Rapid Review

Levers for high-performing health systems

Prepared for Healthcare Excellence Canada

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NAO
North American Observatory on Health Systems and Policies

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About

Healthcare Excellence Canada works with partners to spread innovation, build capability, and catalyze policy change so that everyone in Canada has safe and high-quality healthcare. Through collaboration with patients, caregivers and people working in healthcare, we turn proven innovations into lasting improvements in all dimensions of healthcare excellence. Launched in 2021, HEC brings together the Canadian Patient Safety Institute and Canadian Foundation for Healthcare Improvement.

The North American Observatory on Health Systems and Policies (NAO) is a collaborative partnership of interested researchers, research organizations, governments, and health organizations promoting evidence-informed health system policy decision-making.

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Executive Summary

The *Accelerating Healthcare Improvement: Healthcare Excellence Canada Assessment Tool ©* (formerly published by the Canadian Foundation for Healthcare Improvement) supports healthcare leaders and organizations to apply evidence to improve healthcare through projects and collaboratives, built around six levers for healthcare improvement. This rapid review assesses the relevance of these levers when compared to modern frameworks, and to propose updated and modernized levers that reflect current thinking around how health systems provide high-quality and safe care.

The work was conducted in two phases. Phase I comprised an environmental scan to explore the existing six Healthcare Excellence Canada (HEC) levers in relation to the latest literature on the capabilities and mechanisms through which high-performing health systems achieve their goals of providing high-quality and safe care. The results of this scan informed a set of updated and modernized levers. To ensure these levers reflect real world practice, Phase II was a modified Delphi exercise with health systems leaders to review, refine, and build consensus with an aim to produce a final set of validated levers to inform healthcare improvement and systems transformation.

Round 1 of the Delphi comprised 70 panelists, Round 2 comprised 33, and Round 3 included 28. Across rounds, most respondents identified as women, were in the provinces of Ontario or Alberta, were primarily involved in healthcare as an administrator, and were in a senior stage of their career. In Round I, participants were presented with the updated and modernized levers defined in Phase I, asked to rate their importance on a Likert scale and given the opportunity to provide feedback. The majority of participants in Rounds 1 and 2 rated the levers as “very important” or “extremely important” and provided ideas for further updates to the lever titles and their definitions. Analysis of Rounds 1 and 2 revealed an overall positive increase in percentage change between rounds, with a greater proportion of participants rating the refined levers as important in Round 2 compared to Round 1, indicating that the revisions to the levers were resonating with participants. In Round 3 participants were presented again with further refined levers and asked for any final feedback, as well as given the opportunity to change the ordering of the levers according to importance. Participants in this final round were satisfied with the wording and ordering of the levers and emphasized that re-ordering the levers would be challenging as no one lever was felt to be more important than another, rather they form elements of a complete strategy for transformation.

The modernized six levers for healthcare transformation are:

- Create enabling policies, infrastructure, incentives, and systems for a learning culture
- Strengthen organizational capacity by supporting people to undertake improvement work
- Engage health workers and teams in creating and adopting a learning culture for change
- Focus on people and population needs in the vision, mission, and strategic plans of the organization to advance equitable and culturally safe care
- Partner with patients, families, care partners, and communities to enable improvement
- Use a wide range of evidence from learning for action

These modernized levers and definitions offer a starting point for further research, as well as providing guidance to HEC as they support health leaders and systems to achieve excellence in care.

Introduction & Background

Healthcare organizations, and health systems more broadly, are committed to improving the quality of care delivered and often aim to transform the care they provide based on best evidence (Dhalla & Tepper, 2018). When considering how to transform care, organizations and systems may use different levers to drive change. We define these levers as areas of investment that enable healthcare organizations to advance access to safe and high-quality care and bring better performance toward the Quintuple aim of improved patient experience, better patient outcomes, lower costs, improved provider experience, and overall health equity.[1] Work is ongoing to define and elaborate upon such levers, for example extensive global efforts by organizations including the World Health Organization (WHO), World Bank, and the Organisation for Economic Co-operation and Development (OECD) to better define interventions, processes, and measures towards health system strengthening, resilience, and performance (OECD, 2024; WHO, 2024; WHO et al., 2018).

In Canada, provincial/territorial health systems and healthcare organizations have introduced a range of organizational reforms with a view to bringing about performance improvement. Moreover, there are various tools and supports to assess whether and how these organizations are well positioned to achieve needed change strategies to improve performance. Drawing on research on high-performing health systems and theories of organizational change (Baker & Denis, 2011), in 2014, the Canadian Foundation for Healthcare Improvement (now Healthcare Excellence Canada [HEC]), published an assessment tool to support healthcare leaders and organizations to apply evidence to improve healthcare through projects and collaboratives (Healthcare Excellence Canada, n.d.). The *Accelerating Healthcare Improvement: Healthcare Excellence Canada Assessment Tool ©* (Healthcare Excellence Canada, 2022)[2] is built around six levers for healthcare improvement (**Box A**).

This rapid review aimed to assess the relevance of these levers when compared to contemporary frameworks, and to propose updated and modernized levers that reflect current thinking around how health systems can more effectively provide high-quality and safe care. This report describes a consensus-building process to identify a set of levers for healthcare improvement. By updating and building upon HEC's prior work, we elaborate on foundational elements required to better support systems and teams engaged in positive transformative changes.

[1] https://www.cihi.ca/en/using-patient-reported-data-to-better-assess-quality-of-care/working-toward-achieving-the-quintuple-aim

[2] Previously published as "Accelerating Healthcare Improvement: Canadian Foundation for Healthcare Improvement's Healthcare Excellence Canada's Assessment Tool (CFHIHEC Assessment Tool©) © 2014, Canadian Foundation for Healthcare Improvement."

Box A. *Accelerating Healthcare Improvement: Healthcare Excellence Canada Assessment Tool* © (Healthcare Excellence Canada, 2022)

- **Engaging healthcare providers and front-line managers in creating an improvement culture:** Engaging your healthcare providers and front-line managers to collaborate and become agents for improvement helps build a culture committed to providing better care, better health, with better value-for-money.
- **Focusing on population needs:** Focusing on population needs means understanding the population you serve (e.g., conducting a needs assessment of your catchment area). This will enable your organization to provide the right care, at the right place, and at the right time.
- **Creating supportive policies and incentives:** Creating supportive policies and incentives means implementing organizational policies that ensure a healthy workplace and support employees to acquire and use improvement skills.
- **Building organizational capacity:** Building capacity and self-reliance for improvement within your organization means training staff in healthcare improvement, giving them the ability to identify necessary improvements based on evidence (e.g., through clinical and administrative data and/or literature), supporting them in implementing these changes and recognizing them for doing so.
- **Engaging patients and citizens**: Engaging patients, family and caregivers can drive quality improvement and enable your organization to tap into a wealth of ideas and knowledge about the design, delivery and evaluation of services.
- **Promoting evidence-informed decision-making**: Promoting evidence-informed decision-making means ensuring that healthcare providers and their managers have access to up-to-date information and are trained in finding, assessing, adapting, and applying data and evidence for improvement.

Methods

Phase I: Environmental Scan

We conducted a rapid environmental scan to explore the existing six levers for healthcare improvement (described above) in relation to the recent literature on the capabilities and mechanisms through which high-performing health systems achieve their goals of providing high-quality and safe care.

Our scan focused on frameworks describing health system performance, quality, and innovation in a selection of Canadian health systems (Alberta, British Columbia, Manitoba, Newfoundland, and Ontario), based on the availability of public reports on their performance frameworks, and international comparators (Belgium and New Zealand). This was complemented by examining key frameworks proposed by global organizations (e.g., the WHO, World Bank, and OECD), as well as conceptual frameworks in the academic literature identified by collaborators.

Analysis occurred in three main phases. First, we conducted a thematic analysis of the literature to identify key themes emerging from modern frameworks for health system performance assessment and quality improvement. Second, we conducted a matrix analysis to map the modern frameworks and themes identified in the literature against HEC's original six levers to better understand the gaps in the existing levers and areas for updating the levers and their definitions. Finally, we undertook a collaborative and iterative mapping exercise using Miro, comprised of rounds of discussion and feedback with NAO team members to conduct and de-construct concepts and ideas across different domains from levers and the literature (see **Appendix A** for an example). From this mapping exercise, we proposed revised and updated text for the levers, including their titles and definitions. These levers were further discussed, refined, and agreed upon by the research team and HEC to serve as the basis for Phase II.

Phase II: Delphi Exercise

To ensure the levers identified in Phase I reflect real world practices, we conducted a modified Delphi exercise with health systems leaders to review, refine, and build consensus with an aim to produce a final set of validated levers. The Delphi process uses a series of sequential questionnaires to collect and distil knowledge from a panel of experts, who are anonymous to each other, to build reliable group consensus (Adler & Ziglio, 1996). This phase was guided by the research question: What are the key levers for supporting healthcare organizations and systems to make positive transformative changes?

This study received ethical approval from the University of Toronto Office of Research Ethics (#47281). All participants provided online written informed consent before answering survey questions.

Sample and recruitment

Our panelists comprised a diverse group of healthcare leaders, including people employed by healthcare organizations or health systems in Canada who are actively involved in quality improvement and safety, performance measurement, or systems transformation activities as well as those with perspectives stemming from lived experience. We used targeted, purposive sampling to ensure a breadth of participants with different backgrounds and perspectives among those involved in health system transformation. This included inviting individuals on HEC's distribution list to ensure representation across all of their interest holder groups, and also individuals within the NAO's network. The invitation email was sent in both English

and French. Participants were asked to provide their email addresses at the end of each round in order to be invited to subsequent survey rounds.

Data collection and analysis

The Delphi exercise consisted of three rounds of structured surveys administered using REDCap (see **Appendix B** for survey questions).[3] The surveys were available in both English and French; participants could select their preferred language at the beginning or toggle between languages at any time. Participant consent was obtained at the beginning of each survey, prior to revealing the updated levers and requesting participant feedback. Participant demographics, including gender, location (province/territory), primary role in healthcare, and career stage were captured (optional) at the end of the survey in Round 1 only.

In Round 1, we presented the first iteration of the modernized levers and their definitions established from Phase I. Participants were asked to rate the importance of the lever, using a Likert scale from 1–5, and provide feedback on its wording or content in a text box. Ratings of importance were analyzed using descriptive statistics to determine the relative importance of each. Free text responses were collated, analyzed, and thematically organized to identify consistent areas of respondent feedback, with attention to outlying feedback to ensure a breadth of perspectives from each respondent was considered. This approach acknowledges that essential insights can be offered by voices in the minority that may reflect worldviews frequently excluded from majority decision-making. The entire research team reviewed the analysis and met to discuss participants' feedback and collectively propose and further refine the levers and definitions. Through this process, updated levers were proposed for Rounds 2 and 3. Round 2 repeated the same process as Round 1. For Round 3, we presented the updated levers and definitions, and their ranking of importance based on the average scores calculated from Rounds 1 and 2. Panelists were asked whether they agreed with the ranking, and if not to propose a revised order and explain their reasoning. Finally, all panelists in Round 3 were asked to share any further reflections or suggested changes to the levers in a text box.

Data from Round 3 were analyzed both quantitatively and qualitatively to determine consensus using two prespecified criteria. First, we reviewed rankings of the order in which levers were presented. Second, comments provided in Round 3 were analyzed qualitatively. Any items expressing dissenting views could only achieve consensus if none of the dissenting views were fundamentally incompatible with the inclusion of that item. This approach recognizes that a minority of respondents may provide essential insights and takes into considerations opinions outside the majority.

Limitations

Our sample was comprised of a self-selected voluntary panel of people with expertise in health system leadership, quality improvement and safety, performance management, or health systems transformation in Canada as well as lived experience working within the health system. However, our sample may not be representative of all perspectives and experiences, and key groups may have been missed through our recruitment strategy. To mitigate this, we employed snowball sampling in Round 1 to try and reach a breadth of participants across Canada, working in different health systems and healthcare organizations. Additionally, we asked participants to state only their primary role, which may not reflect the multiple roles held by some participants. Future research on the levers could include greater representation of patients,

[3] REDCap is a secure data-management web application for building and managing online surveys and databases.

their families, caregivers, and communities using patient- and community-oriented research methods to obtain potentially more nuanced reflections.

Results

Phase I: Environmental Scan

Our findings emphasized that new concepts could appear in either the final outcomes/performance objectives of health systems, and/or in the actions or strategies (building blocks/levers) to achieve these objectives. While we were primarily interested in the actions themselves (what governments and organizations can do, or invest in), we also identified new or emerging health system performance objectives that reflect an evolving understanding of what health systems are trying to achieve.

A thematic analysis of the literature included in our scan identified several additional concepts that characterize recent frameworks for health system quality and transformation. Equity and health equity emerge as fundamental dimensions in contemporary frameworks and approaches. Emphasizing people-centredness, whether termed patient-centredness, person-centredness, or client-centredness, is also underscored across frameworks. Additionally, recent frameworks in several Canadian jurisdictions, as well as New Zealand, highlight that it is essential to ensure a culturally safe healthcare system that delivers equitable, high-quality care to First Nations, Métis, and Inuit people. Incorporating elements of digital transformation, technology, and innovation are featured throughout frameworks, as is ensuring coordination and integration to achieve high-quality and safe healthcare. Frameworks also point to the need for strong leadership to create learning systems that drive improvements, while valuing transparency and accountability. Underpinning these ideas was an emphasis on minimizing disruption in the face of ongoing health system stressors that require action at all levels, and the need to consider broader dimensions of health system performance (e.g., environmental sustainability).

Table 1 shows that the concepts emphasized across the 25 reviewed frameworks mapped well to the original six levers for healthcare improvement. **Table 2** displays our mapping of key concepts from the literature to the six levers, their definitions, and their indicators to assess gaps and identify opportunities to modernize the language of the levers. This table was used as a starting point to reformulate the original six levers for healthcare improvement and ensure that updates reflected key concepts identified in our environmental scan. The first iteration of the modernized levers is presented in **Appendix B – Round 1**.

TABLE 1. Analysis of 25 frameworks mapped to concepts in HEC levers for healthcare improvement

Framework/Source	Six levers for healthcare improvement (HEC, 2014)					
	Engaging healthcare providers and front-line managers in creating an improvement culture	Focusing on population needs	Creating supportive policies and incentives	Building organizational capacity	Engaging patients and citizens	Promoting evidence-informed decision-making
PROVINCIAL FRAMEWORKS						
Improving BCs Health System Performance (Doctors of BC, 2017)	✓		✓	✓		✓
Long-Term Care Quality Framework (BC Ministry of Health, 2024)		✓			✓	✓
BC First Nations Pathway for Quality Improvement (First Nations Health Authority, 2023a)	✓	✓	✓	✓	✓	✓
BC First Nations Perspective on Quality (First Nations Health Authority, 2023b)	✓	✓	✓		✓	✓
BC Health Quality Matrix (Health Quality BC, 2023)		✓			✓	✓
Indigenous Healthcare Quality Framework (Ongomiizwin Indigenous Institute of Health and Healing and George & Fay Yee Centre for Healthcare Innovation, 2022)	✓				✓	
Manitoba Quality & Learning Framework (Shared Health Manitoba, 2019)	✓	✓	✓	✓	✓	✓
Health Quality Council of Alberta (Health Quality Council of Alberta, 2022)	✓	✓			✓	
Newfoundland Learning Health System(Quality of Care NL, 2023)	✓	✓	✓	✓	✓	✓
EPIC Learning Health System (Alliance for Healthier Communities, n.d.)		✓			✓	✓
Ontario Health Annual Business Plan 2023/24 (Ontario Health, 2023)	✓		✓		✓	✓
Ontario SPOR Support Unit Learning Health System Research Brief (Reid et al., 2023)	✓	✓	✓	✓	✓	✓
INTERNATIONAL COMPARATORS						
Performance of the Belgian health system: Revision of the conceptual framework 2023 (Gerkens et al., 2023)	✓				✓	✓
New Zealand Health Strategy 2023 (Minister of Health, 2023)	✓	✓	✓	✓	✓	✓
New Zealand National Framework for Home and Community Support Services (Ministry of Health, 2020)	✓				✓	✓
LITERATURE						
House of Trust framework (Vanhaecht et al., 2024)	✓		✓	✓	✓	✓
A framework for value-creating Learning Health Systems (Menear et al., 2019)	✓	✓	✓	✓	✓	✓
GLOBAL						
Rethinking Health System Performance Assessment (OECD, 2024)	✓	✓	✓		✓	✓
Health system performance assessment: a primer for policy-makers (Rajan et al., 2022)	✓	✓	✓	✓	✓	✓
Change Cannot Wait: Building Resilient Health Systems (World Bank, 2022)	✓	✓	✓	✓	✓	✓
Health systems resilience toolkit (WHO, 2022)	✓	✓	✓		✓	✓
Strengthening health systems resilience: key concepts and strategies (Thomas et al., n.d.)	✓	✓	✓	✓		✓
Delivering quality health services (WHO et al., 2018)	✓	✓	✓	✓	✓	✓
Crossing the Global Quality Chasm (National Academies of Sciences, Engineering, and Medicine, 2018)		✓				✓
Framework on integrated, people-centred health service (WHO, 2016)	✓	✓	✓	✓	✓	✓

TABLE 2. Mapping emergent domains in the literature to HEC's six levers for healthcare improvement

Emergent Domains	Six levers for healthcare improvement (HEC, 2014)					
	Engaging healthcare providers and front-line managers in creating an improvement culture	Focusing on population needs	Creating supportive policies and incentives	Building organizational capacity	Engaging patients and citizens	Promoting evidence-informed decision-making
Equity		✓	✓			
Cultural safety		✓				
Environmental sustainability						
Leadership	✓		✓			
Minimizing disruption	✓	✓		✓		
Transparency and accountability	✓	✓	✓	✓		
Digital and innovation			✓	✓	✓	✓
Learning	✓	✓	✓	✓	✓	✓
Coordination and integration				✓		

Phase II: Delphi

Panelist response and retention rates varied across Delphi rounds (Table 3). In Round 1, a total of 70 surveys were completed and included in the analysis. Sixty panelists from Round 1 provided their email address to participate in Round 2, of which 33 responded (53% response rate); for Round 3, 28 of the 33 (85%) responded. Across rounds, most respondents identified as women, were in the provinces of Ontario or Alberta, were primarily involved in healthcare as an administrator, and were in a senior stage of their career.

TABLE 3. Participant characteristics

Characteristic	Round 1 (N=70)		Round 2 (N=33)		Round 3 (N=28)	
	No.	%	No.	%	No.	%
Gender:						
Woman	39	56%	24	73%	20	71%
Man	23	33%	9	27%	8	29%
Not answered/ specified	8	11%	0	-	0	-
Location (Province/Territory):						
Ontario	18	26%	11	33%	9	32%
Alberta	13	19%	6	18%	6	21%
British Columbia	10	14%	5	15%	5	18%
Quebec	8	11%	4	12%	2	7%
Manitoba	3	4%	2	6%	2	7%
Saskatchewan	3	4%	1	3%	1	4%
New Brunswick	2	3%	2	6%	1	4%
Yukon	2	3%	2	6%	2	7%
Nova Scotia	2	3%	0	-	0	-
Northwest Territories	1	1%	0	-	0	-
Not answered/specified	8	11%	0	-	0	-

Characteristic	Round 1 (N=70) No.	%	Round 2 (N=33) No.	%	Round 3 (N=28) No.	%
Primary role in healthcare:						
Administrator (incl. Executives, Senior Leaders, Managers, Directors)	25	36%	17	52%	14	50%
Other[1]	7	10%	2	6%	2	7%
Researcher	6	9%	2	6%	1	4%
Consultant	5	7%	3	9%	3	11%
Healthcare provider[2]	4	6%	2	6%	1	4%
Patient/family member/ community member/person with lived experience	4	6%	2	6%	2	7%
Policy advisor/Analyst	4	6%	2	6%	2	7%
Quality and safety improvement lead	3	4%	2	6%	2	7%
Indigenous Leader	3	4%	1	3%	1	4%
Recreation therapist/Activities coordinator	1	1%	0	-	0	-
Not answered	8	11%	0	-	0	-
Career stage:						
Senior (15+ years of experience)	49	70%	25	76%	21	75%
Mid (5–15 years of experience)	10	14%	6	18%	6	21%
Early (less than 16 years of experience)	2	3%	1	3%	1	4%
Not answered/specified	9	13%	1	3%	0	-

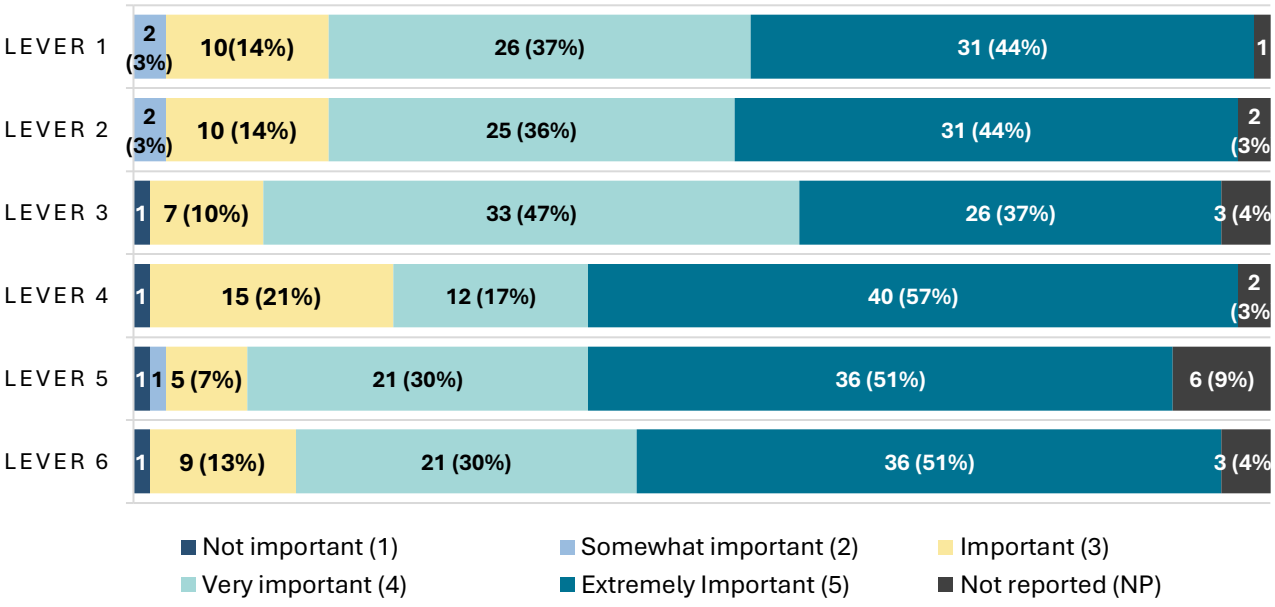
[1] Participants who selected "other" did not specify further.

[2] Healthcare provider: Round 1 included 3 physicians, and 1 nurse (Nurse Practitioner, Registered Nurse, or Licensed Practical Nurse); Round 2 included 1 physician and 1 nurse; and Round 3 included 1 physician.

Round 1

Overall, participants in Round 1 thought that all six levers were important, with most being rated as "very important" or "extremely important." There were few instances where a lever was rated "not important" or "somewhat important" (**Figure 1**).

Figure 1. Lever Importance – Survey 1 (N=70)

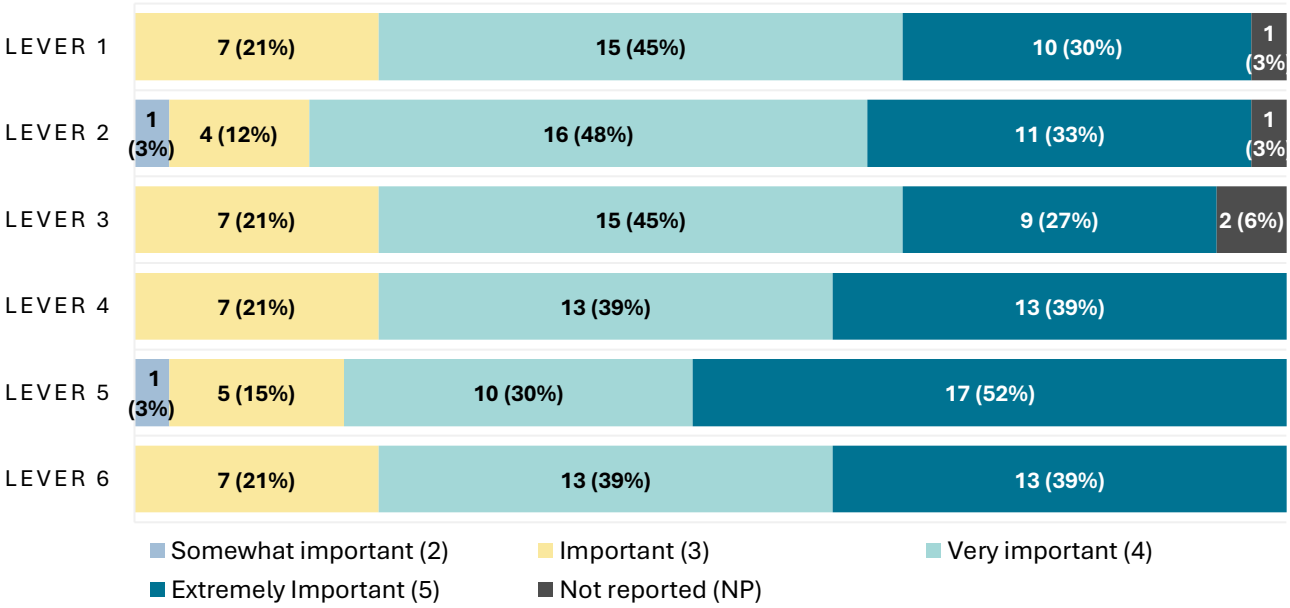


Qualitative thematic analysis of participant feedback for Round 1 revealed that most input included minor editorial suggestions (e.g., alternative wordings and clarifications) and some suggestions for additions or elaborations for conceptual clarity and specificity. Participants also offered more general reflections about ideal versus realistic levers and emphasized the general importance of the lever. For example, participants flagged the use of language and proposed to adjust to more person-centred and inclusive language. Specifically, it was suggested to modify "patient centered" to "person centred" and ensure that all levers are applicable to any person/individual (e.g., LTC residents, clients of social services, etc.) rather than just a patient or caregiver. Another participant suggested moving beyond the term "person-centred" to "person-directed." Relatedly, it was suggested to use "healthcare team" rather than just "providers/managers" to be more inclusive of all healthcare workers involved in care delivery. Finally, there was feedback provided throughout various levers to more substantively consider Indigenous knowledge systems. For example: "Indigenous project management and QI approaches also need to be incorporated to help non-Indigenous health leaders collaborate with Indigenous communities in a culturally safe way."

Round 2

In Round 2, participants again reported that all six levers were important, with most being rated as "very important" or "extremely important." There were few instances where a lever was rated "somewhat important" (**Figure 2**).

Figure 2. Lever Importance – Survey 2 (N=33)



We compared the percentage change in rating between Round 1 and 2 to gauge if a greater proportion of participants were rating the levers as important as we refined the text and definitions based on their input. In Round 2, a greater proportion of participants rated importance for the updated versions of Levers 1, 4, 5, and 6 (with importance being defined as responding "important," "very important," or "extremely important" on the Likert scale provided). There was no percentage change to Levers 2 and 3 between rounds (see **Appendix C** for more granular analysis).

TABLE 4. Percent (%) change rating of importance between Round 1 and Round 2

Lever	Responding Important[1]		% Change between Round 1 & Round 2
	Round 1 (N=70) n (%)	Round 2 (N=33) n (%)	
Lever 1	67 (96)	32 (97)	+1%
Lever 2	66 (94)	31 (94)	0%
Lever 3	66 (94)	31 (94)	0%
Lever 4	67 (96)	33 (100)	+4%
Lever 5	62 (89)	32 (97)	+8%
Lever 6	66 (94)	33 (100)	+6%

[1] Importance rated as responding 3 (important), 4 (very important), or 5 (extremely important).

Participants emphasized the importance of leadership development and training as an "important piece in how to create a learning system" and emphasized the need for training on building leadership capabilities, styles, and practices, specifically around authentic leadership and change leadership. One participant summarized the "need to build leadership practices for the 21st century." Participants also underscored the need for protected time and/or rewards for undertaking learning systems work, highlighting that, "No matter how well-trained and even passionate people are, it won't happen if it's off the side of their desks."

Round 3

In Round 3, participants were presented with the text for each lever updated during Round 2. Participants did not propose any wording changes to the levers from Round 2. They were also offered the opportunity to propose changes to the ordering of the levers.

Participants reported varied responses as to their ordering, with most not completing the ordering exercise but instead providing qualitative feedback. As one participant summarized "I find it difficult to view the levers as one being more important than another. They are all equally important, but what is critical is the sequence in which the levers are pulled! There is a logical order or sequence of events that is necessary to set the next lever activities up for success." Others reported that the presented order of the levers captured the dependencies between levers and layers of action in creating an ecosystem of transformation and learning. One participant summarized this as "Each lever builds on the next to create a complete strategy that focuses on person-centered care." The two participants who provided a complete re-ranking did not rank in the same way and one reported that "I recognize that all are important, and a context-independent ordering is difficult and the levers are inter-related."

Participants also provided some more general and conceptual reflections. However, one participant raised concerns that Lever 4 may not be realistic in practice as organizational mandates may not be able to meet the needs at the population level and to instead "place the focus on health workers and teams slightly ahead of organizational capacity." Another participant also emphasized the nuances and dynamics between policies, organizations, and the capacities needed to undertake this work. Another reflected that "Engaging staff in adopting a learning culture supported by policy/infrastructure is the first step in moving from policy to practice." Participants also underscored the need to use levers to drive towards results and achieving the Quintuple aim. Some highlighted that the needs of health workers, patients, families, and communities

should be even more prominently centered and that these levers can form a starting point to "map out directions together" with one participant cautioning that "focusing on the quality of care offered can inadvertently lead to an increase in health inequalities."

Modernized Levers for Healthcare Improvement

The three rounds of feedback and ratings from participants resulted in six updated levers for healthcare transformation with revised definitions that more directly elaborate on the meanings and elements that underpin each lever. The order below does not indicate a specific order, as research and participant feedback demonstrated that these levers are interconnected, with no single lever being more important than another. Future work led by HEC to develop tools and resources based on these levers may lead to variations of the overarching titles and descriptions, including shorter versions where appropriate.

Create enabling policies, infrastructure, incentives, and systems for a learning culture

At the system level, creating enabling policies, infrastructure, incentives, and systems to support a learning culture means that health workers and managers can become leaders for continuous improvement guided by organizational and community values. This requires investment in policies and infrastructure to encourage learning work, incentives to motivate people to take on learning work, and the digital systems in place for effective and timely monitoring and evaluation. This also requires system supports and mechanisms to ensure learning, from both successes and failures, is translated to practice.

Strengthen organizational capacity by supporting people to undertake improvement work

Organizations value learning, thoughtful innovation, and continuous improvement under a shared vision of a learning system that is embedded in their mission and strategic plans, with protected time to undertake this work. This means organizations empower and support people by ensuring health workers and managers are trained on improvement skills, with authority to undertake improvement work, aligned processes that support them to apply their training, and encouragement to collaborate and pursue innovative ideas. Regular opportunities to refresh and deepen their improvement skillset, leadership capabilities, and recognition for learning leadership are also essential.

Engage health workers and teams in creating and adopting a learning culture for change

Engaging teams to collaborate and become leaders for learning helps build a culture committed to providing better quality and safer care, and better health outcomes with better value-for-money. Engagement means having strategies and processes in place to actively engage and support every staff member in contributing to knowledge and engaging in learning efforts with an emphasis on equity-oriented approaches. This could take the form of peer learning, co-design, consultations, and other forms of gathering feedback. Care should be taken to ensure engagement does not become an additional burden on teams.

Focus on people, community, and population needs in the vision, mission, and strategic plans of the organization to advance culturally safe and equitable care

Understanding the people, communities, and populations being served and the factors that shape their health and well-being means considering their unique strengths and assets, as well as their needs, risks, threats, challenges, and opportunities in the community and health system, and how these impact health service needs and delivery. The vision, mission, and strategic plans of the organization require an

understanding of the people and communities they serve, including those who are systemically and structurally oppressed. Organizations are guided by a commitment to advancing equity and cultural safety through outreach, as well as engagement-driven change to enable the right care, by the right provider, at the right place and time.

Partner with patients, families, care partners, and communities to enable improvement

Partnering with patients, families, care partners, and communities means putting policies, processes, and structures in place that meaningfully include, support, and value lived experience to co-develop and provide safe—including culturally safe and person-centered—care that meets their diverse needs and reduces inequities. This includes a distinctions-based approach to partnering with Indigenous communities. Using a range of carefully selected engagement approaches, methods, and tools in safety and improvement learning activities, with clear feedback and evaluation mechanisms, will ensure change is driven based on partnership with the people impacted most.

Use a wide range of evidence from learning for action

A wide range of evidence from learning should drive action and be used for decision-making to shape health service delivery policy, strategy, and practice at all levels of the health system. This considers, for example, experiential knowledge, Indigenous knowledge systems, and research and analysis. This requires processes and systems in place to collect data and ensure access to up-to-date information, driven by a culture of inquiry, transparency, trust, and accountability to mobilize and use knowledge and evidence at all levels, with networks to share and disseminate learnings.

Conclusion

This rapid review presents an environmental scan and modified Delphi, including quantitative and qualitative analyses, to update and modernize HEC's levers for healthcare transformation. The resulting six levers and definitions offer a starting point for further research, as well as provide guidance to HEC as they support health leaders and systems in pursuit of excellence in care

Future work may include undertaking a broader consultation with other interest-holder groups to explore how the levers can be operationalized and effectively contextualized in health systems and healthcare organizations across Canada. Building on this exercise, indicators can be developed to better assess, monitor, and evaluate progress towards heath system transformation based on the use of these levers. In addition, to more fully operationalize these levers in a given healthcare organization or system will require a careful diagnosis of existing capacities and plan for capacity development, as well as tailored supports to help strengthen their use. **Appendix D** provides some initial questions that could guide further development of monitoring and evaluation efforts.

References

Adler, M., & Ziglio, E. (1996). *Gazing Into the Oracle: The Delphi Method and Its Application to Social Policy and Public Health*. Jessica Kingsley Publishers.

Alliance for Healthier Communities. (n.d.). *The EPIC Learning Health System*. Retrieved January 8, 2025, from https://www.allianceon.org/EPIC-Learning-Health-System

Baker, G. R., & Denis, J.-L. (2011). *A Comparative Study of Three Transformative Healthcare Systems: Lessons for Canada*. Canadian Health Services Research Foundation. https://www.healthcareexcellence.ca/media/figl34io/baker-denis-en.pdf

BC Ministry of Health. (2024). *Long-Term Care Quality Framework* (p. 9) [Policy Directive]. https://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/pdf/ltc_quality_framework_policy_directive.pdf

Dhalla, I. A., & Tepper, J. (2018). Improving the quality of health care in Canada. *CMAJ*, *190*(39), E1162–E1167. https://doi.org/10.1503/cmaj.171045

Doctors of BC. (2017). *Improving BC's Health System Performance* (p. 27) [Policy Paper]. Doctor's of BC. https://www.doctorsofbc.ca/sites/default/files/docsbc_health_system_performance_paper_v8b-web.pdf

First Nations Health Authority. (2023a). *BC First Nations Pathway for Quality Improvement*. https://www.fnha.ca/Documents/BC-First-Nations-Pathway-for-Quality-Improvement.pdf

First Nations Health Authority. (2023b). *BC First Nations Perspective on Quality*. https://www.fnha.ca/Documents/BC-First-Nations-Perspective-on-Quality.pdf

Gerkens, S., Maertens de Noordhout, C., Lefèvre, M., Levy, M., Bouckaert, N., Obyn, C., Devos, C., Scohy, A., De Pauw, R., Devleesschauwer, B., Vlayen, A., Yaras, H., Janssens, C., & Meenus, P. (2023). *Performance of the Belgian health system: Revision of the conceptual framework and indicators set* (370; KCE Report, p. 89). Belgian Health Care Knowledge Centre (KCE). https://kce.fgov.be/sites/default/files/2023-06/KCE_370_Performance_Revision_framework_conceptual_Report.pdf

Health Quality Council of Alberta. (2022). *Quality Matrix Refresh: What we Learned and Heard (Phase One)* (p. 11). Health Quality Council of Alberta. https://hqca.ca/wp-content/uploads/2022/12/HQCA_QMR_What_We_Learned_and_Heard_2022-Dec-16.pdf

Healthcare Excellence Canada. (n.d.). *Assessment Tool for Healthcare Delivery Organizations and Systems*. Retrieved January 8, 2025, from https://www.healthcareexcellence.ca/en/resources/assessment-tool-for-healthcare-delivery-organizations-and-systems/

Healthcare Excellence Canada. (2022). *Accelerating Healthcare Improvement: Healthcare Excellence Canada Assessment Tool©*.

Menear, M., Blanchette, M.-A., Demers-Payette, O., & Roy, D. (2019). A framework for value-creating learning health systems. *Health Research Policy and Systems*, *17*(1), 79. https://doi.org/10.1186/s12961-019-0477-3

Minister of Health. (2023). *New Zealand Health Strategy 2023*. Ministry of Health. https://www.health.govt.nz/system/files/2023-07/new-zealand-health-strategy-oct23.pdf

Ministry of Health. (2020). *National Framework for Home and Community Support Services (HCSS)* (p. 29). Ministry of Health. https://www.health.govt.nz/system/files/2020-06/national_framework_for_home_and_community_support_services_29sept2020.pdf

National Academies of Sciences, Engineering, and Medicine. (2018). *Crossing the Global Quality Chasm: Improving Health Care Worldwide*. The National Academies Press. https://doi.org/10.17226/25152

OECD. (2024). *Rethinking Health System Performance Assessment: A Renewed Framework* (OECD Health Policy Studies). OECD Publishing. https://doi.org/10.1787/107182c8-en

Ongomiizwin Indigenous Institute of Health and Healing, & George & Fay Yee Centre for Healthcare Innovation. (2022). *Indigenous Healthcare Quality Framework*. University of Manitoba. https://umanitoba.ca/ongomiizwin/sites/ongomiizwin/files/2022-10/Indigenous%20Health%20Care%20quality%20framework.pdf

Ontario Health. (2023). *Annual Business Plan 2023/24*.

Quality of Care NL. (2023). *Implementing a Learning Health and Social System in Newfoundland and Labrador* (Practice Points: Volume 10). https://qualityofcarenl.ca/wp-content/uploads/2023/08/PP10_Implementing-a-Learning-Health-and-Social-System-in-NL.pdf

Rajan, D., Papanicolas, I., Karanikolos, M., Koch, K., Rohrer-Herold, K., & Figueras, J. (2022). *Health system performance assessment: A primer for policy-makers* (Policy Brief 49). WHO Regional Office for Europe. https://iris.who.int/bitstream/handle/10665/364198/Policy-brief-49-1997-8073-eng.pdf?sequence=1&isAllowed=y

Reid, R., Wodchis, P., Kuluski, K., Lee-Foon, N., Lavis, N., Rosella, L., & Desveaux, L. (2023). *A Learning Health System Adoption Engine that Integrates Research and Health Systems* (Learning Health System Research Brief 1, p. 6). Institute for Better Health, Trillium Health Partners. https://ossu.ca/wp-content/uploads/Learning-Health-System-Brief-27Oct2023.pdf

Shared Health Manitoba. (2019). *Manitoba Quality & Learning Framework* (p. 14). Shared Health Manitoba. https://sharedhealthmb.ca/files/quality-and-learning-framework-2019.pdf

Thomas, S., Sagan, A., Larkin, J., Cylus, J., Figueras, J., & Karanikolos, M. (n.d.). *Strengthening health systems resilience: Key concepts and strategies* (Policy Brief 36). European Observatory on Health Systems and Policies; WHO Regional Office for Europe. Retrieved January 8, 2025, from https://www.ncbi.nlm.nih.gov/books/NBK559803/pdf/Bookshelf_NBK559803.pdf

Vanhaecht, K., Lachman, P., Van der Auwera, C., Seys, D., Claessens, F., Panella, M., & De Ridder, D. (2024). The “House of Trust”. A framework for quality healthcare and leadership. *F1000Research*, *13*, 503. https://doi.org/10.12688/f1000research.149711.1

WHO. (2016). *Framework on integrated, people-centred health services: Report by the Secretariat*. https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf

WHO. (2022). *Health Systems Resilience Toolkit: A WHO Global Public Health Good to Support Building and Strengthening of Sustainable Health Systems Resilience in Countries with Various Contexts*. World Health Organization.

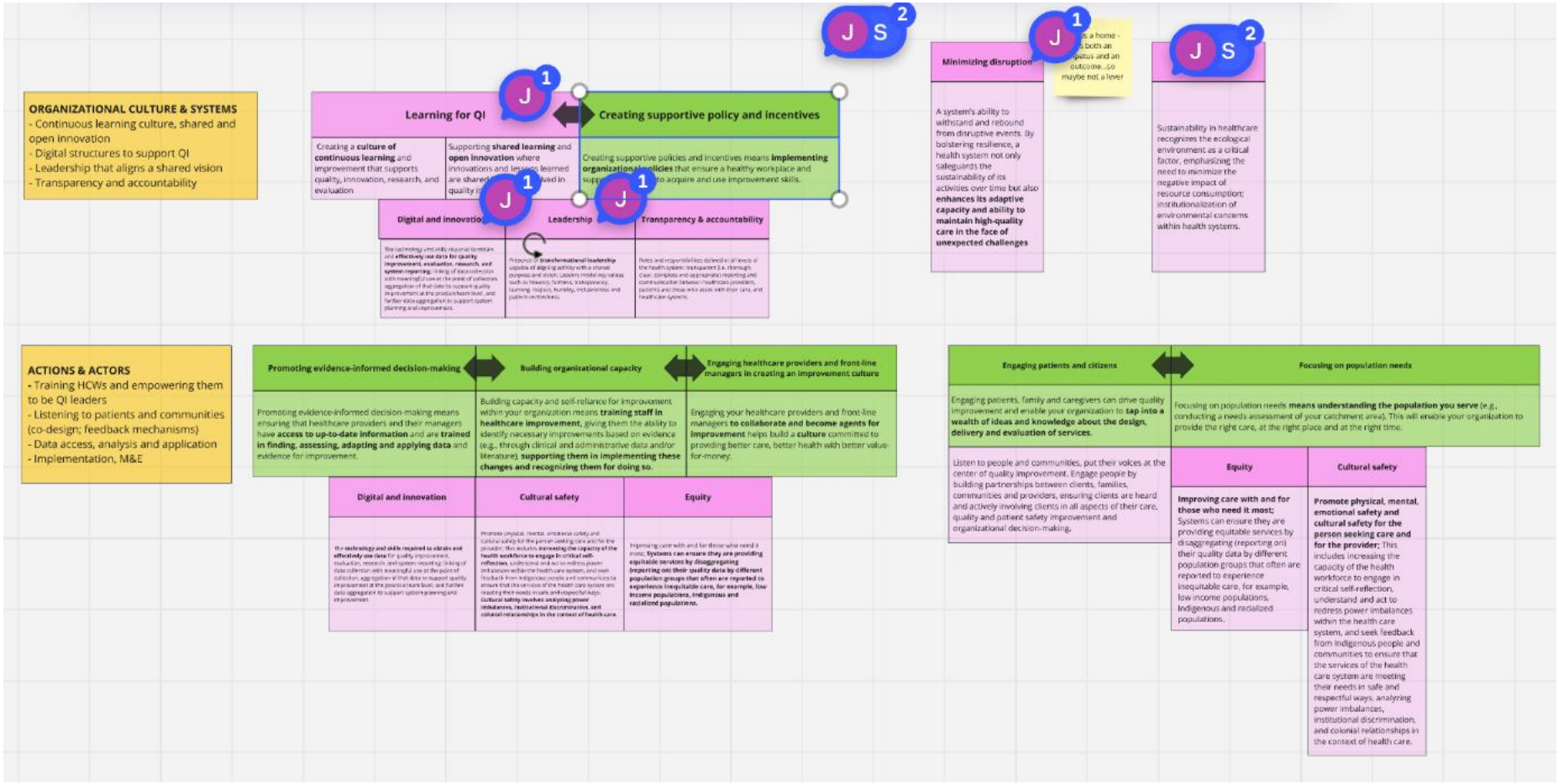
WHO. (2024). *Health system resilience indicators: An integrated package for measuring and monitoring health system resilience in countries*. World Health Organization. https://iris.who.int/bitstream/handle/10665/376071/9789240088986-eng.pdf?sequence=1

WHO, World Bank Group, & OECD. (2018). *Delivering Quality Health Services: A Global Imperative for Universal Health Coverage*. Geneva: World Health Organization. https://doi.org/10.1596/978-92-4-151390-6

World Bank. (2022). *Change Cannot Wait: Building Resilient Health Systems in the Shadow of COVID-19*. World Bank Group. https://openknowledge.worldbank.org/server/api/core/bitstreams/a560d0b2-b2dc-5800-84a3-0ac0b29477cc/content

Appendix A. Example of Concept Mapping Workspace

Example of Miro working space to conceptually map our analysis to the original six levers:



Appendix B. Survey Questions and Levers

Round 1

English Version

MODERNIZING THE SIX LEVERS FOR HEALTHCARE IMPROVEMENT

Below we present the modernized (updated) levers. Please rank your perceived level of importance and provide suggestions on how to improve the title or definition (if applicable).

1. **Create enabling policies, incentives and systems for a learning culture**

   Definition: Creating enabling policies, incentives and systems to support a learning culture means that healthcare providers, front-line managers, and all staff can become leaders for learning and continuous improvement guided by organizational values. This requires investment in an ecosystem of policies to encourage learning work, incentives to motivate people to take on learning work, the digital systems in place for effective and timely monitoring and evaluation, and mechanisms to ensure learning is translated to practice.

Importance:	(1) Not important at all	(2) Somewhat important	(3) Important	(4) Very important	(5) Extremely important
	☐	☐	☐	☐	☐

Feedback (lever 1): _____

2. **Build organizational capacity to empower people**

   Definition: Building organizational capacity to empower people means ensuring self-reliance for learning and continuous improvement. This includes healthcare providers and frontline managers trained on improvement skills, support to use their training with regular opportunities to refresh and deepen their improvement skillset, and recognition for learning leadership.

Importance:	(1) Not important at all	(2) Somewhat important	(3) Important	(4) Very important	(5) Extremely important
	☐	☐	☐	☐	☐

Feedback (lever 2): _____

3. **Engage healthcare providers and frontline managers in creating a learning culture**

   Engaging your healthcare providers and frontline managers to collaborate and become leaders for learning helps build a culture committed to providing better quality and safer care, better health with better value-for-money. Engagement means having strategies and processes in place to ensure that those who are at the forefront of health delivery are heard and feel psychologically

safe to shape improvement and learning efforts. This could take the form of co-design, consultations, and other forms of gathering feedback.

Importance:	(1) Not important at all	(2) Somewhat important	(3) Important	(4) Very important	(5) Extremely important
	☐	☐	☐	☐	☐

Feedback (lever 3): _____

4. Focus on population needs to advance equitable and culturally safe care

Definition: Understanding the people you serve and the factors that shape their health and well-being means considering the unique needs, risks, and threats in your community and how these impact health service needs and delivery. This requires an understanding of all community members, including vulnerable or underserved groups, guided by a commitment to advancing equity and cultural safety through outreach and engagement to enable your organization to provide the right care, at the right place and time.

Importance:	(1) Not important at all	(2) Somewhat important	(3) Important	(4) Very important	(5) Extremely important
	☐	☐	☐	☐	☐

Feedback (lever 4): _____

5. Engage patients, caregivers, and communities to drive improvement

Definition: Understanding the people you serve means engaging with patients, their caregivers, and the wider community, including community groups and leaders, to provide culturally safe and patient-centered care that meets their diverse needs and reduces inequities (e.g., through needs assessments, patient feedback mechanisms). Including patients, caregivers, and communities using a range of engagement approaches in safety and improvement learning activities will ensure they are driven by the people impacted most.

Importance:	(1) Not important at all	(2) Somewhat important	(3) Important	(4) Very important	(5) Extremely important
	☐	☐	☐	☐	☐

Feedback (lever 5): _____

6. **Use evidence from learning for action**

Definition: The evidence produced from learning activities should drive action and be used for decision-making to shape health service delivery policy and practice. This requires systems in place to ensure access to up-to-date information and a culture of transparency and accountability to use evidence at all levels of the organization.

Importance:	(1) Not important at all	(2) Somewhat important	(3) Important	(4) Very important	(5) Extremely important
	☐	☐	☐	☐	☐

Feedback (lever 6): _____

DEMOGRAPHICS

Please complete the following demographics section. If you choose to participate in future rounds of the Delphi survey, you will not have to complete this section again.

**mandatory fields*

1. Name *: _____
2. Email *: _____
3. Gender:
4. Province/Territory:
5. **What is your primary role in healthcare? (Choose one)**:
    1. Administrator (includes Executives, Senior Leaders, Managers, Directors)
    2. Consultant
    3. Healthcare Provider
        a. Allied health professional
        b. Pharmacist
        c. Physician
        d. Nurse (Nurse Practitioner, Registered Nurse, Licensed Practical Nurse)
        e. Personal Support Worker/Care Aide
        f. Other healthcare provider
    4. Indigenous Leader
    5. Patient/family member/community member/person with lived experience
    6. Policy Advisor/Analyst
    7. Quality and Safety Improvement Lead
    8. Recreation Therapist/Activities Coordinator
    9. Researcher
    10. Student
    11. Other
6. Career stage:
    - Early career (less than 5 years experience)
    - Mid career (5-15 years of experience)
    - Senior (15+ years of experience)

French Version

MODERNISER LES SIX LEVIERS POUR L'AMÉLIORATION DES SERVICES DE SANTÉ

Vous trouverez ci-dessous la version actualisée des six leviers. Veuillez évaluer le niveau d'importance que vous attachez à chacun de ces leviers, et formuler des suggestions en vue d'en améliorer le titre ou la définition (s'il y a lieu).

1. **Créer des politiques, des mesures incitatives et des systèmes propices à une culture d'apprentissage**

   Définition : Créer des politiques, des mesures incitatives et des systèmes pour favoriser une culture d'apprentissage afin que les prestataires de soins de santé, les gestionnaires de première ligne et tous les membres du personnel puissent devenir des chefs de file engagés dans l'apprentissage et l'amélioration continue, et guidés par les valeurs organisationnelles. Cela suppose d'investir dans un écosystème de politiques pour encourager les efforts d'apprentissage; de créer des mesures incitatives pour motiver les parties prenantes à s'engager dans cette démarche d'apprentissage; de mettre en place des systèmes numériques pour assurer une supervision et une évaluation efficaces et opportunes; et de créer des mécanismes pour veiller à ce que les apprentissages se reflètent dans les pratiques.

Importance :	(1) Pas du tout important	(2) Relativement important	(3) Important	(4) Très important	(5) Extrêmement important
	☐	☐	☐	☐	☐

Rétroaction (levier 1) : _____

2. **Renforcer la capacité organisationnelle à donner le pouvoir d'agir**

   Définition : Lorsque l'on renforce la capacité organisationnelle à donner le pouvoir d'agir, toute personne peut alors s'engager de façon autonome dans une démarche d'apprentissage et d'amélioration continue. Cela suppose de former les prestataires de soins de santé et les gestionnaires de première ligne aux compétences d'amélioration, de leur donner régulièrement l'occasion de les mettre à profit et de les développer, et de valoriser le leadership en matière d'apprentissage.

Importance :	(1) Pas du tout important	(2) Relativement important	(3) Important	(4) Très important	(5) Extrêmement important
	☐	☐	☐	☐	☐

Rétroaction (levier 2) : _____

3. **Mobiliser les prestataires de soins de santé et les gestionnaires de première ligne dans la création d'une culture d'apprentissage**

Définition : En mobilisant vos prestataires de soins de santé et vos gestionnaires de première ligne pour qu'ils travaillent en collaboration et deviennent des chefs de file de l'apprentissage, vous contribuez à bâtir une culture marquée par la volonté d'accroître la qualité et la sécurité des soins, mais aussi d'améliorer la santé et l'optimisation des ressources. Pour ce faire, des stratégies et des processus doivent être mis en place pour veiller à ce que toutes les personnes directement impliquées dans l'acte de soin soient entendues et se sentent psychologiquement en sécurité pour contribuer aux efforts d'apprentissage et d'amélioration. Ces stratégies et processus peuvent prendre la forme d'une co-conception, de consultations ou de diverses méthodes de recueil de rétroactions.

Importance :	(1) Pas du tout important	(2) Relativement important	(3) Important	(4) Très important	(5) Extrêmement important
	☐	☐	☐	☐	☐

Rétroaction (levier 3) : _____

4. Se concentrer sur les besoins de la population pour progresser vers l'équité et la sécurité culturelle des soins de santé

Définition : Pour comprendre la population desservie et les facteurs qui influent sur sa santé et son bien-être, il faut tenir compte de ses besoins uniques, des risques et des menaces dans la communauté et de leurs répercussions sur les besoins et la prestation des services de santé. Cette analyse doit porter sur l'ensemble des membres de la communauté, y compris les groupes vulnérables ou mal desservis, et reposer sur un engagement à progresser vers l'équité et la sécurité culturelle des soins par le travail de proximité et la mobilisation, afin de donner à l'organisme les moyens de fournir les soins adéquats, au bon moment et au bon endroit.

Importance :	(1) Pas du tout important	(2) Relativement important	(3) Important	(4) Très important	(5) Extrêmement important
	☐	☐	☐	☐	☐

Rétroaction (levier 4) : _____

5. Mobiliser les patientes et les patients, les personnes proches aidantes et les communautés pour susciter des améliorations

Définition : Comprendre la population desservie suppose de mobiliser les patientes et les patients, les personnes proches aidantes et la communauté élargie, y compris les groupes et les leaders communautaires, pour fournir des soins centrés sur la personne et respectueux des valeurs culturelles qui répondent à leurs besoins diversifiés et réduisent les iniquités (au travers d'évaluations des besoins ou de mécanismes de rétroaction des bénéficiaires de soins, par exemple). Intégrer les patientes et les patients, les personnes proches aidantes et les communautés aux initiatives d'apprentissage liées à la sécurité et l'amélioration, à l'aide

d'approches d'engagement diversifiées, permet de veiller à ce que ces initiatives soient dirigées par ceux et celles qui en bénéficieront le plus.

	(1) Pas du tout important	(2) Relativement important	(3) Important	(4) Très important	(5) Extrêmement important
Importance :	☐	☐	☐	☐	☐

Rétroaction (levier 5) : _____

6. **Exploiter les données probantes issues des initiatives d'apprentissage pour passer à l'action**

   Définition : Les données probantes recueillies dans le cadre des initiatives d'apprentissage doivent guider l'action et orienter la prise de décisions pour façonner les politiques et les pratiques relatives à la prestation de services de santé. Pour ce faire, il est nécessaire de mettre en place des systèmes garantissant l'accès aux informations les plus récentes, et d'instaurer une culture de la transparence et de la responsabilité afin que les données probantes soient exploitées à tous les échelons organisationnels.

	(1) Pas du tout important	(2) Relativement important	(3) Important	(4) Très important	(5) Extrêmement important
Importance :	☐	☐	☐	☐	☐

Rétroaction (levier 6) : _____

DONNÉES DÉMOGRAPHIQUES

Veuillez remplir les champs ci-dessous. Si vous choisissez de participer aux itérations suivantes du sondage Delphi, vous n'aurez plus à remplir cette section.

** Champs obligatoires*

7. Prénom et nom* : _____
8. Courriel* : _____
9. Genre :
10. Province ou territoire :
11. Quel est votre rôle principal dans les services de santé? (Choisissez une réponse. :
    1. Responsable de l'administration (cadre, gestionnaire, membre de la haute direction ou de la direction, etc.)
    2. Consultante ou consultant
    3. fournisseur de soins de santé
        a. Professionnelle ou professionnel paramédical
        b. Pharmacienne ou pharmacien
        c. Médecin
        d. Membre du personnel infirmier (infirmière praticienne, infirmière ou infirmier autorisé, infirmière ou infirmier auxiliaire autorisé)

    e. Personne préposée aux services de soutien à la personne, aide-soignante ou aide-soignant
4. Dirigeante ou dirigeant autochtone
5. Patiente, patient, proche, membre de la collectivité ou autre personne ayant un vécu expérientiel
6. Conseillère ou conseiller en politiques, ou analyste des politiques
7. Responsable de l'amélioration de la qualité et de la sécurité des patients
8. Ludothérapeute ou responsable de la coordination des activités
9. Chercheuse ou chercheur
10. Étudiante ou étudiant
11. Autre

12. Niveau de carrière :
    - Début de carrière (moins de 5 ans d'expérience)
    - Milieu de carrière (5 à 15 ans d'expérience)
    - Carrière avancée (plus de 15 ans d'expérience)

Round 2

English Version

Please confirm your name and email address. Demographic questions were collected in Survey 1 and are not required for subsequent rounds.

1. Name *: _____

2. Email *: _____

MODERNIZING THE SIX LEVERS FOR HEALTHCARE IMPROVEMENT

Below we present the levers that have been updated based on your feedback in survey 1.

Please rank your perceived level of importance of each lever and provide feedback on the updated levers, including its title and definition.

1. **Create enabling policies, infrastructure, incentives and systems for a learning culture**

   Definition: At the system level, creating enabling policies, infrastructure, incentives and systems to support a learning culture means that health workers and managers can become leaders for continuous improvement guided by organizational and community values. This requires investment in policies and infrastructure to encourage learning work, incentives to motivate people to take on learning work, the digital systems in place for effective and timely monitoring and evaluation, as well as system supports and mechanisms to ensure learning, from both successes and failures, is translated to practice.

Importance:	(1) Not important at all	(2) Somewhat important	(3) Important	(4) Very important	(5) Extremely important
	☐	☐	☐	☐	☐

Feedback (lever 1): _____

2. **Strengthen organizational capacity by supporting people to undertake improvement work**

   Definition: Organizations value learning, thoughtful innovation, and continuous improvement under a shared vision of a learning system that is embedded in their mission and strategic plans. This means organizations empower and support people by ensuring health workers and managers are trained on improvement skills, with authority to undertake improvement work, aligned processes that support them to apply their training, and encouragement to collaborate and pursue innovative ideas. Regular opportunities to refresh and deepen their improvement skillset, leadership capabilities and recognition for learning leadership are also essential.

Importance:	(1) Not important at all	(2) Somewhat important	(3) Important	(4) Very important	(5) Extremely important
	☐	☐	☐	☐	☐

_____

Feedback (lever 2): _____

3. Engage health workers and teams in creating and applying a learning culture for change

Definition: Engaging teams to collaborate and become leaders for learning helps build a culture committed to providing better quality and safer care, and better health with better value-for-money. Engagement means having strategies and processes in place to actively engage and support every staff member in contributing to knowledge and engaging in learning efforts. This could take the form of co-design, consultations, and other forms of gathering feedback.

Importance:	(1) Not important at all	(2) Somewhat important	(3) Important	(4) Very important	(5) Extremely important
	☐	☐	☐	☐	☐

Feedback (lever 3): _____

4. **Focus on people, community and population needs in the vision, mission, and strategic plans of the organization to advance equitable and culturally safe care**

Definition: Understanding the people, communities and populations being served, and the factors that shape their health and well-being means considering the unique needs, risks, and threats in the community and health system, and how these impact health service needs and delivery. The vision, mission, and strategic plans of the organization require an understanding of all community members, including vulnerable or underserved groups, guided by a commitment to advancing equity and cultural safety through outreach, as well as engagement-driven change to enable the right care, by the right provider, at the right place and time.

Importance:	(1) Not important at all	(2) Somewhat important	(3) Important	(4) Very important	(5) Extremely important
	☐	☐	☐	☐	☐

Feedback (lever46): _____

5. Partner with patients, families, care partners, and communities to drive improvement

Definition: Partnering with patients, families, care partners and communities means putting policies, process, and structures in place that meaningfully include, support and value them to develop and provide culturally safe and person-centered care that meets their diverse needs and reduces inequities. Using a range of carefully selected engagement approaches, methods, and tools in safety and improvement learning activities, with clear feedback and evaluation mechanisms, will ensure they drive change based on partnership with the people impacted most.

Importance:	(1) Not important at all	(2) Somewhat important	(3) Important	(4) Very important	(5) Extremely important

☐ ☐ ☐ ☐ ☐

Feedback (lever 5): _____

6. **Use a wide range of evidence from learning for action**

   Definition: The evidence produced from learning activities should drive action and be used for decision-making to shape health service delivery policy, strategy, and practice. A wide range of evidence considers for example research and analysis, experiential knowledge, and Indigenous knowledge systems. This requires processes and systems in place to collect data and ensure access to up-to-date information, driven by a culture of inquiry, transparency and accountability to mobilize and use knowledge and evidence at all levels.

Importance:	(1) Not important at all	(2) Somewhat important	(3) Important	(4) Very important	(5) Extremely important
	☐	☐	☐	☐	☐

Feedback (lever 6): _____

French Version

Veuillez confirmer votre nom et votre courriel. Les données démographiques ont été recueillies lors du premier sondage et ne sont pas nécessaires pour les séries suivantes.

1. Nom* : _____

2. Courriel* : _____

MODERNISER LES SIX LEVIERS POUR L'AMÉLIORATION DES SERVICES DE SANTÉ

Vous trouverez ci-dessous la version actualisée des leviers sur la base de vos rétroactions au premier sondage.

Veuillez évaluer le niveau d'importance que vous attachez à chacun de ces leviers et nous faire part de votre avis sur cette nouvelle version, y compris les titres et les définitions.

1. **Créer des politiques, des infrastructures, des mesures incitatives et des systèmes propices à une culture d'apprentissage**

   Définition : Créer, à l'échelle du système, des politiques, des infrastructures, des mesures incitatives et des systèmes pour favoriser une culture d'apprentissage afin que les professionnelles et professionnels de la santé et les gestionnaires puissent devenir des chefs de file engagés dans l'amélioration continue et guidés par les valeurs organisationnelles et communautaires. Cela suppose d'investir dans des politiques et des infrastructures pour encourager les efforts d'apprentissage; de créer des mesures incitatives pour motiver les parties prenantes à s'engager dans cette démarche d'apprentissage; de mettre en place des systèmes numériques pour assurer

une supervision et une évaluation efficaces et opportunes; et de créer des mesures de soutien et des mécanismes à l'échelle du système pour veiller à ce que les enseignements tirés, tant des échecs que des réussites, se reflètent dans les pratiques.

Importance :	(1) Pas du tout important	(2) Relativement important	(3) Important	(4) Très important	(5) Extrêmement important
	☐	☐	☐	☐	☐

Rétroaction (levier 1) : _____

2. **Renforcer la capacité organisationnelle en appuyant le personnel pour qu'il entreprenne des démarches d'amélioration**

Définition : Unis par la vision commune d'un système apprenant inhérente à leur mission et à leurs plans stratégiques, les organismes valorisent l'apprentissage, l'innovation réfléchie et l'amélioration continue. Ils donnent le pouvoir d'agir et offrent leur soutien en veillant à ce que les professionnelles et professionnels de la santé et les gestionnaires possèdent la formation et l'autorité requises pour entreprendre une démarche d'amélioration, disposent de processus harmonisés pour mettre leurs compétences à profit, et soient encouragés à collaborer et à concrétiser des idées novatrices. Il est également fondamental de leur donner régulièrement l'occasion d'actualiser et de renforcer leurs compétences d'amélioration, de développer leurs capacités de direction et de valoriser le leadership en matière d'apprentissage.

Importance :	(1) Pas du tout important	(2) Relativement important	(3) Important	(4) Très important	(5) Extrêmement important
	☐	☐	☐	☐	☐

Rétroaction (levier 2) : _____

3. Mobiliser le personnel du secteur de la santé dans la création et le maintien d'une culture d'apprentissage propice au changement

Définition : En mobilisant les équipes pour qu'elles travaillent en collaboration et deviennent des chefs de file de l'apprentissage, vous contribuez à bâtir une culture marquée par la volonté d'accroître la qualité et la sécurité des soins, mais aussi d'améliorer la santé et l'optimisation des ressources. Pour ce faire, des stratégies et des processus doivent être mis en place pour mobiliser et soutenir activement tous les membres du personnel dans la démarche d'apprentissage et de développement des connaissances. Ces stratégies et processus peuvent prendre la forme d'une co-conception, de consultations ou de diverses méthodes de recueil de rétroactions.

Importance :	(1) Pas du tout important	(2) Relativement important	(3) Important	(4) Très important	(5) Extrêmement important
	☐	☐	☐	☐	☐

_____

Rétroaction (levier 3) : _____

4. **Replacer les besoins des individus, des communautés et des populations au cœur de la vision, de la mission et des plans stratégiques de l'organisme pour progresser vers l'équité et la sécurité culturelle des soins de santé**

   Définition : Pour comprendre les personnes, les communautés et les populations desservies, mais aussi les facteurs qui influent sur leur santé et leur bien-être, il faut tenir compte de leurs besoins uniques, des risques et des menaces dans la communauté et le système de santé, et de leurs répercussions sur les besoins et la prestation des services de santé. Pour l'organisme, élaborer une vision, une mission et des plans stratégiques nécessite une bonne compréhension de l'ensemble des membres de la communauté, y compris les groupes vulnérables ou mal desservis, et de s'appuyer sur sa volonté de progresser vers l'équité et la sécurisation culturelle par le travail de proximité et le changement participatif afin de pouvoir fournir les soins adéquats, par le bon prestataire, au bon moment et au bon endroit.

	(1) Pas du tout important	(2) Relativement important	(3) Important	(4) Très important	(5) Extrêmement important
Importance :	☐	☐	☐	☐	☐

Rétroaction (levier 4) : _____

5. **Travailler en partenariat avec les patients, les familles, les partenaires de soins et les communautés pour susciter des améliorations.**

   Définition : Travailler en partenariat avec les patients, les familles, les partenaires de soins et les communautés suppose de mettre en place des politiques, des processus et des structures qui favorisent leur participation concrète, leur assurent un soutien et valorisent leurs contributions, afin de favoriser et de dispenser des soins respectueux des valeurs culturelles et centrés sur la personne qui répondent à leurs besoins diversifiés tout en réduisant les iniquités. C'est en utilisant un large éventail d'approches, de méthodes et d'outils d'engagement rigoureusement sélectionnés dans le cadre des activités d'apprentissage liées à la sécurité et à l'amélioration, ainsi que des mécanismes d'évaluation et de rétroaction clairs, que l'on peut veiller à ce que les changements opérés découlent des partenariats noués avec ceux et celles qui ont en bénéficieront le plus.

	(1) Pas du tout important	(2) Relativement important	(3) Important	(4) Très important	(5) Extrêmement important
Importance :	☐	☐	☐	☐	☐

Rétroaction (levier 5) : _____

6. **Utiliser un large éventail d'éléments d'information recueillis dans le cadre des initiatives d'apprentissage pour passer à l'action**

Définition : Les éléments d'informations recueillis dans le cadre des initiatives d'apprentissage doivent guider l'action et orienter la prise de décisions pour façonner les politiques et les pratiques relatives à la prestation de services de santé. Il peut s'agir par exemple d'études et d'analyses, de connaissances expérientielles ou encore de systèmes de connaissances autochtones. Pour ce faire, il est nécessaire de mettre en place des processus et des systèmes permettant le recueil de données et garantissant l'accès aux informations les plus récentes, ancrés dans une culture du questionnement, de la transparence et de la responsabilité afin que les connaissances et les éléments d'information soient utilisés à tous les échelons.

	(1) Pas du tout important	(2) Relativement important	(3) Important	(4) Très important	(5) Extrêmement important
Importance :	☐	☐	☐	☐	☐

Rétroaction (levier 6) : _____

Round 3

English Version

Please confirm your name and email address. Demographic questions were collected in Survey 1 and are not required for subsequent rounds.

1. Name *: _____
2. Email *: _____

Below we present the levers that have been updated based on your feedback in surveys 1 and 2.

1. Create enabling policies, infrastructure, incentives and systems for a learning culture	At the system level, creating enabling policies, infrastructure, incentives and systems to support a learning culture means that health workers and managers can become leaders for continuous improvement guided by organizational and community values. This requires investment in policies and infrastructure to encourage learning work, incentives to motivate people to take on learning work, and the digital systems in place for effective and timely monitoring and evaluation. This also requires system supports and mechanisms to ensure learning, from both successes and failures, is translated to practice.
2. Strengthen organizational capacity by supporting people to undertake improvement work	Organizations value learning, thoughtful innovation, and continuous improvement under a shared vision of a learning system that is embedded in their mission and strategic plans, with protected time to undertake this work. This means organizations empower and support people by ensuring health workers and managers are trained on improvement skills, with authority to undertake improvement work, aligned processes that support them to apply their training, and encouragement to collaborate and pursue innovative ideas. Regular opportunities to refresh and deepen their improvement skillset, leadership capabilities and recognition for learning leadership are also essential.
3. Engage health workers and teams in creating and adopting a learning culture for change	Engaging teams to collaborate and become leaders for learning helps build a culture committed to providing better quality and safer care, and better health with better value-for-money. Engagement means having strategies and processes in place to actively engage and support every staff member in contributing to knowledge and engaging in learning efforts with an emphasis on diversity and inclusion. This could take the form of peer learning, co-design, consultations, and other forms of gathering feedback. Care should be taken to ensure engagement does not become an additional burden on teams.
4. Focus on people and population needs in the vision, mission, and strategic plans of the organization to advance equitable and culturally safe care	Understanding the people, communities and populations being served and the factors that shape their health and well-being means considering their unique strengths and assets, as well as their needs, risks, threats, challenges, and opportunities in the community and health system, and how these impact health service needs and delivery. The vision, mission, and strategic plans of the organization require an understanding of the people and communities they serve, including those who are systemically and structurally oppressed. Organizations are guided by a commitment to advancing culturally safe and equitable care through outreach, as well as engagement-driven change to enable the right care, by the right provider, at the right place and time.

5. Partner with patients, families, care partners, and communities to drive enable improvement	Partnering with patients, families, care partners, researchers, and communities means putting policies, processes, and structures in place that meaningfully include, support and value them to co-develop and provide culturally safe and person-centered care that meets their diverse needs and reduces inequities. This includes a distinctions-based approach to partnering with Indigenous communities. Using a range of carefully selected engagement approaches, methods, and tools in safety and improvement learning activities, with clear feedback and evaluation mechanisms, will ensure they drive change is driven based on partnership with the people impacted most.
6. Use a wide range of evidence from learning for action	The evidence produced from learning activities should drive action and be used for decision-making to shape health service delivery policy, strategy, and practice at all levels of the health system. A wide range of evidence considers for example research and analysis, experiential knowledge, and Indigenous knowledge systems. This requires processes and systems in place to collect data and ensure access to up-to-date information, driven by a culture of inquiry, transparency, trust, and accountability to mobilize and use knowledge and evidence at all levels, with networks to share and disseminate learnings.

1. The levers have been ranked in order of most (6) to least importance (1), based on the average scores from surveys 1 and 2. Please use the drop-down menus to propose a different order, and the textbox to provide feedback about your ranking.

   [levers presented in order, with drop-down menu to propose a revised order]

   Reasoning / Feedback: _____

2. Provide any additional feedback about the updated levers, including its title and definition:
   _____

French Version

Veuillez confirmer votre nom et votre courriel. Les données démographiques ont été recueillies lors du premier sondage et ne sont pas nécessaires pour les séries suivantes.

1. Nom* : _____

2. Courriel* : _____

Voici les leviers actualisés à partir de vos rétroactions aux sondages 1 et 2 :

1. Créer des politiques, des infrastructures, des mesures incitatives et des systèmes propices à une culture d'apprentissage	Créer, à l'échelle du système, des politiques, des infrastructures, des mesures incitatives et des systèmes pour favoriser une culture d'apprentissage afin que les professionnelles et professionnels de la santé et les gestionnaires puissent devenir des chefs de file engagés dans l'amélioration continue et guidés par les valeurs organisationnelles et communautaires. Cela suppose d'investir dans des politiques et des infrastructures pour encourager les efforts d'apprentissage; de créer des mesures incitatives pour motiver les parties prenantes à s'engager dans cette démarche d'apprentissage, et de mettre en place des systèmes numériques pour assurer une supervision et une évaluation efficaces et opportunes. Des mesures de soutien et des mécanismes doivent également être créés à l'échelle du système pour veiller à ce que les enseignements tirés, tant des échecs que des réussites, se reflètent dans les pratiques.
2. Renforcer la capacité organisationnelle en appuyant le personnel pour qu'il entreprenne des démarches d'amélioration	Unis par la vision commune d'un système apprenant inhérente à leur mission et à leurs plans stratégiques, les organismes valorisent l'apprentissage, l'innovation réfléchie et l'amélioration continue, et réservent le temps nécessaire. Ils donnent le pouvoir d'agir et offrent leur soutien en veillant à ce que les professionnelles et professionnels de la santé et les gestionnaires possèdent la formation et l'autorité requises pour entreprendre une démarche d'amélioration, disposent de processus harmonisés pour mettre leurs compétences à profit, et soient encouragés à collaborer et à concrétiser des idées novatrices. Il est également fondamental de leur donner régulièrement l'occasion d'actualiser et de renforcer leurs compétences d'amélioration, de développer leurs capacités de direction et de valoriser le leadership en matière d'apprentissage.
3. Mobiliser le personnel du secteur de la santé dans la création et l'adoption d'une culture d'apprentissage propice au changement	En mobilisant les équipes pour qu'elles travaillent en collaboration et deviennent des chefs de file de l'apprentissage, vous contribuez à bâtir une culture marquée par la volonté d'accroître la qualité et la sécurité des soins, mais aussi d'améliorer la santé et l'optimisation des ressources. Pour ce faire, des stratégies et des processus doivent être mis en place pour mobiliser et soutenir activement tous les membres du personnel dans la démarche d'apprentissage et de développement des connaissances, tout en accordant une place centrale à la diversité et l'inclusion. Ces stratégies et processus peuvent prendre la forme de séances d'apprentissage entre pairs, d'une co-conception, de consultations ou de diverses méthodes de recueil de rétroactions. Il est important de veiller à ce que l'engagement ne devienne pas une charge supplémentaire pour les équipes.
4. Replacer les besoins des individus, des communautés et des populations au cœur de la	Pour comprendre les personnes, les communautés et les populations desservies, mais aussi les facteurs qui influent sur leur santé et leur bien-être, il faut tenir compte de leurs forces, leurs atouts et leurs besoins uniques, mais aussi des risques, des menaces, des défis et des opportunités dans la

vision, de la mission et des plans stratégiques de l'organisme pour progresser vers l'équité et la sécurité culturelle des soins de santé	communauté et le système de santé, et de leurs répercussions sur les besoins et la prestation des services de santé. La vision, la mission et les plans stratégiques de l'organisme doivent reposer sur cette compréhension des personnes et des communautés desservies, y compris celles confrontées à l'oppression systémique ou structurelle. Les organismes s'appuient sur leur volonté de progresser vers l'équité et la sécurisation culturelle des soins par le travail de proximité et le changement participatif afin de pouvoir fournir les soins adéquats, au bon moment et au bon endroit.
5. Travailler en partenariat avec les patientes, les patients, les familles, les partenaires de soins et les communautés pour susciter des améliorations	Travailler en partenariat avec les patientes, les patients, les familles, les partenaires de soins, et les communautés suppose de mettre en place des politiques, des processus et des structures qui favorisent leur participation concrète, leur assurent un soutien et valorisent leurs contributions, afin de favoriser la co-conception et de dispenser des soins respectueux des valeurs culturelles et centrés sur la personne qui répondent à leurs besoins diversifiés tout en réduisant les iniquités. Il est notamment important d'adopter une approche fondée sur les distinctions pour collaborer avec les communautés autochtones. C'est en utilisant un large éventail d'approches, de méthodes et d'outils d'engagement rigoureusement sélectionnés dans le cadre des activités d'apprentissage liées à la sécurité et à l'amélioration, ainsi que des mécanismes d'évaluation et de rétroaction clairs, que l'on peut veiller à ce que les changements opérés découlent des partenariats noués avec ceux et celles qui ont en bénéficieront le plus.
6. Utiliser un large éventail d'éléments d'information recueillis dans le cadre des initiatives d'apprentissage pour passer à l'action	Les éléments d'informations recueillis dans le cadre des initiatives d'apprentissage doivent guider l'action et orienter la prise de décisions pour façonner les politiques, les stratégies et les pratiques relatives à la prestation de services de santé à tous les échelons du système de santé. Il peut s'agir par exemple d'études et d'analyses, de connaissances expérientielles ou encore de systèmes de connaissances autochtones. Pour ce faire, il est nécessaire de mettre en place des processus et des systèmes permettant le recueil de données et garantissant l'accès aux informations les plus récentes, ancrés dans une culture du questionnement, de la transparence, de la confiance et de la responsabilité afin que les connaissances et les éléments d'information soient utilisés à tous les échelons. Des réseaux doivent par ailleurs être créés pour partager et diffuser les enseignements tirés.

1. Ces leviers ont été classés par ordre décroissant d'importance, d'après les scores moyens attribués dans les deux sondages précédents.
   Vous avez la possibilité de suggérer un classement différent. Pour ce faire, veuillez utiliser les menus déroulants et justifier votre choix dans le champ prévu à cet effet.
   [leviers présentés dans l'ordre, avec un menu déroulant permettant de proposer un ordre révisé]

   Raisonnement / Justifier : _____

2. Si vous avez d'autres commentaires sur la version actualisée des leviers, y compris les titres et les définitions, veuillez les saisir ci-dessous : _____

Appendix C. Additional Data Tables

TABLE C1. Ratings and percent change for all levers, Round 1 (N=70) and Round 2 (N=33)

Rating	Lever 1			Lever 2			Lever 3			Lever 4			Lever 5			Lever 6		
	R1	R2	% Change	R1	R2	% Change	R1	R2	% Change	R1	R2	% Change	R1	R2	% Change	R1	R2	% Change
Not important	0 (0%)	0 (0%)	0%	0 (0%)	0 (0%)	0%	1 (1%)	0 (0%)	-1%	1 (1%)	0 (0%)	-1%	1 (1%)	0 (0%)	-1%	1 (1%)	0 (0%)	-1%
Somewhat important	2 (3%)	0 (0%)	-3%	2 (3%)	1 (3%)	0%	0 (0%)	0 (0%)	0%	0 (0%)	0 (0%)	0%	1 (1%)	1 (3%)	+2%	0 (0%)	0 (0%)	0%
Important	10 (14%)	7 (21%)	+7%	10 (14%)	4 (12%)	-2%	7 (10%)	7 (21%)	+11%	15 (21%)	7 (21%)	0%	5 (7%)	5 (15%)	+8%	9 (13%)	7 (21%)	+8%
Very important	26 (37%)	15 (45%)	+8%	25 (36%)	16 (48%)	+13%	33 (47%)	15 (45%)	-2%	12 (17%)	13 (39%)	+22%	21 (30%)	10 (30%)	0%	21 (30%)	13 (39%)	+9%
Extremely important	31 (44%)	10 (30%)	-14%	31 (44%)	11 (33%)	-11%	26 (37%)	9 (27%)	-10%	40 (57%)	13 (39%)	-18%	36 (51%)	17 (52%)	-1%	36 (51%)	13 (39%)	-12%
Not reported	1 (12%)	1 (3%)	+2%	2 (3%)	1 (3%)	0%	3 (4%)	2 (6%)	+2%	2 (3%)	0 (0%)	-3%	6 (9%)	0 (0%)	-9%	3 (4%)	0 (0%)	-4%

R1 = Round 1; R2 = Round 2

Appendix D. Potential Guiding Questions for Monitoring and Evaluation

The following questions can be used to guide monitoring and evaluation efforts.

Lever	Examples of monitoring and evaluation questions
Create enabling policies, infrastructure, incentives and systems for a learning culture	• Have organizational policies been established to support a learning culture and ensure learning is translated to practice? • How are people incentivized to take on learning work? • What mechanisms are in place to ensure learning is translated into practice? • What funding and resources have been made available to support learning work?
Strengthen organizational capacity by supporting people to undertake improvement work	• Is learning embedded in the organizations mission and strategic plans? • Do leaders have training to support their development and ability to lead a learning culture? • Do leaders, managers and health workers have protected time to undertake improvement training and improvement work? • Are recognition programs in place for learning work and fostering a culture of learning?
Engage health workers and teams in creating and adopting a learning culture for change	• What strategies and processes are in place to engage and support every staff member in contributing to knowledge and learning efforts? • Do staff engagement strategies advance diversity, equity and inclusion in learning and improvement work? • How frequently are peer learning sessions, co-design activities, and consultations conducted? • What feedback mechanisms are used to gather input from staff members? • How do staff members perceive the impact of engagement activities on their workload? • What measures are taken to ensure engagement does not become an additional burden on teams?
Focus on people and population needs in the vision, mission, and strategic plans of the organization to advance equitable and culturally safe care	• What processes are in place to assess the needs, risks, threats, challenges, and opportunities within the community and health system? • How is the organization's vision, mission, and strategic plans aligned with the needs of systemically and structurally oppressed communities? • How does the organization engage with communities to drive change?
Partner with patients, families, care partners, and communities to enable improvement	• What processes, strategies and resources exist and/or are needed to meaningfully engage and partner with patients, families, care partners and communities? • How is the organization partnering with Indigenous communities using a distinctions-based approach, and what specific initiatives have been undertaken to address the unique needs of Indigenous communities? • What feedback mechanisms are used to ensure community voices are heard and acted upon? • What initiatives are in place to advance equity and cultural safety through outreach?

	• What metrics are used to evaluate the effectiveness of care delivery in meeting community needs and goals?
Use a wide range of evidence from learning for action	• How is evidence from learning activities being used to shape health service delivery policy, strategy, and practice? • What actions have been taken based on the evidence produced from learning activities? • What processes and systems are in place to collect data and ensure access to up-to-date information? • How frequently is data updated and made accessible to relevant interest holder groups? • How is a culture of inquiry, transparency, trust, and accountability being fostered within the organization? • What mechanisms are in place to ensure transparency and accountability in the use of knowledge and evidence? • How are networks being utilized to share and disseminate learnings across the health system? • What methods are used to mobilize knowledge and ensure it is applied at all levels of the health system?

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