COVID Corner XI
Evidence-informed Hope: Taking a Global Perspective

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This, the eleventh edition of the COVID Corner, is intended to provide a primer to support CHLNet's November 2022 Network Partners Roundtable dialogue under the theme of '*Leading Health System into the Future—Taking a Global Perspective*'. We also see this series of blogs as helping all leaders better adapt to the ever-changing challenges of COVID and to leading self through and beyond the long tail of COVID.

It builds on our previous exploration of the concept of *evidence-informed hope* where we concluded, that "Ev*idence-informed Hope* is *not* a contradiction in terms, but a powerful motivator for change". [1] This issue of COVID Corner draws on the first-hand experiences shared by Network Partners and the spirit of '*leaders supporting leaders*' coming out of CHLNet's May Network Partners' meeting.

> *"There are no passengers on spaceship earth. We are all crew." - Marshall McLuhan*

The focus here remains on the strategic objective to "inspire, validate, and prepare current and future leaders for 21st century care" by presenting evidence drawn from a global perspective to give us hope for coming out of the COVID-19 pandemic stronger.

As we "zoomed out" and reflected on the international leadership lessons learned over the past two years, it reinforced the extent to which we now live in a 'global health village' that even McLuhan could not ever have imagined. The 'medium is still the message', but the messages are more mixed than ever and are coming at us 24-7. The forces of globalization are far stronger and more complex than pre-pandemic. Technological, cultural, environmental, political and, yes, biological forces have combined to create a *syndemic*[2] that will outlast and outpace the long tail of COVID. And, as McLuhan suggests above all none of us can afford to be bystanders when it comes to 21st century priorities like climate change or preparing for the next pandemic.

We did not have to look very far to find further inspiration and further support for the concept of *evidence-informed hope*. In what follows, we begin by drawing on the evolving partnership between CHLNet, LEADS Global and the *International Leadership Association (ILA)*. Together, we brought together leaders virtually from five continents to share their lessons learned coming out of COVID this past May (2022).

Next, we turn to the extensive work of the *Global Evidence Commission* and the important role that *evidence intermediaries* play in helping leaders integrate research, data and lived-experience evidence into policy and practice. We then turn to the most recent report coming out of the

[1] Tholl, B. Dickson G. and Judd, M. CHLNet COVID Corner: Getting to the Other Side of COVID: Is Evidence-Informed Hope a Contradiction of Terms? April 2022

[2] Van Aerde, J. The health system is on fire – and it was predictable. CJPL 2020 Vol (7) 1.

National Academy of Medicine in the US in its *Learning Health Systems* series and how, with the right leadership, we can emerge even stronger coming out of the pandemic. Finally, we look a bit further afield to build on the hope for a better future going forward from Thomas Homer Dixon's most recent book "Commanding Hope" (2022).

We conclude that, in this *syndemic* world, where the global and multiple forces of fragmentation can overwhelm us all, the fundamental functions of leadership are reaffirmed, namely: (i) to better integrate services for patients with the evidence; (ii) to create or facilitate the creation of healthy and productive workplaces; and (iii) to leverage up the once-in-a-lifetime opportunity to reimagine health policies and practice in service of citizens, patients, families, communities and health care providers.

International Leadership Association (May 2022 Conference): The ILA was created in 1999 to 'bring together professionals with an ongoing interest in the study, practice, and teaching of leadership'[3]. Over the past decade it has undertaken to build a dedicated community of practice in bringing leadership research and practice together. Most recently, it held the 2nd Health Care Leadership Conference under the theme *Strengthening Ties Between Healthcare and Leadership*.[4] The conference featured some outstanding plenary speakers and two expert healthcare leadership panels representing five continents; brought together in partnership with CHLNet and LEADS Global.

Building on the November 2021 roundtable of CHLNet Partners, the panelists were asked to address three key questions going forward, namely: 1. What are the major leadership challenges you have faced as a healthcare leader through COVID-19? 2. What lessons have you learned coming out of your COVID-19 experience? And 3. What are the three most important leadership attributes needed going forward to be successful. These are the same three questions used in the "Leading Through COVID" action research project.[5] [6]

The responses from the panelists were both inspirational and aspirational. Among the *shared leadership challenges* faced going through the pandemic were: how COVID had exposed persistent and growing inequities within and across counties (less developed, developing and developed); heightened interest and concerns around Equity, Diversity and Inclusion (EDI) and the need to redouble collective efforts to use the EDI tools available; how the pandemic has had a polarizing effect politically and economically; the toll the pandemic has taken on the health workforce globally;

[3] For more information on the ILA see link here: https://ilaglobalnetwork.org/.
[4] International Leadership Association (2022) "Strengthening Ties Between Healthcare and Leadership". Link here: https://ilaglobalnetwork.org/2022-healthcare-leadership-conference/.
[5] Dickson G, Taylor D, Hartney E et al. The Relevance of the LEADS framework during the COVID-19 pandemic. Healthcare Management Forum. 2021;34(6):326-331. doi:10.1177/08404704211033002.
[6] Hartney E, Melis E, Taylor D et al. Leading through the first wave of COVID: a Canadian action research study. Leadership in Health Services. 2021;35(1):30-45. doi:10.1108/lhs-05-2021-0042

the insidious effects of misinformation and disinformation throughout the pandemic; and shared concerns around addressing the after-effects of COVID on health leaders and their organizations.

Against these shared challenges, panelists also pointed to *evidence of hope* going forward in terms of the opportunities for transformative change. Some of these included: better appreciation for the benefits of more distributive approaches to leadership, founded on the trusting relationships built up through COVID times; more attention being focussed on being more aware of EDI challenges and opportunities; the importance of supporting one another as leaders to help 'put your armour on every day'; the importance of celebrating successes coming out of the pandemic; the value and importance of coalitions, strategic partnerships and networks to build resilience going forward; the increased attention to global collaborations going forward (like ILA and the proposed World Health Leadership Network or *WHLNet);* and recognition of the ability to work in "COVID time", with increased ability to make real time decisions based on real world evidence.

Going forward, the panelists pointed to the following leadership attributes or capabilities as critical to leading 21st century (learning) healthcare systems: better understanding of complexity, systems and systems thinking; better understanding of leading *in context*, with a concomitant need to adapt leadership styles; grow and improve communications skills and strategies (e.g. using social media to advantage); enhance our understanding of the 'global village' of healthcare leadership challenges and opportunities; and heightened awareness of the moral imperatives around "helping our fellow human across the world as a whole".

Resilience and relationality: Our panels, in quite different contexts, pointed to the ability of successful leaders to build individual and organizational resilience (e.g., through stronger interpersonal and interorganizational networks). Building trusted relationships, as it turns out, helps to explain the wide variations we see in terms of the incidence and prevalence of COVID and differential mortality rates. According to a recent article in *Nature*, by Lento et.al, the number of cases/capita across over 150 countries varied by a factor of about 40 and deaths/capita varied by about 25. As we have found in our previous work, trust in leaders is a critical success factor in building and sustaining relationships. This study found that "trust within society is positively correlated with country-level resilience to COVID-19 as is the adaptive increase in stringency of government interventions when epidemic waves occur".[7] It also pointed out that perhaps not surprisingly given the Canadian experience, that trust is significantly and positively correlated with resilience (number of cases/capita and deaths/capita) and especially with reduction of cases/capita and deaths/capita. This helps to explain why countries such as Japan and Indonesia (and Canada), with relatively high compliance with public health measures such as masking and social distancing, have experienced much lower mortality and morbidity rates due to Covid-19 (after adjusting for normal or customary factors such as demography and geography) relative to the United Kingdom and the United States.

[7] Lenton, T.M., Boulton, C.A. & Scheffer, M. Resilience of countries to COVID-19 correlated with trust. *Sci Rep* **12**, Link here: Resilience of countries to COVID-19 correlated with trust | Scientific Reports (nature.com).

Global Evidence Commission[8]: The basic premise of the Commission's work is that COVID-19 pandemic provides a "one-in-a-generation" opportunity for leaders to increase the relevance and responsiveness of evidence to policy questions. This, in turn, will serve as a catalyst for 'transformational' change. The final report features some 24 high-level, cross-cutting recommendations for leading the charge in addressing health and other social sectors, including that leaders need:

- to better prepare for unpredictable future crises, including but certainly not limited to future health emergencies, where leaders are broadly defined to include government, professionals (including doctors, nurses, others), organizational leaders and citizens.
- to search out reliable, readily access evidence both locally (i.e., what has been learned from their own country, state/province/city) and globally (i.e., what has been learned around the world).
- to tap into 'living' evidence products, meaning they are regularly updated as new data are added or new studies are published to "minimize the noise to signal ratio".[9] The objective is to maximize the sources of trusted, reliable, available evidence in the hope that it drowns out the many sources of 'noise'… aka misinformation and mal-information.
- to recognize and support "evidence intermediaries": those entities or individuals who work 'in between' decision-makers and evidence producers. They support decision-makers with best available evidence (e.g., 'rapid reviews') and they support evidence producers with insights and opportunities for making an impact with evidence. Other terms used to describe this important role include: "knowledge brokers", "boundary spanners" and "mavens".[10]

While hope may not be a strategy on its own, when informed by the best available evidence, it can continue to be one of the *most effective assets* any health leader has in their toolbox as we move through and beyond the COVID-19 pandemic. Commissioners are presently fanning out across the world to help give the report lift. This includes looking at ways and means to inspire health leaders here in Canada regionally, provincially, and federally.

National Academy of Medicine (NAM): In its most recent *Learning Health Systems Series*, NAM provides further evidence in support of hope for "Emerging stronger after COVID-19", the subtitle of the report.[11] The NAM report has a strong focus on leadership, including specific findings and

[8] Global Commission on Evidence to Address Societal Challenges (2022) A wake-up call and path forward for decision-makers, evidence intermediaries, and impact-oriented evidence producers. Link here: https://www.mcmasterforum.org/docs/default-source/evidence-commission/executive-summary---evidence-commission-report.pdf?Status=Master&sfvrsn=d5f745e8_5/Executive-summary---Evidence-Commission-report.

[9] This signal-to-noise ratio is drawn from science and engineering., It is a measure that compares the level of desired signal to the level of background noise (e.g., mal-information and misinformation in a COVID-19 context).

[10] See Malcolm Gladwell's "The Tipping Point". Link here: https://en.wikipedia.org/wiki/The_Tipping_Point.

[11] National Academy of Medicine (2022) *Learning Healthcare Organizations Series* Emerging Stronger from COVID-19: Priorities for Health System Transformation |The National Academies Press

recommendations to address the need to invest. in health leadership to address workforce issues. (p260-262)

It also flags several "deeply rooted problems" consistent with both ILA and Evidence Commission themes, including: systemic fragmentation; perverse incentives (re: need for collaborative leadership); financing/payment systems at odds with integrated, seamless, and focused care; lack of digital interoperability for sharing data; lack of accountability for toxic cultures; a '*dearth of diversity*' in formal leadership positions; inattentiveness to real world learning that is continuous, and timely; the need to support 'dynamic and agile' leadership; the need to invest in clinician well being; the value of "integrated leadership"; and the need to embrace public health integrity "as an explicit responsibility of every organization". (p.12)

The report also speaks to COVID as having "unleashed the potential of *Learning Health Systems.*"[12] The Academy found that: "While the pandemic exposed health care's fault lines, its enormity and the resulting pace of scientific innovation brought the potential and need for Learning Healthcare Systems into sharper focus". (p 236). As we found in COVID Corner X, the Academy stresses the need to take advantage of this window of opportunity (or 'refractory period') coming out of COVID-19 as a catalyst for system-wide change. To maintain momentum for transformation, however, "…it is essential to build on the new ways of working that the pandemic allowed (e.g., partnerships, breaking down siloes), implement the ethos of a learning health system (e.g., by integrating evidence development and application), and strengthen the foundation of trust upon which the transformed system will stand." (p 532). It further finds: "the pandemic has illustrated the value of integrated leadership and centrally coordinated decision-making for integrated delivery systems."

The COVID-19 pandemic has offered an unprecedented opportunity to build coalitions, embrace aspirational goals, and implement lasting change. Hopefully the *Learning Health System* concept can channel the "dash for digital" and help to avoid wasteful spending on siloed systems that don't work together.

Commanding Hope: Zooming still further out in search of evidence-informed hope, Canada's Thomas Homer-Dixon, in his 2020 book "provides great insights on the concept of 'hope', implicit in leadership (i.e., pursuing a vision of the future) and necessary for us to find the will and commitment to go through the challenges of health care deconstruction and reconstruction. *Commanding Hope: The Power We Have to Renew a World in Peril.*

While not specific to health care, Homer-Dixon describes hope as having three dimensions: *honest hope* (i.e., the willingness to embrace the truth about the scope and breath of the challenges we face implicit in the demand for transformation); *astute hope* (i.e., the ability to analyze and identify the worldviews and motivations of the people who must carry out the work within the system that needs to be changed—i.e., deconstructed and reconstructed); and third, *powerful hope (i.e.,* the

[12] A Learning HC System defined as "an organization skilled at creating, acquiring, and transferring knowledge, and at modifying its behaviour to reflect new knowledge and insights". Link here: https://learninghealthcareproject.org/background/learning-healthcare-system/.

ability to adopt a psychological attitude that is committed to a vision of a positive future and the clear roadmap of strategies to get there). Powerful hope motivates the agency of the people needed to engage in deconstruction and reconstruction.

He eloquently describes—in keeping with the notion of *honest hope*—the scope and breadth of the challenges facing humankind today and shows how the interconnectedness of those challenges pose meta problems not unique to each sector, but to all sectors, including health care. In his treatment of astute hope and powerful hope, he suggests that human beings have the capacity to achieve transformation (in the realm of deconstruction and reconstruction) but must believe in their ability to do so. He also argues that the scope and breadth of the deconstruction and reconstruction challenge is daunting; but we must face up to them if a potential positive future is possible.

Wrapping up: We embarked on this zooming out adventure in hope that the evidence from outside Canada might confirm our own key lessons learned based on CHLNet's action research undertaken to date. We were not disappointed. The world experience tends to confirm in many ways the natural experiment ongoing here in Canada. We have, for example, learned as the pandemic has progressed and adapted leadership strategies as needed (i.e., learning healthcare systems). We have seen how evidence-informed, integrative approaches to leadership can counter the natural tendencies for fragmentation during times of crisis. We have confirmed leadership transitions from more directive to more collaborative leadership as the pandemic has progressed. And, we have confirmed the importance of resilience and relationality as critical success factors in responding to the crisis.

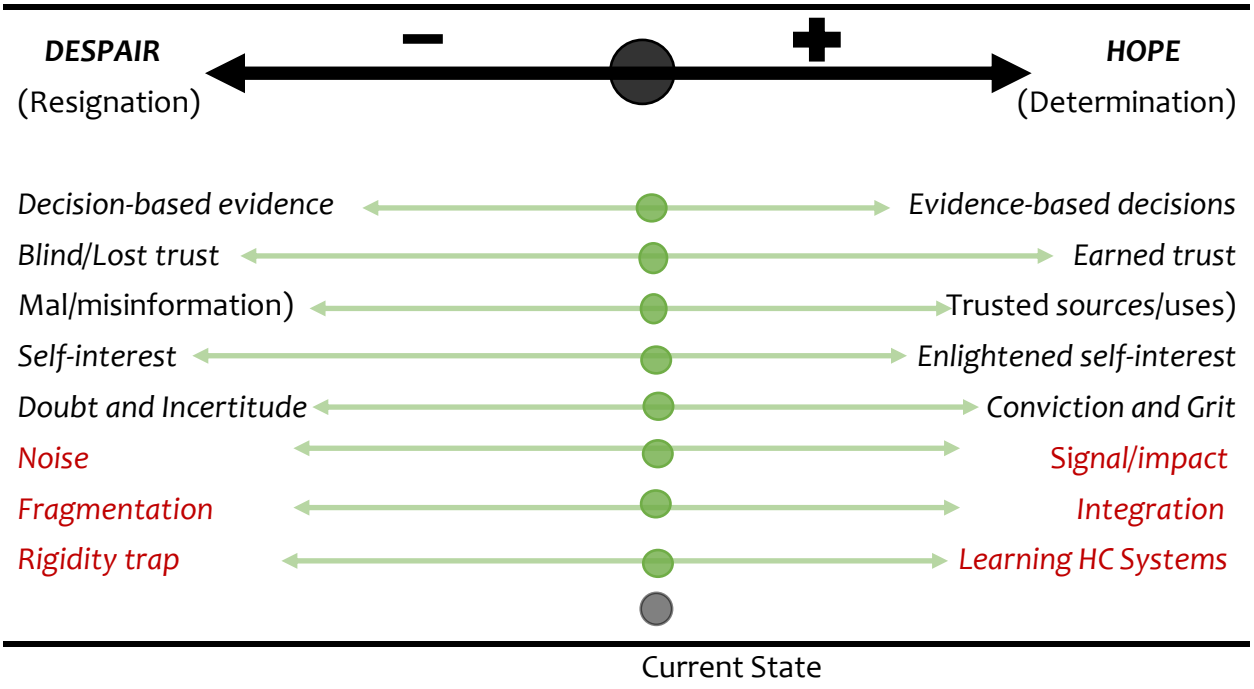
In COVID Corner X on *Evidence-informed Hope*, we summarized our findings on a spectrum ranging from Despair (or Resignation) on the one end to *Hope* (or Determination) at the other end. We have attempted to capture some of the key insights from "Zoom-out" in a modified matrix (See Figure 1 in Appendix A). It features several additional dimensions, including the importance of reducing the *noise to signal ratio* (by increasing the reliance on 'evidence intermediaries') and countering the natural tendency for fragmentation by adopting a more systems view of the challenges of COVID-19.

In conclusion, we turn again to Homer Dixon who recently stated on the topic of hope as a motivator for leaders that:

> *If hope is to be a motivator and not a crutch, it needs to be honest and not false. It needs to be anchored in a realistic, evidence-based understanding of the dangers we face and a clear vision of how to get past those dangers to a good future. Canada is itself flawed, but it's still one of the most remarkably just and prosperous societies on the planet.*

APPENDIX A

Figure 1: Evidence-informed Hope (Evi-HOPE) Continuum: From a Local to Global Perspective



Local: At the one end of the *Evi-HOPE* Continuum we have the opposite of hope and determination: despair and resignation. There are those who, amid the never-ending COVID-19 pandemic, have lost all hope. They have lost trust in their leaders. They are tired of seeing political self interest trumping collective interests and fed up with the polarizing politics of the pandemic. Some are simply resigned to just toughing it out. This underscores the importance of resilience and 'relationality' in getting to other side of Covid-19. Still others are lashing out against authorities and, in some cases, the rule of law.

Global: While Canada is not alone, we have learned do relatively well when objectively looking at COVID cases/capita and deaths/capita. Resilience and trust in leadership is key. We have learned that we can decrease the noise to signal ratio by supporting evidence intermediaries. Zooming out also reinforces the finding that one of the key functions of leaders is system thinking and integrating systems to counter the tendency for fragmentation. And we look to learning healthcare systems as the way out of the "rigidity trap".[13]

[13] Allen, C.R. et al. (2014) Panarchy: Theory and Application. Link here: https://link.springer.com/article/10.1007/s10021-013-9744-2.