National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé

CASE STUDY
La Monteregie

BUILDING LEADERSHIP COMPETENCY IN PUBLIC HEALTH

TAKING ADVANTAGE OF CHANGES IN HEALTH DELIVERY IN QUÉBEC

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- Gylaine Boucher, Gestionnaire de l'Initiative sur le partage des connaissances et le développement des compétences

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ABOUT THE NATIONAL COLLABORATING CENTRE FOR DETERMINANTS OF HEALTH

The National Collaborating Centre for Determinants of Health is one of six National Collaborating Centres (NCCs) for Public Health in Canada. Established in 2005 and funded by the Public Health Agency of Canada, the NCCs produce information to help public health professionals improve their response to public health threats, chronic disease and injury, infectious diseases, and health inequities.

The National Collaborating Centre for Determinants of Health focuses on the social and economic factors that influence the health of Canadians. The Centre translates and shares information and evidence with public health organizations and practitioners to influence interrelated determinants and advance health equity.



About the Case Study

This case study is one of four case studies that illustrate the application of social determinants of health (SDH) in public health. Each of the case studies reflects a different geographical region of Canada. The case studies were developed as a knowledge exchange tool to support a workshop hosted by the National Collaborating Centre for Determinants of Health and the Canadian Institutes of Health Research Institute of Population and Public Health in Toronto, Ontario on February 14-15, 2012.

To enable learning and possible implementation of the processes discussed at the workshop, the four case studies were developed. Each case study includes a description of the context, issues addressed, activities undertaken and the possible application of the approach to public health work.

The process used to develop the case studies is outlined in *Bridging the Gap between Research and Practice: methodology for case study development.*

Other case studies in the series include:

- Empower the Community: New Brunswick's Approach to Overcoming Poverty
- Improving Health Equity in Saskatoon: From Data to Action
- Making the Case for Health Equity Internally: Winnipeg's Experience

All documents are available at www.nccdh.ca

Introduction

Changes in health service delivery present ongoing challenges in Canada. In Quebec, in November 2005, Bill 83 was passed to amend the Act governing the delivery of health and social services. It brought extensive changes to health structures, specifically creating new Centres de santé et services sociaux (CSSS) by merging front-line facilities (Centres local de services communautaires, or CLSCs) with long-term care facilities and hospitals. The result was that health promotion and disease prevention, historically delivered by small front line organizations focused on community needs and prevention, were to be integrated into much larger health service delivery organizations, primarily devoted to health care. Public health services were to be delivered by managers who often had little or no experience in public health.

Dr. Jocelyne Sauvé, Public Health Director for the region of La Montérégie, saw an opportunity in this potential setback. Through an Executive Training for Research Application from the Canadian Health Services Research Foundation, Dr Sauvé was able to develop and deliver a detailed public health training program for the senior managers responsible for public health in the newly created CSSSs. The training program has been adopted by the Institut national de santé publique du Québec, providing an excellent avenue through which to instill a population-health perspective into service delivery. Can a similar approach be used to promote health equity within public health leadership?

The adoption of Bill 83, *to amend the Act respecting health services and social services and other legislative provisions*, brought extensive changes to the administration of health and social services in Quebec. New *Centres de santé et services sociaux* (CSSSs) were responsible for delivering all health services, including public health. The CSSSs were created by merging up to three *Centres local de services communautaires* (CLSC) and many – sometimes up to a dozen - long-term care centres and hospitals. Many were responsible for populations of 200,000-350,000 people. This would make meeting public health objectives more difficult, as health promotion and disease prevention activities would now be integrated into large organizations mainly focused on health care services.

After the implementation of Bill 83, the proportion of public health spending dropped from 20% of the health and social services budget in the CLSCs, to 2% in the new CSSSs. There was clearly a problem. Public health could now be ignored among the priorities of such large centres. At the same time, the change offered a window of opportunity to instill a genuine population-based perspective into service delivery planning within all local facilities.

The Issue/Challenge

To embed a public health focus in CSSSs required a change to the organizational culture from one that merely responded to explicit requests from clients seeking health services, to a culture that took into account the health needs of the entire population. A complete shift in approach was needed to ensure the survival and development of essential public health functions, and to position them at the local level.

To respond to all of these needs within the limited financial resources available, decision-making had to be based on the best evidence. It required a balancing of priorities within the full spectrum of health services, from preventive to end-of-life services.

The Environment

Based on the premise that strong leaders are required at the local level to protect public health services, Dr. Sauvé focused her training on leadership skills and public health knowledge development. Many senior managers of the health service delivery organizations had little knowledge and no training whatsoever in public health. Dr. Sauvé successfully applied to be a Fellow in the Executive Training for Research Application program, which allowed her to pursue the project within a research environment. Within that program, Dr. Sauvé was able to:

- Identify the competencies and knowledge required by local managers to undertake their new duties (through a literature review)
- Identify the best strategies for competency development and knowledge transfer in the context of on-the-job training for senior managers (through a second literature review focused on knowledge translation strategies)
- Prepare, and have local organizations approve, a plan for the implementation, follow-up and assessment of the strategies identified.

Key players in the implementation of public health activities and services in CSSSs were the senior executives responsible for the local public health action plan. To be effective in this role, they needed the competencies and tools required to measure and interpret the state of health of local populations. They also needed to identify best practices to fill the gap between health care needs and public health services. Another challenge was to systematically establish evidence-based administrative practices within the culture of their organizations, to evaluate suggested interventions and ensure their follow-up.

Implementing the Training Program

Dr. Sauvé was not in a position of authority over the eleven CEOs of the CSSS, so she had to engage senior managers in a way that made them want to participate in the training program. To do so, she worked hard to establish a reputation among her colleagues of great competence as a public health specialist. She also made sure that her team was fully responsive to every request from the staff and CEOs of each CSSS, putting their public health expertise at the service of the local level.

Dr. Sauvé met personally with each director, to establish one-on-one rapport and trust. Throughout the process, she ensured that her communication was clear and transparent.

At the heart of the success of the program was selling the idea that, if CSSS managers were better at their jobs, the CEOs of the organizations would have an easier time fulfilling their mandates and, most importantly, the local population would benefit.

Trust, expertise, relationships, leadership and transparency were the keys to success.

Addressing Challenges

Even so, a number of challenges arose during the process, including:

- **Competition between preventive and curative activities –** The amalgamation of front-line facilities with large long-term care facilities and hospitals could have jeopardized certain public health functions at the local level, given the enormous pressure on medical services that existed then, as well as now. While this is an ongoing challenge, highlighting the shared goals of preventive and curative services to the health sector, the public and decision-makers can reduce any apparent conflict. Clear, concise messages about the benefits of prevention resonate with most audiences. Our current care system provides equitable service, once 'inside the door'. Extending that concept throughout the health system will demonstrate that prevention is more than just a platitude, and can make a real difference in creating a healthy population and advancing health equity.

■ **A viable community of practice –** A true community of practice helps to create a bond of interdependence between the regional and local levels. This was a challenge in La Montérégie, given the divergent values, objectives and philosophies of intervention of various players, who were not under the administrative authority of the regional health authority.

The literature review conducted by Dr. Sauvé pointed to certain criteria that were key to effective knowledge translation. These included: a formalized structure; face-to-face exchanges; ongoing interaction between experts and non-experts; and articulation of common concerns and interests. To meet these criteria, an existing mechanism for regional public health coordination was expanded and evolved into a 'community of practice'. It was here that discussions occurred to resolve difficulties with senior managers, succeeding in strengthening the program and the links between managers.

■ **Ongoing support from local CSSSs –** Gaining the support of Executive Directors, through communications and influence, was an important focus. They saw the benefits of staff training, and recognized that their success in the public health field depended on having the necessary skills in these new areas of responsibility. The Executive Directors recognized the public health department's expertise and supported the department's active role in transferring knowledge and developing the competencies of their managers. Dr. Sauvé had gained their support through her eight years of work in the region.

■ **Training that continues to meet local needs –** It continues to be challenging to ensure that participants' learning paths adjust to take into account changing needs, organizational interests, evolving work contexts and changes in the external environment. A mechanism for continuous assessment of satisfaction with the training has been put in place. A more comprehensive

approach is under development to assess the relevance of the Public Health Leadership Competencies and the proposed strategies, as well as the degree of success in transferring the targeted knowledge and learning.

- **Staff mobility –** Once trained, managers were using their new skills to find better positions elsewhere. At the time this case study was written, more than half of senior managers involved in managing public health had changed jobs since the training began. The current situation sees new managers coming on every 3 or 4 months, creating a disparity between the skills of new and longer-standing managers. Given the wide gap in skills, determining training that meets everyone's needs is difficult.

- **Staff availability –** Health managers are busy people. They could not always attend each training session. When participants were absent, someone from the public health department contacted them to see if there was another way they could be accommodated, to "catch up" and be ready to rejoin the group at the next meeting.

- **A sustainable funding stream –** To ensure sustainability, Dr. Sauvé felt that the funding source for this type of project should be regional executive training program. Other than a small amount of funding provided initially, however, no funding from the training program was allocated to the project. Funding still comes directly from the regional public health department budget.

- **Competency development integrated into ongoing training strategies –**Links between professionals working within organizations, and researchers and university faculty can create ongoing opportunities for exchange between practitioners and researchers. Universities are engaged in the training process, through the *Initiative sur le partage des connaissances et le développement des compétences en santé publique et en gestion par approche populationnelle*, described below. However, it continues to be a challenge to involve individual researchers in a sustained way.

Developing Leadership in Health Equity among Managers

Leadership, at both the organizational and systems levels, is an important factor in effectively advancing health equity, and one that is lacking, according to 75% of practitioners surveyed.[1] Many of the lessons learned in training health managers in the 'art and science' of public health in La Montérégie can be applied to developing leadership in health equity:

- **Leadership –** Natural champions and opinion leaders exist throughout the health system. Finding or cultivating a health equity champion in a leadership position can move the issue forward exponentially. At all levels, early adopters exist, who understand health equity and are willing to spread the concept to their colleagues. They should be identified, nurtured and celebrated, and recognized regularly.
- **Build on what is already there –** All aspects of the health system, including acute care, currently face issues of health inequity. Drawing the links between current challenges and the population health issues behind them creates a connection between health equity and the health system. For example, cardiac patients may appear in emergency rooms repeatedly because they did not complete their rehabilitation programs or adhere to their prescribed medications, due to their social or economic circumstances.
- **Adapt the system and create tools to support health equity –** While the concept of health equity may be understood, a system to support its application is required for action. Health equity must be built into planning and performance indicators, with a sensitive health equity lens applied to pick up on problems that could otherwise go unnoticed. Tools to support systems change start with the job description of the CEO and are part of all staff requirements, assessed through performance appraisals, health reporting and, possibly, accreditation.
- **Develop relationships of trust –** Managers are more likely to accept a concept from a trusted, competent colleague. Building relationships between and among managers and communities is a long-term effort that requires demonstrated understanding and support for their issues. Communication must be transparent and ongoing to establish effective relationships.
- **Provide strong economic arguments –** Effective preventive work saves money. Research, combined with local data, can be used to demonstrate gaps in health and actions that may successfully address them. Arguments must be couched in language that speaks to managers and policy-makers.
- **Build on public health successes –** Public health has demonstrated its value in a number of health events and crises. This competency can be built upon to apply public health principles, including health equity, in a way that is relevant to health system issues. Public health successes can be documented and framed in language that health system managers can relate to. An experiential perspective is valuable – shadowing an environmental health officer or public health nurse in the community will broaden understanding of how public health can contribute to success of the health system generally and advance health equity specifically.

[1] National Collaborating Centre for Determinants of Health. (2010). Integrating Social Determinants of Health and Health Equity into Canadian Public Health Practice: Environmental Scan 2010. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University.

Current project status:

Initially, the project targeted public health senior managers in the Montérégie region only, but the tools developed for the project were designed for widespread use. All senior managers and many middle managers of the CSSSs in La Montérégie are engaged in ongoing training in Public Health Leadership. Also, most of the professionals working in the regional public health department of la Montérégie have gone through a training program that was adapted to their particular needs and changing roles. Four other health regions in Québec have shown interest in the overall approach and the tools available.

To make the program available on a broader level, the Institut national de santé publique du Québec (INSPQ), the Université de Montréal, the Université du Québec à Montréal and the Université de Sherbrooke in collaboration with the Ministère de la Santé et des Services Sociaux, health and social service agencies, public health departments and the association of health care facilities, have set up the *Initiative sur le partage des connaissances et le développement des compétences (IPCDC) en santé publique et en gestion par approche populationnelle*. This initiative has four main components:

- "Competence en action" – the name given to the program developed by Dr Sauvé, now part of the IPCDC
- A 'micro-program' for frontline public health practitioners - a 16-credit, on-line program designed for managers and professionals in practice to complete over a 3-year period
- A 'micro-program' in change management – a 15-credit, eight module course that integrates an organizational change program
- A community development approach that sees community organizations work in partnership with CSSS staff on population health initiatives.

Aimed at infusing the entire public health workforce with the competencies, skills, and knowledge to implement the 'national program of public health', the program continues to evolve and improve. The province has completed a review of training programs being offered at the local level and has conducted an assessment of those competencies required for public health in Quebec.

A formal collaboration with Quebec's Regional Public Health Coordinating Committee is now in place. The committee involves all public health directors as well as the President and Executive Director of the INSPQ, and is chaired by the Deputy Minister of Public Health. The INSPQ sees the training of health service managers in public health skills as an opportunity to embed a population health focus into health service delivery. This supports a collaborative approach with community organizations, drawing health services into a longer-term process of health promotion and disease prevention.

While Dr. Sauvé's training program addresses broad public health competencies, it provides the essential building blocks upon which to build a health equity approach, including one of its key success factors – leadership.

> "The development of Public Health is an open door to the development of communities. It has a direct impact on people individually and collectively."
>
> GYLAINE BOUCHER, MANAGER, IPCDC

Elements of Success in La Montérégie

- A strong leader driving the process from within public health, with the respect and trust of senior managers in the region, working through influence rather than authority
- Evidence gathered through two extensive literature reviews
- A solid scientific foundation, along with reason and consideration for the political, social and organizational context
- Well-trained staff, sharing their expertise with others in the region, helping to build credibility for public health initiatives
- Explicit initial vision, with a strong leader to maintain the course while refocusing and adjusting objectives to take into account the changing environment
- A substantial and highly persuasive communication plan
- Shared leadership, among a solid team, to bring about cooperation and innovation, and ensure the continuation of the project in the event that the original leader departs
- Adaptability, flexibility and creativity of the leadership team, particularly in times of transition
- The Regional Coordinating Committee as a mechanism for successful knowledge transfer and competency development
- Strategies aimed at maintaining the commitment of the organizations involved

QUESTIONS
TO CONSIDER

- How would you use training or the development of competencies to embed a population equity approach in health service delivery in your area?
- How would you address the challenges raised in this case study?
  - Competition between preventive and curative activities
  - Establishing and maintaining a viable community of practice
  - Maintaining the support of local service delivery centres
  - Ensuring that training continued to meet local needs
  - Dealing with staff mobility and availability for training
  - Establishing a sustainable funding stream
  - Integrating competency development into ongoing training strategies
- Having heard about the success of training managers in La Montérégie, how would you apply those elements to develop leadership in health equity among managers in your area?

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