3rd Transnational Conference on Integrated Community Care

‘Building stronger communities through Integrated Community Care’

Vancouver – Canada
2 – 4 // Oct // 2019

A synthesis report of conference documents, discussions and learnings

TransForm Integrated Community Care

Transnational Forum on Integrated Community Care

About TransForm

Through a series of four conferences, the TransForm partnership is exploring the undoubted potential that integrated community care (ICC) presents. ICC is an approach that seeks to improve quality of care and quality of life by building strong communities and engaging people as co-producers of care starting from local needs and resources. Even though integrated primary and community care is on the agenda in many countries, major challenges remain in understanding how to design new ways of working across sectors and in supporting effective implementation.

Acknowledgements

This report serves as a synthesis of the key issues and themes brought forward in all presentations and discussions during the Transform conference 'Building stronger communities through Integrated Community Care', held in Vancouver, 2-4 October 2019. We would like to acknowledge all speakers and participating delegates for their contributions during the conference (please see Appendix I for the participants list). For more information, background notes, presentations and video, see www.transform-integratedcommunitycare.com

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1. TransForm Conference in Vancouver: Building stronger communities through Integrated Community Care

The first two TransForm conferences sought to develop a common understanding of the concept of integrated community care (ICC), its potential to have a transformative impact on population health and wellbeing, and how to successfully design and implement it. The conferences have explored how to engage and empower citizens and how to involve local communities. Involving local communities and citizens in the design, governance and delivery of care should be the strategy for promoting public health and developing sustainable primary care.

The third conference examined how to enable participation of communities in decision-making, including how to respond to different cultural contexts and how to build social capital. A selection of existing and emerging practices and models was discussed during the conference, all of them aiming to improve people's health and wellbeing.

The conference was held in Vancouver in British Columbia, Canada. The programme paid particular attention to Canada's Indigenous Peoples, vulnerable populations, social inequalities and discrimination in health, youth and mental health, drug abuse and the role of the Canadian provincial and federal government.

The 3rd TransForm conference had the following main learning objectives (please see the third input paper for more detailed information about the key ideas and literature that inspired the conference):

- To demonstrate through evidence and practical experiences the positive impact that community engagement and empowerment can have on improving people's health and wellbeing
- To understand how local communities can participate meaningfully in local decision-making and governance processes to support integrated community care
- To explore how to mobilise policy makers and community leaders to take the lead towards system transformation through community-led collaborative approaches
- To demonstrate how evaluation and research can support the design and deployment of community-based approaches that enable ICC

1.1 Conference opening

Territorial Acknowledgement and welcome

The Vancouver conference took place on ancient Indigenous territory and *Stewart Gonzalez, from the Squamish Nation – Ayas Menmen Child & Family Service*s opened the conference with an Indigenous territory acknowledgement to K'emk'emelay - the Village of Many Maples.

This ceremony was followed by a welcome from Ian Boeckh, President of the Graham Boeckh Foundation. The Graham Boeckh Foundation, a private family foundation, collaborates with various governments and philanthropic organizations across Canada to catalyse change and galvanise a national movement for integrated youth services. The Foundation aims to fundamentally reorient the mental health system from too much focus on treatment and emergency care towards prevention and early intervention. For the Graham Boeckh Foundation ICC is about building effective services that are based on people's needs and goals, particularly those that are most poorly served by conventional

services. Their approach is guided by principles of respect for youngsters with mental illnesses and/or addictions and their diverse strengths and needs.

Leaders in unexpected places – a young person's perspective

Alicia Raimundo, mental health advocate and Andrea Vukobrat, youth peer support coordinator

Alicia Raimundo, mental health advocate and Andrea Vukobrat, youth peer support coordinator, helped delegates to get in the right mindset by letting them experience the health system through the eyes of young people. Alicia and Andrea shared their powerful stories of what it is like to be young and vulnerable and how young people with lived experience can help other youth through peer support. Their advice for healthcare workers when meeting with young people, was to travel back to the worst time of their life, remember what it is like to suffer and to be the person they needed when they were young.

The two young leaders addressed the difficulties in getting access to the care and support they needed and pointed out that they were here today not thanks to the mental health system, but because they refused to give up. Too many young people trying to access services are turned away, redirected to other services or told to wait – and in doing so their trust is eroded and their situations are worsened instead of improved.

Alicia and Andrea suggested those working in mental health services should slow down and seek input from the experts (youth themselves). What finally helped Alicia and Andrea feel safe was being asked to be involved in designing the solutions they needed. For them, it was a surprise to realise they had something to offer. The feeling of being able to contribute gave them a reason to wake up in the morning. They emphasized that young people want to learn how to help others in the same situation and give something back to their communities, if they are given the chance.

They also called for a greater focus on those being underserved by services today. Every community is different and to ensure cultural safety and humility you must tailor services by speaking to youth and their families about what their needs are and what resources are already available. To heal the system, it is important to listen to a diversity of voices (i.e. the gender diverse, black people, the marginalized).

"Mental health doesn't just live in our brains; it lives in our communities" – Andrea Vukobrat	*"Innovate, challenge assumptions, lean in with curiosity and celebrate wins"* – Alicia Raimundo

1.2 How partnerships with community organisations can lead to true system transformation

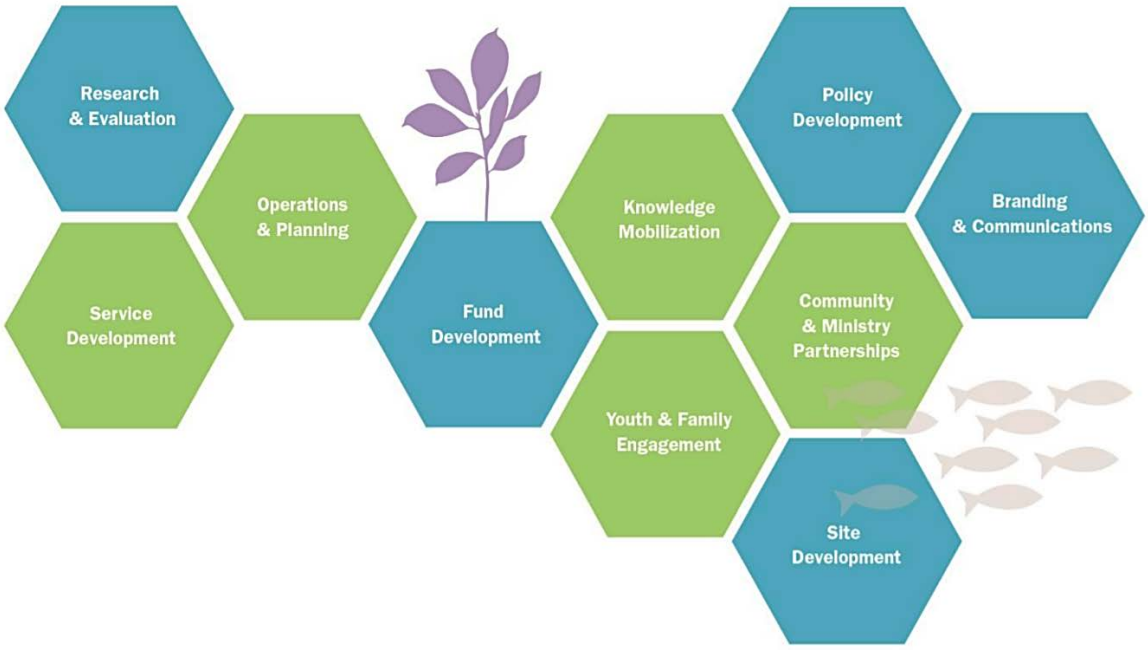
Steve Mathias, Executive Director of Foundry and Tanya Behardien, Executive Director of OneSky Community Resources shared their experiences of re-shaping how youth mental health services are designed.

The disease burden for mental health is heaviest in the age group 12 to 24. In British Columbia there are 145,000 young people needing mental health services at any one time, but only 18,000 have access to them. Spaces, time schedules, the way services communicate – none of these things are designed with young people in mind. It is no surprise they do not work for them. Foundry's vision is to transform access to health and social services and offer what youth and families truly need.

"Building a hospital at the bottom of the cliff will not solve the problems. We felt we could do something different and better" – Steve Mathias

Some of Foundry's success factors include:

- **Asking young people what they need** - confidentiality, respect and not having to repeat their story.
- **Getting the right people at the table**, without the table being too big. People with ability to provide the necessary funding and those who have a stake in the game, including young people themselves (through leadership advisory), researchers, specialists, the government and ministries. Today, Foundry has 140 partners, including NGOs, community organisations, philanthropic foundations, schools and family engagement groups who all pull in the same direction and feed the organisation with ideas on how to co-design innovative services. Appropriate governance is key to making this integrative process happen.
- Recognising that **it takes several years to develop a model that is scalable and replicable** and a strong team of people to shepherd change through. This involves continuously reflecting on lessons learned from research, innovation, policy development, communication, marketing, site development and knowledge mobilisation.
- Be **humble and open to learning**.
- **Collaborative, multi-sector funding model**.
- The **Foundry central team** carefully preserves Foundry as a brand, its values and development. This team is both the internal bridge between different Foundry establishments and facilitates local partnership building, based on the specific features, needs and assets of the community, as well as promoting Foundry to health authorities and government. The picture below shows the core tasks of Foundry central office.



1.3 Overview of the Canadian health and social care system

Ted Patterson, Assistant Deputy Minister of Primary and Community Care, BC and Evan Adams, Chief Medical Officer at First Nations Health Authority (FNHA) gave an overview of the Canadian health and care system.

Ted noted that Canada does not have *one* healthcare system. Instead, there is a mix of at least 13 different private and public insurance programs, funded at both provincial/territorial and federal government level through a voluntary agreement to common principles and laws. The 10 provincial governments are responsible for public schooling, health and social services, highways, the administration of justice and local government.

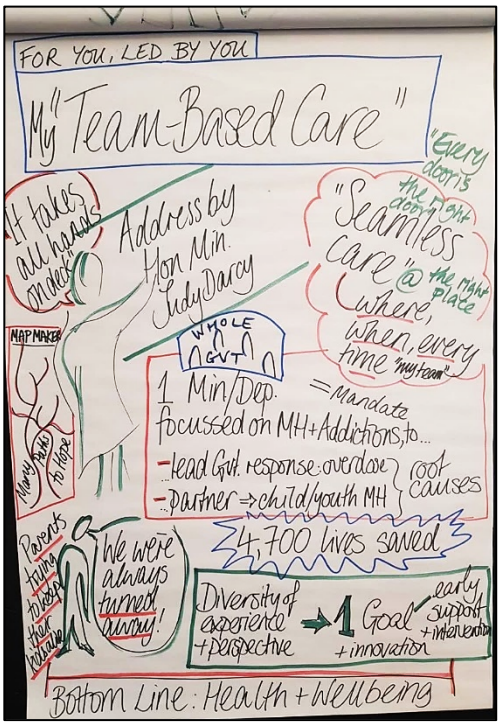
The federal government provides more than 40% of British Columbia's (BCs') health care budget through the Canada Health Transfer. The tripartite agreement between the federal, provincial and First Nations Health Authority is unique in this sense. They have built on existing resources and tried to make new links between social and health services through primary care community networks.

Evan described how colonialism and racism has pushed Canadian Founding Nations to the margins of their territories and has led to the worst health outcomes in Canada. In this sense, the Founding Nations can be described as a nation within a nation, and to have their own health system alongside the provincial and Federal one is positive. The current political climate is liberal and socialist and has expressed wishes to make peace with Indigenous peoples. From FNHA's holistic perspective, good health means reversing over-medicalisation and bringing back old traditions. When FNHA receive complaints about clinicians it is most often not about medical mismanagement, but about racism, insensitivity and lack of cultural humility. FNHA therefore works to educate healthcare workers in Indigenous culture and traditions.

1.4 Canada's first Ministry of Mental Health and Addictions

The Honorable Judy Darcy, *Ministry of Mental Health and Addictions (MMHA)*

Minister Darcy became British Columbia's (and Canada's) first and only Ministry of Mental Health and Addictions in 2017. Her mandate is a response to the biggest opioid crisis in Canada and involves working in partnership with a network of central organisations for mental health, FNHA, and public and private health and social service providers in BC. The opioid crisis has placed a spotlight on inadequacies of the Canadian healthcare system, and it has become evident that no one ministry or organisation can tackle it alone. Families had not received the support they needed. Sometimes the only solution available to families was to get their kids taken into custody. The MMHA's response was to shift the system from being crisis driven to being centred on prevention and early intervention. The MMHA has managed to mobilise the largest partnership ever in Canada to solve this problem and succeeded in saving 100 lives in a year. Foundry, with their open doors has been critical to this transformation.



Through a series of political and legal agreements, the federal and provincial government have committed to eliminate inequities in the health and wellness of First Nations. In 2013, this work culminated in the transfer of federal health programs and services to First Nations control through the FNHA. The Province recognizes that Indigenous communities are in the best position to make decisions about the health and wellness of their people.

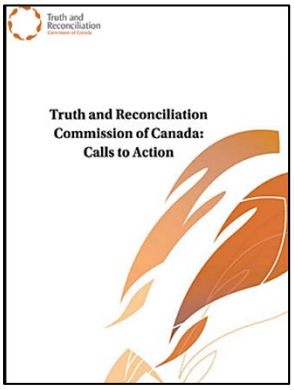
In April 2018, MMHA and the FNHA signed the Declaration of Commitment to Cultural Safety and Humility to embed cultural safety and humility across the provincial system. In 2019, Minister Darcy launched a strategy for mental wellness for citizens of BC, focusing on children, youth and Indigenous people's mental health: A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia. Underlying this roadmap is the government's commitment to reconciliation with Indigenous peoples — a commitment that aims to shape the planning, approach and delivery of new services in BC. It acknowledges the past and present colonial practices leading to Indigenous peoples

lacking access to culturally safe care or care that integrates cultural practices and builds on individual and community resilience. As a result, Indigenous peoples and communities experience far poorer mental health and substance use outcomes. They continue to experience stereotyping, racism and discrimination in the broader health-care system. This has resulted in the greatest inequities in health across virtually every indicator.

Experiencing environmental stress, such as poverty and poor housing conditions can increase the risk of substance abuse. In 2018, the government launched an ambitious housing plan. In partnership with an array of community organizations, 20,000 new homes have either been completed or are underway — including housing dedicated for those who are homeless, for women and children fleeing violence, for Indigenous peoples (both on-and off-reserve), and other types of supportive housing.

1.5 On Truth and Reconciliation

Leslie Varley, BC Association of Aboriginal Friendship Centres and Jennifer Johnstone, CE Central City Foundation (CCF).



The Truth and Reconciliation (T&R) call to action was the result of a court case where residential school survivors sued the Canadian government. However, Indigenous people continue to suffer from structural and systemic racism. It only takes one visit to Vancouver's downtown East side or to the decaying, old building that houses the Vancouver Native Health Society (VNHS) to see what systemic discrimination looks like in Canada.

The Central City Foundation (CCF) is a non-profit social purpose real estate that supports innovative organisations improving lives in our communities. The Foundation has more than 100 years of proof that providing safe, secure and affordable spaces for community organizations is the key to creating innovative and effective programs. CCF owns five social purpose buildings and provide housing and space to support services like the Vancouver Women's Health Collective and the Phil Bouvier Family Centre at highly subsidised rents.

CCF's central premise is not to ask: 'what's wrong with you?' but rather: 'how have you been wronged, what injustice have you faced?' Justice and reclaiming power are the ultimate goals. However, a single organisation is not enough to make a change, so when the T&R report was published, the philanthropic community came together to identify our own plan of action and sign a commitment in 2015: the *Canadian Philanthropic Community's Declaration of Action on Truth and Reconciliation*. Eighty Foundations have signed on so far based on principles and an atmosphere of dignity and respect. CCF Foundation supports Aboriginal Friendship Centres, involving ICC for 50 years through holistic, family wellness services, employment training, parenting training, housing etc. The centres receive no governmental funding. All funding results from proposals CCF applies for. Another example mentioned, where the ministry is absent, is the annual gatherings for aboriginal youths. More than 2000 kids attend these events, which is important for helping them make connections and be with other indigenous children (read more about this event here: https://gatheringourvoices.ca/).

A negative outcome of the T&R report is that more organisations compete for funding.

1.6 Citizens and community leaders' panel

Alicia Raimundo, mental health advocate***, Simon Courtemanche,*** Aire ouverte project in Laval, Quebec, ***Stewart Gonzales,*** Squamish Nation – Ayas Menmen Child & Family Services and ***Liza Bautista,*** Manager, Job Quest and TechWomen programs, ISSofBC (click here to read panelists' bio). Four citizen and community leaders were invited to the conference to illustrate their strategic role in service development and to remind conference delegates why ICC is important. The panel shared their reflections throughout the conference and on the first day they were asked questions to help delegates see ICC from their perspective. These are summarised below.

Why is ICC important?

ICC is about…

- sharing experiences and learning from each other.
- recognising the power of peer-to-peer support connecting to people in new ways.
- understanding from the heart and not just the head.
- recognising that young people often hold the answers
- solving problems together with reciprocal curiosity and humility.
- realising there is no single story that is true for everyone or single solution that works for everyone
- acknowledging the importance of feeling connected to culture, language and traditional practices. These are the roots, and without them people feel lost.

According to the panel, the following questions are the most pressing to make ICC happen

- How can we change how youth mental health services are delivered?
  - How can we break the "not my problem" culture that exists across mental health services?
  - How can we make sure youth are experiencing a safe transition into adulthood and don't' fall through the cracks as soon as they turn 19?
- How can we ensure stability and continuity of ICC funding as well as delivery?
- How can we scale up ICC?
- How can we better tailor and target care to those most underserved?
- How can we improve access to care? (including reflecting on what is limiting people in engaging in the health system)

2. Case studies

Please see the one-pagers prepared for each of the eight case studies for more detailed information available here.

2.1 Local site visits

Delegates could choose to visit one of the following five local examples of promising practices in integrated community care:

1. *Foundry Vancouver Granville*
2. *Foundry North Shore*
3. *Vancouver Native Health Society (VNHS)*
4. *PosAbilities – Kudoz*
5. *Immigrant Services Society of BC (ISSofBC)*

The delegates' key learnings and reflections are summarized for each site below:

Foundry Vancouver Granville and North Shore

Context

Foundry Vancouver-Granville initially opened as the Granville Youth Health Centre in 2015 in downtown Vancouver. It was designed to provide integrated primary care, as well as mental health, substance use and peer support services in a welcoming space designed with young people under 24 years of age. This served as the prototype and inspiration for the Foundry provincial network of centres. Like all Foundry centres, Foundry Vancouver-Granville focuses on early intervention and provides mental health, substance use services, peer support, primary care and social services. It also provides navigation to specialized services, creating seamless pathways of care. Because the centre is in the downtown core, the youth coming through their door often need higher-intensity services, are precariously housed or have substance use concerns.

Foundry North Shore is operated by Vancouver Coastal Health, one of five regional health authorities established by the province of B.C. During the creation of Foundry North Shore and the other Foundry centres, access to services for young people and their families was fundamentally reconfigured by first understanding the community where Foundry operates and then offering a comprehensive and targeted set of health and social care services, interwoven in seamless pathways of care.

What Foundry does differently

- The magic dust is the sense of unity – a true collective way of working and having managed to create a sense of 'home' and continuity for young people. One delegate described it as 'a community of heart which meets the young's need for emotional attachment'
- Its 'open door' policy and neutral (non-clinical) branding is key to successfully attracting youth. This is aligned with the principle of anonymity that is so important to youth.
- Moving health and social care out of institutions into the community and bringing community resources into the local care hub
- Co-design with youth, informed by youth and family advisory councils and a willingness to continually adapt according to on-going developmental evaluation (see section 4)
- Formally employed peer-support worker always available, so that even if there is a slight (e.g. next day) wait time to see a counsellor, the young feel supported. Foundry has moved beyond peer workers. They have created a community of youth who connect and create their own support networks and they have a Youth Advisory Council that helps young people come together
- Forward-thinking. Next thing is virtual care through video conferencing to increase access for youth across the province. In their drive to adopt new technology, Foundry emphasizes relationships first and co-creation with users
- Improving accessibility: continuous mapping of services to clarify roles and define needs (mobile services can be one of the solutions)
- Relationship maintenance with schools, hospitals and other community resources requires ongoing effort. Having a person responsible for this process is useful.
- Focus on branding and corporate identity
- Co-location with a variety of community organizations

Possible barriers to ICC

- In larger communities, you need to be constantly watchful and intentionally secure inclusion of those that are marginalised
- Getting high-quality data is a challenge and evaluation is work in progress
- Funding of physicians is a challenge for integration (fee for service model)
- Integration and team dynamics between different disciplines is difficult to achieve. People from different agencies bring different cultures. To support communication, Foundry arranges triage meetings

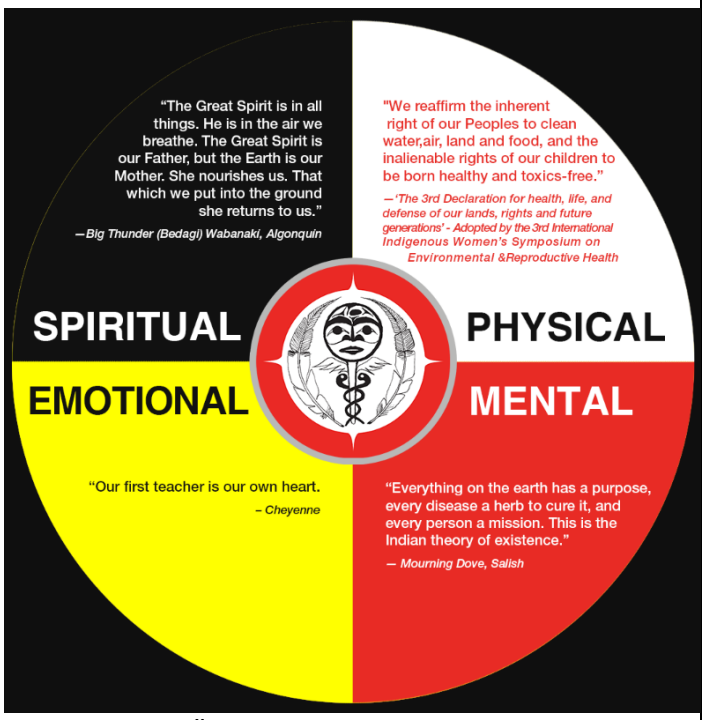
- Peer support takes time to integrate and requires a shift in culture for everyone to get used to seeing them as employees
- Change takes time. To integrate you need to collaborate. To collaborate you need trusting relationships. Trusting relationships take time to develop.
- Reaching all kids that need care is almost impossible
- Urban centres are challenged by the boundaries of a community space
- Assessing and addressing social determinants of mental health effectively
- Integration of volunteers and a comprehensive model for voluntarism
- Data flow within the organisation is a challenge
- How can we measure successful integration? Customer experience, organizational and service integration are as important as traditional measures

Vancouver Native Health Society (VNHS)

Context

Located in Vancouver's Downtown Eastside, the Vancouver Native Health Society's mission is to improve and promote the physical, emotional, and spiritual health of individuals, particularly focusing on the urban Indigenous community of Greater Vancouver.

VNHS is an inclusive, community-driven organization that is free from judgment and works to restore and reactivate the wellbeing of their clients. Their services include Elders and Cultural programs, Medical Clinic, Dental clinic (*a volunteer run facility*), Indigenous Early Years Services (Children and Family).



"*Most of our patients are amongst the most marginalized people of society and because of the complex biopsychosocial issues that exist here, providing appropriate health care to this population is very challenging. Traditional service delivery models are often ineffectual and unfortunately, many people receive limited to no care for their illnesses.*"

Indigenous culture is at the foundation of VNHS approach to health and well-being. ''*We incorporate all four aspects of the medicine wheel (physical, mental, emotional and spiritual health) into our services, programs and community building. As such, we are able to provide guidance through culture and create opportunities for individuals to move into a space of thriving*".

The stories of people who have accessed the Indigenous Elders and participated in some of the healing ceremonies are moving, they have helped people in ways that clinical medicine has been unable to touch and a testament to the team that has worked so hard to create this partnership. This is incredibly significant because for so long this access and the belief in the importance of it has been dismissed and denied.

What VNHS does differently

- VNHS is a great place to learn and witness culturally sensitive services in practice. The role of the Indigenous 'Elder' is unique. They go beyond treating symptoms and focus instead on a holistic approach. Their listening attitude is natural and offers cultural safety.

- The Elders program is transformational; they *are* the program.
- VNHS is not about integrating 'services', it is essentially about taking care of the whole person. Integrated care in native communities has been done for 100s of years- not something 'new'
- Traditional metrics are not useful. They should count what matters to them, even though it is difficult to measure a 'sense of community'. Outcomes should not be forced, rather we must learn to acknowledge the consequences of ICC.
- The power is in the narratives, listen to stories to get a deep sense of understanding and ask people how they self-define
- Be open to learn from other cultures and societies

Possible barriers to ICC

- Lack of appreciation from society for their valuable approaches
- Structural racism
- Lack of funding limits potential: e.g. for VNHS, a new building project which will combine a traditional healing centre with supported housing, health and social care.

PosAbilities/Kudoz

Context

Kudoz was established by three disability organizations in 2014 to combat social isolation and loneliness for people living with a disability in Greater Vancouver. In five years, Kudoz has evolved into an online catalogue offering in-person experiences with community members, a mobile app and regular reflection cafes. Hosts are learning as much as Kudoers and are developing fresh perspectives and connections based on shared experiences.

What Kudoz does differently

- A good example of how volunteers can become part of someone's family and the users become a citizen in their community through linking people
- How to allow all people in the community to participate in activities, create their own narrative and not being offered any pre-designed solution
- How to use conceptual models to show the journey when the user group is diverse. It showed how to form theory into practice and how to implement it
- How participants who are not tech savvy can be included by lending them electronic devices (e.g. Iphones) and give them technical support and training
- Lots of flexibility, bottom-up design and fewer rules
- How to empower people by asking them what they want, not just once, but every time
- Easy access at the front-end and an intelligent back-end learning system. A perfect example of customer friendly design and architecture
- How to create an open space with no criteria to enter and host a lot of open community events to create personal relations
- An example of how you can immerse into other's life using coaching as a care approach

Possible barriers to ICC

- How to reach people who are not community savvy
- Assessing and addressing social determinants of health
- Linking social welfare approach and the more formal health support structures is what really creates ICC and is challenging

Immigration services Society of BC (ISSofBC)

Context

ISS*of*BC is one of the largest immigrant-serving agencies in Canada and works with a wide range of community partners to carry out its mission. They also actively engage their clients through ongoing program evaluation activities and regular service outcome surveys. Every year, ISS*of*BC supports more than 20,000 people with a broad range of services through 16 offices located in Metro Vancouver and across BC.

What ISSofBC does differently

- Wide range of community partners help create a welcoming atmosphere for newcomers
- The right information at the right time to newcomers eases the settling in process
- Support people's independence- 'the goal is that they no longer need our services'
- Constantly learning from other sectors (e.g. social services, schools and community workers)
- Tap into the fact that people and communities are surprisingly open to immigrants and refugees and are keen to help
- Assessing how previous beneficiaries are doing (e.g. how many are employed, studying, are they comfortable at their workplace, are they comfortable using English or French, are they engaged in the community or volunteering?)

Possible barriers to ICC

- Constantly adapting to changing needs, e.g. adjusting services to culture and language of new groups of immigrants
- The need to cater to a wide range of educational backgrounds as their needs can be very different (i.e. from PhDs on one end to people with low literacy skills on another)
- Resources to take good care of people's traumas are limited and referral to mental health support services is not always straightforward
- Demand continues to grow both in terms of arrivals and in terms of organisations wanting to help/collaborate – innovative space solutions are necessary
- Digital illiteracy is a second challenge to language

2.2 Moving health services out of hospital and into the community

By Fiona Dalton, President and CEO of Providence Health (presentation at the venue)

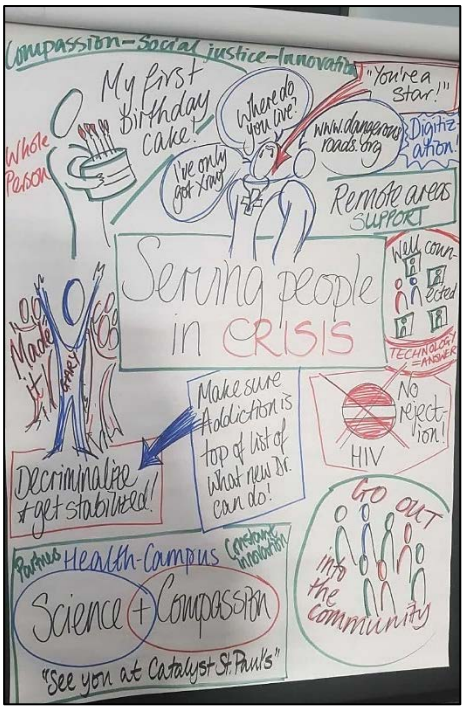
Providence Health is a health and wellness resource for all British Columbians with a courageous mandate. They are driving healthcare transformation through the largest project of its kind in Western Canada, especially focusing on the most marginalised and people in crisis. It takes perseverance, a clear vision and ability to forge strategic partnerships with a range of allies. They started out with a budget of 1.4 billion Euros and an ambition to create a new campus, built on principles of social justice, compassion and respect, that support ICC across the province.

Providence Health is a non-profit organisation, providing services in partnership with the Vancouver Coastal Health and the Provincial Health Services Authority. Providence Health employs 9,000 people working at 16 sites in BC. One of them is St. Pauls Hospital. St. Paul's hospital, with 500 000+ patient visits yearly, works at the front line of the complex public health crisis happening in East side Vancouver. The opioid crisis killed more than 1,500 in overdose in 2018 and more than 3,600 people have lost their lives to overdoses across BC since 2016. The overdose death rate in Vancouver has increased every year since 2014, and the number of deaths continues to surpass historical highs. St.

Paul's ambition is to offer hospital services for the marginalized in the community who experience unprecedented health issues such as mental problems, drug and alcohol abuse, trauma, stigma, poverty and homelessness. According to Fiona, what they do is not destabilising the system, but disrupting it.

What St. Paul's does differently

- The emergency department (ED) has more than 11,000 mental health service contacts a year. Their value statement includes to treat everyone with compassion, challenging themselves to think differently, break down barriers and bring services out to the people who need them.
- They allow people to show up without referral or appointments and also give housing and income support.
- They have a Rapid Access Addiction Clinic Service (RAAC) that provides help on the day someone asks for help and a team to support people in crisis, including peer support workers.
- Their RACE service (rapid access to consultant expertise) has answered more than 25,000 requests, saved 65% of patients from having to schedule face to face appointment. Through RACE, people get faster answers, less waiting time (80% taken within 10 mins.), avoid travel, rural physicians are supported with access to expertise and feel less isolated. They also have an education program for doctors across BC in recognizing and treating addiction.
- They are the only facility in BC to perform adult heart transplants.
- St. Paul's offers people with addiction TasP treatment (TasP refers to HIV prevention methods and programmes that use antiretroviral treatment (ART) to decrease the risk of HIV transmission). TasP has resulted in 74% reduction in AIDS-related deaths and 90% reduction in AIDS cases.
- Because geography and weather can be a challenge with vast distances and sparse population, St. Pauls is an early adopter of virtual technology and artificial intelligence (AI). Their goal is to keep people safely in their community as long as possible. An example she shared was the typical journey for a patient with skin cancer compared to St. Pauls modern and rapid pathway from examination to treatment.

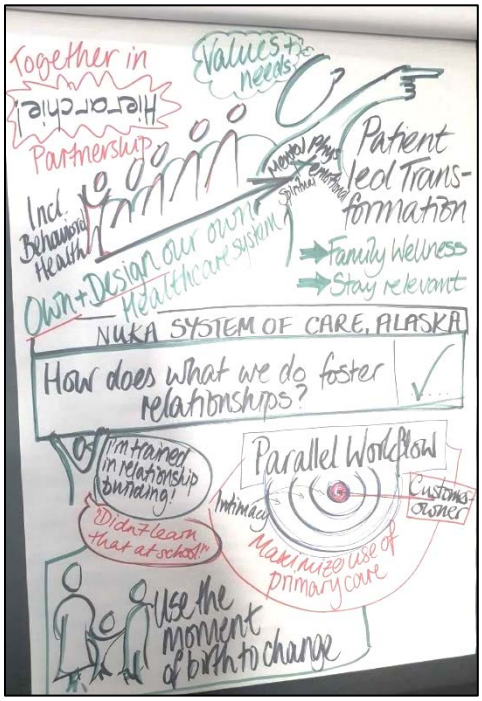


A risk though, is that the healthier and younger use new technology, whilst the rest of the population loses out. An important question then is how to secure social access without undermining services? Their virtual teaching lab teaches healthcare professionals around the world in how to do different procedures and how AI is used to reduce wait times and simplify patient pathways.

2.3 Case study presentations

To further demonstrate how ICC can improve population health and wellbeing, three cases of established practices of ICC were presented: *The Nuka System of Care, the Caring Community Project and Compassionate Communities Canada.*

I. [The Nuka System of Care](), Alaska, USA, *by April Kyle, Vice President of Behavioural Health Services, Southcentral Foundation and Tom Mitchell, Senior Learning and Development Clinical Advisor Nuka System of Care*



According to the Indian Health Determination Act, Native tribes in the US can design and deliver their own healthcare instead of receiving government-funded healthcare. The Nuka System of Care is owned by 65,000 Alaskan Native and American Indian people representing 229 sovereign tribes. About 45% of the Nuka System's funding comes from what is essentially an annual block grant from the Indian Health Service, another 45% comes from Medicaid, Medicare and private insurers and the remaining funding is derived from the philanthropic sector and grants.

It took decades to develop the structures for the NUKA system to be community owned and driven. It is no exaggeration to say that they function despite the system, not because of it. Today, this system illustrates how it looks like when ownership is handed over from the government to the people, and is recognized by:

- A multi-dimensional model for wellness. In contrast to the Western mono-dimensional model based on physical health; mental, physical, spiritual and emotional balance is equally important.
- A model that works together with the community. They say: "thank you for your expertise" to professionals, but also thanks moms, aunts and those people we love and lean on in life. How individuals are doing affects the whole family and family wellness goals are used to secure health and wellbeing for all members of the family goals.
- They are customer owned. It reminds the employees that people own the buildings and provides their pay-check. Being a mom, it reminds April that she owns this place and have something to say if she disagrees with anything. It fundamentally changes the relationship between community and health.
- The NUKA system has a rulebook of operational principles. There is no hierarchy. No one is more important. Everyone has an equal part to play. The product of their healthcare system is not diagnoses, but relationships and sharing of stories with each other and the team.

Some numbers illustrating NUKA's success are depicted below:

Other successes include winning the Malcom Baldrige national quality award in 2011 and 2017 and getting on the front page of New York Times for their Behavioural Health Integration Model.

II. Caring Community Project, *Antoine Boivin, Co-Director and Head of Research, and Ghislaine Rouly, Patient Partner, Centre of Excellence on Partnership with Patients and the Public*

The Caring Community Project is based on person and people-centred care. They work with experienced patients and citizen partners who know what resources are in the community and help people navigate and connect with these resources. People often feel excluded from society once they become a patient. Understanding individuals and clarifying their life goals often functions as a connection back to the community.

Important ingredients to growing a caring community:	**The Caring Community Project advices to others are:**
• Recruitment • Co-Training • Shared Guides & Tools • Community of Practice • Inter-Sectorial Linkages • Co-Governance • Co-Funding • Participatory Evaluation	• Do not be afraid of experimenting. We built this from scratch and did not ask for permission • Know your values and that you can contribute as a patient partner • Action research can be useful as a protected space for innovation • You do not need a strict plan or 5-year protocol, but clarity of purpose and principles are necessary. We build on each others' knowledge and experience to co-create answers with patients, citizens, clinicians and decision-makers. "*It takes a village to care for one another*" (African proverb) • It is all about relationship and regaining people's trust • The first caregivers in the society are not healthcare professionals but families, neighbours and citizens caring for each other in the community. Only 1 in 1000 will be cared for in University hospitals each month (Green et. al, New England Journal of Medicine 2001)

III. Compassionate Communities Canada, *Bonnie Tompkins, Compassionate Communities National Lead, Pallium Canada and Jon Faulkner, Vice President Operations, Pallium Canada*

What characterize a compassionate community?
A compassionate community is a place where people are passionate and committed to enhancing the experiences of those dealing with a serious health challenge, caregiving, dying, or grieving. Through raising awareness about end of life issues and building supportive networks in the community, citizens take an active role in supporting people affected by experiences that eventually will happen to all of us.

Pallium Canada is a non-profit organization focused on building community and professional capacity to help improve the quality and accessibility of palliative care in Canada since 2000. Their partners include a community of clinicians, educators, researchers, carers, administrators, volunteers, Aboriginal leaders and citizen advocates. Pallium Canada is helping communities across the country understand and adopt the compassionate community (CC) model, through education, knowledge mobilisation, project facilitation, and leadership. Compassionate community start-up initiatives have seen a steady increase since 2015 and the start-up toolkit has been used to create national versions in Australia, United States and Belgium.

Bonnie mentioned several important elements supporting compassionate community development:

- Make connections, establish relationships and get everyone in the community involved – this includes the workplaces, schools and universities. We are all responsible for caring for each other and most care is delivered by informal care givers.
- In the CC model, community champions are supported and regarded as important partners. Therefore, a start-up toolkit has been developed to help socialising the champions. It is high level and not prescriptive, - a tool you can use at community engagement meetings. It can guide roundtable discussions based on an asset-based approach to get positive conversations started.
- A Workplace Toolkit is under development and will provide employers, managers, and employees with practical tools, resources and activities to help increase awareness and reduce stigma related to serious illness, caregiving, death and grieving in the workplace.
- Look to what others are doing. The pillars of compassionate communities are similar across the world and aligned with the asset-based community development (ABCD) model.

3. Mini-hackathon – solving 'sticky issues'

A 'mini-hackathon' event was organized to put creative heads together to come up with concrete suggestions and proposals to overcome hurdles, solve sticky issues and provide further options for dealing with real-life challenges to fostering kinder, caring and compassionate communities. The eight challenges listed in the table below were suggested by the case study leaders ahead of the conference. Two case studies from previous conferences participated at the Vancouver conference, and were invited to share their challenges (Habitat-Microaree, Trieste, Italy and Poliklinik Veddel, Germany). The results from the table teams are summarized in the table below.

Challenge & Case Owner	Proposed Solutions
1. Incentives to place-based governance: Maintaining and developing collaboration/partnership *(Habitat-Microaree Trieste)*	**Identify resources and assets** in the community and create partnership where experience and needs can be shared. Do not underestimate voices at the micro level to capture informality. **The approach must be participative** across the whole process and in governance. Co-design must start from the beginning - goals must be negotiated together with the actors in the community, including the workforce. **Raise awareness of tension** that may exist between academic skills, professional specialisation and the value of life experience. Focus on building trust - it is crucial in change processes. Actions for implementation depend on the specific context. I**nvestigation/research and training/capacity-building** are always needed. **Places and opportunities for people to meet** are crucial to make participation and constant innovation possible. You need **a positive narrative** to change self-perception and see the change when it's happening. **Outcomes to look for**: cultural change, increased problem-solving attitude and social capital, inter-professional partnerships, more patients included in decision-making and increased trust.
2. Smart financial mechanisms to sustain and roll-out innovations in ICC: Who will pay for what? *(Caring Community)*	To get funding: define and structure the problem, document the needs, recognise accessible assets, suggest solutions and cooperate. P**roject management** is important! Do not forget **the value of non-financial contribution** (expertise, volunteers, spaces, a wider sense of ownership, new partnerships, emotional investment, shared power). Funding/payment and governance go hand-in-hand. Don't forget to **compensate new contributing actors.** **Social impact investing** is one of the funding options to be considered. Risk takers - often the philanthropic sector or private investors - fund the early stages of innovation and government takes over funding when the project has proven viable. How can we strengthen the **'bridge' between HC providers and the community**? Who owns the bridge and who supports the bridge? In a single payer system, it is difficult for the community to come together and meet the government half-way. If the community owns the "bridge" it can charge for it through direct payments, insurance, taxes and public services. Invest in a **match-making** campaign at local level, gather with people with different value-sets and from different sectors and create a common sense of ownership. This can help create the important link between care providers and the community.
3. Inclusive participation and co-production in ICC: Mobilising people in deprived neighbourhoods *(Poliklinik Veddel)*	**Identify experts, change leaders and the marginalized** in the community. Give a voice to people that are not used to be heard by giving them a seat at community boards. Foster **relationships, loyalty, equity, trust and knowledge.** **Retrieve examples and review research of successful models** of community building, mobilization and participation and reflect together on what formats that suits you needs.
4. Inclusive participation and co-production in ICC: Listening to the voice of the customer *(NUKA)*	Involve care workers from both public and third sector and create **formal work agreements.** Do not forget to **involve youth** early in the process. **Work on the micro-level** to pick up the voice of customers, build trust and negotiate goals at community level. Get leaders who work through co-production **Progress slowly and experiment** your way to the best solutions. Secure a constant evolution according to needs. Make use of **technology** to advance community involvement.

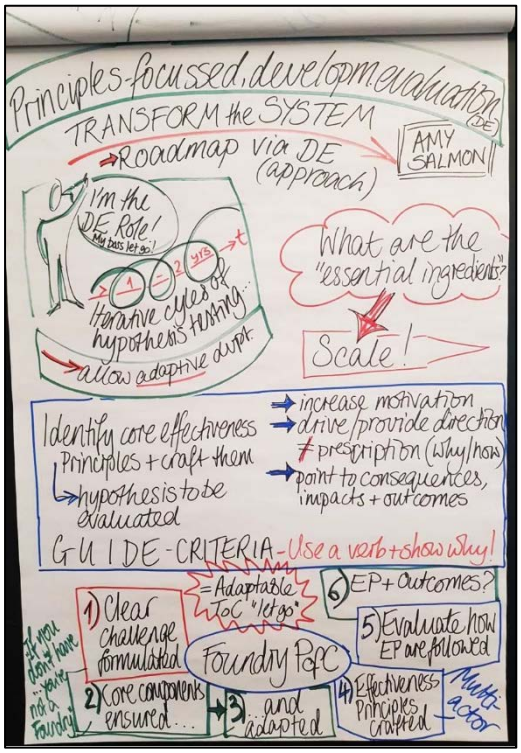
5. New/different skills and competences for ICC teams: Health care system does not meet the needs of Indigenous Peoples *(Vancouver Native Health Society – VNHS)*	**Indigenous knowledge** is necessary when funding Indigenous health and wellbeing programs. Give children, care workers and policymakers **cultural training** and to be curious about our differences. Untrain people's misconceptions. Invest in **training peer workers** and work towards breaking the hierarchy between doctors and community members. Paying peers a reasonable salary is necessary.
6. The issue of scaling: Where's the value of the ongoing development of a social tech start-up for governmental funders? *(PosAbilities – Kudoz)*	To get investment: create a **sale pitch**, show what **problems you are solving** and a journey map. **Be clear about your edge** and what you do different from others. Is your program experienced as **meaningful among users**? Can it be transferred to other domains?
7. The issue of scaling: Limited capacity to accommodate ever-increasing requests for co-tenancy *(Immigration Service Society of British Columbia - ISSofBC)*	Get help in prioritizing by **asking end-users about the most useful core services.** Review **opening and closing hours**. Move non-9 to 5 essential services to **evenings and weekends.** Ask staff to **work from home** or other locations and **reduce size of furniture** to create more space.
8. The issue of scaling: What aspects of ICC practices are replicable and transferable to other regions or countries? *(Foundry)*	Find your **core principles** and stay true to them. Achieving this will require a strong backbone and **consistent and accountable governance at every level.** Do a **gap analysis** and constantly engage in improvement and learning. Listen to stories of lived experience. **Understand the needs of your users**, seek their feedback continuously and develop unique approaches to meet their needs (e.g. outreach and mobile services). Get onboard people who are good at change management, implementation and coordination. **Align existing resources** and bring people together for a shared purpose/vision. Invest in community development and relationships. **Support early adopters.** Create a **stigma free atmosphere** – intentional design with young people and space for families to be included in care.

4. Developmental evaluation

Amy Salmon, *Program Head, Centre for Health Evaluation & Outcomes Sciences. A workshop on developmental evaluation as a tool for systems transformation*

Developmental evaluation (DE) is a methodology and evaluation approach that supports system transformation and can be used to assist innovators developing change initiatives in complex and uncertain environments.

In the formative phase, DE is used to help improve how the initiative is implemented, ensuring fidelity to the model that has been created and assess if what is being implemented is what we planned. In the summative phase, DE is used to judge the merit, worth or effectiveness of the initiative, if this is going to solve the problem or make things better or if there are other options for achieving what we set out to do. DE is of particular interest for policy makers wanting to solve real issues in real-time and helpful for supporting emergent phases of initiative development and early implementation in complexity contexts, when shared measurement platforms haven't been established.



Amy led an evaluation program for Foundry, where the aim for the initial phase was to generate evidence and provide feedback that shaped the content and structure to support Foundry in fostering transformation of delivery of mental health services for youth (not just improve them).

DE is principles-focussed. It means that the model identifies what the essential ingredients of an innovation are, and how it can be adapted to new contexts. The goal is to identify the core effectiveness principles that are clear, meaningful, and actionable in guiding work and assess whether maintaining fidelity to these principles is leading to desired results (see illustration of Foundry's effectiveness principles below). The effectiveness principles provide direction, but not prescription. They point to the why, the consequences, outcomes and impacts and are grounded in values about what matters to those who develop, adopt, and attempt to follow them. In the end, an effectiveness principle becomes the hypothesis to be evaluated, to determine its relative meaningfulness, truth, feasibility and utility for those attempting to follow it (1, 2).

DE is time and resource consuming. Foundry employed a full time DE specialist and two part time assistants, who were thought to pass the baton to people in Foundry when the evaluation period was over. However, that is not how DE work. You must share information throughout the process, be flexible, reflect and adapt according to the results underway. They thought they could evaluate Foundry in general from a broad perspective, but you need to be specific, as your informants will go into details and when you believe the evaluation period is over, it is not. You learn to let go of expected and existing processes and timelines through rapid cycles of testing to challenge, reshape and refine approaches and interventions.

A two-year DE of Foundry's "proof of concept" period was carried out between February 2016 and April 2018 and included more than 150 ethnographic participant and nonparticipant observations at Foundry central office and at 6 Foundry sites, document analysis, semi-structured individual and focus group interviews. Semi-structured individual and focus group interviews were conducted with approx. 115 individuals including: Foundry Central staff, Governing Council, lead agency personnel, partner agencies, leadership table partners, youth and family advisors. This report, prepared by Amy Salmon, Saranee Fernando and Mai Berger, summarizes the findings: Developmental Evaluation of Foundry's Proof of Concept.

Illustration of Foundry's effectiveness principles.

During the workshop, delegates suggested their own effectiveness principles of ICC (these principles were suggestions only and are not necessarily proven meaningful and actionable):

- Re-establish trust in the care system, listen continuously and share power
- Be responsive towards youth and families' needs
- Create an atmosphere of open access and focus on including those who do not usually use care services
- Be non-judgmental and nourish respect, trust and safety
- Provide discrete services, securing confidentiality and privacy
- Help people build capability to establish relations and build your own network and capacity through involving multiple stakeholders. Connect clients with these only if appropriate and desired by them

5. Mobilising local policymakers and community leaders

April Kyle, *VP of Behavioural Health Services, Southcentral Foundation****, Marcy Cohen****, Research associate with the Canadian Centre for Policy Alternatives and Co-chair of the Community-Based Seniors Services (CBSS) Leadership Council for the United Way,* ***Jennifer Johnstone****, CE Central City Foundation and* ***Patrick Dicerni****, Assistant Deputy Minister, Strategic Policy and Planning Ministry of Health and Long-term Care, Ontario*, discussed how to move forward with ICC in different context and at different levels *(click here to read their bios).*

How to make ICC work in different contexts?

Providing money is not enough. To succeed in ICC continuous work on **relationship building with different actors over time** in the community is required. Be clear about your role and what you bring and expect the process to be messy and difficult.
Allow the **community to drive the change**, customize their model according to local culture and population diversity. Mobilize people's courage to connect and **declare the social norms** to ease the process.
As a local leader, be proactive towards healthcare professionals, the municipality, the health authorities, local physician organizations and start creating partnerships. They sometimes come and

sometimes don't, but it is assuring for the community to know you have links to the right people. **Get media on board** by providing them with technical reviews and details.
As a policymaker, **ask your community if what you do makes sense**. Learn what structures are needed regionally to support initiatives locally. Create an informative website. Consider how you can **create opportunities for people to have their voice heard**.

Goal-oriented community care is high on the political agenda but has not happened yet. System leaders try to micro-manage but that will not help us move forward. ICC give us a way to work more openly and allows us to **listen to what makes a difference for people**. It can help **bridge** the work and thoughts of health and social care workers with the direction given by citizens.
There is not enough money in health care systems around the world to provide people what they need to live a meaningful life. ICC is a way **to connect local grassroot organizations, leaders of community-based organizations and volunteers** who can help their co-citizens in improving wellness and live a better life.

6. Conclusions

The conference stimulated rich discussions and ideas among the delegates. The main lessons learned can be summarised as follows:

Getting the basics right…

In terms of how to enable ICC, the first step is **creating trusting relationships** at all levels. This requires an open heart and an open mind, **'leaning in with curiosity'** and daring to listen and be inspired by a wide range of voices and stories. This is the basis for **co-creation of care services** and for creating solid **partnerships**. Services must be co-created with people with lived experience. This does not mean merely including or consulting them; it means **sharing the power** and being led by them.

For co-creation to work, identifying **effectiveness principles** early on (as opposed to more traditional measures of success) and allowing these to evolve with time will serve as a compass. **Access** and an **'open-door' policy** are essential, as is the focus on **prevention and early intervention**. In terms of workforce, valuing and formalising the **role of peers** and providing **culturally humble and safe** services is a must. To ensure services remain relevant, we need to remain **flexible, adaptable and constantly learning**.

'Starting from a place of sharing who we are, we have learnt that you must touch the heart to move the mind. To provide seamless services, we must first understand who people define as their team; there is an abundance of people who have experienced care that did not meet their needs – let them be the ones to transform our future. We must start at the micro-level, asking patients and their families how they would like services to be designed. This seeds a movement at the macro level and effect change at the policy level. The tables have turned – the patient will see you now – and you better listen' - Jodeme Goldhar (TransForm Advisory Group)

The enablers…

The complex nature of ICC needs to be reflected in **governance structures**, where all those with a stake in the game or with something to contribute are considered. This necessitates on-going relationship management.

In the vision of the Nuka System and the medicine wheel of the Vancouver Native Health Society, we saw examples of **'holism-in-action'**, in line with our evolving views on public health and health determinants. These initiatives make such a holistic view seem easy and self-evident. Both cases emphasised that **mental, physical, spiritual and emotional health are equally important** for peoples' health and wellness.

Develop methods that not only include people with lived experience but **allow them to lead change. Value experience** and people who challenge the existing system **as much as academic and professional expertise.** We must understand the processes in which respect happens from the bottom to the top and the other way, e.g. **shared accountability** between the research community, the government and the people.

Reversing the trend of funding public healthcare services over community-based initiatives. Innovative local partnerships should receive enough **seed funding** to develop their own models of caring for their people. **Hybrid and creative funding models** can allow partners to share the benefits and the risks and **reverse the competition about dollars.**

The 'sticky' issues…

No one said ICC was easy.

Instead of **'scaling up'** the focus is often on **'keeping up' with changing needs, sustainability and surviving** despite politics, policies, regulation and suboptimal health systems. Governments and organisations still struggle with the concept of **allowing initiatives space and time to fail** as part of the innovative process. The learning is in the process.

What counts as research evidence needs to be redefined. What are the **metrics of success of ICC** and how to get high quality data to **inform on-going evaluation of programmes**?

And finally how does a **transition towards integrated community care for all** looks like? It implies a challenging shift towards a new vision and strategy for care. The 'TransForm community' should stay involved to accelerate this process.

'There is no one recipe for ICC. Initiatives are not held back by the absence of a template, modus operandi or by lack of consensus. ICC is fuzzy and we should embrace it - approaching it with curiosity and creating space for innovation, giving permission to fail and learning from it. Funding is a constant and unpredictable struggle and we have seen a creative patchwork of solutions to cope

with it. We have learnt to embrace history and use our cultural ancestry in a meaningful way' - Tom Braes (TransForm Advisory Group)

Conference closing

Ian Boeckh, Graham Boeckh Foundation

Ian emphasized the incredible variety of programmes of ICC presented during the conference and the incredible dynamism of the initiatives delegates learnt about. He suggested reflecting upon the following four key elements for being a successful implementor of ICC, where those elements can be valid across different jurisdictions.

1. **Be clear on the principles that govern what you do.**

2. **Reflect on the tools you have available; e.g. do you know what assets you have available in the community? If not, get out and find out. Engage with people and users of services.**

3. **Get insight of the different governance systems affecting your success. How will you evaluate what you do, who do you involve and how?**

4. **How do you unite all the elements together purposefully and in what order?**

7. The 4th TransForm conference in Brussels, 2020: 'ICC for all. Leveraging the power of communities'

***Gerrit Rauws**, King Baudouin Foundation and Fund Dr. Daniel De Coninck*, host of the fourth conference in Brussels, March 2020

Gerrit welcomed everyone to the next conference 17-19th of March 2020 in Brussels, Belgium. The conference will focus on how to bring ICC to the next level and make it the new normal. The agenda for the next TransForm conference is under development, but so far, initial topics include:

- How can we reach out to people's hearts and minds, build relationship capital and support courage to change?
- How can we make sure everyone benefits from ICC in the future? Today, ICC often takes place in isolated pockets of innovation and is not available to everyone. How do we scale up without losing meaningfulness? How to deal with the tension between the need for differentiation and standardisation?
- How do we sustain successful examples and build in continuous learning and improvement from the start to improve quality over time? Some great ideas often die before they are completely implemented and spread. We must find a way to prevent it.

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Appendix I – List of participants

	Name	Organisation	Country
1	Evan Adams	First Nations Health Authority	Canada
2	Sibyl Anthierens	University of Antwerp – Research in Primary Care	Belgium
3	Liza Bautista	Immigrant Services Society of BC (ISSofBC)	Canada
4	Corinne Bebin	City of Versailles	France
5	Tanya Behardien	OneSky Community Resources	Canada
6	Loïc Biot	Ville de Grenoble - Direction santé publique et environnementale	France
7	Roxanne Blemings	Mental Health Prevention, Early Intervention & Child Youth at Ministry of Health Mental Health Substance Use Branch, BC	Canada

8	Marie-Aline Bloch	Ecole des Hautes Etudes en Santé Publique	France
9	Ian Boeckh	Graham Boeckh Foundation	Canada
10	Robert Boeckh	Graham Boeckh Foundation	Canada
11	Antoine Boivin	Center of Excellence on Partnership with Patients and the Public (CEPP)	Canada
12	Broek Bosma	St. Paul's Foundation, BC	Canada
13	Chelsea Bowers	Vancouver Native Health Society	Canada
14	Tom Braes	shiftN, Strategy consultants	Belgium
15	Christophe Buret	Agence pour une Vie de Qualité – Direction Santé mentale (AViQ)	Belgium
16	Valeria Cappellato	Compagnia di San Paolo	Italy
17	Alice Casagrande	Fédération des Etablissements Hospitaliers & d'Aide à la Personne Privés Non Lucratifs (FEHAP)	France
18	Marcy Cohen	BC Health Coalition and the Canadian Centre for Policy Alternatives	Canada
19	Diane Conconi	Conconi Family Foundation	Canada
20	Robert Conconi	Conconi Family Foundation	Canada
21	Victoria Conconi	Conconi Family Foundation	Canada
22	Simon Courtemanche	Centre intégré de santé et de services sociaux (CISSS) de Laval	Canada
23	Michelle Craig	Government of Alberta	Canada
24	Fiona Dalton	Providence Health Care, BC	Canada
25	Judy Darcy	Minister of Mental Health and Addictions, British Columbia	Canada
26	Yves Dario	King Baudouin Foundation	Belgium
27	Katja Daugardt	Witten/Herdecke University	Germany
28	Antoni Dedeu	International Foundation for Integrated Care	United Kingdom
29	Martine Delfosse	Wit-Gele Kruis West-Vlaanderen (Home nursing)	Belgium

30	Anneke Denecker	King Baudouin Foundation	Belgium
31	Luc Deneffe	De Wissel, Youth Care Umbrella Organisation	Belgium
32	Roberto Di Monaco	University of Turin	Italy
33	Patrick Dicerni	Ministry of Health and Long-Term Care, Ontario	Canada
34	Philipp Dickel	Poliklinik Veddel	Germany
35	Nerina Dirindin	University of Turin	Italy
36	Hélène Dispas	Fédération des Maisons Médicales (*Community Health Centers*), Maison de santé Potager	Belgium
37	Adrian Dix	Minister of Health, British Columbia	Canada
38	Nieves Ehrenberg	International Foundation for Integrated Care	United Kingdom
39	Laurent El Ghozi	Elus, Santé publique et Territoires	France
40	Jonathan Faulkner	Pallium Canada	Canada
41	Isabelle Gamot	Ville de Grenoble	France
42	Devis Geron	Fondazione Emanuela Zancan onlus	Italy
43	Krista Gerty	Community Development and Central Operations Foundry, BC	Canada
44	Jodeme Goldhar	The Change Foundation	Canada
45	Stewart Gonzales	Squamish Nation – Ayas Menmen Child & Family Services	Canada
46	Anita Hausen	Catholic University of Applied Sciences Munich	Germany
47	Mélanie Hubault	Fondation de France	France
48	Bernard Jacob	Coordination fédéral des réformes des soins en santé mentale, Service Public Fédéral, Santé Publique	Belgium
49	Jennifer Johnstone	Central City Foundation	Canada
50	Danielle Kemmer	Graham Boeckh Foundation	Canada

51	Nesrin Kosanke	Gesundheitskollektiv Berlin (*Berlin Health Collective)*	Germany
52	Simone Kowalke	Evangelisches Diakonissenhaus Berlin Teltow Lehnin – Unit Health	Germany
53	Anna Kuehne	Gesundheitskollektiv Berlin, (*Berlin Health Collective)*	Germany
54	April Kyle	Southcentral Foundation, Alaska Native-owned, non-profit health care organization	USA
55	Heidi Liston	Department of Health, Government of New Brunswick	Canada
56	Elana Ludman	Graham Boeckh Foundation	Canada
57	Patrizia Luongo	Forum on Inequalities and Diversity	Italy
58	Janine Mack	Zentrum der medizinischen Versorgung Darmstadt-Dieburg (MVZ) GmbH	Germany
59	Lori MacKenzie	Ministry of Mental Health and Addictions, BC	Canada
60	Joanne MacMillan	Ministry of Mental Health and Addictions, BC	Canada
61	Luisa Marino	Network of European Foundations	Belgium
62	Steve Mathias	Foundry, BC	Canada
63	Deborah Mitchell	Providence Health Care, BC	Canada
64	Nicholas Mitchell	Alberta Health Services	Canada
65	Thomas Mitchell	Southcentral Foundation, Alaska Native-owned, non-profit health care organization	USA
66	Paul Morin	Institut Universitaire de première ligne en santé et services sociaux, Université de Sherbrooke	Canada
67	Maria Augusta Nicoli	Health and Social Agency- Emilia-Romagna Region	Italy
68	Alexander Noll	Zentrum der medizinischen Versorgung Darmstadt-Dieburg (MVZ)	Germany
69	Patrick Orth	Aids Hilfe Hamburg	Germany
70	Idrissa Omer Ouedraogo	Aids Hilfe Hamburg	Germany
71	Ted Patterson	Ministry of Health, BC	Canada

72	Maria Peters	Philosophical-Theological University of Vallendar	Germany
73	Brigitte Pierard	Aide à Domicile en Milieu Rural (ADMR)	Belgium
74	Karine Pouchain-Grepinet	Fondation de France	France
75	Alicia Raimundo	Foundry, BC	Canada
76	Salvatore Rao	La Bottega del Possibile	Italy
77	Gerrit Rauws	King Baudouin Foundation	Belgium
78	Anita Reboldi	Compagnia di San Paolo	Italy
79	Tina Röthig	Poliklinik Veddel	Germany
80	Ghislaine Rouly	Canada Research Chair in Patient and Public Partnership	Canada
81	Amy Salmon	Centre for Health Evaluation & Outcomes Sciences (CHÉOS), UBC	Canada
82	Ava-Dayna Sefa	Generation Capital	Canada
83	Nathalie Senecal	Fondation de France	France
84	Fabrizio Serra	Fondazione PAIDEIA	Italy
85	Sanja Simic	Conconi Family Foundation	Canada
86	Lanette Siragusa	Shared Health	Canada
87	Monica Sorensen	International Foundation for Integrated Care	United Kingdom
88	Stef Steyaert	Levuur, Participation experts	Belgium
89	Karen Stone	Department of Health and Community Services (Newfoundland and Labrador)	Canada
90	Karen Tee	Foundry, BC	Canada
91	Livio Tesio	Regione Piemonte	Italy
92	Bonnie Tompkins	Pallium Canada	Canada
93	Gordon Tulloch	posAbilities	Canada
94	Kris Van den Broeck	Antwerp University - Dept. Psychiatry / Dept. General Practice	Belgium

95	Thérèse Van Durme	Université catholique de Louvain, Institute of Health and Society Be.Hive, Interdisciplinary Chair Dr. Daniël De Coninck	Belgium
96	Tinne Vandensande	King Baudouin Foundation	Belgium
97	Leslie Varley	BC Association of Aboriginal Friendship Centres	Canada
98	Kelly Veillette	Ministry of Mental Health and Addictions, BC	Canada
99	Caroline Verlinde	Flemish Institute for Primary Care (VIVEL)	Belgium
100	Emily Verté	University of Brussels & University of Antwerp Primary Care Academy, Interdisciplinary Chair Dr. Daniël De Coninck	Belgium
101	Diane Viens	Graham Boeckh Foundation	Canada
102	Manuela Völkel	Philosophical-Theological University of Vallendar	Germany
103	Andrea Vukobrat	Foundry, BC	Canada
104	Benjamin Wachtler	Gesundheitskollektiv Berlin (Berlin Health Collective)	Germany
105	Natasha Walker	International Facilitation and Communication	Germany
106	Jennifer York	Immigrant Services Society of BC (ISSofBC)	Canada