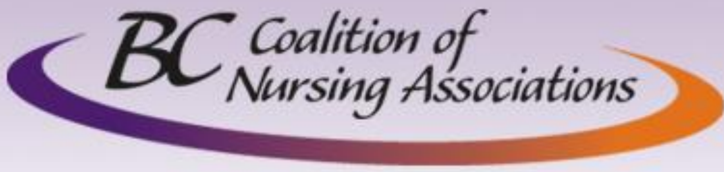

BC Coalition of Nursing Associations (BCCNA)

Visioning health care in B.C. in 2026

2016 Policy Forum Report

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Introduction

On July 19, 2016, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Nurse Practitioners (NPs), Registered Psychiatric Nurses (RPNs), nursing students and representatives from regulatory colleges, unions, professional associations, health authorities and government came together to vision health care in 2026. For many years, the B.C. Ministry of Health and the nursing community have wondered what health care will look like in 5, 10 or even 20 years, and what role nursing will play in advancing health care and the profession toward that future health care system. However, there has never been a platform where nurses from all designations could come together to explore this question collaboratively as one profession. The BC Coalition of Nursing Associations (BCCNA), felt that a visioning exercise, asking ourselves what the future should and could look like, would be an important step in planning toward the health system of the future.

Collectively, nurses across B.C. bring diverse perspectives and expertise in all areas of health care. Nursing understands the current challenges within the health care system, where we need to be, and how to get there. As the organization that represents all nurses across B.C., the BC Coalition of Nursing Associations (BCCNA) has become uniquely positioned to facilitate intraprofessional collaboration in exploring these tough questions. With the recent formalization of the Coalition, the board of directors saw this as a timely opportunity to engage all nurses across B.C. in a visioning forum to determine what changes need to be made to improve health care within this province.

Structure of the Policy Forum

In alignment with the Ministry of Health's policy papers released in 2015, a series of statements were developed and presented to participants, focusing on issues within primary and community care, surgical services, rural health and information management and information technology. Taking into consideration the current gaps within our health care system, these statements were formulated as ideas or solutions that could be explored and implemented by 2026 to bridge these gaps. Some statements were intended to be controversial to encourage participants to think outside of the box and stimulate discussion and debate. There were 20 roundtables, and each table discussed and debated a different set of statements, for each one contemplating the value of the position, and the enablers and barriers to its implementation. *Please see the Appendix for a list of statements.

Key Themes

While there were a broad range of topics covered throughout the forum, much of the discussion focused on two main questions. Within the next decade,

1. How can we improve the accessibility and availability of health care services across B.C.?
2. How can we improve patient-centred care?

Regardless of which policy paper each statement pertained to, five key themes emerged from the roundtable discussions as answers to the two questions above. There was consensus among participants that in order to improve patient-centred care, as well as the accessibility and availability of health care services, the following must happen:

1. Health care must focus on health promotion and prevention rather than treatment.
2. There must be an expansion of information management and information technology.
3. All health care providers must have the skills to provide culturally safe care.
4. Interprofessional collaboration must be present in all areas across the health care system.
5. System level issues in recruitment and retention must be addressed.

1.0 Health Promotion and Prevention over Treatment

Vision: In order to improve patient-centred care, as well as the accessibility and availability of health care services, health care in 2026 must be less reactive and more proactive by focusing on health promotion and prevention rather than treatment.

Know the Needs of the Population

The B.C. population is diverse in many aspects, and the delivery of health care services should not fall under a one size fits all approach. In order to meet the different needs of British Columbians across the province, population health needs must be identified. Participants discussed and debated ideas such as developing a data support tool to identify population health needs in each region across the province.

There was consensus that creating a data support tool to identify population health needs is crucial in providing patient-centred care. This would provide a way to assess the communities, as well as understand what services exist, the various social determinants of health that should be prioritized, the challenges facing each community, and improve our ability to predict issues to ensure funding is based on need. Participants noted that there are some databases that already exist, and as a start, a platform should be developed to communicate with pre-existing data. There should also be thought around the data that already exists, and ways to enrich it to make it more useable. In order to move forward, participants stated that there is a need for government buy-in, collaboration between health authorities, and stakeholder engagement between providers of all clinical areas, end users and patients.

(Statement 16)

Restructure health care Funding

The bulk of health care funding is currently allocated to services related to treatment rather than health promotion and disease prevention. However, evidence indicates that investing in health promotion and disease prevention improves individual health outcomes, the health of communities as a whole, and the overall sustainability of the health care system. Some of the ideas presented to participants included exploring whether the Medical Services Plan should cover health promotion and disease prevention services such as dental, vision, physical therapy prescription drugs etc., or exploring how funding could be reallocated to provide adequate transportation for rural and remote British Columbians to access specialized services.

There was consensus among participants that health care funds need to be restructured, with a greater portion allocated to health promotion, disease prevention and disease management. Participants also stated that community care should be the primary health care model, with community services driving acute care. As a start, increased efforts are needed to make decisions around what services should be provided within the acute care setting versus the community care setting. Neighborhood health centres/community health centres within different geographical regions were mentioned as an idea to manage the needs of each community. These centres would use multidisciplinary teams to manage patient care as well as patient transitions to and from the acute care system. Last, participants spoke about the need for government support to provide assistance to those who cannot afford personal health equipment.

(Statements 14, 15, 23, 55)

Build Capacity within the Community

In order to work toward a health care system that is more proactive and less reactive, British Columbians also need to have the capacity to be in control of their health and well-being. Controversial Ideas presented to participants included requiring all British Columbians over the age of 19 to have an advance care directive, or exploring how we can encourage compliance with immunizations by requiring proof for children attending school. Participants suggested that there should be a focus on working toward ensuring all British Columbians have access to health promotion education in order to better equip society to deal with their health needs. There should also be more thought put into how we can educate the future workforce, the role of nursing and other health professions, and how we can reduce barriers for those wishing to enter a health profession. In order to do this, financial barriers need to be removed, and we must expand our capacity to build partnerships that support health profession education and innovation in public education.

Another idea that was discussed was the expansion of grassroots community based networks to facilitate aging in place, and to bridge some the gaps within the publicly subsidized home health system. Grassroots community based networks already exist within B.C. and other jurisdictions, and many seniors benefit from these models. Participants identified several advantages including the ability to create a healthier population by allowing seniors to be better informed about their health and social needs, becoming skilled organizers and benefiting from the stimulation of volunteerism, as well as cost effectiveness in general. Factors to consider include how accountability will be ensured, quality control issues, the potential for volunteerism to reduce employment for the workforce, and labor code issues.

(Statements 9, 18, 20, 35)

Focus on the Social Determinants of Health

While there are many contributors such as genetics, lifestyle choices and medical treatments that determine health outcomes, the primary contributors to health outcomes are the conditions in which we live, work and play. There was consensus among participants that focusing on the root causes of health issues is key in creating a healthier British Columbia. Participants discussed ways in which health and social policy developed within government could have a stronger focus on addressing the social determinants of health, and explored ways to move toward ensuring that all British Columbians have access to determinants such as nutritious food, affordable housing and a living wage.

Participants identified multiple enablers that could bring greater attention to the social determinants of health. These include greater collaboration between ministries and sectors, collecting and utilizing population health data to model or predict interventions, ensuring health care providers assess the social determinants of health when interacting with patients, shifting the focus to community care, utilizing public health as a point of entry to the health care system for marginalized populations, re-introducing school nurses, increasing access to primary care (e.g..: use of community care clinics, primary care homes), utilizing new funding models that support providers such as nurse practitioners, and utilizing technology. Participants also spoke about the need for health authorities to be accountable for funding received, and the possibilities of using the social determinants of health as guidelines for funding agencies.

There was consensus that any policymaking must involve both providers and patients to ensure all perspectives are heard. There was also agreement that patients should be the 'captains' of their own health. The Nuka System of Care within the Southcentral Foundation was identified as a promising model that produces superior health outcomes. This model focuses on customer ownership, where customers (patients) identify their primary concerns (may not be health related), which are then addressed in collaboration with providers.

(Statements 36, 37, 38)

Increase Access to Primary and Community Care/Supports

Access to timely primary care and emergency care services continue to be a challenge for many British Columbians. While participants explored ideas such as integrating 24 hour Urgent Care Centres as solutions to long emergency room wait times, participants identified the need to move beyond 'Band-Aid' solutions. There was strong consensus that solutions must address the underlying systemic issues that contribute to poor access to primary and community care such as the inadequate accessibility and availability of home care/home support and public health nursing that focuses on prevention and health promotion. Population health needs must first be identified in order to understand which services need to be expanded, what technology should be used, and which health care providers are most appropriate. Participants spoke in favour of adjusting existing primary care clinic hours according to the needs of the community, and expanding models such as primary care homes, community health centres and nurse practitioner led clinics.

Not only is the accessibility and availability of a primary care or community health provider an issue, the accessibility and availability of necessary personal medical equipment continues to impact the health and well-being of British Columbians, especially those in rural and remote communities. Participants were presented with ideas such as implementing medical supply vending machines in rural and remote areas as a solution to the shortage of supplies,

or ensuring hospitals and clinics have health equipment rental programs to increase access to personal health equipment. Overall, participants agreed that more needs to be done to ensure British Columbians living in rural and remote areas can live healthily and safely within their communities.

(Statements 12, 14, 62, 63)

Scale up Harm Reduction Initiatives

Mental health and addictions continue to be a high priority among health care providers. In April 2016, B.C. became the first province in Canada to declare a public health emergency in response to the alarming rates of illicit drug overdoses. There is substantial evidence that supports the effectiveness of harm reduction policies, programs, and services such as supervised consumption sites in improving health outcomes, connecting individuals to health and social services, increasing willingness to access addition recovery, and decreasing the spread of infectious diseases.

Many of the current challenges around scaling up harm reduction initiatives include community opposition, and the lack of awareness around the impact of harm reduction strategies in improving health and well-being. Participants discussed the need for expanding supervised consumption sites (SCS), and believed that the number of SCS should be relative to each community's need. There was also discussion around the need to work toward a more comprehensive and upstream approach to mental health and addictions by focusing on the social determinants of health and accessibility to counseling and treatment. Participants recognized the challenges with scaling up such services in areas such as rural and remote B.C., and suggested the need to explore how technology could be integrated.

(Statement 4)

2.0 Expand the Use of Information Management and Technology

Vision: In order to improve patient-centred care, as well as the accessibility and availability of health care services, technology will be widely integrated across the health care system in 2026.

Implement a Single, Universal Electronic Health Record

While there were many ideas presented to participants around the possibilities of using technology to improve health care, much of the discussion returned to the need for a single, universal electronic health record as the first priority when visioning health care in 2026. Participants spoke about the challenges they face as providers in accessing patient information, and the difficulties of communicating and coordinating care. Patients also spoke about the inefficiencies of not having a single electronic health record such as having to answer the same questions multiple times within one visit. Participants acknowledged the importance of allowing patients to access their own health records, and the role this has on building capacity and empowering patients. Some participants also thought that patients should not only have access to their health records, they should own it and have the ability to add to it.

A single, universal health record would improve patient access to health records, increase patient safety, improve providers' ability to document, communicate with patients and providers, and ensure continuity of care. Participants agreed that moving toward this direction is necessary, and must be kept simple. It also needs to be effective across the continuum of care from community to acute care. Enablers include adequate technology supports, education, leadership which includes nursing, and provider buy-in.

(Statement 97, 98, 103)

Explore Self-Monitoring Technology

Adding on to the idea of building capacity to facilitate a greater focus on health promotion and disease prevention, participants were presented with several ideas in relation to the use of self-monitoring technology. These ideas included technology that would facilitate health behaviour monitoring, allow for the monitoring of changes in health status, and communicate this data directly to electronic health record and health care provider. Overall, participants agreed that these were good ideas that could improve communication between patients and providers, avoid medical complications, build capacity and increase awareness of an individual's own health. However, there was also patient representation that reminded us that over relying on self-monitoring technology could be onerous for patients, lead to over monitoring, and shift the focus to being sick rather than engaging in activities that promote well-being.

The first step would be to engage patients to identify whether this type of technology is useful and assess their ability to use it. Greater discussion is also needed to determine which population should be focused on (e.g.: individuals with chronic diseases versus healthy individuals who wish to be proactive), and which stages of intervention would be most appropriate to integrate the technology. Both providers and patient participants emphasized the need to ensure that technology be used as an adjunct to face-to-face care, and not replace the relational aspect of health care. Additional areas to explore include the use of such technology in less resourced areas such as rural and remote B.C., costs required to implement, privacy issues, resources to monitor information at the receiving end, and the types of collaboration needed. Participants agreed that the needs of patients must be kept at the centre of all decision making to ensure that the development of such technology is in the interest of patients, not providers.

(Statements 99, 101, 104, 105, 106)

Use Technology to Bridge Access Gaps Rural and Remote B.C.

The accessibility and availability of health care services, whether primary health care or specialized services, continues to be an issue in rural and remote B.C. In general, participants envisioned that technology should be widely explored as a solution to these current issues. Ideas discussed and debated by participants range from developing web-based technology for interactive health promotion and disease prevention initiatives, to greater expansion of current virtual technology such as telehealth. There was also recognition on the growing importance of internet access in influencing health and well-being, prompting the question: should internet access be recognized as a determinant of health?

Participants explored novel ideas such as specialists utilizing technology to guide and teach rural and remote nurses in treating patients, to increase access to specialized services. Overall, participants believed that this may increase access to specialized services, support care in place, be cost-effective, and enhance the ability to provide culturally sensitive and safe care within patients' communities. However, issues that would need to be further explored include the potential for the failure of technology, workforce acceptability, and the complexities of building onto the larger scope that rural and remote nurses already have.

(Statements 53, 54, 61, 65, 67)

Use Technology in Surgical Services

Patients receiving surgical care are often required to attend several consults, follow-up visits and pre/post-operative education. This may be cumbersome for many patients who are already experiencing physical and mental distress. Participants discussed and debated the idea of expanding the use of telehealth or web health services to reduce the need for in person hospital visits for surgical consults, follow-up visits, and pre and post-operative patient education. Participants noted that many of these ideas are already a reality, and happening in other areas outside of surgical services. While adopting technology is certainly needed, participants acknowledged that until there is a shift away from a physician-centred medical model, it will be difficult to utilize technology under a collaborative approach. As technology develops, it should be done so around a community care model in order to better utilize all health care providers. Challenges to this include privacy concerns, computer illiteracy, knowledge gaps in utilizing technology and potential for greater staffing requirements. However, utilizing technology in the area of surgical services will increase accessibility, provide patient centred- care, and serve those within rural and remote areas. Greater IT support, cloud-based servers and roles such as E-health triage nurses would be useful to move forward.

(Statements 43, 48)

3.0 Ensure Cultural Sensitivity and Safety

Vision: In order to improve patient-centred care, as well as the accessibility and availability of health care services, all health care providers will have the knowledge and skills to provide culturally sensitive and safe care by 2026.

Cultural Safety Education and Training

B.C. has one of the most diverse populations in the world. As such, British Columbians come from different cultural backgrounds, and their health and well-being is impacted by their ability to access health care services that are culturally sensitive and safe. Aboriginal people are one of the most marginalized populations in B.C., as is evidenced by the large health gap when compared to non-Aboriginal people. Often, Aboriginal people are unable to access health care due to a fear of facing racism, prejudice and discrimination. In order to significantly close this gap within the next decade, participants explored the idea of ensuring all providers be trained in cultural safety in order to provide culturally sensitive and safe care to Aboriginal people. Although cultural safety training does currently exist, it

is inconsistent across schools and workplaces within the province. While there was discussion on the importance of cultural safety training for all cultures, participants recognized that it is important to start with Aboriginal people, considering the large health gap.

Specific ways to achieve this include integrating knowledge early on within the education system (i.e.: elementary school), creating safe environments for Indigenous people, implementing the recommendations developed by the Truth and Reconciliation Commission, recruiting and retaining Indigenous nurses, increasing access to Aboriginal Liaisons, collaborating with Indigenous communities and elders, and utilizing trauma-informed approaches. There was also reference to the Shoah project, an initiative that works to keep the stories of Holocaust victims alive. Participants showed interest in BCCNA leading a project similar to this to ensure the stories of Indigenous people are not lost.

(Statement 34)

Accountability of Culturally Sensitive Care

Participants also discussed and debated how we can work toward ensuring greater accountability among providers in delivering culturally sensitive and safe care. One idea presented to participants included implementing hidden audits to ensure health care teams are providing patient-centred and culturally safe care in hospitals. Rather than hidden audits, participants saw the need to implement automatic tracking to measure outcomes that are patient-centred and culturally safe. There was also discussion around the role of the regulators in collaborating with educators to ensure health care providers are accountable in providing culturally sensitive care.

(Statement 74)

4.0 Interprofessional Collaboration

Vision: In order to improve patient-centred care, as well as the accessibility and availability of health care services, interprofessional collaboration will be integrated successfully into all areas of health care 2026

Remove Physicians as the Gatekeeper

Currently, in order to have access to other health care providers such as physiotherapists, social work, occupational therapists etc., patients require a physician or nurse practitioner referral. Participants discussed and debated whether patients should be able to access other members of the health care team without this type of referral. There was support for this idea and participants spoke about the need to move toward models such as community health centres and/or primary care homes. Participants agreed that the hierarchies within health care must flatten, that patients should be able to choose the health care provider they feel most comfortable with, and determine who they would like to see (which may not be a physician or nurse practitioner).

(Statements 11, 14, 25)

Move Interprofessional Collaboration Beyond Education into Practice

Participants discussed and debated ideas about the role of practice environments in bridging the gap in interprofessional education and interprofessional practice. Interprofessional collaboration is not a new concept, however, has been difficult to move beyond the education sector. Ideas such as having Regional Health Authorities develop a mandatory interprofessional course to be taken by all new hires were presented to participants and discussed. While participants agreed that this is essential and valuable, requiring a 'mandatory' course can be difficult. There was consensus that new hires should be entering the workplace with a foundation of interprofessional competencies from their educational preparation. Many orientation sessions that currently exist are condensed, and there is a need to explore how they can be made more comprehensive. Participants also spoke about the key role that professional practice offices have in bridging this gap, and the need to examine the costs of implementing such initiatives, versus the hidden costs of not addressing gaps in interprofessional collaboration.

(Statements 78, 85, 86)

Utilize health care Providers to Full Scope

There is much potential for various health care providers to bridge the existing gaps in primary and community care, rural and remote health, and surgical services. Nursing knows that utilizing health care providers such as nurses to their full scope can improve access to health care, and there was consensus that intraprofessional and interprofessional collaboration is needed. Participants discussed and debated ideas such as integrating RPNs and LPNs to work alongside RNs in speciality areas such as peri-operative, ambulatory and surgical day care teams, expanding nurses` role in areas such as Medical Assistance in Dying, making better use of paramedics within home care, long-term care and emergency rooms, fully integrating nurse practitioners, and utilizing speciality trained nurses for minor procedures.

Participants also discussed and debated whether NP and nurse-led community health centres could be the norm for accessing primary health care in B.C. in 2026. Many were in favour of this idea, and noted that in general, the primary care model should move toward one that is similar to community health centres or primary care homes, where providers such as social workers, dieticians, occupational therapists, physiotherapists are widely available and accessible. Current challenges include limitations to NPs' scope of practice and the lack of funding models that support their integration. In order to move forward, multiple funding models must be considered and implemented, and shared governance is necessary with strong support from the nursing associations to facilitate positive change.

Participants also indicated that legislation, regulations and education must align in order to ensure that all health care providers are consistent. When considering which health care providers are appropriate, there needs to be a focus on ability rather on designation. Advantages to the ideas explored above include increasing accessibility and availability of health care, facilitating a greater emphasis on health promotion and disease prevention, and improving patient-centred care. However, complexities around regulations and scopes of practice need to be further explored, methods of education need to be discussed, and on-going support to maintain competencies needs to be addressed. In order to optimize the role of health care providers, strong leadership is required.

(Statements 9, 11, 13, 14, 28, 39, 40, 47, 52, 60)

Greater Patient and Caregiver Involvement

There was no debate around the idea that patients and families need to be better integrated as part of the interprofessional team. Participates acknowledged that what providers often think patients need may not always be what the patient wants. Novel ideas such as requiring patient representation on interview panels when hiring health care employees, allowing patients to chart their experiences within their own health records, or eliminating visiting hours to allow for family members to stay with patients 24/7 were discussed and debated. There was consensus that collaboration with patients and families must be explored in every aspect of health care, and that patient engagement become part of all of health and nursing strategic planning. In order to ensure that all health care provided in 2026 is patient- centred, patient engagement must become the norm, and can be done by inviting patients early on in the decision making process by using services such as patient service network. Participants also acknowledged that there are many ways to integrate patient and family perspectives such as creating advisory committees or exit surveys to capture patient experiences.

Facilitating greater patient and caregiver involvement requires collaboration between regulatory colleges, educational boards, professional associations, patient engagement services and government. Participants recognized that in order to truly change the culture, there must be a shift in power. In order to truly provide patient-centred care, providers must ask themselves who should have that power. Strong leadership that values patient-centred care, as well as clarity around how it can be integrated into the systems of care is needed.

(Statements 7, 86, 92, 95, 96, 99)

5.0 Address System Level Issues in Recruitment and Retention

Vision: In order to improve patient-centred care, as well as the accessibility and availability of health care services, greater innovation and investment will be directed toward the recruitment and retention of health care providers by 2026.

Ideas that were discussed and debated on how to achieve this include:

Focus on Rural and Remote health care Providers

A key factor impacting the accessibility and availability of health care services in rural and remote areas is the difficulty in recruiting and retaining health care providers. Participants discussed providing monetary incentives to individuals from rural and remote areas that wish to pursue a career in health care, as well as incentives to practice in rural and remote areas. Participants agreed that there is a need to increase funding for education, educate those living in rural and remote communities on the benefits of entering a health profession early on in the education system, and expand options for pursuing these careers. Participants also agreed that incentives should not only be monetary, but should also address other factors such as the providers' family needs, opportunities for mentorship, continuing professional development, opportunities to maintain and develop skills, etc. Specific ideas presented by participants included establishing a 24 hour buddy/mentor or utilizing sister hospitals as resources. Further,

recruitment and retention of health care providers within rural and remote areas also requires changes in policies and overcoming regulatory barriers.

(Statements 55, 66)

Innovation in Nursing Education and Preceptorship

In order to improve the accessibility and availability of health care, there needs to be a strong health care workforce to meet demands. However, many issues with recruitment and retention of nurse educators and preceptors exist, which impacts the production of new and speciality nurses. At this time, nursing preceptors are not compensated for their additional preceptor role. Participants discussed and debated whether providing nursing preceptors with incentives and proper training would be a solution. Participants noted that this is currently the responsibility of the health authorities, and there are difficulties with accessing preceptors due to factors such as time constraints and staff shortages. There was consensus that both monetary and non-monetary incentives (e.g., support for professional development, certification, continuing education, etc.) are needed.

Nursing instructors are also currently paid approximately $20/hour less than direct care nurses, and the wage discrepancy varies depending on the educational institution, and whether these instructors are clinical or sessional. Current challenges identified by participants include collective agreements, funding differences between schools, resource scarcity, sessional versus permanent staff, and high staff turnover. Some solutions identified by participants include increasing collaboration between the education sector and government to work toward long-term health human resource planning and sustainability, and funding to support innovation and transformation.

Participants were also presented with the idea of utilizing new graduate nurses as educators. Currently, in order to become a nurse educator/instructor, substantial work experience is usually a requirement. However many new nursing graduates entering the workforce with less practice experience do have the skills to teach. There was discussion around the possibilities of providing new graduate nurses with opportunities to hold non-traditional educator roles and not limiting this to faculty or clinical nurse educator roles. Participants stated that many students come into nursing with other educational/work experience, and many graduate with leadership experiences from tutoring or the employed student nurses program.

Ways to work toward this include increasing teaching opportunities during undergraduate nursing education, forging strong partnerships between academic and clinical institutions, and exploring the potential of shifting and reshaping the scope of practice/competencies (e.g., 80 percent clinical, 20 percent education). Technology is becoming a central aspect of nursing education, and many new nurses are experienced with using technology, which positions them well to utilize this knowledge within an educator role.

(Statements 69, 70, 71, 83)

Ensuring Healthy Work Environments

Healthy work environments are pivotal to improving the recruitment and retention of nurses, and there is evidence that illustrates the positive relationship between nurse satisfaction and positive patient outcomes. However, nurses know that there continue to be many challenges within our workplace that create challenges to retention. Participants envision that in 2026, all work environments will have structures and process in place to support the health and well-being of providers, including nurses. Many ideas were presented to participants such as providing nurses with the opportunity to self-schedule their work shifts, which has been done locally in some B.C. hospitals. While advantages to this may include flexibility, work-life balance and improved job satisfaction, participants also emphasized the need to base decisions around the needs of patients. Moving this idea forward would require collaboration with the workplaces and unions.

Workplace bullying is also an issue that nurses have faced for decades. Specifically, among new nursing graduates, bullying is often cited as a top priority that must be addressed. However, many workplaces do not currently have structures or processes in place to eliminate bullying. Participants discussed and debated whether all health care facilities should be required to enforce a zero tolerance bullying policy. There was strong consensus that eliminating bullying is necessary, and that solutions must be upstream, focusing on proactive solutions rather than reactive solutions. For example, specific ideas raised by participants included providing orientation modules or workshops (around conflict management, different forms of bullying, cultural safety and consequences), and adequate mentorship and support for new employees. Most importantly, strong leadership is needed to emphasize the team based approach, to move away from the hierarchal system, and to ensure that these workplaces include mandatory examinations of issues related to bullying.

(Statements 80, 81, 82, 83, 88, 89, 93)

Conclusion

The 2016 BCCNA Policy Forum was a great success. B.C. nurses proved once again their eagerness and willingness to engage in collaboration not only to advance the nursing profession, but to develop solutions to improve the health and well-being of British Columbians. When thinking about how we could improve patient-centred care, as well as the accessibility and availability of health care services, some of the themes that emerged reinforce what we already know, and some provide us with greater clarity on how to move forward.

Participants envision our health care system in 2026 to be one that is more proactive than reactive, one that allows all health care professionals to work to full scope with structures and processes in place to allow for interprofessional collaboration in practice, one that has the mechanisms in place to solve recruitment and retention issues, one that ensures all health care providers have the skills to provide culturally safe care, and one that integrates seamless information management and information technology. Most importantly, nursing understands that to truly strengthen and improve our health care system, we must break down the silos and hierarchies that currently exist, and place the patient at the centre of all discussions and decisions.

Appendix

Policy Forum Statements

*Priority statements highlighted in red.

Primary and Community Care

1. There will no longer be a shortage in long-term care beds. A total of 30,620 long-term care beds will be available and they will have smartphone technology.
2. Patients will be able to check in to walk-in-clinics through the internet, be notified by text messages about their appointment time, and see where they stand on the waiting list on walk-in-clinic websites.
3. Practitioners will be able to prescribe complementary and alternative medicine instead of pharmaceutical prescriptions when applicable.
4. Supervised Injection sites will be established in all cities with a population over 20,000.
5. Health care personnel and family members will be able to use web cameras to remotely monitor frail patients to ensure they can live at home independently and safely.
6. All health care personnel will visit elderly patients within their homes, and online progress notes will be used for interdisciplinary communication.
7. Social Media will be used as a mechanism for patients to provide feedback and rate patient care services provided in hospitals.
8. Specially trained dogs will be used in hospitals as a form of preventive care to pre-identify conditions such as seizures, c-difficile and heart attacks.
9. Nurses will be able to take part in the assessing and determining eligibility for Medical Assistance in Dying.
10. All individuals past 19 years of age (or at 19) will be required by law to have an advance care directive in place.
11. Currently Pharmacists in B.C. can renew or adapt patients' prescriptions. By 2025, Pharmacists in B.C. will be able to prescribe new medication, order lab tests, administer various vaccinations and diagnose patients.
12. 24 hour Urgent Care Clinics will be implemented to reduce emergency department wait times. The Urgent Care Clinics would be located near the emergency departments, allowing for less urgent needs to be tended to within Urgent Care Clinics.
13. Paramedics in B.C. will have an increased scope of practice. Paramedics will perform home visits (make referrals as needed), be integrated in emergency rooms and long-term care homes.
14. Nurse Practitioner and Nurse Led Community Health Centers will be the new norm for accessing primary health care in B.C.
15. Health care funding will be allocated as follows: 20 percent for acute treatment and 80 percent for health promotion, disease prevention and disease management.
16. A data support tool will be in place to identify population health needs in each region across B.C.
17. Palliative Care will shift from being a hospital based service to a home based service.
18. Seniors will be able to age in place by accessing home support services through grass-roots community based networks rather than solely relying on publically subsidized home support services.
19. Patients who want to avoid wait times in the public health care system will have the ability to pay for any diagnostic test they require at a private clinic.
20. Proof of immunizations will be requirement for children attending schools.

21. Patients will be provided monetary incentives to donate blood.
22. All residential care beds in the province will be single room occupancy with an ensuite bath.
23. Complementary and alternative medicine services will be covered by MSP.
24. MSP will cover dental, eye examinations, chiropractic, massage, physical therapy, non-surgical podiatry, counsellors, prescription drugs and psychologists.
25. Patients will be able to access other members of the health care team without a physician or nurse practitioner referral (e.g., Physiotherapist, Social Worker, Occupational Therapist)
26. All B.C. residents' drivers' licences will have electronic information that lists their advance care directive and organ donations status for ease of access.
27. Family members of patients will be able to install web cameras in hospital rooms or residential care facilities to ensure their loved ones are being cared for appropriately.
28. Nurses will be able to discuss diagnostic and laboratory test results with patients.
29. Naloxone take home kits will be available to patients from pharmacies without a prescription.
30. Pharmacies will be able to dispense medical marijuana.
31. Pharmaceutical companies will be regulated in order to control prices of drugs.
32. Smartphone applications will be used as translation tools for patients with language barriers.
33. All aboriginal peoples will be able to access health care services without racism and discrimination.
34. All care providers will receive cultural competency training in order to provide culturally safe care to Aboriginal peoples.
35. Health education will be mandatory in all public schools.
36. Every British Columbian will have access to nutritious food, affordable housing, a living wage and other social determinants of health.
37. Every British Columbian will have access to free education.
38. Policy that is developed throughout government will focus on the social determinants of health, with an emphasis on health equity.

Surgical Services

39. There will be an increased investment in specialized nurses within surgical care (ex: nurse anaesthesiologist, cardiovascular perfusionist) in order to use OR staff optimally.
40. RPNs, LPNs will work alongside RNs in specialty areas such as peri-operative, ambulatory and surgical day care teams.
41. The development and expansion of private surgical clinics will be used as method of decreasing surgical wait lists in public hospitals.
42. A surgical service secretariat will be employed in each health authority to address issues in surgical care (e.g., health human resources, number of bookings, surgical wait lists, etc.)
43. Surgical consults, follow-up visits, and pre and post-op patient education will be conducted using telehealth or web health services instead of in person hospital visits.
44. Inspection and audit results from each hospital will be made public through hospital websites, and within hospitals in order to increase patient awareness and to promote health personnel compliance. (Ex: National Surgical Quality Improvement Programs (NSQIP), nosocomial infection rates, morbidity rates, surgical wait times, readmission rates, hand hygiene compliance etc.)
45. Three dimensional printing technology will be used to construct artificial organs for organ transplant surgeries. (Ex: kidney, liver and heart structures)

46. B.C. will implement a presumed consent model for organ donation. At the time of death, every individual will be considered for organ donation. Individuals who do not wish to donate will be required to ensure that proper documentation is in place to communicate this wish.
47. A solution to long surgical wait lists will be the development of education programs to train specialized nurses to perform minor surgical procedures. Surgeons will focus on major surgeries.
48. Upon discharge post-operative patients will be referred to a Hospital Librarian who will customize a resource package that includes post-op teaching, community resources and referral information. The information given will promote self-care and reduce hospital readmissions.
49. Patients' advance care directives will be respected at all times. In the event of an emergency, family members' wishes will not trump over the patient's directives.
50. Surgical departments will schedule and perform the same surgeries on the same day to allow for more efficient surgical flow.
51. Hospitals will invest in an adequate amount of surgical tools and equipment so that surgeons will not have to wait for equipment to be sterilized to perform a surgery. This will ensure that scheduled surgeries can be performed in a timely manner.
52. Nurse Anesthetists will be employed by health authorities to ensure that surgeries are not diverted to other hospitals, or cases are canceled due to unavailable anaesthesiologists.

Rural and Remote

53. Telehealth and web health services with all health care providers will be available in rural and remote areas 24/7.
54. Interactive health promotion and disease prevention classes will be delivered online to patients in rural and remote areas.
55. All patients living in rural and remote B.C. who require transportation to specialized services outside of their rural and remote community will be able to access publicly subsidized transportation without paying out of pocket.
56. Monetary incentives will be provided to individuals from rural and remote areas who want to pursue a career in health care. They will also be provided further incentives to work in rural and remote areas.
57. Helicopter services instead of ambulances will be the standard means of transportation for health care workers traveling to rural and remote areas to expedite care.
58. MOCAP (Medical On-Call Availability Program) will be available through web casts (face time) in order to assist nurses in rural and remote areas during emergency situations.
59. Customized interdisciplinary care packages (e.g., nutrition, physiotherapy, nurses and pharmacist) will be made upon web consultation in order to develop a shared responsibility of care between health care providers and patients in rural and remote areas.
60. All paramedics in rural and remote areas will be Critical Care Paramedics (CCP) and Advanced Care Paramedics (ACP) in order to expand their roles and increase accessibility to services. ACPs can perform cardiac monitoring, intravenous drug therapy, endotracheal intubation and manual defibrillation.
61. With the use of technology, specialists will be able to guide and teach rural and remote nurses in treating patients without requiring them to travel to the mainland to access specialized services.
62. A shortage of supplies will not be an issue in 2025 due to the implementation of medical supply vending machines in rural and remote areas.

63. Hospitals and clinics in rural and remote areas will have a health equipment program where patients can rent equipment they require within their homes and communities. (Ex: Bath stools, Canes, Commodes, Crutches, Raised toilet seats, Wheelchairs and Walkers).
64. The provincial government will allocate funds to create safe road access to rural and remote communities to ensure the safety of health care personnel and patients when traveling.
65. Mobile health connections and clinics will be the norm for providing health care to small communities.
66. Students living in rural and remote communities who are enrolled in a health profession program will be able complete their education, and obtain employment, without leaving their communities with the use of technology and access employment
67. Telehealth and telenursing will be used as a primary method to provide primary health care.

Health Human Resource (HHR) Management

68. Nursing curriculums across B.C. will be standardized.
69. Currently nursing instructors are paid approximately $20/ hour less than direct care nurses. By 2025, nursing instructors' wages will be comparable to that of direct care nurses.
70. Nursing students will have the opportunity to directly apply for educator roles upon graduation.
71. Educational supports will be provided to nursing students interested in becoming instructors in educational facilities in order to accommodate for shortages.
72. All nurses will be expected to complete volunteer work with professional nursing organizations (association, college union).
73. Schools of nursing across B.C. will develop and offer a mandatory course on leadership, policy and advocacy to all undergraduate nursing students.
74. Hidden audits will take place across the province to ensure that health care teams are providing patient centered and culturally safe care in hospitals.
75. Structures will be in place for patients to rate their experiences with individual nurses during their hospital stay, and nurses will be provided with this feedback.
76. Patient parking stalls will be in close proximity to hospital entrances and parking fees will be eliminated.
77. All hospitals will have free wifi available to patients.
78. All Regional Health Authorities will develop a mandatory interprofessional course to be taken during orientation for new hires.
79. Nurses will not be required to have prior medical-surgical experience before entering a specialty nursing area.
80. Full-time and part-time nurses will be able to self-schedule their shifts.
81. Nurses will work 8 hour shifts instead of 12 hour shifts.
82. Nurses who are working in specialty areas will be paid a premium.
83. All nursing preceptors will be provided with incentives and will receive proper training to become appropriate mentors.
84. The use of technology will become the standard across undergraduate nursing programs.
85. Students in every health profession program will be required to complete an interdisciplinary practicum as part of their diploma/degree requirements.
86. Patient representation on interview panels will be required across the province when hiring health care employees (from direct care to management).
87. Nurses will be required to attend yearly psychologist visits to promote positive emotional well-being.

88. Each hospital will be required to offer a dedicated fitness facility located within the hospital for health care providers to use.
89. All health care facilities will be accountable for enforcing a zero tolerance bullying policy.
90. All hospitals in the province of B.C. will be teaching hospitals.
91. All hospitals will be required to provide healthy meals, and 24hrs
92. Patients' caregivers will be able to stay with the patient 24/7 when in the hospital.
93. All hospitals will have healthy and nutritious foods within their cafeterias for both patients and staff.
94. All hospitals will have common areas for patients to converse and have meals.
95. Patients will be able to document their experiences within their own charts as part of interdisciplinary notes.

Information Management (IM) / Information Technology (IT)

96. All patients and their health care providers will have access to their electronic health records, and be able to chart, through the use of 'the cloud.'
97. All health authorities will utilize the same data information management system to ease transferability of data.
98. All patient documentation (flow sheets, vital sign records, interprofessional notes and physician notes) will be done electronically.
99. Patients will have access to their charts upon request.
100. Biometric fingerprint technology will replace existing patient identification systems and decrease errors when administering patient medication and/or performing diagnostic tests.
101. With the use of technology such as smart phones, photo documentation will be widely used, and automatically transferred to patients' online documentation system.
102. Nurses and other providers will have immediate access to patient charts, and be able to document patient assessments in a timely manner with accessible technology (i.e.: tablets, smart phones or computers) in each patient's room.
103. Cloud-based services will be used to store and transfer patient files.
104. Self-monitoring electronic technology will be used to track health behaviours and changes in health status, with data transmitted directly to health care providers to facilitate on-going monitoring.
105. Smartphone applications will be used to improve the quality of life of those living with chronic diseases. Applications will include a daily to-do list, diet tracker, exercise tracker, medication reminders and online in person counseling.
106. The use of self-monitoring electronic technologies (e.g., watches/mobile applications) will be used as a standard for tracking changes in health status among patients with chronic illness.
107. Nursing documentation within electronic health records will use standardized terminology across the province.
108. All nursing programs will have a course dedicated to health information management and information technology.
109. Drones will be used to deliver prescriptions.
110. Point of care testing will be available in all Canadian homes.