

In Conversation with Howard Waldner

Ken Tremblay

Providing healthcare services to an island population is a bit different for the Vancouver Island Health Authority (VIHA). With unique geography and demographics, VIHA has its share of the usual healthcare challenges plus scale: 18,000 staff, 1,700 physicians across some 150 facilities and a budget of \$1.8 billion. Not usual, though, is VIHA's differential success with chronic disease management, services close to home and senior care and its integrated network of facilities and people who really do work as a system, in every sense of the word. This performance comes as no surprise to Howard Waldner, VIHA's chief executive officer for the past eight years and its current president. Building on his early career in the United Kingdom and a stop in Calgary, Waldner offered his insights to *HQ's* Ken Tremblay earlier this year.

HQ: VIHA's scale and diversity must present leadership challenges. How have you been able to provide consistent leadership to the challenges you face?

HW: Most western Canadian provinces have organized themselves into regional health authority (RHA) models that, for some 10 years now, have been responsible for the health status of the entire population over the whole continuum of care. That model has worked very successfully and is not dissimilar to the healthcare and delivery governance model that you would find in the United Kingdom.

Managing healthcare across this continuum presents many challenges, but opportunities too because there is one governance table. This enables the board and senior leadership to determine, at both strategic and operational levels, what the needs are across the various communities. We can shift funding across that continuum to ensure that we're optimizing the resources we have. I have worked in that model all my life and find it relatively straightforward.

VIHA covers a vast area containing many special populations in terms of geography and the nature of the population. For example, on Vancouver Island we have more than 50 First



Nations bands that have unique and sometimes very challenging situations.

We deliver services in 150 operational sites. We have 18,000 employees, 1,700 physician partners and 2,000 volunteers. Being physically present is very hard work for me and the team: to keep that local connectivity and presence working so that we are aware of what's going on and can ensure our governance and leadership [activities] are consistent and relevant.

HQ: Although a large part of its geography is on the mainland, how has an "island environment" shaped health services planning and delivery? What works well, and what continues to challenge your team?

HW: The majority of services [we provide] are on Vancouver Island, but we also provide healthcare on the Gulf Islands, other islands on the east coast of Vancouver Island and parts of the mainland to

the north and northeast of our region. Very simple things such as the weather, geography and poor transportation infrastructure can make it very difficult for populations to access services; similarly, they make it hard for us to deliver services at times. Adverse weather conditions present their own unique challenges.

HQ: Although it has used several iterations, British Columbia has retained an RHA model, and VIHA itself has 14 local health areas. How have regional structures delivered on performance indices such as quality or safety?

HW: We run a program management model, but it includes a locality model – so it's a matrix structure. That allows us to be sure that we have continuity of standards in quality and service. For example, the person or team that runs our emergency services or our surgical services leads them island-wide. Therefore, we have a consistent approach to pathways and clinical protocols. That's equally true with our quality and patient safety agenda: for example, we are monitoring and managing infection control and handwashing in a very consistent way [across sites and programs].

When I arrived nine years ago, we were not able to measure these indicators. Using a program management model derived from experiences in Calgary and the United Kingdom (now quite universally adopted across Canada) has stood the test of time, requiring that metrics are both strong and present.

We have seen many of our work-life metrics trend in absolutely the right direction: infection control, absenteeism and sick time. Our clinical outcomes, in terms of longevity, are among the best in Canada. We have also managed to be fiscally responsible while improving access and delivering improved programs of care; we have balanced budgets every year for the past decade.

HQ: How have you used information technology (IT) to improve the health status of people living in your region? What are the lessons learned for other jurisdictions?

HW: Everyone in healthcare leadership struggles with the issue of information management and how the health records of patients can be better used to improve care across providers. Thanks to the vision of Tom Closson, VIHA embarked on a partnership with Cerner; together, we have achieved a great deal.

Each of our sites (across our entire region, including hospitals) is now up and running on identical platforms. I do not believe there is another Canadian health system or region of our scale and complexity that has been able to do that. We are moving onto the next level with plans to have our electronic chart integrated with those of community and primary care providers. Our vision is this: one patient, one record. All patients, no matter where they are, know that our entire healthcare delivery team can access, appropriately, their [clinical] record.

HQ: Could any of your lessons learned, based on your experiences to date, be applied to other jurisdictions?

HW: One of the lessons we have learned that has general applicability is to review the experiences of others [in order to] avoid some of their pitfalls. There have been some really good lessons from Spain and the United Kingdom (where nationwide e-health procurement has had some problems). Deployment must be appropriate for the situation, include realistic goals and engage clinicians at the earliest possible opportunity. We were fortunate in having a chief clinical information officer in place from the get-go who could ensure that our IT plans had clinical relevance. I believe that [role] is an absolute prerequisite for large healthcare systems as we roll out e-health strategies and platforms. Unless there is clinical relevance and clinicians are engaged early, there's every chance that a project could fail.

We can shift funding across that continuum to ensure that we're optimizing the resources we have.

HQ: What approaches to community engagement have proven their worth to you as you plan, deliver and evaluate VIHA's services and performance?

HW: As we developed our strategic plan – over a five- to 10-year horizon – we thought hard about community engagement. We went to each of the 40-plus municipalities on Vancouver Island for an extensive round of consultations with stakeholders to get a sense of what was currently [happening] on the ground, how our services were being received and what gaps might be perceived or identified.

We completed a very detailed mapping of our population, its demographics and the health status information that we could access. That led us to the strategic plan for our organization in 2005–2006. That approach stood the test of time, and the plan served us well. We are just about to embark on a very similar methodology to refresh and renew our plans for the next five to 10 years.

But the secret here is keeping close, staying in touch and working collaboratively with other stakeholders involved in our health and well-being agenda. Because as you and many of your readers will know, often the health status of a population has little to do with the health services that are provided; rather, [the health status is affected by] the determinants of health – education, diet, employment etc. One has to go back to those roots to ensure that these connections are carefully considered before moving forward.

HQ: VIHA operates in and provides care to the provincial capital. How has that proximity to the legislature and policy makers affected your communications and advocacy activities?

HW: Many people perceive that there is some kind of special deal for those fortunate or unfortunate enough to deliver care within the capital city of a province. To those with that perception: there is no special status or access. We receive what I believe to be equitable funding through the population-based funding approach used in British Columbia. I don't believe we have better access to government or key decision-makers through proximity.

What is significant, though, is that we are constantly in the goldfish bowl. As events spring up – as they do from time-to-time, particularly if the House is sitting – issues can become political in nature and very sensitive. That is the case for healthcare, but even more so in the politically charged environment of the capital city because some people seek – it's the nature of the beast – to politicize or get mileage on these issues one way or the other. You need a strong communications management shop, and your leaders have to be quite skilled and adept at dealing with these issues quickly and appropriately while still managing the business of the organization.

HQ: In a model as diverse as yours, how do you approach performance standards and their compliance? For example, how tight is the link between your organizational structure, accountability and ability to deliver on priorities established by the VIHA Board of Directors?

HW: VIHA has a very strong and proud track record in these accountabilities. In British Columbia, each RHA has a Government Letter of Expectations – a formal agreement with the province – that sets out a number of key targets and objectives that it is required to meet. They are fiscal, quality, volume-of-activity related etc., and service developments are contained within them. We have a proud track record of being a top-quartile performer in each of these areas within British Columbia and across the country. Our board is very conscious of the provincial fiscal targets as well as our internal targets. Our support services complement this, enabling us to deliver on the vast majority of these targets, on time and on budget.

HQ: What have been the biggest governance challenges for VIHA? How have you shaped your governance processes and structures to deliver on VIHA's mission, vision and values?

HW: I have been blessed with a board of directors at VIHA that really understands governance. The board sets our strategic direction and holds us accountable for the delivery of predetermined goals, objectives and targets. It allows us, as a leadership team, to deliver and execute on these tasks. As we report [on our progress], the board has never strayed from its governance mandate into operations; that's quite unique. Many boards can confuse or, with their enthusiasm, get involved in operational issues. It's easy to do.

The VIHA Board of Directors consists of passionate and highly committed members, directors who have steered the ship in a very appropriate way. They have allowed us to do our job in managing in order to improve the health services for the population that we serve.

Our board meets every two months, and we meet for three days, and that includes board subcommittees. We have three subcommittees: the Governance and Human Resources Committee, Finance and Audit Committee and Health Quality Committee. These committees meet – usually for half a day – with a proactive agenda and a mixture of reports and updates on activities that have been or will be undertaken. That work is reported back through a committee of the whole structure, and then to an open-forum, public board meeting, which includes taking questions from the floor. It is a very open and transparent governance process.

For me, that will be the acid test of every organization in the future: how effectively did it move upstream to prevent the onset of chronic conditions?

HQ: Many jurisdictions are challenged by the need to dovetail chronic disease management with a robust primary care system. How has VIHA leveraged system integration to deliver on population health in order to reduce the burden of chronic conditions?

HW: That's clearly a challenge facing all of us in healthcare in Canada and across the world. As our population ages, we are seeing more and more seniors presenting with chronic conditions, and we do our best to treat and manage their symptoms and conditions. The reality is that we're treating symptoms. If we are going to flatten the cost or demand curves, the only way to do that effectively is to move upstream, to educate and work with our [target] populations. With obesity, diet, exercise and other [interventions] could significantly mitigate the impacts of chronic diseases plaguing our society.

We are very well aware of that at VIHA, and for a number of years we've developed participative and collaborative models of primary healthcare. We have some plans to move to the next level by using home tele-monitoring to help us keep people well at home in their community as well as slow the onset of disease through prevention. For me, that will be the acid test of every organization in the future: how effectively did it move upstream to prevent the onset of these [chronic] conditions?

HQ: Given your leadership experiences on both sides of the Atlantic, how would you rate the Canadian RHA model compared with the United Kingdom's National Health Service (NHS) model vis-à-vis

performance? How have your British experiences shaped your perspective here?

HW: I'm delighted to be working in the Canadian healthcare system and particularly in British Columbia and Vancouver Island. I think we can justifiably hold our head high and be incredibly proud of health leaders in the Canadian healthcare system, one of the finest in the world. Recent reports published by the Canadian Institute for Health Information and other organizations robustly demonstrate that to be a fact. We spend considerably less, compared with many of our neighbouring countries, on the total cost of health and social care. While some comparisons are not apples to apples, in what we do provide and the outcomes that we achieve, we can be justifiably proud. But we can't be complacent; there is clearly much more that we can do as we go forward.

The NHS is a completely different animal. It has different forms in each of England, Wales, Scotland, Ireland and Northern Ireland. Several run regional models very similar to our own. The English model is constantly changing. I think the big difference between the systems here in Canada and the United Kingdom is that healthcare in the United Kingdom is very much a political football. Every two years or so, there's a major reorganization; the average life expectancy of a healthcare leader in the United Kingdom, particularly England, is less than two years. It's a real problem, and it's seen that way by many people who know and understand the system. There are many examples of people who are very successful in these environments who have performed well in roles for decades, but they're the exception.

The quest for new structures and [resultant] reorganization every couple of years is very prevalent in the United Kingdom,

but much less so here. We have more stable organizations and forms of governance. That doesn't mean that we shouldn't change, but I think we need to learn carefully from the experience of others.

HQ: What do you hope will be your leadership legacy at VIHA?

HW: We have built a great leadership team, and I believe we have been very successful in a number of areas. The first is the use of evidence-based design in creating a new healthcare environment. Just over a year ago, we opened our new 500-bed hospital with 83% of our beds accommodated in single rooms. We've used the expertise of the Center for Healthcare Design in the United States to build on evidence-based design attributes. These enable us to deliver healthcare in a very different way than we have in the past, in terms of the environment. That will lead to a higher-quality experience for the patient, reduced levels of infection, reduced lengths of stay and, ultimately, a more effective way of delivering care. I hope that we can be justifiably proud of beginning that evidence-based journey here. The government very generously gave us \$660 million to continue that evidence-based approach with two new hospitals in Comox and Campbell River. Coupled with our fully functional e-health record that spans the entire care continuum as "one patient, one record," I hope these will be legacies that people can look to with pride for some time.

HQ: Thank you. HQ

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