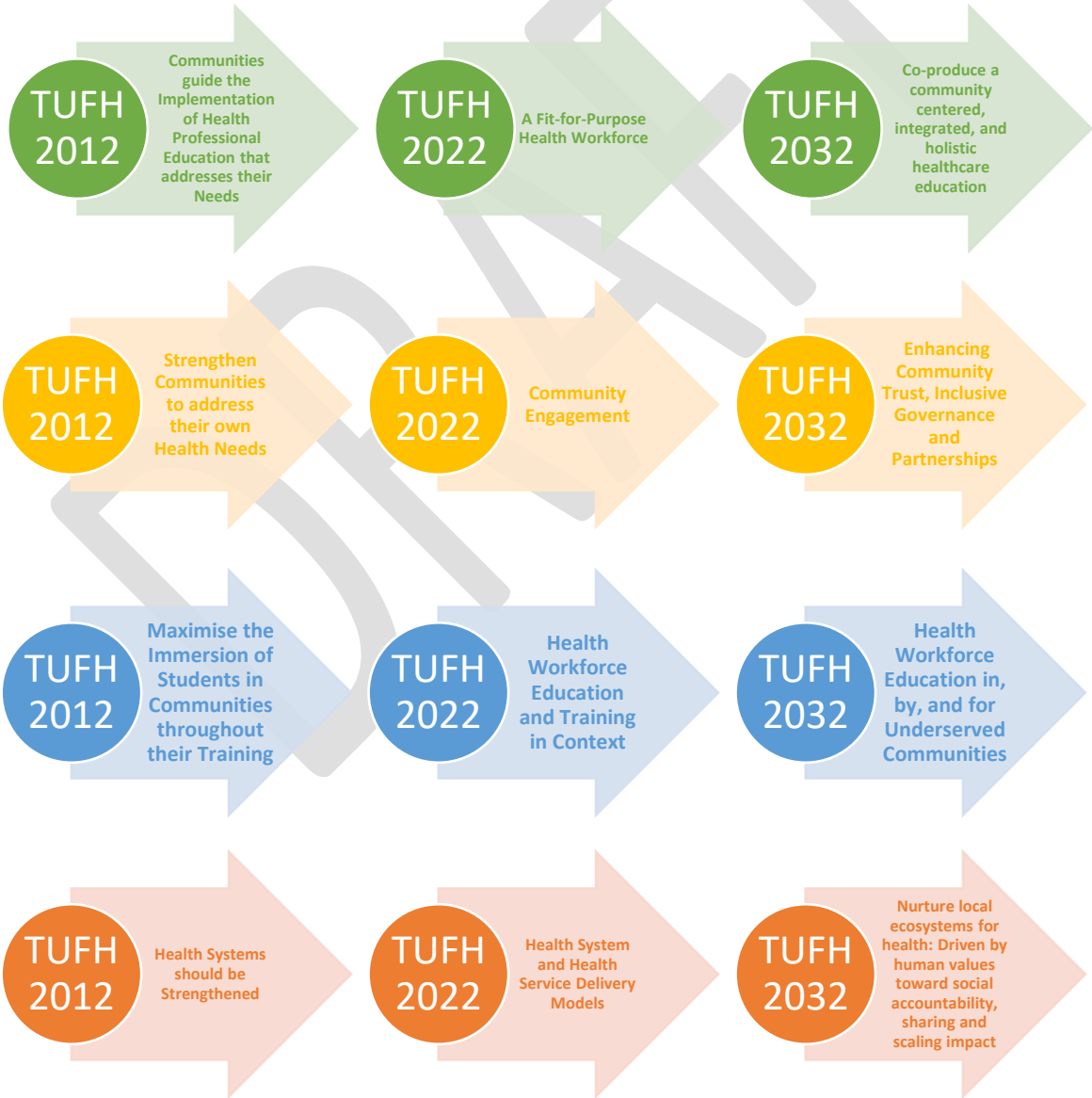
TUFH 2022 Declaration

In August 2022, TUFH2022 in Vancouver gathered members from around the world in a hybrid model of knowledge sharing, vibrant discussion and developed wisdom to determine our collective approach to an ever-changing world, currently in perceived crisis on a range of issues. To aid in making wise choices, a pre-conference day was devoted to looking back 10 years to the ***Thunder Bay Communique*** expressed by those a meeting of five international organizations, including TUFH in 2012. Through a process involving the 4D (Discover, Dream, Design and Deliver) appreciative inquiry approach, the assembled global citizens gathered here in Vancouver distilled the essence of that Communique into four themes and reflected on what relevant achievements had occurred to this point. They then dreamed what we might collectively achieve in the next 10 years and designed what we must deliver in those ten years in order to help build a healthier and more just world.

The overarching themes and dreams are reflected in the following series of arrows thrusting towards that future:



The following pages expand upon these arrows and define the meaning of each dream and the pathways on which we must embark to achieve them. They then turn to defining what is needed for successful achievement and the commitments that we must severally and collectively make as we take our first steps towards a still uncertain future.

It is clear that whatever that future brings forth (and who could have foreseen the toxic cascade of climate change, Covid, galloping inequities and iniquitous wars we now confront) we must build and engage *complex adaptive relationships* developing *learning health systems* in close *concertation* with the *communities* they serve. These relationships must embrace all the professions and include attention to learning, research, application, integration and, above all, authentic engagement with the societies we serve from the local, through regional, national and global scales.

Important steps towards actually **doing** that are outlined in the pages that follow—not only in each theme but in the collectivity of ideas and commitments that are expressed.

To fail to define and then take those steps together is to diminish hope for the joy we dream of being shared at TUFH2032.

Co-production: Working together on creating knowledge

"Iterative and collaborative processes involving diverse types of expertise, knowledge and actors to produce context-specific knowledge and pathways towards a sustainable future"

Community-led, collaborative process

Community centered: community at the center

Community is the key stakeholder, leading the creation and execution of health professions education in collaboration with other perspectives represented in the WHO partnership pentagram plus. (reference)

Communities can identify their own needs and should be supported in the process

Regular feedback on the relevance of the health workforce education from community

Integrated: The full spectrum of life-long-learning from initial education to retirement is linked with strategies for each transitional phase.

Interprofessional skills and community / rural health embedded in the curriculum at all levels

Holistic: recognizing the social determinants of health as key factors

Focus on prevention, public health interventions

Healthcare system not only for the ill persons

Diverse understanding of health and well being

Welcoming traditional medicine practices in health professions education

Healthcare education: teaching about all aspects of health

Physical, environmental, social, emotional, mental, spiritual

What is needed:

Community-centered, collaborative, co-created <u>institutions</u>

Community and its needs are situated at the center of health workforce education process. Engaging and empowering relationships and self-actualization, in turn are necessary components of professional development. No community should be left behind.

The traditional hierarchy of educational institutions needs to be addressed, with shared leadership being developed as a part of health education..

Adequacy of necessary resources—human, social and financial must represent a joint effort in prioritization. Ensuring the sharing of resources and being held accountable for the communities and individuals which are parts of the community. Creating feedback mechanisms where the community can engage with the curriculum, their needs, and the future direction of health education.

Community-centered, collaborative, co-created <u>student recruitment</u>

Admission procedures must reflect the kinds of practitioners needed to address the specific communities Opportunities for students from disadvantaged settings such as on rural and indigenous communities . Students with affinity for rural and community health should be fostered throughout their education.

Community-centered, collaborative, co-created <u>content</u>

Responsive and dynamic education and education curriculum. Building an adaptive skills set which will be able to support the changing needs of the community.

Restructuring health care education to prioritize and support comprehensive general care. Encourage students in exploring other pathways than super specialization. Rural placements integrated early into health professions education.

Recognizing the value of non-western knowledge and incorporating it into the curriculum.

Community-centered, collaborative, co-created <u>health system</u>

Health & healthcare delivered and supported by an interprofessional team with a collective responsibility to “we”

A team of well trained providers can address and support the wholistic health care needs of both individuals and communities

A system in which a team is assigned and takes responsibility for a community of individuals

- Is appropriately incentivized and resources
- Is accountable

A system is in place where there is an equitable distribution of resources to support all communities

Commitments:
To achieve the new state it will be necessary to create an enduring community of practice at the global level through TUFH, a community of practice dedicated to promoting educational change that is dedicated to the values of trust, courage/bravery, equity, empowerment, respect and humility. These key attributes represent the core competencies of leadership to be developed in each professional school and brought to the development of effective collaborative and community based interprofessional learning.

As a part of this effort, youth and student voice must be engaged at every stage in designing and constructing the envisioned future. Throughout the learning life cycle from entry to retirement, there needs to be enhanced attention to the numerous transitions involved—from undergraduate to postgraduate to initial practice to mid-career continuing professional development and mentorship as retirement approaches. This area will require research on needs and efficacy so that the evolution of practitioner development is intentional and maintains the community engagement central to understanding and addressing the health and wellness needs of the communities for which the schools and their graduates are socially accountable.

Accreditation systems, as systems of continuous quality improvement, should assess and feed back accomplishments in these transitional realms as well as interprofessional, community engaged education. Engaging in the ISAATT project is a part of this process.

TUFH, with its rich and growing range of partners, should see itself as a key enabler translating the fine rhetoric of global agreements and statements (eg Alma Ata, WHO papers related to health workforce, World Health reports, Almaty, COP, etc) into applied and practical actions on the ground—in education, research, application, integration and engagement. As part of this commitment Education for Health can communicate developments and their assessments into the literature and TUFH can convene appropriate collaborations and planning events as the need arises.

In all of the above activities the communities and other perspectives of the WHO partnership Pentagram Plus should be present as co-producers of knowledge and co-developers of educational and research priorities, actions and impacts. The relationships thus envisioned should be explicitly developed as complex adaptive and learning health systems. As such, it is the relationships embedded withing the network that need to be constantly nourished and supported and the future should be built upon the strengths and resilience of all partners through such processes as appreciative inquiry.

What is needed:

- Communities can only engage when they have someone to engage with.
- Challenging for the communities to provide insights and feedback when there is no one to engage with.
- Bringing healthcare close to the community.
- Building trust and relationships with communities and people in the communities.
- Working closely with people in building partnerships that are long-lasting
- Understanding that we are all accountable for our health
- Empowerment: Help people realize that they have the power to guide their health.
- Empowering communities to define what health means to them.
- Engaging communities from the beginning
- Moving from empowerment to capacity building because communities are already empowered.
- Identifying and defining the word "community". Community is multi-dimensional, and we wear different hats that we call community.

Commitments:

- Anchoring ourselves in the community and being part of it/ immersing ourselves deeply into the community; being part of the socioeconomic development of a community.
- Start engaging communities at an early stage.
- Moving from empowering communities to empowering healthcare providers to do the work that they are supposed to do.
- Moving away from competition especially the notion of publish or perish in academia and going towards partnerships and working together in research when you are both working towards a common objective.
- Building intentional and Trusting Relationships; and recognizing that it takes time and allowing for it to take time (Ten cups of Tea)
- Placing community at the center of all projects and programs.
- Having champions within community
- Respecting and recognizing other people's cultures.
- Community responsive research (consult the community on research needs)
- Community inclusion in interventions
- Inclusive governance
- Active recruitment from rural settings as well as community health workers in development.

In 2032, health workforce education (HWE) facilitated career pathways (FCP) will begin with well-resourced equitable access to education for people in underserved, underrepresented communities, including Indigenous communities, that helps them to be successful in applying for HWE programs. These HWE program selection and admissions processes favour applicants from underserved and underrepresented populations, including Indigenous peoples to facilitate the “grow your own” FCP.

Students in HWE programs will undertake most of their education in their own communities or similar communities that they will be expected to serve after completing their training. These socially accountable HWE programs will feature immersive community engaged education (ICEE) whereby students live and learn in communities for prolonged placements during which they become community members and members of the health team. ICEE involves seamless combination of education and service facilitated by active community participation or community engagement. Community engagement involves the Pentagram Partners Plus (policy makers, health administrators, health professionals, academics and community members plus linked sectors) in interdependent collaborations for mutual benefit to co-develop, co-produce, co-deliver and co-evaluate education and service programs. A key aspect of ICEE is integrated clinical learning (ICL) which is team teaching and team learning involving an interprofessional team of teachers teaching an interprofessional team of learners.

The FCP continues with postgraduate training that is based in underserved community settings preparing trainees to serve these communities. The transition to practice and continuing service in underserved communities is supported through local and distant continuing professional development (CPD), skills updates and ongoing active community participation helping the health professionals’ families to feel at home and happy to stay. The “cradle to grave” FCP continues with distributed graduate studies that allow health professionals to achieve higher degrees and career progression, including an academic career, without moving to a large academic centre.

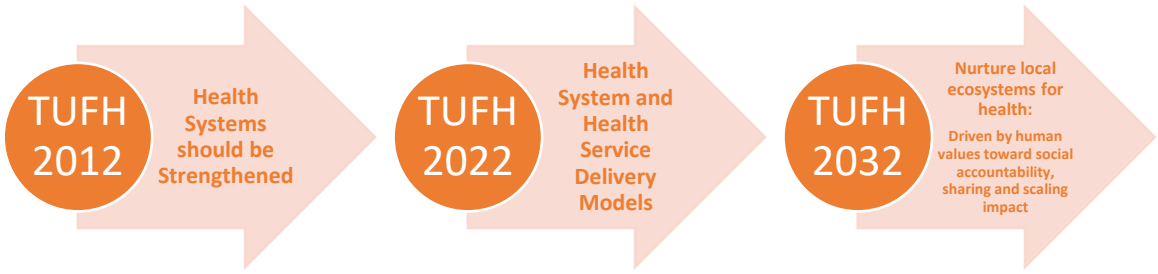
HWE graduates are fit-for-purpose skilled socially accountable practitioners who are located in underserved, underrepresented communities providing care that addresses the health needs of the community that they have the privilege to serve. These practitioners are guided by the values of respect, dignity, humanity, cultural humility and adaptability so that they earn the trust of their communities.

What is needed:

- Community engagement
    - interdependent partnerships between communities, health services and academic institutions for mutual benefit
    - active community participation that recognizes and values community members' knowledge and expertise as of equal importance to the expertise of academic institutions and health professionals
- Indigenous ways of knowing and being
    - woven into education and training
    - health beliefs and traditional healing
    - cultural safety and cultural humility training
- Immersive community engaged education (ICEE)
    - prolonged placements in communities where students are expected to provide care after completing their education and training
    - students living and learning in communities become community members and members of the health team
    - the students learn from their interactions with patients
- Facilitated career pathways (FCP)
    - visible and accessible, well-resourced pathway from "cradle to grave" so that underserved communities are able to "grow their own" health professionals
    - well-resourced equitable access to education for people in underserved, underrepresented communities, including Indigenous communities
    - selection and admissions processes that favor applicants from underserved and underrepresented populations, including Indigenous peoples
    - seamless combination of education and service facilitated by community engagement
    - interprofessional integrated clinical teaching and learning in underserved communities at undergraduate and postgraduate education levels
    - transition to practice, continuing professional development, clinical skills update programs embedded in cohesive interprofessional collaborative practice
    - access to distributed graduate studies (Masters and PhD) to enable career progression, including academic careers, without moving to a larger center
- Essential infrastructure
    - high speed broadband internet to enable completion of academic coursework online rather than travelling to the academic center
    - suitable space and equipment in clinical settings for individual and group learning, as well as patient / client interaction
    - safe and comfortable housing for students and their families

Commitments

- Within institutions, education about and exploration of social accountability and community engagement to ensure organizational support in advocating for dedicated funding.
- Connect with like-minded individuals and organizations for mutual support with aligned values in proceeding with community engagement.
- In the spirit of intentionality, seek out language and concepts, including from Indigenous languages, to consolidate common understandings and purpose.
- Start local to "walk the talk" employing an assets- or strength-based approach, sitting with communities to listen and learn their world views and to value community knowledge and expertise, including with Indigenous peoples.
- Co-development, co-production, co-delivery and co-evaluation of immersive community engaged education
- Set own benchmarks and indicators of success that are measured and monitored collaboratively.
- Celebrate success and recognize excellence amongst all partners.
- Develop and implement needs-based student financial aid to mitigate financial challenges for students from underserved and underrepresented communities.



Nurture: Organically help to grow and reproduce

Local: Community driven and bringing value to community'

Building a good evidence base for this. Once one has evidence then add a voice (advocate), valuing collaboration e.g a Learning health systems approach, recognizing it's a journey

Ecosystems: across silos (e.g. policy domains) and vertically integrated Value on the ground and holistically

Build the team around Pt not disease.

Build the ecosystem for health and wellness around community.

With health being nested in all facets of policy

Health: Health is more than healthcare

Includes social determinants

Human Values: More human health system

Through community humanity and human values like trust relationship respect dignity equity co-creation with community, Inclusivity and humility

Harmony between community and health providers leaders started in community how can we value/prolong/reignite the connection.

Social Accountability: serving society and accountable to each other.

? include Soc accountability definition people and society

Sharing: Identifying and communicating

Scaling: supporting growth: Scaling these community centric health and wellness ecosystems. (Scale what is working in the clinical interface.) e.g. Drive to primary care systems, interdisciplinary health providers regulated and unregulated

What is needed:

Ways to redesign the system leveraging what is working (e.g. two loop model, PPP)
recognizing the challenges of existing system and interests/interest groups

Leadership and advocacy development supporting those values (e.g. compassionate leadership training)

Tech enhanced resilient systems

Rural placements: Community empowered holistic education

Spaces for coproduction of knowledge not just transfer
Education that is responsive and dynamic
Practitioners in leadership (Vertical Bridging)
People connected across silos (Horizontal Bridging)
Strengths based approach

Locally allocated resources with shared decision making attached

Mechanisms for spread. (Adaptability of the commonality)
- Identify what's working
- Communicate what it is
- Cross pollination to others
- Where can we learn from what's not working
- At variety of scale
- Shared measurement

Flip the model
A language to express value and the cost of healthcare need for investment
(e.g. Defining value proposition: quintuple aim, including ecosystems (Across silos like environment)
Ring fencing if primary healthcare in budget.
Relationships with multi sectoral approach e.g. ministry of finance building relationship