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Leaders: The Missing Link in Health System Performance

CHLNet Presentation to CHW Conference
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CHLNet
Canadian Health Leadership Network
Le Réseau canadien pour le leadership en santé

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Health leaders in health workforce research, policy and planning

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Graham Dickson, PhD

Senior Policy Advisor CHLNet and Research Advisor CSPE

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Thesis

- Leadership and Management in the Canadian health system is woefully underfunded and underappreciated for the role it is expected to play.
- It is time we "professionalized" leadership and management.

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International Experience

- Leadership is the "golden thread" that runs through any discussion of NHS reform and improvement (Ham, 2014)
- Both UK and Australia have national approaches to workforce planning that includes health leadership
  - NHS Health
    - NHS Leadership Academy – £50 M per year
  - Health Workforce Australia
    - $5M over 3 years for DM training, tool development and aboriginal leadership development

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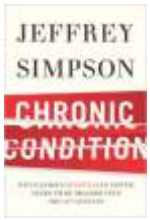
Health Leadership Research



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System Performance

- Commonwealth Fund still lagging 10 of 11 countries (June 2014)
- Only ahead of US
- One of most decentralized systems in developed world
- Inconsistent provincial, territorial, national healthcare insurance plans, policies, legislation, regulation, priorities, funding models and accountability instruments

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EXHIBIT ES-1. OVERALL RANKING

Country Rankings

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

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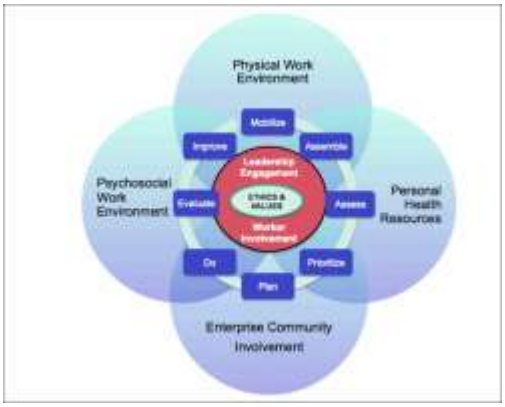
A healthy workplace?

- Healthcare employees are off more on sick leave, workers' compensation and long-term disability than any other business.
- The biggest and fastest growing claims are stress and anxiety related.
- A recent U.S. study: hospital employees are more likely to be diagnosed with chronic conditions like asthma, obesity, and depression, and were five per cent more likely than the general population to be hospitalized.



WHO Healthy Workplace model

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Participatory Action Research Projects Across Canada

Total = $817,500

- **CIHR Grant ($350,000),**
- **MSFHR Grant ($100,000)**
- **In-kind contributions**

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PHSI Results: What we know

- **New capacities** required – systems thinking, strategic thinking, and relationship development
- Quality **physician leadership** – at all levels is required
- Too much **churn**
- **Alignment** of thinking and action around collective leadership capacity
- **LEADS** as a common language
- Need for systematic **succession planning** and leadership development

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What we don't know

- Clarifying the link between investments in leadership development and health performance.
- Determining the practical dynamics of distributed leadership; how it operates and how it can be operationalized to create a common vision for health reform.
- Articulating meaningful, innovative, and practical leadership approaches to engage patients, families and the public.
- Providing greater clarity about the importance of, and development of, engagement strategies to ensure PHYSICIANS are partners in the leadership of reform.
- What needs to be done to professionalize the leadership and management cadre in health; e.g., span of control; education required; credentialing; etc.

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Leadership in Primary Care

Ross Baker, PhD

Professor Institute of Health Policy, Management and Evaluation at the University of Toronto

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Why Has Canada Not Created Stronger Primary Care?

- Starfield (2008): "Canada is a follower not a leader….Any country that is serious about primary care would eschew a sole focus on disease-oriented quality goals"
- Glazier (2012): "Despite Ontario's major investments in primary care … many patients continue to be without timely access to care, and the use of walk-in clinics and emergency departments remains high"
- Hutchison and Glazier (2013): "The past several years have seen profound changes in the funding and organization of primary care in Ontario. However, budgetary constrains….pose a threat to the ongoing process of transformation"

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New Models of Primary Care

- Ontario: Family Health Teams, Nurse Practitioner Led Clinics
- Quebec: Les Groupes de Médecines de Famille
- Alberta: Family Care Clinics
- BC: Divisions of General Practice

- Key questions for all these groups:
  - Do these models promote higher quality primary care?
  - Do they improve system performance?

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Some Critical Issues for Effective Primary Care

- Establishing inter-professional teamwork
- Developing and maintaining programs for chronic disease management and prevention
- Developing effective information systems that informed practice
- Developing systematic performance measurement and quality improvement
- Ensuring timely access to care and continuity within the clinic
- Improving coordination with other providers across the continuum of care
- Creating effective governance

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Leadership for More Effective Primary Care

- Ontario node study of four primary care organizations
  - 3 Family Health Teams
  - 1 Nurse Practitioner Led Clinic
- These four organizations were selected using a nomination process where knowledgeable experts and stakeholders were asked to identify FHTs and NPLCs that were "high performing"
- Detailed case studies were undertaken using interviews and document analysis
- An interview schedule was developed based on understanding leadership in 3 phases of FHT/NPLC development
  - Initiation/creation
  - Design/development
  - Implementation
- In total 44 interviews were done across the four sites with lead clinicians, other members of the organizations and external observers who knew the organizations

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Some Key Findings on Leadership

- In all three FHTs, lead physicians were key to the development of the FHT
  - They saw the opportunities created by the new practice model, sought to be innovative, and to serve their patients and communities
- In the NPLC the leadership emerged from a group of NPs who were concerned about access for patients in their communities and about the unemployment of NPs

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Findings, 2

- Leadership in the FHTs and NPLC was not based on lead clinicians alone, but was distributed across several roles
  - Executive directors in the FHTs were key to successful implementation of the new model
  - Other clinicians played important roles in the development of new programs and practices

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Findings, 3

- Key competencies of leaders included:
  - Abilities to effectively engage and motivate colleagues to explore these new models
  - Strong listening, communication and inter-professional skills
  - Tact, diplomacy and political insight
  - Collaborative skills with both physician and non-physician providers
  - Strong negotiation skills
  - Capabilities to mobilize external stakeholders for support
  - Emotional and political intelligence

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Quebec Case Study: Family Medicine Groups

- Launched in early 2000s
  - Like Family Health teams, Family Medicine Groups are multi-professional teams led by physicians – generally 6 to 10 physicians working with nurses and sometimes other providers
  - FMGs were designed to improve primary and population health needs particularly around chronic disease management and access and to link more effectively to other care providers, most notably CSSS – Centres de santé et services sociaux that combined CLSCs, long term care and hospital services in 95 regions across Quebec

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Quebec Case Study

- Methods
  - Three FMGs were studied in a multi-phase approach using interviews with physicians and other key personnel
  - The 3 FMGs were identified as higher performing groups by decision makers and the researchers
  - A similar interview schedule was used to the Ontario research to allow some comparison between provinces
  - In total 13 interviews were done in the first wave and 6 interviews in the second

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Quebec Case Study Findings

- Findings:
  - Like Ontario, the new primary care groups were based on voluntary participation by physicians stimulated by financial incentives, organizational support and payment for additional personnel
  - Physician leaders played an important role in the initiation of FMGs by engaging fellow physicians and negotiating with government in the development of contracts for services
  - Unlike Ontario, the FMGs were explicitly linked to regional structures and were required to develop agreements that specified these relationships

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Quebec Case Study Findings

- Leadership findings:
  - During the implementation phase, physician executive directors played a key role in helping to set up internal systems and in explaining and promoting the role of nurses within the groups
  - As in Ontario, these higher performing FMGs demonstrated distributed leadership, particularly around the development of nursing protocols, and coordination between FMGs and health system networks
  - The FMGs were required to sign contracts that specified operational characteristics of the groups; in many instances physician leaders sought to negotiate changes in these agreements where different local arrangements made greater sense

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Concluding Remarks

- Full analysis of the similarities and differences between the development and implementation of FHTs and NPLCs in Ontario and FMGs in Quebec will be carried out in the next stage
- Differences between Ontario and Quebec in the policy context and the relationships between the primary care organizations and regional networks make the case comparisons particular interesting
- Key questions include:
  - How did these differences influence the leadership strategies and tactics adopted in each setting?
  - How did the larger size and wider range of health professionals affect the leadership dynamics in the Ontario primary care groups?
  - What are the views of physician leaders and others about the capabilities of these organizations to face current challenges?
- One apparent need in both settings is more additional leadership training and capacity building that would enable other primary care organizations to develop the capabilities exhibited by the organizations that were the focus in this study

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CEO of The Physician Recruitment Agency of Saskatchewan

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Rachel Bard

Former CEO of the Canadian Nurses Association and CHLNet East Champion

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Benchmarking Research Questions

- 1. Is there a leadership gap in Canada?
- 2. What is the size of the gap?
- 3. How important is the gap?
- 4. What is being done to close the gap?

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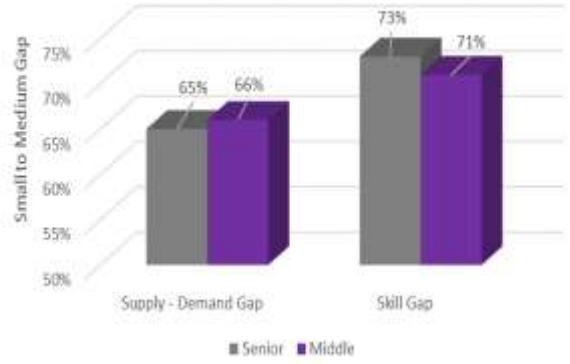
What is the size of the gap?

Results

Figure 1: Size of Leadership Gap



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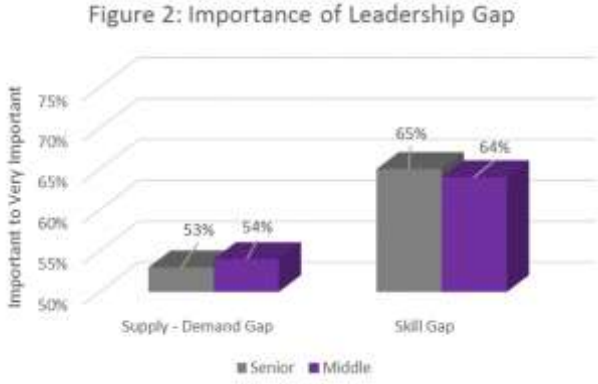
How important is the gap?

Results

Figure 2: Importance of Leadership Gap



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Benchmarking Results

- Some truth to perception there is a leadership gap in Canada although half see as same as five years ago
- ACAHO more concerned about extent of gap and how strong their leaders are on critical leadership capabilities
- More skills gap than supply-demand
- Not protecting time for leadership development and low satisfaction with budgets and programs
- Leadership a key foundational enabler of system performance and health reform

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Nursing Leadership

- Relevancy of the gap
- Taking stock
- Priorities
- Quality Agenda
- 3 – Four – 50 message
- Team Intelligence

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