Employee Engagement Makes the Quadruple Aim:

Connecting Patients and Employees

in Relationship-Centred Care

Submitted to OCAD University in partial fulfillment of the requirements for the degree of
Master of Design in Strategic Foresight and Innovation

Toronto, Ontario, Canada
April, 2016

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Abstract

Common approaches to building and measuring employee engagement focus on the connection of the employee to an organization (i.e., the place of work). This study reveals that current conventional approaches to activating employee engagement are often contrived and will fail to have lasting impact on engagement levels. *What truly engages people is the work they do **with** others **serving** their **constituents**.*

Using an approach that combines field research and foresight methods, this study explores new possibilities that shifts focus from what is done today, "employees to work-place," to a reframing of how we might build and measure employee engagement. This reframing suggests that what is important is what employees do (work task), who they do it with (team/other employees) and who they do it for (constituents) and not about the connection to where they work (i.e., business or work-place).

The context of the study is a large regional teaching hospital that may soon move to a shared service model across the region for services like human resources typically the department tasked with building employee engagement. This particular hospital is also a leader on the topic of patient-centred care, which offers a lens to learn from and reveals common structures between what engages employees and how patient-centred care is practiced.

This study asks the question; how might healthcare organizations resolve the challenges to full employee engagement in the indeterminate contexts of patient-centred care?

Potential answers and insights are offered into these questions. A provocative account is provided of how we might build and measure employee engagement in the future.

Key words: employee engagement, patient-centred care, hospital, measurement, workplace, health care, healthcare

Acknowledgements

Tremendously grateful to **Patrick**, **Hector**, and **Iris** for holding down the homestead and supporting me selflessly while I spent countless hours away fulfilling my quest for knowledge.

Huge thanks to my **siblings**, **father**, and extended **family members** for inspiring me and for listening, entertaining, and discussing ideas endlessly.

Thank you **Peter Jones** for being my primary advisor and sharing your expertise and critical insights generously. You provided the perfect amount of motivation and guidance to ensure completion and the foundation for exciting future possibilities.

Thank you **Robert Pearson** for agreeing to be my secondary advisor and for journeying along with me on this adventure. Very grateful for your expertise, support, and your unwavering belief in me.

Grateful to my **professors** and **fellow colleagues** in the Strategic Foresight and Innovation program for creating the environment for endless possibilities and deep collaboration.

Generous thanks to my **colleagues** at Kingston General Hospital for your encouragement and your ability to embrace ambiguity. Special mention to **Mark Rogers** for your rigorous reviews and valuable feedback as I was nearing completion.

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Introduction

Personal Statement

In the Summer of 2014, I accepted a position in Leadership and Learning at Kingston General Hospital, Ontario. One of the functions within my current role is the stewardship of engagement, specifically employee engagement. The opportunity was appealing as I had spent the last few years of my career focusing on employee engagement in the customer experience context for a company representing the many large brands we as consumers interact with every day. So much of my work in the private sector was focused on enabling employees to deliver on the brand promise through various tactics that built engagement with a focus on the customer. I felt confident that I could contribute in my new role to building effective strategies and tactics to drive engagement here at the hospital.

What I came to understand was that there was a felt difference between my experience in the private sector with large industry brands and my newly-acquired experience with the publicly-funded hospital.

I spent my first few months actively working, observing and learning about the systems within the boundary of the hospital and beyond the hospital into the regional level. I also spent time talking to leaders and employees about this concept of engagement. I asked people, what was it that engaged them, and what did engagement even mean to them?

I wholeheartedly believe that engaged employees can have a positive impact on patient outcomes – and I say this beyond the notion of just patient satisfaction. I take my stewardship of employee engagement seriously and believe the outputs of this exploration can be a catalyst for meaningful change in the design and delivery healthcare (system that facilitates the logistics and delivery of health care)* and in health care (a set of actions by a person or persons to maintain or improve the health of *another*)*.

* definitions derived from http://arcadiasolutions.com/final-word-healthcare-vs-health-care/

The Challenge

In Ontario, the Ministry of Health and Long-Term Care is responsible for the health care system including: setting the overall strategic direction and provincial priorities including legislation and regulations, monitoring the overall performance, and establishing levels of funding. The SELHIN (South East Local Health Integration Network), like the other 13 of its kind, takes direction from the Ministry and provides health care administration at a local level. Its main role is the allocation of funds to healthcare providers within each LHIN and also to work with each provider to "plan, engage, and make decisions at a local level, with the goal to improve the health care system."

LHINs are responsible for the following providers: Hospitals, Long-term Care Homes, Community Care Access Centres, Community Support Services, Community Health Centres and Addiction and Mental Health agencies. They do not have responsibility for physicians, public health or provincial networks (e.g., Cancer Care Ontario). (http://healthcaretomorrow.ca) http://www.southeastlhin.on.ca/page.aspx?id=96 (Figure 1: South East LHIN boundaries).
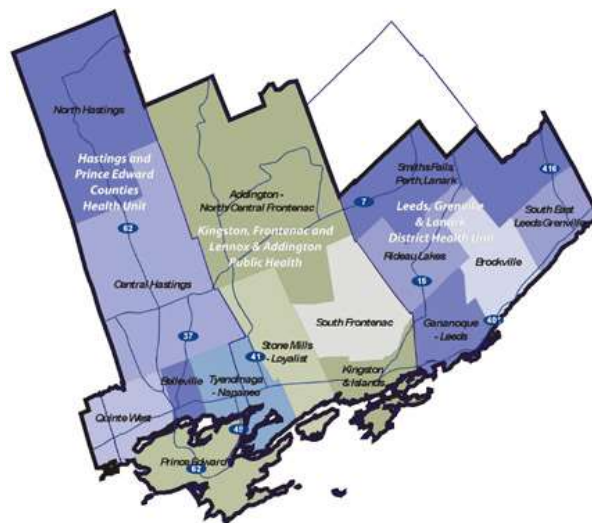
In 2015 the SELHIN started an initiative now known as Healthcare Tomorrow, which comprises a set of initiatives that will redefine the healthcare system across the

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region all in the name of ensuring the best care for patients and families. One of these initiatives is the Hospital Services initiative, a collaborative venture looking to redesign how we deliver services and access to quality healthcare with the ultimate goal of making the hospital experience "seamless, integrated and excellent."

An aspect of this venture is to explore the opportunities for sharing hospital services in three key areas: business functions, diagnostics and therapeutics, and clinical services. Business functions include support services like financial services, facilities management, information technology and human resources. For example, in the current configuration each of the seven hospitals in the SELHIN all have a human resources department, which if they merged, would have tremendous impact on how we build and measure employee engagement going forward.

The challenge presented is that the boundaries of engagement go beyond the walls of each hospital and would essentially reach the boundary of the LHIN. Each hospital currently has a legislative requirement to measure employee engagement. Employee engagement is measured within the scope of each separate hospital as all have distinct cultures and varying missions. The potential amalgamation is a catalyst for rethinking how we measure engagement. What would this look like at the LHIN level if HR was a shared service? How would you measure it?

Kingston General Hospital (KGH) is the largest hospital within the SELHIN and is well-known for its focus on patient and family-centred care. In fact, KGH has a deep commitment to their strategic direction of "Outstanding Care, Always," which includes bringing to life patient and family centred care and driving higher employee engagement

to achieve this direction. They espouse the research that suggests a deep interconnection between patient and family centred care (PFCC) and employee engagement as essential for better hospital performance (Lowe, 2012). If there is great organizational value in deeply engaging employees and practicing patient and family-centred care – how would you marry the two beyond the boundaries of the organization to bring regional value across the breadth of the SELHIN?

Although the outcome of the shared hospital service model is still to be finalized, it is within this context of Healthcare Tomorrow, the Hospital Services Initiative, and the proposed shared service model for HR functions charged with building and measuring employee engagement in particular that this study explores the future value of employee engagement through the lens of patient-centred care.

The Question

Using an approach that combines research methods and foresight methods, this study explores the evolution of the organizational value of employee engagement and patient-centred care to the SELHIN hospital framework. The research question asks: How might healthcare organizations resolve the challenges to full employee engagement in the indeterminate contexts of patient-centred care?

Exploration and consideration of this question will elicit considerations and recommendations that can serve as a potential road map for how the SELHIN might approach employee engagement and patient and family-centred care and may be a first step in understanding new domains of engagement and the flex between regional and organizational dimensions, revealing where the value lies in reframing engagement in the context of patient-centred care.

The Approach

The research and design methods depicted in the model below provide a framework of the approach taken in this study to address the questions outlined in the previous section.
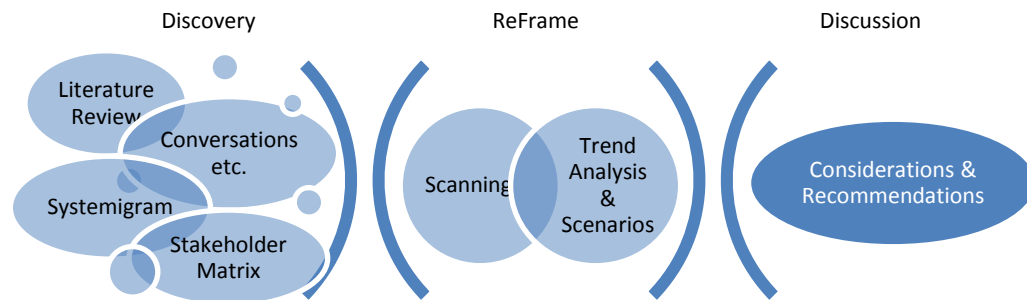
Figure 2: Framework for study

The study combines research methods and foresight methods culminating in the creation of a Blueprint document that will be critiqued by experts in the field. Table 1 depicts how each method relates to the queries or questions posed.

Table 1: Research question aligned to research method

Query	Discovery				ReFrame		Discussion
	Literature Review	Conversations/ Observation etc.	Stakeholder Matrix	Systemigram	Environmental scanning	Trends analysis and Scenario	Recommendations
How might healthcare organizations resolve the challenges to full employee engagement in the indeterminate contexts of patient-centred care?	X	X					

Who are the stakeholders involved and what is their relationship?			X	X			
How are systems within the region working together to achieve optimal employee engagement and patient-centred care?	X	X		X		X	
How could this reframing be sustained?					X	X	X

Literature Review

The study built upon a focused literature review that then informed the creation of interview questions for the completion of semi-structured interviews with identified stakeholders. The goal of the interviews was to investigate the key factors that influence engagement and delivering patient-centred care within a specific organization that can be expanded to the region.

The review explored the domains of organizational behaviour studies, leadership studies, sociology of the work practice and workplace learning and enablement, engagement and professional practice, physician engagement, patient engagement and service design for health.

The review revealed that although there is extensive research on employee engagement, the research on patient and family-centred care is less extensive, and research that considers the relationship between both is emerging at best. Reviewing literature from all of the above domains allows for a "stock-taking" of the environment and allows for powerful questioning of the status quo.

It also allows for a deeper questioning in the field research that looked to consider the value of shared meaning for both engagement and patient and family-centred care.

Observation, Conversations, and Semi-structured Interviews

The observations were done over a full year period with data provided by employees during an employee event. Employees were asked to submit an answer to the question "I'm fully engaged when…" and then submitted their answers. 82 answers were submitted.

The conversations were held over the same year period with Leaders in the organization and included discussion of progress on the engagement plans they had built with their teams for the coming year. The conversations were conducted with 25 Leaders from all levels of the organization (Executive, Directors, and Managers).

Semi-structured interviews were conducted with 10 organization participants including 4 Patient Experience Advisors (proxy for patient perspective), 3 employees, and 3 physicians (two from the Emergency Department and one from Critical Care). Participants were asked a series of 10 questions (see appendix) divided into two sections: Patient-Centred Care and Engagement.

The research tools or approaches were robust enough to gather research data from the "spread" of the question posed, offering a holistic view of the situation and examines the beliefs, behaviours, and organizational culture and current practices surrounding employee engagement and patient-centred care.

Stakeholder Matrix & Systemigram

A stakeholder matrix and systemigrams were created as artifacts that provided further insight to the boundaries of employee engagement and patient-centred care and how they effectively present in relation to their environment and overall system. These artifacts demonstrate the relationship and the complexities of employee engagement and patient-centered care individually and when considered together.

Environmental Scanning, Trends Analysis and Scenario Creation

Much of the field research to this point has focused on internal factors and stakeholders. In order to gain a sense of what is happening in the external macro environment, scanning was done against the STEEP-V framework to capture data for analysis, and to see the shape of trends and potential drivers to help identify potential opportunities and threat. This scanning exercise allowed for deeper analysis across three time horizons and the creation of scenarios. All of which allowed for the development of a coherent and functional forward view and model to put into action.

Discussion

Recommendations can serve as the start of a roadmap for how any LHIN in Ontario or any similar group of organizations may move from conceptual framework to action. The recommendations will focus on how to measure and monitor both employee engagement and perhaps improving ways of building patient-centred care behaviours.

Ideas for additional research are suggested to further investigate or test theories and ideas presented in this study.

Literature Review

The literature review was earlier described as robust as it starts with the researchers own connection to KGH, followed by an exploration of the legislative framework, the evolution of patient-centred care, the evolution of employee engagement, a dive into the meaning of organizational commitment, and then considers engagement survey methodology and finally transitions to consider a reframing of engagement through the lens of patient-centred care.

What attracted me to Kingston General Hospital (KGH), was a stated deep commitment to their strategic direction of "Outstanding Care, Always," which included bringing to life patient and family centred care and driving higher employee engagement to achieve this direction. Subsequent research suggested a deep interconnection between patient and family centred care (PFCC) and employee engagement as essential for better hospital performance (Lowe, 2012).

In fact, the Ontario Government officially cemented the two domains when they passed The *Excellent Care for All Act* (*ECFAA*) into law in June of 2010. The Act puts "Ontario patients first by strengthening the health care sector's organizational focus and accountability to deliver high quality patient care." One of the sections demanded by the Act is that hospitals (among other organizations) must perform patient and employee surveys every two years to measure how organizations are performing or delivering on the high quality of patient care promise.

The idea of patient-centred care has its rediscovered beginnings in the early

1960s (Whitaker, 2014) and definitions and descriptions are as varied as the years

between now and then. Research undertaken by the Tuke Institute in defining and

disambiguating patient-centredness concluded that "patient-centredness continues to

be defined largely in physicians' terms and framed by the characteristics of national,

professional or financial systems." In fact, the study suggests that "the definition of

patient-centredness changes according to the system in which it is expressed" (Whitaker

2014).

Whitaker puts forward a definition of patient-centredness as a specific model of

medicine that is about delivering services and products that help people get well and

stay well. It encompasses two core pillars: health effectiveness and health efficiency.

These two pillars are strongly intertwined and supported with specific values. These

values include a model that is *ethical, collaborative, meaningful, empowering and*

trustworthy. The definition goes further to adopt the World Health Organization's

definition of Health and Wellness, "a state of complete physical, mental and social well-

being and not merely the absence of disease or infirmity" (WHO, 1946).

Whitaker asserts that often what we see in popular literature or as part of

strategic plans for healthcare organizations are elements that are veneers for a

physician-centred model (Eijk, 2011), a model that is organized mainly from the

physician's perspective, which persists beneath the surface. Whitaker notes, specifically

around the definition of health *efficiency* that "nursing is the only fully biopsychosocial

medical profession." The biopsychosocial approach is defined as considering "biological,

psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery" (Frankel, 2003). If we truly want to create patient-centred health services we need to examine our own understanding of what patient-centredness is, create a system where the above noted characteristics can naturally emerge and reassess the methods we have been using that perpetuate the veneers and offer little value in the quest to achieving patient-centredness or patient-centred care.

The interconnection of patient-centred care and employee engagement urges us to re-examine how we consider employee engagement and indeed how we measure it and reassess the methods we use to drive both in our organizations.

According to an article published in Forbes magazine, writer Rodd Wagner (2015) considers the end of what we have come to know as employee engagement. He asserts that the concept of employee engagement became popularized in the 1990s as the output of a study published In the Academy of Management Journal. In this study, William Kahn (1990) defined engagement as "…the behaviors by which people bring in or leave out their personal selves during work role performances. I defined personal engagement as the harnessing of organization members' selves to their work roles; in engagement, people employ and express themselves physically, cognitively and emotionally during role performances." Many other studies have defined engagement as the amount of discretionary effort employees give back to the organization in exchange for working in an environment that motivates and cares about them (Briner, 2014).

An entire industry now exists with a multitude of consultants who help organizations build and sustain employee engagement. Additional studies have demonstrated consistently that employee engagement is linked to driving a range of preferred business outcomes such as "employee performance and efficiency, productivity, safety, attendance and retention, customer service and satisfaction, customer loyalty, and profitability" (Lowe, 2012).

Given the information derived from the 2014 Gallup survey (O'Boyle et al., 2013) on employee engagement that concluded after 10 years of focus, the needle has moved very little in terms of building employee engagement in organizations via the various tactics employed.

A recent cross-sectional study done on Employee Engagement in the NHS, the UK National Health Service proposes a strong connection between engaged employees and better patient care and a better patient experience. The study employed the Utrecht Work Engagement Scale that is an internationally valid measurement tool that measures engagement along three dimensions: vigor, dedication and absorption. The results of the NHS study demonstrated a low score on the first two dimensions and a high score along the absorption dimension. The UWES characterized vigor as "energy, mental resilience, the willingness to invest one's effort, and persistence" and dedication as "a sense of significance, enthusiasm, inspiration, pride, and challenge". Absorption was defined as work going by quickly and difficulty disconnecting from work. The study demonstrated that although employees were absorbed in their work, they were absorbed without energy and enthusiasm. The study did not offer any conclusive

strategies to help build a higher return on vigor or dedication or any strategies on bringing a balance to all of three dimensions.

Subsequent studies distinguish between the connections of the employee to work task versus the connections of the employee to the organization itself (Jeve et al., 2015).

The concept of organizational commitment as developed in the fields of organizational behaviour and psychology have constructed models that look at an employee or individual's psychological attachment to the organization making the connection between how employees *feel* about their jobs and if that could be improved would cement the employee's commitment to the organization.

The work of Meyer and Allen and the three-component model of commitment (Meyer, Allen 1991) in this domain is an exemplar: "…we go beyond the existing distinction between attitudinal and behavioral commitment and argue that commitment, as a psychological state, has at least three separable components reflecting (a) a desire (affective commitment), (b) a need (continuance commitment) and (c) an obligation (normative commitment) to maintain employment in an organization. Each component is considered to develop as a function of different antecedents and to have different implications for on-the-job behavior. The aim of this reconceptualization is to aid in the synthesis of existing research and to serve as a framework for future research" (Meyer, Allen 1991).

Meyer and Allan go on to suggest that a strong affective commitment aligns with *wanting* to stay with an organization (alluding to a deep emotional attachment), while continuance commitment aligns to the *need* to stay, while normative commitment has employees feeling like they *ought* to stay. Three connected components that represent a continuum of reasoning as to why any one employee would remain with an organization and the study does go on to suggest that "employees who want to belong to the organization (affective commitment) might be more likely than those who need to belong (continuance commitment), or feel obligated to belong (normative commitment) to exert effort on behalf of the organization" (Meyer, Allen 1991). The study also notes that using affective measures of commitment report positive correlations to enabling performance. The field research done for the purposes of this study will explore how the data aligns to the three component model, or perhaps to supporting the affective component as a function of unpacking "wanting to stay" as connected to work task.

The connection to work task is interesting as it may lead to an examination of job design within the context of employee engagement. In healthcare there is evidence of physicians and nurses having a commitment to their profession as if to say they had a "calling" to serve in this way, which emphasized their connection to the work task versus any strong connection to any individual organization. Yet when we issue employee engagement surveys we ask about connection or loyalty to the organization. It raises the question are we driving the right behaviours at the right moments to derive the most value towards achieving a given goal? Are we creating and designing jobs and

works tasks to support engagement and patient-centred care? Are we measuring the right behaviours? Are measured engagement factors superficial distinctions in order to show progress in surveys? Are these veneers that need to be peeled away in our current approach to employee engagement?

One study suggests that a successful implementation of patient-centered care is inherently designed to improve patient outcomes and employee and organizational outcomes (Balbale et al., 2014). This would indicate that such an implementation would be a form of transformational change that could potentially impact health services in significant ways. It is arguably organizational factors that can either help or hinder the adoption or acceptance of new ways of practice (Oostendorp et al., 2015).

KGH completed, as legislated, their first ever employee and physician engagement survey in 2012 and had developed a process to communicate the results to each individual team and tasked leaders to build engagement plans based on the results to help fill the gaps that were uncovered in the survey. Indeed the administration built a corporate engagement plan to help fill the gaps that were uncovered in predictable areas such as recognition, building a culture of trust, and providing opportunities for education and career development. The survey currently used at KGH uses a six item scale that measures key concepts that researchers have identified as being central to the concept of engagement (Lowe, 2012).

The rating of engagement is a cumulative rating based on the percent positive scores across the following six questions (Lowe, 2012):

1. I am proud to tell others I am part of this organization.

2. I find that my values and the organization's values are similar.

3. This organization really inspires the very best in me in the way of job performance.

4. Overall, how satisfied are you with your current job?

5. How frequently do you look forward to going to work?

6. Overall, how would you rate (name of hospital) as a place to work/practice?

The survey asks additional questions in regard to different dimensions of care (Lowe, 2012):

- Job
- Work Team/Unit
- Supervisor
- Organization
- Infection Control

- Health and Safety
- Training and Development
- Patient Care
- Patient Safety
- Non-Clinical and Support Services

The above process and approach to engagement surveys follows a common approach of what many engagement consultants and survey purveyors would offer with the desire to achieve some of the business outcomes such as better employee performance and efficiency, more productivity, safety, better attendance and retention, better customer service and satisfaction, more customer loyalty, and more profitability.

It is interesting to note that 4/6 of these questions speak strongly to organizational connection.

The organization conducted their second survey (Autumn 2015) with early results revealing a slight organizational increase in overall employee engagement (<3 percentage points). Results also demonstrate that areas of focus did show positive results.

In my estimation, if high engagement of organizational participants is necessary to achieve patient-centredness, and surveys of various kinds are indicating low engagement amongst employees, we need to examine what we mean by "engagement" and what we measure in terms of "engagement" as well as examine what we mean by and how we measure "patient-centredness." In its current state, achieving high employee engagement is set as a management goal that is a pursuit with a defined end-state, which is perpetuated by the survey purveyors and engagement consultants. Evidence is presented to the contrary that although on the surface engagement and patient-centredness seem elusive, it is our viewing of them that needs to shift and organizations must see both as a living process.

Reframing Engagement in context of PFCC

Given that current focused efforts are not producing desired results on the employee engagement front a reframing is necessary if we are to expect different outcomes. How might we reframe the concept of engagement in the context of patient-centredness and outside the context of an organization? What if we were to consider engagement as deeply rooted in the affective commitment component, as a partnership based on the concept of reciprocity, or the idea that, "employees are driven by reciprocity – motivated by principle, a sense of obligation, and the satisfaction of doing something good for someone else" (Schachter, 2015). Employee engagement and patient-centred care are not only connected but are in fact interconnected in a sort of feedback loop that demonstrates that the level of employee engagement has a direct influence over the execution of patient-centred care and better patient outcomes.
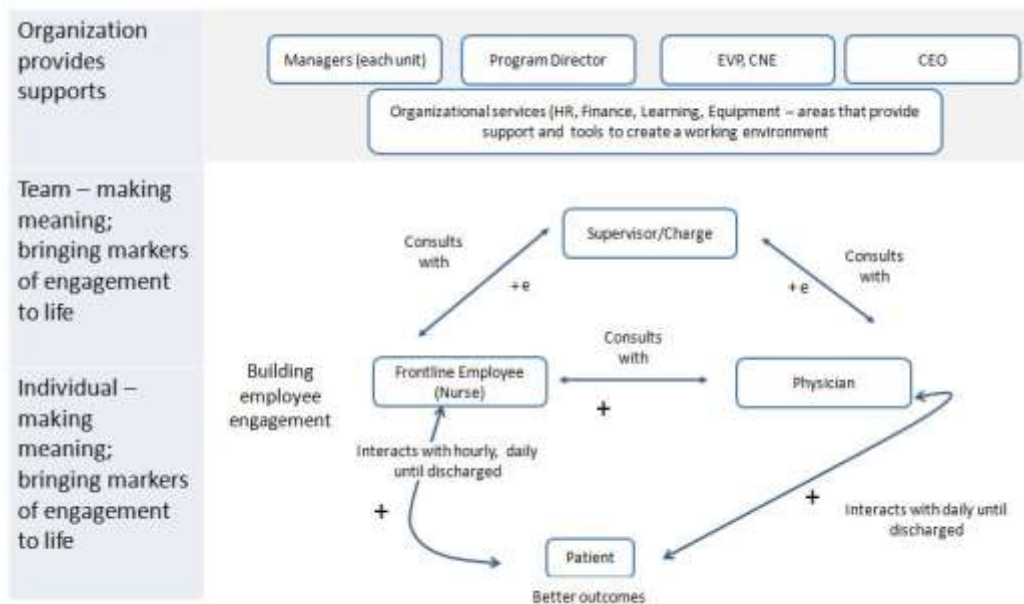
Figure 3: Relationship between patients, employees/caregivers and the organization.

What would this model look like mapped to a specific organization or within a region? How would it impact job design and work tasks? How could it be sustained over time?

Given this view on the subject, when we think about the earlier presented definition of patient-centredness, the definition would extend to include any and all clinicians, and arguably any person supporting the health and wellness of the individual, as practicing medicine or giving care and working toward patient-centredness. It allows for the expansion of the boundaries of caregiving (Jones, 2013).

This speaks to examining how these team members or caregivers interact with each other in the context of their practice. In his BBC Reith lectures, Dr. Atul Gawande spoke about the future of medicine and alludes to the idea that what brings about better patient outcomes are teams of people working better together - continuously improving - and breaking down the barriers to caring (Gawande, 2014). The premise of his lecture was that given the complexities of healthcare particularly on a global scale, there are specific changes we can bring to the practice of caregiving that focus on some fundamental aspects of working with others. He calls for action in terms of more collaboration with others towards a shared vision across systems that bring about better healthcare (Gawande, 2014). Could Gawande's implication of a human-centred, systems thinking approach be scaled to work at the level of the South East Local Health Integration Network (SELHIN) or at the hospital level with KGH? How might the application of systems thinking at the LHIN level bring forward a shared vision of employee engagement and patient-centred care?

Current literature calls for additional research to work to find a common definition (Briner, 2014) or a shared meaning of what organizations are trying to create in order to align or orient an organization's employees or caregivers to bring the shared vision to life in meaningful ways.

A significant organizational factor in creating shared meaning is leadership. One article put forward the idea that although the role of a leader has generally been about offering a vision and then direction to others, the real role of a leader involves "bringing people's ideas together to create a shared vision that everyone can call their own." This idea has been developed by Henry Mintzberg and refers to his theory of communityship (Mintzberg, 2015) and the need for a "better balance between the place taken by the leader and the recognition of collective processes as sources of vitality for organizations and our societies." These collective processes are really an organizational network that works optimally if there is a deep capacity to lead by creating shared meaning. By definition a network involves the sharing by all its actors of a common vision, of values and principles. The foundational glue that holds the network together is the question of "what do we want to do together." This notion speaks to the importance of factoring in the views of employees, patients, and other direct stakeholders when establishing goals or vision, as this will tie into engagement, which facilitates in turn patient-centred care.

If what Bodenheimer and Sinsky offer is correct that "health care is a relationship between those who provide care and those who seek care, a relationship that can only thrive if it is symbiotic, benefiting both parties" (Bodenheimer and Sinsky, 2014), then the idea of communityship connects seamlessly with the notion of the quadruple aim.

In 2008, the executive members of the Institute for Health Improvement (IHI) in the United States introduced what has become known as the "Triple Aim" whereby they asserted "the United States will not achieve high-value health care unless improvement initiatives pursue a broader system of linked goals" (Berwick et al, 2008). The authors went further to describe what these goals were, as such they "…call those goals the "Triple Aim": improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations" (Berwick et al, 2008).

Recent literature refers to the notion of the "quadruple aim" whereby caregivers are a noted stakeholder in the quest to achieve high-value healthcare and their well-being must be considered and addressed, "…the stressful work life of our clinicians and staff impacts our ability to achieve the 3 aims. These sentiments made us wonder, might there be a fourth aim—improving the work life of health care clinicians and staff—that, like the patient experience and cost reduction aims, must be achieved in order to succeed in improving population health" (Bodenheimer and Sinsky, 2014).

The connection is also made to the practice of patient-centred care and the argument is made that if organizations and societal constructs continue to ignore this aspect of caregiver as "burned out and disengaged" (Bodenheimer and Sinsky, 2014), specifically in primary care, but arguably present across dimensions of care, "the feelings of betrayal and the wearing down from daily stress voiced by primary care practitioners will grow. The negative impact on patient-centered care will be deep and long lasting. On the other hand, if an emphasis on the workforce comes at the expense of patients' needs, this focus could have negative consequences" (Bodenheimer and Sinsky, 2014).

One current approach to building patient-centred care through patient engagement involves a multidimensional framework for patient and family engagement within a hospital or similar organization (Carman et al., 2013). The creators of this framework describe it as a "continuum of engagement" and highlight the touchpoints of patients in decision-making moments across three levels of engagement: direct care, organizational design and governance, and policy-making. KGH offers an example of how this framework has been somewhat implemented and will be explored further in this study (Carman et al., 2013). Technically not a continuum of engagement, it betters describes potential levels of engagement and a structure that sets constraints for each level below. This framework relies heavily on specific decision-making moments yet considers only direct caregivers and not all organizational participants. Given the importance of all organizational participants in the delivery of patient-centered care, obtaining their buy-in, involving them, and understanding their unique perspectives are essential components for evaluation and quality improvement (Lowe, 2012; Wakefield et al., 1994), a critical examination of this framework needs to be considered as the boundaries of the system considered are too narrow.

The concept of relationship is clearly noted in the literature on the "quadruple aim" and there is evidence of moving toward an integration of patient-centred care to relationship-centred care, which is not a new concept in itself but seems to be experiencing a form of resurgence. Relationship-based care is based on three caring processes: the relationship with the patient and family, the relationship with self and the relationship with colleagues (Rodney, 2015).

This exploration presents an opportunity to create shared meaning to strengthen the core concepts of engagement and patient-centredness. It also allows for a new form of engagement to emerge, and invites a rethinking of the process of care that can potentially yield positive outcomes for patients, employees, and hospital systems.

Field Research

Over the next several pages, the study will introduce you to Kingston General Hospital (KGH). KGH serves as southeastern Ontario's leading centre for complex-acute and specialty care, and is home to the Cancer Centre of Southeastern Ontario. KGH serves, through its Kingston facility and 24 regional affiliate and satellite sites, almost 500,000 people who live in a 20,000-square-kilometre predominantly rural area, as well as some communities on James Bay in Ontario's north. KGH is also fully affiliated with Queen's University and serves as a teaching facility as part of the Canadian Academic Hospital Association (CAHO). KGH has approximately 7,000 caregivers in the form of physicians, clinicians, learners, volunteers, and employees.

KGH is the location where much of the initial field research for this project took place in terms of conversations, observations, and semi-structured interviews. Although KGH is just one of the seven hospitals within the SELHIN, it is the largest and provides a robust cross-section of employees or caregivers. The people interviewed are a diverse range of stakeholders including front line employees, physicians, nurses, and several patient experience advisors, who represent the patient perspective.

This study presents the findings from the traditional methods of data collection and then employs foresight methods and techniques to identify trends, drivers and implications in this space for potential futures, along with a set of possible scenarios inspired by the field research to bring those futures to life. As such, the study will also

encompass an experience critique by experts in the fields of both employee engagement and patient-centred care to test the future possibilities.

Data and Insights

The selected approach for this study anchors on grounded theory methodology, defined as "a general methodology for developing theory that is grounded in data systematically gathered and analyzed" (Strauss and Corbin, 1994). Grounded theory methodology is "an inductive process of constructing meaningful claims and theoretical proposals from the emic data from participants, by analyzing and coding statements in the data that correspond to developing categories" (Jones, personal communication, 2016). In addition, acknowledging that knowledge and wisdom are summaries of analyses and data is the holistic synthesis of the research:

1. **Data:** Observation notes were taken; conversations notes were taken and semi-structured interviews were recorded and/or transcribed.

2. **Information:** Key points were identified and transcribed onto sticky notes and meaningful references were derived from common or repeated data points.

3. **Knowledge:** Data were extracted and salient statements organized to identify for meaningful themes and relationships.

4. **Wisdom:** Key insights were developed from the wall exercise and theme extraction exercise. Analysis of the DIKW from each data set led to the development of the proposed go forward approach and recommendation.

Observations

After the first ever Employee and Physician Engagement survey was conducted at KGH, an Interprofessional Expo was held onsite in the Spring of 2014. The Leadership and Learning team had a table at the expo and for a door prize, organizational participants could submit an answer to the question, "I'm fully engaged when…" The answers provide a "point in time" indication of what engagement meant to them. There were approximately 82 answers submitted.

"I'm fully engaged when…"

There were two submissions that answered "…everyday when I come to work" and "I am fully engaged when I start my work" that might indicate that these employees are likely to find great enjoyment of work task , and the attribute of "everyday" tying to the notion of attendance and "showing up."

There were three submissions that referred directly to the notion of positivity in the workplace, which is interesting in respect to major approaches to engagement being anchored in positive psychology and approaches such as appreciative inquiry.

Some seemingly random answers could have connections to being appreciated, valued and supported and the removal of barriers to providing care.

Figure 4: Markers of Engagement

The stronger themes that emerged were around **communication** and **recognition**, and having opportunities to **learn and grow.** The strongest themes that emerged were **continuous improvement/involvement/working on challenges and helping others/serving patients,** and **working in teams.**

Out of the 82, there were approximately 23 (~30%) that actually mentioned patients and families in their answers. This emphasizes a connection between the work task, patient care, and engagement levels in this sample group. A significant number of answers (~60%) also **refer to "working" or the work task and are mostly active in definition and written as such by each individual** as, "helping," "contributing," "making a difference," "learning." This insight connects to findings in the literature review around the notion that people in health care feel that they have a calling/sense of duty, and that their engagement is more tied to the task than the organization. This insight fuels the need to rethink

Figure 5: Categorization and analysis of engagement conversation output

how engagement is framed. *If it's these "actions" that are making people feel more engaged what is it about their "work" that stifles this?*

Engagement Conversations

As per organizational process, each leader was to have completed an engagement plan for them and their teams that stood as an action plan with tactics to accomplish for each quarter. Engagement conversations can be defined as informal dialogue around the topic of "engagement" from what specific leaders have developed with their teams towards working better. Mostly one hour in length, the leaders would present their established plans and describe events, feelings about events, perceptions of progress/no progress, or present perceived challenges and barriers. This document considers the content and context these conversations with 25 Directors and/or Managers within the organization on how they were building engagement with their teams. Most often the conversations would begin in the form of a "report back" on the management task given by administration to provide a status update on progress against their engagement plans. These conversations were part of an initial planned touch point to check progress on the plans. It is interesting to note that although conversations began as more transactional in spirit, the majority of them ended in a demonstrated desire to create an environment where employees gave input and shared the responsibility of engagement to their jobs. Also interesting to note was that each conversation would start with a "confession" of sorts where the manager would say they have not done very much, or accomplished very much during the quarter. The continued conversation and sharing of stories however revealed much had been accomplished and achieved yet the things done were not recognized or defined as "engagement tactics" and therefore again speaks to the notion there is not a shared understanding or meaning of what engagement is or what a high level of engagement would look like.

Additional observations were captured via two social events. The first event was a Healthy Workplace Expo, where staff completed a submission form answering the question "what does engagement mean to me?" and then placed their response in a jar for a prize draw. The second occasion was plotting a speech bubble sticker on a map of the organization, noting their physical attachment to an area within along with a note answering the question "what does engagement mean to me?"
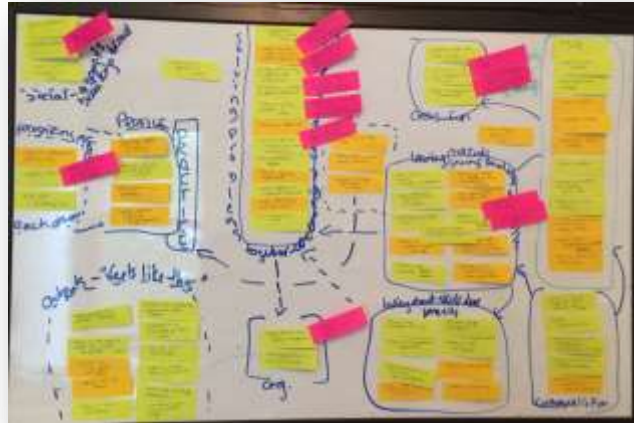
Figure 6: Emerging Data Sets.

These data sets bring together impressions of thought from both leaders and staff members. As indicated in figure 5, the yellowish sticky notes represent the tactics gleaned from conversations with leaders, and the pink sticky notes represent tactics noted by staff members via observation. While reviewing the individual data, connections were made and themes were identified, with further thought given to how the themes interact and inform each other. First pass placed notes that shared a common description such as the 11 notes that spoke to having team huddles or meetings, having them more frequently, sharing host of the huddles, and defining the huddles or meetings as a place to share updates and communicate. The five remaining notes categorized under the theme of communication spoke to a specific identification

of a need for better communication, more of it and giving a voice to those who don't

usually use their own.

Figure 6, displays the interconnections and some of the emerging themes along

with potential relationships between the themes. Distilled further, each theme has been

categorized via an active descriptor that implicates each one in the creation of

engagement at KGH. The numbers in brackets refers to the number of overall comments

that fell into each identified category. The red number in brackets denotes a reference

to the patient.
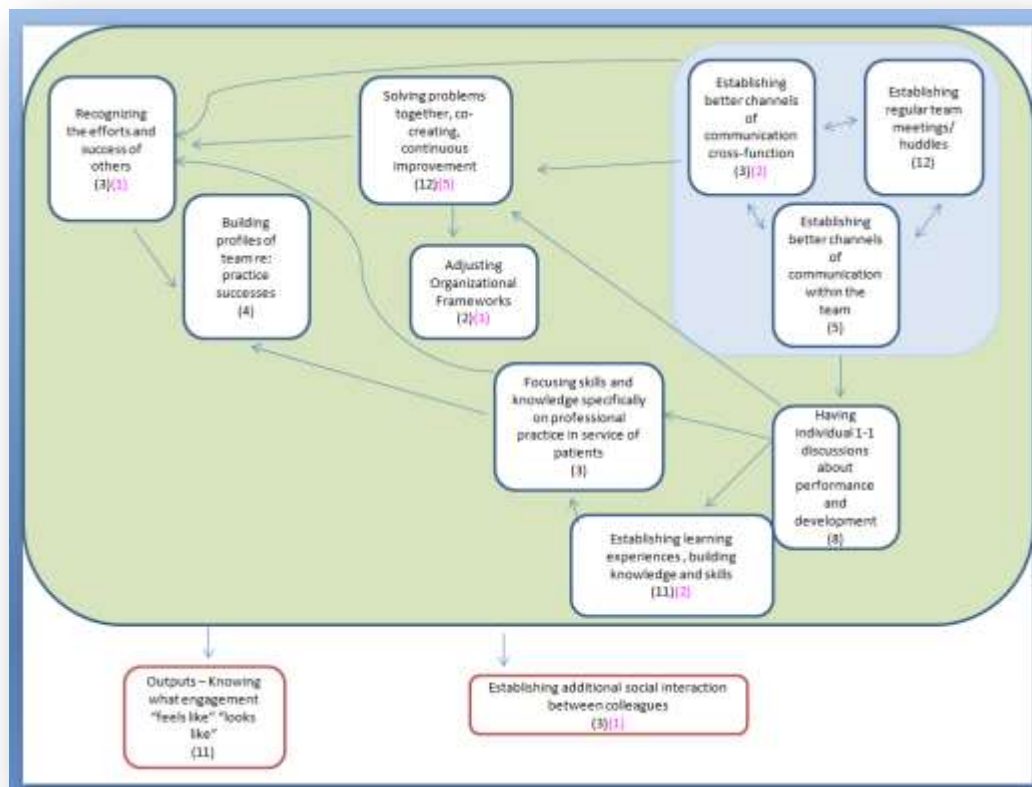
Figure 7: Interconnections and Emerging Themes

To organize the elements of the analysis, the operative question was considered by the researcher of how might an organization build engagement between each organizational participant?

The data was distilled into the following 7 responses:

- Creating opportunities and channels to communicate with others

- Creating space to talk about learning and performance

- Creating an environment that supports and allows employees to learn and perform

- Finding ways to focus deep in craft/practice

- Creating spaces to co-create/problem solve/continuously improve

- Creating opportunities during the work day to recognize each other

- Creating meaningful ways to raise profile of team successes

All of this creates bonds where people want to commune with each other (social interaction, i.e., eating lunch together, baking competitions, drinks with colleagues after work). This leads to an ability to describe what engagement "feels like" or "looks like" and **reveals tangible and measurable markers of engagement.** This adds to or supports the difficulty associated with finding shared meaning of engagement and calls for a deeper exploration on how to create shared meaning.

If we compare the above data to what organizational participants revealed earlier, similar shared themes emerge that are common to both and are defined as the markers of engagement (see Figure 3).

Semi-Structured Interviews

Before this study examines the data provided by the interviewees, it is important to share the official definition of patient and family centred care at KGH. It is as follows: "Patient and Family Centred Care at Kingston General Hospital is healthcare based on a partnership among practitioners, patients and families (when appropriate). Its goal is to ensure decisions respect patients' needs, values and preferences. Its outcome provides patients with information, knowledge and support to participate in their care as they choose."

The structure of the interview question set offered parallel questions on the two subjects: patient-centred care and employee engagement. The question set attempted to extract the benefits of each, descriptions of what they look like and where they could go in the future.

One overall confirmation from the interviews was that every single person interviewed believed that engaged employees (organizational participants) have a positive impact on the patient experience and better patient outcomes.

The insights gleaned from the data demonstrate no shared definition of patient-centred care. A clear confusion surrounds the definition as some of the examples brought forward by interviewees are more comfortable in a patient

experience category (ala customer service experience) vs a patient-centred care category. Much of the data collected around the definition is not aligned to how the concept is brought to life within the organization. Again this speaks to the difficulty associated as well with finding a shared meaning not only for engagement but also patient-centred care.

More than one interviewee, notably physicians, acknowledged the intersection of the re-emergence of patient-centred care as now defined by KGH and other groups as "a politically correct term for a new movement that borrows from the customer service models of the business world and tries to bring it to healthcare to make sure patients *feel* like they have a positive experience."

Worth noting from one interviewee is the timing of adoption and the perception that PCC emerged about the same time as budgets were being cut so this movement is seen in some circles as manipulative in nature. If we don't have the money for giving good care then we can "trick" patients into thinking we have "done a good job." The idea that PCC is "not about giving good care but rather making sure patients feel like they have had a positive experience." The idea that if a patient is "satisfied with a meal" or "if a patient thinks it was good" completely dismisses that in a care giving context, physicians, nurses and other members of the care team are in their professions because they care and indeed took an oath to provide good care, in fact the best care possible. It was also noted that there may be interplay between the emergence of this movement not only with budget cuts but also a method to deal with patients who offer negative feedback or complain publicly about a given experience. In this way, this practice of

patient-care defined as patient experience was felt as something that was "bad for healthcare."

Common themes that emerged from all participants around the question **"what does patient and family care look like?" were respect, communication, partnership, decision-making, listening, being responsive, and partnership in care**. The definitions grew from simple, concise definitions "care that accounts for others" or "care that takes into account the patient and the family's involvement in whatever course of action is being taken." It is unclear if the notion of "taking account" has anything to do with real involvement or inclusion in any decision making process. Other definitions evolved to using language of partnership and considering the other specifically around making decisions. In many ways the majority of definitions were centred around decision making and intentional inclusion of the patient and family at the point of care but more interestingly "higher up the chain" of decisions that are made at an administration levels. One interviewee (a patient experience advisor) distinguished between patient-centred care at the individual level between patient and members of the immediate care team, which is an important evolution but felt the real shift in patient-centred care is the involvement of patient's at a level to influence decisions that potentially impact how care is delivered across the entire organization. This speaks to how patient-centred care is implemented at KGH.

One of the main initiatives is the creation of the role of Patient Experience Advisor, which is a volunteer position. One of the tactics that KGH has used to embed patient-centred care into the organization is having the volunteer PEA involved in

meetings or events that have "a material impact on the patient." These meetings include taking part in recruiting activities like interviews, being part of board committees such as Performance and Planning and being part of different professional practice councils so KGH ensures that the patient voice has a platform to be heard. A critical view of the current role of the PEA indicates it may have outgrown its value in its current form. There is evidence that the initial inclusion of patient experience advisors in meetings and such has had positive impact and an "awakening" of "taking others into account when giving care."

At KGH, a former CEO introduced a checklist known as the Patient-Centred Leadership Checklist. The intention of the checklist was to help drive things an individual leader could do to foster patient engagement and patient-centred care in their own organization. It consists of five questions:

1. Does the decision I am making have a material impact on the experience of patients? If so, was a patient at the table to help shape it? If not, what steps will I take to fix this?

2. What have I done to give a voice to the patient if they are not there to do so themselves?

3. Have I "people-ized" the numbers I am looking at today?

4. What have I learned from a patient today?

5. What story have I shared about something that made a positive difference to the experience of patients in my organization today?

What impact might it have if you were to add or substitute the word "employee" where you see patient in this list? Would it change the overall approach to employee engagement?

This is an intriguing point especially given the notion of high employee engagement producing better patient outcomes and high employee engagement as intermingled with patient-centred care. Why do we not have a frontline employee at the same tables? If we hold employees to the same level and align to the KGH definition "nothing about me without me" for them this would contribute more to a partnership of considering the other. Questions of providing care that looks "at a partnership with the patient to ensure they have a say in the decision making process for their care." What if we substituted the word employee with patient or added the word employee and patient? What if we focused on the relationships between caregiver and care-receiver (patient) and caregiver to employer? What if we were to explore an organization that looked at "a partnership with an employee to ensure they have a decision making process for their work" would it impact how we do "business"? What would the outcome be in terms of measuring employee engagement and this type of care?

Stakeholder Matrix

The key stakeholders include provincial and federal governments in how they set standards and directives for each LHIN and then the LHIN sets priorities for each hospital to implement (i.e. required Quality Improvement Plans). Other key stakeholders connected to this chain include Hospital Boards, Hospital Senior Leadership, Physicians, and Employees (direct and indirect patient care). Outside of this direct chain of stakeholders we have Patients, Families, Patient Experience Advisors, and the community at large. The matrix (Figure 7) maps each stakeholder against a hierarchy of needs and general area of focus for each stakeholder group, along with an assessment of influence and power, interest and positive impact, and concerns and negative impact. There is a natural separation between the green cells and the purple cells as it shows the current "chain of command" on the power spectrum. The green cells denote an emerging level of influence based on a mutual purpose of quality of care.

Red text indicates the "deep" stakeholder meaning those stakeholders who hold relationships with each other that impact the moments of engagement as it relates to the job task at hand, which would be care giving with a patient as part of a team.

It's noted that some stakeholders come with a larger sense of self-interest depending on who is accountable for the work they do. This presents complex patterns of relationships at higher levels within the organization. At the patient care level other complexities inform levels of engagement and levels of patient-centredness as defined

by patients and families. As more complex conditions become the norm and as gridlock

or patient flow challenges becomes a frequent occurrence the more stress is placed on

patient care teams for both employee and physician populations.

Stakeholder	Main Focus	Influence & Power	Interests & Positive Impacts	Concerns & Negative Impacts
Community	• **Quality of Care (all)** • Economic benefits (jobs etc.). • Fiscal responsibility	• Peripheral focus	• Impact to donations to hospital if all running smoothly	• Lose trust in hospital if negative impact or define in patient care becomes critical • Will lose the "best and brightest" if hospital declines in reputation
Families	• **Quality of Care (individual)** • Seamless transitions across health journey	• Focused on "getting family member better" • More informed patients may have more influence • Patient satisfaction surveys can be completed to voice opinion • Complaints handled via PSQR office via specific processes and policy	• Could play advocacy role • Key element of post discharge care (i.e., ensures patient gets what they need post-hospital stay)	• Sometimes works against what actual patient wants • Sometimes not engaged in the process
Patients	• **Quality of Care (individual)** • Seamless transitions across health journey	• Focused on "getting better" • More informed patients may have more influence • Patient satisfaction surveys can be completed to voice opinion • Complaints handled via PSQR office via specific processes and policy	• Is the centre of "patient-centred care" • Works "with" care team to make key decisions about care	• Wide range of patient populations to contend with and ultimately dealing with very sick people • Negative experiences have a negative impact on employee engagement, team dynamics and patient outcomes
PEAs	• **Quality of Care (all patients)** • Seamless transitions across health journey • Status of role within hospitals	• Sit on board committees to influence policy and process • Sit on many committees as non-voting members (can just offer opinion) so limited power	• See the connection between employee engagement and the impact on patient outcomes • Have brought a voice where there wasn't one	• Group in need of some re-invention as some concern they do not represent actual majority of patients at KGH • Shift into bringing more self-interest to the role (as perceived by employees and physicians) • Unable to remain in advisor role – shift to advocate – which they are not qualified to do • Seen as "token"
Employee	• **Quality of Care (individual and all)** • Quality of Workplace • Working in care teams	• 95% unionized so can take action via union • Most have direct relationship with patients and families or a direct impact on patient care • Influence via skills, expertise, sharing knowledge (teaching hospital)	• See the connection between employee engagement and the impact on patient outcomes • Very committed and passionate about the work they do – "higher purpose"	• Caught up in a culture where they believe the organization "needs to take care of them" – little initiative shown • At odds with administration
Physicians	• **Quality of Care (individual and all)** • Quality of Workplace • Working in care teams	• Unique relationship as not "employees" of KGH but more connected to Queen's • Direct relationship with patients and families or a direct impact on patient care • Influence via skills, expertise, sharing knowledge (teaching hospital) with residents and care teams	• See the connection between employee engagement and the impact on patient outcomes • Very committed and passionate about the work they do – "higher purpose"	• At odds with administration • Feel a loss of control from past role is physician-centred model

Figure 8: Stakeholder Matrix

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Stakeholder	Main Focus	Influence & Power	Interests & Positive Impacts	Concerns & Negative Impacts
Hospital Senior Leadership	• Quality of Care (all) • Fiscal responsibility • Quality of Workplace • Economic benefits (jobs etc.).	• **Reporting relationship is ultimately to the Board.**	• **See the connection between employee engagement and the impact on patient outcomes** • **Employees and physicians see their "felt" presence as an engagement builder**	• **Seem to expect quick results** • **More self-interest involved as pay structure based on performance** • **Recent employee and physician surveys would suggest relationship needs rebuilding (i.e., trust)**
Hospital Boards	• *Compliance* • *Fiscal responsibility* • *Quality of Care* • *Quality of Workplace*	• Overall governance • Engagement surveys fall under compliance (ECFAA)	• Seems to be interested in "people-izing"	• Seem to expect quick results
SELHIN	• *Better coordinated access* • ***Quality of Care (all)*** • *Efficient & Effective management (funding)*		Peripheral focus	Peripheral focus
Federal & Provincial Government	• *Fiscal responsibility (allocated value for funds* • ***Quality of Care*** • *Setting policies* • *Setting standards*		Peripheral focus	Peripheral focus

Figure 8: Stakeholder Matrix

Systemigram

A systemigram offers a visual representation of the overall architecture of any given system to help understand connection, disconnection, flow and gives a picture of how the system functions. Figure 8 depicts the current state of patient and employee flow within the seven hospitals that are within the SELHIN. What it demonstrates is that employee and patient flow transcend the boundaries of the SELHIN and the boundaries of any given hospital. Therefore they are shown below as a "placemat" upon which the systems of each other element are predicated. Meaning without patients or employees the hospital and SELHIN system would have no material reason to exist.

The systemigram clearly shows redundancy or duplication of efforts within the system as even though each hospital has a specific specialty or serves a specific need within the region, each hospital has a Board, Senior Leadership, some form of HR Services and some area within that measures patient satisfaction. From the lens of measuring patient-centredness and the measuring employee engagement, each hospital measures both but only within the boundary of each hospital. This means seven hospitals expend resources to collect engagement data on employees and physicians that may actually transcend the boundaries of the physical building. Patents certainly do. Data is not shared at a regional level even though patients (and sometimes employees) have experiences beyond the boundaries of one hospital. This is highlighted in the case of Kingston General Hospital and Hotel Dieu Hospital. Physicians work in

both locations and many employees do as well and many services are shared between

the two hospitals.

So if the question posed was where your loyalties lie, from the field research

many physicians would say Queen's, as that is their primary host. The field research did

demonstrate that actual loyalties had very little to do with any organization but rather

to the patient and teams of people working together to better patient care. So the main

insight is that flow patterns for patients and employees are pervasive across the system,

while measurement of engagement and/or satisfaction for both groups is inward to

each organization.
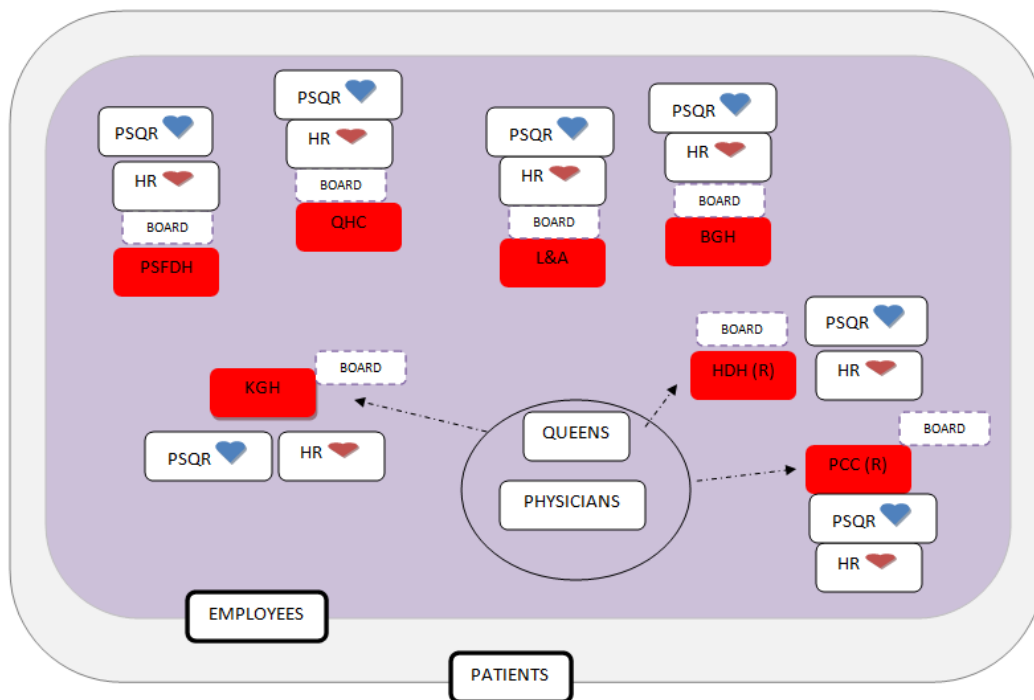
Figure 9: SELHIN Current State

(R)	denotes religious hospital
BOARD	Denotes hospital board
[blue heart]	Denotes Patient Satisfaction surveys
[red heart]	Denotes Employee and Physician Engagement Surveys
HR	Human Resources – typically takes care of Employee and Physician Engagement Surveys
PSQR	At KGH it is stands for Patient, Safety, Quality and Risk and they typically take care of Patient Satisfaction surveys and manage complaints.
PSFDH	Perth Smith Falls District Hospital – 600 employees
QHC	Quinte Health Care – 1700 employees
L&A	Lennox & Addington Hospital- 295 employees
BGH	Brockville General Hospital – 800 employees
HDH	Hotel Dieu Hospital (Catholic) 920 employees – Ambulatory Care
KGH	Kingston General Hospital – 3400 employees, 532 physicians, 500 residents – Complex Acute and Specialty Care; Cancer Centre of Southeastern Ontario
PCC	Providence Care Centre (Catholic) – 1700 employees – Aging, Mental Health and Rehabilitative Care
Queen's	Queen's University – KGH, HDH and PCC are all affiliated with Queen's University

Examining figure 9 and focusing on the aspect of recruitment there is typically a

PEA present to ask one question relating to how the potential employee defines patient-

centred care and how they will "bring it to life" in the role they are pursuing. As noted in

the figure 9, there is an exchange that could be positive or negative. Regardless of what

the feedback is, the PEA can only influence as they don't have an official vote on a

recruitment panel. This means there is no built in accountability to hire people who are

"in tune" with patient-centred care.
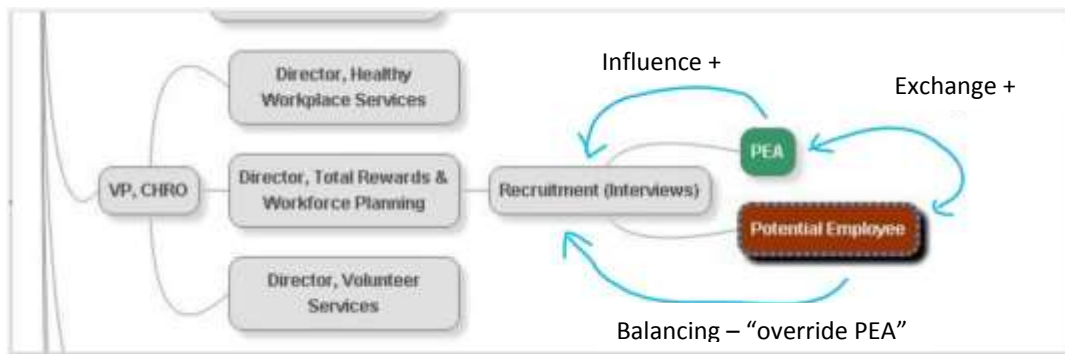
Figure 10: Recruitment relationships

Taking a closer look at KGH, the blue boxes in figure 10 indicate potential

moments of "patient" influence and the green boxes indicate potential influence of the

Patient Experience Advisors (PEAs) – basically the proxies for patients. The figure depicts

the hierarchy of the organization and where PEAs are engaged in either committee or

council work. Here is the vision and definition of patient and family centred care from

the Kingston General Hospital Patient Experience Advisor Handbook:

> *"Vision: The vision of the KGH 2015 strategy is that "our patients are fully in the*
> *driver's seat, participating meaningfully in every initiative that can influence*
> *their care and service." Your partnering with us as a Patient Experience Advisor*
> *will be the means by which this vision is realized. As recently as 2010 there was*

no formal mechanism to ensure the patient's perspective was being considered when Hospital wide patient care decisions were being made.

Definition: Patient-and Family-Centred Care at Kingston General Hospital is healthcare based on a partnership among practitioners, patients and families (when appropriate). Its goal is to ensure decisions respect patients' needs, values and preferences. Its outcome provides patients with information, knowledge and support to participate in their care as they choose.

This definition has been condensed into the 7-word phrase:
RESPECT ME, HEAR ME, WORK WITH ME"

As noted above, some official KGH documents talk about PEAs being involved wherever decisions are made that may have a material impact on patients This would be true of the Patient Care and People Committee of the Board, but arguably it would true of the other two board committees where there is not a presence of the PEA (at least not as per the Terms of Reference for each committee). The systemigram reveals in fact a limited amount of potential influence mostly to groups not involved in direct patient care. This is interesting as it appears they do bring the patient voice to tables where it has not been represented before but the systemigram reveals additional opportunities to involve the patient or a PEA as proxy to influence and bring impact.

Figure 11: Organizational Structure of KGH with PEAs

Examining the systemigram from a program level, there is untapped potential

for deep engagement between the frontline employee and the patient. Interesting to

note that communication becomes indirect from the patient at the level of Director and

higher in the organizational hierarchy. This is the level that the patient proxy, the PEA

influence is felt as depicted by the blue arrows. The green dash indicates the boundary

where the ability to influence is diminished or non-existent from a patient-centred

perspective and also from an employee perspective. The PEA position does not include a

reinforcing loop or a feedback loop as their involvement or the exchange is limited in

terms of influence.
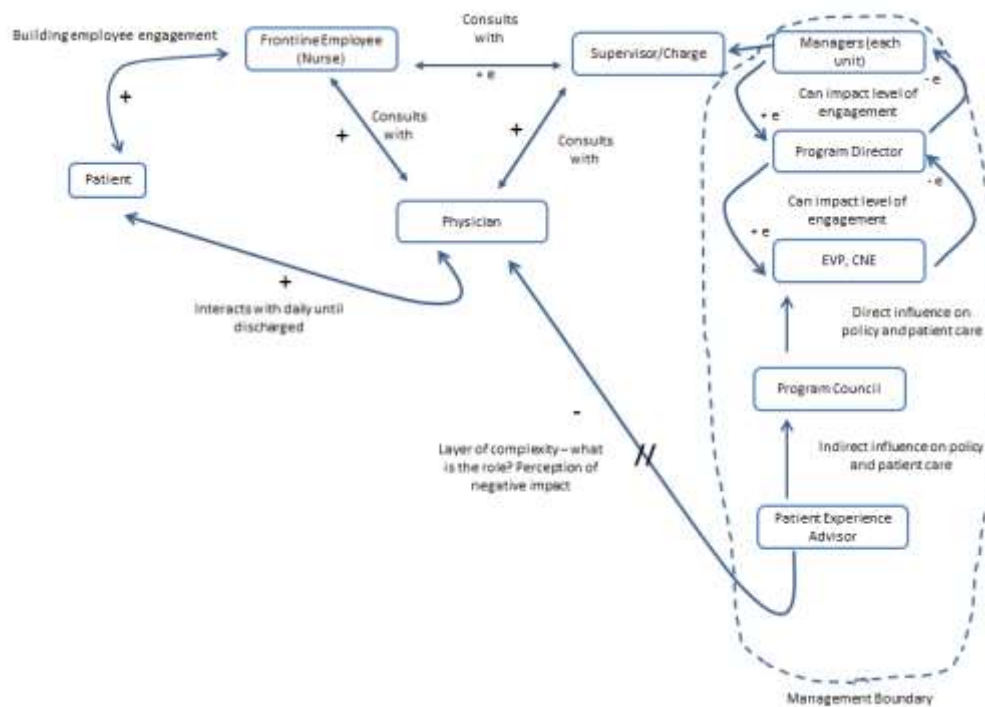
Figure 12: Program Level Systemigram of Engagement Relationships

Examining the relationship of PEA and employees at the Board level indicates, according to the various Terms of Reference for each committee that only the Patient Care and People Committee includes a PEA and there is no indication of a direct relationship with employees with the exception that all employee and physician engagement survey results and action plans are to be reported to this Board committee. Although there may be material impact to patients from a Finance perspective, it is not a committee that is mandated to include PEAs. Considering the voice of the patient and having that contribution has little influence over policy as the PEA as a member of this committee has one vote. As such, there is an influence boundary indicated by the green dash that prevents their influence from penetrated further at the Board level.

Figure 13: Board Level Systemigram of Engagement Relationships

The systemigrams reveal the complexities of patient and employee flow and that they transcend the borders of any physical building or organizational construct. Employees and patients are often "shared" entities. If our goal is to be patient-centred

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the "moments of truth" or opportunities to bring patient-centred care to life currently

exist more so in contrived settings versus those arising naturally through the actual

relationship between caregiver and patient. The attempts to institutionalize PCC may be

counterproductive. If "moments of engagement" were examined here it would follow a

similar pattern in as far as our focus is on the frontline employee. For example, the

frontline employee has no "voice" or direct influence in places where discussions are

had that may have a material impact over their work yet when we look at the markers of

engagement all are activated at the team or unit level specifically within the direct

relationships between the patient, the frontline nurse/employee and the physician, with

a supervisor or charge nurse also implicated in the relationship. What this demonstrates

is the power of the team or unit when it comes to building engagement or bringing

patient-centred care to life. The figure also demonstrates a 'management boundary'

where there is a clear disconnect in direct relationship to the frontline employee. If we

were to use the lens of patient-centred care to look at employee engagement, could it

mean that where currently PEAs are deployed within this 'management' boundary, we

might also deploy a representative of the employee voice?
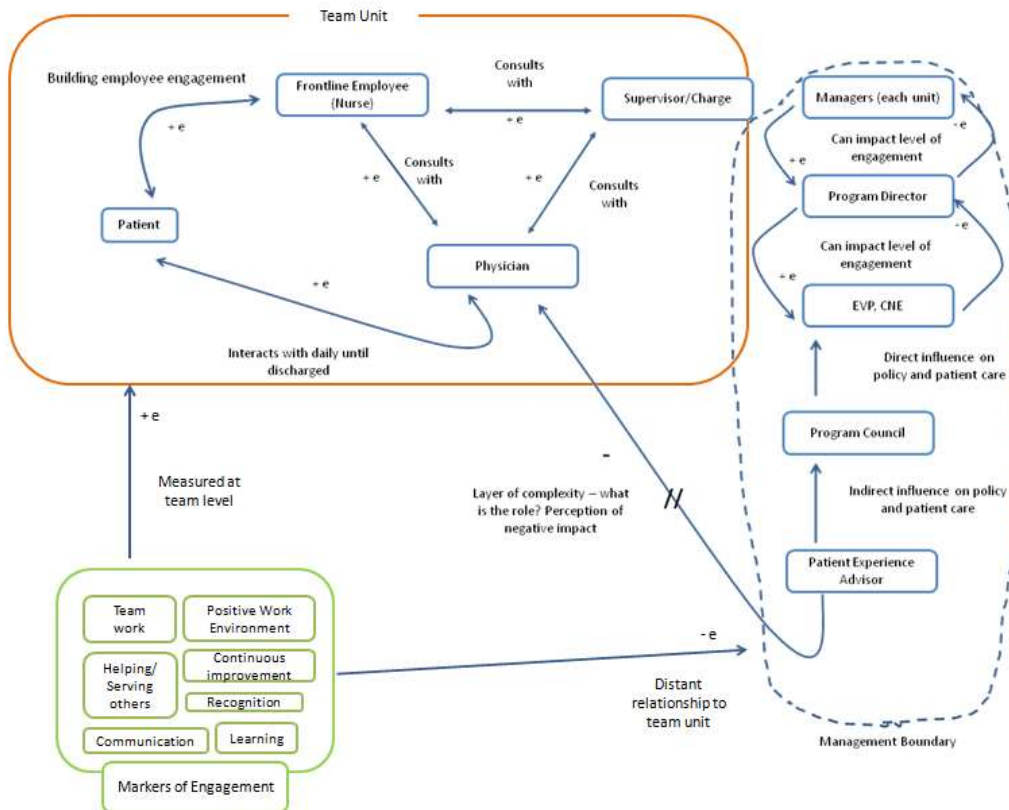
Figure 14: Engagement Markers, Boundaries and Team

Using the Iterative Process of Inquiry method (Gharajedaghi, 2011) we can look

beyond organizational structure and examine the further complexity of the PEA role.

This analysis reveals the way counterproductive influence is wielded by PEAs and

demonstrates a pivotal and potential shift for the position. Left unchecked the PEA

position has and can evolve from that of a representative patient voice to one of patient

advocate. The field research revealed that this shift to advocate and a sense of elevated

"power" has a negative impact on engagement and may also work to undermine the

original function of the position. The impact of this may serve as a catalyst to shift

thought to (or function) to be a more integrated voice or position with the care giving

team and ultimate with the employee creating more of a symbiotic relationship. This

shift would potentially have more impact and strengthen the ability to provide patient-

centred care.
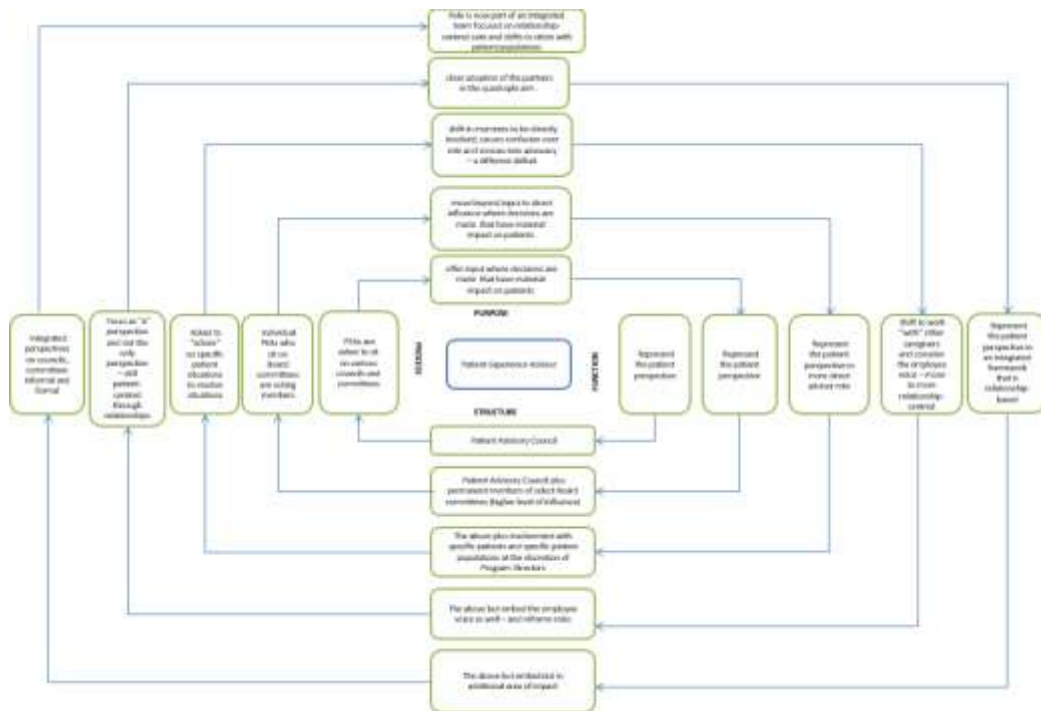
Figure 15: Iterative Process of Inquiry – variation

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Scanning

Environmental scanning "is the art of systematically exploring and interpreting the external environment to better understand the nature of trends and drivers of change and their likely future impact" (Conway, 2009). The first step in the approach for this scan was to identify early signals and then perform analysis to arrive at trends.

The thirty trends were then grouped into trend sets and categorized as potentials drivers of change. A STEEP-V framework was used in the overall approach to scanning to identify and classify the thirty trends in order to contextualize the possible impact and help determine a potential time horizon. STEEP-V has been introduced as a framework for brainstorming (Popper, 2004) and is an acronym where S is for Social); T is for Technology, E is for Economic, the second E is for Environmental, P is for Political and the V for Values.

Here are descriptions of the trend sets, in no particular order.

Environmental Sustainability and the Rise of Chronic Conditions (ST**EE**P-**V**)

Trends: Expectations of environmental sustainability (values); Global threat to environmental sustainability (economic); Increase in chronic conditions (environmental)

Define: Continuing evidence of global climate change and environmental degradation questions the long-term sustainability of our consumptive

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behaviours and poses a deeper conversation regarding the impact on our

health, how we approach patient care, and how our healthcare system can fund

and support inevitable transitions. Connects to expectations of environmental

sustainability and also to the notion of an increase in chronic conditions at a

local level such as higher rates of asthma, Chronic Obstructive Pulmonary

Disease (CPOD) in a population in the SELHIN we have a high rate of smokers.

The perceived increase in additional chronic conditions is demonstrated in 2015

data whereby this LHIN has the higher rates of obesity and inactivity compared

to other LHINs in the province. (South East LHIN, 2016) It presents a "perfect

storm" and collision of values as citizens are increasingly demanding that

organizations and communities fulfill environmental sustainability expectations -

and have a positive impact on the social and natural environments.

Implications: This introduces a layer of complexity where values collide with

economic realities of healthcare infrastructure. The SELHIN hosts the oldest

public hospital in the world in KGH, which is a National Heritage Site and is a

patchwork that depicts the transformation of healthcare in Canada. It's a tricky

balance to maintain historical structures, our cultural fabric and be

environmentally sustainable at the same time – especially without great

expense. Hospitals and LHINs are increasingly urged to adapt to new

operational and engagement models to ensure alignment with patients and

patient populations, communities and updated legislation. The influence of

patients, families, and the community may gain power in this regard to drive

change at a faster rate.

Deepening Globalization and the Pandemic (**S**TEEP-V)

Trends: Deepening globalization (Economic/Social); multiple healthcare crises

(Social); the rise of pandemic diseases and systemic illnesses (Social).

Define: Globalization becomes a defacto force deepening in all aspects of our

lives – mobility across borders underscores the idea from the systemigram that

patients and employees transcend the physical hospital. Evidence of the current

day with impact to patient care would be the Ebola virus (and how triggered

action for new protocols of care throughout the region) and the Zika virus. The

local effect of such pandemics often requires immediate reaction vs a proactive

stance, as local hospitals may or may not be prepared to address.

Implications: Demographic data from the area show an increased need for

healthcare workers as the population ages. (South East LHIN, 2013) If more

pandemics cross borders it may deter people from wanting to work in this

sector and thereby directly impacting the patient experience and the quality of

care. The influence of pandemics could potentially shift the focus of patient

care depending on treatment and protocols thus transforming current

definitions of patient-centred care re: mandatory treatment vs more working

with patients to determine a care plan. Pandemics push health care into crisis

modes, which means that regular protocols or preferred approaches are put on hold.

Shifting Infrastructure – Federal, Provincial and Regional Boundaries (ST**EEP**-V)

Trends: Shifting funding models for healthcare (Political/Economic); Shift to centralization and shared service modes (Political/Economic); LHIN power shift - greater accountability becoming org (Political/Economic); Growth of Urban Centres (Economic)

Define: Spurred by some of the largest land-migrations in human history, the global rise of cities elicits both opportunities and threats - both locally and more broadly - specific impact to SELHIN as most care providing happens in the city vs rural yet currently this LHIN serves the largest rural population. Current projects underway under Health Care Tomorrow and specifically the Hospital Services initiative, which is calling for adoption of a shared service model for such traditional support services like Human Resources, IT, Finance, Clinical Labs and Diagnostic Imaging. The recent announcement from the Ontario Provincial Government to dissolve the current structure of the Community Care Access Centres and recreate them within the LHIN whereby the LHIN actually has employees who are accountable to patients (South East LHIN, 2013) is also a shift in philosophy giving greater power to the LHINs. Some significant indicators requesting a dissolving of the LHIN structure across the province based on

perceptions of it being another layer of bureaucracy highlights a signal that this

structure may change as political leaders and philosophies change over time.

Implications: The boundary that this project works within is that of the LHIN.

The insight that this project reveals is that the intersection point where

engagement happens is somewhat "under the radar" and is not in and of itself

bound by any boundary of a department, of an organization, or the LHIN.

Structural shifts in organizational models and funding models would drive

change in how we view and measure engagement at an employee and patient

level as well as shifting how patient-centred care is realized. The main factor

here is that the shift to more centralized shared services reveals the realities

and complexities of both the patient and employee journey and experience.

Hyper Informed Populations (**ST**EEP-V)

Trends: Smarter populations (Social); Quickly changing social media landscape

(Social/Technological); Hyper-informed patients (Social); Networked Advisor

Committee (Social/Technological); Information overload – decision making

(Technology)

Define: Patients increasingly have access to more information about themselves

and disease states - self-diagnosis - which encourages care providers to be as

up-to-date as possible and current. The rise of the "medical selfie" where

patients take it upon themselves to track health and wellness. Empowerment of

patient through knowledge acquisition i.e., mutual education with clinicians and

also the ability to find health information for co- or self-diagnosis. This creates more informed populations where knowledge is shared collectively versus a model where it is held solely with a medical practitioner. Digital social spaces provide a steady stream of health and wellness and quality of care (i.e., "don't go there it's dirty") advice, information and influences, from trusted personal networks. Social media technologies innovate and morph at an accelerated rate - leaving organizations and care providers and medical schools challenged as to how to leverage and adapt to new citizen behaviours. The overall availability of information causes an anxiety where people feel increasingly overwhelmed by both the availability and the perceived necessities of interaction.

Implications: The rise of all the above may create an increased tension in the relationship between employee as care provider with each patient as new values and expectations force a change in the relationship and perception of service. It may also impact how service is provided as this intersects with other trend sets. The value of any individual's experience delivered as "feedback" to the masses creates a new level of performance evaluation in the court of public opinion, which again is an example of the notion of engagement transcending boundaries of buildings and organizations. These trends lead to more open and transparent environments that reveal the realities of relationships as told by both care provides and care receivers.

Back to Relationship and Personalized Embedded Healthcare (STEEP-**V**)

Trends: Return to slow social relationship (Social/Values); back to relationships (Social); Personalized healthcare (Values/Technology/Social)

Define: With the increasing pace of living, some people decide to consciously "slow down" and experience life in a way that is unhurried and less driven by technology impetus. The impact of a more connected virtual world drives people to find new or revived connections in the physical world at a local level. The complex relationship between the economic, social, and natural environments gives rise to a search for improved engagement models. Creation of models that are value and relationship based versus standardized. Care giving and medicine are increasingly available in a "personalized" format - giving rise to an emerging economy of personalized products and services, adapted to individual needs.

Implications: An increase in the value of the relationship between care provider and teams of care providers with the patient/care receiver. The transformation of medical models from a physician-focused to patient-focused and from patient-centred care to person-centred care to patient-centred as relationship impact the various ways engagement manifests and certainly how we observe and measure. Dr. Atul Gawande's statement of teams being the next frontier of the future of medicine, whereby developing care teams to work better together

to bring about better patient outcomes highlights this focus on relationship and human connection.

Shifting Demographics (**ST**E**E**P-**V**)

Trends: Remote and distributed work and living (Economic/Social/Technology); Permeation of collaborative & awareness tools (Technology/Social); Rise of the Millennials and Generation Z; Always aging population (Social).

Define: Government and organizations manage escalating costs of running administration offices and hospitals, and broadly support remote work or home visits. Shift in traditional organization architecture in terms of workplace design, managerial structures, HR practices, virtual workforce, length and location of workday. The explosive growth of collaboration and awareness tools with their ever-increasing pervasiveness, which affects how organizations are structured, interact and operate. Shifting demographics from an age perspective continue to impact the type of care required within the region and further impacts service expectations.

Implications: Shifting generations creates different demands on services and expectations of service creating distinct new value-systems that inform organizations, lifestyle and policy. The SELHIN currently has noted a future challenge of a larger than most aging baby boomer generation – "Overall, the South East LHIN has a higher percentage of elderly individuals than the rest of the province (17.1% vs. 13.2% for persons 65+ in 2007)." This trend is set to

continue as the late boomers continue to be a large group until 2047. (South East LHIN, 2013)

Rise of Tribe Mentality (**S**TEEP-**V**)

Trends: Rise of global fundamentalism and religious identity (S); Tribalized responses to uncertainty (V)

Define: With the spread of Globalization, some populations feel that their culture and ways of life are threatened - which elicits "tribalized" responses, including attempts at opting-out. (no vaccines, etc.) impact to health systems and population spread.

Implications: In response to Globalization and other effects - such as expansion of modernity - religious identity becomes stronger in some parts of the world, as a preserving force and some are perpetuated within the local system (i.e., Catholic hospitals). Population growth projections show an increased demand upon immigration to maintain economic status from 2016 through to 2040, which may require more intercultural competency training for care providers and may transform the services provided. Consider impact to relationships at every level as values are questioned with the evolving patient base and patient needs against the religious values of organizations and potentially care-providers. This can be amplified with intersections of other trend sets like information overload as patients would have additional access to information or perhaps alternative methods of care unfamiliar to local care-providers.

Realization of Artificial Intelligence (**ST**EEP-**V**)

Trends: Rise of Augmented reality and Virtual Reality for learning and assistive living (Technology); physical printing and local/immediate manufacturing of materials (Technology); mobile location – aware info engagement (Technology); Privacy concerns and the re-emergence of localized trust (social/values);

Define: Information engagement becomes truly mobile, and location aware - offering enhanced opportunities for people to engage and interact with their environments – whether in an augmented way or in a completely virtual way. An increasing availability of "blueprints" and inexpensive equipment, personal printing becomes broadly adopted and affects support, manufacturing and design, with implications for the medical industry as we see more 3D printing of body parts for operations and assistive living. Escalated privacy concerns within digital landscapes give rise to a desire for reliable circles of trust (i.e., US-based hospital hacks where private health information is held hostage in exchange for large sums of money.)

Implications: The ability for patients to have greater access to manufactured devices and equipment that could transform their lives but at current times remains vastly unexplored from a risk and quality perspective. Devices that allow for learning and assist living through augmented reality and virtual reality are becoming more accessible and affordable thus bringing the potential to shift how we teach people in healthcare (care providers and patients) and how we

might offer experiences through virtual reality channels bringing social and new

relationships to bear in a new yet unfamiliar environment. These new landscape

bring exploration of what privacy means and how privacy is protected across

environments. IT infrastructure will need to be enhanced on many fronts to

accommodate such advances.

Quadruple AIM (**ST**E**E**P-**V**)

Trends: Rise in focus of the quadruple aim (Economic/Social); Collaborative

biopsychosocial ways of caring (Values/Social); Shift from patient-centred to

person-centred- holistic (Social/Values); Growing rift administration/care

providers (Values/Social).

Define: The Triple Aim is widely known as a framework that helps organizations

optimize performance and the quadruple aim is the addition of a fourth aim

focused on the dimension of improving the experience and care of the provider.

Adoption of biopsychosocial model of medicine that moves away from the

current presiding system of that has a focus on just the biology or disease state

rather than considering the entire context and centered by the patient. This

connects to a shift from physician-centred care, to patient-centred to person-

centre to the next evolution. Growing acceptance and exploration of all care

forms on an international level feeds into shared knowledge bases and iterative

development in new models of care. There is strong evidence of current

employee engagement approaches being ineffective. Verbatim comments in the

engagement survey results as well as other signals indicate a growing divide and

slight or not-so-slight animosity between healthcare administrators and those

involved in direct patient care.

Implications: Greater acceptance and evidence that employee engagement

increases performance and leads to better patient outcomes will allow for more

dialogue to happen and potential policy or legislative change. Awareness of the

value of the fourth dimension of the quadruple aim will put the care provider at

equal consideration with the patient in the quest for quality in the system. A

growing rift may prevent categorizing health administrators in the same

category as health providers therefore excluding them from the quadruple aim.

This connects back the idea of community and opportunity for teams at all levels

to work together.

Three Horizons

The three horizons method "helps to identify the divergent futures which may emerge as a result of conflict between the embedded present and these imagined futures" (Curry and Hodgson, 2008). This method enables the researcher to do a deeper strategic analysis of the impact of trends as they change, evolve, or devolve over time and also represents this change as part of a larger system allowing one to see the interchange and interplay between the various parts. Applying the three horizons allows for a clearer picture of the potential impact of each trend sets against the notion of employee engagement through the lens of patient-centred care over time.

The trend sets as described in the Scanning section of this document enabled a possible vision as each set relates to the future realities of a 25-year time horizon thus identifying "pockets of the future embedded in the present" (Curry and Hodgson, 2008). Figure 15 depicts this plotting with pivot or bridging points at 2027 and 2037.
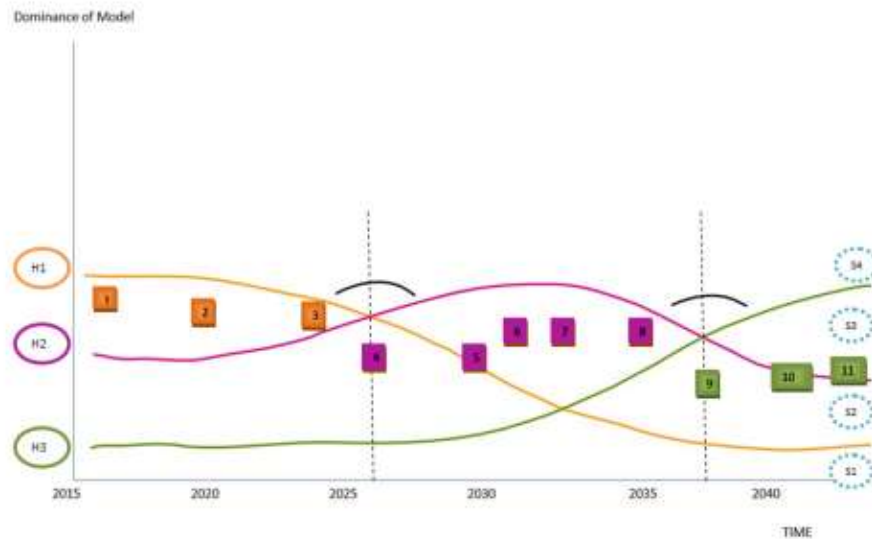
Figure 16: Three horizons with mapped trends

Horizon	2015	
H1 - 2015-2027	2017	1. **Hyper Informed Populations**
	2020	2. **Back to Relationship**
	2025	3. **Shifting Infrastructures**
H2- 2027 - 2037	2027	4. **Prominence of Quadruple AIM**
	2030	5. **Shifting Demographics**
	2032	6. **Deepening Globalization and the Pandemic**
	2033	7. **Rise of Tribe Mentality**
	2035	8. **Personalized Embedded Healthcare**
H3 – 2037-2045	2037	9. **Artificial Intelligence Part of Life**
	2041	10. **Lifestyle and Generational Cycles – Next**
	2045	11. **Environmental Sustainability and the Rise of Chronic Conditions**

It is worth noting that the Shifting Demographic trend set (2025) shares a similar description in the scanning section to Lifestyle and Generational Cycles – Next (2041) as

generational shifts occur over time. Another note is that Back to Relationships (2020)

and Personalized Embedded Healthcare (2035) share the same description and share

the same trend set with the difference being the timing of impact.

Using the descriptions and characteristics of each trend set led to further

sensemaking and convergence, which allowed for the surfacing of "values for each

horizon. Given the "time to impact" or dominance of a specific trend set revealed

Horizon 1 (H1) as that of **Resistance yet Patient-Centred**; Horizon 2 (H2) as **Integration

and the Rise of the Caregiver**, with Horizon 3 as **Embedded Roots and Relationship-

Centred**.

Scenario Creation
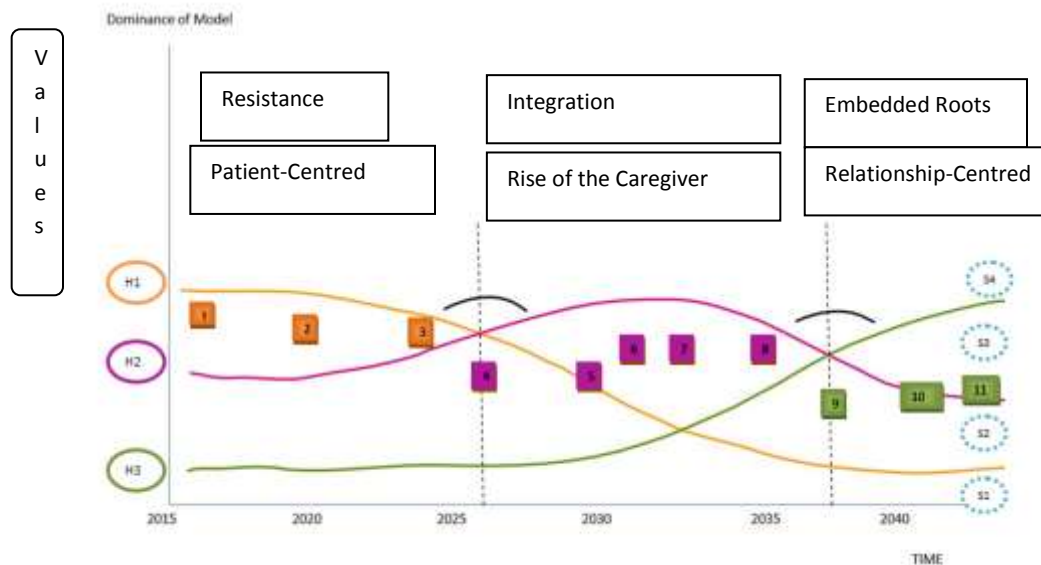
Figure 17: Three horizons with mapped trends and named horizons

A Trends tool spreadsheet as developed by a researcher as part of SFI program course work (Matic, 2013) was used here to determine the trend plausibility as well as impact in the short-, mid- and long term. 'Trend Plausibility' refers to the likelihood that a given trend set or driver might play a formative role in a particular scenario or world – with 1 being the lowest and 3 being the highest probability. The 'Trend Impact' is evaluated numerically from the perspective of a particular scenario or world, again with 1 being the lowest and 3 being the highest as a trend set or driver may start out as more or less intense in the shorter term time horizon but could either accelerate or decelerate in other terms depending on the logic of the given scenario or world. The 'total trend impact' is synthesized by a numerical score where the lowest value is 15 and the highest is 2,025 indicating the level of intensity and/or relevance of the trend/driver to the

formation of a particular world or scenario. Using this tool allows for sorting and

resorting based on weighing the impact of all potential trends/drivers. It also allows for

how best to contextualize the trends /drivers in a particular world or scenario and it

creates space for detecting broader patterns and allows the researcher to infer

additional details that may prove useful in the final recommendations.

S1   **Scenario 1 - Silos and Structures**

#	TREND NAME	STEEP-V CATEGORY	TREND LENGTH (yrs)	TREND PLAUSI-BILITY	TREND PIVOT POINT	TREND IMPACT Short Term	TREND IMPACT Medium Term	TREND IMPACT Long Term	TOTAL TREND IMPACT
2	Hyper-Informed Population	Social	25	3			2	3	1,200
13	Back to Relationships	Economic	20	3				3	560
21	Shifting Infrastructures	Political/Social/Economic	20	3	Yes		3		560
30	Prominence of the Quadruple Aim	Social/Values	25	1			1	1	67
25	Shifting Demographics	Social/Economic	25				2		700
3	Deepening Globalization and the Pandemic	Economic/Social	25				3	3	1,200
7	Rise of Tribal Identity	Value	25				3	2	1,200
15	Personalized Embedded Healthcare	Value	25		Yes		2	2	1,200
23	Artificial Intelligence Part of Life	Technology	25				2		700
6	Lifestyle and Demographic Cycles - next	Social	25				2		700
5	Environmental Sustainability and Rise of Chronic Conditions	Ecological	25				3		700

World logic: The logic of this world is based on a scenario where there is great

resistance to change and organizations are holding onto current notions of patient-

centred care presenting as increasingly siloed organizations where information

regarding the patient or organizational communication isn't flowing yet organizational

structures are shifting. In fact, organizations have invested so much of their identity in

being "patient-centred" that they are not prepared for or open to evolving thought on

this given the changes in infrastructure:

- Pockets within the system transition the hyper-informed population into an early acceptance of personalized embedded healthcare.

- Diversified demands of various stakeholders makes it difficult to standardize rules to ensure infrastructure of the physical space, the IT ability and employee adoption to support change

- Increasing gap in the relationship between care giver and patient, and care giver and workplace mainly due to frustrations because of the perception of lack of support to enable employees/care givers to stay up-to-date or be ahead of where the actual patients are in terms of information and treatment.

- No shared definition about what "patient-centred" means, which creates growing fragmentation and creates rifts in how teams collaborate.

- Greater risk in further fragmentation of the social fabric given the increase in global pandemics and the additional pressures put on caregivers to learn new protocols.

Scenario 2: Inter-Tribal Complexities

#	TREND NAME	STEEP-V CATEGORY	TREND LENGTH (yrs)	TREND PLAUSI-BLITY	TREND PIVOT POINT	TREND IMPACT Short Term	TREND IMPACT Medium Term	TREND IMPACT Long Term	TOTAL TREND IMPACT
2	Hyper-Informed Population	Social	25	3				3	1,200
13	Back to Relationships	Economic	25	3		1	2	3	700
21	Shifting Infrastructures	Political/Social/ Economic	25	2			3		700
30	Prominence of the Quadruple Aim	Social/Values	25	3	Yes	3	3	3	1,200
25	Shifting Demographics	Social/Economic	25	2			3		700
3	Deepening Globalization and the Pandemic	Economic/Social	25	3			3		1,200
7	Rise of Tribal Identity	Value	20		Yes		3		960
15	Personalized Embedded Healthcare	Value	25	1		1	3		525
23	Artificial Intelligence Part of Life	Technology	25	1		1	3		525
6	Lifestyle and Demographic Cycles - next	Social	25				3		1,200
5	Environmental Sustainability and Rise of Chronic Conditions	Ecological	25	3		3	3	3	2,025

World logic: The logic of this world is based on a scenario where there is integration and the rise of the caregiver yet there is disruption on many fronts and acceptance and action of the quadruple aim – bringing a focus on well-being of the caregiver into the equation as the region implements various changes to infrastructure. The changes in infrastructure however coupled with an influx of new immigrants into the region along with an immense increase in the complexity of chronic conditions on the aging population creates a perfect storm for the rise of tribal identity that manifests itself in social and political values as a defensive reaction to change:

- Clear clash of values and beliefs divide public and the multiple religiously-affiliated hospitals in the region creating deeper fragmentation in the social fabric of the community.

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- Fragmented social values block or slow adoption of personalized

  embedded healthcare as it relates to privacy concerns for various

  patient populations and forces dialogue on ethics and religion.

- Increase in the number of caregivers working in the region to work with

  larger more complex patient populations.

- Focus on quadruple aim sees changes in approach to how employee

  engagement is considered and measured.

- Potential to focus on the relationship between caregiver, patient and

  team as resilience tactics to overcome rifts in the social and political

  fabric due to the rise in tribal identity.

Scenario 3: Embedded Roots

#	TREND NAME	STEEP-V CATEGORY	TREND LENGTH (yrs)	TREND PLAUSIBILITY	TREND PIVOT POINT	TREND IMPACT Short Term	TREND IMPACT Medium Term	TREND IMPACT Long Term	TOTAL TREND IMPACT
2	Hyper-Informed Population	Social	25	3			3		1,200
13	Back to Relationships	Economic	25	3				3	700
21	Shifting Infrastructures	Political/Social/ Economic	25				3		700
30	Prominence of the Quadruple Aim	Social/Values	25		Yes		3	3	1,200
25	Shifting Demographics	Social/Economic	25				3		700
3	Deepening Globalization and the Pandemic	Economic/Social	25				3	3	1,200
7	Rise of Tribal Identity	Value	20	1			3		560
15	Personalized Embedded Healthcare	Value	25				3	3	1,200
23	Artificial Intelligence Part of Life	Technology	25		Yes		3	3	1,200
6	Lifestyle and Demographic Cycles - next	Social	25				3	3	1,200
5	Environmental Sustainability and Rise of Chronic Conditions	Ecological	25				3	3	1,200

World logic: The logic of this world is based on the scenario where there is deep embracing of relationship-based care that adapts well and works with the advancement of personalized embedded healthcare and artificial intelligence becoming part of our lives:

- Adoption of the quadruple aim enables any organization or region to not lose sight of the connection between employee engagement and better patient outcomes.

- This focus on relationship – at all levels along the patient journey has enabled people and organizations to thrive in times of change.

- Focus on relationship has decreased the risk of the rise of tribal identity and allowed for more dialogue when defensive tendencies arise.

- People and organizations are more aptly prepared to deal with shifts in the landscape be they environmental, regional infrastructure or global pandemic.

- New skill sets and competencies to be achieved by caregivers in the realm of working with mass-manufactured 3D body parts as integrated partially or entirely into patients.

- Able to embed ways of measuring engagement from patients and employees in real-time due to the focus on relationship.

Scenario 4: Embracing New Frontiers and Parallel Dimensions

#	TREND NAME	STEER-V CATEGORY	TREND LENGTH (yrs)	TREND PLAUSIBILITY	TREND PIVOT POINT	TREND IMPACT - Short Term	TREND IMPACT - Medium Term	TREND IMPACT - Long Term	TOTAL TREND IMPACT
2	Hyper-Informed Population	Social	25						300
13	Back to Relationships	Economic	25	Yes					1,200
21	Shifting Infrastructures	Political/Social/Economic	25						700
30	Prominence of the Quadruple Aim	Social/Values	25	Yes					1,200
25	Shifting Demographics	Social/Economic	25						700
3	Deepening Globalization and the Pandemic	Economic/Social	25						700
7	Rise of Tribal Identity	Value	20						560
15	Personalized Embedded Healthcare	Value	25	Yes					1,200
23	Artificial Intelligence Part of Life	Technology	25						1,200
6	Lifestyle and Demographic Cycles - next	Social	25						1,200
5	Environmental Sustainability and Rise of Chronic Conditions	Ecological	25						1,200

World logic: The logic of this world is based on the scenario where there is deep embracing of relationship-based care that goes beyond the embedded roots of relationship where the world of artificial intelligence and personalized embedded healthcare create a new set of disruptors for 2040. It requires caregivers to consider

parallel dimensions of caring for virtual patients and embedded artifacts within the human body.

- Evolution of personalized embedded healthcare has grown beyond current 2016 concepts and has created new considerations on various fronts: ethics, privacy and religion.

- New skill sets and competencies to be achieved by caregivers in the realm of working with mass-manufactured 3D body parts as integrated partially or entirely into patients.

- Notion of quadruple aim expands to include a wider expanse of stakeholders (i.e., what role does AI as "family" play in terms of influence on patient?).

Preferred Future
Scenario 3: Embedded Roots

Embedded Roots surfaces as a preferred future because it provides an amenable landscape for people to thrive and adapt positively to ongoing shifts. Given potential outcomes of the other worlds or scenarios presented, this "Embedded Roots" world allows for consideration and the ability to navigate across potential disruptive forces. In other words, it would allow for the maintenance of the relationship between caregiver, teams and patient despite the impact of changes at a structural level.

As noted above, this world requires a deep embracing of relationship-based care that adapts well and works with the advancement of personalized embedded healthcare and artificial intelligence becoming part of our lives. The original research questions asked: how might healthcare organizations resolve the challenges to full employee engagement in the indeterminate contexts of patient-centred care?

If the original research question is to be addressed, and there is acceptance that engagement is as deeply rooted in the affective commitment component, as a partnership based on the concept of reciprocity, or the idea that, "employees are driven by reciprocity – motivated by principle, a sense of obligation, and the satisfaction of doing something good for someone else" then logic dictates that working toward an Embedded Roots world makes sense.

Considerations and Additional Research

If one possibility is to work toward the "quadruple aim," which by definition would mean to "acknowledge the importance of physicians, nurses and all employees finding joy and meaning in their work" (Sikka et al., 2015) then this would be a strategic imperative for SELHIN to embrace along with every healthcare provider in the area. Given the number of initiatives underway in the SELHIN there would need to be a significant event or, as industry jargon defines – a burning platform, to serve as a catalyst for change.

There is clear alignment between the definition of the quadruple aim and the markers of engagement uncovered by the field research undertaken in this study. Markers like team work, continuous improvement, serving and helping others, and recognition, specifically in daily work or work task are congruous with Sikka's definition of engagement of meaning. Sikka (2015) refers to this as:

"The core of workforce engagement is the experience of joy and meaning in the work of healthcare. This is not synonymous with happiness, (but) rather that all members of the workforce have a sense of accomplishment and meaning in their contributions. By meaning, we refer to the sense of importance of daily work. By joy, we refer to the feeling of success and fulfillment that results from meaningful work" (Sikka et al., 2015).

This alignment is a significant finding and one consideration would be to explore these markers of engagement further and put a focus on specific relationships and how they are formed and sustained. The semi-structured interviews and other field research pointed to meaningful and fulfilling work based on deep relationships with co-workers,

colleagues, and patients giving a sense of what these look and feel like. Diving deeper into the meaning of these relationships and reflecting how the markers of engagement are activated within and around them can forward the work started here in this study bringing us toward a shared definition or shared meaning of engagement moving us toward relationship-centred care.

Additional research and monitoring could be done at the team level examining team dynamics and specifically the relationship between frontline nurse, physician and patient as well as what role does the organization play in terms of employee engagement? This question also leads to the revelation of a gap in shared meaning for both employee engagement and patient-centred care. Certainly this study revealed markers of engagement in a specific context but further definition and evolution of definitions toward relationship-centred care would be helpful.

A cursory look at literature from the early 2000s revealed a focus on relationship-centred care as being patient-centred leads to a question or potential exploration as to why so many organizations have latched on to "patient-centred" instead of embracing relationship-centred.

Another aspect related to engagement would be researching the impact of burnout and compassion fatigue specifically in acute care centres. If we are truly embracing the quadruple aim, there are elements of "taking care" of the provider that we need to understand and address.

Further foresight work across trends and creating more robust scenarios of the impact of the quadruple aim if it was realized would be of interest. Or given the economic realities of the rising cost of healthcare, will any of this truly matter if we are unable to provide an infrastructure that supports care across the province? (i.e., provide adequate tools and equipment so barriers to job task are removed).

The original intent of this study was to better understand employee engagement through the lens of patient-centred care to help us build and sustain employee engagement even outside the boundaries of the actual organization.

Based on the work of this study and the desired goal, there are a few considerations that if activated now may help guide the organization to our preferred future:

Clearly demonstrate 'sweet spot' of engagement at the team level and move beyond the organization

In early April of 2016, KGH revealed the 2016-17 Integrated Annual Corporate Plan and it has a new target that includes a focus on the people aspect of the strategy and reads as follows: *The top three opportunities for improvement in engagement are addressed.* This is certainly a welcome inclusion and is fairly broad in range and creates a learning opportunity for senior leadership on the elements within the study. For example, there remains conversation about making KGH a 'great place to work' and although that is desirable it doesn't adequately address the markers of engagement and the 'sweet spot' at the team level. Nor does it address the fact that the dialogue about engagement needs to transcend the boundaries of KGH as indeed employees and

patients already do. The conversations about engagement need to be oriented in the direction of caregivers and patients rather than oriented toward any one or solely the organization. Furthermore, connecting people to their "why" as in what is it that connects you to this work? may lead to a need to connect people to a sense of public duty deepening the intersection and convergence with Mintzberg's notion of communityship mentioned earlier. This might be more unique for the public sector versus private sector engagement. This study could trigger a larger discussion about engagement and move towards a shared meaning as the scenarios reveal that if we remain on the current course it would lead to sub-optimal performance for both patients and employees and our communities.

Focus on teams and relationship

Increase in engagement building behaviours where it is most meaningful – at the relationship level between patient and caregiver(s) for those involved in direct patient care and from employee to employee and employee to leader to people in areas involved indirectly with patient care. Such behaviours could mean adapting the patient-centred checklist to include questions like "what did I learn from an employee today?" or things that allow for reflection and empathy and understanding towards our colleagues and teammates to help foster a better working environment. This creates opportunities to make personal connections between the people on the team, as well as an opportunity to grow bonds between people that ultimately build trust. As the scenarios reveal, it is this element of trust that will allow for better management of

change initiatives as the roll across the region. It allows for a stabilization of engagement when it is needed the most.

Shift in how we measure engagement – move to integration

Currently employee engagement is measured every two years as legislated and patient satisfaction is measured annually. The current practice is to perform pulse surveys in some areas between the larger employee engagement survey time and certainly on the patient satisfaction side there are random surveys sent out after discharge. One consideration would be gathering more meaningful and timelier data and then creating perhaps a new index of these two data sets to reveal a true sense of engagement across stakeholders to actually giving a pulse to the symbiotic relationship.

This endeavour in a longer term could involve the use of enabling technologies to gather input from stakeholders in more real-time fashion (i.e., using a mobile app to implement real time surveys). Yet first we need to refocus the questions we ask and perhaps the observations we make. This would be a significant shift from current practice so as opposed to measuring merely "satisfaction" the emphasis shifts away from the orientation towards the organization as a "best place to work – to a question set focused on actions that people perform. The proposed focus would be about what you do for others – who you serve – your patients – your clients – your peers.

Building on the above using the markers of engagement and 'tracking' engagement as it happens using a combination of technologies like near-field communication sending data through application program interfaces (APIs) to inform on

how long a nurse is with a patient and what tasks are being completed thus allowing

more real-time data to be gathered where engagement happens. This would allow one

section of the holistic measure to happen.

Further work would need to be done to identify how we might include

integrating data that is gathered about patient satisfaction and patient experience in

real-time.

Scaling strategies and tactics

Given that the region is moving towards a shared service model for Human

Resources and given that currently there are seven hospitals who manage seven

separate employee engagement surveys, and given that some of our employees and

most of our patients are "shared" there needs to be a focus on how this redesign will

scale to the region.

As the scenarios reveal, we need to be aware of the mix of values and beliefs

that each organization is built upon as we consider how we measure and build

employee engagement. This study revealed that if structured with an orientation to

team and relationship, employee engagement may be able to be a stabilizing force in a

region undergoing change and moving through periods of destabilization. The Three

Horizons (Figure 15) depicts the 'bridges' between horizons. Being mindful of those

bridging opportunities would be paramount and building a framework that includes a

virtuous cycle that measures and builds engagement and remains relevant over time

would be imperative.

System changes in structure and function of the patient experience advisors

Another insight that this study revealed was that the structure and function of the position of the patient experience advisor needs attention and review. The field research noted that the current cohort of advisors is not necessarily reflective of the patient populations we have using the services of the hospital. The process of inquiry also revealed the evolution of the role in how it is perceived or how it manifests now. A review of where advisors are involved in decision-making is actually limited in scope and might not entirely meet our definition of them being involved in places where decisions are made that have material impact on the patient. A review and revisioning of what the future may look like for this function would be advised.

Data from the field research also revealed a perception that can be summarized as 'the patient first, at the expense of the caregiver.' Given this perception, there is a learning opportunity created to perhaps apply some of the tactics that raised attention and brought action to put patients at the centre of care to the world of employees to help move these two stakeholders toward an integrated relationship-centred approach. This would then move the organization closer to this idea of the quadruple aim.

What this might look like is having employee representatives following in the pattern of where we currently have patient experience advisors. This would mean including a rotating role on board committees and councils with the focus of bringing an "employee" voice to those tables.

Recommendations

The future vision is to activate the newly gained insights about employee engagement and to use this powerful lever to bring us closer to the adoption of the quadruple aim. To do this will require a paradigm shift at all levels: from frontline employees to government policy makers – that will ultimately change how we think about employees. What if we thought about employees as healthy patients? How would that change how we care for them? How would it change how they look at themselves? The roadmap to achieving forward movement will be paved with incremental tactics that will be aimed at all levels.

2016-17:

Acting at team level:		Acting at KGH level:	
1	Select a cross-section of teams to facilitate, monitor, and measure engagement activities at the team level based on the markers of engagement.	1	Use the insights from this study to inform the plan for the 2016-17 strategic directions for employee engagement
2	Build skills related to the markers of engagement at the individual and team levels.	2	Evolve the measurement instrument for the markers of engagement for conducting the overall engagement survey.
3	Develop an awareness and education campaign through communication and learning experiences that brings the insights around engagement to life for frontline employees.	3	Work with senior leadership and the lead for PFCC to inform the evolution of PFCC to include more directly the caregiver – shift to relationship.
4	Create and refine a measurement instrument for the markers of engagement for conducting touchstone or pulse surveys.	4	Work with other workplace stakeholders to create an engagement index that includes employees, physicians, volunteers, and patients.

2017-2018

Acting at SELHIN level:		Acting at Health Care System Level:	
1	Partner with either HDH or Providence Care to pilot some of the team level tactics above to glean insights from a different organizational culture.	1	Build partnerships and collaborate with the Canadian Foundation for Healthcare Improvement and the Institute for Healthcare Improvement to forward thinking of moving from Triple Aim to the Quadruple Aim.
2	Based on insights from the above tactics, create an engagement strategy for all hospitals – transcending the boundaries of each organization.	2	Work with Health Quality Ontario to evolve from Triple Aim thinking to Quadruple Aim thinking to infuse engagement into policy.
3	Develop a set of guidelines and better practices including a scalable measurement instrument to support the engagement index.	3	Ongoing awareness campaign to share the evolution of this initiative (i.e., conference presentations; site visits and talks at other hospitals).

Acting at an industry practice level:	
1	Demand a broad reassessment of how our current engagement partners measure and think about employee engagement.
2	Develop a white paper or position paper and series of articles to be published in strategic journals to disrupt current approaches to engagement specifically in the public sector.
3	Explore more deeply the markers of engagement and various API technologies to enable measurement of engagement in real time.

Implementation of Innovation

To briefly expand on forms this innovation could take, here is a draft example of the kind of questions that might be asked in a new instrument for measuring engagement based on the markers identified in this study. As a reminder the identified markers of engagement are as follows:

- Team work

- Positivity

- Recognition

- Helping Others

- Continuous Improvement; Learning; Communication.

Weekly Self-Check	Weekly Team Check-in (Leader perspective)
Did I create opportunities to communicate with my colleagues? Listen actively? Create safety? Achieve dialogue?	Did we create opportunities for the team to communicate with each other? Did they follow team norms? Listen actively? Create safety? Achieve dialogue?
Did I create space to reflect on what I learned or how I performed?	Did we create space for the team to reflect on what they learned or how they performed?
Was the environment set up in a way that allowed me to perform my best?	Was the environment set up in a way that allowed the team to perform at their best?
Was the environment set up in a way that was conducive to learning?	Was the environment set up in a way that was conducive to learning?
Was I able to find ways to deepen my practice and have a positive impact on a patient? Client? People I serve?	Were we able to find ways to deepen the practice of the team and produce a positive impact on a patient? Client? People I serve?
What problems am I working to solve? Or what services or practices could be better?	What problems are we working to solve? Or what services or practices could be better?
Did I take time to reflect and recognize the work of others around me?	Did we take time to reflect and recognize the work of others around us?
Did I take time to reflect and recognize my own work?	Did we take time to reflect and recognize our own work?

Did I find meaningful ways to share successes with others?	Did we find meaningful ways to share successes with others?
What did I learn from a colleague this week?	What did we learn from each other this week?
What did I learn from a patient? Client? People I serve?	What did we learn from a patient? Client? People I serve?
Overall stock-taking on engagement (1 – 5, with 1 being low and 5 being high)	Overall stock-taking on team engagement (1 – 5, with 1 being low and 5 being high)

Conclusion

This study used an approach that combined field research and foresight methods to explore new possibilities for employee engagement looking through the lens of patient-centred care.

Common approaches to building and measuring employee engagement focus on the connection of the employee to an organization (i.e., the place of work). This study was able to reveal the markers of engagement as identified by employees within the context of a specific hospital setting. These identified markers are aligned to elements in common engagement surveys and can be seen as a subset. This confirms that w*hat truly engages people is the work they do **with** others **serving** their **constituents**.*

It's about what employees do (work task), who they do it with (team/other employees) and who they do it for (constituents) and far less about the connection to where they work (i.e., business or work-place). This bodes well for the transition to a shared service model for hospitals within the SELHIN as it allows for a framework to emerge that can focus on building engagement at the team level, which allows other transformation to occur at the organizational level with limited negative impact on employee engagement.

This realization allows any further work to potentially scale beyond healthcare into other industries and should ultimately change how we measure, how often we measure, and how we build engagement across regions for employees, caregivers, and patients contributing significantly to the a paradigm shift that forces us to think

differently about the relationships between stakeholders in health care in order to

produce a win-win-win-win outcome and helps us realize the quadruple aim.

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Appendix A

Semi-Structured Interview Questions:

1. How do you define Patient and Family Centred Care (PFCC)?
2. Can you offer an example of how this is demonstrated in your organization?
3. What do you see as the benefits of PFCC?
4. If you had to rate on a scale of 1-10 how well integrated PFCC is in your organization, what would you say? Tell me more about why you rated it that way?
5. What do you think is done well?
6. What do you think could be done better?
7. What do you think needs to be stopped?
8. What are the behaviours that bring about or contribute to PFCC? From you? From physicians?
9. Describe to me any work you have been involved in to make PFCC a reality in your organization?
10. How do you define engagement?
11. Can you offer an example how this is demonstrated in your organization?
12. If you had to rate on a scale of 1-10 your level of engagement as an employee, what would you say? Tell me more about why you rated it that way?
13. What do you think is done well? What do you think could be done better? What do you think needs to be stopped?
14. What methods do you currently use to support engagement and PFCC?
15. Do you think that engaged employees have a positive impact on patient experience and better patient outcomes?
16. Why or why not?
17. Is the mandate or plan for PFCC and engagement understood and executed at all levels of the organization?
18. What barriers are limiting more frequent, wide-spread implementation of PFCC? Of
19. What can be done to remove these barriers?
20. Describe to me why (or why not) you believe in PFCC? In engagement?