

Pathways to Innovation and Change

A report on the
2016 National Health
Leadership Conference



NATIONAL HEALTH
LEADERSHIP CONFERENCE
Presented by HealthCareCAN & the Canadian College of Health Leaders

CONFÉRENCE NATIONALE SUR
LE LEADERSHIP EN SANTÉ
Présentée par SoinsSantéCAN et le Collège canadien des leaders en santé

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HealthCareCAN is the national voice of hospitals and regional health authorities across Canada. We foster informed and continuous, results oriented discovery and innovation across the continuum of healthcare. This report is funded through an agreement with the Government of Canada. The views expressed herein are those of the authors and do not necessarily represent the views of the Government of Canada.

Introduction

Each June, over 700 health system leaders from across Canada convene at the [National Health Leadership Conference](#) (NHLC). NHLC provides a pivotal forum for questions, debate and the sharing of strategies and solutions to the most pressing health system challenges in Canada.

Co-hosted by [HealthCareCAN](#) and the [Canadian College of Health Leaders](#), and held in Ottawa, Ontario, the 2016 conference theme was *Pathways to Innovation and Change*.

The need for fundamental, transformational change in the Canadian healthcare system is widely recognized. Canada faces many healthcare system challenges that are driving the need for change, including the complexity of an aging population, slow economic growth, and retiring “baby boomer” health leaders. Opportunities provided by greater connectivity and new technologies, and the recognition of the importance of putting patients and families first, are also driving change and transformation.

Achieving and sustaining change is notoriously difficult. Change in the health system is unique and complex. Most transformation efforts fail to deliver and sustain change because of a failure to acknowledge the complexity of healthcare systems. In Canada, our track record for creating sustained and effective health system improvement, and adopting change and innovation, has been slow relative to that of our peers.

Key questions underlie Canada’s efforts to embed innovation within the healthcare system. How do we create a “change culture”, harnessing organizational energy for transformational change? What are the necessary cultural and organizational factors that can lead to profound change and re-orient an organization in a new direction, taking it to an entirely different level of effectiveness? What must be done to fully engage and excite staff, patients, families and others to embrace change and adopt a culture of continuous improvement? How do we ensure that patients and families play a catalytic role as partners for change?

Leadership – at all levels – plays an essential role in effective healthcare transformation and change. How do we create the conditions for leaders to thrive in changing and challenging times? How do we nurture and groom existing talent to replace retiring leaders? Change leaders play a pivotal role in building a commitment to transformation and creating a sense of shared purpose – an essential component in change programs. The most effective change leaders are those who can build and leverage networks to create relationships and partnerships. What role do leaders play in the various stages of change, including preparing for change, implementing change, spreading change, and sustaining change?

Conference plenaries, panels, workshops, oral abstracts, and posters presented at NHLC provided essential insights toward addressing these questions. Key lessons learned and shared have been summarized in this document to assist policymakers in developing and deploying innovation in Canada’s healthcare space.

Plenary Sessions and Speakers

Plenary Speaker: The Honourable Dr. Jane Philpott

Canada's Minister of Health, Hon. Dr. Jane Philpott, gave opening remarks; a copy of which has been attached to this report. Dr. Philpott began by offering her personal perspective on Canada's challenges in responding to the Supreme Court's ruling in *Carter*, in which Criminal Code provisions governing the provision of physician assisted death were lifted. The Minister's remarks were timely, since that very day (June 6th 2016) was the day that the Supreme Court's ruling became the law. As parliament had not yet passed legislation in connection with physician assisted death, this left Canada without a federal framework to guide access to the service. As a result, patients, families, and care providers were uncertain as to when, where, and how the service could be legally provided and whether they might be prosecuted for providing a service that had so recently been illegal.



The Minister also emphasized the need to address large gaps in the delivery of palliative care services; the importance of ensuring adequate and culturally appropriate health supports for Indigenous peoples; the challenges faced by seniors in their interactions with the healthcare sectors, and the opportunity to improve health system efficiency overall. Minister Philpott closed with a stirring commentary on the need to scale-up and spread-out evidence-based innovations already in place across the country: "Healthcare in Canada will not thrive without support for innovation. But I respectfully submit that we need more than Pathways to Innovation. We need pathways *beyond* innovation.... Our biggest problem is not a lack of creative, evidence-based solutions. The problem is our failure to scale up the successful initiatives to be universally applied across the system."

Plenary Speaker: Dr. Helen Bevan

The second plenary address was given by Dr. Helen Bevan, Chief Transformation Officer of the UK National Health Service's Horizons Team. Dr. Bevan began by noting that 'change is changing'; the social and technical environment for creating and sustaining change is very different today than in the past. Dr. Bevan enthusiastically highlighted five key features of this new environment:

- The disruptive character of change is faster and more intense than at any time in the past. Where change project timelines used to have a horizon of two to four years, we now see projects with a horizon of 30-90 days for implementation. An example of this is the move from 'pilot projects' in management circles to 'tests', which are more rapid, less costly, less risky, and involve a smaller management footprint.
- The acceleration of connectedness through social media will require change managers to improve their 'digital dexterity' and to identify and leverage the dexterity of employees and the broader public to achieve change management goals. Notwithstanding its very small team and limited resources, Dr. Bevan's 'Horizons' team boasts 1.8 million Twitter impressions a month reaching many thousands of accounts. That being said, the benefits of communicating digitally run counter to the communication preferences of quality improvement leaders, who express a preference for non-digital modes of communication.
- Hierarchical power is diminishing. Increasingly it is not those highest on the organizational chart who shepherd organizational change, but those who are most connected to others in the organization. These are not necessarily the same people. In terms of change, centrality or connectedness in the informal network is more important than hierarchical position. People who are highly connected may have twice as much power to influence change as people with hierarchical power.
- The Maker Movement – a term denoting the trend whereby ideas and products are produced by individuals or informal groups of specialists – is having a strong impact on the change management community. Increasingly, iconoclastic ideas come from outside the 'usual suspects', and innovative healthcare organizations should create linkages with "Makers" wherever possible.
- Successful change agents often 'lead from the edge'. This means engaging in change experiments at the edge of the organizational chart, or at the points where the organization intersects with the public, and bringing those changes closer to core members and functions only when they have demonstrated their value on the periphery.



From these premises, Dr. Bevan discussed the roles of energy and motivation in the new change management landscape. All too often, change efforts lose momentum due to a lack of sustained energy in the organization. Largely, this is because the wrong *kinds* of energy are used. Change management is frequently centred on an 'anatomical' approach focused on the shape, structure, and process of a desired change. A 'physiological' approach, focused on motivations that give force and vitality to change projects, is rarely employed. The crux is that motivators for leaders are only distantly related to motivators for the workforce as a whole. The result is that change often stalls and fails. A successful change management strategy should capture this energy by employing both extrinsic motivators (levels, prizes, progress measures) and intrinsic motivators (autonomy, meaning, learning).

Change levers were also discussed, and a taxonomy of three different 'types' of levers for change was introduced. Type One change involves 'prod mechanisms' (eg. targets, payment incentives, regulation and competition); these are the levers most frequently used, but Dr. Bevan estimated that less than 10% of the potential for system improvement can be delivered through Type One change mechanisms. Type Two change, termed 'proactive support', relies on mechanisms that build intrinsic motivation among staff. Type Three change mechanisms are 'people focused', relying on education, training, and regulation to incent good behaviours.

Barriers and building blocks for change in the UK's National Health Service were identified and discussed. Barriers include: confusing strategies, micromanagement, one way communication, poor workforce planning, stifling innovation, timorous or 'overly safe' management, undervaluing staff, an inhibiting environment, and perverse incentives. Building blocks include: inspiring and supportive leadership, collaborative working, flexibility and adaptability, conscientious use of resources, autonomy and trust, challenging the status quo, a call to action, fostering an open culture, a nurturing environment, long term thinking, and thought diversity.

Dr. Bevan divided the workforce into two categories: 'contributing' workers who are engaged, collaborative, connected to a higher purpose and change embracing, and 'compliant' workers who resist change and work to a role specification. A key component of change management involves identifying, mentoring, and promoting contributors, who are thought to comprise 13% of the workforce but contribute up to six times the value of a similarly situated compliant worker.

Panel Discussion: Creating the Winning Conditions

The third NHLC plenary was a panel of healthcare leaders, each giving their perspective on the challenges and opportunities of creating the winning conditions for positive change in healthcare.

Panelists included:

- **Dr. Danielle Martin**, Vice-President of Medical Affairs and Health System Solutions at Women's' College Hospital, Toronto, ON.
- **Sharon Nettleton**, Co-Chair and founding member of Patients for Patient Safety Canada.
- **Chris Power**, CEO of the Canadian Patient Safety Institute and former CEO of Capital Health in Nova Scotia.
- The panel discussion was moderated by Toronto Star senior writer and award-winning author **Susan Delacourt**



Dr. Danielle Martin

Dr. Martin discussed physician engagement in quality improvement initiatives, noting that while physicians play a central role in the healthcare system, they have a reputation for resisting change in that system. This, according to Dr. Martin, is because doctors view themselves as outside the system; a viewpoint that is 'baked in' as part of medical training. In this model, a physician's most sacred obligation is to the patient in front of her, but a corollary of this model is that patients are conceived as a vulnerable group to be protected from the system. System-level changes are therefore seen as intrusions into the doctor-patient relationship, and resisted in the spirit of medical caution.

Without the support of the medical community, change management initiatives often stall, especially as the role of doctors transforms from technician (performing procedures) to manager (directing care). So what can we do? The first winning condition is to always assume goodwill. When physicians resist system changes, they usually do so for the best of possible reasons.

A second winning strategy is to frame health system changes in terms of outcomes data that is as transparent as possible. Physicians are men and women of applied science – they will be much more willing to support and advance change when there is a compelling evidence base for the change that is being proposed.

A third strategy is to avoid confusing 'opinion leaders' with 'community organizers'; physicians are generally much more in the former category than the latter, but change management in healthcare often assumes doctors are natural community organizers.

They are not.

Dr. Martin concluded by noting that there is an increasing speculation that the independent entrepreneur model and fee-for-service payment models are primary barriers to system change. But resistance to change in the physician workforce is mostly about culture, and culture is the product of much more than payment and employment models. Physicians can be powerful advocates for system improvement and are worth partnering with to achieve a shared vision – but these changes need to be situated in the context of medical culture if they are to be persuasive and gain traction with physicians.



Ms. Sharon Nettleton

Ms. Nettleton's talk focused on strategies for ensuring that health system 'users' (patients, their families, and citizens) are involved in decision-making at all levels of care. This includes not only consulting users at the point of care, but also in program and system design and in healthcare governance. Ms. Nettleton focused on three key considerations in engaging health system users: people, planning, and appreciation.



Acknowledging 'people' in this context means understanding and acknowledging the roles, perspectives, and contributions of health system users. If the goal of health system change is to improve the patient experience, then the perspective of patients should be foundational to the changes that are proposed and advanced.

Patients need to be empowered to take an active role in their own treatment in the system. Consider the way we talk about patients. Frequently we talk of 'involving' patients in healthcare as though their role were essentially passive; we should instead employ a vocabulary that involves 'enabling' patients through the healthcare system to choose the best path towards their own health and well-being. This requires that the patient voice always be present in discussions around health system change.

Finally, we need to appreciate the way that healthcare goals intersect with the values of health system users. Progress markers in healthcare are often defined in purely clinical terms. These are important, but they can misrepresent those aspects of health and healthcare that matter most to patients. By appreciating the value of interventions from the patient perspective, we create a sense of shared purpose among health system actors and catalyze other changes of the same kind going forward.

Ms. Chris Power

Ms. Power's discussion focused on the role of leadership in creating the winning conditions for health system change. Canada has an international reputation for great ambitions and poor execution of innovation in the healthcare space. We are plagued with institutional exhaustion and misaligned incentives; these problems are complex, but they are solvable.

The role of a leader is to set a vision and to create excitement as a means of breaking the deadlock our system so frequently imposes. This means, among much else, not settling for mediocrity and holding feet to the fire to execute on a compelling vision. As the saying goes "If you're riding on a horse and it dies, get off". At the same time, change leaders need to be respectful of the practices they seek to change. Change is threatening in healthcare because it feels like an indictment of the past; leaders need to position change in a way that acknowledges what has worked in the past while embracing new best practices borne out of new knowledge.



Plenary Speaker: Mr. Jeremy Gutsche

NHLC has a tradition of concluding with dynamic and engaging speakers. Jeremy Gutsche has been hailed as “an intellectual can of Red Bull”; at the age of 28, he is an award-winning author and management consultant to brands, billionaires and CEOs. Gutsche is the founder of trendhunter.com, which has rapidly grown into a trusted showcase for “what’s next” in marketing, design, technology and associated categories. Gutsche is also the author of the New York Times bestseller *Better and Faster: the Proven Path to Unstoppable Ideas*.

Gutsche’s talk focused on the need of leaders and firms to innovate in order to keep pace in a rapidly changing world. But where do innovations come from? Trendhunter.com is based on finding patterns in chaos by analyzing colossal amounts of data to give leaders insights into where businesses are moving. But this strategy does not suit all needs, even if the principle of finding patterns in chaos is timeless.

An important takeaway from Gutsche’s talk concerns the need to cobble together an interdisciplinary workforce no matter where your firm is situated. Getting workers from distinct backgrounds to collaborate and generate ideas together is one way to find ‘patterns’ in chaos, and to generate innovation faster than your competitors. “Almost all innovation happens by making connections between fields that other people don’t realize.”



Selected Concurrent Sessions

This section provides an overview of two concurrent sessions that may be of particular interest to Health Canada policy staff. Information on other concurrent sessions from this year's NHLC can be found at: http://www.nhlc-cnls.ca/default2016.asp?active_page_id=214.

Patient Safety and Engagement – Measuring Patient Safety in Canadian Hospitals

The Canadian Patient Safety Institute (CPSI) and the Canadian Institute for Health Information (CIHI) co-presented on the Hospital Harm Indicator project at a concurrent session on the morning of June 6. This was an opportunity to demonstrate a strong partnership between these two organizations on a very innovative project to address a gap in patient safety measurement and information. To date, there is no standard approach to measuring and monitoring harm and thus, the safety of Canadian hospitals. CPSI and the CIHI are working to address this using administrative data to develop a new way of reporting and improving on patient safety for acute care hospitals.

Through the development of a new hospital harm indicator, the Improvement Resource for the Hospital Harm Indicator, and an analytical report, system decision-makers, hospital executives, clinicians and policy makers will have access to important information on patient safety in acute care hospitals and how to improve it. This collaboration will provide significant benefits to patient safety in Canadian acute care hospitals.

In October 2016 the analytical report with national level results will be released publicly along with the Improvement Resource. The primary audiences of the report are provincial and regional decision-makers, patient safety and quality executives, board quality committees, and clinicians. The primary audiences of the Improvement Resource are patient safety and quality executives and leaders, and clinicians. Canadian hospitals have had private access to their indicator results since February 2016 for validation purposes and to begin to work with their results to identify opportunities for patient safety improvement. The CPSI and CIHI are committed to collaboration and open communication in this work, through meeting with key stakeholders across the country including health regions/ health authorities, hospitals, ministries, health quality councils and pan-Canadian organizations to ensure that stakeholders are aware of the work and upcoming activities.

There were over 50 health leaders participating in the session and interest was high. The full presentation can be viewed here: http://www.nhlc-cnls.ca/assets/2016%20Ottawa/DSilva_Measuring%20patient%20safety%20in%20Canadian%20hospitals.pdf

Embedding Cultural Humility within First Nations and Aboriginal Health Services

Rose LeMay of the Canadian Foundation for Healthcare Improvement (CFHI) and Joe Gallagher, CEO of British Columbia's First Nations Health Authority (FNHA), presented on the need for cultural humility in dealing with First Nations and aboriginal peoples' experiences with the health sector. The experience of BC's new First Nations Health Authority was specifically discussed as a model for a renewed partnership between governments and aboriginal peoples on healthcare.

For a variety of complicated and interconnected reasons involving colonialism, racism, and deprivation, First Nations peoples face distinct health challenges unknown to most Canadians. Public health outcomes for First Nations peoples in Canada are well established and paint a disturbing picture, as First Nations, Aboriginal, and Métis peoples fare worse on a wide variety of indicators of health and wellbeing. But the role of healthcare structures in maintaining this shameful status quo is less well understood.

Canada needs to develop cultural competence among healthcare professionals and incent culturally appropriate care. 38% of First Nations peoples report experiencing racism in their interactions with the healthcare system in a 12 month period; 63% of them report that their sense of self-esteem was significantly affected by these encounters. Stereotyping and lack of trust have stalled progress toward cultural safety and humility in healthcare for First Nations. This helps explain why health outcomes in aboriginal peoples remain so poor. When aboriginal peoples are sick, they do not seek health services because they do not trust their providers. When they do seek health services, their lack of trust is validated.

In 2006/2007, the governments of Canada and British Columbia struck perhaps the largest collaboration between governments and First Nations groups in Canada's history, committing in principle to the creation of a First Nations Health Authority. Because British Columbia is not subject to the same treaties as much of the rest of Canada, the various players were permitted an unprecedented level of policy experimentation during negotiations. FNHA is intended to address a lack of coordination on healthcare services for First Nations peoples, as well as to reform the way health care is delivered to BC First Nations, closing healthcare gaps and improving health and wellbeing. FNHA works with the province and with First Nations to address service gaps through new partnerships, closer collaboration, and health systems innovation. Just as importantly, FNHA aims to promote cultural humility in the provision of health services, developing respectful partnerships based on trust.

In 2013, FNHA assumed the programs, services, and responsibilities formerly handled by Health Canada's First Nations Inuit Health Branch – Pacific Region. These responsibilities include planning, designing, managing, delivering and funding the delivery of First Nations health programs across British Columbia. Mr. Gallagher spent most of the session speaking to the ways FNHA has smoothed the relationship between healthcare providers and First Nations peoples in British Columbia. A notable example involved the strained relationship between a First Nations community and a British Columbia coroner's office in connection with the illness and death of a child. In this case, FNHA representatives were able to intercede in order to allow both the coroner's office and the community to achieve their goals, and the relationship between the two was substantially repaired. Mr. Gallagher concluded that culturally safe care has considerable untapped potential to improve health outcomes among aboriginal peoples across Canada.

The Great Canadian Healthcare Debate

Following on the success of the inaugural debate in 2015, NHLC hosted the 2nd annual Great Canadian Healthcare Debate, moderated by long-time Globe and Mail National Affairs Correspondent Jeffrey Simpson. The debate was the culmination of months of effort and forethought by actors from across the healthcare spectrum.

In November of 2015, NHLC issued a call for submissions resulting in 38 proposed motions to be debated at the conference. Under the Chair of Mr. Tony Dagnone, former CEO of the London Health Sciences Centre, the Debate's Policy Resolution Committee (whose membership list has been attached to this report) distilled these into a "Top 10" list of resolutions based on four criteria: significance, impact, interest and the extent to which the motions were felt to be actionable.

In April, a survey was sent to NHLC early-bird registrants asking them to further prioritize this list into a list of the "Top 5" motions. The motions and issue briefs associated with the "Top 5" motions are included in the attachments to this report. To inform the debate, HealthCareCAN and CCHL commissioned an Ipsos survey to census Canadians' views on healthcare generally and on the motions specifically. Survey results gave a nuanced picture of Canadians' priorities in healthcare and a copy of Ipsos' summary report has been provided in the attachments. On the evening of June 6th, NHLC participants were asked to select three contenders from the "Top 5" motions to be debated on June 7th, day two of the conference. Out of this process, the following motions were selected for debate:

1. **Short title: A Public Reporting of the 15 Never Events** (Debated by Hina Laeeque, Canadian Patient Safety Institute Patient Safety Improvement Lead)

"Resolved that, provincial/territorial governments across Canada commit to patient safety by requiring mandatory public reporting of the 15 Never Events for Hospital Care in Canada within the next three years."

2. **Short title: Indigenous Health – Truth and Reconciliation Commission Health-Related Recommendations** (Debated by Dr. Alika Lafontaine of the Indigenous Health Alliance)

"Resolved that, health care leaders commit to addressing widening health inequities and quality of care of First Nation, Métis and Inuit patients by working to implement the recommendations of the Truth and Reconciliation Calls to Action for Health' beginning with recommendation 19 to "...establish measurable goals to identify and close the gaps in health outcomes...to publish annual progress reports and assess long-term trends..." and establish a coordinated strategy for the other Calls to Action, in partnership with Indigenous Peoples, in the next three years."

3. **Short title: Adopt key recommendations from the Report of the Advisory Panel on Healthcare Innovation ("Naylor Report")** (Debated by Mimi Lowi-Young, Chief Executive Officer of the Canadian Alzheimer's Society)

"Resolved, that the federal government adopt the recommendations in the Report of the Advisory Panel on Healthcare Innovation related to the creation of a Healthcare Innovation Fund, supported by appropriate funding, starting with \$1billion over 5 years, as part of the next Health Accord."



Debaters were given four minutes each to make their case (briefing materials had been distributed to conference participants prior to the conference). These were followed by pointed questions to the debaters by the moderator as well as conference co-chairs Wendy Nicklin (President Elect, International Society of Quality in Health Care) and Alex Munter (President and CEO, Children's Hospital of Eastern Ontario). The moderator then invited questions from the floor over a period of 35 minutes, which provoked a set of thoughtful queries and challenges for the presenters.

Following the question period, participants were asked to electronically vote- from among the "Top 3" motions - for the winner of the 2nd annual Great Canadian Healthcare Debate. The Motion on Indigenous Health won support from the majority of NHLC attendees by a wide margin, indicating that attendees felt Indigenous Health should be the healthcare system's number one priority in terms of the need for innovation and change.

- 15 Never Events – 13% support
- Indigenous Health – 73% support
- Naylor Report – 14% support

Health Canada Director General Marcel Saulnier took the stage after the tally to respond to the vote, voicing Health Canada's interest in the Debate result and commitment to take the Debate's findings under advisement and consideration going forward. **More details about the Great Canadian Healthcare Debate, including a specially commissioned magazine prepared by iPolitics, can be found in the appendices.**



NHLC 2016 - Awards

First Annual HealthCareCAN Legacy of Leadership Award

This year's NHLC saw the granting of the first annual HealthCareCAN Legacy of Leadership award. The award recognizes exceptional individuals who have made long-lasting and outstanding contributions to advancing Canada's health system and have demonstrated significant and sustained commitment toward the enhancement of the health of Canadians. Recipients of the Legacy of Leadership Award embody the very best in leadership, are forward-thinking and have:

- made a recognizably significant and lasting impact on the Canadian health system at the national level over a period of 25 or more years;
- exhibited a life-long commitment to the pursuit of world-class health system leadership;
- demonstrated excellence in past or current senior leadership position(s) within Canadian health organization(s) including hospitals and/or regional or provincial health authorities, health-related provincial or federal non-government organization or association, provincial or federal government department, or the private sector;
- provided outstanding support to other/emerging Canadian health leaders by serving as an exemplary role model; and
- been recognized by their peers within and outside of the publicly funded health system for their distinguished accomplishments.

The winner of the first annual HealthCareCAN Legacy of Leadership Award was **Dr. Patrick McGrath**, Integrated Vice President Research, Innovation and Knowledge Translation at the IWK Health Centre and the Nova Scotia Health Authority.

Dr. Patrick McGrath is a senior health administrator, research scientist and innovator, clinical psychologist and social entrepreneur. His career goal has been to use research to improve patient care.



As Integrated Vice President, he created “Translating Research into Care” grants - a partnership amongst clinician scientists, administrators, patients, the QEII and IWK Foundations. He was instrumental in the development of: BIOTIC - a translational imaging research facility; Comprehensive Research Education Online; and the IWK Research Registry to enable patient participation in research. He is Professor of Science, Pediatrics, Community Health and Epidemiology and Psychiatry at Dalhousie University and founded the clinical psychology PhD program at Dalhousie, going on to lead the program for over a decade.

His research focuses on children’s pain and using technology to deliver health care. He created the not-for-profit Strongest Families Institute, which delivers mental health care to thousands of families across Canada, Finland and Vietnam. His research has helped inform pediatric pain internationally.

Dr. McGrath has published over 290 peer reviewed papers, 50 book chapters and 14 books. He has received national and international awards and recognitions for his leadership, research, mentoring and advocacy including being appointed Officer of the Order of Canada, elected Fellow, Royal Society of Canada and Canadian Academy of Health Sciences. In 2013 he was co-winner of the Principal Award of the Manning Foundation for the best innovation in Canada for the Strongest Families Institute.

NHLC 3M Health Care Quality Team Award (Quality Health Improvement Initiative(s) Across a Health System)

The **Mississauga Halton Local Health Integration Network (LHIN)** received the NHLC 3M Health Quality Team Award at NHLC 2016. In 2012, the Mississauga Halton LHIN launched its new ‘Caregiver Respite Program’. The program involved developing and deploying five separate but interconnected services designed to “wrap around” the caregiver. These include: emergency respite, out-of-home respite (short stay), adult day respite (day, evening, and bathing service) in-home respite and caregiver counselling, and knowledge exchange & support. Today, caregivers have access to all five services, and the program makes use of a single access point for the convenience of clients. The program has also been designed to incorporate the flexibility needed to meet client needs. For example, in-home respite hours are awarded based on assessed need and can be redeemed as the caregiver chooses, rather than according to an arbitrary schedule.

Once admitted, respite advisors counsel and educate caregivers on the services available to them and coordinate entry into one or more services. A learning center has been built and educators provide in-class or in-home training to caregivers in areas such as positioning, turning, feeding and changing dressings to enable caregivers to feel supported in their care. Educators also train respite provider staff in a variety of caring skills for those with dementia, Alzheimer’s disease, difficult behaviours, customer service, and other features of the home care landscape.

A research study was conducted and an interRAI caregiver survey was piloted. Further clinical pilot testing is now taking place in other home care organizations and geographical jurisdictions, the plan being for the caregiver survey to become part of the interRAI standardized assessment system.

The contribution to research and a new assessment instrument, return on investment savings and the targeted development of this much-needed program – which integrates current with new services for a comprehensive approach – is strongly endorsed by the Mississauga Halton LHIN.

NHLC 3M Health Care Quality Team Award (Quality Health Improvement Initiative(s) Within an Organization)

The **BC Ministry of Health and BC Cancer Agency (BCCA)** received the NHLC 3M Health Care Quality Team Award at NHLC 2016. In 2013, the **BCCA** conducted a provincial outpatient cancer care experience survey with 20,000 BC cancer patients and their families. This survey achieved a 65% response rate, and its results indicated an overall 97.5% rate of satisfaction across the province. At the same time, the survey gave a score of 46.8% to questions assessing the comprehensiveness and appropriateness of emotional support provided to patients and their families. While this last score was similar to other provinces in Canada, it was judged unacceptably low.

Beginning in March 2014, BCCA led 56 leaders from BCCA and from each British Columbian health authority in a change management exercise aimed at improving this rating. Focus groups were held with patients, families and staff to explore the reasons for the low scores and to propose solutions. The top four solutions, as prioritized by patients and families, were deployed across the province. BCCA partnered with the Emily Carr School of Art and Design to create an advertising campaign to promote the emotional support resources that are made available to patients and families battling cancer. The campaign's branding elements (i.e. campaign slogan and aesthetics) were decided on by a vote including 156 patients and families as well as 205 staff.

Campaign materials included elevator wraps, posters, business cards, and pamphlets given to all new patients. Program evaluations showed a 300% increase in cancerchat.canada use, a 44% jump in perception of emotional support by patients, and a significant improvement in the awareness of the emotional support resources by staff, patients, and families.

This has been a breakthrough exercise in health system collaboration on cancer care. For the first time, leaders in multiple cancer centres and in 33 hospitals in a province have worked together alongside patients to improve emotional support. As a result, patients and families battling cancer in British Columbia have experienced a marked improvement in wellbeing and in their satisfaction with their care.

Media Impact

The NHLC's 2016 communications objectives were to engage three major target audiences: political players, delegates, and the public. In service to the goal of engaging these audiences, the following communication goals were set for NHLC 2016:

- Raise the profile of the NHLC by increasing media attention and coverage on health issues of national importance;
- Leverage the advantage of hosting the conference in the nation's capital to raise the interest and engagement of politicians and federal health agencies; and,
- Engage the delegates by enabling their participation and influence over the course of the discussions, especially during the Great Canadian Healthcare Debate.
- NHLC's internal media impact report is provided in the appendices. Highlights of that report are summarized as follows:
- The opening remarks provided by Minister of Health Jane Philpott attracted twelve reporters from major media outlets including: CBC National, Canadian Press, Global News, Reuters and Radio-Canada. Although these news stories were not focused on the conference, mentions were made of the National Health Leadership Conference in each of them.
- Social media impressions for this year's NHLC reached an all time high at 21 million; more than double the number in 2015. The Conference generated 10,000 tweets and #NHLC2016 trended on both days of the conference.
- Media coverage was generally most focused on Minister Philpott's speech. Secondary news stories were related to an NHLC-commissioned Ipsos poll outlining Canadian views on the state of the healthcare system. Moreover, media interviews were given to CTV NewsChannel, Radio-Canada and Rogers' Healthcare Network. Altogether, media connected to the NHLC is estimated to have reached up to 46,297,902 consumers.
- A promotional video featuring the conference's two co-hosts was well received and widely redistributed.



HealthcareCAN and CCHL collaborated with iPolitics to produce a special report on the NHLC which was distributed to federal Members of Parliament, conference delegates, and their members. This report includes impressions and analysis of healthcare politics as they relate to NHLC themes. Discussion topics include: the federal government's healthcare agenda, the importance of innovation in health systems, and ongoing negotiations towards a new Health Accord. This document is attached to this report for more in-depth review.

Toward NHLC 2017, June 12-13, Vancouver, British Columbia

Plans are well underway for NHLC 2017. Themed **Value-based healthcare: Embracing a patient and family-centered approach**, the conference will be held in Vancouver, British Columbia on June 12-13, 2017. The call for Abstracts can be found in an attached appendix.

Canada, like health systems around the world, is struggling with rising healthcare costs, uneven quality, and how to ensure that patients and families are at the centre of a sustainable healthcare system. Canada spends more on healthcare, compared to most of its peers, and generally achieves less. Governments, health leaders – and those we serve – are looking for better value, improved quality, better outcomes, and enhancing the “value” proposition through the lens of the patient and family. In an era of increased complexity, with an aging population, a rising prevalence of chronic conditions, and the acceleration of medical innovations – and at a time when health spending is outpacing economic growth – achieving greater value from how health services are delivered, and ensuring that patient and family engagement are central to care planning and delivery, are essential.

There is a growing understanding that the status quo is no longer acceptable - we can and must do better. How do we gain greater value from healthcare investments, achieve better health outcomes, and improve health system performance? How do we ensure that patient and family experience is central to how we define value, and that the patient is a co-creator in the process of creating and sharing value?

A **patient and family-centered approach** is at the heart of value-based care. Patient and family-centered care and engagement have been shown to improve quality and safety, clinical outcomes, organizational efficiencies, organizational culture and patient satisfaction and experience. How do we achieve better outcomes more efficiently? How do we ensure that patients and families are at the centre of decision-making at all levels? Health leaders at NHLC will explore what needs to be done to create a patient and family-centered healthcare system that reflects what patients need.

NHLC 2017 **will showcase leadership and success stories** in achieving a patient-centered approach to value-based healthcare from both Canada and internationally. It will examine many essential dimensions of value-based healthcare, including:

- the role of leadership – at all levels – as a critical enabler of patient and family-centered value-based care;
- the importance of research as a key driver of a patient and family approach to value-based care;
- the essential role of technology, including information technology, electronic health records, and new methods of delivery, including virtual healthcare and mobile health;
- the strategic role of industry;
- the organization of new payment and compensation models and accountability around patients' needs;

- the use of value-based healthcare models that focus on accountability for patient outcomes;
- the use of value-based procurement to boost innovation and improve system performance;
- improved integration of healthcare services across the continuum of care as patients transition through the system; and
- the central role of information systems and measuring outcomes to better understand how effectively the health system is achieving its goals, and support better decision-making.

The conference will build on the 2016 theme *Pathways to innovation and change*, and will address the **extent to which a patient and family-centered approach to value-based healthcare can drive improvement and innovation**.

NHLC 2017 will contribute to this crucial conversation on how Canada's healthcare systems can reduce costs, put the patient and the family at the centre of a sustainable system, and improve quality and outcomes.

NHLC 2017 will include a plenary session on Indigenous Health (June 12th) building on the strong support for the 2016 motion on Indigenous Health at the Great Canadian Healthcare Debate. A one-day special satellite session on Indigenous Health will also be held on June 14th. An invitation has been extended to both Minister Philpott to once again open the conference in 2017.

Attachments

Attachment I: Speaking Notes for the Honourable Jane Philpott, Minister of Health, at the National Health Leadership Conference

Attachment II: The Great Canadian Healthcare Debate Policy Resolution Committee

Attachment III: “Top 5” Motions and Issue Briefs for the Great Canadian Healthcare Debate

Attachment IV: Ipsos Survey Results on Canadian Healthcare and Great Canadian Healthcare Debate Motions

Attachment V: NHLC Communications Report

Attachment VI: iPolitics NHLC Special Report

Attachment VII: NHLC 2017 – Call for Abstracts