Partnerships for Health System Improvement (PHSI)

Leadership and Health System Redesign

National Node Case Study
Final Report

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Executive Summary

This National Node Case report is one of six node projects exploring leadership capacity in the Canadian health system through Participatory Action Research and knowledge translation. The project is overseen by a network of senior decision-makers and researchers from across Canada, and is funded through the Canadian Institutes for Health Research (CIHR) and Michael Smith Health Research Foundation (MSHRF BC) Partnership in Health System Improvement (PHSI) grant. Three research questions guide all node work:

1. What is the current state of health leadership capacity in Canada? What is working, or not working, in terms of stimulating and supporting health system transformation, and what contextual factors influence effective leadership action?
2. Where are the gaps between current practices, the evidential base in the literature, and the expectations for leadership outlined in the emerging health leadership capability/ competency frameworks (e.g., LEADS capabilities framework), and how might a set of national standards for leadership be structured?; and
3. How can knowledge of effective leadership be translated and mobilized by the network into approaches, programs, tools and techniques to develop a culture of effective leadership in Canada, and enhance the development of quality health leaders?

To understand the leadership dynamics of health system reform in Canada, the national node study investigated the practice of leadership to create health system redesign in a national context. Reform goals of access, quality and appropriateness (AQA) focused investigation for this four year endeavour, including how these three goals interacted and the efforts being undertaken to lead reform.

Twelve study participants were chosen by members of the Canadian Health Leadership Network (CHLNet) based on their knowledge of health care, current involvement in health reform, and acknowledgment by peers as a major contributor to efforts in leading health reform in Canada. A semi-structured interview process garnered data across three cycles of research. There were six to eight month intervals between data collection activities. NVivo analysis generated central themes and answers to the sub-questions for each cycle, along with a parallel process of coding and theming undertaken by the research team for triangulation purposes. Overall findings for the three questions guiding the study were compiled after each cycle; and aggregated answers to the three study questions and interpretative insights were subsequently drawn.

Leadership Capacity and Capabilities

Health leadership continues to be identified as a key factor in the success or failure of major health system reform in Canada. Generally speaking, respondent data suggests that Canada does not have the leadership capacity required to lead significant health reform. Some informants believe there that there is individual capacity inherent in the system, but that it is sprinkled sparsely throughout, and held back from realizing its promise because of many

intervening structural, cultural, and political factors that delimit the ability of leaders to be effective. Most believe that collective capacity is lacking. If the standard for assessing capacity is well-organized, well-functioning distributed or shared leadership that generates productive, progressive large scale change, Canada does not have that capacity.

Change fatigue is growing among senior leaders. Consistency of leadership and a renewed focus on clinical leadership are required to simultaneously realize overall access, quality and appropriateness policy objectives.

In Canada's decentralized health system there is a tug of war between the collective ability of leaders to work together and the forces of fragmentation that are inherent in decentralized service delivery. Currently the "tug" forces outweigh the "hug" ones. Numerous examples of both highlighted the challenges implicit in AQA reform.

When leadership worked, and when change happened, the common "hug" forces, in the form of individual leadership capabilities that were able to overcome fragmentation were identified as:

- Emotional intelligence
- Enlightened self-interest
- Personal commitment to a universal health system
- Character
- Resilience
- Longevity
- Ability to access and use data for decision-making
- Creating and leading change
- Complexity theory and systems thinking
- Team-building and teamwork
- Effective two-way communication

Reinforcement of Leadership Theory

Data collected reinforce some basic leadership theories and provide a better understanding of the practice of leadership. Distributed leadership; substitutes for leadership; and complexity leadership were strong themes in cycle two and three. In addition, some robust support for the construct of authentic leadership and servant leadership was identified.

Results show there is a continued reliance in some parts of the health system on hierarchical, heroic leadership models but that those approaches do not stimulate shared reform effort. Formal leaders no longer have the same power or privilege as before; and the political nature of health care heightens the demand for collaborative, coalition-building skills. Health systems are increasingly complex and interconnected and as a result leadership involves striking the right balance between: centralization and decentralization forces; designated and distributed leadership; accountabilities and authorities; organization and system performance; and consensus and engagement strategies.

Leadership Competency/Capabilities Frameworks

System-wide strategic approaches to leadership and succession planning are being undertaken in Australia and the United Kingdom. Competency or capability frameworks are foundational to these efforts. Three frameworks common noted were: Canada's *LEADS in a Caring Environment* framework; *Health LEADS Australia*; and England's *National Health Service Leadership Framework* (currently under revision). The UK approach bears an approximate similarity to the LEADS framework in Canada, while the Australian models is very similar. In both instances (UK and Australia), and unlike in Canada, there is a concerted effort to mount a national program for leadership development and succession planning. Jurisdictions with national strategies were referenced as worthy of being emulated as its sets the bar for both leadership practice and leadership development.

Knowledge Translation and Mobilization

From a national perspective, efforts to translate and mobilize knowledge to support leadership development in Canada, continues to be ad hoc and peripatetic. This situation creates inefficiencies and fragmentation that detracts from serving the health reform agenda. Both collective and individual approaches to creating a better bridge from the research world to the policy world would help, especially if organized to support a national reform agenda (like in Australia and the UK). Informants suggest that there should be a stronger, more comprehensive, high-level emphasis put on succession planning and leadership development (that includes mentoring and coaching) in order to create the depth of leadership capacity needed for health reform. New innovation pathways to effect a stronger national approach to leadership development is supported, although local efforts must continue within a nationally coordinated context. Canadians appear to underinvest in knowledge translation and post-secondary institutions are an integral part of this function.

Longitudinal Approach of PAR

The longitudinal progression of leadership for health system redesign across the PAR cycles derived some interesting insights:

- The strong engagement of interviewees suggest the issues of leadership and health reform are very important to them
- For some, the project stimulated reflection, which enabled a change in individual behaviour over the cycles
- The time-span surfaced contradictions between action and words, within the conflicting dynamics of leadership as it played out in different situations
- Key ideas and constructs were reinforced around the need to strike the right balance between centralization and decentralization; between accountabilities and formal responsibilities; and between distributed and designated leadership.
- The process appeared to encourage more honesty and forthrightness over time as interviewees became more comfortable, punctuated by the interactions among interviewees in the final round.

- There was a growing awareness of the interconnectedness of the different facets of AQA agenda, and the complexity (and to some degree futility) of dealing with them separately. There was a growing awareness of the need for a large system plan of action.

The National Node Case study explored the leadership dynamics at play across Canada in efforts to redesign the health system around the national goals of access, quality and appropriateness. Through the PAR approach, decision-makers and researchers worked together to explore and develop empirical knowledge on health leadership.

Overview findings suggest that quality leadership can facilitate organization and system reform; poor leadership can detract from it. The function of leadership is to exert influence at all levels throughout the system, to generate a shared vision trust, and aligned action in service of a reform agenda. Currently at a systems level, a clear and compelling vision for health leadership in Canada is missing and if a national approach to coordinate and achieve reform is desirable, a national convenor or coalition is required.

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NATIONAL NODE CASE STUDY

Introduction

The purpose of the *Leadership in Health Systems Redesign* Participatory Action Research (PAR) project was to explore, investigate, and inform the development of leadership capacity in the Canadian health system through applied research and knowledge translation. The project was stewarded by a network comprised of senior decision-makers (under the auspices of the Canadian Health Leadership Network [CHLNet]) and senior representatives of the health leadership research community from nine universities across Canada (led by Royal Roads University [RRU]) in a unique collaborative partnership – a *network of networks)*.

Six node projects have been undertaken. This report provides detail on the national node case study. Its purpose has been to explore and understand the leadership dynamics at play across Canada in redesigning the health system commensurate with the national goals of access, quality and appropriateness (AQA agenda). Three research questions guided all node project work:

1. What is the current state of health leadership capacity in Canada? What is working, or not working, in terms of stimulating and supporting health system transformation, and what contextual factors influence effective leadership action?
2. Where are the gaps between current practices, the evidential base in the literature, and the expectations for leadership outlined in the emerging health leadership capability/competency frameworks (e.g., LEADS capabilities framework), and how might a set of national standards for leadership be structured?; and
3. How can knowledge of effective leadership be translated and mobilized by the network into approaches, programs, tools and techniques to develop a culture of effective leadership in Canada, and enhance the development of quality health leaders?

Situational Analysis: Why a National Node Study?

Leadership efforts to move toward the national goals of access, quality and appropriateness, (what we subsequently call the AQA agenda), was the focal point for examining national health reform. The AQA agenda highlights the key challenges inherent in preserving Canada's universal health care system (as defined in the Canada Health Act). Dealing with the AQA agenda is also fueled by the need to curtail health care spending, while retaining a

financially sustainable, high quality system open to all. Sustainability of the citizens' willingness and ability to pay through taxation is directly affected by the growing gap between supply and demand as it relates to available services. Universal, timely access is fundamentally seen as a supply issue. Appropriateness is a demand issue (i.e., only a finite number of most appropriate services can be provided within a finite budget). Variations in quality can affect both supply and demand; and therefore quality—which is a professional issue—is directly linked to both.

How these three goals interact, and the efforts to lead reform to accomplish them, is the central focus of this national node project. In this regard, access, quality and appropriateness are defined in Table 2.

Table 1. Definitions of Access, Quality and Appropriateness

Access
• Access refers to an individual's capacity to gain entry to health care services when it is determined that they are necessary and to the extent they are necessary. Access is a function of both the availability of personnel and supplies and the ability to pay for those services (World Health Organization, 2006). In Canada's universal health system, wait times for services is often used as a proxy to measure access. Good access suggests that patients/citizens can received health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need; poor access implies that individuals have to wait for the appropriate service because it is not available when needed.
Quality
• Within healthcare, there does not appear to be a universally accepted definition of 'quality'. However, the United States Institute of Medicine's definition is often used. The essence of their definition is that quality is the degree to which individuals or populations receive desired health outcomes consistent with their health needs and as informed by current professional knowledge. Accreditation Canada defines quality as "the degree of excellence; the extent to which an organization meets clients' needs and exceeds their expectations" (Canadian Patient Safety Institute, 2012). In their view, quality also embraces patient safety and is measured by a focus on optimal clinical outcomes as defined by the patient.
Appropriateness
• While appropriateness is a commonly used term in health care, there is no standardized operational definition or uniform understanding (Sanmartin et al, 2010). At the core of appropriateness is the idea that there is, at a specific time and to address a specific need, a determination of whether or not a service is medically required or necessary so that a patient/client can become or remain healthy. Assessing appropriateness suggests there is a point before which it is inappropriate to provide a service, largely because the potential for benefit is lost. Appropriateness, therefore, carries with it direct and indirect implications for the right procedure, for the right person at the right time and setting; and has implications from the perspective of the patient, physician, and policy maker. It also provides limits to access in the spirit of the finite tax dollar.

Table 2 outlines a few of the many factors that describe the current state of readiness as of 2011 (the initiation point of the study) around access, quality and appropriateness in the Canadian context.

Table 2. Current State of Readiness Re Access, Quality and Appropriateness in the Canadian Health System (circa 2011).

Access Drivers
• Federal Health Accords (2000, 2003, 2004) • Political imperative as perceived by public and politicians • Increasing demand for services • Easy to measure; easiest to fix • Preponderance of emphasis on 'big 5' procedures/tests and lack of depth of reform—i.e., short term fixes, not systemic fixes. Big 5 refers to: cataract surgeries; hips and knees; cancer therapies; diagnostic imaging; and coronary bypass procedures
Quality Drivers
• Institute for Healthcare Improvement and international impetus especially Triple Aim (Better Health, Better Care; Better Value) • Pandemics such as SARS and H1N1 • Formation of Canadian Patient Safety Institute • Baker-Norton 2004 study on adverse events in Canada • Some real tragic incidents (e.g. Newfoundland biopsies) • Harder to measure compared to wait lists and spending
Appropriateness Drivers
• Issue of rationalizing care across boundaries of the system, as well as 'rationing' the care based on relative medical necessity and not relative ability to pay • Rarely (if ever) articulated as a policy goal, or a priority element of action; no infrastructure, process in place to tackle appropriateness • Appropriateness as the orphan of quality and access

Research Methodology

The three questions guiding the overall research study were outlined up front in this case report. Five sub-questions were used to guide the interview protocols and to gather data to answer the three study questions.

Research Sub-Questions

A series of sub-questions were employed across all case studies and adapted and used in the national node study. They are:

1. What did the leaders do to create the current state of the access, quality, and appropriateness change initiative?
2. Who were the key 'leaders', and what roles did they perform, in order to create the current state of the access, quality, and appropriateness change initiative?

3. What contextual factors, internal and external, impeded or facilitated leaders' abilities to achieve the current state in the access, quality, and appropriateness change initiative?
4. What leadership actions, by whom, at all levels of the system, contributed to the current state of the access, quality, and appropriateness change initiative?
5. What learning activities do leaders identify as required in order to be effective in the next cycle of the access, quality, and appropriateness change initiative?

Participatory Action Research

To understand the leadership dynamics of health system redesign in the national node project, the project conducted action research into the practice of leadership to create health system redesign (AQA agenda) in a national context. This approach reflects the decentralized or 'loose' governmental stewardship and approach to leadership of health care in Canada (Tholl & Bujold 2011, Currie and Lockett 2011).

The longitudinal PAR approach employed three cycles of participatory action research over two years. It utilized mixed qualitative methods to gather data. This method recognized the ongoing, iterative development of understanding phenomena such as leadership of change, distributed leadership and its dynamic manifestation through time, circumstance and situation. The research is both exploratory and interpretive, aimed at helping readers understand the deeper meaning and challenges associated with leading health reform (Nicklin 2012, Varney 2009, Krauss 2005, and Greenfield in Gron, 1983). Concomitantly, this report explores, documents, interprets and describes, in a rich, thick case report, the exercise of the practice of leadership in real life situations demanding or requiring its skills in creating change (Lincoln 2010, Lincoln & Guba 1985). For brevity's sake, much of this data can be found in the appendices.

Study Participants

An advisory panel of individuals currently holding senior leadership positions and the secretariat of the Canadian Health Leadership Network (CHLNet) co-developed a sampling frame that identified key Canadian healthcare leaders with involvement in the national health policy agenda. An original long list of 30 leaders was compiled that satisfied selection criteria identified by the advisory panel members. Interviewees needed to be Canadian healthcare leaders who:

- Had a deep font of health care knowledge, with a track record of active participation in the national Canadian healthcare system.
- Were actively involved in leading reform at the time of selection.
- Were acknowledged by their peers as major contributors to efforts in leading health reform in Canada.

In a second step the long list of thirty potential interviewees was placed in front of the four members of the CHLNet secretariat. Those members were asked to score (on a scale of 1-10, with 1 low and 10 high) the 'suitability' and 'representativeness' of those individuals with respect to their insights into the practice of leadership at a national level. Individual

scores for each of the thirty candidates were then added and ranked according to their total score. The top ten scoring individuals were then selected to be interviewed. Two additional interviewees added to ensure all regions were represented and to ensure that the perspective of a younger leader was also taken into account. Potential interviewees received invitations to participate/consent through publically sourced contact information. Only one of those invited declined (and was replaced with the next highly ranked and qualifying leader).

Data Collection Method

The primary data collection method was the semi-structured interview, which "… allow(s) for exploration of emerging themes, which can elicit further data collection (Erlandson et al., 1993), and which served as "a reflective process characterized as informal conversations to enable participants to describe their experiences on their own terms" (Stringer, 2007, p. 69). It was anticipated that this method of data collection would facilitate a wide variety of impressions and experiences from which to draw further connections. Interviewers were sensitive to observations and clues as to the emerging themes, conflicts and difficulties that developed during the interviews. The interview protocol that guided the semi-structured interview can be found in Appendix A.

Twelve leaders were chosen to be interviewed in this study, over its two-year duration (See Appendix B). Cycle 1—consisting of 12 interviews and confirmation of the interviews—was completed between June 1, 2012 and October 31, 2012. All interviews were face to face except for two. A second round of interviews was held February 1, 2013 through to June 1, 2013 (some face-to-face; others telephone); with a third round (focus group teleconferences) from September 15, 2013—October 15, 2013. The target interval was a space of 6 to 8 months between interviews. Questions were modified slightly between cycles to better reflect the context and the progression of events over the duration of the study.

The methodology in the third cycle of action research shifted from individual interviews to group sessions of two to five participants. Permission was granted by all participants for a focus group approach. On one occasion a one-on-one interview was held. Interviews could not be held with two other individuals due to timing constraints.

Interviews and focus groups were conducted by two members of the research team, Bill Tholl and Graham Dickson, in private, and in convenient locations or by telephone. Each session lasted approximately 90 minutes. Maura MacPhee, a third member of the research team oversaw the data collection and NVivo analysis.

Summary transcriptions were also sent to individual interviewees for validation of transcription accuracy (except for cycle 3).

Data Analysis Method

There were two parts to the data analysis methodology.

Part 1: Cycle Sub-Questions

Data was collected and analyzed at each of the three cycles of research. The methods for doing so are outlined below.

Theme Analysis

Data analysis was conducted in three stages. In the first stage the two interviewer researchers received the transcriptions of the interviews and manually coded the data. Looking for patterns and frequencies, they individually identified the key themes and ideas emerging from answers to the five sub-questions. Each researcher kept their own data analysis results separate from each other.

NVivo Analysis

The third researcher conducted an NVivo analysis of the interview data. Digital interview recordings were professionally transcribed and thematically analyzed using NVivo 9 software, organizing the data contained within the interviews according to its relevance to each of the five questions guiding the study. All data was stored at the University of British Columbia.

Triangulation

Findings were then triangulated through dialogue and discussion among the members of the research team. Through a process of refinement based on common concepts and themes identified by all three researchers, data and themes relevant to the five sub-questions were compiled. NVivo analysis was used to validate the triangulation results.

Part 2: Data Analysis for Overall Study Questions

At the end of each cycle, answers to the sub-questions became the data for answering the three main study questions. A similar triangulation approach was taken whereby each researcher separately analyzed the data for each cycle, and identified key aspects pertinent to the overall study question. A case report for each of the three study questions was then written to reflect the agreed upon answers.

At the conclusion of Cycle three, and analysis of data for cycle three, researchers put the sub-question results for the three cycles side by side and looked for common themes and answers. After doing that individually, they compared results and triangulated their findings to create overall study question answers. They also identified longitudinal learnings—i.e., findings that reflected changing perspectives over the duration of the study.

Limitations

There are two main limitations to this study. A first limitation is that the researchers do not have access to the myriad of documents, agendas and papers that would comprise the overall gamut of activity participated in by the interviewees in the study. The research team was not "fully embedded or at the table". As a consequence, interpretations of the meaning of this data are confined to available data sources. Second, exposure to the 'active world' of each interviewee is just a snapshot of the overall activity they are engaged in, and must be considered perception as opposed to fact.

A third limitation is to the "generalizability" of the findings. When using an interpretive paradigm there are limitations to the generalizability of findings from one context to another. Despite mechanisms to gain consensus on data analysis, interpretations, communication and sharing of findings (e.g., triangulation between NVivo and manual theme construction) the results from this study does not necessarily translate to similar success in other contexts (Yin 2009; Lincoln & Guba 2000).

Part 1: Data Analysis Results by Cycle

A summary of the five sub questions can be found in the referred to appendices. Data is presented below for each of the three research questions for the national node study by cycle. A summary of the overall results by study question can be found in the Findings section of this report.

Cycle 1

1. *What is the current state of health leadership capacity in Canada? What is working, or not working, in terms of stimulating and supporting health system transformation, and what contextual factors influence effective leadership action?*

To answer this question, a definition of leadership is required. The definition used in the original PHSI grant proposal is "leadership is the capacity for self and others to work together to achieve a constructive purpose" (Dickson, 2009). This definition is similar to one used in the United Kingdom (UK) as part of the medical leadership competency framework: a "process of motivating people to work together collaboratively to accomplish great things" (Citaku, F. et.al. 2012, p. 1).

It also has been said that leadership is the ability to overcome the natural tendency to fragment. Using these ideas we can assess the current state of leadership in two ways: first, by answering the question 'what is working in terms of stimulating health system transformation?' We do that by chronicling the efforts that are being made to facilitate 'working together' to achieve the purposes of the Canadian health system; and secondly, outlining what is not working: i.e., the degree to which fragmentation characterizes the system; and whether or not the efforts to 'overcome' the natural tendency to fragment are beginning to cohere more collective action.

This study suggests that the Canadian health system is rife with natural fragmentation: health service delivery is a responsibility of 14 jurisdictions constitutionally, with dynamic tensions between the forces of centralization and decentralization, in which the forces of decentralization--disconnected structures, cultures and politics—are so strong as to reinforce the splintered nature of the system. Indeed, when looking at how Canada stacks up internationally, it has been found that Canada has one of the most decentralized "systems" in the world. (Marchildon, 2012) and therefore the leadership forces required to cohere action nationally are profound.

On balance, it is clear that significant forays have been made by this group of leaders to create systemic and sustainable health reform within their respective locus of control or influence. However the depth of the 'natural' fragmentation issues and the collective understanding of the degree of behaviour change necessary to create deep systemic reform demands a much greater creative, concerted effort than is being currently expended. In short, the centrifugal or "tug" forces are overwhelming the centripetal or "hug" forces of coming together and working to a common cause.

Leadership is also a function of both individual behaviour and structural, cultural, and political factors that exist within an organization or system. The degree to which these elements are in alignment determines whether or not reform—consistent with a shared vision—can move forward in pursuit of a future vision. In this regard, *what is working, or not working, in terms of stimulating and supporting health system transformation*, becomes a factor of the degree of alignment between individual behaviour and structural, cultural, and political factors at play in the health system. Again, capacity is found lacking in that little effort is being made to change structural, cultural and political factors to bring them into alignment with the demands of large scale change in Canada.

Appendix C contains much more detail on this question.

2. *Where are the gaps between current practices, the evidentiary base in the literature, and the expectations for leadership outlined in the emerging health leadership capability/ competency frameworks (e.g., LEADS), and how might a set of national standards for leadership be structured?*

Emerging health leadership capability/competency frameworks have shown themselves to be based on leadership literature as well as empirical qualitative work. Three frameworks are useful for this discussion: the Medical Competency Framework from the United Kingdom; the LEADS framework used in Canada; and the nascent Health LEADS Australia framework, which has just been adopted by Health Workforce Australia for the Australian health system.

Many gaps and similarities can be found between stated attributes and competency frameworks through the interviews. These are:

- Much of what was described by interviewees as 'effective leadership practice' is consistent with the content of the frameworks referenced above, particularly as it relates to the categories in the LEADS framework entitled Lead self, in the UK model

as 'Demonstrating personal qualities', and the Australian model as Leads self. Specific attributes so identified were **character, resilience, emotional intelligence, enlightened self-interest, and personal commitment to a universal health system**.

- Attributes such as **team-building/teamwork, effective communications, and leadership styles** identified by the leaders in this study reflect the Engage others (Canadian framework), the Engages others (Australian framework) and the Working with others dimension of the UK framework. Also consistent with those frameworks is the desire to see more leadership development of staff and management, which is captured under those same categories.
- Qualities such as **knowledge and use of change models/theories, creating and leading change**, and **complexity theory/systems thinking** are consistent with the Systems Transformation component of the Canadian model, the Shapes Systems and Drives Innovation components of the Australian model, and the Setting Direction and Improving Services dimension of the UK model. It should be noted that although these broad categories are somewhat similar, there is a much greater emphasis in the Canadian and Australian model on large system change and related approaches, whereas the UK model does not emphasize large systems as much.
- One area of disconnect between the literature and the leadership qualities espoused by the interviewees relates to the Canadian LEADS framework domain of **Develop Coalitions**. The research that led to LEADS—both the literature review and the results of the empirical work—emphasized the importance and value of a cross-professional organization, cross-organizational boundaries (e.g., between home and community care and the hospital) and cross-regional endeavours. It is interesting to note that our interviewees did not explicitly articulate this skill set as an important leadership attribute; but provided many examples where that skill set was at play. Given what was said earlier, however, about 'natural fragmentation' it may be that the rigour and depth of effort required to build meaningful coalitions for concerted action to support leadership of change is approached from intuitive perspective, rather than an informed, explicit perspective. This might be one reason why efforts at connection across regions, across provinces, to 'overcome' the fragmentation, appear to be episodic, ad hoc, and transitory.

In addition, three other theoretical approaches' to understanding leadership come to light: distributive leadership, substitutes for leadership, and complexity leadership. These leadership constructs are discussed further in the Discussion section of the report.

3. *How can knowledge of effective leadership be translated and mobilized by the network into approaches, programs, tools and techniques to develop a culture of effective leadership in Canada, and enhance the development of quality health leaders?*

Approaches, programs, tools and techniques to develop a culture of effective leadership as suggested by these interviewees included:

- *Enhanced and improved education of volunteer or appointed boards.* One interviewee commented that there are "Huge gaps in terms of sophistication of Boards. We have far too many boards that are CEO-controlled. We have too many boards that are fixated on fiscal concerns, and they are not asking about quality and patient safety."
- *Leadership curricula and programming available to leaders throughout the system*. It was stated earlier that "Very few interviewees have had formal leadership training (although the EXTRA fellowship through CHSRF was highly recommended)". However, the great majority of the interviewees expressed appreciation for the importance of formal leadership training.
- *Formal leader succession planning* within government and non-government organizations, especially so CEO's can cope with the strenuous and stressful demands of that role, would be of benefit.
- *Institutionalizing leadership development as a life-long commitment* and expectation of individuals in leadership positions. "It is a 'continuous learning' activity that requires active participation in any/all learning opportunities, such as committee/council participation, conference attendance, regular examination of the literature, public forum attendance, and "studying lessons from leadership in high performance systems around the world."

Cycle 2

These results build on the reporting out of cycle 1 finds and are again presented as answers to the three 'high level' questions guiding the national node study. Data generated by the five sub questions can be found in Appendix D.

1. *What is the current state of health leadership capacity in Canada? What is working, or not working, in terms of stimulating and supporting health system transformation, and what contextual factors influence effective leadership action?*

A number of new activities stimulating and supporting health systems transformation were identified in the Cycle 2 interviews and represent a very disparate suite of activities. By that we mean that with the exception of the cross-province health quality council meeting, which was on a national scale, the remainder were province, organization specific, or individual specific activities. This circumstance reinforces the impression of peripatetic, uncoordinated efforts to lead change on a national scale found in cycle 1.

While there are collaborative projects happening across provinces at the health authority level they are few and far between and appear to be operating at arm's length from government (and in some cases, despite government). Coalitions at that level are numerous, but in the words of one interviewee, are "extremely fragile….because they volunteer good will which can end in a change in leadership or a change opinion or a change in your mind….It is exhausting."

It is also difficult to know how the provincial initiatives referenced above play out in an efficient, aligned fashion in each province. One interviewee did state (in reference to Ontario) that "we don't have common aims, we have individual aims and we have organizational aims. We don't have system aims," suggesting that alignment both vertically and horizontally—at least in Ontario--is still challenging. It may suggest that each individual leader—particularly as one steps down from the federal or provincial visage—can only see the part of the elephant (the health system) that is stepping on them. In summary, one interviewee captured the consensus well in stating: "…what we need is an engine to start to develop and test new ideas on a bigger scale than we are able to do right now."

A shared view arose on behalf of at least three interviewees that we do not have the leadership development or succession planning infrastructure (i.e., programs and policies) needed to address the current leadership gap. One stated, "In the US some of the really thoughtful systems are building cohorts of leaders, of administrative leaders, physician leaders, nurse leaders and other clinical leaders. Wow. They understand what it looks like in other settings and that gives them a particular understanding of what the culture and strategies are. We don't…do that. In England they have started this scheme trying to train the thousand top leaders that are the next generation of leadership for the NHS. (We treat it [leadership development] as if)…you as an individual have the following needs, (rather than) the healthcare system has the following needs."

This section might be best summed up by the following statement: "There is a resounding deficit in leadership coming through in (Cycle 1) report even though you don't say that." The data suggests that there is clearly a gap between desired leadership capacity as reflected by what interviewees describe as the desirable practices of leadership, and the statements that describe its current state. The contextual factors found in this cycle are discussed further under the overview findings section across the three PAR cycles.

2. *Where are the gaps between current practices, the evidentiary base in the literature, and the expectations for leadership outlined in the emerging health leadership capability/competency frameworks (e.g., LEADS), and how might a set of national standards for leadership be structured?*

In cycle 1 three capability/competency frameworks seemed foundational to assess gap/similarities between stated attributes and competency frameworks. Over the interview timeframe, those frameworks have undergone their own evolution. Whereas LEADS in a Caring Environment has remained the same for Canada, Health LEADS Australia went through a major consultation and was formally adopted in June 2013. At the time of writing, in the UK, the NHS (England) Leadership Framework is being revised. This is, at least in part, due to the turmoil in the NHS as a consequence of the Francis report pointing out leadership deficiencies in the running of the Staffordshire Trust (Francis, 2010). Other studies attempt to outline the leadership needed to direct the NHS (Kings Fund 2011, Storey and Holti, 2013).

Storey and Holti (2013), state that:

> "*contemporaneous expectations of leadership in the NHS will include balanced attention to a clear focus on the needs of service users, efficiency, compassion, clarity in setting challenging and clear goals and a building of a positive emotional climate and team commitment. This involves a set of skills in building and utilising staff engagement. These elements will be underpinned with a focus on improving system performance. This includes three sub-elements of encouraging and supporting service improvement; addressing system problems by pursuing innovation; and the modelling of the required new behaviours including a willingness to show self-doubt at times and a willingness to acknowledge mistakes and a firm intent to address systematically ways to learn from those mistakes."*

In making sense of this set of expectations for leadership it is interesting to note that the United Kingdom (England)'s expectations of "clarity of challenging and meeting the needs of service users", "efficiency", "clear goals", "team commitment" and improving "systems" performance" are consistent with expectations of leaders in our study. They are also consistent with the Engage Others, Achieve Results, and Systems Transformation domains of *LEADS in a Caring Environment*, and the Engages Others, Achieves Outcomes and Shapes System domains of Health LEADS Australia. The "willingness to show self-doubt…and…to acknowledge mistakes" shows consistency with the "humility" or "less ego" suggestions of our informants, and the Lead Self (LEADS Canada) and Leads Self (Health LEADS Australia) domains.

It should be noted too that "building a positive emotional climate" and the emphasis on developing or nurturing a "set of skills in building and utilising staff engagement" were frequently mentioned by our interviewees. One informant was very passionate about the need to concern ourselves with the health and wellness of staff. These "engagement" qualities are present in the expectations laid out by LEADS Canada and Health LEADS Australia (Engage others and Engages others respectively).

3. *How can knowledge of effective leadership be translated and mobilized by the network into approaches, programs, tools and techniques to develop a culture of effective leadership in Canada, and enhance the development of quality health leaders?*

In cycle 1, the importance of enhancing and improving the education of boards arose. One interviewee reinforced that view in cycle 2, stating that "In Ontario LHIN Board chairs and the CEOs meet regularly with the ministers and the deputy minister but…that…is not system leadership. I just think that it is too much around operational daily issues and not enough around long term strategic issues." Cycle 2 also reinforced the notion of a greater emphasis on developing leaders more systematically, more deeply in organizations, and system wide.

Succession planning was also mentioned by at least three interviewees as an important investment. One interviewee (as stated earlier) pointed to the US and the UK as jurisdictions where significant investment in leadership development and succession

planning are happening. He characterized the Canadian opportunity and deficit as follows: "there is a whole opportunity. It is…about embedding effective practice in different levels of the organization and what that looks like. We think leadership is a lot of common sense (rather than) skills that the leaders have…a good cardiac surgeon, give him 3 weeks at Harvard, and all of a sudden he is (a leader)."

A third insight specific to cycle 2 was the suggestion that Canada needs to develop a national research and knowledge mobilization strategy around leadership of health reform. "There needs to be some part of the agenda that is focused on developing models strategies that are going to have long-term impact on performance….We don't do that very well in this country….We have a $200 billion delivery system and we spend almost nothing on delivery system research….We don't invest in developing effect strategies in this country." There are many disparate entities that take on that challenge with minimal and hard fought funding; but on scale it is of no comparison to most other comparable international jurisdictions.

A fourth suggestion emanating from cycle 2 was that more regular and action-oriented meetings of CEOs should happen on a national level to share innovations and insights derived from their experiences with change. A major challenge is to determine who is to play the convener role now that the federal government seems to have vacated this space.

Cycle 3

Results of sub-questions for Cycle 3 can be found in Appendix E. The following results are presented as answers to the three 'high level' questions guiding the national node study, and build on the results of the previous two cycles.

1. *What is the current state of health leadership capacity in Canada? What is working, or not working, in terms of stimulating and supporting health system transformation, and what contextual factors influence effective leadership action?*

Each person was asked to comment on their assessment of 'current capacity' and pace of change. With respect to capacity, there were a variety of perspectives, including:

- We have the leadership capacity, but politicization doesn't allow us to row in the same direction.
- We have the people—the issue is that they are working in silos, and exporting ideas from one to another is very difficult.
- The leadership gap is with policymakers and in government—they are still focused on a sickness model that emphasizes the access agenda.
- There is a renewed faith in collective leadership capacity in spite of all the political interference; a new appreciation of the talent pool we have.
- We really haven't given people the tools to do large scale change.
- We have failed to crack the black box of clinical leadership—unless we crack that we are working around the edges.
- The current cadre of leaders does not have the skills to deal with the change agenda. They have a foot in the new world of leadership and in the old world; in some cases they are exhausted.
- We have aspirations for 21st century leadership, but have 20th century skills.

- Capacity is nowhere near what we need. We have a number of good leaders, but not enough across the system.

With regard to the pace of change relative to the access, quality and appropriateness agendas, interviewees reported that progress has been incremental or "spotty". Access still dominates the policy agenda, quality is dealt with in a piecemeal fashion and appropriateness is only beginning to get traction, precipitated in large measure by a renewed preoccupation with economic iimperatives. To underscore their point the latest major report of the Health Council of Canada gives Canada a "D" on overall progress. Here was almost unanimous agreement that we are achieving below expectations (comments related to this theme were outlined in the previous section).

2. *Where are the gaps between current practices, the evidentiary base in the literature, and the expectations for leadership outlined in the emerging health leadership capability/ competency frameworks (e.g., LEADS), and how might a set of national standards for leadership be structured?*

Responses in cycle three did not suggest a wider array of academic literature to explore, but did identify some grey literature in other jurisdictions that is worthy of review. Specifically, papers related to national leadership development initiatives in the UK (NHS-England) and Australia were mentioned as exemplars that illustrate the value and the effort needed to generate the leadership capacity needed to effect health care reform.

With respect to the issue of standards, there was acknowledgement of the need for standards across the health professions. For a few, there was some reticence about how a set of leadership standards could be compiled to capture the qualities of leadership needed to facilitate health reform in a shared or distributive leadership world. Some others said we have a rapidly emerging consensus around such a set of leadership standards—the LEADS framework—and they would like to see those standards utilized to guide health reform. Almost all did suggest that while standards may be important, what accompanies them is much more important (i.e., succession planning; CEO selection; for investment in their development; for assessment/accountability purposes).

3. *How can knowledge of effective leadership be translated and mobilized by the network into approaches, programs, tools and techniques to develop a culture of effective leadership in Canada, and enhance the development of quality health leaders?*

Most comments here focused on the challenges of developing and supporting current leaders and future leaders. There was recognition that leadership development is different than clinical skill development. Other jurisdictions that have national strategies were referenced as worthy of being emulated. A continuing theme from cycle one was reinforced: current efforts remain ad hoc and peripatetic.

There was a consensus that there should be a focus on succession planning, including mentorship and coaching. Canada has too many "negative models" and "currently...has a healthcare succession planning model called "I quit!"' In terms of implementation, Canada

needs to think globally and act locally (where the mentoring/coaching actually occurs). Not all jurisdictions have the same "readiness" to support the shared leadership required to tackle the access, quality and appropriateness agenda or to support the steps need to realize Canada's current leadership potential.

There is also a need to reframe the narrative or conversation from the negative that leadership is lacking in health care to one of "there is still work to be done, but we have tremendous leaders; with great potential." There is need for a wider consultation with a focus on the end game and where leadership is, as one key informant put it, seen as the "holy grail" of improved organizational and system performance in the health sector.

Related to this theme is the expressed interest in finding new pathways to effect a stronger national approach to leadership development. Ideas included exploiting current structures and processes such as the Conference of Deputy Ministers and 'committee of clerks' to raise awareness and to gain traction at the national level. They have staying power and very much influence where things are headed. Engaging post-secondary institutions more directly was also suggested as another means to this end. A national convener is required…but in absence of the federal government there was no consensus on what that agency might be. The Canadian Foundation for Health Improvement was one suggestion.

Part 2: Overall Study Findings

In this section, the cross cycle PAR findings are discussed for the three research questions.

Question 1: Current State of Leadership Capacity in Canada

In cycle 1 we provided a definition of leadership, a definition that was used as a foundation for this study[1]: "*leadership is the capacity to influence others to work together to achieve a constructive purpose*". In this study, the constructive purpose is national health reform as it relates to the Access, Quality, and Appropriateness reform agendas.

Leadership capacity is a function of three things: first, the number of leaders. Do we have enough to fulfill the demand for leadership? Second, capacity is also a function of whether or not the individual leaders we have, have the capabilities required of them to meet the demand. And third, capacity can also be considered to be a function of how well those leaders work together to fulfill the leadership needs of the system. This study did not attempt to gather data on the number of leaders and will not comment on that; except to say that more leaders is one way of addressing a capacity gap.

[1] This definition was used to outline the purpose for the original CIAHR/MSHSRF grant submission. p. 1, and is drawn from Dickson, 2008: 155).

Using the above definition of leadership, it appears—based on the data provided—that we can make the following statements re leadership capacity in Canada:

1. *Large scale health reform requires more sophisticated leadership than stewardship of operational demands does.*

   Specific reasons for this assertion relate to the "achieving a constructive purpose" dimension of the definition (i.e., achievement of the AQA agenda across Canada):

   - Interviewees indicate that the strategy that is being employed re the AQA agenda is insufficient; (change) just moves at a snail's pace.
   - Relationships are starting to be built; but right now, those relationships are just not fast enough to meet the demand, given the rapid turnover of senior leaders.
   - There has only been incremental reform in access and quality, but not in appropriateness.
   - Unless differentiation is dealt with (i.e., clinical groups beyond administrators) efforts to change are simply working around the edges.
   - The true transformation that many leaders hunger for has not found fertile ground. The statement was made that we've become very good at continuing to do the same (bad) things, rather than adopt behaviours consistent with meaningful change.
   - There have been many incremental improvements—through methods such as lean—but progress in terms of really striking challenges, has not happened.
   - Without a real effort at building teamwork, we can never get progress.

2. *There are many individual leaders in Canada's health system with the capacity to steward localized AQA projects and priorities for change. However, they tend to work independent of one another and their efforts are often severely circumscribed by environmental forces at play in the Canadian system.*

   Specific reasons for this assertion relate to the "influence others to work together" component of the above definition of leadership:

   - Interviewees indicate that there are many current and up and coming individual leaders in the Canadian system that have the ability to influence others to work together (many of the interviewees agreed there is significant potential). However, they also stated that when they venture out of their formal role into reform in the national arena, they "are often not allowed" to exercise that leadership due to the fragmentation forces at play in the system.
   - Fragmentation forces include politicization of the health system, structurally disconnected delivery systems (e.g., across provinces, across regions, even within regions), media controversy, ongoing turnover of senior leaders, and a lack of alignment of effort between different professional groups and stakeholders. This circumstance drains leadership energy. Ongoing individual efforts to "influence others to work together" are difficult, enervating, and hard to sustain over time.

- CEO's of health regions indicated that they were more successful across health regions (i.e., when dealing with peers) rather than influencing politicians, governments, or organizations at the national level.
- Projects that demand coalition-building with peers in the larger system, or ongoing collective action—such as provincial and national health reform—are few and far between, and exhausting to participate in.
- Numerous examples were provided of where clinical leaders, senior executives, and individual leaders stepped up to initiate change consistent with the AQA agenda. However, in most instances interviewees indicated that they were the exception rather than the rule, and that most of the change efforts were incremental at best—hard to sustain over time in the absence of a champion, and rarely, if ever, scaled up across provinces or nationally.

3. *The collective leadership capacity to create a robust, national AQA health reform agenda is severely lacking.*

   Specific reasons for this assertion are:

   - Efforts to build relationships across leaders at various levels of the health system were nascent and fragile.
   - Other comments related to the need for leaders at the mid-management level to 'be present' and to exercise responsibility rather than be a source of inertia, suggest that levels that shared leadership from "top to bottom" through the system is important. Reform only happens when the leadership that is distributed throughout the system works together to create the change.
   - Interviewees indicated that when initiatives to create reform across Canada appear promising in the beginning (e.g., the Premier's Healthcare Working Group) they make little progress due to ongoing turnover of leadership at the provincial level.
   - Teamwork—inter-professional teamwork, including physicians and other professionals—was mentioned by interviewees as vital to create change. Yet the teamwork that exists is ad hoc and not well-developed.
   - Interviewees characterize progress on the AQA agenda as disconnected, incremental, and "playing around the edges" (particularly when it comes to appropriateness). Even coordinated plans at the provincial level are a rarity (with the possible exception of Saskatchewan).
   - There is not national plan, no national vision, no coordinated effort to address the AQA agenda.
   - All interviewees agree that more "shared leadership" or "distributed leadership" is needed for large scale health reform. Many agree that they could work together more systematically to do so. Yet that has not happened.

- The members of the "C- Group" or the "interagency group" still work independently in the most part, rather than collectively.[2]
- Interviewees indicated that there is a need for a renewed focus on clinical leadership and to redouble mentoring/coaching efforts in support of the next generation of health leaders.
- There is continuing ambiguity around the alignment of authorities and accountabilities in the system, with ministerial accountability and responsibility waxing and waning depending on the political environment.
- Governments still don't see the value of leadership and, as a consequence don't adequately invest in it over the longer term.
- The fatigue factor among senior leaders continues to grow as they work independently to create change—often mandated change—but cannot leverage the support of the larger system behind those changes.

In summary results suggest that the "balance sheet" between our collective ability to work together and the forces creating fragmentation remains fluid but strongly balanced in favour of the disconnecting forces. Collective leadership capacity for significant health reform is lacking.

Appendix F outlines a few more examples that the interviews collected of working together but also examples of overcoming fragmentation around the national goals of access, quality and appropriateness.

Also reinforced throughout the three cycles were almost all of the contextual factors that were identified in cycle 1 as impediments to change (see Appendix D). Interesting embellishments to understanding of the forces of fragmentation that evolved over time were:

- **Local politics**, as well as federal and provincial, can be as powerful impediments to change if not engaged with effectively.
- **Technological barriers** remain, in that there is not a holistic take-up of interoperable electronic management systems in most jurisdictions and "will not happen without workflow changes and cultural changes." Effective use of data is also being held back by management/leadership ability to know how to use such data effectively (data analytic skills).
- **The lack of systems knowledge** was identified as a growing need, as was the effective use of strategy and sophisticated coalition building skills, which are otherwise "taken for granted."

[2] This is a group of some eight pan-Canadian organizations cutting across the dimensions of information dissemination (Canadian Institute for Health Information), cross national performance indicators (Health Council of Canada), standards setting (Accreditation Canada) and technology assessment (Canadian Agency for Drugs and Technology in Health).

- **The lack of public awareness** was reinforced (example from one interviewee of surveying the public about appropriateness and finding out they knew little about it) at the same time interviewees argued for the importance of public involvement in health reform. Many interviewees saw engagement of the public as vital. One stated that were "not very good at it."
- The complexity as a system as an impediment was also highlighted. Given the elephant metaphor used earlier, it might well be a major inhibiting factor in getting a system like Canada's to operate as a system.

Question 2: Gaps between Current Practice and Evidential Base

The interviews and focus group approach reinforced much of the leadership literature. Avolio and colleagues (Avolio, Walumba, & Weber, 2009) describe a number of extant leadership theories, including these traditional approaches:

- Trait theory seeks to identify the character traits of a successful leader.
- Behavioural theory posits that it is a leader's behaviour that allows him or her to be successful.
- Situational theory suggests the effectiveness of a leadership style depends on the goals of the organization at the time as well as the nature of the task presented to the leader.

These constructs were present in some fashion in the results of the interviews. In no way can the findings suggest "validation" of one theory over another—in fact theory validation is not the point of the study. Understanding leadership better is; and for proponents of those theories, there may be some illumination inherent in the data.

Cycle 1 suggested that three key ideas emerging in the leadership literature were highly relevant to interpreting finding from this case study: shared or distributed leadership; substitutes for leadership; and complexity leadership. These same three themes re-appeared in cycle 2 and 3. In addition some strong support for the construct of authentic leadership and servant leadership emerged. These interpretative insights are described further in the discussion section of this report.

There was consensus around the common leadership capabilities needed for reform. Overall, the common capabilities identified through the cycles of PAR are listed in Table 3.

Table 3: Common Leadership Capabilities Needed for Reform

Leadership Capabilities	*Description*
Emotional Intelligence	Self-awareness, self-regulatory skills, other-awareness or empathy, and relational skills): These were identified as vital for a modern leader to create reform.
Enlightened self-interest	Self-awareness is needed to be aware of personal motivations and drivers for change. The ability to suppress personal ego and act in the interests of patients, or citizens, was identified as fundamental to the ability to lead reform.
Personal commitment to a universal health system	Interviewees emphasized the importance of having a fervent belief and commitment to a universal, publicly-financed healthcare system. All the leaders confirmed that ultimately, what is "important is the patient" should be a driving force behind reform.
Character	Character qualities, or virtues, included passion, integrity, focus, resilience, commitment, persistence, courage, and credibility. For example, a leader's integrity is often tested in our difficult conversations: as one interviewee stated, "There is real value to the difference between communications and conversations…(as it relates)…to the importance of relationship-building and trust….Your word has to mean something. In reality you only have one tool in your toolbox and that is your word."
Resilience	A specific character element emphasized repeatedly was resilience. For example, one interviewee stated that CEO's and senior management are "…besieged on so many levels: vilified by professions, governments and the media. It is harder and harder to take a bold stance" on significant issues.
Longevity	The demand for resiliency may be a factor that explains why the turnover rate among senior health leaders is so high and shows no sign of abating. In the case of one interviewee, there had been 3 CEOs in the past two years. In terms of the interview panel, 5 of the 12 were no longer in the same position after the 18 month PAR process.
Ability to access and use data for decision making	All the leaders acknowledged the necessity of knowing how to access data, interpret data, and use data for effective decision making. A key component of this is ensuring that the data is accurate, available, and comparable over time. Whereas this was identified as a major skill set, it was acknowledged that the logistical challenges of creating such information systems is progressing slowly across jurisdictions, frustrating many senior leaders because of the inability to do meaningful comparisons.
Creating and leading change	Both within micro-systems and larger systems. Specific skills include: recognizing emerging windows of opportunity for change; identifying and championing innovation and creative ideas; crafting and presenting evidence to influence stakeholder adoption of innovation; piloting innovation; and promoting

Leadership Capabilities	***Description***
	innovation spread.
Complexity theory and systems thinking	The health system is growing in complexity and interconnectivity. Complex adaptive systems require adaptive, agile leaders who can think and act at a systems level. Leaders need to be able to use to understand the complex nature of healthcare systems, particularly systems' unpredictability, fluidity and organic development.
Team-building/teamwork	Teamwork or building teams that work includes the capacity to "surround yourself with competent people" including people who are sometimes "better and smarter than yourself." Some interviewees indicated, for example, that management expertise and finance knowledge may not be their strongest suit and therefore look to surround themselves with individuals who are skillful in those areas of relative weakness.
Effective two-way communications	Effective teams require frequent, open and honest communications, both interpersonally (i.e., the ability to have open and honest conversations) and strategically, i.e., to make information available in an open and honest fashion. Leaders try to listen and make sense of the difference voices: political masters, employees, customers.

Question 3: Knowledge Translation and Mobilization

Efforts to translate and mobilize effective leadership in real time in Canada continue to be disconnected and disengaged (The Canadian Foundation of Healthcare Improvement's Executive Training for Healthcare improvement (EXTRA) program, the Canadian College of Health Leaders' Certified Health Executive Program, Accreditation Canada's Leadership standards, and the Canadian Society of Physician Executives efforts are national programs helping to move leadership capabilities forward; but are not integrated). Both collective and individual approaches are required. There should be focus on succession planning and leadership development (that includes mentoring and coaching). New pathways to effect a stronger national approach to leadership development is required although local efforts must continue. Post-secondary institutions are an integral part of this.

System-wide strategic efforts to improve leadership and succession planning are being undertaken in Australia and the United Kingdom (Dickson and Tholl, 2014). In both those jurisdictions national leadership and management competency frameworks underpin the investment. Post-secondary institutions build the framework into their programs. In Canada it is primarily left to individual jurisdictions and local universities to provide programs based on whatever framework they believe is of value.

The need for leading practices and standardized credentialing did arise during interviews. Canada, like in the NHS, "will need to accentuate different, or at least, newly prioritised, staff behaviours. This in turn means there will be a requirement for different priorities in

leadership behaviours" (Storey & Holti, 2013). This perspective lends credence to the desirability of a set of standards for Canadian health leadership, whether LEADS or not, that can set the bar for both leadership practice and leadership development if significant reform is to happen.

Current efforts by the Canadian Health Leadership Network and its members are aimed at filling that gap; but it is a purely voluntary initiative. Organizations may choose to utilize the LEADS in a Caring Environment framework that has gained popularity in many jurisdictions across the country and many have; but no one framework is mandatory. It is logical to envisage a true distributed leadership system built around a common language around leadership.

Discussion

Highlighted below are interpretive insights that arose from the answers to the study questions, and as a consequence of conducting a longitudinal study over a four year time frame. The purpose of this discussion is to explore interpretations, insights, or possible explanations re the results articulated in the previous **Findings** section of the document. Topics include: The AQA agenda; The Challenge of Reform, Leadership Capacity; Reinforcing Leadership Theory; and Lessons Learned from the Longitudinal Approach of PAR.

The AQA Agenda

There was a greater recognition that the AQA agenda were not three separate agendas, but an integrated one. For example, one interviewee stated, "You push at one and another becomes salient. But because of complexity, there is usually a focus on one thing at a time. Over time, by pushing the bubble different ways, people are beginning to get a broader perspective of the system." Another that "we are looking at (appropriateness) through a quality lens…. we are also looking at it saying…to ourselves that there is a huge efficiency piece to this… this is the holy grail of healthcare and (if we)…solve this one and we will solve a lot of our healthcare issues". Added to that agenda should well be a fourth: the equity agenda. "we have been looking at the who are the most frequent users of our system…and you find that they are most frequent of other systems as well (social services, justice)"; and "There are huge challenges that the south couldn't even comprehend" in the north, as it relates to both access and quality.

The Challenge of Reform

Speaking about the NHS, Helen Bevan wrote, in 2010: "...the scale and pace of change that is now required is probably greater than that achieved previously by any other healthcare system....There is recognition that the thinking and leadership action that has got the system where it is today is probably insufficient for the future. There is a need for big picture, transformational approaches that can be translated into practical changes that deliver quality and productivity benefits for every patient and for the whole country". The Health Council of Canada (2013) stated in 2013 that "Ten years of investments and reforms have

resulted in only modest improvements in health and health care in this country and an unfulfilled promise of transformative change."

It is clear that the informants in this study buy into the concept of transformation: i.e., large-scale change that is more than "tinkering around the edges." They are dissatisfied with the progress over the past ten years on the AQA agenda. It is important to be clear that large system transformation is different to innovation, or continuous improvement.

The essential difference is that an innovation is a micro-adjustment, alternation, or redesign of a specific product line or service delivery. Transformation is when those various different innovations—say in finance, information systems, service delivery (e.g., Lean)—interact to change the whole into a new configuration. Innovation is also a term often related to more mechanical, scientific views of change (i.e., Heifitz's definition of technical change; or Zimmerman's simple/complicated problems that require change) whereas transformation is often used to reflect change in a complex, mutli-variable, turbulent organic systems environment (Heifitz's adaptive change; or Zimmerman's complex problem that requires change). The former kind of change is when you know the answer and want to implement it; the latter is when the answer is not obvious and has to be created. Implicit in transformation is that one does not know what the final result will be—one may have a vision of what should be, but not know what it looks like in practice.

It is quite clear from the interviews with our key informants that the challenges implicit in implementing the AQA agenda are more transformative and complex in nature than not. This form of change recommends shared, collective leadership; national and provincial scope to change; and change that engages professional groups, stakeholders, consumers and the public in shaping the yet to be defined new system. Even though "empirical research on transformational change lags behind rhetoric and practice" (Lee et al 2013), the same authors point out that leadership from CEOs, boards, management teams, and other staff are vital to successful transformation. It is clear that transformation therefore requires greater leadership capacity than simple, or technical change.

Leadership Capacity

Our results showed that whereas our interviewees felt there are many individual leaders with the capability to lead change, there was almost universally agreement that there was not yet the collective capacity to address the demands of a large-scale reform agenda (provincially or nationally).

The question must be asked—as did one interviewee—as to whether there is the will in today's leaders to embrace the challenges and demands of shared leadership for health reform. To do so will require, in keeping with the conjoint and concert notions of distributed leadership described by Currie and Locket (2011), giving up some autonomy of action. Shared leadership is interdependent leadership. Current approaches indulge independent leadership. To embrace interdependent relationships amongst leaders means

constructing, or willingly participating in activities and decisions that fetter independent action in favour of aligned, interdependent action.

One does wonder if the current state of independent, individualized leadership and the behaviours that sustain it subconsciously prevails (emotionally and viscerally) over the intellectual promise of distributed leadership. The statement was made, for example, that there is "no shared Canadian vision"—e.g., no agreed upon definition of wait times, for example; or no coordinated plan for dealing with Access, Quality and Appropriateness. But is that state of affairs intractable? Is it not just a function of convening forums in which agreement on definitions and visions is voluntarily given? Just because the federal government chooses not to exercise its convener role, does that mean no other entity can—or should not—make it happen?

Over the duration of the study there was also a growing awareness of the need to address the "convener role" issues as they look for ways to work in concert. Yet there was little clarity on who might convene such an initiative. Is this because it is easier and more satisfying to retain one's current state of independent action as a leader, and simply rail against the circumstances that cause it to exist, rather than "give up" some autonomy to a truly shared vision of change?

A cautionary point, however. True interdependent action in a democratic context is very difficult to sort out. Democracy—and its attendant disposition of authority and autonomy to different groups—reveres diversity, negotiation, and competitive discourse. True alignment—i.e., fully interdependent action in pursuit of efficiency, for example—has the potential to eliminate that diversity. A true balance, that is, a system that respects diversity and difference while at the same time fulfills some degree of alignment is to be constantly sought. Results from this study suggest it is that very balance that is being tested and collectively sorted out if greater progress in large scale health reform is to happen.

Importance of Context

Contextual factors appear to be stronger than most leaders realize—sometimes so strong as to be unassailable (existing funding structures, professional self-interest, for example). Yet all of these factors are human creations, and therefore can be changed by concerted human effort. A conscious and deliberate effort to change them requires a conscious and deliberate effort to change our leadership mindsets and behaviours. Although there appears to be, amongst our interviewees, a palpable desire to do so, most struggle with it. For example, with regard to acting more strategically, one interviewee stated: "Our boards should be operating on a 5 to 10 horizon, I should be operating in a 3 – 6 year horizon, the VPs should be operating in a 1-2 year horizon and the executive directors should be running the show day to day. But we don't do that… they are energized, but they are constrained by the tyranny by the day-to-day activities at the operational level."

Reinforcing Leadership Theory

Five theories found in the leadership literature were highly relevant to interpreting finding from this case study: shared or distributed leadership; substitutes for leadership;

complexity leadership; authentic leadership; and servant leadership. These theories are discussed further below.

Distributed Leadership

One interviewee said "…you know if they (C-groups, interest groups) ever got their sh--together and if they ever came with one voice they would give government one hell of a problem…." This comment heightens the importance of multiple nodes of leadership working in concert to create change. Jean-Louis Denis, as far back as 2002, and Ross Baker (2011) noted that a focus on individualistic leadership in the context of organizational change "appears ill-suited to the workings of complex organizations marked by a fragmented authority structure." That still rings true in the context of this study.

Baker (2011) identified a number of organizations that exemplified high performing health systems, and noted that they had "consistent leadership that embraced common goals and aligned activities throughout the organization." It is the role of strategy and policy to create that alignment, to allocate resources to supporting change, and for the system itself to develop the leadership we need with the skills to do that. Once that leadership is distributed throughout the system, it is the responsibility of individuals to step up and exercise leadership when required consistent with shared purposes; and to step back to follow when others do so. Our informants suggest that such strategies and collaborative skills are not yet in place.

Further investigation of what could be done to enhance and grow distributed leadership amongst Canadian health leaders might well be productive in a future study.

Substitutes for Leadership

The 'substitutes for leadership' construct suggests that there are a variety of situational variables that can substitute for, neutralize, or enhance the effects of an individual leader's behavior (Nubold et al 2013, Muchiri & Cooksey 2011). Neutralizers are variables that paralyze or mitigate the effectiveness of something else. With respect to leadership this refers to contextual variables which make it effectively impossible for personal leadership to make a difference.

Podsakoff and MacKenzie (1996) conducted a meta-analysis to determine whether or not evidence for the existence of substitutes could be found, and concluded that "on average, the substitutes for leadership uniquely accounted for more of the variance in the criterion variables than did leader behaviours."

The Leadership in Health System Redesign study showed that although many of our leader-informants are working hard to create transformation, they identify numerous contextual variables that impede their ability to do so. It may well be that the power of those contextual variables, and the sheer number of them, is the main reason that individual leader behaviour is not as effective as it could be. For this reason it does take immense courage and effort to challenge the status quo: for to change such factors will take a concerted effort on behalf of many leaders in the system—at all levels--over time.

Complexity Leadership

Many writers contend that modern health care is a complex adaptive system (Heifitz, et al 2009; MacLeod 2011; Tan et al 2005; Sturmberg, et al 2012; Schneider and Somers 2006). Complex systems extend some of the ideas of the substitutes for leadership theory in that large systems with almost an infinite number of variables can take on a life of their own; they can become self-organizing (Best, Greenhalgh, Lewis, et al, 2012). The veracity of these ideas was supported by our interviewees. However, complexity does not suggest that leaders cannot influence the system. They can. However, their actions must be directed at using tools consistent with an organic systems approach (Dickson and Tholl, 2014).

Best el al (2012) suggest, for example, that "simple rules" followed by all leaders could facilitate change. However to do so means giving up traditional methods of control (charisma, command and control) and giving it away to trust consumers and the public to co-create the future of the health system. One of our interviewees stated that "….if we can just park our collective egos, get out of this passive aggressive nature, and work as a collaborative we could be stronger. It goes back to some of the central leadership traits: we give power away and it comes back to you multiple (times) to your benefit." And many of our interviewees agreed that no reform can really take place without engaging the consumer in fundamentally different ways.

There is significant evidence in the interview data that leadership at the provincial and most certainly at the national level is dealing with complex, rather than simple or complicated environments (Glouberman & Zimmerman 2002). Given the elephant metaphor used earlier, it might well be a major inhibiting factor in getting a system like Canada's to operate as a system. But one might also be excused for wondering if complexity is being used as an excuse to not tackle the big problems that fragmentation poses. At least one interviewee stated that fragmentation is what people want; they are more comfortable with it as it gives them freedom of action. If that is the case, then complexity gives them a rationale for not making the effort to fetter themselves in ways a large system might require.

Servant Leadership

Greenleaf (1997) describes healthcare leaders as "servant leaders," people whose role and responsibility is to represent the needs of others and act on their behalf. Health leaders serve and lead patients, providers and citizens; you dedicate your time to their health and wellness and to the system that supports them. Servant leaders make a commitment to sacrifice for the common good as the essence of leadership.

In cycle 2 interviewees reinforced the importance of a focus on understanding servant leadership. Statements like: "We are here not to serve me, we are not here to serve yourself and you are not here to serve the hospital: you are here to serve patients and family and that is it" and "Who acts in the interest of the public and stands on the stage and says, that is not right, this is what we should do, this is what we need as a society from the healthcare system?" underscore the importance of putting the interests of patients and the public first, and of leaders second.

Given the importance of "serving patients and the public" it is interesting to note in our study that we still appear to have a provider-focused rather than a consumer focused system. This circumstance is emulated in the UK paper *Patient Centred Care: Rediscovering our Purpose* (Kings Fund, 2013). The primary theme is that leaders in the UK allowed so many other priorities and factors to cloud their decisions that deaths occurred and patient focus has been lost (Francis, 2010).

One final point: serving the public does not necessarily mean giving them everything that they want. That is in fact the challenge implicit in the integration of the quality, access and appropriateness agendas: can we continue to fund any and all requests for service regardless of need? It is also a fundamental argument for deeper engagement of the public in reform—unless they too understand the challenges, they will simply resist reform that takes away their wants. True servant leadership must come from somewhere in order for a supply and demand equation to remain in balance with the public's ability to pay.

Lessons Learned from the Longitudinal Approach of PAR

The longitudinal progression of leadership for health system redesign over the four years of this study also provided some interesting insights revealed only over time. This was a 'hoped for' dynamic behind the choice of a Participatory Action Research approach. Insights derived from that reflection were:

Strong Engagement

The first is the strong engagement of interviewees in the process (overall participation rate of 94%), suggests—given the very busy nature of their work—that the issues of leadership and health reform are very important to them. They all appreciated the opportunity to express their concerns and frustrations. But they also saw this project as an opportunity to move forward individually and collectively. There were a number of indications that the PAR process led to a number of "mid-course corrections" in how leaders approached, for example, increasing the profile of appropriateness.

Individual Behaviour Change

The PAR process allowed leader participants to reflect or consider changing their own behaviour. One interview stated that the process "helps people sharpen…focus; determine qualities needed to move agendas forward;" another that "Points in time reflections help course correct". One used a knowledge mobilization product of cycle 1 (the *Shifting Sands* document produced by CHLNet to summarize key insights for decision makers from cycle 1 of the overall project) as a discussion point with his senior management team.

Contradictions and Conflicting Dynamics of Leadership Surfaced

Contradictions are differing perspectives, or "ways of seeing the world." An example of a contradiction that surfaced in this study is the attitude toward vision demonstrated by participants. On the one hand, almost all stated that a common vision for health in Canada is lacking; but desirable. There is "no common vision particularly at the national level…we are crying out for it" stated one. On the other hand, another stated that "I think that there is a very profound staff and public cynicism around the body of vision statements."

Reinforces Key Ideas and Constructs

In cycle 2 and 3 numerous findings from cycle 1 were repeated and embellished. Not only did this reinforcement emphasize the importance of concepts such as shared leadership or situational leadership, it often allowed for greater understanding of it through deeper illumination. One example is the concept of the physician's role in health reform. In cycle 1 physicians were identified as key stakeholders who could either block health reform or facilitate it. In cycle 2, we saw examples of both. On the positive side, we heard about how physician leadership was a critical success factor in Saskatchewan's surgical initiatives. Likewise, the physicians' willingness to take on appropriateness challenges in Ontario, and the doctors in Quebec and Nova Scotia who spearheaded significant reform initiatives, emphasized the power of physician leadership.

Encourages Interviewees to be Forthright

The research team felt—an impression, not fact—that the interviewees were more comfortable to be honest and forthright in discussing the leadership issues over the PAR cycles. There was a shift away from generic or hypothetical discussion to providing specific examples over the cycles. More energy and less cynicism was experienced; but also a growing frustration with the inability to change things as quickly as they might wish things to change (in the context of the AQA agenda, and health reform in general). Over time, there was thoughtful reflection brought to bear on issues.

Implications for Future Research and Next Steps

Health leadership continues to be identified as a key factor in the success or failure of major health system reforms in Canada and internationally. Canada's health system has evolved to a decentralized system and yet there is limited research on the practical methods to lead improvement and make large-scale change work. Specifically subsequent research might explore the following questions:

- Do what extent does the current number of health care leaders influence the overall capacity of health leadership in the country? Do we have enough people in leadership roles to facilitate large scale change?
- How can distributed leadership be put into practice? What specific behaviours, alignments of purpose, and collective commitments are required of Canadian health leaders who wish to work together to achieve large scale health reform on a national scale? What mental models need to change, and what attitudes developed?
- What collective action might deal with substitutes for leadership (e.g., neutralizing contextual factors impeding change)?
- What difference does deliberate, system-wide leadership development make, based an agreed upon said of standards or leadership capabilities (e.g., LEADS) when undertaken over time in support of a large-scale change agenda?

- Is 'complexity leadership' and its attendant dynamics real, or just a reason to avoid strategic agendas for national or provincial change? If real, what leadership behaviours are required to steward change in a complex system?

Knowledge Translation

While there was no formal lead for knowledge translation in the national node study, there were a number of important activities or initiatives. These included:

- June 2012 and 2013 presentations at the National Health Leadership Conference in Halifax and Niagara Falls respectively.
- Dialogues around some of the key insights at the Canadian Health Leadership Network meetings held in 2012 and 2013.
- Insights from the National Node study were also incorporated into three high level knowledge mobilization documents entitled "Shifting Sands", created by Bill Tholl and circulated for discussion to all key informants and others on the Canadian Health Leadership Network. At least one key informant discussed that document with their senior executive.
- Presentations by National Node researchers also took place in Hong Kong and are influencing the content of programming and workshops being conducted in Manitoba.
- Reference to the study was made to physicians in the Canadian Medical Association's Physician Management Institute program, and at the Canadian Medical Associations and Canadian Society of Physician Executive's annual leadership conference at the end of May, 2013.
- Insights are also included in the book on LEADS that will be published in 2014 by Springer Publishing.
- Scholarly publication and a dissemination plan and other activities will be part of the broader reporting across the six nodes. These findings will be incorporated into a cross case report on health leadership in Canada and discussed at a March 2014 deliberative dialogue.

It is important to note that the study, in its efforts to unite decision makers and researchers in a coordinated project of investigation of leadership of health reform, highlighted some of the gulf that exists between policy makers and those who do research. This gulf has been discussed at length in the literature; one might hope that by now it would be easier to overcome. Not so.

One difference was language (e.g., disagreeing on the use of the term Findings to refer to perspectives decision makers wished to share with one another as the study progressed, and ultimately agreeing that the term for those perspectives is more accurately the term, Insights). Another was different tolerance for the patience required to ensure a valid research protocol on one hand, versus the need to generate timely information on the other. A third difference revealed itself in how decision makers reacted to high level insights reduced to an "executive summary": "there is nothing new in this" many commented,

tending to dismiss the study. For a researcher, validation of existing knowledge is equally valuable to new knowledge, particularly when that validation is in an empirical context not studied before. And more importantly to the researcher, it is the nuances in that understanding that are particularly interesting and those are often lost in high level summaries decision makers are fond of asking for.

It is also clear from our experience that finding people who are willing to devote the significant time and energy needed to broker the relationship between researchers and decision makers are hard to find; yet vital to the success of such a study.

Conclusion

This National Node Case study explored the leadership dynamics at play across Canada in redesigning the health system especially around the national goals of access, quality and appropriateness. It was designed with the intention of integrating researchers and decision makers to provide more evidence-based knowledge on health leadership. Results show that

Leadership capacity for large scale health reform is lacking; that the leadership qualities needed are well documented in the literature and in frameworks such as LEADS (and other international frameworks); and that a more concerted and deliberate effort needs to be made to use the knowledge for broad initiatives in leadership development and succession planning. The findings from this Participatory Action Research project can help inform and reshape both leadership policy and practice to accelerate health reform in this country.

When all is said and done, more is said than done.
Aesop

Appendix A: National Leader Interviewees for the National Node Case Study

National Leader	Current Roles & Responsibilities
Dr. Research (PhD)	• Academic-quality and safety research • Research focus: Quality and Safety • Advises federal and provincial entities re: quality & safety agenda
Dr. North (Physician Leader)	• In senior administrative role at a university • Currently active as board member of key national organization concerned with national health reform agenda • Has remained active as a both a senior administrator and practicing physician for most of his career
Mr. Systems (national)	• CEO of national organization • Formerly engaged in health reform in civil service role • Engaged in health reform through current role • Regularly publishes leadership lessons
Dr. Ocean (Physician Leader)	• Chair of National Agency. • President and CEO of Regional Hospital • Deeply engaged in quality and access initiatives relative to his hospital, provincially and nationally
Dr. Energize (PhD)	• President and CEO of large health region. • On three national boards • Former professional clinician.
Dr. Tower (Physician Leader)	• President and CEO of large health region. • Leading reform in one of the fastest growing regions in Canada • Known for quality focus
Dr. Measure (Physician Leader)	• President and CEO of large health authority • Active in IT reform • Leading reform in access and quality in his province
Dr. Tire (Medical Doctor)	• Former CEO of a Medical Association. • Practicing senior administrator and physician; Dedicated to pediatric quality initiatives • National board member
Mr. Brando(Prairie)	• Past chair of provincial health quality council; past board member of CPSI. • Senior civil servant in provincial ministry • Active in Health Care Innovation Working Group established by premiers
Mr. Zorro (national)	• Past CEO of national organization • Present CEO of another national organization involved in health reform • Board member provincial health quality council
Ms. Rushmore (national)	• Emerging leader in national health organization involved in health reform • National leader of peers engaged in leadership development • Active in Canadian Health Leadership network
Ms. Sustainability (national)	• Former senior civil servant in provincial ministry • Experienced leader in Canada's northern territories • Current CEO of national organization dedicated to improving sustainability of the Canadian health system

Appendix B: Interview Protocol

Leadership in Health Systems Redesign Project
Partnerships for Health System Improvement (PHSI)
National Node Case Study

KEY INFORMANT INTERVIEW PROTOCOL AND QUESTIONS

Introduction

Thank you for taking the time to be interviewed for the CIHR-sponsored Leadership in Health Systems Redesign project. You and about ten peers from across the country have been selected in consultation with a CHLNet project oversight committee. We are asking you to assist us with understanding better the current effort of the leadership of health system reform agenda at the national level in Canada. We invite you to share, in confidence, your perceptions and ideas during the interview.

Overview of the Project

You have been invited to participate in this case study because you occupy a senior executive leadership role that is an important one in terms of the health reform agenda in Canada. Even more importantly, you have been identified by the CHLNet oversight committee of this project as someone who has a strong interest in leadership, acts as a leader within many organizational contexts, and who has a perspective on what is happening on the national scene that is valuable to this project.
This project consists of five regional research studies, all looking at changes in real time in those jurisdictions, and one national research study (this one) looking at lessons learned on leading change as it relates to the national efforts to improve quality, efficiency, and appropriateness of care. You have played, and are continuing to play, a central role in leading those changes.

Reminder: This is the first of three such interviews. The project is following a Participatory Action Research (PAR) design, which will require you to participate in two more interviews conducted at eight month intervals. The intent of the first interview is essentially to establish a baseline or "situational analysis" that will then allow you the opportunity to comment on the progress of reform in real time— and what is working and not working from a leadership perspective in that context. The interview should last between 60 and 90 minutes. I will be taping the interviews for accuracy purposes, and transcribing them for analysis and review. The individual results of this survey will remain confidential.

A consent form accompanies this interview guide. By signing this, you agree to participate in three (3) semi-structured interviews for the project over the next 18 months.

At no time will any specific comments be attributed to any individual unless your specific agreement has been obtained beforehand. All documentation will be kept strictly confidential and stored in a safe and confidential place at UBC. A summary compilation of your interview at each stage of the PAR process will be returned to you for validation before being incorporated into the final case report(s). The overarching case reports will be submitted to you as well for a second stage of validation. A roll-up of key findings will be shared with key informants if they so wish. Please let us know if you have any questions or need clarification.

Interview

There are 20 open-ended questions and another 10 Likert scale questions that we will ask you. We trust that you will have had an opportunity to briefly review these questions ahead of time. We may also ask supplementary questions for the purposes of clarification or to fully understand your answers. We appreciate your willingness to help us out on this project.

Questions

1. Please tell me about your recent leadership experience as it relates to achieving the goals of quality, access, and appropriateness in the Canadian health system. How well do you think we are doing, as a country, in accomplishing those goals?

2. What role are you currently playing—as a leader—in the pursuit of the quality, efficiency, or appropriateness agenda in Canada?

3. On a scale of 1-7, how well would you rate Canada's current state of overall leadership performance as it relates to progress on access, quality, and appropriateness? Is it better or worse than 5 years ago? Why?

4. What leadership **capabilities** did you, and/or others, display on a national level that were responsible for creating the current state of the access, quality, and appropriateness agenda?

5. From your perspective, how important has leadership (or the lack of it) within different **contexts** (within the national level, across provincial levels, and within various provincial regions) affect the current state of the national access, quality, and appropriateness agenda?

6. Who, in your judgment, was most effective in exercising leadership in order to create the current state of the national access, quality, and appropriateness agenda, and what did they do?

7. If you had to identify two or three other individuals or entities (i.e. governments, provinces) that were vital in initiating implementation of the national access, quality, and appropriateness agenda, who would they be?

Are there specific events that you can point to that galvanized support behind the quality, access, or appropriateness agendas?

8. Currently, where is the impetus for change coming from: national, provincial, regional? Bottom up vs. top down?

9. What contextual factors—nationally, provincially, or regionally—impeded or facilitated leaders' abilities to achieve the current state of the national access, quality, and appropriateness agenda?

10. Are all three agendas receiving the same level of attention and, if not, why not?

11. In the next stage of pursuing these three agendas, what external and internal factors will influence leadership across and between levels of the health system in order to achieve sustained, meaningful change?

12. What do leaders in the Canadian health system need to learn to grow and sustain long-term health system transformation in these three areas of change?

Self-Reflection on Own Leadership Role including Enablers and Constraints

13. What has been the impact of the quality, efficiency, and appropriateness agendas on your day-today activities as a leader in the Canadian national scene? What percent of your time is spent thinking/worrying about QAA?

14. What are the constraints on your ability to make progress on these three agendas?

15. How do you feel about your own **leadership** on these specific goals? (Identify highlights and low points.)

16. What are you committed to do—in the next eight months—to move these agendas forward?

Questions on Doing Leadership

17. While working—to achieve the current level of readiness—what were you able to do as a leader/manager that **changed** your potential as an effective leader later?

18. Who were the people that were critical to your success as a leader/manager in pursuit of these goals? How important was it for you to create alliances inside and outside your organization?

19. Did you have to change the way you interacted with others in order to achieve your goals? How do you think others interpreted your actions as a leader/manager?

20. Did you find that some of the things you did as a leader/manager that helped you succeed at first, ended up hurting you later on?

Thank you for your participation in the interview. We appreciate your willingness to be a key informant for the Leadership in Health Systems Redesign project. We truly appreciate your candor during the interview. If there is something that you wished you had shared, upon reflection, please feel free to email (btholl@chlnet.ca) or call me at 613-796-4441.

Once again, thank you!

Appendix C: Cycle One Sub Question Results

Part 1: Results by Sub-Question

Question1: What leadership capabilities were responsible for creating the current state of readiness in the access, quality and appropriateness initiatives?

To answer this question, we first describe what is referred to in the above question as the 'current state of readiness in the access, quality and appropriateness initiatives.' We will then profile the leadership capabilities as identified by the interviewees.

Current state of readiness re access, quality and appropriateness

It is clear from interview responses that the predominant national focus—over the past ten years--has been on access, with a secondary emphasis on patient safety or quality. This appears to be primarily due to the emphasis placed on Access as a focal point of the 2000, 2003 and 2004 First Ministers Health Accords and the associated earmarking of federal funding. Access has consumed much attention: it "had a narrow focus"… and (in the opinion of some "it was not very successful". An emphasis on patient safety and quality has grown during that same time frame, driven by research and provider concern. One interviewee stated, quality is "…becoming a major process to drive reform as...(it)…appears to be of even greater focus in terms of time being devoted by leaders in their day to day work." Another interviewee stated that quality challenges leaders "…to create systematic initiatives that attempt to get the entire workforce on the same agenda." Quality consumes a lot of the time of these leaders. One described quality as "Job 1".

Appropriateness, on the other hand, is the "orphan" of the three, just beginning to garner attention as the focus shifts back to "bending the cost curve". As a number of interviewees stated: "little attention is being paid to appropriateness"; there is "almost a defocus on appropriateness, which is only being done in pockets." Many agreed with the sentiment of one interviewee who stated, "…my guess would be that this is because we see this as a pretty highly charged political issue—particularly with medical profession." Some see the unfettered focus on access as the enemy of appropriateness and quality...especially in the context of exposing Canadians to unnecessary tests and procedures.

Question 2: Who were key leaders and what roles did they perform in order to create the current state of readiness for the quality, access, appropriateness initiatives?

Answers to this question identified three primary themes.

The first emphasizes the turbulence between different contexts and arenas for action (national, provincial, regional, and local) within the decentralized model of health service delivery in Canada, and its positive and negative impact on leadership. The second stresses that certain individuals and organizations have been effective at moving the agendas of access, quality and appropriateness forward within that context. The third underscores

that there is significant redundancy of function within the various organizations that act at a provincial and national level to create reform.

Different contexts: National, provincial, regional and organizational leadership of change.

In the national node study, participants were practicing leaders in a wide variety of national, provincial/lregional and organizational contexts. Many commented on the challenges of exercising leadership in that 'nested' and 'messy' environment (Denis 2010, Currie & Lockett, 2011). For example, many interviewees mentioned the challenges of the ***federal government's slow diminution of its historical leadership*** role (indeed some commented that the level of federal involvement since May, 2011 can be characterized as 'abandonment'). The leadership void that has been created is most often being filled by peripatetic and disconnected efforts at national coherence, at the very time when there is a growing awareness and thirst for greater standardization and predictability across health entities in Canada (given the globalization of healthcare and the power of the internet and modern knowledge proliferation and its availability, this is not surprising).

Some frustration was expressed about the difficulty in such an environment for leaders to exercise leadership in the absence of functional, formal structures or channels of concerted effort (as initiated by leaders at the federal, provincial and territorial levels or at the CEO level) to align and cohere their reform efforts. As one interviewee stated, you could probably put all the CEO's of health authorities in this country in one room, and have less than one hundred people present, yet, there are "minimal efforts by CEO's to get together" and all-too-few examples of working together (although the PAR process appears to have spawned at least one such joint initiative) Almost all of these individuals found that their 'day job' consumed much if not almost all of their time; and opportunities for national engagement were pursued when they were consistent with those responsibilities (e.g., the creation of a volunteer national 'measurement of quality' initiative promulgated by Dr. Ocean, but done in his spare time). The majority of interviewees stated that there needs to be a clearly defined role for a national convener in the Canadian healthcare agenda that is not present at this point in time. One stated, the "national influence is marginal." For example, some interviewees felt that the federal government should assist with setting pan-Canadian quality/safety standards. One comment was: "We need standardized (federal) health policies." A federal success mentioned by several interviewees was the access issue of wait times. One interviewee commented: "Nationally, there was a strategic decision to bring down wait times-focus on access. We need a broader quality strategic agenda." One suggestion was for the federal government to "build collaborations and accentuate quality innovations at the provincial level."

All the interviewees felt that change in healthcare is often unplanned and uncoordinated and initiated at provincial and local/regional loci of responsibility. The comments imply that national priorities—such as access, quality and appropriateness--are rarely formally aligned across all provinces and territories. One exception that was mentioned is the most recent anomaly of the provincial/territorial Premiers' Health Care Innovation Working Group, but there are concerns about the sustainability of this concerted effort both because

of turnover and the absence of dedicated resources. Similarly, national and provincial associations "primarily protect their own interests" rather than leading change together. There were some interviewees who flagged the need to work at the regional level to initiate change (e.g. western leadership conference) because of the onerous nature of working nationally.

Some examples of provincial change initiatives that were identified are: Saskatchewan's "Leaning" initiative; Nova Scotia's "Fully at the Table" engagement initiative; Alberta's "one super organization;" and Ontario's "patient voice" initiative. Some of these initiatives were explicitly aligned with the goals of access, quality and appropriateness; some were clearly related, but not explicitly aimed at those goals. At the provincial level, health quality councils were frequently cited as instigating significant healthcare leadership initiatives. "Provincial quality health councils have legislative mandate and resources." One summative statement by an interviewee was: "Leadership will come from provincial leadership groups- senior health authority leaders, some government and quasi-government types, health quality councils." Interviewees also provided examples of health authorities' capacity to "marshal resources and jump over government boundaries."

Local/regional initiatives were frequently spearheaded by CEOs. One example is collaboration between two British Columbia health authorities: their CEOs have agreed to harmonize resources and equipment. Provincial politics can both hinder and help change. Sometimes they 'dominate' regional agendas; and more often than not provincial priorities are hard to determine. On occasion they 'interfere' with regional efforts at change.

Individuals and organizations 'leading' access, quality, and appropriateness redesign.

Interviewees named some federally sponsored national organizations of importance to the healthcare agenda: The Canadian Institute of Health Improvement (CIHI), Health Canada Infoway, the Canadian Institute of Health Research (CIHR), the Canadian Foundation for Healthcare Improvement (CFHI) and the Canadian Association for Drugs and Technologies in Health (CADTH). Some interviewees mentioned that the Canadian Patient Safety Institute (CPSI) may be less important to the healthcare agenda than it used to be because of its limited critical mass to get the job done and "shifting to provincial levels" (i.e., provincial health quality councils). Some interviewees also felt that CFHI (formerly the Canadian Health Services Research Foundation (CHSRF) does not have the capacity to act as a national clearing house for quality health research. Others thought it had the potential to serve the role of national convener in lieu of the federal government. The Association of Canadian Academic Health Organizations (ACAHO) was mentioned as supporting a subgroup of leaders focusing on bringing clarity to measuring quality and using measurements for improvement, initiated by a CEO of a large academic health sciences network from Ontario.

Interviewees discussed non-governmental sources of leadership initiatives at different levels. Under the auspices of AHAHO, for example, a pan-Canadian healthcare leadership initiative is gaining ground under the banner of the physician-led academic centre alliance

with the goal of establishing national quality research agendas and identify standardized process/outcomes indicators. National, professional associations such as the Canadian Medical Association (CMA) and the Canadian Nurses Association (CNA) were also noted as influential sources of healthcare agenda support. Health Action Lobby (HEAL) was mentioned by two interviewees as having some leadership presence on the national scene (e.g. commissioning a report to influence reform at the national level [Tholl & Bujold, 2011] and their work in conjunction with the HCIWG).

Redundancy of function within the various organizations

Redundancy of function takes place in two ways. The first method is a deliberate decision to act independently, even though there are common interests and concerns. Each province, each health authority is engaged in isolated reform activity, which while specific to a particular situation, has many common elements—but rather than pool resources, and align efforts, they work independently. An interesting example is health technology assessment (HTA). At the national level, CADTH develops policy/strategy with respect to health technology/drug usage for provinces and territories under the Common Drgu Review , but HTA is also being done by some academic centres (e.g., McGill, McMaster) and some provinces have their own HTA bodies (e.g., the Ontario Technology Assessment Council). The evidence is the evidence, yet these duplicative efforts seem to sustain themselves for various political and other reasons. These kinds of disparate efforts are sometimes explained or excused because of the lack of accountability or responsiveness to "customer" needs.

These and other examples were used by interviewees to highlight the need for better coordination/collaboration among different stakeholder groups and across systems levels. Here the motivation of enlightened self-interest appears to be lacking. It is also difficult to build the trusting relationships needed to tackle politically difficult issues given the rapid turnover in senior leaders mentioned above.

A second way *redundancy of function* appears to occur is through well-intended efforts at reform on a micro-level that are redundant—in that similar initiatives are happening unknowingly in a variety of different sites—without any process to share information about successes and failures, and to maximize the learning across the system. Consequently, in each province there may be an array of successful reform initiatives related to appropriateness, for example (e.g., Fraser Health and cataract surgery; Saskatchewan hosting an appropriateness conference; medical staff retreats on appropriateness in Capital Health), but in the absence of a national strategy, these ideas are not leveraged for change. As one interviewee put it, “We have a lot of tools that allow us to look at appropriateness now, that we didn’t have 10 years ago. There is an opportunity to share information more effectively; to expose the variations now and utilizations at a much more detailed level”. Another interviewee in explaining the purpose of the HCIWG, stated that we had to find the ways and means of "Innovations by design, rather than accident". In the absence of such sharing, redundancy is inevitable.

Redundancy of function was also mentioned relative to the number and role of a large number of national organizations, as it relates to the access, quality and appropriateness agendas. As one interviewee put it, there are "Fifteen groups and agencies… (that)…work together minimally, but no national coordination around these issues."

Question 3: Where did leadership for the change imperative come from to implement initiatives associated with quality, access, appropriateness?

Answers to this question, understandably, often overlapped with the previous two questions. Interviewees noted the need for "leader catalysts" for any initiative and at any systems level. Some to watch 'on a go-forward basis' include:

- **A large Ontario Hospital** acquired a **new CEO** and new Board of Governors because of lack of fiscal responsibility issues. There was a mandate or "burning platform" to establish a new strategic plan and engage the community. The new CEO had experience in clinical leadership but no business management/operations knowledge. He hired a strong COO and CFO to develop a fiscally responsible, operational quality plan. An important outside support for the new quality plan was the Institute of Healthcare Improvement (IHI). The Chief of Staff attended an IHI conference that gave him insights into operational definitions for quality, access, appropriateness. The VP of Medical Affairs was appointed as a quality lead to assure accountability.
- **CIHI's ability** to create leading performance indicators or comparators across the country, as it relates to access and quality—moving ahead with individual hospital performance data was seen as 'leaderful' and a good beginning in terms of shining a light on appropriateness.
- **An informal national quality initiative** began with the vision of **one Ontario – based regional hospital CEO** who personally invited other CEO's of similar regions across the country, to engage in a voluntary project to develop and compare performance measures on quality. Each CEO had to agree to a set of criteria to ensure their commitment to the plan, such as devoting time and resources to quality research and data collection. This leader also mustered important sponsorship support from CPSI, Accreditation Canada and CIHI.
- **The efforts by Capital Health** (Atlantic) to use community and public engagement to craft their reform strategic plan. They engaged thousands of people in the community, and asked them questions such as, *What do you want in a healthcare system?*, and *What do you need?* "Engaging our citizens was…where we came to understand that this is a foundational piece and we needed…to equip people with the tools to lead and manage change in a transformational environment".
- **The Patient First Review** done in Saskatchewan, which conducted extensive focus groups with patients and embedded patient first policies in the mandates of all 11 health regions was seen as having positive potential national impact.
- **Efforts in Fraser Health** to step up efforts to address 'appropriateness' issues and work with another regional health authority (Capital Health) to address the issues of the near frail elderly

Question 4: What contextual factors, internal and external, impeded or facilitated leaders' abilities to achieve the current state of quality, access and appropriateness initiatives?

Contextual Factors as Barriers Impeding Reform:

Interviewees noted a variety of common barriers to accomplishing the goals of access, quality and appropriateness. The chief ones were related to political instability or interference, lack of interoperable or state-of-the-art technology, lack of collaboration within and across systems levels; lack of quality tools and methods; lack of leadership and systems knowledge; budgetary uncertainties; lack of public knowledge/awareness; professional issues; rapid turnover and the complexity of healthcare. More precisely:

- **Personal ego:** A number of interviewees stated that a major barrier to working together in the health system is leader ego. As Mr Systems stated, "The most dangerous barriers to transformation to the quality of play in the Canadian healthcare landscape today is ego, and misplaced ego. It shuts down the conversation, because it brings too early to the table the answers when one hasn't fully articulated the question. Discussion becomes very parochial and superficial as opposed to real and deep." Another refined that perspective, stating that knowing when to have low ego and when to have a big ego is important. In his mind, big ego is having confidence in one's ability to do the job (internal); while small ego refers to not letting your ego interfere with dealing with people (external). A third person stated that ego sometimes causes colleagues to not share credit, and that was "frustrating".
- **Politics and political bureaucracy:** Health is often viewed as garnering a high degree of (unwanted) public attention. This is associated with in delayed agendas and "slowness of change"; rapid political turnover and lack of leader consistency/stability ("won't invest in anything long term"); political agendas that are often based on responding to short term interest group pressure ("political nervousness about sensitive issues, such as appropriateness"); a "piece meal approach to the healthcare agenda" (siloed healthcare initiatives vs. integrating or connecting quality, access, appropriateness); risk aversion ("in the political environment there is very little reward to taking a risk." "The lower you get in the government bureaucracy, it seems the more resistance there is to change"); the militaristic, hierarchical design of political bureaucracy (that contributes to slowness of change, narrow information and resource flow and innovation reduction); and economic restraint ('they're distracted by matters of funding so we can't talk about what is really important. When we do talk it is the same conversation or too much talk and not enough action").
- **Technology:** Technology is seen as a two-edged sword. Challenges include:: lack of integrated/interoperable information technology systems; lack of access to real-time data to inform and administrative decisions (including major issues around privacy/confidentiality); and finding IT products that suit all stakeholder groups. A related barrier is **lack of quality tools and methods**. Interviewees mentioned how healthcare professionals and administrators lack valid, reliable tools and systematic methods for collecting quality data (some of this discussion was related to technology barriers). They also discussed problems associated with inaccurate quality indicators ("…we're measuring apples and oranges-how do you

benchmark?"). That said, technology is also enabling the more rapid dissemination of leading practices and levelling the playing field in terms of engaging and informing patients and their families.

- **Lack of collaboration within and across systems levels**: Interviewees discussed fragmented accountability across jurisdictions and within organizations. As one leader stated, "There is tension between national directives and local or regional innovations." Similarly, another stated that "There are too many national entities competing instead of working together" (e.g., CIHI, CMA, CNA, CADTH). "There are too many redundant entities" (e.g., Health Council of Canada). Within organizations, interviewees mentioned "disconnects between the CEO and Board," and lack of collaboration and communications from executive levels to the frontline ("There are disconnects between leadership levels"). Also noted were "territoriality issues" where individuals are unwilling to collaborate on broader systems issues because of allegiance to local/regional or provincial project work.
- A common problem related to lack of collaboration is **lack of innovation spread.** When people work in "silos" or are wedded to their particular interests (e.g., local/regional/provincial levels), new ideas are discovered and tested but not disseminated properly. One interviewee described Canada as a "country of pilots." "We have the inability to scale-up pilots." Innovations have to be identified, implemented, evaluated and spread-and this may not be happening across and within systems due to lack of collaboration: "We have innovation by accident, not innovation by design."
- **Lack of leadership and systems knowledge:** Interviewees noted a lack of "iconic" and "courageous" leadership to create a vision and inspire others. They also noted a lack of formal training and coaching/mentoring. One "accidental leader" stated: "I wasn't sold on the idea of becoming a leader at all. I thought it was like you get all the hard stuff and none of the fun, and you don't get to be involved directly in the work anymore. People are moved up the ranks without the (needed) support or training."
- Similarly, interviewees talked about the **complexity of healthcare** today and the need to understand complex systems principles. As one interviewee stated: "We lack leadership experience and systems knowledge." "Big learning curves are required to effectively lead in complex healthcare systems."
- **Professional issues** were cited by all the interviewees, such as "lack of professional accountability: we used to have an ethical responsibility to quality care-we all contributed to quality care"; "disengaged physicians"; physician's desire to "own intellectual property" and customize quality resources and tools to suit their specific interests and needs; turf protection; and "power guilds" or union activity through the CMA and CNA to act solely for their own professional interests. Interviewees also noted that healthcare providers are expected to meet so many demands under chaotic work conditions. The work environment can create "low staff morale" and "resistance to change".
- **Lack of public awareness** was considered another barrier by interviewees, because change requires stakeholder buy-in, especially public buy-in and support. Although the public and the media can be drivers for change, such as the wait times access issue or safety issue (e.g. cancer screening), the public also needs to understand finite resource implications and the difficult, complex decisions related to issues such as appropriateness. One interviewee mentioned "public entitlement"

and problems emanating from the public's perception or misperception of what basic medical services should include.

Contextual Factors as Facilitators Enhancing Reform: Facilitators were often the 'flip side' of barriers. Interviewees, for example, felt that:

- **Presence and visibility.** One senior leader stated that leaders who are "present"—both physically and mentally—are hugely impactful, stating that it is important to be "very visible…on the floor as an executive team saying this is the pressure point for us and we are all in and the problem can be solved immediately". A second reinforced this, lamenting that presence is often lacking and a result of "avoidance behaviour"…and needs to be addressed.
- **Humility and passion.** One person stated that leaders who have "passion and genuineness" but who "recognize your role as 'cog in the wheel' not on 'top of the pyramid'" are very effective.
- **Stakeholder engagement** through respectful, honest conversations and shared decision-making would alleviate some of the barriers stated above.
- **Key stakeholders** were **physicians** ("hold medical retreats and engage them in value-based decision-making;" "you need engaged physician champions"); and the **public** ("we have a public advisory council;" "you need grass roots involvement").
- Another important facilitator mentioned by several interviewees was described by one interviewee as **"innovation by design**." Structures and processes need to be in place to "identify successful prototypes through pilots and spread them through shared learning."
- **Political acumen:** knowing when to act and not to act; understanding the dynamics of change and flow of large "P" politics (e.g., "Know the difference between a first term and second term government"), and knowing how to 'work around' the system in order to get results.
- **IT management systems and quality tools for benchmarking and decision-making** were frequently cited by interviewees. One stated that effective measures "…bring truth to the table. That is the power of measurement)." And another stated that IT systems are desperately needed for "…excellent penetration and standardization of data for front-line decision making." In addition, there needs to be "common conformance standards". We require standardization and systematization of how we collect and share/benchmark quality data, and ability within leaders to know how to use that data to generate action. There was some interesting discussion related to what needs to be global versus local IT systems, to serve the various needs of both clinicians and leaders. Interviewees agreed that these discussions need to be inclusive and collaborative, and although there has been progress in this regard over the last number of years, it is still "glacially slow".

Question 5: What learning activities were effective in developing the quality, access, appropriateness initiatives?

National leaders cited **personal and professional experiences** that allowed them to mature emotionally and to grow and develop through "trial and error" learning. Although all the interviewees value the importance of formal education and mentorship, **very few interviewees have had formal leadership training**. This is changing with the EXTRA

fellowship through CHFI having created a cadre of over 300 graduates that are now working their way up the ladder of leadership. A few interviewees mentioned how they regularly reflect on their leadership journey and journal as a way to become more "self-aware." Indeed, this project and the PAR cycles created opportunities for reflection.

A second interesting result is that a few interviewees highlighted leadership development opportunities as a valuable part of their development (e.g., EXTRA program or PMI). However, the great majority did not identify any particular program, commenting that the lack of such opportunities required them and other leaders to develop those skills while on the job. A number stated that the **lack of leadership training and support** (e.g., organizational supports, mentors/coaches, support networks) is a critical national issue, and they endorsed formal training, continuing education and mentoring/coaching for new leaders at all systems levels (perhaps building on the momentum being created by LEADS). They also expressed serious concerns around the lack of formal leader succession planning within government and non-government organizations.

Some interviewees said that a major learning activity was learning from others around them during their career. Some stated that they learned from everybody, although other interviewees were able to identify specific individuals of importance to their leadership learning. In many instances, these mentors were almost exclusively informal: professional colleagues, role modeling effective leadership styles and behaviours that they had had the privilege to work with.

Several interviewees stated that **leadership development** is a "continuous learning" activity that requires active participation in any/all learning opportunities, such as committee/council participation, conference attendance, regular examination of the literature, public forum attendance, and "studying lessons from leadership in high performance systems around the world."

Appendix D: Cycle Two Sub Question Results

Part 1: Results by Sub-Question

Question1: What leadership capabilities were responsible for creating the current state of readiness in the access, quality and appropriateness initiatives?

To answer this question, we will outline our findings from Cycle 2 in two forms. First, we will present the findings from Cycle 2 that reinforce results from Cycle 1 and new insights pertaining to those results. Second, we will outline new insights generated by Cycle 2.

Current State:

Reinforcements for Findings from Cycle 1:

- Appropriateness remained the third priority in the AQA agenda. But it was seen by one interviewee as the third step to the quality agenda; by another as contrary to the appropriateness agenda; and a third was not surprised that it lacks behind the others. "It's all talk" said a fourth.
- Access remains the number one priority. For at least two reasons. First "the public assumes quality is taken care of". Second, "politicians and the public can't understand the appropriateness term".
- Interviewees expressed some criticism of the access agenda because it is being "politically driven" (i.e., takes away focus from quality and appropriateness) and for that reason is treated more superficially in order to get quick results. "It is a fad, it is something that the public can grasp fairly easily."
- A true focus on quality "drives a deeper change agenda than access does". But many still "don't see quality as the critical issue"—i.e., with access and appropriateness subthemes of that issue.
- "Emphasis on a 'sickness model' (e.g., access) means long term change (e.g., appropriateness) is neglected."

New Insights

- Many interviewees discussed the AQA agenda as a connected whole: noting the complexity of the AQA agenda and how to address all 3 together.
    - "You push at one and another becomes salient. But because of complexity, there is usually a focus on one thing at a time. Over time, by pushing the bubble different ways, people are beginning to get a broader perspective of the system."
- The AQA agenda in the north is more challenging
    - "Health service delivery in the North is completely different to the urban areas in the south".
- Institutional memory and succession planning are critically important.
    - They are "key to progress on the AQA agenda. When people leave they take all of that history and experience with them."

- "We haven't done in this country anywhere is to develop a succession strategy."

Leadership capabilities to create reform in support of access, quality and appropriateness.

Reinforcements from Cycle 1

- **Enlightened self-interest and personal commitment to a universal health care system.**
  - Many interviewees made comments related to this attribute. For example:
    - "Leaders are rewarded on independence rather than interdependence."
    - "We are here not to serve me and we are not here to serve yourself and you are not here to serve the hospital you are here to serve patients and family and that is it."
    - "Who acts in the interest of the public and stands on the stage and says, that is not right, this is what we should do, this is what we need as a society from the healthcare system?"
    - "…so you have got to stay humble and focused on the goals that we are trying to accomplish and listen well and try to control any aggressive instincts you have…we have to teach more of that"
  - While many acknowledged the importance of enlightened self-interest, it was clear that they were frustrated that the will to change was not strong enough.
    - "How can trusted conversations happen when everyone is political and fighting for money "
    - "…if we can just park our collective egos and get out of this passive aggressive nature and work as a collaborative we could be stronger."
    - "Leadership done well has to be pretty selfless and I think that (creating) the self-less infectious environment is hard and it needs lots of support."
- **Character:**
  - While not emphasized as much as in the first cycle (there was less listing of leadership attributes) character traits were discussed in the context of the AQA change agenda.
  - In particular, **courage** was identified (in addition to "resiliency" from cycle 1) as fundamental to leading change:
    - Good policy is about courage
    - "there are some courageous Ministers"
    - "the courage of Infoway and CIHI championing hospital standards re mortality ratios."
    - "You have got to be courageous…and be prepared because you are breaking the mold, because you are doing something different. You

are going to likely get a lot of flak for it…you are trying to change the culture."
        - "where are the brave courageous leaders… out there?"
        - "So why are we timid about reform? Maybe we are tired, maybe it's the forces of evil, whatever they are… I just want to get my work done until I am 60 and then get my pension and get out of here."
- **Longevity:**
    - In the context of this longitudinal study, participants suggested that in the six months between the first interview and the second was "relatively stable" in turnover of senior leaders. However, of our 12 interviewees at the time of writing, five had changed roles since the Cycle one interview.
    - Longevity can have both positive and negative effects.
        - "You can't play one off against the other if CEO is long term"
        - "If the wrong people there for too long then you have problems"
        - "You need years to create relationships"
        - "the system suffers from an continuous change of leadership and lack of a cohesive strategic vision or direction and you can't have that with revolving doors"
        - "longevity of a good leadership is great and longevity of a bad leadership is toxic…."
- **The ability to access and use data for decision making:**
    - There is "need for data to make sense of the system and innovate in large context."
    - "You can't have good policy in the modern era without good data." (and the analytical capacity to make sense of the data).
    - Data is "necessary to connect the dots" and justify actions.

- **Creating and leading change**:
    - Front line staff are getting tired of constant change with no sustainable outcomes for effort expended.
    - Structural and cultural change is needed if change is to happen:
        - "We are unable to change without cultural changes and without workflow changes and without…regulations and legislation changes"
    - There is a need to align efforts at change across the country:
        - "It doesn't make sense for us to just…make changes within our own organizations. We need to make changes on these things that are effecting all of us…we don't need somebody from Ottawa to start to tell us we need to do this."
        - "the biggest barrier that we had to change was dueling consultants with dueling methodologies around improvement."
    - Canada needs reform:
        - "Canada is not undergoing fundamental reform—none since 80's. We get seduced into believing we can change things at the margins as

opposed to true transformation; we let change happen rather than lead it."

- **Complexity theory and systems thinking**
  - The complexity of the system makes it difficult to exercise the leadership needed:
    - "The world has effectively changed. It puts even more pressure on these issues of leadership…, integration and how you move forward systems that are so remarkably complex…. unless you live it or in the middle of it is almost hard to describe the complexity of it."
    - "(governments) have actually no idea of the complexity of the system."
  - Complexity also gives energy:
    - "…from time to time new ways of thinking and new ways of doing business emerge. I think it can be quite energizing and I think that is one of the beautiful parts of the complex system."
  - Systems thinking is needed:
    - "I don't think we spend enough time on the…systems thinking, and also understanding the organic properties of the healthcare product."
- **Team-building/teamwork**
  - Effective teamwork is a huge gap in health sector despite being described as fundamentally important.
    - "enabling high performance teams with the patient in the center…that…support new models of care…" is important.
    - "What became clear to us--it is no longer a debate-is this notion of what is teamwork, why would we use teams and how would we use teams and what the compelling reason to move down this path is…it is very, very clear that it is a huge gap within the health sector"
    - "we can't do enough CPG's or team based models to be able to transform a system"
    - "We call them teams but they are not teams. How in the hell can you have a team when the bulk of the team is working part time, or are casuals and they change every day?"

- **Leadership styles/types related to theories:**
  - Distributed leadership, shared leadership was reinforced as pivitol to sustained, transformative change
    - "No group—federal, provincial gov'ts; any group—is leading change in the interest of the public—CEOs need to act in concert on this."

New insights:

- **Character: Determination**
  - Required to sustain change through obstacles of inertia and self-interest
    - "The impact on the hospital of cancelling one little lady is nothing (compared) to the impact on that family; it is devastating. So…in August 2011 senior management said, "no you won't cancel surgeries anymore. None." Now that's leadership. I'm looking at this moving patient flow. We will be going to shift work seven days a week make no mistake about it. I am not popular with that but that is coming in the transparency and public reporting on performance…what it means loss of autonomy and entitlement, different staff mix, less beds, more accountability for results….."
- **Systems Transformation:**
  - Not well-developed or sophisticated enough:
    - "Informal leadership at grassroots level often gets the local initiatives going (e.g., development of CPGs, team-based care delivery), but they are not enough to transform systems."
    - "…we should all be concerned that we have not created the kind of narrative that we have to create to connect all of the pieces."
    - "Right now we are working mostly on compliance….we have to really worry about not bringing out the best in people. We have got good people in the system, who are now cynical about the ways in which the systems are being managed."
    - "There is a disconnect in our delivery systems"
    - "We don't have the skills to lead transformation"
  - Importance in large health regions:
    - "I think also in our organization the system transformation part is really, really important….Basically you are changing the entire paradigm of what a hospital is, right?…You just can't survive today without having a really different way of looking at what the healthcare system is all about."
  - The incrementalism that is happening in local jurisdictions versus the potential for systems transformation nationally:
    - 3 impediments to systems transformation: a) No systematic way to share ideas-no formal structures or processes for vetting new ideas/ innovation; b) no will (people are happy with incrementalism); and c) no carry through on successes or pilots (no spread-and no mechanisms for innovation spread).
    - "We will always need concrete work that flows from there (local), but we can't do enough CPGs or team-based models to be able to transform a system at this pace. There is too much work to be done. So how do you unleash every profession and every worker, every governor and every stakeholder in making improvements that are

necessary to sustain the Canadian healthcare system? The fact is that you are not going to get there from here. So what has transpired today has been less than revolutionary or transformative."

- **"**I think the problem is that we get seduced into thinking we can only work at the margins. Because as leaders (if) we go too bold and broad you get put back in your box…and those that are invested in the status quo are quite influential in constraining the systems desire for change."
- "What stood out for me was how you fundamentally get reform, that is, true reform and not incremental fiddling around the margins of our Canadian healthcare system."

- **Inspiration:**
  - "As a leader I think that my something I did best was to get the good people to do even greater things"

- **Data analysis and measurement skills:**
  - The introduction of Fraser Health's quality performance management system and IT system demands ability of leaders to have data analysis skills.
  - " My problem is no longer one of do you have data, (it) is do you have well developed analytic functions. I guess in the 6 months I have gone from being worried about data (and obviously always worry about data quality) (but) now I am going "do we have the right analytic skills and do we have the right questions in order to be able to analyze our business." In healthcare analytics have been pretty lagging"
  - "You can't connect the dots unless you have some level of good data that you have started to look at and that you have started to review or you are looking at (in context of) events that have occurred."
  - "We can really measure now, we're beginning to be able to measure and we are getting more robust about measuring."
- **Strategic thinking:**
  - CEO and VP job, but not well trained to do it:
    - "strategic tools for me are part of a given…"
    - "(At the) CEO level or vice president level, (our) job is to set policy and strategy for the future of this organization and it should be stimulate innovation in the form of change"
    - "….I don't think that we were trained to do it and we want to grab the task of solving more issues that become falsely strategic because of the political world."
    - "one of the things that is an issue is how to influence the priority setting of government. How to influence policy action and change….Too often the system is reacting to those things."
    - "…you clearly have to deal with the daily issues right but there needs to be some part of the agenda that is focused on developing models

strategies that are going to have long-term impact on performance and we don't do that very well in this country…. we have $200 billion delivery system and we spend almost nothing on delivery system research… we don't invest in developing effect strategies in this country."

- "LHIN Board chairs and the CEOs meet regular with the ministers and the deputy minister but it that is not the same, it is not a system leadership. I just think that it is too much around operational daily issues and not enough around long term strategic issues."

- Our policies on drugs and technology need to change:
  - "We have outdated policy constructs on drugs, technology—we separate leadership from policy and they are related."

- **Accountability confusion:**
  - "Accountability is singular; you can't have more than one person accountable……our current accountability is soft, it drifts into responsibility rather than accountability."

Question 2: Who were key leaders and what roles did they perform in order to create the current state of readiness for the quality, access, appropriateness initiatives?

<u>Different contexts: National, provincial and regional leadership of change</u>

Reinforcements for Findings from Cycle 1:

- Leadership void from federal government
  - "No federal strategy"
  - "Federal government is absent up north"
  - "…lack of federal direction"
  - "they provide dollars and they protect the Canada Health Act but there is no federal strategy of implementation of anything"
  - "the federal withdrawal is profoundly disappointing"
  - "the ultimate separation of Quebec from the health provincial healthcare council…is brutal"
- Re Premier's working group)…
  - "I have to be careful what I say but it is surprisingly absent from my radar screen."
  - "…what has been illusive to date…is to try and build…consensus around the strategic approach that we ought to take nationwide…"
  - "Premiers' working group is not a game changer"
- Changes required are similar across provinces, but how we approach it is fragmented
  - "Stark differences between provinces on how we are innovating, but not the challenges"

- "every province has its own quality and risk management going and they are all are targeting what needs to be done in their own daily way"

New Insights

- Emergent cooperation between provinces (Alberta and Ontario) re dealing inter-provincially with drugs and docs, but sometimes conducted in a somewhat 'non-collaborative' way—demonstrates the situational nature of leadership.
  - "So we have been working away for the last couple of months, trying to figure out what Alberta was after and they just announced 18%."
  - "it depends where you sit; if I was Palmer I would say that the terrible leadership decision and if you were Fher you would say that it was a greatest leadership decision."
  - "there is a lot more sharing about success stories and friends between provinces then I have ever seen before….classic example between Ontario and Alberta, and the negotiation with the docs"
- Greater disconnect between provincial and federal governments
  - "since you and me spoke I would think that there would be a larger disconnect between the provinces and the feds…"

<u>Individuals and organizations 'leading' access, quality, and appropriateness redesign.</u>

Reinforcements from Cycle 1

- **CIHI** has a clear role to play—and can do more to provide regions with comparable data.
- **Physicians who exercise leadership** were once again identified as important to achievement of the AQA agenda.
- **CADTH** continues to play an important role

New Insights

- **The Canadian Foundation for Health Improvement** was mentioned as having promise by three people.
- **The Conference Board of Canada** was mentioned by one.
- **Infoway** appears to be making headway
- **IHI (US) re Triple Aim** was mentioned by one stating that "we did not go through (a) checklist of what Canadian entities might have models….Some of the best guidelines in the world have already been developed and…do we have to do everything uniquely in Canada to get value?"
- **The Dean of Medicine at U of M** was identified as someone who is making a difference in the training of doctors (re AQA agenda), and building strong collaborations in Quebec.

- **Group of pediatricians** in McGill who challenged the government's new immigration policy and won.
- **Psychiatrist at Capital Health.** He has developed the center for emotions to treat mental health patients in the emergency ward.

<u>Redundancy of function within the various organizations</u>

Reinforcement of Findings from Cycle 1:

- Collective action far more powerful but not happening:
  - "(When I was in government)… I thought…you know if they ever got their sh-- together and if they ever came with one voice they would give me (government) one hell of a problem…."
- Deliberate decisions to not work together:
  - CADTH develops national policy/strategy with respect to health technology/drug usage but the Health Employers Association of BC (HEABC) "has instituted a health technology assessment program."
- C-group remains fragmented (5 people)
  - "we all like the people that run them but question the duplication; they not as connected to Deputy Council as they used to be—they have no value up north"
  - "As long as the Harper government is in power there is no way you are going to see at super C organization."

New Insights

- C-Group beginning to collaborate more (1 person).
  - "there is a greater opportunity going forward for a much tighter and cohesive alignment and work between the C's….(they are) struggling with amalgamation of different mandates but there is commonality on certain elements that we can work on together. We are not there yet but we are doing a different conversation today than six months ago and different than it was 12 months ago."
- Efforts at integration. There appeared to be a shift towards greater recognition of what has to happen across the country if there is to be a national level. Most leaders still focus on what is happening in their own jurisdictions, but they appears to be a more conscious effort to integrate functions.
  - "we are beginning to see a lot more and another example of the integration between primary care and um, acute care…" in Ontario
  - National policy conference to discuss IT healthcare innovation
  - Collaborative project between Fraser and Capital Health on EXTRA for frail elderly navigator
  - Provincial Quality Councils are coming together in October

Question 3: Where did the leadership for the change imperative come from to implement initiatives associated with quality, access, appropriateness?

Reinforcements for Findings from Cycle 1:

- Continuing efforts from a large Ontario academic hospital to pursue the quality agenda in spite of funding constraints and political interference:
    - "efficiency means doing the same volume with less nurses, less beds, less ORs less clinics and less resources--but think about how governments react when you have layoffs nurses! Every time you make a efficiency change in healthcare the troops rise up."
    - "I was transparent and I also worked with the government to ensure that I wouldn't have a government official saying that we will have to check and see what's going on…you cannot over prepare or over communicate it is impossible to do that….
- Ongoing support for the work of CIHI and Infoway
    - "Infoway and CIHI championing hospital standards mortality ratios…if you look at what has been happening over the last ten yearsthere has been a vast improvement across the country."
- Capital Health continues to use community and public engagement to shape direction:
    - "We…hired a company to do a survey of our district and decide what people's understanding of it was, very few understood the term as you would expect. 72% actually didn't understand what the term appropriateness meant in our community….Only 22%...were…so that is…our baseline….We are starting from and dialoguing and having conversation with the public…"
- Efforts in Fraser Health to address appropriateness have in fact been stepped up with the formation of an appropriateness office and standing committee

New Insights:

- There appeared to be a shift away from generic or hypothetical discussion to specific examples of efforts to enhance one or all of the three agendas. For example:
    - Creation of the Fraser Health appropriateness office
    - Atlantic provinces' (CEOs and Ministries) collaborating on appropriateness issues
    - Saskatchewan's surgical initiatives and use of physicians to lead appropriateness agenda
    - Ontario Quality Council ($several hundred million target re appropriateness)
    - Alberta is looking at demand—based on "heavy users" of the system as a way to deal with all three; clinical networks are also doing so

  - Report on appropriateness coming out of Institute for Health Systems Transformation in BC
  - *Health Links* in Ontario, to address needs of co-morbid patients
  - *Lean* in Saskatchewan
  - Ontario Quality Health Act
  - Atlantic Health Quality Collaborative
  - Fraser Health: Quality Performance Management IT system
- It is to be noted that the list above represents a very disparate suite of activities.
- Much stronger emphasis on involvement of public and consumer in change. Seven interviewees mentioned the importance of embracing patients and the public; one suggested that we don't know how to do it well in most instances (unlike on environment issues, for example)
  - Infoway's strategic planning exercise (2018):
    - "we orchestrated a strategic plan interviewing some 500 hundred people across Canada…a lot of them…consumers of health."
  - Saskatchewan reached out to population for major change:
    - "facilitated conversations with 10,000 people in the province: there is no way that we could have moved top down a plan of that magnitude with those kinds of targets in that timeframe without the engagement of the broader audience…."
  - Capital Health's survey of public on appropriateness (mentioned earlier)
  - On access, quality and appropriateness:
    - "The new consumer will have much more access than we had, than our parents had; so if there was ever a time to be in to pay attention to the consumer it is actually long overdue."
    - "If you want to further that agenda then you need to figure out how to put patients into that conversation in a meaningful way"
    - "…the rise of the patient is fundamental to this and this is why we created a new patient advisory council here"
    - "if you really want to stimulate reform, go to the people. In the age of the internet we could empower people to drive reform in the healthcare system…."
  - Involvement of younger generation:
    - "I put my hopes in a very young generation which I think is reverting back to (a civic society)….They are going to force the agenda.
  - Not skilled in doing it.
    - "the bigger issue is that we don't know how to do public engagement the way that we really need to do it…there are examples worldwide mainly around environmental areas that (show) you can engage people differently and they actually can create the policy right there in a way that industry and government…can actually work together….It is a new skill and a new way of doing public engagement"

Question 4: What contextual factors, internal and external, impeded or facilitated leaders' abilities to achieve the current state of quality, access and appropriateness initiatives?

Contextual Factors as Barriers Impeding Reform:

Reinforcements for Findings from Cycle 1:

- **Personal ego** "gets in the way" of collaboration.This theme was also reinforced by the quotations found in the **Enlightened self-interest and personal commitment to a universal health care system** section in Question 1. Others stated:
    - "if we can just park our collective egos and get out of this passive aggressive nature and work as a collaborative we could be stronger."
    - "**...**so you have got to stay humble and focused on the goals that we are trying to accomplish."
    - Re the Arthur Porter case in McGill: "(In) a culture that is self-serving, maybe a culture of corruption, what do you do?....there is a general aura of distrust."
    - "people actually like the fragmentation…even though they complain about it…fragmentation is being entrenched for self serving reasons."
- **Politics** remained a factor—see earlier sections on role of federal government, lack of willingness of provincial governments to collaborate, etc.
    - **Technology barriers remain:"**65% of practitioners, primary care practitioners in BC only have an electronic billing system--not even a damn computer system! The doctors resist that because they don't want you spying on what they do"
- **Lack of collaboration within and across systems--**The structure and policy frames that might guide collective action in a more aligned way still do not exist.
    - "…what has been illusive to date…is to try and build…consensus around the strategic approach that we ought to take nationwide…"
    - "People like fragmentation—governments like fragmentation for self-serving reasons"
    - "so if you had a really good idea about how to manage care complex population how would you put it into place? Who is necessary and what are the skills and the capabilities that you need, how would you test it out and how would you spread it? So there is no forum to ask those questions so there is no organization that has as its mandate the focus on that."
    - "…there is even no Canadian shared definition of a waiting list" (e.g., re access agenda).
    - "…we are not spending that time focusing on the alignment of problems. We have (from my perspective) a history of short sightedness and the way to fix alignment is structure."

- **Lack of innovation spread—was reinforced in answers to question 2 (e.g.)**
    - Changes required are similar across provinces, but how we approach it is fragmented.
        - "Stark differences between provinces on how we are innovating, but not the challenges"
        - "every province has its own quality and risk management going and they are all are targeting what needs to be done in their own daily way"
        - "We haven't prepared people in this country to really do that on a broad scale basis. So what we have is little isolated islands of excellence in a broader sea of ignorance."
- **Lack of leadership and systems knowledge:**
    - See 'new insights' for theme of **<u>Leadership capabilities to create reform in support of access, quality and appropriateness for comments re systems knowledge.</u>**
    - Re leadership:
        - "I think that there is a resounding statement coming through that there is a leadership deficit"
        - "We think leadership is a lot of common sense (rather than) skills that the leaders have…. you can have a good cardiac surgeon and give him 3 weeks at Harvard and all of a sudden he is (a leader).
    - Demand for physician leadership simply shows the lack of leadership in the system
        - ""I see it (the demand for physician leadership) as a development that arises from necessity because nobody is there leading the way. (It is) second best…"

- **Professional Issues continue to act as barriers to creating change**
    - Interesting that five doctors in leader roles who were interviewed all made the point that doctors are resistant to change: e.g.,
        - "Doctors—aren't accountable to anyone"
        - "hardest to communicate with"
        - "feel immune to budget cuts"
    - Unions, medical associations, nursing associations don't want anything more than incremental change
        - "the CMA, the provincial medical associations and the nurses unions… are quite comfortable with incremental reform and change."
        - "Unions are invested in status quo"

New insights

- **Fragmented approaches to leadership development and its importance**
    - ""…leadership is everything frankly and you are not going to change anything without it."

  - *"*In the US some of the really thoughtful systems are building cohorts of leaders, of administrative leaders, physician leaders, nurse leaders and other clinical leaders. Wow. In England they have started this scheme trying to train the thousand top leaders that are the next generation of leadership for the NHS."
  - *"*I think that the leadership capacity at both the medical and the clinical and the delivery arm and then within the government department and government is really suffering from a capacity issue"
- **Physicians are also facilitators of change**
  - Importance of physician leadership for health reform
    - *"*I think there is a deficit for physician leadership. Not physicians leading health systems, (but) true physician leadership with the capability of being both clinical providers and at the same time as they are leaders.
    - Examples of where doctors 'stepped up' into a leadership role and made a difference.
      - Capital health psychiatrist (see question 2)
      - Pediatric doctor at McGill (see question 2)
      - "the clinicians got together:" Doctors on appropriateness steering group in Ontario taking on targets of several hundred million in terms of appropriateness
      - Doctor taking the lead in Saskatchewan on appropriateness: "we are going to build a team around him to crack the political black box"
- **Absence of shared vision**
  - Need a people-centred vision
    - *"*health care is delivering healthcare to the people and if you start by putting the people as the end goal you might be able to work together."
    - *"*No common vision particularly at the national level…we are crying out for it."
  - Discuss vision with staff
    - "if we are not used to talking to you how in the hell do we become part of your mission, your vision and your values going forward."
  - Organization rather than system vision
    - "we don't have common aims, we have individual aims and we have organizational aims. We don't have system aims."
  - Cynical views of vision
    - *"*I think that there is a very profound staff and public cynicism around the body of vision statements."

Contextual Factors as Facilitators Enhancing Reform:

Reinforcements for Findings from Cycle 1:

- **Presence and visibility:**
  - *Reinforced in the negative:*
    - "(CEO) lived by fear…he…lead by fear because he threatened people…. extremely subtle….(He) was not there…to the world he was present but he was totally unavailable."
- **Humility:** referenced in comments re ego as a barrier.
- **Stakeholder engagement:**
  - Numerous comments about the importance of stakeholder and coalitions to successful health reform:
    - "We have a municipal government advisory council and all 20 mayors come to meet once a quarter….We partner with them about helping them with social issues that can influence health, we…get their guidance on issues that are plaguing them…. and I have a first name basis relationship with every mayor here."
    - **"**Coalitions… are absolutely the life-blood of reform."
    - Innovation corridor in Fraser Health: "good for the industry and good for the economy and good for healthcare and good for research."
    - "…it does come down to natural leadership instincts knowing full well that you can't move any agenda in healthcare without building coalitions."
- **IT management systems continue to be a major factor that makes reform difficult.**
  - Importance of population data:
    - "…we have the data that we have never had before and the detail that we have never had before and basically (we) have become sort of a major holder of provincial data (re vulnerable populations). We know exactly what services people are having and who is having what intervention, and we know what services we are receiving…"
  - Difficulty in embedding IT changes
    - "IT is just unable to change without cultural changes and without workflow changes"

New Insights

- **Link between Quality and Leadership:**
  - "People see healthcare leadership as separate from health quality. My view is that modern view of leadership and healthcare is rooted in an understanding of what are the strategies to drive higher performance, higher quality and value for money…And if you look at the organizations

worldwide who have done that, they understand that those are two sides of the same coin…."

- **Aggregated population data important for reform—virtue of large region**
  - "…we have the data that we have never had before and the detail that we have never had before and basically (we) have become sort of a major holder of provincial data (re vulnerable populations). We know exactly what services people are having and who is having what intervention, and we know what services we are receiving…"
  - "In healthcare analytics have been pretty lagging….we just have a glimmer of what they can do"
- **Patient responsibility:**
  - **"**changing patient behavior so that we go to a wellness type of care doesn't seem to be addressed in this document…"
  - "There is a lack of…making the patient into part of team and trying to orchestrate some change through the patient."
- **Importance of shared vision to collective leadership**
  - Patient first review in Saskatchewan
    - **"**several years later…it is still front and center to what we do… it was a vision before but it is a practice now. We have patients that are involved in every improvement."
- **Potential for collective action**
  - Growing awareness of power of CEOs working together:
    - "So who is left? Who acts in the interest of the public and stands on the stage and says, that is not right, this is what we should do, this is what we need as a society in the healthcare system? The only people in the queue that could act that way are us. It has to be the leaders you are interviewing."
    - "do you need like government permission to create something like that?...obviously you don't."
    - "The good news is there has been a shift in the system in the last 6-8 months. I think people are beginning to understand that they can't do it alone…. it is a louder voice now.
  - Example in west (no longer operational):
    - "Canadian pediatric cardiac care network…all of the children in western Canada became the group of interest. Then folks worked together to sort out where they could best get the care they needed both in cardiology and cardiac surgery, that was cross-political boundaries and it was jointly funded by 4 provinces."

Question 5: What learning activities were effective in developing the quality, access, appropriateness initiatives?

Reinforcements for Findings from Cycle 1:

- **Value of EXTRA program**
    - Collaborative project between Fraser and Capital Health on EXTRA for frail elderly navigator
        - Fraser Health is "going to marry up with Capital Health in Halifax to generate a class of EXTRA students…who are for their project, looking at how we can create a new worker that coordinates and navigates healthcare for the near frail elderly and the frail elderly."
- **No Canadian programs were identified but importance of leadership development and succession planning was highlighted**
    - "Quality leadership leads to quality healthcare"
    - "Need to cultivate emerging leaders so that they will be well positioned to lead when they are in higher positions. "
    - "…you look at the age and the experience, where is the next level being groomed?"
    - "I think that there is a resounding statement coming through (cycle 1 report) that there is a leadership deficit, even though you don't say that."
    - "need to develop leadership programs different to MBA style."
    - "Well I think you shouldn't understate what you are trying to accomplish I think this is a huge area that needs development."

New Insights

- **Need to learn strategy, coalition building:**"(At the) CEO level or vice president level, (our) job is to set policy and strategy for the future of this organization… But we don't do that….I don't think that we were trained to do it. We want to grab the task of solving more issues that become falsely strategic because of the political world."
- "we don't know how to do public engagement the way that we really need to do it…"
- **Need to learn data analytics (mentioned earlier):**"In healthcare analytics have been pretty lagging….we just have a glimmer of what they can do"
- **Paucity of leadership up north:***"*I think that the leadership capacity at both the medical and the clinical and the delivery arm and then within the government department and government is really suffering from a capacity issue."
- **Other national jurisdictions show the way:***"*In the US some of the really thoughtful systems are building cohorts of leaders, of administrative leaders, physician leaders, nurse leaders and other clinical leaders. Wow. In England they have started this scheme trying to train the thousand top leaders that are the next generation of leadership for the NHS."

Appendix E: Cycle Three Sub Question Results

Question1: What leadership capabilities were responsible for creating the current state of readiness in the access, quality and appropriateness initiatives?

Focus group participants were asked to rate overall progress—as it relates to the access, quality and appropriateness agendas nationally—from 1 (less than expected); 2 about what one might expect; and (3) less than desirable (in terms of serving the population effectively over the duration of this project (two years). Once those responses were recorded, participants were then asked what leadership steps should be taken to improve progress. The results are:

Progress:

- Some incremental improvement
- Progress has been "spotty" on all three fronts
- Access continues to crowd out quality and appropriateness
- Not enough progress; less than desirable
- Better, but less than desirable
- Appropriateness continues to lag way behind, but recent increased emphasis on "bending the cost curve" has increased attention being given to appropriateness
- Agree with last report form Health Council of Canada, which gave progress a D—which is about right.
- Not making measurable progress; but must be making some.
- Every province in the country is struggling with appropriateness issues.
- There is no clear end date in mind; no single end game; even though we have researched this—and could have one.

Steps to Improve:

- Step #1 is for all Canadians to understand and agree that the health care system in Canada isn't nearly as good as they think it is and in fact it's much less effective than they would think it is. Recognize that it is in dire need of repair now.
- Step #2 is to create a common vision and common set of goals.
- Step #3 would be to create the metrics and targets that would allow us to see how we perform against regional scores.
- Improving the patient experience in digital health; provinces together and the medical community have to initiate.
- Establish a target and a timeframe that we are going to be able to achieve that we like.
- Courage to crack the clinical leadership "black box". Go after those clinical leads. They are the wave of the future.

- First: we can't wait any longer for the politicians. We need to get a group of like-minded leaders getting together to talk about how do you go about implementing stuff at local, regional and national levels…
- Shift resources away from acute care into home care
- Give people the skills to work on small scale system problems and how to scale them up
- Give people team time for huddles; time to form teams, sit down and work at the interventions
- Can get those people (senior leaders who have access to most influence) together…lean in together to push on a single agenda.
- We need a new military-like strategy here…a new approach that creates transformation that is so compelling to the customers, citizens, that vested interests will get out of the way.
- Target the older population, especially `near frail` elderly…no one oversees all facets of elder population treatment.
- Make the public aware of the status of the health system in the broader context.
- Until we get the federal government back at the table as a convener of change and using its spending power to lever change
- The Canadian Foundation for Healthcare Improvement could make a meaningful contribution in the context of convening a national agenda.
- We have to find a way for politicians to have a safe haven to think out loud and experiment with various approaches to the health system.
- Change the incentives. The whole system is incentive to give us exactly what we've got. So you've got to change the incentives as well. This is the transformational piece that nobody seems to be able to have a discussion about.
- Leadership programs need to be a mixture of leadership skills development, but also a knowledge of the various situations in health care.
- We should invest even more in our leaders. Not a conversation we have had a political level.
- A formal national convener to bring leadership development together, yes, I think that would be desirable.
- We need greater investment. Common toolkit; but also skills of situational leadership.
- Let's start with high energy people who want change and are inspirational. And then work on the skills and core competencies to make sure they communicate and strategic and all that.
- Mentoring is very important. Basic knowledge as well.
- National leadership development succession planning strategy would be a means to get CEOs across the country to compare and contrast leadership development and succession planning, because we don't do that now and it's hit and miss.
- Maybe, as a start, three or four provinces might wish to collaborate without a Canadian brand.

- Maybe greater standards for training and certification.
- Every industry needs champions. We need to hold best exemplars up.
- Leadership must respond and take charge of this, not wait for gov`t to intrude, but it is a journey and we have to be patient.
- Why not combine our planning with LEADS so they can see the link…so they (gov`t) can see what it is like to be on the receiving side of policy implementation.
- At national level we have endorsed Triple Aim. We need to set few and focused targets and timeframes. We need then to draw a line of sight directly to the local unit or community level who is responsible; especially their metrics and watch them every day.

Question 2: Who were key leaders and what roles did they perform in order to create the current state of readiness for the quality, access, appropriateness initiatives?

- Health Council of Canada—showing real leadership/courage in monitoring and reporting out to the public on system performance, even though it is not what is wanted by gov't.
- Infoway—slow but important progress.
- EXTRA program—good building block in terms of leadership development and bringing senior leaders together.
- Lean initiative in Saskatchewan…taking off across the country (but concern about the DM change and its impact on this and other leadership initiatives.
- EXTRA project between Capital Health (NS) and Fraser Health (on near frail elderly transition person).
- Potential for CHA/ACAHO to play a convener role in leadership development/ grooming.
- Potential for CFHI to play a role in national convening and reporting out role (to fill void left by demise of Health Council of Canada)
- Triple Aim framework as adapted in Canada to include "better teams"

Question 3: Where did the leadership for the change imperative come from to implement initiatives associated with quality, access, appropriateness?

Answers to this question, understandably, often overlapped with the previous two questions. Participants noted the need for consistent/present leadership and leaders with strong change capacity for any initiative, at both organization and systems levels. Some comments re the change agenda and its challenges include:

- The strategy that is being employed is insufficient; (change) just moves at a snail's pace.
- Relationships are starting to be built; but right now, just not fast enough given the rapid turnover of senior leaders.
- Has been incremental reform in first two areas, access and quality.

- Unless we can deal with differentiation (i.e., clinical groups beyond administrators) we are simply working around the edges.
- True transformation we hunger for has found fertile ground. We've become very good at continuing to do the same (bad) things.
- There have been many incremental improvements—primarily lean—but progress in terms of really striking challenges, has not made much progress.
- Without a real effort at building teamwork, we can never get progress.
- We have made a big investment in lean; but with small scale impact (so far). We're good at redesigning processes where you know who is doing it and what is to be done; however, the problem is thinking of how to do different things and do these in concert.
- The fatigue of trying to move into any kind of change agenda is very hard on everyone, but especially senior and mid-level leaders. It's exhausting to try to get anything moving and keep it moving.

In terms of individuals or groups exercising leadership participants outlined the following:

- Efforts by CEOs to engage consumers in NS and Fraser health.
- Individual CEOs who persevere to make change even though their efforts are resisted by self-interest groups.
- Efforts of a few DMs to challenge the rest to leverage up leading practices across jurisdictions.
- Efforts by former CEO of CHSRF Jonathan Lomas to bring politicians and CEOs together for "Chatham Rules" discussions.

In addition, the following qualities were stressed as key to choice of future leaders:

- A leader has to be someone who wants to lead change...wants change, knows change is inevitable. But we seldom put that "out there".
- We need people with the desire to change the system, and they have to be passionate and inspire others.
- There are a lot of good people…but I don't think that the (political) capacity to accept change exists across the country.
- We have amazing talent across the country—but we haven't called on them to do anything different. We allow politicians to get in our space.
- Sometimes current leaders are passive aggressive; and we are so busy we ignore strategy. The potential talent must be given opportunities to be creative…need for a creative culture.
- There is also a lot of negative role models; new emerging leaders need to be allowed to see the difference between a positive and a negative models. For example:
    - Every day people look to see if they will be made a scapegoat.
    - Bottom line—taking risk—is not valued in the system. As a result innovation is not regarded and we are stuck with the status quo.

  - Developing a level of courage together with all the other characteristics is important and we don't see it in our system.
  - We need leaders to break from the tradition of long meetings that spin in circles.
- Current leadership culture needs a basic refresh. There is not a great value placed on health mgt and admin in this country.
- We need to better align accountabilities and authorities in the system.
- We need to surround ourselves with people who want change, have high energy, are optimistic and inspire people to change.
- Health care is complex; ever-changing due to more active/demanding patients and politicians.
- Potential leaders need to contribute to the greater whole; and selected for that.

Question 4: What contextual factors, internal and external, impeded or facilitated leaders' abilities to achieve the current state of quality, access and appropriateness initiatives?

Impeded:

- **Politicization of the agenda does not allow us to row in the same direction over the longer term.**
  - There is a leadership gap between senior healthcare leaders and policy makers. Still focused on a sickness model (ie short term access issues trump other longer strategies).
  - Too much "flavor of the month"--people either tune out or are confused.
  - We can't wait for politicians to make a decision…we know we must be in synch; but we can't do things that don't make sense to us.
  - We've lost the convener of the system…the federal government. We've lost our collective way.
  - The ministers are ultimately accountable for things…and they are always looking for someone to be responsible.
  - Health Authorities—LHINs, etc.—are being more and more affected by short term political imperatives.
  - The current politicization is a perfect example of how the pragmatic takes over what we know about more thoughtful, effective leadership.
  - The Council of Federations is like herding cats.
  - There is an overall intolerance (at the political level) to taking measured risk...it is not valued in the system.
- **Safety.**
  - The problem is media. There is something to creating a safe dome where everybody can say what they feel and say what needs to be done without feeling that their careers are in jeopardy, and that goes especially to the heads of the medical associations.

  - There's no forum that's safe to have a serious discussion without reading about it in the local newspaper. The media has a very negative tone regarding health care. We have to find a way for politicians to have a safe haven to think out loud and experiment with various approaches to the health system.
  - We know "what to do", but we seem incapable of executing the "how". It goes back to leaders who step forward get hammered. It's not safe because there are too many vested interests groups that influence the public and the political response. It gets pretty lonely out there.
  - There is some risk aversion, for sure.
- **Fragmentation of interest groups and stakeholders and their resistance to reform:**
  - A strategy that is broader than individual provinces might work, but a Canadian strategy is not in the cards**.**
  - Some leaders report they don't have the energy or stamina or stomach to do it ever again…they get "hammered" by the premier's office, the minister's office, the unions, local newspapers, the people who donate to the hospital, the foundation, the public. Everybody believes that change is for the worst.
  - We lack the capacity to accept the change exists in the country. That's for sure at the political level, 100% at the associations level (the CMAs, CNAs, in spite of what they say), the unions and the public.
  - When you think about what we spend our money on, 70% of it is on people. So if you're going to be more efficient and you're going to do more with less, it's less people and no one wants to fall on their sword.
  - All the C agencies in part can play the convening role by trying to bring things together in specific areas, but without the spending power, has its limits.
  - Primary care is discombobulated; it has defaulted out of the role to deal with frail elderly**.**
  - It is difficult to tackle the "lords" of the status quo…collective agreements, professional standards; relationships.
- **Ability to capture and analyze data strategically, and systematically:**
  - There are probably 4,000 metrics out there that everybody measures and feeds to somewhere, someplace; but we need to arrive at a consensus on the vital few and use them to improve performance. We're trying to do too much.
  - We measure anything that pops into our head without sorting out what we should measure that will have an impact and then try to measure the impact of any changes we propose.
  - 20th century leadership skills re informatics for the 21st century
- **Churn of leaders**
  - The churn in system is at a higher pace than we have seen before and this is seriously impeding leadership on the AQA agenda.
  - Deputies are not there long enough to specialize…but if you really want to transform a system that doesn't work, you need continuity/longevity.

- CEOs are turning over at a more rapid pace than in the past (but longer shelf life than DMs) . Reasons include: maybe it is because they not supported; maybe expectations weren't clear; maybe our expectations are out of whack.
- All schools of public policy actually promote the idea of "deputy of everything"
- We have a health care succession planning model. It's called, "I quit".

Factors Enhancing Change

- Improving the patient experience in digital health. We have the infrastructure; better access; virtual visits, online scheduling, etc. is a grasp away….all possible. Really something the provinces together and the medical community have to initiate.
- High energy, optimistic and inspirational leaders that people want to follow.
- We need greater investment in leadership development. Common toolkit; but also skills of situational leadership.
- We actually have implemented an operating plan that pulls $30 million out…it was 300 positions (100 ONA members, 100 CUPE and 100 administration). And in the end, the beauty of that is that you can eliminate positions and not necessarily people--we eliminated 300 positions, but only 2 people.
- We have to do some transformational things and show we can make a difference and show the value of leadership.
- We need to look to physician cadre for clinical leaders. Many more are needed: they must not be tokens, but true corporate leaders. They need to be trained in leadership skills.
- I can only be optimistic. It is something we have to tackle
- Integrity of leadership will grow…if clarity of purpose and alignment happens.
- It would be great if we could present this work to the DMs of Health to have this conversation.
- Our leadership must respond and take charge of this, not wait for gov't to intrude.
- We have to reframe the conversation from the negative…"leadership is lacking in health care"— We have to give them a focus; lift them up. Make the endgame clear. Be more positive about the strength of our leadership in the country today.
- Influential individuals are thinking differently about collaboration of effort and are poised to do something different.
- Need to nurture a renewed faith in our leadership capacity in spite of all the interference.
- A common vision. In NS, we have been working on this with Department of Health. With DM and his team. It requires a10 year window. Change cannot be done in 4 years.

Question 5: What learning activities were effective in developing the quality, access, appropriateness initiatives?

No questions related to this sub-question were asked in Cycle 3.

Appendix F: Overcoming Fragmentation

The following table outlines examples of working together and overcoming fragmentation.

Working Together Examples
• *Federal Funding*: efforts to improve access were partially successful (at least for the "big five") due to significant new, targeted federal funding and ease of measurement of success, a clear priority as outlined in the Accords of 2003 and 2004 at the national and provincial levels, and perceived as easiest to fix. Quality is harder and requires deeper change; appropriateness even harder still both because of difficulty in measurement and because of resisters to saying "no".
• *Performance Indicators*: collective efforts represented by CIHI's work on performance indicators and agreement on data standards, performance measures, benchmarks, and comparative frameworks. A corollary effort is being pursued by 11 CEO's across Canada in terms of measures of quality that they can all agree on and compare results; and use those results to stimulate reform.
• *Electronic Information Systems*: collective successes by health leaders at the national (e.g. Infoway), provincial, regional and local levels to move forward on creating electronic information systems—e.g., electronic medical records, extending interoperable data platforms, etc.
• *Technology Assessment*: CADTH's efforts to generate agreement across all jurisdictions in terms of technology and appropriate drug interventions.
• *Quality Councils*: the creation of Provincial Quality Councils in some provinces, and a general trend towards greater collaboration across provincial and regional boundaries in terms of sharing knowledge and information.
• *Health Regions*: efforts in health regions to cohere direction and focus re access, quality and appropriateness across a region.
Overcoming Fragmentation Examples
• *Federal Spending*: the federal government, by virtue of its position, can be a leadership force at the national level through its strategic use of spending power. However, many interviewees touched on the importance of the diminished federal leadership role in terms of the AQA policy agenda. The federal government had historically played an important "convenor" role (as well as financing role) in national efforts aimed at advancing the AQA agenda.
• *Policy:* no national quality or appropriateness policy, or co-led provincial/territorial initiative that coheres efforts either nationally or across provinces or regions, even though to do so makes a fair degree of sense.
• *Innovation:* even with pockets of innovation that are stellar across Canada, no national or interprovincial sustained support for knowledge sharing, evaluation of success, and scaling up of successful innovations across regions, provinces, or Canada.
• *Shared Vision*: no shared vision for the future of health care guiding reform, as articulated by the national government, most provinces and territories either collectively or severally, and CEO's collectively.

• *Inequities:* challenge of addressing inequities across the country (e.g., aboriginal health; geographic disparity) and of the need to devote energy to that challenge.
• *Focus on Strategic Issues*: inability to focus on strategic issues because of efforts of the media, continual turnover of leadership personnel, perceived emergencies, political agendas, and even personal ego that 'fragments' their attention and demands that it be focused on emergent rather than long term reform issues.
• *Deep Change*: a sense that deep change is required to create a sustainable reform agenda and that many interest groups—politicians, professional bodies, individual leaders (ego, again)—have difficulty letting go current practice and change the behaviour that is needed for deep change to happen.

Appendix G: Impediments to Change

Similarly reinforced throughout the three cycles were almost all of the contextual factors that were identified in cycle 1 as impediments to change. Interesting embellishments to understanding of the forces of fragmentation that evolved over time were:

- **Local politics**, as well as federal and provincial, can be as powerful impediments to change if not engaged with effectively.
- **Technological barriers** remain, in that there is not a holistic take-up of interoperable electronic management systems in most jurisdictions and "will not happen without workflow changes and cultural changes." Effective use of data is also being held back by management/leadership ability to know how to use such data effectively (data analytic skills).
- **The lack of systems knowledge** was identified as a growing need, as was the effective use of strategy and sophisticated coalition building skills, which are otherwise "taken for granted."
- **The lack of public awareness** was reinforced (example from one interviewee of surveying the public about appropriateness and finding out they knew little about it) at the same time interviewees argued for the importance of public involvement in health reform. Many interviewees saw engagement of the public as vital. One stated that were "not very good at it."
- **The complexity as a system** as an impediment was also highlighted. Given the elephant metaphor used earlier, it might well be a major inhibiting factor in getting a system like Canada's to operate as a system. But one also wonders if complexity is being used as an excuse to not tackle the big problems that fragmentation poses. At least one interviewee stated that fragmentation is what people want; they are more comfortable with it as it gives them freedom of action. If that is the case, then complexity gives them a rationale for not making the effort to fetter themselves in ways a large system might require.

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