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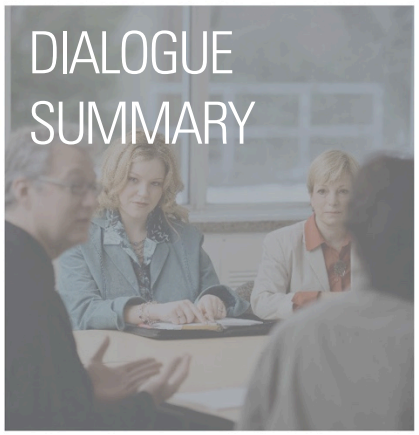

IMPROVING LEADERSHIP CAPACITY IN COMMUNITY CARE IN ONTARIO

EVIDENCE >> INSIGHT >> ACTION

Dialogue Summary:
Improving Leadership Capacity in Community Care in Ontario

6 November 2015

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary, but the authors had final decision-making authority about what appeared in the dialogue summary.

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SUMMARY OF THE DIALOGUE

Dialogue participants built on the insights developed in a previous dialogue focused on strengthening leadership capacity in primary and community care in Ontario. This dialogue focused more intently on which problems were most pressing in the context of community care. While many similar challenges were identified across primary and community care, participants identified four interrelated aspects of the problem as most salient: 1) the heterogeneity in community-care providers, services and settings makes it challenging to clarify the types of leaders (and leadership) required to transform the system; 2) leadership capacity in community (and primary) care organizations exists, but there are deficiencies in the extent to which emerging leaders in these settings are supported, and uncertainty about the best ways to help them thrive; 3) there is a misconception about the imbalance between the leadership capacity in community (and primary) care settings on the one hand, and acute-care settings on the other hand, with little cross-pollination of leadership capacity across sectors; and 4) current health system arrangements create additional challenges.

Participants began deliberations about viable options to address the problem by adjusting two of the three options that had been reframed in the previous dialogue (and captured in the corresponding dialogue summary) and adding a new (third) option. While deliberations about the options did not result in a clear preference for any specific approaches, the following themes were raised with some consistency: 1) establishing a new provincial committee is not essential, whereas informal, distributed models of ownership over the leadership-improvement process can help the sector to achieve the results it wants; 2) focusing on strengthening community (and primary) care will provide ample opportunities for leadership-capacity development (because leaders will emerge in a more robust environment, and strong leaders will be attracted to work in the sector); 3) leadership-training opportunities that meet the specific needs of community (and primary) care are needed, but should also be integrated with leadership training for other sectors to avoid isolation from these sectors; and 4) leadership-training opportunities should include an array of formal and informal approaches and opportunities to practice new skills, while serious consideration should be given to selecting a common leadership framework to underpin formal training initiatives (e.g., LEADS).

While participants committed to a diverse range of next steps, there was general agreement on two important overarching considerations that should help drive action now. First, participants felt that it was essential to recognize that recent political developments have created unique opportunities to act at this time, and that it was important to 'seize the day' and take advantage of the current focus on community (and primary) care. Second, while there was a considerable amount of debate surrounding each of the options considered in the dialogue, it is important to stop debating, pick an approach, and move forward before the opportunity is missed.

SUMMARIES OF THE FOUR DELIBERATIONS

This was the second dialogue convened to discuss improving leadership capacity in primary and community care in Ontario. Those who participated in the first dialogue, which took place on 30 January 2015, felt that a second dialogue was needed to ensure that the views and experiences of stakeholders from the community-care sector were considered, given the first dialogue engaged a disproportionately large number of participants drawn from the primary-care sector.

The second dialogue began with an overview of relevant reports released and commitments made since the initial dialogue, notably, the release of *Bringing Care Home* by the Expert Panel on Home and Community Care, the release of *Patients First: A Roadmap to Strengthen Home and Community Care* by the Ontario Ministry of Health and Long-Term Care, the release of *Patient Care Groups: A New Model of Population Based Primary Health Care* by the Primary Healthcare Expert Advisory Committee, and a speech by the Honourable Minister of Health and Long-Term Care, Eric Hoskins, at the HealthAchieve 2015 conference. Participants noted in particular three key commitments made in the minister's speech: 1) equitable, population-based and integrated primary and community care; 2) a bigger role for Local Health Integration Networks (LHINs) in primary care; and 3) a re-consideration of the relationship between LHINs and Community Care Access Centres as part of a broader effort to 'tackle structure' in the community-care sector.

Along with the evidence brief, participants reflected on the dialogue summary prepared after the first dialogue. Most participants agreed that, rather than wiping the slate clean from the earlier dialogue, the focus of the second, shorter dialogue should be to build on what was learned during the first dialogue and complement it with additional input from community-care stakeholders.

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

1) it addressed an issue currently being faced in Ontario;
2) it focused on different features of the problem, including (where possible) how it affects particular groups;
3) it focused on three options (among many) for addressing the policy issue;
4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three options for addressing the problem, and key implementation considerations;
5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible options for addressing it;
6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
7) it ensured fair representation among policymakers, stakeholders and researchers;
8) it engaged a facilitator to assist with the deliberations;
9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
10) it did not aim for consensus.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

DELIBERATION ABOUT THE PROBLEM

Dialogue participants identified four interrelated aspects of the problem as most salient: 1) the heterogeneity in community-care providers, services and settings makes it challenging to clarify the types of leaders (and leadership) required to transform the system; 2) leadership capacity in community (and primary) care organizations exists, but there are deficiencies in the extent to which emerging leaders in these settings are supported, and uncertainty about the best ways to help them thrive; 3) there is a misconception about the

imbalance between the leadership capacity in community (and primary) care settings on the one hand, and acute-care settings on the other hand, with little cross-pollination of leadership capacity across sectors; and 4) current health system arrangements create additional challenges.

First, many dialogue participants highlighted that the diversity of community-care providers, services and settings in Ontario means that a broad range of leaders and leadership types are required. Several participants agreed that this makes it difficult to determine the sector's leadership needs. In particular, a number of participants highlighted that the community-care sector is very heterogeneous with respect to the providers who are involved (e.g., from registered nurses to community volunteers), the scope of services provided (e.g. from comprehensive assisted living to 'Meals on Wheels' programs), the settings in which these services are provided (e.g., from large community centres to an individual's home), and the scale at which they operate (e.g., from the entire province to a single municipality). Most participants agreed that these dynamics make it difficult and unrealistic to identify one type of leader or one set of leadership skills that will apply across the board. However, some participants noted that collaborative leaders – which they described as those who can work across and between boundaries in the 'interstitial space' – should be considered one of the common types of leaders who should be engaged across the community-care sector in order to overcome sectoral variation. Some participants also identified the need to consider how leadership needs differ between clinical and administrative settings in community (and perhaps especially primary) care. A number of participants discussed a 'dyad model' of leadership, with clear roles for both clinical and administrative leaders. Some participants also flagged that there has been a lack of emphasis on fostering clinical leadership, and that without strong clinical leaders, there cannot be strong administrative leadership. One participant pointed to HealthLinks as an initiative that has attempted to foster the dyad model of leadership.

Second, participants broadly agreed that leadership capacity in community (and primary) care organizations exists, but that the emergence of leaders is hindered by a lack of clearly defined approaches and structural capacity to support their development and enable them to thrive. Some participants suggested that building a stronger community (and primary) care sector might naturally result in the development of stronger leadership, suggesting that "if you build it, they will emerge." This suggestion was rooted in a widely held belief among participants that leadership development has been prioritized in acute care because the health system has prioritized the importance of this sector over others. Some participants noted that recent initiatives in Ontario aimed at strengthening the community and primary care sectors was an opportunity to shift how policymakers and stakeholders viewed priorities for leadership development across sectors. However, a number of participants didn't fully agree with this more passive approach to leadership development. Specifically, these participants noted that there was a need to consider explicit opportunities for leadership development within existing reform strategies, and to actively seek out and identify leaders to be part of these changes. While some participants appreciated this optimistic outlook, many discussed whether it was really possible to tease out leadership needs from the overall need for system strengthening alongside the rebalancing of system focus from acute to community and primary care.

Third, most participants agreed that there is a general misconception about where the balance of leadership exists in the system, with many believing that there is greater capacity in acute care compared to community (and primary) care. While some participants agreed that this was in large part the result of the historical emphasis placed on the acute-care sector, there were other factors that may underpin these views. Some participants pointed to organizational depth as a potential factor. Specifically, a number of participants suggested that large organizations in the acute-care sector have deeper organizational resources to call upon in order to foster leadership development and to encourage participation in leadership opportunities. In contrast, participants noted that smaller organizations (in both community and primary care) face a challenge because of the difficulties they have replacing resources. As such, several participants highlighted that the system tends to rely on pulling emerging leaders from large acute-care organizations, because they have greater capacity to absorb the impact – despite the fact that there is much potential and existing leadership capacity within small- and mid-sized organizations. Some participants questioned whether consolidating

smaller organizations into larger ones may help address the size issue (and thus the perception of which organizations have leadership capacity), although many participants suggested that while this could address the extent to which organizations were affected by leadership recruitment, this would not necessarily address the broader problem of determining how to strengthen leadership. Other participants questioned whether large organizations could become more creative by releasing funds to enable the staff of smaller organizations to take up leadership opportunities. However, another participant noted that cobbling together resources made available from larger organizations, while helpful, creates challenges for the long-term sustainability of smaller organizations.

Within this discussion of the third aspect of the problem, dialogue participants also noted that there was currently little 'cross-pollination' in leadership capacity across sectors. Several participants noted that the community-care sector generally, and the mental-health sector in particular, has been siloed from the rest of the health system, which has resulted in a lack of flow – of staff in general and leaders specifically – between them. Furthermore, participants also noted the challenges that arise when encouraging emerging leaders to move across sectors. For those moving from acute care to community (and primary) care, participants felt that there is likely a perceived lack of opportunities for career growth and leadership in community (and primary) care. One participant noted that people who are drawn to leadership roles are very good at managing their careers, which includes identifying opportunities and making choices that ensure they're progressing. In response, a number of participants stated that it was essential for attention to be paid to creating leadership opportunities in community (and primary) care that are attractive to those in acute care so that they see these roles as career-building opportunities. Movement in the opposite direction (i.e., from community and primary care to acute-care leadership positions) was also viewed by participants as rare. Most participants agreed that very few leaders in community (and primary) care were asked to lead, and almost never asked to lead in acute-care settings. Participants considered this to be related to the historical emphasis on acute care in Ontario, and a general perception that the strongest leaders exist in that sector and should be given opportunities when they arise. Overall, while most participants agreed that the flow of leaders needs to be bi-directional (not one way), one participant was concerned that there was a need to consider how we can retain strong leaders in community (and primary) care through attractive and comparable salaries and by offering a range of leadership opportunities.

Finally, participants discussed how current health-system arrangements present barriers to fostering leadership in community (and primary) care. Several participants pointed out that there are significant salary discrepancies among leaders, which make some leadership opportunities more attractive than others. For example, leaders in acute-care settings (e.g., hospital executives) or those leading large organizations (e.g., CCACs) are paid more than leaders working in other settings (e.g., an executive director in a Family Health Team), despite the fact that those in the latter settings are no less important to system outcomes. Several participants also referred to the challenge community organizations face in 'backfilling' positions and financially supporting individuals so that they can participate in leadership-development opportunities. They also noted that remuneration models (e.g., fee-for-service models) can impede the ability of some professionals, such as primary-care physicians, to participate in leadership opportunities (e.g., they'd need to take personal leave to participate in leadership training, which would present a significant opportunity cost given the loss of income they would face). One participant emphasized that many emerging leaders in community (and primary) care are financially penalized for pursuing training opportunities. Another participant suggested that there were insufficient structures and incentives in place to reward leadership development and support career progression (e.g., by paying those with more leadership training and capacity more money), and that the path is much clearer and the returns on investment in training greater in the acute-care sector. In addition to the challenges posed by financial arrangements, one participant noted that there is a lack of provincial direction or mandate for leadership-capacity development within professional-accreditation programs (although efforts are being made at organizational and association levels).

DELIBERATION ABOUT POLICY AND PROGRAMMATIC OPTIONS

Participants began deliberations about viable options to address the problem by focusing on the revised options coming out of the first dialogue. However, many participants felt strongly that the reframed options still required additional adjustments in order to be meaningful inputs into a discussion, and they collectively decided to focus their deliberations on only two of the three original options, with a new option proposed as the third. The three options that were deliberated were:

1) convene a provincial committee charged with supporting the integration of (and filling of gaps in) leadership initiatives in community care;
2) identify current and emerging leaders in community care and support their participation in a national leadership initiative; and
3) prioritize systematic strengthening of the community-care sector to make it an attractive option for leaders.

Option 3 came to be referred to in the deliberations as the "build the system and the leaders will come" option.

Option 1 – Convene a provincial committee charged with supporting the integration of (and filling of gaps in) leadership initiatives in community care

Deliberations about option 1 resulted in mixed views about the need for a provincial committee, with all participants expressing some reservations about pursuing this approach. As a first source of caution, many participants felt that this option was unclear with respect to who is best positioned to lead such an initiative. Several participants highlighted the fact that many of the important sector representatives already sit on the same boards or committees (e.g. Community Health Ontario), and some participants noted that one of these boards or committees could take on the role that had been planned for a new committee. However, a number of participants disagreed, and suggested that this would be difficult because many organizations and committees don't have the funds needed to take on new and large initiatives like this. Participants in the first dialogue raised the possibility of the Ontario Primary Care Council (OPCC) as a good platform for this work. However, participants at this dialogue did not feel the OPCC was a natural place for leading this initiative. The reasons they identified for their views included:

- the OPCC already has too much on its plate;
- the OPCC already struggles to financially support its existing activities; and
- the OPCC is focused on primary care, and the community sector needs to be at the table for any discussions related to leadership capacity in that sector.

During the deliberation about this option, participants acknowledged a need for the issue of leadership to rest somewhere, and expressed concern about the ability to move this issue forward without it, but they did not feel that expanding the mandate of an existing committee to play this role was the solution. Participants were also hesitant to create a "stand alone" committee. One participant rejected the idea of a committee altogether, suggesting that leadership initiatives need to be an integrated part of the system transformation that the province is undertaking. Another participant reinforced this point, noting that there have been many positive changes in Ontario's health system that have not been led by provincial committees, and concluding that it was possible to function without one in the context of leadership as well. In contrast, other participants suggested that the targeted and strategic use of a committee may, in fact, yield benefits – at least in the short term. For example, one participant argued that a committee could add value if it was conceived as a time-limited entity, while another agreed that it could be helpful, but concluded that it wasn't what was needed most urgently at this time.

Option 2 – Identify current and emerging leaders in community care and support their participation in a national leadership initiative

Deliberations about this option focused less on the identification of current and emerging leaders and more on existing leadership-development opportunities, and how they could be enhanced or improved.

Many of the participants suggested that while there are many opportunities for potential leaders to build their skills, those working in smaller organizations in community (and primary) care are often not able to take advantage of these opportunities. Participants identified several reasons for this, including:

- those in the community-care sector are sometimes uncomfortable engaging with those coming from the acute-care sector (who often make up the bulk of those in classes focused on leadership capacity);
- the traditional focus of leadership-training programs has been on acute care, and the curricula of these programs typically do not address the day-to-day realities of those working in community (and primary) care; and
- community (and primary) care organizations do not have human-resource departments to offer leadership training, and there is a lack of 'flex capacity' (e.g., middle-management layer) that can cover people who attend training.

Several participants suggested that existing training programs also fall short in providing students with a range of essential 'real world' skills, although they also noted that much of this 'real world' skills development could be achieved without a formalized training approach. For example, several participants noted that the best way to obtain governance experience that can translate into better management and leadership capacity is to be on a board of directors. Furthermore, a preference for informal 'distributed' leadership-development strategies was also voiced by a number of participants. Potential examples include bringing emerging leaders to observe and take part in important meetings alongside their senior mentors, and engaging emerging leaders in high-level decision-making processes. In general, participants appeared to have a preference for interactive and 'hands on' approaches to leadership development, and for moving away from traditional concentrated or centralized models towards distributed leadership.

A number of participants also noted that the variation in existing formal programs was also a cause for concern. Specifically, some participants flagged that many programs use different leadership frameworks, which adds to the confusion surrounding what type of leadership is ideal, and who should become leaders in community (and primary) care. Most participants felt that it was important for those involved in leadership-capacity building to agree on the use of a leadership framework for the community (and primary) care sector in Ontario. They acknowledged that while many potentially helpful frameworks exist, choosing one would help streamline training and set expectations for, and adequately reward, emerging leaders working in the sector. A number of participants suggested that the 'LEADS in a caring environment' framework could serve as a starting point for discussion around a common framework. One participant thought that LEADS might be considered the best fit for Ontario given it has a significant amount of traction across the country already. However, similar to the lack of clarity around who should take a leadership role in pursuing option 1, a number of participants were unclear who it was that needed to endorse the framework.

Option 3 – Prioritize the systematic strengthening of the community-care sector to make it an attractive option for leaders

Throughout the deliberations, participants revisited the idea that rather than cleaving leadership away from the broader system-improvement initiatives currently being pursued in community (and primary) care, leadership development should be considered an integral part of these initiatives. In their view, a strengthened system would play a dual role in both attracting leaders and supporting their emergence. This sentiment was supported by many participants, and rooted in the idea that policy legacies have resulted in an imbalanced

emphasis placed on the acute-care sector in Ontario. Specifically, several participants suggested that imbalances and a perceived lack of capacity in leadership in community (and primary) care were established and reinforced because of the way the system was set up years ago, and that this would now shift with the emerging emphasis on community (and primary) care in the province. In other words, nearly all participants believed that community (and primary) care strengthening will result in leadership improvements because it will create more opportunities for leaders to develop capacity, and will also provide incentives for leaders to work in the sector. One participant noted that the concept, which was originally framed as "build the system and the leaders will come," should shift to "build it and they will emerge," to reflect the fact that leaders already exist in the community (and primary) care sector, and do not only need to be sought from different sectors. Some participants also noted that it isn't just about the structure, but also about the supports that are available to leaders, and that beyond just making these sectors attractive places for leaders to be, we need to emphasize retaining them.

Considering the full array of options

When taken as a whole, none of the options resonated with participants as a clear way forward. While some participants argued that it was essential for someone to take the lead in establishing a working group or committee to help push forward strategies to improve leadership capacity, no clear existing committee or organization emerged as a natural home. Within the deliberation focused on option 2, there was some consensus around the idea that any strategies to be pursued (including enhanced training opportunities) should be adapted to the unique needs of community (and primary) care leadership, and focus much more on collaboration, engagement and 'distributed leadership' approaches that make leadership development a hands-on endeavour. However, there wasn't a consistent commitment to identifying what the 'standard' leadership framework ought to be (although LEADS was often mentioned), or agreement around what it would mean to establish a uniform initiative for leadership development in community (and primary) care. With respect to the third option, participants mostly agreed that recent developments in community (and primary) care strengthening provided a golden opportunity for leadership development, although details about what types of strengthening were most likely to yield leadership results were not considered.

Overall, the following four themes emerged among participants with some consistency during deliberations about the options:

1) establishing a new provincial committee is not essential, whereas a deliberate, well-sequenced distributed model of ownership over the leadership-improvement process can help the sector to achieve the results it wants;
2) focusing on strengthening community (and primary) care will provide ample opportunities for leadership-capacity development (because leaders will emerge in a more robust environment, and strong leaders will be attracted to work in the sector);
3) leadership-training opportunities that meet the specific needs of community (and primary) care are needed, but should also be integrated with leadership training for other sectors to avoid isolation from other sectors; and
4) leadership-training opportunities should include an array of formal and informal approaches and opportunities to practice new skills, while serious consideration should be given to selecting a common leadership framework to underpin formal training initiatives (e.g., LEADS).

Given the government's role in driving system transformation, participants emphasized that it was important for those in government to be aware of, and explicitly draw upon, community (and primary) care leaders to assist with the development and implementation of the new vision for these sectors. They also noted that it is important for the government to embed leadership considerations into the plans for a transformed system.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Deliberations about implementation considerations centred on four major issues. First, participants identified that communicating the results of this dialogue with the right policymakers and stakeholders would be essential in order to ensure the insights extended beyond those who attended the dialogue. While a comprehensive list wasn't developed, a range of policy-support organizations, professional associations and regulatory colleges – all of whom would likely have a vested interest in movements towards leadership development in community (and primary) care – were discussed as ideal targets. Second, participants reiterated the need to tailor any leadership curriculum to the needs of community (and primary) care, and after discussing a range of existing leadership initiatives in the province (some of which have involved leaders in the community and primary care sectors), these participants suggested that it would be important to connect with curriculum developers to explain perceived gaps and get their perspective on how to fill those gaps. Third, the issue of financial constraints was raised, with many participants suggesting the need to financially support access to leadership training by a range of community (and primary) care professionals. Fourth, participants highlighted that challenges still exist with respect to identifying and taking stock of current leadership capacity in community (and primary) care in Ontario. Some participants noted that without a more fulsome understanding of existing capacity, any efforts to improve capacity may not be accurately targeted, and more importantly, there will be no indication as to whether things are getting better (or worse) over time. As a related point, some participants felt that the sectors weren't doing a good enough job measuring and monitoring leadership capacity, and recognizing leadership potential within their own membership. Many agreed that while leadership recognition could be driven by associations, there needed to be mechanisms in place that could ensure continued cross-pollination. This would help to establish a collaborative, rather than polarized, leadership atmosphere. On this same point, another participant suggested that it was important to consider the necessity of recognition at different levels of the system – from the point of care upwards.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

At the conclusion of the dialogue, each participant reflected on the next steps that could be taken. In general, dialogue participants felt a distributed approach that is well sequenced was most appropriate. Specific next steps were framed as a range of actions that would need to be pursued at three levels: 1) the individual constituency/membership level; 2) the sectoral level (primary and community care as a whole); and 3) outside of the sector.

The actions that participants agreed to take at the individual/constituency/membership level included:

- bringing knowledge about existing resources for leadership to their membership, while noting that it will still be a challenge for people to understand how they can take advantage of them;
- utilizing existing opportunities to support leadership development and to mobilize the knowledge about what exists;
- being more strategic regarding advocacy for leadership at local levels while engaging with partners about what is needed on the ground (with a focus on persuading and educating partners about what is possible);
- responding to generational differences in how leaders connect by utilizing new technologies and social media to allow emerging and existing leaders to gather virtually as well as in-person; and
- encouraging leadership renewal by mentoring and bringing 'young' leaders along so that there is not a gap when existing leaders retire.

The actions that participants agreed to take at the sectoral level included:

- convening a core group of community (and primary) care stakeholders to put together a framework/strategy and resource plan;

- fostering clear linkages between community and primary care to ensure capacity building is pursued in a coordinated way and that leadership in these sectors is jointly enhanced;
- developing a provincial platform or conference (annual or bi-annual) targeting community and primary care (and possibly public health) that includes leadership programming;
- promoting and practising distributed leadership, while working with others in community (and primary) care to ensure there are opportunities to engage emerging leaders in cross-professional training and capacity building; and
- developing a forward-looking vision and plan that anticipates what types of leadership will be required in a transformed system (i.e., 24+ months from now) and sharing it with government colleagues so that leadership considerations can be included in the vision for a transformed system.

The actions participants agreed to take that include other stakeholders in other sectors were:

- working with government partners to take advantage of the pending changes in the system and integrating leadership development into these changes, including creating opportunities for emerging community (and primary) care leaders to participate in planning the changes as they unfold;
- investigating how other sectors are tackling these challenges, especially those who are doing it well (e.g., Association of Municipalities of Ontario); and
- approaching institutions that host training programs (e.g., Rotman School of Management, IDEAS – Improving & Driving Excellence Across Sectors) to identify barriers and brainstorm solutions to ensure leadership training meets the needs of those working in the community.

Overall, participants felt that it was essential to recognize that recent political developments have created unique opportunities to act now. Many participants emphasized how important it was to 'seize the day' and take advantage of the current focus on community (and primary) care, while continuing to focus on the opportunities for enhancing leadership capacity. While it was acknowledged that there was a considerable amount of debate surrounding each of the strategies considered in the dialogue, participants were confident that the deliberate and well-sequenced distributed approach they identified would yield important gains. As one participant reiterated, it was important to stop debating, pick an approach, and move forward before the opportunity is missed.

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