# What Does It Take to Lead a Learning Health System?

## Competencies and Collective Priorities

Insights and priorities from CAHSPR pre-conference workshop

**Workshop Partners**

INSTITUTE FOR BETTER HEALTH'S
LEARNING HEALTH SYSTEM
LEADERSHIP CENTRE

Jim Pattison
Centre for Health Systems
Learning + Innovation

CIHR IRSC
Institute of Health
Services and Policy Research
Institut des services et
des politiques de la santé

CHLNet
Canadian Health Leadership Network
Le Réseau canadien pour le leadership en santé

# Contents

Executive Summary: What Leaders Can Do ..... 1
Context ..... 1
Key Insights ..... 2
Going Deeper: Defining the Top Two Priorities ..... 3
  Priority 1. Building Capacity to Use Data, Evidence, and Knowledge ..... 3
  Priority 2. Building a Learning Health System Culture ..... 4
Cross-Cutting Insights ..... 5
Looking Ahead ..... 5
Appendices ..... 6
  Appendix A. Group Prioritization ..... 6
  Appendix B. Deep-Dive Responses ..... 7
    Priority 1. Building Capacity to Use Data, Evidence, and Knowledge ..... 7
    Priority 2. Building a Learning Health System Culture ..... 8

# Executive Summary: What Leaders Can Do

The barrier to a learning health system is no longer technology. It is leadership and culture.

Health care organizations generate significant amounts of data, evidence, and expertise, yet leaders consistently described a gap between knowledge and action. Evidence use and culture were treated as one agenda, not competing investments: building the capacity to use data and evidence while creating the conditions that enable people to act on it. The challenge is not generating more evidence, but making it accessible, usable, and actionable.

The opportunity is clear: build the leadership capacity and learning culture needed to turn evidence, lived experience, and data into action. Core areas of focus include:

- Approach evidence use and culture as an integrated strategy, not separate initiatives.
- Embed partnerships into project structures to strengthen the relationships between researchers, clinicians, operational leaders, policymakers, and communities.
- Invest in leadership capacity at every level through shared leadership across teams, mentorship, and peer learning beyond the organization.
- Build repeatable ways to turn evidence into action, and support them with the structures, resources, and accountability needed to sustain change.

## Context

This report summarizes *What Does It Take to Lead a Learning Health System? Competencies, Canadian Highlights, and Collective Priorities*, a three-hour interactive pre-conference workshop held on May 25, 2026, alongside the Canadian Association for Health Services and Policy Research conference. It reflects the discussion in the room and a synthesis of the priorities leaders identified, drawn together to show where shared investment and action would matter most.

For more on the detail behind this report, contact:

**Laura Desveaux**
Director, Learning Health System Leadership Centre, Trillium Health Partners
laura.desveaux@thp.ca

# Key Insights

We asked each leader in the room to independently identify the most important thing to focus on to help leaders do their work better in learning health systems. Their colleagues then rated the importance of each priority. The group's insights converged on five themes. Presented here in order of priority, they point to where the need is greatest and where shared effort would create the most impact.

It is worthwhile to note that capacity to use data and evidence was the most identified priority area, signalling that it was top of mind for many participants coming into the discussion. Notably, building a learning culture earned the highest average importance rating when evaluated by peers, meaning it resonated the strongest with the leaders in the room. The most salient priority and the most strongly felt one point in the same direction: capability and culture as necessary and interdependent elements.

### 1. Build the capacity to use data and evidence in everyday decisions.

Capacity to use data and evidence was the most widely shared priority. Leaders described a system that generates significant data but struggles to access, connect, and apply it in time to inform decisions. They pointed to stronger research literacy, evidence embedded in everyday decision-making, and closer partnerships between those who generate evidence and those who use it.

### 2. Create a culture where learning and change can take hold.

Culture is the foundation everything else depends on. Trust, collaboration, autonomy, and responsiveness enable learning and change. Leaders emphasized environments where people feel safe to challenge assumptions, test ideas, and learn from failure without unnecessary barriers.

### 3. Strengthen the relationships that carry knowledge across the system.

Relationships accelerate learning and impact. Leaders called for stronger connections among peers, researchers, clinicians, and system partners, and for opportunities to share experience and learn across organizations.

### 4. Build leadership capacity at every level, not in a few individuals.

Leadership works best when it is shared. Leaders emphasized distributed leadership, developing existing and emerging talent, and reducing the burden carried in isolation.

### 5. Put repeatable mechanisms in place to turn evidence into action.

This was a clear ask across the room. Leaders called for practical, repeatable ways to move from evidence to implementation, supported by the funding, partnerships, and structures needed to sustain change.

# Going Deeper: Defining the Top Two Priorities

The group selected its two highest priorities and had a more focused conversation, exploring why each matter, what success would look and feel like, how to get there, and where to start.

## Priority 1. Building Capacity to Use Data, Evidence, and Knowledge

### Why it matters.

Leaders described a system rich in data but poor at using it. Turning data into decisions takes specialized skills that are in short supply, so much of it sits unused. They were clear this is not only technical: evidence has to be valued, and using it has to feel safe and worthwhile, for that capacity to grow.

### What success looks and feels like.

Leaders pictured data that is well used and well translated, feeding steady improvement: better outcomes, more transparency, a clearer view of the gaps, and more sustainable care. They were just as clear on how it feels: less waste, less burnout, staff who feel supported, and a shared sense of direction where the work makes sense.

### How we get there.

Access to data was named as the biggest barrier, and a culture that values using data as the precondition for everything else. From there, leaders pointed to bringing communities, patients, and the stories behind the data into the conversation; sustainable funding for embedded research; and simplifying the work so evidence feels usable, not intimidating.

### Where to start.

- Put evidence into plain language that supports decision-making.
- Create opportunities for researchers, data holders, and decision-makers to work through priorities together.
- Sustain funding and support for researchers embedded in health systems.
- Build partnerships that strengthen the shared use of evidence, expertise, and capacity across organizations.
- Embed evidence-informed decision-making into existing programs, processes, and planning activities.

## Priority 2. Building a Learning Health System Culture

### Why it matters.

Leaders were strikingly consistent about the culture they want, returning almost word for word to trust, collaboration, autonomy, and responsiveness. Without it, the system stagnates and good ideas stall. With it, people can take risks without fear, and the knowledge already in teams gets used.

### What success looks and feels like.

Leaders described drawing on the team's collective knowledge, moving with more nimbleness, and having the safety and autonomy to decide. They expected innovation, higher performance, and stronger retention and engagement, held together by shared accountability. The word they kept returning to was safety: safety to try, to take risks, and to learn from mistakes, where hard conversations become a reason to connect rather than retreat.

### How we get there.

Leaders pointed to clear roles and accountability, genuine diversity of views, and the everyday habits that build trust, like asking colleagues what they need and working through discomfort rather than around it. Aligning policies and incentives behind the culture is what makes it stick, rather than leaving it to individuals.

### Where to start.

- Connect and be present.
- Communicate openly and work through discomfort rather than around it.
- Build relationships and trust across teams, organizations, and sectors.
- Create space for diverse perspectives and shared learning, so teams can draw on the knowledge they already hold.


LHSCentre@thp.ca
www.instituteforbetterhealth.com
100 Queensway West, Mississauga, ON

## Cross-Cutting Insights

### Relationships are critical infrastructure.

Connection was not described as a nice-to-have but as the mechanism through which everything else moves. Knowledge, capacity, and improvement travel through relationships, which makes them as worthy of deliberate investment as data systems or funding.

### Leadership must be distributed.

Concentrated leadership emerged as a risk, not just a preference: it drives burnout and makes improvement fragile. Spreading leadership across the system is what makes change sustainable.

### Capacity constraints are primarily human.

While infrastructure and data access matter, the barriers leaders returned to were time, workload, competing priorities, and burnout. Building a learning health system requires investment in people, relationships, and organizational conditions, not only technology and tools.

## Looking Ahead

This session produced a shared agenda, not a list of problems. Participants were remarkably consistent in both the challenges they identified and the future they hope to create: a health system that uses data, evidence, and knowledge effectively, supported by cultures of trust, collaboration, autonomy, and responsiveness. The priorities they identified point to practical opportunities for action, many within reach today. The challenge ahead is not building further consensus, but creating the conditions that allow evidence, people, and culture to work together in service of continuous learning and improvement.

# Appendices

## Appendix A. Group Prioritization

Each participant identified the single most important priority to address, and six colleagues rated it on a one to five scale, summed to a total out of thirty possible points. The items below are grouped by theme and ordered from highest to lowest score. Responses are presented as written, normalized lightly for readability.

| Capacity to use data and evidence | Peer Importance Rating (out of 30) |
|---|---|
| Building organizational and system cultures that value data and evidence as levers for transformation: invest in embedded research and academic partnerships, equip leaders with research literacy, and show the value of research in driving positive change. | 30 |
| Building collective leadership capacity by using evidence-informed leadership practices. | 24 |
| Integration of health data so leaders can make decisions efficiently. | 24 |
| How we need to better embed researchers in the health care system, leverage their skills in research, evaluation, and leading change, build their skills, and reduce the load of this work from clinical health care leaders and managers. | 22 |
| Better resources in rural and remote areas. Service delivery is the primary priority. There is no time for collecting and analyzing data to make system change. Who can implement it? How can they measure it? | 22 |
| Share the load of leadership and reduce leader burnout by strengthening leadership pathways and letting more people lead: junior, emerging, and diverse leaders. | 19 |
| Access to high-quality data at the local system level in order to identify problems and suitable solutions. | 18 |
| Practical data and ensuring outcomes are improving health care systems. | 18 |

| Building a learning health system culture | Peer Importance Rating (out of 30) |
|---|---|
| We need to develop leaders to lead high-performing teams where there are high levels of trust, collaboration, and evidence-based decision-making. | 27 |
| Horizontal mentorship and peer mentorship, using collective and collaborative ability to learn from each other and work with each other when traditional hierarchical leadership is constraining. | 26 |
| Ability to act on LHS information, including data, knowledge, and practice, when it counters organizational mandates. Flexibility and responsiveness. | 24 |
| Culture of relationship-building, mentorship, and trust to enable leaders to build the capacity of others. | 22 |
| Permission to change culture. Allowing leaders to get their jobs done without unnecessary red tape. | 22 |
| A more integrated, accountable, and responsive health system. | 21 |

| Building new connections | Peer Importance Rating (out of 30) |
|---|---|
| Creating opportunities for leaders to connect with others outside their organization to learn and share. | 25 |
| Time: prioritize the time for leaders to connect with their teams and other leaders. | 23 |
| Creating partnerships between knowledge users, end users, and researchers. Creating opportunities to work together so researchers can use their skills to address top issues faced in the health system. | 21 |
| Have the opportunity to observe work in a different sector of the health system, such as a hospital leader going to primary care, to promote shared understanding and increased integration across the system. | 18 |

| Leadership development | Peer Importance Rating (out of 30) |
|---|---|
| Invest in leadership training in health systems and organizations. | 20 |

| | |
|---|---|
| Give resources to develop leadership capabilities at the middle management level. | 20 |
| Democratic leadership to better describe and understand the complex social problem we want to solve and create value through a shared vision. | 17 |

| **Process: turning evidence into action** | **Peer Importance Rating (out of 30)** |
|---|---|
| A mechanism that could translate evidence into actionable strategies for continuous improvement. | 25 |
| Practical solutions to influence change, including funding, innovation, implementation, and execution. | 21 |

| **Bridging capacity and culture** | **Peer Importance Rating (out of 30)** |
|---|---|
| Helping people understand what a learning health system could look like at the organizational level, and communicating and sharing the necessary competencies that need to be in place. Vision: we are all learning organizations, ready for whatever comes. | 20 |

| **Other priorities** | **Peer Importance Rating (out of 30)** |
|---|---|
| Practical solutions that are easy to implement. | 24 |
| Incorporating patients' perspectives into improvements. | 21 |
| Space, time, and bandwidth. | 14 |
| Entrepreneurship alongside adaptability and flexibility. | 11 |
| We need to address the overwhelming system demands that outpace and reduce the capacity of leaders, especially middle managers and team leaders who are most proximal to teams, to do the relational work needed. | 10 |

## Appendix B. Deep-Dive Responses

The two highest priorities were explored through four prompts. The responses below are presented as collected, normalized for readability, with each row representing one participant's contribution to that prompt.

### Priority 1. Building Capacity to Use Data, Evidence, and Knowledge

| **Why is this important?** |
|---|
| It is more reliable to use real-world data to inform real-world practice and decision-making. |
| Drives decision-making. |
| Because what we use, apply, and implement is reliable. Stands on the shoulders of giants. Supports continuous growth. Feedback can be used in real time to make positive change. |
| Often there is limited capacity in the system to access data, but also to package it in ways that can inform decision-making. Utilizing existing data to inform decision-making. |
| Evidence-based, data-driven care and decision-making. Use data we collect. Capacity is currently low, needs specialized skills. |
| Supports evidence-based care. Leaders need time to be proactive and seek out opportunities to use data to answer questions. |
| We want positive, impactful change. Inform choices and priorities around where to invest energy. |
| Data and evidence. |
| Legitimizes study and change. Builds accountability. Promotes rigor. |
| Ensure evidence uptake into decision-making and implementation. Enable learning based on new data. Numbers don't lie, build trust. But data is not always numbers. |
| Positive, impactful change. Where to invest efforts: energy and resources. Better policies. Better decisions. |

| **If we get this right, what are we seeing, hearing, and feeling?** |
|---|
| Data are well-used. Evidence is well-translated. |
| An iterative loop that makes continuous positive change. |
| Better outcomes. More transparency. Increased perceptions of competency. Increased evaluation capacity. Understanding of gaps. Tailoring to needs. Supporting sustainability. |

| |
|---|
| Better outcomes (cost, quality). Patient experience increases through more personalized care. Transparent decisions. Sustainable care delivery, staff supported, reduced burnout. Evaluation of programs and services, and knowing where gaps are. |
| Better outcomes for patients, providers, and the system. Competency around using data to inform care decisions. Health system sustainability. |
| Less moral distress and more impactful initiatives. Real investment and focus around leadership. Increased engagement, easier to recruit and keep people. Investing wisely. |
| Reduces echo chambers and siloed work. Builds trust. |
| Reduction of siloed work and echo chambers, and a shared direction. Feeling like voices are heard and work has impact. It feels like things make sense. |
| Less waste. Impact. Real transformation. Higher level of engagement. High-quality data. Wise investment. |

| **How might we get there?** |
|---|
| Adequate funding. |
| Building a learning health system culture. |
| Build learning health systems. |
| Access to evidence. Stories and voice. Adequate and sustainable funding. Walk in different ways. |
| Dedicated effort to build a data culture from the ground up, not just with senior leaders. Let people in, let people ask questions, acknowledge and leave space for discomfort. |
| High-quality, real-time, interoperable data systems. Broaden data indicators and make them more equitable. Easier to collect and more accessible data. Share and publish. |

| **What are the first 2 to 3 steps we can take?** |
|---|
| Sustainable system for data management. |
| Reduce the time it takes to access data, from many months to a few. |
| Make evidence simpler and clearer for decision-makers to understand and use. |
| Bring this to conversation with community health organizations to understand what might be within short-term capacity versus long-term sustainable solutions. |
| Make the data collected by independent scientists available to decision-makers, and work with health systems so the data is in a form they can use meaningfully. |
| Facilitate discussion of data, evidence, and knowledge, and include this as part of an organizational gathering or event. |
| Be a champion for plain language. |
| Help people digest knowledge by using simple language to describe insights obtained from data. |
| Create space for decision-makers and the people who generate and hold data to discuss priorities and needs. |
| Encourage more students to build research capacity. Increase engagement. |
| Create intersectoral partnerships to support capacity to use data and share evidence together. |
| Encourage frontline staff to look at the dashboards in the electronic health record. |
| Build connection between researchers and health leaders around real research questions. |
| Connect with health system leaders and providers to understand their issues and priorities and develop a shared program of research and innovation together. |
| Integrate and share with policymakers and expand implementation science so evidence and data turn into everyday practice. |
| Continue to embrace evidence-based decision-making in programs. |

## Priority 2. Building a Learning Health System Culture

| **Why is this important?** |
|---|
| Build learning health system cultures that put trust, collaboration, autonomy, and responsiveness at the core. |
| Culture drives everything. Autonomy, mastery, purpose. |
| Without a learning health system culture there will be stagnancy. We need a shared goal and commitment. We can take advantage of different strengths across team members and stakeholders. There is untapped potential. |
| Ability to be open and honest. There is a lot of knowledge in people already, and we should use it. |
| Systems need to be supported to make change and take risks, without fear of repercussions. |
| Increased team and system cohesion, and organizational resilience. Less risk aversion. Team cohesion enabled. |
| Need a culture to support change, for example a culture that values evidence so we can act on the first priority. Foundation. Organizational level and system level. |

| If we get this right, what are we seeing, hearing, and feeling? |
| --- |
| Benefit of the whole and access to the brain trust. More nimbleness to respond, with the safety and autonomy to make decisions. Innovation and higher performing. Better retention, attraction, and engagement. Shared accountability. |
| Taking uncomfortable feelings as a signal to communicate. Building connections. |
| Good buy-in across stakeholders. A collaborative environment where everyone's voice is considered. Things get done faster. |
| More engagement. A safe, supportive community that can do things differently. Purposeful, with a sense of purpose in work. |
| A sense of safety to take risks and learn. Team cohesion. Aligning policies and systems. |
| Feeling safe to try new things and learn from mistakes. |
| Feeling we can try new things, take risks, and fail, with less fear. Encouraged to innovate. The system enables learning. |

| How might we get there? |
| --- |
| Higher performance. Better results. Great ideas. |
| Clear roles, responsibilities, and accountability. Ensure diversity of views and expertise. People will be more likely to ask for help. |
| Asking colleagues what they need. Working through the discomfort. Noticing what people actually experience and feel. |
| Align policies and systems behind the learning health system. |
| Incentives for innovation. Celebrate trying. |

| What are the first 2 to 3 steps we can take? |
| --- |
| Connect. Be present. Communicate. |
| Build relationships. |