CHLNet Network Partner Virtual Roundtable Minutes

November 3 and 4, 2021

Secretariat

Kathy MacNeil, Island Health
Susan Moffatt-Bruce, Royal College of Physicians and Surgeons of Canada
Alain Doucet, CCHL
Bill Tholl, CHLNet
Emily Gruenwoldt, Children's Healthcare Canada
Graham Dickson, CHLNet
Kelly Grimes, CHLNet
Maria Judd, Healthcare Excellence Canada
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Network Partners

Amy Riske, Yukon Health
Andrea Johnson, NHSA
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Caroline Heick, CIHI
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Carole Rochefort, CSPL
Cheryl Heykoop, RRU
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Jennifer Zelmer, Healthcare Excellence Canada
Jo-Anne Poirier, VON
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Jonathan Mitchell, HealthCare*CAN*
Katherine Chubbs, Good Samaritan Society
Karen Cohen, Canadian Psychological Association
Karen Stone, St. Joseph's Health Care London
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Polly Stevens, HIROC
Rita Notarandrea, Canadian Centre for Substance Use and Addiction
Roy Butler, St. Joseph's Health Care London
Sharon Bishop, Saskatchewan Health Authority
Sue Meagher, NS Health
Stevie Colvin, Alberta Health Services
Susan Good, PHSA
Venetia Lawless, Health Canada
Wendy Sullivan, CPAC

Observers and Panelists

Hélène Sabourin, CAOT/HEAL (Day 2)
Katharine Smart, CMA (Day 2)
Tim Guest, CAN (Day 2)
Sarah Downey, Michael Garron Hospital (Day 1 and 2)
Jennifer Verma, McMaster Health Forum (Day 2)

Regrets

Pamela Fralick, Innovative Medicines Canada
Shelagh Maloney, Canada Health Infoway

On November 3 and 4, CHLNet held its virtual Network Partner Roundtable due to the COVID-19 pandemic. 54 participants (~45 per day) zoomed in over the two days representing almost all of our partners.

November 3rd[h], 2021

Kathy MacNeil, Co Chair of CHLNet began with a land acknowledgement. She noted we have shifted from a day long session to two two-hour sessions, twice a year. The Secretariat acts as CHLNet board and has been meeting quarterly. Kathy welcomed today's observer, Sarah Downey CEO Michael Garron Hospital. The Minutes of July and October Secretariats, CHLNet 2020-2022 Strategic Priorities, Progress Report on CHLNet 2021 Workplan, Committee List, and CHLNet Value Add were all accepted as information.

Motion by Graham Dickson, seconded by Alain Doucet and carried to approve the Minutes of the May Network Partner Roundtable.

Motion by Graham Dickson, seconded by Alain Doucet and carried to approve Kathy MacNeil for a second term as CHLNet Cochair.

Partners interested in any of the working and steering groups or know of other leaders interested in being part of this network please contact Kelly Grimes.

Leadership Roundtable

Over the years, one of the most valued reasons for getting together as health leaders is to share leadership challenges in a "safe" environment especially important during these uncertain times. Only high-level takeaways noted (i.e., Chatham House Rule). Two questions are posed that will feed into CHLNet's action research on *Leading Thru COVID*. Two documents were shared as background to the conversation Leading Thru COVID Phase 1 Executive Summary and HCMJ Article.

a. *Please reflect on leadership 'lessons learned' from COVID during the first three waves. How have your experiences in the fourth wave either reinforced those lessons or illuminated new ones?*

b. *Given the above discussion, as a group explore what are the implications for future leadership action, and what you would want health care leaders to learn about leadership moving forward?*

Members of CHLNet's *Leading Thru COVID Steering Group* facilitated small group discussion. Thanks to Johny Van Aerde for doing the IT/Zoom support.

High level takeaways include:

1. *Fallout of 'dehumanizing' health leaders:* Public health leaders globally, nationally, provincially and locally have gone from being behind the scenes to being in front of the cameras. Health Ministers, CEOs of Regional Health Authorities, Chief Medical Officers (CMOs) provincially and locally have been in the nightly spotlight. In fact, through waves 1-3 of COVID, health leaders became, in the opinion of one NP 'super humanized'. CHLNet Network Partners discussed concerns that "in the process of 'super humanizing' healthcare leaders, we may have inadvertently 'dehumanized' them, leaving them open to attacks and deterring them

from seeking the help or support they now need to recover". "Repeated assaults on individual leaders are taking a serious toll on them and on the system as a whole" (NP). Threats, especially on-line, are commonplace. We now have CMOs with security details. "This (consequence of dehumanization) needs to be acknowledged and addressed in a concerted, ethical way". Indeed, recent federal legislation referred to above is one effort to respond to this need.

2. *Build resilience organizationally as well as individually:* Resilience--the ability to bounce back in the face of adversity--has always been critical to the success of any leader. "I was so impressed, during the first three waves with the resiliency of health leaders" (NP). What the November NPs session underscored, however was that the fourth wave is a "different story". "People are tired and it's bone deep" (NP). "We need to pay much more attention going forward to resilience and avoiding slipping back into a 'pull-yourself- up -by-the-bootstraps' culture or attitude". We need to recognize as a community of practice in health leadership that "Burnout is an organizational or systems issue, not just an individual responsibility". Many NPs report growing as a leader as we enter the next COVID wave (i.e., "post traumatic growth"). "But only if the organization does its part. It can't be just an individual responsibility". As one of the articles referenced in this e-blast notes: "to lead means to guide. To resile means to respond or be guided by circumstances through a process of adaptation and growth within a risky environment". The resilience of health leaders will continue to be tested and grow through this wave and well into the future.
3. *Premium on clear, concise, consistent communication:* This was flagged back in May 2020 as an overarching leadership challenge given the "pervasiveness" of social media and the difficulties of controlling or regulating online content. But little did healthcare leaders know then just how right Marshall McLuhan was when he famously suggested (1964) that the *Medium is the Message*. Social media is the ultimate two-edged sword, permitting CMOs and healthcare leaders to convey essential public health messaging to all concerned in real time, servicing the 24-hour news cycle. But it has also enabled the rapid spread of misinformation and, increasingly 'malinformation' or that information intentionally designed to fuel, for example, vaccine hesitancy; and in keeping with the earlier theme of dehumanizing, demonizing establishment health care leaders. NPs feel a heavy burden of responsibility amid this *infodemic*, to help set the record straight and as 'trusted sources' address misinformation immediately with the sometimes 'brutal facts'. "Communications going forward will have to be even more deliberate, more carefully constructed and more timely" (NP). Leaders will also have to challenge, directly, those who purvey malinformation.
4. *Model effective leader behaviour:* Back in May 2020, NPs already flagged compassionate, empathic leadership as key to effectively leading through COVID. This remains a key expectation and attribute of effective leaders as we confront the next wave. As one NP noted "self-effacement and humility, not over confidence" is key going forward. Leaders must be "honest with themselves" when it comes to knowing how best to deal with the virus and the seemingly endless 'variants of concern'. "Leaders will have to be even more empathetic and more 'present' in the workplace: not just seen and heard but listening even more carefully to what is not necessarily being said explicitly." (NP). "Fatigue is the story of the 4th Wave". "We can't continue to rely on adrenaline to get us through the next wave".

Modelling effective leadership means stressing the importance of leading self "the ability of leaders to get through this and not drop the ball for all those they are leading". (NP). It also means "respecting boundaries and limits of when work begins and ends. These will have to be more clearly established and respected going forward". This concern is giving way to increased attention, for example, around so-called "dusk to dawn" digital workplace practices and policies.

5. *Need for systems thinking and national strategy*: Canada came into the pandemic with significant overall capacity issues: with occupancy rates at or near capacity and widespread physician and nursing shortages. COVID has only exacerbated these capacity issues as the fourth wave now "washes over us". ICU patients are being transferred from one province to another. "Family medicine is imploding across the country" (NP) "We're being forced to provide care in a system that doesn't care about you" (NP). In addition to this capacity of the "system" being tested to the limits, the fragmentation of our loosely connected healthcare systems has been exposed. While early on there was great coordination across jurisdictions over COVID, it has become more politized in the early days of the fourth wave. "Better data and better workforce planning are required...with multipronged strategies to deal with the current crisis (i.e., expected 'exodus' from the health workforce in the wake of wave 4) and the longer term (e.g., need for a national workforce body). And looking ahead, "Nothing is linear going forward" (NP) "A certain bravery" will be needed going forward to address these systemic issues.
6. *Consider the silver-lining of COVID*: While COVID waves 1-3 have posed numerous challenges, many unprecedented, the pandemic has also had a silver lining. It has, for example, brought the research and policy community closer together. There is a "strong bond" now that wasn't recognized before. "Nuggets of innovation" have been introduced that now need to be extended into the future (e.g., value of virtual care as an extension of traditional care processes). Decision-making processes have been streamlined. Consideration needs to be given to how 'work arounds' that have been exploited due to COVID (e.g., streamlining licensing requirements) can now be embedded longer term. New, trusting relationships have been formed which will ensure beyond when we finally do turn the corner on COVID.
7. *Greatest lesson learned is 'speed over perfection'*: Policy makers and healthcare leaders have learned through the first three waves of COVID that 'dithering is dangerous. Nowhere has this been more in evidence than in the long-term care sector, where some have gone as far as to say when it comes to decisions like mandatory masking in healthcare facilities that "delay is deadly". This increased attention to speed has also created more pressure on healthcare leaders when it comes to explaining why they did or did not act more quickly to address the most recent outbreak.
8. *Embrace the agility quotient:* In the early days of COVID-19 top-down, 'command and control' leadership was seen as both expected and appropriate. But this has changed over time. By May 2021, NPs reported that this top-down approach had to give way to a more distributed or collaborative leadership styles as the pandemic continued. Creating and empowering teams was (and continues to be seen) as key to turning the corner on COVID. Over the past number of months this view has changed yet again. NPs now report that effective leaders must shift from directive leadership to collaborative leadership and vice versa quickly as

circumstances dictate and as the needs of the leadership team demand. The so-called 'agility quotient' reflects one's ability or capacity to swiftly adapt to changing circumstances or needs. Agile leaders are effective in optimizing on the right leadership style at the right time for the right people. "A lot of rules have had to be cancelled" (NP). As we continue through the fourth wave of the pandemic, some leaders can embrace ambiguity better than others and agility comes more easily to some leaders. "We need to be flexible and agile in how we support staff" (NP).

9. *Existence of the polarizing effects of the pandemic:* The "narrative" going into the next wave of COVID is increasingly polarizing and this is of concern to healthcare leaders. Mandatory masking and ongoing tensions around mandatory vaccination continue to polarize communities and cause friction in families. The recent policy reversal in some jurisdictions in relation to mandatory vaccination of healthcare workers is perhaps the most recent and disturbing example of the polarity surrounding pandemic, with tough decisions being downloaded onto local decision makers. This adds to the stress and burnout of healthcare leaders. The politicization of the pandemic is some quarters hasn't helped and while NPs believe the media are doing a good job (on balance), "…we have (fact-based) policies reported in the media not holding true any more when someone can tweet or share a view and advocate for whatever they happen to believe in". "Working through polarity is a key leadership skill going forward" (NP). It points to the need, for example, for stepped up efforts to develop media kits for members and the ongoing need for media training for healthcare leaders. The overall message emerging from NPs in addressing the polarizing effects of the pandemic is that we need to "let science and the scientists lead". (And that is medical science, not political science!)
10. *Heightened importance of networking:* Interest in and support for CHLNet in general and for special purpose networks in particular (e.g., CanCOVID) continues to grow, in part due to the recognition that networking…both personally and organizationally…is one important factor in building system level resilience over time. Leaders value time to reflect, even amid a pandemic, to "celebrate all that we have been able to accomplish and recognize the tremendous accomplishments to date". "Not sure we are compassionate enough with ourselves".

CHLNet Project Updates

This portion of the agenda is an update and input into a few of CHLNet's working groups and projects given by each project's chair(s) and/or researcher.

a. **Leading Thru COVID Action Research Study: Phase 2 and 3**

Graham Dickson and Deanne Taylor presented on this project that has been ongoing for 1.5 years. Currently analyzing data from dialogue that was gathered during wave 3. Two key high-level points emerging – burnout to the point where rest can't actually address it now and as well the concept of the whole person. Dialogue today highlighted that wave 4 is reaping the challenges of wave 3 in the frame of polarization. Dee noted that groups such as this are important venues to support lateral leadership conversations.

b. **CIHR/SSHRC Healthy Professional Worker Project**

Ivy Bourgeault shared findings from this CIHR/SSHRC funded project. CHLNet has been an integral partner in this. Mixed methods approach of a survey and qualitative interviews on the experience of mental health and leaves of absence from work (especially gender nature of this pathway). There is a need to de-stigmatize mental health issues and encourage support from supervisors and colleagues. Significant difference of how the pandemic affected the professions. Project has created a catalogue of interventions. Updated slides will be shared via email to partners.

c. **Leadership Huddles**

This huddle is a collaborative effort between CHLNet, Canadian College of Health Leaders and Healthcare Excellence Canada. Its modelled-on work Healthcare Excellence Canada is doing with the long-term care sector and others. We've now done 3 huddles. he first two were successful pilots that sold out very quickly so have now launched to continue this effort into next year. Our next one is December 7th and we are just working out the details with a leader in long term care. Health leadership huddles offers an opportunity where executive leaders on the front line of the pandemic can meet to discuss a pressing leadership challenge being faced using Chatham House Rule.

d. Wellness/Burnout Project – Introduction

A subgroup of the Secretariat of Susan Moffatt-Bruce, Scott Malcolm, Wendy Nicklin, Doran Walker and Kelly met over the summer to discuss how we could move this forward. In August, CHLNet hired 3 system designers to embark on a project to define leadership opportunities and action to address health workforce burnout and wellness at a collective and individual organizational level through a structured design process. Preliminary findings will be shared tomorrow. A final *Insights to Action* report will produced following this and shared with CHLNet and HEAL partners.

November 4th, 2021

Susan Moffatt-Bruce, CHLNet Cochair welcomed all to the second day and acknowledge the land where we are coming from. As we look forward in the demobilization and recovery phase post pandemic what are the system design issues, we need to think about as health leaders to shape the health system of the future? At our last network partner roundtable, we began the conversation with on *Shaping the Health System of the Future: Wellness of the Health Workforce.* Our featured speaker and panel members were: Barry Rubin (University Health Network), Alicia Carey (Saskatchewan Health Region), Pam Hubley (SickKids Toronto) and Sarah Topps (Emerging Health Leaders Calgary). Four questions then framed our small group discussion of: 1. Recovery plans underway 2. How to build a healthier and more psychologically supportive workforce and workplace 3. Practices and tools to share 4. How can CHLNet, be more supportive of health leaders during the pandemic? On this last question, we heard that we need to work together as a network of partners on wellness (see May Network Partner Minutes 1a.).

Given this, the Secretariat brought on 3 system designers (Oksana Niedzielski, Raffaella Loro and Joe Doiron) to aid us in a project to define leadership opportunities and action to address health workforce burnout and wellness at a collective and individual organizational level. Their work to date has included focused interviews with five health leaders, and a short survey distributed to our Network partners and HEAL members (thanks to the HEAL Co chairs Hélène Sabourin and François Couillard who are here today) to organize and prioritize near term and longer-term leadership actions to address health workforce burnout and distress in Canada.

Both CNA and CMA Presidents were and discussed the recent Call to Action on health workers, including why they each made this a priority (i.e. impact on nurses and physicians) and what each of their organization efforts are to combat burnout and promote wellness. Given the richness of the discussion the session was extended for an additional 30 minutes. It feed into the remainder of the agenda to organize and prioritize near term and longer-term leadership actions to address health workforce burnout and distress in Canada.

Top 10 Takeaways

The Q&A session at our roundtable garnered much dialogue and need for action. Partners asked for high level takeaways to be shared quickly and these are outlined below including next steps.

1. *Measures show chronic stress and moral distress at all time high*: critical fatigue levels of our health workforce and its leaders, exacerbated by high and ongoing workload levels ("24 hr shifts"). Chronic burnout and stress continue for a workforce who are already demoralized. Innovative strategies and tools for tailored long-term support for the health workforce are required for their wellness.

2. *"Heroes to Zeros" is rampant:* Increasing levels of violence from the public. Health providers have sacrificed their own personal health and safety to deal with the pandemic. Governments and politicians must support our health workforce and their work. Providers must feel safe rather than being attacked in social media, entering workplaces and more. Public needs to push governments to hold account.

3. *Burnout is an organizational/system issue not individual:* how we lead is important. Leaders are responsible for workforce policies, organizational design, depiction of roles/responsibilities, workload, and personal supervisory behaviours. We need to look at all of these as parts of the solution.

4. *Concrete and harmonized solutions to be taken to government*: explicit action is required on what is needed from government to address this crisis now. Leaders need to offer solutions to government that can be implemented both in the short and long term. Better data (e.g., how many, where located) and better workforce planning (e.g., needs based, harmonize regulations) are longer term. Multipronged strategies to deal with current crisis (retain, recruitment) and long term (national health workforce body) are needed. Government must provide supports, funding and infrastructure for the provinces/territories to work together collectively on this.

5. *Strong and sustained intervention*: addressing HHR crisis by crisis has not worked. There is pandemic-related burnout but that is compounded for those who already suffered from under-recognition and burdensome workloads (e.g., mental health and substance use.), and then there's the burden of contending with the global societal challenges (e.g., climate crisis; lack of trust in institutions; growing gender-based violence).

6. *Accountability and outcomes driven investment:* federal provincial/territorial transfers must have strings attached to ensure accountability (accountability of health care providers then follows). What are we getting for health care investments such as home care? Lack of data makes this difficult to assess.

7. *Organizational redesign and dedicated capacity needed*: how do we shift from allocating time to activities that demand human interaction—and that we know we should do as leaders—from how our time is spent now on tasks and administration? Leaders must define the interventions needed right now such as recognition and redesigning work so capacity can be liberated.

8. *Model effective leader behaviour*: leader behaviour contributes to the health and wellness of the health workforce. Most clinicians and health care workers interact most regularly with their immediate supervisors (as opposed to those at provincial or even corporate levels). How those immediate supervisors are acting, giving recognition or not, providing compassionate support, etc., is likely of greater short-term import. Studies show that every additional point a supervisor receives on a 60-point leadership score reduces the chance of burnout by "followers" by 3%.

9. *Integrate research and innovation into the health system for the rebuild:* "research and innovation is care". Learning health systems must be promoted to operationalize research. There needs to be a way to validate and support that re-shifting of priority and measuring it. How do we know what works or not? Research and evidence to support new technologies into care is needed.

10. *Heightened importance of networks*: we must learn from others and hear what others are doing. We need to share effective tools and practices. But also, to define what network partners can do to help both as a collective and individual organizations.

Shaping the Health System of the Future: Wellness of the Health Workforce

Joe Doiron, Oksana Niedzielski, and Raffaella Loro from the Design Team overviewed their methodology, shared early mapping results, and validated insights using polls. Facilitated small groups work on burnout/wellness took a deeper dive into the early insights. Some high-level themes included:

- Need for organizational redesign. How do we shift from allocating time to activities that demand human interaction—and that we know we should do as leaders—from how our time is spent now on tasks and administration? How do we operationalize that?
- Becoming a learning health system: there needs to be a way to validate and support that re-shifting of priority.
- Many of us sit at tables where we can make changes. We should have the ability to do that. But how do you adjust a way of working that is decades old?
- There appears to be 4 areas of need:
    - Data issue. What do we have, what do we need, and how do we use it.
    - Money. To support what needs to be done. There is a cost associated with these issues/actions.
    - People. With people leaving, and with the system going to be in flux for a long time, keeping track of numbers that are meaningful will be a challenge.
    - Outcomes. We don't know what the outcome of some of these moves will be.
    - And then there is the challenge of imposing these on organizations, systems, and of course individual people at multiple levels of responsibility.

An *Insights to Action* report will be developed and shared widely.

Next Meeting Date and Evaluation

Secretariat discussed and the next meeting will be virtual again on May 4, 5 1130 to 130 pm EST. In the Spring will decide if November will be in person or not.