LEADerShip at a Glance

CHLNet's "Top Ten" Suggested LEADS Reading[1]

Abrametz, B., Bragg, T and Kendel, D. (Dr.). (2016 December). Optimizing and Integrating Patient-Centred Care: Saskatchewan Advisory Panel on Health System Structure Report.

Baker, G.R., Judd, M. and Malka, C. (Eds.). (2016). *Patient Engagement: Catalyzing Improvement and Innovation in Healthcare.* Longwoods Publishing: Toronto.

Collins, M.D., and Jackson, C.J. (2015). A Process Model of Self-Regulation and Leadership: How attentional resource capacity and negative emotions influence constructive and destructive leadership. *The Leadership Quarterly*, 26(3): 386-401.

Davies, S., Herbert, P., Wales, A., Ritchie, K., Wilson, S., Dobie, L., and Thain, A. (2017). Knowledge into action – supporting the implementation of evidence into practice in Scotland. *Health Information & Libraries Journal*, *34*: 74-85.

Development Dimensions International, Inc. (2016). High Resolution Leadership: A synthesis of 15,000 assessments into how leaders shape the business landscape.

Johnstal, S.P. (2013). Successful Strategies for Transfer of Learned Leadership. *Performance Improvement,* 52(7): 5-12.

Mohammed, K., Nolan, M.B., Rajjo, T., Shah, N.D., Prokop, L.H., Varkey, P., and Murad, M.H. (2016). Creating a Patient-Centered Health Care Delivery System: A systematic review of health care quality from the patient perspective. *American Journal of Medical Quality*, 31(1): 12-21.

Ontario Chamber of Commerce. (2016). *Prescription for Partnership: How New Models of Collaboration in Health Care Can Make Outcomes a Priority.* Part II of the Ontario Chamber of Commerce's 2016 Health Transformation Initiative. Ontario Chamber of Commerce: 1-23.

The King's Fund. (2017). *Leading Across the Health and Care System: Lessons from experience.* The King's Fund: London.

West, M., Eckert, R., Collins, B., and Chowla, R. (2017 May). Caring to Change: How compassionate leadership can stimulate innovation in health care. The King's Fund: London.

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

Abrametz, B., Bragg, T and Kendel, D. (Dr.). (2016 December). Optimizing and Integrating Patient-Centred Care: Saskatchewan Advisory Panel on Health System Structure Report.

Focus: Regionalization in Saskatchewan – Optimizing Patient-Centred Care

On August 18, 2016, the Government of Saskatchewan announced the appointment of an Advisory Panel on Health System Structure tasked with providing advice on the future structure of the health system in this province. The Advisory Panel was given a four-point mandate:

- Recommend a structure with fewer Regional Health Authorities to achieve administrative efficiencies as well as improvements to patient care.
- Consider opportunities to consolidate clinical or health system support services currently delivered by Regional Health Authorities or other health care agencies that may be more efficiently delivered on a province-wide basis and the mechanism(s) to best organize and deliver such services.
- Review current legislation and processes to ensure they adequately establish: the roles of health systems boards; their composition; and structure and reporting relationship to achieve appropriate accountability.
- Identify processes to enhance management information to improve and observe on performance management of the health care system.

To inform the recommendations, the advisory panel's first step was to obtain input from health sector agencies, partners and leaders, and from Saskatchewan citizens.

The central recommendation was "In support of achieving a singular system that is focused on meeting patient needs through seamless, integrated and team-based care, consolidate the 12 existing RHAs into a single Provincial Health Authority with responsibility for all services governed by the existing RHA Boards. This, and other recommendations, are described by the panel as requiring a "thoughtful approach to implementation" given apprehension and disruption to the system; yet they go on to say that "in the long term, unified governance and administration of the system will improve patient care and enable the system to more sharply focus on the patient and patient experience."

The paper provides a comprehensive and detailed review of input from stakeholders and providers in the province, and outlines a plan forward for the province of Saskatchewan.

Implications

Regionalization has not yet "been proven" to accomplish the goals as outlined in the paper for the province of Saskatchewan. Yet the paper presents a strong argument for its value. Whether the system can indeed realize the potential of these recommendations, and whether it has the leadership strength to bring them into practice, is a bold experiment for Canada to be watching.

Link to LEADS and CHLNet's Mission

Better Leadership, Better Health – Together is the vision for CHLNet. This paper suggests that moving to one region is a powerful vehicle to stimulate that togetherness. Whether better health arises is a function of whether or not Saskatchewan's leaders can indeed realize the promise of such a major transformational decision. This of course will require the use of all LEADS capabilities, in particular, the domain of Systems Transformation.

Baker, G.R., Judd, M. and Malka, C. (Eds.). (2016). *Patient Engagement: Catalyzing Improvement and Innovation in Healthcare.* Longwoods Publishing: Toronto.

Focus: Patient engagement as a catalyst for innovating and improving healthcare.

This book is designed to provide compelling examples of healthcare organizations in Canada, the US and England that have advanced patient-centred care and patient engagement. These selected healthcare organizations have demonstrated that patient engagement contributes to improving care, outcomes, and the experiences of patients and families. By illustrating these organizations' strategies, investments and experiences, the authors intend to illustrate pathways to increased engagement for innovation and improvement. They describe important common themes and approaches to patient engagement that can be adapted for different types or organizations and environments.

Implications

Almost all provincial jurisdictions across Canada emphasize a shift to patient-centred care as the cornerstone of "better health" in the future. Practical cases and examples of how patients can be engaged for innovation and improvement, in order to create such a system, is valuable to Canada's leaders in healthcare.

Link to LEADS and CHLNet's Mission

People in formal positions of leadership within healthcare must generate the conditions for patient engagement and involvement. If that leads to better health, the approaches described in this book are valuable for those leaders. The content – focused on patient engagement for improving service delivery and to stimulate innovation – is consistent with the Develop Coalitions (demonstrate commitment to customers and service) and the Systems Transformation (encourage and support innovation) domains of LEADS.

Collins, M.D., and Jackson, C.J. (2015). A Process Model of Self-Regulation and Leadership: How attentional resource capacity and negative emotions influence constructive and destructive leadership. *The Leadership Quarterly*, 26(3): 386-401.

Focus: Self-management in stressful situations.

This article examines why difficult or demanding work, such as making accurate decisions with scarce or incomplete information in volatile conditions, increases the chance of destructive leadership in some leaders but not others. Leaders have the potential to inspire others and achieve long-term desirable organizational and social goals, but evidence suggests that they can also cause unintentional harm and irreparable damage. The authors present and test a model of self-regulation and transformational leadership that describes the process by which both constructive and destructive leadership occurs. Over a 15-month period, the authors collected quantitative data from 187 healthcare leaders attending a leadership development program in Australia. The findings suggest that attentional resource capacity during demanding task performance is required for effective self-regulation and transformational leadership.

Implications

The results have important implications for better understanding the selection and recruitment of individuals for positions of organizational leadership, particularly for demanding and stressful roles.

Link to LEADS and CHLNet's Mission

This article is a perspective on the LEADS capability of *Manage themselves*, in the domain of Lead Self.

Davies, S., Herbert, P., Wales, A., Ritchie, K., Wilson, S., Dobie, L. and Thain, A. (2017). Knowledge into action – supporting the implementation of evidence into practice in Scotland. *Health Information & Libraries Journal*, 34: 74-85.

Focus: Building processes to integrate evidence into decisions and actions to deliver safer care.

The authors of this article propose a conceptual model of knowledge brokering to deliver safer, more effective care within the context of the Scottish NHS and describe how the model was developed along with examples of methods in action. Research on knowledge mobilization has recognized the importance of converting knowledge into decisions and actions to support improvements in clinical practice and quality outcomes. The model consists of eight elements, including: 1) knowledge broker network; 2) technology platform; 3) building capacity and capability; 4) defining knowledge gaps; 5) sourcing and quality assuring knowledge; 6) creating and combining knowledge; 7) sharing knowledge; and 8) research and evaluation. The authors used small working groups to define the requirements of the wider community of potential knowledge brokers and establish tools, systems and processes to support and develop the network. The study suggests that it is necessary but not sufficient for those involved in knowledge brokering to facilitate the transfer of knowledge from producers to users. There is also a requirement to develop a deep, shared understanding of knowledge needs and application through building strong relationships and trust.

Implications

The article adds insight into how knowledge is moved into action through practical and feasible activities to support practitioner change – in particular, safer and more effective care.

Link to LEADS and CHLNet's Mission

Integrating evidence to create safer and more effective care leads to better health. Leaders need to have models that they can employ in organizational practice so as to facilitate meaningful evidence integration. Better leadership, better health. The article also supports the Achieve Results capabilities of: *Strategically align decisions with vision, values and evidence*; and *Take action to implement decisions*.

Development Dimensions International, Inc. (2016). High Resolution Leadership: A synthesis of 15,000 assessments into how leaders shape the business landscape.

Focus: Insights from the private sector into how to maximize strategies for effective leadership development.

In this report, Development Dimensions International (DDI) has undertaken the task of conducting research on better leadership by using their proprietary data envelope. The data included over 15,000 participants who were being considered for leader levels ranging from front line to the C-suite. The database included highly reliable evaluations from rigorous leadership simulations involving "day in the life" scenarios, giving all leaders equal opportunity to demonstrate their skills. They also augment simulation data with other sources of information, including personality and intelligence tests.

The findings fall into four categories. First, they proved that stronger leader skills, as measured by their assessments, predict actual business metrics such as profit and revenue growth. They also took stock of the business context within which leaders must operate. Second, they showed how personal attributes and skill patterns – the DNA of leadership – influence leaders' success as they rise through the ranks. Third, they gauged the hard-wired readiness of leaders within three regions facing turbulent business climates for driving their regions forward in the future. Finally, they looked at how the details of a leader's background can drive a more accurate understanding of how skill strengths and deficiencies are arrayed within a leader population. As a result, organizations can better predict and proactively shape leader success.

In each section they provide specific actions and implications for HR professionals and senior leaders seeking to translate the analytics into short- and long-term strategies for bolstering leader skills by initiating or revising assessment and development programs.

Implications

This study – although conducted in the private sector – has some very interesting information about what leadership skills can be developed and the best methods for their development. It unpacks the "is a leader born or is a leader made" construct, providing interesting insight for organizations wishing to maximize their leadership development strategies.

Link to LEADS and CHLNet's Mission

The focus on "better leadership" and how it can be developed is strongly linked to CHLNet's mission. It also provides insight into what aspects of the LEADS framework might be best developed through education programs and through experiential learning in one's organization.

Johnstal, S.P. (2013). Successful Strategies for Transfer of Learned Leadership. *Performance Improvement,* 52(7): 5-12.

Focus: Key elements for successful transfer of learning from a leadership program to the workplace.

There is no single model of leadership development and no single source of learning that can be applied to all organizations or to all learners. The key elements of success in creating impactful leadership programs are (1) the use of development methods that address the learning need identified through a needs assessment; (2) alignment to the organization goals and mission; and (3) the inclusion of appropriate learning transfer strategies. Specific tactics include:

- Developmental relationships: Provide participants with support, information and challenges to meet their developmental needs. This includes working in partnership with a subject-matter expert.
- Coaching: Goal-focused one-on-one learning.
- Mentoring: A formal or informal relationship, usually with a senior manager, where the participant is provided with advice for development needs or opportunities.
- 360-degree feedback: Multisource ratings of performance from assessment instruments provided to individuals, usually from peers, subordinates, or superiors.

- Instruments or assessments: Assessment instruments that enhance self-awareness and self-knowledge, identify strengths and weaknesses, and enhance effectiveness, or instruments that provide a self-assessment of competencies through inventories and scales.
- Individual development plans: A process whereby the individual takes responsibility for developing and implementing a development plan.
- Simulations and videos: Role play, interactive exercise, or electronic performance systems that enable skill acquisition without affecting business goals as well as videos that demonstrate concepts, review examples, or discuss and evaluate demo content. The aim is to engage users in real-world situations in a practice setting where they try out, review, and evaluate various options and outcomes.
- Classroom learning: Participants attend instructor-led training based on needs, priorities, and level-specific roles.
- Development assignments: Assignments that challenge participants and provide opportunity and motivation for learning another aspect of a business or organization and support trying out new skills, behaviours, and thinking.
- Action learning: Project-based learning where a small group, typically a cross-functional team, works together on a real, complex business problem. Projects are generally outside the typical expertise of the learning participants.

Success of transfer also depends on explicit support from one's direct supervisor; executive leadership; evaluation; and ensuring that there is a match between the learning goals to both the individual and the organization.

Implications

Leadership programs, to be impactful, must be designed for that purpose and also be integrated into the day-to-day work of the organization and its leaders.

Link to LEADS and CHLNet's Mission

Good leadership development programs – well-designed – lead to better leaders; better leaders can accomplish CHLNet's vision of Better Leadership, Better Health.

Mohammed, K., Nolan, M.B., Rajjo, T., Shah, N.D., Prokop, L.H., Varkey, P., and Murad, M.H. (2016). Creating a Patient-Centered Health Care Delivery System: A systematic review of health care quality from the patient perspective. *American Journal of Medical Quality*, 31(1): 12-21.

Focus: Measuring patient perspectives on quality of care.

In the United States, the Centers for Medicare and Medicaid Services are the US Federal Agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program. These centers fund hospitals on a formula that includes a 30% score for the quality of patient experience. The authors contend that the measures used to determine patient experience may or may not be an appropriate way to gauge the quality of patient experience. They believe there may be a number of other factors,

not measured by patient satisfaction or experience, that affect how patients view the quality of a health care system and how they choose where to receive their care.

The research team conducted a systematic review of the published literature to better understand the factors that affect patient perceptions of health care organizations. The aims of the study are to explore patient perceptions of quality of health care and to understand how patient perceptions may differ by settings and condition.

Health care quality indicators, in descending order of importance, were: quality of communication; access to health care; shared decision-making; provider clinical quality; the physical environment of health care delivery; pain control; patient education; existence of an electronic medical record; the discharge process, and preventative services. The 10 dimensions identified can be used in the planning and evaluation of health care delivery.

It should be noted that when compared to studies in other countries, the results for other countries did differ significantly from those in the US.

Implications

This systematic study suggests that the use by leaders of patient satisfaction surveys on their own to determine overall patient satisfaction with the quality of care is not an accurate determination of that quality. More robust measures including multiple factors may be more reliable in decision-making.

Link to LEADS and CHLNet's Mission

CHLNet's vision is Better Leadership, Better Health. This study provides an interesting description of what "better health" means to the patient. This study operationalizes the LEADS domain of Develop Coalitions; in particular, the capability of *Demonstrate a commitment to customers and service.*

Ontario Chamber of Commerce. (2016). *Prescription for Partnership: How New Models of Collaboration in Health Care Can Make Outcomes a Priority.* Part II of the Ontario Chamber of Commerce's 2016 Health Transformation Initiative. Ontario Chamber of Commerce: 1-23.

Focus: Potential private sector involvement in health care reform in Ontario.

This paper is the second of five being published by the Ontario Chamber of Commerce to articulate its views on potential private sector involvement in health care reform in Ontario. The report argues that if Ontario wants to deliver the best care to its citizens and take advantage of home-grown talent in the health and human sciences sector, Ontario cannot treat the health system as just a series of pre-defined tenders waiting to be filled. The argument is as follows:

Ontario needs to move from a "cost-containment" philosophy towards a "value-generation" philosophy. This requires a re-orientation at a structural level and a complete renegotiation of the relationship between decision-makers in the public sector and partners in both the for-profit and non-profit sectors. Through initiatives like the creation of an Office of the Chief Health Innovation Strategist and the release of Patients First, the government has recognized this and is moving to bring about system-wide reform through strategic planning, re-organization and increased transparency and accountability. The will is there, now the question to be answered is: how?

The Ontario CC believes that there is a means of approaching public/private interaction that could address these challenges and encourage a re-alignment of priorities commissioning. Commissioning is a way of focusing less on what is done and more on the results of what is done. In this way, it is a means of putting patients first. The article then goes on to explain the logic and reasoning behind this position.

Implications

Health care reform is indeed a negotiation between various parties and their beliefs, philosophies, and interests. The private sector has a perspective on revitalizing health care that needs to be understood and explored in terms of its potential to stimulate patient-centred health reform. This series of articles help health leaders do that.

Link to LEADS and CHLNet's Mission

The series of documents created by the Ontario Chamber of Commerce highlights the importance of leadership that is collaborative, patient-centred, and innovation focused. It presents ideas that CHLNet members may wish to review in order to see their relevance to CHLNet's mission of "better leadership, better health" together.

The King's Fund. (2017). *Leading across the Health and Care System: Lessons from experience.* The King's Fund: London.

Focus: Compassionate leadership and innovation in health care.

This paper offers those who are leading new systems of care some guidance on how to address the challenges they face. It draws on The King's Fund's work on the development of new care models, sustainability and transformation plans, and accountable care organizations. It is also informed by the experience of people who have occupied system leadership roles and draws on case studies from our research and organizational development work.

National leaders in the NHS are seeking to move away from competition as the guiding principle of the NHS toward collaboration. Integration is being favoured in place of fragmentation. And leadership is conceived as shared and collective rather than heroic. The development of new care models, sustainability and transformation plans (STPs), and accountable care systems are all examples of where these shifts are taking place.

In this context, it can be tempting for organizations to look after their own interests and performance rather than to work in partnership with others. However, the paper argues that this would be a major missed opportunity to transform the delivery of care to meet the changing needs of the population. Doing this requires NHS organizations and their partners to work together to improve services and make the best use of limited resources. This paper offers those who are leading new systems of care some practical ways in which to work together to address the challenges they face.

Implications

The practical examples of how people build collaborative initiatives to improve services, based on cases in the NHS, are relevant to Canada. It is interesting to note that in a unitary system – such as the NHS – the challenges of fragmentation and dispersion are challenging for them; and even more so in Canada, of course, because of our decentralized constitutional model of health service delivery.

Link to LEADS and CHLNet's Mission

The article profiles key elements of "collaborative leadership" that are consistent with the content of the LEADS framework (Engage Others, Develop Coalitions).

West, M., Eckert, R., Collins, B., and Chowla, R. (2017 May). Caring to Change: How compassionate leadership can stimulate innovation in health care. The King's Fund: London.

Focus: Lessons from experience of senior leaders.

Improvement efforts are widespread within the National Health Service (NHS), stimulated and supported by a variety of organizations and initiatives. However, examples of radical and sustained innovation are exceptions in the NHS landscape. There are examples that offer hope and direction from local systems that have triumphed over adversity through:

- whole-system redesign;
- radical rethinking of organizational roles;
- empowering teams to innovate; and
- persistently nurturing continuous improvement.

The authors argue that enabling leadership and cultures are essential for ensuring that such innovation spreads and becomes a cultural norm within the NHS. However, without innovation generally, and quality improvement specifically, attempts to meet the challenges of modern health care are less likely to succeed. Leadership is central to this and compassionate leadership is a fundamental enabling factor that will create a culture of improvement and radical innovation across health care. The paper also presents case studies of how compassionate leadership has led to innovation.

Implications

CHLNet partners – and other health organizations in Canada – are also embracing the challenge of transformation and change. Insights into how to practice leadership grounded in the values of caring and compassion is therefore of importance to all CHLNet members.

Link to LEADS and CHLNet's Mission

Leadership of change is fundamental to CHLNet's mission. It promotes the *LEADS in a Caring Environment* capabilities framework as a guide to how to lead that change. This article provides insights into the caring aspect of LEADS.