LeaderShift Conference

Connect.
Collaborate.
Transform.

JULY 11 • BMO INSTITUTE FOR LEARNING • TORONTO

LeaderShift Executive Sponsor Welcome Address

Deborah Simon
CEO, Ontario Community Support Association &
LeaderShift Executive Sponsor

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Deputy Premier Welcome Address

Christine Elliott
Deputy Premier and Minister of Health

LeaderShift

Conference Moderator and Subject Matter Expert

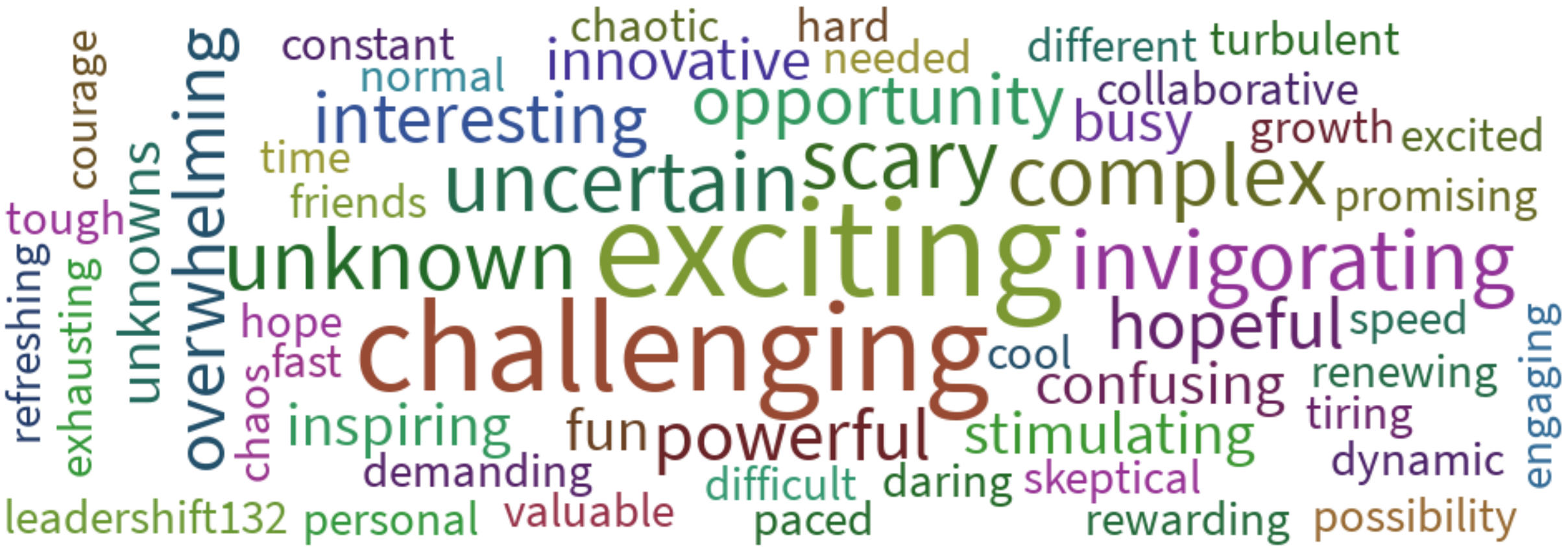
Ellen Melis
Certified LEADS Facilitator and Coach &
Leadership Development Consultant

LeaderShift

In one word, how would you describe what it is like to lead change in these times?

Respond at **PollEv.com/leadershiftp132**

Text **LEADERSHIFTP132** to **37607** once to join, then text your message



Getting to know each other

Sectors Represented

- Team & Community-Based Primary Care
- Home Care
- Community Support Services
- Community Mental Health & Addictions
- Other?

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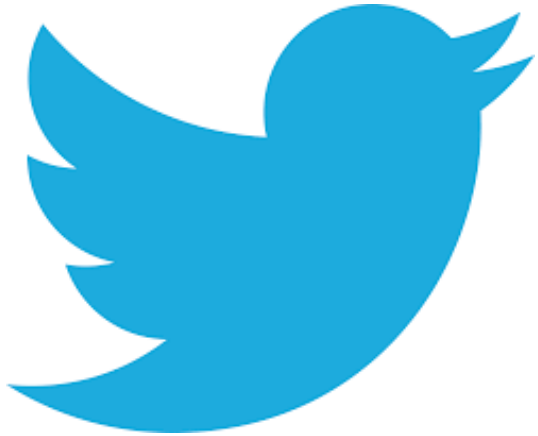
Please Tweet as you go…



@LeaderShiftON

#shapetheshift

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We're Building The Future

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We're Building The Future

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Confidence to Lead

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Capacity to Collaborate

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Courage to Transform

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We're Building The Future

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Morning Panel

Painting a New Health System Canvas: Early Beginnings

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Leadership Learnings from One Ontario Health Team Submission

Joanne Pearson
Executive Director
Burlington Family Health Team

Kathleen Whittaker
Executive Director
Caroline Family Health Team

Kathy Peters
Director, System Collaboration and Partnerships
Joseph Brant Hospital

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Leadership Learnings from One Ontario Health Team Submission

LeaderShift Conference
July 11, 2019

Joanne Pearson, Executive Director Burlington Family Health Team
Kathleen Whittaker, Executive Director, Caroline Family Health Team
Kathy Peters, Director, System Collaboration & Partnerships, Joseph Brant Hospital


Caroline
Families First
Early Supported
Discharge Model
Remote Patient
Monitoring Pilot
Palliative Shared
Care Model
Seniors Care
PHAST Mental Health
& Addictions Program
INSPIRED! COPD
Self-Management Program
Aging in the Home
Integrated Discharge
Planning
Working Together…
Seniors' Community Hub
Project
Bundled Care
Models
Burlington Community Access to
Rehabilitative Services (B-CARS)
Community Paramedicine
Program
Burlington Community Access to
Psychotherapies (B-CAP)

Trigger For Change in Burlington

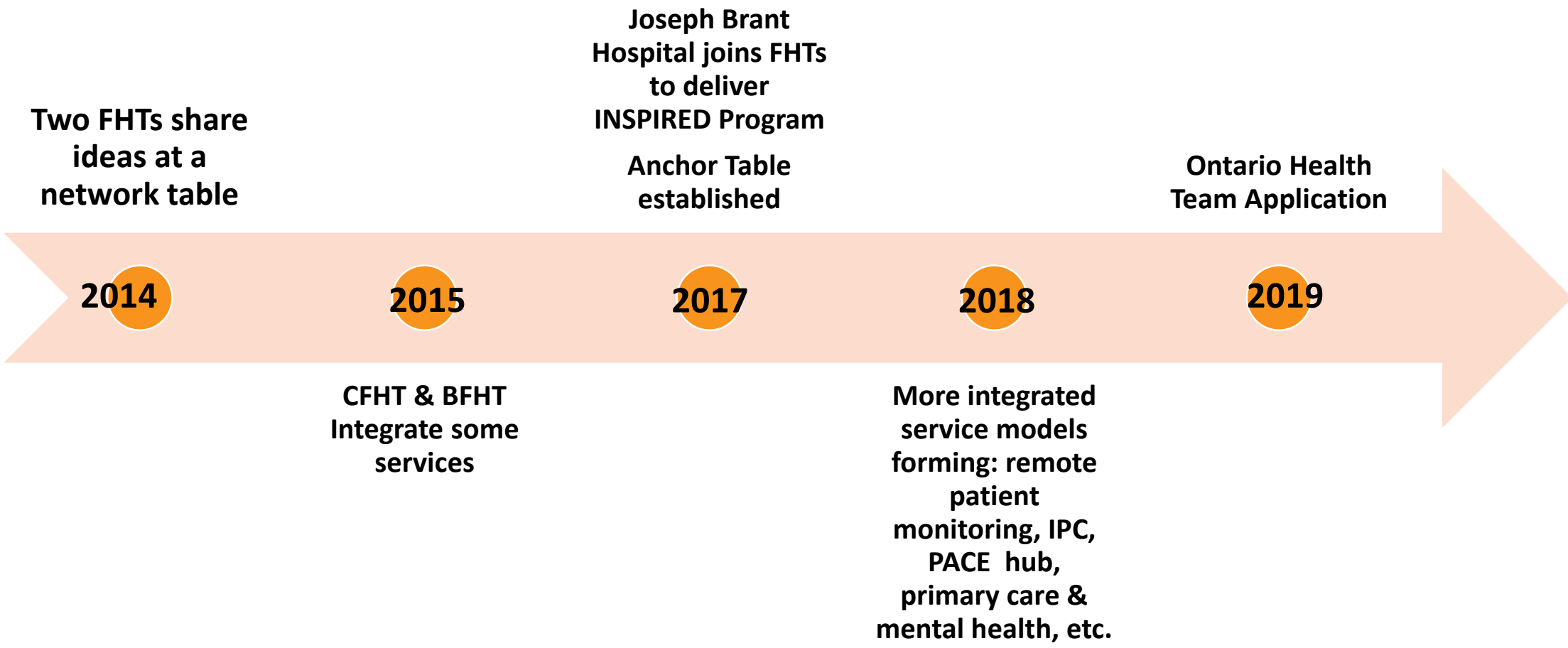
- **Fragmented, siloed system that did not meet patient expectations**
  - **Long wait times**
  - **Avoidable admissions and readmissions to hospital**
  - **High ALC rates (35%)**
  - **Gaps in transitions of care**
  - **Inequitable access to services**
  - **Cold hand-offs**

5 Years Ago a Relationship Began…

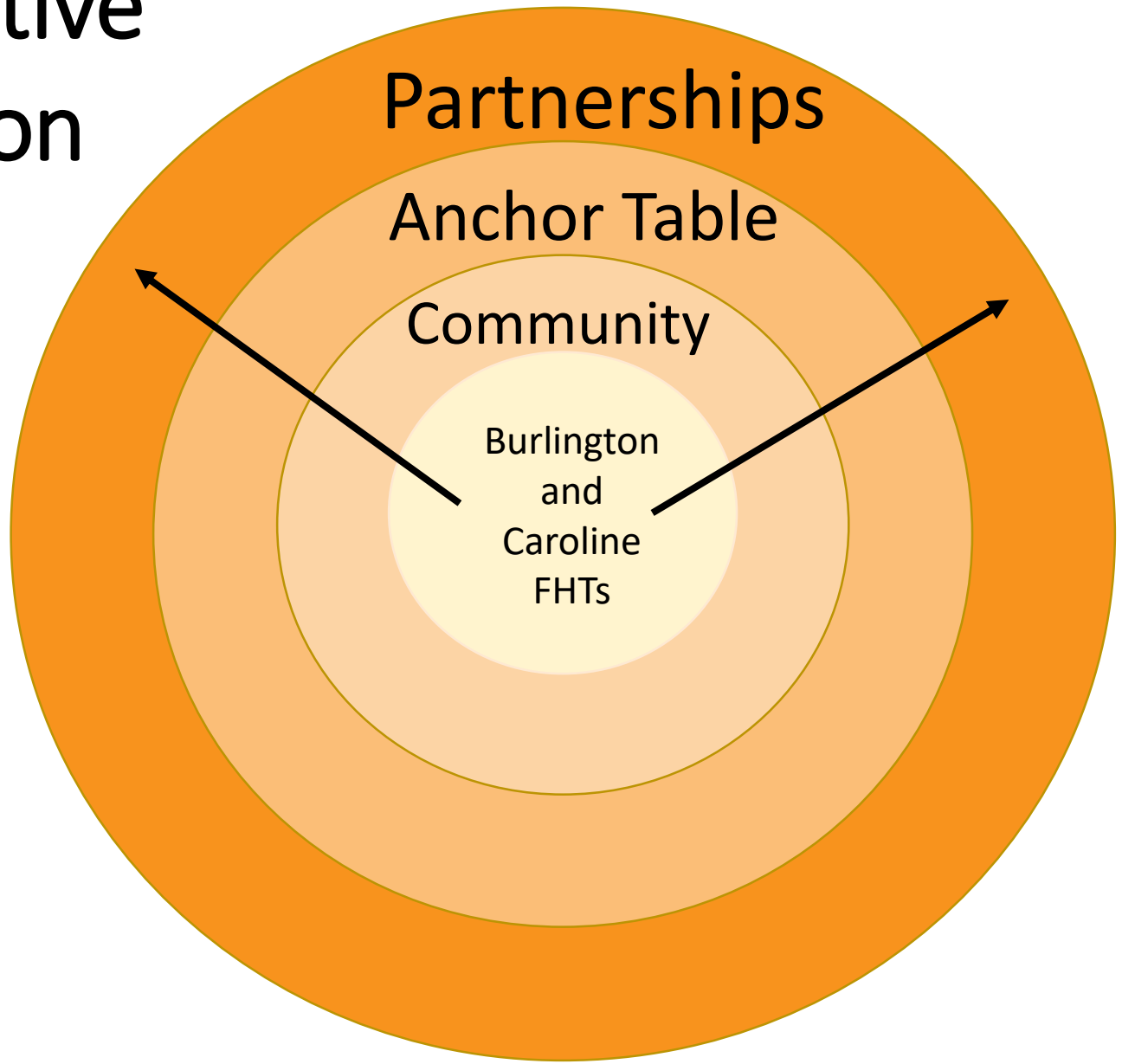
- **Two Family Health Teams located in Burlington:**
  - Burlington Family Health Team
  - Caroline Family Health Team

- **Family Health Teams Overview**
  - Funded by the Ministry of Health and Long-Term Care
  - First established in 2005, there are 187 FHTs across Ontario
  - Improves access to primary care, programs & services
  - Most FHTs consist of doctors, nurses, nurse practitioners, social workers, dietitians and other health care professionals

The Relationships Grew and the Journey Began



Collaborative Progression



Burlington Anchor Table
System Collaboration Formalized

Tools helped us to be *Action Oriented*

- Structured tables that are **action** oriented
- Frameworks
- Quality Improvement tools
- Project Charters
- Work Plans
- Letters of Intent

JOSEPH BRANT HOSPITAL

A3 Improvement Tool

Theme:	Support Burlington older adults living well in the community: Provide an integrated care strategy to meet the Triple Aim of 1) Improved Population Health, 2) Improved Experience of Care and 3) Lower Per Capita Cost.	Date/version June 28, 2018/v.2

Overall Reasons for Improvement:
Members of the Burlington Sub Region Anchor Table have identified an opportunity to collaborate across sectors to support Burlington's population of older adults living in the community (including Retirement Homes and Assisted Living).

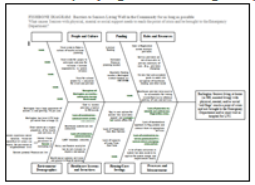
This work aims to improve care using an integrated approach that identifies and responds to physical, mental and social 'red flags' before patients arrive at the Emergency Department in crisis and/or must wait in the hospital for an appropriate care setting (Alternate Level of Care).

Current Performance and Reflections on Current Performance

IHI Triple Aim	Current Performance	Reflections
Population Health:		
TBD	TBD	- Lack of care options for those who need RH level care and can't afford it negatively impacting ability to live well in community.

Analysis: What is driving gap between current and target performance?

See accompanying Fishbone Diagram. (Click icon)

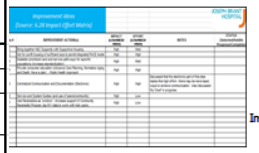


Fishbone

Analysis and Root causes:
- See Burlington Leadership Report (Presented6.28 by Councillor P. Sharman)

trategies to reach target performance:

ee accompanying Impact-Effort Matrix. (Click icon)



Impact-Effort Matrix

3Ws Follow up Plans (use for status reporting):

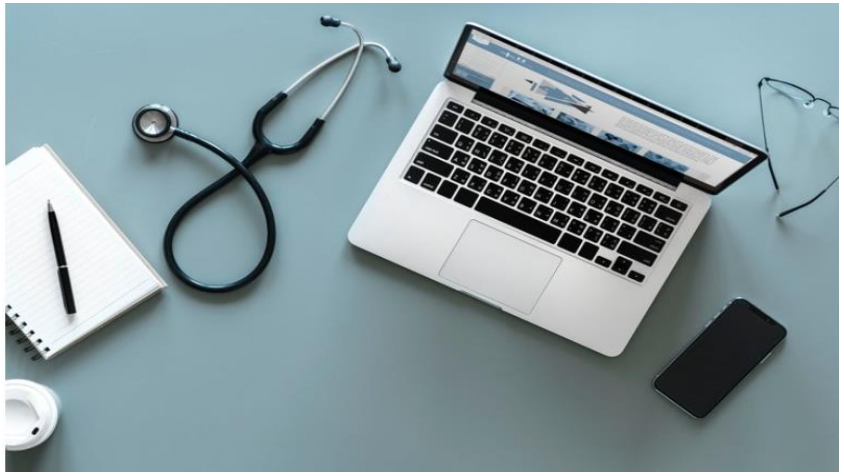
What	Who	When
• Analyze prelim health system data and define target population.	Burlington Anchor Table	5.24.2018 Complete
• Analyze gaps in current system (fishbone)	Burlington Anchor Table	6.28.2018 Complete
• Identify/prioritize improvement ideas (Impact-Effort Matrix) – complete work from June mtg.	Burlington Anchor Table	8.232018 In Prog
• Committee members to consult their organizations/stakeholders and determine what role they could play for future state (add services to existing Community Housing)	Burlington Anchor Table – all members	Bring to 8.23.2018 meeting
• Draft Terms of Reference for possible future action table –to review	Cheryl Williams	For review at 8.23.2018 meeting

Measurement Tracking

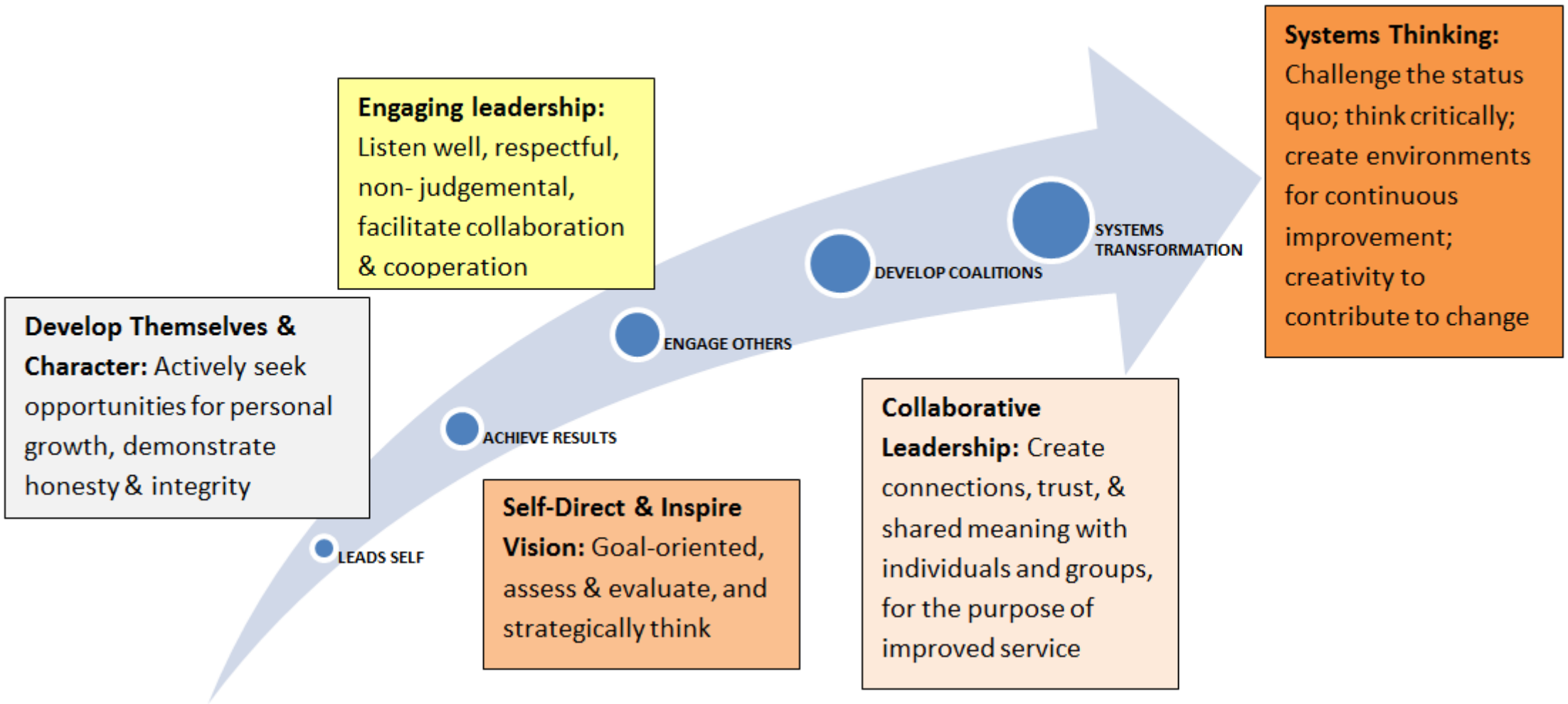
Improvement Ideas
(Source: 6.28 Impact-Effort Matrix)

Idea #	IMPROVEMENT ACTION(s)	IMPACT (LOW/MED/ HIGH)	EFFORT (LOW/MED/ HIGH)	NOTES	STATUS (Selected/Hold/In Progress/Complete)
1	Bring together H&C Supports with Supportive Housing	High	Med		
2	Not for profit housing of sufficient size to permit integrated PACE model	High	High		
3	Establish prioritized care and service pathways for specific populations (increase standardization)	High	Med		
4	Provide consumer education (Advance Care Planning, Normalize Aging and Death, Have a plan) - Public Health Approach	High	High		
5	Centralized Communication and Documentation (Electronic)	High	High	Discussed that the electronic part of this idea makes this high effort - there may be more basic ways to achieve communication. Also discussed 'My Chart' in progress.	

Barriers? Enablers?



The Self-Aware Leader is the Enabler!



Lessons Learned

Final Lesson: *Be bold and talk about the elephant*

THANK YOU!

Leveraging Partnerships to Improve Performance: Shifting How We Measure Success

Julie Callaghan
Senior Director, Community Health and Quality
Unison Health and Community Services

Tammy Décarie
Director of Health Services
Davenport-Perth Neighbourhood and Community Health Center

Faten Mitchell
Senior Executive
Quality Improvement for Health Care Inc.

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Leveraging Partnerships to Improve Performance

LeaderShift Conference
July 11, 2019

West End Quality Improvement Collaboration (WEQI)

Davenport-Perth
Neighbourhood and Community Health Centre

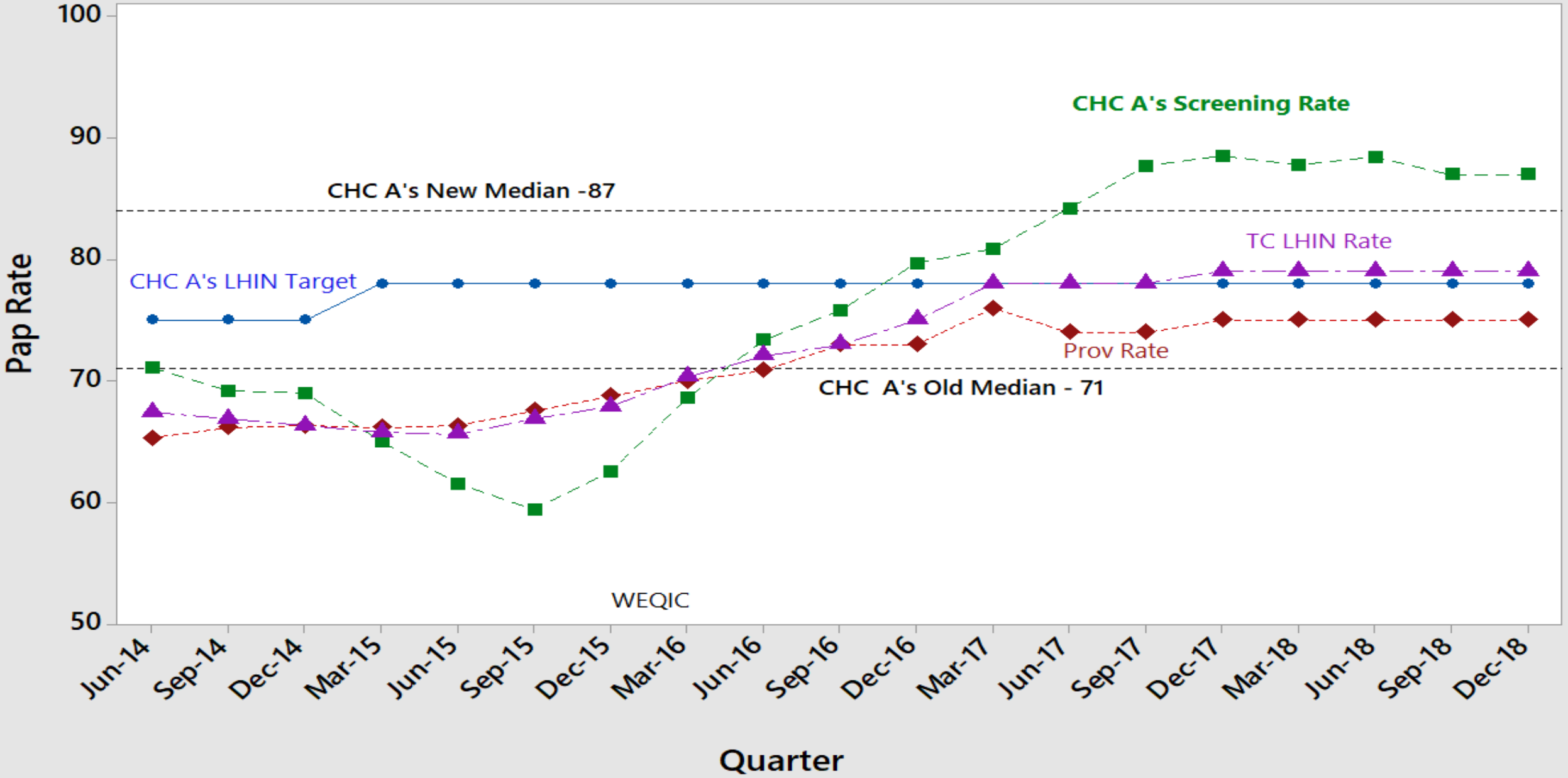
Access Alliance
Multicultural Health and Community Services

Unison
Health & Community Services

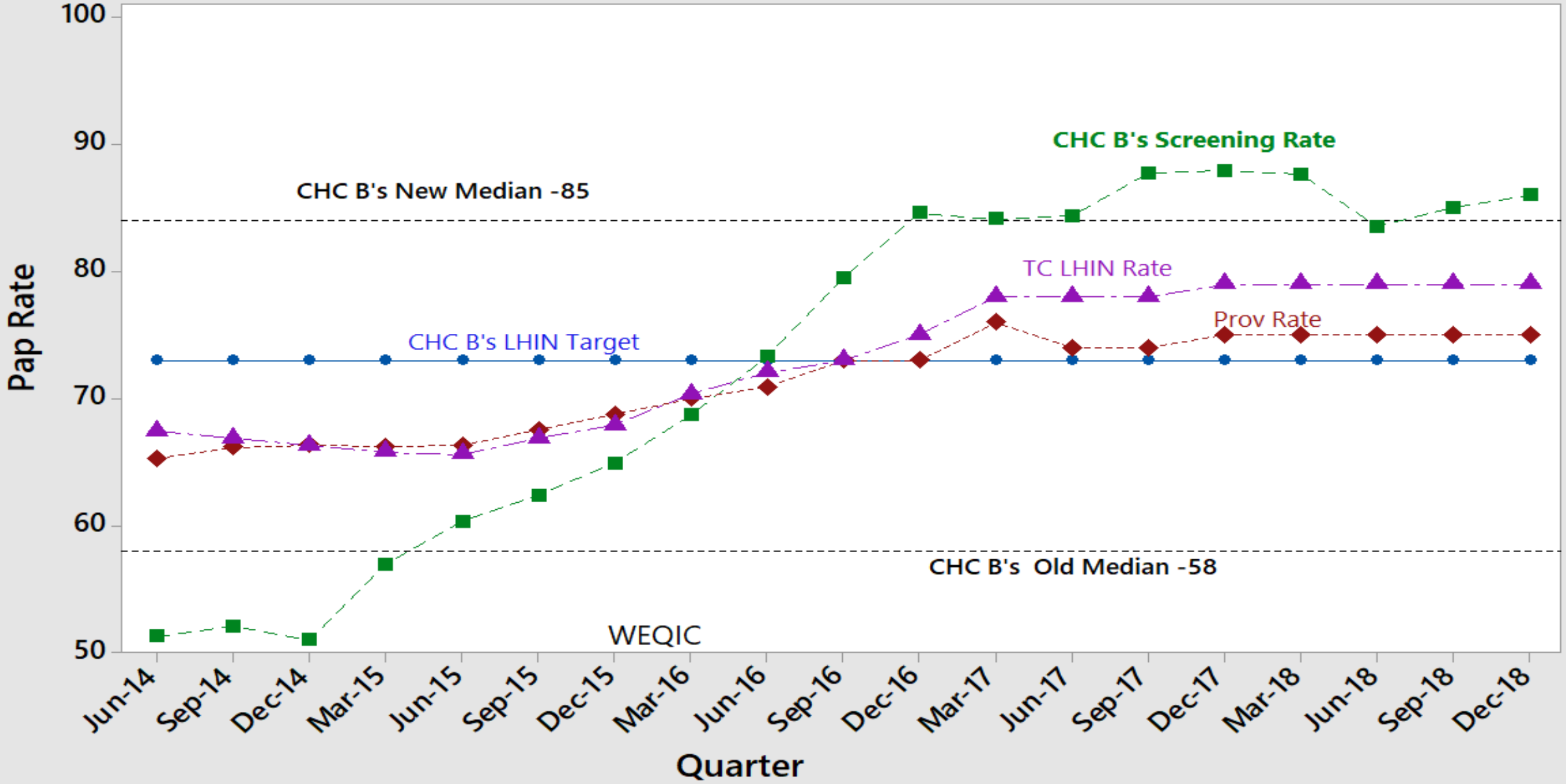
The Four Villages
Community Health Centre
Working Together for Whole Health

PARKDALE
QUEEN WEST
Community
Health Centre

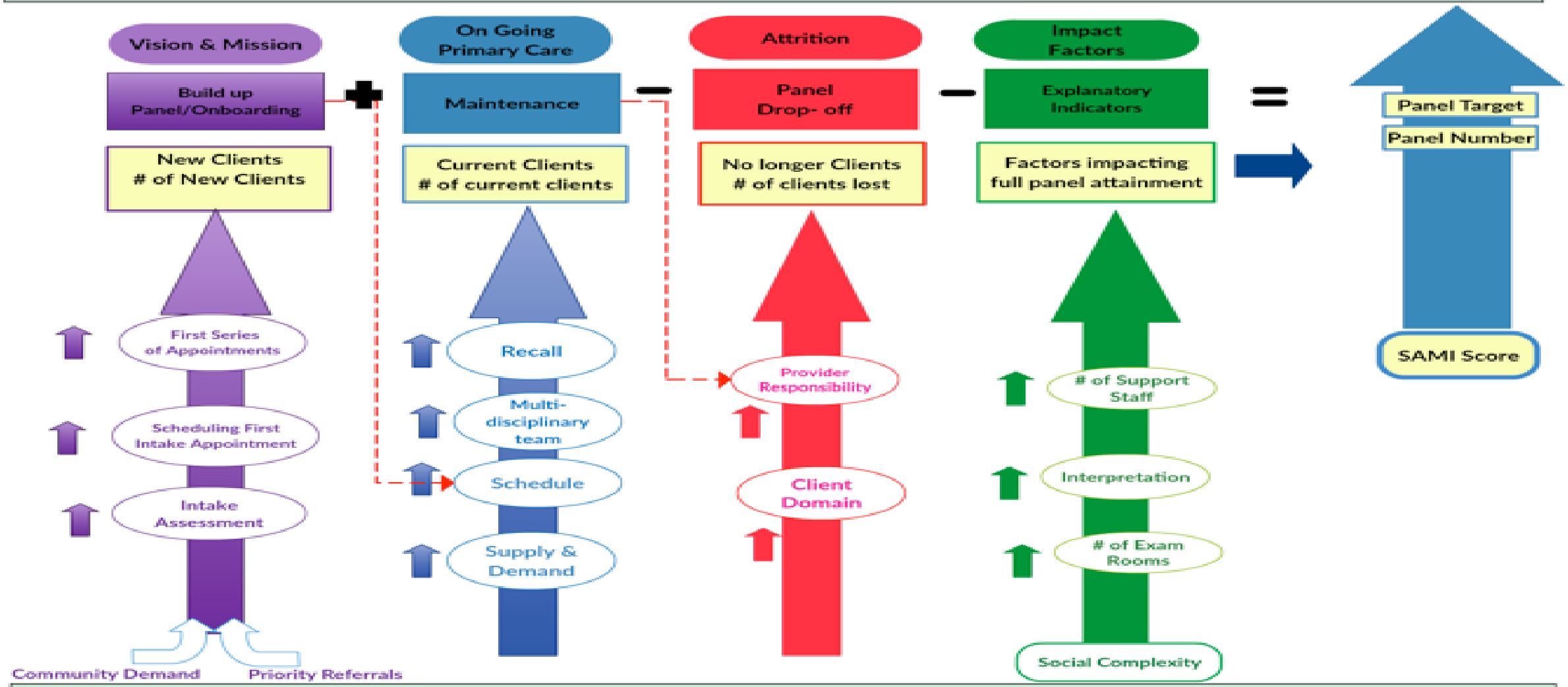
CHC A's Pap Rate



CHC B's Pap Rate



Complexity of Access to Care Eco-System in Order to Achieve Panel Size



Client Centred & High Quality Clinical Care

The Four Villages Community Health Centre
Working Together for Whole Health

Davenport-Perth Neighbourhood and Community Health Centre

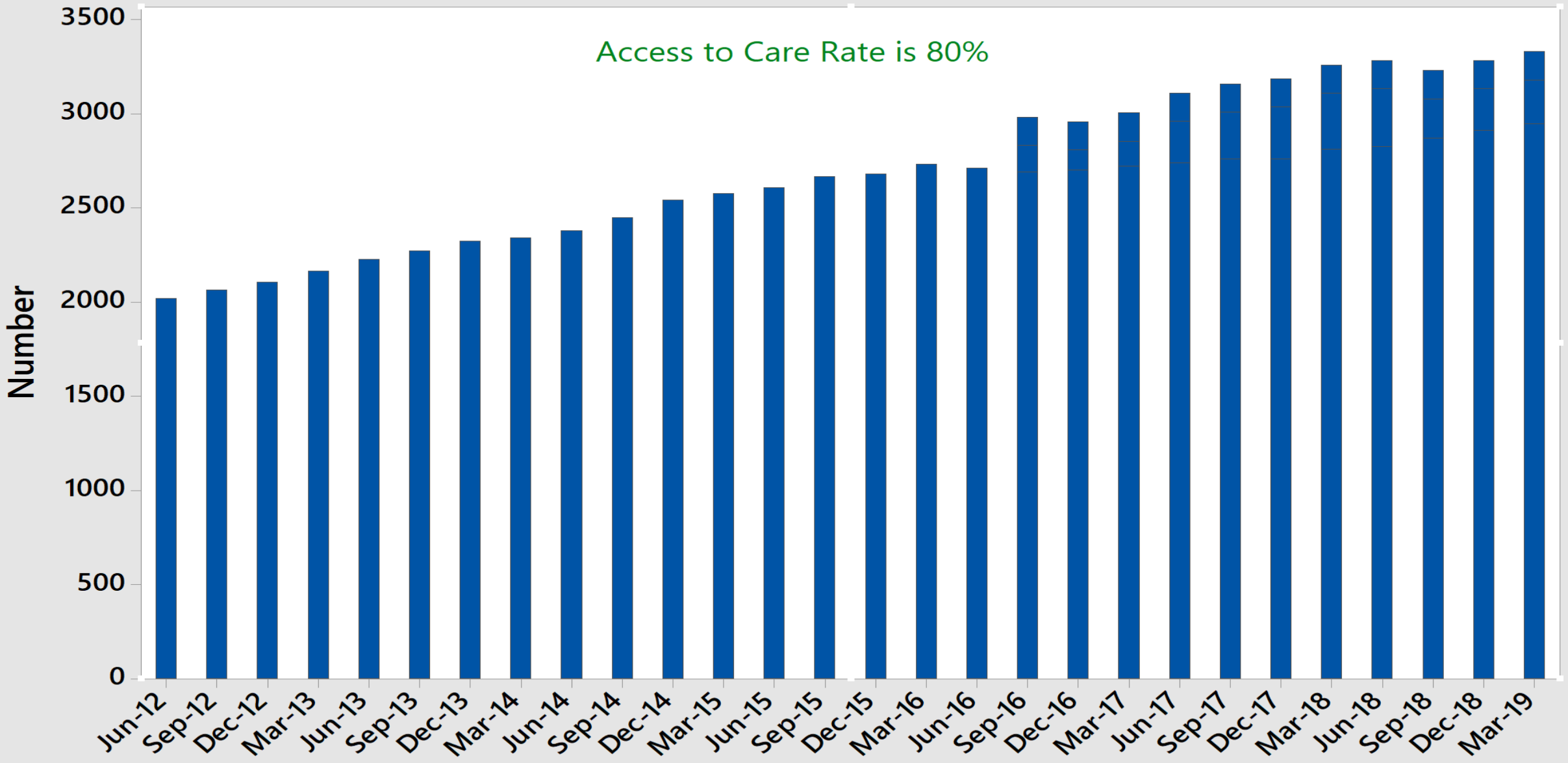
Access Alliance Multicultural Health and Community Services

Unison Health & Community Services

PARKDALE QUEEN WEST Community Health Centre

March 2019

CHC Panel Size



Quality Improvement for Health Care Inc. *Faten Mitchell*

Lessons Learned

1. Importance of expertise
2. Clinical directors were best positioned to lead the project due to their combination of strategic and operational knowledge
3. Working on real projects works best
4. Consider prioritizing an easier project first, even at the expense of prioritizing an area of greater importance
5. Importance of focus on sustainability of changes
6. Working in collaboration with partners has led to faster and deeper improvement

Learning Event - June 19, 2019

Breakout rooms

On your nametags:

- Presentation Hall (Ellen Melis)
- Room 200 (Nadine Whelan)
- The Studio (Kathleen Paterson)
- The Forum (Bruce McLeod)
- Room 104 (Bruce Swan)

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Transformational change

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"First, the future state is unknown when you begin, and is determined through trial and error as new information is gathered. This makes it impossible to "manage" transformation with pre-determined, time-bound and linear project plans. You can have an over-arching change strategy, but the actual change process literally must "emerge" as you go. This means that your executives, managers and frontline workers alike must operate in the unknown—that's scary, unpredictable place where stress skyrockets and emotions run high."

Second, the future state is so radically different than the current state that the people and culture must change to implement it successfully. New mindsets and behaviors are required. In fact, often leaders and workers must shift their worldviews to even invent the required new future, let alone operate it effectively."

(Ackerman-Anderson and Anderson, 2010)

Afternoon Panel

Leading Change Through Collaboration: Examples and Learnings from the Field

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Joint Community Cardiopulmonary Rehabilitation Program: A LeaderShift Start

Christina Dolgowicz
Lung Health Coordinator
Lanark Renfrew Health & Community Services

Peter Hamer
Executive Director
Ottawa Valley Family Health Team

LeaderShift

Cardiopulmonary Rehabilitation Program

A joint partnership between Ottaway Valley Family Health Team and the Lanark Renfrew Lung Health Program:

A LeaderShift Story

Christina Dolgowicz, BHSc, RRT, CRE
Lung Health Coordinator, Lanark Renfrew Lung Health Program, Lanark Renfrew Health & Community Services

Peter Hamer, *Executive Director, Ottawa Valley Family Health Team*

LANARK RENFREW LUNG HEALTH PROGRAM
A program of Lanark Renfrew Health & Community Services

Ottawa Valley FAMILY HEALTH TEAM

Objectives

- Background: OVFHT Tele-Cardiac Rehab and Lanark Renfrew Lung Health Pulmonary Rehab Program
- Applying Lead Domains (Lead Self, Engage others, Achieve Results, Develop Coalitions, Systems Transformation)
- Challenges and Opportunities
- Next Steps

LANARK RENFREW
LUNG HEALTH
PROGRAM
A program of Lanark Renfrew Health & Community Services

Ottawa Valley
FAMILY HEALTH TEAM

Ottawa Valley Family Health Team

- Tele-Cardiac Rehab Program
  - Program launched Fall 2014
  - Program is offered twice weekly for 8 weeks, includes cardio, strength, and education
  - 0.4 FTE RN, 0.4 FTE RPN (OTN), RD 2 x month, Physio for intake and PRN
  - Partner - University of Ottawa Heart Institute, Ontario Telehealth Network, (PCVC)
  - Patient visits: 2014/15 YR 1 – 126, 2018/19 - 1090
  - Challenges: access to space at OVFHT, cost and access to staff, and equipment

LANARK RENFREW
LUNG HEALTH
PROGRAM

A program of Lanark Renfrew Health
& Community Services

Lanark Renfrew Lung Health Program

- Pulmonary Rehabilitation Program
  - Launched May 2015, located in a plaza in town of Almonte
  - Program is offered twice weekly for 8 weeks, includes cardio, strength, and education
  - Reg. Respiratory Therapists (0.4 FTE) and Physiotherapist (0.4 FTE)
  - Clients Served : 101 Unique Pulmonary Rehab Participants (2018-2019)
  - Challenges: staffing ratios restricted growing program, overlap of disease process

LEADS: Domains

LANARK RENFREW LUNG HEALTH PROGRAM
A program of Lanark Renfrew Health & Community Services

1. Lead Self

- Similar values between leaders
- Shared attitude and vision to 'Lets just do it'
- Patient care at center of decision making

2. Engage Others

- Important to focus on reasons for integration for staff buy-in
- Like-programs serving similar clientele
- Inability to grow because of limitations in staffing & space
- Identification of duplication of services

3. Achieve Results

- Goal set: Joint Program with team agreement
- Ability for leaders to guide but front line workers to create program and have 'ownership'
- Agreement of sharing of outcomes (good/bad)
- Formal/information joint evaluation for quality improvement

Ottawa Valley FAMILY HEALTH TEAM

LEADS: Domains

4. Develop Coalitions

- Joint letterhead
- Joint communication
- Commitment to move forward with project
- Sharing Electronic Medical Records
- Shift away from ‘my data’ and instead a move towards ‘what is easiest for the user AND can be used for data collection’

5. System Transformation

- Program launch Feb 2019
- Formal Evaluation of joint program (University of Ottawa Heart Institute & University of Ottawa)
- Spread of joint program resources and ‘lessons learned’ to three other tele-cardiopulmonary rehab sites in area
- What’s next? Integration of Diabetes, Osteoarthritis, Post-Transplants

Challenges & Opportunities

Challenges

- Different Electronic Medical Record, (EMR) systems
- Different reporting structure different payment systems, (MOHLTC & LHIN)
- Flow of patient referrals, (multiple sources) with two streams, (cardiac and pulmonary)

Opportunities

- Ability to spread rehabilitation program to other chronic diseases
- Ability to pull in partners (i.e. Regional LHIN Palliative Care Programs, Primary Care Outreach for Seniors)
- Integration of services and resources (including electronic medical record) beyond rehabilitation

LANARK RENFREW LUNG HEALTH PROGRAM
A program of Lanark Renfrew Health & Community Services

Ottawa Valley FAMILY HEALTH TEAM


LUNG HEALTH PROGRAM
Ottawa Valley
FAMILY HEALTH TEAM
ALMONTE
CARDIOPULMONARY
REHABILITATION
A PARTNERSHIP BETWEEN
LANARK RENFREW LUNG HEALTH PROGRAM
AND
OTTAWA VALLEY FAMILY HEALTH TEAM

Integrating Peer Support for Health System Transformation

Christina Jabalee
Director
Centre for Innovation in Peer Support @ Support & Housing-Halton

Betty-Lou Kristy
Director
Centre for Innovation in Peer Support @ Support & Housing-Halton

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CENTRE for INNOVATION in PEER SUPPORT

SUPPORT & HOUSING - HALTON

Transforming Health Care into Authentic Person Directed Services Through Collaboration

LeaderShift Conference

TEACH
Teach, Empower, Advocate, for Community Health
Our Beautiful Minds

CENTRE *for* INNOVATION *in* PEER SUPPORT

Direct Service	Train & Support	Evaluation
Recognized Consumer Survivour Initiative (CSI) Best Practice in Peer Support Programming Groups and volunteer programming	**Focused on TEACH Volunteers** (To support sustainable recovery, meaningful activity & build safe stigma free space that promotes recovery culture)	Program Evaluation

System Support	Train & Support	Evaluation and Research
Infrastructure Supporting 11+ Organizations (Recognized as a Provincial Promising Practice from Evidence Exchange Network)	Peer Staff Roles & Supervision Communities of Practice	-Focus on system wide measurements/data -Quality Improvement initiatives -System Wide Service Integrity & Impact

Centre- Scope of Practice

Development, Implementation, System Transformation & Sustainability

Engaging and supporting 11 Mississauga Halton LHIN funded & accredited Health Service Providers (HSPs) with over 60 peer support workers, 30 peer supervisors across 30 different programs in community, residential & hospital settings . Active engagement and support provided to many other HSPs & organizations ; plus regional, provincial, national & international collaborations.

11 Accredited HSP Partners

TEACH – Teach, Empower, Advocate for Community Health – Our Beautiful Minds

Support & Housing - Halton

Summit Housing & Outreach Programs

one-Link – Connecting you to addictions and mental health services

Trillium Health Partners

Halton Healthcare – Georgetown · Milton · Oakville

ADAPT – Halton Alcohol, Drug and Gambling Assessment Prevention & Treatment Services

HOPE Place Centres – Freedom from Addictions

PAARC – Peel Addiction Assessment and Referral Centre

pchs – Serving Diverse Communities – Punjabi Community Health Services

Canadian Mental Health Association Halton Region Branch – Mental health for all

STRIDE – Supported Training & Rehabilitation in Diverse Environments

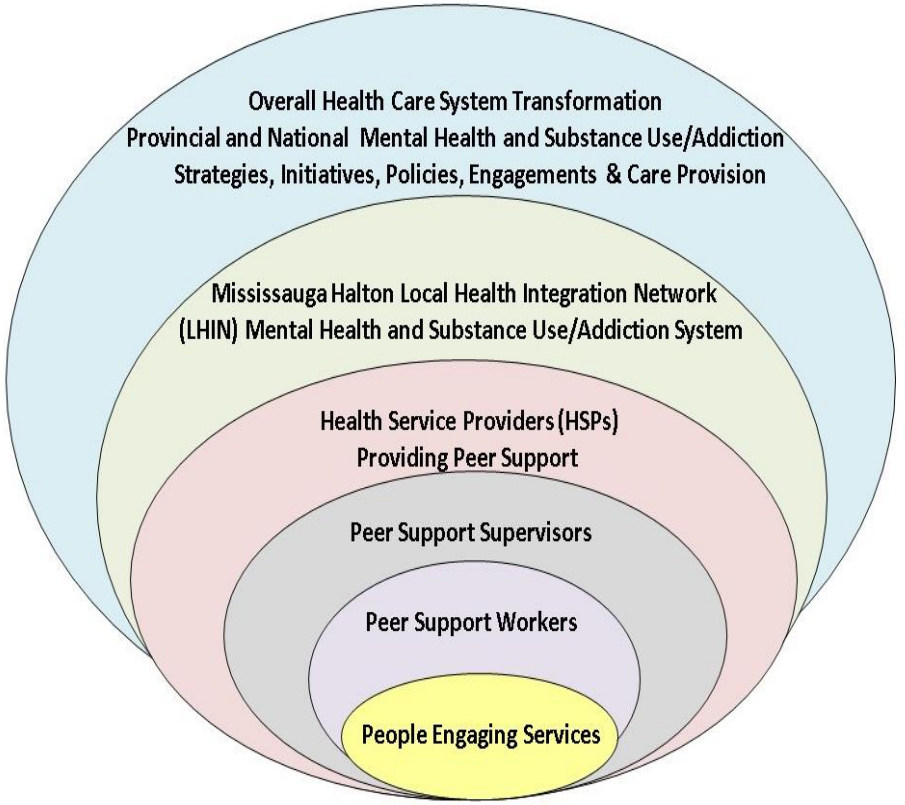
6 Priority Streams

- ✓ Training
- ✓ Implementation
- ✓ Evaluation & Research
- ✓ Capacity Building
- ✓ Knowledge Brokerage
- ✓ Quality Improvement

7 Areas of Reflective Practice

- ❑ Person Directed Services
- ❑ Developing a New Role in a System
- ❑ Emergence
- ❑ Governance
- ❑ Service Integrity
- ❑ Communities of Practice
- ❑ "Marrying" all of those

6 Spheres of Influence/Impact



Key Messaging

- Its not about US and THEM…its about all of us.
- Its about relationships
- We all want the best care possible for those we love and ourselves
- Our system is always growing.

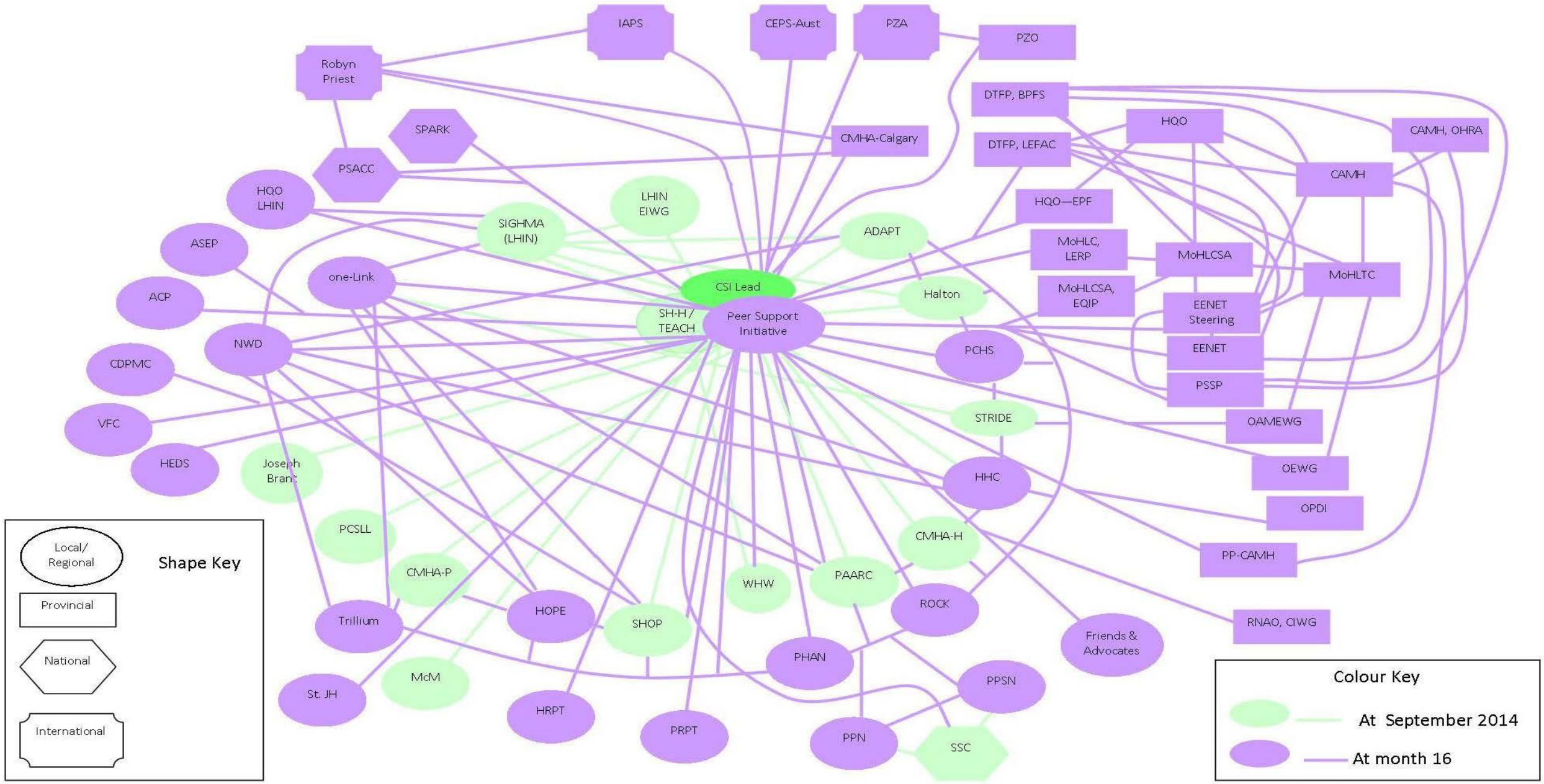
Supporting Transformational Change:

- Engaging all stakeholders
- Stay grounded in common values and language
- Focus on evaluating everything!
- Create evidence to bridge and validate values based work to system outcomes
- Knowledge Exchange events and sharing to energize the movement
- Communities of practice to keep connected
- Developing common guidelines to follow in each organization
- Consistent messaging and training for peers, supervisors, teams and systems
- Recognizing it was more than introducing a new role, it was system transformation. Change takes time.
- Reminding everyone it is about relationships…with everyone.
- Shifting minds happens through relationships

Working Together

- **Provincial Health Leaders**
- **MH & A Leaders**
- **Peer Position Network**
- **Peer Position Supervisors Network**

Peer Support reach in Mississauga Halton LHIN BEFORE the Centre is in green (Sept 2014). The Centre's reach is mapped below in purple. (This was done at month 16 and we are now almost 4 years in and have an even LARGER network.



Authentic Engagement Solution:

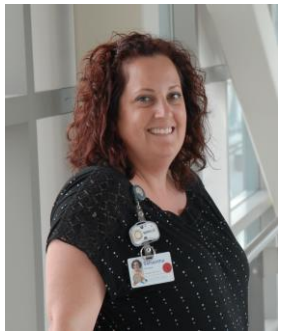
What if the Health Care System Engagement Bird came to nest in the Peer Support Values Tree?

“When allowed full and equitable political and social power with meaningful involvement in healthcare governance, policy development, planning, delivery, and evaluation, people with lived experience, family members and peers can provide unique and relevant context upon which to work with and base decisions on”

“The lived experience of people, families and peer support is shaping the cultural shift from ‘storytelling’ to evidence. It provides a road-map to affirmative change”

Centre for Innovation in Peer Support White Paper 2016

Southlake @ home: Collaborating Across Sectors to Support Transitions Home for the Frail Elderly



Samantha Hennigar
Operations Manager
Southlake @ home and ALC Manager Southlake Regional Health Centre

Nancy Kula
Director of Client Care and Services
CHATS Community & Home Assistance to Seniors

LeaderShift

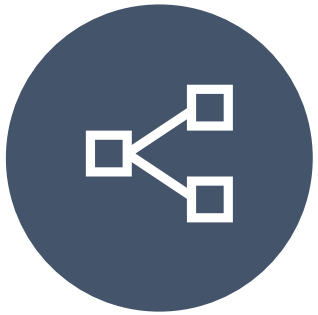
Southlake@home

Collaborating Across Sectors to Support Transitions Home

Presentation Aims

DESCRIBE THE OPPORTUNITY

HIGHLIGHT THE APPROACH



SHARE THE OUTCOMES

SHARE THE LEARNINGS

The Opportunity

CHATS with an interest in targeted work to help address health system pressures and existing relationships with Southlake.

Southlake Regional Health Centre with an identified 27% of total ALC days are attributable to patients waiting for home and community care services.

Synergies between CHATS strategic plan and Southlake's desire to collaborate with partners in the development of a new transitional care prototype - Southlake@home.

Southlake@home is a catalyst for community partners and the hospital to meaningfully collaborate and an opportunity to inform the model of care in the future Integrated Health Systems (Ontario Health Teams).

The Approach

- With clients and caregivers at the heart of each discussion, a cross sector group of health/social service providers, physicians, hospital staff and community service providers work together as one team to develop unique patient-centered transitional care plans.
- Leveraging quality improvement methodology, a team of program champions meet each week to make improvements to the model.
- A low rules environment enables thinking outside of the box to innovate.
- Building trust through dialogue and serving as equal partners enables the building of solid operational relationships and creative problem solving.

The Program Model

Medically and socially complex and frail elderly

One team: hospital and community meeting the patient's care needs

Partnerships with community supports and primary care

Increase value and reduce duplication

Continuous quality improvement and evaluation

Improve patient outcomes and experience

One Team – Patients, Caregivers, and Providers

- 16-week transitional care program for medically complex and frail elderly
- Each community has a dedicated interdisciplinary care team providing 24-hour coverage
- Joint home visits with primary care and community support services
- 24/7 phone line for patient and family support
- Technology is leveraged to promote communication and self-care

Seamless Care

- Coordinator liaises with primary care and social service providers
- PSW, nursing and rehab supports are matched to the patient's care needs
- Explore opportunities to improve continuity of care by connecting electronic records
- Primary care provider informed of progress and change of patient status
- 7-days post hospitalization primary care visit will be supported

Community Partnerships

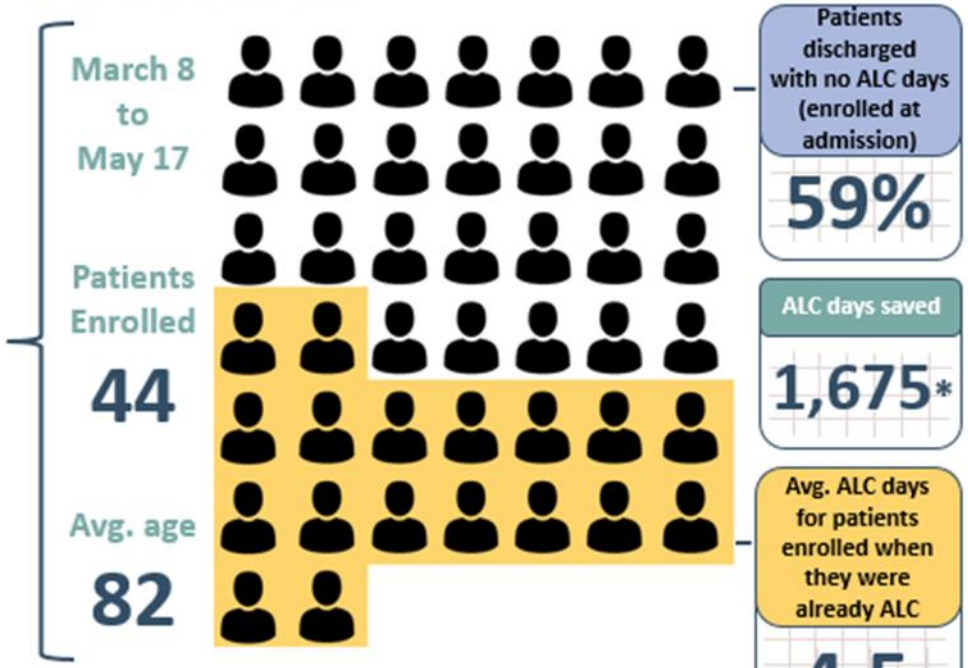
- Collaborative approach to continuous quality improvement and evaluation
- Enhanced access to supports to improve caregivers' resiliency
- Salaried model where homecare provider is flexible and nimble to quickly adapt to changing care needs and patient/family preferences
- Shared risk and benefits for Southlake and the homecare provider

Expected Outcomes

Value and Efficiency	• Save 5,000 ALC days/year and reduce ALC wait for homecare from avg. 14.2 days to 0 ($2M cost avoidance*) • Explore the opportunity to transfer additional ALC destinations (i.e., LTC) to save further ALC bed days • Use bed days saved for funded acute purpose and reduce hallway healthcare by 5,000 bed days/year • Reduce unnecessary ED visits ($0.3M/year cost avoidance*) • Build on lessons learned and critical success factors from previous Ontario bundled care pilots
Improved Patient Outcomes	• Reduce risk of hospital-acquired infections, deconditioning, falls and delirium • Prepare individual transitional care plans using geriatric best practices • Improve access for acute care patients who need acute beds (i.e., beds will be used for funded purpose) • Improve patient and family satisfaction
Improved Care Coordination and Patient Experience	• Avoid ED visits via a 24/7 phone line for patient/family (build on Southlake's successes for cancer patients) • Patients, families, and caregivers will understand their transitional care plans • Patients and families know their community care team members and plan prior to hospital discharge • Improve patient, family, and physician confidence that homecare will be provided per transitional care plan • Leverage Southlake's 100-member Patient and Family Advisor network at all stages
Improved Provider Experience	• Hospital and community teams will work together (e.g., warm hand-offs, design care, and problem solve) • Enhance staff morale associated with reduction in hallway healthcare at Southlake • Improve communication and collaboration with primary care providers • Improve utilization and inclusion of homecare providers in transitional care planning, specifically PSWs

Early Results

RESULTS TO DATE



* One patient was ALC for 40 days and waiting for LTC. Southlake@home successfully transitioned the patient home within a few days. The patient's expected ALC wait for LTC was 3 years. This translates to 1055 days saved. The remaining 620 days saved are from the other 43 patients.

PATIENT SATISFACTION

85% of patients strongly agreed/agreed they were provided the info they needed to be supported at home prior to discharge

86% of patients strongly agreed/agreed that they received the support they needed at home

PROVIDER SATISFACTION

100% of homecare providers strongly agreed/agreed they felt they were part of a health care team

82% of homecare providers strongly agreed/agreed that they were satisfied they joined Southlake@home team.

Share the Learnings

LEADS Framework

Importance of being purposeful about partnerships and coming together with alignment on both values and goals.

- Engaging CHATS and other partners early in the conceptual phase of the program was a critical success factor
- Collaborating to co-design with partners and to redesign and refine the model

Complexity of cross sector collaboration with accelerated time frames and the internal/external leadership needed.

- Flexibility and nimbleness is required throughout the process
- Acknowledge and develop plans to address cultural differences such as ‘different clocks’
- Use patient stories to learn and to grow
- Think as one team

Value of investing in leadership at an operational level

- Co-designing ongoing education sessions with partners
- Ongoing acknowledgement of the organization impact – take time to have these important discussions
- Supporting operational leaders to participate in systems level initiatives
- Enable the rethinking of roles and organizational priorities

Breakout rooms

On your nametags:

- Presentation Hall (Ellen Melis)
- Room 200 (Nadine Whelan)
- The Studio (Kathleen Paterson)
- The Forum (Bruce McLeod)
- Room 104 (Bruce Swan)

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Strengths

- Emotional intelligence, value based services and client centred commitment
- Existing relationships and collaborative initiatives
- Systems thinking and intersectoral thinking
- Adaptable leadership and resiliency
- Outcomes: data, critical thinking, accountability, use of tools, continuous improvement
- Ability to leverage resources
- Existing experience and expertise
- Diversity and breadth of services
- LEADS framework
- Innovation
- Readiness for change

What needs to shift?

- Funding: levels, timelines, flow
- Information and data: access and sharing, digitizing
- More transparency
- Shared accountability and outcome measurement
- Finding and then closing the gap
- Share failures and take risks
- Focus on keeping people in communities
- More client engagement and focus
- Building a common language/understanding between sectors
- Focus on equity
- Leave the past behind us
- Maintain momentum of change

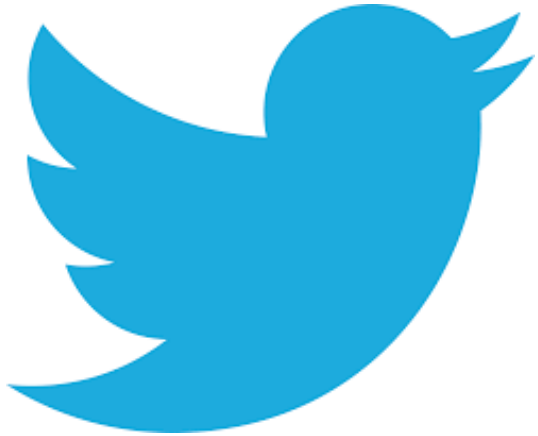
What do we need to embrace?

- Innovation and creativity
- Instability (for a while..) and flexibility
- Change and risk—embrace mistakes!
- Trust and transparency
- Opportunity and collaboration
- Feedback (including from our clients)
- Expertise of others
- Embrace what is working well and replicate
- Vulnerability
- Richness of difference
- Systems based on equity
- Best interests of the client/patient
- Courage to explore the unknown
- Holistic/social determinants of health

What do we need to let go of?

- Attachment to “tried and true”
- Competitiveness/ego/territorialism
- Narrowing thinking
- Historical norms
- Fear and distrust
- The power and comfort of the silos
- Negativity
- What we don’t do well

Tweet your learnings as we go…



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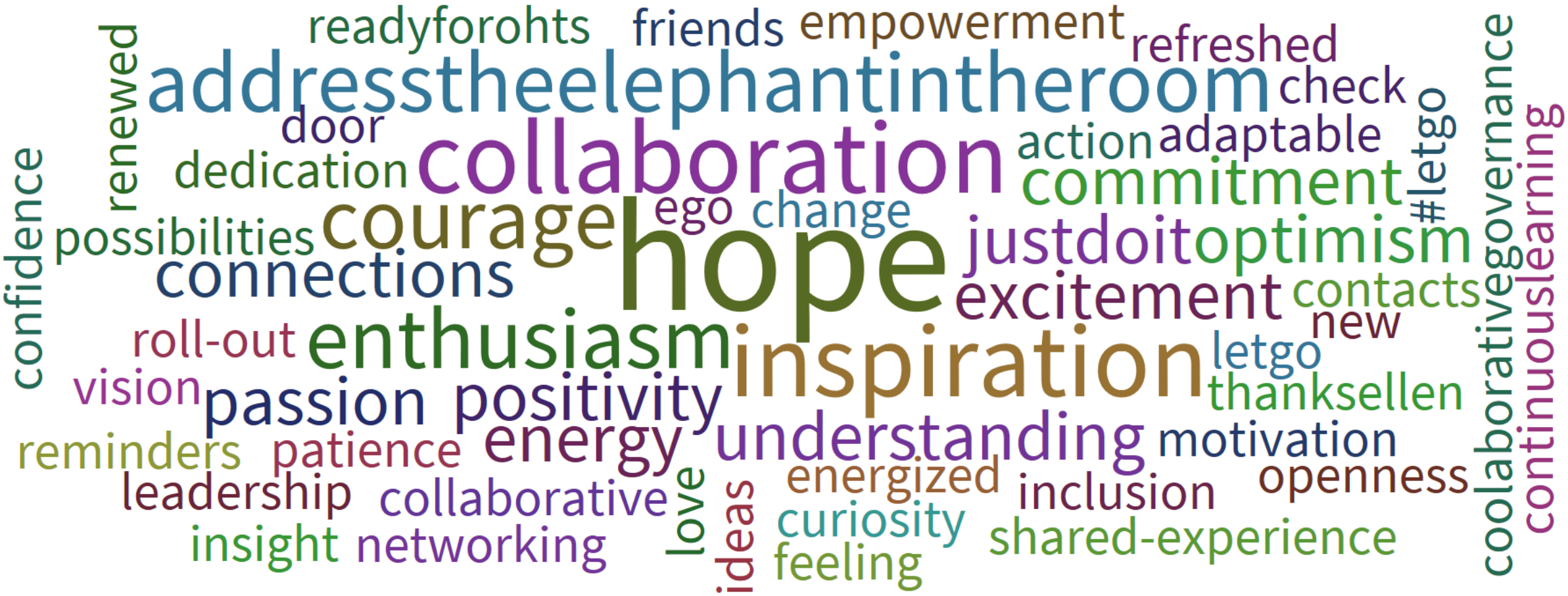
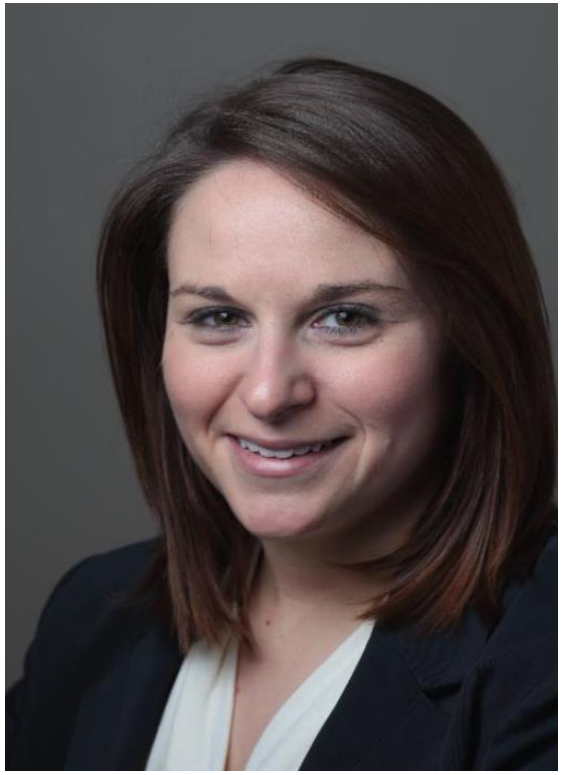
In one word, describe what you are leaving with at the end of this LeaderShift conference as we #ShapetheShift

Respond at **PollEv.com/leadershiftp132** Text **LEADERSHIFTP132** to **37607** once to join, then text your message



LeaderShift Governance Executive Closing Remarks



Adrienne Spafford
CEO, Addictions and Mental Health Ontario

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Collaborate.
Transform.

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