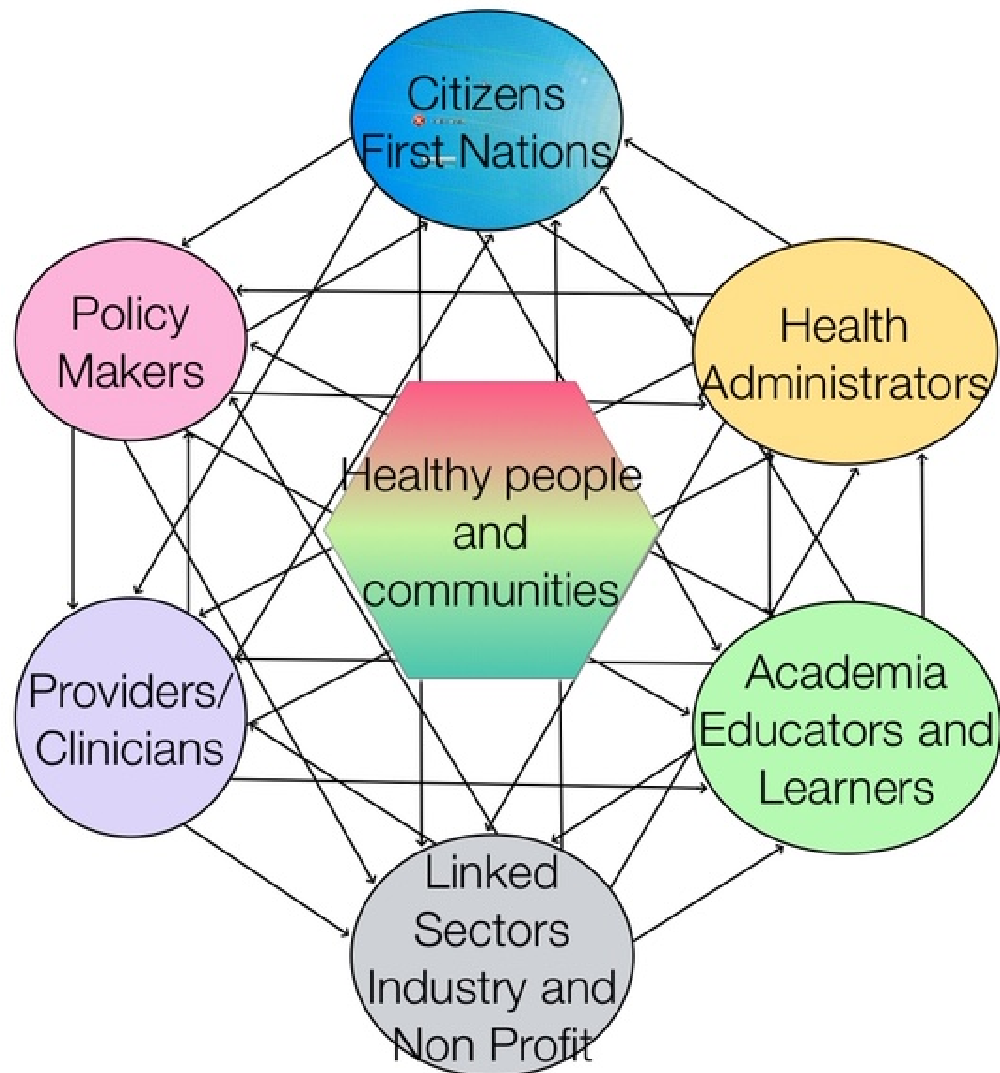
Appendix A: Partnership Pentagram Plus defined and contextualised:

Charles Boelen authored a paper for the WHO in 2000 around the partnership Pentagon/Pentagram. This has subsequently become the foundational model, accepted by all medical schools in Canada as a framework for Socially accountable health education. We have adapted this by adding a 6th partner to use this framework for socially accountable health system change.



Each of these partners brings their perspective (not coming as a representative).

Who would these partners be in this context?

Citizens: The people of BC at a provincial level they would include a coalescence of groups looking at supporting health in First Nation and rural communities. From an equity perspective we need to ensure a strong First Nations Voice here.

Health Administrators: In our context Health Authorities

Policy Makers: Ministry of Health initially but one can quickly see the potential for other ministry involvement.

Academia: Educators and learners

Providers: The perspective of those providing healthcare services

The 6th group we have added to this model is:

Linked sectors: this includes industry who has a vested interest in health of the people working for them and the impact of their work on health, as well as non-profits working in areas related to the social determinants of health e.g. environment, housing etc.

Below is a Quote from the original paper (p65/66)

"The value of partnership depends on the level of commitment of each partner. Contact between stakeholders is not enough to guarantee productive partnerships. Some cynical observers may depict the "partnership pentagon" as a collection of competitors concerned mainly with protecting their own turf, lacking the systems view required to help create sustainable and socially responsive consortia.

Another word of caution! Can the pentagon become a hexagon, or a polygon with even more sides? Yes: the partnership can be enlarged to include other parties directly or indirectly involved in health-related activities with economic, social, cultural and environmental determinants in health. But pragmatism should prevail in efforts to enlarge partnership. It should be recalled that the approach advocated by the TUFH project focuses in the first instance on the partnership needed for health services delivery based on people's needs. In the quest to optimize services delivery and health promotion, TUFH advocates should collaborate with agencies or individuals from sectors as varied as education, agriculture, industry, nutrition, transportation, employment or environmental control as and when health-threatening or health-promoting events in these sectors are identified. Very often, these events can be dealt with through one of the partners of the "partnership pentagon", notably community representatives, for instance, for health protection and promotion in homes, schools and workplaces. On the national scale, on one hand, governmental authorities should take into account the implications of economic and social policies for people's health. For example, the conditions for restructuring and revitalizing the national economy and the corollary privatization and decentralization, as well as the influence of globalization, require regulatory action and coordination at the highest level of government to minimize the threat of inequities, unemployment and poverty. On the other hand, an approach such as the TUFH project, while considering the political and economic decisions taken on a macro scale, favours a bottomup approach, starting with recognition of the priority health needs of a reference population and coordinating the use of resources and talents available at that level. As a bottom-up approach requires constant updating through research and development to adapt to people's needs, it merits being considered as a way to address the formulation of national health policies."

What we are embarking on is a Partnership approach at a:

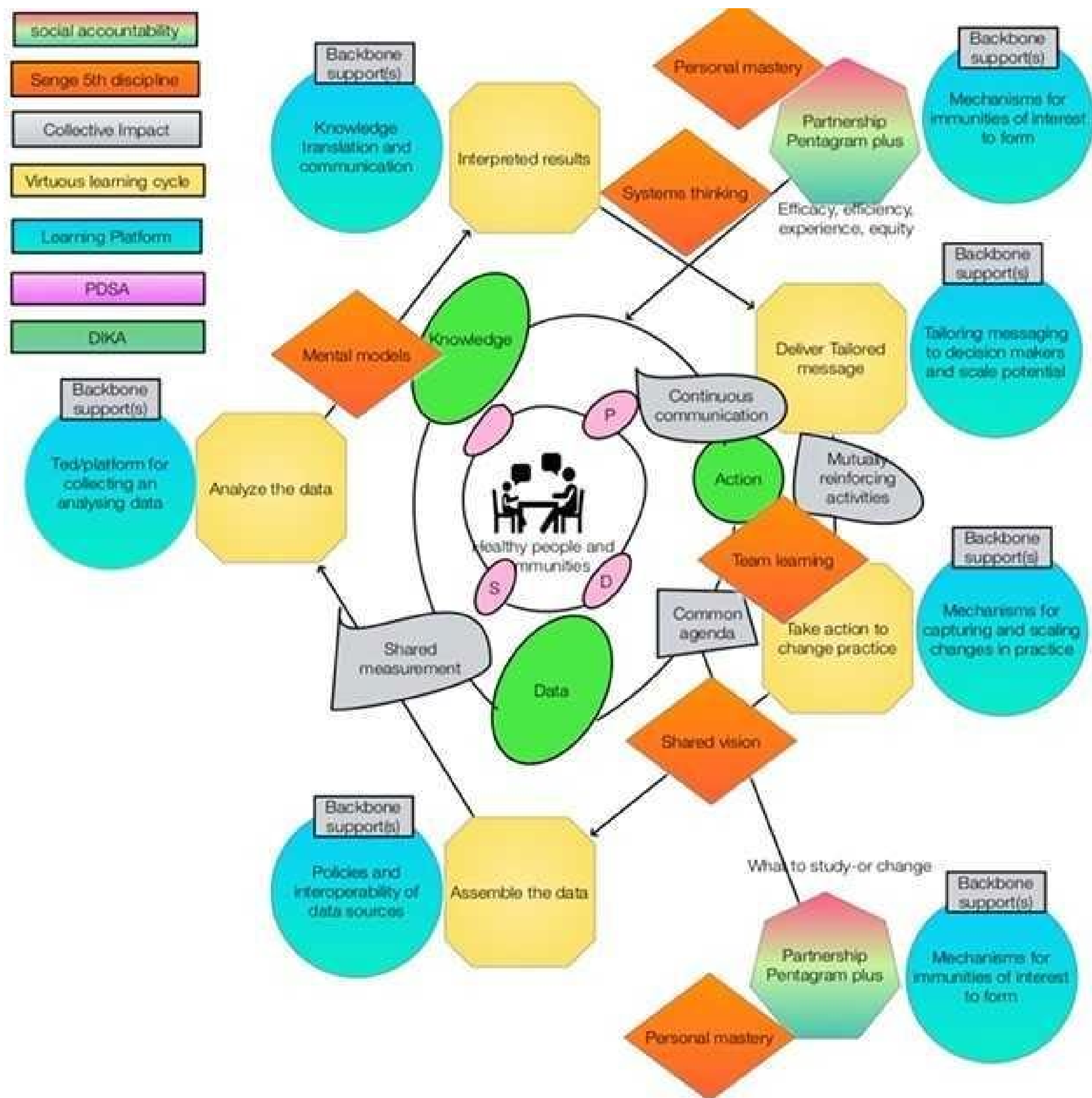
Macro level (Provincially): Deciding overall direction and supports

At a Micro level (Community) the partnership shapes the practical operationalisation in that context.

At a meso level (Regionally) the environment and operational supports are implemented.

Appendix B: Learning health systems approaches distilled

In British Columbia healthcare is not delivered and supported by a single organisation. In our seemingly complex provincial context, regarding learning health systems including PDSA, DIKA framework, Friedland's work on learning health systems and the virtuous learning cycle, Sege's work on system change, PDSA, Collective Impact, Developmental evaluation and Boelen's work on Social Accountability. Often these tools are used as flags to forge alliances or wage wars. The diagram below is an attempt to illustrate some of the many aspects and overlaps of each of these approaches.



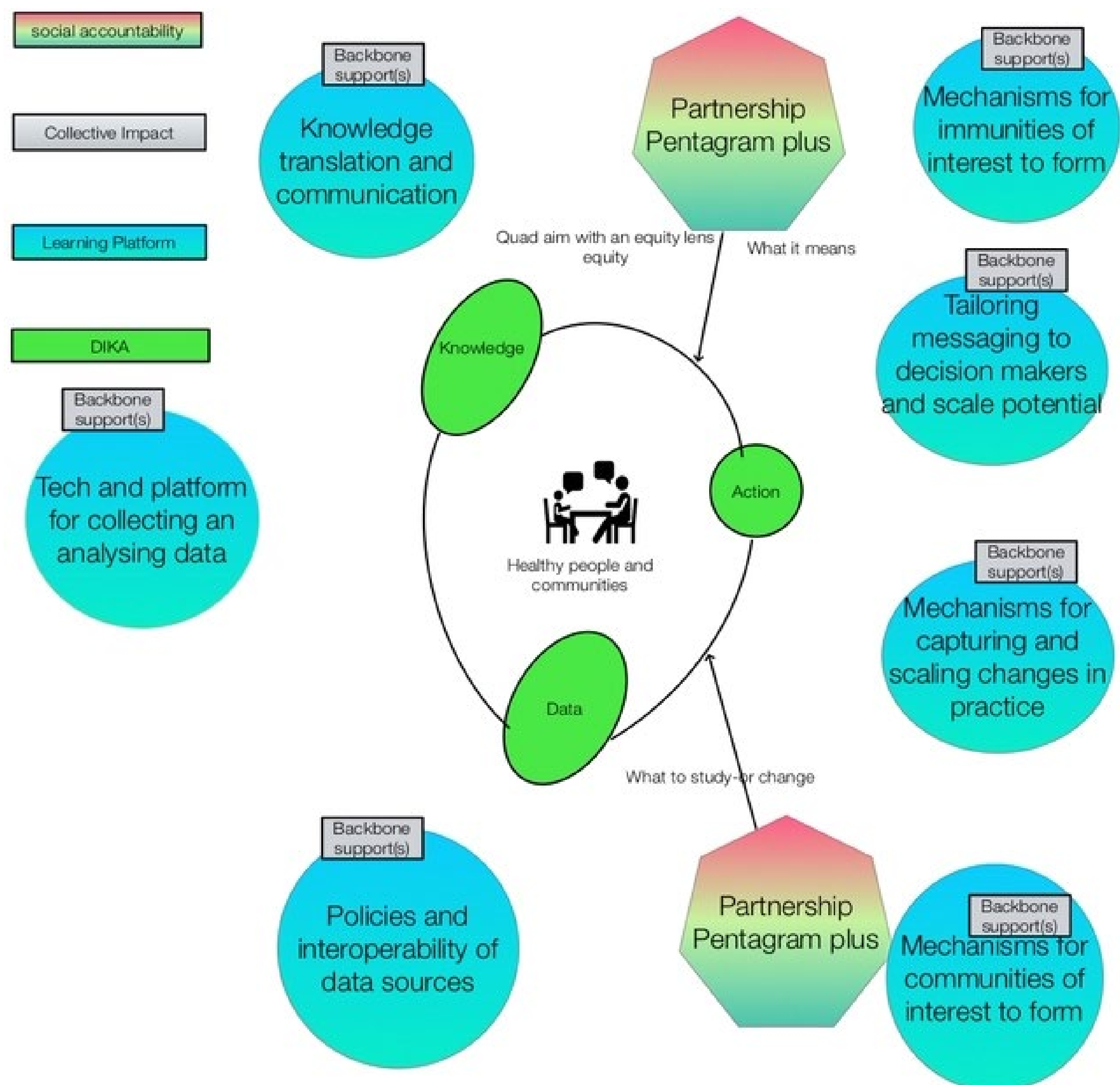
This is really only helpful to illustrate that, these many approaches are not what are important. The system (for better or worse) that they are looking at is what matters, each approach offers unique tools to help improve, move or understand what is going on. We have taken an Appreciative Inquiry approach to the use of these tools. These tools should be used interchangeably. So what tools might help us at this time for this work? The diagram below picks out 2 elements (framed in a couple of different approaches languages).

Partnership Pentagram Plus approach: A socially accountable means of deciding what we should look at improving, and how to interpret feedback, shaping it into a feedback loop (leading to change). We are framing this as providing the collective wisdom to help that change be improvement. This happens at a Micro (community) level, Meso (regional) and Macro (Provincial) level, and is further explained in the Parnership appendix. The Partnership gets to decide what we are working on (in our context 150+ people in January, and then the April 1 meeting).

The Partnerhsip gets to decide what the work means as we do it, bending the trajectory of data-information-knowledge to wisdom leading to action.

Platforms: As we accelerate pieces of work, there are components that help accelerate other learning cycles and could provide economies of scale in system change, growing "a healthsystem based on people's needs". We have the opportunity to identfy existing platforms that could be supported to do this at scale as well as identify where there might be opportunities to fill a need if nothing exists in this area.

The diagram below is an attempt to illustrate this, highlighting some potential platform functions.



These include (The platforms are not limited to this list):

Communities of interest: Mechanisms to support these to form: Currently the RCCbc's work on the Partnership Pentagram Plus would be an example.

Data sources: Interoperability of Data sources and Policy to support and enhance this. Examples would include Work undergoing by the Provincial Data strategy group, CDX, HDC Sipson etc.

Tech Platform: For receiving data from various sources, applying questions to it and producing outputs that apply the data to the question as well as working with the partnership to interpret or modify the process.

Knowledge translation and communication: Leveraging those with expertise to maintain connection between the partners, and with potential partners as well as society. In addition these is a change management function here.

Tailoring messaging to decision makers and looking for potential scale: For want of a better work Marketing, and maintaining links to look for alignment opportunities with existing and ongoing work

Mechanisms for capturing change: and helping with scale and building offramps while the work is going on so it can be ebedded in system structures.

As a Process it is always important to keep connected to our collective purpose. Framework questions may be generated and addressed through Sinec's logic continuum of:

1) **WHO?** (People, communities, HCPs, budgets...) >
2) **WHY?** (Quad Aim, BCHQ Matrix…) >
3) **HOW?** (Cultural safety, virtual & F2F, wholistic risks & costs, Pentagram +, teams, clinic/hospital/community…) >
4) **WHAT?** (Type of HC collaboration, scope of practice, blended funding see below…)