CO-CREATING OUR FUTURE:
INTEGRATED HEALTH HUMAN
RESOURCE PLANNING, REIMAGINED

February 2024
EXECUTIVE SUMMARY

Over two days in October, the Canadian Medical Association (CMA) hosted a co-creation event with representatives from a diverse group of more than 40 national and provincial health care organizations and the CMA’s Patient Voice group. The aim of the meeting was to create a shared vision of integrated health human resource planning (IHHRP) in Canada for a reimagined future health care system — one of the goals of the CMA’s Impact 2040 strategy.

Building on collaborative work done in other settings, attendees worked through a series of breakout sessions in small groups in a facilitated process to determine:

- Existing barriers to effective IHHRP
- A vision and ideal state for the future of IHHRP
- Foundational principles of a patient-partnered framework
- Implementation considerations, including conditions for success
- Possible next steps

Following extensive discussions and prioritization by those in attendance, FIVE VARIABLES WERE IDENTIFIED AS PRIORITY HEALTH WORKFORCE PLANNING COMPONENTS that would make up a pan-Canadian framework required to reach the ideal state:

1. Patient partnered and rooted in community

2. Governance

3. Data and insights

4. The social determinants of health

5. Integrated workforce
Other themes that the group identified included:

- Respecting the unique governance issues of Indigenous peoples and Indigenous data sovereignty and involving Indigenous communities in IHHRP (the term intersectionality was raised in relation to Indigenous communities)
- Having a learning health care system
- Basing planning on needs of patients rather than focusing on who is providing the service
- Respecting the Quintuple Aim of a quality health care system with a focus on advancing health equity, enhancing clinician well-being, improving population health, enhancing the patient experience and reducing costs
- Reimagining health professional education to involve patients more fully, break down learning silos and support the new model of care
- Considering the balance between optimizing scopes of practice and maintaining/improving quality of care
- Improving access to care that is integrated and offers continuity
- Having long-term planning goals and a constantly refreshed set of quantitative and qualitative data to support these goals

Partnership with patients, represented at this event by members of the CMA Patient Voice committee who served as speakers and participants, was acknowledged by various participants as a fundamental part of the meeting. Similarly, codeveloping an IHHRP framework with active partnership of patients and caregivers as well as the various communities impacted by this planning was repeatedly identified as essential to an IHHRP framework, as evidenced by the priority principle of “patient partnered and rooted in community” receiving the highest ranking.

In concluding statements, it was noted that the collective work done at the meeting, coupled with the shared desire to move forward together, had laid the groundwork for transformational change and there was an open invitation from the CMA to continue collaborative work on the topic.

**PREFACE**

This report summarizes key elements of a two-day event, including presentation highlights, discussions and working group outputs, focused on creating a collective vision for the ideal state for an integrated health workforce in Canada and developing priority considerations for a framework for planning for this ideal state. The intent is that future co-created work will develop an integrated health workforce plan that will be rooted in the elements of this shared vision, moving beyond the vision to dive into the practical work of building out the priority elements, with consideration for implementation.

Consistent with the commitment of co-creation, participants at the event asked for the opportunity to review and validate this summary report. In this report, an effort has been made to reflect the supplementary feedback gathered and represent the diverse perspectives of the participants who came together to build a shared vision for integrated health human resources planning in Canada.
Developing an integrated health human resource planning (IHHRP) framework to support a reimagined Canadian health care system was the focus of a two-day invitational conference hosted by the Canadian Medical Association (CMA) on Oct. 26 and 27, 2023. Acknowledged as involving complex but foundational issues impacting all people in Canada, such an IHHRP framework is one of the priority issues for the CMA in its Impact 2040 strategy. The co-creation event was held with representatives from a diverse group of more than 40 national and provincial health care organizations and the CMA’s Patient Voice advisory group (see Appendix 1). Allison Seymour, CMA executive vice-president for strategy and partnerships, noted that development of the IHHRP framework is closely connected with other priorities of Impact 2040, which is deliberately aspirational and based on finding collaborative solutions.

Just before the meeting, the CMA released results of an [Ipsos poll] of MORE THAN 3,000 CANADIANS showing

- 87% agree a long-term plan for the health workforce is needed
- 83% agree a lack of cooperation and coordination between levels of government is a significant barrier to implementing a long-term health workforce plan
Day 1

The meeting was structured around keynote speakers and panels and a series of breakout sessions (see Appendix 2) designed to create a shared vision of IHHRP in Canada to reimagine health workforce planning from a systems perspective. In introductory remarks, the CMA meeting facilitator emphasized the diverse nature of those in attendance and the importance of using this opportunity to build new relationships and foster existing connections. The complex but foundational nature of the issues to be discussed was also noted.

Citing work by Dr. Ivy Bourgeault, leader of the Canadian Health Workforce Network, the meeting facilitator noted that current health workforce planning in Canada “is ad hoc, sporadic, and siloed by profession or jurisdiction.” Continuing to cite the work of Dr. Bourgeault, the facilitator added that “this patchwork approach also tends to ignore changing professional life cycles, demographics and population health.”

Several speakers set the stage for the sessions that followed.

In her opening remarks, CMA President Dr. Kathleen Ross touched on the widespread challenges associated with access to care and high levels of burnout among health workers, making it the right time to come together around IHHRP. She provided an example from her own practice of how Canada’s current approach to planning — or lack thereof — is directly affecting patients and providers. Dr. Ross noted the diverse nature of those in attendance and said she hoped they would bring their front-line experiences to help develop a collaborative solution to the issue.

“Our ultimate goal is to ensure that people in Canada have equitable access to care when they need it, that we have a healthy, engaged and fulfilled workforce and that our system is culturally, physically and psychologically safe for our workers to stay in.”

Dr. Kathleen Ross, CMA president

Canadian Nurses Association President Dr. Sylvain Brousseau addressed the specific challenges facing the nursing profession in Canada in attracting and retaining the necessary number of nurses. He talked about the importance of advocacy and building consensus on future action on IHHRP. “When partners unite, we are stronger and governments cannot ignore us,” he said, noting governments are now starting to adopt the language used by health care organizations in discussing health care issues such as IHHRP.
“Retention will increase if we improve workplace wellness by getting rid of violence, racism, harassment and discrimination in our health care organizations. And we should invest in collaborative teams and reduce the administrative burden on health workers so they can focus on patient care.”

Dr. Sylvain Brousseau, Canadian Nurses Association president

Dr. David Peache, principal at Health Intelligence Inc. and an expert in health policy and planning, provided the theoretical basis for the meeting in two presentations. In his first talk, Dr. Peache gave an overview of the culture of planning in health care and its importance. Here he noted that resource planning and associated policies will be dysfunctional unless they are integrated and coordinated across the health workforce. He introduced the concept that such planning must always be done with a focus on the needs of the patients or population at the centre of care delivery. In his second presentation, Dr. Peache talked about how planning models for an IHHRp framework have evolved and matured and outlined the essential elements of a planning framework. He also listed many lessons learned from earlier IHHRp initiatives, including the need for a commitment to prioritize collaborative care and to refresh the population data upon which an IHHR plan is based.

“Health care systems all have potential, but you are not going to achieve their full potential unless you have a [HHR] plan.”

Dr. David Peache, principal, Health Intelligence Inc.

A patient panel with four representatives from the CMA’s Patient Voice presented their perspectives on the challenges they faced with the existing system and their priorities for an IHHRP framework. They raised several themes that were reiterated throughout the meeting, including the need to involve patients and caregivers from the start and throughout all aspects of IHHRP, the importance of team-based care, and the need to emphasize preventive health services. They also highlighted the lack of integration of health services and communications between providers.
"We would not have gotten to this current state of the health care system and collapse if patients and caregivers were involved at the beginning of workforce planning.”

CMA Patient Voice representative

Before moving into small-group work sessions, attendees voiced strong agreement for developing an IHHRP framework that would support a reimagined health care system in Canada rather than working on a plan to enhance and improve the existing system.

After setting out their expectations for the meeting, attendees then outlined the primary barriers to effective IHHRP, including the following:

- Challenges for government — planning and delivery of care constrained by election cycles, federated model
- Lack of national coordination on cross-cutting issues
- Lack of integration, with roles of health care professionals not being clearly defined
- Lack of comprehensive, interoperable, timely and granular health data that can be easily accessed
- Lack of health worker data that capture scopes, competencies and specifically what providers are doing, not just what type of provider they are
- Siloed training of health care professionals
- Lack of patient involvement in IHHRP process
- Lack of universal, accessible, funded care from all health professionals
- Challenges within health worker training and education systems that prepare learners for future practice, including the need for a learning environment that promotes wellness and embodies the vision(s) for the future health workforce and related planning
- The need to rethink planning, structure, funding and legislation to enable the practical application of innovative solutions to create the ideal state of health workforce planning in Canada
Following a discussion on current barriers, **SIX THEMES CONSISTENTLY EMERGED AS CORE PRINCIPLES** required to support an ideal IHHRP framework

1. Whole person/patient centred

2. Data driven

3. Requiring governance/leadership

4. Rooted in the community, team based

5. Supported by technology including artificial intelligence (AI)

6. Requiring accountability/incentives

“We felt that we really need to rethink beyond acute care, beyond the Canada Health Act, to a more inclusive and comprehensive care model. Central to that should be a learning culture that is engineered to be adaptable to the needs of the community.”

*Small group report*

“I'm one of the people that people can't see when they swipe an OHIP [Ontario Health Insurance Plan] card. If we're talking about integrated health human resources — psychology, occupational therapy, social work and a number of other allied health professions are part of the health care system. If we want people to truly be able to access all of the services in the health care system, we have to take the barriers away from that.”

*Meeting participant*
Day 2

Day 2 of the meeting began with CMA Patient Voice representative Dr. Michelle Hamilton-Page setting the stage by reaffirming the importance of patient involvement in the IHHRP framework development process. They referenced earlier work done in the McMaster University Health Forum with citizen panels to address the politics of the HHR crisis. They also spoke favourably about the CMA process of partnering with patients in all phases of their planning work.

“Any time that you are talking about patient partnered or patient centred, I want you to just check in. Does your organization partner with patients? That doesn't mean doing polls or doing surveys. Are you partnering with patients?”

Dr. Michelle Hamilton-Page

Small working groups then discussed what variables were needed to create the ideal future state (see Appendix 2), an IHHRP framework that would be jurisdiction agnostic and could be applied by any province or territory. From these discussions and subsequent voting, **FIVE VARIABLES WERE IDENTIFIED AS THE HIGHEST PRIORITY FEATURES** of a national IHHRP framework for a transformed health workforce

**PATIENT PARTNERED AND ROOTED IN COMMUNITY**
Health workforce planning must include patient partnering at all stages to ensure that an integrated health human resources plan is designed to meet patient and population health needs

**GOVERNANCE**
Exploring essential aspects of governance of an ideal-state integrated health workforce plan

**DATA AND INSIGHTS**
Necessity to identify the ideal state for health workforce data to inform planning

**THE SOCIAL DETERMINANTS OF HEALTH**
Social determinants of health as a necessary lens to understand current and anticipated patient and provider needs and experiences as well as implications and considerations for integrated health workforce planning

**INTEGRATED WORKFORCE**
Ideal-state health workforce planning in Canada must be integrated and move beyond professional and jurisdictional silos
Other themes that emerged during several of the discussions included:

- Respecting the unique governance issues of Indigenous peoples and Indigenous data sovereignty and involving Indigenous communities in IHHRP
- Having a learning health care system
- Basing planning on needs of patients rather than focusing on who is providing the service
- Respecting the Quintuple Aim of a quality health care system with a focus on advancing health equity, enhancing clinician well-being, improving population health, enhancing the patient experience and reducing costs
- Reimaging health professional education to involve patients more fully, break down learning silos and support the new models of care
- Considering the balance between optimizing scopes of practice and maintaining/improving quality of care.
- Improving access to care that is integrated and offers continuity
- Ensuring funded care from all health professionals so that integrated care is truly accessible and appropriately planned
- Having long-term planning goals and a constantly refreshed set of quantitative and qualitative data to support these goals

“An IHHRP framework needs to be funded based on data-driven or evidence-based outcomes of the population that we're serving.”

Small group report

“We (health care providers) want employment that is attractive, equity based and wellness focused so that people want to work for us and when they do come work for us, they want to stay. We’re looking for reasonable expectations relating to caseload size and number of hours worked based on the dollars that are paid.”

Small group report
“Ultimately you have a responsibility to the TRC [Truth and Reconciliation Commission of Canada] Calls to Action and to the United Nations Declaration on the Rights of Indigenous Peoples [UNDRIP], not me. It’s not my exercise, it’s yours. Own it. But I will be at the table with the physicians and all the other Indigenous health care provider organizations to ensure that when you want to address TRC and UNDRIP we will be there to help you in those baby steps and they will be baby steps. We are going to develop that path together. And it will be a positive one. It will be a successful one.”

Meeting attendee providing Indigenous perspective

From there, the participants self-organized around the key features to discuss further implementation considerations and to identify potential starting points for next steps.

In closing comments, Drs. Kathleen Ross, Sylvain Brousseau and Michelle Hamilton-Page were all positive about the outcomes of the meeting. Dr. Ross said, “we all know” one jurisdiction or group was not going to solve the conundrum of HHR planning and she hoped the collaborative process would continue with “one common purpose and one common voice.”

NEXT STEPS

1. On the basis of event and report feedback, the CMA will continue in its role as convener to bring together interested groups that are able to co-create an IHHRP framework.

2. The CMA is contacting participants from this co-creation event, invitees who were unable to attend, and prospective partners and contributors identified by event participants to discuss opportunities to collaboratively advance the shared vision that was created at the event.

3. As this work is to be co-created, we propose to convene contributors to co-create the path forward, co-create structures to guide this work, co-create elements of the framework for collective review and discussion, reconvene when necessary and collectively determine proposed next steps for engagement and implementation.
## APPENDIX 1: PARTICIPANT LIST

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Title</th>
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<tbody>
<tr>
<td>Alexander, Em</td>
<td>CMA Patient Voice</td>
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<td>Barre, Sudi</td>
<td>CMA Patient Voice</td>
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<td>Bell, Krissy</td>
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<td>Bell, Maxime</td>
<td>Fédération médicale étudiante du Québec</td>
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<td>Bourcier, Dax</td>
<td>Canadian Health Workforce Network</td>
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<td>Canadian Nurses Association</td>
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<td>Cohen, Deb</td>
<td>Canadian Institute for Health Information</td>
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<td>Dattani, Shelita</td>
<td>Neighbourhood Pharmacy Association of Canada</td>
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<td>Dinniwell, Robert</td>
<td>Ontario Medical Association</td>
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<td>Glazier, Rick</td>
<td>Institute for Clinical Evaluative Sciences</td>
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<td>Guest, Tim</td>
<td>Canadian Nurses Association</td>
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<td>CMA Patient Voice</td>
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<tr>
<td>He, Jingyi</td>
<td>Canadian Nursing Students’ Association</td>
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<td>Jessel, Chaten</td>
<td>Canadian Federation of Medical Students</td>
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<td>Johnston, Rob</td>
<td>Canadian Medical Protective Association</td>
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<td>Kelly, Miranda</td>
<td>Indigenous Health Consultant</td>
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<td>Canadian Forces Health Services</td>
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<td>Ma, Amy</td>
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<td>Mai Muise, Gertie</td>
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<td>Moineau, Geneviève</td>
<td>Chief medical workforce advisor, Health Canada</td>
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<td>Nowgesic, Marilee</td>
<td>Canadian Indigenous Nurses Association</td>
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<td>Onagbeboma, Ovie</td>
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<td>Peachey, David</td>
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<td>Health Policy Consultant</td>
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<td>Weston, Susan</td>
<td>Health Canada</td>
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APPENDIX 2: RAW DATA COLLECTED DURING THE BREAKOUT SESSIONS

Day 1 – Breakout session 1 – Why is this issue important to you and how might patient-partnered care enable better patient outcomes?

- Innovating HHR
- Redefine base services
- Understanding unique opportunities for: physio, nursing and psychology
- Prioritizing the problem space
- Broadening scope and reach toward the needs of the future
- Understanding how my colleagues and other participants feel they can make the biggest difference
- True integration
- What policy changes are needed
- Increased clarity on short-, medium- and long-term plans
- Clear cohesion in terms of overarching principles across parties
- Ensure people understand the need for patient voice
- Exposure to new perspectives
- Mindset change generating new ideas
- Strengthening interorganizational relationships
- Commitment to change with inclusion of all professions that serve community
- Incorporating med student voices at the table
- Hearing and appreciating trans voices
- A mechanism to exchange public knowledge
- A structured plan to achieve true codesign
- Respectful engagement
- Several “a-hah!” moments
- Insight in next steps
- Action plan
Day 1 – Breakout session 2 – From your perspective, what are the primary barriers to effective HHR planning?

- Siloed training models
- Lack of comprehensive data
- Mechanisms of accountability
- Lack of interdisciplinary collaboration
- Inequitable payment models
- Lack of a national strategy for HHR
- Market challenges
- Scope of practice (difference between what you are trained to do, legislated to do and what your employer asks you to do) – and how current data may not reflect who is doing what, where (e.g., a family physician may be providing all of their care in an emergency department, or a nurse with pediatric specialty certification may not be providing care to pediatric patients/clients)
- Manual processing of information is disconnected across sectors
- There are regulatory and legislative barriers to move to the ideal state, lack of cultural awareness
- Lack of anticipation of future planning
- Interprovincial competition
- There is no systemic support to implement change management
- Leadership isn’t collaborative or integrated
- Data
  - Lack of granularity
  - Comprehensiveness
  - Interoperability
  - Timeliness
  - Access fit for purpose use
- Funding mechanisms and cost avoidance
- No safe mechanism between the person and the provider and the communities to understand, synthesize and act
- Lack of education between the patient and the provider
- Electoral cycle encourages short-term vision at the expense of long-term planning
- Inability to make decisions at the governance levels
- Lack of understanding of all available options to different health professionals
- Lack of inclusion for marginalized groups in planning
- Not enough patient engagement
Day 1 – Breakout session 3 – If you could redesign how people give and receive health care services, what would you suggest in terms of new approaches to health workforce planning, and demonstrate how it might improve health outcomes.

- Health care is not just a governmental problem
- Move toward universal health care
- Harmonized system (depoliticized)
- Measurement is based on impact and access/quality of care
- System is redesigned taking into consideration the needs of people with disabilities
- Resources maximized
- Bringing care into community
- When it comes to data we can monitor, manage and predict
- Every actor and sector are connected
- Health care is part of the community
- Population is informed
- Health system must be based on family care
- Based on iceberg visual
  - Visible part of the iceberg represents the Quadruple Aim
  - Below the water - First layer – learning health systems
  - Second – structure (governance, incentive, accountability frameworks)
  - Third – mindsets
- Patient centred/owned
- Driven by social determinants of health
- Focuses on services not providers
- Meets people where they are
- Access to team-based care
- Digital
  - Health data follow the patient
  - Leverage AI
  - Digital ID for patients and providers
  - Virtual care
- Payment structures
  - Away from fee for service
  - Reduced admin burden/inefficiencies
- Person-centred design
  - Accessible
  - Self-scheduling
  - Non referred
  - Increase health literacy
• National licensure across professions
• Cohesion between politicians and practitioners
• Training to meet both current and future needs
• Universal access
• Free tuition for all professions
• Health records that follow patients through their life
• AI supporting all levels of decision-making
• Process for ethical recruitment of internationally educated health professionals
• Retention should be based on worker wellness
• Continuous quality improvement
• Shared principles and goals

Day 2 – Breakout session 4 – What must be part of an integrated health human resource framework to reach the ideal state?

• Quadruple Aim foundation informs nonpartisan, data informed, co-creation, equity
• Redefine to human and social system, team culture, consistency and clarity
• New roles? Sunset unneeded roles
• System needs to be patient centric and innovative
• Funding permanence, equity based and wellness focus, caseload size reviewed
• Better communication with funders and employers
• Information sharing
• Funded by data-driven insights based on social determinants of health
• Preventive care based on wellness beyond Canada Health Act toward a learning culture (adaptable to the needs of the community)
• Technology governance
• Integrated with all care providers
• Workforce quality of working life should support fair compensation, feeling valued, supported and focused on retention
• Learning: measurable goals, variables and capacity
• Integrated and accountable governance; should be relationship driven
• Adaptable, sustainable and future focused
• Principles and guidelines based on learning
• Interoperability around health data
• Evaluation – funding incentives to continue to build institutional coordination
Day 2 – Breakout 5 – Priority selections (after dotmocracy vote): To achieve this element/feature, what are new and fresh ideas of how it could be implemented?

- Patient partnered in community
  - Trauma informed
  - Collaborative leadership – grassroots implementation
  - Help with developing policy
  - Journey mapping and storytelling
  - Education of health providers on the patient experience
  - Power sharing so that the onus isn’t on the workforce to fix everything

- Integrated workforce
  - Multiple access points into the system
  - Citizen informed
  - Funding models – best aligned funding and incentives
  - Integrated electronic health records
  - Patient data accessible to provider and patient
  - Optimized scopes of practice
  - Think about intersectionality
  - Clear accountability
  - Policy to make it long lasting

- Governance
  - Putting patients and community first
  - Employers and regulators
  - Education on the process
  - Linking shared goals of all professions to Quintuple Aim
  - All of this should be at an arm’s length from authorities to be able to make scorecards available to the public with indicators and data to bring transparency to the governance process

- Social determinants of health
  - Must understand patient realities
  - Education and training
  - Define needs through the social determinants of health – how they impact health overall
  - Workforce is only as good as workforce planning
  - Models of care wrapped around the community

- Data and insights
  - Indigenous data sovereignty principles must be respected
  - Define what you want to do with data
  - Develop standards, both content and exchange standards, that align to facilitate fit-for-use (quality) and comparable data
  - Content standards will enable alignment across multiple sources of data as there is no one source for HHR data; a unique identifier will support linking of the sources to create a comprehensive, useful data set
  - Exchange standard will enable interoperability to improve sharing information and timeliness of the data
  - Regulatory colleges need to be involved
  - Data literacy