



QUALITY WORKLIFE QUALITY HEALTHCARE
SUMMIT *March 19th, 2008*
Crowne Plaza Hotel, Ottawa

**"A fundamental way to better health care is through
healthier healthcare workplaces.
It is unacceptable to work in, receive care in, govern, manage
and fund unhealthy healthcare workplaces."**

(QWQHC, 2006)

INTRODUCTION

The 2008 Quality Workplace Quality Healthcare (QWQHC) Summit was held at the Crowne Plaza Hotel in Ottawa on Wednesday March 19, 2008.

On the Monday and Tuesday preceding the summit, a Knowledge Exchange session was convened to share progress on the Healthy Workplace Initiative projects (funded by Health Canada), which have been underway since 2005. As well, on the Tuesday a special invitational meeting was held for Aboriginal Health Human Resources (AHHRI) representatives from First Nation and Inuit Health Branch (FNIHB) regions to discuss First Nations, Inuit and Métis implications of the QWQHC strategy, and to begin to share leading practices.

Approximately 120 people attended the Summit, many of whom had attended one or more of the preceding sessions, lending integration and continuity to the discussions.

Gratitude is expressed to the following Summit Sponsors:

- Health Canada Office of Nursing Policy
- Health Canada First Nations and Inuit Health Branch
- Canadian Health Services Research Foundation
- Canadian Federation of Nurses Unions
- Canadian Council on Health Services Accreditation
- Calgary Health Region

GOALS

The goals of the 2008 QWQHC Summit were:

- to facilitate networking and a great exchange of ideas on QWL
- to learn from workplace champions who are implementing the QWQHC Strategy
- to launch the QWQHC 2008 progress report
- to celebrate organizations that have signed the QWQHC Charter

OVERVIEW OF THE SUMMIT REPORT

This report will provide the agenda for the summit and brief descriptions of the various panels and presentations. 'As it was said and recorded' notes of the breakout sessions will be included in the Appendixes following. All slides used by the presenters, as well as the complete Progress Report will be available on the QWQHC website (www.qwqhc.ca).

AGENDA-AT-A GLANCE

- 7:30 a.m. **Traditional Ceremony**
- 8:00 a.m. **Continental Breakfast**
- 8:30 a.m. **Welcome, Opening Prayer and Greetings**
- 9:00 a.m. **Healthy Work Environments Within Our Grasp – A Report on Progress 2008**
- 9:30 a.m. **Panel Presentation: Momentum for System Change**
- 10:45 a.m. *Health Break*
- 11:00 a.m. **Break-out Group Discussions:**
1. **Organizational Leaders/Champions** - Workplace Experiences with the QWQHC Action Strategy
 2. **System Leaders** – Accomplishments re: the Four QWQHC Priority Actions for the Health System
- 12:30 p.m. *Networking Lunch*
- 1:30 p.m. **Commitment and Care!** - A celebration of those that have signed the Healthy Healthcare Leadership Charter
- 1:45 p.m. **Panel Presentation: Relationships - the Heart of Healthcare**
- 3:00 p.m. *Health Break*
- 3:15 p.m. **International Healthy Workplace Experiences in Healthcare**
- 3:45 p.m. **High-level Feedback from Morning Breakout Sessions**
Closing Remarks and Where to from Here

NOTES

OPENING

Before breakfast, **Simon Brascoupé** (Elder Helper, Anishenabe Nation) performed a traditional smudging ceremony, for those who wished to attend.

Following breakfast, **Judith Skelton-Green** (Facilitator) welcomed participants, and reviewed the goals and agenda for the day.

The summit was officially opened by **Simon Brascoupé**, who offered an opening prayer. Greetings were brought by **Shelagh Jane Woods** (Director General, Primary Health Care and Public Health Directorate, First Nations and Inuit Health Branch, Health Canada), **Sandra MacDonald-Rencz** (Executive Director, Office of Nursing Policy, Health Policy Branch, Health Canada) and **Wayne Strelloff** (Chair of QWQHC) in English and **Mélanie Lavoie-Tremblay** (Expert Advisor on QWQHC and Assistant Professor, McGill University) in French.

QWQHC - *WITHIN OUR GRASP* - PROGRESS REPORT

In the weeks leading up to the summit, a brief survey was sent to selected system and organizational leaders across the country, in an attempt to ascertain their understanding and uptake of the key actions in the *QWQHC Within Our Grasp* strategy. **Michael Villeneuve** (Scholar-in-Residence, Canadian Nurses Association) provided a high-level overview of the responses on behalf of the QWQHC Partners. At the time of the summit, fifteen system-level surveys had been returned, with responses from all but four federal/provincial/territorial jurisdictions. Forty-six organization-level surveys had been received, with responses from eight provinces. While there were respondents in both groups who either were not familiar with the work of the QWQHC or had not read the report; all respondents personally believe that healthcare outcomes are linked to QWL, and all feel that this is an important problem for the Canadian healthcare system. Responses from both groups indicated that work on QWL indicators has begun, and that a majority believe that reporting of indicators should be mandatory.

At the system level, responses to questions regarding the QWQHC recommended actions were generally highly supported on the personal level, but less evident in practice. At the organizational level responses were more encouraging, with respondents indicating that activity has begun or is underway for most of the QWQHC recommended actions. The majority of organizational respondents indicated that all of the recommended actions (with the exception of fatigue management) will be a priority for their organizations in 2008. Overall, these findings – while based on relatively small sample sizes – suggest a very good uptake of the QWQHC agenda in a relatively short time. Analysis of the findings will be completed shortly, and the full progress report will be available on the website.

PANEL PRESENTATION: MOMENTUM FOR SYSTEM CHANGE!

Next on the agenda was a Panel Presentation featuring five speakers who have been working to advance the QWQHC agenda at the system level. Panel Members had been asked to speak to the following questions:

1. What initiatives have you put in place to improve quality worklife in your jurisdiction?
2. How did you implement the initiative?
3. What obstacles did you encounter, and how did you overcome them?
4. How do you/ will you know it is making a difference? (What indicators are you using?)

Carla Anglehart (Director Organizational Development, Nova Scotia Association of Healthcare Organizations - NSAHO) opened the panel presentations by describing **Nova Scotia's** journey in developing a province-wide **Healthy Workplace Initiative**. In 2005, Nova Scotia hosted a conference to share ideas and activities that were being implemented across the province related to quality workplaces. Following the conference, action plans were created and implementation activities began. When provincial leaders were in their third round of meetings about the provincial initiative, the QWQHC *Within Our Grasp* strategy was released. The timing was propitious, and assisted in sharpening the focus of activities already underway. In November 2007 the Chief Executive Officers of all Nova Scotia health authorities signed the QWQHC Healthy Healthcare Workplace Charter, securing a broad-based support for critical implementation activities across the province. [Link www.nsaho.ns.ca/]

Adam Nagler (Senior Policy Advisor, Sector Labour Market Branch, Ontario Ministry of Health and Long Term Care - MOHLTC) then outlined Ontario's health human resources strategy emphasized the importance which Ontario attaches to the principle of healthy work environments in the health sector, and described **HealthForceOntario's** approach to promoting **Healthy Work Environments**. *HealthForceOntario* - created by the Ministry of Health and Long-Term Care in partnership with the Ministry of Training, Colleges and Universities and the Ministry of Citizenship and Immigration - is Ontario's innovative multi-year plan to ensure that the right number and mix of appropriately educated professionals are available now and in the future to meet the needs of Ontarians. The *Healthy Work Environments Strategy* is multi-sectoral, interprofessional, and consistent with the QWQHC strategy. It engages several partners in the design and implementation of a number of pilot projects and other initiatives delivered throughout the province, in the following key areas: health and safety (including violence prevention), workload; professionalism, training and education, and leadership development. [Link www.healthforceontario.ca]

Next, **Gary Teare** (Director Quality Measurement and Analysis, Saskatchewan Health Quality Council) shared **Saskatchewan's** plans and progress in developing a **Quality of Worklife Database and Reporting System**. The *Saskatchewan Association of Healthcare Organizations (SAHO)* currently provides a payroll service for all Regional Health Authorities, the Saskatchewan Cancer Agency, and most affiliate health care organizations in the province. This payroll database captures data necessary for most of

the organizational factors and outcomes identified in the QWQHC indicators; however the current reporting function is tabular and requires some end-user sophistication, hence it is not being used by many front, or middle-level managers. With a CHSRF project development grant, the Saskatchewan Health Quality Council is currently in the process of developing an e-Dashboard tool tailored to different levels of system management. Funding is being sought for the implementation and evaluation of the dashboard. In addition, the Quality Council is currently engaged in work which will integrate QWL indicators with other health care quality reporting in Saskatchewan. [Link www.hqc.sk.ca]

Victoria Gubbles (Director of Aboriginal Employee Development, Saskatchewan Ministry of First Nations and Métis Relations) followed, sharing the intent and very encouraging progress of **Saskatchewan's Representative Workforce Strategy**. Fifteen percent (15%) of Saskatchewan's population is Aboriginal, and by 2017 37% of school aged children will be Aboriginal, which means that in the future Aboriginals will be a significant part of the workforce. The *Aboriginal Employment Development Program* (AEDP) promotes Aboriginal training and employment in the province. Part of AEDP, the **Representative Workforce Strategy (RWS)** is a broad strategy, designed to prepare the workplace to become representative over the long-term. With the **goal** of "a representative workforce where Aboriginal people are hired in all classifications and at all levels, not just entry level or in designated classifications", the strategy has focused on identifying and addressing barriers (including workplace cultural attitudes, policies, collective agreements and hiring practices), and on developing solutions that create an 'equal playing field'. Health Sector results as of March 2007 included the following:

- 26,000 participated in Myth and Misconception Training
- 2400 Aboriginal new hires
 - 1300 Aboriginal people trained as LPN's and Community Care Aides
- 225 Aboriginal nurses in training
- Significant increase of Aboriginal students in pharmacy and medicine
- Tripartite Partnerships with unions
- Collective Agreement Language

[Link www.fnmr.gov.sk.ca]

The panel concluded with a presentation by **Wendy Nicklin** (Chief Executive Officer & President, Canadian Council of Health Services Accreditation - CCHSA) who shared progress and plans which CCHSA has for **Advancing Quality Worklife through Accreditation**. CCHSA has been involved in promoting quality of worklife since 1999, when 'worklife' was introduced to the Council's definition of 'quality', and worklife standards were added to the accreditation program. Since that time, CCHSA has conducted worklife seminars, established an expert *Worklife Advisory Committee* and a *Patient Safety Advisory Committee* (which clearly made the connection between patient safety and quality of worklife). In CCHSA's new *Qmentum Program* 'worklife' is one of the key dimensions of how CCHSA defines quality (along with accessibility, safety, client-centred services, continuity of services, effectiveness and efficiency). CCHSA has been an active participant in the QWQHC *Performance Indicators Working Group*. Starting in 2008, CCHSA will require all organizations undergoing accreditation to complete the *Worklife Pulse Tool*. As the Performance Indicators Working Group

identifies performance indicators for pilot testing, CCHSA will be engaged in testing and evaluating indicators appropriate for the accreditation program.

Finally, in November 2007 CCHSA launched a leading practices area on its website. It is anticipated that, as the area grows, it will become a good source of ideas and information related to quality worklife. [Link <http://www.cchsa.ca>]

BREAK-OUT GROUP DISCUSSIONS

Following a health break, participants were invited to select one of two break-out groups: a discussion amongst people who have been or anticipate working on system-level QWQHC initiatives, or a discussion amongst those who have been or anticipate working at the organizational level. Approximately 40 persons chose the **system** discussion (which was facilitated by *Mylene Dault* (Director, Organizational Learning, Canadian Health Services Research Foundation –CHSRF), and 30 individuals selected the **organizational** group (which was facilitated by *Judith Skelton-Green*).

Organizational-level Discussion Group

Workplace Experiences with the QWQHC Action Strategy

In the *QWQHC Within Our Grasp* document, four priority areas and eleven key actions are identified for organizational leaders and champions:

- A. Create strategic leadership and management system for QWL
 1. Build a strategic foundation for QWL initiatives
- B. Implement a comprehensive and integrated human resources, healthy workplace and organizational development strategy
 2. Implement an integrated disability prevention and management system
 3. Introduce a more comprehensive support system for employee wellness
 4. Build a healing environment
 5. Provide healthy leadership support and development program
 6. Implement structures and processes that facilitate collaborative working practices
 7. Implement opportunities and paid time for training development
 8. Implement a fatigue management policy and program
 9. Implement new and innovative approaches to workload and staffing systems
- C. Link QWL to performance management systems
 10. Implement data systems to track and analyze QWL and support increased accountability
- D. Develop internal and external knowledge exchange capacity
 11. Internal and External Knowledge Exchange

The purpose of the organizational breakout session was to provide participants the chance discuss their own experiences and challenges with implementing the various priority activities. Participants were invited to identify one of the 11 priority actions which they (on behalf of their organizations) wished to discuss, and to join colleagues at a table focusing on that area. Groups of three to six developed around the following seven action areas: 1, 3, 4, 5, 6, 9 and 10.

In each table group, participants were asked to undertake three activities in relation to the priority action area:

1. Those with good news, share what they/their organizations are doing.
2. Those who want to see improvements, describe what it is they hope to accomplish and any major challenge(s) in moving forward.
3. Identify three concrete actions which they, as individual leaders, can take over the next 3 months to strengthen their organization's performance in this area.
[Facilitator's Note: participants were urged to focus on what they can and will do, not what someone else ought to do].

In all groups except one, participants were able to identify and share **progress** (good news) that is occurring in organizations across the country. It is hoped that many of the work identified in this exercise will find its way to the leading practices area of the QWQHC website.

Participants in all groups were clearly able to identify where they would like to go next, and the **challenges** to getting there. A review of the seven tables' outputs yielded some common challenges worthy of note:

- Getting to a common/shared vision
 - The need to ensure inclusivity of all parties who will be affected
 - Challenges in addressing the expectations of all stakeholders
- Obtaining buy-in, commitment and/or support from the needed levels of responsibility and accountability
- Resolving competing priorities (for attention, for funding)
- Ensuring coordination and communication for large or complex teams
- Creating openness - as opposed to resistance - to change (at the individual, professional, and organizational levels)
- Overcoming the historical 'blaming' culture of healthcare organizations

Despite these challenges, participants in all groups were able to identify **concrete actions** which they, as individual leaders in their respective settings, could undertake to advance the QWL issues of concern to them.

An 'as it was said and recorded' transcription of the table outputs from the organizational break-out session can be found in Appendix 1.

System-level Discussion Group

Accomplishments re: the Four QWQHC Priority Actions for the Health System

In the *QWQHC Within Our Grasp* document, four key actions are identified for system leaders:

- Create and support a national QWL database and support mandatory reporting of standard QWL indicators;
- Enhance performance accountability agreement and accreditation standards;
- Create a pan-Canadian QWQHC knowledge network to recognize and share leading practices; and
- Focus a national workplace health promotion program that starts within the health community.

The system-level discussion was designed to seek answers to the following questions:

1. Where have you had success in moving forward with the priority actions? What critical success factors have contributed to the successes? What advice would you give to others who are ready to move forward?
2. What are the major challenges at the system level in moving forward with improving Quality Worklife? How can we continue the momentum, despite these challenges?
3. Can we identify a key area for pan-Canadian activity this coming year?

Following is a high-level summary of the outputs from the system breakout group. A more detailed 'as it was said and recorded' transcription of the notes from the system session can be found in Appendix 2.

1. Successes-to-date

1) National Database and QWL Indicators

- QWQHC: Development of 7 indicators, and ongoing work with CCHSA and CIHI to refine/expand
- CIHI: Has databases across many professions
- Manitoba: Has had a private sector benchmarking survey conducted
- British Columbia: Has come together as province in gathering "*White data*" information
- National Survey on the Work and Health of Nurses

2) Accountability and Accreditation

- QWQHC work engagement measures
- CCHSA/OHA "Pulse" Tool
- Canadian Medical Association is working with others internationally to develop a survey on physician worklife and burnout
- Saskatchewan Population Health and Evaluation Research Unit (SPHERU) toolkit helps to consolidate, integrate and prioritize of issues

3) *Pan-Canadian Knowledge Network to share Leading Practices*

- [Nurse One Portal](#) (CNA)
- [Nurse Staffing Patient Safety Knowledge Network](#) (CHSRF)
- [CIHC, CIHR, PHAC HHR Conference](#)
- Health Sciences Placement Network ([HSP Net](#))
- The Electronic Health Library of British Columbia ([e-HLbc](#))

4) *National Workplace Health Promotion Program*

- Implementing [WHO Health Promoting Hospitals](#)
- [Kailo](#) (Halton Healthcare)
- [National Survey on the Work and Health of Nurses](#)
- Increased focus on [community health](#)

2. Major challenges in moving forward at the system:

- Need for common definitions, common language;
- Gaps/missing information in QWL indicators, and the need to link indicators to patient care outcomes;
- While there have been some successes at the regional, district and provincial level, there is a need to build at the national level, and to connect efforts amongst jurisdictions
- Communication (of both challenges and successes) needs to be enhanced at all levels
- When advancing a particular agenda (irrespective of level), the need for buy-in at the top (and then top-down); the need for a business case; and the need for a change management strategy
- Sustainability – in light of the rapid policy cycle and the political ‘quick fix’
- Survey overload
- Unique challenges for First Nations, Inuit and Métis

3. Key pan-Canadian activities for the coming year

- Collection of indicators, and derivation of common definitions (note leadership role for CCHSA)
- Continuing partnership efforts with
 - The Advisory Committee on Health Delivery and Human Resources (ACHDHR)
 - The Health Action Lobby (HEAL), which has been newly appointed to ACHDHR
 - [re Aboriginal implications] Assembly of First Nations (AFN), Inuit Tapiriit Kanatami (ITK), the Métis National Council, National Aboriginal Health Organization (NAHO)

COMMITMENT AND CARE!

Celebration of those that have signed the Healthy Healthcare Leadership Charter

After lunch, all participants joined QWQHC Secretariat **Melissa Barton** in celebrating the following 29 organizations that have demonstrated their leadership in quality worklife by signing the *Healthy Healthcare Leadership Charter* to date:

National Organizations

1. Canadian Nurses Association
2. Canadian Council on Health Services Accreditation
3. Canadian Federation of Nurses Unions
4. Canadian Healthcare Association
5. Canadian Health Services Research Foundation
6. Academy of Chief Executive Nurses
7. The Health Action Lobby
8. Canadian Medical Association
9. VON Canada
10. Canadian Association of Social Workers
11. Canadian Physiotherapy Association

Nova Scotia

12. Nova Scotia Association of Health Organizations
13. Annapolis Valley Health District Health Authority
14. Cape Breton District Health Authority
15. Capital Health
16. Colchester East Hants District Health Authority
17. Cumberland District Health Authority
18. Guysborough Antigonish Strait District Health Authority
19. IWK Health Centre
20. Pictou County District Health Authority
21. South Shore District District Health Authority
22. South West District Health Authority

New Brunswick

23. South East Regional Health Authority

British Columbia

24. Vancouver Island Health Authority
25. Vancouver Coastal Health Authority
26. Interior Health Authority
27. Northern Health Authority
28. Provincial Services Health Authority
29. Fraser Health Authority

As a reminder, in signing the charter, organizations ***commit to act now*** to:

- Make quality of worklife a strategic priority.
- Assess, monitor and report on QWL including the standard QWL indicators identified by the QWQHC.
- Identify priority action strategies that we will implement and evaluate.
- Identify and build knowledge on leading practices related to healthy workplaces.
- Exchange knowledge and network with other health leaders on healthy workplace practices.

PANEL PRESENTATION: RELATIONSHIPS - THE HEART OF HEALTHCARE

After the celebration, ***Jeanne Besner*** (Director of Health Systems and Workforce Research Unit, Calgary Health Region, and Chair Health Council of Canada) moderated a panel focusing on the importance of relationships, not only for client care, but also for the quality of worklife of care providers. In her introduction to the panel, Jeanne noted that in her research on the health workforce, interpersonal relationships feature as a huge element of "what is wrong" with the quality of our health workplace. We don't know much about each other as professionals, which means we don't trust each others' contribution in health care delivery. As a result of this lack of respect of each others' roles and abilities, we tend to "dis-allow" people to perform their work to the maximum of their potential. That leads to loss of professional autonomy, which eventually causes people to go on "auto pilot", becoming rule- and procedure-bound and ceasing to think as critically as they ought. The tension among professionals that results from not knowing or respecting each other as professionals contributes to not treating each other very well, leading to job dissatisfaction, turnover, etc.

John Gilbert (Chair Canadian Interprofessional Health Collaborative – CIHI, and Principle Professor Emeritus, College of Health Disciplines, University of British Columbia) led off the panel by differentiating between cooperation, coordination and collaboration in his presentation entitled **Well-Structured Interprofessional Collaborative Teams: Elements of Relationships**. *Cooperation* is the willingness to work with others to achieve a common purpose, and requires that participants 'be available' (in space, time and interdependent expertise), and that they 'be receptive' (have an interest, are willing to engage in give-and-take communication, and demonstrate trust and respect). *Coordination* is synchronizing the work of a team to achieve the best timing, and to sequence efforts at optimal levels efficiency and completeness. *Collaboration* - working together across boundaries - is a specific and high level learning comprised of knowledge, skills, attitudes, and behaviours, which requires cooperation and coordination as antecedents. *Collaboration in healthcare practice* occurs when there is an interprofessional process for communication and decision making that enables the separate and shared knowledge and skills of different care providers to synergistically influence the care provided through changed attitudes and behaviours. Well-structured interprofessional teams hold benefits for innovation at the individual, team, and organizational levels. However, these teams need to be supported by individual

job autonomy and a positive sense of community in order for these benefits to be maximized. [Link www.cihc.ca]

Barry Lavallee (MD and Treasurer, Indigenous Physicians Association of Canada - IPAC) then shared the work of IPAC, the Royal College of Physicians and Surgeons of Canada and the Association of Faculties of Medicine of Canada (AFMC) toward identifying a national set of **Core Competencies which physicians require to be Culturally Competent** in their care of First Nations, Inuit and Métis individuals, families and communities. Competencies are under development in seven domains adapted from the CanMEDS format (medical expert, communicator, collaborator, manager, health advocate, scholar and professional). As an example, the *professional core* competency states, “the graduating student will demonstrate a commitment to engage in dialogue and relationship building with First Nations, Inuit, and Métis peoples to improve health through increased awareness and insights of First Nations, Inuit, Métis peoples, cultures, and health practices”. In order to achieve this standard, it is expected that students are able to

- Identify, acknowledge and analyse one’s own considered emotional response to the many histories and contemporary environment of FN/I/M peoples and offer opinions respectfully;
- Acknowledge and analyse the limitations of one’s own knowledge and perspectives, and incorporate new ways of seeing, valuing and understanding with regard to FN/I/M health practice;
- Describe examples of ways to respectfully engage with and give back to FN/I/M communities as a medical learner; and
- Demonstrate authentic, supportive and inclusive behaviour in all exchanges with FN/I/M individuals, health care workers and communities.

[Link: www.ipac-amic.org]

The panel concluded with a moving presentation by **Jacoba Lilius** (Assistant Professor, Queens University) reporting on the results of a study on **Compassion in the Workplace**. In the study researchers collected 150 stories of compassion from a health system in the Midwest US using the prompt, “Describe a time when you witnessed or experienced compassion at work”. Content analysis of the stories yielded the following key findings, each of which was illustrated by one or more excerpts from the stories:

- “There is always pain in the room”;
- The big impact of ‘small’ acts;
- The power of collective action;
- The lasting impact of acts of compassion;
- Paying it forward;
- Damage done by a lack of compassion;
- Spillover into patient care;
- Organizations can enable compassion.

The presentation concluded with a number of key ‘takeaways’ for the QWQHC audience. First, compassion doesn’t have to take the form of large dramatic gestures to make a difference. Second, organizational context can enable (or disable) compassion (through formal policies, norms, and examples or stories). And finally, compassion matters (as evidenced by connections with employee retention, commitment, satisfaction and quality of care).

PAHO'S EXPERIENCES RELATED TO THE HEALTH OF HEALTH WORKERS IN THE AMERICAS

The last presentation of the summit, by **Felix Rigoli** [Regional Advisor, Human Resources for Health, Pan-American Health Organization - PAHO], was entitled ***A Decade for Health Human Resources: Partnerships for promoting Healthy Workplaces and Retention of Health Workers***. PAHO has identified five major areas of focus in its HRH plan for the next decade (2006 to 2015): put the right people in the right places; link training institutions with health services; build labor relations and commitment of the workforce; manage migration; and policy and planning. In the *labour relations and commitment* area, one of the key directions will be "to promote healthy work environments and foster commitment of the workforce to the institutional mission to guarantee quality health services for all the population". While there is a growing appreciation for the importance of healthy workplaces as part of a retention strategy, and discussions have taken place in some countries promoting the notion of *decent work* in the health sector, many of the specific initiatives to date are at the occupational health and safety level (i.e. focusing on programs to reduce work-related illness and injury).

CLOSING

At the close of the day **Mylene Dault** and **Judith Skelton-Green** provided very brief and high-level summaries of the discussions in the system and organizational break-out groups.

Wayne Strelloff (Chair of QWQHC) thanked Melissa Barton for her outstanding work as Secretariat of the QWQHC and wished her well in her new position with RIM.

Wayne Strelloff and **Wendy Nicklin** (President and Chief Executive Officer, CCHSA) closed the Summit by congratulating all participants and their organizations on progress-to-date with the QWQHC strategy. They also announced the decision of the QWQHC partners that – going forward - the collaborative will officially be housed within the CCHSA, with a continued strong leadership role for the Partners advisory committee. Application has been made to Health Canada for ongoing funding, and an announcement is anticipated shortly.

[Link: www.qwqhc.ca]

Respectfully submitted



Judith Skelton-Green, PhD, FCCHSE
President, Transitions: HOD Consultants Inc.



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APPENDIX 1 – OUTPUTS FROM THE ORGANIZATIONAL LEADERS/CHAMPIONS BREAK-OUT SESSION

**Organizational Priority Action Area #1 -
 STRATEGIC LEADERSHIP AND MANAGEMENT SYSTEM FOR QWL**

1. Successes/Promising Practices

All of the individuals who selected this topic for discussion were hoping to get ideas to begin to provide strategic leadership for the advancement of quality worklife initiatives in First Nations, Inuit and/or Métis organizations/communities. None of them felt in a position to share successes; hence there are no notes for this section.

2. Major Challenges to Improvements Desired

Initiative/Improvement Desired	Major Challenge(s)
Translation	<ul style="list-style-type: none"> ▪ Work is happening at the First Nations level, but getting it translated into QWL indicators is required
Accreditation	<ul style="list-style-type: none"> ▪ Funding to initiate the accreditation process at the First Nations level is available; uptake is needed
Team work	<ul style="list-style-type: none"> ▪ Task-oriented / project-based actions forget about the workers quality of worklife ▪ Need to spread the word; open discussion across projects
<i>Within Our Grasp</i>	<ul style="list-style-type: none"> ▪ Is this document culturally competent/safe? ▪ Has there been consultation with FN/I/Métis? ▪ Is there FN/I/Métis representation on necessary committees, etc?

3. Concrete Actions – Top 3 Suggestions

(Which you, as a leader, can take over the next 3 months to strengthen your organization's performance in this area)

- 1) Bring back *Within our Grasp* to key people at community level for review
- 2) Network with other FN communities
- 3) Begin asset mapping

**Organizational Priority Action Area #3 -
EMPLOYEE WELLNESS**

1. Successes/Promising Practices

Brief Description	Organization	Contact Person (more information)	Email	Phone #
<p>Integrated employee wellness program</p> <ul style="list-style-type: none"> ▪ 22,000 employees ▪ Individual health assessments ▪ Great muscular-skeletal injury program since early 90s (and Occupational Health and Safety) ▪ EFAP program 'Shifting to Wellness' ▪ PEERS program ▪ Follow-up immunization 	Vancouver Coastal Health	Heather Straight	* Catherine.kidd@vch.ca Heather.straight@vch.ca	None provided
<p>Kailo</p> <ul style="list-style-type: none"> ▪ Holistic Psychological Framework ▪ 2800 employees ▪ On-site Occupational Health department does chronic disease management ▪ EAP provided ▪ Teambuilding in-services and games ▪ Social Work support for sandwich generation ▪ Linked with Brock University for evaluation 	Halton Healthcare	Anna Rizzotto	arizzotto@haltonhealthcare.on.ca	905-338-46990 X 6346
<p>NL Health Authority</p> <ul style="list-style-type: none"> ▪ Some health promotion with occupational health nurses, chronic disease management ▪ Department recognise as 'Employee Wellness, Health and Safety' ▪ EFAP, CSID, mediators trained ▪ Employees supported to take leave ▪ Follow-up immunization ▪ Some evaluation 	Central Regional Health Authority, Gander NL	Gail Huang	ghuang@cehcib.nf.ca	709-256-5620

2. Major Challenges to Improvements Desired

Initiative/Improvement Desired	Major Challenge(s)
Define wellness within organization (incorporating expectations at all levels)	<ul style="list-style-type: none"> ▪ Everyone wants something different ▪ Discourse between safety and wellness ▪ Collecting data
Defining an organizational wellness philosophy	<ul style="list-style-type: none"> ▪ Providing a consistent philosophy within the context of different cultures (size, demographics, professions)
Increase funding for wellness (Human Resources)	<ul style="list-style-type: none"> ▪ Competing priorities including patient safety and regulatory frameworks
Define wellness more broadly	<ul style="list-style-type: none"> ▪ Look at organizational health at levels of responsibility and accountability
Wellness regulations	<ul style="list-style-type: none"> ▪ Wellness needs to be protected by regulations, as is occupational health and safety

3. Concrete Actions – Top 3 Suggestions

(Which you, as a leader, can take over the next 3 months to strengthen your organization's performance in this area)

- 1) Integrate wellness into existing OH&S programs
- 2) Explore wellness philosophies
- 3) Strongly encourage my organization to adopt the QWQHC collaboration

**Organizational Priority Action Area #4 -
HEALING ENVIRONMENT**

1. Successes/Promising Practices

Brief Description	Organization	Contact Person (more information)	Email	Phone #
Research Project <ul style="list-style-type: none"> ▪ Individuals or collectives demonstrating caring through acknowledging individual circumstances which is organizationally supported/enabled ▪ Tax-free fund to donate money for long-term disability 	Queens University	Jacoba Lilius	Jacoba.lilius@queensu.ca	613-533-6064
Kailo Project <ul style="list-style-type: none"> ▪ Holistic approach to employee wellness with originated at Mercy Medical Center, Iowa, USA ▪ Kailo means 'wellbeing' ▪ Importance of relationships in the workplace ▪ Organization pays part; supported by federal grants 	Halton Healthcare	Marlene Hall Anna Rizzotto	mhall@haltonhealth.on.ca arizotto@haltonhealthcare.on.ca	905-845-2571 X2260 905-338-46990 X 6346
PlaneTree Hospital <ul style="list-style-type: none"> ▪ Creates compassionate healing environment 		Contact Halton Healthcare	s/a	S/a
Healing Circles	Mnaamodzawin Health Services	Beverly Nahwegahbow	beverly@mnaamodzawin.com	705-368-2182
Stress Management Program for nursing	Health Canada, Walpole Island Health Centre	Rosemary Williams	Rosemary.williams@wifn.org	Not provided
Social/Governmental Services/Resources	211 Ontario	Google 211 Ontario	www.cominfo-ottawa.org	n/a

2. Major Challenges to Improvements Desired

Initiative/Improvement Desired	Major Challenge(s)
Connecting QWL initiatives to operational dollars	<ul style="list-style-type: none"> ▪ Paradigm shift to create environment to reach desired outcomes at organizational/ leadership level
People are 'jaded'; hard to sustain initiatives	<ul style="list-style-type: none"> ▪ Need fresh eyes to view/address problems
	<ul style="list-style-type: none"> ▪ Staff need to be assured that no stigma is attached to use of holistic services
	<ul style="list-style-type: none"> ▪ Geographical work barriers

3. Concrete Actions – Top 4 Suggestions

(Which you, as a leader, can take over the next 3 months to strengthen your organization's performance in this area)

- 1) Follow-up with Trillium Health for KAILO and PlaneTree, from a research perspective
- 2) A resource list in the form of a handout brochure of available counsellors, services, etc (e.g. grief counselling, EAS, alternate therapies)
- 3) A small staff recognition event (e.g. 'Death by Chocolate' on Valentine's Day)
- 4) A system to 'donate vacation days'

**Organizational Priority Action Area #5 -
HEALTHY LEADERSHIP DEVELOPMENT AND SUPPORT PROGRAM**

1. Successes/Promising Practices

Brief Description	Organization	Contact Person (more information)	Email	Phone #
<ul style="list-style-type: none"> ▪ Development fund for self-referral and development ▪ Twice annual leadership retreats including self-assessment process and best practice review 	CCHSA	Sarah Dixon	Sarah.dickson@cchsa-cccass.ca	Not provided
<ul style="list-style-type: none"> ▪ Training programs within local programs ▪ Some management training, but less employee training 	James Bay, QU	Francine Noel, HR Coordinator	Noel_francine@hotmail.com	Not provided
<p>FACE</p> <ul style="list-style-type: none"> ▪ Focused, aligned, competent, engaged managers ▪ Training for all levels of managers to reinforce value-added competency, and celebrate team success ▪ VON is leading practice site for accreditation 	VON Canada	Richard McConnell	Richard.cmconnell@von.ca	Not provided
<p>Community support perspective</p> <ul style="list-style-type: none"> ▪ In planning stage ▪ Working with community health leaders 	FNIHB	Not provided	Not provided	Not provided
<p>Leading in a Healthcare Organization (LILO)</p> <ul style="list-style-type: none"> ▪ Develop potential leaders/managers ▪ 80 hours skill training (modules) spread over 6 months ▪ Focus on leadership development and personal wellness 	Vancouver Island Health Authority	Claire Winfield	claire.winfield@viha.ca	Not provided

Brief Description	Organization	Contact Person (more information)	Email	Phone #
Leadership Development Program <ul style="list-style-type: none"> ▪ Partnership with College and OSD ▪ Ongoing training 	Winnipeg Regional Health Authority	Sherry Mooney	smooney@hsc.mb.ca	204-787.0810

2. Major Challenges to Improvements Desired

Initiative/Improvement Desired	Major Challenge(s)
Management preparation and succession planning	<ul style="list-style-type: none"> ▪ Employees do not want to give up worklife balance to become managers ▪ Huge barrier to management (long hours) ▪ Very key issue in health care
Management belief and commitment to training	<ul style="list-style-type: none"> ▪ Time for managers to attend ▪ Workload span of control ▪ Pace of work issues
Delegation to others to carry on – faith in team to allow manager to be away	<ul style="list-style-type: none"> ▪ Control issues and expectations
Management training and development delivery	<ul style="list-style-type: none"> ▪ Attitude – being open to change and creating action ▪ Prioritizing
System improvement – Population health approach	<ul style="list-style-type: none"> ▪ Lack of benchmarks, comfort or compassion to create learning opportunities ▪ Lack of mindset of evaluations as learning vs. evaluation as blame ▪ Entrenched opinions... feeling that it is difficult to implement training

3. Concrete Actions – Top 5 Suggestions

(Which you, as a leader, can take over the next 3 months to strengthen your organization's performance in this area)

- 1) Talk to leadership about training and have 1 training program for 1 department within next 3 months (no training going on now)
- 2) Stop sending/receiving emails in the organization before 6AM/ after 6PM
- 3) Add QWL indicators workshop to the leadership development workshop schedule
- 4) Recognize management limitations with respect to workload and worklife issues, and support each other
- 5) Incorporate physical activity into leadership meetings, as an agenda item

**Organizational Priority Action Area #6 -
COLLABORATIVE WORKING PRACTICES**

1. Successes/Promising Practices

Brief Description	Organization	Contact Person (more information)	Email	Phone #
<ul style="list-style-type: none"> NB undergoing structural change, going from 7 to 2 regions Prior to that lots of work was done on defining leading practices and collaborative practice competencies, raising awareness in NB of collaborative interprofessional education and practice 	New Brunswick 'BRAID'	Brenda Kinney	kinbr@reg2health.mb.ca	506-649-2859
<ul style="list-style-type: none"> Definition of collaborative practice that excludes the term 'interprofessional' Health system and workforce optimization initiative based on collaborative practice 	Calgary Health Region	Jeanne Besner	Jeanne.besner@calgaryhealthregion.ca	403-943-0181

2. Major Challenges to Improvements Desired

Initiative/Improvement Desired	Major Challenge(s)
Inclusivity: let go of the term 'interprofessional'	<ul style="list-style-type: none"> 'Interprofessional' excludes many workers Ensuring that all members of the team are included
Uptake of research findings is very slow	<ul style="list-style-type: none"> Lack of 'know-how' among those responsible for managing change Role ambiguity at the core of many problems Need senior leadership commitment – often lacking

Initiative/Improvement Desired	Major Challenge(s)
Integrate 'silos' as system change occurs	<ul style="list-style-type: none"> ▪ Don't make collaborative practice a 'stand alone' issue; incorporate into all elements of the organization
	<ul style="list-style-type: none"> ▪ Dealing with people who think they know everything (e.g. professionals) and people who think they know nothing (e.g. cleaning staff) ▪ Lack of ability to communicate effectively across all members of care team, including support workers

3. Concrete Actions – Top 3 Suggestions

(Which you, as a leader, can take over the next 3 months to strengthen your organization's performance in this area)

- 1) Strike a committee to look at how to go forward with collaborative practices across the corporation (Opportunity: new CHIEF EXECUTIVE OFFICER, new regional structure)
- 2) Focus on inserting high standards of excellence into strategies for moving toward collaborative practice models
- 3) Tackle 'lack of vision' regarding appropriate utilization of health professionals across practice, education and regulatory bodies.

**Organizational Priority Action Area #9 -
WORKLOAD AND STAFFING SYSTEMS**

1. Successes/Promising Practices

Brief Description	Organization	Contact Person (more information)	Email	Phone #
Time and motion study of nurse work <ul style="list-style-type: none"> ▪ 3 units which were piloting the introduction of LPNs ▪ 2 year study – evaluation will be done 	CHUM	Luce Belanger Josee Breton	Luce.belanger.chum@ssss.gouv.qc.ca Josee.breton.chum@ssss.gouv.qc.ca	514-890-8000 X8071

2. Major Challenges to Improvements Desired

Initiative/Improvement Desired	Major Challenge(s)
Better utilization of professionals	<ul style="list-style-type: none"> ▪ Holding to 'old ways' of functioning ▪ Fear of letting go of traditional role
Needs to be population-based	<ul style="list-style-type: none"> ▪ Unit formulas will be different based on population
Staffing based on 85% occupancy, where reality is 103% occupancy	<ul style="list-style-type: none"> ▪ Templates must be changed and premises need to be challenged
Involve the patient and family in care more	<ul style="list-style-type: none"> ▪ Laws re: hospital responsibility need to be addressed (legal issues resolved) ▪ Professionals need to revisit views of family involvement

3. Concrete Actions – Top 3 Suggestions

(Which you, as a leader, can take over the next 3 months to strengthen your organization's performance in this area)

- 1) CFNU can take to the bargaining table of each province to work collaboratively with employers to look for staffing tools/systems/approaches
- 2) Re: intergenerational gaps and perceptions – Develop workshops to share information and concentrate on common values and sharing
- 3) Underpinning of any initiative should be communication and involvement of grass roots professionals and employees.

**Organizational PRIORITY ACTION AREA #11-
QWL LINKED TO PERFORMANCE MANAGEMENT SYSTEMS**

1. Successes/Promising Practices

Brief Description	Organization	Contact Person (more information)	Email
<ul style="list-style-type: none"> ▪ Human Resource Benchmark Network to try to marry HRBN indicators with QWQHC indicators ▪ SAP data management system for finance and materials management has elements that can be used for human resources information ▪ Sick time reports – system-wide. Targets are flagged, and there is a specific process for those who are ‘flagged’ ▪ Safeline – incident reporting by phone (no paperwork) 	Capital Health Nova Scotia	Joy Stevens	Joy.stevens @cdha.nshealth.ca
		Joy Stevens	
		Joy Stevens	
		Erin Graham	Erin.graham @cdha.nshealth.ca

2. Major Challenges to Improvements Desired

Initiative/Improvement Desired	Major Challenge(s)
Standard indicators and standard/structured methods for documenting/reporting them	<ul style="list-style-type: none"> ▪ No standard way for reporting data in certain provinces ▪ Need automated system that is affordable
Standard definitions for indicators	<ul style="list-style-type: none"> ▪ Definitions are not presently standardized
Method/process/system for tracking education and standard definitions for education/training	<ul style="list-style-type: none"> ▪ No system for capturing education information/data
Career planning tool	<ul style="list-style-type: none"> ▪ No tool at present
	<ul style="list-style-type: none"> ▪ Communicating data trends to management and employees ▪ Translation of data to employees in a health promotion manner as opposed to a negative manner

3. Concrete Actions – Top 3 Suggestions

(Which you, as a leader, can take over the next 3 months to strengthen your organization's performance in this area)

- 1) (NS) Develop action plan to centrally record all staff education
 - Meet with IT to plan, develop, use training modules for Medworxx
 - Then meet with decision makers
 - Set up a process
- 2) (PEI) Learn more about indicators and tracking healthy workplace indicators
 - Network with colleagues in and out of province
 - Learn capacity of our present system
 - Meet with present players/decision makers around tracking healthy workplace indicators
- 3) (NB) Build on present strategic planning around healthy workplace indicators provincially and through QWQHC strategy

APPENDIX 2 – OUTPUTS FROM THE SYSTEM LEADERS BREAK-OUT SESSION

System Priority Action Area #1 NATIONAL QWL DATABASE & SUPPORT

Successes (Brief Description)	Critical Success Factors	Advice
QWQHC <ul style="list-style-type: none"> ▪ Development of 7 indicators 	<ul style="list-style-type: none"> ▪ QWQHC working with CIHI and CCHSA to explore more indicators and data sources <ul style="list-style-type: none"> - Accreditation data - CIHI data ▪ Need indicators on diversity 	<ul style="list-style-type: none"> ▪ Don't be concerned with definition, etc. ▪ Begin/continue to do this work. ▪ Expect it will be a long-term commitment
CIHI <ul style="list-style-type: none"> ▪ Many databases across professions 	<ul style="list-style-type: none"> ▪ Important to avoid duplicating efforts; partnership and collaboration 	<ul style="list-style-type: none"> ▪ Standardize reporting ▪ Challenge – definitions are different (Stats Canada vs. hospitals, e.g. hours of work for an FTE)
FNIHB <ul style="list-style-type: none"> ▪ Developing a survey tool to examine Aboriginal recruitment and retention 	<ul style="list-style-type: none"> ▪ Need indicators specific to Aboriginal concerns ▪ Need indicators re: chronic disease and how it affects workforce 	
Manitoba <ul style="list-style-type: none"> ▪ HR benchmarking survey (private sector survey) ▪ HayGroup <ul style="list-style-type: none"> - Different needs at different levels (organization, provincial government, federal government) - Difference between survey data and administrative data (e.g. cost base vs. where they work) 	<ul style="list-style-type: none"> ▪ Central organization (like a collaborative) to coordinate projects and funding 	<ul style="list-style-type: none"> ▪ If private, limited sharing because seen as 'proprietary information' ▪ Cost of accessing existing databases

Successes (Brief Description)	Critical Success Factors	Advice
<ul style="list-style-type: none"> - Consistency between framing research data and reporting data) 		
British Columbia <ul style="list-style-type: none"> ▪ "White data" ▪ All of BC gathering data which covers all indicators except 'training and development' (with some problems) 	None noted	<ul style="list-style-type: none"> ▪ Need to make QWL a system priority ▪
National survey on the work and health of nurses <ul style="list-style-type: none"> ▪ Collecting baseline information in the acute care sector and developing improved information at the community level 	None noted	<ul style="list-style-type: none"> ▪ Diversity issues could be collected in the "Pulse" tool

**System Priority Action Area #2 -
ENHANCED PERFORMANCE/ACCOUNTABILITY AGREEMENTS & ACCREDITATION STANDARDS**

Successes (Brief Description)	Critical Success Factors	Advice	Contact Person (for more information)
QWQHC <ul style="list-style-type: none"> Work engagement measures Exploring approaches to integrating multiple data collection tools 	<ul style="list-style-type: none"> Inclusion in accreditation increases legitimacy Presenting consequences and building into agreements (performance and funding) 	<ul style="list-style-type: none"> Avoid 'survey fatigue' Ensure alignment across surveys so you collect once and use multiple times 	
CCHSA – OHA Pulse tool <ul style="list-style-type: none"> Use of 'Pulse' tool and other blended surveys to <u>utilize</u> information 	<ul style="list-style-type: none"> Build trust by using information collected for positive change 	<ul style="list-style-type: none"> Make sure that the information is used, not just collected 	Cheryl Woodman, Ontario Hospital Association
Canadian Medical Association <ul style="list-style-type: none"> International collaboration and work with Canadian Medical Association to develop survey on worklife and burnout 	<ul style="list-style-type: none"> International literature search and study <ul style="list-style-type: none"> High response rate, reliability and validity 	<ul style="list-style-type: none"> Consider impact of context and use in different settings 	Michael Leiter
SPHERU.ca <ul style="list-style-type: none"> Saskatchewan Population Health and Evaluation Research Unit Toolkit helps to consolidate issues and enable integration and prioritization of issues 	<ul style="list-style-type: none"> Allow for integration and prioritization 	<ul style="list-style-type: none"> Match funding from 'siloed' initiatives to initiatives which seek to be integrated 	Larry Sanders (Health Canada) larry_sanders@hc-sc.gc.ca
Workplace Compensation Boards (provincial) <ul style="list-style-type: none"> Use the compensation board as leverage to bring workplace issues to the table of senior managers 	<ul style="list-style-type: none"> Legislative influence 	None noted	None noted

Successes (Brief Description)	Critical Success Factors	Advice	Contact Person (for more information)
General Comments <ul style="list-style-type: none"> ▪ Increase in number of utilization indicators compared to many years ago 	<ul style="list-style-type: none"> ▪ Ensure that there is a manageable and meaningful number of indicators ▪ Pervasiveness ▪ Dedicated resources (money <u>and</u> time) ▪ Consistency on agenda ▪ Embed in culture ▪ Continuity and consistency of message 	<ul style="list-style-type: none"> ▪ Ensure that the indicators are linked to purpose ▪ Link indicators to strategic directions 	Gary Teare (Saskatchewan)

**System Priority Action Area #3 -
PAN-CANADIAN KNOWLEDGE NETWORK TO SHARE LEADING PRACTICES**

Successes (Brief Description)	Critical Success Factors	Advice	Contact Person (for more information)
Nurse One Portal <ul style="list-style-type: none"> ▪ Canadian Nurses Association ▪ FNIHB Communities of Practice 	<ul style="list-style-type: none"> ▪ Connecting with partners ▪ Access 	<ul style="list-style-type: none"> ▪ Focus on young nurses 	Canadian Nurses Association (CNA)
Nurse Staffing and Patient Safety Knowledge Network	<ul style="list-style-type: none"> ▪ Bridge research, policy ▪ Partnerships 	<ul style="list-style-type: none"> ▪ None noted 	Canadian Health Services Research Foundation (CHSRF)
CIHC, CIHR, PHAC HHR Conference <ul style="list-style-type: none"> ▪ Focus on retention, recruitment and staff satisfaction 	<ul style="list-style-type: none"> ▪ Partnership ▪ Inviting everyone to the table ▪ Inclusive 	<ul style="list-style-type: none"> ▪ None noted 	Canadian Institutes of Health Information (CIHI)
Health Sciences Placement Network (HSP Net) <ul style="list-style-type: none"> ▪ Common platform for linking health professionals, students and employers 	<ul style="list-style-type: none"> ▪ Cost sharing ▪ Partnerships ▪ Government funding ▪ Low cost to join ▪ Including nurses 	<ul style="list-style-type: none"> ▪ Don't reinvent the wheel ▪ Connect with those who are using 	http://www.hspbc.net/
e-Library <ul style="list-style-type: none"> ▪ The Electronic Health Library of British Columbia (e-HLbc) ▪ Access to library for all persons working in healthcare as opposed to only faculty 	<ul style="list-style-type: none"> ▪ Activities of health librarians association ▪ A great resource 	<ul style="list-style-type: none"> ▪ Include Canadian Association of Health Librarians in discussions 	http://www.bcahc.ca/pdf/e-HLbc%20Report%20-%20Feb07.pdf
Patient Safety Agenda	<ul style="list-style-type: none"> ▪ Is a fundamental issue in worklife 	<ul style="list-style-type: none"> ▪ Increase education ▪ Physician Management information tool 	None noted

Major challenges (and advice) in moving forward (Priority Action Area #3)

- Pan-Canadian vs. provincial/ territorial responsibility:
 - Pan-Canadian has to expand
 - Find out what it is in it for them
 - It is not one size fits all
- How to get it at the workplace level
- Lack of knowledge exchange or is it information overload?
 - Create a network similar to 'Physician Health Network'
 - Bring it to the source
- Do we really need to create communities of practice?
 - Communities of practice often exist (e.g. Aboriginal Health) but we need to promote/support and or expand

**System Priority Action Area #4
NATIONAL WORKPLACE HEALTH PROMOTION PROGRAM THAT STARTS WITH THE HEALTH COMMUNITY**

Successes (Brief Description)	Critical Success Factors	Advice	Contact Person (for more information)
WHO HEALTH Promoting Hospitals Model	<ul style="list-style-type: none"> ▪ Considering evidence and leading practices in international models and Quebec ▪ Network development 	<ul style="list-style-type: none"> ▪ Implementing cultural shift from curative to include preventative ▪ Increase collaboration for health promotion ▪ Build on evidence base ▪ Caution – don't just move LPNs into health promotion positions 	Cheryl Woodman (OHA) cwoodman@oha.com
Kailo <ul style="list-style-type: none"> ▪ Halton Healthcare ▪ Innovative workplace health program 	<ul style="list-style-type: none"> ▪ Risk taker and champion ▪ Senior management support ▪ Shifting culture – not just program-focused ▪ Taking care of ourselves as much as we take care of our patients ▪ Developed playbook – had faith that this innovative practice would succeed 	<ul style="list-style-type: none"> ▪ Collaborations with leading organizations ▪ Throw away small physical programs; implement <u>organizational</u> change ▪ Go to senior team and interview for their priorities ▪ Clinical <u>must</u> partner with non-clinical 	Bonnie Harrow, Anna Rizzotto (Halton Healthcare)
National survey on the work and health of nurses <ul style="list-style-type: none"> ▪ Collecting information to monitor health of nurses 	<ul style="list-style-type: none"> ▪ Expanding it to look at other health professions 	<ul style="list-style-type: none"> ▪ None noted 	<ul style="list-style-type: none"> ▪ None noted
Increased focus on community health due to CHR positions	<ul style="list-style-type: none"> ▪ Address differences in each region ▪ Educational facilities on board to develop curriculum 	<ul style="list-style-type: none"> ▪ Consult front-line stakeholders 	<ul style="list-style-type: none"> ▪ None noted

Major challenges (and advice) in moving forward (Priority Action Area #4)

- Commitment and passion of senior management and leaders
 - Identify those committed to workplace health
 - Instil importance of workplace health in management
 - How to get it at the workplace level
 - Identify champions for the cause
 - Hire those who have shown commitment to workplace health
 - Legislation
- Focus on holistic health for healthcare workers
 - Put focus back on healthcare workers as people
 - Bring back the human element for healthcare providers

Major challenges (and advice) at the system level in moving forward with improving Quality Worklife

[Facilitators Note – the following challenges were generated by a brainstorming of all individuals who attended the systems breakout discussion group. The challenges were clustered post-session, by the workshop facilitator]

- Need for common definitions, common language
- Indicators
 - Gaps/missing information (in indicators)
 - Linking indicators of QWL to patient care outcomes
- Inter-jurisdictional implications
 - While there have been some successes at the regional, district and provincial level, need to build at the national level
 - How to connect pan-Canadian with provincial/territorial with regional/local
 - Collaboration
 - [At same time] no need to always wait for federal or provincial level in order to act locally
- Communication
 - Between practices
 - Between organizations
 - Learning from each other so we don't need to repeat
 - Talking clearly at all levels
 - To get to the 30 second message
- Implementation
 - Buy-in at the top (and then top-down)
 - Need for business case
 - How to implement change when we are all busy; need a change management strategy
- Sustainability – in light of
 - Quick policy cycle
 - Political quick fix
- Survey overload
- Unique challenges for First Nations, Inuit and Métis
 - Needs are different... may need unique indicators; may not be able to follow other standards
 - This is not on the agenda of Health Canada