IN SERVICE OF ALL:

Co-Designing an Inclusive Person-Partnered Model of Care in the Canadian Forces Health Services

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ABSTRACT

Since being formalized in the 1980s, the model of patient-partnered care has become somewhat of a gold-standard in healthcare. Many health organizations have been working to implement this model, including the health services branch of Canada's military. The military's implementation of this model has been challenged by several factors, including ongoing sexual misconduct allegations, systemic racism, and the COVID-19 pandemic, among others.

The goal of this research project was to explore how a patient-partnered care model can be transformed into a person-partnered care (PPC) model that is meaningfully inclusive, diverse, equitable, and accessible (IDEA). This project further aimed to figure out how such a model can be implemented within the health services branch of the Canadian military.

To this end, the authors used primary and secondary research methods to assess the current state and model of Canada's military healthcare. Three Horizons, a participatory foresight technique, was then used to design an IDEA PPC care model, and to identify possible opportunities and challenges with the model's implementation in the military's health services branch.

The findings provide an initial model of IDEA PPC for the military's health services branch. Further research – particularly in terms of engagement or participatory knowledge-building – is required to enhance the initial model concept so it can work in all the varying contexts of military healthcare. Resources will also need to be dedicated to both design the model and to its implementation.

ACKNOWLEDGEMENTS

Our research project was conducted on sacred Indigenous territory. We would like to recognize the original owners and custodians of the particular lands on which we live, work, learn, and create. Julia Kowal is on the Treaty Lands and Territory of the Mississaugas of the Credit First Nation, and the traditional territories of the Haudenosaunee, the Anishinabek, and the Huron-Wendat First Nations. Trisha MacLeod is on the traditional territorial land of the Anishinabewaki and Algonquin First Nations.

We are settlers with other identities and experiences that afford us power and privilege. With power comes responsibility, and we are committed to using ours to uplift Indigenous issues and perspectives as part of making meaningful contributions to the Truth and Reconciliation Commission's Calls to Action. We have approached this work from a place of respect for the history, languages, and cultures of the First Nations, Métis, Inuit and all First Peoples of Canada.

Many people were involved in this project becoming a reality. Our deep, heartfelt thanks go to:

- Michele Mastroeni, our primary advisor, for offering such insightful comments and for giving us the intellectual freedom to explore such a deep topic.
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- All the participants. In the spirit of "Nothing about us, without us", it is no exaggeration to say that this project would have been impossible without you. We were blown away by your passion, feedback, and desire to be part of this process. We hope this project will inspire momentum and continued development in this field.

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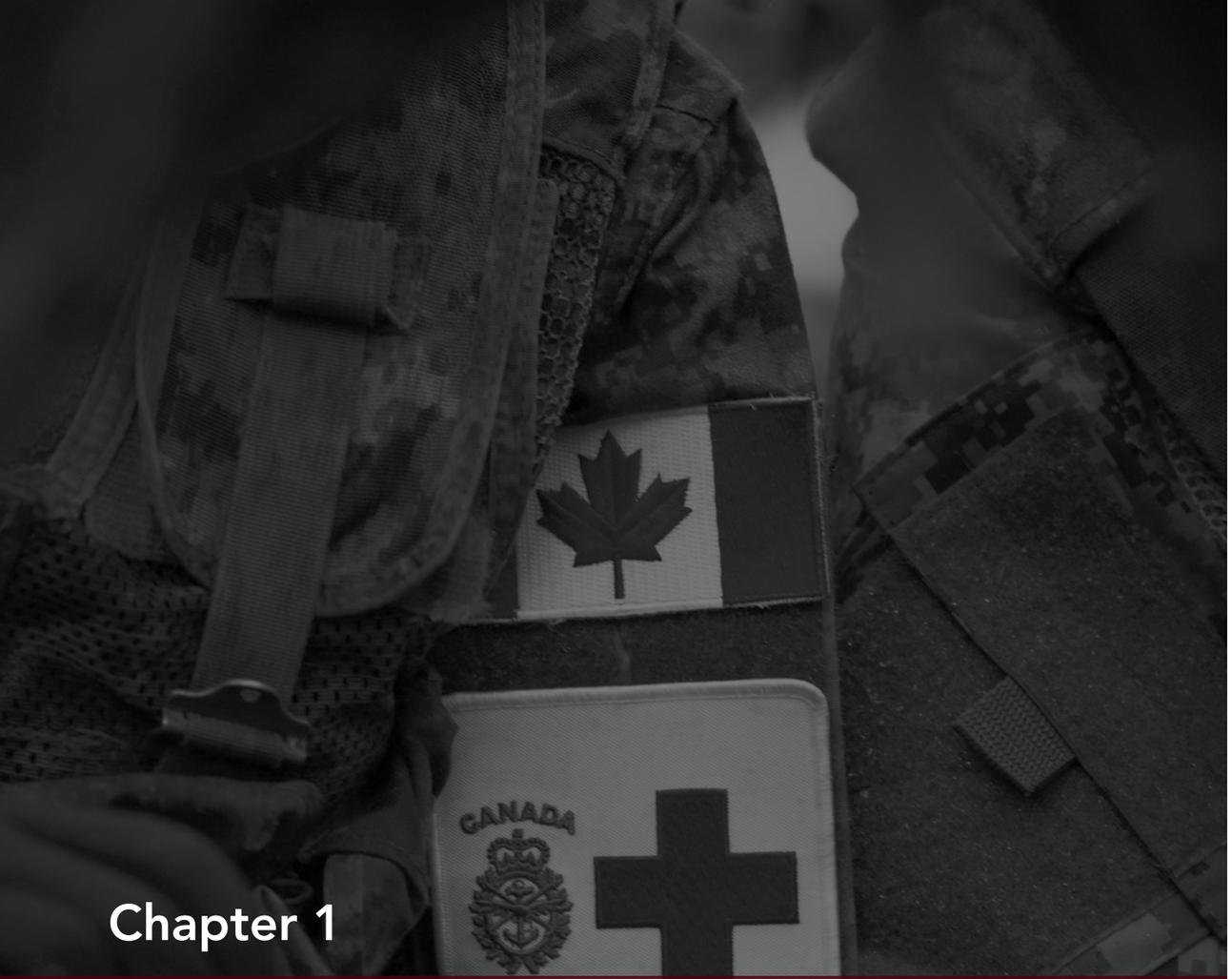
STATEMENT OF CONTRIBUTIONS

This project was a true partnership from start to finish.

Julia Kowal and Trisha MacLeod were both equally involved in the conceptualization of project aims and methodology.

Research methods were designed together, but Julia was the primary conductor of the expert interviews while Trisha set-up the survey and workshop. Both researchers were equally responsible for and involved in the analysis of the collected data.

Julia and Trisha drafted and revised the report together along with envisioning its figures. The final report was brought to life by Andrea Mendoza, a graphic designer hired to create the report's final layout.



Chapter 1

INTRODUCTION

INTRODUCTION

Military Healthcare in Canada

Canada's military – comprised of the army, navy, air force and special forces – performs several national and international defense functions. It sometimes needs to respond quickly to situations, which may mean deploying personnel at a moment's notice. Since being ready to deploy is a key element to fulfill the military's mandate, the physical and mental fitness of personnel is of paramount concern. To that end, the military has a designated health services branch, ensuring members are medically fit for the rigors of service (Government of Canada, 1985a, 1985b; Government of Canada et al., 2006).

The military's health services branch has a few unique dimensions that set it apart from most public health systems. Firstly, it is Canada's only federal-level health system, as established by the Canada Health Act. Healthcare is otherwise planned, funded, delivered, and regulated on a province-by-province basis. Secondly, the health services branch is the designated provider of healthcare to military members, and while the services vary from location to location, they generally include primary care, mental health services, physiotherapy, pharmacy, and diagnostic imaging. Certain additional services – such as after-hours emergency care or specialist services – are delegated or contracted to the regular civilian health system. Thirdly, the health services branch also has an advocacy and reporting function within the broader military. As the designated primary healthcare provider for all military members, it collects and monitors data about the health of members in order to provide advice and strategic guidance to the military.

The health services branch is a complex and intriguing system for exploration due to its multiple functions, place within Canada's military, and relation to other healthcare systems.

The Current Situation

No organization or health system exists in a vacuum and is untouched by broader social forces. At the time of writing, there are several social and political issues which many public-facing organizations are having to address: in particular, systemic racism and sexual harassment. The Canadian military is no exception to this; it is experiencing intense public scrutiny about their culture to a degree not seen since the Somalia affair and cover-up scandal of the 1990s (Foot, 2019; Report of the Somalia Commission of Inquiry, 1997). Several academics have criticized the culture within the military as being particularly problematic for women and racialized members (George, 2020; Okros & Brown, 2019).

The military, to its credit, has acknowledged the need for "substantial changes to [its] culture" in light of "reckonings like #MeToo, Black Lives Matter, the Truth and Reconciliation Commission, the LGBT Purge class action, the Heyder and Beattie [sexual harassment and discrimination] class actions, and other [legal] settlements" (Government of Canada, 2021c). In response, the military has made attempts to address the ongoing inequities, to mixed results. For instance, while the government's current defence policy states that diversity and inclusion are core values of the military, it does so from a standpoint that these values are simply a means to achieve efficiency and efficacy - desirable traits for the force. The defence policy does not acknowledge why diverse and inclusive military workspaces are not already present nor does it set out concrete steps for how to make them real to a meaningful degree (Canada. Department of National Defence, 2017). Following other ineffective

measures, the government has committed to a second external review of sexual misconduct and the establishment of a new role: Chief, Professional Conduct and Culture. This branch is tasked with leading a fundamental transformation in the military by addressing sexual misconduct, hateful conduct, systemic barriers, harassment, violence, discrimination, employment inequity, unconscious biases, and abuse of power in the workplace (Brewster, 2021a, 2021b, 2021c, 2021d; Government of Canada, 2021a).

The numerous sexual misconduct allegations and ineffective overtures to address systemic racism in the military demonstrate a problematic culture, which has important implications for the military's health services branch (Brewster, 2021c; Cousins, 2021; Deschamps, 2015; Neustaeter, 2021). By being responsible for the health of members, it falls to the health services branch to provide appropriate supports to victims and survivors of sexual misconduct and racialized trauma. Beyond the ongoing cultural challenges, the health services branch has also had to contend with the COVID-19 pandemic. One of the branch's most obvious pandemic challenges pertained to coordinating the rapid deployment of members to quell outbreaks in Ontario's long-term care homes (Government of Canada, 2021b). However, the pandemic has highlighted the vulnerability of our social systems as well as the inequities that they perpetuate; the military's health services branch will now need to be mindful of the pandemic's disproportionate impact on marginalized communities, and adjust the supports for their members accordingly (Han, 2018; Williams, 2012; Williams & Mohammed, 2013).

Opportunity for Change

As mentioned previously, both the military and its health services branch have been attempting to make their work more inclusive. One of the main ways the military is doing this is through its commitment to adopt and integrate the federal government's Gender-Based Analysis Plus (GBA+) lens in all its activities. GBA+ is "used to assess how different women, men and gender diverse people may experience policies, programs and initiatives", and is intended to help the military revise its work to make the space more diverse and gender inclusive (Government of Canada, 2016). Inclusion has been top-of-mind for the health services branch since it was restructured (prior to the adoption of GBA+) to make its services and care "accessible and universal" (Simard, 2005). The branch's new model was rolled out in the early 2000s and used a patient-centred care framework with the intention to shift away from the provider-centric, often patriarchal healthcare model that typically exemplifies western medicine practices (Canadian Forces Health Services Group, n.d.).

Patient-partnered care is "an overall philosophy and approach" to healthcare where patients are considered equal and respected members in the discussions and decisions around a person's healthcare (Fooks et al., 2015). It can happen "at all levels of care, from the [patient's] bedside to the boardroom" and deal with planning, designing, and evaluating the delivery of programs (Ginn Moretz & Abraham, 2012). Since being articulated in the late 1980s, the notion of patient-partnered care has become widely viewed as a 'gold standard' in healthcare and many accreditation bodies considered it a criterion in the measurement of the quality of healthcare (Accreditation Canada, 2021; Barry & Edgman-Levitan, 2012; Cleary, 2016; Fix et al., 2018). Many healthcare settings have adopted a patient-partnered care model and more still are moving ahead to implement it (Fix et al., 2018).

Patient-partnered care is a multi-faceted topic; it is sometimes used interchangeably with 'patient-centred care' or 'client-centred care' (Barry & Edgman-Levitan, 2012; Fix et al., 2018). There are some nuances between these concepts, but they essentially are all approaches to care where the dynamic in the healthcare relationship is one where patients are intentionally closely involved. Patient-partnered care or other 'patient'-based terms are so widely used in this field and are easily understood, which is why we initially used them in framing our research project. We fully agree with the premise of these concepts but, over the course of the research, we came to feel that the language was limiting by only calling out the patient role. The military health system is unique in that patients may also be providers or employers; each of those three roles play an important, but different, part in healthcare, and we wanted our language to respect that. We tried to balance having easily understood concepts and language that is more nuanced. We feel that our adapted term of 'person-partnered care' is more appropriate for this context; it reflects the multiplicity of roles that people have in the military health system, while still referring to the foundational concepts of equitable, participatory dynamics in the healthcare relationship. In this report, we will defer to using the acronym 'PPC' and only specifically use 'patient'-based terms when indicated or originally used by a source.

The health services branch's new model is structured as per a guidance document (Canadian Forces Health Services Group, n.d.). The document reflects the branch's determination and aspiration to implement a patient-centred care framework. While the framework's philosophical principles are well articulated in the document, the spirit of the principles is not translated into practical elements. The document outlines rigid structures and processes for the provision of health services in the branch, but only from the perspective of what the provider must do. Furthermore, it fails to establish well-rounded expectations for what patient-partnered interactions might look like in practice. The document sets very general expectations for care, such as: treating everyone with respect; fully informing patients; maintaining privacy of health information; and having patients (and their family, where appropriate) be actively involved in decisions about their care and treatment. There are no details about methods to actively involve patients nor is there a defined standard against which to measure achievement. The document is also vague on how the expectations collectively contribute to the stated objective of "provid[ing] quality patient-centred care [...] that meets their [patients'] unique needs anytime, anywhere," leading one to infer that meeting the overall expectations is how patient-centred care is realized (Canadian Forces Health Services Group, n.d.). The document also touches upon some mechanisms for engagement, but they are not robust enough to solicit the full scope of lived experiences of patients, providers, and employers. Incorporating lived experience is an important part of patient-partnership because it can be the basis for quality improvement of health policy and services.

When the new military health services model was instituted, this vague end-state vision left much about patient-partnered care to the discretion of the more than 25 clinics spread across Canada. This self-directed approach to change management has resulted in varying standards, different practices and approaches within and between military health clinics, and an overall sense of dissatisfaction with the model's roll-out (Burt et al., 2021; Canadian Forces Health Services, 2017; Macleod, 2019). In acknowledgement of the difficulty of the framework to take root or have the intended impact, early 2021 saw the health services branch partnering with a cohort of graduate students in OCAD University's Strategic Foresight & Innovation program to identify ways to re-invigorate the implementation of the model using a design thinking process (Burt et al., 2021).

The end of the pandemic will offer a number of opportunities for health system redesign – both to embed a new care model into practice and to address deeply entrenched social inequalities and biases. Our project intends to create a vision of a PPC model that responds to society's calls for inclusion, diversity, equity, and accessibility that can be implemented within the health services branch of the Canadian military.

Chapter 2

APPROACH TO PROJECT

Conceptual Project Design

A defining element of patient-partnered care, as implied by the name, is the partnership with patients in the planning and delivery of health services. In that vein, and in keeping with the principles of human-centred design, we knew that the perspectives of patients and other healthcare stakeholders would be essential to our research project. We felt that our research approach should be participatory in nature so that both our process and outcomes could be said to reflect the principles of the care model we are exploring; we did not want to simply ask the opinions of people and then make decisions for them. We wanted our project to be one where we not only worked to understand participants but where we involved them in the development of a healthcare model that could work better for them. This would align with the Involve and Collaborate phases of the IAP2 spectrum of public engagement (as represented in Figure 1), developed by the International Association for Public Participation Canada (2021).

	INFORM	CONSULT	INVOLVE	COLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives and/or solutions.	To obtain public feedback on analysis, alternatives and/or decision.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision-making in the hands of the public.
PROMISETO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

Figure 1: *The IAP2 spectrum of public engagement (International Association for Public Participation Canada, 2021)*

The aim of our study is to co-create a vision of an inclusive, diverse, equitable, and accessible (IDEA) PPC model for Canada's military health services branch so that the healthcare programs may be in service to all. This has a few underlying presumptions: that PPC is a desirable healthcare model; that the current patient-centred care model in the military's health services branch has some gaps; and that incorporating IDEA principles can make the system more robust and enhance health outcomes for stakeholders. To achieve the project aims, we worked to engage with patients, providers, and employers so that they could be a part of envisioning a change that they would like to see in their military healthcare services.

There were three additional considerations we kept in mind when designing our study and selecting

our methodological approach. First, was our standpoint. Our interest in this topic originates from our professional experiences as healthcare providers (from within and outside of the military) and personal experiences as design thinkers. This meant we needed to ensure that we could maintain appropriate boundaries and just 'be researchers', rather than contributing our own pertinent experiences or knowledge to the topic. Second, was the notion of power and hierarchy. Distinct and subtle power structures guide and influence military interactions and how its healthcare is experienced by patients, providers, and employers. As such, we needed to ensure that power dynamics were not having adverse effects on the marginalized or underrepresented communities with whom we intended to engage. Third, was timing; while many organizations are looking to use the upheaval of the pandemic and socio-political climate as a springboard for making systemic changes, these same events may also be particularly distressing or re-traumatizing for various communities. As such, engaging with such stakeholders must be done authentically and sensitively.

Method

For our study, we used a participatory grounded theory approach (Campbell & Gregor, 2008; Charmaz, 2006; Kumar, 2013; Sanders & Stappers, 2012). Grounded theory is one of the more frequently used qualitative methods in medical research and is intended to examine "what happens and how people interact" within social processes (Sbaraini et al., 2011). To do this, researchers presume "that they may know little about the meanings that drive the actions of their participants" and use open questions and observation to induce an understanding of norms, processes, and behaviours of participants (Sbaraini et al., 2011). This was quite valuable for us since our research focuses on a number of communities whose lived experience(s) differ from ours, and we cannot and should not presume to know their experiences or motivations better than they do. In the analysis, we used some ethnographic techniques – such as creating memos (Charmaz, 2006) – to both organize our thoughts and to critically reflect on what we did not know, as a way to check our bias.

The federal government and the military are using the GBA+ lens in their diversity initiatives. We chose not to use a GBA+ lens in our project because we felt it was too narrow a concept. By its very name, the focus of GBA+ is on gender, and all other aspects of identity are sidelined. We instead chose to use an IDEA lens for a few reasons: it does not explicitly focus on one dimension of identity, so it allows for a greater exploration of intersectional identities; it explicitly identifies the outcomes that are intended to be fostered; and it considers the element of accessibility, which is often overlooked in most diversity lenses, but is inextricably tied to the field of health, wellness, and disability. Accessibility and the concept of (dis)ability are really important in the study of the military; since mental and physical fitness are key to the military's readiness to deploy, there are policies that permit the suspension or even the discharge of a member if they cannot perform to certain minimum levels required for deployment (Government of Canada et al., 2006).

Grounded theory and its focus on understanding complex social experiences was foundational to our project. It gave us a way to form a basis of knowledge that was previously non-existent about the current experiences of military healthcare based on IDEA principles. Once that foundation was built, we could use it as starting point for the collaborative exploration and co-creation of desired future healthcare models.

The ultimate aim of the project is expressed in our primary research question: What can inclusive, diverse, equitable, accessible (IDEA) person-partnered care (PPC) look like across various practice settings in a military healthcare setting?

To satisfactorily address our research question, we needed to involve impacted stakeholders. Given the uncertainty in the current social climate, we chose to frame the participatory dimension of the project with foresight techniques so that the resulting model could be more applicable and versatile. This was done by using future-oriented, context-seeking questions, such as:

- What might patients see or experience in their care when they are an equal and respected team member in the discussion, planning, and decisions about the delivery of patient care?
- What knowledge and capacities will providers have that will enable them to work with patients in a collaborative, respectful, meaningful manner in the discussion, planning, and decisions about the delivery of patient care?
- Where do changes need to happen to move from the current state of healthcare towards a desired future state of IDEA PPC?
- How can the military's resources, knowledge, and expertise be leveraged to bring about the change to a desired future state of IDEA PPC?
- What lessons, knowledge, or expertise can the military leverage from other community institutions about implementing organizational culture changes?

Who Was Involved

The military's health services branch has many stakeholders, ranging from politicians to policy makers, to the families of military members. This project is an initial foray into the topic of IDEA PPC in a military context. With such little previous research to guide our work, we needed to have parameters to manage the scope and breadth of our project; this is why we decided to focus on a few main stakeholders. The main stakeholders can be categorized broadly as:

- Patients, who are military members who have accessed or used military healthcare services for their health needs;
- Providers, who are professionals who work in the health services branch and help deliver medical services (e.g. military administrators or clinicians); and
- Employers, who are people who manage people in the military (e.g. military or civilian leaders).

We sought out participants from all three groups because each would have important insight to offer about PPC based on their different relation to the health services and with each other. The interrelation between stakeholders can be described as multi-faceted: while the patients seek or receive healthcare from providers, the providers also report important health data to the employers so the employers can effectively manage personnel (the patients) and uphold the military's mandate. Of note, while we did ask participants to pick the role with which they primarily identified, we were aware that individuals could have current or former experience of multiple roles; we made sure to ask about the additional role experiences too. As inclusion criteria, we required participants to be over the age of 18 and be comfortable communicating in English.

We also sought out subject matter experts, both 'internal' ones who are familiar with the Canadian military and 'external' ones without familiarity of the military. Internal experts did not need to be members of the military; they could be civilians or academics who work closely with military members. Of particular interest were people with knowledge or experience in healthcare policy, patient-partnered care, and/or IDEA principles. Our intention was to get 'bigger picture' information that could contextualize or inspire the design of PPC with IDEA principles for the military's health services branch.

Since our study involved human participants, we obtained ethical approval from OCAD University's Research Ethics Board (Reference #2021-50) and the Surgeon General Health Research Program (approval # E2021-05-357-012-0001).

Structure

Over the four months of our project, we had two main phases: one to understand the current state and experiences, and the other to collaboratively re-envision care. Different methods were used in each phase. In the 'Understand' phase, which was the bulk of our project, we conducted a literature review, subject matter expert interviews, and a survey. In the 'Envision' phase, we conducted a foresight-based workshop. We hoped that our project could result in useful data, novel tools specific to IDEA PPC, and a collaborative process all of which could be built upon or altered to support future military healthcare evaluation or re-design. We generated some possible next steps that could evolve from our work, but were beyond the scope of what could be undertaken in this project.

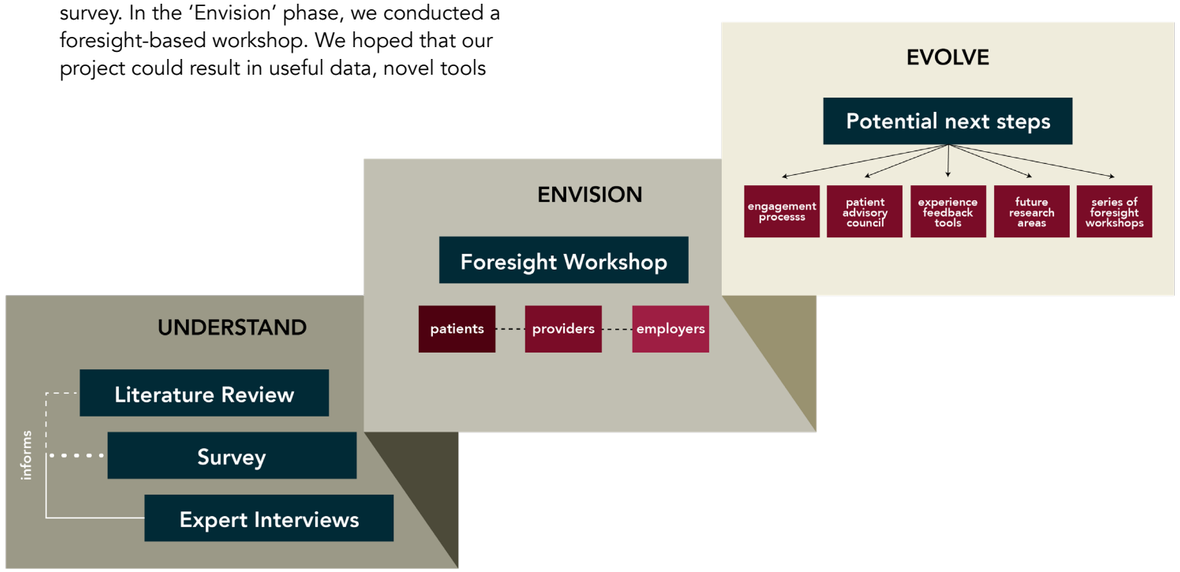


Figure 2: *Diagram of the research project journey*

Our Thoughts on the Method

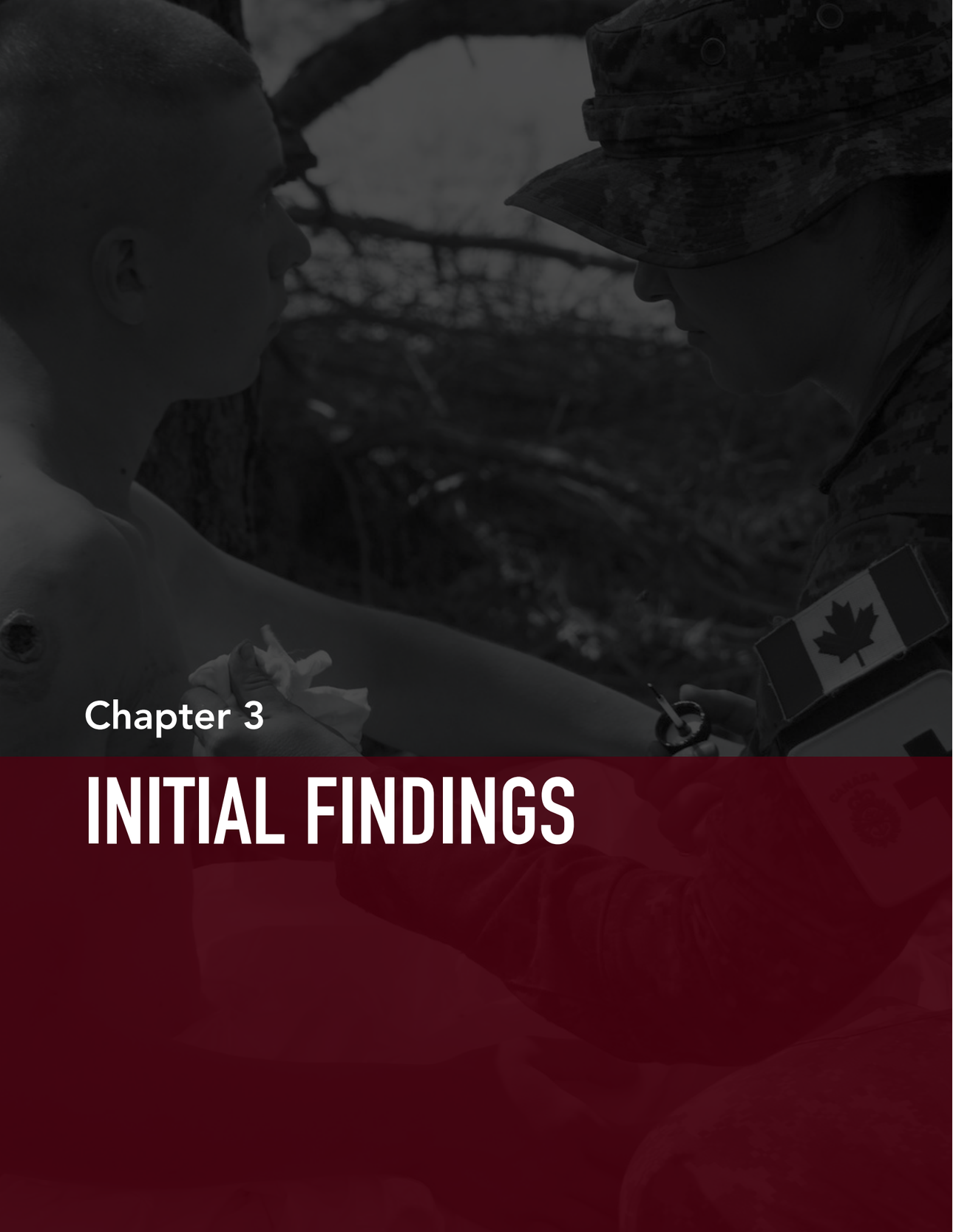
We chose grounded theory as our method for this project because it is an ideal exploratory method that relies on the presumption of ignorance on the part of the researchers as a way to keep them open to ideas (Charmaz, 2006). Since we were working with people from so many communities with different elements of identity, we did not want to make assumptions about their experiences, rationales, or values. This was helpful in the set-up of the participatory workshop since it offered participants 'space' to be themselves and share their opinions without being in conflict against us as 'researchers', a role that traditionally has inherent power imbalances in it. Grounded theory had another benefit; given its inductive nature, we designed and conducted the project in distinct phases that were each based on the collective trends and findings from previous phases. This meant we were doing ongoing data analysis and planning, which allowed us to keep our emerging findings fresh and top-of-mind. This in turn gave us the opportunity to alter the way in which we asked questions in a way that could be most meaningful and relevant to participants.

While grounded theory was ideal in many ways, it posed a few practical challenges. Due to the inductive nature of grounded theory, there were limits to how far ahead or how in-depth we could plan our project's tools and questions. This presented a challenge to us as researchers because the tools and questions for our entire project had to be carefully planned out and approved before the research could be started, as is typical for many forms of academic research involving people. Another pitfall of the project – but not necessarily grounded theory itself – was due to the fact that we analyzed the data collected from each tool twice (once as individuals and then once together) and then supplemented with elements of self-reflection. This process produced a large volume of data which was valuable, and also somewhat difficult for us to handle efficiently, given our limited resources and unfamiliarity with thematic coding of qualitative information (Olesen, 2007).

For the participatory foresight part of the project, we used the Three Horizons framework in an interactive workshop. The Three Horizons framework is an excellent way to generate and prioritize innovative ideas to bring about transformative change in a large company or government agency (Sharpe et al., 2016). Utilising this framework in our workshop enabled us to produce a broad vision about what an IDEA PPC model might look like in the military healthcare context and a number of possible ways to realize it. Given that we had intended to collect a breadth of concepts – not to build a consensus – we wanted to maximize participation. Our original plan was to conduct several real-time virtual workshops with patients, providers, and employers. However, this was impractical due to scheduling availability, so we adapted our workshop to be asynchronous and run on Mentimeter, an interactive presentation platform.

The Mentimeter platform allowed participants to contribute their opinions, then see others' comments and then back to submit additional responses, if inspired to do so. This opportunity for interaction was a key dimension we wanted to have in the workshop, no matter the style, since no such dialogue had been possible in any of our other methods. Despite the advantage of interaction, the asynchronous workshop still had its limitations.

Firstly, in order to run asynchronously, the prompt questions had to be reframed so that they could be understood without any facilitator explanation or elaboration. Similarly, the responses were briefer than we had hoped to collect simply because there was no opportunity for participants to explain their points further. This meant that both the questions and the responses likely did not capture the full degree of nuance of the topic. Additionally, we did not ask any identity-related information because the responses were viewable by participants, and we wanted to protect participant privacy. This means that, unlike the survey, we cannot disaggregate the responses into categories. Taken together, the workshop's vision of the future state of military healthcare is informative, but could be explored in greater depth by running additional workshops, especially if using the real-time workshop guide with groups of patients, providers, and employers.



Chapter 3

INITIAL FINDINGS

Literature Review

We conducted a scoping review as the initial stage of the study. We considered both peer-reviewed articles and grey literature in the form of reports or policy documents from healthcare or government agencies. The intent of the review was to understand the general shape of the literature and what it had to say about patient-partnered care in military healthcare, especially when it comes to serving marginalized communities. In total, we reviewed documents on the topics of patient-partnered care, healthcare, the Canadian military, and/or IDEA principles. While there is an extensive volume of research on these topics, we noted that it tended to be concentrated in some areas, leaving notable gaps. We hope our research can be a starting point to address some of the gaps.

What did we learn?

Generally, patient-partnered care research is conducted from specific standpoints. These standpoints are usually categorized by: healthcare settings (acute care, chronic care, palliative care, etc.); patient groups of interest (children, seniors, people with a particular diagnosis, etc.); or provider perspectives (nurses, doctors, managers, etc.). These standpoints are used to frame explorations of elements of PPC such as: shared decision-making, organizational change and implementation challenges, and tools to enhance the partnership or involvement of select communities.

There is quite a bit of research about patient-partnered care within specific communities, usually by focussing on one type of identity – such as race, gender, or sexual orientation. Such identity-specific literature intends to highlight a particular community's barriers to care, the resulting health disparities, or to suggest ways to address the disparities (Hebert & Hernandez, 2016; Jones et al., 2016; Symeonidou & Loizou, 2018; Williams & Mohammed, 2013). This information has value but is too narrow for our purpose; there are multiple aspects of human diversity – such as socio-linguistic background, culture or religion, age, and (dis)ability – which need to be considered collectively in the establishment or provision of PPC. The intersection of identities produces an array of experiences that may differ from the experiences of any single aspect of identity; focusing on one aspect of identity may overlook the compounded impact other aspects of identity have on a person and their challenges, needs, or wants (Cykert et al., 2017; DeMeester et al., 2016; Government of Canada, 2019; Jackson, 2016; Macleod, 2020; Pomey et al., 2015). Since the military's stated desire is to increase diversity in the force, this would necessitate building a healthcare system that is responsive to the needs of all members (Department of National Defence, 2017); we believe that leveraging the field of inclusive design may be worthwhile to such an end. Inclusive design is usually associated with designing for (dis) ability, which is a complex notion because of the sheer breadth of medical conditions, circumstances, and needs. The resulting designs are ones that help people with disabilities but also can benefit other groups who do not have disabilities (Roy, 2015). In that vein, practicing inclusive design with deliberate consideration of intersectionality could work to make the Canadian military health system 'fit' people in the most complete sense possible.

The body of patient-partnered care research from civilian healthcare contexts are not completely transferable to military healthcare because of nuances between the two systems. For instance:

- The military deploys around the world on a variety of missions including peacekeeping, disaster relief, and armed conflicts. The type of mission impacts what type of care may be needed and the locale impacts what resources may be readily available. Therefore, the wildly varying conditions of care may not be equally conducive to the implementation of key PPC principles, such as shared decision-making. Healthcare for deployments is such a large and complex element of military healthcare that we

decided it was beyond the scope of this initial research project.

- The health services branch in Canada's military has multiple purposes, which is reflected in its practices and approach. The branch does not only tend to members' health for the sake of their health; the branch maintains the health of the whole force so the military can quickly deploy and uphold its own mandate. This means that the main intent of military healthcare treatments is to get someone back to levels of operational fitness. (Department of National Defence & Canadian Armed Forces, 2019; Government of Canada, 1985a).

- Military healthcare providers have a unique dynamic in their interactions with patients that is not present in civilian healthcare; military providers have much more power over patients, primarily due to their role as a provider or sometimes due to their rank. The military has many policies that reinforce such power imbalances; providers are in positions to charge patients with health-related offences such as malingering ('playing sick'), refusing immunizations, and charges of disobedience of lawful command or insubordinate behaviour if a patient disregards medical orders (Department of National Defence & Canadian Armed Forces, 2019; Government of Canada, 2021c). Patient-partnership relies on shared decision-making (Barry & Edgman-Levitan, 2012), but this is hard to do within an inherently and deliberately unequal patient-provider power dynamic, where 'dissent' or divergence from medical opinion may be punished as per organizational policy and culture.

Literature on the topic of patient-partnered care in military healthcare is usually examining the American system (Hebert & Hernandez, 2016; Jones et al., 2016), which is notably different from the Canadian system. The American military is significantly larger and better resourced than Canada's. The American military healthcare system is also more integrated with the civilian healthcare system (Best, 2005; Ross University School of Medicine, 2021); in the United States, a military member can be treated at a civilian hospital, and a civilian can go to a military hospital. This is in sharp contrast to the set-up in Canada, where the two systems are mostly separate. This distinction between countries means that any research findings generated within the American military context may need extensive adaptation before being applied to the Canadian military context.

Taken together, there is a lack of research on patient-partnered care in relation to IDEA principles that can be applied to the context of Canadian military healthcare. To address this gap in the literature, we used a combination of a survey and expert interviews to collect general views of the current state of military healthcare. After getting a broad perspective, we would be able to identify prominent themes or emerging issues worth further exploration.

Survey

We built a survey to hear from current or former Canadian military members about their perspectives on military healthcare, its barriers, and how it can be more inclusive. Participants were recruited by general email through a variety of distributions lists, professional networks, and social media invitations.

The survey was open from August 13, 2021 to September 14, 2021; it received 320 responses, of which 318 met eligibility criteria and had consented to participate in the survey. Following an in-depth demographic identity trait section, the survey asked participants about their experiences and beliefs on the topics of Inclusivity, Access to Care, and Patient-Partnered Care. (Please refer to Appendix A for the full survey questions.) The Inclusivity section had 12 questions where participants could rate the degree to which they have felt excluded (a signal of lacking inclusion) from specific experiences within the broader military that they believe was because of their personal traits. These specific experiences were drawn from "a list of [general workplace] activities and events that should be experienced equally by everyone" and touched on categories such as skill use, learning and growth, career opportunities, and recognition (Gaudiano, 2019a, 2019b). In the Access to Care section, participants would be able to select what they perceived as barriers to military members accessing care or factors that contribute to the varying quality of care. In the Patient-Partnered Care section, participants could rate how much they agreed with statements about the perceived 'attitude' towards partnership between patients, providers, and employers in the context of health interactions. The survey ended with two open-text questions where participants could provide parting thoughts on IDEA PPC or any additional comments about military healthcare that may not have otherwise been addressed. We later coded these open-text questions as per the code list in Appendix B.

What did we learn?

As we had hoped, our survey received responses from across the categories of patients, providers, and employers. Of the 318 eligible respondents, 316 chose to identify themselves with a primary stakeholder category. Of those 316 respondents, 209 identified as patients (66.1% of responses), with 64 (20.4%) as providers, and 43 (13.6%) as employers. Interestingly, 140 of the 316 respondents (44%) had experience in more than one role. As illustrated in Figure 3, when taking into account these additional roles, 291 participants had experience being patients, 98 had experience being employers, and 97 had experience being providers. This meant that our respondents were well-positioned to offer multi-faceted commentary.

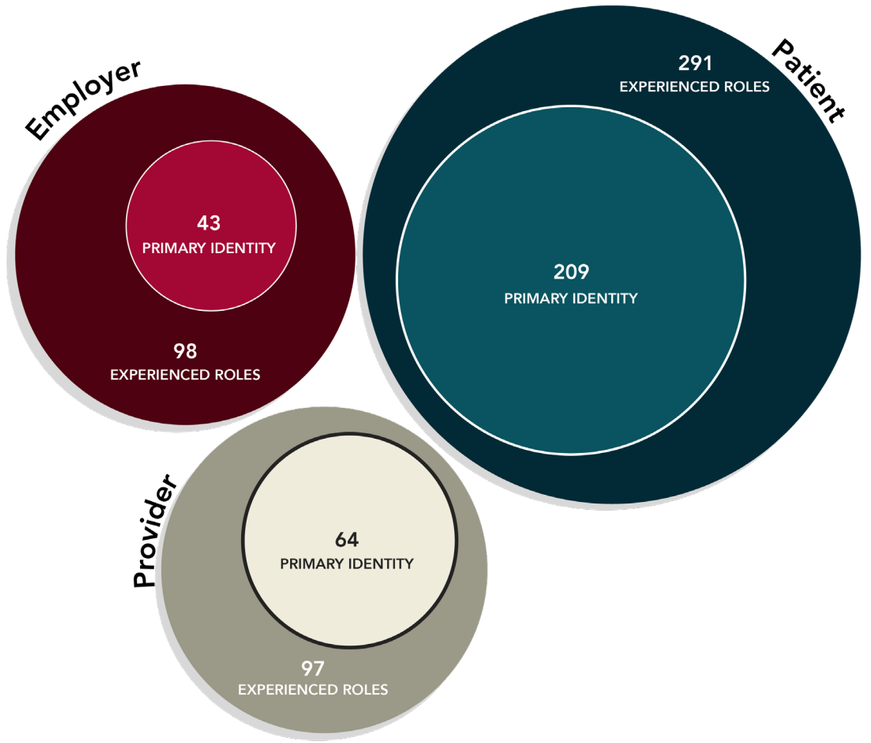


Figure 3: *Survey respondents' experienced roles and primary identity*

In our survey, we asked about the barriers in military healthcare. We gave a list of areas from which the respondents could indicate the ones they saw as barriers to accessing healthcare or as factors in receiving different levels of quality in care. The top five barrier areas were related to: appointment scheduling; geography or location; getting second opinions; choice of provider; and navigating the health system. These five were chosen as 'top' barriers because they were identified as barriers two to three times more than the other options.

Elements of these barriers were also echoed in the free text responses of the survey. This was not a surprising result, since these seem to be quite persistent barriers; even back in 2017, the health service's branch Patient Experience Survey specifically measured these elements to gauge the quality of care (Canadian Forces Health Services Group, 2017). Given their prevalence, these five barriers are some of the most crucial issues that should receive attention as part of implementing PPC and any quality improvement initiatives.

Figure 4: *Top five barriers to accessing healthcare*

Based on the self-reported identity traits from the 318 eligible responses, participants who completed our survey generally were:

- 25-34 years old (36% of responses) or 35-44 years old (35.5% of responses)
- Married or in a domestic partnership (68%)
- Assigned male at birth (55.9%)
- Identifying with the male gender (53.7%)
- Heterosexual/straight (71%)
- White/Caucasian (91.8%)
- Non-Indigenous (92%)
- Christian (42%) or not religious (39.9%, with 22% being Atheist and 17.9% being Agnostic)
- Non-disabled (83.6%)

This composite picture is based on the options that received the highest number of responses for any given identity trait, but is not wholly accurate of who responded. Some respondents chose not to provide their self-identity for some traits. In other cases, respondents were able to select multiple options or provide an option not listed. Furthermore, responses that diverged from this composite picture were not limited to a few individuals; we had 227 responses from participants who identified differently from the composite picture based on any element of sex, gender, sexual orientation, race, ethnicity, indigeneity, religion, or disability status. The remaining 91 responses were from participants who identified as white, cis-gendered, heterosexual males, in line with our composite picture. For the purpose of analysis, we refer to the group of 227 responses as 'non-normative' and the latter group of 91 responses as 'normative'. This choice in language was deliberate; the characteristics of the latter group are often considered to be prominent or prevalent in both the military and broader society, and as a result are treated as 'the norm'. The previous group has characteristics that fall outside of 'the norm' and are then treated as being outside of 'the norm'. We wanted to use terms that acknowledge the underlying expectations of identity traits, but without putting any judgement on the traits or people themselves, because all parts of a person's identity are valid.

When analyzing the survey, we categorized the responses as belonging either to normative or non-normative profiles and compared how the attitudes and beliefs of military healthcare may differ between the two groups. In the Inclusivity section, participants could rate on a Likert scale (1=Never, 5=Always) the degree to which they experienced exclusion as a result of their personal identity traits. As a trend, there was a general inverse relationship between number of respondents and degree of exclusion. This means that few respondents reported significant exclusion while many respondents reported limited exclusion. However, there are some nuances to this trend in the form of discrepancies between the two analytical categories. (Please refer to Appendix C for the full set of graphs of the trait-based exclusion survey questions.) Respondents from the non-normative category reported experiencing exclusion based on their identity traits far more than the respondents from the normative category. Across all exclusion-measuring questions, the levels of 'Always' feeling excluded was higher amongst the non-normative category than the normative category. In these same questions, the non-normative respondents were between 1.15 to 2.5 times less likely to report 'Never' feeling exclusion, compared to the normative respondents.

In terms of the inverse relationship, the majority of responses in the normative category reported 'Never' feeling excluded; the rates of 'Never' responses ranged from 54% to 73% across the questions. The rates steeply decreased as the frequency of exclusion increased. This meant that the participants whose responses fell into the normative category feel strongly included in the military. The non-normative responses, while having a similar inverse relationship, was not nearly as pronounced; the frequency of exclusion was more moderate, or spread out, in comparison. This meant that the participants whose responses fell into the non-normative category do not feel included in the military to the same degree. The non-normative category most frequently reported moderate degrees of exclusion when asked about the subtler forms of exclusion. Such exclusion was represented in the cases of: being interrupted or talked over in meetings; being unable to use a strong or direct tone without blowback; being the target of microaggressions; or feeling they were able to share their traits openly. This speaks to exclusion (or lack of inclusion) being tied to elements of psychological safety and a sense of being welcomed in teams, in spaces, and in an organization.

This discrepancy between the two groups about experiences of exclusion is echoed in the survey's final Inclusion question. This question measured the degree to which participants feel that diverse perspectives are encouraged and respected in the Canadian military. For that question (as represented in Figure 5), normative responses were more likely to report diversity being frequently encouraged and respected, while non-normative responses had a more middle-of-the-road perspective about the matter. This divergence in perceived encouragement could be indicative of a schism in the military's collective understanding of diversity, or on what it truly means to encourage and support such perspectives.

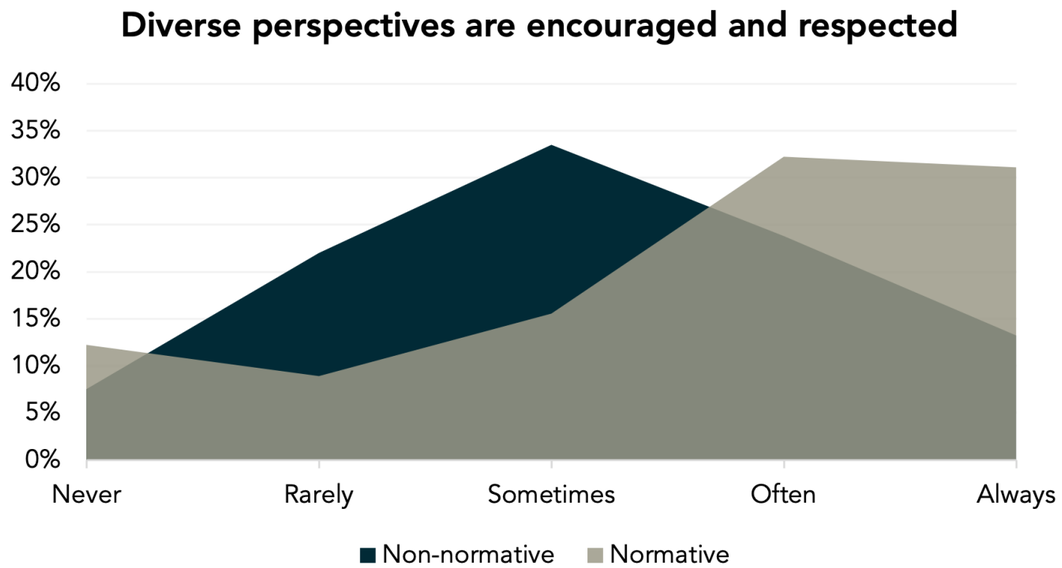


Figure 5: *Graph of responses to the survey question "I see that diverse perspectives are encouraged and respected in the workplace"*

Another interesting observation from the survey came from the Patient-Partnered Care section, where we asked participants about their opinions and perspectives on patient partnership in military healthcare. We used the term 'patient-partnered care' in the survey because it is more familiar and therefore more easily understood than person-partnered care (PPC). Participants rated their agreement to our statements on a Likert scale (1=Strongly Disagree, 5=Strongly Agree). Overall, the responses in both the non-normative and the normative categories mirrored each other quite closely. However, there were a few key insights that we drew from this section. (Please refer to Appendix D for the full set of graphs about patient partnership survey questions).

Firstly, when asked if they felt their voice matters in healthcare, almost half of respondents agreed (45.3% non-normative, and 35.5% of normative), with another large portion feeling neutral on the matter (22.5% and 30% respectively). It is interesting that respondents within the non-normative category had stronger positive feelings compared to the normative category, despite generally feeling more excluded in the military (as mentioned previously). This distinction could be because people whose responses are in the non-normative category may have a more acute feeling of their sense of agency.

When we asked about patients not having enough knowledge to contribute to discussions or decisions about their healthcare, respondents had no clear-cut feelings – most were neutral on this matter. However, the highest levels of 'Strongly Disagree' and 'Strongly Agree' came from the non-normative category. The level of strong disagreement (meaning that patients have enough knowledge) could be attributed to a belief that patients have an inherent 'knowledge' of self, one's experiences, and a sense of agency. By contrast, the level of strong agreement (meaning that patients lack knowledge) may be speaking to a belief about how patients lack knowledge about medicine or the health system, and therefore lack power in their interactions with healthcare providers. Either way, if IDEA PPC is to be realized, specific knowledge needs to be cultivated among patients, providers, and employers. Education and training could address topics such as plain-language communication, strengths-based approaches, or cultural competency training so that healthcare interactions between patients, providers, and employers can be more equitable. However, further research and exploration should be done to confirm what kind of knowledge would be most useful to impart in this context, and to whom.

We asked if the needs of employers were a consideration in healthcare-related decisions, so as to gauge the strength of their presence in the healthcare process. The responses were distributed across the board, with most being neutral on the matter. When comparing the responses of the normative and non-normative categories, the normative group had higher levels of 'Strongly Disagree' and low levels of 'Strongly Agree'. This seems to indicate some sort of ambivalence about or disconnect from the role of employers in the healthcare space, which is somewhat troubling. So much about military healthcare is tied to job performance (and, consequently, employability) that there should be a better or clearer understanding of what role the employer can and should play in healthcare, and how the military healthcare system can impact employers.

The final key observation from the survey is about policy. We asked participants if they thought the military healthcare system had clear policies about how to balance the needs between patients, providers, and employers. Both normative and non-normative categories had low levels of agreement (15.6% and 16.7% respectively) and much higher levels of disagreement (47.7% and 55.1%, respectively). This affirms our previous findings about the lack of clarity in the roles between stakeholders in the provision of military healthcare. One probable cause of this ambiguity could be that either existing policies need clarification, or they are not written at all. Ongoing consultation and collaboration with all three stakeholder groups will be necessary to build policies that set out what a PPC relationship would be like between them.

Expert Interviews

Following the end of the survey, we conducted semi-structured interviews with people who are experts in one or more dimensions of our project: the Canadian military or its health services branch, patient partnership in healthcare, or IDEA principles. From the interviews, we hoped to learn about organizational change and PPC- or IDEA-implementation initiatives, with focuses on commonly encountered obstacles or practical examples that contribute to the success of such work.

Nine experts were interviewed between September 21st and September 30th; five experts were 'internal' and had familiarity with Canada's military or its health services, and four experts were 'external'. We developed two sets of questions – one for internal experts, and one for external experts (please refer to Appendices E and F for the respective interview questions). The questions in both sets were general, so that the experts could give answers that reflected their expertise in healthcare, IDEA, or the military. Immediately after each interview concluded, we individually produced short memos capturing our initial impressions of the content and the connections we may have made to the other research. We then later coded the interview transcripts (see Appendix G for the list of codes). The codes for the interviews were developed based on some of the most common themes raised from the survey coding.

What did we learn?

We were able to identify several common themes between the coded transcripts and the analysis of post-interview memos. The experts emphasized that successfully implementing organization-wide change initiatives requires a commitment of resources, including specialized knowledge or perspectives. But, as experts pointed out, a resource commitment on its own is not enough to meaningfully bring about change in the area of PPC. There are two other needed elements: engagement structures and a supportive organizational culture.

Organizations looking to embed patient-partnership in their care model require clear, formalized engagement structures "in which individual providers or healthcare organizations solicit patient needs and preferences" to make sure the health services being offered are appropriate (Fooks et al., 2015). As one interviewee explained, without formalized engagement structures, truly understanding patient needs and preferences "just [isn't] going to happen, [healthcare workers] just [can't inherently] know that stuff". The framework developed by Carman et al. (2013) shows that patient engagement can happen at multiple levels – in direct care, organizational design, or in system-wide policy making – and to varying degrees. Because of the many levels for engagement, the type of structures used may vary. As one interviewee said, "[e]ngagement looks so different for different people in different organizations and where they're at [in the PPC process], and it doesn't mean that they're doing it wrong – they're just doing it differently." Engagement structures may include, but are not limited to: post-service quality evaluations; advisory councils; patients (or other individuals with pertinent lived experience) as members of hiring panels or governing bodies; or recruiting patients to join collaborative service re-design initiatives (Fooks et al., 2015). As one interviewee noted, when it comes to engaging with patients who may be underserved by health services, "it's so incredibly important to think outside the box on how to connect with those vulnerable groups […] to ensure that their voice can be part of it." In terms of Canada's military healthcare system, there are some existing structures that can be enhanced or built up to fulfill this engagement function, as explored further in Chapter 4.

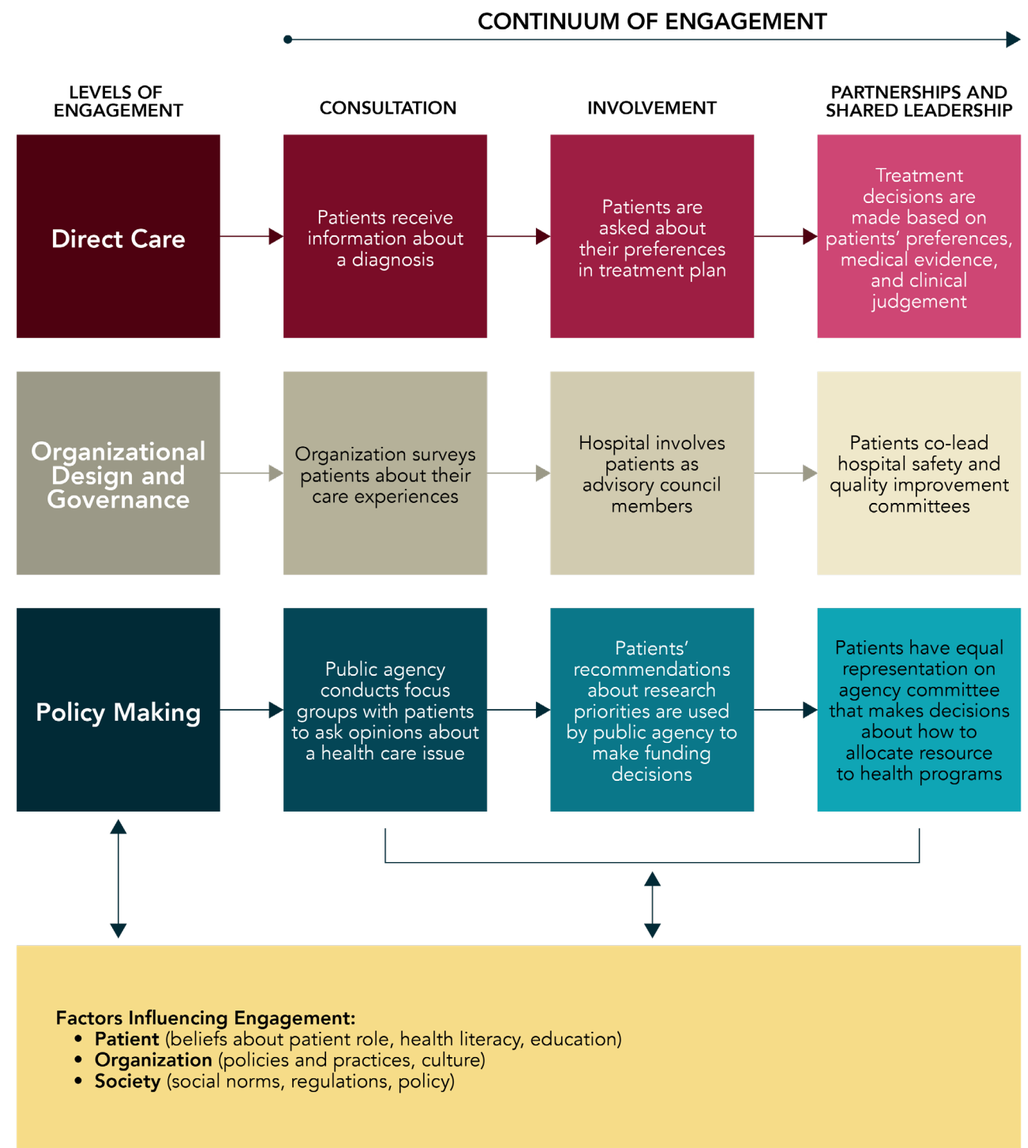


Figure 6: *Framework for patient engagement in health (Carman et al., 2013)*

Experts highlighted that healthcare organizations also need to have a culture that is conducive to patient-partnership; "[a]t the end of the day, […] it's about a shift in culture within the organization […] in order for [PPC] to work." One necessary element of this culture shift is collaboration because, as one interviewee explained, PPC is "a whole team approach" in which "patients, families, providers, stakeholders […] are all players." This means that an organization's policies and practices need to be set up in a way to allow for cross-role communication and decision-making – including having dedicated mechanisms to incorporate feedback from engagement structures. The requisite organizational culture could also be described as one that continually learns and strives to improve in order to respond to changing patient needs and external environmental factors. Features of a supportive learning environment involve elements such as establishing time for critical reflection, instilling psychological safety, and being open to new ideas – from both within and beyond the organization (Garvin et al., 2008). Building a sense of psychological safety in the organization is characterized by people being able to admit mistakes, uncertainties, and doubts, as well having space to be more open about themselves – all without fearing reprisal or judgement.

This 'openness' and psychological safety can help to foster a mentality of trust and respect, which are crucial elements that underlie the engagement process in PPC. As one expert who works in the field of patient engagement emphasized, "[y]ou have to form really good relationships and trusting relationships; you're dealing with people that have been harmed by health systems, and [have] lost trust [in it]." Expanding on that: if people do not feel respected or safe to be their full selves, it will be harder to engage with them in a meaningful way. This is especially important for people (especially patients) with non-normative identity elements who, consequently, may be underserved by current systems. As one expert noted, "the development [process] of services must reflect the [patient] population," which is why, as another expert explained, "[e]quity, diversity, and inclusion are really important, but it's really hard [...] to create and think of different ways to partner so that we're ensuring that we are capturing the voices of as many people as we can."

The experts' comments about the importance of trust and respect, especially with groups that may be considered non-normative, echoes the survey findings. Through the survey, we received several responses about the tensions and the perceived lack of trust between patients, providers, and employers – especially ones from non-normative communities. This could be one explanation for why the current patient-partnered care model failed to take root in the military's health services branch. Consequently, for PPC to be realized going forward, there will first need to be strong, determined progress towards the re-establishment of trust, especially among communities that have been marginalized. Trust is a key element in relationships and as one expert said, PPC "is about […] breaking down those silos and building relationships between your team, between your patients, between your community, between the organization." Working to become an authentic learning organization can both help the military's health services branch to become more agile and adaptable, as well as psychologically safe and supportive of a PPC model (Garvin et al., 2008).

Workshop

While our previous methods relied upon collecting information about the current state of military healthcare, we wanted to be able to involve users in the building of an IDEA PPC model. That is why we decided to pursue a collaborative virtual workshop where participants could give feedback and constructive opinions in a self-directed manner, rather than one prescribed by the researchers. We recruited workshop participants from the pool of 146 survey respondents who had been interested in being contacted about further study opportunities. We initially had planned to do multiple virtual workshops – ones dedicated for patients, providers, and employers. However, to maximize the number of people who could participate, we pivoted to running a single asynchronous virtual workshop. (Please refer to Appendix H for the outline for the real-time workshop and to Appendix I for the real-time workshop questions.)

We ran the asynchronous workshop on the Mentimeter platform from November 8th to 15th, 2021. It received responses from 15 participants. In response to our questions (included in Appendix J), participants could submit answers in the form of "top 3 words" or short free-text. At the end of the workshop slideshow, participants were able to see representations of the anonymous responses to each of the questions. For instance, the responses to the "top 3 words" questions were represented as word clouds. We also permitted (even encouraged) participants to submit more than one response over the course of the workshop so they could reflect and respond to others' ideas, as they would be able to do during a real-time 'live' workshop.

The design of both workshops was based on foresight principles and used the Three Horizons model (International Futures Forum, n.d.). Foresight, as a practice, is a way for people to imagine, design, and envision what potential futures might look like based on any number of changing conditions. Using foresight was appropriate because the model of IDEA PPC healthcare would not and could not take place in the present day. It would be situated in a future that is still emerging, being shaped by the many ongoing social and political events whose impacts have yet to fully unfold.

The purpose of the Three Horizons framework (illustrated in Figure 7) is to explore what is happening in the prevailing current state, what might be happening in a future state, and what would happen in the interim period to support or to impede the transition from one to the other. It is a framework that is often used in business planning and preparing for change projects, so we thought it could be useful in a context of health services planning and change projects. We used Kate Raworth's (Goodwin, 2020) Three Horizons guide to structure our asynchronous workshop, but we adapted some of the prompt questions to be more strengths-based. To make sure participants were on the same page, we set the context of the future state as being 7 to 10 years from now. To inspire participants' best hopes for this future state, we asked them to imagine that an IDEA PPC model of healthcare had been successfully co-created, implemented, and widely adopted in the military.

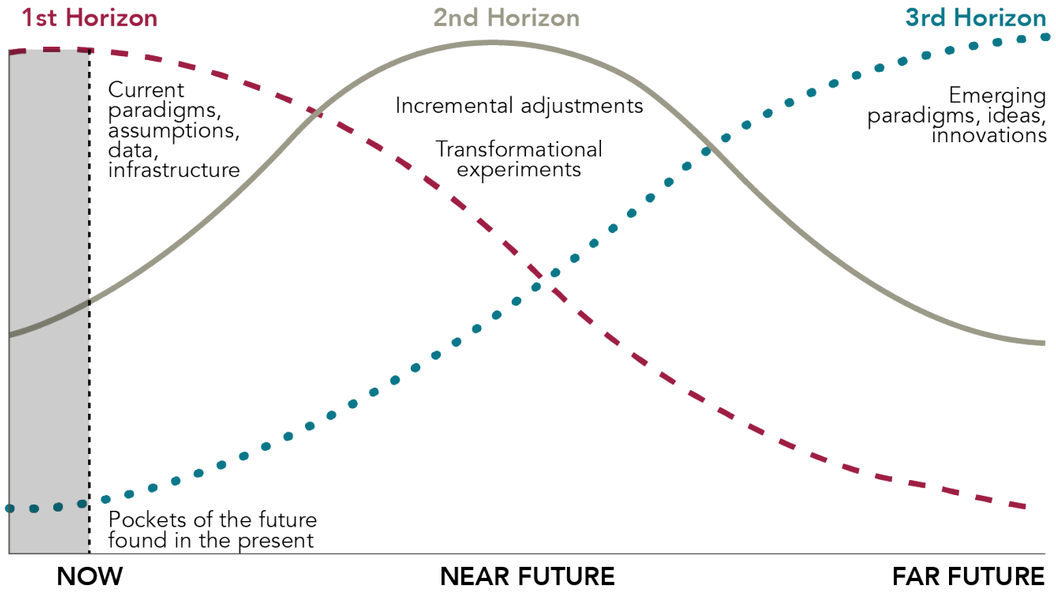


Figure 7: *Three Horizons framework (International Training Centre, n.d.; Sharpe et al., 2016)*

What did we learn?

There were several findings from the workshop, spread over each of the horizons.

While we had already collected a lot of information and research about the current state of military health services, we still asked questions in this area to form 'Horizon 1'. Doing so would help reintroduce participants to our topic area and would serve as a segue into the next horizons of the model. As findings in this horizon, respondents (re) identified several barriers to military health care; this reaffirmed information that was collected in previous phases. Unlike previous methods, we also asked what about the current military health services system is useful or beneficial. Highlights include:

- Having quick access to basic medication through 'sick parade' (a short-duration, same-day military triage system for acute ailments. It is similar in function to civilian walk-in clinics);
- Offering mental health supports, which is an important but often neglected element of healthcare;
- Permitting dialogue and knowledge exchange between medical providers and between providers and employers.

These well-regarded elements of military health services should be kept in mind, and hopefully maintained, in future iterations of health services.

The next part of the workshop was about 'Horizon 3', the still-emerging future state. We set-up this 'future state' as 7 to 10 years from now, and where an IDEA PPC model of healthcare had been successfully co-created, implemented, and widely adopted in the military. This open-ended prompt gave participants the space and freedom to define what this future and its military healthcare system would look like to them. This element was important because the military's current clinic model document strongly states the adoption and use of a patient-centric model, but does not describe what this would look like in practice (Canadian Forces Health Services Group, n.d.). While the practical details may be absent in the current clinic model, the examples generated from this workshop activity may be a good starting point. The point of this horizon was not to come to a consensus, because when asking a diverse group of people what they hope to see in the future, there could not be a singular 'right' answer. The purpose is to paint a broad picture of what might be possible or preferred in this future.

When workshop participants generated the key characteristics of this future healthcare model (as represented in Figure 8), many of the terms used are opposites of or are responding to the current system's shortcomings. If these characteristics are desired traits in the future, then the present state will need to change to align to them. One way this could be done is by making the characteristics the basis for metrics or quality standards. The metrics or standards could be used to track overall healthcare quality in individual clinics or the system, or as progress markers in healthcare redesign initiatives. Further consultation and engagement with different stakeholders would be necessary in order to understand more fully the practical implications of these characteristics. For example, what would it mean to have a military healthcare system that is streamlined? Or personalized? Or one that is family-focused or not based on gender? How would that impact the people and the process of healthcare? As mentioned previously, the practice of intersectional inclusive design may offer a way to explore such questions in depth.

Figure 8: *Word cloud of the key characteristics of the healthcare system comprising Horizon 3*

The final part of the workshop was about 'Horizon 2', the phase that represents transformation from the current state (Horizon 1) to the defined future (Horizon 3). The purpose of this phase was to identify what supports may be needed to bring about change towards an IDEA PPC system. Although Horizon 2 is numerically and chronologically between Horizons 1 and 3, it is deliberately done last in the workshop. This is because the start point (current state) and the end point (desired future state) need to be defined first before making plans about how to go from one to the other.

There were a few particularly interesting outcomes from our workshop's Horizon 2. One was about where the transformation would be needed and what tools would be needed to support the transformation.

Participants identified a few areas that would likely undergo change in Horizon 2. These areas touched on elements of economics, policies, technology, culture, or social norms. Examples include:

- Investing in personnel and equipment, to address low or insufficient capacity in the health services branch;

- Having needs of non-normative communities be deliberately considered or prioritized at the outset of decision-making, not added as an afterthought;

- Overcoming geographic barriers to provide healthcare to members not on/near a military facility;

- Building transparent policies and embedding mechanisms within them for patient engagement;

- Encouraging providers to step outside of their comfort zone and expand their knowledge base, rather than default to making referrals to specialists; and

- Understanding and accepting that a person's identity is more complex than binaries.

From the suggested areas for change, the tools to make such changes might include:

- Extensive policy revisions and updates to standards of care to account for the role of engagement mechanisms and diverse identities;

- Increasing or redeploying resources – such as funding, staff, facilities, or IT infrastructure – to meet the changing needs of the system;

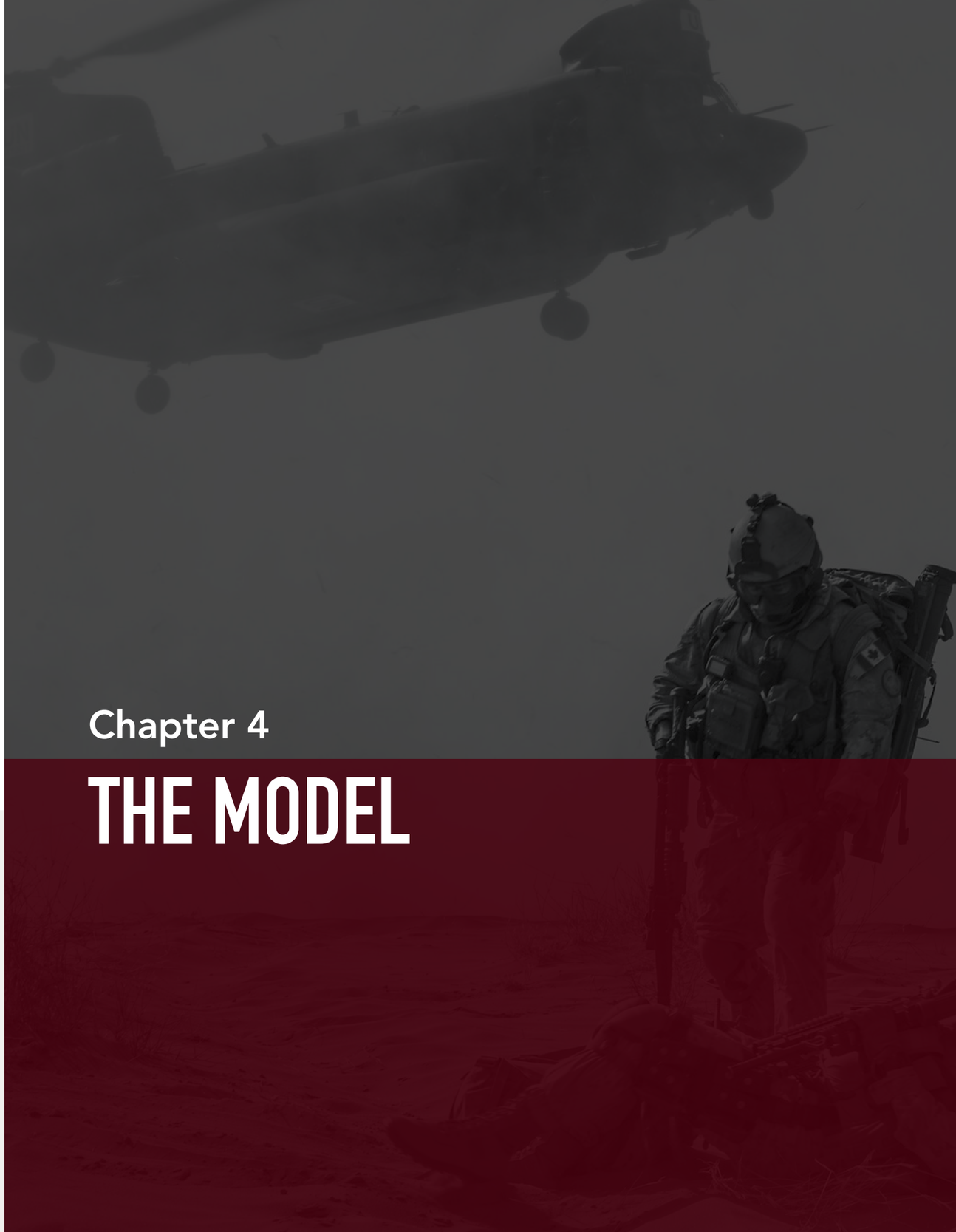
- Embracing the nuances of identity by replacing identity binaries with more choices – on forms, in electronic health records, and in decision-making flows;

- Running a breadth of IDEA-related education and professional development opportunities; and

- Conducting research and collecting data to make evidence-informed leading practices.

Another interesting finding from the workshop was who participants would hope to see involved in the change process. Participants emphasized that they hoped 'patients' could be involved, alongside a wide range of potential change agents (as illustrated in Figure 9). Some agents were from high levels of leadership and other agents were less frequently involved in systemic change initiatives – including the collective Defense Advisory Groups, educators, and members of the reserve force. This range of responses indicates that respondents had a broad awareness about who may be impacted differently by military healthcare, or whose experiences and perspectives would be valuable to consult. However, this list of prospective change agents is not exhaustive. There are many other groups that could have information that might be useful, such as external organizations with a strong understanding of PPC, or other militaries. When it comes to implementing IDEA PPC or other service redesign initiatives, many of these groups should be involved and intentionally engaged in planning, designing, and carrying out the change.

Figure 9: *Word cloud of the desired change makers, identified from Horizon 2*



Chapter 4

THE MODEL

THE MODEL

Each of our research tools produced findings that contribute to the overall picture of an IDEA PPC model for the Canadian military's health services branch. The findings were derived from the responses and comments of 318 participants and nine experts, which is a sufficiently large enough group that our outputs can have some statistical relevance.

In this section, we have synthesized our findings into an initial model of IDEA PPC and generated some approaches for how it may be implemented by the health services branch and the military. For ease of communicating this model and its implementation options, we populated a Three Horizons framework to represent the desired state and the transition to get there from the current state.

Horizon One: The Current State

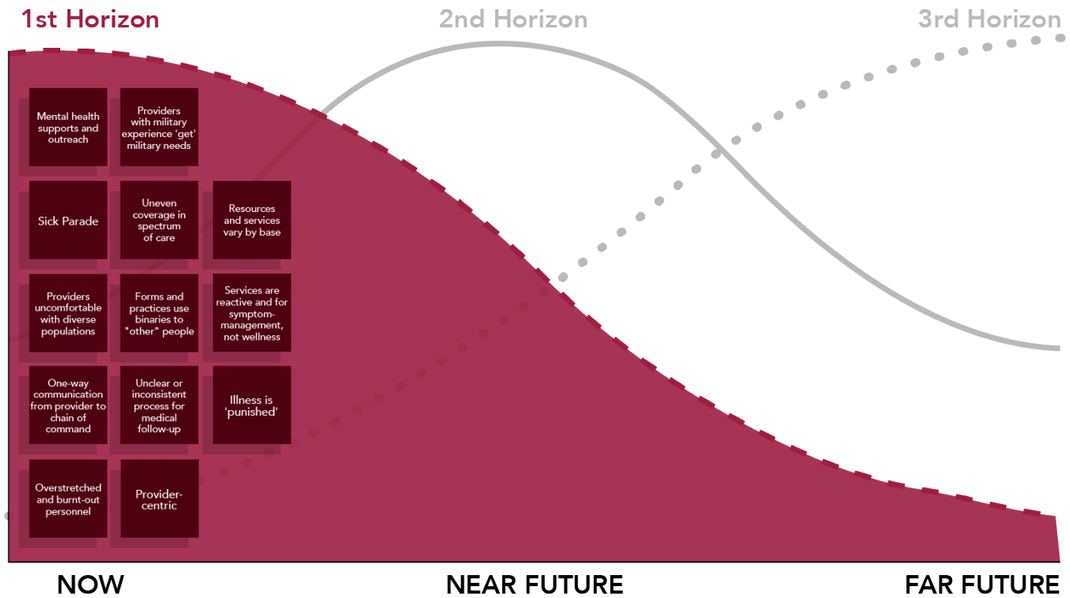


Figure 10: *Representation of the current state of the military health system (Horizon 1)*

The present-day structure of the Canadian military's health services branch is based on a policy document that espouses a patient-centric care framework. The document is well prepared from a conceptual perspective. It acknowledges that patients, providers, and employers have different perspectives within the health space that need to be accounted for. The guiding principles of the model involve "putting the patient at the forefront of service design" and "[d]ecentralizing decision-making and the delivery of services" so that individuals can have a role in the process (Canadian Forces Health Services Group, n.d.).

Unfortunately, when it comes to wide-reaching change projects, "[y]ou do not rise to the level of your goals. You fall to the level of your systems" (Clear, 2018). That is to say, although the document had set out ambitious underlying principles for the health services branch, it did not have sufficiently developed expectations for what PPC would be like in practice. This meant that the document prescribed a rigid process to standardize experiences with limited engagement mechanisms. With so much of the implementation up for interpretation, the resultant systems failed to live up to the hopes of PPC.

Understandably, participants had mixed feelings about the current state of the health services branch. A few of the main advantages of the current system, as identified by participants, are:

- the inclusion of mental health supports;
- the presence of healthcare providers with military experience, who 'get' what being in the military entails and can tailor their communications and approaches to treatment accordingly; and
- the opportunity to receive same-day treatment or simple prescriptions through sick parade.

The current system has several notable drawbacks, as well. Although the clinic model document acknowledges many features – such as the ease of appointment scheduling and choice in provider – as being important to the ideal patient care experience, these same features were identified in the survey as having significant barriers (Canadian Forces Health Services Group, n.d.). These drawbacks can take the form of:

- difficulty in booking an appointment in a reasonable timeframe and limited choice in provider;
- uneven treatment coverage in the spectrum of care for different roles;
- uneven resource allocation, leading to inconsistent services and expectations from location to location;
- knowledge gaps, biases, or microaggressions against people with non-normative identity elements; and
- services generally being 'reactive', oriented around injury recovery and returning to work, rather than being 'proactive' and oriented around long-term wellness of members.

However, the most deeply entrenched downsides of the current health system are based on how closely interrelated it is with the field of military employment.

Our research highlighted tensions based on the role that the health services branch plays in providing strategic or occupational advice to the military. For example, if a patient is injured or ill, a provider may put restrictions on the patient and their job so they can receive treatment and return to work when suitably recovered. When needing to share a patient's health-related occupational restrictions to employers, providers have a unidirectional communication process known as a chit. Many employers considered this communication process to be unclear, jargon-heavy, lacking in formal opportunities for dialogue, and insufficient for their needs. As one interviewed expert explained, "we often have the situation […] where a chain of command [employer] is uncertain of exactly what the chit means, or [has] questions about how they can safely employ the individual within these restrictions," which may be resolved through "informal conversation[s] between the employer and the healthcare provider." Patients also had many concerns about this process because they are not involved in the provider-employer interaction; consequently, they have doubts about whether their confidential health information is really being protected from their employers. Health privacy policies in the military prevent the release of patient information without express patient permission, however these policies are not widely known by patients, and providers actively opt to not disclose the information at all, rather than seek permission to disclose it. All in all, the organizational advising function of the health services branch

have processes that are poorly understood. This contributes to patients and employers feeling left out of the conversation with providers, and the building of frustrations and distrust.

There are also tensions based on the military's universality of service policy, which requires members to meet certain expectations or standards for deployment (Government of Canada et al., 2006). In the words of one interviewed expert, "[i]f you cannot deploy [on missions], you cannot serve in the Canadian Armed Forces under the existing regulations of the universality of service." A person's ability to be deployed is gauged by their mental fitness, their physical fitness, and if their health needs can be met by the operation's personnel, resources, and policy. If the health needs of a member have the potential to get them deemed 'undeployable' under the universality of service policy, the member may feel like they are risking a suspension or a discharge from the military for seeking healthcare to address the concern. On the flip side, one expert pointed out that "the [financial] benefits of [...] a medical release, compared to a voluntary release, are significantly greater for the medical release; it would almost be irresponsible for an individual to request a voluntary release, rather than pursue a 3B [medical] release." Taken together, these conditions under universality of service make the military healthcare system punitive for people who need its services and rewarding for people who do not need its services but who can afford to be released (Government of Canada et al., 2006). This further contributes to the sense of distrust between providers and patients, who are doubtful or wary of the intentions of the other in care interactions.

Given that military healthcare does not work well enough for everyone, even at the best of times, means that systemic redesign is warranted. Under current stressors such as the COVID-19 pandemic, systemic racism, and ongoing sexual misconduct, it can be said that the military health services branch is operating in conditions that are far from optimal. In the months and years ahead, circumstances are not likely going to become any less complicated or strenuous, so the system needs to adjust accordingly.

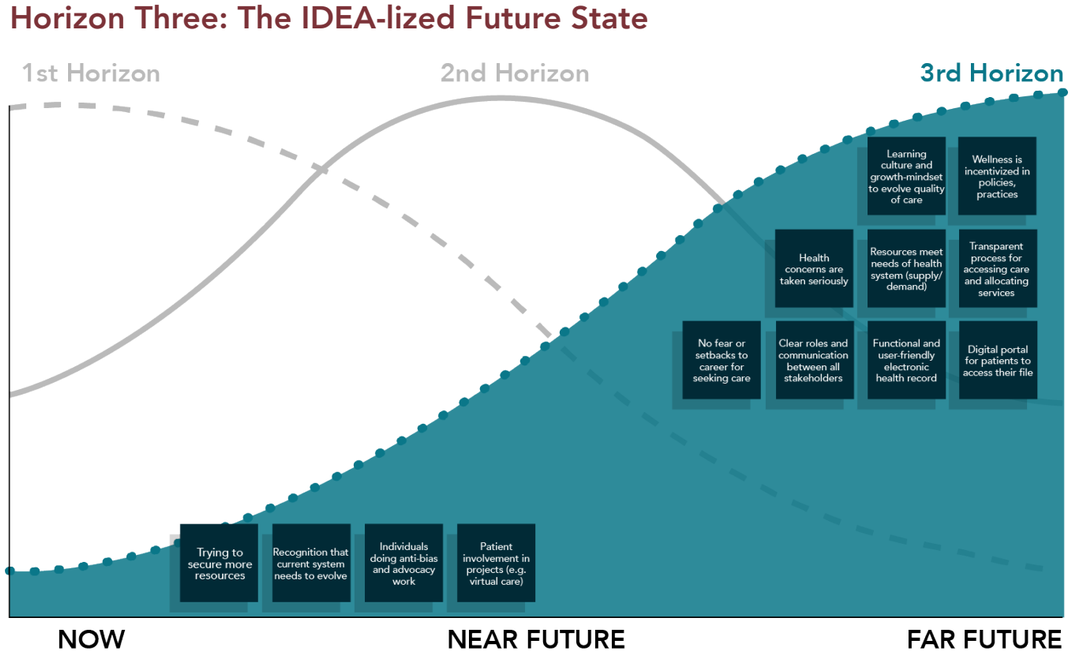


Figure 11: *Representation of the desired future state of military healthcare, and some of its present indicators (Horizon 3)*

From early in the research process, we noted that people and policy lacked a shared understanding about what the health system's current patient-partnered care framework should be like. When it came to defining a vision for a new model of IDEA PPC, in keeping with our foundational principles, we decided not to define this ourselves; we asked people who would be impacted about what in the system design would be meaningful to them. During the workshop, when we asked people to envision the desired future state of military healthcare, we set a 7 to 10 year time horizon. This time horizon was used to contextualize or ground the activity, not to impose a deadline on the health services branch. We chose 7 to 10 years in particular because it was far enough from the present for people to imagine without being tied down by present-day constraints, but not too far into the future for circumstances to be unfamiliar or too uncertain. The health services branch or military leadership may have other timeframes in mind for taking action; different timeframes may have different implications on the end state and the action plan.

Throughout the research process, people spoke, and we listened. When we asked people what they hoped or believed an IDEA PPC model should be like, many people listed elements that generally constitute 'good healthcare' experiences: short wait times; clear ways to access services; feeling that health concerns are understood and addressed; integrated care between providers; and being informed about all aspects of their care. These are all valuable elements that should be worked towards. However, IDEA PPC is meant to be more than just good healthcare; it represents active co-ownership or a shared accountability of a patients' health in a manner that accounts for and accepts individual identity.

Defined Roles

For IDEA PPC to be possible in the military context, the policies and structures as expressed in the clinic model document would need two main revisions. Firstly, the process for engagement and decision-making would need to reflect clearly defined roles for patients, providers, and employers. The current structure document barely touches on employers despite employers having "both a duty to accomplish a mission but also a responsibility to ensure the recovery of the individual [patient]," as one of the interviewed experts noted. Therefore, in an IDEA PPC model, all three of these groups "hav[e] the ability to provide input into these decisions" which requires mechanisms for open communication and dialogue. Over the course of our research, there was one often-raised suggestion to improve communication and information sharing: upgrade technology in the health services branch. This would open the possibility of having a user-friendly electronic medical record - an idea that patients also quite liked, especially if there was potential for them to be able to view their medical information through a virtual portal.

Another element of military healthcare that could benefit from enhancing communication mechanisms is the process where members have health-related restrictions on them and their job. Formalizing a dialogue-oriented approach between all parties could help bolster trust and transparency. An example to consider is from outside the military: the accessibility accommodation process in post-secondary education in Ontario. The accommodation process in post-secondary education is similar to the health-based job restrictions in the military, but the important distinction is in how the multi-stakeholder collaboration is more transparent. In those cases, a student meets with an accessibility coordinator to explore the student's needs and what accommodations would best support their participation and success in school. Once agreed upon by student and coordinator, these accommodations are listed in a letter that is then shared with the student and their instructors. If an instructor requires clarity on the implementation of accommodations, they can discuss the matter with the student or with the coordinator. The coordinator is also able to advocate for the student's needs to the instructor and the institution more broadly. While the accommodation process in post-secondary education has its own pitfalls, it may inspire the military to consider looking at other settings for tools, or processes to support dialogue between the various stakeholder groups of patients, providers, and employers.

Entrenched IDEA principles

The second way in which policies and structures would be different in the specified future state is that they would intentionally seek perspectives from non-normative communities, thus advancing IDEA principles in the organization (Brown, 2018; Mitchell et al., 2018; Roy, 2015). This objective could be achieved through the culmination of a number of elements. One element could be the clinic model document. It currently has a well-developed section about the principles underlying care, which could be built upon to incorporate IDEA principles explicitly. This would then need to be translated into action in the form of IDEA-specific engagement mechanisms and decision-making at the leadership level. An IDEA-specific engagement mechanism could be developed by leveraging the network of Defence Advisory Groups. These currently are voluntary groups within the military and the Department of Defence that act as a voice for select communities within the military, including women, racialized members, Indigenous members, 2SLGBTQIA+ members, and people with disabilities. As one interviewed expert explained, "[the Defence Advisory Groups] advise on a number of broad issues" that members in their respective communities may be experiencing and then "provide advice or guidance, if requested, as […] [units or teams] develop policies or processes around resolving the issue that's been identified."

The local chapters of the Defence Advisory Groups collect information, then the regional groups aggregate it and present the findings to the military leaders. This widespread information gathering and reporting function makes these networks ideally situated to have a larger and formalized presence in the health services branch.

Focused on Wellness

Ultimately, the envisioned notion of IDEA PPC goes beyond 'good healthcare' or more robust communication and engagement mechanisms. Even if all these features were to be implemented, they do not necessarily address one of the biggest underlying sources of distrust between patients and the health services system. There needs to be a cultural change in how the health services branch does its work. While patients fear reprisal or risk career setbacks simply for seeking healthcare under the current system, this is not what participants desired for the future. In the future state, the system structures, policies, and practices should be intentionally incentivizing wellness rather than punishing people for illness or injury.

Shifting towards a wellness focus is not a simple task and would likely involve a number of parts. For example, health protocols may be updated to move away from reactive treatment or simple symptom-management towards a proactive, preventative approach. Provider skillsets and facilities may be expanded to treat a wider array of chronic conditions, rather than just acute injuries or ailments. The spectrum of care may also cover additional services, which can include massage therapy, counselling, hormone therapy, Indigenous health and wellness practices, and procedures related to gender transition. Wellness may be incorporated into a variety of performance metrics that are used across the organization, with corresponding professional recognition for increasing or sustaining a unit's reported wellness. These are just a few ways to approach a wellness focus, but there are likely to be many more methods that should be considered too.

This expansive vision of military healthcare is not simply the product of wishful thinking; just as the military is grappling with the need for culture change, there is already an awareness in the health services branch that its current model is inadequate for all the current members' needs. If no changes are made to the system, it may continue to perform to similar levels far into the future, which may not be acceptable, especially if the military hopes to recruit and retain more members from diverse communities. There are signs that work is already being done in the health services branch to improve the system, but it is being done in pockets with limited centralized coordination. For example, the health services branch pivoted to some virtual care methods in the face of the COVID-19 pandemic, and the related working group consulted some patients in this process. In other cases, individual providers or teams are taking anti-bias or cultural competency training. These are all good steps, however, intensive and intentional nurturing is needed on the part of the organization in order to bring about wholesale culture change, as many of the interviewed experts emphasized. Given that the military and the health services branch have exhibited the motivation, it is quite possible that the seeds we observe in the present may grow into the change participants want to see.

Horizon Two: The Journey

The military's health services branch has been in higher-than-usual demand, and this will likely be the case for the foreseeable future. Its capacity is being heavily strained by responding to the COVID-19 pandemic and coping with internal changes led by the Professional Conduct and Culture branch. All of this is in addition to its current and pending defence operations. We acknowledge the inherent difficulty of these situations, but we feel these can be a crucible, a test of the adaptability of the military's healthcare system. We have high confidence that the military can rise to the occasion.

Changing to an IDEA PPC model is possible because we believe that there is motivation and impetus to do so. First, in our project, we had overwhelmingly high response rates. Participants from across the military were deeply moved by and interested in improving their healthcare system. Further, the health services branch has a time-tested commitment to continuous quality improvement through its status as the only accredited health system at the federal level. Patient-partnered care is one notable element in the accreditation criteria. The work of IDEA PPC also aligns with both the defence policy and the directives from the Chief of Defence Staff and Minister of Defence (Brewster, 2021d; Stone, 2021). There are many reasons why the military should want to pursue IDEA PPC, but the question remains: when should this happen? While it might be nice to say 'immediately', we know a change of this scale takes time. Results may not be apparent in the short term since, as mentioned previously, the health services branch already has a lot of competing priorities and obligations to contend with. Therefore, implementing IDEA PPC is likely to require a longer-term game plan. In this section, we outline some activities that may be suitable next steps in the journey to the desired future state of IDEA PPC.

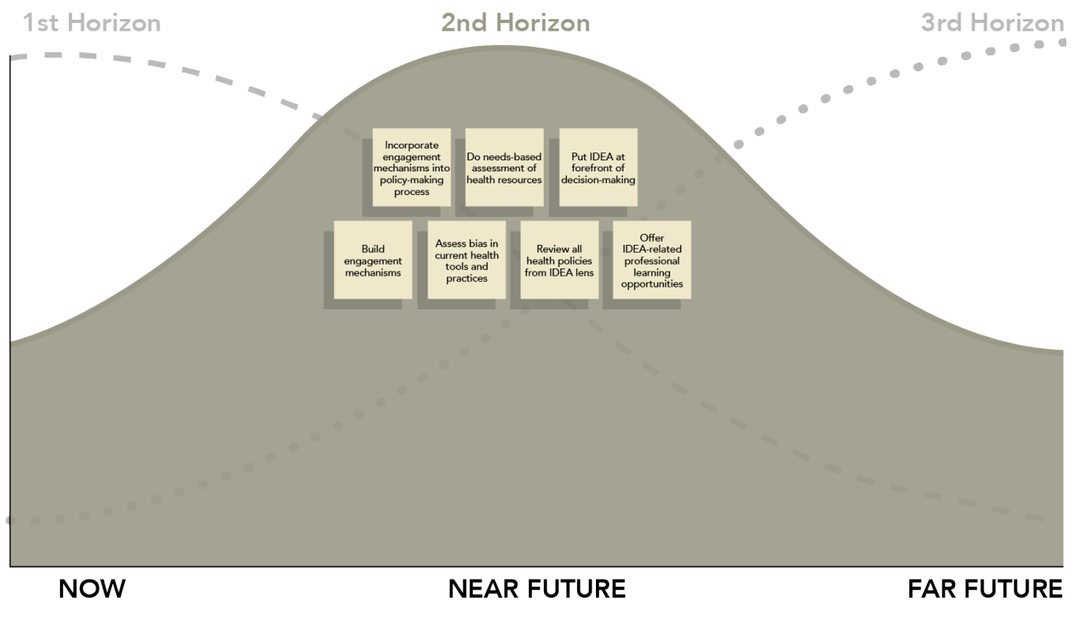


Figure 12: *Representation of the activities that may be required to arrive at desired future state of military healthcare (Horizon 2)*

Clarify the Destination

The best first step to moving towards a future of IDEA PPC would be to continue where this research ended: building a more detailed vision of the future state of military healthcare. Our project received input from over 300 people and resulted in an initial design. The military is an incredibly large organization with an influential presence across the country, and even around the world. Each clinic in the health services branch is different; they support unique populations, have different infrastructure and resources, and are in very different states of readiness for IDEA PPC initiatives. As such, our initial design should be expanded and built upon to consider a wider audience by facilitating further workshops to validate or revise the work done. There is great value in reaching out to people and communities that we were unable to access, in order to understand their specific needs and hopes for the system. This vision of IDEA PPC can be iterated upon through running our workshop again (or as many times as needed). The asynchronous workshop may be suited to understanding broad conceptual elements of the model whereas the real-time workshop could go further into depth with a specific community or about the design of niche processes. Design tools other than the workshop may also be used to this end, but whatever is used should be sure to include patient, providers, and employers along with other prospective change agents, as identified in the workshop.

Invest in Relationships

Another important, ongoing step would be to strengthen the connections and trust that patients, providers, and employers have in each other and in the healthcare system. Relationships between these roles matter because "[e]fforts to transform healthcare culture require robust, multi-pronged efforts at all levels of the organization; leadership is only the beginning." (Bokhour et al., 2018). Relationships are also important because everyone has a role to play in PPC (Ogden et al., 2017); "consider[ing] patient-centred care as inherent to specific positions […] risk[s] undermining patient-centred care implementation by limiting transformational initiatives to specific providers" or teams, thereby reducing the likelihood of collective uptake in practice (Fix et al., 2018). Many patients, providers, and employers see the value of moving towards IDEA PPC, but doubt that the system and leadership feel similarly, or have the same motivation. Overcoming those doubts and skepticism will require leadership in both the health services branch and in the military to show their commitment and support of this endeavour. This will have to be done differently than other times when leadership is called upon to support a change – not just in the form of buzzwords or speeches 'when convenient', but in actions large and small. This may take the form of seeking knowledge-advancing opportunities, or making spaces for ongoing discussion and dialogue, or otherwise showing that leadership is willing to change themselves. IDEA PPC and the associated culture change needs to be sponsored and endorsed authentically by the leadership and the organization as 'proof' to people that this change is seen as worth making, and for the right reasons.

We also recommend working closely with groups such as healthcare industry leaders, advocacy networks, and/or universities to strengthen connections between military healthcare stakeholders. One option is to further work with the local Defence Advisory Groups, which are networks of people with extensive expertise in IDEA matters who have cultivated trust on a local level with individual military members or teams. Both their expertise and the established trust make them ideal liaisons through which to reach out to and solicit feedback from non-normative communities. Regularly reaching out to or running facilitated events with impacted stakeholders may become the basis for building engagement mechanisms, possibly evolving into a formalized patient advisory council. Our workshop process may also contribute to building empathy among the triad of patients, providers, and employers, which are conditions for stronger relationships and buy-in to reinforce the future system. After all, if people have helped design something, they are more likely to be invested in supporting it. Reaching out to external groups is an important part in being a learning organization. Such partnerships not only can help with community outreach, research, and knowledge translation, but they expose the military to new perspectives and practices. The act of seeking out and acknowledging the value of these players can play a critical role in the military begin situated to approach repairing the distrust within the organization from an authentic and humble place.

Review Policies and Practices

The next phase of work can only meaningfully begin once some headway has been made in addressing the relationships with stakeholders. Engagement would need to be incorporated into the policy processes, especially mechanisms that can assess for bias in current health tools and practices. A comprehensive review of the policies in the health services branch would be an extremely beneficial, albeit daunting, task. To start, we would recommend a review of the foundational clinic model document (Canadian Forces Health Services Group, n.d.). In our literature review, we found this clinic model document to be incredibly progressive for its time, with a vision of integrated patient-centred care. However, some elements of it are out of date – such as its presentation, language, and concepts. The intentional use of an IDEA lens and the expansion to PPC (thus reflecting the multiplicity of roles) can bring this policy document, and other subsequent ones, to where it needs to be to serve the entire Canadian military community.

Build Outlets for Engagement

The realization and operation of IDEA PPC will rely on the presence and use of meaningful feedback mechanisms. Such mechanisms will also be key to the journey of instilling IDEA PPC because even though "talk about patient-centred care is ubiquitous in modern health care, one of the greatest challenges of turning the rhetoric into reality continues to be routinely engaging patients" (Barry & Edgman-Levitan, 2012). According to the clinic model document, the health services branch "supports patient-centred care through the following: patient-satisfaction surveys; Collaborative Practices and the associated case conferencing; and the CF Health Record." (Canadian Forces Health Services Group, n.d.). This is a good starting point to see patient needs and build communication mechanisms between providers and patients. However, these need to be expanded upon. As an example, the military's current patient satisfaction survey does not disaggregate identity traits, meaning that the results collectively skew towards the normative category (Canadian Forces Health Services Group, 2017). Disaggregating responses by identity traits – as we did with our own survey – can offer valuable information about sub-groups within the non-normative category; differences between non-normative sub-groups or in comparison to the normative category may indicate that other factors are at play or that other approaches are needed. The patient satisfaction survey also does not account for the employer's perspective, which is an oversight that would need to be changed in an IDEA PPC model. Further, many of our own research findings echo or closely mirror the findings from the 2017 survey (Canadian Forces Health Services Group, 2017). This means that, in the four years between the military's 2017 survey and our own, there have been few discernible improvements in key areas such as accessibility, patient choice, or communications.

Without action, the health services branch runs the risk of stagnating, which will not help to repair the damaged trust within their population base. Having mechanisms for engagement that are more robust (like advisory councils or enhanced experience surveys) can produce more useful feedback for the health services branch. An important element to consider is what happens to the information when it is collected. If doing any widespread engagement on a topic (such as pandemic-related burnout, or mental wellness), having the general results be widely available may make them more usable. Some smaller projects could benefit from having such results as evidence to support or to inform their work, but may not be in a position to conduct such widespread engagement itself. To that end, it may be worth exploring or developing an easy-to-access tool or dashboards for clinics that would present aggregate IDEA-related information on various topics to aid decision-making or project designs. This pursuit would, again, require close stakeholder involvement to ensure that the end product reflects IDEA principles authentically.

Commit Resources

As is the case in many change initiatives, resources and how they are used can make or break the successful implementation of any change. The process of entrenching IDEA PPC into the Canadian military healthcare space is no exception and is likely to be quite resource intensive. The overcoming of the foreseeable obstacles and resistance to change in organizational practice is worthy of an entire study of its own. One of the keys to success will be to incentivize the change itself. Incentives can come in a variety of shapes, from formal honours and awards to informal simple thank you notes. These will also be important considerations in the maintenance of an IDEA PPC system, particularly if pivoting to a wellness-oriented purpose. In addition to this, under a PPC model, resources will need to be planned and managed in an agile manner. The services will need to adapt to the changing health needs of members, so the right kinds of resources will need to be made available in response. This means that assessments of needs will have to be done on a regular basis, in order to know where and what kind of resources are required before they can be allocated appropriately.

In conclusion, there is a lot of work ahead of the military and the health services branch to design and then to implement a model of IDEA PPC. The upside of this undertaking is that the model outlined here is adaptable; the end vision can be re-iterated and clarified through ongoing engagement, and then the mechanisms, practices, and policies can change accordingly. While some people may feel put off by this process not having certainty or sure answers, the ambiguity is one of the best ways to have the flexibility that is needed to stay relevant to the needs of individual members, and the organization (Aiken & Keller, 2009; Beer, 1979; Galvin & Clark, 2015; Kotter, 1995; Shin et al., 2017).

Chapter 5

REFLECTION

Project Limitations

Despite our best efforts for inclusion and representation, this project was limited by several factors including language, financial resources, access, and trust.

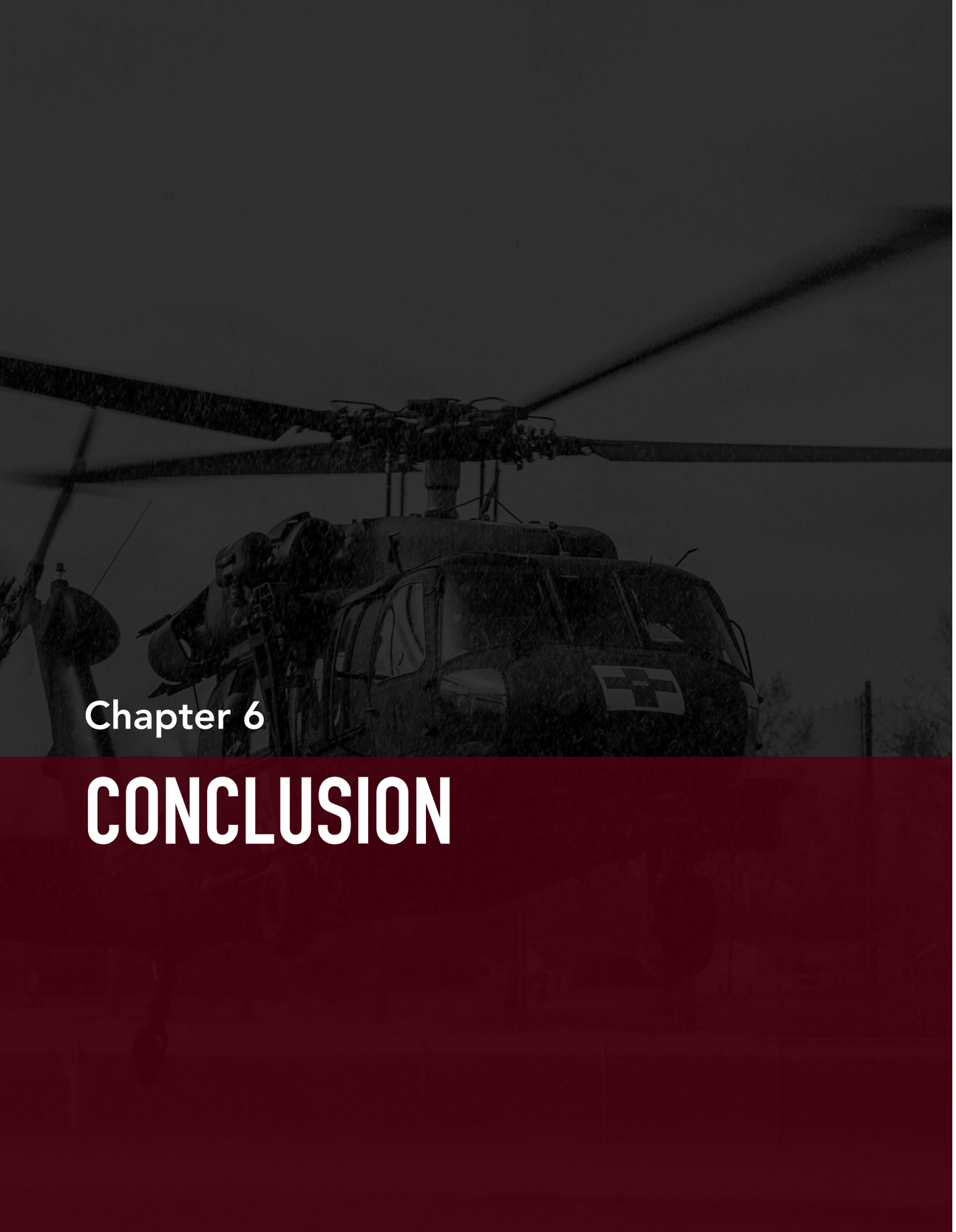
While the Canadian military, as a federal agency covered by the Official Languages Act, is required to operate in both English and French, our study was not able to do so (despite our wishes otherwise). We knew our own skills in this area would not be sufficient to support francophone individuals, and we did not have resources for official French translation or interpretation. Our project's inclusion criteria that required participants to be comfortable communicating in English had the effect of being a barrier to participation for French-speaking members, unless they could otherwise communicate in English.

This study's second limitation was resources, specifically funding. This project did have some expenses, but we did not pursue sponsorship or grants to offset them. Had we acquired funding or grants, we could have explored additional technology avenues, such as specialized coding software or participatory co-creation platforms. Funding could also have gone towards translation services; having all aspects of the project, from recruitment materials to final report, in both official languages would have provided a more equitable approach for some participants and would have increased the relevance of our findings.

This study's third limitation is the (in)equitable access to participation opportunities. The project was conducted entirely virtually, permitting us to connect with a high number of participants over a vast area, but this did not mean that all voices were heard. For example, we intended to reach under-represented groups in the military through general avenues of recruitment. Although we used both email and social media recruitment, some avenues may have been less effective, or were supplemented by word of mouth. Additionally, we are aware that not everyone who wanted to complete the survey was able to do so; some military members were on operations in areas with limited access to the internet, and not doing the survey made them ineligible for subsequent study opportunities (the asynchronous workshop). While our participants ranged from across Canada (and beyond, as represented in Figure 13), we do not assume that all voices were heard; levels of response may have been lower in certain regions or communities and may not have had their perspectives reflected in the research.

Figure 13: *Map of Canada showing distribution of participants*

Finally, our research was limited by trust. Participatory research projects such as ours rely upon mutual respect between participants and researchers. While we did not notice any indications that participants lacked trust in us as researchers or our project, there were indicators in the data that the military and its health services branch writ large struggle with trust. From the outset of our work, we made it clear to participants that our work is a graduate project that is not sponsored by the Canadian military or its health services branch; our findings may or may not find traction with the military and the degree to which it results in tangible positive change is unknown. People may have been reluctant or disinclined to participate in our project simply because the impetus for health system change lies with the military – an institution in which many may have lost faith. Throughout the project, we have noted the tensions between the system and the people. Many of these tensions stem from the dual purposes of the health services branch as both the main provider of medical care to members and as the provider of strategic health-based advice for the broader military. With guiding policies containing little clarity on the roles of each stakeholder group, the system's purpose and function are most clearly seen to be working to the advantage of decision makers, people in positions of relative power. This leaves patients and others uncertain how to proceed. It was unsurprising that trust was such a prevalent theme from the research, especially among participants whose responses were in the non-normative category. We feel that the relevance of trust to the topic of IDEA PPC, especially in the context of marginalized communities within the military, merits further dedicated research.



Chapter 6

CONCLUSION

CONCLUSION

Taking Action

Based on our research, it is fair to say that there is a lot of work ahead for the health services branch in Canada's military to manifest a PPC model that incorporates IDEA principles. The 'to-do' list for this undertaking may be overwhelming, but there is one other real barrier to forward momentum: the military's 'no-fail' mindset. The military may be inclined to hold off on taking bigger steps until the IDEA PPC model and implementation plan are fully developed and perfected. However, this presumes that PPC and its requisite systems, engagement mechanisms, and relationship-building can all be 'done right' in one try; it is not possible. Refraining from changes and improvements until PPC can be 'done right' is misguided, and likely to result in inertia within the health services branch. It is important to get started and to celebrate the learning and incremental achievements along the way, since PPC is "a continuous journey of quality improvement", as one expert noted. Furthermore, while it might be tempting to apply a single approach to IDEA PPC to all clinics across Canada, achieving the desired outcome overall may require using multiple approaches that are tailored to individual/specific clinic locations or communities. Each community has its own perspectives and needs, and each clinic location has certain resources available to it. By letting go of the notion that there is one 'right' way of doing IDEA PPC, and focussing instead on forward momentum, each base and wing can "echo the tone from the top" at their own pace while working collectively towards the bigger picture together (Deloitte, 2016).

Building Buy-in

We acknowledge that IDEA PPC is an ambitious vision, and that it will be susceptible to resistance, like many other organizational change initiatives. Deliberate steps will need to be taken to build buy-in and to overcome resistance to change; having leadership mandate this change will not be enough to bring about the desired or intended effect. According to one expert we interviewed, "you have to show that it's something you really want to do" by "building it into your learning objectives as an organization and make it a priority. I think it's incredible to have the idea, the concept, the principles, […] but if you don't have the support and the structures in place to carry that through […] it means nothing."

We recommend that the military and health services branch start building buy-in within the executive leadership. After the executive leaders are on board, support should cascade down to the leaders of the bases and wings; their teams can then start collaborating with stakeholders in the local communities to understand their unique needs. Once there is a well-spread support for IDEA PPC, resources will be needed in order to set up and run a shared learning pathway to enable patients, providers, and employers to grow their collective understanding of PPC. As an example, this step could involve sponsoring attendance to international conferences on PPC and bringing those lessons to the local community to grow and to spread. It could involve running a series of panels, hosting town halls, or establishing professional knowledge-sharing networks. The process for building buy-in may be unique for each clinic, to reflect the local geography, population, and evolving micro-culture.

Expanding the model

This project examined IDEA PPC in the context of primary care services. However, there are other health contexts within the military that could benefit from an IDEA PPC participatory redesign. As we mentioned previously, deployments are an integral part of the military's work, and their healthcare contexts may be incredibly varied. We feel that further exploration is merited to come up with generalized models of IDEA PPC for deployments. Since our project was situated within primary care, the process and tools we used would likely need to be adapted significantly to suit the different context. Another alternative care context would be when members are transitioning between or being discharged from military healthcare to the civilian healthcare system. This IDEA participatory redesign process could also be useful to anticipate or to respond to substantial organizational pivots. For example, the current military health system only treats service members, but not their families. This process could be useful to envision what may need to happen for family members to be partners in the PPC relationship or even recipients of care. Similarly, this process could be used to envision how the health services branch may need to adapt if the military's universality of service policy ends; upon the reversal of the policy there will potentially be whole new groups of patients with conditions and needs that may not be addressed by current medical services.

Members of the military work incredibly hard to serve Canada and all Canadians; it is high time that their healthcare is in service to them all.

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APPENDIX A: SURVEY QUESTIONS

Section 1: Survey Invitation

Project Title: In Service of All: Co-Designing an Inclusive Person-Partnered Model of Care in the Canadian Forces Health Services.

The **purpose** of this research study is to understand the perspectives of patients, providers and employers in the Canadian Armed Forces (CAF) to design healthcare models that are more inclusive, diverse, equitable, and accessible.

This research is not funded by either the CAF or the Canadian Forces Health Services.

Screening Question:

This section will determine if you meet the participant criteria for our study.

Participants must be over the age of 18, comfortable communicating in English and be a current or previously serving member from one of the following groups:

- Canadian Armed Forces member;
- Healthcare provider within the Canadian Forces Health Services; and/or
- Professional that represents organizations who employ or manage people in the CAF (e.g. a unit, leadership, etc).

[Branching question:] Yes (survey continues); No (survey ends); I don't know (survey ends)

Section 2: Involvement, Risks and Benefits

Before participating in this study you should understand what is involved.

What is the purpose of the study?
In collaboration with participants, this study aims to understand the challenges patients, healthcare providers, and employers encounter with patient-partnered care models in the Canadian Armed Forces (CAF). Researchers will then use foresight methods to co-design primary healthcare models that are more inclusive, diverse, equitable, and accessible.

What does the research involve and how much time will it take?
The survey should take about 10-15 minutes to complete. You will be asked questions relating to your identity traits, healthcare experiences, and your perception of barriers to inclusion in healthcare.

Survey results will be used by researchers in subsequent phases to co-design healthcare models that are more inclusive, diverse, equitable, and accessible in the CAF. You may indicate your interest in being contacted about participating in these future study opportunities.

What are the benefits of this study?
Possible benefits of participation include:

- the opportunity to have your voice heard on issues related to inclusion, diversity, equity, and accessibility in the CFHS and the CAF
- supporting the creation of future models of patient-partnered care that address the needs of underserved and marginalized members

There may not be further direct benefits to you from participating in this study, but the vision and knowledge from this research may be used to build pathways for inclusive, diverse, equitable, and accessible models of primary care. Any change in the care system can directly benefit military patients, healthcare providers, and employers as well as inspire change in other healthcare systems at provincial, national and international levels.

What are the risks to doing this study?
There are some foreseeable risks involved in participating in this survey.

- Emotional discomfort about revealing personal information about your identity
- Privacy risks (limited anonymity and confidentiality)
- Social or professional risk
- Threats to the security and integrity of information
- Vicarious trauma

We have ways to mitigate some of the risk.

- Provided a "prefer not to answer" option to identity-related questions
- Survey results will be aggregated and presented/reported as a group.
- Comments or quotations will be de-identified and not associated with a participant.
- Security measures will be taken to safeguard information throughout the entire life cycle of the study (collection, use, dissemination, retention, and disposal).
- A list of resources for health support is available

What if I change my mind about being in this study?
Participation is voluntary and you are not obligated to consent to participate. If you decide to participate, you may withdraw at any time before survey submission. If you decide to withdraw, there will be no consequences for you. In case of withdrawal prior to survey submission, any information you have provided will not be kept.

Section 3: Confidentiality, Data Storage & Results

Confidentiality
All information you provide will be considered confidential; your name will not be included or, in any other way, associated with the data collected in the study. We are interested in the average responses from the group, so your individual responses will not be identified in written reports of this research. De-identified quotations may be used.

Information collected will not be released to any other party for any reason, except in the event of allegations or references received that require a professional duty to report (e.g. discrimination, harassment, abuse). Information will be reported to legal authorities with the possibility of third-party access to data (e.g., court subpoena of records).

Storage and data
Data will be securely stored on university servers which are a Canadian Data Centre. Once the research study is complete, raw data will be destroyed. Only the Graduate Student Investigators and their Faculty Supervisors will have access to the research data.

How do I find out what was learned in the study?
Results of this study will be published in the form of a research paper written by the Principal Investigators which will be publicly accessible through OCAD University's Open Research Repository: http://openresearch.ocadu.ca/

Contact Information and Ethics Clearance
If you have any questions or require further information, please contact the Graduate Student Investigators Julia Kowal/Trisha MacLeod or the Faculty Supervisor Dr. Michele Mastroeni using the contact information provided. This study has been reviewed and received ethics clearance through OCAD University's Research Ethics Board (Reference #2021-50) and the Surgeon General Health Research Program (approval # E2021-05-357-012-0001).

If you have questions regarding your rights as a participant in this study please contact:
Research Ethics Board c/o Office of the Vice President, Research and Innovation
OCAD University
100 McCaul Street
Toronto, M5T1W1
416 977 6000 x4368 | research@ocadu.ca

Agreement
By selecting "I agree" you are consenting to the following statements: 1. I have read the information provided and understand the study being described; and 2. I freely consent to participate in the research study.

[Branching question:] I agree (survey continues); I disagree (survey ends)

Section 4 - Identity Traits

What is your age?
- 18-24
- 25-34
- 45-54
- 55-64
- 65 and over
- Prefer not to say

What is your marital status?
- Single (never married)
- Married or in a domestic partnership
- Widowed
- Divorced or separated
- prefer not to say

Are you a parent, guardian or primary caregiver (e.g. child or eldercare)?
- Yes
- No
- prefer not to say

Where do you live? [Choose one of the following]
- Alberta
- British Columbia
- Manitoba
- New Brunswick
- Newfoundland & Labrador
- Northwest Territories
- Nova Scotia
- Nunavut
- Ontario
- Prince Edward Island
- Québec
- Saskatchewan
- Yukon
- outside of Canada
- prefer not to say.

Do you identify as an Indigenous person, that is First Nations (status or non-status) Métis, or Inuk (Inuit), or as having Indigenous ancestry? [Choose one of the following]
- Yes
- no
- do not know
- prefer not to say

What is your sex assigned at birth? [Choose one of the following]
- male
- female
- prefer not to say

What gender identity do you most identify with? [Check all that apply]
- Woman
- Man
- trans woman
- trans man
- gender fluid or non-binary
- Indigenous or another cultural gender identity
- prefer not to say
- an identity not listed (please specify - free text)

What is your sexual orientation? [Choose one of the following]
- Asexual
- Bisexual
- Gay
- Straight (heterosexual)
- Lesbian
- Pansexual
- queer, questioning or unsure
- Same-gender-loving
- prefer not to say
- an orientation not listed (please specify - free text)

What race do you identify yourself with? [Check all that apply]
- Arab
- Black
- Caucasian/White
- Chinese
- Filipino
- Japanese
- Korean
- Latin American
- South Asian (e.g. East Indian, Pakistani, Sri Lankan, etc.)
- Southwest Asian (e.g. Vietnamese, Cambodian, Thai, etc)
- West Asian (e.g. Iranian, Afghan, etc)

- Prefer not to answer
- A race not listed (please specify - free text)

Please indicate your ethnicity [Check all that apply]
- African - Central or West (e.g. Ghanaian, Liberian, Nigerian, Senegalese)
- African - Northern (e.g. Egyptian, Libyan, Tunisian)
- African - Southern or Eastern (e.g. Ethiopian, Kenyan, South African, Ugandan)
- American
- Asian - West, Central or Middle Eastern (e.g. Afghan, Iranian, Iraqi, Israel, Lebanese)
- Asian - South (e.g. Bengali, Punjabi, Sri Lankan, Tamil)
- Asian - East or Southeast (e.g. Chinese, Filipino, Japanese, Korean, Vietnamese)
- Canadian
- Caribbean (e.g. Cuban, Dominican, Jamaican, West Indian)
- European - British Isles (e.g. English, Irish, Scottish)
- European - French (e.g. Breton, French)
- European - Western (e.g. Austrian, Dutch, German)
- European - Northern (e.g. Danish, Swedish, Norwegian)
- European - Eastern (e.g. Czech, Hungarian, Polish, Ukrainian)
- European - Southern (e.g. Croatian, Greek, Italian, Portuguese, Spanish)
- Indigenous (e.g. First Nations, Inuit, Métis)
- Latin Central and South American (e.g. Argentinian, Brazilian, Mexican)
- Oceania (e.g. Australian, New Zealander)
- Pacific Islands (e.g. Fijian, Hawaiian, Samoan)
- Prefer not to say
- An ethnicity not listed (please specify - free text)

What religious family or spiritual practice do you most identify with?
- Agnostic
- Atheism
- Bahá'í
- Buddhism
- Christianity
- Confucianism
- Hinduism
- Indigenous spiritual practices
- Islam
- Jainism
- Judaism
- Shinto
- Sikhism
- Taoism
- Zoroastrianism
- No spiritual or religious affiliation
- Prefer not to say
- A spiritual or religious family not listed (please specify - free text)

Are you a person with a disability? [Choose one of the following]

The UN Convention on the Rights of Persons with Disabilities defines persons with disabilities as "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." This may include (but is not limited to) persistent or episodic physical, cognitive, psychosocial/mental health, sensory, developmental/intellectual or learning impairments; and difficulty hearing, seeing, communicating, walking, climbing stairs, bending, learning or doing any similar daily.

- Yes
- no
- prefer not to say

Are you proficient in another language aside from English? [Choose one of the following]
- Yes
- no

If you are proficient in another language, which language(s) do you speak?

Below is a list of the top ten languages spoken in Canada (aside from English) based on census data. [Check all that apply]

- Arabic
- Canadian Indigenous languages
- Cantonese
- Farsi
- French
- German
- Italian
- Mandarin
- Portuguese
- Punjabi
- Spanish
- Tagalog
- Prefer not to say
- A language not listed (please specify - free text)

Section 5 - Inclusivity

Inclusion can be measured by the absence of negative incidents that make one feel excluded and may seem to be 'invisible' to people who are already included.

We are interested in your work with the CAF about how you may have experienced incidents of exclusions as a result of your personal traits (e.g. race, ethnicity, religion/spirituality, age, sex, gender, sexual orientation, disability, language, marriage or family status).

Likert:1-5 where 1 = never and 5 = always

- My personal traits have impacted my being able to participate meaningfully in discussions
- My personal traits have impacted my being included in meetings and projects that leverage my skills
- My personal traits have impacted my opportunities to participate in stretch projects and leadership
- My personal traits have impacted me being given a fair chance or consideration for promotion
- My personal traits have impacted my supervisors being supportive of personal time off
- My personal traits have impacted my access to caregiving services
- My personal traits have impacted my being recognized for my contributions to a team
- My personal traits have contributed to my being interrupted in meetings
- My personal traits have impacted my being able to use a strong or direct tone without being called bossy, aggressive, and/or abrasive
- My personal traits have impacted my being able to share them openly
- My personal traits have been the subject of microaggressions (e.g. comments about personal traits such as hair, clothing, accent, body type, education level, etc)
- I see that diverse perspectives are encouraged and respected in the workplace

Section 6 - Military Identity

Patients is the term we use to refer to the people who accessed or used healthcare services for their health needs.

Providers is the term we use to refer to the people who organize, deliver, and monitor healthcare services.

Employers is the term we use to refer to the organizations and people who employ or manage people in the CAF. This includes supervisors, units, and formations.

A person may belong to more than one category.

I identify primarily as a current/formed: (Check one)
- Junior Non-Commissioned member
- Senior Non-Commissioned Officer
- Junior Officer
- Senior Officer
- Civilian - (Public Servant and/or Contractor)

I have worked with or for the Canadian Armed Forces for: (check one)
- Less than 5 years
- 5-10 years
- 11-15 years
- 16-20 years
- 21-25 years
- Over 25 years
- Prefer not to say

I have experience with being a current/former: (Check all that apply)
- Patient
- Provider
- Employer

I identify primarily as a current/former: (Check one)
- Patient
- Provider
- Employer

Section 7 - Access to Care

Barriers to accessing care, systemic racism, and other obstacles result in members receiving different levels of care, inadequate care and contribute to varying health outcomes.

We are interested in your perspectives on identifying the barriers to care.

I believe the following is are barriers for CAF members to accessing healthcare: [check all that apply]
- Geography, distance, and physical location
- Language (proficiency in patient's language of choice)
- Health/medical jargon
- Tele-medicine or virtual care
- Scheduling appointments
- Presence or inclusion of family/friends, support network at medical appointments
- Choice in provider
- Process for getting second medical opinions
- Factors related to gender (e.g. preference for a provider of a certain gender)
- Cultural competencies amongst providers
- Navigating the health system
- Other (free text)

Section 8 - Patient-Partnered Care

A patient-partnered care model is rooted in engagement and moves towards true partnership in care when the patient is considered a caregiver of themselves. They are a respected member of the treatment team based on their competencies in care (not just by taking into account their personal experiences)(Government of Canada, 2019; Jackson, 2016; Pomey et al., 2015).

Section answered with Likert (1 = strongly disagree and 5 = strongly agree)
- I feel my voice matters in healthcare interactions
- Currently, patients do not have enough knowledge to contribute to discussions or decisions about their healthcare
- Currently, providers regularly consult patients for their opinions when making care decisions
- Currently, patients proactively share their opinions/needs when care decisions are being made
- The needs of employers are considered in care decisions
- The Canadian Forces Health Services has policies and guidance about how to balance the needs of patients, providers, and employers in care decisions

What is one thing that the Canadian Forces Health Services could do that would help make you more ready for patient-partnered care? [free text]

What else is on your mind? [free text]

Section 9 - Further Participation Opportunities

We will be conducting more research to better understand patients, providers and employers' perspectives of inclusion, diversity, equity, and accessibility in the CAF. We will also be collaboratively designing alternative futures of care in the Canadian Forces Health Services.

Please indicate your willingness to receive more information about the future study phases. Participation is voluntary; you are not obligated to participate if you express interest in hearing more about the future phases. You can express interest through the form below, or by contacting the student researchers.

Would you like to be contacted about future study opportunities or be kept up to date on the research?
- Yes/No [branch question]
- Yes: If you would like to participate in future study opportunities or be kept up to date on the research progress, please enter your email below [free text]
- No: Form goes to submission page

Section 10 - Survey Submission

Thank you for completing this survey. Your response will be submitted once you click 'submit' below.

[Submit survey]

APPENDIX B: SURVEY CODE LIST

Social	• S1: Experiencing stigma, discrimination • S2: Supporting peers • S3: Relying on trust in interactions • S4: Communicating with clear words and directions • S5: Feeling isolated • S6: Differing experiences by location • S7: Feeling excluded by biases and double-standards • S8: Involving patients and/or families with providers or 'experts' • S9: Understanding responsibilities • S10: Advising on select perspectives • S11: Fearing reprisal/punishment • S12: Waiting for services ("Continuity of Care") • S13: Feeling understood or validated
Economic	• E1: Allocating resources • E2: Un-funding or not funding 'niche' services • E3: Maintaining career
Policy	• P1: Shifting accountability • P2: Using system structures to individual's best interest • P3: Requiring disclosure for action or redress • P4: Anticipating foreign policy or public policy changes
Legal / Mandate	• LM1: Licensing and reporting to professional colleges • LM2: Providing medical advice – to individuals • LM3: Providing medical advice – occupational or for organization • LM4: Providing medical services • LM5: Conflicting priorities or roles • LM6: Following orders • LM7: Outsourcing to third-party or civilian health services
Technology	• T1: Synchronizing health and employment information • T2: Communicating unilaterally • T3: Using tele-health tools (e.g. phone, video, portals)
Knowledge and Expertise	• KE1: Having personnel with relevant lived experience representing populations • KE2: Being bilingual • KE3: Understanding different cultures • KE4: Knowing where information/file is or how it goes through the system • KE5: Contextualizing practices for diverse populations • KE6: Researching and collecting data • KE7: Sharing information • KE8: Managing expectations • KE9: Navigating the system • KE10: Having knowledge to follow best practices
Values	• V1: Desiring representation • V2: Abiding by or reinforcing hierarchy or status quo • V3: Changing organizational culture or attitude • V4: Exploring additional or alternative treatment options

APPENDIX C: GRAPHS OF RESPONSES TO TRAIT-BASED EXCLUSION SURVEY QUESTIONS

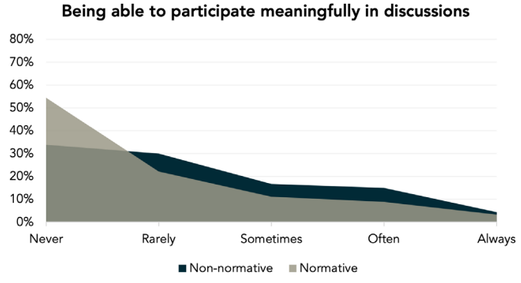

Figure C1: *Graph of responses to the survey question "My personal traits impact my being able to participate meaningfully in discussions"*

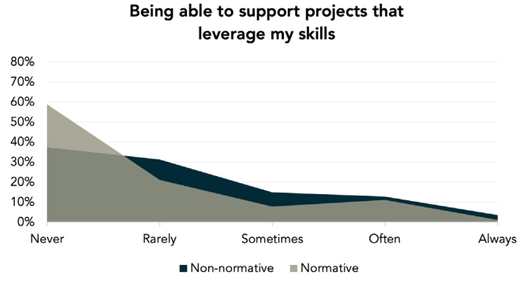

Figure C2: *Graph of responses to the survey question "My personal traits have impacted my being included in meetings and projects that leverage my skills"*

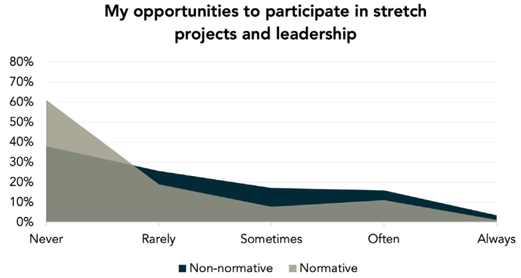

Figure C3: *Graph of responses to the survey question "My personal traits have impacted my opportunities to participate in stretch projects and leadership"*

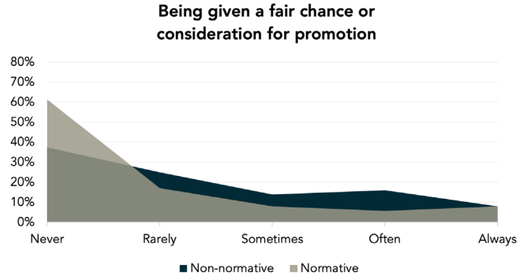

Figure C4: *Graph of responses to the survey question "My personal traits have impacted me being given a fair chance or consideration for promotion"*

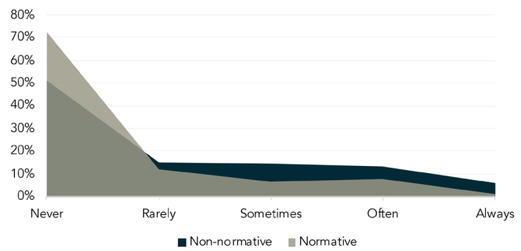

Figure C5: *Graph of responses to the survey question "My personal traits have impacted my supervisors being supportive of personal time off"*

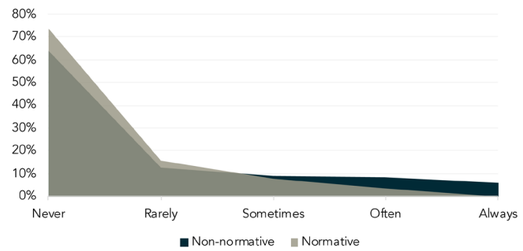

Figure C6: *Graph of responses to the survey question "My personal traits have impacted my access to caregiving services"*

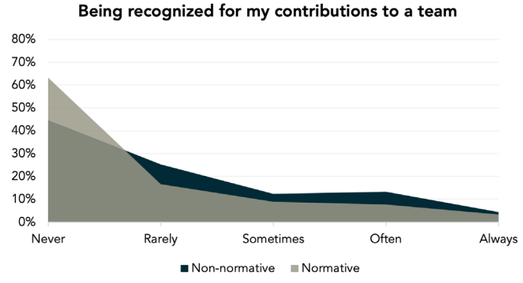

Figure C7: *Graph of responses to the survey question "My personal traits have impacted my being recognized for my contributions to a team"*

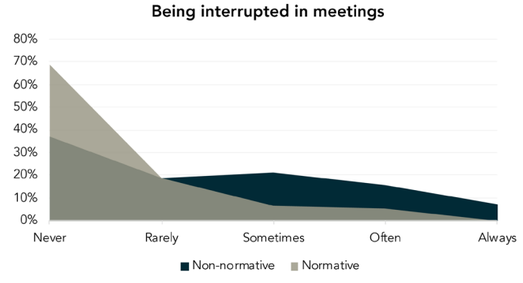

Figure C8: *Graph of responses to the survey question "My personal traits have contributed to my being interrupted in meetings"*

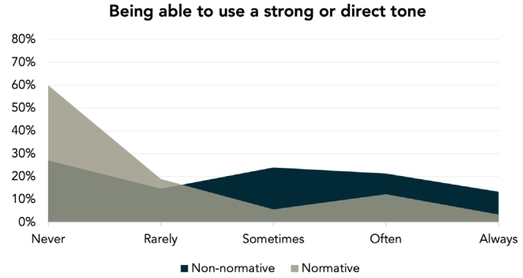

Figure C9: *Graph of responses to the survey question "My personal traits have impacted my being able to use a strong or direct tone without being called bossy, aggressive, and/or abrasive"*

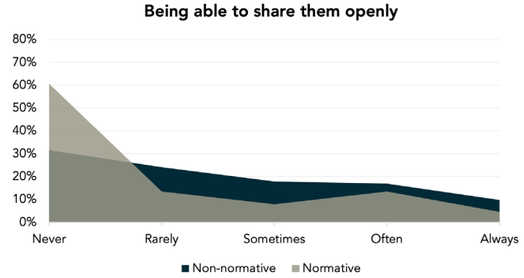

Figure C10: *Graph of responses to the survey question "My personal traits have impacted my being able to share them openly"*

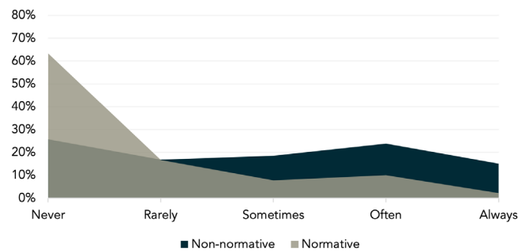

Figure C11: *Graph of responses to the survey question "My personal traits have been the subject of microaggressions (e.g. comments about personal traits such as hair, clothing, accent, body type, education level, etc)"*

APPENDIX D: GRAPHS OF RESPONSES TO PATIENT PARTNERSHIP SURVEY QUESTIONS

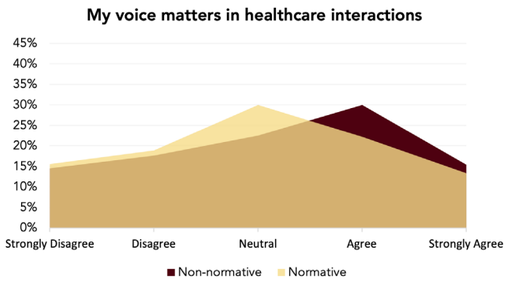

Figure D1: *Graph of responses to the survey question "I feel my voice matters in healthcare interactions"*

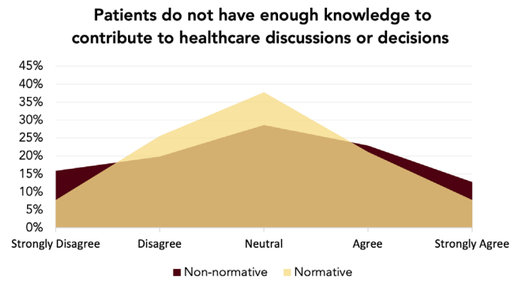

Figure D2: *Graph of responses to the survey question "Currently, patients do not have enough knowledge to contribute to discussions or decisions about their healthcare"*

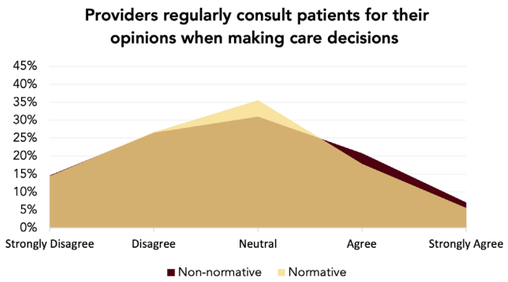

Figure D3: *Graph of responses to the survey question "Currently, providers regularly consult patients for their opinions when making care decisions"*

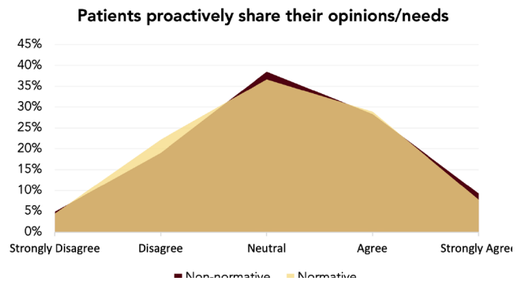

Figure D4: *Graph of responses to the survey question "Currently, patients proactively share their opinions/needs when care decisions are being made"*

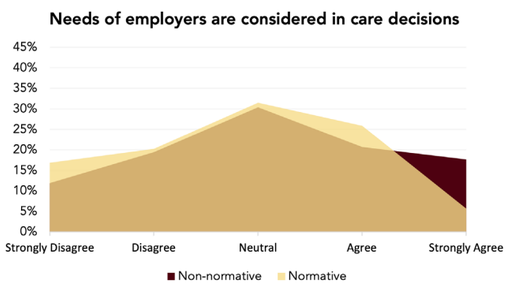

Figure D5: *Graph of responses to the survey question "The needs of employers are considered in care decisions"*

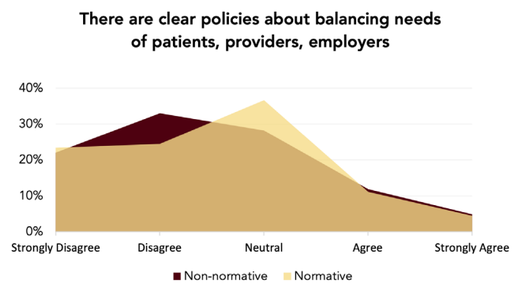

Figure D6: *Graph of responses to the survey question "The Canadian Forces Health Services has policies and guidance about how to balance the needs of patients, providers, and employers in care decisions"*

APPENDIX E: INTERNAL EXPERT INTERVIEW QUESTIONS

1. Could you please tell me a bit about your current role and the main type of function it entails?
   1.1. Follow-up/Reframed: For example, do you mostly provide direct patient care, conduct research, have a leadership function in operations, develop policy, training and education, etc.?

2. Could you please describe the roles and functions you have had with respect to health services policy and guidance?

3. Could you please take us through a routine patient - provider - employer encounter?
   3.1. Follow-up/Reframed: What are the steps? What are the pain points?

   [Segue]: We believe patient partnered care is an approach that means patients, families and health providers actively collaborate to plan, deliver, and evaluate services. In the current social climate, we believe that now is the opportunity to strengthen the PPC model by deliberately addressing inclusion, diversity, equity, accessibility to create psychologically safe spaces. There are multiple elements of human diversity which need to be considered in the provision of healthcare, especially since the intersection or overlap of identities pose additional, unique challenges for people.

4. How do guiding institutional policies or practices hamper or add burdens to the process for patient partnered care?
   4.1. Follow-up/Reframed: what norms or precedent behaviours are set?

5. What concerns or issues will the organization likely encounter and need to address in the implementation of patient-partnered care?
   5.1. Follow-up/Reframed: what type of pitfalls or obstacles would have to be addressed in a healthcare change management process to bring about successful change?

6. How does the Canadian Forces Health Services / Canadian Armed Forces do change well, and how might these be applied to implementing patient-partnered care?
   6.1. Follow-up/Reframed: For example, what has CFHS done in the past to change…?

7. How else can health services be made to be more inclusive, diverse, equitable, and accessible?
   7.1. Follow-up/Reframed: For example, the Ministry of National Defence and Strong, Secure and Engaged require inclusion for a diverse force. How can the Canadian Armed Forces get there?

8. How might the Canadian Forces Health Services headquarters be more inclusive of patients in the development and delivery of programs and services?

General Prompts and Probes

- Can you tell me more about that?
- What else?
- What did that look like in practice?
- Could we revisit [previous topic]?
- How is that different from what is being done now?
- How is that different from what was done in the past?

APPENDIX F: EXTERNAL EXPERT INTERVIEW QUESTIONS

1. Could you please tell me a bit about your current role and what it functional entails?
   1.1. Follow-up/Reframed: For example, do you mostly provide direct patient care, conduct research, have a leadership function in operations, develop policy, training and education, etc.?

2. Could you please describe how you have been involved with patient-partnered care?
   2.1. Follow-up/Reframed: For example, have you revised organizational practices or established a staff training regimen?

3. How do guiding institutional policies help or hamper the operation/viability of patient-partnered care and/or IDEA?

4. What concerns or issues did your organization encounter with the implementation of patient-partnered care?

5. How can other healthcare organizations start to implement a model of patient partnered care?
   5.1. Follow-up/Reframed: For example, what knowledge or skills are needed by leaders or employees?

6. What are some ways for patient-partnered care to be made more inclusive, diverse, equitable, and accessible?
   6.1. Follow-up/Reframed: For example, what would this look like for providers? for patients?

General Prompts and Probes

- Can you tell me more about that?
- What else?
- What did that look like in practice?
- Could we revisit [previous topic]?
- How is that different from what is being done now?
- How is that different from what was done in the past?

APPENDIX G: INTERVIEW CODE LIST

THEME	CODE
Resourcing	• R1: Lacking sufficient personnel • R2: Offering full spectrum of programs and services • R3: Committing resources to change/improvement initiatives • R4: Acquiring specialized knowledge/perspectives/tools • R5: Accessing full spectrum of programs and services • R6: Feeling overwhelmed with demands of service
Trust and Respect	• T1: Feeling believed, that needs are understood • T2: Feeling treated as a whole person • T3: Looking to others for growth/mentorship • T4: Acknowledging a need to change or to learn • T5: Having space and mechanisms for feedback • T6: Framing care for wellness, not just injury-repair • T7: Fearing reprisal or back-lash • T8: Conflicting motivations or priorities
Navigation	• N1: Waiting for service • N2: Knowing where patient file is/the status of their care • N3: Knowing process or how to get referrals • N4: Communicating clearly and timely with patients • N5: Communicating clearly and timely with healthcare providers • N6: Managing their own care • N7: Encountering policy barriers

APPENDIX H: REAL-TIME WORKSHOP OUTLINE

SECTION	ACTIVITIES	FACILITATION TIPS
Introduction (20 mins)	• Land Acknowledgement • Purpose of workshop • Overview of research to date • Ice breaker	• Ice breaker: names and "what is one thing you hope to get out of the workshop today?"
Horizon 1 – Here and Now (20 mins total)	• Goal: to understand the current state of healthcare and the factors that have contributed to it being the way it is	• Reveal all prompts at once, but introduce them one at a time • Use Incognito mode for participants to add to Mural board • Reveal and discuss
Horizon 3 – Desired Future (20 mins total)	• Goal: to picture the desired military healthcare system that is inclusive and patient partnered. • Context prompt: "Imagine it is 7-10 years from now, and an inclusive model of healthcare has been implemented, resourced, and widely supported in the military."	• Reveal all prompts at once, but introduce them one at a time • Use Incognito mode for participants to add to Mural board • Reveal and discuss
Break (5 mins)		
Horizon 2 – Transition (20 mins total)	• Goal: to identify the leverage points and threats involved in changing the current state to the desired future	• Reveal all prompts at once, but let participants answer them in any order • Use Incognito mode for participants to add to Mural board • Reveal and discuss
Summary / Wrap-Up (5 mins)	• Thank participants • Answer outstanding questions • Overview of project's next steps • Outro ice breaker	• Outro ice breaker: "In one word, what stood out for me / the thing I am taking away from the workshop is..."

APPENDIX I: REAL-TIME WORKSHOP QUESTIONS

Horizon One

- How would you describe military healthcare? What do you see as the key characteristics of the system?
    - What do you notice (see/hear) or get from this system when you do your job?
- Look back – how did we get here? What values, policies, events have contributed to the system being the way it is now?
- What about the current system is not suited to providing care that is inclusive, diverse, equitable, accessible or person-partnered?
- What about the current system is valuable/useful that we/you would want to keep?

Horizon Three

- What are the key characteristics of this future healthcare system?
    - Patient: what would you see/hear/feel when accessing care here?
    - Provider: What would you see/hear/feel when providing care to participants OR working with their employers?
    - Employers: What would you notice (see/hear) or get from this system that would help you do your job?
- What things are happening now that point to/are signals of this future emerging? [Give specific examples]
- How could these "seeds of that future" be scaled and spread? Give examples of people/groups that could help them grow.
- What other futures is IDEA PPC competing against? How do we prevent this competition from derailing IDEA PPC?

Horizon Two

- What about the economy, technology, politics, environment, society and culture need to transform to go from current state into desired state?
- Who would you hope to see involved in this change process? What action are they taking?
- What practical things are needed to get there?
- Which concepts or beliefs will be most challenged by change?

APPENDIX J: ASYCHNRONOUS WORKSHOP OUTLINE

Introduction

- About Us
- The Research Question
- Ground Rules for the Digital Workshops

Horizon One: Here and Now

- Purpose
- "Describe military healthcare – What do you see as the key characteristics of the system today?"
- "In the current healthcare system, what do you notice (see / hear / feel) that helps you do your job?"
- "What about the current system is not suited to providing care that is inclusive, diverse, equitable, accessible, or person-partnered?"
- "What about the current system is valuable, useful, and should be kept?

Horizon Three: Desired Future

- Purpose
- Set the Conditions. "Imagine it is 7-10 years from now. An IDEA + PPC model of healthcare has been successfully co-created. The model has been implemented, resourced, and widely adopted in the military."
- "What are the key characteristics of this future healthcare system?"
- "In this future healthcare system, what do you notice (see / hear / feel) that helps you do your job?"
- "What things are happening now that point to or are signals of this future emerging?"

Horizon Two: Transformation

- Purpose
- "What needs to transform to go from the current to the desired state? Consider the economy, technology, politics, environment, society, or culture."
- "Who would you hope to see involved in this change process?"
- "What actions are being taken by these change makers?"
- "What practical things are needed to get there?"
- "Which concepts or beliefs will be most challenged by this change?"

Conclusion and Thanks