President’s message

Value for health care dollars

Gillian Kernaghan, MD

This spring, the Ontario Action Plan for Health Care was subtitled “Better patient care through better value from our health care dollars.” With the rising costs of health care, the exponential rise in chronic diseases, the expanding senior population and the economic realities in Canada and other jurisdictions, there is increased focus on attempting to articulate the value of spending on health care.

Webster’s dictionary defines value as “a fair return in goods, services or money for something exchanged” or “relative worth, utility or importance.” As we consider the concept of value for health care dollars, multiple perspectives come into play: those of funders, providers, individual patients, the community as a whole, employers and family members, to name a few. The value attributed by one may not be shared by another.

In recognition of the rising costs of health care in the United States, the Institute for Healthcare Improvement articulated the concept of the “triple aim”:

- the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

This approach takes a system approach to health care that is more feasible in some Canadian jurisdictions than others, because of silos of funding and accountability related to various components of the health care system.

In an important article on the value of health care, Dr. Michael Porter from the Harvard Business School speaks to the importance of defining value around the “customer” — the patients in the system. Value, he argues, should be dependent on results or outcomes achieved not inputs. He further states that value should not be based on the volume of services provided nor the process of care used.

In a presentation, Dr. Thomas Lee, the network president of the Partners HealthCare System in Boston shares the organization’s experience with trying to operationalize a “value framework.” The organization focused...
on a number of conditions, articulating the desired medical and functional outcomes while tracking resource use over the course of care. The focus of the work was on improvement and collaboration. Many of us would agree that the rising costs of health care are not sustainable. A value framework provides an approach that keeps the system focused on the patients and their outcomes. The triple aim challenges us to balance the needs and costs associated with an individual patient outcome with the costs to the health of a population.

In the Crucial Conversations model there is a concept called the “sucker’s choice.” As physician leaders, many of us have been engaged in discussions with colleagues where it is believed that you can have quality or cost savings but not both. Instead of accepting this either/or sucker’s choice, we are challenged to put an “and” into our thinking, so that the dialogue focuses on how to retain or improve quality and achieve the required budgetary savings. Both the IHI’s triple aim and the value framework articulated by Dr. Porter provide physician leaders with a way to engage colleagues in these challenging conversations.

Bobby Orr the famous Canadian hockey defenseman is quoted as saying, “Forget about style; worry about results.” May we as physician leaders continue to focus our colleagues and organizations on the important results — patient outcomes — within a sustainable health care system.

References
I sometimes ask myself why I’m involved in physician leadership. Although I’m happy doing what I do, from time to time I still ask myself, how the heck did I end up getting into this job?

I’m the medical director of a large mental health program at the Ottawa Hospital and, more recently, I’ve taken on a position on the Board of Directors of the Ontario Medical Association. As to why I became involved in leadership activities, I think the common denominator was that I wasn’t satisfied with aspects of our health care system at various times in my career and felt the need to do something about it.

I first became involved in physician leadership in the late 1990s when hospitals were being restructured and merged by our provincial government. At that time, the local health care council recommended the elimination of the department of psychiatry in our hospital. I thought this was without sound rationale and very short-sighted. Furthermore, I’ve always believed that mental health care must be part of the general health care system and that front-line mental health care should be provided by primary care physicians, community health agencies and general hospitals. In collaboration with my department head, I presented these views to the Ministry of Health and Long-Term Care and the Ontario Health Care Restructuring Commission.

What I learned was that physicians need to stand up and have their voice heard in their capacity as health care experts, and not leave systems planning to those with non-clinical backgrounds. After merger of the two large academic teaching hospitals in Ottawa, I ended up as deputy head for several years and, for the past 5 years, I’ve been head of the department of psychiatry at the Ottawa Hospital.

In recent years, I’ve focused my clinical work on providing mental health care on-site in family health teams. I started working closely with family physicians as part of a clinical research project that evaluated collaborative mental health care in a primary care setting. This project convinced me that patients greatly benefit from close relations between specialists and family physicians and that care provided in a community setting often decreases the burden on the hospital sector. However, I’ve found that there often seems to be a challenge bridging the transition between care provided by hospitals and primary care. Because of my satisfaction working with family physicians and a belief that hospital-based physicians have to interact with their community counterparts, I became involved in the Academy of Medicine of Ottawa, and I’m now a member of its executive.

Finally, a couple of years ago, there was an initiative by the provincial government to change the composition of boards of directors of Ontario hospitals. It seemed to me that the role of our hospitals’ physician leaders was being compromised by some of the proposed changes. This galvanized me to apply for a role as a delegate to our provincial medical association’s council and, more recently, to run for the position of academic representative on its Board of Directors. In this position, I have had the privilege of working with many physicians from across Ontario and meeting physician leaders from other Canadian provinces at national meetings.

Why have I jumped at leadership opportunities, rather than just complaining about the deficiencies of the system (which I certainly have done at times)? I felt the need to “step up to the plate” and do something. I suspect that what holds some physicians back from taking on leadership positions is a concern that they don’t know enough about management or think that non-physician administrators or planners are in a better position to manage the health care system. However, I’ve found that physician leadership programs have definitely helped younger physicians gain confidence that they can learn these skills and let them know that their clinical expertise is a huge asset in contributing to a better health care system.

Dr. Swenson heads the Department of Psychiatry at the Ottawa Hospital and is professor and associate chair of psychiatry at the University of Ottawa.
Executive search: a snapshot

Michael Naufal and Francine Bilodeau

You’ve decided to explore executive leadership opportunities or you’ve been asked to participate on a committee tasked with recruiting an executive for a non-physician leadership role. In either case, you could find yourself interacting with an executive search firm.

What should you expect? It depends on the type of firm you are dealing with. There are two types of firms — contingency and retained — as well as hybrids of these. In fact, many firms will provide contingent and retained services depending on the client’s needs.

Contingency firms are paid once the client hires a candidate; that is, their fee is contingent on successful placement regardless of the amount of time and effort the firm has expended to complete the search. To keep the cost down, the contingency recruiting process is often streamlined. In fact, many contingency firms are highly specialized in one or two areas and have access to a large network of contacts they can call on. The main benefit to a client of this type of arrangement is that payment only occurs if a candidate presented by the firm is hired.

Retained executive search firms operate as both recruiter and management consultant. The firm is paid for conducting a comprehensive recruitment process, advising and guiding the client through the search, providing detailed reports and presenting a strong slate of executives for a committee to select from.

In this article, we describe a retained executive search process, which is the more common process when recruiting at the executive level. It is intended for those contemplating a non-physician leadership role, as physician recruitment can be very different from a standard executive recruitment process.

Step 1 — Confirming the committee’s terms of reference
Before a search is launched, an organization usually appoints a search committee to lead it. In most cases, this is also the selection committee, that is, it is responsible for managing the recruitment process and making the hiring decision. In some cases, the search committee is a subcommittee of a larger selection committee and is responsible for managing the process and preparing a slate of candidates from which the selection chooses. In this article, we assume the search and selection committee are one and the same.

The committee is typically involved in all aspects of the search, including but not limited to assisting in defining the core requirements and responsibilities of the executive position and the ideal candidate; providing guidance on the search strategy and outreach campaign; identifying potential candidates and avenues to pursue; participating in the selection of a short list; conducting the interviews; and negotiating the employment offer.

Step 2 — Preparing materials for candidates
Many serious contenders for a position go through an emotional transition from “cold” to “committed.” When qualified people, especially those immersed in a busy clinical, teaching or research practice, are first contacted by the search firm, they are usually taken aback because they have not been waiting for a call about joining the client organization. Ideally, however, by the time they are interviewed (if the committee and search firm have done their jobs well), the candidate will be 100% committed. That is, they understand the challenges of the position, the culture of the organization, the expectations of the senior team and staff, broad thoughts regarding compensation and they should be motivated to accept the position if it is offered.

The best way to warm up candidates is to enable them to see themselves in the role. This has the greatest chance of happening when candidates are provided with relevant information in a personally engaging manner, in a step-by-step process. The more relevant the information provided and the more personally engaging the firm can be in conveying that information, the higher the likelihood of the person becoming a candidate.

Therefore, the first step in the cold-to-committed process is accomplished with a highly customized candidate-briefing document, prepared by the firm in conjunction with the committee. This brief should include detailed information about the organization, the role, the ideal profile and the organization’s priorities, opportunities and challenges. It should provide a truthful and accurate picture of the opportunity and allow the candidate to make an informed decision as to whether the role is right for him or her. As a courtesy, the brief should also outline the recruitment process, as candidates may not know what to expect.

Step 3 — Developing and executing a search strategy
With guidance from the committee, the search firm develops and executes a recruitment strategy. Most search strategies involve proactive outreach as well as a targeted and cost-effective advertising campaign. The firm reaches out to candidates by telephone to solicit and gather interest, accepts and manages the flow of applications and reviews the applications against the requirements of the role. Following the initial screening, the firm assembles and presents a list of candidates to the committee, and then facilitates a discussion to assist the committee in its review of the candidates and its selection of a short list to interview.

Step 4 — Assessing and selecting candidates
The firm assists and facilitates multiple rounds of interviews, including managing the logistics and scheduling process. Short-list interviews usually take place...
over a concentrated period and in a neutral setting. The interviews are largely behaviour-based and are designed to invite candidates to share experiences that demonstrate their ability and experience in key competency areas. The interviews also focus on executive leadership and intelligence, which involves a series of questions designed to test an individual’s intellectual capacity to deal with highly nuanced questions or challenges.

In more and more cases, organizations request, and are well advised, to have their selected candidates complete a series of psychometric assessment exercises. The committee can choose from a number of approaches, from simple online questionnaires to intensive full-day sessions with an industrial psychologist to obtain more data to support or, in some cases, change its decision.

**Step 5 — Referencing**
Once a candidate is selected, the firm verifies education and conducts the necessary background and reference checks. Contacting the traditional “three references” is not the norm when using a search firm; nor should it be. There is usually a lot riding on the committee’s selection especially when recruiting for senior leadership roles. Most firms contact at least eight to ten references including staff, peers, partners and superiors to get a full 360 view of the candidate.

Assuming the assessment is positive and all checks come back clean, an offer is presented to the candidate. In some cases, the firm assists the committee with negotiations and facilitates an agreement between the two parties. Committees are well advised to have an offer and the terms understood and spelled out before the interviewing phase of the search. The terms of the total package (base, bonus, pension, vacation, perquisites, etc.) should not come as a shock to candidates at the end of the process.

**Step 6 — Integrating the candidate**
To ensure successful recruitment, the search process does not, and should not, end when a candidate is hired. Most professional executive search firms provide some sort of “on-boarding” process to ensure the individual integrates into the new role. Having developed a relationship with the executive during the search process, the firm is generally in a good position to give credible advice in an objective and unthreatening manner as the successful candidate transitions into his or her new role.

Although the executive search process seems rather straightforward, it can be foreign and byzantine to those who have never experienced it. Each firm operates differently, but their processes can be quite similar, differing only by degree and quality. In any case, whether you are a committee member doing the hiring or a candidate hoping to be hired, it is important to get to know the firm and to know its process.

Michael Naufal is a managing partner and Francine Bilodeau is principal at Odgers Berndtson, an international executive search and recruitment company with offices across Canada.

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Bridging connections to coaching experts for physician success is what the CMA’s new Coaching Connections service is all about. Scheduled to launch on October 1, 2012, CMA will provide physicians access to a roster of 11 professional, qualified coaches from across Canada who can provide support and guidance to those leaders who desire help in overcoming challenges, want to enhance their leadership effectiveness and achieve professional performance excellence.

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Supporting innovation in medicine

Mamta Gautam, MD, FRCPC, CPDC

One of the courses in the first year of my MBA program was on innovation and entrepreneurship. Our class finished the year with a trip to Silicon Valley, to examine first hand the elements of the habitat that make it synonymous with the pursuit of innovation and entrepreneurship and that have led to exceptional job growth and wealth creation.

This area has attracted attention and interest worldwide. What is it about this location that creates such success? The book, *The Silicon Valley edge: a habitat for innovation and entrepreneurship*, edited by Chong-Moon Lee and associates, identifies several key factors that have contributed to the development of such a successful environment.

I was highly intrigued by this combination of factors, especially the one described as “existence of a climate that rewards risk-taking and tolerates failure.” As I embarked on this trip, I had one question in the back of my mind. How can we learn from this and adopt some of these elements in medicine?

In Silicon Valley, people have rebelliously left the established stability of proven companies to take risks and branch out on their own. The key is to “see beyond what the customers are asking for,” and develop it before they even know they need it. Young engineers are forward thinking, sharing new ideas in clusters of innovation and trying them out — not knowing which ones will take off. Venture capitalists and angel investors take risks too, supporting new ideas and development.

Accepting risk and potential failure became an integral part of starting a business here. Entrepreneurs set challenging goals and work hard. They seek advice, support and help from everyone who wants to see their company succeed, harness networking opportunities and recruit top talent. Their venture capitalists want to “pay it forward” and guide, connect and mentor them to success. In this insider culture of shared ideas and support, knowledge is free to those who network.

It follows that taking such risks leads to inevitable failures. Silicon Valley is built on the “rubble of earlier debacles.” However, like forest fires, failures are seen as having a positive effect, clearing out old growth and allowing new life. There are many examples of failed ventures, yet people wear them like a badge of honour. They are viewed as learning experiences, as if “someone else has paid the tuition for you.” People are rarely punished for failure, but instead supported to carefully start over.

How can any of this possibly translate into medicine? Medicine is highly traditional. In the culture of medicine, there is little support for risk-taking and failure is not tolerated. This makes inherent sense. We cannot take risks with our patients and their clinical care. However, this thinking is pervasive in all areas of medicine, not just those aspects related to patient care. This blocks innovation.

Innovation is critical for human progress, either by continually improving things around us or by creating new things entirely. In his blog, Ted Ball of Quantum Transformation Technologies often refers to the ingrained culture of blame and shame in health care. Many physician executives do not feel there is a safe environment for innovation in processes or strategy. The organizational culture does not promote thinking outside the box. There are too many rules, regulations and protocols. We are encouraged to comply and to do things the way we always have. In fact, why fix it if it is not broken? Innovation implies taking risks; but medicine is highly risk-averse. As physicians, we are trained to be evidence-based, but innovative ideas, by their very nature, are untested. They make us very uncomfortable; it is easier to avoid them and not deal with the unknown.

Yet, without innovation, our health care system will not survive. The system is failing and in strong need of an overhaul. Among the members of the Organisation for Economic Co-operation and Development, Canada is near the top in terms of health care spending, yet our health outcomes are relatively poor. Addressing this will require thinking outside the current box, to ensure our intrinsic values of equity, access and solidarity, while exploring other models of delivering health care. We can improve on addressing the key social determinants of health and promote health, not just focus on treating illness.

This will require a fundamental change in the culture of medicine.
Coach’s corner

Health care executives must show leadership, speak up and be creative — and be open to trying new things. It will also require us to create a safe environment for innovation in medicine. We can encourage our colleagues to think proactively, support their thoughts and ideas and reduce their anxieties about the unknown. We can demonstrate how new models and processes can be embraced without negatively affecting patient outcomes. We want health care providers to start from scratch and think about how they can design processes that would be the best possible for the patient. We need to invite them to share their ideas, create clusters of innovation and test them out. When ideas with potential do not succeed, we must look to understand why without apportioning blame and support leaders to modify their ideas and try again.

There is no guarantee of success. The only guarantee is that things will not improve, and may likely fail, if we do nothing. We can work together to find that sweet spot where we have the right balance of being creative and innovative, while remaining responsible and accountable.

Replicating the insider culture of shared ideas and support in health care requires courage and strength. With shared fixed initial goals of improving the system for both patients and providers and improving health outcomes and the health of our communities, we can work together and succeed. The future of our health care system depends on our openness to and support of innovation.

Mamta Gautam, president of PEAK MD, is a pioneer, specialist and champion of physician health. After 20 years of experience as a psychiatrist exclusively treating physicians and physician leaders, she brings her expertise to PEAK MD, offering leadership advisory services to health care leaders, cultivating personal resilience to enhance professional effectiveness and performance. She is the ideal coach for physician executives, to help them achieve and sustain success. Dr. Gautam is an internationally known expert, a sought-after speaker, a faculty member of several physician leadership courses and the author of articles, books, videos, podcasts, and columns on physician health. She has been honoured with multiple awards for her work in this field. Questions or suggestions for future topics may be addressed to mgautam@rogers.com.

Operation Family Doc needs you!

Major (retired) Karen Breeck, MD

When I retired from the military it was the first time I needed to find my own family doctor in over 20 years. Being a physician myself and new to the city of Ottawa, finding a family doctor willing to take me on as a new patient was not a simple exercise.

I know that accessing a family physician is a challenge that many people (military or not) face but the challenge is especially magnified for military families who typically move every 3–4 years. There are also a number of former military members who are also unable to establish any continuity of primary care by securing their own family doctor. I am therefore very heartened to hear that Ottawa has put a program in place to assist former military members and the military family members of serving military members to access primary health care services.

“Operation Family Doc” is the result of a partnership between the physicians of Ottawa (as represented by the Academy of Medicine Ottawa (groups.ontariomd.ca/groups/amo) and the Military Family Resource Centre — National Capital Region www.familyforce.ca. All military members undergoing release or retirement from the Canadian Forces and/or any military family members of serving military members can apply. Participating in the program is as simple as downloading an application form from a link at www.familyforce.ca/sites/NCR/EN/Pages/default.aspx and sending it in by email, fax or mail.

Hopefully with increased awareness of this need for family physician access in support of the troops, this program can become one of many across Canada. If you have any further questions on how you can be involved or start up a similar program in your city, please call 613 998-4888 or email OFD@mfrc-nrc.org.
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Si vous œuvrez dans le secteur des services de santé, vous aurez probablement à vous associer à des efforts d’amélioration, si cela n’a pas déjà été fait. De nombreux gouvernements provinciaux consacrent plus de la moitié de leur budget aux services de santé, ce qui exerce une pression considérable sur les organismes de santé pour qu’ils fassent preuve de rendement accru et améliorent les services de santé.

Le programme FORCES est justement conçu pour aider à relever ce défi de leadership. Ce programme de 14 mois offre une formation spécialisée à des équipes de hauts responsables de la santé qui ont une vocation et qui travaillent sur des projets d’intervention visant à améliorer ou à transformer le service.

Entièrement bilingue, le programme FORCES consiste en une combinaison de séances en résidence, d’apprentissage en ligne, de possibilités de réseautage ainsi que de mentorat par des enseignants.

Les équipes FORCES peuvent, au terme du programme, s’attendre à :
• acquérir les compétences et les connaissances nécessaires pour diriger l’amélioration éclairée par les données probantes;
• apprendre des techniques, des tactiques et des stratégies de leadership pour déployer, gérer et diffuser l’amélioration;
• concevoir et mettre en œuvre une initiative d’amélioration organisationnelle ou multicentrique;
• travailler avec des mentors pédagogiques et des instructeurs en gestion du changement qui leur sont affectés pour réaliser des progrès mesurables au regard de leur projet d’amélioration respectif;
• établir des liens et collaborer avec des collègues animés des mêmes idées ainsi qu’avec des chefs de file en amélioration, et ce, au-delà des frontières provinciales et régionales.

LES FORMULAIRES DE MISE EN CANDIDATURE SONT DISPONIBLES EN LIGNE DÈS LE MOIS D’OCTOBRE DE CHAQUE ANNÉE À MEILLEURSSERVICESSANTE.CA