Exploring Leadership
During Implementation of the
Integrated Primary and Community Care Initiative
in the
Chilliwack Community Based Service Delivery Area

December 1 2013

Photo by Elly Meyerlink, Chilliwack

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BC Node Team 2011 – 2013

The membership of the BC Node Team changed throughout the project, reflecting many of the challenges and realities the participants were describing. This list shows the evolution of the BC Node Team over the two years of the study.

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BC Node Case Study Report

December 2013

Exploring Leadership During Implementation of the Integrated Primary and Community Care Initiative in the Chilliwack Community Based Service Delivery Area

Executive Summary

Leaders in the health care system today are faced with complex and constant change and are challenged by external and internal factors.

The paper describes the research that was done in one health authority in British Columbia as the participants experienced large system change, in the form of integrating primary and community care. The BC Node Case Study *Exploring Leadership During Implementation of the Integrated Primary and Community Care Initiative in the Chilliwack Community Based Service Delivery Area* was chosen as a result of conversations with Ministry of Health executive. There was a desire to understand leadership in the context of Integrated Primary and Community Care (IPCC) at different levels of the system and across local, regional, and provincial levels. This study is one of six that took place across Canada between 2011 and 2013.

The results reported here are based on the content of 28 semi-structured interviews, one focus group, and observational notes taken at 19 organizational meetings. The data were collected in three cycles between January 2012 and July 2013 and the results were shared with participants at the conclusion of each cycle.

This research asked the participants about their views on necessary leadership capabilities, differing needs according to context, key leadership roles and activities, leadership impetus for initiatives, internal and external contextual factors, and leadership lessons. These questions will inform the larger research objective of contributing to knowledge about the current state of leadership capacity in Canada, the gaps between current practice and the literature and how a national set of standards might be established, and how knowledge of effective leadership can be translated and mobilized into practice at all levels to develop quality health care leaders.

This report documents the findings from the three data collection cycles and provides a picture of the evolution of the IPCC initiative. We see what concerns and challenges leaders faced at the launch of a large system change and tracked their efforts and results over time. We are able to learn what they deem important at different phases of a change initiative, and what aspects gave them pause for concern.

The participants in the study described what they saw as enablers and supporting influences of change, and they talked frankly about what held them back and impeded their efforts. Through their comments we are able to identify some opportunities for leaders to heed when undertaking change and pose some questions for leaders to consider.

The themes that stood out in this report that are relevant to the overarching questions are:

- Participants in the same system may have very different perceptions of the system, leading to misunderstandings and incorrect assumptions.
- There are different cultures within the system and there are challenges in working and communicating with different groups.
- System barriers such as the inability for information to move freely between different parts of the system force leaders to make decisions with incomplete information.
- There is a need to provide solid and relevant evidence to give the organization a means to measure progress.
- There is a need to bring in new blood to introduce fresh perspectives and reduce the workload of leaders, which is in conflict with the need for stability and consistency.
- Relationships between members of the system are vitally important to build trust and confidence in the change effort. Communication and making time for dialogue, listening to hear, and resolving conflict are integral aspects of relationship building, and there is not always time to do this properly.
- Demographics will play a large role in the profile of the health care system. Not only will large numbers of physicians and health care workers approach retirement age in the next few years, our Baby Boom population means we are

beginning to see an increase of people with chronic and complex health care issues.

- At a time when we desperately need to develop new leaders, we are not actively preparing people to take on these roles.

This study provides a picture of the current leadership capacity, the challenges, the factors, and the context, in one component of one community in one health authority in British Columbia. While not a provincial picture it does give us a sense of what health care leaders are faced with as they navigate the waters of change.

Background

The underpinnings of addressing the challenges and gaps in health care service in British Columbia began in 2002 when the General Practice Services Committee (GPSC) was formed. This committee was made responsible for creating new initiatives, an example of which is the creating of the Divisions of Family Practice, which coordinates and supports family doctors at the regional levels (Tregillus & Cavers, 2011).

In September 2010 the Ministry of Health presented a paper entitled Delivering an Effective, Integrated System of Primary and Community Care. This document was the beginning of the Integrated Primary and Community Care initiative in British Columbia.

The paper outlines the rationale and pressing need for a system change, citing increasing demands on services that impact patient care. These demands bring a significant increase in health care costs, making a more effective way of delivering care to those who need it imperative. Our aging population and associated chronic disease among that demographic have put a strain on our current system, and as the population of our province continues to increase, new ways of delivering care need to be found to sustain both hospital and residential care services.

Maternity care, mental illness, substance use, and First Nations health care needs also need better integration between acute care and community resources. The IPCC initiative was developed in order to address the serious and changing health care needs of British Columbians.

Fraser Health prepared their Report from the Fraser Health Primary Health Care Forum in October 2010, supporting the Ministry's views on integrating primary and community care and listed objectives as:

- Facilitate dialogue and collaboration among stakeholders in shaping Integrated Health Network and Attachment Initiatives within Fraser Health;
- Celebrate accomplishments and showcase current initiatives; and
- Move toward a culture of integration that includes embracing collaboration among health care practitioners and recognizing patients as partners.

This document provides detail on the process for developing the framework for IPCC in Fraser Health, using Chilliwack as the pilot location. It also describes the

creation of the Divisions of Family Practice, to enable conversations with physician groups in the development of IPCC processes.

Reasons for Selection of Regional Case Study

The BC Node Case Study *Exploring Leadership During Implementation of the Integrated Primary and Community Care Initiative in the Chilliwack Community Based Service Delivery Area* was chosen as a result of conversations with the Assistant Deputy Minister with the Ministry of Health. This individual was also a member of the Royal Roads University Centre for Health Leadership and Research Advisory Council. There was a desire to understand leadership in the context of Integrated Primary and Community Care (IPCC) at different levels of the system and across local, regional, and provincial levels.

The Ministry of Health Executive Director at that time suggested that we conduct our research in a health authority that was furthest along in developing IPCC. After some internal discussions, the Chilliwack Community Based Service Delivery Area was suggested and a Royal Roads University representative met with key stakeholders in Chilliwack, Fraser Health, and the Ministry of Health to discuss the project and determine if sufficient interest was present.

Fraser Health is the largest health authority in British Columbia and serves more than 1.6 million people. It is one of the fastest growing health authorities in Canada and includes a diverse population with unique demographics that present their own challenges and opportunities for delivering accessible, high-quality healthcare. The region features large populations of First Nations peoples, Asians, Indo-Canadians, Koreans, and Filipinos and is home to about 40% of all British Columbia's immigrant population. A significant proportion of this population is elderly, resulting in a steep increase in the prevalence of chronic disease.

The health care system in BC can be considered a 'complex adaptive system' in that it is a system comprised of subsystems, and is a subsystem of the national health care system. Each of these subsystems has its own processes, feedback loops, relationships, and hierarchies. The subsystems are interdependent on each other with multiple

connection points, subject to the dynamics internal and external forces, and are adaptive in their capacity for experiential learning.

Brief History of Case Study including Original Vision, Objectives, Chronology of Key Leadership Decisions

Through 2011 the proposal was developed and ethics approval was secured from the Fraser Health Ethics Review Board.

The vision of the project was to explore the qualities of leadership, significance of leadership, and the factors that influence leadership effectiveness in different contexts, to effect change in support of the integration of primary and community care in the Chilliwack CBSDA. At the end of the project we will have a better understanding of leadership capabilities needed in a change initiative that includes different agencies and different locations, and the complexities of leadership relationships that exist throughout the different levels in different contexts. Knowledge of contextual factors that impeded or facilitate change would also be gained, and a better understanding of how stakeholders and participants accessed learning opportunities and applied them would also be gained.

The overall project purpose is to generate knowledge and implement an evidence-based intervention that will set the foundation for creating a more sustainable and high performing system for the 1.6 million people in the Fraser Health region.

The objectives of the research can be described as:

- Collaborate with leaders in the Chilliwack CBSDA (in addition to key stakeholders at the FHA and MOH levels) to: identify leadership actions for change; support implementation of those actions; reflect on their success and determine what practices worked or didn't work; and, based on the findings identify what should be done.
- Examine leadership behavior within and across levels of responsibility associated with implementation of the project, specifically the Chilliwack CBSDA, FHA and MOH levels.
- Document and share the lessons learned to improve leadership and change management practices.

- Connect the knowledge and experience of health system leadership researchers and decision-makers in the Chilliwack CBSDA initiative to the pan-Canadian PHSI project, and vice versa.

BC Node Research Design Plan

This research used a Participatory action research (PAR) approach. PAR involves the participants and engages them in the inquiry. Members of the community being researched become 'active participants' in the process. PAR studies involve participants in every phase they choose to participate in, including defining the topic, being research subjects, interpreting results, and applying results to address the challenge. Through the cycles of collecting data, interpreting, reflecting, and acting, PAR makes it possible to empower the research participants to design new ways of being to improve practice.

The data for this research project was collected in three cycles using a set of questions in semi-structured interview format and focus groups as a means of data collection. Observational data was also collected from Fraser Health IPCC Steering Committee meetings and Ministry of Health Integrated Leadership Committee meetings.

At the end of each data collection cycle the findings were shared with participants for the purpose of opening discussions on leadership and how perceptions of leadership change over the course of the research project. Leadership practices may or may not have changed as a result of this study. The diagram below illustrates the cycle and the activities sequence. Each data collection cycle was six months in duration.

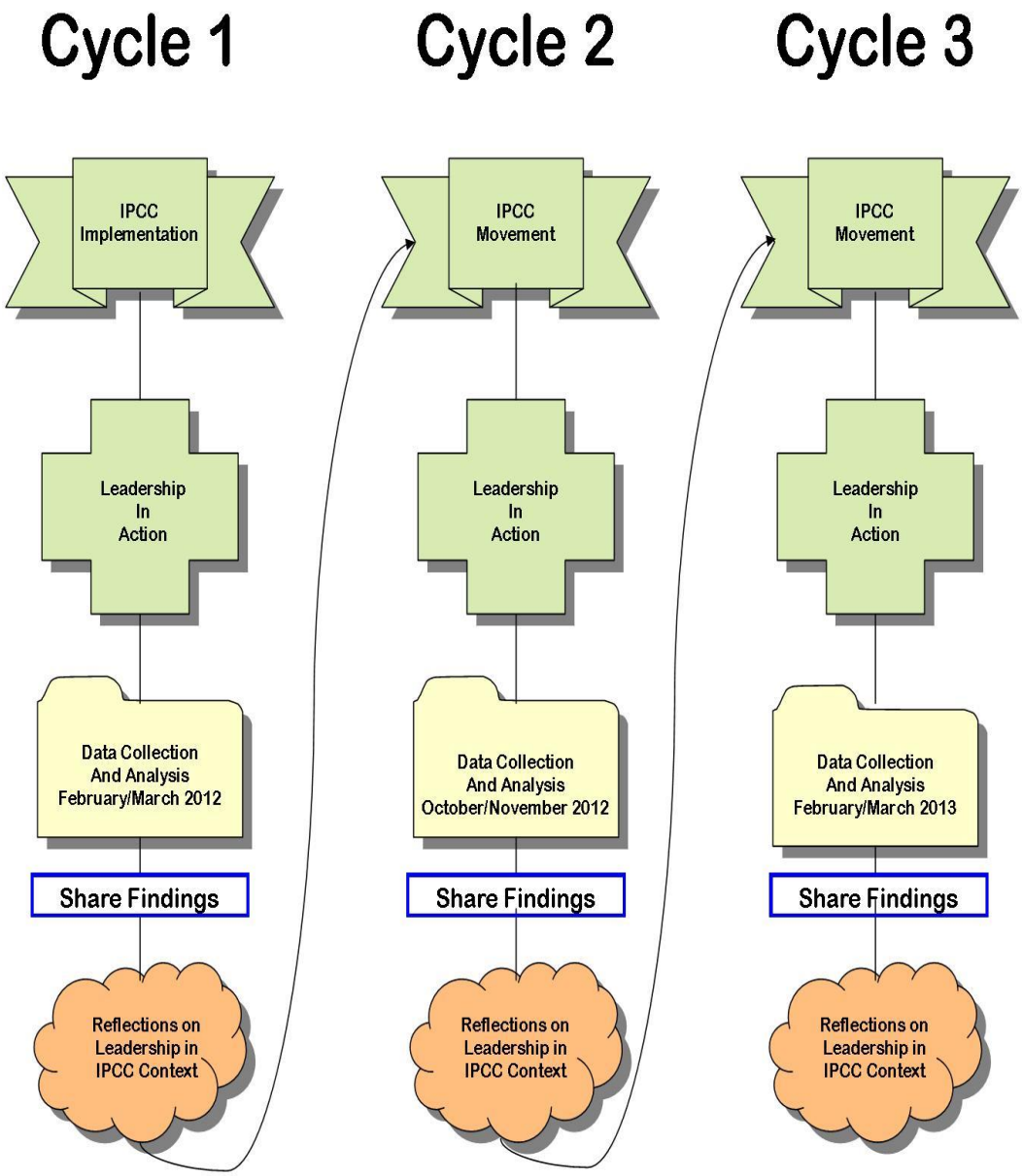

Figure 1. Cycle Sequence

Cycle One

The preliminary research findings in this report are organized by, and in order, of the interview questions asked. The research questions explore the participants' perceptions of leadership (their own and others') through three frames; past, present, and future.

The key findings from Cycle One, grouped by question area, include past, present, and future and provide a good baseline for Cycles Two and Three. Cycle Two and Three omit the questions pertaining to the past because it did not change.

Leadership Capabilities

The first question asked participants about leadership capabilities, and what they considered essential capabilities for creating readiness for the change to IPCC, to contributing to the goals of IPCC, and to accomplish the objectives for the next phase(s) of the initiative.

Vision, courage, and communication.

Participants told us they thought it important that a leader be able to translate the vision and engage and enable others to implement it. They cited a leader's courage and perseverance as qualities essential to seeing a change through, and providing a role model for others. Communication was mentioned again and again, but not broadcast communications. Two way communication was necessary and being heard (not just listening) was vital to establishing the trust and respect necessary to engage and sustain motivation. They said being heard also meant taking action by clearing obstacles or adjusting the plan when information deemed it necessary. They told us that being heard also contributed to building relationships, and fostering trust and respect. They consider the ability to do that effectively was considered a leadership capability.

Leaders who invested time and energy in the 'front end' of the IPCC initiative reaped the benefits. Devoting time and space to ensuring that there was enough time for people to absorb what was proposed, and to have a part in shaping the change was important in the success of the launch of IPCC. The signal was that this was important enough to warrant time (which is money) for people to fully grasp what IPCC means in terms of their day-to-day work, meant that people felt committed to it, and that it was not something that would be done off the side of their desk.

Process and systems.

We heard that participants considered the ability to facilitate process and keep a systems perspective was a leadership capability that supported the IPCC implementation. They emphasized systems thinking as being aware of all the working parts and how they interacted, in order to ensure that communications flowed to and from necessary points, inclusion was appropriate, and by extension, trust was established within the system was an attribute of leadership that was called on for IPCC to succeed. They told us that having a systems perspective, and encouraging a systems perspective was considered a skill that would discourage silos among the IPCC stakeholders.

Participant quotes that illustrate some of the points are:

> "You can have the vision and the attitude. You can demonstrate intent but to make space and time for this is huge". WALK THE TALK
>
> "Visionary leadership is first....it's not just from one person."
>
> "Someone who fundamentally believes the whole system needs to work as a whole and the interconnecting parts are linked.."

Leadership in Different Contexts

The second question inquired how leadership in different contexts affect and align the IPCC initiative. In the BC Node research the contexts are the Ministry of Health, Fraser Health, and the Collaborative Services Committee in Chilliwack.

Ministry of Health, Fraser Health, and Collaborative Services Committee Relationships.

Participants described the Ministry of Health's leadership role as providing visionary leadership, clearly communicating overall direction, removing barriers, providing resources, and modeling leadership. They considered this the 'seed' of the IPCC initiative.

Fraser Health was seen as also providing visionary leadership, as well as the important role of being the bridge and conduit for integration of programs, and modeling leadership. They hold responsibility for the 'background work'.

The Collaborative Services Committee are the ones tasked with on the ground work, also modeling leadership in that capacity. Their work is what is most visible to the public and the patients.

When talking about the contexts, people said that the relationships are built between people, not roles, so when there is turnover in one of these areas, new relationships may have to be established, which takes time. They added that trust may or not be present at the beginning of the relationship.

Participants said:

> "Modelling at the provincial level and setting the expectations."
>
> "Creativity to take the framework set by the Ministry and starting to create what it would look like for communities."
>
> "Demonstrate positive intent to work differently together and have a transparent approach."

Leaders and Roles

The third question explores what leaders are doing, and what roles they are working in that contributes to IPCC.

When asked the question as it is stated in the documentation, people usually began giving names of specific leaders. While this helped to identify some key leaders, it doesn't take into consideration what happens if that particular individual leaves the

organization or changes jobs. There was also a tendency to mention the people in official leadership/managerial roles, while not recognizing the leadership that is occurring at all levels.

In broad terms, the leaders who are influential are the people who participate in:

- the Implementation Leadership Committee (MOH)
- the IPCC Steering Committee (FH)
- the Collaborative Services Committee (Chilliwack)

The leaders in public health who co-designed how IPCC would be implemented in different locations played a leadership role too. There was also a member from the Chilliwack City Council and a patient representative, but the key players were the health authorities and the division physicians and the relationships that were developed over time.

Participants shared what they thought was important for leaders in any role:

> "Taking responsibility for addressing concerns and issues as they arose and taking answers back."
>
> "Consistent commitment to the vision of an integrated primary community care service."
>
> "...mutual commitment to be seen as working as a team." Referring to the leaders in the health authority and the physician group.
>
> "Demonstrating a truly linked relationship with physician groups in a way that was very different than how we worked in the past."
>
> "Relationships are built between people, not between roles, so turnover slows things down and introduces an element of uncertainty. New relationships take time to be built."

Source of Leadership

Question Four asks about the source of leadership to implement, shape and develop, and sustain the IPCC initiative, or "Where is the on-going leadership impetus coming from for the IPCC initiative?"

This question was often answered as part of the previous question. Participants did not clearly differentiate between the two, and the quotes included below reflect that. What they added here was that they felt like the engine on the train and felt the challenges of keeping it on the tracks, along with the exhilaration of being out in front.

Continuous learning and celebrating results.

They talked about continuous learning and how that learning was folded back into what they were doing. Continually gathering information from stakeholders allowed the learning to build on each interaction, each experience.

They emphasized the importance of cheering the early adaptors and supporting the middle adaptors – seeing some results, celebrating them, and spreading the word about positive outcomes and benefits to patients.

What they told us:

> "Everybody desires a better outcome and better way of working together."
>
> "As people start seeing successes it becomes self-perpetuating."
>
> "...those individuals are extremely creative and outside the box thinking that makes you want to participate and listen."
>
> "We're committed to working in this new partnership and we're committed to looking for opportunities to enhance that partnership and to grow it ."

Contextual Factors

This question explores what contextual factors, internal and external, impeded or facilitated leaders' abilities to support the IPCC initiative.

Positive factors.

On the positive side, participants cited seeing the benefits of change and the resulting positive ripples that created. They said trust in the leaders played an enormous part in their ability to view this IPCC initiative as something worthy of their commitment.

The time spent in the early stages to hold important conversations and voice ideas, concerns, and implications in a safe place made it possible for people to trust the leaders, trust the process, and feel some ownership of the initiative.

They said that learning from the experience, reflecting on what was happening, and making course adjustments as a result of their learning increased their capability to effect change and feel more effective in the process. They added that good feedback loops, and the trust they felt for each other allowed information to be shared, and learned from.

New channels for communication were opened, allowing for a more systems perspective. New relationships were formed and more collaboration was possible.

What they said about positive contextual factors:

> "A truly heartfelt belief that this would improve the quality of care and continue to make a positive difference."
>
> "Believing at the end of the day that we all had a common goal about quality care and service."
>
> "A will to be the best and a true commitment to engage physicians."
>
> "We think it's the right thing to do and we have the support of the senior executive to do it."

Factors that hindered progress.

On the other hand, some things hindered the progress and provided challenges for leaders. The initial reaction to change is one we might expect. Staff attitudes, fear of change and its implications, change weariness, and a jaded attitude from past experiences were certainly mentioned by participants. We heard that sometimes people felt 'collaborated at' not 'with'.

Add the ever-growing number of initiatives and competing priorities everyone has on their plate, along with funding and resourcing issues and you have a legion of people who are skeptical at best about another proposed change. One person acknowledge the

workload and framed it as a catalyst for finding a better way to work. The participant said if the breaking point is near, then urgency to find a better way increases.

They candidly said that time for training in new ways, new processes, and meeting after meeting wore on people and increased stress and worry over yet another priority.

In British Columbia this was taking place against the backdrop of uncertainty around our provincial government and the possibility of an election. In addition the Physician Master Agreement (PMA) was being negotiated and physicians were pushing back about compensation and timing for this project. They questioned the multiple data gathering initiatives (Michael Smith Foundation research) and were reluctant to grant time to the IPCC study.

They told us:

> "What slows us down is the number of initiatives on the go."
>
> "The complexity of the project was at times overwhelming."
>
> "Fear of change and fear of the unknown had to be overcome."
>
> "I think the Ministry and the CSCs and the Health Authority are not as completely aligned as the Ministry thinks."
>
> "Quality sometimes compromised in favour of time and budget constraints"

Learning

The last question concerns learning and how that is occurring in regards to IPCC. The question, as stated, refers to learning events or activities, but participants clearly consider the experiential learning to be the most valuable and applicable.

Events and sessions.

They said that the provincial forums and sessions were a good place to connect people, ideas, and served to visibly reinforce that this is a large system with many implications.

However, they told us that the most valuable learning came from their smaller meetings where there was space, time, and opportunity for informal conversations. This is where they could discuss strategic items such as where to start (which communities to engage in what order) and who needs to be included, consulted, or informed. They learned the importance of working with the uniqueness of communities and how best to customize the initiative to fit the locale.

They learned pragmatic things like how to make sure the structure supports the initiative, and how to frame the context for co-creation with stakeholders in a variety of positions. They talked about learning with, about, and from others.

They spoke of learning the value of being consistent and persistent, of using testimonials to fan the flames, and learning how to learn from the process and apply it. They said they learned the importance of taking time for reflection and debriefing, allowing the learning to happen.

They told us about their learning:

> "Constant and regular forums for meeting and dialoguing is key. Constantly building the relationships and connections."
>
> "It's really about changing the way we work. Changing the way we talk to each other to attain a goal." Transformational
>
> "My team and I have to take on the responsibility for seeking out opportunities to connect. We have to own it."
>
> "Multi health authority discussion on how to work differently together to change an outcome."

What Stood Out

The five things participants referred to most:

- Communication
- Relationships, Partnerships, Connections
- Alignment
- Trust and Respect
- Experiential Learning

What's Emerging as Important

- Allowing time and space for dialogue and for people to 'get comfortable' with change is key to engagement
- Co-creating the process maximizes the chance of individual and shared ownership of outcomes
- Working towards common goals makes a difference
- Alignment of individuals' values as well as organizational goals is key to commitment
- Experiential learning most valuable

Some Observations

- Vision. Although a vision statement isn't front and centre, participants are living the vision. They have each interpreted it and own it.
- Alignment of personal values to the organizational objective underpins commitment to the outcomes.
- Experiential learning is the most valuable. Participants talk about learning from and with others (learning in relationship) and about applying practical learning.

Additional Notes

The BC Node gathered data by the use of semi-structured interviews, a focus group, and observation at a series of meetings.

In the process of conducting this research, several tools in the form of a process map, a research journal, and a checklist were created, which will be used throughout the project. A bibliography has also been created and references were added to the list as the project proceeded.

Cycle One data collection was complete as of April 30/12 and included 10 hours of interview data, one focus group, and attendance at seven meetings. Cycle Two will include some of the same participants, and some new ones, due to availability and turnover. It will also include more physicians and more Ministry of Health staff.

We often did not complete all 18 questions in the allotted hour.

When a participant was interviewed for the second time, the responses from Cycle One were reviewed and explored further or in greater depth if appropriate or necessary.

Cycle One participants included one person from the Ministry of Health, seven from Fraser Health, and three physicians. Seven participants were female and one was male.

We amassed 223 pages of typed transcripts containing a total of 63,378 words. NVivo was used to support the data analysis.

Scheduling continued to be a challenge. Participants had full calendars and it was difficult to book interviews with them. Often interviews were re-scheduled, sometimes more than once.

Refinements to the method, the questions, and the process were made based on the findings, feedback, and experience of conducting the first cycle of data collection.

Cycle Two

The research questions explore the participants' perceptions of leadership (their own and others') through two frames; present, and future. The 'past' frame has been omitted because the answers given in Cycle One will not have changed. With the focus on the present and future, the participants' comments reflected a shift from thinking of IPCC as an initiative to a movement, indicating more permanence. One participant noted that more attention was given to the continuous improvement aspect rather than a project management approach.

Some of the participants in Cycle Two also participated in Cycle One, but due to turnover and availability, some joined the study in Cycle Two. Cycle Two provides us with a more even distribution of participants from all three areas; Ministry, health authority, and physicians.

Leadership Capabilities

The first question asked participants about leadership capabilities, and what they considered essential capabilities for achieving the goals of IPCC. The comments participants shared span the spectrum from personal leadership attributes, and attributes that demonstrate the ability to lead others, to organizational leadership competencies.

Personal or attitudinal capabilities.

Qualities that demonstrate personal leadership were described as attitudinal. Being open to change, exhibiting forward and future thinking, spotting and seizing opportunities, listening, showing passion for the work, having the strength of their convictions, providing reasons to be trusted and respected, having an appetite for learning, assessing and taking risk, showing courage, consistency, and perseverance, practicing self awareness, and taking time for reflection were noted as personal leadership capabilities. "…stepping back and looking at change and asking what it means for people as individuals and what it means for the organization".

Many of the personal leadership attributes were included in the capability to lead others effectively. Participants spoke of role modeling all the attributes noted in the above paragraph and added the ability to empower others, actively developing leadership in others, engage and enable others, support others, and foster a collaborative environment. Participants expressed that leaders were shifting 'the way we work' and that was being role modeled for others. Listening skills and taking time to understand other perspectives rated high in their opinion of leadership capabilities. Being aware of others' context and what their limitations are, what their pressures are, and what their workload involves is part of understanding other perspectives. Providing clarity and focus on team goals was important, as was demonstrating accountability and integrity. One participant spoke of 'leadering' rather than leadership, implying an active verb rather than a static state.

Another factor that was raised was the leader's ability to realize that change of this magnitude takes time because the whole system has to shift. One participant recognized that people need to be supported to adopt new mindsets and set aside some of their assumptions.

Language.

Language in the context of organizational communication was a point made by participants. The ability to 'translate' administrative language into vernacular that could be easily understood by other groups was key in collaboration and the leaders who could function as bridges between these groups and translate the information played a crucial role in creating a collaborative atmosphere. "I think we learned that each of the levels involved in the change had not communicated very well in the past and they were all different with their different language and their different agendas and that is was going to take time in order to bridge some of the gaps in communication. I can think of an early conversation that we had with the Ministry of Health and several phone conversations where all the physicians were so frustrated and I am sure all the people in the Ministry of Health were just as frustrated because we weren't able to communicate and we couldn't understand each other's perspectives".

Organizational leadership.

Organizational leadership capabilities again overlap with many of the personal and team leadership traits. Thinking into the future and planning strategically are traits that were mentioned by participants. Seeing the system as a whole and appreciating the interdependencies was integral at this level of leadership, as well as networking and developing partnerships to further collaborative work.

Leaders who continue to invest time and energy in the process for communication and bringing people together for dialogue were recognized for their astuteness in group process. Devoting time and space to ensuring that there was enough time for people to share their experience and to learn from others' experience was crucial to the relationships that were formed in the early stages of the initiative. "Making space for what is needed to have a good conversation about what change will look like" continues to be important, along with "making space for everybody's voice". A leader must also know when there has been enough dialogue and to push for a decision or action.

One participant said that "knowing who you are meeting and knowing where they are at is critical" saying that being able to make that assessment and adjust leadership interactions accordingly was a factor in successful relationship building. Along with that skill being able to assess who needs to be involved, who needs to be consulted, who needs to be updated, and then who needs to be at the table, and they might not be the same people!

Conflict resolution.

Another point that was raised was the ability to "raise conflict constructively and work through the conflict objectively" and the first step in resolution is to recognize when things are going off track and being able to deal with the conflict and any negative feelings that are arising and not avoid the unpleasantness of the situation. Perspectives as well as people might be in conflict. A leader who can "wear different hats and hold different perspectives even when one might conflict with another and role model that ability" was deemed a good example.

We heard that participants considered the ability to facilitate process and keep a systems perspective was a leadership capability that supported the IPCC implementation. They emphasized systems thinking as being aware of all the working parts and how they

interacted, in order to ensure that communications flowed to and from necessary points, inclusion was appropriate, and by extension, trust was established within the system was an attribute of leadership that was called on for IPCC to continue to succeed. They told us that having a systems perspective, and encouraging a systems perspective was considered a skill that would discourage silos among the IPCC stakeholders. The dance floor metaphor was used to describe the balance of watching from the balcony and keeping track of the larger scene and stepping onto the dance floor when appropriate and joining in. Part of working effectively in and with a system is the ability to be aware of an enormous volume of information and synthesize the pieces that are relevant to the circumstance.

Participant quotes that illustrate some of the points are:

> "…getting people to think about things before they actually happen and put them in situations where they have conversations about possibilities…"
>
> "It requires continued risk taking on the part of leaders to have, I suppose the gall, to face up to the parts that didn't work out and persevere through those difficulties".
>
> "…spent the time to understand the perspective of each of the respective parties and went to great lengths to understand the problems before trying to weigh in and address them..".
>
> "You have to do what it is you expect to be done and there has to be physical evidence of leaders having implemented what they said would be done".

A metaphor was used that paints a good picture of where many people see themselves at this point in the IPCC initiative. The participant described "being like Columbus setting on a journey to the new world. Nobody is there yet. Nobody has arrived". They don't know exactly how things will look, or exactly what to expect when they declare arrival, and there's no turning back. There were several comments about being able to be comfortable in ambiguity and uncertainty and confidence to be honest about that.

Leadership in Different Contexts

The second question inquired how leadership in different contexts affect and align the IPCC initiative. In the BC Node research the contexts are the Ministry of Health, Fraser Health, and the Collaborative Services Committee in Chilliwack.

From initiative to movement.

We may be seeing some signs of a paradigm shift regarding IPCC in our second cycle of data collection. People are referring to it now as a movement rather than an initiative, implying a more permanent way of working. In addition to alignment of organizational objectives and personal values, people are now including the alignment of actions in a 'level appropriate' sense. For example, in this cycle people spoke about how the structural changes support or hinder progress. One participant suggested that legislation needs to be aligned. Currently we have several acts that support a silo structure and if IPCC is to truly be engrained, the acts will need to reflect the integration. The interdependencies mentioned in Cycle One were about roles and relationships, now people are speaking of the system interdependencies. The Ministry has the power and influence to change the legislation, funding, and structure to enable change. The health authority can make sure the logistics support it and prepare people. The health authority and physicians implement the change on the ground. All the parts of the system need to do their part to make it function.

Turnover.

Cycle Two there were other factors that should be considered as context. There was a high degree of turnover in positions within Fraser Health, among IPCC research participants, and with nurse practitioners. The case manager turnover was mentioned several times by physicians as an aspect that was affecting both their medical practices and their views on the new structures created by IPCC. For instance, if a case manager is sick or away for any length of time, it's a much bigger problem for the physician (and patient) now. Before there were multiple case managers, but with only one per physician now, when they are away there are serious implications. Doctors are impatient with the limitations of union agreements and their solutions can't be implemented due to restrictions such as that. The physicians expressed a desire for more continuity, stability, and consistency in their relationships with case managers. It is possible that any

resistance to IPCC stems from the disruptions in relationships, brought about by IPCC. They told us "Certainly we need some continuity in our workforce. Some of us are doing the same job we were doing five years ago and will likely be doing the same job five years from now, and we need some continuity with the people that we are having the relationships with". Another confided "I want to have the confidence to believe that I will be speaking to the same person a few years from now. Today I do not have that confidence. I'm not even confident that the same people will be there next week".

In June 2012 the Ministry of Health tasked all the health authorities to address issues of hospital and emergency room congestion and gave them 150 days to do so. http://www.newwestnewsleader.com/news/158600045.html http://www.fraserhealth.ca/about_us/quality-and-safety/

This additional and time sensitive priority consumed huge amounts of participants' time and energy and had an impact on our data collection. Meetings were cancelled, reducing the researcher's ability to observe leadership practice in real time. Data collection interviews were rescheduled, sometimes more than once and sometimes interviews were cut short as participants could not devote a whole hour to the process.

Communication, trust, and perception.

An incident occurred in Fraser Health that affected the context and peoples' perceptions of IPCC. Funding for a rehab facility was cut, without consulting the stakeholders and that undermined some of the trust between and within the groups. One physician described the aftermath as a big disconnect saying, "Different programs don't speak to each other and they make individual decisions that aren't well coordinated at the community level". Another described the consequences of that action and how it damaged trust "Fraser Health had basically stopped funding one of the rehab boards at our hospital. The fallout from that was huge because we had started to make some in-roads. We heard "We are going to work together and we are going to let you know what we are doing and we want your input" then basically they go off on their own and basically fall into some of the old patterns and we are back to where we were five years ago where we don't have the trust and we are not working together and we are working alone". The physicians heard about this closure by email which did not seem like the appropriate way to communicate the news.

In the opinion of one participant, Fraser Health (and all the other health authorities) will face more funding challenges and cost pressures. These challenges could result in more decisions that are unpopular with physicians and the public. Relationships will depend on how leaders make and communicate these decisions them.

One participant spoke of learning from the process and "If you make a mistake we have a big eraser and we are allowed to erase and start over again" however, when trust is damaged, it may not be possible to erase what has happened and start over again so easily.

Connection, conflict, and collaboration.

Participants talked more about collaboration and the events that brought them together, rather than describing separate roles as they did in Cycle One. The sense of a common goal and working together to achieve it was much more evident in this round of data collection.

They spoke specifically of the Provincial Learning Session held in June 2012 and held it up as an example of leadership in bringing together all the health authorities and many physician leaders across the province to learn what has been achieved so far, to share insights, learning, and strategy and to be inspired about the future. They talked about the opportunity to build relationships across health authorities and the alignment that was possible through those conversations. They also saw the session as a way to demonstrate commitment to the integrated, collaborative framework.

On the other hand, the physicians surfaced some concerns about what some of them saw as a lack of visible collaboration. Some skepticism about the success of IPCC was expressed and a call for solid evidence of progress was voiced. They noted that the Ministry has not been very present at Collaborative Services Committee meetings and felt there was a disconnect at that level. The Ministry shared that they are working within the confines of a travel ban, making it difficult to be present at meetings, and a hiring freeze, resulting in staff being spread very thin across the province.

Credit was given to leaders who heeded these voices of concern and addressed it by gathering the parties together and facilitating a frank discussion of the issues, listening to understand, and adjusting the process as and where needed. According to one

physician, that alone contributed to a renewed sense of trust, confidence, and enthusiasm for IPCC.

When conflict occurs, one participant described how effective leadership might be demonstrated. The participant shared that there can be a great deal of criticism when things are not going smoothly, and a leader needs to be able to separate themselves personally from that and take a non-defensive stance in order to resolve the conflict successfully. They described the criticism as being directed at them as 'visible targets' but knowing that it was not meant for them as individuals, but rather at the situation.

Participants said:

> "We are working through a collaborative process that is consensus based and an equal partnership, so constantly reinforcing that we are acting in those ways".
>
> "The more we are meeting around the same tables, locally, regionally, or provincially, we are taking the time to meet, to listen to each other, to hear the ideas, to problem solve together".
>
> "Right now it is not working. Physicians were not seeing a benefit of this for their patients".
>
> "We constantly have to nurture the relationship and develop new relationships as people change and go the next phase of work that is done within the relationship".
>
> "Fraser Health is showing some leadership across the province. Other health authorities are looking to us in these areas. We are being seen as leaders in this work".

Leaders and Roles

The third question explores what leaders are doing, and what roles they are working in that contributes to IPCC. Many of the attributes mentioned in the first question were remarked on in Question 3.

There continued to be a tendency to mention the people in official leadership/managerial roles, while not recognizing the leadership that is occurring at all levels. People referred to pushing leadership 'down the levels', but no one mentioned or gave examples of leadership demonstrated by support staff or program workers.

Turnover and change.

One participant sensed that turnover would increase. They reflected that in their view, there had been a period of relative stability, with many key leaders staying in the same roles, allowing for continuity in dialogue which has served the partnerships well. They acknowledged that people had free will to stay in a job, or to move on, and they predict that there will be many changes ahead in leadership positions and the potential loss of corporate knowledge, and shared knowledge and commitment. It was also recognized that a provincial election within the next year is creating a high level of uncertainty among leaders.

The reality of constant change in the Ministry and Fraser Health is in contrast to the physician's world. One physician described how doctors tend to stay in the same community, seeing the same patients over a span of many years. They confided it was a struggle to understand the fluidity of other roles. People coming and going was one of their main frustrations with the system. Other groups recognize the different perspectives too. One participant said "We come from different worlds. GPs are business people, entrepreneurs, and obviously they are very pure clinicians and we come as custodians of a system or network of care. We have to learn to speak the same language and focus on the same needs of the population".

Communication and scope.

Participants listed some of the things that leaders are actively demonstrating that is contributing to the momentum of the IPCC movement. Continued dialogue was mentioned as a key aspect of problem solving and conflict resolution. The relationships that have been established are the basis of honest and authentic conversations, allowing people to be frank about what is presenting a challenge for them and allowing for collaboration towards solutions.

There was a sense of expansion in participants' thinking this time around. In the first cycle people spoke of the relationships and interactions between the Ministry, Fraser Health, and the physician group. Conversations this time included reference to the British Columbia Medical Authority (BCMA) and the need to include them in some of the discussions and plans that involve physicians. For example, the issue of patient

attachment and corresponding dollar amounts is pertinent to IPCC and will need the BCMA to be at the table as negotiations proceed.

Finding the balance.

Participants described the balance between pushing and being respectful. At one point it was obvious that if visible progress was not made, one group would disengage from the process. One of the leaders found it was necessary to be blunt in describing the situation and pressing for action, while at the same time being respectful of where the group was and what their circumstances were.

Participants again talked about a leaders' ability to separate themselves from the issues. How a leader reacts and how they respond was cited as important to the others around them, taking their cue from the leader. Leading by example in times of pressure, stress, and conflict was seen to be important as a role model.

There was a sense that participants had gained a deeper understanding of what collaboration means. In the first cycle, they described it in terms of working together and forming relationships toward a common goal. This time they talked more about understanding what the other stakeholders are really needing and working more on alignment at a deeper level. One participant spoke of a cultural shift that has its roots in peoples' hearts.

Timing was raised as something leaders are now aware of. As plans are formed, various people or groups need to be involved at different times. Bring people in too early and you may not know what to do with their input, and they may lose interest. Bring them in too late and they may feel left out of the planning and preparation.

One participant recognized the importance of allowing space for creativity. The energy that is created around new ideas was described as contagious. The opportunity to build on good ideas and work with the synergy was cited as one reason the participant loves the job. It's also important to make sure everyone is building the same 'house' and everyone is informed of the design and they all know what the land and footing parameters are. Within that, innovation is cultivated. To carry the construction metaphor further, one participant emphasized the ongoing nature of this work and said it's like having an 'Under Construction' sign hanging on the door to remind people that there will not be a finished product, but rather a continuous change and improvement project

underway. In fact, it was described as "building the blueprint and constructing at the same time". Leaders are demonstrating a comfort level for living with ambiguity and role modeling that comfort level to others, supporting them in their own efforts to find their level of comfort.

Patience, perseverance, and learning.

Patience and perseverance were mentioned as noticeable attributes. When staff are unconvinced of the need to change, or don't understand the changes, leaders are confident in their roles as stewards and are able to demonstrate patience in their interactions and engage those who are uncertain of how to proceed or why it is necessary. When physicians or staff are introduced to IPCC, leaders back up and make sure they are brought up to speed so they can engage in the process.

Mistakes are not considered mistakes. They are reframed as experiments and caulked up as learning experiences. The leaders have demonstrated this attitude and encouraged people to take calculated risks and the whole IPCC movement in Fraser Health has benefited from this attitude.

One leader talked about engaging people by not directing what they should do, but instead giving them enough context without too much subjectivity and inviting people to offer their ideas and suggestions. These conversations were described as offering leadership opportunities and framing it that way instead of asking them to do something.

Keeping perspective is another leadership example that was mentioned. It was described as not getting overcome with the challenges, but instead working through them, and making sure the people were looked after in the process. The issues that pop up and need to be dealt with were referred to as "those things that happen in our day to day work that can actually take away from focusing on where we need to go".

Participants shared what they thought was important for leaders in any role:

> "A key thing is being able to realize that there is a conflict and having the courage to address it and follow through".
>
> "The cultural shift takes a while and it is not something you can mandate. You cannot mandate change because the behaviour and the attitudes and the beliefs don't change quickly. I am starting to see that being internalized with folks".

> "It is a skill to recognize the need to have that kind of a setting where ideas can be shared and maybe some of them will take root, but just to have that kind of an atmosphere that it is OK to have those discussions".

> "What's important is the ability to have thoughtful, purposeful dialogue with people that is consistent and really building trust that is consistent".

> "I encourage people to think beyond the walls of the Ministry and tap into the capacities that are out there".

Source of Leadership

Question Four asks about the source of leadership to shape, develop, and sustain the IPCC movement, or "Where is the on-going leadership impetus coming from for IPCC?"

As in the first data collection cycle, this question was often answered as part of the previous question. Participants did not clearly differentiate between the two. In this cycle, participants talked about the impetus coming from the front line, or grass roots, rather than the mandate from the Ministry. "Now every front line clinician is seeing this new collaborative partnership arrangement, however that is defined, is now the leadership for that change". A Ministry representative shared how the grass roots is helping to determine priorities for change, and those priorities may have been identified differently without their input.

Shifts in thinking.

One participant described how the understanding of the scope of the IPCC movement is becoming apparent. "When people understood the magnitude of the change that has already happened, and the massive wave that is going to come from this, then all of a sudden people got their ears perked up".

Another used the example of how people are changing the way they do their job to accommodate the new processes. "... change the way in which they do their role, and change the way that they approach their role, and in essence change that system at that level. So if you look at how a home care nurse in Chilliwack has actually fundamentally shifted how she does her work, same as the family physician that fundamentally shaped how they do their work". The leaders have fundamentally shifted the way they work and

are now modeling that shift for others. One participant said that leaders were aware of the outcome they were trying to achieve, and they were aware of where they needed to make shift in order to improve patient care, and then they felt empowered that they could just go ahead and model it and do it. They were aware of the need to work differently, and aware of the reality that they were going to have to step up as leaders and show the way by example.

Leadership capacity at all levels.

The realization that leadership at all levels needs to be developed is evident at this stage. One participant noted that "Just because a certain sect of leaders understand how to do this doesn't mean that their staff will have that skill set". As the movement works its way through the system, workers in all areas will be involved and will need to be prepared for changes in their roles.

Other participants commented that they were seeing more leadership dispersed throughout the organization and empowerment and accountability are being 'pushed down' through the organization. They noted that as this happens, "folks start to be more committed to the longer range outcomes, there is more ownership about the work and more commitment, more understanding so it is always better to move decision making down to the lowest level possible to the goal is the closest to the bedside if you will".

Consistency in leadership was deemed important as a stabilizing element at this point in time. "We have a lot of history with those people now and that gives us a lot of confidence that as problems come up we can work on them".

Collaboration and the attitude of sharing information and supporting others' learning and progress was also evident in the comments. "In the past it was much more a competition and now it is much more about sharing and you know looking over each other's fences and saying you petunias are nicer than mine how do you get them that way?" This generous sharing is characterized as a fundamental shift from the previous competitive environment. When asked what made that possible, participants said it was partly about timing, and partly because the group of leaders who were in the roles at the time, weren't possessive of ideas. They saw the opportunities that working in innovative ways and breaking the molds of the past could bring.

They modeled a collaborative, sharing way of working and other leaders followed their example.

The ability to assess risk and assign priorities was identified as a key aspect of leadership in this point in the movement. "I just made it a priority, that is the other thing building time - I think in leadership you have to make the time and say this is something that needs to get done because if you don't invest the time right now you are going to pay the price down the road" and "it is all about accessing risk and doing the risk litigation and so I think some of the leadership is the stronger focus on risk and risk related issues and constantly doing that for that stand, where you do it consciously or unconsciously constantly doing that as you go forward and be proactive as you can".

What they told us:

> "I think in this particular movement we see much more of it [leadership] coming from the front lines that you necessarily would see in other ones [change initiatives]".
>
> "...the consistency of the top posts the people who are in leadership positions in health authority".
>
> "Some of what I see happening at the provincial meetings is the sharing between the health authorities of great ideas and successes in a way that making it easier for health authorities to spread good approaches or good ideas and this is different than in the past".
>
> "We are seeing evidence of leadership throughout the whole system to a greater extent than we have previously".

Contextual Factors

This question explores what contextual factors, internal and external, impeded or facilitated leaders' abilities to support the IPCC initiative.

Positive factors.

At this point in the study consistency was identified as an important factor in facilitating leaders' abilities to maintain positive progress in the IPCC movement. One participant shared their belief that any significant change in directive from the Ministry of

Health could have serious negative impacts. If it appears that leaders change their minds about priorities, or 'change the contract' they will risk losing the engagement and commitment of the participants. It would erode trust and undermine some relationships, and that could seriously impede the success of the movement. One participant cautioned leaders not to assume that if the contract was changed, people would automatically want to participate in the new version.

The time spent in the early stages to hold important conversations and voice ideas, concerns, and implications was important then, and now leaders must be able to determine the balance between time for dialogue and time for action.

Leaders who role model the capabilities necessary for successful change continue to be a positive factor. One participant described admiration for a specific leader's ability to "hold different perspectives even when one might conflict with another and really role model for colleagues".

Relationships continue to be cited as a factor that facilitates leaders' abilities to affect change, as well as the momentum that has been created to date. There have been "some good wins" and some "proven good outcomes" so now "people are sitting up and taking notice and putting their hand up and saying they would like to participate".

Sharing of information among participants was mentioned as a facilitating factor. One person said that there was a greater sharing of information within the organization resulting in a snowball effect of producing more willingness to share and learn from one another's experiences.

What they said about positive contextual factors:

> "We need more of these role models".
>
> "We are working to pull together strategic initiatives that are linked versus responsive to public or political noise".
>
> "You've got to tailor your innovation to fit each community and adjust the approach based on what we know about how our individual communities function and operate".
>
> "I think our structure is facilitating".

Factors that hinder progress.

The participants talked about the obstacles and barriers they saw as hindering progress.

Everyone has multiple priorities and this continues to be a challenge that saps the energy of health care leaders in BC. Turnover continues to plague the system and eat up valuable resources. One participant used the example of the rapid turnover in case managers and the time needed to train each new recruit, then do it all over again a short few months later.

Resources surfaced repeatedly as a challenge for participants at all levels. Each part of the system must work within its own budget restraints, creating a host of potential delay-points in the initiative. This also makes it hard for participants to fully collaborate – resources are stretched and each part of the system has priorities that may not fully align. Unrealistic timelines was another challenge that participants felt got in the way of leading effectively. One said these things "add a strain to how fast and how much momentum you can garner".

Technology is one of the resources that has been identified as an obstacle. Technology in itself was not the issue, it was the variety of software programs that don't interface that participants said was a major issue. Information cannot be managed across the system, or move through the system because software applications cannot talk to each other and accommodate a flow of information. Technology is costly. Decision makers may be faced with the choice between purchasing software or CT scanners, software or MRI machines and they have to make an objective decision based on the needs of the community.

Not only does the technology impede the ability to share information, so does our province's privacy policies. Information cannot flow freely between the Ministry, the health authorities, and the physicians' offices because of our protection of privacy agreements.

Legislation was identified as a foreboding impediment. "We have different legislation acts that prevent us ever from becoming one integrated system". One participant described how the different acts (e.g. hospital act, mental health act, etc.) are a huge barrier to integration. People can collaborate to a point, then the legislation gets in

the way and separates the programs that would support integration and a patient-centered approach. It was suggested that the legislation not only be rewritten to facilitate an integrated health care approach, but that it be rewritten by physicians and front line personnel, not bureaucrats from the public service. The current legislation structure was described as demonstrating a lack of understanding of how changing one part of the system affects the entire system. "We have this old act that only actually believes that hospitals are a good system and that is how it is written. The health act is called a hospital act and then you have the continuing care act and then you have other kinds of acts. Even though the patient is governed by tons of different acts they aren't integrated and don't look at a patient-centered approach". An example of how the acts impede support for integration is that if a patient requires IV tubing or a pain medication pump, they pay for that if acquired through community care, but it is free if the patient is an emergency department patient.

As the acts are separate, so is the funding, which can result in inefficiencies and a barrier to integration. It was described as "The program areas have their funding silos that gets in the way of integration. A nurse can work in mental health and a nurse can work with the frail elderly and she can work around chronic diseases but when we actually do the planning we do them in silos and we end up with three nurses instead of one nurse and a social worker".

One participant talked about the challenges in creating awareness and understanding of what integrated care means. Pointing out that "hospitals and beds are something that are much more widely understood than this whole thing called primary community care" the participants highlighted a fundamental barrier to IPCC – the public don't understand it well enough to lobby for it. The news media fills our televisions and newspapers with stories about bed shortages and emergency room waits, but rarely do we hear news about how the community care programs are helping to prevent issues.

Each community has its own culture which needs to be accommodated and leveraged for successful change. How communications are phrased, how the community is approached, and through which channels are all aspects that a leader needs to be cognizant of when introducing and sustaining change. One participant repeated that a

cookie cutter approach was not useful and that leaders need to be informed about the nuances of a community before launching programs and creating structure.

In Cycle One British Columbians were pondering the possibility of an election. We are now preparing to go to the polls and uncertainty about the continuation of funding, direction and resources is a real concern.

They told us:

> "We discovered we needed to train case managers in this new way of working and some had been around for a long time and were resistant".
>
> "Each system in the Ministry is trying to deal with has their own budget problems".
>
> "We are still dealing with a lot of the same problems that we had several years ago and I think there is a lack of insight in understanding the scope and depth of the problems that each other is facing".
>
> "We've got to pare down here and we have to slow up here because we don't have the individual or the bodies to make change happen".
>
> "The inability to swiftly and quickly share information seriously impedes our progress. The software simply doesn't talk to each other".
>
> "As we get closer to an election nobody wants to do anything and budgets are tight and we are waiting in a sense for the new leadership to be established. There is a feeling of being in limbo prior to an election".
>
> "We have to let go of the mindset we have that politicians and bureaucrats are the ones who should be writing policy".

Learning

The last question concerns learning and how that is occurring in regards to IPCC. The question, as stated, refers to learning events or activities, but again, participants made no mention of leadership development programs or opportunities and instead talked about the experiential learning they engaged in and how they shared information with others for their learning.

Formal learning is a luxury.

During a meeting of health care representatives from across the province, the findings from Cycle One were shared. The facilitator asked if the group thought there was adequate opportunities for people to attend courses, seminars, or other learning events. The answer was that there may be opportunities, but there is no time for people to take them. They said they work 14 hour days as it is, and they simply cannot afford the 'luxury' of taking time away from the job to engage in learning activities.

Learning from each other and from experience.

As in Cycle One the participants spoke of the value in learning with and from each other in terms of how they are approaching various elements of integration. Cross-pollination on committees was described as an effective way to learn from each other and keep each other informed as was the development of communities of practice. The provincial learning sessions were mentioned again as a good way to keep in contact with other health authorities and learn how others were addressing challenges. The provincial sessions also reminded people of the scope of the IPCC movement and kept them aware that it was far broader than their own community or health authority. Not everyone agreed that the provincial learning sessions were making a difference. "I think they are very good at putting on provincial displays where they like to think alignment is present and cooperation is open but there is just lots of ideas floating and it doesn't translate in terms of tangible on-the-ground changes".

Participants talked about how they learned best practices and how they've learned how to share them effectively, but not about what they learned about leadership. One participants shared that there was learning around language and learning about the time involved to embed a transformation such as IPCC.

Mentoring and change management.

A physician commented on a desire for a more structured change management approach. "It isn't rocket science, it is Business 101 and most of us involved at this level have been into physician management institutes and this [IPCC] was not run as a business. We didn't follow the approach that modern management practice should". Training in this area was said to be lacking and mentoring was suggested as a practice that physician leaders could benefit from. "We need someone to take responsibility of

this as a physician and we need to support them and train them into this [change management]". It was felt that transferring the wisdom to work in management systems instead of "throwing physicians in at the deep end" would benefit patients and colleagues alike. "Physicians who are involved with managing the project [IPCC] need some mentoring in what managing a project and leadership really means as opposed to turning up at a meeting and giving them the physicians' input".

The physician may have identified a key aspect that is not being addressed, and that is supporting people to shift their approach, their beliefs, their attitudes, as well as their practices and this could be done through a physician leadership mentoring program. One physician described the challenge of "balancing these leadership roles with a full time job and the roles have nothing to do with patient care and it is a pretty challenging juggling act sometimes".

Another physician shared that "You can't just do a 'star trek' and just say make it so [change] and it happens. It has to be actively managed – the relationships have to be managed and the people have to meet regularly and there must be a change management plan. There must be a plan to manage the change and to manage the process and if there ever was I certainly wasn't aware of it, me or any other physician in town".

And yet another physician expressed disappointment in saying "The family doctors were prepared to walk away from it [IPCC] because we didn't have anywhere near the benefits that were hoped and it was becoming an irritation. The process was very dysfunctional here in Chilliwack and there were lots of complaints". To the health authority's credit the physician added "Rather than walk away from it they (FH) identified the problems and talked openly about what their problems were and we understood each other's problems". As a result "It [trust] definitely is improved and I think that it was improved because of the frank disclosure of the problems and admission that this project in our area had not been as well managed as it could have been or should have been".

The health authority uses technology to share information and learning. Participants spoke of connecting with other health authority personnel using phone, fax, and email. They developed presentations to share with one another and found this to be an effective way to communicate. The physicians, on the other hand, expressed a desire

for face-to-face communication. One physician said that "human interaction was key" and recommended that "time be given to develop relationships by physically meeting, not by emails and faxes". It was added "health authorities seem to work only on a few meetings and faxing or emailing people. No wonder it doesn't work".

They told us about their learning:

> "I think the key learning is just because we are doing it like this now, doesn't mean that we should keep doing it like this, or that this is the best way to do things".
>
> "What needs to be learned is that if you are going to run a public healthcare system with changing leaders you're always going to run into the same problems in terms of new people having to learn the system from the beginning".
>
> "What I have learned is that it continues to be hard, not easy".
>
> "We have learned to a lot of things that were not possible before and I think that is what leadership is".

What Stood Out

The things participants referred to most:

- Awareness of the system
    - Scope of the system
    - Interdependencies within the system
    - Connections outside the system
- Relationships and maintaining meaningful contact
- Communication in regards to conflict and listening to understand when things go awry
- The importance of managing the process
- Nuances of leadership

What's Emerging as Important

- It's time to provide concrete evidence that IPCC is working and truly making a difference in the eyes of all participant groups.
- The changes can only go so far until legislation is changed (including privacy laws regarding sharing of medical information).
- Technology and software interface is a substantial barrier.
- Physician leadership development and leadership mentoring.

Some Observations

- Cycle Two is revealing a perceived disconnect between groups and understandings.
- Most of the positive comments relate to internal relationships and processes in Fraser Health.

Additional Notes

The BC Node gathered data by the use of semi-structured interviews and observation at a series of meetings.

Cycle Two data collection was complete as of November 7/12 and includes 12 hours of interview data, attendance at six meetings, and a two-day provincial learning session held in Vancouver. Cycle Two included some of the same participants, and some new ones, due to availability and turnover. It also included more physicians and more Ministry of Health staff.

When an participant was interviewed for the second time, the responses from Cycle One were reviewed and explored further or in greater depth if appropriate or necessary. However, the participants were in a different context (six months hence) and had new perspectives and examples to share.

Cycle Two participants included four people from the Ministry of Health, four from Fraser Health, and four physicians. Seven participants were female and five were male.

Cycle Two amassed 150 pages of typed transcripts containing a total of 71,877 words. NVivo was used to support the data analysis.

Scheduling continues to be a challenge. Participants have full calendars and it's been difficult to book interviews with them. Often interviews are re-scheduled, sometimes more than once.

Since the completion of the Cycle Two interviews a key leader has resigned from Fraser Health. This individual has been referred to by many participants as an outstanding leader and one that has been instrumental in the launch and ongoing efforts for IPCC. This loss has been keenly felt by all those who worked with this person. Just before this person's last day I had an opportunity for a closing interview (which is considered Cycle Three data) and heard that the reasons for leaving were both personal (toll on personal time and energy), unrealistic requirements of the job (travel in Fraser Health to evening meetings, etc.), and a change in structure (from reporting to one VP to reporting to five VPs) which is incongruent with the principles of integration. It was hoped that the Cycle Three interviews could take place earlier to capture some of the initial reactions of the participants to this departure, but the rigid timing of the cycles prohibited that.

Refinements to the method, the questions, and the process were made based on the findings, feedback, and experience of conducting the second cycle of data collection.

Cycle Three

The research questions explore the participants' perceptions of leadership (their own and others') through two frames; present, and future. The 'past' frame has been omitted because the answers given in Cycle One will not have changed. With the focus on the present and future, the participants' comments revealed that the last several months have provided an opportunity for reflection on leadership in general, their own leadership practice and style, and some topics that are on their mind regarding the future of IPCC.

Some of the participants in Cycle Three also participated in Cycles One and Two, but due to turnover and availability, there are fewer participants in this cycle than the previous one.

Leadership Capabilities

Participants were asked again about leadership capabilities, and what they considered essential capabilities for leaders at this stage of the IPCC project. Not surprisingly, many of the same attributes that were identified in the first and second cycles of data collection were named again in this round. The capabilities leaders' identified include both leadership skills (can be learned) and leadership attributes (personal characteristics).

Self awareness and self management.

Self awareness and self management capabilities were described as essential skills for effective leaders and a number of examples were given. The ability of a leader to put their own perspective aside and consciously communicate and reframe into others' perspectives, and to separate their own 'baggage' from the situation and be objective was described as an important quality when working in collaborative environments.

System awareness and systems thinking.

System awareness and systems thinking were aspects the participants thoughtfully remarked on. Without an understanding of the system, how it works, where the interdependencies, connection and leverage points are, it is almost impossible to create and sustain change. Like the Japanese martial art, akido, a leader can employ systems awareness to work with the flow of the system, rather than against it to affect change. One participant explained that the better people understand the system and the work that others in the system are doing, the better able people are at influencing behaviour, process, and change, and the easier it is to enlist help from others. It is also easier to help others too as one leader said "The more I understand what others are doing, the more I can help them along."

Understanding the system, the leverage and connection points, facilitates the ability to be collaborative and continue to reshape a shared vision. It is part of "focusing on how we articulate our mandate together and create that sense of 'us' and that sense of shared vision."

In order to understand the system it is necessary to reflect on the system, to stand back and see it as a whole, so that the areas "where the work can be done with ease and where it will require effort" are revealed.

The system is comprised of people, each with their own history, their own objectives, their own interests, and their own challenges. A leader needs to be very cognizant of the complexity involved and the human element is one of the most important aspects. One leader stressed the importance of keeping an awareness of "where others are and being able to gauge what is going on with them so you can find the balance of keeping everyone engaged, on board, committed and motivated." "It is important for a leader to hear the signals and ask questions like "Why is this happening at this point?" and "What is missing for that group?" "I wonder what is happening for them to feel that way." You need to explore that and explore that appreciative inquiry approach rather than judge." Being available to others was said to be a good way to keep your finger on the pulse of situations, and gives leaders an opportunity to be good resources for those around them and support the development of leadership in others. Another participant

noted the reality that "there are huge challenges in particular in the way that systems support people and there are still areas that people feel skeptical about."

Courageous leadership.

It's complex, it's exhausting, and it requires courageous leadership, a phrase that was spoken more than once in the interviews. While difficult to define in exact terms, one participant said that a leader "can't shy away from the hard stuff." While 'hard stuff' may be a vague term, participants did give some clues as to what it means for them as leaders. Initiating difficult conversations, showing integrity in their actions and comments, persevering when personal reserves of energy are depleted, listening when given frank and candid feedback and then demonstrating that it's been heard are a few examples cited in the interviews. Follow through on feedback was also deemed important to building trust and demonstrating integrity. One participant reflected that it was the "little things", which are really the big things, that built trust. Keeping confidential things confidential, being forthcoming with information that can be shared, being dependable, being respectful, and listening are some of the elements of a trustful relationship. "You have to do a lot of less important things to develop trust." "You have to invest the energy in collaboration and communication and take the time to really develop the trust in those relationships."

"Being constant and giving confidence to everybody else around the table even when you are feeling uncertain. If you stop giving confidence it will be seen as an opportunity to go in another direction. So we just have to stay the course." "You have to be looking at your own leadership approach and be out there leading your staff and your team" and help others through the 'tough spots' and transition points. Along with this perspective is the ability to remain positive, hopeful, and confident. "I always try to project a positive world view, recognizing that every challenge is also an opportunity, and every opportunity exists for a good reason, and that we can always do better with what we have."

Clearing roadblocks and untangling obstacles is one way to demonstrate courageous leadership. Technology issues are a serious roadblock that IPCC leaders are aware of. This barrier to communication, data sharing, and information flow is an opportunity for leaders to collaboratively address.

Framing and reframing concepts to others was described as exhausting but necessary as the project moves forward, and as new people come on board. "As new people come on the team and become involved they have to be briefed and communicated with in a different way than the people that have been there from the beginning."

Turnover.

The constant framing and reframing is necessary due to the high rate of turnover in leadership roles. This has been a touch-point throughout this research and continues to be a challenge for all involved. Stability, or lack of, in leadership roles is something underscored by all the participants. Each time a leader leaves their position "it provides an opportunity to pause and reflect, so the loss of a leader really destabilizes that incremental process and progress." While change is one of the things we have to live with daily, it has a big impact on our work world. The difference in the culture of the physician world and that of the administrative world is highlighted by the difference in the rate of turnover in each. IPCC has spotlighted an interesting social phenomena in that people within organizations have 'free will' in changing roles and jobs contrasted to doctors who base their practice on long periods of time in one location. "You will see many of the doctors that have participated in initiatives like this are ones that have been in those communities and committed to the patients they serve for 20 or 30 years. That can't be said about most professions, including administrators."

Cultural differences.

A difference in culture is often evident in the language and communication style used in that culture. "A leader has to able to walk into many different rooms and be able to relate to the people in that room." The ability to relate to different groups and different stakeholders and speak their language was essential in forming bonds and building trust among the collective and discussing the shared vision. A leader must be able to frame the vision in stakeholders' context and reframe that vision to tailor it to each group within their priorities and mandates and in their language.

"Being willing to adapt and work with others so that not one single party is always doing the adapting" was a point made by participants as a capability a leader should be equipped with in order to be effective in a collaborative setting. Sometimes

adapting means "letting go of the agenda of the day, but be aware of doing it, and for what purpose you are doing it."

In summary, participants identified the same leadership capabilities as important saying that this stage is more about 'maintenance'. One participant reflected that things are much more complex than a year ago, and likely to continue to be more so in the future. "it is a much trickier environment and the programs we are trying to run in our community are much more complicated and the expectation around outcomes is much more finely tuned." Leaders must be able to recognize that complexity and work with it, speaking the language of multiple stakeholders in order to keep them engaged and on board. Complexity applies to the multitude of priorities as well as to the mosaic of cultures.

When asked about leadership capabilities for the future, and the nature of leadership required, leaders said the capabilities mentioned in Cycles One and Two will continue to be needed. They added the need for the recognition and support for champions. "Celebrating those successes is part of maintaining those leaders' energy, and in the environment we are in people are gun shy to have anything that looks like a joy about celebrating what we've been doing." Courage, perseverance, and the interpersonal skills to "nudge people along" and maintain the engagement of a variety of stakeholders remains a capability that will be essential moving forward.

Celebrating successes.

Celebrating successes involves recognizing what has been done to date, and the absence of solid measures as evidence is a gap that was identified by several participants. One participant expressed that in future, establishing the criteria for success in clear terms and measureable results would be a benefit to a change initiative. Stakeholders need to be clear on "whether it is measurement for performance, measurement for improvement, or measurement for evaluation." Clear measurement criteria was seen as a grounding element. One participant described the consequences of vague measurements as "just throwing darts everywhere and just hoping that some of them will land."

It was acknowledged that progress occurs at various levels and timeframes throughout the system and leaders can "allow those pieces of evidence and data to guide where improvements can occur and then allow that movement to happen at various levels

whether it be change at the community level or change at the regional level and change at the provincial level. “Not stifling at any of those levels or saying one is a priority over another but being able to focus on in supporting the ‘lots of lots’ approach.” ‘Lots of lots’ was used to describe how multiple actions throughout the systems move the change forward. “It is OK to have different things at different levels. At the operational level people might be trying to do different changes than they are doing at the strategic level and then right on the ground there is different pieces that need to happen. I think leadership needs to be really cognizant that there is just not one level making change, it is at many levels and leaders need to be supportive in thinking about how they are supporting that right down to the grass roots level.” This speaks to understanding the complexity of the system, the far reaching implications, interconnections, how it is going to move forward as a mass, and owning how that is done.

Relationships.

They also acknowledged that while there were many other priorities and time was often in short supply, it was important to make time to meet face to face to build relationships and have discussions on moving forward collaboratively and collectively. It takes time to build and maintain relationships and it takes discipline to protect that time throughout a change initiative. If things are hurried, if shortcuts are taken, and if time for meeting is truncated or eliminated, consequences such as decreased commitment, erosion of trust, and closed channels of communication may surface. “The timeframe for doing a really good robust engagement wasn’t there and [when that happens] people afterwards can become quite angry or just disengage and say “It is not my initiative”. Inadequate time can undermine the whole process and may mean that stakeholders don’t feel a sense of ownership over the initiative.

Structure and process.

Participants hope for a reconfiguration of current delivery models, a reflection on the philosophy of integration, and new ideas for approaches, all of which have implications for leadership in the times ahead. “A stabilized period and time to reflect and course correct” is another item on the wish list that leaders can have some influence over. Reconfiguration will require more collaborative discussion on what the future vision looks like. “We still need a clear vision of what it is that we are trying to achieve.”

Rethinking structures with an eye on sustainability in light of strained resources will call for innovative thinking by leaders. Rethinking policy and legislation to support integration will be a cornerstone of any restructuring undertaken by leaders in the health care system. Solid data to back up any proposed restructuring will be essential, and leaders will be called on to work in new ways, possibly outside of their current comfort zones.

That process could include a serious look at how actions are affecting relationships. "Sometimes health authorities are a one trick pony and they have one way of doing things and you just feel that they have already made up their mind about this and they are just being polite. We hear "This is the way we do things and this is our program and this is our mandate"." That comment mirrors the sentiment expressed in Cycle One that some groups feel 'collaborated at' rather than with. Communication will remain crucial in that "leaders are going to have to be persistent and consistent in the message. Leaders will have to be good listeners and find ways to discover mutually shareable goals. They are going to have to be respectful in the ways that they work with people who are pretty pressed for time."

Some participants confided their exhaustion and said they hoped to bring in some 'new blood'. This seemed a surprising comment in light of the challenges they cited in regards to the rate of turnover and the energy and time required to onboard new leaders. Fatigue and exhaustion were mentioned several times in the interviews and the desire to "just step out and catch my breath because we are just on the treadmill", aware that the speed and incline of the treadmill is ever-increasing. "Our next emergent planning and rework is going to take massive leadership to do that, and people are tired."

Public perception.

Another area worthy of leaders' attention is how to shift public awareness of community as opposed to hospital care. "What you see in the press and what you hear some politicians talking about is hospitals. People are still much more aware of the hospitals and the hospital services as opposed to services. One of the important phases and work that needs to be done in the IPCC world is much more engagement with patients and families and the public at large. It is really to build awareness of community care services as an alternative to the hospital."

Participant quotes that illustrate some of the points are:

> "…the ability to separate your own personal baggage or feelings or opinions from what is going on and be able to deal with it objectively and mindfully. It is easy said but very hard to do sometimes."
>
> "…do way more than just send out emails and memos and say that we are integrating. Actually meet people and bring people together and start the integrated process of change which is never done simply as telling people to change."
>
> "In order to increase their commitment to any change process a lot of it is based on relationships so if the people continue to cycle through those leadership roles they have to start from scratch and build their relationships. It is possible for individuals to just decide to give up and it's not worth it."
>
> "The role of a leader isn't related only to IPCC work. It is time consuming and energy draining and you need to have the motivation and commitment to want to walk through the change and be accountable."
>
> "It is about building trusting relationships and being open to a new way of doing business and being open to system change."
>
> "It does require more complex leadership skills and flexibility and people have to be willing to be nimble and patient and be able to understand and support the vision and direction. It is a different way of leading than perhaps people are used to."
>
> "How are we going to know we got there? Being clear about what we want to accomplish and then knowing the changes that we want to make and then actually be able to measure whether we are making those changes along the way."
>
> "When you want large scale system change you can't just make little tweaks…you must make multiple tweaks and it might take many changes to get the system to make a large shift."
>
> "We are just at risk right now with so many people burning out and we are also at risk for the changeover. If you get too many new people and you have to go back to the beginning and get the buy-in again and build that awareness and confidence in the direction that we are going. Some of the people that have been working so hard might just drop off and say that they are too tired."

> "There are new people coming on and we are telling the stories over and over and over again and it is that framing and reframing for the people that are left behind to do that. That is hard so for creating that vision and framing and reframing we are going to need to have people that have some energy so maintaining the leaders is important."

> "Integrity is the biggest thing."

> "So it is really knowing or being mindful of the stakeholders because we are bringing all the voices around the table to ensure that you have good representation of input and feedback."

Leadership in Different Contexts

The second question inquired how leadership in different contexts is aligned to achieve the IPCC objectives. In the BC Node research the contexts are the Ministry of Health, Fraser Health, and the Collaborative Services Committee in Chilliwack.

Constant change.

Change is one of the things that we all have to live with every day and it has big impact on all aspects of our lives, including our work. Two things impacted the IPCC movement during the third cycle of data collection; the rate of turnover in the Ministry of Health and Fraser Health, and the provincial election, which was held in May 2013.

One participant described the context during the late fall and winter as having a very 'temporary feel'. As turnover continued people stepped in to interim posts, resulting in an atmosphere of uncertainty and instability. Leaders were feeling exhausted and experienced change fatigue. The personal toll on their well being was beginning to show. Long hours and increasing workloads were creating an unsustainable situation for some leaders.

Demographics.

The turnover will continue, not only due to people changing jobs, but to the number of health care providers and administrators who will retire in the next few years. "In Fraser Health there is quite a bit of turnover in the leadership and senior leadership level and that is going to continue at the manager level and staff levels also. We are a baby boomer generation so that is a problem. A lot of this work is based on relationships and there are new people stepping in at a time when the health care system is changing." Physicians also identified this circumstance as a resource problem in human resources

and a shrinking physician community due to demographics. Some of the older physicians have dedicated huge amounts of time to their profession and find it challenging to change systems now. Younger physicians have a different view of work life balance and are not keen on 60 hour work weeks.

Turnover means a delay in progress while the new person learns the ropes and builds relationships, and it is also an opportunity for renewed partnership between the groups. It could be a time to reflect, assess, and plan the next steps, incorporating the new person's experience and knowledge into the work.

Structure.

During the autumn of 2012 a structural change was made in Fraser Health, resulting in an increase in the number of VPs, which to some seemed incongruent with the intent of integration. "Now reporting to different places doesn't look or feel like integration." It was "directly at odds with integration" and "really negatively impacted the integration of the primary and community care at the highest executive level." One participant described the mixed messages as "One of the high-priority initiatives from the ministry is the integration of primary and community care but it was like that wasn't the high priority initiative because the high priority became congestion and capacity optimization."

One participant described the context as being "at a transition point" due to the reassignment of some leadership roles within Fraser Health, the reassignment of some people, and others leaving the health authority. The election provided the potential for even more shifts in personnel in the Ministry of Health. This situation poses a challenge for alignment due to the instability and inconsistency of the collaborative group composition. "Alignment isn't naturally occurring – it is constructed" and alignment in the next phase will depend on the next government and their priorities. One participant sees the alignment revolving around the overall triple aim common mandate and says each stakeholder sees where their work aligns and fits into the bigger objectives.

Election inertia.

The weeks leading up to the provincial election in May resulted in the integration work coming to "a bit of a standstill", and was termed 'election inertia'. The election

pulled the leaders' energy in a variety of directions and directed attention, resources, and energy away from the IPCC work and created delays in the IPCC process.

Disconnection and composition.

Others were describing a feeling of disconnection from each other and the process. "The Ministry of Health may be the funder but there is basically no connection with the ministry whatsoever that I am aware of." "They are so far removed from the patient face that their role seems to be more limited to saying "Yes, this is a good idea" but they are so far away that I can't see a ministry person. We are generally not aware of things like cabinet council and healthcare councils that operate at a very high level."

Leaders were eyeing their committee composition and asking "Do we have the right membership on this committee to move this collaboration along?" One of the recommendations made by leaders is to "take a look at our committees and make sure they are working and aligned properly" and then aligning the overall work of various committees.

The physicians reported being engaged with inter-divisional committees and with provincial roundtable groups, but expressed concern and frustration about the lack of "tangible meaningful integration" from the health authority and the ministry. "There is just programs and individuals that are still doing basically what they have always done maybe in a slightly different way but not being integrated with the primary care system. The primary care system continues to evolve in and of itself but not gainfully integrating with the rest of the system." Skepticism was expressed as to whether integration is really happening in the way it is being described by the health authority. The feeling of disconnection is heightened by the ministry's absence at some tables and discussions, and they are not seen as a true partner in one physician's eyes. The ministry is challenged by scale and logistics. There are presently "32 Divisions of Family Practice in BC that encompass 127 communities, and discussions are under way in up to another seven areas of the province" making it extremely difficult, if not impossible, to be present for every community services committee in the province, given the travel restrictions and hiring limitations in place at this time. https://www.divisionsbc.ca/provincial/home

Not everyone is viewing the context in the same way. One participant shared that they had observed a culture shift in their workplace and saw people working more

cooperatively internally. Further differences in context were revealed in participants' comments about the system. Some held a system view that includes physicians, specialists, Ministry of Health, the British Columbia Medical Association, and health authorities, painting a large and inclusive picture of governance leadership tables with many stakeholders as key partners. Some views used a zoom lens to tighten in on a cropped picture of those in close proximity with fuzzy representation in the background while some views were much broader, as if viewed through a wide angle lens. A participant candidly shared that "there is a real fear that if we invite physicians and patients in they will be critical or they won't see our agenda or they won't align with our agenda but our experience has been the opposite so I think we are getting there with our governance and leadership tables and that they are supporters, not enemies and they are our strengths and voice, not our opposition." In order for the inclusion of all stakeholders to be effective "the messaging out has to make sense to those outside of the formalized ministry and health authority system."

Alignment and language.

One person described how they experienced alignment in "crystalline moments of leadership" where people from different organizations or groups have a moment of insight and realize they are trying to achieve the same thing - they are just using different language to describe it. This leader capitalizes on those moments to create momentum to move forward together. Walking in others' shoes, using their language, looking through their eyes is a practice that can bring about new revelations and insights and light the path for respectful collaborative work. It's not always easy to do that and learning the others' language can be a challenge. It was summed up by one of the participants in the question "What does this group mean by integration and what does that group mean be integration because they could be talking about totally different things but using the same words. "

One participant shared that it took them a long time to learn to speak the other tongue. It's a two way street as one physician observed and there needs to be a 'shoe exchange' if both truly want to understand the other. "We want them to walk in our shoes, but we have to be prepared to walk in theirs too." Language can also set the tone and "even the language you are using can sound kind of adversarial whereas collaborative language has a whole different vision."

Participants said:

> "The workload was just too much. I would do 12 to 15 hours a day in the field and then I would come home and do all of my emails in the evening and early morning. A pretty onerous position to be in. So I was the frog in the boiling water. I can feel the temperature rising."
>
> "In BC we never have the same Minister of Health in government long enough to make a change and sustain it. They always come in and change what the previous guy did so we just don't have the long-term stability."
>
> "Seemingly capable people step in but you don't have the relationship with them and you sense a significant disconnect between what the senior leadership says and what people who are on the ground in the communities working on the front lines are doing. That has always been the case and it's probably worse now than it ever has been."
>
> "There are lots of good people there but I think that their management model is failing them in terms of when it comes to the community level. There are lots of good things going on regionally in terms of big picture programs, but in terms of community health and community hospital, I think that they have lost the plot."
>
> "I think the IPCC has helped folks in leadership in a sense that there has been a cultural shift in terms of leadership roles. I think that for people and leaders in Fraser Health that have been related to the IPCC it is much more automatic for them to work collaboratively and in partnership with the focus on integration and coordination and better improving the overall system as opposed to working more independently at any specific program area. So philosophically I see the cultural shift."
>
> "Everyone is coming from a different agenda with different viewpoints."
>
> "We want to feel good about the value of our work, whether we work as an individual professional practitioner, whether we are managers or project managers or data collectors. No matter what it is that we do we all bring our insights to the table but when we take a moment to walk in someone's shoes and use some shared language, then we get these moments of introspection and we say "Oh, my God! We are actually trying to do the same thing and if we work together we might be more likely to achieve some sort of success!"
>
> "I try to use language that isn't offensive to either party recognizing that there are physicians that are turned off by what they would call 'administrative talking'. It is like the Herman cartoon where the dog is saying "Blah, blah, blah" and the human says "Blah, blah, blah" and no one is really listening to one another

> because we use a different language. So if you make the language the same and try to just be a good communicator then people start to understand it and it is easier to move forward."
>
> "It's all about relationships and the trust in relationships so when turnover happens and there are new people at the table there is a little bit of a time lag because people have to decide whether or not they are going to invest in this relationship and how much trust and respect they have and so there will be a little bit of a slowdown in terms of the relationship building and community building."

Leaders and Roles

The third question explores what leaders are doing, and what roles they are working in that contribute to IPCC. As in previous cycles, participants would often refer to comments they made in the first question.

Commitment, respect, and integrity.

Commitment, respect, and integrity were things participants mentioned as qualities leaders were demonstrating that were contributing to support IPCC. In the words of one participant "Integrity is the biggest thing" and is demonstrated in the ways leaders relate to and support others, and in how they show they value those around them as people and as colleagues. One specific way leaders can build commitment, respect, and integrity is the way they approach resolution. When concerns, issues, or conflict arises and the leader cannot resolve it themselves, taking those concerns to those who can facilitate resolution, and following up and communicating the progress or verdict goes a long way to building integrity. Another participant concurred and supported listening to colleagues' problems and complaints when they identify road blocks for this process and taking that to the wider group for discussion and resolution. "It is important that when a local leader hears something they don't just say "Too bad" but they actually try and investigate and do a root cause analysis of where the problem is with the breakdown, what is the breakdown in the process and then turn that into an opportunity to get back to the person and improve the experience." It was summed up as "addressing the issues and not letting them slide and raising them and bringing them to the attention of the people who can actually do something about it. Bringing them to the people that have direct responsibility."

A leaders' commitment is signaled out in a myriad of ways that are picked up by others. "As a leader in this work you have to have a real commitment and if you don't have that commitment it shines through loud and clear. There is no faking that."

Communication.

"Having open lines of communication is the most important thing and having confidence in the divisional structure to be meaningfully engaged with them [Ministry of Health and Fraser Health]" were two key things identified by one participant. "Meaningful integration means that from a system perspective things work better and the communication lines are more open and people are working as a team", but this is the ideal and not the reality in the view of some participants. There is frustration when the talk doesn't match the reality and the administration is seen to be too far removed from the community to be making statements about how well integration is working and there is little evidence from patients and their families that it is.

Having the system channels to facilitate resolution and communication flow also provide access to whole areas of the system in addition to the individuals. One leader described how they not only connected program people with each other, but also connected whole departments such as the project with the finance people so that important information that was relevant to both groups would flow unimpeded by third party delays. Network connections are key in the opinion of one participant "I would never just be sitting at my desk doing things alone. I would always be using my network."

Supporting others and developing leadership in others requires presence and availability. One leader explained "I need to be there to support them and get them answers when they are asking a question that they need an answer to. I am a sounding board giving them lots of feedback." Giving feedback to frontline workers so they feel listened to and heard and acknowledging their work and efforts was mentioned several times.

Challenges.

Leaders confessed to feeling challenged and overwhelmed at times. "The challenges people are feeling now are in terms of sustainability and being able to make change on a broader scale. It is pretty daunting." It can mean "constantly

communicating and being honest and up front about what your capacities are and what resources are and at the same time keeping that engagement with our partners." It requires constant framing and reframing "the vision as being a living thing that is not going to be the same from month to month and as new people come on the team and become involved they have to be briefed and communicated with as well in a different way than the people that have been there from the beginning."

Working and building with what you have is a hallmark of leaders in IPCC. "You work with your available infrastructure and build with what you have and you make it about the care as opposed to the facility." Giving choice, empowering, and trusting others to work with what they have and "working within the regulatory framework in more creative than policy-driven ways" is what leaders strive to do and encourage others to do too. Working with what you have requires having a knowledge of what you have and what is available to you, including the internal political milieu. "A good leader understands and knows how to maneuver and leverage the internal politics and is able to move projects forward in that context as well." It is about "stepping back a little bit and looking at things with an eye to assessing and looking for opportunities to grow and to leverage and to maybe fill in some of the gaps."

Building with what you have doesn't absolve a leader of the responsibility to be proactive and plan ahead so that the initiative doesn't drift away from the vision.

Collective leadership.

The term 'collective leadership' was phrased by leaders as meaning that everyone has to be practicing leadership. It differs from collaborative leadership which implies leadership in the spirit of cooperation and working together and includes the responsibility of each leader to be a leader and moves leadership from an "I" perspective to a "we" perspective. This requires drawing on leadership skills at all levels and not leaving leadership to be practiced by a select few.

Awareness.

Leaders may not be able to curb the turnover rate, but they must be aware of the challenges the instability and inconsistency it is creating. "In all of the three groups – the physician group, Fraser Health, and the ministry – there is a large number of people set to

retire over the next five years so that will mean more change and turnover" and signals an urgently growing need to have a succession plan for leadership continuity.

"There are limitations of infrastructure" because of the way services are presently delivered. Leaders in the Ministry of Health were further cobbled in what they could do or say prior to the provincial election. They were "not allowed to do anything that could be seen as interfering with the election" so things were slowed or stopped altogether. Decisions were postponed, actions were delayed, and plans were put on hold.

A long-term vision is needed. "Leaders have to know where they are going and they have to have a goal as to what they see the system looking like in 10 or 15 years' time" and they will need to be prepared to "help people transition through whatever changes need to be made."

The long-term vision will probably include doing more with less. If funding is decreased, "it will throw the health authority into another accelerated tail spin and they will focus all their energy on saving cash and that will limit this work." More than one participant shared a concern that the success of IPCC so far has been the result of dedicated funding, and if that funding is no longer forthcoming the gains made will be lost. "Many are relying on additional resources that have an end date, an expiry date."

When asked to look into their crystal balls and consider what leaders need to be doing in the future, leaders told us it will be important to have people who are genuinely interested in promoting integration in their leadership roles. They see the importance of continuing to arrange opportunities for contact and connection, and they cited the need to consciously devote time to tend to leadership practice.

Leaders will need to make "compelling arguments for why the partners should stay at the table" and they need to clearly articulate what has been achieved and celebrate those successes. They need to determine how they will "create conditions to remove barriers" including system barriers, attitudinal barriers, and financial barriers.

Participants shared what they thought was important:

> "Any physician on any collaborative services committee knows how hard I work and they usually say that to me because they will send me something late in the

evening or on the weekend and I always answer them. I see them as my customers."

"I think sometimes people who don't work in the ministry feel that the politics get in the way and I think what people don't understand is that politics are where we are today. It shouldn't be seen as a barrier but seen as what is driving us and our job is to constantly bring information back to the politicians of the day for accountability purposes so if it is not working we can look at options and strategies on how we are going to understand that better and make refinements in our processes."

"Leaders need to be 'constant' and give that confidence to everybody else around the table even when feeling like we don't know. "I don't know this but I have to demonstrate confidence because if I stop it will be seen as an opportunity to go in another direction"."

"Leaders are going to have to be a lot more patient-centered and describe their experiences and the work they are doing at a system level in a way that speaks to what difference they will make for the patient who is being served or who no longer has access to those networks."

"There has been a big reorganization of home health in terms of how they work and the way they work but they are not really working with us any differently than they always have and they are not using the information that they can bring to the table more effectively and they are not using any sense of a functional team between us and them improving the way that they deliver care or making systems better."

"The health authority is too big and the people running it and making decisions are very, very far removed from the communities where the changes go on and so they can talk in broad brush strokes and big pictures about what is going on and about the changes, but there is a huge disconnect on that and what is happening in the community and the people perceptions. They are going to have to look at that because it is not integrated and it is not better and it is not less expensive and we are not keeping people out of hospital."

"We struggle with bringing physicians in because they aren't part of the legislative system with the health authorities and we also struggle with bringing patients in because they are not part of the legislative system. We are better at working where we have influence and where there are staff and where we need to be directive. That doesn't mean that is a good thing or a bad thing but we are able to engage people because we can mandate it. When it is physicians and community and patients you actually have to build that collaborative environment so they volunteer and they want to be engaged because it is the right thing to do. At the leadership level we haven't always invested the time and the resources that we need to in order to fully engage those 'troops on the ground'."

> "We are not all the way there and we are not at the tipping point but I think that we are certainly seeing that it is adding value and we are seeing through measurement and through qualitative stories that it is making a difference in bringing together the priorities in the system."
>
> "We are not really cognizant about what is driving this. It isn't that we did such a great job getting everybody to focus on a couple of themes – it was because we gave them money to focus on those themes so those themes could move forward."
>
> "Form follows funding. So as leaders we have to be careful to not have people just running after dollars and try to think about how we add to system drivers and add a few pieces that are already in the system and build on it versus us just funding new initiatives or innovation initiatives because as soon as that innovation money is gone we risk losing everything we have gained."

Source of Leadership

Question Four asks about the source of leadership to shape, develop, and sustain the IPCC movement, or "Where is the on-going leadership impetus coming from for IPCC?" As in the previous cycles, participants were unclear about this question and often clarified "Do you want names of leaders?" Leadership is being shown within the three groups in this case study; the Ministry of Health, Fraser Health, and the Chilliwack Division of Family Practice. Each group is moving the transition forward according to their own context, and leaders are demonstrating the traits described in the first question. All of the effort that every group has put into IPCC and all the conversations and discussions and negotiations that have occurred demonstrate how the combined, coordinated, and collective leadership actions have gotten the movement to where it is now.

Vision of the future.

The vision continues to be an important guide and leaders "have to know where they are going and they have to have a goal – what they see the system looking like in 10 or 15 years' time." The metaphor of a jigsaw puzzle was used with the stakeholders all holding different pieces that will all need to be in place in order to see the picture. "There is some real leadership and starting to be some alignment around the common mandate....but really our work - it is to move forward and work together." There may be more pieces of the puzzle in the hands of groups who are at the periphery now but will

need to be invited to put their puzzle piece in place. One participant used the term "coordinated leadership" to describe the sequential interdependency of the work that is done by the various stakeholders. With coordinated leadership the events and activities are organized, not duplicated, and intersect, creating consistency, and mirror the principles of integration.

Sustainability.

Leaders wondered aloud how to sustain energy and momentum. Changes to Fraser Health's leadership team have some wondering if the changes can support sustainability. One participant noted that it was difficult to sustain the momentum because there are some staff who are tempted to revert back to a more siloed way of working because it is easier than dealing with the complexities of the larger system. The leader recognizes those temptations as signals that people are challenged and tired and may want to return to a more compartmentalized approach because it is familiar. Acknowledging and addressing those signals means employing an appreciative inquiry approach and holding coaching conversations with those who are having trouble maintaining the new ways of working. One participant said that leaders "need to have the courage to advocate for and champion this change" because it is gruelling work.

No matter who is at the helm participants stressed the need to have consistency and sustainability beyond what any one leader can provide. "It needs to be embedded in the process" in order to be sustainable and withstand the turnover that will continue as people pursue career opportunities or approach retirement.

One leader sees the leadership source as the ministry executive and the ministers who are political figureheads who can talk about the work that is being done integrating primary and community care to a larger audience and in public forums. These figureheads can use their media exposure to inform the public about new ways of accessing health care and how it can benefit patients and their families.

One participant mused that although the objective is to create equal partnership throughout the three-group coalition, in reality IPCC is led by the Ministry of Health. How the initiatives that are carried out under the banner of IPCC are shaped involves the health authorities and the divisions of family practice, but the direction overall in terms of how a key result area would be contracted is created between the Ministry of Health and

the health authority and is significantly influenced by how it is written up with the ministry. The process was explained as a tiered approach. "The Ministry of Health wrote the contract, then the health authorities influenced and reshaped it, negotiating boundaries, deliverables, approach and the degree of autonomy." Physicians were not included in discussions about what their commitment would be until after the contracts are established and the deliverables determined. One participant stated that in their opinion, the "physician interface" is an area where leadership will continue to need to be demonstrated as it is a crucial connection point in the IPCC system.

When asked about where leadership is coming from, some participants looked to the internal aspects that leaders personally draw on. Many of these aspects have already been mentioned in previous questions and are seen as a source of internal leadership. One participant talked of maintaining leadership energy and strength by worrying only about the things that they could personally influence or "do something about." One of the things that leaders in the health care system are able to do is "have a good hard look at the programs that we are responsible for and decide if the taxpayer is getting good bang for their buck" and making sure there is accountability in the system. This participant also suggests "taking a hard look at some of the unintended consequences" and making sure that the purpose of integration has not been forgotten.

Some good hard questions.

Along with 'good hard looks' participants suggested asking some 'good hard questions'. Is the current model sustainable given the changing demographics in the physician population? What is in place to ensure that people are working in a way that is going to improve patient experiences? What barriers (e.g. union restrictions and limitations) can be removed? What policies are constraining rather than supporting? How can decisions be made closer to the delivery point and better informed?

When asked about leadership sources in the future, participants talked about systems awareness regarding how information needs to flow, assuming fiscal responsibility, and the need for sustaining leaders and welcoming new blood into the ranks. Feedback and the need "to get better at communicating back to the powers that be about what is not working" and having strong feedback loops, taking the feedback seriously, and working with it to make improvements and strengthen relationships and

trust, and those feedback loops need to be translated into the language of the receiving community.

Another participant warned of the need to be careful not to let the process drift and not to assume that the integration no longer needs to be nurtured and tended to. Turnover will continue and "a lot of this work is based on relationships and there will be new people stepping in at a time when the health care system is changing" and there will be a need to plan how the next generation of leaders will be developed. Looking outward one leader notes that things like the economy will likely impact IPCC work even though not directly related to it.

Participants said:

> "It really takes a much longer time to change people and change the culture and ingrain that as the new way of doing business."
>
> "My concern is that the structure is based on convenience without foresight to strategy."
>
> "From a leadership perspective I keep trying to keep people engaged and not retract."
>
> "IPCC shouldn't be seen as an initiative but as a transformation that continues in that we have to come up with solutions on how to continue this transformation service design through the leaders we have and where can we pool our resources and work together to get us there."
>
> "[Leadership comes] from the division and the close liaison with the hospital physicians and the department of general practice and Fraser Health."
>
> "First the problem gets defined and it is framed and the contract or the key result area followed by the effort by a local health authority to redesign the way they approach their delivery, and if implemented requires them to work with significant stakeholder groups."
>
> "Mostly it will be about work / life balance. One of the reasons that people continually cycle through these roles is it is very difficult to sustain the level of effort and it seems like two to three years is really long and it is because many times you lose your entire life. You start early in the morning and you work into the evening because there are evening meetings at different times with different stakeholder groups and after all those meetings you catch up on emails and prepare for the next day. There is less and less admin support and we set it up

that there is more and more of these amalgamated roles. And it is not going to get any better. It is going to get harder and harder."

"Leaders look at what is doable for them and what they can do to nurture themselves."

"You can have all of these high level meetings and come up with all sorts of ideas and really hold your colleagues and the health authorities in high esteem but it really doesn't matter if things don't translate down to the community level effectively."

"In terms of really trying to change things on the ground and improve things for patient care it is hard, it is hard work and there are all sorts of barriers in the system in terms of union rules."

"Decisions are made in the health care system all the time that are made from a programmatic perspective and with obviously no understanding to its part in the complex system, whether it is the community or the hospital. There have been some incredibly bad decisions made by very smart people that are working from a programmatic perspective."

"I think that we just have to be very careful that we don't drift and we keep our focus on growing and developing this movement and this cultural change and not just assume that it has taken root."

"We've done some very good work and it occurs to me that maybe we have gotten our easy wins. Maybe we have done the easy stuff."

"Now it is going to be harder and even though that is the case we still have to sustain the work that we have done which got us so far and we have to be consistent in our messaging to those people and respectful of the risks they took to put themselves in the situation they are in and we have more hard work ahead of us with the people who don't have as much good will perhaps or are more skeptical of working with health authorities to meet their needs."

"I think we have started to broaden our view as to who our partners are and who else needs to be in the room."

"I am a little bit jaded by the whole thing and I find it a little disconcerting."

"We [physicians] could probably fix the hospital care program for less money than they were giving us if we had the flexibility."

Contextual Factors

This question explores what contextual factors, internal and external, impede or facilitate leaders' abilities to support the IPCC initiative. Many of the points mentioned as sustaining forces could be considered facilitating supports as well.

Positive factors.

The individuals in all three groups who are seen as champions of IPCC are making a positive contribution by exhibiting good will, a positive attitude, and modeling adaptable leadership.

The groundwork has been laid by the champions who have invested effort and time into the conversations, discussions, and negotiations that have occurred and have brought the movement to its present situation. One participant commented on the high level of commitment to collaboration and said "What I have seen that is helpful here is the exceptionally high level of commitment to the collaborative processes, even people who don't know how to do it very well are committed to it." People see themselves in relationship and part of something bigger, which is a powerful enabler. There is a continuing thread that runs through IPCC since its inception that "allows folks to understand that they are still going in a direction that is meaningful overall with the partners." This thread provides leaders with a tool to describe the work in a way that affords people enough historical context and present initiatives to understand the scope and depth of the changes IPCC is bringing.

Conversations at the local levels have been instrumental in engaging stakeholders in deepened conversations and meaningful discussion, resulting in better outcomes. Those leaders acting as bridges between stakeholder groups are the channels through which information flows and discussions are linked. These 'boundary spanners' are key connections and vital components of IPCC in this case study research.

The ability to shape the changes at the local level is another important aspect in the progress made to date in shifting the culture in the local health care system. Physicians appreciate the autonomy they have at the community level to run programs that fit the community and to learn from that experience as they add new community care services. Support in the form of a budget for admin support has been a facilitating factor,

taking that responsibility off the shoulders of physicians so they can focus their efforts on integration at the patient service points.

The General Practice Services Committee (GPSC) has implemented positive changes which has helped to keep people engaged. "When I think of the bigger picture stuff that is going on in the GPSC it makes it easier to keep people interested and engaged and the structure of entrusting the divisions with the money to run the programs and to administer those programs is also huge and it really helps with the profile of the division in the community and the relevance of the program and that is all good."

In one participant's opinion provincial strategies are supporting IPCC initiatives and that is seen as a facilitating agent. The provincial strategies support regional strategies that have a cascading ripple. An example given is the GP for Me program that endeavours to "ensure that access to and benefits of primary care are available to all British Columbians, including those who may be hard to serve in traditional practice settings." https://divisionsbc.ca/provincial/attachment

At the root of IPCC is the relationship between patients in BC and their physicians. One physician sums it up as "opportunity for patients and the opportunity for the well being of the health care system is not exceeded by any other system because of the meaningful relationships that patients can have with physicians that facilitates good care."

Stepping back from the grassroots view to the provincial picture, one participant reflects on the fact that we have a new deputy minister and the possibilities that individual might be able to bring to life. The work done to date with the British Columbia Medical Association (BCMA) and the health authorities serves as a strong base to continue forward motion, in the view of one participant. There is funding for work plans that include integration and partnerships, and there are initiatives already launched to provide not only the momentum to continue, but some evidence to work with.

What they said about positive contextual factors:

> "We are trying to create a new culture or environment which increases the likelihood that the family doctors will see value in what is at stake in the health

> system in a meaningful way for patients that all partners can agree to, so that foundational work really helps to change the landscape of what is possible."
>
> "There are a few individuals that take it upon themselves to make sure that things are understood and that everyone is included."
>
> "Most importantly it is the local dialogue that I have seen in collaborative services committees and the partnership between the health authorities and GPs services committees."

Factors that hinder progress.

The participants talked about the obstacles and barriers they saw as hindering progress at this stage of the IPCC transformation.

In the context section of Cycle Three the changes at the VP level was described as counter to the principles of integration. One participant reported sensing mixed messages and felt that undermined the efforts of collaborative and integrated work. That seemed to cause some doubt about senior leaders' commitment to integration, at least in the heart of one participant. Another acknowledged that "There are huge challenges in the way the systems support people and there are still areas that people feel skeptical about."

The constant turnover and the continual need to establish new relationships was an obstacle in that it consumed energy and time that leaders did not have to spare. Conversely the inability to hire new people was also seen as an obstacle "I need to bring in some other people and it has been the hardest time because we haven't been able to hire and I think that is part of the challenge for me, that I have had no new blood coming in and I need that." To add to the shifting sands IPCC stands on, turnover is occurring in affiliated groups like the British Columbia Medical Association, making it more complex as the connections to these groups are also changing and new relationships and trust is established.

One leader noted "I think what gets in the way is changes in staffing, changes in procedures and processes that you have got to put in place and that just takes my time away and we just don't have the capacity for that extra work." These types of changes require communication and although in Cycle One participants were appreciative of the time and space allowed for discussion now there is less time devoted to sharing and "we keep not building enough time for those discussions and debriefs." Short timelines may

have been a factor from the beginning of the IPCC work. One participant reflected that the physicians' groups were formed at the onset of IPCC and they needed time to form before they could be expected to be fully engaged in the integration work with the health authorities.

Data sharing agreements and the inability to use data for improvement and performance assessment is a big thorn in the side of some leaders in the IPCC movement. The Ministry of Health doesn't have all the data, nor do the health authorities, so what data is generated is piecemeal which makes it impossible to use the data for effective measurement purposes. Privacy restrictions limit how data can be shared and recent breaches in data security in government have prompted the BC Office of the Privacy Commissioner to publish new guidelines on data sharing. http://www.google.ca/url?sa=t&rct=j&q=accountable%20privacy%20management%20in%20bc%E2%80%99s%20public%20sector&source=web&cd=1&ved=0CC8QFjAA&url=http%3A%2F%2Fwww.oipc.bc.ca%2Fguidance-documents%2F1545&ei=47nZUdFCqLaKArW0gcgJ&usg=AFQjCNHmmikh6J8l5wS0Guyi_XYOwlIohw&bvm=bv.48705608,d.cGE

Even when data is available there are not always staff who can translate it into something meaningful for the organization to work with. Restrictions on what can be shared with whom result in diminished trust as people err on the side of caution and keep data locked down. One leader lamented that "it doesn't really foster an environment of improvement and innovation if you can't measure together" and "We just have to make some strong decisions at the leadership table as to whether we value measurement as part of our strategy."

And it is important to keep the data in perspective and make sure that people are not encouraged to invest in things that generate numbers but don't reflect quality. "It is better to be a bit more careful now than to be putting out data that may not actually demonstrate success."

Understanding the political aspect of change is important to collaborative work, and if that understanding is lacking that can cause a barrier. If people do not work close to the political environment it may be more difficult for them to appreciate the nuances,

the channels, and the benefits of keeping politicians informed so they can champion the cause on behalf of the organization.

Fear can be a debilitating barrier in that it can impede communication if people are afraid to voice concerns or are reluctant to share bad news. "That is another barrier – that people think that it is not working and they are afraid to talk about it or they just afraid of losing."

Bureaucracy presents a barrier for some and is a source of frustration for many. The difficulty in navigating the system and reaching the appropriate person for any given situation was cited as a major irritation, especially given the resourcing issues when staff are "taking holidays and going off sick and there isn't financial resources there to replace them." Along with bureaucracy, the culture in some pockets is seen as a barrier and described as "they work in a different universe than the one we work in." One participant expressed their experience trying to communicate across organizational lines as disappointment in "some of the attitudes of some of the long term staff who see this [IPCC] as an imposition, as extra work."

Sometimes strong personalities can hinder the development of trust. It was lamented that opportunities to build constructive relationships can be lost because individuals sometimes place themselves in an adversarial role. "If the personalities are too strong or too confrontational they don't have trust. There are communities in the organization in which I work that basically lose out because they see themselves in an adversarial or an unfavorable environment and sometimes no matter how much they work together they just don't agree that their potential partner can be trusted." "Sometimes there is acrimonious debate because people don't feel happy about the work that is being done" and derive no personal satisfaction from the work.

One participant shared that they thought program management will continue to be a significant barrier unless silos can be dismantled. "As long as people are working under a certain budget and trying to make their little part of the system work better it is not going to change." When reporting includes praise for the success of one part of the system, those looking at the larger picture see that as only part of the information, and may even feel that the larger system is being misrepresented and assumptions made based on one small area. "This is a little example of effective integration but the system is not

integrated and so I guess it is all about spin." Another participant confessed "One of our barriers is that we have some independent silos and I don't think we are working as effectively as we could be."

One leader reflected that they were still learning about engaging partners and that there were challenges with working with groups and individuals external to their organization. It takes more time, patience, and energy but is the right thing to do even though it is not easy at times or straightforward. It requires some self-assessment on the leaders' part, and reflection on one's own leadership style and approach. "It is not always easy particularly when folks have other priorities, sometimes competing and sometimes conflicting so the role of the leader isn't related to only IPCC work." It can be a challenge for leaders to maintain motivation and commitment to long-term large system change because it "is a different way of leading than perhaps people are used to" and leaders need to be able to adapt.

Demographics continue to present a human resource problem and a shrinking physician community is a reality. The older physicians "will retire in the next 10 to 15 years" and "physicians coming in later think about work / life balance in a profoundly different way." They are not interested in working 60 hour work weeks with additional time devoted to leadership activities. The same goes for administrators and government leaders. "So not surprising we hear that in government the new young leaders are not going to work the same pace and the same hours and neither are providers."

However even in the face of multiple challenges and impediments there exists the possibility for creative and innovative solutions. "I think that it is an opportunity to do things differently. When you take money out of the equation people find ways to collaborate more together because they can't do it on their own and they are forced to do it together."

What participants said was impeding change in the IPCC project:

> "This is all about relationships and the trust in relationships so when turnover happens and there are new people at the table there is a little bit of a time lag because people have to decide whether or not they are going to invest in this

relationship and how much trust and respect they have so there is a bit of a slowdown in terms of the relationship building and community building."

"They [the divisions] are not on the same page. They had to form themselves first and perhaps weren't ready to go to the next step because the needed to form themselves first."

"Someone gets excited about something and then they get fired or they move on and then the next new shiny thing comes up. Doctors have been disillusioned with this kind of approach for decades."

"It was workload and it was new work coming in and the volume of work and everyone is exhausted from all that work."

"[Software] Programs don't interface very well so the information doesn't travel through the system very easily."

"So my number one for impeding is around our legislation at the ministry level and our sharing agreement and our ability to use data for improvement and for performance, which then trickles down to health authorities and data access issues which then trickles down to division of family practice and data access issues."

"We have been three years working with the Michael Smith Research Centre around data measurement and they have come up against huge barriers around access in order to support measurement evaluation and learning."

"Also knowledge translation. Even when you get the data you don't necessarily have the staff who can really tell us what the data means."

"Until we resolve the measurement issues to legislation and the ministry, there is going to be a barrier. That is a leadership issue – how come we can't remove the barriers?"

"We don't have the dollars to put the resources into the physical environment and we keep investing in initiatives that we can't measure."

"We are at a huge risk of burning people out at so many levels. We have a huge initiative under our belt with this complex change and I just worry about maintaining leadership energy."

"The new doctors that come to these committees will not work at the pace of the doctors that just left because for the doctors that just left, this was their legacy and they built it because they were passionate and the ones that are coming in are interested but they see the work and they are not signing up for what they guys just left and that is kind of typical – the generation coming up are not going to work 24/7."

> "There is just so many times that you can just sit there and listen to people spout off about the implications of the system as a result of their initiatives and think "Well, have they really changed very much. No." I think that in terms of service delivery, and in a lot of ways, things are worse for patients."
>
> "Here is an example. Patients with dementia have been referred from their doctor but the family is not really needing any help yet so they are struck off the list and then when help is needed it is as if the patient is new to the system all over again and we have to redo the assessment even when we have been seeing the patient on a regular basis and we can tell them what is going on, but in their system this is now a new referral and will take eight weeks to process."

Learning

The last question concerns learning and how that is occurring in regards to IPCC. As in the previous cycles, the comments reflect experiential learning rather than formal learning events, activities, or opportunities. Taking lessons where they are found is a skill as one leader says "There has to be something we learn from all situations. No one is perfect and systems are not perfect and there has to be a way to improve."

Continuous learning.

Participants describe the ongoing learning as "learning as we go along'. Participants used the words clarity, consistency, openness, transparency, honesty, and authenticity to convey not only what they have learned about leading a large system change, but what has been reinforced in their hearts about what is important. They added reflective thoughts such as "collaboration doesn't mean consensus – it is about everybody clearly stating what the issues are and what their interests are and then working it through to a place that we can all agree is the next step forward." The importance of reflection was also described as "reflecting on your own experiences in relationship to the work you are doing is a fundamental priority." "Listening and learning" were listed as things leaders have learned to be more aware of, along with tending to the interpersonal aspects and being "strong on culture and light on management." Learning occurred around the value of a structure that provides stability, guiding principles, and documentation that people can fall back on. "When we don't have structure is where we get into trouble" because decisions can't be documented and referred to, or the process doesn't provide enough structure for people to have confidence and trust in it.

One leader said it was about "learning what you don't know" and "reflecting back on where you can do this work with ease and where it really requires effort and what effort do you need to do." Another said that although they didn't think they learned anything new, some key principles were reinforced. The importance of staying true to the vision and using that as a guide when making decisions and planning work, continuing to look for opportunities to further the objectives, and reflecting on what the system is doing were listed as points that were touched on over the past year. The conclusion one participant arrived at was that if the work was valued, meaningful, and was moving the organization where it needed to go, that should outweigh individual personalities and the mission should not be jeopardy due to turnover or the departure of any one leader. "Systems are more important than personality. A personality leaving shouldn't change everything and I think that the work has to speak for itself and if the work stays true to the principles then the work will persist and persevere." "You can't be in every room and in every meeting but the ideas and the concepts and the principles can be." Another leader agrees and says "I think that we should be moving people around a little bit rather than investing too much decision-making and responsibility in one or two people."

Another leader shared an important learning about setting aside what the calendar says needs to be done if there are relationship-oriented conversations that need to happen. The key is to be aware that you are setting aside an agenda, not just following whatever comes up. Another participant spoke of setting aside the notion of having the perfect vision and carefully crafted message. "People have kind of moved away from having the perfect diagram and the perfect elevator speech" and simply working towards the vision for the community and the triple aim framework.

Learning from others.

A participant suggested that the stakeholders could be learning from external and international sources who have more experience in integrating large system components. "I think it would be a great idea to have someone talking about the system that works elsewhere in Europe or the UK about what we should be working toward and what it can look like." Although, it was acknowledged that making time to attend learning events is a challenge and sometimes impossible. One way to attract physicians to learning events

would be to grant CME (continuing medical education) credits and to provide some funding for physicians to attend because time away from their practice means lost income. For learning and leadership, you need to "protect the time and make sure the time is protected, and funded, for doctors" to undertake leadership roles in addition to their medical practice.

One participant, external to Fraser Health referred to a program in that organization. "Looking at Fraser Health authority, they have instituted a leadership training program of sorts" although no one else mentioned this program. Another participant indicated "in the Division of Family Practice is a leadership training program through Simon Fraser University for physician leaders that are running or participating on boards of directors." This was not included in any other participants' comments, perhaps because it is/was not linked directly to IPCC.

The idea that formal learning opportunities should be available to leaders was questioned as one participant said "When you get to a certain level in an organization you are not hired to grow in the experience. You are hired to already have that knowledge. From my perspective there is less and less tolerance for individuals not having the skill set necessary to deliver on the job." Given that, one leader has learned to "be as charitable as possible about the skill level for interpersonal skills and approach to the work of other leaders that I work with."

When asked about learning for the future and the next steps, one participant advised continuing to hold provincial sessions where "folks continue to learn from each other across the province" but have the material set in a context what is more transferable and applicable to others. "Usually lessons learned and approaches to work are amalgamated and rolled up to such a level where it is general lessons learned" that are presented. "Most often it eliminates a lot of the contextual factors that allow the individuals that are learning about how to overcome system change barriers and make sense of what is different between the experience that is being described and that of the experience that the listener is currently embedded in. Different geographic spaces and social services that support work that is occurring and municipal involvement levels, school system structure, levels of poverty, levels of chronic disease, and all of those things come into play here, so easy to access interactive case studies and structured

examples that allow you to easily navigate from a very high level 'here is what happened' to more concrete examples of tools and templates that people can use to effectively lead change."

Evidence.

Learning about the importance of measurement was front and centre for one participant. It was obvious to this leader that without the data and the evidence to defend the work done to date there was a risk that people would become disengaged and budget cuts might be faced if IPCC leaders are not able to justify value of the time and effort that has been expended so far. Progress needs to be charted and shared with internal stakeholders, external partners, politicians, and the public. Several participants voiced a need for evidence, and some leaders are connecting the dots between data and evidence.

One leader summarized the learning nugget as the importance of planning for an evolution in leadership and succession planning. The importance of building relationships and creating community was another eye-opener. "You are really only as good as you are cohesive as a community." A participant learned that maintaining those relationships becomes more difficult during change as people are challenged with coming to terms with what the change means, keeping up with the 'regular' workload, and incorporating new practices into their day.

Personal leadership learning.

Others reflected on what they've noticed about their leadership practice over the course of IPCC work. An awareness of wanting to make a personal change, "keep reflecting on what my role really is" and of being "more of a facilitator and less of a doer" were things mentioned as self-awareness learning. One leader spoke of the strength of their convictions and their belief in this work. "My biggest leadership take-away is as much as possible when everything is falling apart around you is to still feel comfortable doing the right thing and hope that you can carry it to the point where it makes a difference in the lives of different people that are being served." One participant spoke of learning to work within their sphere of influence, finding job satisfaction in that sphere, enjoying the positive relationships, and letting go of what is outside that parameter. It was described as "getting things done locally" and "working where you can

be the most effective." Letting go also means accepting the way others, and other stakeholder groups, have to work without trying to change what you cannot influence. "You just have to figure out how to enjoy each day and make it so you feel like what you are doing is worthwhile." Leaders take ownership of their situation and know that "if you are not happy with the way things are working then it is really your own fault and you need to make it work for you." One participant voiced their learning about relationships being fundamental to success and creating a culture of 'us' instead of 'us vs. them'. Creating that collaborative culture includes continuing to make space and time for conversations, which has been identified as a challenge as the workload increases and everyone's day seems to get longer.

Some practical learning was listed as well during the interviews. One leader told of learning to always end a conversation on a positive note and to close the loop on the discussion, addressing any outstanding concerns or items raised. The value of face to face meetings was expressed as "being forced to look someone in the eye forces you to communicate in a different way than you might if you were just blasting off an email." "People must physically get together and talk." Asking for feedback on their own style is a practice adopted by more than one leader in this study. Learning about the roles of others in the organization was a key piece for one participant. This expanded awareness allowed for more shared and collective leadership, in their view. The value of properly onboarding new members was important learning that one participant noted.

In hindsight one leader said that they learned not to underestimate how much time a change of this magnitude will take and how much effort needs to be afforded to preparing people for the shift. "One of the things we underestimated was how much change management had to happen. We underestimated the amount of change management resources we had to put in." People need time to feel confident and comfortable with the change and there are some learning curves as people transition into new jobs and roles, and there is a delay in the work as they get up to speed.

When asked what leaders may need to learn in the future, we were told that leaders need to learn to be more aware of the impact of local leadership and the basic tenets of a functional community health system. "You need people living in the communities committed to the local system" and "their level of engagement is only as

good as their direct leadership, and if their direct leadership doesn't live or have investment in the community then it is limited."

They talked about learning:

> "The Ministry of Health is so limited in their [formal learning] opportunities because they are under public scrutiny. Always it seems like they get zero professional development and certainly can't go to conferences unless they are in the same city and definitely can't go outside the province. And at least at the leadership levels, even if they could peel themselves away to take a training program to strengthen their leadership styles, they probably don't have the time. They are certainly more stretched, it appears, than the health authorities or the BC Medical Association."
>
> "I am the kind of person that is wanting to be a learner and if I am not learning something I get bored."
>
> "I don't know if I've learned anything new. I think it confirms for me that over the past year is was important to have vision when there is uncertainty and to stay true to the vision."
>
> "I learned how much leadership costs you financially."
>
> "I work with those that try and find a way to share it so that other people are learning that something is changing and that on balance it is a positive experience, or positive change."
>
> "I've learned to keep the goal and the objective of this whole exercise in mind."
>
> "A big leadership learning for me is that there are so many system drivers – those common themes that we are working on together, common messaging and getting those key themes so that people can align their work. But if we are not also thinking about other drivers like leadership, funding, and measurement, we won't able to sustain this."
>
> "I have learned to appreciate other stakeholders' points of view. I needed to listen, work on a solution together and not come up with a solution myself...really appreciating the lens of other people and not just applying my vision or my mental model."

Closing Perspectives on Leadership

This study took place over an 18 month period and offers a chronological look at the key aspects of leadership effectiveness as the integration movement unfolded in one community in one health authority in BC. The research took three 'snapshots' of the change process near the beginning of the movement, six months later, and twelve months after the first data collection cycle. In the early months of 2012, the first data collection cycle, participants talked in excited voices about the positive energy that was generated through developing new relationships and inventing new processes. Some said it felt like an innovative atmosphere and they enjoyed connecting with people they had not previously worked with. It was a time of expansion in their circle of working relationships and of learning new processes. This stage presented challenges for leaders in that they needed to get buy-in and support from their teams and they had to facilitate communications and connections on a broader scale and communicate a different, much larger, picture of the system.

The second snapshot indicated that the integration project was becoming more embedded in the way people approached their work. The term 'movement' was now used in place of 'initiative' and there was a sense that there was no going back. This cycle also revealed that leaders were feeling the effects of leading others through this change process, and were beginning to feel overwhelmed with the scope of the changes. Dissatisfaction was surfacing in some areas, as the expectation of stability was compared with the reality of turnover. Organizational cultural differences were also apparent in this phase as the groups were now discovering. External pressures such as addressing hospital congestion, and the upcoming provincial election added to the heat and leaders were drawing on an ever-decreasing store of energy.

By the time the third data collection cycle was underway it was clear that many were feeling the effects of working in an ever-changing environment, dealing with the issues that prevented complete integration, and an increased workload.

Throughout the study participants referred to the importance of relationships in the context of one-on-one, their work groups, and relationships as a bridge to other stakeholder groups. In a complex adaptive system, especially when turnover is high, the ability to build and maintain relationships across organizational divides, cultural

differences, and as a network to gather information is a key element of the health care leaders' work. Weberg (2012) notes that traditionally leadership referred to a role or position in an organization rather than personal attributes and skills. He says that now "Leadership ... is a process that occurs in situations where groups need to learn their way out of unpredictable problems and situations" (p. 269) and that requires an attention to relationships in way that was not called for in the past.

This research explored the qualities and attributes needed in leaders throughout a change process. It considered the significance of leadership at each stage of change and the factors that influenced leaders at different points of this study.

When given the opportunity to include any additional comments, participants offered some interesting thoughts on their perspective on leadership.

One leader reflected that they have grown comfortable in not having all the answers and being able to reframe in response to others' concerns. There is no one right answer that will satisfy everyone so this leader has become at ease in the space of uncertainty and is modeling how to 'be' for others. "I don't have all the answers. As a leader I may not have the answer. I may not be able to help you but we might be able to get to the answer."

Assessing where people are and what might be helpful is something one of the participants has learnt to do. Playing devil's advocate is a practice that helps to move people to approach the challenge from a different angle rather than stay stuck. "This gets people thinking and involved and engaged again."

A leader shared thoughts about being the first community project in the IPCC project and said that although they "suffered more" as a result of being the first, others will be able to learn from that example. At times it felt like "extra work with no apparent benefit" along with frustration at the slow pace and high level of bureaucracy and at "this time last year we were thinking of just backing out of the whole thing."

Demographics and succession planning.

Demographics was mentioned by several participants. They are very much aware that the next few years will see a tide of people leaving their work and retiring. This situation will no doubt have a profound effect on our society and our health care system. Leadership will be impacted and challenged as the younger generation appears to have a

different view of what work / life balance is and it remains to be seen how upcoming leaders will approach leading organizations.

Leaders in this study talked about the need to develop succession plans and provide leadership development for leaders. One leader talked about "the importance of being realistic about the burden of leadership and making sure that people who are stepping into leadership roles really understand it." Leading in the health care system is not for the faint of heart! Another leader stressed the importance of senior leadership being in touch and engaging with local levels, not leading from afar.

Seeing the system.

Integrating primary and community care has forced people to look beyond their own immediate work area. As noted in a previous section of this report, some views of the system include a larger arena than others. Nonetheless, it would seem that there is more awareness of the system and a new awareness of the implications of actions or decisions. One leader characterized this enlightenment as taking time to think about implications and seeking solutions that do not compromise one area for another. For others it means looking through a community services lens instead of a hospital lens. For many it includes being more open about plans and decisions, being more transparent about intent, and demonstrating commitment and a desire for collaboration. Integration has found its way into the very heart of processes now. One leader realized that IPCC is linked to everything else they do and that many other things either contribute to it or are the result of IPCC 'by product' work, and it can't be separated. "I can't de-link it from everything else I do."

One leader shared how they learned to be comfortable letting go of things they had no control over and giving up the temptation to micromanage and let people get things done in their own way. "Sometimes the solutions people choose and the way the do it is not exactly the way I thought it would be best, but they have done it and they are committed to it, and I can't be pulling on every string." This leader learned to empower others and feel comfortable with the outcomes.

Scanning the environment.

Keeping an eye on the radar screen, looking around and seeing what, and how the world is working now needs to be something that leaders are doing on a regular basis.

Scanning the horizon and noting what they need to be aware of and what they could be using, is key to leveraging the forces that are shaping how we work today. "You can't function without doing that" and "Recognizing that people get information in a variety of ways [like Twitter and Facebook] and they get it from other than government sources."

One participant pointed out that leaders need to look even farther than the boundaries of the organizations participating in IPCC and involve the patients if a deep-seated shift is to be made. Using the program to reduce the use of antibiotics as an example (Not all bugs need drugs), this leader astutely notes that the public and patients will have to be convinced of the value and benefit to them of accessing services through community means rather than hospitals and a slogan and public awareness campaign would be effective in tipping the scale towards integrated health care and changing the expectation and assumption that health care takes place only in hospitals.

Themes That Stood Out

The themes that emerged from the case study of the BC Node research provide us with a picture of one community in one health authority. However, they are worth considering as possible factors in the larger health care system in Canada. If we overlay the themes and comments from this group, we can ask if it is reasonable that these themes are present in the larger national picture.

Differing system views.

Participants are seeing the system differently. Some see the system as their own organization with other groups on the periphery while others include all the groups and other partners in their system view.

When sharing the findings of Cycle One with participants this image was used to illustrate how participants were viewing the vision differently. Now it seems apparent that participants are looking at the system and seeing different versions of system scope. If this is happening in one area of one province it seems logical that it is happening at the national level too. When we consider the complexity of the national health care system, with multiple provinces and health care systems, we can imagine that the picture below would be much more fractured.

Figure 2. Distorted Image used with permission from Dreamstime Images

System barriers.

Participants cited system barriers as a serious detriment to working effectively and efficiently. Information cannot move freely between different groups due to interface inadequacies and policies. This affects not only the ability to communicate and share information that could benefit the patient care aspect, but also prevents measurement of progress toward objectives. The amount of potential barriers that could exist in the national system is staggering when we consider the potential number of separate software systems and the limitations that exist between provincial privacy and information sharing policies.

Need for evidence.

The system limitations noted earlier have prevented the Ministry of Health and Fraser Health from gathering a comprehensive set of data. There is a need for measurement and evaluation that demonstrates success in meeting objectives. This includes data collection, data interpretation and analysis, translation of analysis into something stakeholders can apply.

Not only is it difficult to provide evidence that the integration is a more efficient use of health care resources, it is a challenge to know if it is making a difference in the lives of patients and caregivers. If data for evaluation is difficult to acquire in one health authority in one province, the challenges of doing so at a national level must be gargantuan. Participants in this study spoke of the challenges of aligning the objectives and goals of multiple stakeholders. When we consider the alignment challenges of a national health care system we gain a new appreciation for the role of leaders at that level.

Turnover vs. new blood.

Two conflicting premises surfaced in the BC Node research. On one hand we heard that there is too much turnover among leaders and executives, resulting in an atmosphere of constant churn. Relationships are hard to maintain and the energy, time, and trust required to establish new relationships are in short supply. Without effective relationships, shared ownership of change and objectives is difficult. We also heard that new blood is needed to relieve tired and overwhelmed leaders.

Demographics.

As Canadian Baby Boomers retire all sectors are affected by the change in demographics. There may not be a large enough talent pool to draw from and those overworked leaders may not be able to find replacements. The physician population is also expected to shrink, putting more pressure on the national and provincial health care systems and more demands from the population to address this shortage. The work ethic differs between generations and we were told that leaders observed that younger people and physicians hold different views on what work / life balance means and they are establishing boundaries around their personal time in a way that older workers have not.

Leadership development.

How are new leaders being prepared for the demanding roles facing them? We heard there is room for improvement in this area. It is difficult for leaders to take time to attend formal leadership programs so innovative means of developing leadership skills are becoming more attractive. Mentoring was mentioned as an attractive approach to leadership development. Leadership learning most often occurs as a result of experiential learning and personal leadership reflection. While operational learning was well documented by the participants in this study, leadership learning was not recognized.

Communication.

Not surprisingly, communication was a theme that ran through all participants' comments in each cycle of data collection. Making time for dialogue, listening to hear, and resolving conflict were things listed by participants over and over, and we can say with confidence that communication is a challenge for leaders in the national health care system too.

Culture.

Our study participants felt the challenges of working and collaborating across organizational cultures and 'industry jargon'. Our country is a mosaic of different cultures and languages, so it is reasonable to say that our national health care leaders must consider as well.

What's Emerging as Important

- It's time to provide concrete evidence that IPCC is working and truly making a difference in the eyes of all participant groups.
- Maintaining and sustaining leaders' energy.
- Technology and software interface is a substantial barrier along with privacy policies.
- The challenge of keeping people engaged and making sure new people are onboarded properly.
- The disconnection between some groups.
- Knowledge exchange and how to best facilitate it for learning.

Some Observations

- The disconnect identified in Cycle Two between groups and understandings could be the result of the groups not viewing the system the same way.
- The difference in language may also be contributing to the sense of disconnection. Administrators tend to use buzzwords and 'corporate speak' that is foreign to physicians.
- Most of the positive comments relate to internal relationships and processes in Fraser Health. This may also be due to how they view the system.
- The walk and the talk do not always match. In all cycles participants expressed the importance of regular communication and face to face meetings. They appreciated the time and space devoted to discussion around IPCC.

Some Questions & Opportunities for Leaders

- How is a shift in mindset/way of working/culture recognized, acknowledged, rewarded, and celebrated?

- How are accomplishments and progress marked and celebrated? How often do leaders initiate a 'taking stock and marking our achievements' session?
- Turnover has been cited as a challenge and a negative factor, yet there have been comments about the need for new blood. How do these comments reconcile with each other?
- Fraser Health speaks of positive aspects of integration and seems to benefit from improved internal processes and relationships as a result of IPCC. On the other hand, physicians say the programs are not functioning as fully integrated units. How is integration being defined and understood by all the groups? How will leaders address the feeling of disconnection that physicians have expressed?
- Some seem to view the system as their group and partners as external. "Who do you consider to be part of your system?" Do the three groups view the system the same? Does this explain why in Cycle Two all the positive comments came from one group and the issues came from another?
- How can leaders address the technical issues around data collection, data sharing, and information flow?
- How can the issue of evidence of success be addressed?
- What would it take to create a mentorship program for physician leaders?
- How can the findings from this research be connected to issues leaders face and used as tools for solutions?
- How could a social network analysis review be useful to leaders in the IPCC collaborative?

Additional Notes

The BC Node gathered data by the use of semi-structured interviews and observation at a series of meetings.

Cycle Three data collection was complete as of July 10 2013 and includes six hours of interview data and attendance at six meetings. Cycle Three included some of the same participants, and some new ones, due to availability and turnover. It was comprised of even distribution through the three stakeholder groups, Ministry of Health, Fraser Health, and the Division of Family Practice in Chilliwack. Cycle Three participants

included three people from the Ministry of Health, three from Fraser Health, and three physicians. Five participants were female and four were male.

Overall, only four participants were interviewed in all three cycles. Five participants were interviewed twice, and seven participants were interviewed only once. Turnover and churn affected the research, as it affected IPCC work.

When a participant was interviewed for the second or third time, the responses from their previous interview(s) were reviewed and explored further or in greater depth if appropriate or necessary. However, the participants were in a different context (six or 12 months hence) and had new perspectives and examples to share.

Cycle Three amassed 183 pages of typed transcripts containing a total of 59,103 words. NVivo was used to support the data analysis.

Regional Node Analysis of Leadership of Change

This section speaks to the BC Node contribution to the overall study (organized around the three main questions posed in the original proposal and answered from the individual regional contexts).

The Current State of Health Leadership In Canada

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?

In order to address this question, findings from across the country will be considered together to create a composite picture of health leadership capacity in Canada. The questions asked of participants in the BC study did not address health leadership capacity in Canada, but asked them to describe their experiences and perceptions of leadership in relation to the Chilliwack Services Base IPCC initiative.

While composing this composite view of leadership capacity in Canada it is important to consider the context health care leaders are working in. Weberg (2012, p. 268) has identified some important aspects and challenges that leaders must incorporate into their practice. He cites rising cost and limited resources, system inefficiencies, increasing complexity, and an evidence gap that makes it hard to determine causal factors. The Baby Boomer generation is not only approaching retirement years, but they are putting an additional strain on our health care system as they begin to experience chronic health problems. There are fewer doctors accepting new patients and fewer health care professionals. Enticing these professionals to areas outside major cities is a challenge for some provinces.

In Cycle One, participants identified continuous learning as a factor that supports transformation, and the attitude that 'mistakes' are learning experiences and are viewed in a positive light, rather than an issue that carried negative connotations. The inclusion

of multiple stakeholders and the invitation to co-create the structure was also viewed as an aspect that supports transformation. Investing time to hold conversations about change and allow for dialogue and the sharing of ideas, concerns, and implications was cited as important in creating an atmosphere that supports system transformation. It is in investment in change, and investment in the 'front end' of change that creates the environment most likely to foster engagement and commitment to change.

A positive attitude toward change was described, cheering on the early adaptors in order to foster a positive environment for change was deemed important. Another factor in creating a positive attitude is the trust that is earned by the leaders.

If these things are not tended to then the expected outcome is resistance to change, and by extension, resistance to system transformation. Priorities that compete for people's energy and time hinder system transformation, and can slow down the processes that support transformation.

As Cycle Two was underway, British Columbians were preparing to go to the polls and the uncertainty about the future of programs and structure was mentioned by participants as an important factor in how they look at system transformation. In fact, given that we face the possibility of an election every few years, this is a constant threat to the success of system transformation. At this point in the study, participants also demonstrated an expanded view of the system, and a realization that the scope of the integration project was larger than they first realized. They grappled with the complexity of creating and maintaining numerous new partnerships and relationships, and experienced some conflict in the process. They became aware of the differences in language and the importance of communicating for different cultures.

By Cycle Three participants were feeling a bit overwhelmed and spoke of the challenge of maintaining energy and spirit in the face of mounting workloads and constant turnover. The need to produce solid evidence (both qualitative and quantitative) was expressed by many participants. They highlighted the challenges in obtaining data for evidentiary purposes and the restrictions on sharing it across the integration plane. Several leaders shared that they felt there is a widening disconnect between some of the groups and highlighted language as an area where it was evident to them that they spoke in different tongues.

Given what we learned from the research participants in the Ministry of Health, Fraser Health Authority, and the Chilliwack Division of Family Practice, we can contribute the following for inclusion of the aggregate report on the capacity of health leadership in Canada:

- *The current state.* Leaders are feeling fatigued and overburdened. Leaders are concerned about succession planning, the demographic reality of the large numbers of physicians and health care leaders who will retire in the next five to ten years. Leaders are not able to take advantage of structured leadership development opportunities.
- *What is working.* Whole systems awareness, courageous leadership, dedicated funding to change programs like IPCC. Leaders' commitment to working effectively and making a difference.
- *What is not working.* Barriers to data and information sharing. High rate of turnover resulting in inconsistency and instability. Different cultural approaches (e.g. administrative vs. physicians) and cultures and the difficulty in bridging the gap between their priorities, language, and world view and the resulting disconnect between the groups. Legislation that divides rather than integrates. Restrictions on professional development and the ability to network inter-provincially which enforces silos provincially and stifles learning from others. Leaders who are unprepared and not equipped for the demands of the role. Lack of evidence for change success. Budgets that restrict leaders' ability to make connections and build relationships Differing views of the system.

Wegerg (2012) sums up the challenges for leaders in our health care system today and identifies an important area for leadership capacity building when we says

> "As more and more political, environmental, and social pressure is placed on healthcare delivery and outcomes, the need for innovation and rapid change becomes more evident. By leading at the intersections, through strong networking, allowing for distributed decision making, and fostering conditions for the organization to quickly and effectively adapt to these pressures, we can assure survival of healthcare organizations" (p. 275).

Gaps, Expectations, and National Standards

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?

The BC Node did not incorporate questions that directly address the LEADS framework, however, the participants did speak to leadership capabilities which appear in the LEADS framework. LEADS has specific definitions for capability and competency and these definitions were not explained to participants so their comments are couched in their definitions of the terms.

Lead self.

The first LEADS capability is *Lead Self* and participants did offer comments and examples that demonstrated their capability and understanding of self-awareness, self-management, and character. A gap in the current practices is in the area of developing themselves. While experiential learning opportunities abound, the learning is not captured to be reflected on or shared with others. According to the leaders in this study, formal learning events are not on their agenda. They cannot spare the time to attend, and in many cases travel and funding restrictions prohibit them from attending.

Engage others.

Funding, time, and travel limitations hobbled leaders in the LEADS capability *Engage Others* by hindering their ability to send staff to formal learning events for professional development. Resourcing challenges impacted leaders' ability to "ensure that resources are available to fulfill their expected responsibilities" (Leaders for Life, 2010). Leaders spoke of being stretched to the breaking point with diminishing administrative support and an uncertain future. Effective communication skills and the ability to build teams were areas of the LEADS framework that participants spoke about in positive terms.

Achieving results and develop coalitions.

Achieving Results was not always easy. Leaders were able to set direction using the vision as a guide, and they were able to take actions that support the vision and move integration forward. Aligning the three groups, Ministry of Health, Fraser Health, and the Division of Family Practice was more of a challenge as this required coordinating and collaborating across different working cultures and expectations. Similar challenges were faced as leaders strove to *Develop Coalitions* and bridge the gaps between the three groups. Partnerships were struck and commitment was abundant, but the different world views made navigating the socio-political environment difficult. Some viewed the political channels as opportunities to further integrate primary and community care while others saw it as a bureaucratic obstacle. Mobilizing knowledge was extremely difficult and sometimes impossible due to the difficulty in obtaining and interpreting data into a form that was meaningful and useful for basing decisions on.

Systems transformation.

The fifth LEADS capability, *Systems Transformation* was evident in the ability of study participants to practice systems and critical thinking, encourage innovation, orient themselves to the future, and champion change. As was highlighted in the findings, not all of the participants viewed the system using the same lens, and the scope of the system varied depending on which group defined it.

A paradigm shift.

The literature review was created in conjunction with the three data collection cycles, and identified authors and emerging themes the participants identified through the course of the research. Throughout the study, participants spoke of the changes they were experiencing and they shared their thoughts, insights and concerns about large system change. Heifetz, Grashow, and Linsky (2009) address the fundamentals of supporting a paradigm shift in regards to system transformation and differentiate technical (adaptive) challenges from adaptive (capacity) challenges. They reflected on a combined total of over 60 years of leadership consulting in a variety of sectors around the world. They consider technical challenges as problems that can be diagnosed and solved by applying solutions using the current knowledge, structure, skills, expertise, or process. These are problems that can be clearly stated, have clear, straightforward solutions, and

usually don't impact the people involved. Adaptive capacity challenges are tougher to solve because they involve people's priorities, beliefs, habits, and loyalties. An organization with adaptive capacity has both the ability to deal with 'technical' and 'adaptive' challenges.

Proactive adaptive challenges involve tolerating a degree of discomfort, a shift in mindset, and/or a whole new approach, often including a loss of some kind. The participants talked about a 'new way of working' implying a loss of the 'old way'. The failure of change initiatives is often connected to an organization's or leader's error in applying a technical fix to a problem that is in need of a proactive adaptive solution. Bridges (1991) recognizes that people will feel a loss (p. 19-33) and shares some strategies for supporting people through the transition. Scott and Jaffe (1989) also provide a map for 'letting go' of what is familiar and taking steps to accept and explore the effects of change on individuals.

Seeing the larger picture.

Thatchenkery and Metzker (2006) talk about leaders that are predisposed to seeing the larger picture and the connections at multiple points in the system and view these connection points as possibilities for further connections. The framing of a system as full of potential, rather than a series of boundaries is reflected in the participants comments about tapping into the vast wealth of resources, rather than protecting information in isolated silos. Thatchenkery and Metzker also speak of the capacity to 'embrace ambiguity', which was again repeated several times in participants' comments. Meadows (2008) writes extensively on systems and reminds us of the importance of viewing the whole system in order to understand the implications of change to any part of the system. She points out several 'systems traps' that can occur if a leader is not consciously aware of, and operating with the whole system in mind. She offers the Sufi teaching story "You think that because you understand 'one' that you must therefore understand 'two' because one and one make two. But you forget that you must also understand 'and'" (p. 14). Draper Kauffman, Jr. (1980) adds "Everything is connected to everything else. Real life is lived in a complex world system where all the subsystems overlap and affect each other. The common mistake is to deal with one subsystem in isolation, as if it didn't connect with anything else. This almost always backfires as other

systems respond in unanticipated ways" (p. 38). This can be a challenge because, as Oshry (1995) points out "We know what life is like for us in our part of the system. Other parts of the system are, for the most part, invisible to us" (p. 1). The implications are serious. Senge (1990) cautions us about what happens when we make decisions regarding our part of the system without considering the whole system when he says "We learn best from our experience, but we never directly experience the consequences of many of our decisions" (p. 23).

Fulmer (2000) also stresses the interdependencies of a system and how the connections support system transformation. The importance of maintaining connections, which the participants stressed repeatedly, is explicit in Fulmer's comments "They cannot respond in a constructive way if they do not know what is happening around them" (p. 88). Fulmer also echoes participants' thoughts about being comfortable with ambiguity "What is needed in this kind of environment is an organization staffed by people who can respond to the uncertainty in a positive way rather than being frightened by what may lie ahead" (p. 152) and "It requires an organization made up of people who are willing and able to change. That is a fundamental characteristic of an adaptive organization" (p. 172).

Being willing to change involves a degree of risk. Thatchenkery and Metzker (2006) aptly word what participants shared about taking risk. "But for innovation to occur there must be some risk and the willingness to accept failure or setbacks as part of a learning process before finding a new solution" and "The ability to reframe or reinterpret a given situation enabled them to perceive that a positive consequence could be built from even the most drastic or devastating circumstances" (p. 29).

The inner source of leadership.

Otto Scharmer (2009) invites us to look at organizations and the world in a more purposeful way. He examines the elusive elements of leadership and says that we can observe the outcomes of leadership (e.g. the environment or culture of an organization) and can see how leadership is demonstrated, or the process (e.g. in communications) but we haven't been able to determine the **source** of leadership. What is it in each of us that guides our choices....to step up to the plate or not....to demonstrate leadership or not? He offers the analogy of an artist. We can see the artist standing at the blank canvas. We

can watch the technique, but we can't see what inner source produces the painting and what prompts those brushstrokes (p. 21).

Scharmer (2009) states that leadership is needed at all levels, not just at 'the top' because "significant innovation is about *doing* things differently, not just *talking* about new ideas" (p. xvi). He believes the primary job of leadership is to help people "discover the power of seeing together" (p, 136) which was described by the participants in their comments about collaboration and co-creating the vision. Scharmer also states that the only way to effect system transformation is to work collaboratively with all involved (p. 137).

In the second cycle of data collection and analysis, it was apparent that participants were thinking about IPCC in a different way. Clues in the language used by participants indicate a paradigm shift in the way they view integration in the way they work. Anderson and Anderson (2001) describe the transformation of mindset to one of "reality as a living system" that is characterized as an awareness of the human and system dynamics at play. They list elements as relational, co-created and participatory. They acknowledge the uncertainty of situations and contexts, the need for continuous processes and the fact that order can arise out of chaos (p. 44). They say "Transformational change requires leaders to shift from project management thinking to process-oriented thinking" (p. 46). In the second round of interviews participants used 'movement' instead of 'initiative' and 'continuous improvement' instead of 'project management'. They talked of sharing, rather than competing, and they indicated an awareness of system interdependencies where in the first cycle they spoke of role interdependencies. One participant coined the term 'leadering' indicating a more active presence and more proactive leadership activities. As mentioned above, Thatchenkery and Metzker (2006) note another clue to a paradigm shift as reframing and communicating about a situation so that a positive outcome could be achieved and people can be engaged, motivated, and committed.

Language.

Although some terms in language were new, it is evident in the interviews that the participants are not using the same terms for the same things. They have not yet developed a shared language that is understood in the same way by all stakeholders.

Heifetz, Grashow, and Linsky (2009) share their opinion of the importance of shared language as ""*Shared language* is important in leading adaptive change. When people use the same words with the same meaning, they communicate more effectively, minimize misunderstandings, and gain the sense of being on the same page, even while grappling with significant differences on the issues" (p. 9).

Shared goals may be hard to achieve if the language and understanding of the terms are different. Dan Sanker (2012) tells us that common goals are the key element in collaboration and is what brings people together and motivates them to commit the time, energy, and resources necessary to accomplish the objective. (p. 80-81).

An aspect of leadership that was not mentioned by participants in the first cycle, but was evident in the second round of interviews was the awareness of leadership in three domains; leading self, leading others, and leading in the organization. Van Velsor, McCauley, & Ruderman, (2010) describe 'leading oneself' as demonstrating self awareness, the ability to balance conflicting demands, the ability to learn, and the ability to hold values congruent with leadership. They express 'leading others' as the ability to build and maintain relationships, support effective work groups or teams, demonstrate developed communication skills, and the ability to develop skills (including leadership skills) in others. They speak of 'leading the organization' as having management (different from leadership) skills, the ability to think and act strategically and creatively, and the ability to initiate and implement change (p 14-17).

According to Dickson, (2008) these groupings are also aligned with three of the five domains of the LEADS framework – lead self (being self aware, managing and developing themselves, and demonstrating character). Engage others (foster the development of others, contribute to healthy organizations and workplaces, effective communication skills, and the ability to build teams). Systems Transformation – demonstrate systems and critical thinking, encourage and support innovation, be future oriented, and champion and orchestrate change.

Role modeling.

One way leaders demonstrate their capabilities in the domains of leadership is by role modeling leadership skills, attitude, and behaviour. Thatchenkery and Metzker (2006) tell us what happens when over time, leaders role model appropriate behaviour.

"Through their behaviors, leaders create an organizational climate that, in turn, encourages others to consider similar actions and initiatives. Such repeated behaviors, over a period of time, become norms – the group's shared beliefs regarding behavior, values, and attitudes" (p. 94).

There are many opportunities for leaders to role model effective leadership practices. Anderson and Anderson (2001) talk about learning from experience when things do not go as planned. They say "A major theme of transformational change is ***learn*** *from what is happening and immediately* ***course correct*** *the process and the outcome"* (p. 47). When leaders recognize the signals that something is going off the rails, address it promptly and effectively, and learn from the experience others will take note. One participant said it involved "Doing what you can to make it right".

Bennis (1989) reminds us that conflict can be seen as a positive event. He says "Leaders do not avoid, repress, or deny conflict, but rather see it as an opportunity." (p. 158). One participant stressed the importance of a leader's ability to separate themselves from the conflict. Covey (2004) talks about seeking a resolution to conflict that involves setting aside personal emotions that may trigger resistance or aggression, and focusing on solving the issue to the satisfaction of both sides (p. 186-214).

Political astuteness.

Conflict resolution is one area of leadership that requires a degree of political astuteness. Participants' comments are echoed by several authors (Arino and de la Torre, 1998; Doz, 1996; Doz and Hamel, 1998; Huxam and Vangren, 2004; Leaders for Life, 2010; Marshall, 2004; Ring and Van de Ven, 1994; and Spekman, Isabella, and MacAvoy, 2000) in their descriptions of what a politically astute leader does. According to the authors and reinforced by the participants, being a politically astute leader means:

- Being aware that the 'right' people need to be around the table and what roles each of these individuals needs to claim. This includes the realization that turnover is constant and new people need to be invited, briefed, and included. Being strategic about inclusion. Knowing how to create and structure groups that can work together for a common objective.

- Being aware that communications need to be tailored for different groups. So, synthesizing information from one source, 'translating' or repackaging appropriately for other groups in the system.
- Recognizing that the system includes different languages and different cultures and participating appropriately in each.
- Recognizing the external factors that are affecting the system and interacting appropriately with those.
- Dealing with conflict in a constructive way, taking into account the political aspects of the individuals/groups involved in the conflict. Anticipating where conflict might arise and taking steps to address potential conflict issues proactively.
- Recognizing that being comfortable with uncertainty and ambiguity are part of leadership and how others perceive a leader's comfort is important. Being aware that how a leader talks about uncertainty affects others.
- Being aware of ethical concerns and how they are handled.
- Being aware that all these aspects of relationships are ongoing and require active nurturing.

Others take a cue from a leaders' comfort level with ambiguity and uncertainty. Thatchenkery and Metzker (2006) describe ambiguity as "dealing with two seemingly contradictory ideas at one time, not knowing and answer, not knowing how to resolve a problem, or being unable to foresee the result of a given situation" (p. 26). Anderson and Anderson (2001) add "...the future state is not clear at the beginning, the process for getting there cannot be clear either....Since the change process cannot be "managed" a new way of leading is needed" (p. 41-42). Fulmer (2000) reminds us that although we live and work in a world subject to constant change we seek out what is familiar and consistent and leaders can endeavour to maintain some consistency in their environment in order to support people through change. He says ""A few things will need to remain fairly constant. In fact, it is these relative constants that help the people of the organization deal effectively with the changes they confront" (p. 173).

As the participants grapple with finding the balance between turnover and stability it is interesting to consider how the situations can be reframed to a positive, what

needs to be accepted as the reality of the environment, and what the cost of change in terms of dollar amounts, investment in time, and the effect on others' commitment. Leana and Barry (2000) examine the tension between the desire for stability and the need for change. Individuals in workplaces seek stimulation and variety, while at the same time, yearn for consistency and predictability (p. 753). The presence of both stability and change is a reality in our workplaces, and individuals have varying levels of tolerance for and resilience to change (p. 756).

An important way for leaders to model leadership is in the building and nurturing of a trusting work environment. Some participants referred to an incident that occurred that severely damaged their level of trust in the system. Covey (1989) refers to the 'emotional bank account' (p. 188) and describes it as a metaphor for the amount of trust that is built up in a relationship. When courtesy, respect, honesty, and integrity are demonstrated in the relationship, they are 'deposits'. When trust is damaged, it is like a withdrawal in the bank account, possibly to the point of an overdraft.

Developing leaders at all levels.

Participants called for evidence that IPCC was having the desired effect. Scott and Jaffe (1989) talk about the shift that happens as people begin to see the possibilities, through evidence, that change brings. When evidence is seen that the change is producing positive outcomes, people can better set aside misgivings and embrace what the change has to offer. Scott and Jaffe illustrate the process using a curve in a grid to show the process people often experience when faced with change (p. 27). The diagram below, from their book, allows individuals to map where they feel they are in the process, and provides leaders with a tool to open discussions about change and support people through the stages.

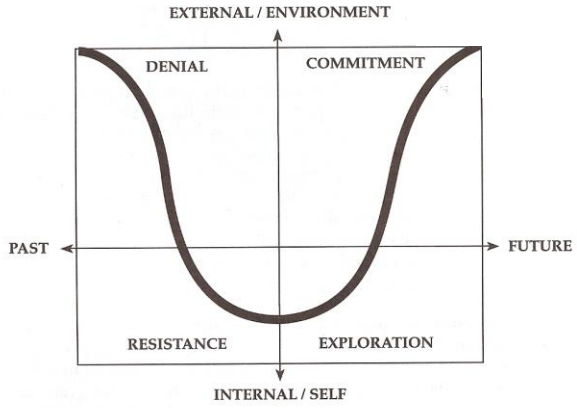

Figure 3. Transition Curve. Adapted from *Managing Personal Change: A Primer for Today's World*, a Crisp series book by by Cynthia Scott and Dennis Jaffe, available from Axzo Press, www.axzopress.com

The participants spoke of developing leaders at all levels of the organizations and one group identified succession planning as a crucial element for the next phase of IPCC. Dickson (2008) agrees and says "Anyone – regardless of their role, or the position they occupy in the health system – must be able to lead themselves, engage others, achieve results, develop coalitions, and conduct systems transformation" (p. 24). He adds "...each person in the system, regardless of position or title, must exercise leadership when it is required. This is distributed leadership" (p. 24).

Developing leaders at all levels requires learning on everyone's part. Participants' comments indicate a high value for learning, and the reality that they cannot find the time to take formal programs and courses. They spoke often of learning on-the-job, or as Fullan (2001) calls it "learning in context" (p. 125). He considers this learning to be the most effective and says "learning in the setting where you work, or learning in context, is the learning with the greatest payoff because it is more specific (customized to the situation) and because it is social (involves the group)" (p. 126). An interesting point revealed in the second cycle of data collection was that learning about leadership has not been documented. Best practices, operational learning, or 'process learning' was well documented, but leadership learning has not been recorded.

Participants' comments about leadership development at all levels are supported by Fulmer (2000) in his remarks about making mistakes in the process of learning. "Adaptation occurs as a result of learning – and learning rarely occurs unless mistakes are made" (p. 164).

Mentoring was raised by participants as a viable means of developing leaders and there is ample literature that supports that concept. Bell (2000) describes mentoring as a learning relationship where both mentor and mentee have equal value in the relationship and both contribute to each other's learning. Thomson (2009) tells us that mentoring may create relationships that allow individuals to "develop organizational friendships to cope with the challenges of organizational change, become more knowledgeable and marketable in their field of work, and to also allow them to eventually become mentors". Clutterbuck (1991) adds that mentoring "helps to ensure that key cultural values are passed on which allows the company to prepare protégés for leadership" (p. 31).

Benefits to mentees include: employment retention, increased self esteem, job satisfaction, career advancement opportunities, support for goal achievement, increased visibility in the organization, ability to cope with change and new demands, close the knowledge gap between employees. (Bass 1981; Fiedler & Leister, 1977; Higgins, 2000; Kram 1983; May 2003).

Benefits to the mentor include: learning from the mentee, learning to better understand individual needs, opportunity to contribute to another's success. (Marte, 2009; Mikitka, 2009; Potter et al ,2009).

Key themes arising from the literature suggest that topics the participants raised as; capabilities of effective leaders, language, change vs. stability, leadership development and mentoring, and systems awareness are well documented.

Earlier in this literature review the analogy of an artist was used to describe the elusive forces that guide leadership traits. According to Michael Staver (2006) these traits can be described as the artistic characteristics of leadership. He tell us "The artistic side of leadership consists of intangible skills such as your ability to motivate staff, to articulate a clear vision, and then to persuade staff why it matters" (p. 65). Staver's article is titled *Leadership Isn't for Cowards*, inferring that a great deal of courage is needed to lead a large system change. He defines leadership courage as "the willingness

and ability to confront all challenges and complete all tasks to that leaders are confident that their values are upheld" and "courage is about clarity and mindfulness – clarity regarding what you believe and mindfulness in practicing those beliefs in the culture" (p. 65).

Participants in this study talked about the need to demonstrate courageous leadership and how essential that quality is in building trusting relationships and sustaining the energy it takes to lead in a complex system with multiple priorities and a shrinking support resources. Bender (1997) lists many of the same things the participants expressed as requiring continuous courage. Bender and the participants agree that leaders need to draw forth the courage to overcome; fear of failure, fear of loss, fear of criticism, resistance to change, lack of confidence, negative inner thoughts, past mistakes, and impatience (p. 145-148).

Where do leaders find that courage? What do they draw on to face the daily hurdles and challenges? How do they generate energy to persevere? Margaret Wheatley (2005) thinks it comes from an internal conviction that the work and the outcomes will be worth it. She says ""Courage comes from our hearts." "Where do we find the courage to be leaders today?" "We have to be engaged at the heart level in order to be courageous champions. As much as we may fear emotions at work, leaders need to be willing to let their hearts open and to tell stories that open other people's hearts" (p. 129). It's tiring work to demonstrate courageous leadership day in and day out. Participants confessed to feeling weary and sense that their energy reserves are being depleted at a rate faster than they are being replenished. They see fatigue in the eyes of those around them too. Wheatley (2011), in her recent work, has written about creating oases where leaders and those with them can work without the distractions of tension and conflict. She says one way leaders demonstrate courage is by creating these spaces and describes the intent as "They use their formal leadership to champion values and practices that respect people, that rely on people's inherent motivation, creativity, and caring to get quality work done. These leaders consciously create oases or protected areas within the bureaucracy where people can still contribute, protected from the disabling demands of the old system" (p. 11).

Those calm oasis may provide the nourishment leaders need to carry on. Forck (2011) also speaks about the fortitude needed to sustain the drive to continue the work of change and to continue to support others to continue. He draws on a quote by Mary Anne Radmacher who says "Courage doesn't always roar. Sometimes courage is that quiet voice at the end of the day saying 'I will try again tomorrow'" (p. 34). Trying again tomorrow may not mean attempting Herculean acts. It may mean what one participant referred to as the "less important things". Trying again tomorrow may mean continuing being authentic in interactions and developing courageous leadership "through a series of small acts. By being willing to provide alternative viewpoints, go against the deeply worn grain and focus on dedicated self-honesty, you can climb toward more courageous, effective leadership" as Robert Pater (2006, p. 20) describes. It may take more courage to do the "small stuff" than it does to do the larger, more public actions.

Succession planning and developing the next generation of leaders was very much on the minds of the research participants in this study. They acknowledged the difficulty in attending formal learning sessions and frequently mentioned the experiential learning that occurred on an ongoing basis. Raelin (2010) puts more store in the day-to-day learning and emphasizes "Clearly the competencies embedded in performing a reflective or learning-to-learn response are not readily available from classroom training. It cannot be a matter of attending an off-site to learn the "list" of leadership skills. It is not the skills that count as much as the principles attending to the acquisition of learning competencies. In this sense, the skills are metacompetencies that address how one might learn in the midst of experience. So, in the instance of leadership, it is not a question of bringing people to leadership training as much as it is bringing leadership to the group so that everyone can participate in the practice of leadership" (p. xxii).

The opportunities for learning about leadership are plentiful every day. Van Velsor, McCauley, and Ruderman (2010) tell us that "managers [and leaders] learn, grow, and change throughout their careers – not just from formal programs, but also from the challenges in their working and nonworking lives, the relationships they cultivate, and the adverse situations they encounter" (p. 2). They define leader development as "the expansion of a person's capacity to be effective in leadership roles and processes. Leadership roles and processes are those that facilitate setting direction, creating

alignment, and maintaining commitment in groups of people who share common work" (p. 2).

One of the participants commented on the on-the-spot learning that comes with an aha! moment. The participant described their experience as insightful when they realized that despite using different language, the three groups in this study were aligned toward a common goal, even though their way of speaking might belie that to an observer. The participant called those moments of clarity 'crystalline moments of leadership' and takes the opportunity afforded by that clarity to translate so all the parties can see the commonalities in their objectives. Kounios and Beeman (2009) call these insightful moments 'aha! moments' and describe them as "a sudden comprehension that solves a problem, reinterprets a situation, explains a joke, or resolves an ambiguous percept" (p. 210). In the context of this study they occur when a different perspective is suddenly revealed, 'the lights come on', or the magic when the all the dots connect and a new picture is revealed.

Differing system views.

It became evident that different perspectives on the system was a reality for the participants. The participants' comments reflected their view of the system and their descriptions of the system clearly showed that some views held a much broader scope than others. They were looking at the same system, yet not necessarily seeing the whole entity. Oshy (1995) calls this 'spatial blindness" (p. 1) and describes the situation for us as "Generally, if we are paying attention, we know what life is like for us in our part of the system. Other parts of the system are, for the most part, invisible to us. We do not know what others are experiencing, what their worlds are like, what issues they are dealing with, what dilemmas they are facing, what stresses they are undergoing. And what makes matters worse, sometimes we *think* we do know when, in fact, we do not. We have our beliefs, myths, and prejudices, which we accept as the truth and which becomes the bases of our actions. This blindness to other parts of the system – which we call *spatial blindness* – is a source of considerable misunderstanding and conflict".

This blindness creates problems in understanding the implications of actions and decisions in any part of the system. Kofman and Senge (1993) agree and caution us against making assumptions on the whole system based on one part. "The defining

characteristic of a system is that it cannot be understood as a function of its isolated components. First, the behavior of the system doesn't depend on what each part is doing but on how each part is interacting with the rest ... Second, to understand a system we need to understand how it fits into the larger system of which it is a part ... Third, and most important, what we call the parts need not be taken as primary. In fact, how we define the parts is fundamentally a matter of perspective and purpose, not intrinsic in the nature of the 'real thing' we are looking at" (p. 13). Like the Sufi adage about the blind men describing the elephant (Senge, 1990, p. 66, 67), Wheatley (1999) tell us "A system is composed of parts, but we cannot understand a system by looking only at its parts. We need to *work with the whole of a system*, even as we work with individual parts or isolated problems" (p. 139).

We can connect the dots in these points. When a leader has an aha moment and it is evident that the system is viewed differently by various members, an opportunity exists for that leader to share their insight and become a bridge to join the groups, and the views of the system together. Gladwell (2002) calls that role 'boundary spanning' and it is practiced, and has been observed, in this study. Gladwell describes the role as 'connectors'. "Connectors, people with a special gift for bringing the world together" (p. 38). They are bridges and function like ambassadors creating connections between people, groups, and/or organizations. They translate messages, pave the way for relationships, and introduce people. In this case, they see the disparity between system views and set about creating alignment where they can.

The objective of this research was to explore the qualities of leadership, the significance of leadership, and the factors that influence leadership in the context of integrating primary and community care in the Chilliwack Service Delivery Area. The participants in the study shared their examples, their thoughts, and their views on what is required of leaders in large system change initiatives. They gave their opinions on what characteristics, qualities, attributes, and traits leaders need to have in order to be effective, and two terms they used are 'collective leadership' and 'coordinated leadership'. Raelin (2010) helps us differentiate between the two terms. He says leaders need to be concurrent, allowing for more than one leader to be leading at any given time, willingly and naturally sharing leadership with others (p. xv). Participants described it as

calling on everyone to contribute to leadership and adding to the leadership collective, or leadership capacity of the group or organization. Raelin's view of coordinated leadership includes a commitment to collaborate in their actions and that "they don't contribute to leadership sequentially, however, or one at a time; they do so all together and a the same time" (p. xiii). The participants add to that the necessity of coordinating efforts so they are not working at cross purposes or doing things out of sequence that can cause issues or confusion and delay progress.

This brief literature review has explored the points made by participants throughout the case study and lends credence to the comments made by the leaders who were immersed in the integration of primary and community care in the Chilliwack Service Delivery Area. The literature reviewed for the purpose of this paper reflects the views and experiences of the participants at different periods of time over the course of the study.

The question of how a set of national standards for leadership could be structured will be able to be answered at the conclusion of the study. In order to address this question, the composite findings will need to be examined as a whole and include learning about leadership over the period of the entire research project and incorporate the results from all the nodes.

Translating and Mobilizing Knowledge About Effective Leadership

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?

Knowledge of effective leadership could be translated and mobilized in a number of ways. At the completion of the project we will be able to compile a comprehensive inventory of the ways, approaches, programs, tools that could be implemented to develop a culture of effective leadership in Canada, using the strategies used by all the nodes in this research project. A template is being developed to capture the activities, events, and

tools used to transfer and mobilize knowledge used by stakeholders to disseminate the learning. The chart below documents what has been done in the BC Node.

The challenge is to connect the research findings to issues that leaders face so that leaders see the findings as tools for solutions. Since the challenges are so contextual and unique to each setting, leaders must be able to translate the findings into strategies that will be useful to them in their own setting.

When translating and mobilizing leadership knowledge for application it is important to consider a couple of aspects. The knowledge, learning, and information will be best received if it is tailored to fit the local environment. Leaders can then sort through the knowledge and determine how to best mobilize and apply it to their circumstance. This includes determining what can be done at various levels or areas of the system. One of the participants in this study used the term 'lots of lots' meaning that small changes can be implemented in synchronization and the cumulative effect will nudge the system along as a whole. Leaders can use the question "What needs to happen in each area and what is the best way to begin implementation?" to guide their knowledge mobilization plan.

Leaders in the BC Ministry of Health give us an example of how the findings of this study were used to generate discussion on leadership in the context of their workgroup. Below is an excerpt taken directly from the notes taken at an IPCC Implementation Leadership Committee session. The participants included leaders from the Ministry of Health and all health authorities in BC. The italicized bullet points (also taken directly from the meeting notes shared by the Ministry of Health) are the questions that were posed to meeting participants, followed by the reported-back points from the roundtable discussion. Participants were challenged "What can you do differently this afternoon…tomorrow….next week?"

*** Notes and discussion points from June 13 2013 IPCC Implementation Leadership Committee Session. "Exploring Leadership to Advance Integration for Priority Populations" – Small table discussions on 2-3 questions, followed by a report out on group discussions.**

- *What do the findings mean to you/us? Collective vs. individual leadership?*

- *Does ILC need to consider distributed leadership (engaging others)?*
- *What is important to raise and manage up to IPACCC (strategic), leadership role at this table?*
- *What is our collective and individual leadership role in sharing and learning (individual and collective)?*
- *How will we lead locally, regionally, provincially in an integrated way? What are the key features of integrated leadership?*
- *How would you describe your leadership presence at ILC? How does this presence contribute to integrated primary and community care across the system?*
- *What have you learned about leadership in a collaborative environment, including at the ILC?*
- *What motivates you and sustains you as a leader in IPCC?*
- *What assumptions are you making about your leadership?*
- *As leaders for IPCC, what do we need to do less of/more of?*

The room was divided up into four groups, consisting of representatives from each health authority and the Ministry of Health. **Key Highlights:**

- The need for more tables to communicate with both internally and externally, focussing on relationship building and shared learning, all teach, all learn
- The need for balance between transformational and transactional leadership and between culture and process
- Develop a mechanism to achieve balance and to model shared leadership
- Acknowledgement of energy fluctuations, relationships assist in balancing energy
- The need to make time to understand partner perspectives and foundational principles
- Joint understanding of integration and collaboration – frame and reframing and visioning
- Shifting culture, creating new mind sets
- Taking leap of faith, risk, courage, building trust and having the safety to fail/learn

- Openness to change/adapt

Leadership in a Collaborative Environment

- Understand common language/vision
- Aware of subculture
- Influence management
- Developing trust, relationships
- Understanding the business
- **Sharing learning**
- Up and down feedback/input

Integrated Leadership is strengthened through:

- Collaboration
- **Engagement and key stakeholders**
- Align related work to become more efficient
- **Common/language/vision**
- Accepting constant change _PDSA, adaptive actions
- Influence management – understanding political environment
- Awareness of subcultures and able to work within
- No shortage of willingness
- Need to turn willingness into action
- Ability to keep positive/keep energy and reflective time
- Courageous leadership needed
- Early learning – there is cost avoidance but how do we move this to the system?
- Need some innovation funding approach??
- **Leadership in decision making that is collaborative and empowering**
- **Believe in the vision**
- **Engage people**
- Ability to work collaboratively and share and learn from each other

Knowledge Mobilization Activities (Integrated and End-of-Grant)

Cycles One, Two, and Three:

The KM template is under construction so in the meantime this table is the means we will use to share our KM / KT / KE activities.

BC Node KT / KM / KE Activities			
	Cycle One	**Cycle Two**	**Cycle Three**
Planned Activities	PAR activities • Presented Cycle One findings with the BC Node team • Presented Cycle One findings with the FH Steering Committee. This presentation generated rich discussion • Presented Cycle One findings with the MOH participants Developed and circulated BC Node newsletter • 2 issues distributed, 3rd issue in progress IPCC Provincial Forum in June 2012 (no presentation given but several conversations with attendees) Prior to the 2nd interview with participants, the findings are again provided to them	PAR activities • Presented Cycle Two findings with the BC Node team • Presented Cycle Two findings with the FH Steering Committee. • Presented Cycle Two findings with the MOH participants, ILC and Steering Committee • Presented Cycle Two findings with the Chilliwack Collaborative Services Committee. Developed and circulated BC Node newsletter • 2 issues distributed, 3rd issue in progress Prior to the 3nd interview with participants, the findings are again provided to them	PAR activities • Present Cycle Three findings to the BC Node team (Feb 2014) • Present Cycle Three findings to the FH Steering Committee. (Jan 29 2014) • Present Cycle Three findings with the MOH participants, ILC and Steering Committee. (Dec 2013). Set of discussion questions used for roundtable discussion *questions and discussion points below this table • Present Cycle Three findings to the Chilliwack Div of FP. (Jan 14 2014) • Roads to Research presentation Feb 12 2014 (RRU research community)

BC Node KT / KM / KE Activities			
	Cycle One	**Cycle Two**	**Cycle Three**
Unplanned Activities	Informal conversations with participants and others about IPCC (verbal and email)	Informal conversations with participants and others about IPCC (verbal and email)	Informal conversations with participants and others about IPCC (verbal and email)
Key Messages	Updates on project Information on qualitative research Building community	Updates on project Emphasize PAR approach Information on qualitative research Building community	Updates on project Emphasize PAR approach Building community How to use findings to solve problems and address challenges
Who the Findings Were Shared With	BC Node Team and liaisons IPCC Steering Committee MOH representatives Research participants	BC Node Team and liaisons IPCC Steering Committee MOH representatives, ILC and Steering Committee Research participants	BC Node Team and liaisons IPCC Steering Committee MOH representatives, ILC and Steering Committee Research participants
Barriers to Exchange Process	Protocol – reliance on liaisons to share newsletters and findings Getting participants to commit time to presentations and discussion Cost to attend conferences and prepare presentations	Protocol – reliance on liaisons to share newsletters and findings Getting participants to commit time to presentations and discussion Cost to attend conferences and prepare presentations	Getting participants to commit time to presentations and discussion. Physician engagement in PAR activities because it is time out of their revenue-generating work. They need to be compensated for their time. Cancellation of meetings

BC Node KT / KM / KE Activities			
	Cycle One	**Cycle Two**	**Cycle Three**
	Cost of travel to present to participant groups	Cost of travel to present to participant groups	Differences in language between stakeholder groups
Key Messages	The five things participants referred to most: • Communication • Relationships, Partnerships, Connections • Alignment • Trust and Respect • Experiential Learning What's Emerging as Important: • Allowing time and space for dialogue and for people to 'get comfortable' with change is key to engagement • Co-creating the process maximizes the chance of individual and shared ownership of outcomes • Working towards common goals makes a difference • Alignment of individuals' values as well as organizational goals is key to commitment • Experiential learning most valuable • Vision. Ability of a leader to clearly	The five things participants referred to most: • Communication • Relationships, Partnerships, Connections • Alignment • Trust and Respect • Experiential Learning What's Emerging as Important: • Allowing time and space for dialogue and for people to 'get comfortable' with change is key to engagement • Co-creating the process maximizes the chance of individual and shared ownership of outcomes • Working towards common goals makes a difference • Alignment of individuals' values as well as organizational goals is key to commitment • Experiential learning most valuable • Vision. Ability of a leader to clearly	The five things participants referred to most: • Need for Evidence • Sustaining Energy • Succession Planning • Rate of Turnover • Demographics What's Emerging as Important: • The difficulty in acquiring and interpreting data for evidence of progress • Maintaining leaders' energy • Technology and software interface along privacy policies are seen as a key barrier • The challenge of keeping people engaged and motivated • The disconnect between some groups • The challenge of interpreting and sharing information for knowledge exchange purposes • Lack of time for formal leadership development

BC Node KT / KM / KE Activities			
	Cycle One	**Cycle Two**	**Cycle Three**
	interpret it and translate it to peoples' context. • Alignment of personal values to the organizational objective underpins commitment to the outcomes. • Experiential learning is the most valuable.	interpret it and translate it to peoples' context. • Alignment of personal values to the organizational objective underpins commitment to the outcomes. • Experiential learning is the most valuable.	

Future Opportunities	Other health authorities in BC Other organizations implementing large scale change CSC group in Chilliwack, including board members Collaboration with the Michael Smith Foundation to jointly present qualitative and quantitative findings Use of social network analysis tools
Ideas to Expand KM / KT / KE	InspireNet website Videos, YouTube clips PowerPoint presentation bank Visual recording documentary of project Pecha Kucho Poster session at relevant conferences Blog Facebook and Twitter posts PHSI website Webinar PPTs with voice recording speaker notes Public awareness campaign like "Not all bugs needs drugs" Storytelling approach

	Intranet and internal bulletins 3 fold ‘brochure’ of research findings and applications Incorporate into participants’ performance reviews Knowledge management depositories Facilitated discussions Standing item on select agendas Relevant leadership communities of practice

We use the terms knowledge transfer, knowledge mobilization, and knowledge exchange interchangeably. It would be helpful if we defined what we mean by each and identify any distinctions.

Overall Findings and Lessons Learned

Summary analysis of the patterns and trends about leadership and change that emerged over the course of the project and link back to the three overarching project questions from Part IV.

- Timeframe needs to accommodate time for people to be brought on board at the start of the planning for change. People need to have time to feel they own the change so they can engage others more effectively. Usually the timeframes are unrealistic for this initial engagement, and the consequences appear later and can undermine the entire change effort.

- There also needs to be time allotted to 'learning to work together' and to speak each other's language in order to support a culture shift. There are often assumptions made about meanings (e.g. integration) and people may be interpreting key terms differently and making assumptions about how others are interpreting them.

- A high rate of turnover not only slows the process down but decreases the level of trust in the organization for a time until the relationship can be 'tested and tried'.

- Succession planning is imperative for system improvement and stability.

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