CHLNet

Canadian Health Leadership Network
Le Réseau canadien pour le leadership en santé

# A Pan-Canadian and International Project on Return on Investments in Leadership Development in Healthcare: A Proposal

January 2016

# Contents

# A Pan-Canadian and International Project on Return on Investments in Leadership Development in Healthcare

## Introduction

The Canadian Health Leadership Network, through the auspices of its Research and Evaluation Working group (CHLNet-R) is designing and conducting both a pan-Canadian and international research project aimed at developing a valid and reliable tool and/or technique for determining the Return on Investment (ROI) from formal leadership and leadership development programs. ROI can be a powerful tool to help identify health leadership interventions or programs that have the greatest potential to improve outputs and outcomes in relation to their costs. Over the past eight months—based on the initiative by Michael West from the King's Fund in the United Kingdom[1] (UK), augmented by additional discussions Dr. Graham Dickson has had with Vijaya Nath, Director, Leadership Development at the King's Fund and David Sweeney, Director of Leadership at Health Education and Training Institute in New South Wales Australia—CHLNet-R has outlined an approach to this project that is profiled in this proposal. However, if the international project becomes not viable, a pan-Canadian only project will be undertaken. We believe this proposal adds great value to both CHLNet as a whole and for individual network partners. At the May 26th CHLNet Roundtable, network partners approved moving forward and seeking additional individual partner participation and funding.

## Background and Rationale

In the past year CHLNet and its network partners have been promoting a Canada-wide action plan aimed at gaining support from the national government, provincial governments, and health regions across the country for a coordinated national/regional initiative to grow leadership development in support of health reform in Canada. As part of that plan a Research and Evaluation subcommittee was formed. In the process of carrying out consultations and making presentations to government bodies, it has become clear that the "return on investment'—i.e., the benefits that would accrue to the various partners from a heightened investment and effort in leadership development across Canada—is neither known, nor clear. While it is common sense to argue that improved leadership will improve health outcomes and support health reform, evidence is required to justify that investment—that is, to move money from one place of investment to another in support of leadership development. Cost-benefit analysis is also close to the concept of ROI, where benefits and costs are translated into dollar values. ROI subtracts the costs from the benefits and the higher the ROI the better in making decisions.[2] ROI has

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[1] West, M. (2015). *Leadership and Leadership Development in Health Care: The Evidence Base.* King's Fund: London, UK. Available online @ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf

[2] Roberts and Grimes. (2011). *Return on Investment – Mental Health Promotion and Mental Illness Prevention*. CIHI. Available online @ www.cihi.ca

been shown to work in all types of sectors and programs including leadership development.[3] Benefits by health care organizations have been seen for leadership development programs when individuals return to their workplaces[4] but a simple tool that can be employed to evaluate outputs and outcomes in relation to their costs has not been developed.[5]

While domestic interests in an ROI tool were transpiring, other countries were making similar arguments and investing funds for leadership development based on common sense "faith". However, as competition for funds gets more difficult, and as their need for sustainable leadership talent management funding faces hard questions from policy makers, partners in other countries are faced with a similar challenge: how to show, with evidence based data, that leadership development investments lead to better results, whatever those desired results might be (e.g., better care and outcomes related to patients, easier transformation of the health system, improved health and wellness of staff, and more efficient use of the taxpayer dollar, amongst others). Indeed, one of the main challenges of this study is to be clear about what the potential impact of leadership programming can, in all logic, be; and to then design a model that can be used to assess ROI of leadership programming investments[6]. Some additional factors that lend credence to this study are:

- A number of books and reports published recently in Canada—notably by André Picard (2012), Jeffrey Simpson (2013), Henry Lazar et al. (2014), Marchildon and Matteo, and Naylor (2015)—point out both the reasons why Canadian healthcare should change, as well as the reasons why it does not.[7] André Picard stated that to address these issues "...we need leadership...(and)...The kind of leader we need in Canadian health care is one who is willing to step back from the daily fray and

[3] Phillips, Phillips and Ray. (2014). *Leadership Development and the ROI Methodology: Measuring Leadership Development: Quantify Your Program's Impact and ROI on Organizational Performance*. McGraw-Hill. New York.

[4] Snell and Dickson. (2011). *Optimizing Health Care Employees' Newly Learned Leadership Behaviours. Leadership in Health Sciences* Vol. 24(3), p 183-195.

[5] West, M. (2015). *Leadership and Leadership Development in Health Care: The Evidence Base.* King's Fund: London, UK. Available online @ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf

[6] It may also be that the potential impacts of a program may differ individual to individual in that program; i.e., each person may have a desirable result for their personal leadership growth—in the context of improved organizational outcomes—that is unique to their role. A model of ROI may have to take this circumstance into consideration if it is to be an effective tool for evaluation purposes.

[7] The books and reports are: Lazar, H., Forest, P-G., Lavis, J.N., & Church, J. (Eds.) (2014). *Why is it so hard to reform health care in Canada?* Queen's Policy Studies Series - School; 1 edition: Montreal; Picard, A. (2012). *The Path to Health Care Reform: Policy and Politics.* The 2012 CIBC Scholar-in-residence Lecture. Conference Board of Canada: Ottawa; and Simpson, J. (2013). *Chronic condition.* Penguin Group Canada: Toronto. Picard, A. (2012). *The Path to Health Care Reform: Policy and Politics.* The 2012 CIBC Scholar-in-residence Lecture. Conference Board of Canada: Ottawa, p. 189; Marchildon, G.P., and L.D. Matteo. (2014). *Bending the Cost Curve in Health Care: Canada's Provinces in International Perspective*. Toronto: University of Toronto Press; Naylor D (2015). *Unleashing Innovation: Excellent Healthcare for Canada*. Health Canada: Ottawa.

address the big picture."[8] In addition, a recent Partnerships for Health System Improvement study (2014)—*Leadership and Health System Redesign*—concluded that Canada did not have the leadership capacity to lead system change and collective action is required.[9] Finally, a parallel CHLNet study (2014) sent to Canadian health organizations found that over 75% of respondents felt that there was a significant leadership gap between the leadership skills needed to foster health reform, and current leadership skills. Only 39% of total respondents had a formalized approach to succession planning.[10] All of these studies point toward a predisposition to increase investments into leadership development programming.

- There is support by CHLNet for adoption of, and actual use of, the *LEADS in a Caring Environment capabilities* framework in many health jurisdictions in Canada. LEADS defines the shared qualities of leadership for leaders/managers, physicians, other clinical professions, and employees alike. There are now a number of jurisdictions that have been using LEADS for a few years and that might well be mature enough in their use to be considered as potential 'research cases'. There is also the potential to use other LEADS-compatible frameworks to ensure comparability based on a common leadership language. Accordingly, one might also ask the question as to whether or not the use of a common language—across many programs and many jurisdictions—has had an impact on the success of health reform.
- The National Health Services (NHS) Health Leadership Academy delivers health leadership development programs based on the premise that better leadership leads to better patient care. It has its own leadership framework based on nine leadership dimensions.[11] The King's Fund (West, 2015) recent work on an evidence base for leadership in health care showed that "overall there is little robust evidence for the effectiveness of specific leadership development programmes" and "more evidence-based approaches to leadership development in health care are needed to ensure a return on the huge investments made."[12] Further discussions with the King's Fund reveals that there may be some gaps in the literature review including medical leadership and engagement, and international evidence. In follow-up discussions with the King's Fund in January 2016, verify their participation in the project. As their project year-end is December 2015, details on what that contribution will be are still being discussed and will be firmed up in the near future.

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[8] Picard, A. (2012). *The Path to Health Care Reform: Policy and Politics.* The 2012 CIBC Scholar-in-residence Lecture. Conference Board of Canada: Ottawa, p. 189.

[9] Dickson & Tholl and PHSI Research Team (2014). Cross-case analysis final report. Available online @ http://chlnet.ca/tools-resources/research

[10] CHLNet. (2014). *Final Report: Canadian health leadership benchmarking survey report*. Canadian Health Leadership Network: Ottawa. Available online @ http://chlnet.ca/tools-resources/research

[11] NHS Leadership Academy. (2013). *Healthcare Leadership Model*. NHS: UK. Available online @ www.leadershipacademy.nhs.uk/wp-content/uploads/dlm_uploads/2014/10/NHSLeadership-LeadershipModel-colour.pdf

[12] West, M. (2015). *Leadership and Leadership Development in Health Care: The Evidence Base.* King's Fund: London, UK. Available online @ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf

- In Australia the Health Education and Training Institute (HETI) has initiated a significant effort to grow leadership and management talent throughout the state of New South Wales, as HETI provides leadership development programming to hospitals and regions in that state. (HETI) has also adopted a version of the Canadian LEADS framework; the NSW Leadership framework.[13] HETI has worked extensively on its website to provide tools and resources to augment their programming with quite impressive results.[14] They too are "under pressure" to evaluate the effectiveness of their programs before those programs can be expanded across the state. In discussions with Dr. Graham Dickson (as an international advisor to their work) they have shown interest also in joining in with a four-country study that would help them solve their issue. Subsequent discussions in January 2016, reveal that HETI is under new leadership and will not be able to participate at this time.

## Methodology

This proposal is for CHLNet to develop and carry out a research study aimed at (1) developing a model to assess ROI for health leadership development programming;(2) designing and piloting that model in a number of jurisdictions where robust leadership development has been happening over the past three years; and (3) finalizing a cost-effective method for determining ROI as a matter of program design and delivery. To reflect these objectives, a three phased approach is proposed plus a pre-phase to seek funding.


The intention is that this research study will be done as an international study to be cooperatively developed and carried out by representatives of one or more of the countries (and individuals) identified in this paper. If context and time does not allow for this, then it will be undertaken in Canada to begin (i.e., with a research team made up solely of interested individuals, network partner organizations, and universities from across Canada) and then shared internationally.

### *Phase I: Scoping Review*

An initial scoping review will be undertaken to validate Dr. West's work in the UK, and gather as much intelligence as possible on the theory and practice of effective ROI determinations (and other health economic evaluations such as cost-effectiveness and cost utility) and leadership development interventions. A conceptual or "logic model" for linking leadership quality to organizational outputs and outcomes will be developed (see Appendix B for an initial concept piece). Desired outputs and outcomes

[13] NSW HETI. (2013). *The NSW Leadership framework*. New South Wales. Available online @ www.heti.nsw.gov.au/Global/HETI-Resources/leadership/HETI-leadership-framework.pdf

[14] NSW. *Leadership and Management Springboard* website http://www.springboard.health.nsw.gov.au/

will be defined and might include patient experience, patient mortality/morbidity, staff engagement and well-being, turnover, presenteeism/absenteeism, quality of care or financial performance.

Regardless of whether a program uses LEADS as a guide for program development, or a compatible framework, in order to determine the appropriate "potential impacts" of leadership programming, there are three factors that need to be taken into account in assessing program effectiveness. Effectiveness will differ according to the role and responsibility each person in a program has (e.g., a front-line supervisor may wish to improve teamwork in his or her unit, while a CEO may wish to improve the transition between hospital care and community care); the context for delivery of the program (i.e., is it aimed at individual development or a broader organizational purpose); and of course the comprehensiveness of the delivery model used to develop leaders (e.g., one cannot expect from a one-day program what one might expect from a year long program).

The review will define the scope of health leadership for the project in its various contexts such as: continuum from emerging to executive; by type including nurses, physicians, citizens, community members, etc.; and by sector. The rationale is that LEADS, the leadership language CHLNet has endorsed embraces the notion that anyone can exercise leadership capabilities regardless of position.

The scoping review will refer to the Arksey and O'Malley's methodological framework of: identifying the research question; identifying and selecting relevant studies; charting the data; collating, summarizing and reporting results[15], as well as other methodological frameworks (e.g., Phillips et al, 2014) as recommended by partners in the study. Academic partnerships will be sought to undertake the review (including peer review and grey literature) for the design of a ROI evaluative instrument. Connections to support universities and show the value of leadership development in terms of health reform projects is needed e.g., interprofessional teamwork; workforce wellness; implementation of reforms such as changes in scope of practice. These connections may well attract support within that community for this project and CHLNet.

### *Phase II: Design Instrument and Pilot Test*

Following the scoping review, a two-step process will be employed to create the desired ROI instrument: a design stage and a pilot test stage. Ideally, the instrument will fulfill two purposes. The first is to determine the ROI of an individual leadership program. A second purpose is to be able to allow for the pooling of results to make determinations of ROI overall in a broad multi-program initiative. The tool must also meet the following criteria; that is it must be:

- Elegantly simple—i.e., intuitive to use, easily and quickly administered and the data able to be reasonably quickly interpreted;
- Valid—i.e., it tests both the desired potential impacts of a program and can relate it to the investment in the program;

[15] Arskey, H. and O'Malley L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, 8(1), 19-32.

- Reliable—i.e., is robust and useful with a variety of programs that differ in approach, content, and focus; and
- Cost effective—i.e., is not resource intensive to be carried out.

Once the design stage is complete, Stage 2 is to pilot test the proposed ROI instrument. A more detailed approach will be developed but at this time, it is proposed that the instrument would be pilot tested in selected jurisdictions in Canada who have demonstrated a robust investment in leadership development over the past three years, and that reflect distinctly different contexts and a variety of desired outcomes. If feasible, randomly selected jurisdictions in addition to those "where robust leadership development" has been happening will be chosen to act as a comparator group. Similar cases may well be carried out in various international contexts. Diverse leadership programs that cross provider groups and that span the lifecycle of leadership will be considered. The research team will ensure comparable data can be accumulated and aggregated for benchmarking work (i.e. compare best practices and metrics).

### *Phase III: Final ROI Instrument and Implement*

The instrument to assess ROI that can be used by network partners and other stakeholders on an ongoing basis will be finalized and shared. This will include standardizing materials and tools for implementation and distribution. An effective knowledge mobilization (KM) strategy with advice from the CHLNet KM Working Group will be devised.

## Workplan: Key Activities and Deliverables

The phased approach is outlined below. The workplan begins with a confirmation of the scope, structure and approach for this work. Adjustments to the workplan may need to be made after each Phase pending the outcomes of the previous work. Both a pan-Canadian and international approach is reflected in the plan.

| Phase | Activities | Timeline |
|---|---|---|
| Pre-Phase: Funding | Liaise with network partners, universities and other possible funders for financial and in-kind contributions. Contributions to date are:<br>• Manitoba Centre for Healthcare Innovation: in-kind support<br>• Canadian College of Health Leaders: $7,500<br>• HealthCare*CAN*: $5,000<br>• Canadian Nurses Association: $5,000<br>• Canadian Society of Physician Leaders: $5,000<br>• CMA/New Co: $5,000<br>• Accreditation Canada: $5,000<br>• University of Ottawa: in-kind support<br>• Ontario Hospital Association $5,000 | May to December, 2015 |

| Phase | Activities | Timeline |
|---|---|---|
| | • Alberta Health Services $5,000<br>• Alberta Innovates - Health Solutions $5,000<br>• Canadian Foundation for Healthcare Improvement: in-kind support | |
| Phase I: Scoping Review | • Develop and confirm project charter, structure, team, budget, risk, communication strategy, and workplan<br>• Develop terms of reference for secretariat, steering committee and other potential structures (i.e. core secretariat and work team, etc.)<br>• Implement project management structure and processes<br>• Recruit researcher(s) to undertake scoping review<br>• Establish search protocol (search terms, databases, etc.) and criteria, grouping/cataloguing strategy and assessment process<br>• Undertake scoping review of both peer and grey literature that includes a draft report of findings<br>• Ongoing discussion with UK on international piece<br>• CHLNet Network Partner Roundtable reviews proposal and findings to date<br>• Steering Committee reviews report and revisions made if required<br>• Confirm the conceptual model (e.g. logic model) for linking leadership quality to organizational outputs and outcomes<br>• Identify a methodology for evaluating the impact of leadership development programs both in terms of outputs and outcomes<br>• Identify key concepts, approaches, and components of a cost effective ROI evaluative instrument<br>• Further develop the implementation, budget and timelines for phase II of the project<br>• Confirm if project will include an international pilot test<br>• Seek further funding for phase II | January 1st to March 31, 2016 |
| Phase II: Design and Pilot Test | **Stage 1: Design**<br>• Create work team to build instrument | April 1st to December 15th 2016 |

| Phase | Activities | Timeline |
|---|---|---|
| | • Determine size, scope and breadth of instrument from a "meet the criteria for utility" perspective<br>• Identify key elements of investigation and data collection<br>• Determine data collection procedures<br>• Determine data interpretation and meaning processes<br>• Create accompanying assessment tools, interpretation guides, etc. for use<br><br>**Stage 2: Pilot Test**<br><br>• Establish case study selection criteria for three Canadian jurisdictions. If feasible, randomly select jurisdictions in addition to those "where robust leadership development" has been happening to act as a comparator group<br>• Flesh out evaluation strategy and mechanism for the pilot test (If international pilot is feasible include)<br>• Create a structure for ongoing liaison with international jurisdictions i.e. an international steering committee<br>• CHLNet Network Partner Roundtable progress report<br>• Education and training of pilot test sites<br>• Pilot test the instrument ensuring comparable data and metrics are collected<br>• If feasible, pilot test in various international contexts<br>• Draft report<br>• Steering Committee reviews and evaluates the pilot test findings and makes recommendations for final instrument | |
| Phase III: Finalize ROI Instrument and Implement | • Finalize the methodology for a cost-effective process to assess ROI that can be used by network partners on an ongoing basis<br>• Implement an effective knowledge mobilization strategy with advice from the CHLNet KM Working Group | January 2017 |

| Phase | Activities | Timeline |
|---|---|---|
| | • Steering Committee meets for the last time for final implementation on January 1st 2017<br>• Final ROI instrument presented to CHLNet Network Partner Roundtable | |

## Budget

The budget for this project reflects work being done in three phases. It assumes CHLNet will bear the secretariat costs including long distance phone calls, teleconferences, photocopying, administrative support, budget, etc. It includes only minimal costs for travel during the pilot test phase and therefore assumes most meetings will be done virtually. A more detailed budget for phases II and III will need to be developed after phase I has been completed. An in-kind contribution has been provided to undertake the scoping review. Given the current reality, the budget for this project is estimated to be $50,000 however will be reassessed after each phase. In Phase I, this is mainly for a researcher for 20 days @$750 per day[16] to:

- conduct and analyze findings from the scoping review
- develop the conceptual framework
- provide the evidence-based recommendations that will guide the design of the ROI evaluative instrument

In Phase II, again this is for a consultant (40 days @ $750 a day) and work team (in kind contributions) to:

- design the ROI instrument
- create appropriate tools and processes for the ROI instrument's implementation
- create case study selection criteria
- develop an evaluation strategy for pilot
- conduct education and training of pilot sites
- adapt/adjust the instrument and tools to reflect evaluation feedback
- create a final deliverable of an instrument and tools for use
- write a draft report

The costs for Phase III for full implementation of the ROI instrument cannot be determined at this time. The budget and associated timelines are provided below:

| Phases and Deliverables | Timelines | Cost ($) |
|---|---|---|
| Phase I: Literature Review | January 1 to March 31, 2016 | $ 15,000 (20 days @$750 per day) |

[16] Graduate students may be used which will substantially reduce the per diem rate.

| Phases and Deliverables | Timelines | Cost ($) |
|---|---|---|
| Phase II: Design and Pilot Test | April 1 to December 15, 2016 | $ 35,000 (40 days @ $750 per day plus $5,000 for additional materials and travel, if necessary during the pilot) |
| Phase III: Finalize ROI Instrument and Implement | January 2017 | To be confirmed |
| *Total Timeline/Cost* | January 1, 2016 to January 2017 | $50,000 plus HST |

# Organization, Project Structure and Team Bios

## Organization: The Canadian Health Leadership Network (CHLNet)

**Vision: Better Leadership, Better Health – Together.**

**Mission: Working together to create value and grow leadership capacity across Canada.**

**Values: Trust, reciprocity and transparency.**

*The Canadian Health Leadership Network's mission* is to grow health leadership capacity in Canada. We have a bold vision that Canada's health system can be restored as an example of excellence internationally, and that improving the quantity and quality of health leaders in the country is essential to delivering on this mission.

Please see the CHLNet 2013-2016 Strategic Plan for details on how we plan to achieve our vision and objectives. The Plan and additional CHLNet documents are located under our Tools & Resources menu.

**Our Philosophy: Leadership without Ownership**

We believe no one organization can own health leadership. The evidence suggests that individual health organizations have systematically under-invested in leadership development due to a failure to see leadership as a social good. As a country, Canada must build now focus on the collective organizational leadership capacity rather than individual leadership development.

As we work to expand the leadership capacity of health organizations and realize the full potential of individual health leaders, CHLNet believes that the overall health system performance will improve. This is the driving force behind CHLNet. The network now reaches from coast to coast and across a growing spectrum of professions.

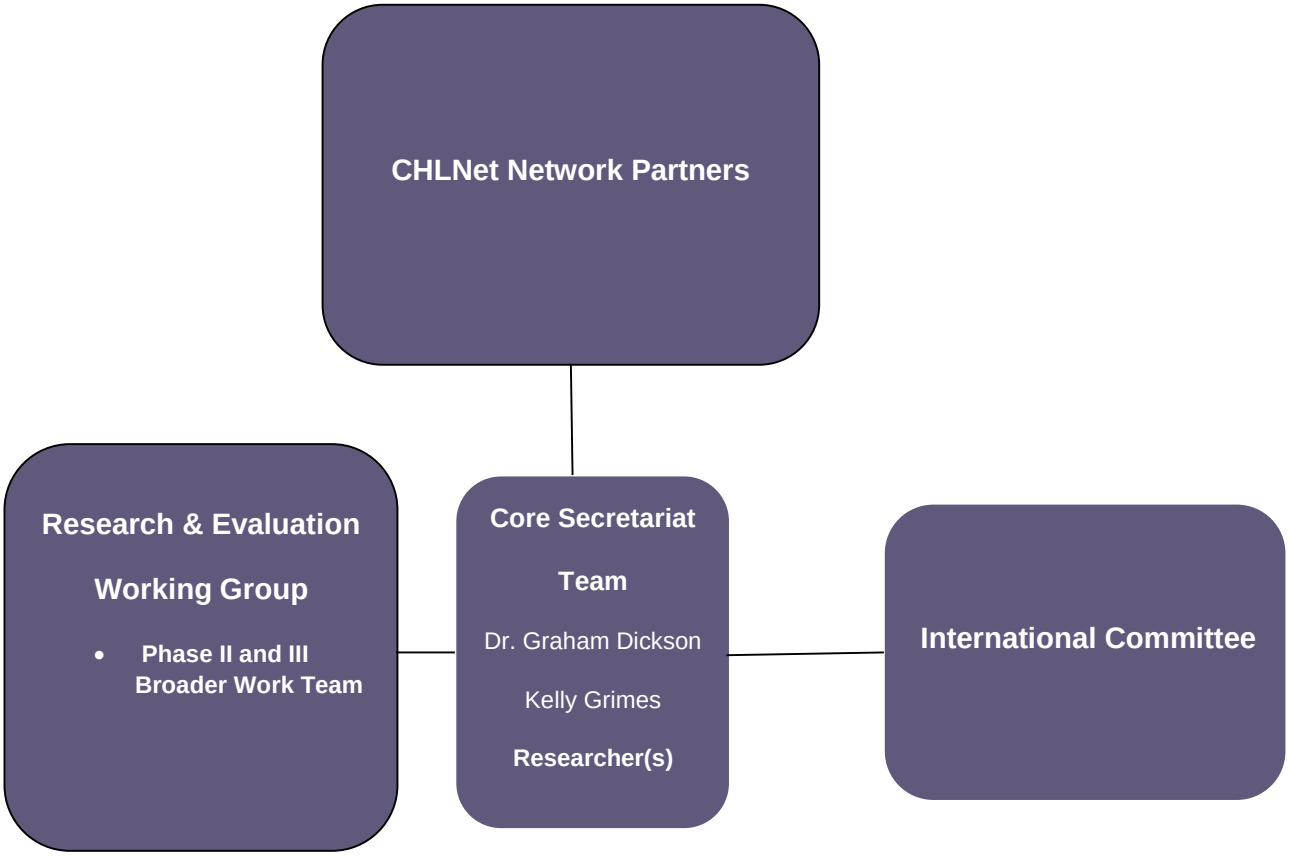
*CHLNet Network Partners* include: Current network partners include: Academy of Canadian Executive Nurses, Accreditation Canada, Alberta Health, Alberta Health Services, BC Health Leadership Development Collaborative (BCHLDC), BC Ministry of Health, BIOTECanada, Canadian Agency for Drugs & Technologies in Health, Canadian Blood Services, Canadian College of Health Leaders (Host Secretariat), Canadian Federation of Nurses Unions, Canadian Foundation for Healthcare Improvement, Canadian Institute for Health Information, Canadian Medical Association, Canadian Nurses Association, Canadian Patient Safety Institute, Canadian Pharmacists Association, Canadian Society of Physician Leaders, College of Family Physicians of Canada, Eastern Health, Emerging Health Leaders, George and Fay Yee Centre for Healthcare Innovation, HealthCare*CAN*, Health PEI, Manitoba Health, MEDEC, Mental Health Commission of Canada, Nova Scotia Health Authority, Ontario Association of Community Care Access Centres, Ontario Hospital Association, Ontario Ministry of Health and Long-Term Care, Patients Canada, Public Health Agency of Canada, Royal College of Physicians and Surgeons of Canada, Royal Roads University, Rx&D, Saskatchewan Health, Société Santé en français, Victorian Order of Nurses and Yukon Health and Social Services.

## Project Structure

The proposed secretariat will include two core members: Dr. Graham Dickson and Kelly Grimes plus any administrative and research support. Additional members will be added each phase. For example, phase I will also include a researcher(s) conducting the scoping review, and other experts. The CHLNet Research and Evaluation Working Group, that bridges academics and knowledge users would be used as a sounding board or Steering Committee to provide advice and oversee the project from the Canadian perspective. It will take on additional members as required especially funders (see Appendix B for the terms of reference). The proposal and its progress would be presented to the CHLNet Network Partners at the semi-annual roundtables. A separate international committee will need to be established for ongoing communication and liaison.

| Research and Evaluation Group Member | Position |
|---|---|
| Graham Dickson (Chair) | CHLNet Senior Policy Advisor, Academic advisor to the Canadian Society of Physician Executives (CSPL) |
| Ross Baker | Professor and Program Director, MSc. Quality Improvement and Patient Safety Institute of Health Policy, Management and Evaluation, University of Toronto |
| Ivy Bourgeault | Professor, Telfer School of Management & The Institute of Population Health, U of O; CIHR Rep |
| Chris Eagle | CHLNet West Champion (former CEO of Alberta Health Services) |
| Kelly Grimes | CHLNet Executive Director |
| Frank Krupka | Executive Director George and Fay Yee Centre for Healthcare Innovation, University of Manitoba |
| Jonathan Mitchell | Manager, Policy and Research Accreditation Canada |
| Denise Perret | ADM, Alberta Health |
| Michel Tremblay | Société Santé en français |
| Bill Tholl | President and CEO HealthCare*CAN* |
| John Van Aerde | President, Canadian Society of Physician Leaders |

The project structure is indicated below:




## Secretariat Team Bios

Additional member bios will be added as the core secretariat team is confirmed.

### *Graham Dickson*

Graham Dickson is a senior policy advisor to CHLNet and is an academic advisor to the Canadian Society of Physician Leaders. He is also a member of the LEADS Collaborative, a not-for-profit start-up dedicated to applying LEADS to enhance leadership capacity in the health sector. Currently he participates in an international initiative called the World Federation of Medical Managers, devoted to developing a common approach to developing medical leaders in both developed and underdeveloped countries. Prior to leaving Royal Roads University, Graham was the founding Director of the Centre for Health Leadership and Research. Graham lead the development of LEADS and helped develop the Master of Arts in Leadership (health specialization) at Royal Roads University.

### *Kelly Grimes*

Kelly Grimes is the part time Executive Director with CHLNet. In addition to this role, she is an experienced consultant who has participated in multiple federal and provincial initiatives, including: the Role of Pharmacists in Primary Health Care; Strengthening Primary Health Care in Alberta through Family Care Clinics; Evaluation of Family Health Teams in Ontario; and ROI in Mental Health Promotion and Prevention. Kelly was previously Senior Director of the Quality Worklife Quality Healthcare Collaborative and Director of Research at Accreditation Canada. With 20 years of experience in the policy, research and management fields in health care, she has a strong understanding of the health system and its interactions at all levels of care and service. Kelly has a Masters of Health Sciences from the University of Toronto and Science and Business Degrees from the University of Ottawa.

### *Work Team: Phase II and III*

During the pilot test and implementation phases, it is envisioned that a broader work team will be required. These may include:

- A representative from the George and Fay Yee Centre for Healthcare Innovation (who has offered to be provide research services)
- John Parker, Hamilton Health Sciences (who is undertaking an ROI project on interdisciplinary care)
- Susan Drouin, McGill University (just completed a Doctor of Social Sciences at Royal Roads University) that utilized a methodology to determine the effectiveness of a McGill University leadership program that utilized LEADS
- Consultant(s) who undertake the literature review
- Volunteers from CHLNet member partners (with first priority to funders)

## Conclusion

CHLNet will undertake this ambitious applied research project aimed at answering questions pertinent to the return on investment of leadership programming to determine whether or not such programs ‘make a difference’ and can be used as a tool in decision-making. To do so requires consideration of a number of factors, the potential engagement of a number of partners, and a commitment of CHLNet to the value of the project. Both financial and in-kind support has been found. We believe the evidence generated will help make the business case needed to advance leadership and leadership development across this country to improve health system performance and sustainability that will ultimately benefit the patients of Canada and beyond.

# Appendix A

## CHLNet Research and Evaluation Working Group

## Terms of Reference

### Purpose

To stimulate and grow applied health leadership research in order to better understand the emerging discipline of health leadership, inform leadership development efforts, and assess how leadership impacts system performance.

### Principles

- Dedicated to improving Canadian health performance through evidence-based leadership.
- Will demonstrate trust and reciprocity: i.e. are willing to work together, share resources, and seek to achieve a collective result that each will benefit from; and that ultimately benefits the patients and citizens of Canada.
- Believe that evidence is foundational for best practice of leadership and leadership development.
- Agree that a stronger link between the research community and the decision maker community is required.
- Accept the importance of leadership in all contexts.

### Duties and Responsibilities

- Link academic researchers with knowledge users (e.g. decision-makers within CHLNet) to build a body of evidence around health leadership.
- Encourage research that sees health leadership as both an enabler of and a set of skills/capabilities for effective system transformation.
- Serve as a sounding board for potential and current CHLNet-related health leadership research projects.
- Discuss and advise on grant and other funding opportunities to build a body of evidence around health leadership, leadership development, and the impact of both. Research should include a focus on systems thinking and strategy, the leadership interface between the political sphere of influence and the health service delivery organizations, and francophone and aboriginal health services. It must be patient-oriented and if possible linked to strategic initiatives across the country such as SPOR.
- Build partnerships amongst member organizations to coalesce resources to seek out mutually beneficial health leadership research opportunities.
- Ensure connectedness to other CHLNet working groups including knowledge mobilization and the health action plan to ensure health leadership research is built into policy, planning and practice.

## Terms of Operation

- Meet at least quarterly for one-hour teleconferences.
- Maintain quality records of meetings.
- Distribute agenda and materials one week ahead of the meeting (responsibility of Chair, along with Executive Director of CHLNet).
- Operate in a spirit of trust and reciprocity.
- Ensure the composition of the group reflects researchers and knowledge users (who are network partners).
- Assign work to volunteer sub-groups when appropriate so as to inform and fulfill goals and objectives of this working group.
- Review the terms of reference on an annual basis.
- Establish quorum of at least 50% of the members at each meeting.
- Provide reports on the working group activities to the network partners for information purposes at the semi-annual roundtables.
- Ensure approval of major deliverables of the working group such as a plan or policy through a motion of partners at the next roundtable and quarterly Secretariat meetings.
- Vacancies will be filled by the working group or Secretariat as required.

*Approved: March 31, 2015*

# Appendix B

## LOGIC MODEL FOR RETURN ON INVESTMENT IN LEADERSHIP DEVELOPMENT PROJECT