In Conversation with Chris Power

Ken Tremblay

Capital Health in Halifax, Nova Scotia, is that province's largest healthcare provider, operating nine hospitals and many health centres and community-based programs. With over 12,000 employees, physicians, learners and some 2,000 volunteers, Capital Health serves 400,000 people with an $800-plus million operating budget. It is also the hub for specialist services for the balance of the province and Atlantic Canada. At the helm as president and chief executive officer (CEO) since 2006 is Chris Power, a seasoned executive whose career has spanned 30 years, several provinces and a journey from front-line nursing to the C-suite. Named three times as one of Canada's Top 100 Most Powerful Women in the Public Sector, selected as one of Atlantic Canada's Top 50 CEOs and an award winner for excellence and innovation by her peers, Power offered her insights to HQ's Ken Tremblay earlier this year.

HQ: How does an "Easterner" get to lead one of the jewels of Atlantic Canada?

CP: The majority of my career was here in Atlantic Canada. I started in Halifax as a nurse and worked my way to vice-president. After some 11 years, I needed to breathe new air and gain exposure to something different. I was very fortunate to join Trillium Health Centre as vice-president. I was there for three years and then, as luck would have it, a CEO search for Capital Health was under way, and the rest is history. I felt blessed to be able to come back to Nova Scotia and to lead Capital Health because this is home for me. It's been a wonderful experience, and I'm into my sixth year as president and CEO.

HQ: Nova Scotia's experience with regional structures seems to have survived the test of time. To what do you attribute that success?

CP: Like most provinces, Nova Scotia has undergone variations [with these models]. The key has been a belief that, no matter the party affiliation, local influence remains important and we need to ensure that people in rural Nova Scotia are as well served as those in larger cities like Halifax. We have continued with regionalized models because that is what really serves the interest of the public best. We will be undergoing some changes in the future – there have been lots of conversations with all three of our political parties – as we anticipate a spring election. In a province of less than a million people, you don't really need 10 separate entities. The CEOs are working collaboratively at the system and provincial levels, setting the stage toward a more manageable number of district health authorities. We will stay true to regions because that is what we believe serves Nova Scotians best.

HQ: I noted your commitment to involving patients and citizens in a dialogue where "each shares accountability for individual health, the healthcare system and the health of the community." How has that approach made a difference in program delivery and disease management?

CP: Our approach has made an incredible difference for us here at Capital Health. Everyone in healthcare understands that patients and families are an important piece of what we do, and we talk about patient centredness to varying degrees. When I returned to Capital Health, we developed a new strategic plan in a much different manner than we, and probably most other organizations, had done before.

Engagement was a huge piece of what we did. We engaged thousands of people: we went into soup kitchens, dock areas, churches and schools. We brought people to us, and we went to them. We had sessions with over 800 staff, and physician picnics – to understand what people wanted and needed from the healthcare system. It fundamentally changed for us what we believed to be best for everybody.

What did they say? Be there when we really need you; but, mostly, we want you to help us to stay well because many of us don't know how to do that. [That finding] changed our focus to one of working in partnership with our public, not just our patients. We shifted our focus to help people to stay well, and we have a joint accountability to do that.

A great deal of my time is focused with business and community leaders talking about a shared accountability with the formal healthcare system and citizens. Our [shared] goals are really focused on helping people to stay well. For example, we're leading the country in a healthy food [strategy] in our institutions, cafeterias and concession stands. We're having that dialogue with our community. At the annual spring dinner of the Chamber of Commerce, we talked about health, the role of the healthcare system and a personal accountability to stay well as long as one can.

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To me, this transformation is not about more technology, more beds or more physicians or nurses or others; it's about switching the focus to helping people stay well. It is very rewarding to engage our patients and our citizens in this work. What they tell us is so different from what we believe. It is truly important and worthy for healthcare providers to experience such a journey. It's enriching, and I learn something every day.

HQ: Nova Scotia has led the country with several information technology–based strategies that link providers and patients across the province. What investments have created the greatest dividends for Capital Health and the province?

CP: There are a number of system-wide initiatives. We were one of the first to have a picture archiving and communication system (PACS) throughout the province; that made a huge difference for us. We're in the process of launching a provincial bed utilization management program to understand where beds are available in the province. [Still early in the rollout], we are expecting a significant dividend.

Provincially, the MUSH sector (municipalities, universities, schools and hospitals) has moved to [a single vendor] back-office strategy. That's great because now we have a common playing field for all of our back-office systems, in terms of infrastructure and support across all of the health districts in the province; it's been tremendous.

HQ: Capital Health has made an explicit commitment to transformational leadership as a prerequisite for

success in today's healthcare environment. How has that attention to organizational development and talent management benefited patient care, the organization and the province?

CP: When we completed our strategic plan, we recognized that if you are going to lead in transformational times, you need different skills from those learned through the ranks. It became a foundational piece for us. We sent out invitations to people around the world (but primarily in North America), inviting them to Capital Health to share with us what one needs to lead in transformational times. We had no money, so we asked them to come on their own dime. They helped us develop the program we call My Leadership. We made it mandatory – the first time we made anything mandatory in this organization – so that all leaders would understand what capabilities we need to lead in transformational times. Once we had the foundational piece, we rolled it out to the remaining 12,000 staff across the organization. We had 100% compliance from all of our leaders, and it continues as new people join the organization and as part of team-based learning.

We also recognized that our physicians didn't have skill sets around leadership. While great with their patients, they really didn't understand budgets and labour relations and were not interested in taking two days off to complete leadership training. In conjunction with the IWK Health Centre, we developed a program called Fully at the Table. We are now in our third cohort of 30 and 35 physicians, where we teach them about physician leadership and how to lead in a co-leadership model. That has been hugely successful.

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We are trying to help leaders to be risk takers, to be innovative, to understand how to engage with people and build relationships. We are seeing tremendous success as teams initiate innovative projects, and a cultural shift in the language people speak and in the accountability we see throughout the organization. We wouldn't have seen [these outcomes] five years ago. From a sustainability perspective, we are going to finish our sixth year with a balanced budget, and I credit our leaders, physicians, managers, directors and vice-presidents for an amazing job.

HQ: When you evaluate your organization's performance, what indices are top of mind? For example, referencing Capital Health's "Declaration of Health" statement, what metrics make it to the boardroom?

CP: Our Strategic Indicator Report goes to the whole organization, but we've done some extra work on indicators the board would like to see. Certainly the basic ones track wait times (for hip and knee surgeries and in the emergency department) because that's the priority of our government. Patient satisfaction – mostly quality indicators – goes to the board, and every board meeting dedicates 30 minutes to quality and patient safety. We have different presentations and discussions for our board: access; financial indicators; satisfaction – patient complaints and patient concerns; safety; and infection rates. We use 140 or so indicators, with less than that number going to the board.

We survey our community every couple of years. Those results go to the board: what is important to our public and the communities we serve. There are a number of population health indicators we use to help us determine if we are truly making a difference in the work that we do.

HQ: Capital Health's service area goes beyond the province and includes Atlantic Canada. How does that inter-provincial mandate and utilization affect your accountability framework? For example, how do you relate to colleagues or health ministries in adjacent provinces?

CP: The relationship with the health ministries [in other provinces] is through our deputy minister and minister of health. We don't have a whole lot of conversations, although there are lots of issues on the table, for example, inter-provincial rates for routine care, tertiary and quaternary work and subspecialty services such as transplantation and cancer care. We were never set up for one province to be the host province; it has some issues for us. The CEOs of the academic health science centres meet frequently to talk about how we can do some things differently, certainly in Atlantic Canada.

Small provinces really need to work this way so that a critical mass of expertise can be created to enable us to provide that service. The issue for us is about appropriate remuneration for the work that we do – I'll leave that to the deputy ministers to work out. Our mandate and mission span Nova Scotia for all adult tertiary and quaternary care; we need relationships with the district health authorities as we are the safety net for the province. It's complex, but it works because of goodwill and a focus on patients.

HQ: The governance of Capital Health includes seven community health boards. What have been the rewards and challenges of that structure for you and the organization?

CP: Our challenge over the years was gaining an understanding of the role and focus of community health boards, and there were growing pains. They weren't mini-boards of

Capital Health; they truly were representing the community and feeding information to our board of directors. We have 10 years of experience now, and our success was because we supported them well. Initially, we had a coordinator/director for each community health board to help understand their needs from a population health perspective. We changed our model as our community health boards matured, but they remain invaluable. They keep their finger on the pulse of the community they represent and understand what [factors] impact on the health of that community. They work together developing plans that come to our board on an annual basis to inform our strategies and our goals for the following year.

The people serving on these community health boards are very dedicated to improving their neighbourhoods and communities. It has been a wonderful model but one that requires investment and strong links with the district. I wouldn't say that they are all equally successful around the province. There are varying degrees of success, but, on balance, my colleagues in Nova Scotia would say they provide tremendous benefits.

HQ: Most healthcare leaders are engaging the primary care system through the lens of population health to reduce the burden of chronic diseases. What have been your success stories, and what issues remain as a leadership challenge?

CP: We have great stories but many challenges on the primary healthcare front. We have a Department of Primary Care and a Department of Family Practice here at Capital Health. We train family practice residents, but the Department of Family Practice also engages over 1,000 family practitioners throughout Capital Health. We've been tremendously successful in engaging our family practitioners: listening to them and determining what they need and how we can connect with them better. We have developed community health teams out in the community, including our nursing homes, where, working with paramedics, we have seen a remarkable reduction in patients coming to our emergency departments.

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We are a good way down the path of having primary care physicians feel that they're part of the Capital Health family, and we are rolling out primary healthcare [models] throughout our district. Compared to where we were five years ago, we are leap years ahead. For anyone new to the community, there's a number they can call for a match with a family physician – about 98% of our citizens have family physicians. Family physicians are a difficult group to engage because their solo or group practices are not as connected to the district as we might want. But we're seeing improvement each time we ask about their level of connectedness. We are working hard to make them feel part of Capital Health.

HQ: How are students and faculty – medical, nursing, allied health – at Capital Health touched by the new paradigms shaping healthcare and delivery systems: chronic disease management, system integration, collaborative practice, population health?

CP: We are the main centre for Dalhousie University. Over 5,000 students come through our doors on an annual basis, and that includes medical students and residents. They receive an orientation from us so that they understand what we're about and our expectations of them when they are in our midst. We are working with Dalhousie on inter-professional education: starting in the very early days of medical school, nursing, physiotherapy, occupational therapy, pharmacy and all the various health professions. We're working in a collaborative fashion so that graduates are familiar with that model. We are trying to refresh the curriculum with our colleagues at Dalhousie to better reflect the needs of the public and patient population. We're doing tremendous work with Dalhousie University, but students from around the world are gaining experience with us. The best we can hope for is that we are transmitting to them what's important about the transformational journey we're on.

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

CP: I hope my legacy will be about the engagement and the dialogue around appropriateness of care. We are going down that path at Capital Health. We started this dialogue a few years ago during these strategic conversations with our public. I'm hopeful that [the approach] gets legs and starts to take off so that we are helping people receive the care that's appropriate and effective. That would be one.

The other is healthy eating [and lifestyle]. If I can contribute to making an impact on the health of Canadians – getting people to watch what they eat and what they do with their feet, to improve their health – then I will consider all my time in healthcare well spent.

HQ: Thank you. HQ