VANCOUVER COASTAL HEALTH'S COMMITMENT TO

IMPROVING THE PATIENT EXPERIENCE JOURNEY

VCH PATIENT EXPERIENCE THINK TANK – SESSION ONE

Patient Experience Foundational Discussion

OCTOBER 2022

Collaboratively prepared by VCH Indigenous Health & Patient Experience, Quality & Patient Safety Teams

Indigenous Health | Vancouver CoastalHealth

We wish to acknowledge the funding & partnership of VPSA in the final report of the Think Tank.

FACILITY ENGAGEMENT
Vancouver Physician Staff Association

Table of Contents

EXECUTIVE SUMMARY

Vancouver Coastal Health Authority (VCH) has a published commitment to deliver exceptional care to the 1.25 million people who access healthcare services within our geographical boundaries. Every patient (and their families and/or caregivers or support members) expects and is entitled to receive exceptional healthcare but how do we truly know we are achieving this commitment.

As a Health Authority, we acknowledge we still have much to do to improve a patient's experience. Amongst our aim of improving access to healthcare, preventing disease, communicating more effectively, and improving quality of life, our system is still severely fractured. We struggle to capture how to measure an experience and make systemic change – this Patient Experience Report, prepared through a collaborative partnership between VCH Indigenous Health and VCH Patient Experience (as "Experience Teams") aims to change this narrative through various strategies including the undertaking of Patient Experience Think Tanks.

In this context, Patient Experience is what the process of receiving care (and healthcare) feels like for the patient, their family, caregivers, and/or support members. Patients want to be heard, acknowledged, respected, and empowered in their entire pathway regardless of where their access point is. Therefore a system wide humanizing and reconciliation approach is required in order for a patient to have a positive experience when receiving healthcare. A system where 'everybody' takes more time – takes a relationship moment – and commits to understanding why a patient's experience is important.

To guide and inform our Patient Experience journey, we explored a number of best practice 'patient experience' models from across Canada and Globally. Through this exploration, it was easily determined that there is growing recognition around the world of the importance of patient-centredness in improving healthcare experiences among patient populations. The Beryl Institute Framework and National Collaborating Centre for Indigenous Health's (NCCIH) Indigenous Cultural Safety Measurement Framework were two models identified as bringing the strongest benefits to a Patient Experience Metric Program for VCH. The Beryl Institute Framework defining its patients experience as "the sum of all interactions, shaped by an organizations culture, that influence patient perceptions across the continuum of care", and the NCCIH identifying six key relational themes for embedding Indigenous cultural safety both resonating with the objectives and vision of the VCH Indigenous Health and Patient Experience teams. While we are in the infancy of what this means and how these two frameworks can be applied across the organization, VCH will utilize these two intersecting models as our Patient Experience concept – namely the VCH Experience in Care Program.

The VCH divisions of Indigenous Health and Patient Experience recognized an opportunity to gather together with a representative/reflective group of VCH Senior Leaders to build/deepen the understanding of "experience" and "experience in action" using these dual and interlinked frameworks and to guide a VCH Patient Experience Metrics Framework. This being the impetus to host a collaborative Patient Experience Think Tank on 12 October 2022 as a foundational discussion. A total of eighty (80) representatives (90% from VCH) attended the Think Tank including Elders and representation from four (4) other Health Authorities. It was purposeful to invite as many VCH teams as possible as ultimately, we all play some form of role in enhancing a patient's experience.

Through storytelling and a relational approach, leaders were engaged and shared their wisdom at the first (of many) VCH Patient Experience Think Tank. Attendees participated in rotating breakout groups and a combined discussion circle to understand and contribute to the VCH Experience in Care Program concept informed by the seven (7) NCCIH Indigenous Cultural Safety Measurement themes – to

demonstrate the Indigenous Health lens - and the eight (8) Beryl Institute Experience Framework Principles – to demonstrate alignment to Patient Experience. Through the wisdom shared by attendees, we were able to identify areas for improving and measuring Patient Experience as a foundational discussion. These areas of focus also informed potential actions for future Patient Experience discussions. Themes, discussions, and actions are documented as follows:

1) **Prioritize Relationship Building** through the following actions:
    - Pause, Make the Time for Reflections
    - Prioritizing Relationships First (before asking questions or seeking knowledge)
    - Setting the context and view everything as a CARE process, rather than a data collection process
    - Demonstrate empathy and sincerity in the approach
    - Repair to restore relationships

    Actions for future Patient Experience Think Tank discussions:
    - What is our patient experience measures to monitoring humanizing actions?
    - Can we develop a strength-based relationship building assessment and complaints tool?
2) **Uphold Inclusivity** through the following actions:
    - Reduce Tokenization and strive for inclusion
    - Respect (and don't assume) Identity through a patients lens
    - Create safe spaces by reviewing each site for inclusive messaging
    - Being mindful of family inclusion

    Actions for future Patient Experience Think Tank discussions:
    - Do we implement a policy for mandatory Indigenous cultural safety training for all frontline staff who collect patient demographic information?
    - Can we review and redesign our policies and physical spaces to promote inclusivity?
    - Explore the inclusion of reconciliation and inclusion in Job Descriptions and Contracting
3) **Promote Speak-Up Culture** through the following actions:
    - Have difficult conversations without fear or apprehension
    - Challenge stigma by taking a relational moment and/or educating others
    - Develop a Leadership-driven speak-up policy that is implemented and encouraged
    - Learn the language and commit to speaking up

    Actions for future Patient Experience Think Tank discussions:
    - How do we implement a speak-up culture from a strength-based quality improvement lens?
    - How do we embed an ICS lens into our healthcare system and into all initiatives from their inception to completion?
    - Can we demonstrate our commitment to unlearning biases, unlearning racism, and elevating Indigeneity?
4) **Empower Autonomy** through the following actions:
    - Centre the patient in every aspect of care and in all strategies
    - Respect the patient's rights by being open to listening to patient perspectives on their wellbeing
    - Being mindful about communication perceptions e.g. non-judgemental commentary and use of body language

    Actions for future Patient Experience Think Tank discussions:
    - What are specific processes we can implement to humanize care?
    - Can we facilitate role playing to humanize care and improve communications?
5) **Embed and Normalize Traditional Practices** through the following actions:
    - Promote Traditional Storytelling as narrative measurements to give meaning

- Acknowledge and respect patients traditional ways of knowing
- Apply a strong listening lens to stories shared

Actions for future Patient Experience Think Tank discussions:

- How do we effectively capture qualitative storytelling? What innovative technology can we use (acknowledging consent parameters)?
- How do we strengthen our Indigenous Patient Navigator Program?

6) **Mandate Indigenous Cultural Safety Education** through the following actions:
    - Address knowledge gaps about Indigenous cultural safety and decolonization
    - Apply a wider reach to the patient experience including those who are responsible for asking demographic/identify questions
    - Create strategies to ensure Indigenous staff safety
    - Promote lifelong learning behaviours

    Actions for future Patient Experience Think Tank discussions:
    - How can we promote or encourage teams to consider ICS training mandatory?
    - Can we promote self-learning better?
7) **Create Legacy Leadership** through the following actions:
    - Consider leadership structure adaptations that include Indigenous leaders and/or patients
    - Role model humanity in care through careful listening and capturing excellence in care
    - Create a Values-Based Leadership framework
    - Dismantle the power dynamics through reciprocal partnership approaches
    - Encourage transparency through positive accountability

    Actions for future Patient Experience Think Tank discussions:
    - Can we adapt our leadership/governing structure to include and empower the patient or Indigenous perspectives? What might that look like?
    - How can we learn from excellence?
    - Do we need to review our values-based leadership framework?
    - Is there upfront questioning that would dismantle the power dynamics of a patient and health provider relationship?
    - As part of the speak-up culture policy, how do we encourage transparency?
8) **Be the Leader in Patient Experience** through the following actions:
    - Be stronger together strategically to change the system by building allies and collaborating more
    - Make relationships important to clinical care excellence and collaborative efforts

    Actions for future Patient Experience Think Tank discussions:
    - Can we create a collective impact model for VCH?
    - Can we create baseline measures that include patient reporting experiences and satisfaction outcomes in healthcare? (Could this include the ability to compare Indigenous and non-Indigenous measurements and indicators)

This first VCH Patient Experience Think Tank Gathering aimed to create an experience that strengthens relationships – and not seeing this as “one and done” but rather a journey – of perpetual spread, outreach, and evolution for patient experience. There were many ideas shared about the possible next steps with overwhelming commentary about continuing the discussions and holding more Patient Experience Think Tank events which we commit to organize. This commitment will give VCH the opportunity to formalize the identified actions and create a well-informed VCH Experience in Care Framework and Program.

INTRODUCTION

Vancouver Coastal Health (VCH) boundaries encompass nearly 59,000 square kilometres with 12 municipalities and four regional districts. Our geographical area covers urban and rural communities including Richmond, Vancouver, North Shore, Sunshine Coast, Sea to Sky corridor, Powell River, Bella Bell, and Bella Coola. VCH delivers healthcare to approximately 1.25 million people – this includes First Nations, Métis, and Inuit peoples in our region, and within the traditional territories of the Heiltsuk, Kitasoo-Xai'xais, Lil'wat, Musqueam, N'Quatqua, Nuxalk, Samahquam, shíshálh, Skatin, Squamish, Tla'amin, Tsleil-Waututh, Wuikinuxv, and Xa'xtsa.

VCH has a published commitment to deliver exceptional care to every single one of the 1.25 million people we serve. Every patient (and their families and/or caregivers or support members) expects and is entitled to receive exceptional and culturally safe healthcare, but how do we truly know we are achieving this commitment and how do we interrogate our systems to ensure that our patients experience is optimal and free from discrimination and racism. This Patient Experience report and subsequent journey aims to further advance and challenge ourselves to fundamentally rethink and redesign the way we plan, deliver, and measure a patient's experience – acknowledging that this is only one contributing factor in the wider scheme of VCH as an organization.

WHAT IS PATIENT EXPERIENCE?

Patient Experience is what the process of receiving care (and healthcare) feels like for the patient, their family, caregivers, and/or support members. It is a key element of quality, alongside providing clinical excellence and safer care. Patients want to be heard, acknowledged, respected, and empowered in their entire pathway. This means all touch points in the healthcare journey from the parking experience, receptionist or referral process, admissions, receiving care, treatment, provision of food, hospital staff, after care etc. This entire journey is not restricted to one VCH member – we ALL play a role - and therefore a system wide humanizing approach is required in order for a patient to have a positive experience when receiving healthcare. A system where 'everybody' takes more time – takes a relationship moment. Patients are exercising their rights more in managing their healthcare, and therefore VCH are needing to adjust accordingly on how to improve patient experiences and better understand the importance and relevancy of what patient experience means to each individual.

WHY IS PATIENT EXPERIENCE IMPORTANT?

Although this question may sound obvious, can we truly say that we consider a patients experience when accessing or delivering healthcare or are there aspects of care that are more important than others that tend to take priority? And is this perception according to 'us' or the 'patient'? Furthermore, do we consider the prior journey of the patient when they present themselves to you – do we consider how much strength it may have taken for someone to acknowledge they have a healthcare issue; if they have had to leave their rural community (and family); or did they simply spend 30 minutes looking for a carpark. All these things can contribute to how they may be feeling before their interaction with VCH staff when accessing healthcare.

There are many reasons which validates why further exploration into patient experience is important, with the following being only a sample of these:

- There is limited or no comprehensive patient experience source or method to contribute to improving quality healthcare services across VCH for Indigenous patients/clients/residents/users and their families.

- There continues to be interest and willingness to broaden planning and operational focus to include and value the experience of patients/clients/residents/users through their care journey.
- Organizational commitment to transformative outcomes requires changing strategies that support scaling and spread. Periodic recalibration, networks of committed leaders aligned to overarching principles, identifying opportunities for greater shared leadership, and sharing examples change are some of the effective components of such strategies.
- We must commit to ongoing opportunities to gather together to build/deepen the understanding of "experience" and "experience in action."
- Indigenous Health and Patient Experience/Quality are strengthening their partnership, recognizing their shared interest and leadership in Reconciliation and Humanizing Care. Partnership requires getting INTO the work together, walking the path together.
- Improved patient perceptions of cultural humility and knowledge of VCH staff and feeling of safety accessing care without fear of racism or discrimination.
- Demonstrate the commitment - In (2015) VCH signed the Declaration of Commitment along with its 6 Health Authority counterparts - and reconciliation efforts as identified in TRC, UNDRIP & In Plain Sight calls to actions and recommendations.

As a Health Authority, we must acknowledge we still have much to do to improve a patient's experience. Amongst our aim of improving access to healthcare, preventing disease, communicating more effectively, and improving quality of life, our system is still severely fractured. We continue to receive regular complaints and our reputation is tarnished, particularly with our Indigenous patients. The In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care report published in November 2020 further validating this, which explicitly highlights that Racism and Discrimination continues to exist today. An example of these quotes highlights this:

IN PLAIN SIGHT QUOTES:

- **Indigenous Woman:** "I am afraid to go to any hospital. When I do have to, I dress up like I'm going to church, in order to receive proper treatment. It's ridiculous"
- **First Nations Women attending hospital:** I'm sad to say that I experienced racial stereotyping…I was made to feel ashamed, and they did not believe that I had food poisoning but that I was just wasted. I was so sick I could barely keep my head up but understood the stigma I was experiencing. I felt judged and mistreated. I left feeling shame….
- **Grand Chief Stewart Phillip, President Union of BC Indian Chiefs:** It is a glaring fact that Indigenous Peoples encounter racism on a regular basis in the health care system and we need an effective mechanism or complaint process to bring the issue to light and have it addressed.

Despite this continual feedback to improve patient experiences (in addition to commitment to the Calls to Action of In Plain Sight, TRC, MMIWG, and UNDRIP), there has been no development of standardized indicators that are created and developed in collaboration with Indigenous Peoples. And while most health systems thrive on data to drive progress or change, we still struggle to capture how to measure an experience and make systemic change – this report and patient experience journey aims to change this narrative.

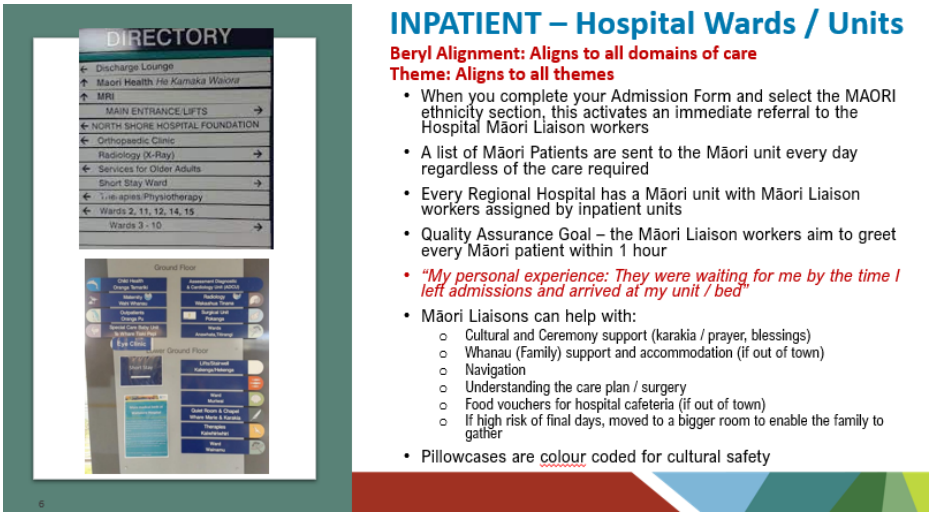
WHAT PATIENT EXPERIENCE MODELS CAN GUIDE OUR APPROACH?

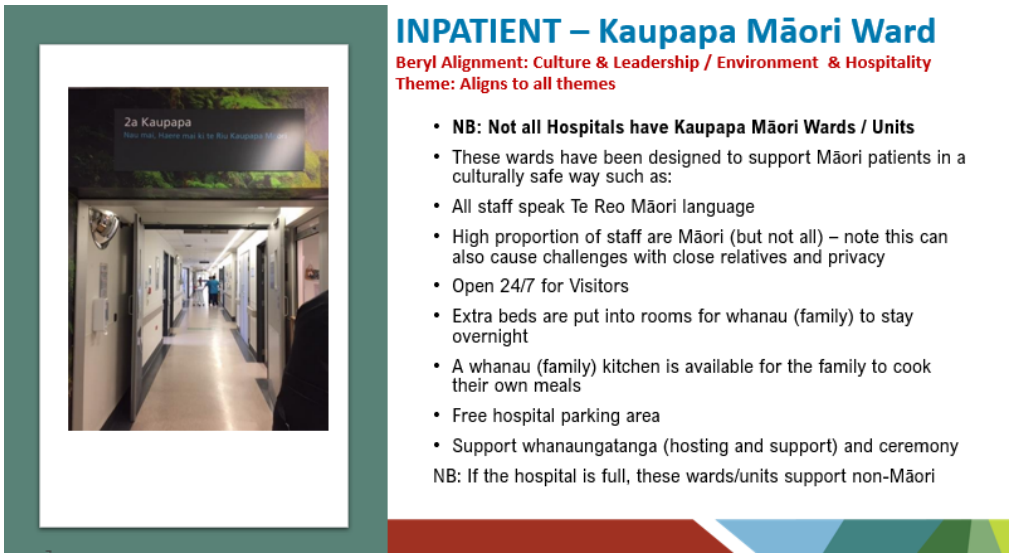
NEW ZEALAND - INDIGENOUS MAORI PATIENT EXPERIENCE PRESENTATION

As part of the Patient Experience Think Tank, Careene Andrews (Indigenous Māori Consultant from Aotearoa - New Zealand) presented and shared personal aspects of a typical patient experience pathway for an Indigenous Māori person accessing care in the Aotearoa (New Zealand) health system. It was acknowledged that the presentation was an opportunity to share wisdom and that New Zealand does not have it right. There are also some key differing factors that enable an easier process for implementing patient experience initiatives for Indigenous Māori peoples in New Zealand – for example:

- Indigenous Māori make up 17% of the total population giving a stronger weight and voice to policy changes and considerations
- There is ONE Indigenous Māori language (there are 34 First Nations languages in BC) which therefore supports easier Māori language usage and promotion across the health system
- There are 29 iwi (tribes) in the whole of New Zealand (there are 205 First Nations in BC alone)
- Indigenous Māori have their own voting system and Māori seats in parliament
- The Treaty of Waitangi is a foundational document in New Zealand

The following are a sample of the presentation slides that generated discussion and possibilities for the VCH Patient Experience Think Tank:



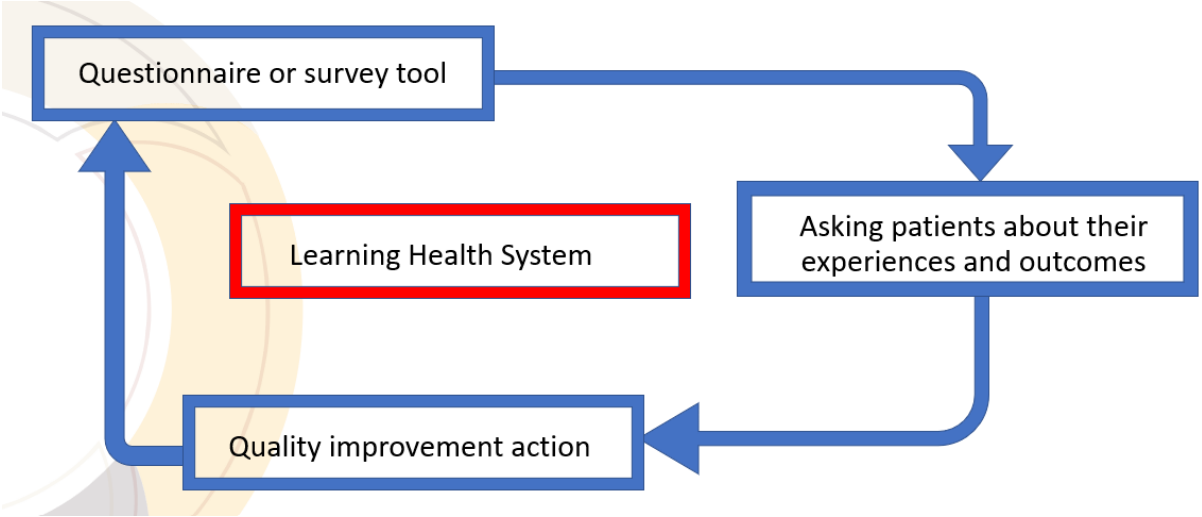


PATIENT EXPERIENCE LITERATURE REVIEW

In order for VCH to determine what an appropriate and effective Patient Experience Framework and measurement process may look like it was pertinent to determine what already existed. Undertaken in August 2022 by Dr Brittany Bingham – Director of VCH Indigenous Health Research and her research team, we have drawn from the findings of a literature review (and recommendations) regarding Patient Experience Metrics as summarized below.

Patient Experience Metrics in VCH and British Columbia:

There are some standard patient experience metrics in use across various health authorities, such as VCH, that are used to evaluate and analyse patients' experiences within the health authority. These can involve asking patients about how they feel as described in the following graph:



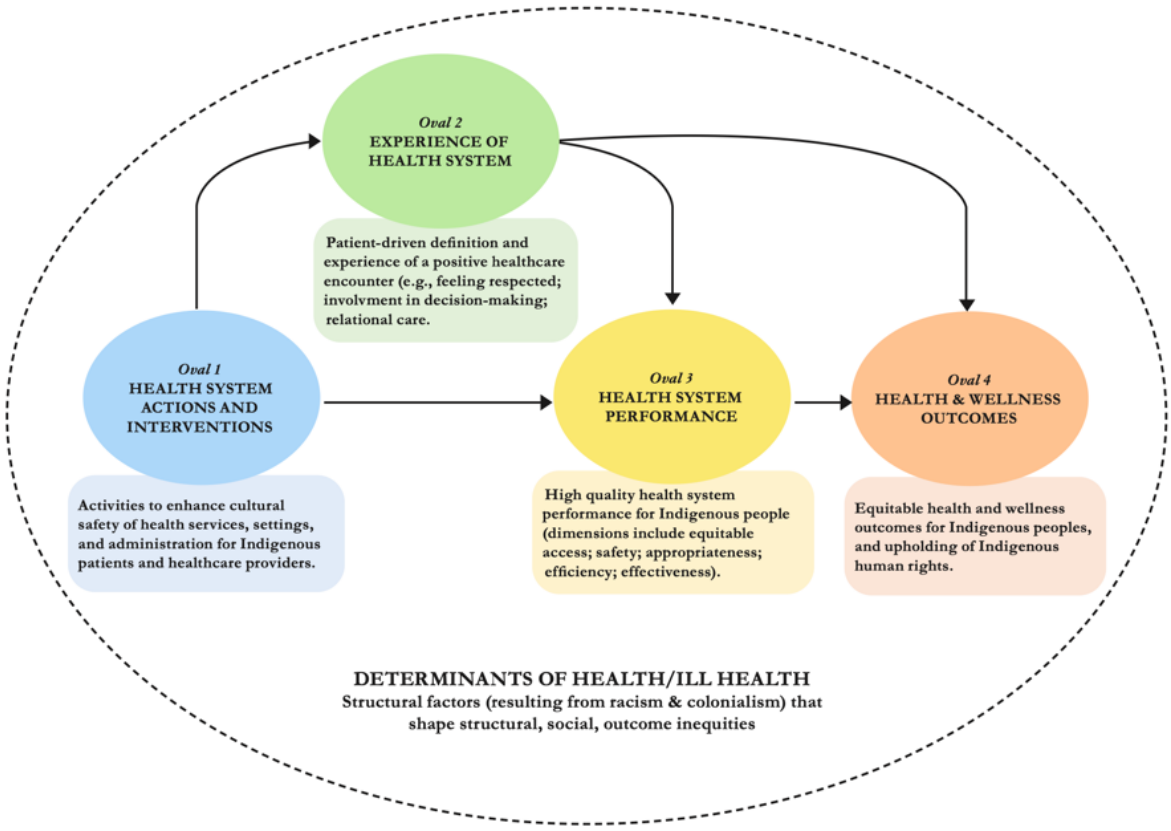
While there are a number of smaller scale patient experience metrics that are used within VCH and BC, there are two primary patient experience measurement tools that have demonstrated benefits. These include the Canadian Patient Experiences Survey of Inpatient Care (CPES-IC), and the Dynamic Analysis and Reporting Tool (DART). These patient surveys are tailored towards the general population and health care experience – although they can still be applied, they sadly do not contain patient experience measures that are specific to Indigenous Peoples.

The Canadian Institute for Health Information (CIHI) developed the CPES-IC as a tool to measure surgical, medical, and maternity services through patient experience surveys. It is a standardized tool that collects data about: admissions processes, communication, involvement in decisions and respect for patient preferences, coordination of care, discharge information, and patients' overall care experiences. The second system in place within B.C. is the Dynamic Analysis and Reporting Tool (DART), which is managed by British Columbia Patient Centred Measurement (BCPCM). The DART is an online reporting system for patient survey data that is collected, synthesized, and published in a provincially coordinated manner. It is an attempt to provide close to real-time look at patient experience for any systems that use their reporting tools. Both of these tools have good guiding methods to support measuring Patient Experience.

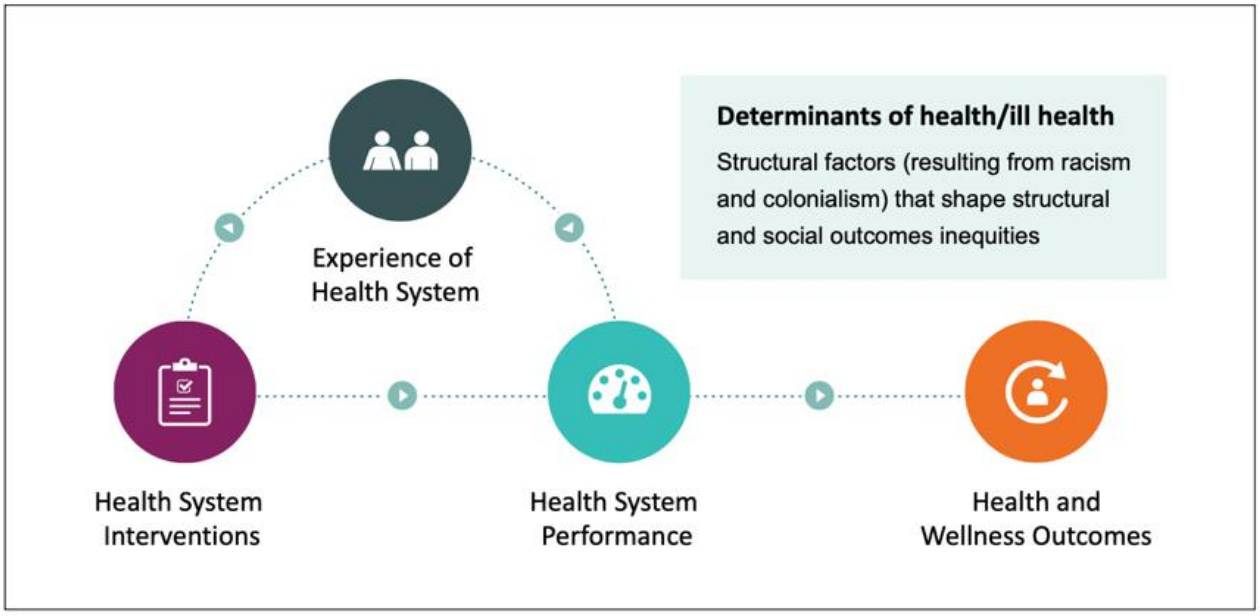
Indigenous Specific Patient Experience Metrics

Through the literature review, there were three frameworks found that have been created to help support patient measurement, although of worthy note and identified earlier, there are currently no Indigenous-specific validated metrics within Canada. All three of these frameworks are based in the same foundations, and centre patients and Indigenous perspectives on wholistic health and wellbeing throughout the frameworks. The frameworks are the National Collaborating Centre for Indigenous Health's (NCCIH) Framework for Indigenous Cultural Safety Measurement, CIHI's Report on Measuring Indigenous Cultural Safety in Health Systems, and the Indigenous Healthcare Quality Framework from Ongomiizwin Indigenous Institute of Health and Healing and the George & Fay Yee Centre for Healthcare Innovation.

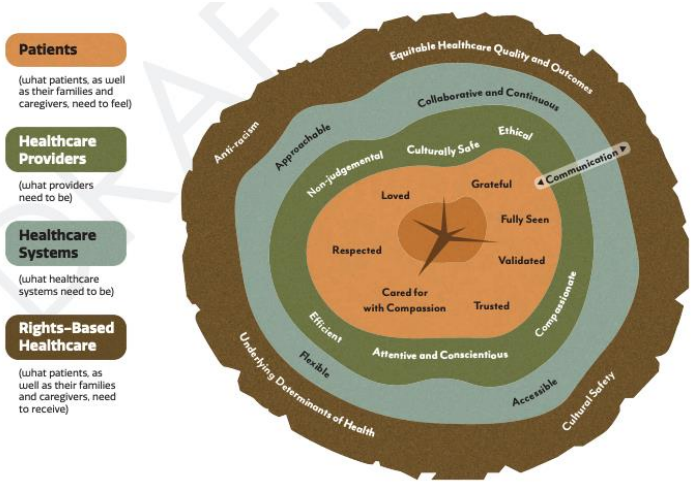
1) NNCIH Cultural Safety Measurement Conceptual Framework:



2) CIHI's Report on Measuring Indigenous Cultural Safety in Health Systems



3) Indigenous Healthcare Quality Framework from Ongomiizwin Indigenous Institute of Health and Healing and the George & Fay Yee Centre for Healthcare Innovation



Global Examples of Indigenous Patient Experience Metrics

In other jurisdictions, there are other solutions to draw upon. The themes gathered were centred around relationships and respect, rather than the patient's medical condition. Although brief literature search showed that there are many examples of metrics for various conditions, primarily from Australia and Aotearoa (New Zealand), and that there are important insights to be gained from these metrics and studies that can be used in development of a general metric at VCH. Various examples of the ways in which patient experiences can be collected and used are demonstrated below.

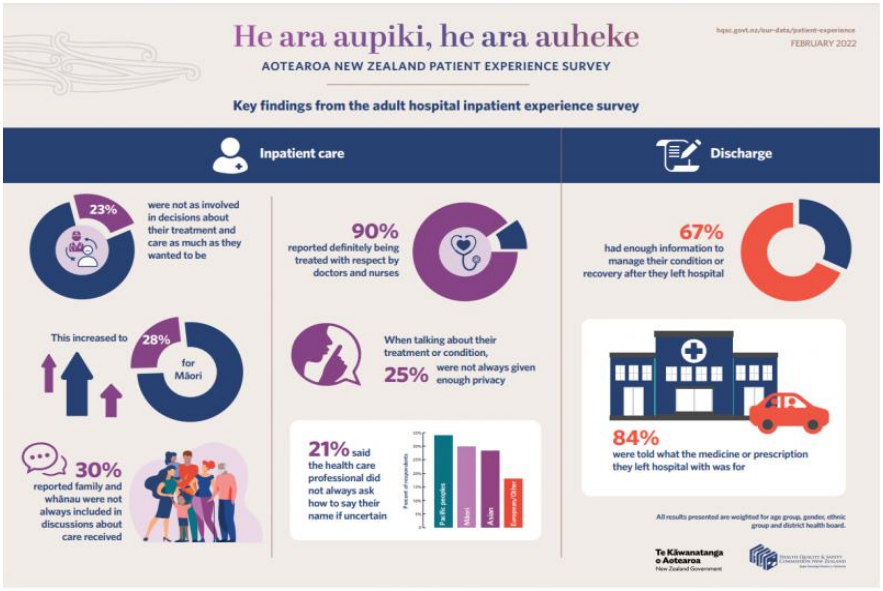
Australia - Cardiac Patients Using Yarning for Storytelling**:** With Indigenous cardiac patients, a study was done that used Yarning (a method of storytelling) as data collection, in which participants were asked a single question – "Can you tell me about your experience this admission?". This approach provided participants with full control over the stories they shared with the researchers without interruption and concluded when the participants indicated that they had nothing else to share.

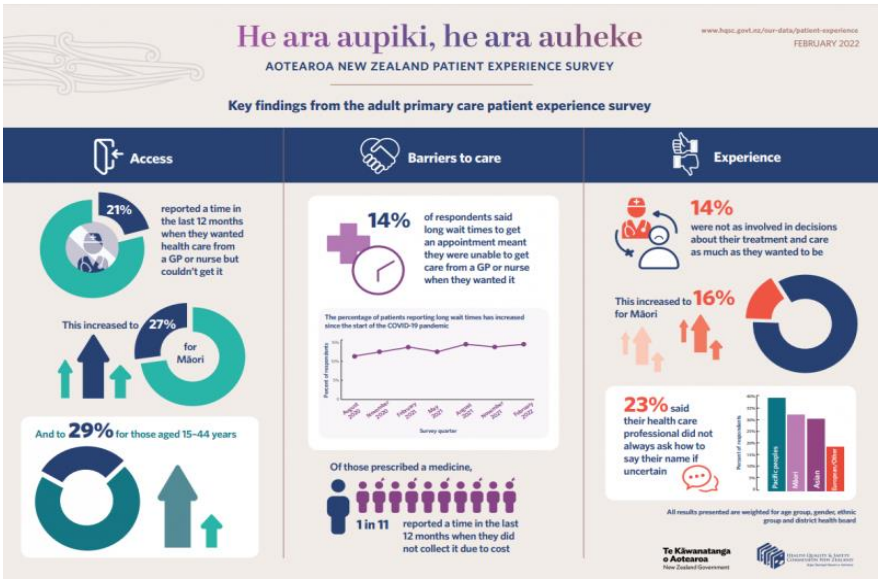
Australia – Metro Health Services Using Surveys and Open-Ended Questioning: This study was done within Peninsula Health in Victoria with Aboriginal and Torres Strait Islanders, using a combination of the validated Victorian Patient Satisfaction Monitor (VPSM) and open-ended survey questions. Like the HCAHPS and the CPES-IC, it is a general survey questionnaire that is used to gain insight into the experiences of patients in all care settings.

Aotearoa/New Zealand - Systematic Review of Māori Experiences in Public Healthcare: A systematic review in Aotearoa found 14 papers that covered the area of Māori experience in the public healthcare system, all of which used face-to-face interviews as a method of gathering patient experience data, with some using the additional tool of hui (focus groups). All the articles used similar thematic approaches to gather themes and outcomes from their interviews.

Aotearoa/New Zealand - He Ritenga Whakaaro: The Mauri Ora Associates in Aotearoa developed a survey questionnaire by and for Māori to gather information about issues, barriers, constraints, and incentives around Māori use and experiences of health care and disability services. The surveys were done by phone, except for face-to-face interviews for Māori peoples who were deaf or hard-of-hearing, with all participants given the option to complete the interview with Māori speaking interviewers.

Aotearoa/New Zealand – Patient Experience Survey: The Health Quality & Safety Commission in Aotearoa developed its baseline survey in 2020 and captures the following information on an annual basis.





Global Patient Experience Metrics – The Beryl Institute

In addition to the above patient experience metrics, one model for consideration, that resonates best for VCH is from the Beryl Institute. The Beryl Institute is a global leader in patient experience measurement, providing frameworks, resources, and opportunities for health organizations to evaluate their metrics or interventions, and identify opportunities for improvement. They define patient experience as "the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care." There are eight strategic lenses that the Beryl Institute deems as important to patient experience, which include: (1) culture and leadership; (2) infrastructure and governance; (3) staff and provider engagement; (4) policy and measurement; (5) environment and hospitality; (6) innovation and technology; (7) patient, family, and community engagement; and (8) quality and clinical excellence (9). These resonate well with what VCH are aiming to achieve.

Literature Review Conclusions

Overall there is growing recognition of the importance of patient-centeredness in improving healthcare experiences among patient populations. Central to this is measuring and understanding patient healthcare experiences – which includes assessing satisfaction with care, but also by capturing and analysing peoples' unique and nuanced experiences when accessing health care. More specifically, while patient satisfaction refers to the gap between a patient's expectations and their treatment experiences, one's experience includes the specific interactions and events that contributed to whether they felt that their health care needs were met. This places an emphasis on whether, or how often, they experienced aspects of care rather than a rating of different aspects of their care or treatment. The Beryl Institute Model does not tend to silo aspects of care but rather look at the entire journey and for this reason is a preferred approach.

Through the literature review, it was further identified that there a combination of various methods used to collect patient experience data, ranging from multiple types of storytelling methods, focus groups, interviews, and surveys. Accordingly, evidence indicates that storytelling is an important method for collecting patient experience data given the importance of storytelling within many Indigenous communities. Conversely, there were concerns with how resource-intensive storytelling methods were in addition to challenges around their usability in the longitudinal analysis of patient experiences and how experiences change over time. Based on this information, employing a mixed methods approach that combines both validated measures and storytelling provides a more robust understanding of people's experiences in healthcare.

INDIGENOUS CULTURAL SAFETY PATIENT EXPERIENCE FRAMEWORK

As indicated earlier, the National Collaborating Centre for Indigenous Health's (NCCIH) Framework for Indigenous Cultural Safety Measurement places a strong emphasis on improving Indigenous Cultural Safety. It is a framework developed to fill a gap that exists in the systemic measurement of Indigenous cultural safety with the intent of improving health system performance and Indigenous Peoples' experiences of health care.

Indigenous cultural safety is an important outcome for Indigenous Peoples and therefore must be considered in our patient experience approach. Indigenous cultural safety is not defined by the provider, but by the client or patient experiencing care, which helps to shift power dynamics from the provider to the client, acknowledging cultural values as valid and restoring self-determination within a healthcare setting. VCH must commit to developing Indigenous specific patient experience tools to measure Indigenous cultural safety from the perspective of a patient, which aligns with the findings from the In Plain Sight: Addressing Anti-Indigenous Racism and Discrimination in B.C. Health Care, where Recommendation 9, calls for a system wide measurement framework on Indigenous cultural safety, Indigenous rights to health and Indigenous-specific racism.

Mainstream metrics may not reflect the needs, or experiences of Indigenous patients. Presently, the data collection, storage, and usage policies around patient experience data is centred in Western colonial perspectives, and do not integrate or accurately reflect the unique health care needs of Indigenous communities, perspectives on health and wellbeing, and challenges of accessing health care. These priorities are similarly highlighted in other foundational documents, including the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), and within the Truth and Reconciliation Commission's (TRC) Calls to Action.

The NCCIH Framework for Indigenous Cultural Safety Measurement describes areas within a healthcare system where Indigenous cultural safety can be enhanced and also describes six (6) main themes that represent what is required for Indigenous cultural safety in healthcare[1]. These six themes are described below:

Respect	Identity	Empowerment and Equity	Safety	Relationality	Reciprocity
•Involves the feeling of being valued and one's dignity being upheld by a health care provider and health care environment.	•Refers to positive •acknowledgement or affirmation as an Indigenous person or part of an Indigenous culture	•Encompasses an equal partnership that supports the self-determination of the client and enables the client to feel heard, and in which the provider and patient are in a cooperative and reciprocal relationship.	•Refers to a sense of protection from harm or risk, and an experience free of racism	•Includes a sense of dignity, an experience of connection with a health care provider, and observations of health care providers demonstrating care, compassion and empathy	•Involves two-way or shared learning, curiosity, interest and effective communication, facilitated by an understanding of the impacts of colonialism on Indigenous Peoples

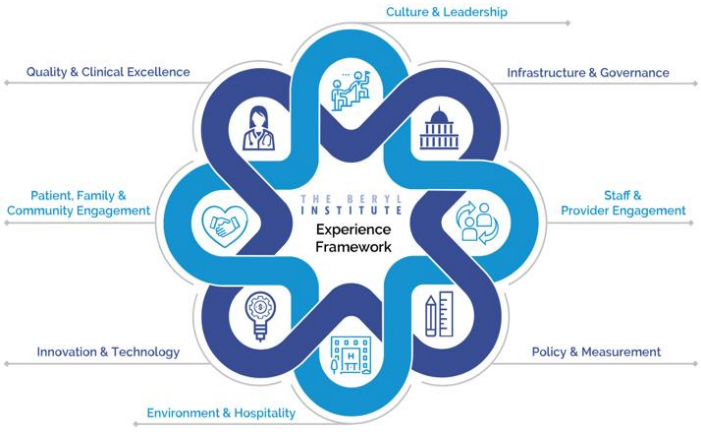
This approach to Indigenous cultural safety encompasses words, concepts, and components that can supplement existing patient experience metrics aligned to those that VCH are aiming to achieve. Potential questions can also be derived from each theme. The author of this framework states that "Mirroring the relationality is inherent in Indigenous cultural safety, and each domain has a relational component to each other. Any single indicator cannot, on its own, measure the concept of Indigenous cultural safety, instead, each indicator is influenced by, and in relationship with, many other indicators", demonstrating the importance of an Indigenouscultural safety measurement within all sectors of a health system. For example, each theme can intersect with the Beryl Institute Experience Framework which is a desired patient experience model for VCH.

[1] Johnson H, Sutherland J. A conceptual framework for Indigenous cultural safety measurement. 2022.

A PATIENT EXPERIENCE GUIDING FRAMEWORK FOR VCH

Findings from the literature review and other pertinent material demonstrated common themes across the various patient experience metric frameworks. The Beryl Institute Framework and NCCIH Indigenous Cultural Safety Measurement themes bringing the strongest benefits to a Patient Experience metric that can be applied in a variety of ways across multiple contexts within VCH. The Beryl Institute Framework defining its patients experience as "the sum of all interactions, shaped by an organizations culture, that influence patient perceptions across the continuum of care", and the NCCIH identifying six key relational themes for embedding Indigenous cultural safety. VCH included an additional theme being Health System utilization which will underpin all of the Indigenous domains and empower patients to determine equitable and appropriate care. This theme is the entire experience a patient has – it is the compliment, the patient story of gratitude, it is also the complaint that gets escalated, the story that goes to the media. Both experiences are elevated to highlight where a person felt cared for or forgotten.

Respect	Identity	Empowerment and Equity	Safety	Relationality	Reciprocity	Health System Utilization
•Involves the feeling of being valued and one's dignity being upheld by a health care provider and health care environment.	•Refers to positive •acknowledgement or affirmation as an Indigenous person or part of an Indigenous culture	•Encompasses an equal partnership that supports the self-determination of the client and enables the client to feel heard, and in which the provider and patient are in a cooperative and reciprocal relationship.	•Refers to a sense of protection from harm or risk, and an experience free of racism	•Includes a sense of dignity, an experience of connection with a health care provider, and observations of health care providers demonstrating care, compassion and empathy	•Involves two-way or shared learning, curiosity, interest and effective communication, facilitated by an understanding of the impacts of colonialism on Indigenous Peoples	• This is the patient experience receiving what THEY determine to be equitable and appropriate care. • This will be the underpinning of all the Indigenous Domains



While we are in the infancy of what this means and how these can be applied across the organization, VCH will utilize these two intersecting models as our Patient Experience metrics for the VCH Experience in Care Framework and Program. This being the impetus to hold a collaborative Patient Experience Think Tank hosted by VCH Indigenous Health and VCH Patient Experience.

VCH PATIENT EXPERIENCE THINK TANK FOUNDATIONAL CONTEXT

UNITED APPROACH TO A PATIENT EXPERIENCE THINK TANK

VCH Indigenous Health and VCH Patient Experience identified that it was essential to collaborate and work in partnership as "Experience" teams to prioritize and identify a critical approach to measuring Patient Experience. While there was acknowledgement that existing patient experience efforts were in place, it was not the optimal model that both departments of VCH were seeking. Patient Experience is undoubtably gaining momentum, not just in BC but globally and in order to be leaders in measuring patient experience we realized that more needed to be done. Key priorities from each department that aligned and were essential to implementing a Patient Experience metric included:

Indigenous Health:

- Implementation of Indigenous Worldviews
- Decolonizing Care
- Addressing Indigenous-Specific Anti-Racism
- Commitment and action to the Calls to Action and Recommendations of TRC, UNDRIP, In Plain Sight, MMIWG

Patient Experience:

- Identifying quality domains
- Humanizing Care
- Nothing About Us Without Us approach
- Relationship-based Care

Jointly designed between VCH Indigenous Health and Quality & Patient Safety, the following mandates were developed to guide this work:

- **Compassion and Healing** – Commitment to building a culture in VCH that embodies compassion, connection, and dignity in all interactions
- **Partnership and Involvement** – Commitment to define and drive participation in care, decision making and strategy for improved experience
- **Experience Measurement** – Commitment to lead assessment and measurement of human experience to inform and improve quality of care and overall experience
- **Experience Strategy and Improvement** – Commitment to create and embed the human experience strategy within VCH and build capacity for people to improve experience across VCH

It was easily determined that in order to enhance the Patient Experience approach, that we must bring along everyone in VCH on this Patient Experience journey – as ultimately, we all play a role in enhancing a patients experience. It was therefore proposed to VCH SET to host a Patient Experience Think Tank as an initial first step – predicting that this would be one of many and recognizing that this is just the start of the journey.

Indigenous Health | Vancouver CoastalHealth

PATIENT EXPERIENCE THINK TANK ORIGINAL INTENTIONS AND OBJECTIVES

VCH Indigenous Health (IH) and VCH Patient Experience (PX) teams established a working group and identified the following objectives for Patient Experience:

Grow the understanding of and commitment to IH and PX across and within VCH

- Grow the ideas, ways of thinking, and ultimately world views that are Indigenous Health and Patient Experience
- Increase the understanding of frameworks/ world views that guide Experience and Indigenous Health
- Together we are interested in fundamentally influencing and changing the experience of care
- Identify where we are "the same and different"

Begin to Share the Responsibility across the Organization

- We need to share the responsibility of embedding the values and value of Indigenous Health and Patient Experience into the fabric of VCH. This is supported by having leaders from across VCH come together to learn, discuss, and then take action.
- Build commitment to 'consistency' and why a lack of consistency is dangerous
- Demonstrate that how we learn together and walk together is important

Make the commitment to Relationship-Based Care

- Visible through how we engage in the learning and begin to shape the action
- Honour the patient, the family, the community and the provider throughout the process of inquiry and dialogue and by decolonizing and humanizing care
- Build understanding through Relationships and Storytelling
- Build awareness of the ecosystem: provider – patient/family – team – system
- Build relationships and commitments
- Make our commitments active – how do we LIVE our intentions?

ADDITIONAL PATIENT EXPERIENCE THINK TANK CONSIDERATIONS

Through the IH & PX working group meetings, the following were also identified as key considerations in the Patient Experience Think Tank or future Patient Experience Think Tank events:

- How do we positively and genuinely impact patient experience?
- How do we encourage the curiosity?
- How do we promote speak-up behaviours?
- Reflecting on how we are enacting Reconciliation – and address the calls to action.
- What can YOU do to make change in a patient's experience?
- How do we humanize our work? Are we authentic when we deliver healthcare?
- How do we create a mindful system?
- Do we centre the patient?
- Is there proof by changing design concepts that actually change how people feel?
- What are the indicators of success? How many complaints did we NOT receive today (rather than how many received)

PATIENT EXPERIENCE THINK TANK GATHERING - OBJECTIVE & ATTENDEES

Together IH and PX planned and hosted a gathering on 12 October 2022 to seek commitment from VCH Leadership and expert partners to participate, share, and contribute to the development of the VCH Patient Experience in Care Framework.

While there were many topics to discuss during the gathering, the IH & PX teams agreed upon and co-facilitated the Patient Experience Think Tank on the topic of transforming health systems at the point of care as a foundational discussion. The goal of the day was to create allyship on the topic of humanizing care through humility and as a step towards reconciliation.

Since many VCH employees play a role in enhancing a patient's experience, invitations to the Patient Experience Think Tank were sent to leadership of following VCH departments inviting individuals or representatives to attend:

OPERATIONAL	SYSTEM & STRATEGIC	PRACTICE
• Comm/Acute/LTC • Coastal/Vancouver/ Richmond • Patient Services	• Quality • Risk • Data/Epidemiology • DEI • Talent & Culture, People (HR) • Leadership / Corporate Governance • Communications • Finance • Transformation • Research • Public Affairs & Stakeholder Relations • Strategic Partnerships • Safety, Health & Wellness • Business Initiatives • Accreditation	• Professional Practice & Clinical Education • Physicians • Nurse Practitioners • MHSU • Allied Health • Primary Care • IPU • Access and Patient Flow • Emergency / Ambulatory discharge • UPCC • Surgical • Legal Counsel • Ethics • Volunteers

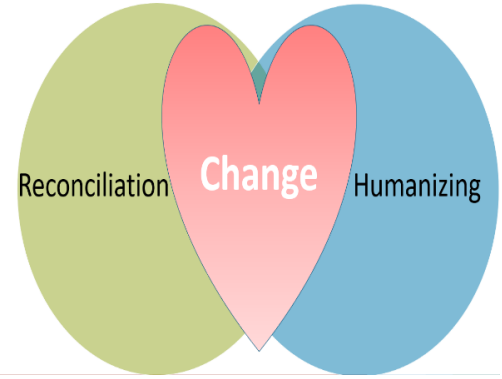
It is pleasing to report that 80 representatives from 90% of the above VCH departments including Senior Executive Team VP representation, attended the Patient Experience Think Tank validating the importance of the discussion and topic. We wish to acknowledge PHSA, Island Health, Fraser Health, and Interior Health who also attended and contributed to the discussions with their wisdom as a partner Health Authority.

A special acknowledgement to Elder Bruce and Elder Ruth who provided cultural guidance to the Patient Experience Think Tank, not only with opening and closing prayers and food blessings but with sharing their essential wisdom with the discussions held throughout the day.

PATIENT EXPERIENCE THINK TANK GATHERING – RECONCILIATION AND HUMANIZING CARE

VCH VP Indigenous Health – Leslie Bonshor provided an overview of the objective and impetus of the Patient Experience Think Tank and what we are aiming to achieve on the patient experience journey – a system transformation approach to providing healthcare. This included the commitment as VCH to the Indigenous reconciliation reports and calls to action. Leslie also explained the Indigenous Worldview context surrounding Indigenous patient experiences where foundationally and traditionally were about people and families sharing oral stories (story telling) and listening. This being key facets in humanizing care.

Lori Quinn – Indigenous Health and Elizabeth Baron – Patient Experience co-facilitated a session on Reconciliation and Humanizing Care being the two primary concepts for grounding the Think Tank. This session involved explaining the intent of Experience in Care and the idea of Humanizing Care, re-humanizing care, and bringing CARE back into healthcare. To complement the words shared by the VP Indigenous Health, it was explained how using an Indigenous worldview and a relational and people-centred approach to humanize care is an act towards reconciliation.



It was further explained that because the two worldviews (reconciliation and humanizing) have a great deal in common and overlap – that it is at this intersection that will be the impetus of transforming a health system (change) to reconcile and humanize the care we provide to those we are meant to serve – patients and families (the patient experience). The difference of Intersecting and interwoven was also described in that iintersecting means to pass by – and when you pass by you see, you hear, you learn – but is it enough? Interwoven means to become linked, to become locked together closely, or to become tightly knit together. Indigenous worldviews and Experience worldviews are more than intersections – they - we are woven together tightly.

We cannot humanize care for Indigenous Peoples without acknowledging and committing to reconciliation. Through humanizing care by listening to people using a relational approach and storytelling to share their experiences we can begin to appreciate their feelings and perceptions of care and the impact the health system has on the wellbeing of those it serves. This is the true indicator of our success in the care we are delivering. We know that experience accounts for more impact on patients and families than simply providing excellent clinically competent care.

It was explained to participants that before we can ground ourselves in the concepts and how they intersect with the principles of experience, we must first understand how we will incorporate an Indigenous Worldview into meaningful reconciliation and restoration within the systems for which we work. Participants were asked to spend time reflecting on their own journeys in this work and what our responsibility is as leaders, leading the 27,000 people across VCH. The following table was described to participants:

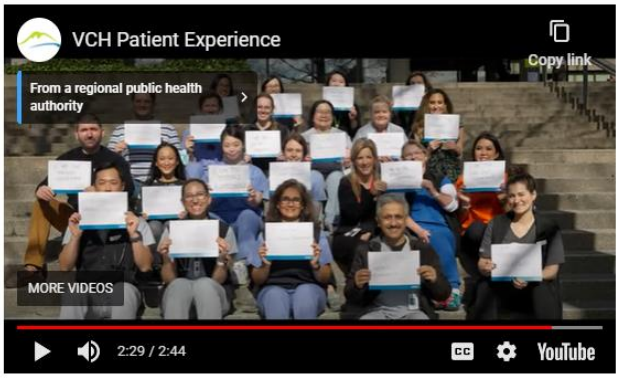
RECONCILIATION - RESTORATION	HUMANIZING CARE
Meaningful Reconciliation: Meaningful or meaningfulness is defined as the quality of having great importance, usefulness, purpose, or impact. We cannot have meaningful reconciliation and restoration without understanding what is meaningful, what is important, what matters to Indigenous Peoples. **Reconciliation** is defined as the restoration of friendly relations or the action of making one view or belief compatible with another. In Canada the term has come to describe attempts made to raise awareness about colonization and its ongoing effects on Indigenous Peoples. The audience was asked to deeply consider what restoration of an Indigenous worldview, of Indigenous Perspectives, of Indigenous Priorities when considering: • What matters to Indigenous Peoples and what would restore their experience in care from one of fear, distrust, and harm to and experience of trust, care, and safety. • How are you taking steps to restore a lost, a taken, a stolen Indigenous worldview personally, professionally, and how is the organization addressing this. The work of the **Truth and Reconciliation Commission** began in 2007. After 6 years of gathering information, travelling throughout Canada, listening to over 6500 witnesses, and hosting 7 national events to raise awareness, share, and honor the experiences of Residential Students and families - the findings were presented on Ottawa in 2015 with 94 calls to action. The **In Plain Sight report** on addressing Racism in healthcare in BC, which was constructed by the honorable Dr. Mary Ellen Turpel-Lafond in 2020 revealed that there is ongoing racism in our health systems today. The report made 24 recommendations and calls to action which catalyzed a focused effort in transforming healthcare. In 2021 and updated in 2022 the BCCNM and CPSBC launched a collaborative practice **standard on Indigenous Cultural Safety, Cultural Humility and Anti-Racism** for all registrants.	Patient Experience is the sum of all interactions, shaped by an organization's culture, which influence patient perceptions across the continuum of care (Beryl Institute Framework). Experience is not a project nor is it a single initiative. It is the outcome of organizational alignment of people, processes, and place towards a common goal of providing exceptional care experiences for all patients, families, and caregivers from the first touchpoint to the last. So …what is patient experience? And what do we mean by humanizing care? Four aspects to this fairly simple definition. "Interactions", experience is based on human interactions (personal and clinical) and connections; Grounded in Culture (the kind of organizational culture we build is the means by which we deliver those interactions); Happens at all the touchpoints across the continuum of care and also the spaces in between; and ultimately the perceptions of patients and families and their support networks are the indicator of our success in experience". Healthcare is the business of human beings caring for human beings.

Lori Quinn closed off this session by saying "I believe with my whole being and with my 20+years of nursing, that if we get this concept right with Indigenous folks, we will get it right for all people seeking care. And so, our journey as healthcare leaders has begun and there is no turning back – you have the power to influence and transform our health system - it really is exciting to be part of this journey of change".

PATIENT EXPERIENCE THINK TANK GATHERING – HUMAN INTERACTIONS

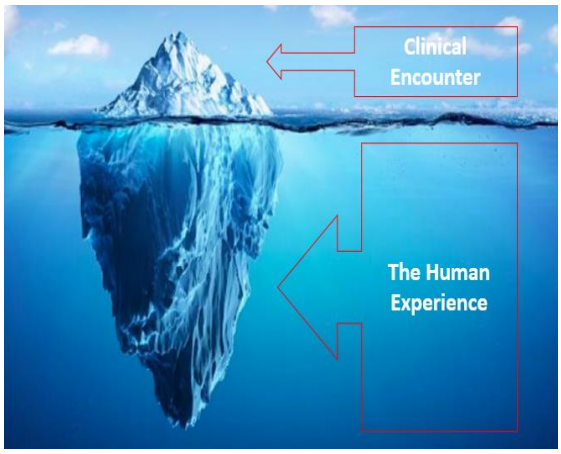
To further enhance the humanizing care concept, the essential component of human interactions was presented. Healthcare is the business of human beings caring for human beings, and yet we often reduce it to body parts, diagnoses, labels, silos of care and so on. The question was asked "How do we consciously protect the human part of healthcare?" Human experiences in care are strongly relational and relationship-based across every interaction along their journey. Every single one of us contributes to the care experience, no matter what their role within the organization.

The following 2022 patient experience video (https://www.youtube.com/watch?v=3l9wrqEWY-E) was played which illustrates the importance of each interaction with a patient. Participants were asked to think about their own experience as they watched the video and how it made them feel. Many participants applauded the video and the impact it had including the visuality of a patient's possible interaction with VCH.



Everyone on the continuum of care has an impact on experience.

To follow on from the video, a further presentation was held on the differences between a clinical encounter and the human experience. Traditionally, healthcare teams have tended to focus on clinical outcomes e.g. a body part, a tumor, a failed organ system. Was the recovery from hip replacement surgery consistent with the clinical pathway established by the medical team? What was the rate of recidivism for clients who were discharged after open-heart surgery during the last quarter, and how does this compare to the previous quarter? In other words, we were viewing clinical drivers almost exclusively as measures of success.



However, what we know from research and many of our own experiences, including what is happening in the world right now, is that clinical and quantitative measures only tell a part of the story, and not necessarily the part that is most important to the people receiving care: Did the person receiving care feel respected and listened to? Did they fully understand the treatment they were consenting to? Were they set up with appropriate services and supports on discharge so that the person receiving care as well the team providing care view the discharge as safe, and not cause anyone moral distress?

Elizabeth Baron shared that "As a clinician and also a patient myself albeit a white female with privilege, I have learned that while the interventions themselves, diagnostics, imaging, interventions,

bloodwork, surgery and so on are important they do not create the moments that matter to most of our patients. What matters to them is how we make them feel, at a time when they are often scared, vulnerable and unsure what to expect. They remember the connections that are formed, the kind faces and often names of the people who made them feel safe and helped them trust the system. They remember the people who gave them hope in a time of fear. They remember people who made them feel like more than their diagnosis. Who inquired about their loved ones, their hobbies, and their goals beyond the clinical encounter. This is why humanizing care matters, and why the actual clinical encounter represents only a fraction of the care experience for both those providing and receiving the care".

Participants were asked to read the following quote which suggests we humanize the experience through commitment, partnership, humility, and action to build a systemic solution to humanizing care.

An Unwavering Commitment to Human Experience

"We cannot stand by in declaring an unwavering commitment to human experience if we cannot ensure that all humans are seen in that light, as people who deserve the same rights, opportunities, freedoms and respect regardless of race, ethnicity, socio-economic status, gender, gender identity or beliefs. It is incumbent on each of us as individuals to gauge our own stand, dig in to understand our privilege, uncover our biases and then work diligently to honor the essence of what humanity calls from all of us. For we are only as strong as a community in the strength of respect we give to and show for one another."

~ The Beryl Institute

Jason Wolfe, President at the Beryl Institute refers to the biggest barrier in Experience right now being "people trying to get their arms around what it is," we tend to make assumptions about things we think we understand and often dismiss them too easily like a box that can be checked. Whether we plan for it or not people are going to have an experience in health care, and they are today and every day. It behooves us to consider whether we are going to create that experience, proactively and in partnership or… leave it to chance.

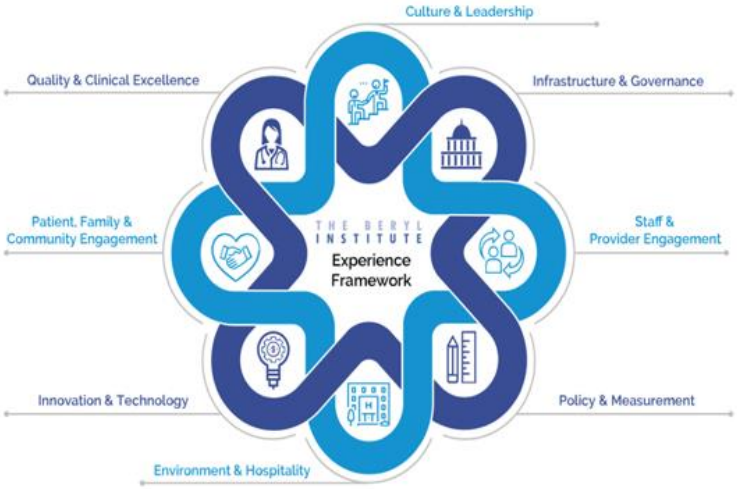
This isn't about a ticky box or a survey, or even about "empathy" or "compassion" or "patient or person centred care"…these are very healthcare centred terms… still making assumptions about where our patients "want to be" and what we "do for them" It is about what this looks like in action, what the actions are that we take to ensure our patients, families and those providing care feel heard, are communicated with effectively and are engaged in ways that matter to them. We humanize care by moving beyond the words, and into action.

PATIENT EXPERIENCE THINK TANK GATHERING – BREAKOUT SESSIONS

VCH'S EXPERIENCE IN CARE PROGRAM - LEARNING TOGETHER – THE PRINCIPLES AND THEMES OF CARE CONCEPTS

By setting the grounding approach with the overall reconciliation and humanizing concepts, participants were presented with the following descriptions of VCH's Experience in Care Program guided and utilizing: 1) The Beryl Institute Experience Framework and 2) NCCIH Indigenous Cultural Safety Measurement themes (as referenced earlier as the preferred guiding patient experience frameworks).

The Beryl Institute Experience Framework:
The Beryl Institute Framework defining its patients experience as "the sum of all interactions, shaped by an organizations culture, that influence patient perceptions across the continuum of care". The experience principles guide a humanized healthcare experience:



The following table was presented to explain each component of The Beryl Institute Framework:

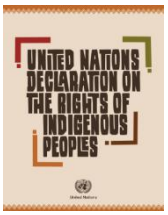
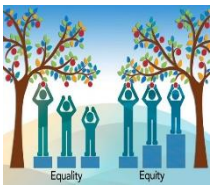
PRINCIPLES	DESCRIPTION	APPLICATION OF IMPORTANCE
Culture & Leadership	**The foundation of any successful experience effort is set on who an organization is, its purpose and values, and how it is led.**	Why is this important? • The structure, leadership and values of an organization greatly impact its culture, and how care is both provided and received. • Live the values, 'walking the talk' is critical. • Policies alone are not enough, and do not ensure compliance. • Speak up Culture, Just culture - necessary to create safe spaces, free of bias. • It is incumbent on leadership to model the purpose and values and ensure all staff know they play a role in contributing to a patient's overall experience
Infrastructure & Governance	**Effective experience efforts require both the right structures and processes by which to operate**	Why is this important? • Structures, processes, and formal guidance to ensure there is a sustained strategic focus

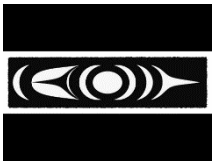
	and communicate and the formal guidance in place to ensure sustained strategic focus.	integrated in the work as well as ongoing for progressive improvement
Patient, Family & Community Engagement	**Central to any experience effort are the voices of, contributions from and partnerships with those receiving care and the community served.**	Why is this important? • Because it's the right thing to do • Think of a successful business anywhere that doesn't consider the perceptions, feelings, voices, wants and needs of their clients. In Canada we don't necessarily see healthcare as a business but in some countries the consumers of health care and their perceptions and experiences in care are drivers on revenue and where patients choose to go. • "Nothing about me without me" – decision making in healthcare requires continuous input from clients and communities. This is critical to ensure that the people receiving our services feel that they are being provided in a way that is culturally safe and enhances connectedness rather than increasing feelings of stigma and marginalization that many vulnerable patients and clients experience when in our care
Staff & Provider Engagement	**Staff and Provider Engagement: Caring for those delivering and supporting the delivery of care and reaffirming a connection to meaning and purpose is fundamental to the successful realization of a positive experience.**	Why is this important? • Many healthcare organizations have missed an important point; that the best way to improve the patient experience is to build better engagement with and experience for their employees who, then, will provide better service and healthcare to patients. • Our staff care a great deal about the patients and clients we work with. They want to bring their absolute best to work every single day, and they need to be supported to ensure that they feel heard, valued and experience joy at work. • Literature supports this also has impact on staff recruitment, retention, and burnout.
Environment & Hospitality	**The space in which a healthcare experience is delivered, and the practices implemented to ensure a positive, comfortable, and compassionate encounter must be part of every effort.**	Why is this important? • We learned in the pandemic through our entrance screeners the importance of how we receive people at our doors. No different than any space we enter, (a restaurant, a hotel, a park) patients want to feel seen, welcomed, recognized, expected, comfortable and supported. • Part of this includes a respectful, compassionate, and empathetic approach from clinical and non-clinical staff all stages of a patient healthcare journey. • How we engage with patients, introduce ourselves, create connection even in challenging conversations also has a significant impact on how patients feel.
Innovation & Technology	**As a focus on experience expands, it requires new ways of thinking**	Why is this important?

	and doing and the technologies and tools to ensure efficiencies, expand capacities and extend boundaries of care.	• Another thing we saw widely illustrated with the pandemic was the importance of access to virtual care which has forever shaped care delivery for our patients and families making visits, more efficient, accessible, and affordable in many cases. We saw similar technology support visits with family and friends and even including loved ones in care meetings and planning. • We use technology now to communicate with our patients, to share information and for efficient and expedient processes. • Technology is another tool in our bag to ensure we can elevate the patient experience.
Policy & Measurement	**Experience is driven and influenced by external factors and systemic and financial realities and requires accepted and understood metrics to effectively measure outcomes and drive action.**	Why is this important? • We need to be measuring what matters and Experience measurement is both qualitative and quantitative, so it requires a multi modality approach. Surveys alone won't capture what is needed. To truly learn what impacts experience for our patients we need relational ways of listening, through stories, conversations, focus groups and so on. • While there are policy requirements for what VCH measures and reports on along with financial implications, there also needs to be a clear, simple, comparable, and actionable system of real time measurement to help us understand and improve experience efforts across our organization. • Builds credibility and better understanding of the measurable impacts of this work in healthcare. • Different modalities are used for experience initiatives, depending on the issues identified and the goals of the teams with partner with • Having a solid metrics framework helps measure not only project outcomes, but also to understand whether actions identified from our initiatives have had the anticipated impact
Quality & Clinical Excellence	**Experience encompasses all an individual encounters and the expectations they have for safe, quality, reliable, and effective care focused on positively impacting health and well-being.**	Why is this important? • Traditionally many healthcare QI initiatives have been focused on clinical interactions/outcomes. • We are now starting to understand that there are many additional factors within our influence and control that contribute to patients and providers experience which wrap around quality care and clinical excellence such as being treated with respect and dignity, feeling listened to, culturally safe and inclusive care and so on.

NCCIH Indigenous Cultural Safety Measurement themes

The NCCIH identifies six key relational themes for embedding Indigenous cultural safety. VCH included an additional theme being Health System Utilization which will underpin all of the Indigenous domains and empower patients to determine equitable and appropriate care. This theme is the entire experience a patient has – it is the compliment, the patient story of gratitude, it is also the complaint that gets escalated, the story that goes to the media. Both experiences are elevated to highlight where a person felt cared for or forgotten. These guiding themes will act as the Indigenous domains of health for the Indigenous Cultural Safety Experience, further explained as follows:

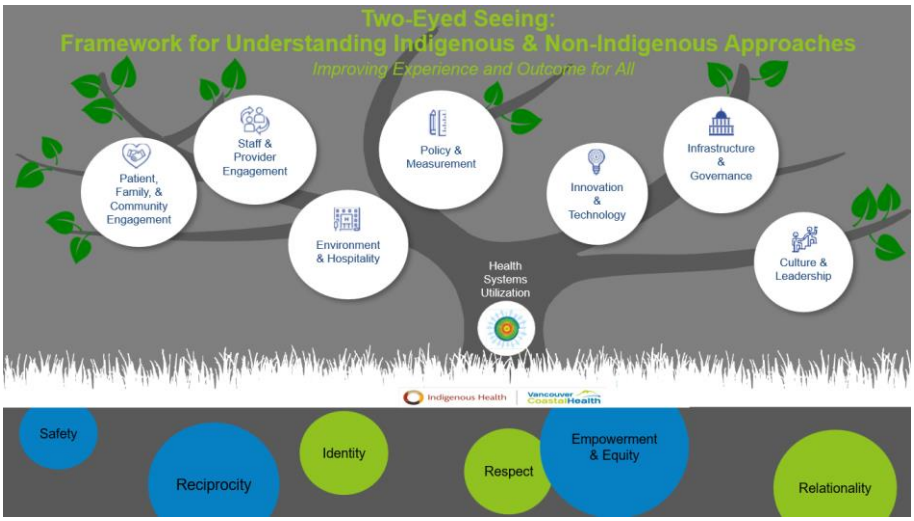
THEME	DESCRIPTION	ALIGNMENT
Respect	**Involves the feeling of being valued and one's dignity being upheld by a health care provider and health care environment.**	 **The eagle symbolizes respect, honor, strength, courage, and wisdom. Respect takes time. When respect is lost – there are secondary and tertiary impacts for patients, families, providers, anyone who witnesses these acts. Making time to address respect is difficult in the current climate – HHR crises that was seen as a limitation to being able to do this work. Power dynamics must be considered when approaching patients and families.**
Identity	**Refers to positive acknowledgement or affirmation as an Indigenous person or part of an Indigenous culture.**	**UNDRIP – The rights of Indigenous Peoples in Canada. Reconciliation means that Indigenous perspectives are embedded into the health system. Can parts be dismantled, rebuilt, and redesigned.** 
Empowerment and Equity	**Encompasses an equal partnership that supports the self-determination of the client and enables the client to feel heard, and in which the provider and patient are in a cooperative and reciprocal relationship.**	 **Teamwork – working together not in silos to be able to exchange ideas and work. Consider power imbalances must be considered. Creating resources to improve equity – IPNs, peer support roles, patients/families, elders, etc. Empowering patients in healthcare.**
Safety	**Refers to a sense of protection from harm or risk, and an experience free of racism.**	**Creating opportunities to come together, listen, build relationships, tell stories, and engage. Create safe space for truth telling. Identify and understand what subverts safety.**

		Mindful of the various and different dimensions of safety – social, psychosocial, spiritual, physical, cultural, etc. Pathways for speaking up and readjusting the norms. Equity, time, and intention creates safety – time is a limitation in the current climate. Learn from the act of reconciliation and use this in the whole of the health system to repair relationships and create safety. 2 eyed approach – learn from the past and look into the future to be able to restore and build. 
Relationality	**Includes a sense of dignity, an experience of connection with a health care provider, and observations of health care providers demonstrating care, compassion, and empathy.**	 **Lots of obstacles and challenges that hinder the ability to develop and form relationships – time, power dynamics. Trust, intent, humanization – ingredients for relationality. Authenticity – not a checklist. Small moments of connection and humanized approach can create relationality and matter. Role modelling - actions and commitments of leaders speaks volumes (Representation in governance: at the very highest levels)**
Reciprocity	**Involves two- way or shared learning, curiosity, interest, and effective communication, facilitated by an understanding of the impacts of colonialism on Indigenous Peoples.**	 **The Coast Salish eye – on the left, depicts a two eyed model. The "Salish Eye" shape represents the watchful eyes of past and future generations. It adorns Squamish carvings such as paddles and hulls of the magnificent seagoing canoes of this Coastal Salish Nation. This two eyed approach honors the story of the past, which helps us understand our current place and situation in the world and encourages us to use this knowledge and wisdom to envision the future. BY understanding history, we can learn from it and make the future better. This requires work and effort, going through the steps of acknowledging truth, like systemic racism, is essential before being able to move forward in a good way. The focus should be on frontline staff, leaders often have the opportunity to learn – we need to give that to frontline workers. Acknowledging racism and applying humility.**

VCH'S EXPERIENCE IN CARE PROGRAM - LEARNING TOGETHER – BREAKOUT GROUP METHODOLOGY

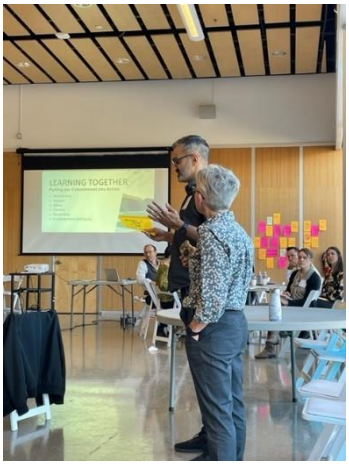
To further understand and explore the VCH Experience in Care program, attendees were asked to participate in five (5) rotating breakout tables to implement or commit to action. Each table was allocated one of the six (6) Indigenous Cultural Safety Measurement themes (explained above). Each theme, as it intersects with the Beryl Institute Experience Framework was the centre theme for a story that was shared at each breakout table utilizing a Two-Eyed Seeing approach for understanding

Indigenous and Non-Indigenous approaches for improving experience and outcomes for all patients. In the series of round tables, participants were tasked with discussing each theme, and questions were facilitated by the IH and PX team members.



The purpose of the rotating breakout groups was to see the principles in action; to clarify any uncertainty about the approach; to create an opportunity to hear about examples of ways to bring action to the ideas (through storytelling); and to create connections amongst the entire group – the groups were purposely mixed across VCH departments to build these connections. The groups were also rotated around every table to ensure participants could get a good understanding of each principle and theme in action, as well as opening up conversations for each participant to contribute to each discussion with their own comprehension and potential example.

The concepts (principles and themes) were further illustrated through the six table exercises where facilitators shared their experiences of how they utilized a theme/domain and patient experience principle or lens to apply the concepts to the work they did. Presenters/facilitators briefly described (and re-clarified) the area of focus and utilized a story or example to help participants see the patient experience theme and principles in action. It was also an opportunity to explain the value and connection to "Humanizing Care and Reconciliation". Upon completion of the story or example, participants (of each rotating group) were then asked if there was a theme or principal that they wanted to specifically draw a linkage to or make visible. Participants were also asked to share where they have used, where they thought they could use, or where there were clear gaps in the use of the particular Indigenous Theme/Domain or Experience Lens and let the brain power flow through conversation.



The themes and patient experience lens were shared at the end to the larger group. In the next phase of work we asked each person to choose a theme that resonated with them. They formed new groups where they took a deeper dive into what each of the themes meant to them: personally, professionally, for their teams, and for the organization. The results were shared to the larger group. We reviewed and presented in circle the findings that were captured. The final phase – we asked individuals to write out their commitments and share them. The following questions were also asked at some of the tables where time permitted:

- Where do you see or use this theme/domain or principle in the organization or in your role?
- Where in the organization or in your current role have missed utilizing and prioritizing this theme/domain or principle?
- How does this experience domains resonate most in your context? Do you have examples of where/how you are paying attention to the theme/domain?
- In what ways have you found this theme/domain challenging to uphold, and why? What wisdom does the group have to brainstorm potential ways to tackle that challenge?
- Were there ideas from the morning that can specifically be brought into the ideas that we have generated about how we can begin to spread and embed these "frameworks?

The following table describes each breakout group topic, Patient Experience Principle, and Indigenous Cultural Safety Measurement theme. As a collaborative approach, we purposely co-facilitated each session with a Patient Experience and Indigenous Health team member(s):

LEARNING TOGETHER			
Breakout Group Topic	**Patient Experience Lens (Beryl Institute Experience Principles)**	**Indigenous Health Theme/domain (Indigenous Cultural Safety Measurement Theme)**	**Co-Facilitators (Patient Experience - PX & Indigenous Health – IH)**
Group 1: Indigenous Self-Identity (ISI) and Clinical & Systems Transformation (CST)	Policy and Measurement	Identity	Serena – PX Brittany - IH
Group 2: Story Telling – Patient Stories Project (PSP)	Patient, Family, and Community Engagement	Relationality	Lara – PX Brianne – IH
Group 3: Restorative Approach to Patient Care Quality Complaint Management (PCQO)	Culture and Leadership	Empowerment and Equity	Kyle, Karen, Helena, Tara - PX Andreas – IH
Group 4: Supporting Experience in Care – Sex and Gender	Environment and Hospitality	Respect and Safety	Florence Miranda Jessie
Group 5: Understanding, Learning & Applying Indigenous Cultural Safety in order to transform	Quality and Clinical Excellence	Reciprocity	Alan, Kimi – PX James – IH

VCH'S EXPERIENCE IN CARE PROGRAM - LEARNING TOGETHER – BREAKOUT GROUP PRESENTATIONS AND DISCUSSIONS

The following section briefly describes the presentations from each breakout group linking one of the themes and one of the principles using a story or example. Facilitators were given the flexibility to present and capture the feedback from participants in whichever way best resonated for them and group participants. The commentary then identified findings and informed some tangible actions for going forward. We wish to acknowledge the facilitators, presenters, and/or scribes who contributed to the success of the Patient Experience Think Tank.

TABLE/GROUP 1: Clinical & Systems Transformation (CST) & Indigenous Self-Identification (ISI)

Theme: Identity
Principle: Policy & Measurement

Story/Example:

Facilitators shared their experience and example of how the "Identity" theme and the "Policy & Measurement" patient experience lens were utilized in applying the concepts to implementing CST (and subsequent ISI). Some VCH sites had either recently transitioned to the CST Cerner system (or will be) which features an identity data collection field built into the system. To utilize this feature it will require VCH staff to routinely ask patients about their demographic information which will create the opportunity to collect more rigid data on patients. While collecting enhanced data will likely bring significant benefits to VCH and community wide, requesting this information from Indigenous Peoples including First Nations, Inuit, and Métis will require a respectful and informative response process and policy (unless the patient is willing to self-identify). This is due to Indigenous Peoples historic mistrust of the health system and how their information will be utilized of which historically was used against them. Therefore it is critical that the patient experience is positive.

Prior to CST Cerner implementation, demographic data collection processes originally had much more invasive questions on ISI. Using the principal of policy and measurement, these questions have since been paired down and modified with the lens of Indigenous cultural safety and humility, which aligns to the Indigenous Cultural Safety Measurement theme of Identity – this being one example of transforming our system and humanizing the process. Furthermore, there is an intent to also ask if patients would like to be connected with Indigenous services - again a process that will enhance the patient experience and demonstrates the commitment to reconciliation efforts. E-learning Indigenous cultural safety modules and FAQs were also developed specifically for how to ask identity and demographic information in culturally safe way – this again enabling a humanizing context to the interaction.

Why it Matters:

Asking about Indigenous Self Identification (ISI) in a culturally safe way contributes to:

- Better patient experience and linkages to appropriate culturally safe care:
  - Elders, relational care, enhanced family-centred care
  - Early connection can prevent negative experiences
- Strengthening data systems to work towards Learning Health Systems
  - Knowing where Indigenous patients are and where supports are needed
  - Information on patient journeys and patterns and effectiveness of programs, health outcomes

- Healing Health Systems and Reconciliation through first point of contact
    - Healing from history of patients feeling unsafe
    - Makes patients feel safe, heard, seen from the first touchpoint
    - Encourages people to feel proud to be Indigenous

ISI is important for three key streams of reasons: (1) For improved patient experiences and for (2) building strong systems of data to work towards a learning health system, (3) healing between nations, community members and colonial systems. ISI contributes to better patient experience and linkages to appropriate culturally safe care. Our system is able to identify Indigenous patients early – connecting them to resources and supports. A patient can be identified and be offered wrap around care such as Elder connection; Relational care; and enhanced family centered care. Making these connections early prevents patient complaints and bad experiences through connecting to indigenous supports right away. It is essential that we have services to offer – as if we asked these questions in invasive ways and yet had nothing to connect patients to it defeats the purpose and leads the patient to not understand why these are being asked. Further explanation included:

- There is great fear among Indigenous patients to self-identify as often racist experiences have followed in the past. ISI being asked in culturally safe ways is essential to this.
- Strengthening Data systems and moving towards Learning Health Systems. As the hope is to move towards a learning health system with real time input of patient data – preventing complaints, enhancing experiences and intervening with supports when necessary we need stronger systems of data input.
- Identity is important for this to know where indigenous patients are and where they come in and out of our system.
- As well as strengthening our data systems to later give us strong information on patient journeys and patterns and effectiveness of programs, treatments, and overall health indicators.
- Healing Health Systems and Reconciliation are often asked at the first point of contact ISI. Often not by a physician or nurse or care provider who may have had much more access to ICS. At times this question has been asked in culturally unsafe ways leading patients to feel unsafe in identifying and leading to gaps in data and lack of linkage to Indigenous supports. Our first step in healing our system and reconciling with Indigenous Peoples is our first point of contact – and making patients feel safe, heard, seen at the first time they are asked basic demographic questions.
- Indigenous People should be and feel proud to be Indigenous when they walk into the doors of one of our services and feel happy to identify and feel safe in doing so. Once patients and our systems begin more of this healing this can be a positive interaction for many people. This requires reflection, responsibility, and humility but also knowledge and skills to ask this question in safe ways.
- Also how will we use data? Nothing about us without us means that we need Indigenous leadership in how the data is going to be analyzed and used to drive decisions. Example: provincial acute inpatient and emergency department surveys: we have FNHA in our steering committee to guide how analysis is done on responses from patients who self-identify as Indigenous. Without them, it would have been easy to make incorrect assumptions about what the data indicated. With their leadership, we were able to get to a more accurate story: people are reluctant to self-identify if they do not know how that info is going to be used (% who self identify is lower than expected population size). Also, people who are feeling unsafe will be reluctant to give low overall experience scores, but when looking at specific experience elements (i.e. having clear information, physical comfort, pain control, being involved as much as wanted in care decisions etc.…) those higher ratings did not hold up, indicating those experiences had a lot of room for improvement.

Sample of Table Comments:

During the discussion many table members were primarily concerned with HOW we ask, WHY we ask, and WHEN we ask about self-identification.

"Questions need to be asked in ways that do not trigger racism". [Table members did not seem clear on how this can be done—begging the question of whether it can even be done, given the history of ethnicity labeling in medicine]
"It is the patient's right to choose to identify or not [this is about autonomy and exercising their rights]"
"Fears of labeling, stigma (e.g. purple-dotting patients for aggressive behavior) highlights the need for sharing "the why" with patients"

Table members also raised the concern about how many times (i.e. at how many different stages in accessing the health system) we ask a patient about their identity.

"Will we experience concerns from patients over where and when the ID will be attached"
"How many different departments/teams does this sensitivity intersect?
Are we flagged in the system forever? Will it come up next time?
"Is it attached to each encounter, and therefore asked each time? Can patients ever remove the identifier if they wish?
"Is there a (almost step-by-step) formula for how to ask patients about their Indigenous identity – at what stage of engagement? How many times? Will it be safe each time? There might be an important training gap here"

A few table members asked if we could instead ask if folks want to be connected with Indigenous services, as an indirect way of asking about a patient's self-ID. Potentially reframing the ISI questions as connecting to Indigenous services:

"We don't have an ethical reason to identify Indigenous patients where we don't have relevant services to offer in response/reciprocity [Do we have an Ethics process?]"
"Patients may not need/want support from Indigenous services, but still identify as Indigenous"
"It is imperative for care providers & teams to know how to connect patients to appropriate care EARLY, before something goes wrong and becomes urgent"
"Patients need "the why" in order to determine their own safety in the context of being asked about their Indigenous identity"

Another worthy discussion was surrounding the benefits and risks of demographic data collection. For example, inadequate data leads to over-incarceration of people in MHSU who would benefit more from treatment.

"There are larger implications for representative data beyond the health system—acknowledging holistic systems larger than ourselves is key"
"There needs to be greater discussion of Indigenous ERASURE in health data, and the harms that come with a lack of Indigenous representation in data. This means we are often not included in the evidence used in decision-making and service delivery"
"Data gaps=harms!"
"Data literacy would improve compliance with data collection and would resonate with patients' priorities and care needs"

Findings:

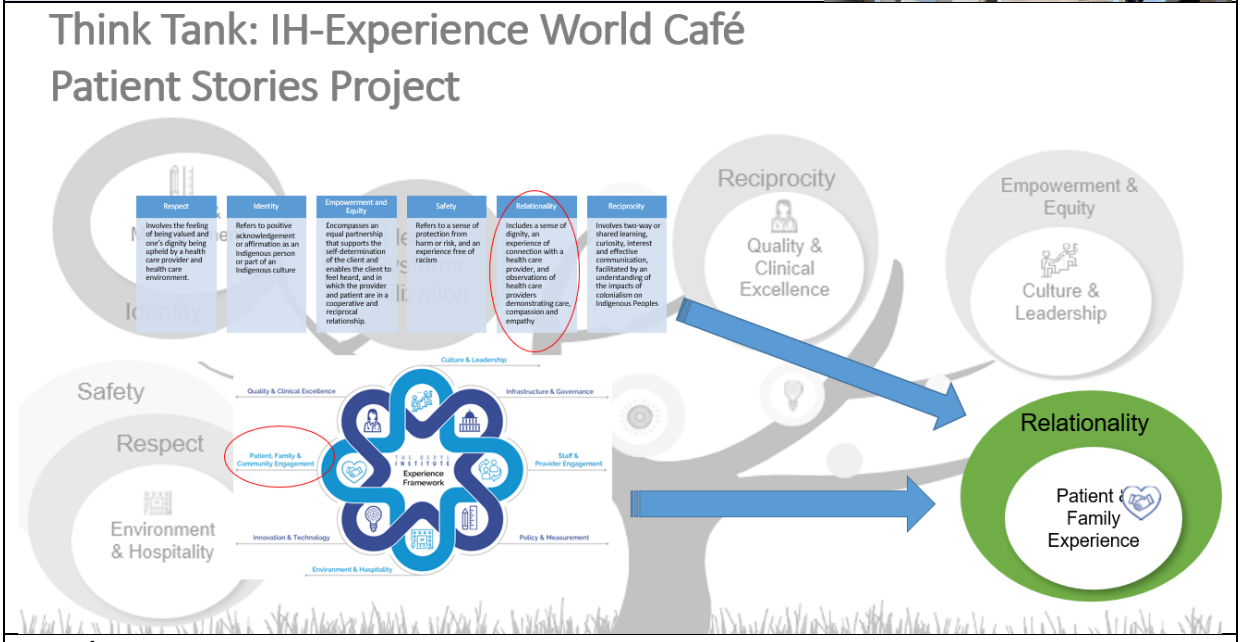
1) PRIORITIZE RELATIONSHIPS FIRST: Waiting until the relationship is more established before asking [the patient] about demographic information would be more culturally safe.

Acknowledging that patients' fears, concerns, experiences, and skepticism regarding Indigenous self-ID are valid.

2) SETTING THE CONTEXT MATTERS: The question of self-identification needs to be viewed as a CARE process rather than a DATA process, and the ethical reason to identify. Being in a care relationship requires acknowledgement of histories and experiences and acknowledging the harms (historic and ongoing) of collecting Indigenous ID data. E.g. birth alerts. Service oriented lens: context, autonomy, ethics, care, accountability are central to this. We KNOW that when the system works in connecting people to care, it works well. We just have to identify the risks and reduce the instances that go wrong.
3) WIDER REACH: It should be important to include clerical and admission teams in these discussions, as they are also responsible for asking identity questions, therefore are a contact point in the care process (in asking the question in a way that makes a patient feel unsafe, targeted, etc.). There was also consideration for Indigenous staff in that it can also be difficult for some staff to want to identify as Indigenous when it might be unsafe to disclose amongst their team(s). How can they create a safer space for patients if they don't feel safe at work?
4) EDUCATION: We need more training and advocacy for undertaking the Indigenous cultural safety training in order to adhere to a high data standard for consistency and accuracy of reporting. At the point of care, there IS a training module to help train staff in how to ask the self-ID question. In this case, how can we promote it or encourage teams to consider this training mandatory? Discussions on identity need to be prefaced by "the why" to provide context for more informed consent and for the patient to have more information to assess their own safety.
5) POLICY & MEASUREMENTS: We need to promote narrative stories more. Acknowledging other ways of knowing and being in narrative measurement and giving meaning.

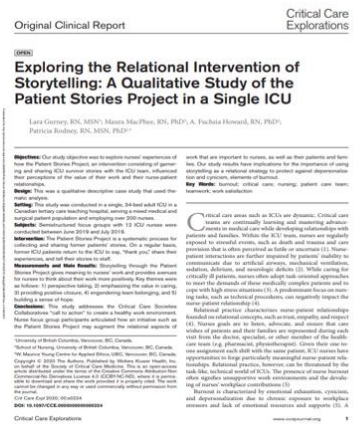
TABLE/GROUP 2: Story Telling - Patient Stories Project

Theme: Relationality
Principle: Patient, Family, and Community Engagement



Story/Example:

Facilitators shared their experience and example of how the "Relationality" theme and the "Patient, Family, and Community Engagement" patient experience lens aligned with a Patient Stories Project and initiative that uses storytelling as a means to build culturally safe care and humanize health care. The development and expansion of this project were guided by trauma informed practice and Indigenous Cultural Safety.


Original Clinical Report
Critical Care Explorations
Exploring the Relational Intervention of Storytelling: A Qualitative Study of the Patient Stories Project in a Single ICU

This Patient Stories Project aligns with the recommendations of the In Plain Sight report and is built on creating safe places, safe people, and safe systems. Storytelling spans generations and is fundamental in Indigenous cultures as a way of sharing knowledge and experiences. Therefore, we needed to understand how we restore that into health care in an act of reconciliation which once was.

The facilitators explained the inception of the Patient Stories Project (PSP) noting that often in clinical practice, we wonder if we are doing the right thing, would the patient even want this? And that was part of the journey which led to the creation of the Patient Stories Project.

One of the facilitators shared the following patient story which provides a good example of how the theme of relationality and the patient lens of family can be applied:

"We were caring for a patient who sustained a life altering high spinal cord injury and a traumatic brain injury where he required multiple surgeries. We wondered if he was going to survive, and would he want to live like this. One day he came back to the unit in this motorized wheelchair with his nephew on his lap and while he has not returned to his baseline self, nor would he ever be, and nor would he ever look the same - he clearly was able to enjoy being with his family and adapting to his new health status. After he left, we all couldn't stop talking about him – the tone of the unit changed – people were happy, felt energized and felt encouraged. This really struck me – it had a significant impact on staff and their feelings about work. I became curious how we could leverage that to help health care staff find meaning and joy in their work and build resiliency to humanize health care."

We started the PSP as a way to hear stories from patients and share them with those who cared for them as a way to humanize care and remind ourselves of the impact we can have on families. Upon initiation of the PSP, patients were invited to answer 5 questions with the option to submit a few photos of their recovery journey. The stories were able to be submitted through a various of means (to remove any technology barriers) including online (by scanning the QR code, email, mail, or they can book an interview with an experience leader over the phone or zoom (Interpreter support was also available). If the patient self identifies as Indigenous, we partnered with IH and involved the Indigenous Patient Navigators who could offer support with the patients sharing and following up if they wish. We also involved our PCQO team to support if there was a need for complaint management.

Story telling starts from a trusted relationship, we must learn about the who, why, and how, and where, this being particularly crucial when engaging with indigenous patients and families. Improving the indigenous patient experience necessitates a commitment to relationality. It is imperative healthcare providers apply a relational lens when including the voices of contributions from and partnerships with those receiving care and the community served.

To create a trusted relationship and to apply a relationality and Indigenous cultural safety lens, the following areas guided the Patient Story Project:

1. In our posters and handouts, we specifically call-in voices that are marginalized.
2. Every patient who submits their story was asked an ISI question in a respectful way. It was important that every person who asked an ISI question was properly trained. There will be transparency about why ISI questions are being asked.
3. Patients who identified as Indigenous were offered interviews by members of the Indigenous Patient Experience Team (IPET)
4. Patients can remain anonymous and withdraw their story at any time.
5. If the act of telling their story is triggering, resources are provided to contact for further support.
6. Safeguards are in place to connect patients to PCQO if necessary.
7. Patients are asked for consent to be further contacted in the future to ask additional questions about their experience, invite them to share their story in person, or to participate in other quality improvement or education opportunities.
8. To take Patient Stories Organizational wide – a partnership with Indigenous health was created to apply a two-eyed seeing approach.

Why it Matters:

Storytelling is one method to support patient centred care and has a direct correlation to Indigenous cultural safety. Storytelling spans generations and is fundamental in Indigenous cultures as a way of sharing knowledge and experiences. How can improve experience in care if we do not create a culturally safe way to ask and listen. Story telling helps with this by:

- Shifting power dynamics from the provider to the patient/client
- Acknowledging cultural values as valid and restoring self-determination within a health care setting
- Providing an opportunity to utilize a patient narrative to improve care and the health care system
- Inviting our patient/client, family, care givers to share *their* story in *their words.* The lived experience really matters and empowers the patient.
- Stories are an opportunity to heal us, connect US – the provider/staff and the Patient.

This project also aligns with the recommendations on the In Plain Sight report and is built on creating safe places, safe people, and safe systems.

Sample of Table Comments:

Participants shared a number of general comments about the benefits of story telling and how the PSP resonated with them.

"Connecting with each other through storytelling is good for patients to sit and be heard [its about humanizing of care]"

"The Indigenous Patient Navigators help with supporting the ICS policy and acting on the In Plain Sight Calls to Action"

"Sharing teachings, unlearning, re-learning and creating ways to implement change throughout all levels of the organization is Indigenous cultural safety [how many of you have taken the ICS training?]"

"Holding the space for story telling – not only the physical but how you bring yourself to these conversations [Body language, not interrupting and offering a support system]"

Findings:

1) CREATING TRUSTING RELATIONSHIPS IS ESSENTIAL: The project identified that there is a need to create a safe and trusting space before the undertaking of any projects – particularly those projects that require the sharing of knowledge from patients. It is essential to apply a relational approach and take the time to listen to whatever may be shared. This is all part of humanizing care.
2) EDUCATION: We need more training and advocacy for undertaking the Indigenous cultural safety training in order to implement projects such as Patient Storytelling. Knowing the climate of the healthcare system right now (referring to the In Plain Sight report and staffing crisis) we need to be creative in exploring ways to foster storytelling in our areas of work to ensure compassion and empathy, but this also requires the Indigenous cultural safety knowledge to implement this respectfully.
3) EMBEDDING TRADITIONAL PRACTICES (STORYTELLING): The Patient Story Project demonstrated the benefits of Storytelling which spans generations and is fundamental in Indigenous cultures as a way of sharing knowledge and experiences. We will need to be mindful to continually create spaces for embedding historical and traditional practices into care (such as storytelling promotion).

TABLE/GROUP 3: Restorative Approach to Patient Care Quality Complaint Management (PCQO)

Theme: Empowerment and Equity
Principle: Culture and Leadership

Story/Example:

Facilitators shared their experience and example of how the "Empowerment and Equity" themes, and the "Culture and Leadership" patient experience lens could be applied to a restorative approach in the context of responding to healthcare harm within the Patient Care and Quality Complaint Management process.

The facilitators provided an overview of "What is a Restorative Approach, and why is it appropriate for resolving care related issues." Restorative justice focuses on the future, not the past, highlighting what needs to be healed, repaired, and learned from the care experiences of our clients, their supports, and our staff and service providers. Rather than focussing attention on the actual event, the focus is on what needs to change to promote more positive care experiences for all moving forward. A restorative approach helps ensure that every voice is heard.

The facilitators explained the following restorative approach including understanding the importance of the principles and approach in healthcare as well as why a restorative approach should be applied.

Restorative Approach
(prepared by Alan Caplan, Director of Experience in Care)

What are the Principles of a Restorative Approach (Llewellyn et al. 2014)**?**

Relationally focused:
- Understanding and seeking to structure/support just relations
- Analysis of power/inequality – attentive to intersecting oppressions

Comprehensive/Holistic/Integrative:
- Connecting the dots between issues, incident, contexts, causes & circumstances
- Working in integrated, not siloed or fragmented ways

Inclusive/Participatory:
- Empowering first voice
- Trauma-informed/Do no further harm
- Culturally sensitive
- Needs based

Responsive:
- Contextual, flexible practice
- Focused on need

Focus on individual and collective responsibility
Collaborative/Non-adversarial
Forward focused:
- Educative, problem solving/preventative and proactive
- Oriented to outcome

When Can a Restorative Approach be Used in Healthcare?

As a response to events that span the full spectrum of harm
As a response to client/staff complaints
To address issues of systemic racism and DEI in healthcare
To address workplace toxicity (bullying behavior, burnout, etc.)
As a means to address care-related issues that we become aware of through non-traditional means (e.g. media, as opposed to client initiating further contact with VCH)

Why Should We Use a Restorative Approach (Campbell et al. 2022)**?**

Helps VCH move from a reactive to a more proactive process regarding addressing care concerns
Opportunity to apologize:
- Meaningful apology is facilitated by creating a safe space and trust
- Many individuals involved in these situations are looking for a sincere apology

Addresses needs:
- Focus on the individual and their needs
- Restorative approach acknowledges that harmed parties have psychological, procedural, and other substantive needs

Storytelling approach:
- Focuses on hearing people's stories as they see the event
- Multi-perspective
- Equity of voice

Questions to consider…

What is my role as a leader?
What can I do to shift the culture?
How can we empower patients, families & staff?
How can we create an equitable environment to support restorative approach to care complaints?
Where are the opportunities? How do we rebuild the system to allow for restorative approach?

Who will take the lead?

Inspirational YouTube video of First Follower: Leadership Lessons from Dancing Guy

Restorative approach has been highlighted as one of the most effective methods to reverse the damage done, as its function is to repair relationships. It brings everyone involved (in the complaint) together to address the harm that was caused, discuss the impact of the experience on the patient/family, and find a solution that works for everyone.

It was acknowledged that this approach is inspired by Indigenous worldviews and is rooted in practices that are woven throughout a perspective of ethos of healing and justice - a whole approach. And so, when thinking about a restorative approach, it's beyond a program, it's beyond one thing. It's really

about how do we connect with one another. How do we create spaces where healing and justice occur naturally?

One of the facilitators shared that they had attended a workshop on restorative approach. One of the topics discussed at the workshop was a case study reflection (Keegan's story) that lays bare on the health impact of colonialism upon present day First Nations people. Keegan's Story is about a young man who experienced discrimination and profiling and was relegated as a drug user, and consequently, their accidental poisoning was overlooked. Sadly, Keegan passed away. Keegan's family wishes were not to punish people, or apportion blame, but rather to come together, where they respectfully shared their concerns, harm, and feelings. The goal was to repair relationships and honor Keegan, so healing can occur. This is what restorative approach looks like.

Keegan's family publicly released and gifted in ceremony on his birthday, this Case Study Reflection to all leaders of the BC health system. The Case Study's Reflection's aim is to highlight how personal and systemic biases shape health professional's practice. The Case Study Reflection's intention is for the creation of cultural safe environments and experiences for First Nations people and to ensure what happened to Keegan does not happen to others. Participants were invited to take the time to carefully read and review Keegan's story. Keegan's story brought together leaders to engage and prevent similar deaths or harm in the future and he has been heralded as a 'transformer stone' for change for the region.
This story is an example of how a restorative approach emphasizes accountability for the past and seeks to find a positive way forward for all parties. It is a pathway to healing through which the health care provider/leaders and patient/families can recognize the root cause of the problem through Restorative Process. Restorative Process is a voluntary, relational practice, whereby all those involved in healthcare harm come together, in a safe and respectful environment. With the help of skilled facilitators, truthful dialogue about what happened and its impact on their lives can be acknowledged.

It can clarify accountability for the harms and compound harms, that have occurred, and collaboratively resolve how best to promote repair and bring about positive changes for all involved. It also humanizes both sides and gives the opportunity to understand each other's perspectives.

A restorative approach is envisioned as guiding values and principles that establish the importance of 'just relations', and the inherent interconnectedness between people. A restorative approach embodies empathy, equity of voice, care, concern, respect, and dignity. Furthermore, it identifies and addresses the justice needs for all affected parties.

A restorative approach is not the answer to every form of misbehavior or healthcare harm, but it does use a holistic process to mend those relationships when a harm has occurred. It also means working outside a process that is colonial. The Principles of a Restorative Approach were created to help health providers and people better engage. Restorative approach can enhance the patient experience, humanize process, address power imbalances, and decrease disciplinary measures for staff. A restorative approach seeks to find balance and supports the values of institutions who are committed to ensuring diversity, equity, and inclusion.

Restorative approach requires is to fundamentally shift our paradigm, with our language, with our ways of being, with how we meet with one another, it requires us to engage at a deeper level in understanding and feeling a greater connection to real people, in real settings, with real problems going on around them.
It matters not who we are or how lofty our credentials are, when we see the world around us with a lens of being humble, we begin to understand humility. It comes as we go about our work with an attitude of serving our fellow man. Indigenous Peoples have endured much, and will no doubt have

to endure more, but we have begun to mend the sacred hoop by breaking the banal bonds of bigoted imperialism and returning to traditional ways of knowing and healing practices.

The facilitators shared a quote from a university paper on Manifest Destiny that talked about a true understanding of what it really means to be an 'Indian'. John R. McLeod, a Cree Elder from Saskatchewan, a post-Indian survivor/warrior, encapsulated this sentiment: "I am an 'Indian', and what has happened to me as an 'Indian', will never happen to you." This quote was shared to close the presentation in the hope that the discussion about a restorative approach is taken in this light of understanding as it was the intention to help clarify and bring awareness.

Sample of Table Comments:

Overall participants were honored to hear the stories shared and how the context clearly articulated how a restorative approach was not about blame but creating spaces to respectfully discuss and recognize the situation, repair the relationship, and find solutions for healing to occur. A clear alignment to humanizing the care and empowering the individual or family which has a clear alignment to the themes and principles of the session.

Participants were asked to self-reflect on the discussion and provide their thoughts:

"This is about improving healthcare experiences"
"We need to be better about embedding Indigenous in the culture of the organization"
"We have more to learn about what does it mean to VCH to fully understand and embed Indigenous perspectives and truth and reconciliation?
"Where can we do more with our Indigenous cultural safety education and decolonizing our ways?"
"There is a knowledge gap on the history and consistent ways of teaching and learning (and unlearning)"
"Leadership matters!"

Findings:

1) EMPOWERING AND CULTURALLY SENSITIVE RELATIONSHIPS: In the context of the patient complaint management process, creating spaces to repair and restore relationships is critical. It is vital that there is upfront acknowledgement of any situation or harm – whether VCH is in the wrong or not – to enable a respectful and culturally sensitive conversation to occur. It is about centering the individual and family to empower them on how best we can support the situation and learn from any wrong doings. This is all part of humanizing care.
2) KNOWLEDGE GAPS: Through these discussions, it was easily identified that there is still much more to learn about Indigenous cultural safety and decolonization and how to understand and apply Indigenous perspectives to healthcare across the entire organization.
3) TRADITIONAL WAYS OF KNOWING & HEALING PRACTICES: Aligning to the above bullet and more pertinent to Indigenous Peoples (as well as aligning to the In Plain Sight report) we need to respect and acknowledge traditional ways of knowing and healing practices. This does not mean we need to know how to practice healing but more to create spaces for families to gather and respect their protocols.

TABLE/GROUP 4: Supporting Experience in Care – Sex and Gender

Theme: Respect & Safety
Principle: Environment and Hospitality

Story/Example:

Facilitators shared stories of how the "Respect and Safety" themes and the "Environment and Hospitality" patient experience could be related and applied to gender inclusivity. The discussion also explored how the framework can impact patients receiving care including both the physical spaces and practices.

The following definitions were presented along with a description of the diagram:

- *<u>Gender</u>: A person's gender is how they identify internally and how they express this externally. People may use clothing, appearances, and behaviours to express the gender that they identify with.*
- *<u>Gender Identity:</u> The term gender identity refers to the personal sense of an individual's own gender.*
- *<u>Sex</u>: A person's sex is typically based on certain biological factors, such as their reproductive organs, genes, and hormones.*
- *In many Indigenous languages and cultures throughout Turtle Island gendered language does not exist and in reality, many languages speak to the work or responsibility of a person.*

Facilitators presented and discussed sex and gender in the context of three (3) patient personas, which were an amalgamation of patient stories and touchpoints in healthcare across patient's lifetimes:

1) Patient Story: Accessing Sexual and Reproductive Healthcare in Community:

Discussed the stigma that some patients may experience when accessing sexual/reproductive healthcare services especially in smaller communities and among younger people. There can be the challenge of when staff may know the patient or community members when accessing clinic services. This can deter patients from accessing services and can lead to negative sexual or reproductive health outcomes. In this example, it was important to remember to offer services in a non-judgemental way, ensuring that privacy and confidentiality are respected.

2) Patient Story: Giving Birth in an Acute Setting

This case study involved a lesbian woman who was birthing within a hospital setting. There were consistent requests from multiple nurses asking the patient about her "husband" and when he was expected to arrive. The nurses were rebutted each time by the patient to explain that their partner was a woman, and she was at work. The patient grew frustrated with each consecutive nurses' inquiry about her "husband" and she conceded that her "husband" would be arriving later. This example spoke to the assumptions being made and there being no recognition of the frustrating experiences of gender-diverse or people of different sexual orientations when accessing services. This emphasizing the importance of communication within healthcare teams around gender/sexual orientation, and how this is central to providing safe care.

3) Patient Story: Entering Long-Term Care

The facilitators used a case study of a gay senior who was entering a long-term care facility. The patient was asked to hide their sexual orientation when entering the facility. The rationale from healthcare staff being that this was seen as a way to reduce potential violence or harm towards the patient. There was little consideration to how this may have made the patient feel and not prioritizing and addressing the unsafe/homophobic environment and instead placing the onus on the patient. This example continues to raise the importance of ensuring we are creating safe spaces within LTC/healthcare facilities where all people, regardless of gender-identity or sexual orientation, are able to be themselves.

Sample of Table Comments:

Participants were very appreciative of the stories that were shared with some having familiarity with genderized care.

"I hadn't fully reflected on the stigma and shame we can cause"
"As healthcare providers we can influence change"
"I have appreciation for those situations"
"Could we create a binary assessment tool to assess acute/long-term care settings to support gender-diverse and queer folks?"
"We need to be challenging it (referring to sexual health stigma)"
"It's our role as people in power to work towards that, not just providing the testing. It's a systemic conversation to challenge stigma and shame throughout"
"We can't talk about decolonization without sex and gender - Patriarchy/matriarchy and how does it look like. Both Indigenous health and our health authorities"
"We need to look at gender supportive care and the gaps they experienced"
"We as health care providers need to consider both as we can contribute to inclusive practices and advocate for safer spaces for all"
"I still have questions about which hospitals still print "mother" and "father"

Further comments were shared about the Environment and Hospitality Lens:

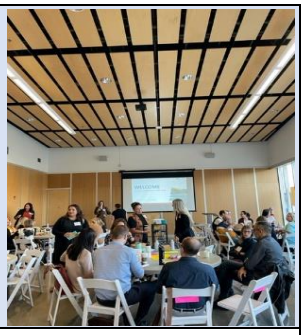
"The pillowcase colour example from New Zealand is a great way to ensure patient safety"
"Need to better understand the system/sociopolitical structure and shifts and how it influences this leadership priority"
"Layering Indigenous perspectives onto existing colonial structures is important - do we actually need to dismantle some things and rebuild? Redesign?"

Findings:

1) RESPECTING IDENTITY (DON'T ASSUME): The stories shared highlighted how gender diversity assumptions can have significant impacts on patients' experiences when accessing healthcare. Rather than assuming a person's gender identity, sexual identity, or relationship, it is encouraged for healthcare staff to take a reflection and grounding moment and look at situations from the patient's perspective.

2) MINDFUL COMMUNICATION: Emphasizing the importance of communication within healthcare around gender/sexual orientation is central to providing safe care. Communication must be delivered in a non-judgemental way – this includes being mindful in all forms of delivery, such as language use and body language (amongst others). We also need to ensure that privacy and confidentiality are respected at all times and if there is a perceived conflict of interest (situations where we may know the patient) that we offer solutions to the patient to address this.
3) CREATING SAFE SPACES: Comments shared from the session highlighted the importance of ensuring we are creating safe spaces where all people, regardless of gender-identity or sexual orientation are considered in all design elements including signage and messaging.
4) PROMOTING SPEAK-UP CULTURE: There were many comments shared about challenging stigma. Healthcare providers play a significant role in influencing change, but they must also be supported and empowered to make this shift. It is therefore vital for leadership to implement system wide strategies and policies that promote a speak-up culture.

TABLE/GROUP 5: Understanding, Learning, & Applying Indigenous Cultural Safety



Theme: Reciprocity
Principle: Quality and Clinical Excellence

Story/Example:

Facilitators shared their experience of how the "Reciprocity" theme and the "Quality and Clinical Excellence" patient experience lens aligns with applying Indigenous Cultural Safety (ICS) initiatives. Improving patient outcomes necessitates a commitment to Indigenous cultural safety, however it is imperative that healthcare providers recognize Indigenous cultural safety is not an end point or goal. It cannot be achieved by simply completing a course, watching a set of videos, or reading articles – it is a continual learning and unlearning process. In this context, Indigenous cultural safety is defined by those experiencing care – it is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination where people feel safe when receiving health care (First Nations Health Authority, 2022).

A critical first step toward Indigenous cultural safety is to understand the history of colonization in Canada, ongoing experiences of racism and discrimination, and how these historical and current experiences impact the health of Indigenous Peoples. However, this is an initial step on a life-long journey. We sometimes hear health professionals ask the question, why so much focus on Indigenous Cultural Safety, and less focus on the safety of other cultures? It's important to recognize that Indigenous Cultural Safety has an impact on everyone in the healthcare system. Transforming the health system to address and improve Indigenous cultural safety won't have an impact only on Indigenous People. It will improve the health system and healthcare outcomes for everyone.

When applying a reciprocal and relational approach, a pertinent story was shared about a patient in ICU during the COVID pandemic. In ICU there were no visitors permitted. The family had voiced their distrust in the system, and this was particularly evident when care was being provided to their loved one in ICU. The patient was in distress not only due to their condition but by being separated from their family and this was causing further anxiety and fear which they were required to cope on their own without this essential family support. The healthcare provider used their initiative and obtained a tablet for the patient to connect virtually with their family. This simple solution reinstated a sense of trust between the family and the patient and the healthcare provider. Sometimes the simplest ideas can bring big impacts to families and their experience during difficult times – we need to continue to find those innovative solutions that help the patients experience.

Sample of Table Comments:

"As we move forward individually and collectively on our journey of embracing cultural humility, it is really incumbent on all of us to do better when we know better"

"Early on in my career working in long term care, our leadership team had a strong focus on quality improvement initiatives, based on what we felt should be important to residents: quality food, availability of activities, hospitality services that met their needs, etc."

"I worked in a non-denominational facility that had 130 residents from very diverse backgrounds. As a new Resident and Family Services Manager, I took the time to learn the names of all the

residents and their families. I took the time to learn about their lives, and what is important to them. I got along very well with the residents and their families. They knew I cared about them, and that was important"

"It never once occurred to me to ask Indigenous residents if they feel that we were respectful, not only to them, but also of their culture and traditions"

"I now know better, and every single day I come to work, I vow to do better, and keep asking myself the difficult questions"

Findings:

1) EDUCATION: In discussing this topic, it was clear that more Indigenous Cultural Safety training, education, and opportunities for learning (and unlearning) are needed. This was not only from a training perspective but also from staff's own commitment to read and reflect during their own time. The journey of learning is continual and a life learning process. The more that can be learnt, the more the knowledge can be applied to practice and ultimately to improving a patient's experience.
2) RESPECTFUL & EMPATHETIC RELATIONSHIPS: As identified in the session, Indigenous cultural safety is defined by those experiencing care – the patient experience. It is based on establishing respectful relationships that are empathetic and free from any biases, discrimination, and racism. It is about finding those solutions that create a sense of safety and trust to support the patient on their healing journey.
3) FAMILY INCLUSION: We recognize that we can improve our efforts enhancing a patient's experience however this must also extend to the support system around the patient such as the family, friends, caregivers, and support teams. Communication being a key role with this and keeping the patient's family informed e.g. family circles.

PATIENT EXPERIENCE THINK TANK GATHERING – COMBINED GROUP CIRCLE DISCUSSIONS

Proceeding the breakout groups, participants were provided the opportunity to ask further questions, or share any of their own stories that could be applied to the VCH Experience in Care Program – specifically the Indigenous Cultural Safety themes and how it intersects with the Experience Framework Principles. A number of thoughts, ideas, concerns and therefore opportunities arose through the group discussions which have been summarized as follows (some of which align or complement the findings from the breakout group sessions):

INDIGENOUS CULTURAL SAFETY THEMES	SUMMARIZED GROUP FEEDBACK (*Intersection with Experience Framework Principles)
RESPECT	**LACK OF CAPACITY TO BUILD RESPECTFUL RELATIONSHIPS** Patient, Family, & Community Engagement: • Respect is the feeling of being valued and having one's dignity upheld. Respect takes time - because you are building a relationship. You respect each other when you don't know each other – whether it be patients, providers, or as colleagues. And in experiences where there has been a lack of respect, there are always secondary and tertiary impacts on a family and on the healthcare provider who's witnessed something that's happened to another person. Culture & Leadership: • There are efforts being made across specific teams to address this concern of taking the time to build respectful relationships however due to the excessive workload, a lot of this dedicated time is falling into After Hours' time. We need to ask if that is the constant of 'outside of working hours' an expectation of leaders in VCH? And what does that mean as an organization?
RELATIONALITY	**PERCEPTION OF TIME CONSTRAINTS:** Culture & Leadership / Patient, Family, & Community Engagement: • There are a lot of structural challenges within the health system that hinder the ability to develop and form relationships. But a huge hurdle is the perception that we don't have a lot of time. The perception is that we are busy, there are many patients to see, many tasks to do and time goes by the wayside, and this is where the friction develops into challenges for us to develop or establish relationships and do the things that are important to the patient and the families. Trust, intent, and humanization are all the things we lose when we can't or don't develop relationality. • "There's a lot of myths or preconceived ideas around time but I think it is true, that our system structurally is set up that we are pressured into moving quickly with getting information. Quickly jumping and going to the next patient, and the next chart as quickly as we can. That's hard to ignore". • However, we forget that we can develop relationships in the 'small' things: Our body language (facing the person rather than having your hand on the door ready to leave), our tone, how we show up and amplifying our own sense of time constraints that are dictating the clinical encounter.

	• There are going to be missed opportunities in developing that connection, building the partnership with the family, the individuals. This is where we need to take the time to sit down, square up, and spend that time up front. "This goes a long way, right? In fact, it's a more efficient way in terms of getting information and a better experience for all involved". The investment at the front end of the initial encounter will shift the relationality downstream. **PERFORMATIVE RATHER THAN AUTHENTIC CHANGE**: Quality & Clinical Excellence • So how do we realistically bring forth relationality into an organization? There is concern that sometimes what we do, or we're tasked to do feels performatory. We try to institute things into a large organization, or a system and it becomes a checklist. You've done this, you've done that, whatever. But that is not authentic; our clients or patients can read through this performance, and so can our staff. And when it is performative that gives way to a lack of consistency of care and attention. **ROLE MODELLING:** Infrastructure and Governance / Culture & Leadership • People look to the actions and commitments of leaders and if our governments demonstrated that this (referring to relationships) is a big deal then I think we would solicit a different response – such as was evident in the presentation about the incorporation of the Māori representation in governance: at the very highest levels, they've said, "This is such a big deal that we're going to embed specific seats into our Federal government". We need to be cognizant of the messages that are being sent from provincial and federal leadership.
SAFETY	**IMPROVE RECONCILIATION EFFORTS:** Patient, Family, & Community Engagement: • Often in healthcare we move forward in action without spending the time to really listen and understand and acknowledge. Its why we need ReconciliACTION with our patients: It's about asking, and then really listening: "How can this experience today be different from your previous experiences?" How can we understand what has been someone's previous experience and spend the time, demonstrate the respect, and honor for them in a way that helps us change what their experience is going forward? It's about embedding the two eyed approach. Culture & Leadership / Policy & Measurement: • How do we embed what we've learned from our Indigenous colleagues around the importance of reconciliation and actually restore friendly feelings in order to create safety? How can we embed safety in the very fabric of what we do? We need to understand the data and act on it – not just admire and refer to it. **PROMOTING A SAFE SPEAK-UP CULTURE**

	Staff & Provider Engagement • Also, we need to identify what subverts safety and what do we really need to call attention to; assumptions and power subvert safety in so many different ways. Equity, time, and intention creates safety. Safety is complex and fluid in nature, sometimes eluding a simple definition. We need to be mindful of different dimensions: social, psychological, spiritual, clinical, physical, Indigenous cultural safety. We need to address staff safety and create safe pathways to speak up, readjusting norms, that it is encouraged and that individuals are not fearful of retaliation. • Opportunities like the Think Tank – where we come together, to listen, to build relationship, to tell stories, and really engage with each other – these create an opportunity for safe truth telling and are an instrumental part of safety. • We have power dynamics (referring to a patient complaint story). And so this question of how did the healthcare providers even get to that as a decision!? How did no one speak up? How did no one say something? Was there a power dynamic? We must create safe spaces for people to speak up.
IDENTITY	**IMPROVE RECONCILIATION EFFORTS:** Patient, Family, & Community Engagement: • Reconciliation in our system requires that Indigenous perspectives are embedded into existing colonial structures within our healthcare system. **CREATING WELCOMING AND INCLUSIVE SPACES:** Environment and Hospitality • It will also be important to consider that certain parts of the system may need to be dismantled, rebuilt, and redesigned. It is important to move towards a culturally safe system – which is better for staff and better for all patients. The pillowcase example resonated as a really wonderful actionable step - something that we could take action on in the near future.
RECIPROCITY	**EDUCATION ON SYSTEMIC RACISM:** Staff & Provider Engagement / Quality & Clinical Excellence • Reciprocity is not something that you can just “do”. You have to “do the work”, and that includes going through the steps and acknowledging systemic racism that it's real and what your contribution might be to that. This includes non-Indigenous people being able to address their fragility around racism. When embedding reciprocity into the workplace our focus should be on frontline staff. • We need to come from a place of humility and for most of us this requires engaging in ‘unlearning’. It's not it's about coming from a place of humility and being open to learning from experiences of Indigenous Peoples. **EDUCATION WITH A WIDER AUDIENCE** Culture & Leadership / Staff & Provider Engagement / Quality & Clinical Excellence

	• As leaders we are fortunate to be able to receive training like this (referring to the Think Tank), but we need to bring frontline staff into these sorts of training days. How do we take what we learn today and include the frontline staff in that. All of the Think Tank participants have the opportunity as leaders in our respective areas to take this work back to their teams and workspaces. • Reciprocity also requires a culture shift. It is important to recognize that we usually approach from a 'deficit' perspective where we think we don't have the resources, we don't have the money to be able to do this. But if we lead from a place of abundance what are the opportunities to create the culture shift that we need to foster reciprocity.
EMPOWERMENT AND EQUITY	**LEARNING TOGETHER – SHARING OUR WISDOM** Innovation and Technology • This is an area where we must exchange ideas and examples as we know that there is activity in this area, but we are not aware about what each other is doing. The importance of working together and not operating in silos and being able to use the linkages and partner up with others to make better use of the resources that we do have. • There is a need to look at transformative change and not just the small incremental change. Disrupting who sees the patient record is an example and implicates how we view patient empowerment. This is a huge piece of empowering a patient or a family member. Quality & Clinical Excellence • The power imbalance that patients experience once they set foot on our premises is great. How do we look at levelling the playing field, humanizing the care that we provide so that there's less of an imbalance? Patient navigator roles, peer support roles can be an outside voice in support of the patients and families going through clinical experiences.
HEALTH SYSTEM UTILIZATION	**ROLE MODELLING:** Culture and Leadership • The HR crisis in health care right now means that people are stretched, and we don't have senior staff who really provided mentoring and role modelling. Respect can be built through role modelling, mentoring and through having compassion and care for each other. • We need a values reset. VCH has values, but we don't seem to be upholding them currently. We need to figure how VCH values align to this work and how we restore the VCH's values.

PATIENT EXPERIENCE THINK TANK CONCLUSIONS

Through storytelling and a relational approach, leaders were engaged and shared their wisdom at the first (of many) VCH Patient Experience Think Tank. We introduced the VCH Experience in Care Program concept informed by the seven (7) NCCIH Indigenous Cultural Safety Measurement themes – to demonstrate the Indigenous Health lens - and the eight (8) Beryl Institute Experience Framework Principles – to demonstrate alignment to Patient Experience.

It was a successful day where leaders shared their extensive patient experience work – the objective being to create a safe place for participants to learn, reflect, and commit. Through sharing stories about real life experiences that have occurred across VCH we made the experiential connection to theory – theory to practice. We were able to make direct connections to humanizing care and reconciliation and how these concepts would inform health transformation (change) strategies. It was a fulsome day with rotating breakout groups facilitated by the VCH Indigenous Health and Patient Experience teams. We acknowledge the facilitators who shared their knowledge and wisdom and who also had the opportunity to build their own capacity.

The following conclusions were identified across the breakout groups and group circle discussions of where we can take action or where we can delve further at future Patient Experience Think Tank forums:

PRIORITIZE RELATIONSHIP BUILDING	• **PAUSE, MAKE THE TIME:** There is a perception that we are busy, and we provide reactive care – pause, take time for reflection, truly listen to what is being shared, and bring relationality into our work. • **PRIORITIZE RELATIONSHIPS FIRST:** Focus on building trusting relationships before asking questions or asking patients to share their knowledge. • **SETTING THE CONTEXT MATTERS:** View everything as a CARE process rather than a data collection process. Acknowledge upfront, the situation and/or historic experiences or harm to enable a respectful and culturally sensitive conversation to occur. • **DEMONSTRATE EMPATHY AND SINCERITY:** Approach conversations with humility and empathy. • **REPAIR TO RESTORE:** Create spaces to repair any harm or complaints as a step towards restoring the relationship. Its not about accepting blame but about acknowledging the situation. Potential topics for future Patient Experience Think Tank Events: • What is our patient experience measures to monitoring humanizing actions? • Can we develop a strength-based relationship building assessment and complaints tool?
UPHOLD INCLUSIVITY	• **REDUCE TOKENIZATION:** Strive for Indigenous inclusion without tokenization. Be authentic, not only through

	performative action but by being consistent, caring, and attentive. • **RESPECT IDENTITY (DON'T ASSUME):** Acknowledge patient fears about self-identifying. Rather than assume a person's identity, gender, or sexual orientation, apply a patient's lens to your interactions. • **CREATE SAFE SPACES:** Undertake an infrastructural review to ensure messaging, signage, and materials are inclusive. • **FAMILY INCLUSION:** Be mindful that respectful interactions are not limited to only the patient – ensure that families and supports are informed of patient care status. Potential topics for future Patient Experience Think Tank Events: • Do we implement a policy for mandatory Indigenous cultural safety training for all frontline staff who collect patient demographic information? • Can we review and redesign our policies and physical spaces to promote inclusivity? • Explore the inclusion of reconciliation and inclusion in Job Descriptions and Contracting?
PROMOTE SPEAK-UP CULTURE	• **HAVE DIFFICULT CONVERSATIONS:** Promote a culture that enables and praises employees having difficult conversations with those displaying unacceptable behaviours and actions (including discriminatory and racial comments or actions). • **CHALLENGE STIGMA:** Be aware of your and your colleagues' attitudes and behaviours. Take a relational moment and choose your words carefully or educate others to challenge and reduce stigma. • **LEADERSHIP-DRIVEN SPEAK-UP POLICY:** Be an accountable system that implements a policy that promotes a speak-up culture. • **LEARN THE LANGUAGE:** Commit to speaking up about storytelling, unlearning racism, elevating Indigenous, indigeneity and learning equity. This commitment might include actually learning a language or expanding your own knowledge to learn and unlearn and influence others. Potential topics for future Patient Experience Think Tank Events: • How do we implement a speak-up culture from a strength-based quality improvement lens? • How do we embed an ICS lens into our healthcare system and into all initiatives from their inception to completion? • Can we demonstrate our commitment to unlearning biases, unlearning racism, and elevating Indigeneity?
EMPOWER AUTONOMY	• **CENTRE THE PATIENT:** Every aspect of healthcare delivery should be about centering the patient (and family/supports). Guide the solution – don't be the solution. Empower the patient to make an informed decision and how best we can support the situation. Acknowledge and learn from any wrong doings. Humanize the care towards reconciliation.

	• **RESPECT PATIENT RIGHTS:** Respect the autonomy and rights of patients. While our credentials may validate us to provide clinical expertise, we don't always know what other contexts may be impacting or beneficial to a patient. Be open to listening to the patient – whether wrong or right. • **MINDFUL COMMUNICATION:** Effective communication will always benefit a patient's experience. However communication must be delivered in a non-judgemental way – this includes being mindful in all forms of delivery, such as language use and body language (amongst others). Potential topics for future Patient Experience Think Tank Events: • What are specific processes we can implement to humanize care? • Can we facilitate role playing to humanize care and improve communications?
EMBED AND NORMALIZE TRADITIONAL PRACTICES	• **TRADITIONAL STORYTELLING:** Traditional storytelling spans generations and is fundamental in Indigenous cultures as a way of sharing knowledge and experiences. We have surpassed quantitative only data – we can learn from encouraging, listening, and producing (qualitative) stories orally or through advanced technology. Acknowledging other ways of knowing and being in narrative measurement and giving meaning. • **TRADITIONAL WAYS OF KNOWING & HEALING PRACTICES (IT'S NOT FOR US TO LEARN)**: Aligned to the reconciliation reports we have a commitment to support and respect traditional healing practices and medicines. This does not mean we need to know how to practice it but more to create spaces and provide support to patients and their families with their traditional practices. • **LISTEN FOR THE STORIES:** It is important to listen to the stories shared as they can help us with providing care as well as helping us to heal and understand each other better. Potential topics for future Patient Experience Think Tank Events: • How do we effectively capture qualitative storytelling? What innovative technology can we use (acknowledging consent parameters)? • How do we strengthen our Indigenous Patient Navigator Program?
MANDATE INDIGENOUS CULTURAL SAFETY EDUCATION	• **SIGNIFICANT KNOWLEDGE GAPS:** There were significant comments validating that there is still much more to learn about Indigenous cultural safety and decolonization and how to understand and apply Indigenous perspectives to healthcare across the entire organization. • **WIDER REACH:** It is vital to include clerical and admission teams in the Patient Experience Think Tank discussions, as they are also responsible for asking demographic questions (in asking the question in a way that makes a patient feel unsafe, targeted, etc.). Discussions on identity need to be prefaced by

	"the why" to provide context for more informed consent and for the patient to have more information to assess their own safety. • **INDIGENOUS STAFF SAFETY:** There is also consideration for Indigenous staff in that it can also be difficult for some staff to want to identify as Indigenous when it might be unsafe to disclose amongst their team(s). How can they create a safer space for patients if they don't feel safe at work? • **IT'S LIFELONG LEARNING:** It is clear that more Indigenous Cultural Safety training, education, and opportunities for learning (and unlearning) is needed. This was not only from a training perspective but also from staff's own commitment to read and reflect during their own time. The journey of learning is continual and a life learning process. The more that can be learnt, the more the knowledge can be applied to practice and ultimately to improving a patient's experience. Potential topics for future Patient Experience Think Tank Events: • How can we promote or encourage teams to consider ICS training mandatory? • Can we promote self-learning better?
CREATE LEGACY LEADERSHIP	• **LEADERSHIP MATTERS:** What would it look like to shift the operational leadership from just a dyad (physician and operational leader) to a triad and that third person is an Indigenous health leader or patient or family, so that we are grounded in what we are doing - actually embed it into a leadership and governance structure. • **ROLE MODELLING IS POWERFUL AND TRANSFORMATIVE:** Model humanity in care, invite patients, clients, families, and other informal supports to have a role in making care decisions as part of the healthcare team. Role modelling can be about demonstrating the importance of listening and wanting to listen more. What are we doing well, including in our care for our patients? How can we target excellence to know what we can achieve when you focus on the good, rather than the bad. "Focusing on wellness and keeping people healthy is just as important as treating people when they are sick". (An upstream approach). • **VALUES BASED LEADERSHIP:** Common value themes were continually identified throughout the Think Tank, particularly around integrity, listening, commitment to follow through and commitment to each other and knowing that we are doing the work together. Recognizing power imbalances and empowering Indigenous voices in care, bringing equity in our healthcare landscape. All of these words had the impetus to creating a values-based leadership framework. • **EMPOWER OTHERS (NOT BE THE POWER):** How do we make change and dismantle the power to a reciprocal partnership? How do we invite the patient to have the same role as us

	(referring to healthcare provider) – a shoulder to shoulder partnership. An approach that takes away the power dynamic, the labelling, the listening and being authentic and learning together. We could take that approach to everything we do - changing that power dynamic as a pathway forward. This approach can aim to build great leaders who do not recognize or enforce their own power but empower others. • **ENCOURAGE TRANSPARENCY:** This is not uncommon in any industry but there is a fear of hiding things if we do something wrong. We must change this narrative to a quality improvement opportunity and encourage transparency. Recognize that good data is crucial in providing excellent care, and any gaps in how we measure the experiences of Indigenous clients can cause actual harm. Develop and implement data collection methods to analyze **Health System Utilization** for Indigenous Patients. Potential topics for future Patient Experience Think Tank Events: • Can we adapt our leadership/governing structure to include and empower the patient or Indigenous perspectives? What might that look like? • How can we learn from excellence? • Do we need to review our values-based leadership framework? • Is there upfront questioning that would dismantle the power dynamics of a patient and health provider relationship? • As part of the speak-up culture policy, how do we encourage transparency?
BE THE LEADER IN PATIENT EXPERIENCE	• **WE ARE STRONGER TOGETHER. ACT LIKE IT:** We have many allies, but we need to be better at connecting with each other. We need to be thoughtful about the work that we do so that we don't drown in the immediate, urgent stuff and lose the sight of the big picture. And that's what partnerships help us do. We could be a little more thoughtful and strategic about how we actually change the system together. We're doing a lot of that work one client at a time. Right now, we're trying some innovative things, but how do we build on those one-on-one experiences to create a body of evidence of what works so that we can do things differently. Tell others about this work as we are stronger together in partnership and we can model **Reciprocity.** • **MAKE RELATIONSHIPS IMPORTANT TO CLINICAL CARE EXCELLENCE:** We do our best work when we come together in collaboration. It is very noticeable when there are multiple lenses on the work that it doesn't become a subject matter expertise in one area. We should continue as leaders and collaborate more in our work as relationships are critical to achieving clinical care excellence. Potential topics for future Patient Experience Think Tank Events: • Can we create a collective impact model for VCH?

	• Can we create baseline measures that include patient reporting experiences and satisfaction outcomes in healthcare? (Could this include the ability to compare Indigenous and non-Indigenous measurements and indicators)

NEXT STEPS AND CLOSING COMMENTS

The Patient Experience Think Tank Gathering aimed to create an experience that strengthens relationships – and not seeing this as "one and done" but rather a journey – of perpetual spread, outreach, and evolution for patient experience. It was an opportunity for leaders to reflect and share what they would commit to going forward to improve the patient experience for all those accessing healthcare services. It is a journey that can guide the patient experience baseline measures and act as a method for addressing the reconciliation calls to action (e.g. In Plain Sight).

There were many ideas shared about the possible next steps with overwhelming commentary about continuing the discussions and holding more Think Tank events. This was a think tank that was the first conversation of many where we explored Indigenous cultural safety as an experience that can inform the values of VCH and impact how we move towards embracing patient experience as a key element of the delivery of health care as **we care for everyone, are always learning, and strive for better "patient experience" results.** The future aim is to hold different events that will include different leaders and frontline staff – as a way to continually engage, build networks, weave relationships and stories together.

Further feedback and ideas were provided on future gatherings which have been grouped into the following focus areas:

- **Share Findings:** Many participants asked if the Patient Experience Think Tank presentations, learnings, and findings could be shared (this report)
- **Education:** Participants requested the following education opportunities:
    - Indigenous specific patient experience gatherings
    - More Indigenous Cultural Safety education for all VCH employees
    - Explore and create independent online learning modules on EiC and Disclosure Conversations for all staff.
    - After Care and Follow-up support to improve efforts in Patient Experience
- **Resources:** Participants identified a few specific information resource solutions:
    - Share Indigenous Resources – business cards, webpage, team information and exposure, Patient Stories Project, etc.
    - Are there Experience in Care resources that could be developed.
- **Upscale to More Sites:**
    - Plan another Think Tank ensuring dedicated teams work collaboratively.
    - Provide opportunity for frontline staff with some relevant content and exercises.
    - Webinars, lunch and learns, panels.
    - Exposure in leadership education sessions etc.
    - Dedicated and regular support for the UBC Hospital site
- **Patient Experience Metrics:**
    - Develop a Patient Experience Metrics that is informed by the Indigenous domains of culturally safe experiences and experience frameworks.
    - Work towards measuring what VCH does with the strategic insights provided to VCH staff/leaders e.g. Strategic lead/Cultural insights are provided to VCH leadership but what are those leaders doing with that information.

Based on this feedback, we will strive to have a flow of communication regarding future Patient Experience Think Tank Gatherings as there was overwhelming comments to support this topic. This will include increasing our reach to wider audiences across VCH (including frontline staff) as well as through differing events e.g. lunch and learns.

We will also aim to provide education opportunities through a patient experience lens including those specific education opportunities highlighted by participants. VCH Indigenous Health will utilize your feedback to enhance its Indigenous Patient Experience Framework, and this will be presented as one of the education opportunities. The sharing of patient experience and Indigenous resources was also considered important and therefore we will undertake a stocktake of what is already in existence and share these amongst participants.

The VCH Indigenous Health and VCH Patient Experience teams will continue to work collaboratively with our colleagues and peers across VCH to develop more relational and restorative approaches to working through care concerns raised by patients and their families, both Indigenous and non-Indigenous.

It would be fair to say that the topic of Patient Experience resonates strongly across VCH and to those who participated in the Patient Experience Think Tank. We acknowledge and thank all the feedback from participants who graciously contributed to this informative day.

Upon completion of the Think Tank, attendees were asked to either complete a short evaluation survey or share general comments. While many comments were shared verbally, the following are a few survey comments to conclude this report in a good way.

"Keep up this great work and continue to strengthen and solidify partnerships across VCH highlighting the importance of patient experience"

"The workshop set up was great. Presentation was very help for understanding the concept of the domains"

"Facilitators did great job with asking questions and engaging the audience, getting connected with colleagues was excellent"

"Wonderful collaboration and opportunity to connect with leaders across the organization to spread this important work"

"I love the name of the workshop Think Tank. Sue was full of energy and spreading it to the environment during facilitation.

"Lori, Liz and Careene presentation was so informative and interesting"

"Keep up the great work and have more sessions"

"This was wonderful, thank you!"

"Was inspired by the culturally relevant vibes -- one heart one mind"

"Well organized, great balance of large and small group discussion, warm welcoming environment, and SOOOOO wonderful to meet in person - slow down - and connect about this meaningful important work!"

"Nice to see such a broad array of participants from all over the organization, and the collaboration between quality/experience and Indigenous health"

"I look forward to future opportunities like this. It was great to provide the Central Coast experiences"

"Thank-you for the invitation and everyone's efforts to make this day such a wonderful learning experience and success!"

Acknowledgements:

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Lori Quinn
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Lorraine Blackburn

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