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

Top Ten
December 2016

LEADerShip at a Glance
CHLNet's "Top Ten" Suggested LEADS Readings[1]

This year-end version of the Top Ten for 2016 groups article synopses by theme headings that are of greatest relevance and value to CHLNet and its member partners. Three themes are chosen for this issue:

1. The Challenge of ROI in Leadership Development
2. Leadership in the Policy Arena—Policy as a Leadership Tool
3. The Growing Centrality of Patient Engagement in Health System Change

Boon, C., and Biron, M. (2016). Temporal issues in person–organization fit, person–job fit and turnover: The role of leader–member exchange. *Human Relations*, 69(12): 2177-2200.

Center for Creative Leadership (2016). *Driving Performance: How Leadership Development Powers Sustained Success.* White Paper: pp. 1-7.

Wakefield, N., Abbatiello, A., Agarwal, D., Pastakia,K., and van Berkel, A. (2016). *Global Human Capital Trends 2016.* Deloitte University Press, pp. 1-35.

Callard, F., and Rose, D. (2012). The mental health strategy for Europe: Why service user leadership in research is indispensable. *Journal of Mental Health*, 21(3): 219-226.

Helman, H.J., Smith, L.L., MacKool, M., Mitchell, D.N., and Bayer, C.R. (2015). Health Policy Training: A Review of the Literature. *International Journal of Environmental Research and Public Health.* 13: 1-12.

Verma, A., and Bhatia, S. (2016). A Policy Framework for Health Systems to Promote Triple Aim Innovation. *HealthcarePapers*, 15(3): 9-23.

Tamblyn, R. (2016). *A Perfect Storm: Get Ready for a Paradigm Shift in Health Services and Policy Research.* Longwoods: Open Letters from Canadian Leaders in Healthcare.

Seale, B. (2016). *Patients as partners: Building collaborative relationships among professionals, patients, carers and communities.* The King's Fund.

Baker, G.R., Fancott, C., Judd, M., and O'Connor, P. (2016). Expanding patient engagement in quality improvement and health system redesign: Three Canadian case studies. *Healthcare Management Forum*, 29(5): 176-182.

[1] As recommended by Dr. Graham Dickson (CHLNet Senior Policy Advisor) and Kelly Grimes (CHLNet Executive Director).

Cabaj, M., and Weaver, L. (2016). *Collective Impact 3.0: An Evolving Framework for Community Change.* Community Change Series 2016: Tamarack Institute. 14 p.

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Theme 1: The Challenge of ROI in Leadership Development

CHLNet has embarked on an ambitious project to develop a simple and reliable tool to measure the return on investment of health leadership and leadership development. These three articles help to show the impact on workplaces.

Boon, C., and Biron, M. (2016). Temporal issues in person–organization fit, person–job fit and turnover: The role of leader–member exchange. *Human Relations*, 69(12): 2177-2200.

Focus: The relationship between leadership quality and employee engagement.

This empirical article demonstrates, through a two-year study, the link between the quality of the leader—member (employee) relationship, and two factors important to organizational productivity: perceptions of employees as to their "fit" with the organization and their job (high better than low); and the outcome of employee turnover. For employees in high-quality leader—member relationships, there is a higher perception of organizational and job fit. In terms of turnover, however, a dual finding occurred. First, the quality of the leader—member relationship is positively correlated with turnover only when one aspect of fit—needs and supplies is present. A second finding is that when the needs and supplies dimension of fit is lacking, high quality leader—member relationship may actually increase turnover. In this case, a high-quality relationship with one's supervisor can provide motivation to leave the company and seek challenges elsewhere. In fact, in these cases, the supervisor may even be a driving force for moving on to a better position, not necessarily with the same employer. Indeed, fulfilling the needs of employees such that they perceive high needs—supplies fit seems to be the most salient factor in explaining turnover decisions.

Implications

Employees experience the workplace very directly through their relationship with their supervisor. However, a more important factor in retaining employees—when that relationship is strong—is to ensure that employees receive the materials they need to do their work. Otherwise they will be motivated to leave the organization. What happens, however, if the span of control is so big as to preclude the development of a relationship between a supervisor and employee?

Link to LEADS and CHLNet's Mission

The article provides evidence on the relationship between leadership quality and employee productivity and turnover, consistent with the intent of the ROI study.

Center for Creative Leadership (2016). *Driving Performance: How Leadership Development Powers Sustained Success.* White Paper: pp. 1-7.

Focus: Leadership development and organizational performance.

Using evidence drawn from the private sector, the Center for Creative Leadership (CCL) analysts identified four productivity outcomes that demonstrate the value (return on investment) of leadership development:

- Improved bottom-line financial performance;
- Enhanced ability to attract, develop, and retain talent;
- Improved strategy execution; and
- Increased success in navigating change.

The paper goes on to say that "*when it is done right*", leadership development unquestionably delivers impact. The italics are mine. Clearly there are good leadership development programs and not so good leadership development programs. Other papers by CCL do identify what some of the best practices of leadership development are. It is not good enough just to have a program; that program must itself have the strength to facilitate behaviour changes in leaders.

Implications
If the evidence "proves" leadership development can provide a return on investment (ROI), but only if the proper program is used, then two activities must occur. First, any organization wishing to gain ROI must ensure the program's design is robust enough in order to achieve those goals. Second, the program should be formulated to address the particular purpose/outcome that the organization wishes to achieve. An ROI tool must also therefore be flexible enough to adapt to the potential variety of goals.

Link to LEADS and CHLNet's Mission
The article provides further support for the efforts of CHLNet to develop an ROI tool that can show similar results for leadership programs in the health sector.

Wakefield, N., Abbatiello, A., Agarwal, D., Pastakia,K., and van Berkel, A. (2016). *Global Human Capital Trends 2016.* Deloitte University Press, pp. 1-35.

Focus: Global survey amplifies the importance of leadership

Leadership remains a top priority for senior executives worldwide, ranking second in overall importance in this year's survey. The percentage of companies that rate this issue as important or very important grew to extremely high levels. Today, organizations need to explore new approaches to leadership development. They should seek to apply rigorous, structured, scientific methods to succession planning and development, aiming to identify potential leaders earlier and fast-track them into leadership positions. Also important is to find ways to develop leaders who can collaborate extensively, recognize the need for new leadership skills (such as conceptual thinking), and focus on new leadership cohorts (millennials, women, and diverse individuals). All of this requires implementing a comprehensive culture around leadership to address the leadership gap continuously and systemically. The leadership world continues to be dominated by stories, myths, and fads, often promoting superficial solutions that appear effective but fail to address the issue of helping leaders to learn and that do not deliver measurable impact and results.

This paper contends that leadership efforts remain uneven across companies; and are not rigorous enough. Too few leadership programs are designed on a foundation of research, clear priorities, and assessments of needed leadership thinking and outcomes. Best-practice organizations are developing

an integrated system of leadership that includes a specific leadership strategy, detailed pre- and post-program assessments to measure effectiveness, research-driven content, and blended learning programs with stretch assignments, intensive coaching, and continuous opportunities for leadership development—all relying heavily on data, evidence, and science-based approaches. High-performing companies outspend their competitors on leadership by almost four times.

Implications
Unless leadership programs are designed and delivered according to best practices—with the appropriate rigour and intensity—these programs will not provide a meaningful return on investment. Using an ROI tool for programs not meeting those criteria is a waste of time and energy. Standards for leadership development programming need to be developed.

Link to LEADS and CHLNet's Mission
Better Leadership, better health is CHLNet's vision. If member partners are to invest in developing "better leadership", it would be prudent to ensure that best practices are followed. Similarly, an ROI tool must assume best practices are followed in order to determine return on investment; otherwise, the process itself is flawed.

Theme 2: Leadership in the Policy Arena—Policy as a Leadership Tool

Recently the role of policy in health reform has been debated significantly in the literature, as policy implementation appears to be lacking. As well, CIHR's most recent efforts to "modernize" policy training implies a need to explore attributes of good policy-making and implementation strategies.

Callard, F., and Rose, D. (2012). The mental health strategy for Europe: Why service user leadership in research is indispensable. *Journal of Mental Health*, 21(3): 219-226.

Focus: Engaging mental health service users in mental health research for policy-making.

This article is interesting because it addresses two important themes: mental health improvement; and mental health service user leadership in creating meaningful policies for improvement.

In March 2011, WHO Europe announced the development of a new mental health strategy for Europe. There is clear commitment to include service users and families in the strategy's development. The announcement of the new strategy came on the heels of other European declarations, strategies and projects that emphasize the indispensability of service user involvement in the development, implementation and evaluation of policies that relate to service users.

Of particular interest to the authors was service user and family leadership in research into mental health, as "good policy is based on good research". If service users are to be involved in the development and evaluation of policy relating to them, as well as in research pertaining to them, there needs to be greater commitment to facilitating service users' ability to participate in these activities.

The article outlines a number of factors that can stimulate greater service user engagement in research related to policy-making:

- Establish funding and other mechanisms to support service user leadership in research;
- Utilize the specific expertise and insights of service users within the research arena;

- Transform hierarchies in mental health settings;
- Assess distribution of and control over resources; and
- Support service user organizations.

Implications
Improvement of mental health services is a priority in Canada. Research that is done to influence policy related to that improvement should engage service users and families to ensure that the policies themselves, being research based, reflect the needs and concerns of mental health service users. Five approaches to engage service users and families in a leadership role in research are outlined. These should be evaluated for potential use in the Canadian context.

Link to LEADS and CHLNet's Mission
One of the LEADS capabilities under the Develop Coalitions domain is "Demonstrates a commitment to customers and service". Given the important role of research in shaping policy, and policy being needed to improve mental health services, demonstrating that commitment to the mental health service users and families by giving them a leadership role in research is consistent with LEADS leadership.

Helman, H.J., Smith, L.L., McKool, M., Mitchell, D.N., and Roth Bayer, C. (2015). Health Policy Training: A Review of the Literature. *International Journal of Environmental Research and Public Health.* 13: 1-12.

Focus: A literature review to illuminate needs for improvement to health policy leadership and associated developmental programs.

The context within which health care and public health systems operate is framed by health policies. There is growing consensus about the need for increased health policy leadership and a health professional workforce prepared to assume these leadership roles. Health professional leaders and educators from medicine, nursing, public health, and other disciplines have advocated for the importance of health policy training to support engagement and leadership in public policy issues that impact their professions and the health of communities they serve. At the same time, there is strong evidence supporting the need for a broader policy lens and the need to intentionally target health disparities—i.e. an approach that not only looks at policies affecting the health care and public health systems, but also looks at the health effects of policies in non-health sectors.

This literature review provides an overview of recent literature to inform health policy training approaches (albeit in a US context). Most articles framed health policy as health care policy and only a small number adopted a broader health in all policies definition. Few articles specifically addressed vulnerable populations or health disparities. The need for more rigorous research and evaluation to inform health policy training is compelling. In the opinion of the authors, providing health professionals with the knowledge and skills to engage and take leadership roles in health policy will require training programs to move beyond their limited health care-oriented health policy framework to adopt a broader health and health equity in all policies approach.

Implications
CIHR's efforts to "modernize" health policy training to include leadership skills and to reflect the more "real" world view of health organizations—including public health—is a worthwhile endeavour for CHLNet and its member partners to be engaged in.

Link to LEADS and CHLNet's Mission

The "growing consensus about the need for increased health policy leadership" suggests that CHLNet and its partners can be vital players in reshaping our thinking about what good policy is, and how it can be used as a leadership tool to support change: not just in terms of health disparities as this article suggests, but overall health system reform. Participating in efforts to improve policy training and development is important to CHLNet.

Verma, A., and Bhatia, S. (2016). A Policy Framework for Health Systems to Promote Triple Aim Innovation. *HealthcarePapers*, 15(3): 9-23.

Focus: How policy interventions can facilitate large-scale change at the provincial level.

The Institute for Healthcare Improvement Triple Aim articulates fundamental goals that can guide health system transformation: improved population health, enhanced patient experience and reduced or stable per capita costs. Advancing fragmented and costly health systems in pursuit of these goals requires transformative, as opposed to iterative, change.

Provincial governments are ideally suited to lead this change. By acting as "integrators" who link health care organizations and align incentives across the spectrum of delivery, they can align actions in favour of Triple Aim goals. In this paper, the authors argue that provincial governments in Canada should adopt the Triple Aim framework for health innovation. To do so, they consider the lessons from current efforts towards system-level Triple Aim innovation from jurisdictions outside Canada. They examine a number of policies that are being used to promote the Triple Aim innovation, all of which can be categorized under the classic functions ascribed to health systems: financing, stewardship and resource generation. Finally, they discuss barriers to system-wide Triple Aim innovation and some potential remedies to those challenges.

Implications

Provincial governments need to develop enabling and integrative policy frameworks to guide health reform, if indeed such reform is desired. Those frameworks should address the primary function of such governments: financing, oversight and stewardship of service delivery, and resource generation (i.e. health information technology).

Link to LEADS and CHLNet's Mission

Effective leadership creates the conditions for change and reform. Provincial governments are in a position to exercise that leadership through good policy-making and implementation strategy. If they do so consistent with the goals of Triple Aim, and retaining their role as "enabling leader" so as to enable geographical jurisdictions to contextualize the implementation of those policies, they can be partners in the realization of CHLNet's mission. LEADS is itself an "enabling"—transformational—leadership framework; policy frameworks around the principles of LEADS will be the integrator for subsequent leadership at the local level.

Theme 3: The Growing Centrality of Patient/Consumer Engagement in Health System Change

There are four articles in this theme. All of the articles address the pressures and opportunities that modern social change has brought to health care. Indeed, the earlier article focusing on service user and family leadership in mental health research could just as easily been included in this section, as patient involvement and leadership is now pervading many aspects of health leadership in support of system transformation.

Tamblyn, R. (2016). *A Perfect Storm: Get Ready for a Paradigm Shift in Health Services and Policy Research.* Longwoods: Open Letters from Canadian Leaders in Healthcare.

> **Focus: Major forces in economics, demographics, and information technology create new visions for health service delivery.**

There are major forces, worldwide, that are shifting the way in which health systems will operate, how health services will be delivered, and the role that health services and policy research will play in this emerging frontier. Together—because of their interaction potential—they suggest a massive shift in ways we can conceptualize, support, and practice health service delivery. Consequently, new models of policy development, implementation, and applied research must be employed to "learn" how to change health systems to be in sync with these outside social changes.

The author argues that four major forces are currently at play:

1. The unsustainable escalation in health system costs, exceeding $219 billion in Canada in 2015.
2. The greying of the baby boom generation that will create a very different kind of consumer of health care services: educated, and in need of care.
3. Widespread digitization of health services, coupled with an explosion in consumer-oriented wearable devices, point-of-care diagnostics, and social media has created the opportunity to deliver services in a very different way—e-consults, tele-homecare, self-care robots, and smart homes.
4. The power of "big data" that can create digitalized solutions in health, social, and consumer services.

These trends will also create the demand for research that can interpret the role of context into policy solutions.

Implications

Modern leaders need to envisage the impacts of these changes, and support and encourage new models of research and policy creation/implementation. CHLNet's efforts, and those of its member partners, to stimulate leadership of large-scale change—commensurate with the implications of the social forces outlined in the Tamblyn article—may need to be amplified in the next phase of CHLNet's development.

Link to LEADS and CHLNet's Mission

Better health care and the leadership to achieve it must adapt to context and to the pace of social change; as society changes so must health care models and the leadership needed to adapt to these changes.

Seale, B. (2016). *Patients as partners: Building collaborative relationships among professionals, patients, carers and communities.* The King's Fund.

Focus: Building the relationships that will make patients partners.

This guide is a response to the question, "What helps to build collaborative relationships among health and care professionals, patients, service users, carers and communities?" It stems from an evolving body of work focused on exploring and supporting shared leadership. It is reinforced by a growing consensus that health services, agencies, patients and communities need to work together more—and differently. It presents five practical ways to develop collaborative relationships among health service providers, the patient, and community partners. They are:

1. Find your collaborative partner(s);
2. Invest in developing leadership and collaborative relationships;
3. Make time for learning—and share it;
4. Go where the energy is (under the radar); and
5. Embed collaborative activity (authorize it, make it legitimate).

Implications

The monograph suggests that encouraging patients and community groups to engage in leadership development with health care providers is beneficial to achieving true partnerships between the provider system and their patients/community partners. Some of the methods described in the monograph are worthy of consideration in Canada.

Link to LEADS and CHLNet's Mission

Patient/community engagement is seen as vital to better health care that is patient-centred. Better leadership—collaboratively pursued by both providers and patient(s) community groups is a potential strategy for achieving that goal.

Baker, G.R., Fancott, C., Judd, M., and O'Connor, P. (2016). Expanding patient engagement in quality improvement and health system redesign: Three Canadian case studies. *Healthcare Management Forum*, 29(5): 176-182.

Focus: Expanding patient engagement in quality improvement.

Health care organizations face growing pressures to increase patient-centred care and to involve patients more in organizational decisions. Yet many providers worry that such involvement requires additional time and resources and do not see patients as capable of contributing meaningfully to decisions. This article discusses three efforts in four organizations to engage patients in quality improvement efforts. McGill University Health Centre, Saskatoon Health Region, Vancouver Coastal and Fraser Health Regions all engaged patients in quality improvement and system redesign initiatives that were successful in improving care processes, outcomes, and patient experience measures.

Patient involvement in redesigning care may provide a way to demonstrate the value of patients' experiences and inputs into problem-solving, building support for their involvement in other areas. Further study of these cases and a broader survey of organizational experiences with patient involvement may help elucidate the factors that support greater patient engagement.

Implications
These cases outline measures taken to engage patients, and demonstrate that deliberate and focused efforts to engage patients into quality improvement and system redesign initiatives can work. Organizations with a similar need may benefit from emulating some of the practices described in this qualitative study.

Link to LEADS and CHLNet's Mission
Quality improvement and system redesign are key elements to better health. Leadership that involves patients—as the LEADS framework suggests—can achieve that goal.

Cabaj, M., and Weaver, L. (2016). *Collective Impact 3.0: An Evolving Framework for Community Change.* Community Change Series 2016: Tamarack Institute. 14 p.

Focus: A "systems thinking" framework for community change.

Across Canada there are hundreds of community-wide initiatives to end homelessness, reduce poverty, improve early childhood development outcomes, increase high school graduation rates, and strengthen community safety. There are thousands more across the world. Many of them are inspired and informed by the Collective Impact (CI) framework. CI was coined in 2011 by John Kania and Mark Kramer of FSG Consulting. Their Stanford Social Innovation Review article of the same name distils some of the key ingredients of successful community efforts to move "from fragmented action and results" to "collective action and deep and durable impact." These ingredients (or "conditions") are a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone support.

This paper describes the virtues of the CI framework and efforts to revise it in the form of Collective Impact 3.0., moving the model from a management approach to what they describe as a movement-building approach. It cultivates broad ownership and long-term commitment to the change process amongst a broad spectrum of system stakeholders. A true common agenda requires leadership to bring key stakeholders together; to review the key data which informs the problem or issue; to develop a shared vision for change; and to determine the core pathways and strategies that will drive the change forward. The model described as Community Impact 3.0 is a method for accomplishing that.

Implications
Major health system changes in which we wish patients and communities to be involved might benefit from the Collective Impact approach: one that truly engages stakeholders as partners in system redesign. This approach might be directly relevant to creating new models of community care.

Link to LEADS and CHLNet's Mission
LEADS—as a leadership model—emphasizes the importance of a systems thinking approach to leadership. The Collective Impact 3.0 approach is one model that might be used to lead community change, to truly make better health through better leadership: and really together.