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McMaster HEALTH FORUM

PLANNING FOR THE FUTURE HEALTH WORKFORCE OF ONTARIO

28 SEPTEMBER 2016

EVIDENCE >> INSIGHT >> ACTION

Dialogue Summary:
Planning for the Future Health Workforce of Ontario

28 September 2016

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary, but the authors had final decision-making authority about what appeared in the dialogue summary.

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SUMMARY OF THE DIALOGUE

Dialogue participants focused on six dimensions of the problem: 1) health workforce planning is not routinely or systematically undertaken; 2) health workforce regulation complicates planning efforts; 3) the needs of patients are not incorporated into planning efforts; 4) the definition of health adopted by policymakers and stakeholders is too narrow to make meaningful progress in health workforce planning; 5) demographic changes and shifts in health-system arrangements create uncertainties when planning for the future health workforce; and 6) political constraints have hindered progress in health workforce planning.

Participants generally supported element 1 (determine health needs and describe functions required to meet those needs) and element 2 (establish models of care and determine health workforce requirements) and they rejected the idea that element 2 could be used as the 'hit the ground running' approach without first pursuing the 'build from the ground up' approach outlined in element 1. Participants also called for a more expansive view of element 3 (select appropriate policy levers to meet health workforce planning objectives). For all three elements they identified a number of requirements for the elements to be as helpful as they could be. Participants also identified several cross-cutting themes that should be front and centre in discussions about health workforce planning: 1) consider how to best invest in the software that will allow for the dynamic modelling of the workforce and simulations of the impacts of changing models of care on the workforce; 2) recognize that the political and change-management costs will be high; and 3) commit to striking the right balance between local and provincial planning and between system-wide planning and market forces.

During the deliberation about next steps, most dialogue participants agreed that there are a number of commitments that could be considered by all stakeholders interested in improving health workforce planning: 1) establishing an inclusive group to achieve consensus around health workforce-planning priorities, including the creation of a comprehensive process for health workforce planning to ensure progress is made; 2) committing to a true 'patients first' approach to care, whereby health workforce needs are matched to the diverse needs of communities across the province; 3) taking advantage of the opportunities that government initiatives present for initiating system transformation and disruptive innovation (e.g., the *Patients First Act* and 'health accord' renewal); 4) pursuing the many short-term wins that present themselves, evaluate what works, and commit to scaling up effective approaches; 5) recognizing the need to balance macro-level system needs with micro-level needs of local communities; and 6) working collectively and inclusively to avoid the turf wars that have plagued past efforts.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Dialogue participants generally agreed with the way the challenges related to health workforce planning in Ontario were framed in the evidence brief. However, in deliberation about the problem, participants focused most of their attention on six specific dimensions of the problem:

1) health workforce planning is not routinely or systematically undertaken;
2) health workforce regulation complicates planning efforts;
3) the needs of patients are not incorporated into planning efforts;
4) the definition of health adopted by policymakers and stakeholders is too narrow to make meaningful progress in health workforce planning;
5) demographic changes and shifts in health-system arrangements create uncertainties when planning for the future health workforce; and
6) political constraints have hindered progress in health workforce planning.

Health workforce planning is not routinely or systematically undertaken

The first dimension of the problem that dialogue participants focused on was that Ontario does not routinely or systematically undertake comprehensive health workforce planning. Many participants began the deliberation about the problem by stating that they did not think there has ever been any true health workforce planning done in the province, while others said that it had been done to some extent but not in an optimal way (e.g., not coordinated or sustained, and focused at the local level without considering the broader system).

A number of dialogue participants noted that the lack of an established process for health workforce planning in the province has created a vacuum, which has enabled politics to play a large role in decision-making. More specifically, some participants suggested that the political interests of the health professional associations with the most power (e.g., physicians and nurses) have been able to dominate the decision-making process and dictate outcomes – even to the extent that the health workforce is now more defined by these power dynamics than by estimates of what the supply, mix and distribution of health workers

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue, in order to inform action. Key features of the dialogue were:

1) it addressed an issue currently being faced in Ontario;
2) it focused on different features of the problem, including (where possible) how it affects particular groups;
3) it focused on three elements of a potentially comprehensive approach for addressing the policy issue;
4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three elements of a potentially comprehensive approach for addressing the problem, and key implementation considerations;
5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible elements for addressing it;
6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
7) it ensured fair representation among policymakers, stakeholders and researchers;
8) it engaged a facilitator to assist with the deliberations;
9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
10) it did not aim for consensus.

We did not aim for consensus because coming to agreement about commitments to a particular way forward can preclude identifying broad areas of agreement and understanding the reasons for and implications of specific points of disagreement, as well as because even senior health-system leaders typically need to engage elected officials, boards of directors and others on detailed commitments.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

should be. Other participants suggested that this power imbalance has also negatively affected data availability – with sources skewed towards information about physicians and nurses – and hence the comprehensiveness of workforce planning. One participant suggested that "we're currently making decisions on one profession, when it is clear that we're increasingly relying on more than one." For example, many participants noted the growing role of personal support workers in Ontario – particularly as more care is being provided in community settings – and reflected on the limited efforts that have been made to plan for the right supply and distribution of this particular cadre of health worker.

Several dialogue participants highlighted as a complementary feature of this dimension of the problem that the generation and use of research evidence was less than optimal. They noted that of all the health research conducted in the country, only a small proportion focuses on health services and policy research, and of that an even smaller proportion focuses on better understanding how to plan for the future health workforce. A number of participants also suggested that the health workforce planning that has been undertaken in the province has not been consistently informed by high-quality research evidence.

Health workforce regulation complicates planning efforts

Dialogue participants then turned to a second dimension of the problem: how Ontario's current approach to workforce regulation can and will complicate planning efforts. First, several participants indicated – and most participants agreed – that the separation and independence of professional regulatory colleges created silos among professions (and fostered a culture of competition rather than cooperation) and left unclear lines of accountability to the provincial government. Some participants also suggested that the separation of colleges fostered 'turf wars' over scopes of practice and created uncertainty about who can and should do what in areas of overlapping scopes of practice.

Second, several dialogue participants noted that the regulatory focus on scopes of practice has not been complemented by system-level supports for health professions (e.g., nurses) to work to their full scope of practice and for health professionals to adapt their scope of practice to their context (e.g., nurse practitioners working in remote communities). One participant helped to illustrate the lack of scope optimization: "we train people to do 100 things, regulate them so that they can do 80% of that or less, and in reality they only do 50% of what they're regulated to do." A number of participants agreed that many health professionals are working below their skill level, while other participants suggested that health workers should never consider anything that their patients require as something which is 'below' them. Most participants agreed that failing to optimize scopes of practice means we are under-utilizing the health workers we already have in the health system.

Third, a number of participants asserted, and many agreed, that shifts in how the health system is organized will likely disrupt the current regulatory approach to scopes of practice (and hence workforce-planning efforts). For example, if more professionals are working in interdisciplinary teams, and more care is being provided in outpatient settings and complemented by patient self-management and supports from caregivers, the current rules that establish who can do what will need to be reconsidered.

Finally, several participants pointed out that we also have several types of health worker that we rely upon heavily in the health system, but that are not regulated through the *Regulated Health Professions Act, 1991* but through other legislation and regulations (e.g., paramedics) or that are not regulated at all (e.g., personal support workers). Any effort to include these types of health workers within the traditional regulatory approach would likely create issues that need to be considered in future workforce planning.

The needs of patients are not incorporated into planning efforts

Most dialogue participants agreed that a third dimension of the problem was that the needs of patients are not incorporated into health workforce-planning efforts. First, many participants noted the lack of data at the individual and community level about health needs and care preferences, both in general and in relation to ethnocultural and other perspectives, which is needed for optimal workforce planning. Second, some participants suggested that the current composition of the health workforce does not reflect: 1) local communities' health needs and care preferences, which suggests that past workforce planning has not been attentive to these considerations; or 2) local communities' ethnocultural and other characteristics, which in some cases may be desirable but in others may reflect racism that the health system should not allow. One participant noted the particular challenges faced in workforce planning for Indigenous peoples given the even larger gaps in available data and the small numbers of trained Indigenous health workers of different types.

The definition of health adopted by policymakers and stakeholders is too narrow to make meaningful progress in health workforce planning

The fourth dimension of the problem highlighted by dialogue participants is the 'diseases and symptoms' definition of health being used (implicitly or explicitly) to inform decision-making about healthcare and hence planning the health workforce. Several participants argued that a focus on keeping the population healthy would give greater attention to disease prevention, health promotion and the broader social determinants of health and hence to a much broader array of types of workers in workforce planning.

Demographic changes and shifts in health-system arrangements create uncertainties when planning for the future health workforce

Dialogue participants noted as a fifth dimension of the problem the uncertainties created by demographic changes (both among patients and professionals) and shifts in health-system arrangements (such as team-based care). Participants gave the most attention to demographic changes among health professionals, and specifically to millennials entering the health workforce with a different set of expectations about work-life balance, technology, and collaborative and team-based workplaces than the generations that preceded them, all of which will have implications for workforce planning.

Political constraints have hindered progress in health workforce planning

Finally, the sixth dimension of the problem that participants identified was that political constraints have hindered progress in health workforce planning. Participants noted how the four-year mandates of politicians limit the ability of themselves, public servants, and stakeholders to pursue long-term health workforce planning approaches that set the stage for system transformation. Instead, workforce planning is often based on reactions to stakeholder demands.

DELIBERATION ABOUT ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH FOR ADDRESSING THE PROBLEM

Before discussing each element individually, most dialogue participants agreed that all elements needed to be pursued together. Despite the implication in the evidence brief that some of the elements could be pursued without the others (e.g., that element 2 could be used as the 'hit the ground running' approach without first pursuing the 'build from the ground up' approach outlined in element 1), participants suggested that the elements should not be viewed as alternatives, but as necessary complements to each other. Furthermore, a number of participants agreed that each element should be considered in ways that ensure flexibility, not rigidity.

Element 1 – Determine the short-, medium- and long-term health needs of the population, and describe the healthcare and health promotion/disease prevention functions required to meet those needs

Dialogue participants generally agreed that element 1 was an important part of a comprehensive approach to workforce planning, however, they identified five requirements for this element to be as helpful as it could be: 1) more and better data to inform our understanding of health needs and care preferences; 2) an inclusive process for defining and prioritizing needs; 3) a balanced approach that acknowledges the difference between needs and wants; 4) greater emphasis on health promotion and disease prevention; and 5) a systematic, transparent and routine planning process.

More and better data to inform our understanding of health needs and care preferences

The first requirement participants discussed with respect to element 1 was more and better data to inform our understanding of Ontarians' health needs and care preferences. Participants gave particular attention to the lack of data about health needs and care preferences by demographic, ethnocultural and socio-economic group, although some cautioned that being overly attentive to preferences for care by someone of similar ethnocultural background could lead to divisions in the province rather than equality and inclusiveness (which we return to in the next paragraph). Many participants suggested that getting the right data was a key first step in health workforce planning.

Inclusive process for defining and prioritizing needs

A number of dialogue participants agreed that any process established to define and prioritize needs would need to be inclusive, given how the process would create winners and losers and hence be inherently political. They suggested that the process should engage the full spectrum of policymakers and stakeholders, including citizens, patients, caregivers and health workers. They also indicated that an inclusive process could help to gain buy-in and offer an opportunity for discussing the rationale for any tough decisions that are made.

Balanced approach that acknowledges the differences between needs and wants

The third requirement identified by participants in discussing element 1 was differentiating needs and wants. Some participants suggested that this could be addressed within a systematic and transparent process for establishing the health needs of Ontarians. One participant suggested that it would be difficult to get around this challenge, and as such the focus should instead be on determining what people are willing to pay for (either out-of-pocket or through their tax contributions).

Greater emphasis on health promotion and disease prevention

The fourth requirement discussed by participants was paying greater attention to health promotion and disease prevention in workforce-planning efforts. Specifically, many participants stated that the concept of health needs should be broadened beyond what patients need when they're sick to include what they need to keep them from getting sick. They noted that such a broadening would likely mean relatively less attention to hospital-based and physician-provided-services and more attention to other types of health and social services, which would have significant implications for the workforce in both health and social systems. Some participants suggested that the need for supports that are beyond the health system should be addressed before proceeding with efforts to plan around the absence of such supports.

Systematic, transparent and routine planning process

Participants also discussed the need to establish a systematic, transparent and routine planning process, which several participants acknowledged was currently lacking. Some participants highlighted the quantitative

aspects of such a process, and in particular the need to develop (or adopt and adapt) robust modelling software, and one participant cited the positive experiences with such software in Alberta. Other participants highlighted the more qualitative aspects, and in particular the need for capturing 'frontline intelligence' (which they described as including lived experiences and on-the-ground realities) through stakeholder and health worker engagement. Participants differed in their views about whether the planning process should be developed and implemented by a central body – whether existing or newly established – that would be held accountable for ensuring health workforce planning was systematic, transparent and routinized.

Other observations

A number of sub-elements included in element 1 in the evidence brief were not focused on during deliberations. Specifically, there was little discussion about whether it was important to draw on syntheses of evidence about the effectiveness and cost-effectiveness of interventions to address the health needs of Ontarians, and about the safety, effectiveness and cost-effectiveness of the health workers who could potentially deliver these interventions. Additionally, there was little discussion about whether there was a place for deliberative processes within which agreements could be pursued related to which functions are adopted by whom (although the point was made that the process needs to ensure that a big-picture lens is taken to ensure that we don't simply continue with the status quo).

Element 2 – Establish the most appropriate models of care for meeting population health needs, and determine health workforce requirements, while balancing effective demand

Dialogue participants also generally agreed that element 2 was an important part of a comprehensive approach to workforce planning and they identified five requirements for this element to be as helpful as it could be: 1) adequate integration of technological advances when determining the most appropriate models of care and health workforce requirements; 2) clearly defined roles within existing professional scopes of practice; 3) greater diversity in the mix of health workers incorporated into models of care; 4) better integration of diverse population needs into health workforce planning processes; and 5) strong leadership at all levels of the health system.

Adequate integration of technological advances when determining appropriate models of care and health workforce requirements

The first requirement identified by dialogue participants in relation to element 2 was that technological advances – ranging from information and communication technologies to diagnostic and treatment innovations – be considered when defining functions and models of care. Participants noted that these technological advances are already influencing: 1) how care is delivered (e.g., by creating opportunities for remote consultations in place of traditional face-to-face encounters between patients and providers); 2) the settings in which care is delivered (e.g., by creating opportunities to move services out of hospitals and into community settings); and 3) by whom care is delivered (e.g., by creating opportunities for patients and their caregivers to take a greater role in self-management). They also suggested that these advancements would continue to redefine functions and models of care in the future.

Clearly defined roles within existing professional scopes of practice

Dialogue participants identified as a second requirement greater clarity in professional roles and more collaboration in addressing grey areas. Participants differed in how vigorously to pursue this, however, with some advocating for collaboratively finding ways to get rid of overlaps in professionals' scope of practice to reduce confusion about who can and should be doing what (e.g., through deliberations among all professional colleges), and others suggesting that some overlap and a certain amount of flexibility would be needed to meet the diverse needs of communities across the province (e.g., it isn't always possible to ensure there is a set number of doctors or nurses in a particular community). Some participants also suggested that more

effort was also needed to address within-profession variations, with one participant noting that "a nurse is not a nurse is not a nurse."

Greater diversity in the mix of health workers incorporated into models of care

The third requirement identified by dialogue participants was greater diversity in the mix of health workers incorporated into models of care. Several participants noted that most models of care involve only a few types of health professions and that the focus on interprofessional teams over the last decade has not been embraced everywhere and has typically not accommodated categories of health workers (such as personal support workers) who are not covered by the *Regulated Health Professions Act, 1991*. One participant also noted that planning for models of care have seldom played up the role of patients (e.g., in self-management) and caregivers (e.g., as members of the care team).

Better integration of diverse population needs into health workforce planning processes

Dialogue participants identified diverse population needs as a fourth requirement when defining functions and models of care. Several participants stated that not all communities can be well served by a standard model of care. One participant suggested that better frameworks, tools and resources are needed to obtain an accurate representation of population needs across diverse geographic (e.g., northern), ethnocultural (e.g,. Indigenous), linguistic (e.g., French-speaking) and other communities, and then models of care need to be adapted to best meet these needs, and many participants agreed with the latter point. Some participants also suggested that models of care need to account for diversity among health workers (e.g., not all physicians have the same level of motivation, interests and training).

Strong leadership at all levels of the health system and outside of the health system

The fifth and final requirement identified by participants was strong leadership at all levels – from the community to the provincial government – given the political 'costs' associated with working through these challenging issues. Keeping in mind these political costs, one participant suggested that the most realistic (and perhaps the most rational) approach to pursuing element 2 (and element 1) would be for system planners to focus on those approaches that would best position the health system to achieve marginal gains from the current starting point, while taking into account the anticipated behavioural responses and competing interests that are likely to affect the adoption and implementation of these approaches. This same participant noted that while this may not be the most popular framing, it reflected the view taken by a number of economists focused on how best to approach health workforce planning, and provides a helpful alternate lens.

Element 3 – Select appropriate policy levers to meet health workforce planning objectives

Dialogue participants had mixed reactions to element 3 (which we return to in the next sub-section) but, as with elements 1 and 2, they identified four requirements if this element were to be pursued: 1) expand the list of policy levers considered to meet health workforce planning objectives; 2) move beyond incremental change and towards significant transformation; 3) pursue a collaborative pan-Canadian approach to health workforce planning; and 4) ensure adequate attention is paid to the domains outside of health that can influence health workforce planning.

Expand the list of policy levers considered to meet health workforce planning objectives

Many dialogue participants stated that the list of policy levers provided in the evidence brief were too focused on health workers (and regulated health professions in particular) and they identified a number of additional levers to be considered:

- improving patient education to support self-management, improving awareness of different treatment options, and facilitating engagement in shared decision-making;
- improving the support provided to caregivers, and further formalizing their roles in models of care;
- making choices that leverage technological advances, particularly the information technology infrastructure;
- identifying effective models of care and scaling them up;
- harnessing leadership to promote an organizational culture that prioritizes systematic, transparent and routine health workforce-planning initiatives; and
- optimizing approaches to governance (e.g., sub-regional planning) to support improvements in health workforce-planning efforts.

Move beyond incremental change and towards significant transformation

The second requirement identified by participants emerged from the observation that, while the levers presented may be considered feasible, they represent 'tinkering' around the edges rather than fundamental change that can lead to significant health-system transformation. Several participants noted that using the standard toolkit of policy levers would only maintain the status quo. Others insisted that there was a need for 'disruptive innovation' to challenge established practices, as well as incentives to promote such innovation, and they provided examples of what was needed:

- integrating education and training programs so that health workers are trained in teams to practise in teams (which is already employed by a number of schools);
- adjusting educational approaches so that they take into account the diversity of settings in which health workers are needed (e.g., urban versus rural and remote northern communities); and
- training healthcare workers in the same settings in which they intend to work (e.g., training nurses in rural settings if they are going to work in rural settings).

Some participants also argued for the use of policy levers that would match the number of available health workers to the needs of the province, while others suggested using policy levers to address the barriers that international medical graduates face when trying to practise in the province.

Pursue a collaborative pan-Canadian approach to health workforce planning

Dialogue participants noted that this element also needed to acknowledge how planning decisions in one province affected other provinces and hence to incorporate a collaborative pan-Canadian approach to workforce planning.

Ensure adequate attention is paid to the domains outside of health that can influence health workforce planning

Lastly, dialogue participants suggested that this element also needed to consider non-health policy domains that have an influence on the health workforce, such as federal immigration policies. One participant gave the example of an immigration policy that attracted pharmacists from other countries who were found to be ill-prepared for the Ontario labour market after they'd arrived in the province.

Considering the full array of elements

As noted above, dialogue participants generally supported elements 1 and 2 but they called for a more expansive view of element 3 and they identified a number of requirements for these elements to be as helpful as they could be. Participants also identified several cross-cutting themes that should be front and centre in discussions about health workforce planning:

- considering how to best invest in the software that will allow for the dynamic modelling of the workforce and simulations of the impacts of changing models of care on the workforce;
- recognizing that the political and change-management costs will be high; and
- committing to striking the right balance between local and provincial planning and between system-wide planning and market forces.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Overall, participants acknowledged that when planning for the future of the health workforce, there are a number of promising ways forward that could be pursued. They also identified a number of conditions that could facilitate action on health workforce planning: 1) the current federal/provincial 'health accord' discussions; 2) the introduction of Bill 41 (the proposed *Patients First Act*); 3) the apparent openness of at least some professional regulatory colleges to promote more sustainable, system-wide change; and 4) renewed commitments to invest in and support innovation in the health system. However, they identified three types of barriers that would need to be overcome: 1) interest groups and politics; 2) existing regulatory approaches; and 3) lack of imperative to take action.

Interest groups and politics

The first barrier noted by most participants was the challenge posed by interest groups and the existing politics in the province. Starting with interest groups, many participants felt that there would be winners and losers in pursuing any of the elements discussed, which would serve as an impetus for professional associations and organized labour to mobilize in support of or opposition to any efforts being pursued. This kind of friction, particularly when it involved professional scope of practice, was noted by many participants as the key factor underpinning 'turf wars' in the province. Unfortunately, most participants stated that it would be difficult to overcome professional interests, despite the need to focus on the most effective and efficient way to meet the needs of Ontarians. Turning to politics, many participants noted the politics created by our four-year election cycles. Specifically, a number of participants pointed to the limited incentives for elected politicians to move beyond short-term political imperatives to focus on longer term and 'big picture' priorities like improving health workforce planning.

Existing regulatory approaches

The second barrier identified by dialogue participants in the deliberation about implementation considerations was existing regulatory approaches. Many participants suggested that the biggest institutional barrier was existing regulations that dictate labour dynamics, define scopes of practice, set out the parameters of decentralized professional accountability ('self regulation'), and determine how organizations like hospitals behave. One participant used as an example of the latter some midwives not having hospital privileges. Other participants suggested that professional regulatory colleges' habit of working in silos makes collaboration and change difficult.

Lack of imperative to take action

The third and final barrier highlighted by dialogue participants was the fact that while big changes are needed over the long term, they are not necessary needed in the short term. That said, some participants suggested that making adjustments to the current workforce may be an option, given it includes many motivated and talented individuals who can be engaged, and that successes here could be used to make the case for bigger changes in future.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

During the deliberation about next steps, most dialogue participants agreed that there are a number of commitments that could be considered by all stakeholders interested in improving health workforce planning.

1) establishing an inclusive group to achieve consensus around health workforce-planning priorities, including the creation of a comprehensive process for health workforce planning to ensure progress is made;
2) committing to a true 'patients first' approach to care, whereby health workforce needs are matched to the diverse needs of communities across the province;
3) taking advantage of the opportunities that government initiatives present for initiating system transformation and disruptive innovation (e.g., the *Patients First Act* and 'health accord' renewal);
4) pursuing the many short-term wins that present themselves, evaluate what works, and commit to scaling up effective approaches;
5) recognizing the need to balance macro-level system needs with micro-level needs of local communities; and
6) working collectively and inclusively to avoid the turf wars that have plagued past efforts.

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