Provincial Health Care Partners' Planning Retreat Summary Report

April 2019

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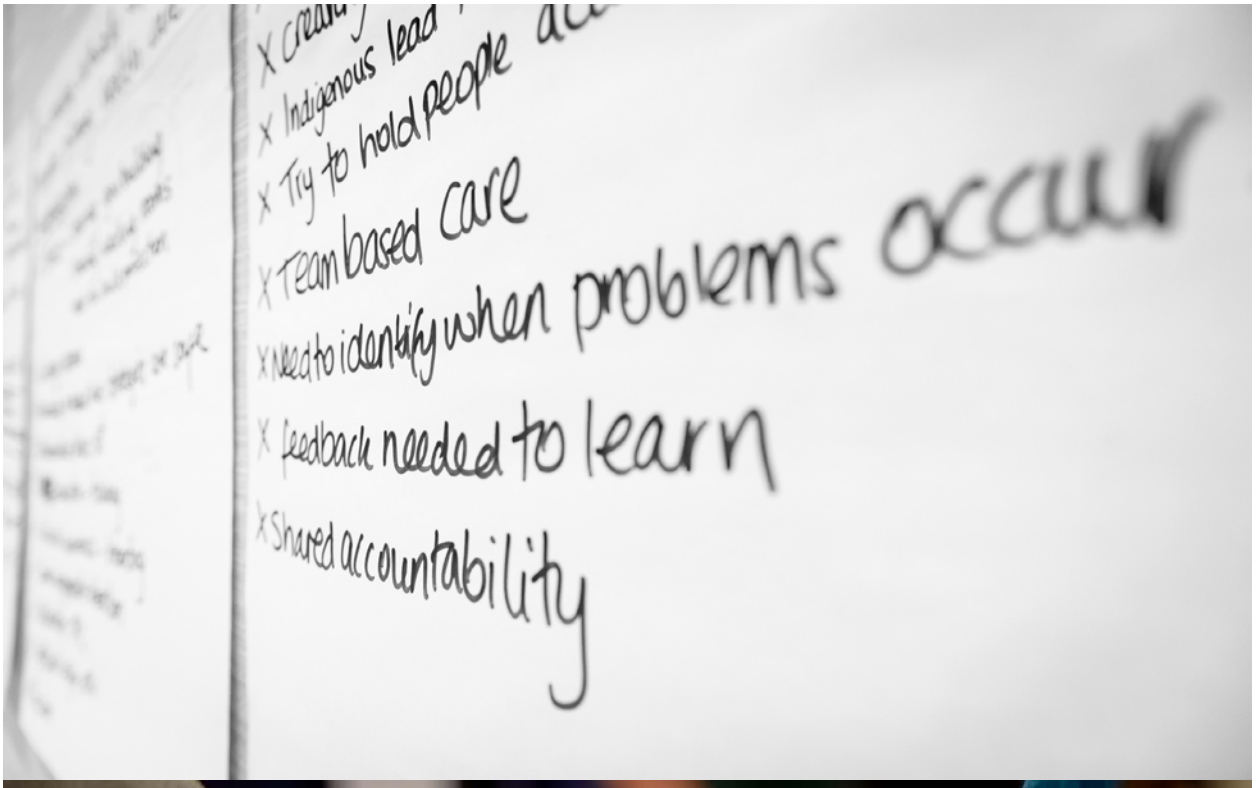
1. Introduction

During January 27, 28 and 29, health care leaders and partners gathered on the unceded, traditional, ancestral territories of the Skwxwú7mesh (Squamish), xʷməθkʷəy̓əm (Musqueam), and səl̓ílwətaʔɬ (Tsleil-Waututh) Nations to build relationships and co-develop shared priorities for the future of health care re-design and transformation in BC. The gathering was led by important teachings from Elders and knowledge holders Syexwaliya (Ann Whonnock) and Shane Point, as well as the valuable teachings in the dances of Coastal Wolf Pack and the Rainbow Spirit Dancers. Tsow-Tun Le Lum healers were instrumental in supporting everyone toward healing and wellness during our three days together. We express our thanks to you all.

The gathering was predicated on the belief that there is no health care system without people—the people are the system. If people change, then the system changes. Changes that lead to improved patient and community health outcomes requires courage and the ongoing practice of talking together, planning together, and weaving collective wisdom and insights to co-create a new way forward together. These practices applied over time can translate into actions leading to an improved health care system in BC. Six overarching purposes defined the reason for the gathering of health care partners in Vancouver, which included:

- Engaging in cultural learning about the First Nations' territory on which the gathering took place;
- Participating in learning and activities to ground participants in the purposes of the planning retreat with a focus on developing relationships;
- Advancing peer learning about topics relevant to advancing culturally safe and humble health care services, with learning across different mandates and perspectives;
- Engaging in learning about and collectively describing the context in which primary health care re-design and transformation is taking place, with a focus on rural and remote communities;
- Following Appreciative Inquiry guidelines and identifying strengths from which to co-create visions for short term next actions in the primary health care transformation efforts of health care partners and peer groups; and,
- Participating in knowledge exchange and consensus building in pursuit of practical actions that can be implemented in follow up to the Health Care Partners' Planning Retreat.

This report entails a brief overview of the process and a summary of the strategic actions and commitments that were shared. With thanks to bethink, a separate report about the relationship assessment exercise at the gathering has been produced and has been added as an appendix to this summary report. Further, videos collected during the gathering have been produced and can be viewed here: https://www.youtube.com/playlist?list=PLzll0dvViPsXhEmOSEk44-PximyO2tOFt

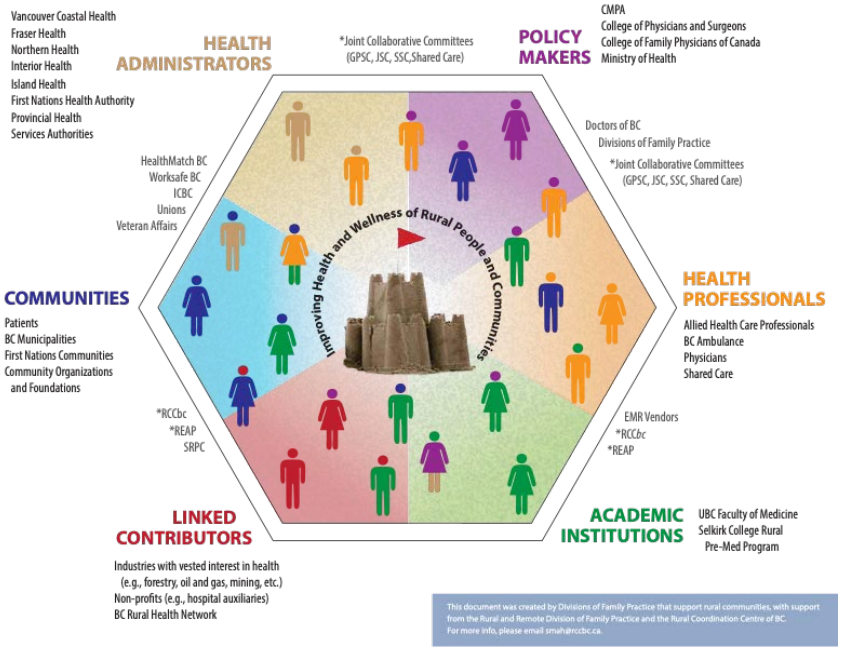

Indigenous lead
Try to hold people
Team based care
Need to identify when problems occur
Feedback needed to learn
Shared accountability

2. Co-Creation of a Planning Retreat Design

A provincial planning team was formed under the leadership of the Rural Coordination Centre of BC, which included: Dr. Ray Markham (RCCBC), Dr. Alan Ruddiman (GPSC), Dr. Granger Avery (Doctors of BC), Meghan Hunt (First Nations Health Authority), Paula Carr (Doctors of BC), Ed Staples (BC Rural Health Network), Kim Williams (RCCBC), Anne Lesack (RCCBC) and Scott Graham (SPARC BC). The planning retreat incorporated an **Appreciative Inquiry** approach that supports organizations grow towards what they want to be by emphasizing their inherent capacity to enrich and enhance the quality of life of people and communities they serve. The Appreciative Inquiry method follows an iterative flow of four stages:

- **Describe:** diligent and extensive search to understand the "best of what is" and "what has been";
- **Dream:** exploration of "what might be"—thinking big, out of the box, outside of the boundaries;
- **Design:** making choices about "what should be"—a conscious re-creation or transformation that more fully aligns systems, structures, strategies, processes and images with the organization's positive past; and,
- **Deliver:** inspired actions that support ongoing learning and innovation or "what will be."

Drawing upon principles of weaving, the design of the retreat process featured alternating rounds of dialogue and deliberation within Peer Groups and Partner Groups, following the four stages of Appreciative Inquiry. Peer Groups were comprised of individuals from the same health care stakeholder sector (see hexagon diagram below). Partner Groups were comprised of individuals coming from different health care stakeholder sectors.



Engagement between diverse perspectives was encouraged through this weaving of short timed group meetings, which supported learning from new angles and the development of dynamic relationships throughout the planning retreat. This methodology aimed to support stakeholders to reach consensus around future actions and commitment-making to ensure social accountability for progress in the health system redesign and transformation process. These actions and commitments are expressed in the following **Living Strategic Framework**.

3. Living Strategic Framework

"Redesign the system of care so
all people in BC have equitable access to care."

"Your wellness should not depend on where you live."

The statements above reflect the recurring themes discussed at the planning retreat. Building on these participant statements, we present a **Living Strategic Framework** below that has been created to summarize the main insights and outcomes from the gathering, as well as to facilitate ongoing dialogue and deliberation about the improvements and innovation required for BC's health care system.

The Living Strategic Framework is living in the sense that it is designed to grow, ought to be re-engaged overtime and refined to reflect new collaborations. It is a framework in the sense that it aims to support and maintain the qualities of a stable and sustainable pathway for responding to needs and opportunities using the assets of our current systems, building up effective programs and expertise, and securing political and executive commitment from educational institutions, ministries and their partners. The framework is structured around the four strategic priorities that were co-created by the partner organizers who co-delivered the gathering:

1. Co-creating culturally safe and humble primary health care;
2. Designing, planning for and implementing Team-Based Care;
3. Increasing citizen and community involvement in health care transformation processes; and,
4. Improving access and transitions for patients in rural and remote communities.

The four strategic priority areas are supported by recommended actions that were produced from the group dialogues and expressed during a Big Share among all participants on the final day of the planning retreat. Each bundle of recommended actions is accompanied with commitments by some organization leaders that respond to the calls for action that were set at the end of the final day of the planning retreat. The organization commitments were provided as part of a participant review process with the draft summary report.


Cathy Ulrich

Strategic Priority	Actions	Organization Commitments
1. Co-creating culturally safe and humble primary health care[1]	1. Continue to resolve health disparities by implementing the Truth and Reconciliation Commission's calls to action and the UNDRIP principles. Support community led, culturally safe training and continuous learning, and Indigenous self-determination to fund and develop a holistic PCN and PHC ++ system 2. Honour and partner with existing First Nation governance structures and engagement pathways in PCN development throughout planning and implementation processes, including: knowledge exchange, meetings hosted at a local level and building awareness of local First Nations governance among health care partners 3. Develop unique partnerships to ensure work is undertaken in a way that aligns with principles of OCAP and simultaneously meets high standards of evidence production[2] 4. Redesign the compensation frameworks and provide funding mechanisms that support community engagement and relationship building that will lead to culturally safe services and experiences	**Sheryl Martin, Ministry of Health, Primary Care** • Continue work with FNHA on supporting First Nations engagement in the PCN development process, specifically enabling the funding for First Nations community members to be actively engaged to the extent they want within the PCN development process • In collaboration with FNHA, create funding mechanisms for Indigenous health care providers that were identified as being critical and as recommendations through the TRC and UNDRIP. • Develop communication around what is the value proposition of PCNs for rural, urban and Indigenous communities, providers and others

1 This strategic priority is informed by the First Nations Health Authority's policy statement on cultural safety and humility. Accessed March 11, 2019 at: http://www.fnha.ca/documents/fnha-policy-statement-cultural-safety-and-humility.pdf

2. The First Nations Principles of OCAP™ (ownership, control, access and possession) means that First Nations control data collection processes in their communities. For more information, see "Ownership, Control, Access and Possession (OCAP™): The Path to First Nations Information Governance, produced by the First Nations Information Governance Centre, 2014, accessible at: https://fnigc.ca/sites/default/files/docs/ocap_path_to_fn_information_governance_en_final.pdf

Strategic Priority	Actions	Organization Commitments
	5. Increase the number of practicing health and wellness professionals with Indigenous and rural backgrounds by improving the supports for recruitment, admissions, training and retention	**Shannon McDonald, FNHA** • Be true partners in reciprocal accountability to plan, design and deliver innovative systems of health and wellness for First Nations people in the Province of BC. To do this, we need relationships with people from many sectors of the health care system as we have limited human resources. It is essential that we continue to be invited to the table, not as token members of a committee, but as active and responsive partners • Supporting First Nations populations through partnerships in their planning, design, governance and delivery of primary care, understanding that communities know best what they need to move towards wellness in their communities—and it's our job to help them get there
2. Designing, planning for and implementing Team-Based Care	1. Pursue the design and implementation of Team-Based Care in a manner that attends to a four-part aim, including: patient engagement (in the office, community and system), holistic risk-benefit-outcome (examples: inclusion of cultural safety and consideration of patient travel), sustainable practice (consider:	For future discussion.

Strategic Priority	Actions	Organization Commitments
	leaders, successors, satisfaction and full scope), and true and complete costs to all 2. Mandate and facilitate support for vendors to translate 'noise' of EMR data into usable signals 3. Enhance both in-office and local teams through facilitation of team modelling sessions that apply community needs data with community members to match HR resources with community care needs	
3. Increasing citizen and community involvement in health care transformation processes	1. Develop principles of engagement that are intentional (not tokenizing), inclusive of all voices, deliberative, and multifaceted. Incorporate these principles into the practices of all stakeholder groups, as well as into Ministry of Health policies, and at the PCN and local levels 2. Create and resource a provincial backbone organization in order to support flourishing teams within an ecosystem of individual communities across BC. This is needed to ensure effectiveness and optimization across several dimensions of health system redesign and transformation, including: HR, funding, data and translation, leadership, analytics, and iterative process to support changes moving forward[3]	**Sheryl Davies, Provincial Health Services Authority; Ed Staples, BC Rural Health Network** • Ongoing collaborative forums engaging even more stakeholders. Seek greater sense of purpose, accountability and roles regarding what we do with our collaboration • Support innovation at community levels and look at structural system of care to support great work that happens in pockets across the province • Exploring the definition of community engagement so that there are principles and clear definitions of who constitutes "the

1. Backbone organizations within a collective impact model typically: guide vision and strategy, support aligned activities, establish shared measurement practices, build public will, advance policy, and mobilize funding. From "Understanding the Value of Backbone Organizations in Collective Impact: Part 2", by S. Turner, K. Merchant, J. Kania and E. Martin, 2012, *Stanford Social Innovation Review (Online)*, accessible at: https://ssir.org/articles/entry/understanding_the_value_of_backbone_organizations_in_collective_impact_2#

Strategic Priority	Actions	Organization Commitments
	3. Establish a local community health network with principles of engagement. Explore developing a local steering group to help ensure that engagement pathways are honoured for First Nations, that processes of inclusion are animated for diverse population groups, and to support future developments of PCN, PMH and TBC models 4. Continue to advance Informed Patient Consent Technologies such by developing a digital patient consent which will engage citizens directly in the management of their clinical data 5. Build upon the success of Patient Portal (like LifeLabs) to better involve citizens directly, including expanding the data directly available to patients/citizens, adding more educational components so that citizens are better informed; and allowing patients to forward data to specific providers	community" to be engaged with • Involvement in higher-level discussions around PCN, as presently most information comes second-hand, to be used in decision making affecting people in the community
4. Improving access and transitions for patients in rural and remote communities	1. Engage in strategic evaluation and applied research that pinpoints positive qualities in the system, undertaken in partnership with citizens, learners and researchers as co-investigators using culturally safe methods, including patient journey mapping. Ensure there are effective feedback loops to link evidence and action, with periodic assessments of risks and benefits of those concepts that are most promising for systems transformation	For future discussion.

Strategic Priority	Actions	Organization Commitments
	2. Work to improve the transport of patients with a view to decreasing the amount of time it takes from the moment of an accident/incident and the arrival of the patient at the first level of higher care (e.g., hospital) 3. Work to put more Ambulance Service Personnel (APCs) in rural areas to provide better service to rural residents 4. Create regional health provider float pools, with supportive infrastructure, to support sustainable rural health services and patient access and outcomes 5. Transform the discharge process across BC with an emphasis on vulnerable populations to improve patient outcomes 6. Increase local capacity and support with resources and a linked provider network including IT virtual technologies to enhance outcomes across the continuum of patient wellness 7. Establish a strategy to support tech-enabled generalism as a corner stone of rural health care for the benefit of doctors and patients. Implementation requires decisions on ownership, structure, governance and a sustainability plan for CODI 8. Establish an ongoing inclusive positive feedback loop based on data prioritized from the individual, to local, to regional, to provincial level	

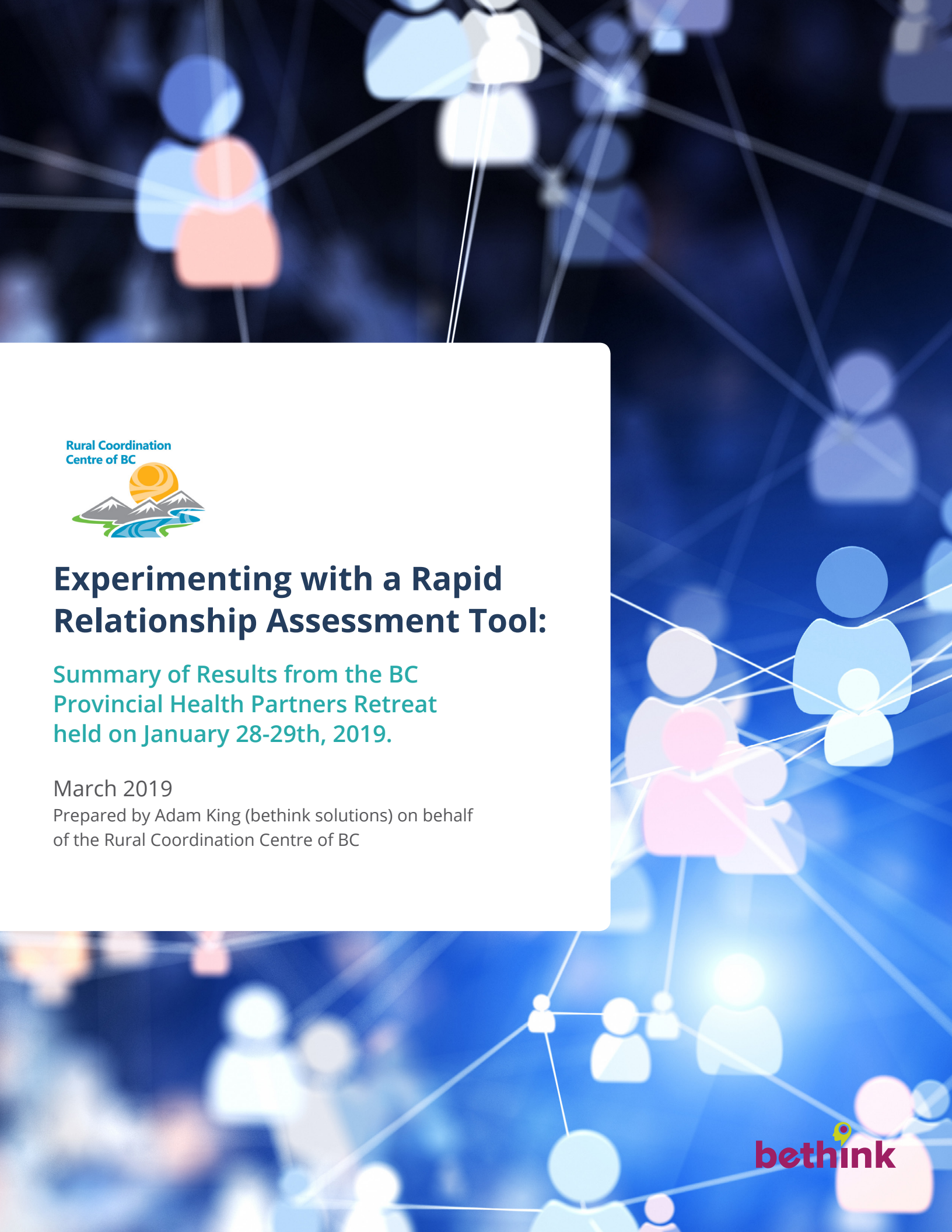
5. Summary and Next Steps

The Health Care Leaders' Planning Retreat was an important moment in the history of health care design and delivery in British Columbia. One of the most important outcomes of this gathering is the demonstrated capacity to meet and plan together across organizational mandates. The Health Care Leaders' Planning Retreat showed that bringing health care partners together is valuable to participants, and essential for mobilizing our collective capacities and resources to further develop a health care system that is patient-centered, culturally safe and equitably geared to positive health outcomes – regardless of where one lives.

Although the success of coming together to co-identify priorities and action steps for next stage re-design work is encouraging, the challenge of maintaining the momentum of working together remains pronounced. To make the most of this new collective planning capacity, it is imperative to develop a sustainable rhythm of planning together. We look forward to working together to continue to focus our time together in productive ways. The Living Strategic Framework and related actions and commitments is a starting point for future dialogue and deliberation. We thank you for helping get us to this point and we look forward to the next steps together.

Please take some time to view the videos collected during the gathering. They are available as individual shorter sessions or as a whole.
https://www.youtube.com/playlist?list=PLzlI0dvViPsXhEmOSEk44-PximyO2tOFt


Emerging shared priorities from our heart, head and hands
Nurture a backbone
for flourishing teams in an ecosystem that supports individual communities across BC
Harmonize all relevant stakeholders to optimize



Rural Coordination Centre of BC

Experimenting with a Rapid Relationship Assessment Tool:

Summary of Results from the BC Provincial Health Partners Retreat held on January 28-29th, 2019.

March 2019

Prepared by Adam King (bethink solutions) on behalf of the Rural Coordination Centre of BC

bethink

The Rural Coordination Centre of BC is exploring innovative ways to measure and support relationships between health system partners. To this end, a rapid relationship assessment tool was piloted during a BC Provincial Health Partners Retreat convened on January 28th and 29th, 2019, in Vancouver.

The rapid relationship assessment tool piloted was an adapted version of the *Inclusion of the Other in the Self*[1] (IOS) Scale. The high-level goal for piloting the rapid relationship assessment tool was to determine its utility for such an event as well as determine whether the results would instigate helpful reflection and discussion among the participants and partner groups. The more specific goals of the assessment tool were to assess:

1. *how close participants felt their relationships were to the organization or group they identified most closely with for the meeting;*
2. *how close participants felt their relationships were to the people they worked within other organizations/groups involved in health improvement;*
3. *if the frequency of working together impacts how close participants feel to the people they work with in other organizations or groups.*

It is important to note that the sample size for this pilot was small and that there are methodological limitations to the approach taken (described in 'Limitations' section). For these reasons, any interpretation of the results needs to be weighed with a degree of caution. In fact, Bethink's evaluation team has intentionally avoided generating and including any specific interpretations of the results in this summary report. **Our intention is to share the results with participants and inquire whether they thought this type of relationship assessment was valuable and whether there is any interest in implementing this assessment more broadly and systematically within their organizations and groups.**

METHODS:

The relationship assessment tool piloted was an adapted version of the *Inclusion of the Other in the Self*[2] (IOS) Scale. The IOS Scale was developed by behavioural scientists to measure the subjectively perceived closeness of relationships between individuals, and has been validated as a psychologically meaningful and highly reliable measure[3]. In line with adaptations made in another study[4], this pilot adapted the IOS Scale to focus on participants' subjective perceptions of how close they felt to their own primary organization or group. The tool was also adapted to assess how close participants' felt to the people they worked with in other organizations/ groups involved in health system improvement. Surveys were administered in-person on the morning of day one to all participants (approx. 150), and again to all participants near the end of day two (approx. 80). A total of 123 surveys were completed during the pre-event assessment and 61 surveys were completed during the post-event assessment. At the start of the survey,participants were asked to identify one organization/group that they identified with most strongly *(see list in box below)*.

ORGANIZATIONS / GROUPS LISTED IN SURVEY:

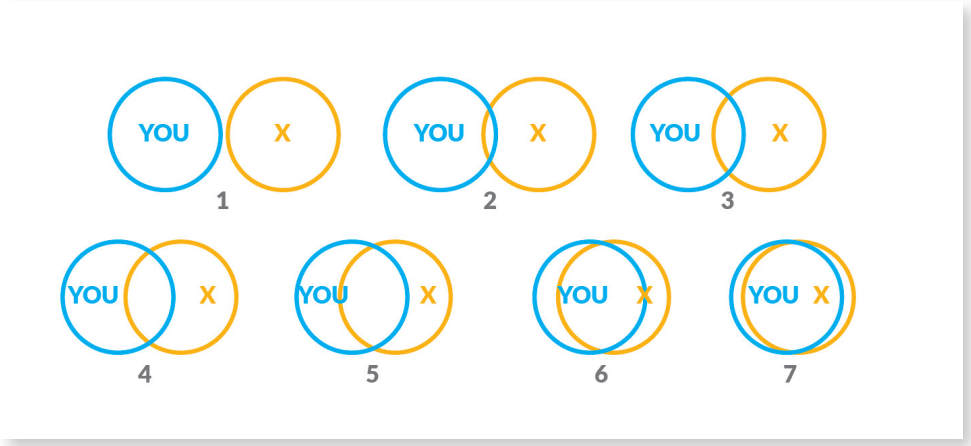
1. First Nations Community (please specify)
2. Community Group or Patient Group (please specify)
3. Physician Organization (please specify)
4. Allied Health Providers (please specify)
5. Health Authority / Admin (please specify)
6. Ministry of Health (MOH)
7. General Practice Services Committee (GPSC)
8. Specialist Services Committee
9. Shared Care Committee
10. Joint Standing Committee on Rural Issues
11. Academic Institution (please specify)
12. Others (please specify)

If participants identified with more than one organization/group, they were asked to identify which one was most appropriate for this meeting (i.e. the primary perspective they were contributing during the meeting).

Using the IOS Scale, participants were then asked to assess how close they felt their relationships were to their own primary organization/group (1 to 7 Likert scale where 1 is distant and 7 is very close). Participants were also asked how often they work with their own primary organization/ group (daily, weekly, monthly, quarterly, annually).

For each of the remaining organizations/groups, participants were asked:

1. Whether in their current role, they worked with people from that organization/group?
2. If yes, how often did they work with them (daily, weekly, monthly, quarterly, annually)?
3. Which pair of circles best described their relationship with the people they worked with from that organization/group?



The following instructions were given to participants: In each pair of circles, one circle refers to you ("You") and the other circle to the people you work with from a specific organization/group (referred to as "X" in the diagrams). For example, if you feel really close to the people you work with from the Divisions of Family Practice, it would make sense to choose the almost completely overlapping pair of circles (number 6 or 7). However, if you do not feel very close to the people you work with from the Divisions, it would be natural to choose the first pair of still disjointed circles (number 1 or 2).

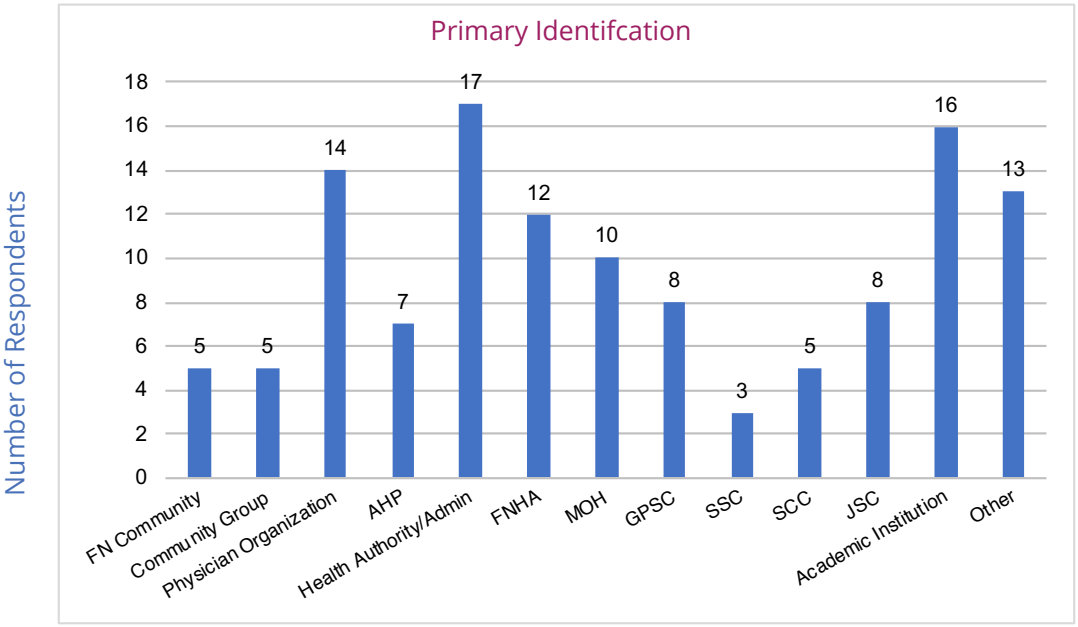
ANALYSIS:

Participants were aggregated into their self-identified primary organizations/groups. An average relationship closeness score and frequency-of-working-together score was calculated for each organization/group. With these two scores, simple frequency tables and radar charts were generated.

After the initial results were analyzed, we decided (in consultation with RCCbc colleagues) to separate out First Nations Health Authority participants from the larger Health Authority / Administration group to more accurately reflect their unique role and relationship with First Nations Communities.

PRE-ASSESSMENT RESULTS AND OVERVIEW OF PARTICIPANTS:

Organization or group that participants identified with most closely for this meeting



Sub-Groups	Frequency	Valid Percent
First Nations Community	5	4%
Community Group or Patient Group	5	4%
Physician Organization	14	11%
Allied Health Providers	7	6%
Health Authority / Admin	17	0
First Nations Health Authority	12	0
Ministry of Health (MOH)	10	8%
General Practice Services Committee (GPSC)	8	7%
Specialist Services Committee	3	2%
Shared Care Committee	5	4%
Joint Standing Committee on Rural Issues	8	7%
Academic Institution	16	13%
Others	13	11%
Total	**123**	**100%**

NOTE TO READER:

While reviewing the results below it may be helpful to reflect on one or more of the following questions:

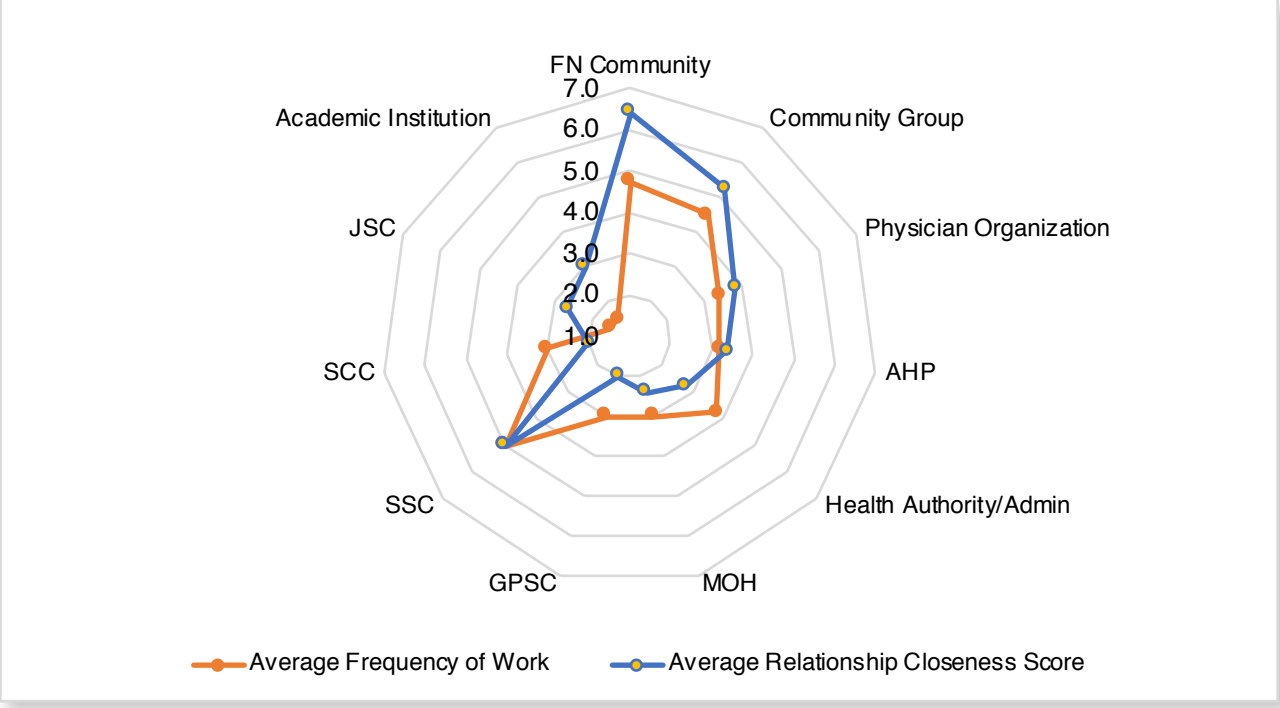
- *Do the average relationship closeness scores for each organization match your general expectations?*
- *Do any of the results surprise you?*
- *Would you be interested in seeing how the results may or may not change if this assessment was rolled out more comprehensively in each organization or group?*

1. Average relationship closeness scores and frequency of working together scores

First Nations Community

Number of Respondents: 5

Relationship closeness score of FN Community group for other primary identity groups



How close the First Nations Community group feels (on average) to the other primary identity groups

Primary Identification	Average Frequency of Work	Average Relationship Closeness Score
First Nations Community	4.75	6.40
Community Group or Patient Group	4.50	5.25
Physician Organization	3.40	3.80
Allied Health Providers	3.20	3.40
Health Authority / Admin	3.80	2.80
Ministry of Health (MOH)	3.00	2.40
General Practice Services Committee (GPSC)	3.00	2.00
Specialist Services Committee	5.00	5.00
Shared Care Committee	3.00	2.00
Joint Standing Committee on Rural Issues	1.50	2.67
Academic Institution	1.50	3.00

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*

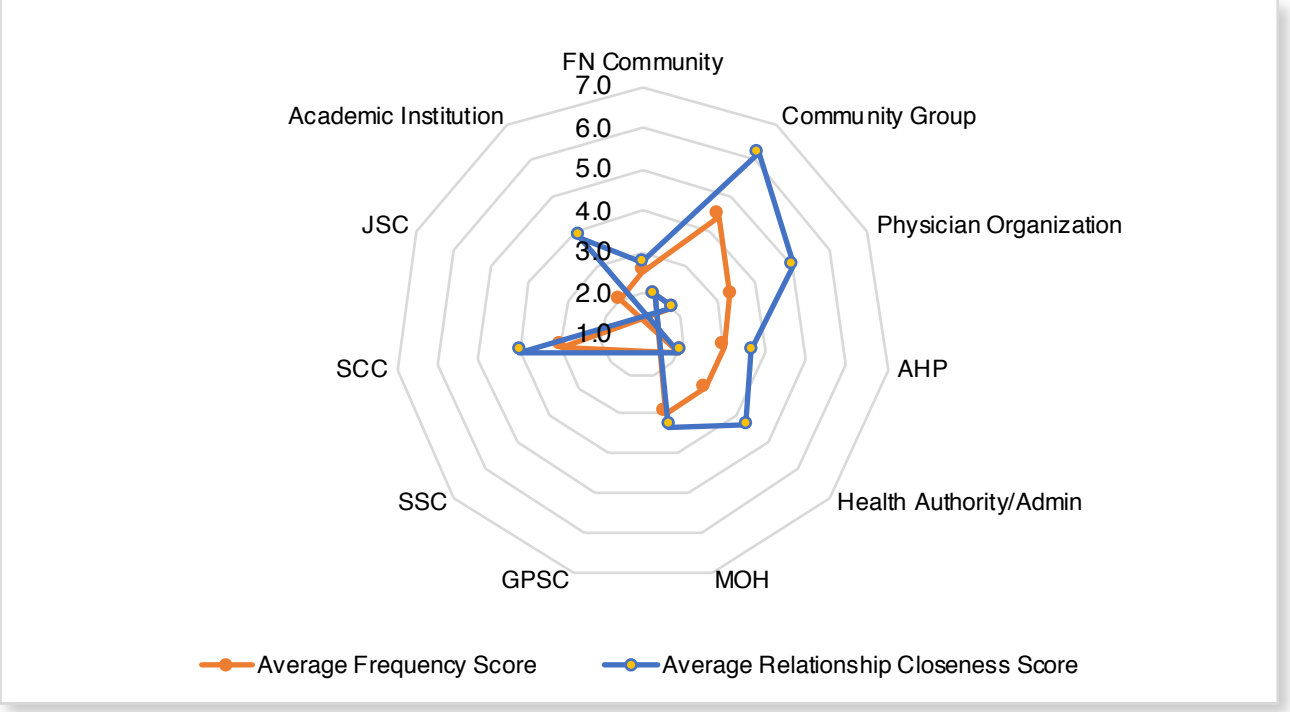
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*

** Top 3 Relationship Closeness Scores highlighted*

Community Group or Patient Group

Number of Respondents: 5

Relationship closeness score of Community group for other primary identity groups



How close the Community Group or Patient Group feels (on average) to the other primary identity groups

Primary Identification	Average Frequency Score	Average Relationship Closeness Score
First Nations Community	2.50	2.75
Community Group or Patient Group	4.40	6.20
Physician Organization	3.33	5.00
Allied Health Providers	3.00	3.67
Health Authority / Admin	3.00	4.33
Ministry of Health (MOH)	3.00	3.33
General Practice Services Committee (GPSC)	0.00	0.00
Specialist Services Committee	0.00	0.00
Shared Care Committee	3.00	4.00
Joint Standing Committee on Rural Issues	0.00	0.00
Academic Institution	2.00	3.80

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*

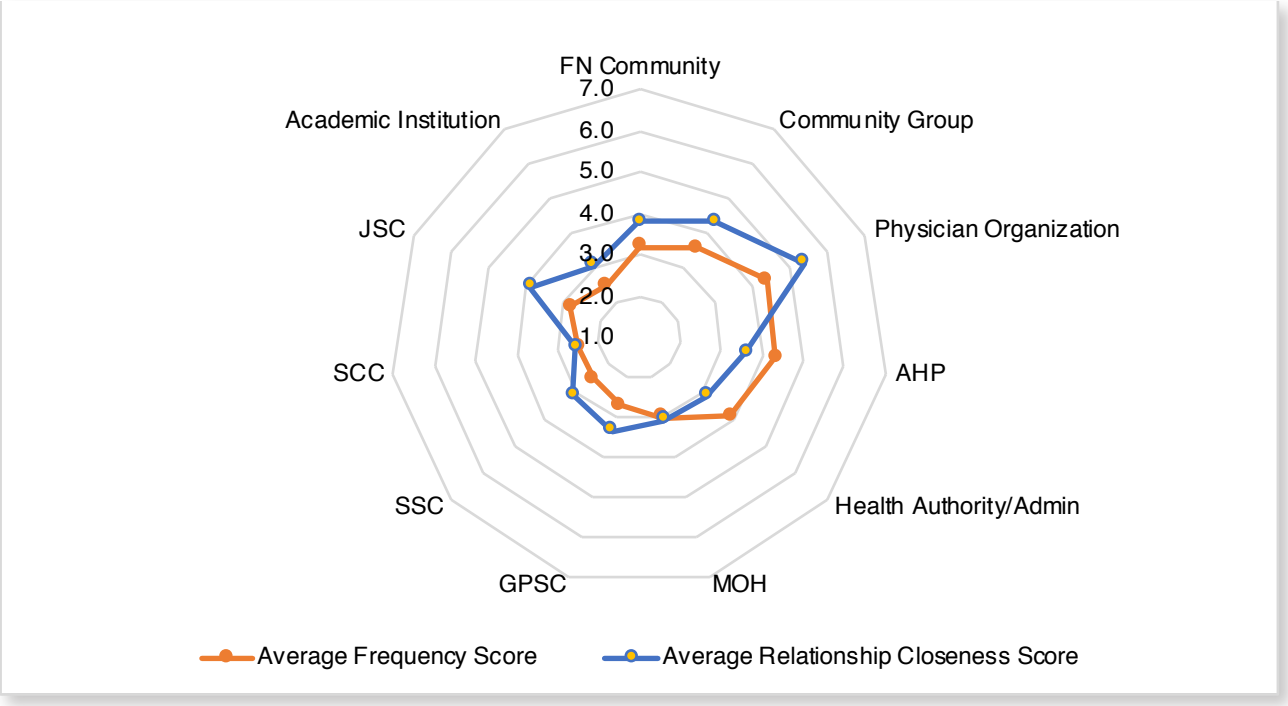
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*

** Top 3 Relationship Closeness Scores highlighted*

Physician Organization

Number of Respondents: 14

Relationship closeness score of Physician Organization for other primary identity groups



How close the Physician Organization group feels (on average) to the other primary identity groups

Primary Identification	Average Frequency Score	Average Relationship Closeness Score
First Nations Community	3.20	3.80
Community Group or Patient Group	3.56	4.33
Physician Organization	4.36	5.36
Allied Health Providers	4.33	3.60
Health Authority / Admin	3.92	3.15
Ministry of Health (MOH)	3.00	3.08
General Practice Services Committee (GPSC)	2.73	3.36
Specialist Services Committee	2.50	3.13
Shared Care Committee	2.50	2.56
Joint Standing Committee on Rural Issues	2.82	3.91
Academic Institution	2.50	3.08

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*

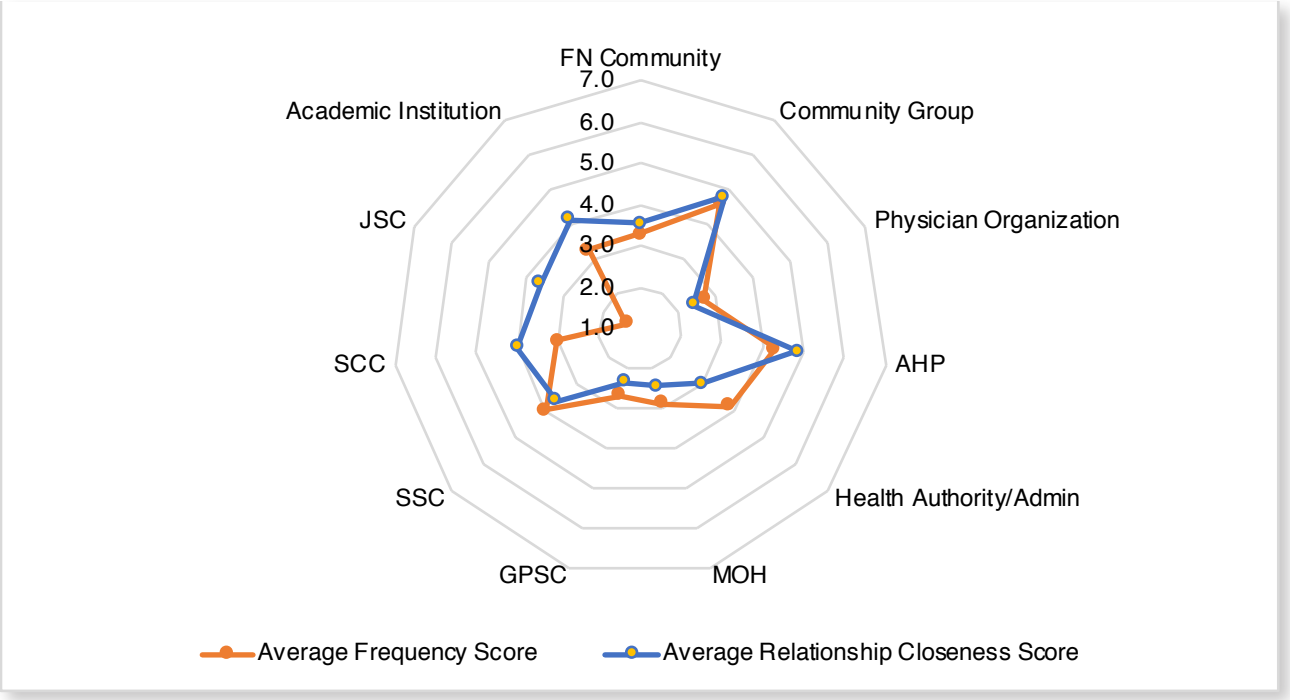
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*

** Top 3 Relationship Closeness Scores highlighted*

Allied Health Providers

Number of Respondents: 7

Relationship closeness score of AHP group for other primary identity groups



How close the Allied Health Providers group feels (on average) to the other primary identity groups

Primary Identification	Average Frequency Score	Average Relationship Closeness Score
First Nations Community	3.29	3.57
Community Group or Patient Group	4.60	4.80
Physician Organization	2.71	2.43
Allied Health Providers	4.29	4.86
Health Authority / Admin	3.86	3.00
Ministry of Health (MOH)	2.86	2.43
General Practice Services Committee (GPSC)	2.67	2.33
Specialist Services Committee	4.00	3.67
Shared Care Committee	3.00	4.00
Joint Standing Committee on Rural Issues	1.33	3.67
Academic Institution	3.29	4.14

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*

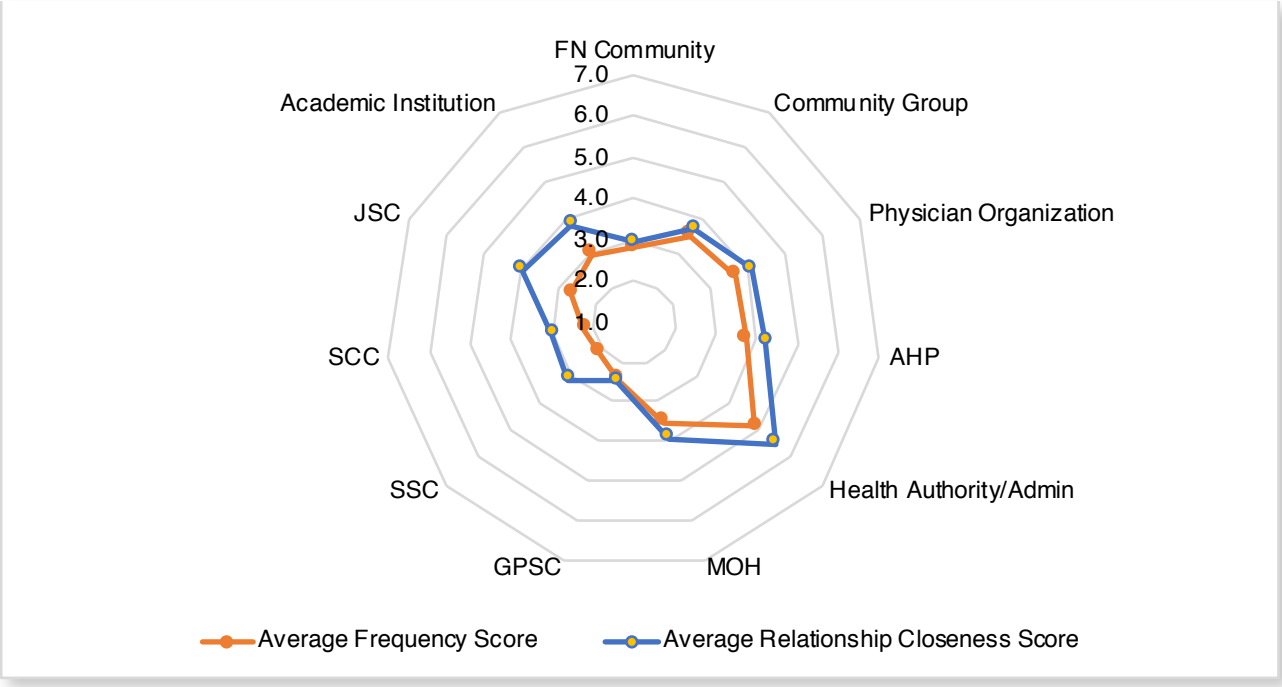
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*

** Top 3 Relationship Closeness Scores highlighted*

Health Authority / Admin

Number of Respondents: 17

Relationship closeness score of Health Authority / Admin group for other primary identity groups



How close the Health Authority / Admin group feels (on average) to the other primary identity groups

Primary Identification	Average Frequency Score	Average Relationship Closeness Score
First Nations Community	2.81	2.94
Community Group or Patient Group	3.50	3.67
Physician Organization	3.67	4.13
Allied Health Providers	3.73	4.20
Health Authority / Admin	4.88	5.50
Ministry of Health (MOH)	3.53	3.94
General Practice Services Committee (GPSC)	2.45	2.50
Specialist Services Committee	2.13	3.11
Shared Care Committee	2.22	3.00
Joint Standing Committee on Rural Issues	2.67	4.00
Academic Institution	2.93	3.80

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*

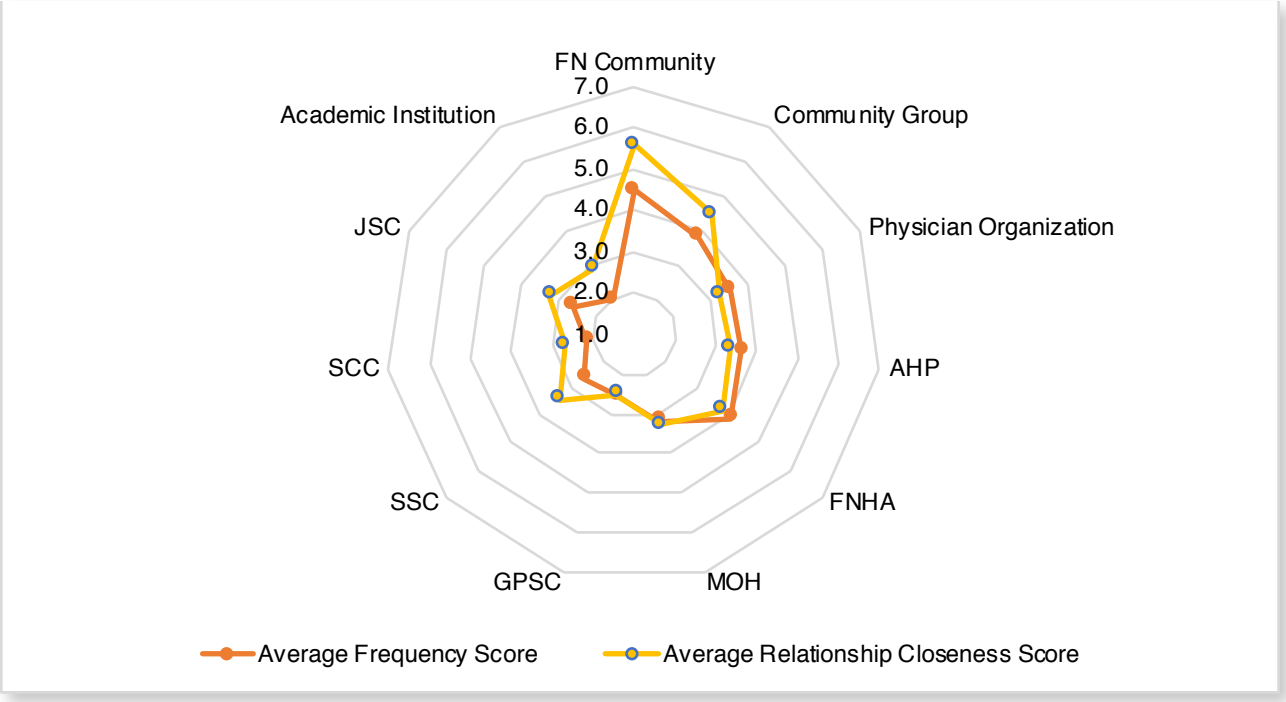
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*

** Top 3 Relationship Closeness Scores highlighted*

First Nations Health Authority

Number of Respondents: 12

Relationship closeness score of FNHA group for other primary identity groups



How close the First Nations Health Authority group feels (on average) to the other primary identity groups

Primary Identification	Average Frequency Score	Average Relationship Closeness Score
First Nations Community	4.50	5.58
Community Group or Patient Group	3.82	4.45
Physician Organization	3.55	3.27
Allied Health Providers	3.64	3.33
First Nations Health Authority	4.08	3.82
Ministry of Health (MOH)	3.18	3.27
General Practice Services Committee (GPSC)	2.56	2.50
Specialist Services Committee	2.60	3.40
Shared Care Committee	2.14	2.71
Joint Standing Committee on Rural Issues	2.63	3.25
Academic Institution	2.00	2.88

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*

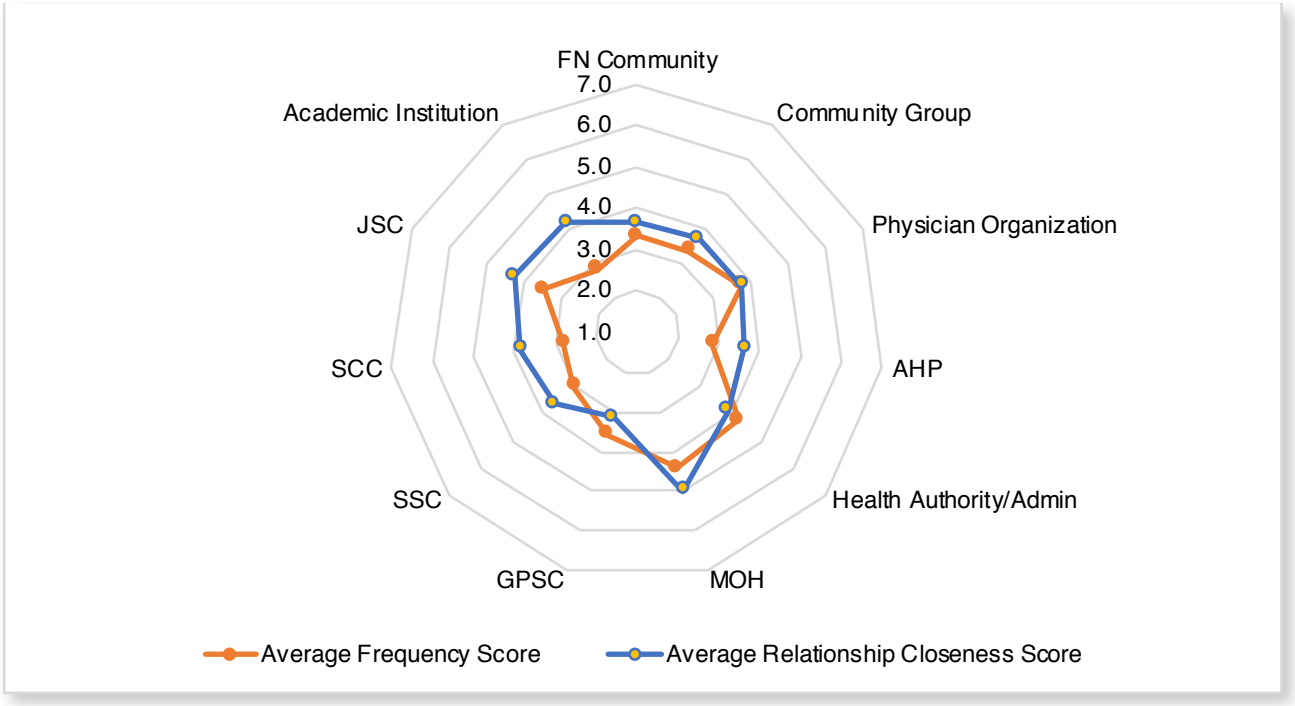
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*

** Top 3 Relationship Closeness Scores highlighted*

Ministry of Health (MOH)

Number of Respondents: 10

Relationship closeness score of MOH group for other primary identity groups



How close the Ministry of Health (MOH) group feels (on average) to the other primary identity groups

Primary Identification	Average Frequency Score	Average Relationship Closeness Score
First Nations Community	3.33	3.67
Community Group or Patient Group	3.33	3.71
Physician Organization	3.75	3.78
Allied Health Providers	2.86	3.63
Health Authority / Admin	4.22	3.90
Ministry of Health (MOH)	4.43	5.00
General Practice Services Committee (GPSC)	3.57	3.13
Specialist Services Committee	3.00	3.67
Shared Care Committee	2.80	3.83
Joint Standing Committee on Rural Issues	3.50	4.29
Academic Institution	2.83	4.17

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*

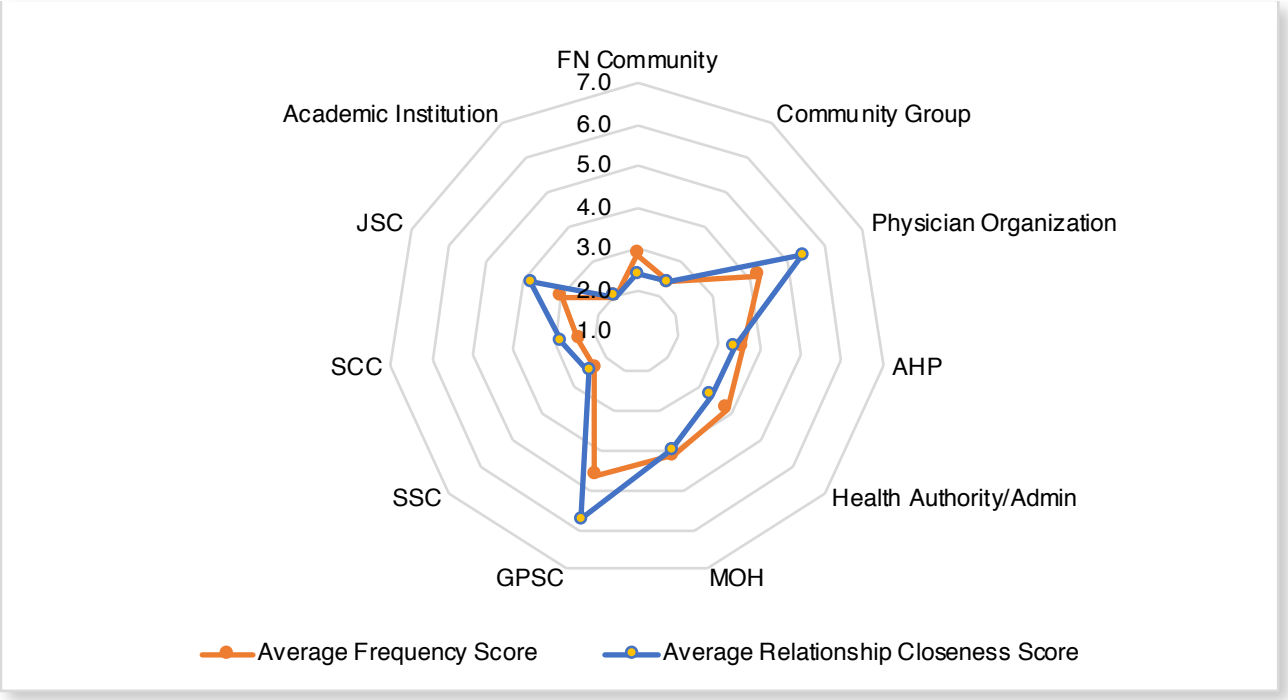
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*

** Top 3 Relationship Closeness Scores highlighted*

General Practice Services Committee (GPSC)

Number of Respondents: 8

Relationship closeness score of GPSC group for other primary identity groups



How close the General Practice Services Committee (GPSC) group feels (on average) to the other primary identity groups

Primary Identification	Average Frequency Score	Average Relationship Closeness Score
First Nations Community	2.88	2.38
Community Group or Patient Group	2.43	2.43
Physician Organization	4.25	5.43
Allied Health Providers	3.60	3.40
Health Authority / Admin	3.88	3.38
Ministry of Health (MOH)	4.13	4.00
General Practice Services Committee (GPSC)	4.63	5.75
Specialist Services Committee	2.33	2.50
Shared Care Committee	2.43	2.86
Joint Standing Committee on Rural Issues	3.00	3.83
Academic Institution	2.00	2.00

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*

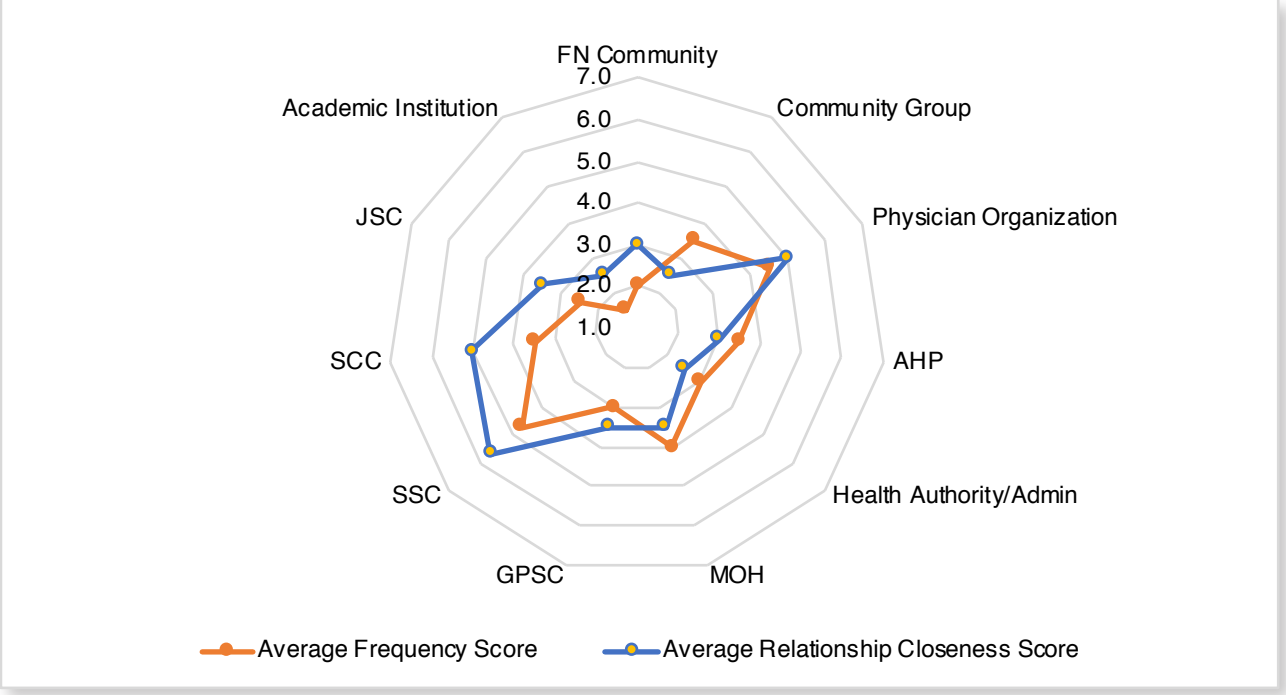
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*

** Top 3 Relationship Closeness Scores highlighted*

Specialist Services Committee

Number of Respondents: 3

Relationship closeness score of SSC group for other primary identity groups



How close the Specialist Services Committee group feels (on average) to the other primary identity groups

Primary Identification	Average Frequency Score	Average Relationship Closeness Score
First Nations Community	2.00	3.00
Community Group or Patient Group	3.50	2.50
Physician Organization	4.50	5.00
Allied Health Providers	3.50	3.00
Health Authority / Admin	3.00	2.50
Ministry of Health (MOH)	4.00	3.50
General Practice Services Committee (GPSC)	3.00	3.50
Specialist Services Committee	4.67	5.67
Shared Care Committee	3.50	5.00
Joint Standing Committee on Rural Issues	2.50	3.50
Academic Institution	1.50	2.50

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*

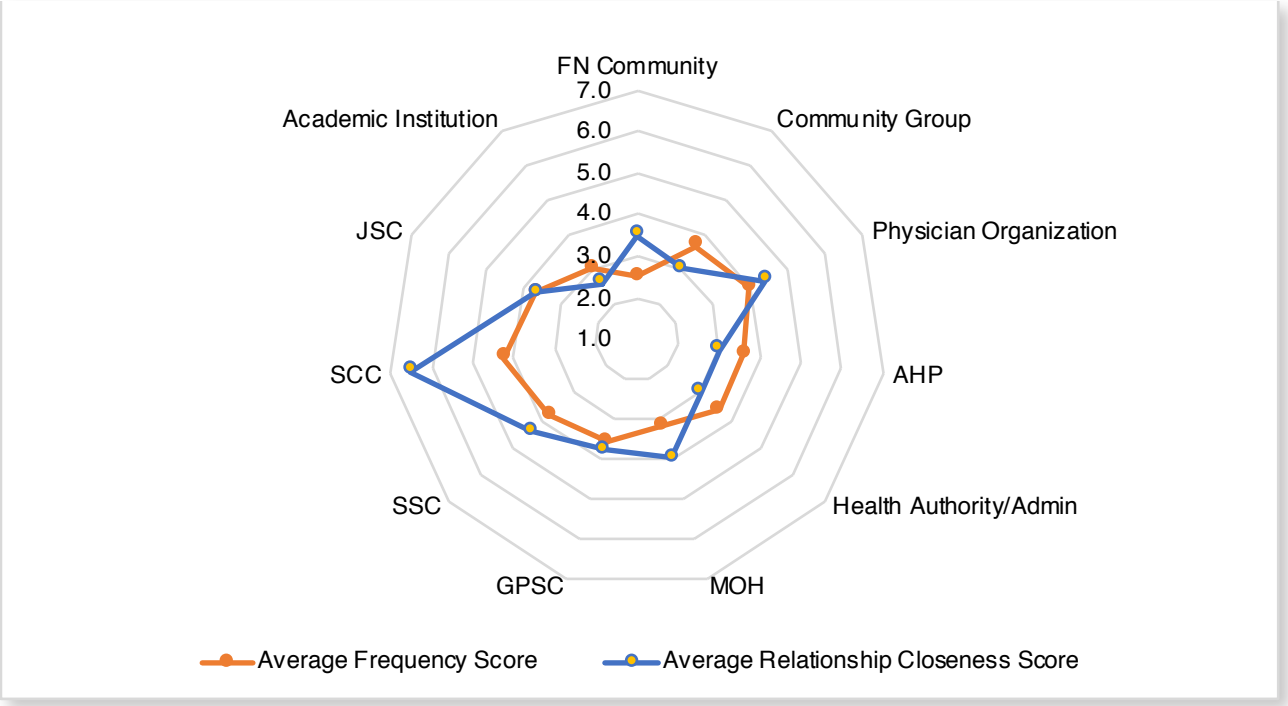
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*

** Top 3 Relationship Closeness Scores highlighted*

Shared Care Committee

Number of Respondents: 5

Relationship closeness score of SCC group for other primary identity groups



How close the Shared Care Committee group feels (on average) to the other primary identity groups

Primary Identification	Average Frequency Score	Average Relationship Closeness Score
First Nations Community	2.50	3.50
Community Group or Patient Group	3.67	3.00
Physician Organization	4.00	4.40
Allied Health Providers	3.60	3.00
Health Authority / Admin	3.60	3.00
Ministry of Health (MOH)	3.20	4.00
General Practice Services Committee (GPSC)	3.60	3.80
Specialist Services Committee	3.80	4.40
Shared Care Committee	4.25	6.50
Joint Standing Committee on Rural Issues	3.67	3.67
Academic Institution	3.00	2.60

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*

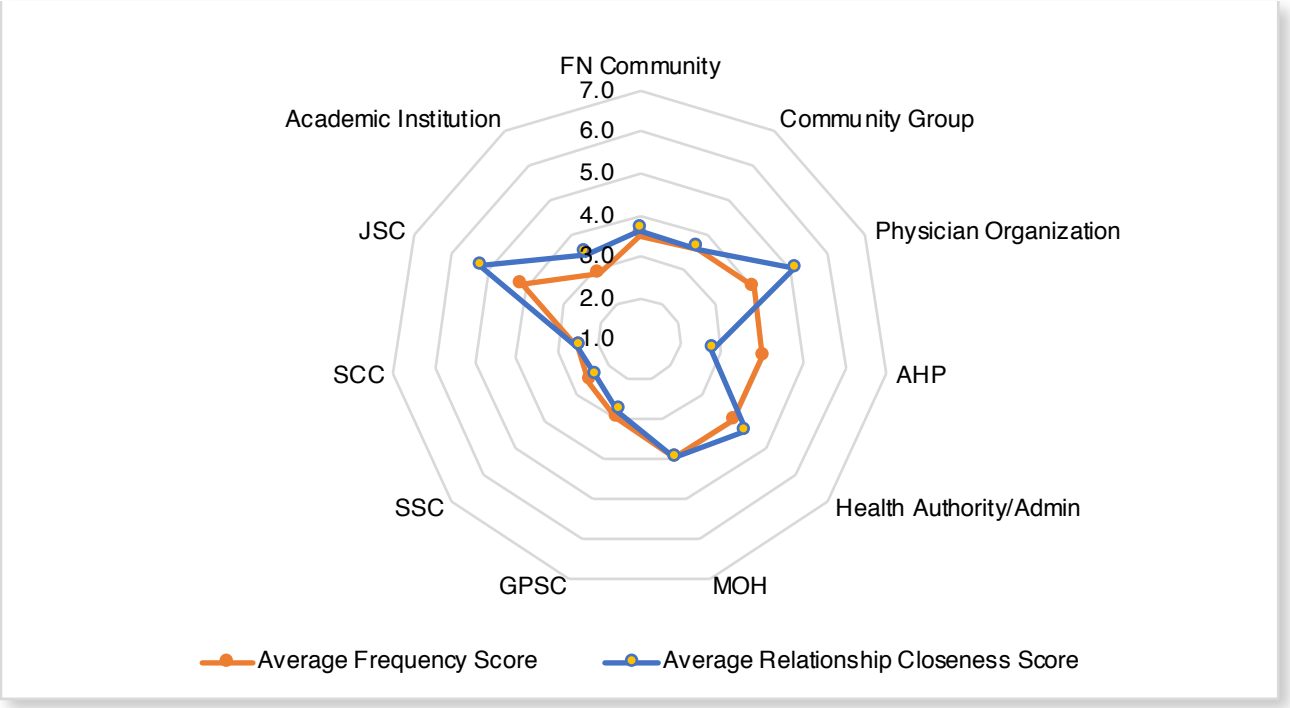
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*

** Top 3 Relationship Closeness Scores highlighted*

Joint Standing Committee on Rural Issues

Number of Respondents: 8

Relationship closeness score of JSC group for other primary identity groups



How close the Joint Standing Committee on Rural Issues group feels (on average) to the other primary identity groups

Primary Identification	Average Frequency Score	Average Relationship Closeness Score
First Nations Community	3.50	3.63
Community Group or Patient Group	3.60	3.60
Physician Organization	4.00	5.13
Allied Health Providers	4.00	2.75
Health Authority / Admin	4.00	4.38
Ministry of Health (MOH)	4.00	4.00
General Practice Services Committee (GPSC)	3.00	2.80
Specialist Services Committee	2.60	2.40
Shared Care Committee	2.50	2.50
Joint Standing Committee on Rural Issues	4.13	5.25
Academic Institution	2.86	3.43

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*

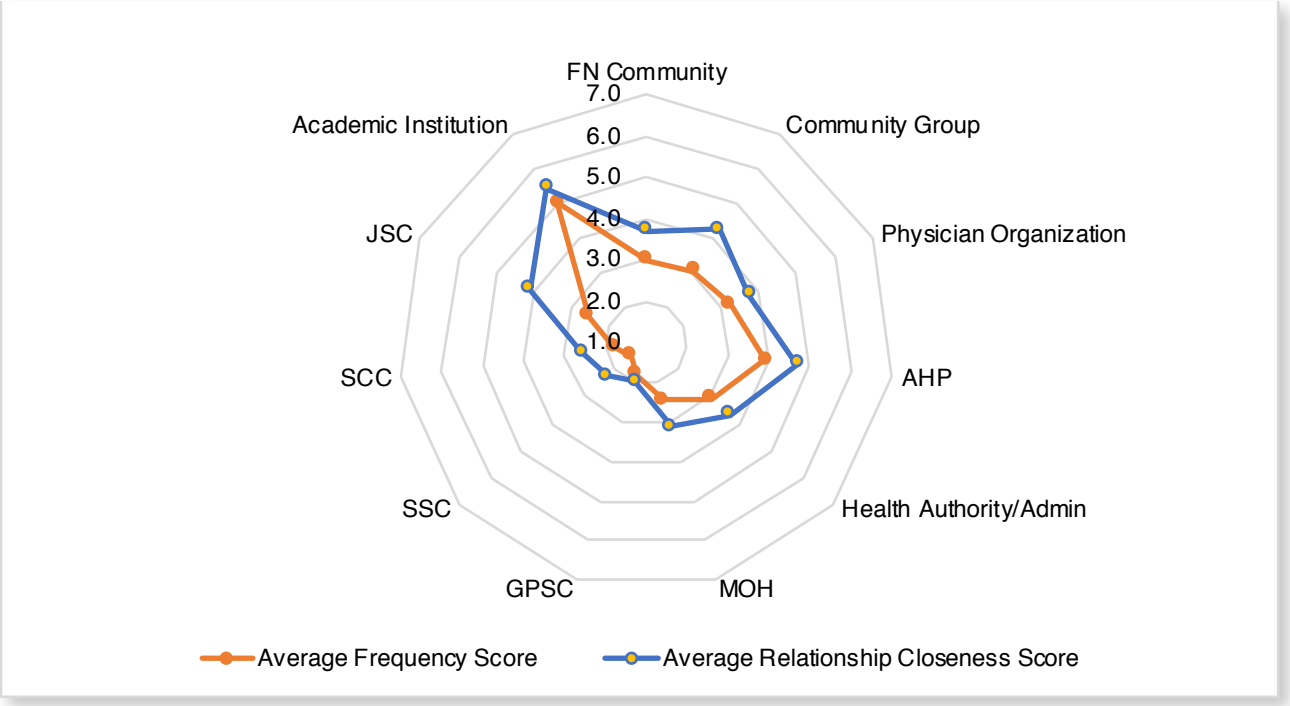
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*

** Top 3 Relationship Closeness Scores highlighted*

Academic Institution

Number of Respondents: 16

Relationship closeness score of Academic Institution group for other primary identity groups



How close the Academic Institution group feels (on average) to the other primary identity groups

Primary Identification	Average Frequency Score	Average Relationship Closeness Score
First Nations Community	3.00	3.69
Community Group or Patient Group	3.08	4.23
Physician Organization	3.20	3.73
Allied Health Providers	3.92	4.69
Health Authority / Admin	3.07	3.67
Ministry of Health (MOH)	2.44	3.11
General Practice Services Committee (GPSC)	1.83	2.00
Specialist Services Committee	1.50	2.25
Shared Care Committee	1.80	2.60
Joint Standing Committee on Rural Issues	2.56	4.11
Academic Institution	5.00	5.44

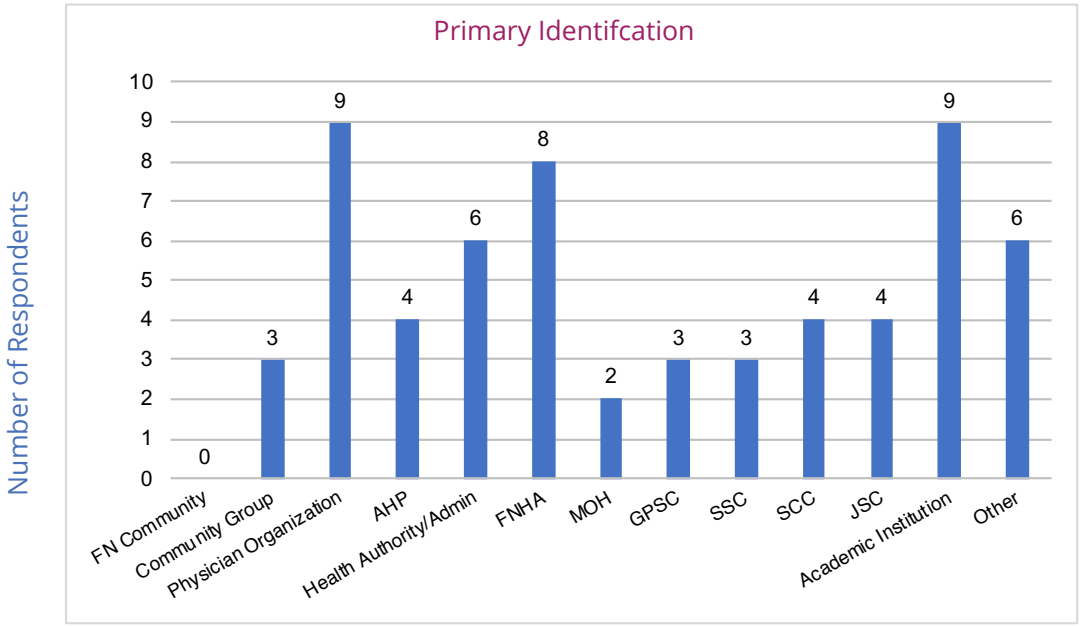
** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*

** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*

** Top 3 Relationship Closeness Scores highlighted*

POST-ASSESSMENT OVERVIEW OF PARTICIPANTS:

Organization or group that participants identified with most closely for this meeting



Sub-Groups	Frequency	Valid Percent
First Nations Community	0	0%
Community Group or Patient Group	3	5%
Physician Organization	9	15%
Allied Health Providers	4	7%
Health Authority / Admin	6	10%
First Nations Health Authority	8	13%
Ministry of Health (MOH)	2	3%
General Practice Services Committee (GPSC)	3	5%
Specialist Services Committee	3	5%
Shared Care Committee	4	7%
Joint Standing Committee on Rural Issues	4	7%
Academic Institution	9	15%
Others	6	10%
Total	**61**	**100%**

NOTE TO READER:

The post-assessment survey was conducted at the end of the second day of the retreat. Understandably, many participants had to depart the retreat an hour or two early to catch flights. It is important to review the comparison data below with the understanding that the number of participants in the post-assessment (61) were significantly lower than the pre-assessment (123). Thus we can expect some of the differences shown to be a reflection of this fact.

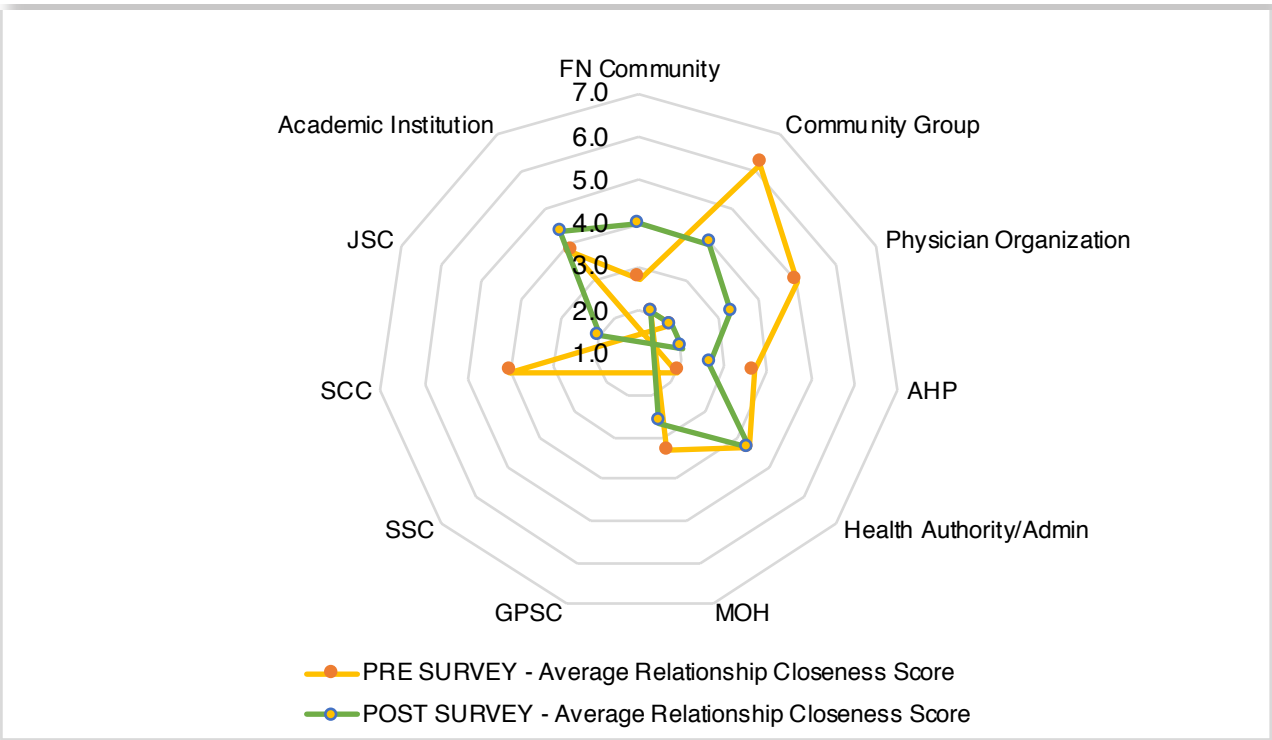
As there were no post-assessment surveys completed by participants identifying in the First Nations Community Group, we could not conduct a comparison analysis.

PRE-POST ASSESSMENT COMPARISON RESULTS:

Community Group or Patient Group

Number of Pre Respondents: 5 Number of Post Respondents: 3

Relationship closeness score of Community group for other primary identity groups



How close the Community Group or Patient Group feels (on average) to the other primary identity groups

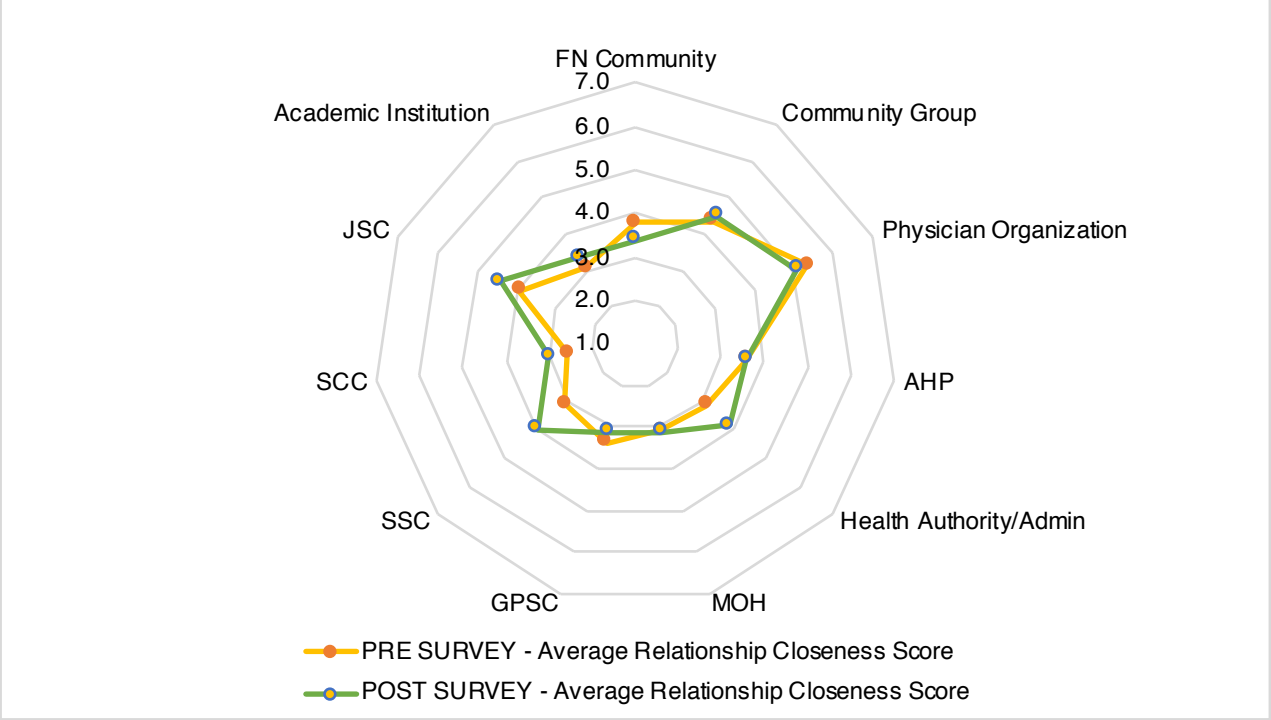
Primary Identification	PRE SURVEY - Average Relationship Closeness Score	POST SURVEY - Average Relationship Closeness Score
First Nations Community	2.75	4.00
Community Group or Patient Group	6.20	4.00
Physician Organization	5.00	3.33
Allied Health Providers	3.67	2.67
Health Authority / Admin	4.33	4.33
Ministry of Health (MOH)	3.33	2.67
General Practice Services Committee (GPSC)	0.00	0.00
Specialist Services Committee	0.00	0.00
Shared Care Committee	4.00	0.00
Joint Standing Committee on Rural Issues	0.00	2.00
Academic Institution	3.80	4.33

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*
** Top 3 Relationship Closeness Scores highlighted*

Physician Organization

Number of Pre Respondents: 14 Number of Post Respondents: 9

Relationship closeness score of Physician Organization for other primary identity groups



How close the Physician Organization group feels (on average) to the other primary identity groups

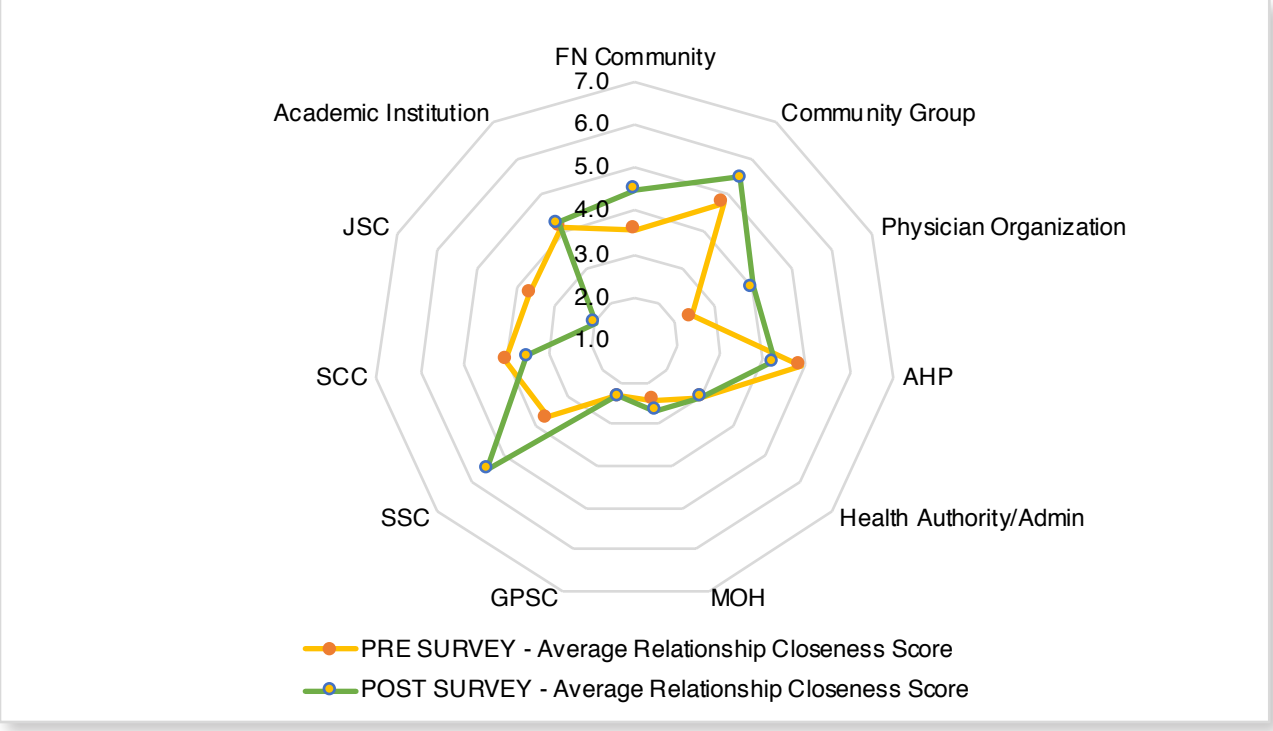
Primary Identification	PRE SURVEY - Average Relationship Closeness Score	POST SURVEY - Average Relationship Closeness Score
First Nations Community	3.80	3.38
Community Group or Patient Group	4.33	4.50
Physician Organization	5.36	5.11
Allied Health Providers	3.60	3.57
Health Authority / Admin	3.15	3.86
Ministry of Health (MOH)	3.08	3.13
General Practice Services Committee (GPSC)	3.36	3.13
Specialist Services Committee	3.13	4.00
Shared Care Committee	2.56	3.00
Joint Standing Committee on Rural Issues	3.91	4.43
Academic Institution	3.08	3.38

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*
** Top 3 Relationship Closeness Scores highlighted*

Allied Health Providers

Number of Pre Respondents: 7 Number of Post Respondents: 4

Relationship closeness score of AHP group for other primary identity groups



How close the Allied Health Providers group feels (on average) to the other primary identity groups

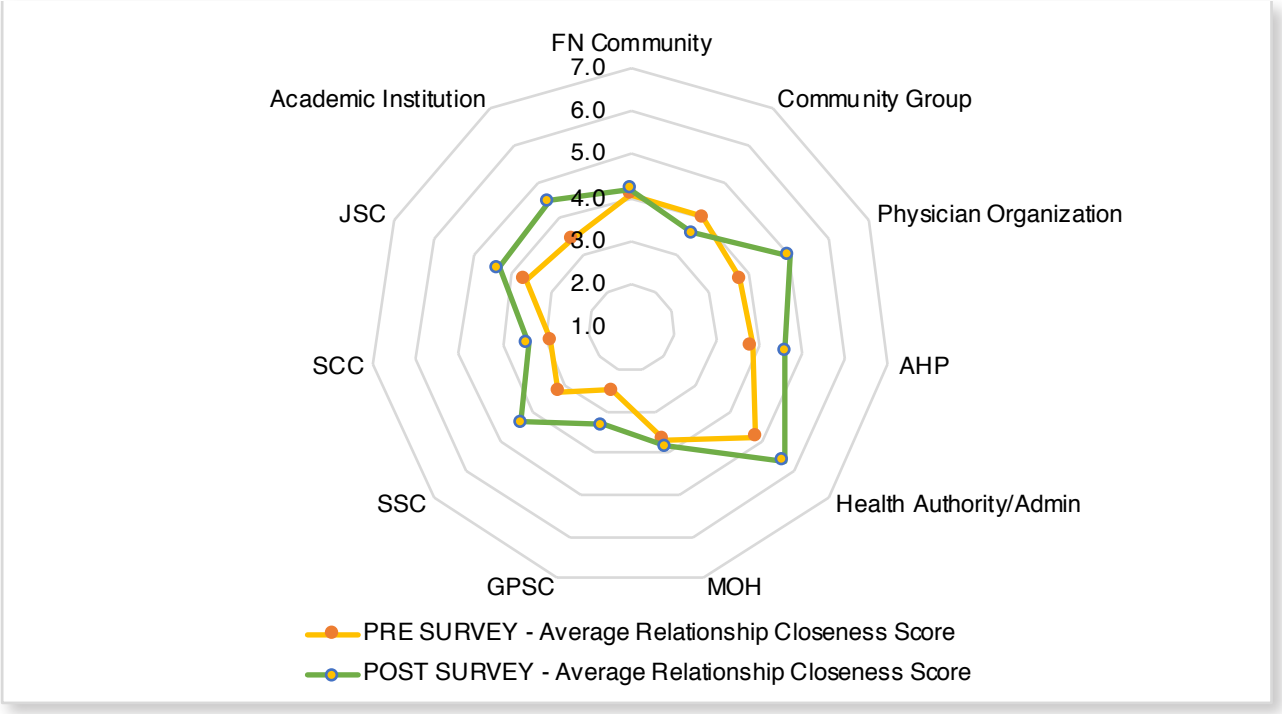
Primary Identification	PRE SURVEY - Average Relationship Closeness Score	POST SURVEY - Average Relationship Closeness Score
First Nations Community	3.57	4.50
Community Group or Patient Group	4.80	5.50
Physician Organization	2.43	4.00
Allied Health Providers	4.86	4.25
Health Authority / Admin	3.00	3.00
Ministry of Health (MOH)	2.43	2.67
General Practice Services Committee (GPSC)	2.33	2.33
Specialist Services Committee	3.67	5.50
Shared Care Committee	4.00	3.50
Joint Standing Committee on Rural Issues	3.67	2.00
Academic Institution	4.14	4.25

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*
** Top 3 Relationship Closeness Scores highlighted*

Health Authority / Admin

Number of Pre Respondents: 17 Number of Post Respondents: 6

Relationship closeness score of Health Authority / Admin group for other primary identity groups



How close the Health Authority / Admin group feels (on average) to the other primary identity groups

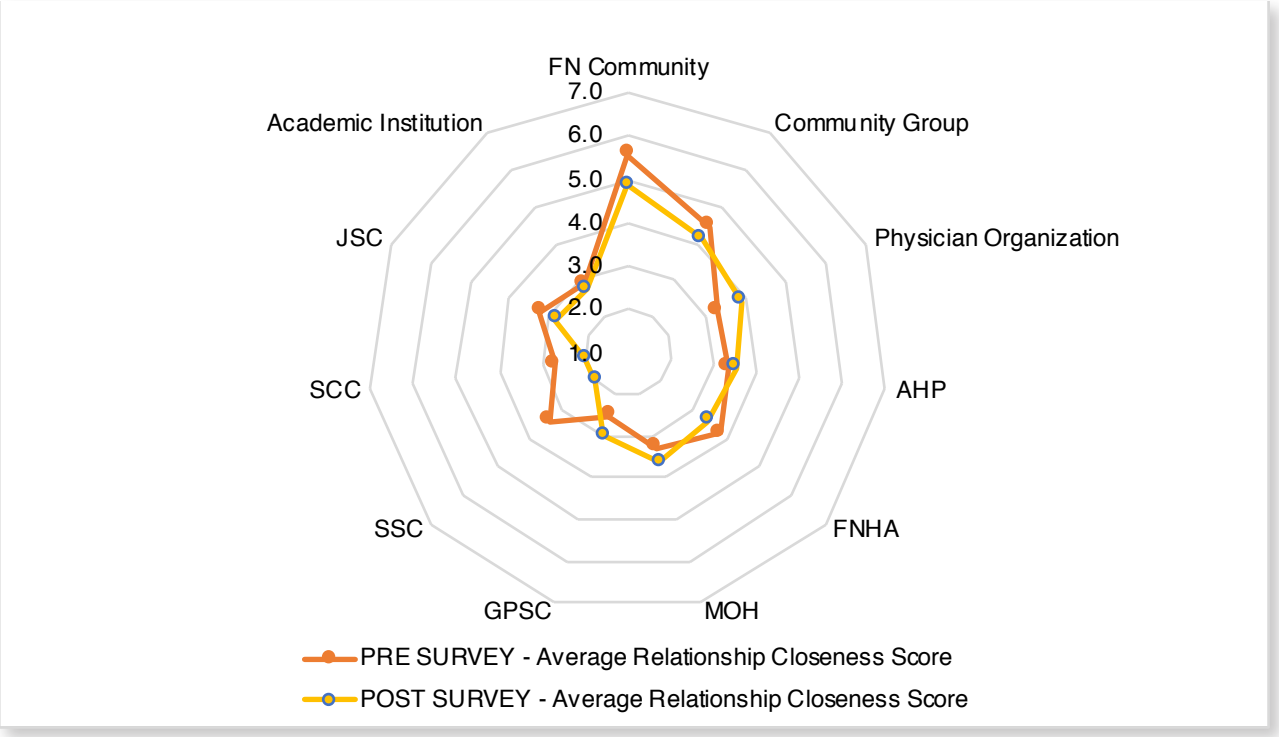
Primary Identification	PRE SURVEY - Average Relationship Closeness Score	POST SURVEY - Average Relationship Closeness Score
First Nations Community	4.07	4.20
Community Group or Patient Group	4.04	3.60
Physician Organization	3.78	5.00
Allied Health Providers	3.81	4.60
Health Authority / Admin	4.81	5.67
Ministry of Health (MOH)	3.68	3.83
General Practice Services Committee (GPSC)	2.50	3.33
Specialist Services Committee	3.21	4.33
Shared Care Committee	2.88	3.40
Joint Standing Committee on Rural Issues	3.67	4.33
Academic Institution	3.48	4.50

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*
** Top 3 Relationship Closeness Scores highlighted*

First Nations Health Authority

Number of Pre Respondents: 12 Number of Post Respondents: 8

Relationship closeness score of FNHA group for other primary identity groups



How close the First Nations Health Authority group feels (on average) to the other primary identity groups

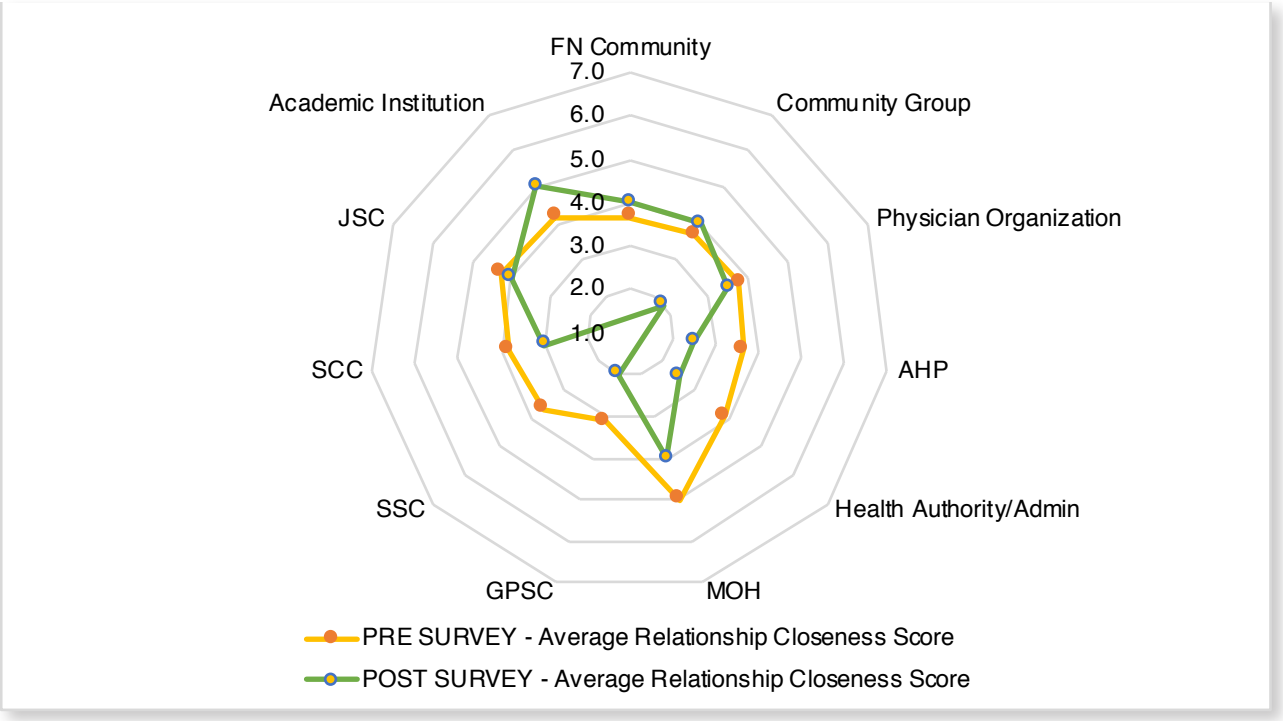
Primary Identification	PRE SURVEY - Average Relationship Closeness Score	POST SURVEY - Average Relationship Closeness Score
First Nations Community	5.58	4.88
Community Group or Patient Group	4.45	4.14
Physician Organization	3.27	3.86
Allied Health Providers	3.33	3.50
First Nations Health Authority	3.82	3.43
Ministry of Health (MOH)	3.27	3.63
General Practice Services Committee (GPSC)	2.50	3.00
Specialist Services Committee	3.40	2.00
Shared Care Committee	2.71	2.00
Joint Standing Committee on Rural Issues	3.25	2.83
Academic Institution	2.88	2.75

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*
** Top 3 Relationship Closeness Scores highlighted*

Ministry of Health (MOH)

Number of Pre Respondents: 10 Number of Post Respondents: 2

Relationship closeness score of MOH group for other primary identity groups



How close the Ministry of Health (MOH) group feels (on average) to the other primary identity groups

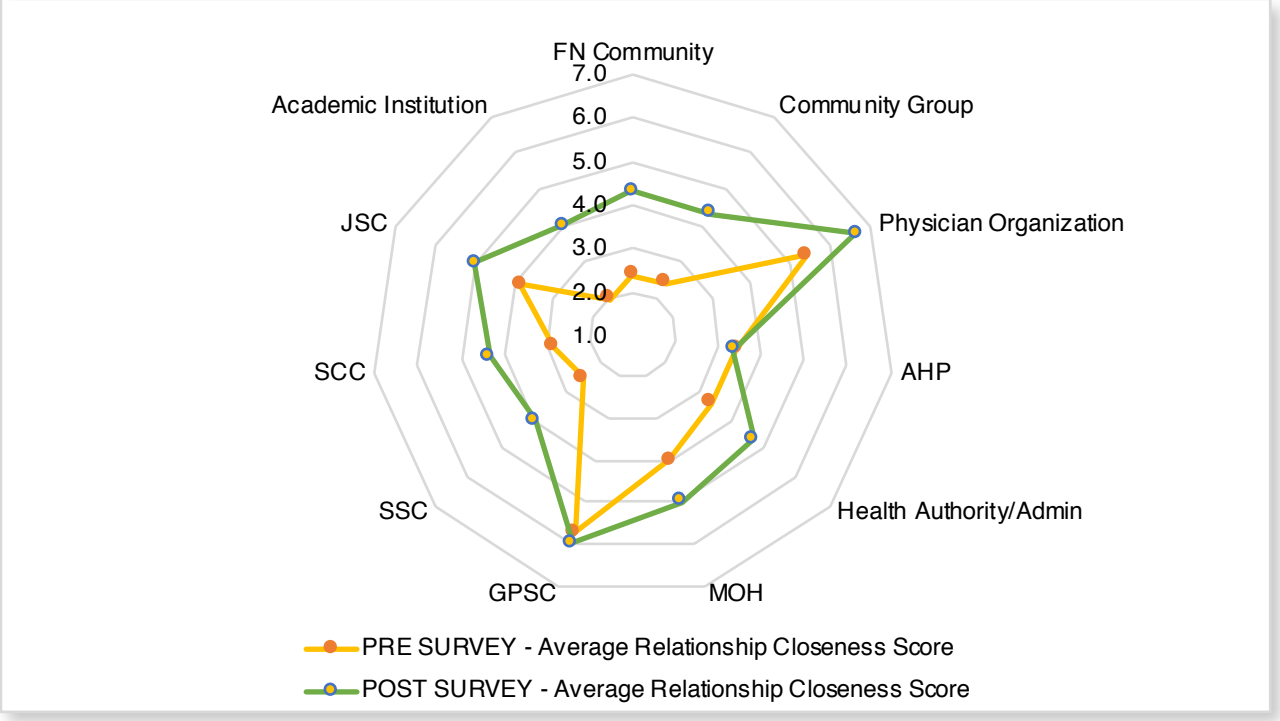
Primary Identification	PRE SURVEY - Average Relationship Closeness Score	POST SURVEY - Average Relationship Closeness Score
First Nations Community	3.67	4.00
Community Group or Patient Group	3.71	4.00
Physician Organization	3.78	3.50
Allied Health Providers	3.63	2.50
Health Authority / Admin	3.90	2.50
Ministry of Health (MOH)	5.00	4.00
General Practice Services Committee (GPSC)	3.13	2.00
Specialist Services Committee	3.67	0.00
Shared Care Committee	3.83	3.00
Joint Standing Committee on Rural Issues	4.29	4.00
Academic Institution	4.17	5.00

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*
** Top 3 Relationship Closeness Scores highlighted*

General Practice Services Committee (GPSC)

Number of Pre Respondents: 8 Number of Post Respondents: 3

Relationship closeness score of GPSC group for other primary identity groups



How close the General Practice Services Committee (GPSC) group feels (on average) to the other primary identity groups

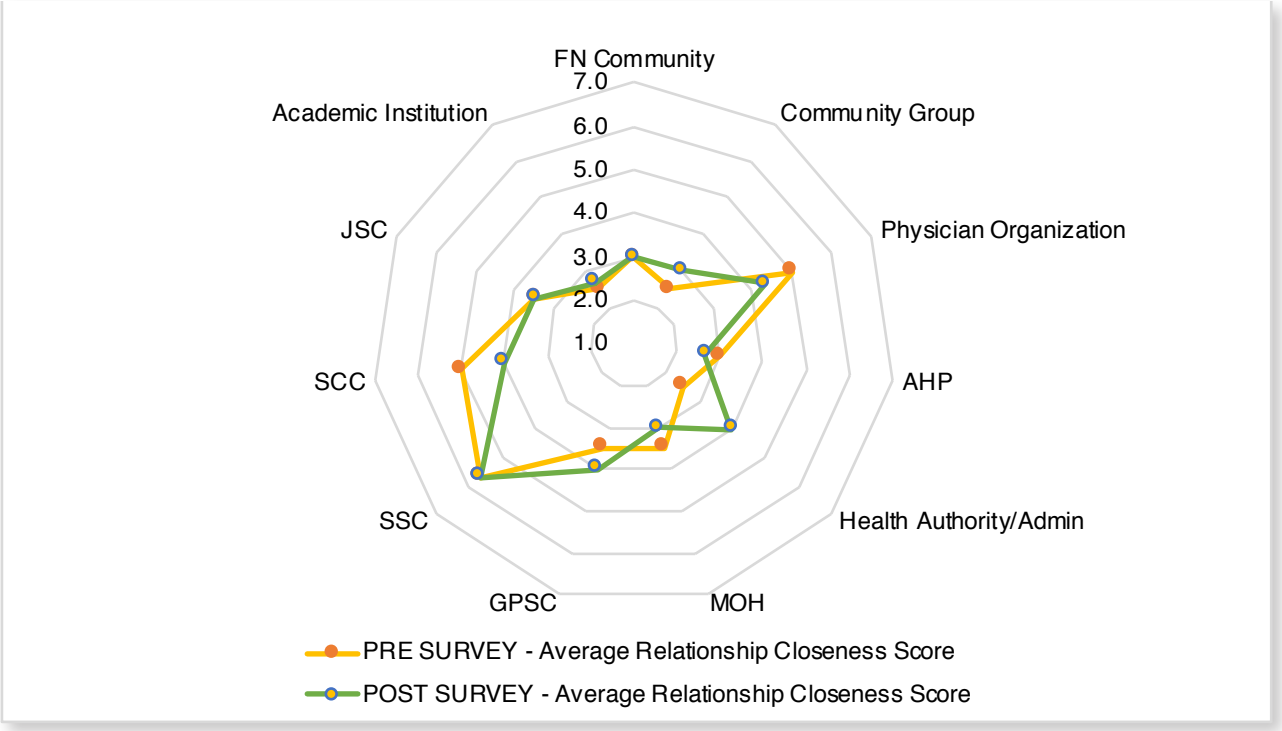
Primary Identification	PRE SURVEY - Average Relationship Closeness Score	POST SURVEY - Average Relationship Closeness Score
First Nations Community	2.38	4.33
Community Group or Patient Group	2.43	4.33
Physician Organization	5.43	6.67
Allied Health Providers	3.40	3.33
Health Authority / Admin	3.38	4.67
Ministry of Health (MOH)	4.00	5.00
General Practice Services Committee (GPSC)	5.75	6.00
Specialist Services Committee	2.50	4.00
Shared Care Committee	2.86	4.33
Joint Standing Committee on Rural Issues	3.83	5.00
Academic Institution	2.00	4.00

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*
** Top 3 Relationship Closeness Scores highlighted*

Specialist Services Committee

Number of Pre Respondents: 3 Number of Post Respondents: 3

Relationship closeness score of SSC group for other primary identity groups



How close the Specialist Services Committee group feels (on average) to the other primary identity groups

Primary Identification	PRE SURVEY - Average Relationship Closeness Score	POST SURVEY - Average Relationship Closeness Score
First Nations Community	3.00	3.00
Community Group or Patient Group	2.50	3.00
Physician Organization	5.00	4.33
Allied Health Providers	3.00	2.67
Health Authority / Admin	2.50	4.00
Ministry of Health (MOH)	3.50	3.00
General Practice Services Committee (GPSC)	3.50	4.00
Specialist Services Committee	5.67	5.67
Shared Care Committee	5.00	4.00
Joint Standing Committee on Rural Issues	3.50	3.50
Academic Institution	2.50	2.67

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*

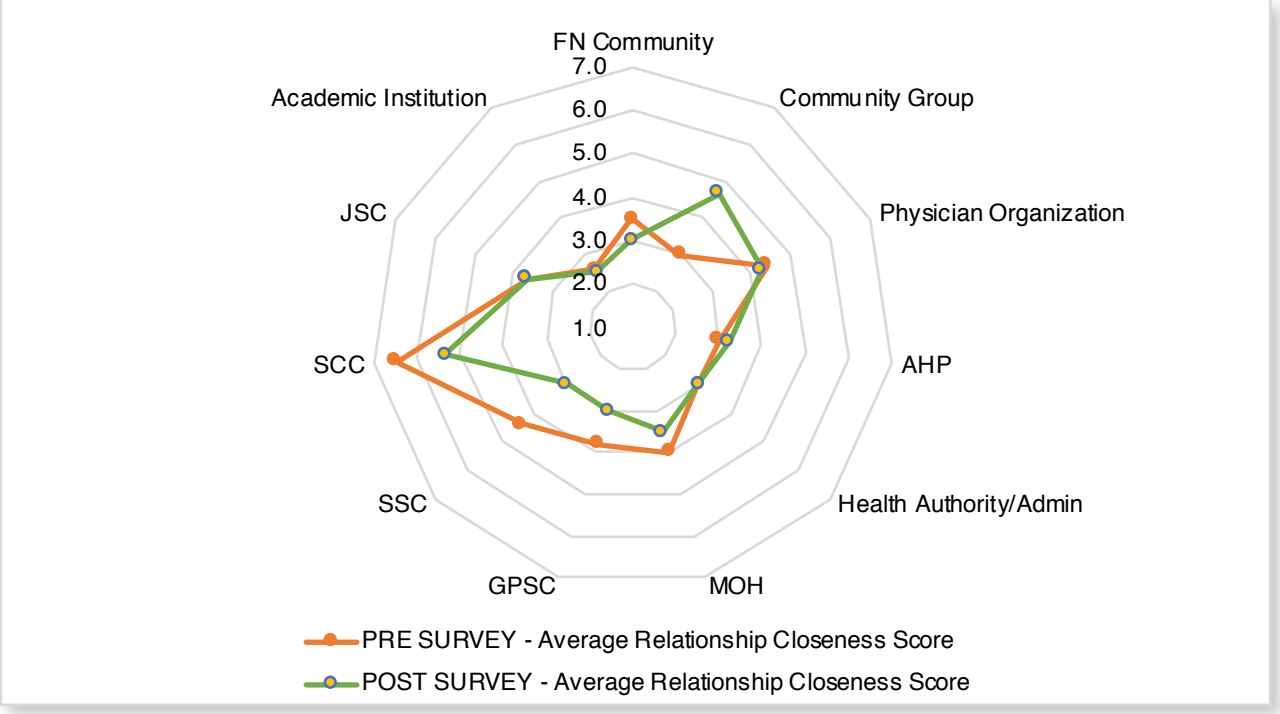
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*

** Top 3 Relationship Closeness Scores highlighted*

Shared Care Committee

Number of Pre Respondents: 5 Number of Post Respondents: 4

Relationship closeness score of SCC group for other primary identity groups



How close the Shared Care Committee group feels (on average) to the other primary identity groups

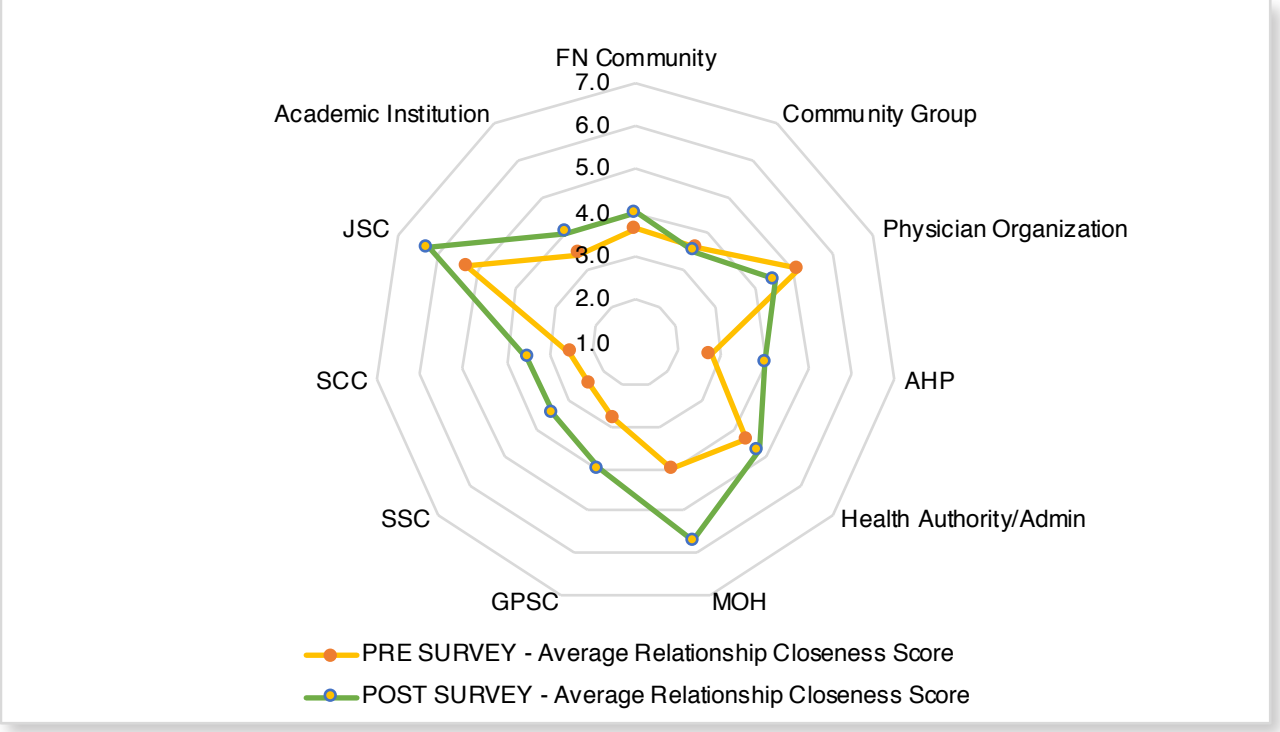
Primary Identification	PRE SURVEY - Average Relationship Closeness Score	POST SURVEY - Average Relationship Closeness Score
First Nations Community	3.50	3.00
Community Group or Patient Group	3.00	4.67
Physician Organization	4.40	4.25
Allied Health Providers	3.00	3.25
Health Authority / Admin	3.00	3.00
Ministry of Health (MOH)	4.00	3.50
General Practice Services Committee (GPSC)	3.80	3.00
Specialist Services Committee	4.40	3.00
Shared Care Committee	6.50	5.33
Joint Standing Committee on Rural Issues	3.67	3.67
Academic Institution	2.60	2.50

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*
** Top 3 Relationship Closeness Scores highlighted*

Joint Standing Committee on Rural Issues

Number of Pre Respondents: 8 Number of Post Respondents: 4

Relationship closeness score of JSC group for other primary identity groups



How close the Joint Standing Committee on Rural Issues group feels (on average) to the other primary identity groups

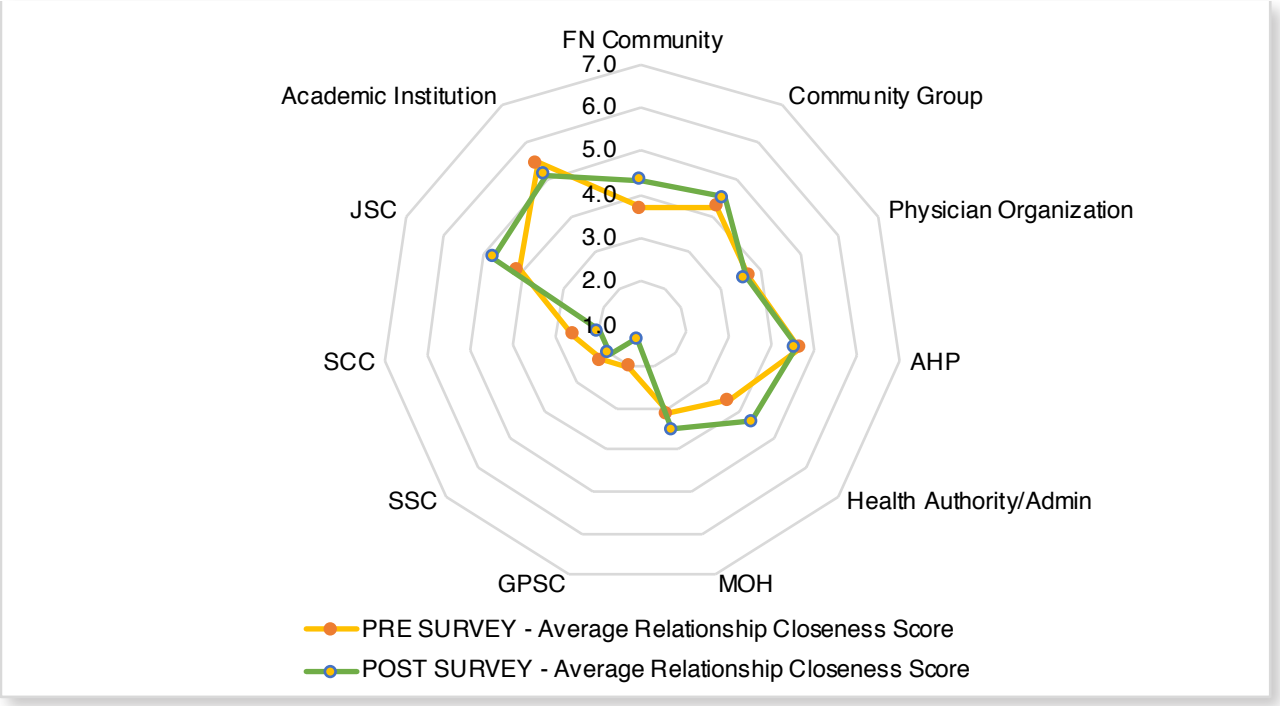
Primary Identification	PRE SURVEY - Average Relationship Closeness Score	POST SURVEY - Average Relationship Closeness Score
First Nations Community	3.63	4.00
Community Group or Patient Group	3.60	3.50
Physician Organization	5.13	4.50
Allied Health Providers	2.75	4.00
Health Authority / Admin	4.38	4.75
Ministry of Health (MOH)	4.00	5.75
General Practice Services Committee (GPSC)	2.80	4.00
Specialist Services Committee	2.40	3.50
Shared Care Committee	2.50	3.50
Joint Standing Committee on Rural Issues	5.25	6.25
Academic Institution	3.43	4.00

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*
** Top 3 Relationship Closeness Scores highlighted*

Academic Institution

Number of Pre Respondents: 16 Number of Post Respondents: 9

Relationship closeness score of Academic Institution group for other primary identity groups



How close the Academic Institution group feels (on average) to the other primary identity groups

Primary Identification	PRE SURVEY - Average Relationship Closeness Score	POST SURVEY - Average Relationship Closeness Score
First Nations Community	3.69	4.33
Community Group or Patient Group	4.23	4.50
Physician Organization	3.73	3.63
Allied Health Providers	4.69	4.57
Health Authority / Admin	3.67	4.38
Ministry of Health (MOH)	3.11	3.50
General Practice Services Committee (GPSC)	2.00	1.33
Specialist Services Committee	2.25	2.00
Shared Care Committee	2.60	2.00
Joint Standing Committee on Rural Issues	4.11	4.75
Academic Institution	5.44	5.11

** Frequency of work Scores assumed (Daily - 5, Weekly - 4, Monthly - 3, Quarterly - 2, Annually - 1)*
** Relationship Closeness Score (1 to 7), 7 being highest, and 1 being lowest*
** Top 3 Relationship Closeness Scores highlighted*

LIMITATIONS:

Sample sizes for the pre- and post- survey assessments were relatively small (pre:123, post: 61), and the number of participants in several subgroups were very small (e.g. 2-3). Participants were aggregated into subgroups based on the organization/group they self-identified as being the primary perspective they were bringing to the meeting. The results represent the individual perspectives of each groups' participants and should not be taken to representative of that entire organization or group. The Inclusion of the Other in the Self (IOS) scale was originally developed and validated to assess individual's subjective perceptions of relationship closeness to other individuals. This pilot adapted the scale to focus on how close participants felt to their own primary organization or group. Although the same adaptation has been made in another study[5], it should be acknowledged that this is a deviation from the tool's initial application.

1: Aron A, Aron EN, Smollan D (1992) Inclusion of Other in the Self Scale and the structure of interpersonal closeness. Journal of Personality and Social Psychology 63: 596–612.

2: Aron A, Aron EN, Smollan D (1992) Inclusion of Other in the Self Scale and the structure of interpersonal closeness. Journal of Personality and Social Psychology 63: 596–612.

3: Gächter S, Starmer C, Tufano F (2015) Measuring the Closeness of Relationships: A Comprehensive Evaluation of the 'Inclusion of the Other in the Self' Scale. PLoS ONE 10(6): e0129478.

4: Bergami, M, Bagozzi, RP (2000) Self-categorization, affective commitment and group self-esteem as distinct aspects of social identity in the organization. The British Journal of Social Psychology; Dec 2000; 39, Sociology Collection pg. 555

5: Bergami, M, Bagozzi, RP (2000) Self-categorization, affective commitment and group self-esteem as distinct aspects of social identity in the organization. The British Journal of Social Psychology; Dec 2000; 39, Sociology Collection pg. 555