2019 NATIONAL HEALTH LEADERSHIP CONFERENCE

NHLC

Healthcare innovation: Advancing better outcomes and economic growth

FINAL REPORT

CONFERENCE HIGHLIGHTS

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Healthcare innovation: Advancing better outcomes and economic growth

Speaker – Sue Paish, CEO, Digital Technology Supercluster

Ms. Paish has led innovation and transformation across the professional services, healthcare and technology sectors. She was an influential employment and labour law lawyer before transitioning to corporate leadership roles. Ms. Paish has been honoured multiple times for her commitment to business leadership with several awards, including the Hall of Fame for Canada's Top 100 Most Powerful Women.

She opened her presentation with a harsh reality – the Canadian economy is slipping on the global stage in terms of research and development investment, productivity per person and income potential.

The Digital Technology Supercluster was one of five superclusters selected for a strategy aimed at driving commercially successful innovation, fostering growth and creating jobs across Canada to share in $950 million of funds dedicated by the federal government to the Innovation Supercluster Initiative. The other four Canadian superclusters are Protein Industries Supercluster, Advanced Manufacturing Supercluster, Scale.Ai Supercluster and Ocean Supercluster.

The Digital Technology Supercluster selects and invests in ambitious, collaborative technology leadership projects. Their main objective is for the world to view Canada as a leader in developing digital products and platforms. The Digital Technology Supercluster is dedicated to the following initiatives:

- Building powerful partnerships and alliances, inducing matching organizations that would not normally work together
- Increasing the breadth and diversity of professionals ready for a digital economy by focusing on programs and projects that will improve the talent base
- Providing small and medium-sized enterprises (SME) an opportunity to grow, scale their businesses and increase ecosystem performance by exposing them to new markets and conducting business internationally
- Developing globally competitive platforms and companies

The Digital Technology Supercluster is a member-based organization. At the time of the conference, there were over 340 Digital Technology Supercluster members. They partner with Innovation, Science and Economic Development (ISED), a department of the Government of Canada, and are committed to fostering a growing, competitive and knowledge-based Canadian economy.

In the Canadian economy, as well as around the world, data is a currency. This organization focuses on collecting data, analyzing data and visualizing data for the industrial, natural resources and healthcare industries. The Digital Technology Supercluster is the sole Canadian supercluster focused on healthcare.

Collaboration is essential to create a successful partnership and potential project. The Digital Technology Supercluster facilitates partnerships. To be eligible to submit a formal project proposal, applicants need at least three organizations working together (one must be a SME, one must be a post-secondary education organization). Proposals are accepted every six months. If a team of internal and external reviewers selects the project, the Digital Technology Supercluster co-invests with the project team.

As of June 2019, seven projects have been selected to move forward with guidance and support from the Digital Technology Supercluster. A brief description of the three healthcare projects follows:

1. Pharmacogenetics – using a cheek swab and pharmacogenetic technology, the patient, pharmacist and physician can see the effect of the patient's genetics on the top 900 commonly prescribed medications to improve the accuracy of prescribing effective medications for patients.

2. Dermatology Point-of-Care Intelligent Network – dramatically decreasing the time it takes to diagnose a patient with skin cancer by having a dermatologist review a picture of a lesion or mole. With this technology, patients can send a picture to their doctor, and it will be analyzed by artificial intelligence to diagnose and begin treatment within weeks instead of months.

3. Secure Health & Genomics Platform – a single platform to collect, secure, store, protect, access, share, leverage, use and commercialize health data to drive better and more cost effective patient care and accelerated research.

The Digital Technology Supercluster has had a tremendous impact on the Canadian economy since its inception in February 2018 with the following results:

- Seven technology leadership projects
- 162 estimated full-time positions created by the projects
- $15 million investment by the Digital Technology Supercluster in cycle one projects
- Cycle one investment leveraged to $40 million
- Over 100 Expressions of Interest (EOI), 300 member organizations and 120 SMEs

In closing, Ms. Paish asked the audience, "why should you care?" about the Canadian economy and this initiative. If our global competitiveness continues to decline, it will negatively affect us all. If we become the global centre for the collection, protection, securing, accessing, sharing and monetization of health data, we could significant reduce the current investment—nearly 50% of our provincial budgets across the country—and transform healthcare into an area of economic growth. Nationally and internationally, the Canadian economy has the potential to thrive if we harness the power of innovation.

Concurrent Session #2: Strategic planning from the inside-out: How to use the voice of the patient as a differentiator

Facilitators: Susan (Sue) Owen, CHE – Impreza Consulting and Nicola (Nicki) Morris – The Neoteric Group

This concurrent session started with the idea of discussing how to integrate the patient's voice into the strategic planning process for improved healthcare models via patient engagement and consultation.

Both presenters have extensive experience in the Canadian healthcare system. Ms. Owen's experiences are in a hospital environment and Ms. Morris works in long-term care, home care and retirement facilities.

A positive patient experience can improve patient outcomes, overall satisfaction, elevate an organization's reputation and save money. Measuring a patient's experience is challenging because compassion, the family's experience and the patient's experience are subjective concepts. Design thinking is a tool to quantify "gut feel" and "fuzziness" to engage patients on an emotional level, and integrate these concepts into healthcare environments.

The current state of healthcare is complicated and complex with a variety of drivers (i.e. economic realities, value for money, revenue creation, shifts in models of care, etc.). There is a nationwide shift to a value-based model of healthcare prioritizing economy, efficiency and effectiveness without additional government funding.

A design thinking application, co-creation, allows patients to become co-producers of their care experience. This is a transformation from a provider-centred model to a parent-centred model of healthcare. Smart care solutions and self-directed care are becoming more popular, and tools (e.g. patient care survey) currently in use will become obsolete. Technology and industry tools aggressively driving accessibility and the ability to customize interactions will grow in popularity in the healthcare system.

During patient summits, the most common feedback the facilitators of this session heard was, "I was afraid." There is a need to address patients'/residents'/clients' emotional reactions and experiences with Canadian healthcare. Leaders and staff are asked to respond to emotional needs along with quantitative aspects of patient care (e.g. length of stay, mortally rate, etc.). This shift creates new ecosystems of change, a notion of change from examples of mental health care, and the empathy that care promotes. The goals of the design process include:

- Providing opportunities for patients to co-produce their own care and enable self-care (e.g. home dialysis)
- Reliability of care organization, the ability to connect patients with the appropriate care/support (e.g. providing accessible options appropriate for each patient)
- Removing "friction" by reducing accessibility challenges, stigmas associated with treatments, conditions and needs, ensuring patients feel supported and giving a sense of control in their care/experience

Many healthcare facilities focus on service (e.g. valet parking, self-scheduling patient systems, etc.). Patients may feel supported, but the fear and anxiety associated with the patient care experience is not being fully addressed. Three tools to leverage the voice of the patient in planning care delivery were discussed:

1. Patient Persona – this tool helps categorize types of patients for planning patient services, physical spaces, imagining connectivity and developing care ecosystems.
2. Empathy Map – a tool that measures the emotional response related to the care provided. Staff are often surprised that they are not doing "enough" to support patients. This tool illustrates the gaps between the patient's experience versus what is perceived by healthcare staff.
3. Experience Map – this tool generalizes the concept of customer-journey maps across user types and products. It focuses on measuring friction or pain points (e.g. the patient repeated a request several times before it was met), and encourages the patient to describe their experience for healthcare workers to understand their perspective.

These tools serve as vehicles to create forums for patients to express their experiences as a patient from their perspective, and assist staff in becoming more aware of friction or variations in patient care. Leaders and staff are now being encouraged, in many healthcare settings, to allocate time and resources to shift their current culture to a patient-first model, and for all staff to view themselves as ambassadors of patient-centred care.

Concurrent Session #5: Measuring for improvement using leadership metrics and performance measures

Abstracts: Driving the transition: An outcome evaluation of Assertive Community Treatment Teams (ACTT) Stepped Care Model

Presenters: Scott Pepin, Ontario Shores Centre for Mental Health Sciences and Faisal Islam, Centre for Addictions and Mental Health

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Abstracts: Creating safer therapeutic environments – Using real time data to reduce the use of seclusion and restraint in mental healthcare

Presenters: Mark Rice, Ontario Shores Centre for Mental Health Sciences and Jim McNamee, Ontario Shores Centre for Mental Health Sciences

First Presentation

A study on the effectiveness of the Stepped Care Model created to provide client support outside of the ACTT model dedicated to improving client outcomes was the focus of this presentation. The ACTT model bridges the gap between hospital in-patients with mental health challenges and their release outside of daily care; however, this program is often full. While in the ACTT model in a hospital facility, clients thrived, but they lost their support system after they were released and often required readmission. With each readmission, their prognosis declined.

Eight teams and six organizations in central eastern Ontario served 100 clients in the Stepped Care Model ACTT pilot program. This program operated without additional provincial or federal government funding. At the end of the program, 20% of patients in ACTT did not require full care, but needed some intervention to ensure their health did not decline.

A new model with one nurse responsible for providing modified activities and support for 20% of clients who required additional support (e.g. psychiatric intervention and community programs) on an as needed basis was piloted. At the end of the program, clients graduated; their graduation was linked to positive self-esteem. This modified Stepped Care Model opened 25 new positions across eight teams in central eastern Ontario.

From 2014-2017, 240 clients transferred to the new model; 11 patients were readmitted after graduating from the program, hospital stays were drastically reduced (544 admissions versus 109 admissions) and there was a 91% rate of client satisfaction.

Another study involving 301 clients was conducted at five sites in three distinct groups, Stepped Care clients, ACTT clients and clients who were discharged elsewhere (i.e. deceased, withdrawn, moved to another model). It reported on the following variables:

- Number of days in a hospital
- Decompensation
- Client demographics
- Socioeconomic values

Findings from this study included:

- 98% of clients in the Stepped Care model stayed zero days in a hospital
- 83% of clients in the ACTT model stayed zero days in a hospital
- 86% of clients in other programs stayed zero days in a hospital
- Clients in the Stepped Care model were nine times more likely to spend zero days in a hospital than clients outside of the program

- Clients in the Stepped Care model were three times more likely to secure employment; they also faired better than their peers regarding addictions and psychosocial impact

In summary, the Stepped Care Model mitigates the need for hospital stays, and the additional level of support has proven to be more effective than the original ACTT model in terms of patient care.

Second Presentation

Ontario Shores is a public hospital providing specialized assessment and treatment services to those living with complex and serious mental illness. It has been operating for almost 100 years, and changing an established culture has proved to be challenging.

Using restraint or seclusion (R&S) is difficult for patients and staff; it is also a human rights issue. R&S are considered treatment failures, and outside of the patient care norm. A clinical study monitored the following variables:

- Quality Improvement Plan (QIP), such as the length of stay using historical logs; the desired length of stay is 10 hours or less
- High visibility, immediate reporting and follow up procedures
- A strong recovery environment

Six core strategies were implemented:

1. Leadership – daily staff meetings regarding challenging patients
2. Sharing data with the team
3. Workforce development
4. Use of prevention tools, such as Dynamic Appraisal of Situational Aggression (DASA), to assess the likelihood that a patient/client will become aggressive within a psychiatric in-patient environment and alternatives to restraints
5. Consumer roles in in-patient settings to ensure the patient's voice was heard
6. Debriefs within each report

Status reports were issued at 9:00 a.m. and 9:00 p.m. every day. Any incidence of R&S triggered an email notice to several groups, including shift managers, senior leaders and directors to reintroduce the patient. There was full reporting, and support was offered. For patients in seclusion, the report included a plan to reintroduce them back into the regular treatment environment.

Ontario Shores has used comprehensive reporting since 2014; it includes the average seclusion hours, individual patients and seclusion incidents. A separate report details mechanical restraint use and hours in seclusion.

Collaborating as a team brought leaders of various departments together working to a common goal. There has been a culture shift over the past five years. Management no longer operates in silos. The staff recognizes the balance between fostering an environment that promotes patient health and prioritizes the staff's health and safety. Metrics dedicated to patient and staff safety have significantly improved.

Senior leadership created a real sense of ownership and accomplishment across the organization. Units are regularly recognized for their efforts (e.g. a 24-hour R&S free time triggers a notice to celebrate).

Concurrent Session # 6 – Healthcare organizations of the future and smart healthcare centres

Abstract: Bringing healthcare to the home

Facilitators: Krista Anderson – Nova Scotia Health Authority and Cathy Cruz – Nova Scotia Health Authority

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Abstract: Why some patients who need an alternative level of care don't get it, and what we can do

Facilitators: Paul Holyoke – SE Health and Hélène LaCroix – SE Health

First Presentation

The team from Nova Scotia Health Authority (NSHA) asked the audience who has had video conference appointments via a secure connection at the private location of their choice to open the session. A healthcare delivery program in Nova Scotia was rebranded to provide virtual care via secure video conference in rural communities using a web-based platform. Patients in rural communities can receive specialized services without leaving their community or even their homes. The conference is meant to complement, not replace a face-to-face visit, and it saves the patient's time, stress and the expense of traveling. For patients in Nova Scotia, one to six hours of time is saved because travel is no longer required.

NSHA investigated gaps in service delivery. In 2017, they started a five-month pilot to bring virtual care to the home. NSHA collaborated with 10 providers to determine if Medeo was a viable solution for NSHA, and if it had the ability to improve accessibility and healthcare in Nova Scotia.

A toolkit for providers took several months to develop. Data was collected using servers, provider forms and ad hoc and scheduled check-ins. Biweekly check-ins with providers were meant to foster a shared environment to provide a way to discuss how well Medeo was working, but attendance was lower than expected.

Onboarding consisted of training (30-minute practice visit). Virtual care leads provided training to healthcare providers and a mock visit with program leaders. Patients were also given an information guide to tell them about the pilot and Medeo software. Clients were given a link to Medeo, and technical support was offered through an online form through the Medeo website.

The program had a total of 159 offered, and 57 were accepted and completed. Visits were declined for the following reasons:

- Lack of technology
- Poor Internet connection issues
- Preference for in-person appointment
- Distress with technology

Travel time was eliminated, and there was minimal setup time prior to the appointment. 94% of people who used Medeo stated that they would use it again, and 87% were satisfied overall. People who have used Medeo had positive feedback (e.g. easy to use, well managed and especially convenient for seniors).

Providers expressed positive feedback for using Medeo (good image quality, easy to use and use of Medeo when clients cannot leave their home). Two concerns expressed were a loss of control of the therapeutic environment and a different level of intimacy, including distractions that may not occur in the office setting. Conversely, the change in setting provided an insight into the home environment. Overall, the program received positive feedback from providers, and they viewed it is a change agent for the delivery of care in Nova Scotia.

The LEADS framework guided the pilot process. LEADS stands for:

- **L**eads self
- **E**ngage others
- **A**chieve results

- **D**evelop coalitions
- **S**ystems Transformation

The presenters responded to the following audience questions:

- What were their demographics associated with people who refused Medeo?
- Did physicians or patients have any issues with sharing confidential information?
- Does Medeo store any patient-based information? An audience member expressed some concerns about privacy, but no information is stored beyond responses to patient screening information
- Would it be worth investing in providing Internet connections to make Medeo available to more patients? The NSHA encourages patients to share or leverage existing technology in the community
- Which industry standards supported the development of Medeo?
- Recruiting physicians to Nova Scotia is a challenge. Does having a virtual care option entice new physicians to settle in smaller communities?

Second Presentation

SE Health is a social enterprise. They provide many different types of health care services (home and community care, long-term care, acute care and primary care). Customers include governments, regional health authorities, local health integration networks, hospitals, the seniors' living sector, community organizations and consumers.

SE Health has been involved in alternative level of care (ALC) programs aimed at integrating patients back into the community for the past eight years. In most cases, approximately 50% of patients could return home with ALC support. SE Health led a collective case study looking for trends across hospitals. Four issues were uncovered:

1. The patient's admission to the hospital could have been avoided with adequate home care
2. General deconditioning of hospitals
3. A routine estimation of the patient's capacity for independence by physicians and hospital staff
4. Home care is generally not understood in hospitals

These findings have informed a number of ALC programs.

There is a worldview dissidence across healthcare. In the acute sector, there is a view that care must be immediate, medical and focused on the problem for admission. In the community sector, there is a view that the focus should be on the social context of the person and their level of independence (e.g. a patient's ability to buy groceries). The acute sector is viewed as powerful, and the community sector is not perceived as very powerful. There is dissidence in the home and community sector, and there can be difficulties with healthcare providers working together.

Despite the challenges, there has been some encouraging progress made improving the transition from hospital to home (i.e. safety, alternative location that is not the hospital or home).

SE transitional programs include PPATH and Southlake@HOME that focus on healing in a home environment, and there are many others.

Transition programs that focused on bedded reactivation (i.e. a hospital-like facility focused on mental health, older patients, patients with dementia). Hillcrest Reactivation Centre is an example of a transition program. The target length of stay (LOS) is 60 days.

Another bedded transition program focuses on less medically complex patients who can transition home from a retirement home sooner with a shorter LOS of 15-45 days.

SE Health conducted a formal research study at Hillcrest Reactivation Centre. It was a two-phase evaluation centre examining people coming into the centre, and documenting what happens when they leave. In phase one, the profiles of patients differed from what was initially anticipated. Patients had more clinically complex issues (mental health was present in all categories). Studies have shown that patient's conditions improved in the areas of cognitive pain and daily pain, but saw less improvement in the areas of depression. 81% of

caregivers had high levels of stress, and they do not feel that the patient will be able to manage on their own. Caregivers had high needs due to high levels of stress.

In phase two, the study more critically examined what is working and what is not as well as planning and reviewing care. The SEIPS model (related to patient safety and outcomes) indicated that collaboration needs to improve within the centre.

In the other programs, SE Health is assessing needs in faster moving healthcare environments. The PPATH (post-cardiac surgery care) program is a highly effective program; this is likely due to the fact it is focused on a single issue and has consistency in care.

SE Health is continuing to learn and spread the information with healthcare providers across the country.

The presenters responded to the following audience questions:

- What are readmission rates?
- In your opinion, is there an opportunity to improve worldview dissidence in a community setting?
- How does SE Health get funding?
- Tell us about your relationship with Hillcrest. How does the project receive funding?
- How do you support caregivers, specifically caregivers exhibiting signs of burnout?

Canadians have the challenge of serving an aging demographic, and meeting the pressing demand for physicians in rural areas.

Concurrent Session # 11: Circles of Change – Bringing Indigenous-inspired co-design to your organization

Facilitators: Asmita Gillani, CHE – Accreditation Canada, Scott Livingston, CHE – Saskatchewan Health Authority, Heather Thiessen – Saskatchewan Health Authority (Patient Representative), Brenda Andreas – Saskatchewan Health Authority (Patient Advisor) and André Letendre – Saskatchewan Health Authority (Cultural Advisor)

The Saskatchewan Health Authority's (SHA) process of co-design is dramatically different from many other healthcare system approaches because it is community-driven to include patients, their families, Métis and other First Nations people. The First Nations and Métis were previously excluded from healthcare system discussions in Saskatchewan even though they receive nearly 50% of healthcare in Saskatchewan. This new system engages and includes First Nations, Métis and Non-First Nations people.

The SHA collaborated with the Métis and First Nations to develop a healthcare system with a clear vision of how these groups viewed the future of healthcare in their province. The main issues were providing accessibility to care, upholding a commitment of a local treaties and entering into an agreement with the highest degree of ethics.

Historically, the first interactions between Europeans and First Nations occurred when European settlers arrived in Saskatchewan in the 1600s. The European settlers were ill and malnourished. The First Nations people looked after them with care and empathy. From that moment, care became a foundation in First Nations/European relations, and it has been woven through this model.

The Métis and First Nations people believe that health begins at conception; there is a need for care from the beginning to the end of life. This people-centred healthcare model is a visual and self-perpetuating model of care with four parts:

1. Commitment (spirituality)
2. Inspiration (emotion)
3. Who are your partners? (intellectual)
4. What are your actions? (behaviour)

In 2010, there was a shift from system-centred care to patient-centred care in Saskatchewan. This model documents the paradigm shift and implementation process. It fully integrates the Métis/First Nation approach to cyclical conceptions of life and healthcare.

This model has the core values of the co-design at the centre. It represents the commitment from SHA's board, the CEO and leadership teams to create partnerships within SHA and communities to instill a culture of care.

The SHA's five values (safety, accountability, respect, collaboration and compassion) are in the inner circle at the centre of the model.

The secondary circle with quadrants represents each year and what will be measured for governance purposes. The respective areas are for meeting standards of care and policy objectives for each respective area.

The third circle is dynamic; the dial represents the four areas the surveys will focus on, and ensures the SHA is maintaining/developing ethical relationships internally and externally. The last circle "System Line Standards" is also dynamic and applied to surveys (for accreditation purposes) as areas of focus. The model functions on a clockwise dial. It is circular as opposed to linear because it is a never-ending and self-perpetuating cycle of survey and assessment. It mimics the human lifecycle, the Métis/First Nation style of thinking, rationalization and overall approach to life. The truth and reconciliation movement also guides the model, and it has helped to redefine the SHA as an organization. Embedded in this model are these key values:

- Physical proof that systems can change (i.e. from a linear model to a circular model)
- Change does not mean indigenizing colonial systems because the spirit cannot be colonized (derived from an emphasis on the spirituality of the treaties)
- Prevention instead of reacting to an illness or a health crisis
- Improved resources to better manage human resources and financial resources by providing tools to care for others before there is a health-related crisis
- All employees had to reapply for different positions to be included and align with the SHA's new vision and focus
- The people working in and creating the system needed to be part of the paradigm shift. Elders and family/patient counsellors were hired and contributed to the policy development process
- The Knowledge Keeper Council interacts with the board, governance and the SHA
- Métis/First Nations are represented on advisory councils within the SHA

These values enable the SHA to listen to all communities, involve them in ongoing development as well as make the Métis and First Nations visible in the healthcare system. The SHA created a cohesive plan and foundation for patient-centred care, balanced the need for patient first/patient friendly care and committed to being "accreditation ready" for annual accreditations (instead of four-year cycles). The SHA is dedicated to teaching and empowering patient care providers to ensure care is consistent across the province, and believes that patients and families are co-producers of their healthcare experience.

Some of the challenges the SHA faced from jurisdiction and communities include:

- Positive and negative leadership/relationships with Métis/First Nation communities (i.e. a large variation in the quality of relationships across the province)
- Allocating time to build credibility, commitment and trust with multiple partners (80 bands and tribal councils) to discuss how to be active, equal partners
- Understanding the roles and responsibilities of all, and how to involve people
- Politics and intergovernmental relations

Many enabling factors worked together to create a model of care that is a culturally safe environment for healthcare across the province. This model would not be possible without 600 Patient Care Advisors. Patients and families bring their voices, visibility and passion; they are the inspiration behind putting care back into the healthcare system across the province of Saskatchewan.

Concurrent Session #15: Leveraging partnerships to support large scale adoption of quality and safety best practices

Facilitators: Elizabeth Brandeis – Association of Ontario Midwives, Allyson Booth – Association of Ontario Midwives and Joanna Noble – Healthcare Insurance Reciprocal of Canada

The session opened with a discussion about effective partnerships. Collaboration, shared goals, commitment and respect were some of the responses from the audience about what is required for an effective partnership. The Association of Ontario Midwives (AOM) and Healthcare Insurance Reciprocal of Canada (HIROC) discussed their unique, long-term and mutually beneficial partnership.

The AOM is the professional association and advocacy body that represents midwives in Ontario. Midwifery has been regulated as a health profession in Ontario since 1994; the only province without regulatory status for midwifery is Prince Edward Island. The AOM has a very robust risk management process, and is supported by HIROC. The AOM supports out of hospital births, including at a birth centre or in homes, and these births are covered by HIROC. AOM's provincial government funding is linked to midwifery birth data and healthy outcomes for home births.

HIROC is a not-for-profit reciprocal owned and governed by the organizations they ensure. They partner with their organizations (large health regions, long-term care centres and midwives), and insure over 1,000 midwives.

Prior to being regulated in 1994, midwives sought insurance due to a sense of responsibility to compensate families who had suffered a loss. The AOM engaged HIROC in 2003, and they have had a very positive relationship over the past 16 years. The AOM submits incident reports and claims to HIROC for critical incidents; this information is useful for assigning a dollar value as well as a base of knowledge. Midwives are diligent about reporting data. HIROC and AOM's relationship extends far beyond insurance coverage; it has led to risk management collaboration activities that are at the heart of the AOM-HIROC partnership.

According to research from the AOM, key elements of collaborative partnerships include a shared vision, a clear relationship between partners, working as learning organizations and thinking about the complex healthcare system using a lens of shared thinking. HIROC believes in partnering with organizations they insure, and working together to develop a shared vision. HIROC has a deep understanding of midwifery, and can provide a national perspective on healthcare issues. Midwives advocate for giving clients choices; clients are placed at the centre to promote the highest and safest quality of care, and are fully supported by HIROC to facilitate this model of care.

HIROC's risk assessment checklist ranks data by claims cost to provided evidence-based information for the top 30 hospitals and the top 10 list of patients (for midwifery data). A risk reference sheet is created for each case to summarize case examples, literature and mitigation strategies for the future. These most impactful mitigation strategies rooted in evidence-based strategies are vetted and uploaded into the risk assessment checklist tool. The AOM was the first group of midwives to participate in this program.

The AOM and HIROC's relationship has evolved over time due to committed individuals, collaboration on risk management activities (i.e. co-creating tools together) and working toward shared goals. Both organizations are committed to being great organizations; this common ground has resulted in a partnership because key stakeholders are willing to learn, collaborate and foster trust. For example, HIROC's first iteration of risk management sheets required many revisions by the AOM to reflect the values that midwives hold.

HIROC has a great deal of respect for midwives; HIROC respects the concept of informed choices, birth location and that midwifery will continue to grow and evolve.

The AOM changed its constitution to include Indigenous midwives in 2017 to have Indigenous midwifery programs funded and supported by the Ontario Ministry of Health. There were insurance implications related to this change, and one of the distinct differences of midwives regulated by the College of Midwives and Indigenous midwives (practicing under an exception to these regulations) was the level of regulatory oversight.

The AOM was pleased that HIROC undertook the challenge to create a new model to provide coverage for Indigenous midwives.

HIROC is pleased to provide adequate insurance for the AOM as midwifery practice needs change and continue to evolve. Hospitals and midwives are insured differently; midwives are insured as independent practitioners. The AOM sees data as "their friend" because funding and best practices are tied to data collection. Due to the AOM's collaborative relationship with HIROC, they do not fear sharing data with HIROC because it benefits both organizations.

Data is also used to drive quality improvement in the practice of midwifery. HIROC presented the top 10 risks in midwifery to AOM annually. This information aided HIROC in developing resources, including facilitating nine regional workshops across Canada. The AOM had over 90 midwives participate in nine regional workshops dedicated to increasing safety, mitigating risks and sharing best practices last year.

The strength of the partnership has been fortified by working together through growth and ambiguity. HIROC and AOM consult regularly to ensure they are making sound decisions based on facts instead of assumptions. The reciprocal support for each organization is evident. For example, a leader within HIROC is an AOM board member.

The financial barriers of the HIROC-AOM partnership works very closely together to mitigate challenges. Roles and responsibilities are clearly defined, and both organizations are transparent about how funds and resources are allocated.

In the early days of the partnership, AOM respected the fact that HIROC was willing to learn about midwifery as a profession, regulated midwives, Indigenous midwives and informed choice beyond providing insurance coverage. HIROC approached the learning curve with humility with a genuine desire to learn about and support AOM. HIROC has been the platinum sponsor of the AOM's annual conference, and midwives can clearly see that the AOM and HIROC have a supportive, reciprocal partnership. Prior to midwives graduating into the profession, there is a presentation about insurance and HIROC's coverage and support for midwives in Ontario.

HIROC and AOM's partnership is an excellent example of how two organizations willing to work together respectfully and collaboratively in the healthcare sector has improved the overall quality of care, risk mitigation and safety in midwifery.

Concurrent Session # 12: Advancing better outcomes by focusing on change. Partnerships, power and professionals. The role of physicians in healthcare reform

Facilitator: Colleen Grady – Centre for Studies in Primary Care

Ms. Colleen Grady explained that she conducts research in the areas of physician leadership and burnout. She examines change and dynamics; getting behind and momentum; the power to stop, partners/stakeholders and professionalism.

An activity for workshop participants showed that change is uncomfortable because individuals prefer to find or use their own method of completing tasks. Recognizing the value of unique perspectives helps stakeholders see that every perspective matters.

It is important to acknowledge the difference when people participate in changes in comparison to instances when they are expected to comply with changes. A second activity demonstrated that feelings and emotions are linked to the concept of change.

Various models of change can be effective, but it is most enduring and sustainable when people are active participants in change. A slide focusing on the first two steps of Kotter's Eight Steps to Change, establishing a sense of urgency and creating a guiding coalition, were presented and discussed.

A research study involving doctors in Ontario had two main objectives:

1. Understanding physician engagement
2. Developing physician leaders

This study concluded that physicians were viewed as leaders by others; however, many physicians do not have formal leadership training. Another finding was that family physicians would be more likely to learn about changes if they were compensated for their time; as a result, patient care would become more evidence-based and physicians' work would be more relevant to their area(s) of practice.

A third activity involved a physician case for change, and resulted in a discussion about establishing urgency and forming a guiding coalition. With guidance from Ms. Grady, solutions should meet the following criteria:

- Establishing a clear why (i.e. defining results and benefits)
- Defining a critical nature of change (i.e. now, future, funding, employment status, consequence without change)

Creating urgency may include imagery, emotional connection or inspiring action to show patient reaction, financial stress or future problems. Criteria for how to establish a guiding coalition included:

- Engaging expertise (i.e. acting as a champion without an ego)
- Engaging someone in a position of power to initiate change
- Engaging people with credibility
- Engaging individuals regarded as trustworthy

Stakeholder groups will adopt the following roles to proposed changes:

- Resisters (i.e. people who overtly or covertly oppose change)
- Bystanders (i.e. people with a neutral reaction to change who can be swayed)
- Helpers (i.e. people who will move the cause forward)
- Champions (i.e. influencers who fully support the change)

A final exercise focused on stakeholder analysis for a particular change process. Participants were asked to relate the exercise to their own work environment. Answering the following questions identified how to assess stakeholders in each group, and how to leverage that information to move change forward:

- Who are they?
- Why are they in this group?
- What would success look like to you to move them into change?

- What would success look like to them?
- What is the most important thing you could do to influence this group?

In conclusion, not all stakeholders will support proposed changes. Some may need to leave the environment if they continue to resist after the change is implemented. Participants were encouraged to critically examine stakeholders in each group, and commit to understanding their unique perspectives to achieve the highest rate of change adoption in a healthcare environment.

Plenary Session – Great Canadian Healthcare Debate

Panelists/Debaters: Dr. Philippe Couillard – Former Minister of Health(2003-2008) and Premier of Québec (2014-2018), Julie Drury – Chair, Patient and Family Advisory Council, Ontario Ministry of Health and Long Term Care, Dr. Danielle Martin – Executive Vice President and Chief Medical Executive, Women's College Hospital

Speaker: David Coletto – CEO and Founding Partner, Abacus Data

Moderator: André Picard – Health Reporter and Columnist, The Globe and Mail

Aramark Healthcare sponsored the fifth annual Great Canadian Healthcare Debate. The debate opened with an update from the winner of the 2018 Great Healthcare Debate, Mr. Nicholas Watters, Director, Access to Quality Mental Health Services at the Mental Health Commission of Canada. Since last year's conference, the following results have been achieved:

- The Mental Health Commission of Canada developed a new department dedicated to improving access to quality mental health services
- Four additional communities joined the Roots of Hope Suicide Community Prevention initiative
- Facilitated over 60 conversations to inform the development of a post-secondary standard for mental health on Canadian campuses
- The Canadian government has committed to a $5M investment in mental health over the next ten years

With a federal election upcoming this fall, the debate focused on a public opinion poll on Canadians' most pressing healthcare concerns; patients, patient care providers, health leaders and the general public had an opportunity to share issues that are most important to them. Mr. David Coletto, CEO and Founding Partner of Abacus Data, presented 15 different issues related to Canadian healthcare.

Prior to listening to the participants in the debate, the top three issues in healthcare in Canada, with percentages, were presented:

- 43% of poll respondents chose embracing digital technology as the most important issue
- 36% of poll respondents indicated that addressing poverty by providing a guaranteed basic income was the most important issue
- 20% of poll respondents selected closing the pharmaceutical coverage gap as the most important issue

Opening Statements

Dr. Danielle Martin is the Executive Vice President and Chief Medical Executive, Women's College Hospital, a practicing family physician, a professor at the University of Toronto and a national bestselling author. In 2019, she was the youngest physician to receive the F.N.G. Starr Award, the highest honour available to a Canadian Medial Association member. Her goal was to persuade the audience that reducing poverty is the best way to improve overall health in Canada.

Dr. Martin challenged the audience to think about what actually constitutes health. In her opinion, the most important policy Canadians can endorse to improve overall health is to support the elimination of poverty through a basic income guarantee for three main reasons:

1. **Income is the most important determinant of health.**
   The lower an individual's income is, the more likely they are to get sick, suffer with a chronic disease and have a lower life expectancy. The social and economic environment determines 50% of the health of a population. Income disparity is associated with the premature death of 40,000 people per year (more than breast cancer, lung cancer and dementia). 20% of our spending in this country can be attributed to low incomes. A basic income guarantee is a viable solution to combat this issue. It is important to remember that 70% of people who lived in poverty were employed.

2. **Poverty reduction is an unquestionable role for the government to play.**
   There are very few healthcare policy issues that the federal government can actively get involved in and participate in to have a direct impact. It is very important that we offer an idea that the government can actually deliver improved healthcare.

3. **We have a solid tradition of success in Canada to build upon.**
   There are basic guaranteed income supplements in Canada already for seniors (old age security and the guaranteed income supplement) and for children and families (the Canada Child Benefit). In the 1970s in Manitoba, a guaranteed annual income was implemented, and hospitalization rates dropped by 8.5%.

Ms. Julie Drury, Chair, Patient and Family Advisory Council, Ontario Ministry of Health and Long Term Care, is passionate about the patient/family/professional partnership. She has firsthand experience in system navigation, complex care, care coordination, palliative care and patient safety. She is advocating for improved digital health to advance healthcare in Canada.

Communication and information are the foundation of an effective healthcare system. 90% of patient-related complaints are related to poor communication and process breakdowns. Data for Ms. Drury's own daughter was difficult to access; in response to this issue, she made a binder of information with her daughter's diagnosis, medical history, medications and the names of the specialists and clinicians who treated her because the hospital did not have accurate information despite having an electronic medical record system. Disjoined data affects patient safety, and it is an imbalance of power. Close to half of Canadians believe that digital improvements would improve overall patient care overall by reducing wait times and promoting the self-management of patient care.

Ms. Drury asked, "Does Canada need a federal digital health strategy?" Yes, she believes we do, and it needs to include standardization and structure to succeed. Innovation needs guidance and must adapt to patients, healthcare providers, etc. Innovation and design can focus on effective digital healthcare infrastructure to share information across and between healthcare organizations. Patients should own their health care information; hospitals and doctors should be custodians of that information. Currently, we do not have transparency when receiving care across the country; patients should be able to make decisions pertaining to their own care. The unintended consequences of multiple disjointed systems thinking that they will be connected later causes patients and families to suffer in the interim. The federal government can support and challenge provinces to think differently about information in the healthcare structure. Physicians, healthcare providers, patients and families deserve the level of efficiency and effectiveness that coordinated digital patient information can provide.

Dr. Philippe Couillard was a leader in the field of neurosurgery serving in hospital and academic settings in Canada and Saudi Arabia prior to entering politics in 2003. He was appointed Minister of Health and Social Services from 2003-2008. In 2013, he was elected to lead the Liberal Party of Québec, and was the Premier of Québec from 2014-2018. Dr. Couillard believes that the fundamentals of the healthcare system are good; we do not need to destroy the healthcare system to reform it. Globally, Canada has one of the highest investments in healthcare, but Canadians are also paying more than countries with user fees to access healthcare. The need for additional investment is due to a large gap in coverage of pharmaceuticals; 10% of Canadians are not covered, 10% are covered inadequately and 10% do not purchase medication due to the cost.

In Canada, the public sector funds 36% of total pharmaceutical spending while the UK covers 67% and Australia covers 48%. Dr. Couillard proposes introducing mandated insurance across Canada as Québec has already done. The public health expense needs limits, but the current mix of public and private insurance needs to be improved. He proposed the following recommendations:

- Completing the proposed reforms of the federal system's listings and pricing
- Improving negotiation power by uniting public and private pharmaceutical buyers
- Providing more consistency on pharmacist's fees and agreeing on a basic formulary

Universal pharma-care should be achieved by revising the current public and private mix of coverage. He encouraged the audience to follow the Canadian way by coming together in the spirit of respect, negotiation

and compromise when needed. Dr. Couillard wants to close the gap to provide Canadians with universal, fair and affordable healthcare.

The moderator, asked the panelists to answer the following questions.

Dr. Martin was asked if providing a basic income for all Canadians would be too expensive. While she acknowledged this is a significant investment, it will save money and result in improved overall health for Canadians.

Ms. Drury was asked if patients should care about digital health information. She responded that lacking access and basic interoperability is frustrating, and can result in delays and safety issues. She also advocates that patients should own their data.

Has universal pharma-care in Québec been successful? Dr. Couillard stated that it can definitely be improved. Trying to decide what is "in" and "out" of the basket of services needs to be decided by the government.

The audience asked panelists the following questions:

- How can federal healthcare priorities be provincial healthcare priorities?
- How does your position improve the quality of life?
- If you give someone a basic income, will they spend the additional funds on items that are detrimental to their health?
- How do you ensure the private sector does not get involved in pharma-care resulting in larger bills?
- How do you think your arguments specifically improve the health of women and girls?
- Regarding the hemophilia model, do you think that greater involvement of patient groups like this be reproduced for other diseases?
- How can we engage federal politicians in each of your topics?

Closing Statements

Dr. Couillard stated that healthcare is one of the most precious assets in Canada. It has been largely successful, but we have areas of half achievements (opportunities for improvement). From his political experience, he has learned to let other cabinet ministers have access to funding because there are other factors that impact healthcare, such as education, the environment and poverty reduction.

Ms. Drury encouraged the audience put information into the hands of patients to ensure safe coordination and allow physicians to do their best work with the information they have available. Everyone in this room is a healthcare leader who can challenge the digital health space. In each province, she advocated the audience to question why we are each operating on different digital platforms. Be bold and question this in your community. 76% of Canadians want a standardized digital health care platform.

Dr. Martin acknowledged that the other two debaters have important agendas worthy of improving healthcare across the country. Today, we must choose one argument or agenda. She thinks that we should endorse the policy that will impact the most amount of people, is least likely to be bogged down and has the power to combat not only illness but generate health.

At the end of the debate, the audience voted for the most important issues in healthcare in Canada. The results indicated that:

- 67% of poll respondents voted in favour of addressing poverty by providing a guaranteed basic income as the most important issue
- 27% of poll respondents chose embracing digital technology as the most important issue
- 6% of poll respondents selected closing the pharmaceutical coverage gap as the most important issue

Plenary Session – Unleashing the power of innovation: Perspectives on digital health

Panelists: Tim Blake – Managing Director, Semantic Consulting, Dr. Michael Leonard – Managing Partner, Safe & Reliable Healthcare, Huda Idrees – Founder and CEO, Dot Health and Andrea Palmer – Founder and CEO, Awake Labs

Moderator: Vincent Dumez – Codirector, Centre of Excellence on Partnership with Patients and the Public, Faculty of Medicine and CHUM Research Center, University of Montreal

This session focused on the power innovation as it relates to digital health and patient empowerment from multiple countries.

Mr. Vincent Dumez is a passionate advocate for engaging patients in every aspect of their care. He was instrumental in developing the patient partner program at the University of Montreal as well as co-lead the Centre of Excellence on Partnership with the Patients and Public, which have had tremendous impact. As the moderator for this session, Mr. Dumez introduced the panelists. He spoke about his personal experience in the healthcare system as a hemophiliac patient. He encouraged the audience to be open minded, inclusive and focused on patients with the changes related to the digital healthcare revolution. This powerful message from an Eclinical Medicine article addressed the digital healthcare revolution, "This is a cultural revolution. The sacred power of diagnosis now lies in the literal hands of every man."

Ms. Huda Idrees is the Founder and CEO of Dot Health (a real-time personal health data platform established in March 2017). Through her experience in the financial and healthcare sectors, she has learned that not all problems in healthcare are related to care delivery, and people with perspectives from different educational and professional backgrounds are valid and useful. In 2019, people are not staying in one place, and their data needs to follow them. Access to data is essential in healthcare. True progress in healthcare cannot be achieved independently; however, knowledge can leveraged from learning from other healthcare systems around the world, other industries and other studies.

The biggest way to accelerate any movement is to move your data with you. In Canada, patients move around the country (and beyond) to receive care, and their health data should follow them. Dot Health has the ability to move your data with you around the world. They are committed to becoming champions for global innovations and leveraging them. Healthcare is often reactive instead of proactive. There is a notion in healthcare that everything most be developed in-house. She believes in seeking people who excel in their professions, regardless of the industry they come from, leveraging their knowledge and working with them.

Dr. Michael Leonard, founder of Safe & Reliable Healthcare, is a cardiac anesthesiologist by training who has practiced in the Greater Denver Area. He advocates for unleashing the power of innovation to improve access to information through digital health. For example, safety has greatly improved in anaesthesia due to technology. He fully supports technology and innovation as long as people are mindful of how they are using it. Electronic medical records were tied to billing processes; the revenue process in the healthcare system is not how doctors think abut patient care. The disconnect between these systems is problematic.

The first patient diagnosed with Ebola had no records available to the attending physician. The patient had previously travelled to western Africa and had a fever; he contaminated dozens of patients in the local community before he was admitted to the hospital. There is a social process in being a patient. In healthcare, there is a wealth of technology available. Technology is an enabler, not a magic answer. Simply stated, technology does not have the power to fix all problems. Technology that is developed without the influence of people actually using it is unlikely to be used or effective.

The lessons learned in other high-risk industries is that technology creates risk until the culture learns to use it appropriately. Cultures are explicit attitudes of groups of people working together; culture is measurable and changeable. If there is a strong collaborative culture, the team can deliver world-class care. Conversely, if there is a group of people that cannot work collaboratively, there will be high rates of avoidable patient harm.

If you are not able perform a process well in an analog fashion, digitizing the process will not be more effective. Healthcare professionals must understand the work in the context of the work imagined versus the work actually being completed. How many hospitals have information systems that do not talk to each other? Unfortunately, there are far too many.

In reference to an article about physician burnout published a couple of years ago, there was a survey with two questions:

1. Do your leaders participate in walk-arounds?
2. Did you get an answer back on the issues you raised?

Many instances occurred when staff members did not get an answer back. People who received answers were able to deliver far better care. What we learned many years ago is that people want and need a voice. This was the beginning of boards and reflective practices. As simple as this process of documentation is, it is profound.

Ms. Andrea Palmer is the Founder and CEO of Awake Labs, a digital health company dedicated to empowering people with intellectual and developmental disabilities to live independent, fulfilling lives. She is committed to keeping people healthy outside of the hospital.

She told a story about an anemic patient who came to a hospital, and a case manager learned before he was discharged that his house was infested with bedbugs. Instead of sending him home, his house was fumigated and he was sent to a short-term residential facility before moving back home. He received adequate support to keep him out of the hospital; this was a successful outcome.

Ms. Palmer wants to be able to duplicate situations like this to ask the right questions. She works with people with intellectual and mental disabilities to manage anxiety to be able to meet their basic needs to do regular activities (i.e. shopping, volunteering, exercising, etc.). Anxiety is often the barrier that prevents people from getting there. Very often people do not or are unable to directly communicate they are getting anxious, and they communicate through their behaviour (incorrectly seen as acting out). Awake Labs uses a smart watch that measures the heart rate, shows the information to a care provider to monitor patient's behaviour to help the patient and deescalate the situation. In closing, she urged the audience to focus on what they have control over; doing what they can to meet people's needs, meet people where they are, keep them out of primary care/hospital settings and embrace healthcare in the true sense of the word by keeping people healthy.

Mr. Tim Blake is the Managing Director of Semantic Consulting, a consulting firm focused on leading digital healthcare. This is his first time in Toronto, and he will provide insight into the Australian health system. He works with an international interoperability community. Australia has provinces that run their own health systems, a universal public health system and a national digital health strategy. Australians have a national digital health record (called My Health Record) with approximately 90% of Australians opting into this earlier this year. Patients and caregivers can access it through a portal. Patients do not own their information, but there are a number of controls associated with it. The quality of data varies. In addition to the My Health Record, there has been a digital health innovation boom in Australia, but they only have genuinely succeeded in terms of generating funds. He said that the health system has many digital health accelerators in an environment that is very risk averse and resistant to change. Mr. Blake is focused on patient-reported outcomes because they are the single best predictor of a patient's future state. He is excited about patient reported outcomes gathered in real time and fire (the emerging standard for interoperability). Interoperability is not about technology, it is about patient safety. Without real time information crossing healthcare boundaries, we cannot put data to work to improve care.

Mr. Dumez commented on how human-focused each of the panelists' presentations were instead of focusing on the tools. He asked the audience how to avoid waste and to promote efficiency in the digital healthcare revolution. The panelists provided answers; while each panelist had different ideas, they all agreed that solutions should be proactive instead of reactive. Additional questions from the audience included:

What should the government's role be, provincially and federally, in digital health? Mr. Blake stated that governments can regulate, legislate, store data and create a regulatory environment. Governments risk overstepping boundaries, and their role needs to be carefully negotiated with a strategy that is clear and

committed to innovation. Most governments are not good at creating user experiences. Boundaries should be carefully considered and clearly communicated.

With regard to partnership and engagement, what kinds of questions or issues are coming up with the research ethics boards or others involved in the approval process of enabling that type of innovation research to occur in institutions in Canada? Dr. Leonard stated that integrating patient-centred processes in an organization needs to be built. He used the Dana Farber Cancer Association as an example of the need to give patients a voice in the organization.

With regard to interoperability, where does government have a role, and where should they stand back and let health authorities show leadership? Who should own the data? Ms. Idrees said that each layer of government should recognize their role, but need to translate it to the health authorities. Healthcare authorities act as banks or custodians for patient data. Currently, the healthcare authorities do not have standards or guidelines to be good custodians of data. Ms. Palmer said that community based health providers have the ability to grant access to data as well as to revoke access; if interoperability had clear parameters, we would have less patient data access issues. Mr. Blake added that patients should own their own data. Lack of data ownership can result in failures, especially when organizations do not share data. He said that governments need to regulate interoperability to improve overall patient safety. This is not a complicated concept, but it will take time to resolve.

In reference to two comments from Dr. Leonard and Mr. Blake, there is a push in Ontario with very different cultures integrated healthcare teams, how can we get everyone to work together? Dr. Leonard said that patients should own the data, and people need to work and anchor to that common goal. If you can anchor to a common purpose and define goals with rules for every person to follow, this will promote collaborative, integrated health teams. Mr. Blake said that variation in care is a negative concept; there is too much technology and not enough consistency with standards. He said that healthcare leaders and teams should not argue as much to deliver better patient care.

One of the main challenges to translate the value in for-profit sectors in healthcare. There are some ethical issues from physicians to trust digital health technologies, what was your first reaction? Ms. Idrees says that we have become an international example of patient care excellence; a lot of these technologies can deliver improved care for less money. We should focus on bringing in the best tools. Mr. Blake said that there are a lot of issues from physicians saying they do not want to change, fear of privacy, etc. You cannot say “ethics,” and the conversation stops. Ms. Palmer said that it is important to ask patients what their goals are, and use the tools to work toward them.

What would be your digital advice for Canadians? Ms. Idress said that the advice that we can give to the federal government may not translate to the provincial level. Each ministry and the provinces need to have a conversation around standards, and make sure that time is of the essence and move forward with change. Mr. Blake said that poor experiences with digital tools should not start patient portals, pick what you want to change, work backward and put the patients’ needs first.

Mr. Dumez said that this was an excellent debate. He is not sure we are ready to face a dramatic change in terms of systems, make cultural shift and inclusivity a focus, this movement should be patient driven and align with their needs. We need to ensure we are focusing on the right things, and be dedicated to aligning people with the same goals.

Concurrent Session #19: Caring for healthcare workers, a vision for the future

Panelists: Ed Mantler, CHE – Mental Health Commissions of Canada, Chris Power – Canadian Patient Safety Institute and Kelly McNaughton – The Hospital for Sick Children

Healthcare providers dedicate their lives to caring for others. While there are many very rewarding professions, healthcare providers have to deal with many challenges in their professional environments. This session focused on bringing visibility to the Second Victim Phenomenon (healthcare providers involved in unanticipated adverse events, medical errors, patient injury and the ongoing impact to their mental and physical health) and discussed strategies to provide care and support for healthcare workers.

Mr. Ed Mantler shared some startling statistics about Canadian healthcare workers. They are 1.5 times more likely to be off work than employees in other professions, over 40% of healthcare workers reported feeling burned out and they suffer from vicarious trauma and compassion fatigue.

While complex issues contribute to the challenges many healthcare workers face, appropriate scheduling can have a big impact on the mental health and performance of care workers. Many healthcare workers are inundated with a steady flow of calls and texts during a day of rest, and they may face pressure to work overtime. Some workers are placed in positions they are not qualified for or are not suited for. All of these issues can cause stress and negatively affect their mental health, even before the worker begins their shift.

There are mental health stigmas faced by healthcare workers in the same environments used to treat patients with mental health issues. If a healthcare worker cannot work due to a mental health issue, they may be perceived as weak or incompetent. Employees label themselves as "burned out" to avoid the trauma, backlash and stigma associated with reporting they have anxiety or depression.

The federal government's national standard for implementing health and safety in the workplace is available here. It outlines 13 factors contributing to psychological wellbeing, a guide for establishing work/life balance and tools to implement sound practices. Healthcare workers in Canada need environments where they feel important, safe and valued, especially when they ask for support. Healthcare workers who are supported in their environments are better able to care for patients, perform their duties and embrace the functions of their role. There are several in-person and online training programs to support healthcare workers through the Mental Health Commission/Health Care Canada related to mental health, suicide prevention and cognitive behavior and interpersonal skills.

The Second Victim Phenomenon (SVP) in healthcare workers has only been studied for the past few years. It has a long-term impact on the worker; it can involve a deep sense of shame, fear, remorse and even suicide. Most workplaces do not have the tools to support employees, and healthcare workers do not seek assistance after incidents. There are support programs being developed for healthcare workers, but changes need to be imbedded in policy design and accreditation frameworks to have the kind of impact healthcare workers need to be supported. Dalhousie University helped develop an online resource that is very easy to use. According to the Canadian Patient Safety Institute, the next steps to support healthcare workers include:

- Creating an Expert Advisory Committee for peer to peer support systems/programs and best practices and development
- Developing a Peer Support Network for support
- Influencing governing bodies to include support for healthcare workers in accreditation standards
- Using a growth mindset to make leaders of workers who have experienced SVP to give a voice for employees who have experienced SVP
- Guiding Peer Supporters and researching the impact the vicarious trauma has on the supporter

Ms. Kelly McNaughton discussed the Psychological Health and Safety: The Peer Journey at SickKids. The program objectives are:

- Caring for and supporting staff by providing immediate care during the trauma response of a critical incident

- Leveraging the credibility and knowledge of existing SK support staff; they understand the culture of hospital and units where outside workers did not
- Training staff internally, using them and engaging them
- Reducing stress and increasing resiliency
- Being preventive as opposed to reactionary to stress and trauma and ensure supports are in place along the continuum to deal with workers' support needs
- Building capacity by emphasizing the post-traumatic growth of worker
- Using the Logic Model to map the development of program

The program started as one on one staff support, but there are no clear limits on what workers can seek support for because the program recognizes that workers' needs will be dynamic. The program uses other tools and methods including:

- Critical Incident Stress Management (CISM)
- Serious Safety Event (SSE)
- PAWS (therapy dogs)
- Training and education – a two-day training program for staff dedicated to support management and trauma
- Manager consultations
- Occupational stress injury in nursing
- New hire orientations – equipping new staff with tools and support to deal with workplace trauma

Workers can seek discretionary components of the program on an as-needed basis. Participation is 100% voluntary. Mandatory support is automatically provided if the following event(s) occur:

- Any event charged with profound emotion
- Code Orange
- Codes resulting in adverse outcomes
- SSE investigations
- Death of a staff member
- Second victim events
- Prolonged experiences

In the first year of the program, there were 44 debriefings, 1,045 peer outreaches to staff, 14 SSE support interventions and 27 manager consultations.

The most important component of developing a successful peer to peer program is the people associated with them. Recruiting and retaining the right people (engaging, supportive and qualified candidates) is critical to the success of an effective peer to peer program.

Concurrent Session #20: Intentional digital health solutions: Building a culture of safety and highly reliable care

Abstracts: Intentional Innovation: Why great digital health solutions don't happen by accident

Tim Blake – Semantic Consulting

Leveraging digital technology to accelerate building a culture of safety and highly reliable care

Dr. Michael Leonard – Safe and Reliable Healthcare

First Presentation

Digital health is a new approach beyond the e-health model. E-health was introduced with supply systems, but lacked patient interaction and connection of various systems. Digital health starts with the patient providing empowerment, and can result in better outcomes.

Digital health is a set of tools that work in the existing system. Clients can access information regarding their own health, and data can be shared directly with physicians and teams. This information can easily be shared with caregivers. With 95% of care occurring in the home, several issues can be addressed concurrently (e.g. obesity, mental health and isolation are often occur in one patient.)

The introduction of the cellular phone made technology once available only available to affluent members of society readily available and accessible. However, it can add to the negative aspect of data silos. The capacity for data sharing with cellular phones is far beyond its current uses. For example, data received by a physician triggers an appointment to prevent a crisis, or medication instructions are shared with a patient or caregiver.

Ten critical measures for data sharing were highlighted:

1. Healthcare needs will not change in 3-5 years like financial services.
2. Data silos must be avoided.
3. Data streams must be filtered before reaching doctors to avoid overload.
4. Current funding and policies currently do not support the model.
5. A new label on an old data system will not work.
6. Apps must have physician input, but be professionally developed by software experts.
7. The idea of robot doctors and magic wearable technology must be discouraged.
8. Patient reported outcomes must be acted on, not treated as data.
9. The importance of changing behaviours and beliefs is as important as technology development.
10. Human contact is still the basis of healthcare, and cannot be lost in technology.

Second Presentation

Dr. Leonard advocated for keeping people at the centre of providing good healthcare. Technical processes are important, but culture impacts patient satisfaction and/or burnout for doctors or nurses. Culture allows an offensive approach as the best solution, ahead of systems, reactivity or unmindful function (the worst case scenario).

Various studies and their findings were identified tracking hospital culture. There must be an assurance of safety, education and feedback. One study revealed that one-third of nurses were hesitant to express a concern over patient safety. 47% of healthcare staff reported burnout, and 25% of registered nurses leave during their first year in practice.

The culture of a hospital reflects behavior and beliefs within the organization. Data shows when performance is tracked at less than 60%, patients report 50% satisfaction, and staff only slightly higher at a 55% rate of satisfaction. Above 60% performance tracks very differently with the patient experience at 98% and staff experience at 91%. More tracking clearly results in healthier outcomes for all.

Statistics in various studies repeatedly show that psychological safety of staff is directly correlated in all wards of a hospital to infections, deaths, successful surgeries, etc. Systems on bulletin boards in departments initiated years ago tracked problems and solutions with timeliness with a red, yellow and green system. This improved department morale and patient care, and has now been updated with cellular phone apps for real time tracking. Technology makes data entry immediate and easy. A commitment to learning and continuous improvement must be integral elements of the culture in a healthcare environment.

Concurrent Session #23: The rural road map for action: Health organizations working together to enhance healthcare close to home and stimulate rural and remote Canada's economic potential

Panelists: Dr. Jean Bartkowiak – Thunder Bay Regional Health Sciences Centre and Dr. Sarah-Lynn Newbery – Wilson Memorial General Hospital

Moderator: Dr. Ivy Oandasan – College of Family Physicians of Canada

The Rural Road Map (RRM) provides a framework for Canadians living in rural communities to obtain equitable access to healthcare services. Preventable and treatable mortality rates are much higher in rural/remote areas versus urban areas. Rural communities across Canada are often underserviced. They constitute 18% of the country's population, but are served by only 8% of physicians treating patients in Canada.

The RRM has 20 recommended actions and four directions. The directions are as follows:

1. Social Accountability and Medical Education
2. Policy Alignment
3. Rural-specific Practice Methods
4. Rural Research

To learn more about the RRM, please visit https://www.cfpc.ca/arfm/.

When Dr. Newbery graduated in 1996 and was looking for a community to settle in, there was one physician in Marathon, Ontario. For the size of the area, four physicians were required. She wanted an opportunity to work in an underserviced area. In a very short time, there were six physicians in Marathon. With six physicians, there was greater capacity to engage with the current systems and build new programs.

In 1996, the hospital had lost its accreditation, and there had been no policy updates since the 1970s. With six physicians serving Marathon, the hospital regained its accreditation, policies were updated and an obstetrics and chemotherapy program were created and implemented. Higher quality and diversified care has been consistently achieved since 1996. Many seniors will not leave Marathon because they know they receive excellent care. The healthcare sector is the second largest employer in Marathon. Physicians are major employers with an average of eight people working for every physician in the community. Physicians earn a high income, and they will invest in and financially support the community.

Dr. Oandasan graduated and worked in rural Manitoba for one year to fulfill an agreement she had made prior to graduation. She wanted to work and settle in an underserviced area. She found the first year terrifying due to lack of support, and left Manitoba after one year because she did not have a support network.

Mr. Bartkowiak has been the President and Chief Executive Officer at Thunder Bay Regional Health Sciences Centre since January 2016. He has worked diligently to change the culture of the hospital, particularly the belief that they would only treat local patients. He serves patients within a 1,000 kilometer radius from the hospital. Instead of turning away patients if the hospital does not have the capacity or specialty to provide care, he will accept a patient and then source or provide the care they need.

Dr. Newbery represents the educational sector on the panel. She stated that researchers and accreditation bodies must value the principle in the Canada Health Act that every Canadian has equal access to healthcare. The Rural Road Map Implementation Committee works together in a collaborative process because they recognize that the recommendations and goals they wish to achieve need a great deal of support and visibility.

In Inuvik, NWT, this community went from one doctor to 11 doctors in six years. Success stories like this need to be shared and replicated across the country. Dr. Newbery advocated for supporting and training medical students to function well in rural environments. The federal and provincial government needs to create policies and incentives to support and promote physician recruitment and retention in rural communities.

Mr. Bartkowiak operates three dialysis clinics because there is demand in the area. This is challenging because there have been instances when physicians have relocated to Thunder Bay from smaller communities to meet a need in his community.

Dr. Oandasan stated that long-term planning is a very important component of recruitment processes to maintain capacity in a rural community. Meeting the current need for physicians does not generally assist with future needs. It is very challenging to advance healthcare for rural communities at the federal level because it is not stated in the new Minister of Rural Economic Development's mandate. Mr. Bartkowiak supported Dr. Oandasan, and he regularly engages with the local mayor. Projecting into the future is incredibly important because it takes five to ten years to train physicians. Dr. Oandasan stated that municipalities can support the physician recruitment process by hiring a physician recruiter; this task should not fall to physicians because they may not have the time to project the right image in addition to caring for patients.

The panel answered audience questions about collaboration, capacity and the importance of physicians learning how to work effectively with other professionals.

This presentation resonated with the audience in the session, and the panelists received a sincere applause. Their messages were heard and appreciated, especially by Canadian health leaders in rural communities.

Concurrent Session #26: Empowering women leaders in health

Facilitators: Dr. Ivy Bourgeault – Telfer School of Management and Jamie Ludine – University of Ottawa

This session focused on examining key issues, observations and progress related to women leaders in healthcare. Leadership diversity is important to ensure everyone has access to leadership positions.

The first part of the presentation focused on an overview of the Empowering Women Leaders in Health (EWoLiH) initiative and the second on the LEADS-based tool kit of promising individual, team, organizational and system-level practices. After the presentations, participants broke out into smaller working groups to discuss the challenges and enablers to women's leadership; these sessions were facilitated by project investigators and research associates.

Diversity encourages more innovation, enhances creativity thinking, problem solving, service delivery, organization effectiveness and financial performance. A great deal of literature exists to support this, particularly in the financial sector, and the EWoLiH initiative will be looking to conduct more research focused on women in leadership in the health sector over the next three years.

With women holding over 80% of healthcare positions in Canada, they occupy very few leadership positions. For example, across 23 teaching hospitals in Ontario, only four CEOs are female. Indigenous women account for only 2.2% of the Canadian healthcare workforce, and they represent 4.9% of the population.

The concept of intersectionality, a theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, SES, and disability intersect at a micro level of individual experience to reflect interlocking systems of privilege and oppression (i.e. racism, sexism, heterosexism, classism, etc.) at the macro social structure level, was introduced. Intersectionality is foregrounded by sex and gender, but there is more to unpack intersections via gender diversity, class, race, indigeneity, age and visible minorities, etc.

The team's main objective in not about changing women, or changing diverse groups of women, but changing their environment. The team is dedicated to empowering women and men as allies to bring transformative change in the health care, health science, and Indigenous heath contexts.

The leadership literature focusing on women is very limited, especially as it gets specific into Indigenous women, women of colour and different abilities because the pool becomes very small. Issues of women's equality and equity are most prevalent in this field.

International movements, such as the United Nations High Level Commission on Health Empowerment and Economic Growth, call for action towards maximizing women's economic participation, fostering empowerment through institutionalizing their leadership, addressing gender biases, inequalities in the education and labour markets and taking on gender concerns in the healthcare sector.

Some current data for women in leadership roles in Canada follows:

- Canada has never had a female premier
- 30% of health ministers and 38% of deputy ministers have been female
- 68% of Presidents/CEOs and 48% of Vice Presidents are female; however, females have a tendency to hold leadership roles in smaller organizations compared to males

Four key areas to improve for women highlighted by the Gender Equity Hub are:

1. Occupational Segregation
2. Gender Pay Gap
3. Leadership
4. Decent Work

According to the World Health Organization (WHO), "Leadership gaps are driven by stereotypes, power imbalance, discrimination, and privilege, and are important to acknowledge."

Micro-aggressions are assumptions made about women, by men and other women, why women are unconsciously excluded. Conscious exclusions are much easier to correct than unconscious exclusions. Women face more hurdles (i.e. social implications, cultural implications, childrearing responsibilities and domestic tasks) to manage along with their careers than the majority of men do. The cartoon (right) shows the obstacles women face trying to balance their careers.

When men seek funding in healthcare, they receive 81% more than women supporting or championing the same cause or initiative.

Two main objectives for the EWoLiH initiative are:

1. Establishing a strong and supportive network and community practice amongst established and emerging women leaders, enhancing their capacity for change.
2. Developing and implementing evidence-informed tools/capacity building for transformative systemic change throughout our network.

The toolkit for individual/team level organization systems framework overlaps with the LEADS framework; it consolidates their framework with the existing LEADS framework to help integrate this new model of thinking and awareness into best practices across the healthcare industry. This slide (left) depicts how the EWoLiH toolkit aligns with the LEADS framework.

The last hour of the session was five breakout sessions of the LEADS framework and discussions about how gender, diversity and leadership affected/reacted/resonated with the participants and their individual workplace experiences.

Concurrent Session #28: Leading practices in patient engagement for improved patient safety

Panelist Team 1 – St. Joseph's Health Care London, Parkwood Institute Mental Health
Speakers: Dr. Thomas Telfer, Patient Advisor and Professor, Western University, Faculty of Law, Katerina Barton, Leader, Special Projects, Dr. Sandra Northcott, Chief of Psychiatry

Panelist Team 2 – Eastern Health, Newfoundland, Mental Health & Addictions
Speakers: Natalie Randell, Expert by Experience (Patient Advisor), Evelyn Tilley, Manager Mental Health and Addictions, Diane Dunphy, Mental Health Social Worker and Terri Jean Murray, Collaborative Care Consultant

Moderator: Jessica Schierbeck, HealthCare*CAN*

This panel presentation was dedicated to two teams who have shown leadership in successfully engaging patients and families in the measureable improvement of patient safety. Each team shared their journeys and discussed how they engaged patients and families in their patient safety initiative or practice, the successes that have resulted, as well as the important lessons they have learned.

Health Standards Organization, Canadian Patient Safety Institute and HealthCare*CAN* sponsored this session. The 2019 recognition program had 25 nominations from across the country. The two successful teams were both dedicated to improving mental health.

First Presentation

St. Joseph's Health Care (SJHC) has two locations dedicated to mental health, Parkwood Institute and Southwest Centre for Forensic Mental Health Care. They believe that suicide is preventable, and are dedicated to making suicide a "never" event. They created this program to address gaps in suicide care, promote patient safety, train and support clinical staff and treat patients.

The main driver behind this program is that one month prior to committing suicide, patients had contact with the health system:

- 45% were seen by their primary clinicians
- 10% visited the emergency room
- 30% were seen by a mental health clinician

The team at SJHC believed that too many lives were being lost to suicide. Phase one of this flagship systematic implementation program was piloted with 1,200 patients; this first phase operated from July 2016-December 2017. It focused on adult ambulatory and concurrent disorders services. Phase two of this program began in January 2018, and will be completed in December 2019. It is focused on inpatient units, assertive community treatment teams, remaining ambulatory teams, forensics and the operational stress injury clinic. Phase three of this program is scheduled for January 2020-December 2020, and will engage community services and partners (e.g. Canadian Mental Health Association and London Health Sciences Centre).

The process for this program includes:

- Assessing lifetime/recent risk on admission
- Screening for risk at every visit
- Collaboratively developing a preventative coping plan
- Creating a suicide management plan for patients with elevated risks
- Transition support, including a call within 24 hours to check in, because this timeframe is when most suicides occur

Spreading this program across the media and the country is important to leverage and share best practices as well as to engage in current and future research.

A strong patient and family connection is essential to suicide prevention. The program's patient presentation uses language directly from patients for this reason, including having patients who have been through the program to relate to other patients and families. The presentation included a moving and inspiring video.

Suicide is the ninth leading cause of death in Canada, and the second highest cause of deaths in young people. Professor Tom Telfer, one of the presenters, appeared in the video. He serves as a Patient Advisor for Zero Suicide. He told the audience that he attempted suicide multiple times, and discussed what helped him, what did not help him and how he used his experiences to guide and shape this initiative. He shared a letter written by Abraham Lincoln when he contemplated suicide 20 years before he became the President of the United States, and an award-winning poem about suicide written by his son.

The next steps for Zero Suicide include rolling it out to the community, working on safe transitions and follow-up procedures, releasing screening and training tools in the near future. In closing, Ms. Katerina Barton thanked the sponsors for this opportunity, and invited people interested in the program to visit the website, http://zerosuicide.sprc.org/ and contact her at Katerina.Barton@sjhc.london.on.ca.

Second Presentation

After the small rural community of Grand Bank, Newfoundland lost four people to suicide in a very short time the local team at Eastern Health collaborated with support from the local community to identify service delivery and patient care issues. These painful losses served as a catalyst for change. The previous process was difficult to access and very complicated. With so many losses in a short time, it clearly was not working. Through experimentation, the team at Eastern Health piloted a program that was much simpler.

A diverse group of key stakeholders instrumental in redesigning the programs include:

- Community members
- Eastern Health's front line staff and leadership team
- Schools
- Para medicine
- Persons with lived experience
- Clergy
- Municipalities
- Champions

There were some early adopters while others questioned the changes. The team at Eastern Health transformed the program from a referral and waitlist model to a patient-centred model. People are waiting only 30 minutes in a walk-in, open door environment to speak with someone; there are no waitlists or no-shows for appointments, and 97.5% of program users recommend the program with many glowing comments. A local psychiatrist is available for ongoing consultations. Eastern Health partnered with schools, mindfulness groups and community services. A community member designed T-shirts advertising the program.

The team at Eastern Health has learned the following key lessons through this program revision process:

- Involve the community in experience-based co-design
- Leadership support is needed for quality improvement
- Facilitation is essential
- Data must be interpreted and understood
- Listen to and incorporate feedback
- Assess individual's readiness for support and change
- Move forward and try something new
- Be open to evaluation, such as using the plan-do-check-act (PDCA) method
- Celebrate successes

Ms. Terri Jean Murray, Collaborative Care Consultant, was featured in a moving video and addressed the audience. She used the losses of her husband and brother-in-law within a few months of each other to find a

new purpose. The team welcomed her and valued her experiences. She views them as friends and family. The audience stood in appreciation of her courage and contributions to this remarkable program.

Ms. Natalie Randall, Expert by Experience (Patient Advisor), also lost her husband to suicide. Shortly after, a friend asked her to contribute to the mental health reform at Eastern Health. Ms. Randall was intimidated initially because she did not have a clinical background, but has real-life experience with losing a loved one to suicide and is a valuable contributor to the team.

Since January 2018, there are fewer calls for an ambulance to a person in crisis, and people are using the program to ask for support. The barriers around discussing mental health are being broken. The team at Eastern Health believes that this level of change is possible in all communities in Newfoundland and Labrador and elsewhere. There is a tremendous sense of pride in this program because it has given the community of Grand Bank hope and purpose again.

Concurrent Session #29: Value by design: Identifying promising innovations in a Canadian context

Panelists: Erik Sande – Medavie Health Services; Cheryl Williams – Joseph Brant Hospital and John Ash – Saskatchewan Health Authority

Moderator: Dr. Jennifer Zelmer – Canadian Foundation for Healthcare Improvement

Representatives presented a discussion of three models of success in value-based healthcare from Medavie Health Sciences, Joseph Brant Hospital and Saskatchewan Health Authority. A direct correlation between financial investment and outcomes that matter to people were the primary considerations for success. Each model represents a new model for care in a unique environment.

The Integrated Primary Health Care Model in the province of New Brunswick has adopted a private sector contract for public healthcare services. Medavie Health Services (Medavie) has a vast knowledge of various aspects of Blue Cross administration and emergency service models across eight provinces. They proposed a healthcare delivery model expanding into further home care services to improve the patient experience through streamlining services.

Medavie works on a performance-based pay structure; risk is mitigated politically, operationally and financially. Services now include ambulance, 811 telehealth, homecare, such as occupational and speech therapy and palliative care in this Extra-Mural Program (EMP). Services are coordinated through a central source, and some health services crossover to other areas, such as paramedics providing palliative care services. Results from the first 15 months of a multi-year contract have shown great promise.

The second model provides a new upstream and bundled approach to Chronic Obstructive Pulmonary Disease (COPD) care through the Joseph Brant Hospital in Burlington, Ontario. In 2015, the Breathe Easy outpatient program was created to lower admissions and length of stay in hospital. This model provides peer support, education, a revised group program, and was honoured in 2016 with the Inspired Integrated Comprehensive Care model for those who could not get out or access online learning. A team from the hospitals and homecare facilities collaborated to create a budget and program that prioritized patient's needs. The program's initial success inspired a subsequent phase that partnered with family health teams to further elevate the level of service to the patient. Results showed significant improvement in testing, rehabilitation, smoking cessation programs, a 95% patient confidence rate in self-management and over $1.1 million in avoided costs. The hospital results reduced the average length of stay by 24%, and readmission was reduced by 68%.

The final model presented an accountable care model through the Saskatchewan Health Authority in an inpatient setting. It was a fragmented system with uncontrolled costs redesigned to establish a value-based solution in the midst of cost efficiency measures. The model focuses on four main areas:

1. Geographic/Unit Based Teams
2. Unit Based Metrics
3. Unit Based Routines
4. Unit Level Co-Leadership

One doctor works in a designated unit with nurses, physiotherapy and other services directly connected to only those patients in that unit. Staff instructs and advises each incoming shift with a nurse-to-nurse handover in the room with the patient. Physicians and nurses co-lead structured daily bed rounds to allow family and patients to know when doctors make their daily rounds for information sharing purposes. Patients and staff satisfaction have reported improved patient outcomes and reduced levels of stress. Outcomes have shown a reduction in length of stay, readmissions, staff turnover, less overtime and a 50% improvement in patient satisfaction.

In conclusion, all three pilot projects have exceeded expectations. However, each situation has unique factors that make scaling and adapting programs challenging. Key elements can be leveraged for best practices in the healthcare community, but specialty knowledge and structured programs are difficult to replicate.

Plenary Session: Empowering a multi-generational workforce: Leveraging AI insights to enhance teamwork and engagement

Speaker: Dr. Mary Donohue – Founder and CEO, Donohue Learning (a division of DBTC)

Cerner sponsored this session.

Dr. Mary Donohue is a social scientist who has pioneered research in generational psychology with a focus on team leadership, creativity and management through technology. She is passionate about inspiring people to become more ethical leaders. Dr. Donohue is a world-renowned speaker and TEDx presenter, best-selling author, television personality and columnist. Her work appears in the Huffington Post and Financial Post. She is also an Adjunct Professor, Graduate School of Management, Dalhousie University. She began the session asking the audience a number of questions:

Who would like more me time or focus time? How many of you feel like you're under stress at work (e.g. going to too many meetings or cannot understand all your emails). How many of you would like to make more money?

She tells the audience they cannot reach these goals unless they change how you communicate digitally. Less than 20% of what people communicate online is being understood…80% is an assumption, and that prevents people from saving time. This means that 80% of the population today is digitally disabled.

Dr. Donohue asked the audience how their day was going while giving a speech. Most people responded with a one-word answer. She was pleased because this was an appropriate response; people knew that she could not respond to them because she was giving a speech. She tells the audience that they need to answer 40% of their emails. Most people are spending over half of our day in meetings. The mammalian brain does not have the digital social cues to respond to digital communication because it is relatively new. It has only been in use since 2007, so people are still learning.

She tells the audience that she has tools to help save time, make money and alleviate stress. She has tested the data with 27,000 people for a 95% confidence level, 3% margin of error and 10% response rate. The qualitative portion was tested with 7,000 documents coded and triangulated the data with over 325 academic articles. This system of communication strategies works because it has been tested, peer reviewed and it is simple.

Our brains have digital static in them. There is a crisis; the messages sent are not the messages received.

When Steve Jobs launched the iPhone, he said that it would revolutionize the world. It transformed an auditory culture into a culture based on text messaging, likes, hearts and virtual meetings. Technology has changed this because of assumed messaging (communication disconnects).

Dr. Donohue shared an example of miscommunication over text with her husband. She told him about her flight arrangements via text and he told her that he had a previous commitment. She texted back, in capital letters, "really?" thinking that he would understand the sarcasm and pick her up. He did not come, and she was wet and frustrated because this situation could have been avoided if they had spoken to each other on the phone. This phenomenon is called disengagement rates by Gallup; currently disengagement rates are 80% and rising. This results in lack of trust and collaboration. The average worker spends over 40 hours answering emails and participating in meetings before they can begin doing their actual work. People become tired.

We can get rid of the digital static by creating new communication patters. There are four generations currently in the workplace, and each worker learns their communication patterns when they are in school (kindergarten to grade eight). These generational cohorts are categorized as Boomers (1945-1960), Generation X (1960-1980), Generation Y/Millennials (1980-2000) and Generation Z (2000-Present).

Once employees begin to understand and deploy these patterns, they can save 10% more time because they do not need to repeat themselves in meetings and emails. This is called digital emotional intelligence (DEQ). An individual's share default means how people think in terms of using digital tools. Millennials and Generation Z have an attention span of seven minutes (the length of an average YouTube video). Generation Z's attention

spans will be even shorter at three minutes. Boomers and Generation X have an attention span of 22 minutes for a learning pattern.

Learning changed a great deal in in the 1980s due to trickle down economics. This resulted in classrooms with more students. Desks were grouped together to have strong students teach the weak students. It created democratic learners and democratic people, which resulted in the shared economy. Boomers and Generation X learned in rows. Boomers had a truant officer. Millennials and Generation Z were the first children of working parents; these employees crave experiences together even more than money. Generation X is the smallest cohort in the workforce; they have a tendency to be scrappy and tenacious.

Millennials and Generation Z do not anticipate feedback in an annual review. They get feedback constantly through their phones. These two generations share. Boomers and Generation X were trained to do the work, then share it with others. Millennials grew up with calendars on the wall indicating where everyone was supposed to go at what time; they were the first generation of latchkey kids. This is the most coached generation ever; the calendar dedicates their life. Boomers and Generation X will always say, “I’m busy,” when you ask them how they are. Being busy is viewed as a badge of honour because they can demonstrate to their bosses how busy they are and how much they matter.

Millennials love new technology and are comfortable using it. Boomers and Generation X do not have time to learn new things. They also saw technology fail on a spectacular level (e.g. the fail of the Challenger and the danger of using “shift” and “F7” to delete files). For people who will be onboarding new employees in a few years, they will need to be told to use it for talking purposes because this is a foreign concept. When Millennials are working with Boomers and/or Generation X and have a communication misunderstanding, the best response is, “I will give you a deck, and then we’ll talk about it.” Millennials will text clients while Baby Boomers and Generation X feel that texting is too intimate, and prefer to use email.

The audience took a survey to measure their digital emotional intelligence (DEQ). It is important to understand that everyone, based on their age, processes language through digital information differently. The share default and task default is how each cohort learns. Here is how each generation reacts to digital information.

Boomers have a task default style of learning. They are great mentors, excel at build teams, they work on legacy, they do not like being left alone digitally and they are triggered by the phrase “you don’t know.” Radio and television is how they heard the news; they are auditory learners.

Generation X members also have a task default style of learning. They are visual learners focused on tasks. They are between two huge cohorts, and they are brilliant at strategy. They use technology for a sense of independence to get the job done when it is convenient for them. They attend the most meetings of all generations, and they are rushing through things. Their downfalls are too many assumptions and can lose their patience. The phrase that triggers them is, “no, you won’t,” because they entered the workforce during a major recession. They are used to doing more with less, and are extremely resilient.

Generation Y (Millennials) have a share default style of learning. They have had to adapt to situations. They were taught in teams because it is less expensive to teach groups than individuals. Everything they do is shared. They have been online since grade five; they are the first generation to have their whole lives online. They are the first generation with two parents working. They become stressed when asked, “What do you think?” because that is what their parents asked them.

Generation Z also have a share default style of learning. They are the most interesting generation ever. Lockdowns were the very first concept they were taught; they learned to think that a bad person would come to the school and hurt them. This generation has the most in common with their grandparents’ parents, the Great Generation. They will do anything that is asked, and they will hide from technology but can find anything they need to. Technology has been their soother since they were very little. If these children were fussy, they were handed phones to allow parents an opportunity to speak to each other. The words that cause them distress is, “no Internet.” However, if you tell this generation that not using their phones is a rule, they will respect and abide by it. They will respond favourably when asked, “What do you believe?” because they are the most moralistic generation walking into the workforce today.

Dr. Donohue discussed some common issues in the workforce and offered the following solutions:

- Frequently moving jobs (lack of loyalty) – Generation Z expects people to assist in their professional development and time off. In 2008, there was a depression and a lack of trust affected this generation. Generation X and Y are motivated by money to build a pension and a legacy; vacation time is not as enticing to them
- Improving your digital intelligence – be aware of your audience. For example, if you are writing a letter, find out the age of the recipient using LinkedIn because each generation of workers will respond differently and have different expectations. You need to keep their attention (e.g. do not send an email to Generation Z because they do not trust email; they are more receptive to a text)

In healthcare, how do we use this information to communicate with patients? Dr. Donohue advocates to use tools as they are intended, and to keep messages clear and concise. For example, physicians book longer appointment times with patients who are Baby Boomers than Generation Y to offer sufficient time to each patient.

How do you look at Baby Boomers who have become conservative over time? Each generation is aging differently. For example, Millennials are different decisions than many of their parents. They are choosing to have smaller families, not to get married and not to buy homes.

Which generation will solve the excessive meetings and emails issue? Dr. Donohue said people who have knowledge of digital tools and collaboration can solve this problem. People will save time and money by having a higher level of digital intelligence will be successful. When Mr. Picard asked for a universal approach to solve this issue, Dr. Donohue recommended short responses that align with the digital culture of the organization. She recommends a tip from the Amazon culture, which includes building time into the meeting to read the agenda. Prior to meetings, most people will not take the time to read the agenda.

As a leader or supervisor with staff, how do I treat each employee fairly? Dr. Donohue recommends catering the communication style and tools to the primary capital (the largest group of people) and secondary capital (the second largest group of please). For example, the Globe and Mail has a large number of Baby Boomers. Meetings, emails and ongoing reviews will resonate with this group. Communication is not an assumed skill; it is a learned behaviour. Organizations should retrain employees by giving clear expectations to help them understand how to communicate in the company's culture.

Mr. Alain Doucet, President of the Canadian College of Health Leaders, thanked all of the sponsors, conference committee members, volunteers and attendees for their support and attendance. In closing, health leaders, care providers and patients must continue to look forward with a keen focus on achieving excellence. He hoped that the lessons learned during the conference help to improve the current system and nourished participants' ideas.

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