December 2015

LEADerShip at a Glance

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

Arroliga, A.C., Huber, C., Myers, J.D., Dieckert, J.P. and Wesson, D. (2014). Leadership in Health Care for the 21st Century: Challenges and Opportunities. *The American Journal of Medicine*, 127(3): 246-249.

Focus: Health care challenges for leadership in the USA.

This article argues that the costs of health care in the US—the single largest contributor to the national debt—does not result in acceptable outcomes. As a system, it "often provides chaotic care of poor quality associated with patient and family dissatisfaction" (p. 246). Stating that the business of medicine is organized around physicians rather than patients, the authors go on to argue for major organizational efforts to change the model, and that that requires high-caliber leadership. Health care leaders must:

- Change the models by which we provide health care by putting the patient and the community at the center of the medical practice;
- Ensure that 3 issues are understood by the work force: performance matters; value is key; and performance improvements require teamwork; and
- Build interdisciplinary teams to deliver service to patients in practices and organizations.

They describe a progression of leadership development for doctors, beginning in undergraduate school and moving to what they describe as the new leader in health care (i.e. an individual in an organizational position). They describe a number of leadership programs that are aimed at developing these leadership attributes.

Implications

Regardless of whether health care is pursued in the US, Canada, or abroad, leadership development for clinicians is deemed important to realize the need for change in how health care systems serve patients. This article's focus on programs to assist physicians to gain leadership skills demonstrates the broad base of development that is required across a system for it to be successful in change.

Link to LEADS and CHLNet's Mission

Almost all of the factors identified as key for effective "modern" clinical leadership are found in the LEADS framework. This study—although it uses slightly different language—validates the content of LEADS, and therefore the work of CHLNet; but also the importance of having organizations that represent clinical professions, like the CMA and the CNA as partners in the work of leadership development.

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

Feser, C., Mayol, F. and Srinivasan, R. (2015). Decoding Leadership: What really matters. *Leadership Excellence Essentials*, 32(2): 25-26.

Focus: Leadership attributes that breed corporate success.

New research suggests that the secret to developing effective leaders is to encourage four types of behaviour. This study—conducted in 81 diverse organizations around the world—assessed how frequently certain kinds of leadership behavior are applied within their organizations. They then divided the sample into organizations whose leadership performance was strong. Leaders in organizations with high-quality leadership teams typically displayed 4 of the 20 possible types of behaviour. Those 4 explained 89% of variance between strong and weak organizations. They are:

- Solving problems effectively;
- Operating with a strong results orientation;
- Seeking different perspectives; and
- Supporting others.

Sixteen other factors, including statements such as "develop others", "communicates prolifically and enthusiastically", "champions desired change" and "offers a critical perspective" were isolated in the study.

Implications

Although conducted primarily it appears with private sector companies, it is intriguing to see the four "most significant" leadership behaviours identified. Working on developing those four would appear to have the potential to raise the leadership quotient in an organization.

Link to LEADS and CHLNet's Mission

If all of the 20 factors identified in this study were mapped to the LEADS framework, none of the 20 factors would be absent. This study—although it uses slightly different language—validates the content of LEADS, and therefore the work of CHLNet.

Health Canada. (2015). Unleashing Innovation: Excellent Healthcare for Canada. Report of the Advisory Panel on Healthcare Innovation. Accessed on September 12, 2015.

Focus: Strategies to improve innovation in healthcare.

Health Canada commissioned a blue chip advisory panel drawn from many disciplines, with Dr. David Naylor at the helm, to make recommendations, within the parameters of the Canada Health Act, to improve practices of innovation in the Canadian health system. In their introduction, they state that the facts are that healthcare reform in Canada has proven extraordinarily difficult for every jurisdiction. Consequently the Panel's key recommendations strongly suggest that all Canadian governments—and all Canadians—would benefit from a stronger culture of inter-jurisdictional collaboration in healthcare; and specifically provide "going forward" recommendations to accomplish that collaboration in the realm of healthcare innovation. Some of those recommendations include the creation of a healthcare innovation agency and a one billion dollar healthcare innovation fund, as well as the implementation of a national strategy to promote patient and family-centred care.

Although the panel's recommendations have not been endorsed by any political party or Health Canada, their report still provides valuable guidance into the challenges of generating innovation in Canada, and its recommendations can serve as focal points for very meaningful discussion—and hopefully, action—by agencies who agree with their perspicacity.

Implications
Sooner than later, assertive action will be taken by either the federal government or provincial governments (or both) to stimulate greater innovation and change in the Canadian health system. All senior and junior leaders need to have their ears to the ground and of necessity, should explore the implications for their organization in that context. Action will happen as a consequence of their own initiative, or will be imposed on them by circumstance.

Link to LEADS and CHLNet's Mission
Innovation, change and transformation demand effective leadership. The Naylor panel report is clear that greater change is needed in Canada's health system. LEADS is a common language to help CHLNet members—maybe in the context of the Canadian Health Leadership Action Plan—determine how to respond to such reports and to seek solutions together in the spirit of the vision of CHLNet: *Better Leadership, Better Health—Together*.

MacLeod, H. (2015). Local Health Integration Networks: Build on their purpose. *Healthcare Management Forum*, 28(6): 242-246.

Focus: Making LHINs Work.

This article provides a high-level overview on the creation of Local Health Integration Networks (LHINs) and illustrates the complexities involved in their implementation. To understand regional structures such as LHINs, one must understand the context in which design and execution takes place. It also means that leaders need to understand the patterns of behaviour—e.g. culture as shared beliefs and customs—that drive behaviour and resist change, often because they are unconscious. Change of that nature needs time to progress and mature. The article ends with a commentary on how Ontario is performing post-LHINs and discusses next steps.

Implications
A recent (November 25) Toronto Globe and Mail article indicated that the Ontario government is contemplating major change in how the health system is governed: including expanding the power of LIHNs and potentially eliminating Community Care Access Centres. Understanding the philosophy behind LHINs will help leaders know how to progress if indeed these changes come about.

Link to LEADS and CHLNet's Mission
LEADS is a framework that outlines individual capabilities needed to lead change. CHLNet members—through its action plan—intend to see it used in that manner. Hugh MacLeod, in his article, states that in the context of Ontario's LHIN challenges moving forward, LEADS "provides a tool and process to develop the capabilities required to accomplish healthcare transformation".

Martin G.P. and Waring J. (2013). Leading from the middle: Constrained realities of clinical leadership in healthcare organizations. *Health (London)*, 17(4): 358-374.

Focus: The challenge of creating distributed leadership in middle roles.

In many developed-world countries, there have been efforts to increase the "leadership capacity" of healthcare professionals, particularly lower-status staff without formal managerial power. Creating frontline "leaders" is seen as a means of improving the quality of healthcare, but such efforts face considerable challenges in practice.

This article reports on a qualitative, interview-based study of 23 staff in two UK operating theatre departments, mostly nurses by professional background, who were given formal leadership responsibilities by their hospitals and re-designated as "team leaders" and "theatre co-ordinators". While participants were familiar with leadership theory and could offer clear accounts of good leadership in practice, they were often limited in their ability to enact their leadership roles.

Professional and managerial hierarchies constrained participants' leadership capacity, and consequently the exercise of leadership rested on alignment with managerial relationships and mandates. The findings highlight difficulties with accounts of leadership as something to be distributed across organizations; in healthcare organizations, established institutional structures and norms render this approach problematic. Rather, if fostering leadership capacity is to have the transformational effect that policy-makers desire, it may need to be accompanied by other, wider changes that attend to institutional, organizational and professional context.

Implications

Leadership programs that do not permeate into the very fabric of our organizations—i.e. that do not assist all partners in change to make adjustments to their leadership behaviour, but also to the environmental factors that may constrain individual and collective leadership behaviour—will not develop the leadership capacity, collectively, required to support health system change.

Link to LEADS and CHLNet's Mission

The messages in this article have significant meaning to the work that CHLNet is promoting through its Canadian Health Leadership Action Plan based on LEADS, and its ROI study. Part of our challenge is to generate enough leadership improvement so as to create system change—and that requires awareness of models and approaches that will unleash the power of all to exercise that capacity.

McMaster Health Forum. (2015). *Improving Leadership Capacity in Primary and Community Care in Ontario. Evidence Brief*. Accessed on November 21, 2015.

Focus: Building leadership capacity for primary and community care reform.

This Evidence Brief, created by the McMaster Health Forum Deliberative Dialogue team, compiles research pertaining to assessing and developing leadership capacity to facilitate primary and community care reform in Ontario. The Evidence Brief establishes the research foundation for a meaningful day-long dialogue amongst healthcare leaders "who can make a difference" in terms of putting their efforts to work on primary and community care reform.

The Evidence Brief has three major components to it. First, there is the definition of the problem: i.e. Ontario's primary- and community-care sectors are increasingly being called upon to work as part of an integrated system to achieve key health-system goals related to access, quality, health outcomes and value for money. Achieving these goals will likely require strong management, governance and leadership, and particularly leadership at multiple levels and at the interface between these levels. Existing leadership capacity is not yet up to that task. Second, the Evidence Brief reviews what is known from a systematic review of the literature about three options to deal with the problem. Although there is little systematic evidence in support of any of the options, decisions must be made—and it is the purpose of the Deliberative Dialogue to use what evidence there is to inform decision-making as it pertains to the problem. Third, the Evidence Brief discusses the implementation considerations—that is challenges that exist, or supporting practices already in play—that need to be taken into account by leaders for the change to be made.

Implications

The study suggests that "the demands for leadership capacity have never been greater" and the potential for a toolkit to assist leaders in their development, as well as a provincial steering group to identify leaders to participate in this initiative, are first steps in moving forward. This is also a second Evidence Brief on the topic of leadership for health reform; and it points out the paucity of valid, reliable evidence in the leadership of change field to guide action, as well as the important fact that the evidence that does exist validates the content of the LEADS framework. Indeed, the Brief contains a detailed chart to show how the evidence and LEADS correlate.

Link to LEADS and CHLNet's Mission

Validation of the content of LEADS as a framework which provides support for CHLNet in its endeavours and in using LEADS in creating leadership initiatives aimed at health reform.

Stuart, M. and Wilson, C. (2015). Mentoring in healthcare: A rehabilitation hospital's launch of an innovative program for emerging leaders. *Healthcare Management Forum*, 28(1): 4-7.

Focus: A mentoring program for emerging leaders.

With enterprise-wide interest by physicians, management, staff, and volunteers in developing future leaders across their organization, this article describes efforts to design, implement and evaluate an inaugural, 1-year formal mentoring program for the Glenrose Rehabilitation Hospital, Alberta Health Services. Motivated by a desire to build leadership capacity by treating leadership as a process, rather than an attribute of individuals, Glenrose used the LEADS framework as a backdrop to the content of the program. Evaluation surveys were analyzed highlighting critical success factors incorporating a broad, diverse mentee/mentor applicant process, well-defined mentee/mentor selection/matching criteria, and use of a formal program to support knowledge acquisition through projects, learning sessions, and presentations.

Implications

This article shows how a dedicated effort by an organization to create a mentoring program for emerging leaders can contribute to the completion of actual projects that are of significant importance to the organization. It also outlines the framework of such a program so that others might learn from their experience.

Link to LEADS and CHLNet's Mission

This study is a practical example of how leaders in Glenrose hospital used LEADS to create change commensurate with CHLNet's vision of *Better Leadership, Better Health—Together*. It also demonstrates that a program, designed with the purpose of creating change using leadership as the catalyst, can create practical reforms.

The King's Fund. (2015). *Staff engagement: Six building blocks for harnessing the creativity and enthusiasm of NHS staff.* The King's Fund: London UK. Accessed on November 15, 2015.

Focus: How leadership can improve staff engagement.

According to The King's Fund, there is now an overwhelming body of evidence to show that engaged staff really do deliver better health care. The NHS providers with high levels of staff engagement (as measured in the annual NHS Staff Survey) tend to have lower levels of patient mortality, make better use of resources and deliver stronger financial performance (West and Dawson, 2012). Engaged staff are more likely to have the emotional resources to show empathy and compassion, despite the pressures they work under. So it is no surprise that trusts with more engaged staff tend to have higher patient satisfaction, with more patients reporting that they were treated with dignity and respect (Review of Staff Engagement and Empowerment in the NHS, 2014).

Yet despite the evidence, the question of how to create an engaged workforce does not seem to be a priority for many organizations (and their boards). It may seem like a vague concept and there are always other, seemingly more immediate challenges. For example, Mid Staffordshire NHS Foundation Trust had among the lowest levels of staff engagement in the NHS throughout the mid-2000s, but the alarm bells were not heard. The good news is that we now know a huge amount, from the NHS and other sectors, about the conditions that create an engaged workforce. Developing engaged staff is a long-term endeavour and requires sustained effort throughout an organization. But board members and other leaders can start making a tangible difference immediately, simply by focusing on the following six building blocks for success:

- Develop a compelling, shared strategic direction;
- Build collective and distributed leadership;
- Adopt supportive and inclusive leadership styles;
- Give staff the tools to lead service transformation;
- Establish a culture based on integrity and trust; and
- Place staff engagement firmly on the board agenda.

Implications

A much more focused and deliberate effort must be made in organizations that have slow staff (and medical) engagement to improve it. Indeed, it must take on the same priority as quality improvement, or other clinical practice improvements. It is also true that the most important individual who needs to make this a priority in their work are the formal leaders in that organization.

Link to LEADS and CHLNet's Mission

This article validates the *Engage Others* and *Achieve Results* domains of LEADS. It also provides some evidence to show that improving leadership in these two domains should have a positive impact on organizational outcomes; and therefore feeds into the CHLNet ROI study that is being proposed.

Van Aerde, J. (2015). Opinion: Relationship-centred care: toward real health system reform. *Canadian Journal of Physician Leadership*, 2(2): 3-6.

Focus: The centrality of relationship-centred care to health transformation.

Dr. Van Aerde outlines an argument to address the challenge of competing interests and perspectives that permeate discussions on health care reform. He states that most of the debates that occur have more to do with perpetuating self-interest structures and systems, rather than focusing on the patient; and that these debates are "divorced from meaningful action". His own perspective is that most of us long for a transformation that returns some of the "caring" to the system: caring for patients, caring for staff, caring for each other's interests as well as our own. In other words, to make a patient-centred system work in optimal fashion.

Patient-centred care was to focus on the patient's goals and values, making him or her an active participant and sometimes the ultimate decision-maker. He makes the case that Relationship-Centred Care (RCC) is a very helpful model to understand the nature of the changes that need to be made. RCC requires an explicit focus on the relationship between the partners who are all working towards the welfare of the patient: with the physician-patient relationship at the core.

There are four principles to RCC:

- Relationships in health care ought to include the personhood of participants (the patient's and clinician's unique experiences, values, and perspectives);
- Affect, empathy, and emotion are important components of these relationships;
- All health care relationships occur in the context of reciprocal influence (although the patient's goals take priority, both clinician and patient influence each other and benefit from the relationship); and
- RCC has a moral foundation, allowing clinicians to develop the interest and investment needed to serve others and to be morally renewed by those they serve.

He goes on to show how the Cleveland Clinic has embraced RCC as an approach to service delivery and the impact it had on hospital outcomes. He finishes by stating that physicians, together with other caregivers and patients, have to lead transformational changes like relationship-centred care at the front line

Implications
True relationship-centred care demands relationship-centred leadership. A focus on making all of our relationships—at all levels of the system—focus on working for the patient's benefit. This challenges us all.

Link to LEADS and CHLNet's Mission
LEADS emphasizes the importance of relationships in two of its five domains: *Engage Others* and *Develop Coalitions;* and a relationship approach is necessary for *Systems Transformation* as well. It also emphasizes the need for everyone to have these leadership capabilities—regardless of position, or authority. As such it can be a catalyst to create patient-centred relationships within the Canadian health system—which will create better leadership, better health—together.

VanVactor, J.D. (2012). Collaborative leadership model in the management of health care. *Journal of Business Research*, 65(4): 555-561.

Focus: Designing practices necessary to build collaboration in leadership.

Leadership exists within relationships that are present throughout an organization. Encouraging a collaborative environment promotes an ongoing integration of ideas and interdependency among multiple stakeholders throughout an organization. The purpose of this work is to provide an overview and analysis of collaborative leadership and shared management tactics. The overview includes an identification of differences between leadership and management, and applies the concepts to creating collaborative management practices in the modern health organization.

To facilitate change, health care organizations should begin to evaluate defined management roles outside of traditional parameters. Collaborative leadership must be a central element in the design of management processes and must be the basis upon which leadership and management practices are built. Collaboration is defined as a synergistic work environment wherein multiple parties must work together toward the enhancement of health care management practices and processes. The authors also present a collaborative communications model developed through the conduct of an academic study. Health care management practices are changing and leaders must embrace change, in the form of new collaboration practices as practiced by managers in order to remain successful in the management of health care.

Implications

- Tactical structural organizational design practices must be employed in order to create conditions for collaborative leadership throughout (vertically and horizontally) health care organizations.
- New communication practices are required for collaboration to be enhanced.

Link to LEADS and CHLNet's Mission

The LEADS framework envisions leadership as a process as well as an individual developmental model. Collaborative leadership aims at creating process; and structural changes can stimulate collaborative leadership. Collaborative leadership is also implicit in the CHLNet vision statement.