance health outcomes, equity, and systems

About Us

The Office of the Vice-President, Health at the University of British Columbia was established in 2018 to build on the work of the College of Health Disciplines in advancing interprofessional and collaborative health education and research and to create synergies and alignment across all areas of UBC that contribute to the health and wellbeing of individuals, communities, and society.

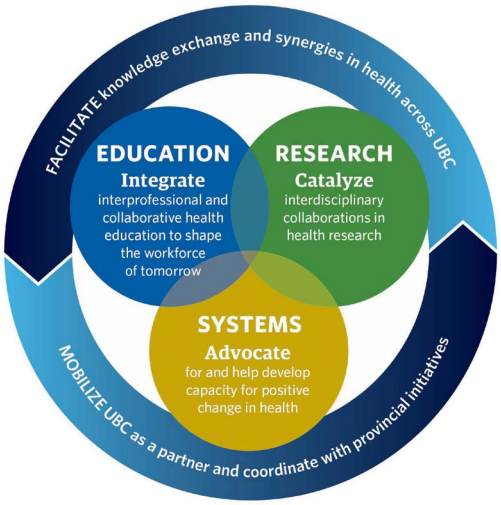
UBC Health works under the Office of the Vice-President, Health to enhance and enable interprofessional and collaborative health education and interdisciplinary research to train people, develop knowledge, and shape policy—seeking to address inequities and improve the systems that produce health. We advance these aims by promoting and facilitating collaborations across all faculties at UBC's Vancouver and Okanagan campuses, as well as with communities, institutions, and government organizations throughout BC.

In 2021, we revised our governance structure and completed the development of a five-year strategic plan, which reflects a broad remit in health education, health research, and health systems. Our work in collaborative health education and practice education continues to grow and is enhanced by this new structure. We are actively working to coordinate university and sector activities to establish evidence for new approaches to health.

UBC Health is governed by the UBC Health Executive and guided by the UBC Health Council and advisory committees for education, research, and systems. The work of UBC Health is also informed by a student caucus and a patient, public, and community advisory committee.

Our Work

Our work focuses on three core areas—collaborative health education, interdisciplinary health research, and health systems, with directors in education and research as well as special advisors for Indigenous health and health systems.



Collaborative Health Education

We help develop collaborative health learning opportunities that extend into practice and ensure students are ready for the team-based care models that are emerging across the province. For example, we facilitate the delivery of the *Integrated Curriculum*, a series of workshops and online modules that supports the development of the interprofessional competencies needed for collaborative practice and provides learning experiences around complex health topics, such as ethics and Indigenous cultural safety. Through the *Practice Education Network*, we facilitate a coordinated approach to sector partnerships and inform strategies for interprofessional placement opportunities.

Interdisciplinary Health Research

We foster interdisciplinary health research collaborations that address pressing health challenges facing society. For example, through the *Health Innovation Funding Investment (HIFI) Awards*, we catalyze cross-faculty and cross-campus collaboration at the Vancouver and Okanagan campuses by providing grants to develop, undertake, or translate innovative health-related research activities that have the potential to create change. Through the *Health After 2020* program, we are leveraging the inflection point in our society created by the COVID-19 pandemic to build a community of scholars that will engage in interdisciplinary collaborations and may lead to new research programs and engagement with policymakers and communities.

Improvements in Health Systems

We work with health sector partners across BC to enable dialogue, activate assets, and advance policies and innovations to improve health systems at individual and community levels. For example, we have partnered with the BC Centre on Substance Use to improve substance use and addiction education for health profession students. This will help ensure graduates enter practice with foundational training in substance use and addiction prevention, treatment, and recovery to accompany the knowledge, skills, and attitudes needed to support people who use substances. Through the *TBC@UBC Network*, we connect faculty and staff who are working to advance team-based care. Network members are collaborating to support and connect team-based care efforts across the province, create synergies across initiatives, and disseminate lessons learned from campus-based and other experiences.

Our Leadership

- Dermot Kelleher, Vice-President, Health
- Christie Newton, Associate Vice-President, Health *pro tem*
- Donna Drynan, Director of Education, UBC Health
- Kim McGrail, Director of Research, UBC Health
- Ray Markham, Special Advisor to the Vice-President, Health on Health Systems
- Nadine Caron, Special Advisor on Indigenous Health to the Vice-President, Health
- Victoria Wood, Assistant Director, Strategic Initiatives, UBC Health
- Ben Fair, Assistant Director, Health Systems, UBC Health
- Angela Towle & William Godolphin, Patient & Community Partnership for Education, UBC Health

Learn More

For more information:

- Visit our website at health.ubc.ca
- Subscribe to our newsletter at health.ubc.ca/newsletter
- Follow us on Twitter at @ubc_health