Redefining Health Care

A DIALOGUE ON HEALTH POLICY





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Ontario Hospital Association 200 Front Street W., Suite 2800, Toronto, ON M5V 3L1 Canada +1 416 205 1300, oha.com

External Contributors

Dr. Mira Backo-Shannon, Trillium Health Partners

Dr. G. Ross Baker, Institute of Health Policy, Management and Evaluation, University of Toronto

Angela Bishop, Red Lake Margaret Cochenour Memorial Hospital

Susanne Bjerno, Ontario Medical Association

Dr. Jean-Louis Denis, Institute of Health Policy, Management and Evaluation, University of Toronto

Dr. Cathy Faulds, Ontario College of Family Physicians

Dr. Brian Golden, Rotman School of Management, University of Toronto

Dr. Steven Jackson, Mackenzie Health

Dr. Gillian Kernaghan, St Joseph's Health Care London, Canadian Society of Physician Leaders (CSPL)

Dr. Bert Lauwers, Ross Memorial Hospital, Physician Hospital Issues Committee (PHIC)

Dr. Lynn Mikula, Peterborough Regional Health Centre

Elaina Orlando, Institute of Health Policy, Management and Evaluation, University of Toronto

Ron Sapsford, former Deputy Minister of Health and Long-Term Care, and former CEO, Ontario Medical Association

Dr. Andy Smith, Sunnybrook Health Sciences Centre

Altaf Stationwala, Mackenzie Health

Dr. Adam Steacie, Upper Canada Family Health Team, Physician Hospital Issues Committee (PHIC)

Dr. Stephen Viherjoki, Dryden Regional Health Centre

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Key Quotes from this Issue

"For transformation of the Canadian health care system to be successful, physicians must play a central role in planning and implementing change."

> - Dr. Gillian Kernaghan, President of the Canadian Society of Physician Leaders, and President and CEO, St. Joseph's Health Care London

"If you have the appetite and aptitude for it, it's every bit as thrilling as full-on clinical work."

> - Dr. Andy Smith, Executive Vice President and Chief Medical Executive, Sunnybrook Health Sciences Centre (and CEO as of July 1, 2017)

"Gone are the days where administration views physicians as adjunct. They have to be embedded in every element of the day-to-day operations and over-arching strategies."

- Altaf Stationwala, President and CEO of Mackenzie Health

"There is a crucial need for physician leaders at the senior level... I see my role as a bridge between two stakeholder groups, enhancing the understanding and cooperation between physicians and non-physician administrative leaders."

- Dr. Steven Jackson, Chief of Staff, Mackenzie Health

"All leaders, whether in health care or other sectors, know that their number one job is to align the interests of their employees and staff with those of the organization. That is, to make them partners."

> - Brian Golden, Vice-Dean and Sandra Rotman Chaired Professor of Health Sector Strategy at the Rotman School of Management, University of Toronto

"Hospital management must be clear in declaring that strong, positive physician relationships are a priority for the successful operation of the hospital. It is imperative that the key elements of that relationship are established, documented and then practised."

- Ron Sapsford, Chair of the Board, Associated Medical Services Inc., Director, Schlegel Health Inc., and Director, Michael Garron Hospital

"Sometimes the best leaders are the ones least willing, who don't identify themselves as "big L" Leaders at all. They come to participate out of a desire to improve the system that restricts their ability to provide that ideal patient care that they strive for. They are the curious ones who study the effects of process and policies on the ground, identify trends, and, though they may not have the answers, aspire to learn more and do better."

- Dr. Mira Backo-Shannon, Program Chief and Medical Director for Primary Care, Seniors Care, Palliative Care, Rehab, CCC and the Family Medicine Teaching Units at Trillium Health Partners, and Primary Care Physician Lead for the Mississauga Halton LHIN

"It is surprising that in 2017 there are still some organizations that don't recognize the symbiotic relationship that must exist between physicians and hospitals. To effectively manage this interdependency we need to move beyond the historical divide between physicians and administrators, but this won't happen simply with wishful thinking."

- Brian Golden, Vice-Dean and Sandra Rotman Chaired Professor of Health Sector Strategy at the Rotman School of Management, University of Toronto

The Importance of Hospital-Physician Alignment



The hospital-physician relationship is a pivotal one, and has arguably never been more important than at this current juncture. The system is undergoing major transformation and health care organizations are struggling to meet the needs of a growing and aging population; at the same time, efforts are still underway to negotiate a new Physician Services Agreement.

Most recently, the parties reached a deal on the use of binding arbitration, a sign of progress as the parties continue to work towards a new agreement. While it's too early to determine what implications arbitration may have on hospitals and the broader health care system, one thing we know for sure is that physicians are critical to a high performing health care system as are strong partnerships between hospitals and physicians.

To that end, the OHA has worked closely in recent years with system partners such as the Ontario Medical Association and the Ontario College of Family Physicians to develop guidance materials to support hospitals and physicians in establishing effective working relationships. A Physician Leadership Resource Manual was developed to help physicians become more effective leaders and to ease the transition from physician to physician leader, and throughout the past year, the OHA published a collection of success stories from hospitals to illustrate the important work our members are doing to improve relationships. Most recently, we have completed a series of regional forums in seven communities across the province, which provided an opportunity for hospital and physician leaders to share their successes and challenges in building effective models for hospital-physician alignment. These valuable insights will assist the OHA in identifying how to most effectively support the hospital-physician relationship moving forward.

What this work has illustrated is that significant advancements can be made when there is alignment of purpose and effective teamwork. Yet, we recognize that there is much more to be done.

Our second issue of *Redefining Health Care* focuses on the uniqueness of this relationship, as well as the opportunities that might be explored to facilitate better alignment. Included in this edition are examples of strategies used to improve the relationships with physicians working both within and outside the hospital; reflections on new and emerging models for physician leadership; research and analysis from the University of Toronto's Institute of Health Policy, Management and Evaluation and Rotman School of Management; as well as an examination of efforts to modernize the *Public Hospitals Act*.

As the articles highlight, hospital-physician alignment cannot be achieved through a single program, tool or engagement exercise. Instead, it demands a long-term commitment to understanding how each perspective can inform organizational and system change and quality improvement. It's about a continuous dialogue between hospital and physician leaders at all levels of the organization.

It is also clear that as the structure of Ontario's health care system continues to evolve, and as hospitals begin to redefine their role within the community, the clinical expertise and practical implementation knowledge of physicians must be integrated into the decision-making process in a meaningful way. While this is an ongoing journey, we hope that *Redefining Health Care* serves to

foster both discussion and action as we individually and collectively embark on this critical work.

Elizabeth Carlton Vice President, Policy and Public Affairs ecarlton@oha.com @ecarltonoha

Inspiring Improvement: Hospital Successes in Strengthening Hospital-Physician Relationships



Enhancing the relationship between hospitals and physicians results in greater levels of satisfaction and engagement on the part of physicians working in hospitals, which ultimately improves the patient experience. Because of the importance of this relationship to its member hospitals and the overall health system, the Ontario Hospital Association has identified hospital-physician alignment as one of its three areas of thought leadership.

This publication is a collection of success stories from Ontario hospitals that reflect how various organizations have implemented initiatives to improve hospital-physician relationships. It is our hope that these experiences will inspire other hospitals to implement programs with similar goals.





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OHA/OMA Physician Hospital **Issues Committee**

By: Dr. Adam Steacie and Dr. Bert Lauwers

There is no shortage of common issues for which PHIC will remain a valuable forum.

The Physician Hospital Issues Committee (PHIC) was established in 2010 as an important opportunity for the Ontario Hospital Association (OHA) and the Ontario Medical Association (OMA) to work collaboratively on identifying solutions to issues that directly or indirectly impact both physicians and hospitals.

Both the OHA and the OMA appoint four members to serve on PHIC, with a term of two years. Historically, the OHA's membership has included the Chair and Vice Chair of the OHA's Provincial Physician Leadership Council, a group established in 2010 to provide strategic advice to the OHA on various physician-related matters that impact hospital-based practice in Ontario. OMA is represented by members of OMA's Hospital Issues Committee.

At its core is the overriding objective to maintain a strong and positive working relationship between the OHA and the OMA. In addition to facilitating the sharing of information between the organizations, PHIC also serves as an important forum for developing mutual advice and guidance for the OMA and the OHA.

PHIC also provides the opportunity for the OHA and the OMA to jointly initiate outreach to other system partners, such as the Ministry of Health and Long-Term

Care, Local Health Integration Networks, Health Quality Ontario, community providers and others as required on issues of mutual interest.

Over the last few years, PHIC has developed a number of key resources for the health care sector. In 2014, the OHA and the OMA published A Framework for the Redistribution of Hospital Services to provide guidance when considering and/or implementing the redistribution of clinical services among providers.

Recognizing the importance of the relationship between hospitals and physicians in delivering quality patient care and to support the work of the OHA's Thought Leadership Mandate on hospital-physician alignment, the OHA and the OMA jointly produced the Guidance for Developing an Effective Hospital-Physician Relationship in the fall of 2015. In March of last year, PHIC collaborated on a joint video to raise awareness about the importance of the hospital-physician relationship in achieving high quality patient care. Both the guidance document and video can be found on the OHA website at www.oha.com.

There is no shortage of common issues for which PHIC will remain a valuable forum. Improving physician/hospital



partnerships, both within hospitals and within communities, is of key importance for both the OHA and the OMA. In addition, we expect that concentrated efforts on enhancing physician leadership within hospitals will be a significant area of focus moving forward.



Physician Leadership and Engagement as a Key Strategy for Health Care Reform



By: Elaina Orlando, G. Ross Baker and Jean-Louis Denis

The need for dramatic reforms aimed at improving the performance of Canadian health care systems is echoed widely in the literature, in provincial reports as well as in several federal commissions and by key stakeholders such as the Canadian Medical Association. Analysis of high-performing health systems elsewhere also suggests the need for fundamental changes to make Canadian health care systems more efficient, effective and patient centred (Baker & Axler, 2015).

Diagnostic and treatment decisions by physicians directly and indirectly influence a large proportion of health care costs - these decisions are key in determining where care is delivered and what outcomes are experienced by patients. Thus, physicians will need to play a key role in designing and implementing changes ranging from clinical care decisions within acute and non-acute settings, to recommendations on redesigning patient journeys to improve continuity and experiences across these settings.

Research indicates that engaging physicians as leaders of change improves performance within microsystems (Bradley et al., 2006; Peterson, Jaen & Phillips, 2013), healthcare organizations and broader systems (Baker and Denis, 2011; Clark, 2012; Reinertsen, et al., 2007). Engaging physicians in change efforts cannot be considered optional, but rather an imperative if we are to transform the current health care system.

Engaging physicians in change efforts cannot be considered optional, but rather an imperative if we are to transform the current health care system.

The Challenge

Health care organizations and systems possess structures and cultures that are highly resistant to change, both at the policy or managerial level as well as the clinical level. Historically speaking, involving physicians in efforts to reform the system has been difficult.

Tuohy (1999) notes that the structure of Medicare in Canada incorporated a "bargain" that maintained the clinical autonomy of physicians, despite the role of the state as funder and regulator. Physicians' fears that a government-controlled system would diminish both their incomes and professional autonomy led to compromises in the Saskatoon Agreement of 1962 that paved the way for the adoption of Medicare across Canada, creating a structure (replicated in other provinces) that limited challenges to fee-for-service reimbursement and enhanced physicians autonomy on professional practice issues (Lawson, 2009 as cited in Marchildon & Schrijvers, 2011).

Lazar (Lazar et al., 2013) describes this historical legacy as a key issue in the "paradigm freeze" of Canadian health care, limiting system reform. This historical context remains an important factor that continues to re-emerge in the efforts to engage physicians in efforts to achieve system changes.

Despite this challenge, efforts across Canada demonstrate that physicians are playing key roles in system changes at different levels. These experiences, as well as lessons learned in other countries, suggest three sets of factors that influence physician engagement and leadership for change (Denis et al. 2012). These factors, integrating physician leaders in health care structures, creating supportive contexts for physician engagement and leadership, and developing the leadership competencies of leaders, both individually and collectively, offer multiple levers to engage physicians in system changes and to create facilitating structures and cultures that align physician roles and values with broader system objectives.

In this article, we explore these different mechanisms and evidence on ways in which health care systems have engaged physicians in change, and we offer reflections on the opportunities for Ontario to move forward on this important dimension of system improvement.

Mechanisms for Change

Structure

The historical divide in health care between clinical work and management is mirrored in the traditional two-tier structure of health care organizations. Denis and colleagues (2012) and Clark (2012) argue that changes in structure alone cannot be the sole focus of engagement mechanisms; however,

structure is an important lever for engagement and contributes to the cultural changes required to support enhanced physician engagement.

Denis et al. (2012) cite multiple sources of evidence that structural levers such as the creation of formal leadership roles for physicians and economic incentives have a positive impact on physician engagement (e.g. Dickson, 2012; Shortell et al., 2000). Snell et al. (2011) suggest that for physicians, becoming engaged in change initiatives often requires physicians to extend themselves beyond their existing clinical roles to new leadership and management opportunities, often without compensation or administrative support.

For both formal and informal physician leaders, time is a constraint that challenges their involvement in improving systems. Given that structural factors, such as the limited roles of physicians in leadership, have often been seen as barriers to physician engagement, it is no surprise that many system leaders have focused on structure as a tangible means by which to drive reform.

Integrating physicians into the leadership of delivery organizations has been a key mechanism by which organizations and systems have sought to facilitate physician engagement.

Since the 1960s, the National Health Service (NHS) in the United Kingdom has engaged physicians as leaders in clinical directorates in hospitals with accountability for performance, quality and finances. This particular role has changed in recent years, with a shift from senior physicians working full-time in this administrative capacity to the part-time appointments of

physicians throughout the system who maintain a clinical practice (Clark, 2012).

In the United States, physicians are often appointed as department and program leads, and as leaders of major improvement initiatives (Gosfield and Reinertsen, 2010), influencing the nature and pace of change and maintaining the relationship between the organization and its physicians.

In Ontario, physicians have traditionally assumed leadership roles as Chiefs or Heads of Service within organizations, a role which typically divides them between clinical and administrative practices with financial compensation for the former role. Within the Local Health Integration Networks (LHINs), Ontario has also created physician leads for various sectors and areas of focus. While leadership is a facilitator of engagement and there is a need for physicians to assume leadership roles, formal positions alone do not ensure either successful leadership or broader engagement. Physician leaders, like other leaders, benefit from leadership training and skills development to help them lead other physician peers.

Another widely used structural change to integrate physicians as change leaders within organizations is the creation of leadership dyads: paired physician and nursing or administrative leaders who share decision-making at multiple levels throughout the organization. Johns Hopkins, Kaiser Permanente, Mayo Clinic and Intermountain Healthcare have all employed leadership dyads (Baker and Denis, 2011; Denis et al. 2011). Similar structures have also

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been implemented in both Alberta and Saskatchewan where there is standard work for each role and clearly defined expectations as to how the paired leaders will work together to achieve desired aims (Paulus et al., 2008).

The success of these leadership dyads is heavily dependent on the context of the organization or system in which they are implemented. Physician leaders perform optimally in organizations that support both their development and their participation in organizational changes. Such physician leadership needs to be integrated with wider organization leadership and should be participating fully in achieving the strategic goals of organizations (MSEQWG, 2012).

New organizational models address this issue explicitly. For example, Accountable Care Organizations (ACOs) in the U.S. aim to engage physicians fully within the systems in which they practice. The structure of the ACO model creates incentives for clinical integration and financial accountability to help ensure better coordination of care and outcomes for patients (Press et al., 2012).

ACOs create explicit accountabilities for physician groups for their performance and costs, and allow providers to participate in shared decision-making (Bansal & West, 2012). These efforts have had some success, but research by Addicott & Shortell (2014) suggests that accountability for physicians' performance and quality of care has been limited in practice, a finding

that suggests the need to reinforce such structural mechanisms with supportive contexts and wellprepared physicians.

In both the U.S. and in Canada, the development of physician compacts has also been used as a structural lever to drive change. These compacts define the expectations of both leadership and physician groups within an organization and how they will interact with one another to contribute to better working arrangements and organizational change (Shukla et al., 2009). O'Hare & Kudrle (2007) describe the development of a physician compact to help clarify roles, expectations and accountabilities of physicians and administrators to each other. The Ottawa Hospital underwent a similar process to enhance engagement (Scott et al., 2012).

Context

Organizational culture is critical in facilitating or hindering efforts to drive change. A key facet underpinning the culture of an organization is the trust between key players and across various levels of the organization. Zuckerman et al. (1998) cite the importance of trust between physicians and their organizations as a key factor contributing to the extent of their involvement within the organization.

Trust is created through a shared vision, effective collaboration and transparent communications. In an examination of the organizational factors associated with high performance in quality and safety, Keroack and colleagues (2007)

found that a shared sense of purpose was key in top performing organizations. Similarly, Hockey and Bates (2010) note that in highperforming organizations physicians and administrators were aligned in vision and had developed trust from their shared values and commitment to providing high-quality care. This work demonstrates that working relationships, trust and shared goals impact structural arrangements aimed at enhancing physician engagement. Physicians and managers can have different mental models regarding care delivery, improvement approaches and professionalism (Dickson, 2012) that need to be understood and reconciled, or these differences can undermine trust and relationships.

Many physicians practicing in Canada have practices independent of the hospital, are paid by the government through fee-for-service arrangements and are connected to the hospital only though their hospital privileges, factors which have reinforced the autonomy of the physicians from the organizations in which they practice. Reinertsen et al. (2007) suggest that organizations should position physicians as partners in achieving quality, transitioning away from traditional perspectives of physicians as disparate parties of the organization, or "customers". The CMA (2010) notes that agreements between physicians and organizations in Canada are shifting to include contractual and employment agreements and appointments, pointing back to the emphasis on structural supports for engaging physicians in leading change.

Trust is created through a shared vision, effective collaboration and transparent communications.

Bohmer (2012) suggests that engaging physicians as leaders of change is critical for achieving improved health quality because physicians are leaders of the clinical microsystems that manage daily care. Clark (2012) concurs, noting that physicians have the greatest influence on variations in health outcomes; thus organizations must support physicians at the centre of their improvement programs.

Distributed leadership, first described by Gibb (1954), refers to leadership that is collective in nature and extends beyond a single individual. Several terms are often used interchangeably to describe this concept, including collective leadership, shared leadership and collaborative leadership. The importance of leadership that is not solely top-down in nature has been reinforced in a number of studies, as important to facilitating organizational change. (Battilana, Gilmartin, Sengul, Pache, & Alexander, 2010; Best et al., 2012; Buchanan, Caldwell, Meyer, Storey, & Wainwright, 2007; Connor et al., 2007; de Búrca, 2008; Denis, Lamothe & Langley, 2001; Lukas et al., 2007; Roberts & Coghlan, 2011; Shaw et al., 2012).

Health care structures naturally support a distributed leadership model (Denis et al., 2012); we need to acknowledge and capitalize on this by training physicians to be leaders at all

levels and by creating organizational contexts that are supportive of this leadership model. Senior leaders can encourage distributed leadership through appropriate structures (Roberts & Coghlan, 2011) and processes (Buchanan et al., 2007), while being cognizant that organizational cultures can also act as a barrier to the development of distributed leadership (Roberts & Coghlan, 2011).

Individual Factors

Engagement can be seen as a continuum of human capabilities within specific work roles, ranging from merely obedient employees, to those with passion for their roles (Hamel, 2013). Individuals with the highest degree of engagement view their work as a calling and as a means to contribute positively to society. For such individuals there is often little distinction between vocation and avocation.

Denis and colleagues (2013) suggest that in addition to the organizational efforts required to enhance engagement, there are individual factors that may enhance the likelihood of some physicians becoming engaged over others. Spurgeon et al. (2011) points out that for an individual physician, the desire to become engaged is necessary but insufficient and organizations must create the conditions necessary to facilitate engagement.

A critical driver for physicians is their interest in providing quality patient care. Full engagement enables individuals to look beyond high quality of care for specific patients to the overall quality of care and performance of the team and organization in which he or she is practicing (Reinertsen, et al., 2007).

There are several structural features of our health care system that will make engaging physicians in leading change challenging, including traditional approaches to individual professional development. Clinical training shapes physician mindsets.

Gillam (2011) suggests that clinical training for physicians often stresses the imperatives of autonomy, reinforcing the broader structural autonomy of Medicare. This mindset creates barriers to efforts to integrate physicians as equal team members within collaborative care structures and in improvement exercises. Braithwaite (2010) found that during periods of change, physicians tend to identify more strongly with their profession or service than with the organization in which they practice.

Within a system that is perpetually striving to change and improve, the focus on autonomy and professionalism that is engrained in traditional medical education may become more pronounced, unless professional education shifts to emphasize physicians' responsibilities to the broader system (as foreseen in the CANMEDS 2015 framework), and when health care organizations support physicians in assuming leadership roles.

Health care organizations need to see leadership and engagement as system issues: how do we engage physicians more broadly and support their development as leaders?

Efforts focused on influencing individual leadership skills may be supported through structural changes, creating formal leadership roles or physician-leadership dyads. Across Canada, there have been a number of efforts to better develop existing physician leaders through training programs: British Columbia, Saskatchewan, Ontario and Nova Scotia, for example, have all created educational opportunities for physicians to develop leadership skills. The CMA Physician Leadership Institute and the Canadian Society of Physician Leaders also support pan-Canadian efforts to improve leadership.

A number of large health systems have employed internal educational mechanisms to enhance physician participation in quality improvement, including the Veterans Healthcare Administration (VHA) System, which initiated a multi-component quality improvement strategy, including a Quality Fellows Program to provide physician education about quality improvement methods and encourage future leadership (Aron & Neuhauser, 2002).

Intermountain Healthcare has also invested in education aimed at enhancing physician participation in quality improvement through their Advanced Training Program, which teaches physicians quality improvement principles and methods to enhance patient outcomes (Intermountain Healthcare, 2015). In Ontario, the Improving and Driving Excellence Across Sectors (IDEAS) is an educational program that supports clinicians to develop hands-on skills in leading improvements within their organizations.

Next Steps

Organizational and system strategies for engagement need to incorporate elements of these three dimensions, facilitating engagement and moving past a singular focus on the development of individual leadership skills. Health care organizations need to see leadership and engagement as system issues: how do we engage physicians more broadly and support their development as leaders?

Horne (2012) calls for collective engagement strategies, reinforcing the need to focus on structural, contextual and individual levers to support physician engagement in leading change. Denis and colleagues (2012) suggest that while physicians may often be perceived as resisting change, they are often only resisting changes in which they have had limited participation and input.

In recent years, provincial governments have placed increased emphasis on the accountability of physicians for practice, organizational and regional outcomes. But this focus needs to be complemented with an equal or greater emphasis on developing leadership skills and meaningful opportunities to participate in local and system level changes.

Table 1 summarizes the levers supporting the successful engagement of physicians as leaders to achieve systems change. These levers are complementary and interdependent; actions need to be taken in each dimension rather than focusing on one alone.

Denis and colleagues (2012) suggest that physician leadership for engagement spans a continuum and that individual, organizational and system influences can reinforce, or undermine, each other. Being attuned to the interplay across the levers and within the different levels of the system is essential to create and sustain the physician leadership and engagement needed to drive desired system changes, overcoming the current "paradigm freeze" (Lazar et al. 2013).

Despite growing efforts across Canada to create formal physician leadership roles in support of system transformation, many challenges remain. Few organizations have invested in the individual and

Table 1: Structural, Contextual and Individual Factors for Physician Engagement and Leadership

Structural Factors		
Lever	How Lever Supports Engagement & Leadership for Change	Influenced By
Accountability Mechanisms	Creates formalized agreements through which physicians are held accountable to the organization and/or system for performance, quality, and/or financial improvements	PartnershipsTrustLocal support in achieving goals
Compacts	Mutually-defined contractual agreements between administrators and physicians define roles and working relationships to achieve organizational change, creating alignment of work and purpose	TrustNegotiation skills
Economic Incentives	May align the work and interest of physicians with organizational or system interests, reinforcing desired behaviours and outcomes	Careful analysis of impact to avoid unintended consequences
Formal Leadership Roles	Creates opportunities for physicians to participate in decision-making and priority setting for systems and organizations while embedding joint accountability for outcomes	Leadership developmentOrganizational support
Contextual Factor	ors	
Distributed Leadership	Generates opportunities for change and priority-setting to occur at all levels within systems and organizations by removing decision-making that is concentrated among a small number of individuals	 Accountability mechanisms Formal leadership roles Clinical education Leadership development Talent planning
Partnerships	Effective partnerships between administrators and physicians diminishes the view of physicians as separate from organizations and systems	 Economic incentives Formal leadership roles Trust
Trust	Through shared vision, transparent communication and the alignment of values, trust between clinicians and administrators creates a culture that supports deeper involvement and a commitment to the organization and system	CompactsFormal leadership rolesPartnershipsWider view of physicians' work
Individual Factor	's	
Clinical Education Emphasizing System-Based Practice	Formative education that reduces a emphasis on clinical autonomy and reinforces interdisciplinary teamwork as a means to achieve the highest quality care and value formation that inculcates system roles rather than only professional allegiances	Economic incentivesPartnerships
Leadership Training	Produces physicians with skills in improvement, governance and collaboration with administrators to generate more similar mental models that support trust and effective partnerships	Formal leadership rolesDistributed leadership
System Responsibility	Physicians who embrace their roles in contributing to effective system changes	

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contextual levers necessary for ensuring broad and sustainable improvements.

The CANMEDS 2015 Framework will stimulate leadership, change management and interprofessional skill development in medical education. These changes to professional training and continuing professional development programs will increase the numbers of physician leaders and deepen their capabilities to support transformation, but these efforts could have even broader scope and wider participation.

More attention needs to be focused on influencing the contextual levers, which, as Denis and colleagues (2012) suggest, are the most challenging. Sustained health care transformation will require a reframing of the culture of medicine, so that physicians value their roles in supporting system transformation, and see these efforts as a core professional responsibility as critical as the quality and attention paid to individual patient care.



Organizations that invest in physician leadership development and create new leadership roles will witness greater engagement by their medical staff. Such concerted efforts to integrate physicians in transformation, not as separate players, but key collaborators with others, will help shift the culture supporting changes that are well designed and sustainable.

Taitz et al. (2012), in their review of the engagement of physicians in quality and safety initiatives, suggest that such engagement is critical in developing high-performing organizations. This engagement needs to be carried out in a context that supports physicians, working with others, to improve care.

Successful engagement requires strong vision and leadership within the organization, support in accessing and using data, and working in an environment where there are professional rewards for those physicians who contribute to clinical and organizational changes. Thus leadership and engagement need to be system strategies, not just individual career paths. Effective leadership must be distributed across the system so that physicians and other clinicians can contribute to a shared vision of improvement and the partnership needed to create change.

Accountability mechanisms and formalized roles should be defined to support such vision and collaborations; but creating greater accountabilities and roles alone will not shift mindsets. Health care systems that wish to improve outcomes and patient experiences while reducing or limiting increases in costs must be redesigned. Physicians are key players in this transformational change, and they cannot be effective unless such responsibilities become a core part of their roles within a supportive system.

Sustained health care transformation will require a reframing of the culture of medicine, so that physicians value their roles in supporting system transformation, and see these efforts as a core professional responsibility as critical as the quality and attention paid to individual patient care.

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Physicians as Catalysts for Change

By: Dr. Gillian Kernaghan

For transformation of the Canadian health care system to be successful, physicians must play a central role in planning and implementing change.

That's the argument by Drs. Johny Van Aerde and Graham Dickson in "Accepting our Responsibility," a new white paper by the Canadian Society of Physician Leaders (CSPL), released early 2017.

Grounded in recent Canadian research related to physician leaders and Canadian and international literature, the paper challenges physicians personally and collectively to be active participants in system transformation.

As noted in the paper, "the need to introduce these opportunities throughout the Canadian health care system is urgent and is a pre-condition for the required transformation of that system."

Additionally, the authors state that physicians in the CSPL community are prepared to step up to accept the responsibilities associated with being a partner in reform effort, bringing new energy and passion to system transformation.

There are three sections. The first outlines the extent and pace of health reform in the various jurisdictions in Canada and the importance of engagement of physicians to further the reform. Although we have 15 delivery systems, most are focused on patient-centred reform and fiscal control. There are varied relationships across the country between medical associations and other parties in the system.

The second speaks to the importance of developing medical leadership and the attributes of leadership. The authors highlight the importance of "the capabilities associated with modern collaborative leadership, especially the ability to act as a partner in the reform process."

"Collaborative leadership emphasizes the centrality of relationships and highlights the importance of interpersonal, political and strategic leadership to build substantive connections across and throughout a system." The authors recognize that it is not only physicians who must be committed to collaborative leadership, it is all those contributing to the system.

The encouragement to physicians is to realize the importance of leadership development both educationally and experientially. The paper highlights some of the professional and system challenges when physician aspire to leadership roles.

Potential suggestions for action comprise the third section. These suggestions are designed to stimulate reflections at an individual physician level and dialogue at an organizational or system level.



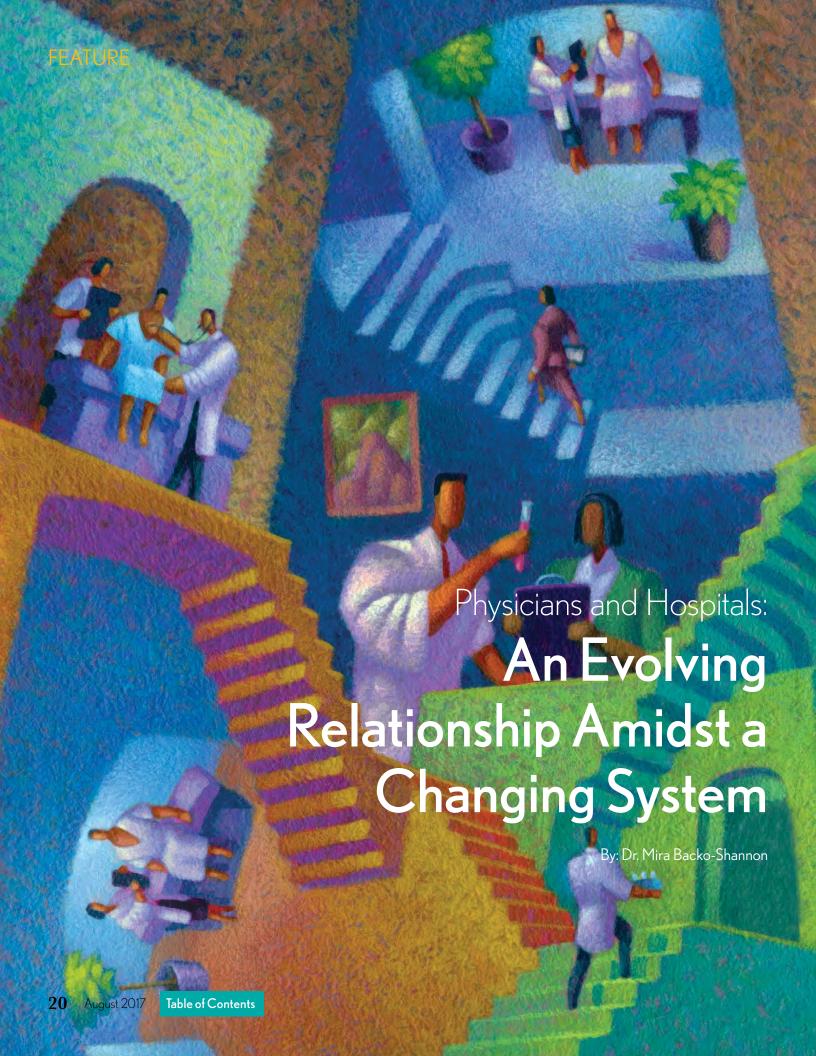
Among other recommendations:

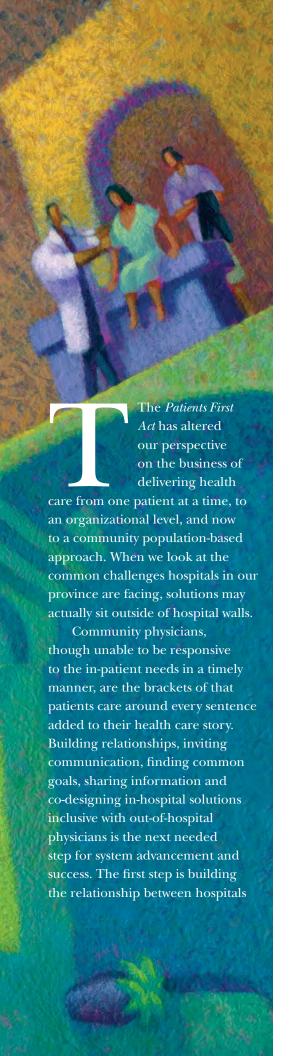
- Physicians are challenged to reflect on their mindset that limits engagement, participate in, or champion colleagues involved in the reform agenda.
- Organizations are encouraged to understand the level of physician engagement while creating the enabling structures and processes to increase engagement and the development of physician leaders.
- Provincially, ministries and associations need to build relationships of trust that recognizes the benefits of physicians of physician engagement and supports leadership development.
- Nationally, associations and professional colleges need to champion physician leadership in the educational and practice environments and publicize best practices to enhance engagement.

Most importantly, this paper speaks to the need for each of us in leadership, whether in individual organizations, provincial or national associations or ministries, to create a climate and culture that welcomes, encourages and enables meaningful engagement of physicians. I look forward to hearing feedback from physicians and our partners across the health care system.



To view a copy of the paper, please visit www.physicianleaders.ca.





Like any good marriage, partnership between hospitals and physicians must be founded in respect and built on common values and goals.

and physicians. As with all healthy relationships, it is founded on respect, expressed value of each party, inclusivity in all parts of the dynamic, and seeing each other as partners in this together.

This article will provide a lens into the complex dynamic of hospitals, the physicians who work there, and the skills needed to foster this important relationship.

Relationship

Employer-employee relationships are thought to flourish when clear objectives, realistic timelines, and transparent accountabilities are in place. Top companies reap benefits of loyalty, retention, productivity and innovation when they focus on the human elements of motivating their work force. These concepts are challenging for a health care culture where patients' needs are constant and intense. Cost restraints are forcing us to do more with less, etching out free time to daydream and dabble. However, culture might be the perfect environment for doing just that.

Improved patient care comes from the human elements of medicine. Creating calming

environments for both patients and staff feeds back into a healing atmosphere with less agitation-provoking scenarios for patients. It also reduces the "noise" in an environment which is the largest cause for error in a health care setting, as recently presented in a Harvard Business Review, *The Cost of Inconsistent Decision Making*, by Daniel Kahneman.

But, you may be asking, what about physicians? If, in general, physicians are not employees, then how do hospitals and physicians work together effectively? It is the lack of a clear understanding of that dynamic that leads to frustration. Like any good marriage, partnership between hospitals and physicians must be founded in respect and built on common values and goals. Foundational to the strength and success of this relationship is communication.

Communication

Medicine is a people business.

Physicians spend their days entrenched in decision-making, problem-solving and communicating. Understanding your communication style is an important self-refection. Mike Murphy of Forbes magazine summarized the

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four key styles, described below, in a simple article published online in 2015.

It is critically important to know the communication needs of your audience, and to develop the skills needed to be agile to adapt your style to theirs. In general, physicians are analytical communicators; they like stats and data. Their profession, founded in science, attracts this personality type; one of ongoing learning and curiosity, repeat study and challenging of hypotheses. Physicians are skeptical about new ideas and theories without the detailed supporting methodology, declaration of assumptions and analytics.

Some physicians will also fall into the functional communicator column. This group is focused on detail and precision, needing each step shown along the path to gain comfort in knowing that all mitigating factors have been considered. This is a trait we value in our physicians when delivering patient care.

Contrast that to many system leaders, hospital administrators, CEOs, policy makers, who tend to gravitate toward an intuitional style. These big picture talkers tend to move through the thought process in a quick manner, focusing on key milestones and impatient to get to the final result. They speak in generalities, and are confident in the details along the way as being solvable without needing to linger over each one.

The final category is a personal communicator, with which I would suggest, many of our hospital patient care staff align. Naturally their Since physicians are not employees, the carrot-and-stick approach to changing behavior and yielding results is often a failed tactic.

attention falls to how somebody is feeling about the information, and how it is impacting the relationship amongst the group.

It is understandable that when you have multiple styles in a room, communication can shut down quickly. Finding the balance in sharing the end goal, then backing up to go through the steps to getting there supported by the data and pausing to pulse check how people in the room are feeling about the message can be an involved and tedious process; though well worth the investment.

Finally, it's important to recognize that many physicians working in the hospital don't always understand the day-to-day operations of the hospital. It is difficult to have a conversation about bed mapping and alternative level of care strategies, when your physician group, on whom you are counting to be part of solution, do not understand the various designations or impact on funding it has. Sharing a glossary, or beginning with a few foundational definitions and points of clarity is useful at the start of each communication, whether written or verbal. Physician leaders can be a valuable resource in educating their groups. Introducing them to the vernacular of hospital administration will allow them to engage in a meaningful way.

Engagement

Physicians, by nature, are curious. Likewise, they are the providers of care, who can rapidly cycle a new project through their cohort of patients, assessing the impact of the intervention on outcome. However, it can be paralyzing to make rapid decisions when people are siloed in their work stations (McChrystal, Stanley, et al. 2015).

To be agile at this time of health care transformation, we need people whose skills and knowledge are blended across departments and professions. Finance and out-patient clinics need to know what each other are doing. The same is true of the emergency department and lab, the hospital and the community physicians.

Fulsome, transparent communication is the starting point. Identifying who needs to know the information shifts to the question of who doesn't need to know. There is a fine balance in these words, and is not intended to provoke carbon copy "all" emails to every member of the organization. It does call out to including your physician leaders in important decision points in the organization at the design phase.

Drawing on them to co-design, sharing in the articulation of the problem, identification of important data sources and vetting the design options to mitigate those unintended consequences is needed. As a partner valued for their on-the-ground experience, problem dissection skills and critical analysis, inviting them at the question phase is a key contributor to success.

Meeting overload is another pitfall in getting physicians to the table. Cancelling patient visits is a significant request, and meeting outside of patient hours becomes taxing for an organization that is supporting a worklife balance for its staff and physicians.

Decisions and information can move in a more pointed fashion with great productivity outside of the traditional committee structure. Rather than requesting a one to twohour section of time, consider if this conversation can happen in a focused conversation over the phone, through webinar, a shorter face-to face meeting or through written form (yes, I mean email.) When things begin to falter, it is worth pausing to consider the communication style being used and the assumptions about the knowledge that are being made, change tactics and re-engage.

Leadership

Since physicians are not employees, the carrot-and-stick approach to changing behavior and yielding results is often a failed tactic. When seeing this key influential group as partners, you must identify a common goal, which will be found in patient care and quality.

Who your physician leaders are is important. Sometimes the best leaders are the ones least willing, who don't identify themselves as "big L" Leaders at all. They come to participate out of a desire to improve the system that restricts their ability to provide that ideal patient care that they strive for. They are the curious ones who in their offices study the effects of process and policy on the ground, early identify what trends are there, and though they may not have the answers, aspire to learn more and do better. If time and history have not made them skeptical to contribute, then cultivating these young leaders is essential.

Leading peers requires a different skill set from managers and directors in the organization. In medicine, there is no organizational chart with direct reports or a hierarchy of wisdom. Physician leaders need to have a willingness to learn and a desire to improve the system. They also need to be affable and approachable to their peers, while being clinically credible. They need courage to try new things and fail, which for physicians is difficult, as we are taught early that failure is not acceptable.

These "small I" leaders are the greatest untapped resource. Once identified, supporting them to develop new skills to set them up for success is important. Onboarding to a formal leadership position needs to come with a basic 101 on the health care system from economics and funding to dealing with conflict. I have heard many leaders express a loneliness when you are a leader; it need not be that way.

Visioning

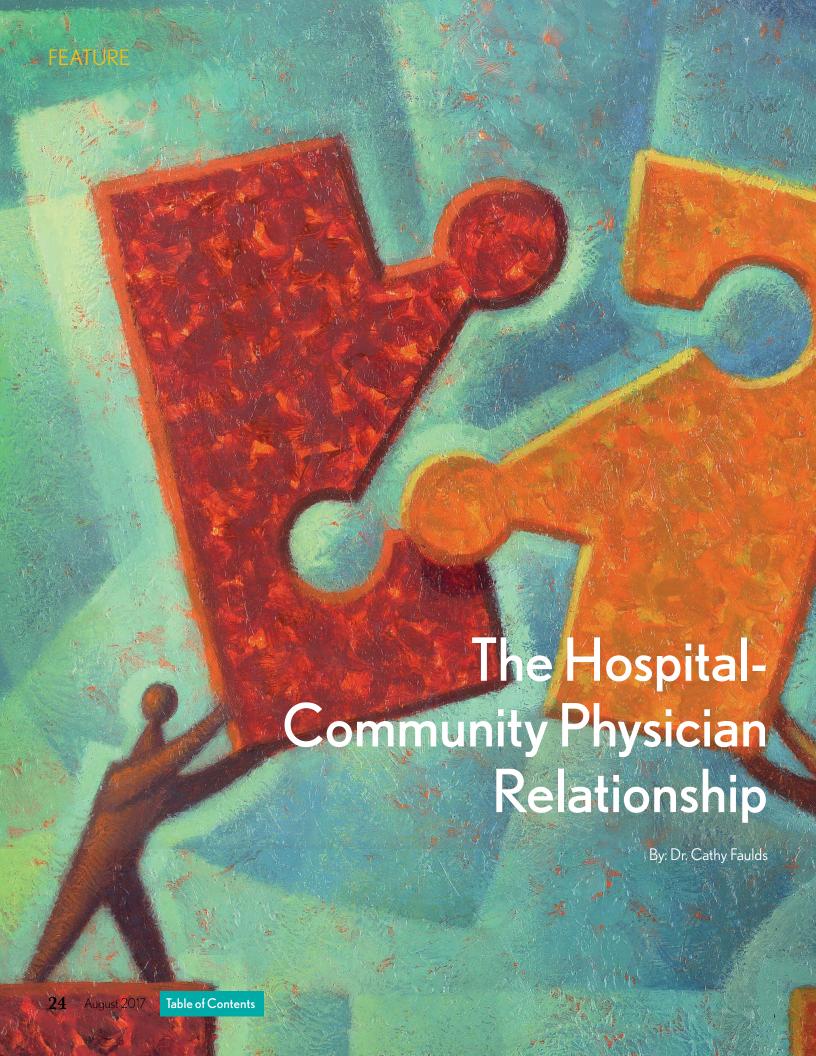
Physicians can be a powerful ally in system change and re-design. In the *Patients First Act*, integration is the hallmark word. Patient-empowered care calls for partnerships amongst all sectors. Engaging key influencers, listening to understand the nay-sayers, and moving communication through the network are needed. In a time of engagement fatigue and information apathy, we need to welcome physicians to be part of this co-design.

Dr. Backo-Shannon is the Program Chief and Medical Director for Primary Care, Seniors Care, Palliative Care, Rehab, CCC and the Family Medicine Teaching Units at Trillium Health Partners. She is also Primary Care Physician Lead for the Mississauga Halton LHIN. She is former Director of the Hospitalist Program at Halton Healthcare Services.

Dr. Backo-Shannon welcomes comments and feedback at Mira.Backo-Shannon@thp.com

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Thirty years ago, it was normal to have family physicians provide comprehensive and continuous care with a generalist lens. We went from office to hospital to long-term care settings on a daily basis. As a discipline, we provided obstetrics, surgeries, emergency, inpatient, office and community house-call care. Somewhere along the line, the value of 'generalism', and the definition of comprehensive and continuous care delivery have changed. In my experience, there are factors that are owned by the family doctor and by the hospital for the loss of these important system levers. Family doctors providing palliative care, rehabilitation medicine and geriatric care in chronic care facilities have not been financially valued in the same fashion as other physician groups. It seems that, respect for family doctors in an urban and academic 🐠

Effective care co-ordination reduces duplication, increases quality of care, facilitates access and contributes to better value by reducing costs.

setting has eroded over the last 30 years, largely because of assumptions that only patients in rural settings need the benefit of their family physician's care in hospital.

Patients, both urban and rural, require primary and secondary hospital care. Communities with large academic centres providing tertiary care also lose out if family doctors abandon their role in hospitals. As a family doctor, I would miss a truly rewarding aspect of my career if I practiced only in an office setting.

Family physicians are responsible for building a strong primary care foundation with the provision of comprehensive care. At the same time, they are responsible for coordinating care, between the community and hospital, which is essential to a high-functioning health care system.

Care coordination has been defined by the joint work of the Ontario Primary Care Council (OPCC) as: "a dimension of quality primary care that is patient-centred and leads to effective and more seamless transitions between settings and among providers. Effective care co-ordination reduces duplication, increases quality of care, facilitates

access and contributes to better value by reducing costs. It ensures continuity of care for patients regardless of setting, including home, community, hospital, long-term care facility or their family practice."

Improved care coordination is a desire of Canadians. Mendelsohn et al (2002) states that Canadians value universality, portability, accessibility and comprehensiveness in the health care system. Their opinions are formed through a "lens" based on their own experiences; however, a common thread described is the need for care coordination. Most "complaints" about our system are related to the complexity and lack of coordination within our system.

Care coordination or an integrated health care delivery system will only happen when the community aligns and works with the hospital on integration care metrics. Health Quality Ontario (HQO) is a provincial agency mandated to advise government and health care providers on the evidence to support high-quality care, to support improvements in quality, and to monitor and report to the public on the quality of health care provided in Ontario.

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HQO has been developing a Quality Improvement Plan (QIP) that will allow all sectors to work collectively on the same metrics. Two such metrics are readmission rates to hospital within 30 days of discharge and use of the emergency department by patients with chronic disease or low acuity. Primary care practice reports from HQO includes these two metrics, and allows primary care providers to compare themselves to their LHIN and provincial peers. As a family physician working in partnership with hospitals, I look forward to the day when we can use these metrics to further enhance our understanding of how family doctors providing care in hospitals can improve care coordination.

In addition to the metrics that are volume-based, there is the qualitative benefit of the relationship that family doctors have with their patients. Having a prior knowledge of the patient's history and story helps care to be patient-centred. This knowledge provides family and patients with emotional safety and conservation of energy in advocacy.

The generalist lens provided by a family physician is especially helpful in a tertiary care academic centre. They can avoid emergency department transfers by providing a community link for frail elderly and patients receiving palliative care by forming a team home and community care, which provides 24/7 on-call service. This enhances the timing for the delivery of discharge reports or investigations when family physicians have access to hospital records or have been the most responsible provider for an admission stay.

Family doctors understand the health system as they work in all of the silos facilitating the coordination of care. As physicians, they have been trained to look at the "big picture" and deliver care to a population of patients in diverse care settings. Health systems need hospitals, specialists, and family doctors to work in a collaborative and synergistic fashion. The unique skills and long term relationships that family doctors bring to the hospital setting allow them to manage the totality of patient care in all its complexity including mental health and spiritual needs. This long-term relationship also instills trust, which has been shown to motivate patients. Motivated people accept responsibility for their health outcomes, which is the ultimate goal of self-management and decreased reliance on the health care system.



A graduate of Western University, Dr Cathy
Faulds received Certification in Family Medicine
from the College of Family Physicians of
Canada (CFPC) in 1989 and became a Fellow
of the College in 2004. She began her term
as Director-at-Large with the CFPC Board
of Directors in 2015. After practising in rural
southwestern Ontario, Dr Faulds continued
her comprehensive family medicine practice
in London, Ontario, and formed the London
Family Health Team, where she served as clinical
leadfrom 2010 to 2015. Currently, Dr Faulds is a
palliative care physician with St Joseph's Health
Care and a staff family physician at London
Health Sciences Centre

Reference

Mendlesohn M. Canadians' thoughts on their health care system: preserving the Canadian model through innovation. Commission on the Future of Health Care in Canada: June 2002. Hospital-Physician Alignment Regional Forums

Red Lake St. Joseph
Sioux
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Kenora Dryden

Rainy
Loke
Frances

Thunder Bay

In March and April of 2017, the Ontario Hospital Association (OHA) conducted regional discussion forums in seven communities across the province. These invitation-only forums allowed more than 70 hospital and physician leaders to share their enablers and challenges in building effective models for hospital-physician alignment. Participants were asked to reflect and identify how the OHA can more effectively support the hospital-physician relationship moving forward, through resource development, education and advocacy efforts.

Provincially, there was wide-spread recognition that hospital-physician engagement is critical to the success of quality improvement efforts, health system funding reform, and other system priorities. In the short time ahead, forum themes will be synthesized in a summary report, and an implementation strategy will be developed. There are significant opportunities for the OHA, in collaboration with our system partners, to better support an enhanced and better aligned hospital-physician relationship.

Kingstor

Designing for Hospital-Physician Alignment: Values, Economics and Organization



By: Brian Golden

Though my academic appointments have always been in business schools, I have spent my academic career studying and working with hospitals and health systems. My business school colleagues look rather perplexed when I try to describe one of the fundamental challenges that hospitals face, that is, how to align physicians and hospitals.

Perplexity quickly moves to anxiety when I say that inside hospitals are these very smart people (physicians), who aren't really employees, who hold a virtual monopoly on decisions such as which patients to admit and for how long, what procedures to perform, and how this care will be supported by pricey pharmaceuticals and medical devices – all of which impact the costs to the hospital (Burns and Muller, 2008).

All leaders, whether in health care or other sectors, know that their number one job is to align the interests of their employees and staff with those of the organization. That is, to make them *partners*.

Therefore, the most effective and sustainable hospitals and health systems have brought physicians into the tent and have aligned physicians' personal and professional interests with those of the hospitals.

I go on to say that the decisions of physicians impact more than 80 per cent of medical costs globally, and yet physicians typically have no financial accountability for these decisions. In fact, few are provided sufficient information to actually understand the financial implications of their decisions.

Physicians are not to blame; we have designed our health systems and hospitals to result in precisely this situation. Imagine a management consulting firm, for example, where consultants felt and had no accountability for the human resources they devoted to a project (the greatest cost driver), travel costs, etc., nor did they know the revenue generated by the consulting engagement. How long, my colleagues say, would such a firm – typically organized as a partnership – stay in business?

All leaders, whether in health care or other sectors, know that their number one job is to align the interests of their employees and staff with those of the organization. That is, to make them partners.

Therefore, the most effective and sustainable hospitals and health systems have brought physicians into the tent and have aligned physicians' personal and professional interests with those of the hospitals.

Since the 1990s, researchers have identified the dimensions of effective hospital-physician alignment, yet few organizations consistently get it right.

In my own work on hospital performance improvement and change, which often centres on the hospital-physician relationship, I focus on three types of alignment that hospital leaders must attend to: (1) Values alignment, (2) Economic alignment, and (3) Organizational alignment. All three are critical and must exist simultaneously for both physicians and hospitals to be comfortable with their relationship.

Values Alignment

Physicians experience the most intense socialization processes of any professionals, beginning in medical school but continuing over their careers in their professions and their organizations (Trybou, Gemmel, Desmidt and Annemans, 2017). Research my colleagues and I have conducted has shown that this results in the development of very different mental models of the world, often leading physicians and administrators to value different things (Golden, Dukerich and Fabian, 2000; Dukerich, Golden and Shortell, 2002).

For instance, physicians value autonomy in the pursuit of providing the best care for the patient standing in front of them. Hospital administrators see the world with a lower resolution, focusing less on an individual patient. Their job is to ensure financial well-being and organizational effectiveness in order

to provide the best possible care for all patients coming through the hospital doors. This can often be interpreted by the two camps, physicians and the stewards of the hospital, as valuing different things.

In our research, we found that when hospitals and its administrators' values were aligned with the values of physicians, physicians felt more committed to the hospital. In these organizations, physicians were most likely to partner with administrators and were more likely to make resource-utilization decisions that benefited the hospital - so that the hospital could most benefit its patients (Dukerich, Golden and Shortell, 2002).

Administrators who were largely seen as representing the "business" interests of the hospital reinforced the frequently-seen chasm between physicians and hospitals. Working hard to demonstrate an alignment of values is critical for hospital-physician alignment.

Economic Alignment

A classic paper in the management literature refers to the "Folly of hoping for A, while rewarding for B" (Kerr, 1975) — a challenge that we continue to face today (e.g., paying on a fee for service basis, or for "transactions", when payers really want improved outcomes, which may be separate from the volume of activity).

This seems like common sense to most managers, but I'm repeatedly struck by how "uncommon" common sense seems to be when trying to align hospitals and physicians. In Canada, this is largely a function of how we narrowly define rewards, but also the relatively little discretion hospitals have to reward physicians directly.

In contrast, the most effective of systems in the United States (U.S.) have implemented economic risk (or gain) sharing arrangements with physicians such that when physicians utilize hospital resources in the most effective way (i.e., the best care for the least cost), these physicians receive a part of the financial benefit. Despite the somewhat romantic notion of physicians always putting their patients' interests above anything else, it turns out that physicians are just like other human beings — responsive to incentives.

The most sophisticated hospitals in the most effective systems have found ways to share gains of value enhancement, while also sharing the pain of physicians that lessen the value of health care expenditures (Trybou, Gemmel and Annemans, 2011). These rewards need not be dollars in the pockets of physicians, and instead can be directed to benefiting their programs in some way. As Kerr reminds us, if we truly want A, we must reward for A and not for B.

Organizational Alignment

In order to ensure values and economic alignment, hospitals must be designed, or organized, to share information, support physicians' understanding of the implications of their decisions, and be structured in a way that facilitates value and economic alignment.

A few years ago, I was working with a major Ontario hospital that had been experiencing severe deficits

ACADEMIC ARTICLE

for a number of years. The Minister of Health and Long-Term Care appointed a seasoned supervisor and interim CEO who quickly recognized that while physicians were concerned about the well-being of the hospital and truly wanted to help, they had virtually no idea about how their decisions benefitted or harmed the hospital.

As an example, a group of cardiac surgeons in the hospital regularly used a particular stent in procedures that was minimally funded by the Ministry. Another stent used by their colleagues, and considered just as effective, was fully funded. The choice of using the first stent was costing the hospital \$8 million in totally unnecessary costs, unbeknownst to the well-intentioned surgeons. This hospital, on its path to financial solvency, opened up the books to physicians and shared the knowledge that up until this point was protected in administration. The leadership of the hospital knew that making the

hospital's financials transparent to physicians required that these smart individuals be trained to interpret them; few physicians had ever had any exposure to management and business training.

In other hospitals I've worked with and studied, we've seen a commitment to clinical governance and the pairing of clinicians and administrators in a dyad model. This dyad model pairs – or aligns – administrators and physicians to a common cause at the program level. Early adopters of this model were seen in the U.S. (e.g., Mayo Clinic, Intermountain), but today we see this among leading Canadian hospitals (e.g., The Ottawa Hospital, The University Health Network).

Conclusion

I recently led a physician leadership program for a hospital where one physician chief said, "We'd all be better off if we didn't have the

It is surprising that in 2017 there are still some organizations that don't recognize the symbiotic relationship that must exist between physicians and hospitals. To effectively manage this interdependency, we need to move beyond the historical divide between physicians and administrators, but this won't happen simply with wishful thinking.

administration." Thankfully this was the start of the program, and by the end of the program – where part of our focus was on helping administrators maintain the health of the hospital so that physicians could improve the health of their patients – this same physician said, "Now I know why they keep saying 'no' to me, and they are right to." The next evolution of this physician development program will include an equal number of administrators working alongside them, and making explicit their mutual interdependence.

It is surprising that in 2017 there are still some organizations that don't recognize the symbiotic relationship that must exist between physicians and hospitals. To effectively manage this interdependency, we need to move beyond the historical divide between physicians and administrators, but this won't happen simply with wishful thinking.

First, hospital administrators must demonstrate that the dominant values of the hospital are entirely consistent with those of clinicians. Simply having aligned values isn't enough; hospitals leaders must work hard to consistently communicate this, and when decisions are made that seem to run contrary to this, some of which is inevitable, physicians must be told why.

Second, values are partially, and sometimes largely, expressed by how hospitals allocate scarce resources and provide reward, which is not only financial. Relative to peer organizations in other countries, Canadian hospitals have somewhat limited discretion in the incentives they have to align their



Just as we don't expect hospital CIOs or CFOs to perform surgery, we should not expect physicians to be naturally able to work alongside administrators.

interests and those of physicians. At a minimum, they must work to eliminate disincentives to work collaboratively for individual patients and the hospital's wellbeing – thereby supporting care for the broader community of patients.

Finally, hospital leaders have some organizational levers available to them to better align the hospital with physicians. This includes information-sharing, education and training, and the targeted recruitment of physicians to pair up with their administrative partners. As my colleagues Gillies, et al suggest, critical to physician-hospital integration is actively engaging physicians in the planning, management and governance of the hospital (Gillies, et al, 2001).

Just as we don't expect hospital CIOs or CFOs to perform surgery, we should not expect physicians to be naturally able to work alongside administrators. Hospitals must make the necessary investments in supporting the partnering with physicians, showing them they hold common values, tying together their fates, and organizing for alignment. This isn't rocket science, but it is hard work and requires commitment from hospital leaders and their boards.

Brian Golden is Vice-Dean and Sandra Rotman Chaired Professor of Health Sector Strategy at the Rotman School of Management, University of Toronto. He is Academic Director for Rotman's Global Executive MBA in Healthcare and the Life Sciences.

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Improving Hospital-Physician Relationships: Lessons Learned from Mackenzie Health

Recognizing that ongoing physician engagement is key to better decision-making and improved quality metrics, Altaf Stationwala, President and CEO of Mackenzie Health, has long-focused on strengthening the hospital-physician relationship.

"Great hospitals have well-defined and collaborative relationships with their physicians and physician leaders," he said.

"Physicians have a huge amount of influence over how your resources will be used, and the quality of care that your patients and families will ultimately receive in your hospital."

In the past, Mackenzie Health experienced an "unnecessary tension" or "friction" between the physicians, physician leaders and executive office of the hospital. Even small changes were met with resistance and opposition, making it difficult for the hospital to evolve. After examining the issue, he determined the source of frustration was simply based on misunderstanding on both sides. Since then, he's learned that hospital leaders must have open, two-way communication, education and engagement with physicians and physician leaders.

Mackenzie Health has taken several steps to attempt to improve this relationship.

The first step has been determining what engagement means to physicians and determining how they want to be involved. For example, physician time is limited and physicians cannot be expected to attend meetings scheduled throughout the day or be expected to respond frequently to emails. Instead, communication must be tailored to their schedule.

At Mackenzie Health, several unique structures were put in place that facilitates physician dialogue and provides physicians with a clear point of access to leadership. For example, the Chief Executive Officer, Chief Nursing Executive and Chief of Staff hold monthly interactive breakfast sessions in the physician lounge to answer any questions physicians may have.

When new programs are being developed, cross-department committee structures are developed with physician representation to ensure physician input is provided early on in the planning process. For Stationwala, this step cannot just be perfunctory.

"Physicians must be given the opportunity to influence decision-making. You can't just ask for an endorsement, you must actually ask for help and input with a solution."

When new and challenging projects arise, the hospital also empowers physicians to lead them. For example, when new electronic medical record was implemented this year, the Chief of Staff led the project.

This leadership decision helped improve physician engagement and helped ease resistance to this significant change.

The hospital has also focused on education to help build leaders and to encourage physicians to move into these roles. Physician Boot Camp was developed, which helps build foundational knowledge about topics like Health System Funding Reform (HSFR), patient relations and information technology initiatives. Thus far, the Boot Camps have been well-attended and have allowed for a rich dialogue between hospital administration and physicians.

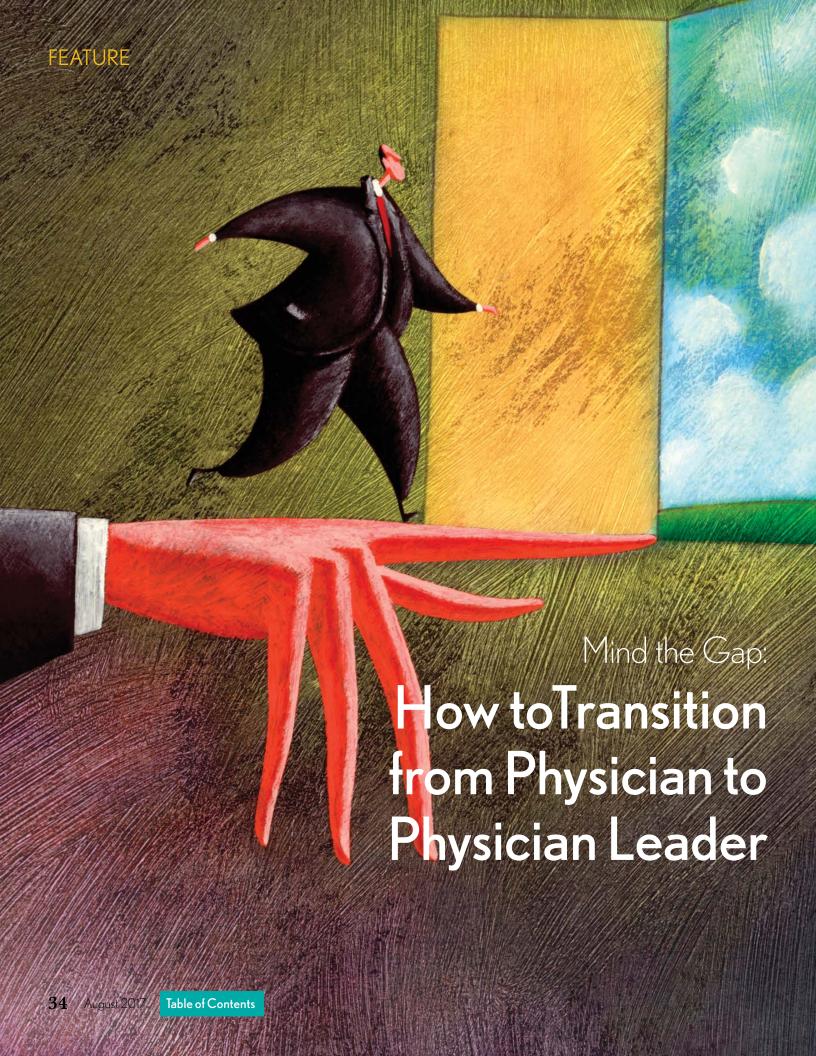
Mackenzie Health is already benefiting significantly since implementing these initiatives. Engagement

scores have increased consistently, there has been more physician support for fundraising activities, and physicians are attending more hospital events than ever before – such as the annual holiday party.

As Mackenize Health grows, Stationwala expects this engagement to increase and continue.

"Gone are the days where administration views physicians as adjunct. They have to be embedded in every element of the day-to-day operations and over-arching strategies."







important to implementing quality

and improvement initiatives,

Baker and Axler (2015) note

be difficult.

that managing and incentivizing

physicians to take on these roles can

As Ontario moves forward

with wide-scale structural changes

to the entire health system under

the Patients First Act, it's arguably

more important than ever before

for hospitals to ensure they have

Physicians are uniquely qualified to provide clinical expertise that must be part-and-parcel to administrative decision-making.

strong physician leaders. As the system transforms, physicians are uniquely qualified to provide clinical expertise that must be part-and-parcel to administrative decision-making. To discuss some of the perceived barriers associated with physician leadership and to provide advice to other physicians seeking to make this transition, Redefining Health Care spoke to three physician leaders in hospitals.

- Dr. Steven Jackson, Chief of Staff, Mackenzie Health;
- Dr. Lynn Mikula, Chief of Surgery, Peterborough Regional Health Centre; and
- Dr. Andy Smith, Executive Vice President and Chief Medical Executive, Sunnybrook Health Sciences Centre (and CEO as of July 1, 2017).

What Challenges Exist?

Dr. Jackson began as Chief of Staff at Mackenzie Health in September 2013. The appointment is a fiveyear term, ending in 2018 – with the potential to take on a second five-year term. Before beginning at Mackenzie

Health, Dr. Jackson spent almost 20 years at The Scarborough Hospital, serving previously in many leadership roles, including Chief of Staff, Medical Director Perioperative Services, Chief of General Surgery, and President of the Medical Staff Association.

"I always enjoyed being involved with planning and leadership in general," he said. "There is a crucial need for physician leaders at the senior level... I see my role as a bridge between two stakeholder groups, enhancing the understanding and cooperation between physicians and non-physician administrative leaders."

Despite this clear need, there are a number of truly unique challenges. The first is that most physician leadership positions are time-limited. Physicians choose to take on leadership roles knowing that after their terms end, they need to reassume the role of being just "one of the gang." For example, Department Chiefs often find it challenging to make difficult decisions or to deal with disruptive physicians for fear of negatively impacting their relationships with their peers. They depend on these positive relationships for the provision of quality patient care.

Secondly, it can be difficult for

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top-down change. Physicians often stay in the same hospital their entire careers, Dr. Jackson said. Change that seems to be coming from leadership is often resisted as some physicians feel that a particular change may be a fad that will wither over time. Administrative leaders tend to come and go more frequently than physicians, so many physicians feel if they resist long enough, that "this too shall pass."

Thirdly, physicians have a slightly different mindset and perspective on patient care than non-physician leaders. Physicians are trained to be advocates for the individual patient and not necessarily the entire system. While they may have some training in the efficiency and effectiveness of a particular treatment, Dr. Jackson said they tend to be less concerned with managing budgets than providing high-quality and safe patient care to the individual.

Finally, there is a fear of the unknown. Dr. Mikula has been with Peterborough Regional Health Centre since 2011. She became Division Head in 2012 and became Chief of Surgery in 2015. "It was a huge jump. I felt like jumping off the deep end," she said. "The transition was tough, but I've had a lot of support along the way."

The Path to Leadership

To transition successfully, Dr. Mikula spoke to the merits of ongoing education, mentorship, and an optimistic attitude.

"Running a hospital is like running a business," she said. "As a doctor, you think you understand the health care system. While you understand medicine, you don't know business."

Dr. Mikula credits much of her success to the open-door policy of her administration, courses she took through the Canadian Physician Leadership Institute, as well as the advice received from her mentors (one being Dr. Smith, who she worked with during her residency).

Before he was appointed to CEO in July 2017, Dr. Smith served as Head of the Division of General Surgery at Sunnybrook, Chair of the Division of General Surgery at the University of Toronto, Regional Vice President at Cancer Care Ontario, and Chief of the Odette Cancer Program as well as Executive Vice President and Chief Medical Executive at Sunnybrook.

When physicians move into an administrative role, it is natural to feel

out of depth. However, it's important to remember the significance of your clinical background, said Dr. Smith: "Charted accountants are already at the table Being a clinical leader is highly respected – and your knowledge is critically needed."

He suggest physicians moving into a physician leadership role start small and master lower-level leadership jobs before moving up. "If you have the appetite and aptitude for it, it's every bit as thrilling as full-on clinical work."

He credits much of his success to mentors like Dr. Barry McLellan, former CEO of Sunnybrook, who encouraged him to enroll in advanced health leadership training at Rotman and to apply for progressively more senior positions throughout his career. "I had great mentorship at every stage. I can't believe how lucky I've been," he said. "You need deliberate, comprehensive, and thoughtful mentorship by someone who is helping you learn every part of the role."

Mentors can also help encourage physicians to take a chance on a leadership opportunity when it arises. "I liken it to a bus coming into the station. When a bus comes in, you have to be smart enough to know that's your bus and to jump on. If you don't, you might wait a long time for the next one."

While the learning curve is steep, Dr. Mikula said physicians shouldn't be afraid to lead. "We are so needed. Our input is so needed... In this current political climate, there is a tendency to disengage a little bit – but we only hurt ourselves by doing that."

"You need deliberate, comprehensive, and thoughtful mentorship by someone who is helping you learn every part of the role."

- Dr. Andy Smith

Stronger Together: Family Physicians and Hospitals Inspiring New Ways of Caring





High-quality health care across the system requires strong relationships between hospitals and family physicians. For this reason, the Ontario College of Family Physicians and the Ontario Hospital Association have collaborated to create an Ideabook showcasing the valuable work that hospitals and family physicians are undertaking on behalf of patients.

Each story is a testament to the great work being done in Ontario, with hospitals, family physician leaders, primary care practices, and community services working together towards a common goal.



Hospital-Physician Relationships within Small, Rural, and Northern Communities

Practicing medicine in a small, rural and northern (SRN) hospital is a distinct experience. This is the result of lower patient volumes and fewer health care provider resources available within the community. This setting undoubtedly influences the approach to managing the relationship between hospitals and physicians. Two hospital leaders working in SRN hospitals have shared their insights and experiences working in this unique environment and how it has affected the dynamic of this relationship.

Openness and Communication: The Key to Thriving Hospital-Physician Relationships

Dr. Stephen Viherjoki is Chief of Staff at Dryden Regional Health Centre (Health Centre). Having grown up in Thunder Bay, Dr. Viherjoki says he feels rooted in northwestern Ontario. He began his full time practice in Dryden almost 10 years ago and has never looked back. During his tenure, he has gradually taken on more responsibilities, and has therefore, gained both the perspective of a practicing physician and a senior physician leader within the organization.

The Health Centre employs a number of formal mechanisms that facilitate and strengthen the hospital-physician relationship. This work has been inspired by and gained momentum through the Health Centre's collaboration with the Studer Group over the span of four years.

Most importantly, physicians feel supported by their organization and its leaders. Dr. Viherjoki says he's fortunate to be a part of the Health Centre because of its forward-looking CEO, Wade Petranik, who also has strong roots in the community and is very dedicated to advocating for their needs. Petranik has an open-door policy and is always ready to listen, a culture which is echoed by the senior team members who are also as responsive and as engaged.

Broad exposure and clinical courage

Physicians working at the Health Centre are able to practice to their full scope in areas such as primary care, acute care, emergency medicine, assisting with surgeries and delivering babies. This broad exposure is, at times, attractive to practicing physicians who are able to gain experience across a range of clinical areas and also offers better continuity-of-care to the patients they treat.

As a result, Dr. Viherjoki says physicians require "clinical courage," or having a higher tolerance for risk. With a limited number of physicians working in the community, Dryden is home to a cohesive group who rely on each other for support. In total, there are 14 physicians practicing in Dryden: two general surgeons and 12 family physicians.

One-on-one outreach

Last year, the Health Centre initiated quarterly physician rounds where the Chief of Staff and the Nursing Executive meet with all the physicians in town. This is an opportunity to discuss the physicians' successes,

recognize excellence, and to inquire if any additional supports are needed.

Key to this process is dubbed "closing the loop," which means that the Chief of Staff and Nursing Executive follow up with the physicians they met with during the rounds. While physicians needed a couple of meetings to familiarize themselves with the process, they now appreciate regular check-ins.

Engagement with senior leaders

So far, there have been four physician engagement surveys. Survey results are discussed at a medical staff meeting group, which feeds into the Medical Advisory Committee (MAC), and at meetings with senior leadership. The hospital then develops action items, and progress on these is reported via stoplight reports, which are presented at each medical staff and MAC meeting. Physicians also have the opportunity to speak informally with senior leaders about their concerns. While there is often tension when it comes to budgetary issues, through these informal touch points, physicians are able to voice their concerns and challenges, and hospital leaders are able to listen and also share their limitations in being able to deliver on physicians' requests.

"Quest for the best" philosophy

Every year, as part of the budget planning process, physicians are asked to share their wish lists, which are discussed at the Medical Staff Committee meetings. The group prioritizes and categorizes between wants and needs. For items that are beyond the budgetary scope of the organization – the team considers whether funds can be raised to achieve them.

This process is supported by a motto coined, "quest for the best," developed in collaboration with the Studer Group. As part of this philosophy, managers at all levels are encouraged to take responsibility for their areas and to engage and listen to team members, including physicians. The crucial step is following through on these discussions – which effectively "closes the loop" and shows physicians that managers are taking action on the feedback they receive.

In the same regard, physicians are encouraged to provide frank input and to also willingly listen to the priorities of administrators, in order to get a better understanding of the challenges and limitations they face. Dr. Viherjoki says it may be simpler to manage the hospital-physician relationship in smaller facilities because there are fewer people at the department level. However, the small size of the physician group also makes it "fragile" as it is easily affected by any changes such as the loss of one member.



Strengthening the relationship is a shared commitment

For Dr. Viherjoki, having a strong hospital-physician relationship is vital to the performance of any organization. Physicians and their team members will look forward to coming to work every day, which impacts patients: it helps them become more engaged, feel better cared for and have confidence in the system. Some tips he suggests for strengthening the hospital-physician relationship, include:

- A senior leader or leaders who are genuinely involved in and committed to their community.
- Leaders sitting down with physicians and physician leaders openly to discuss concerns. Ensure that there is follow-up on these discussions to demonstrate that feedback is being considered, and where possible, acted upon.
- Leaders should have an open-door policy, maintain an open mind and be truthful.
- Senior leaders should be willing to advocate for patients and physicians.
- Front-line physicians should be willing to share their ideas and engage with leadership. They should also be open to taking on more responsibility within the organization, and even leadership roles that help support patients and/or improve quality of care.

Dr. Viherjoki says that there will be growing pains in any process, but as long as all parties are committed to providing excellent patient care, good team relationships can be built. Also, seeking help from outside experts can provide additional guidance and expertise to better ensure success.

The town of Dryden,
Ontario is considered
an SRN community, with a population of only about 8,000 residents. The closest referral centre is about four hours away in Thunder Bay, which in comparison, is home to more than 100,000 people.

CEO Perspective on Strong Hospital-Physician Relationships in Small, Rural Communities

Angela Bishop is the current President and CEO of Red Lake Margaret Cochenour Memorial Hospital. She grew up in northern Ontario, and spent most of her career working in SRN hospitals. This close-knit environment creates a strong connection between health care providers and patients/clients.

In SRN communities, providers need to wear many hats and there is a real opportunity for a broader scope of practice.

Providers become generalists, which means that there is a lot of room for professional growth.

Some physicians are attracted by the wider scope of practice, but this demands higher confidence in one's diagnostic skills.

For example, Red Lake Margaret Cochenour Memorial Hospital, which serves a population of about 6,000, does not have a CT or MRI scan, and sending a patient for these

diagnostic tests is a big investment in time and effort for the patient. As such, physicians' diagnostic expertise must be well-developed to ensure that patients do not needlessly travel for these specialized diagnostic tests.

Providing wide-ranging supports

One of the ways to improve hospital-physician relationships in a town as small as Red Lake is ensuring that physicians feel supported in every possible way. Professional coverage is maintained by way of recruitment and access to locum replacements through HealthForceOntario.

However, it is difficult to attract locums due to the remote location.

To make the town more attractive to physicians, the hospital owns a home which provides temporary accommodations to physicians, and lakeside lots have even been set aside exclusively for physicians who choose to settle in Red Lake.

Physicians who choose to work in Red Lake can also avail of turn-key operations at the medical clinic, which was built with funds donated by Goldcorp to the municipality. The municipality looks after building maintenance, snow plowing, water and sewer costs, grass cutting, among other amenities, making it much simpler for physicians to set up practice. The clinic includes the Red Lake Family Health Team and medical associates.

All the physicians who work in the town's medical clinic also have privileges at the hospital, and every clinician, and most locums, work in both settings.

Currently, they have four full-time physicians, and four part-timers, who provide care at the 18-bed hospital.

In terms of day-to-day support, the hospital has established formal partnerships with larger centres like Thunder Bay Regional Health Sciences Centre

(TBRHSC) and nearby Winnipeg, which enable patients to access specialist care. For example, TBRHSC's critical care team consults with patients in Red Lake via video-conferencing technology. Soon, trauma care will also be linked.

Equally important to the hospital is physician involvement in care delivery. Feedback on hospital policies through channels like the Medical Advisory Committee is important, and the hospital seeks physicians who are willing to be engaged in hospital operations aimed at improving care delivery. This means taking on more leadership responsibilities by sitting on committees, guiding and implementing quality improvement initiatives, among other important initiatives.

An informal relationship between the Chief of Staff and the President and CEO, also helps ensure that physician input is captured for the benefit of patients. Keeping a close watch on the pulse of the physician community – helping them feel supported in every way possible within the resources available to the hospital and the community – has made a tangible difference at Red Lake. In such small, remote communities, it is important to ensure that physicians are engaged and know that they are part of a bigger, cohesive team because with scarce health care resources, each individual is integral to the success of the entire organization.

"As a provider, you know who you are providing a service to – possibly a neighbour – which introduces a sense of greater accountability to the role."

- Angela Bishop



with Ron Sapsford: Lessons in Leadership

Ron Sapsford has been Deputy
Minister of Health and LongTerm Care, and the Assistant
Deputy Minister of Institutional
and Community Services within
the Ministry of Health. Before his
retirement in 2015, Sapsford was
the Chief Executive Officer of the
Ontario Medical Association and has
also previously served as Executive
Vice-President and Chief Operating
Officer of Hamilton Health Sciences
Corporation and Chief Operating
Officer of the Ontario Hospital
Association. He is currently, Chair

The best solutions are found when physicians and surgeons are asked to participate in decisions for clinical program development, changes and operating policy. of the Board, Associated Medical Services Inc., Director, Schlegel Health Inc., and Director, Michael Garron Hospital. Sapsford holds a B.Sc. from the University of Toronto and a Master of Health Administration from the University of Ottawa.

Reflecting on the many positions you have had in the health care system, why do you believe there is often such a strained relationship between hospital management and physicians?

RS In my career, I have met several CEOs whose view was that, "the hospital is mine and the docs will toe the line." This is, of course, a recipe for conflict. At the same time, I have also met physicians groups who remain aloof and uninvolved, more interested in giving negative critique then assisting in finding more relevant and successful solutions.

There are so many pressures on hospitals and doctors. The pressure of technology, aging, chronic diseases, differences in views about priorities and, of course, resources all contribute. All of these pressures together make the environment in hospitals not only complex but challenging to make decisions about the direction of the organization and productive work environments.

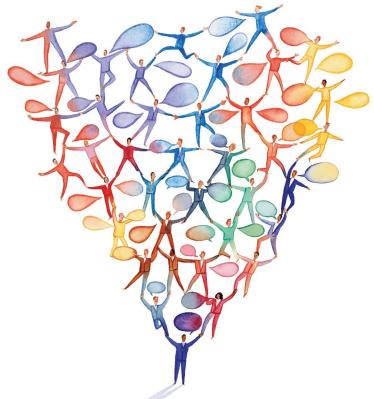
There are many individuals in hospital management and physician groups who have a high interest and are committed to making the hospital an excellent place for care and work. Fortunately, there are many that respond positively to the challenges of hospital management and operation. They understand that it is in the interests of patients, to find cooperative solutions to the many problems that the hospital must confront on an annual basis.

Hospital management can contribute to the quality of the relationship that exists with the medical staff. If the methods used to make decisions are characterized by open communication, consultation and joint ownership, there is bound to be improvement with relationships.

Based on where these relationships have been in the past, where do you envision them heading in the future, 10 to 20 years down the line?

There continues to be a move towards increasing integration in the health care system, with the goal of better patient management and care. As the health care system moves along this path, there will be an increasing requirement for physicians to take responsibility for assisting hospitals in decision-making.

The best solutions are found when physicians are asked to participate in decisions for clinical



Integration is a long-term project, and the future success of our system will depend on strong collaborative relationships among physicians, hospital management and the wider health care system.

program development, changes and operating policy. A consensus among physicians that meet the parameters of management is always a better approach than management decreeing decisions from behind closed doors.

An example of this move to integration is the hospital hub model, which found its genesis through the Ontario's small hospitals. One cannot begin to organize and manage wider services in health without close cooperation of physicians. The redefinition of how care is provided at the local level will demand that physicians be involved because of larger impact on their patients and

practices. Integration is a long-term project, and the future success of our system will depend on strong collaborative relationships among physicians, hospital management and the wider health care system.

Is there any advice you would give to hospital CEOs who wish to help build a stronger relationship with their organization's physicians?

RS | Hospital management must be clear in declaring that strong, positive physician relationships are a priority for the successful operation of the hospital. It is imperative that the

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key elements of that relationship are established, documented and then practised.

As an overall approach, the concept of stewardship has much to offer. Stewardship is based on the idea that the needs of those we serve are greater than our own self-interest. Both hospital management and physicians have the same goal of serving the needs of patients, so there is already a strong base for hospital and medical staff collaboration.

A model of stewardship has been outlined by Peter Bloch in his book, *Stewardship, Choosing Service Over Self-Interest.* A key element of stewardship is the concept of partnership. Hence the core of the hospital/physician relationship is one of partnership. Bloch outlines the essential elements of successful partnership as follows:

Exchange of purpose

The notion that the partners develop a common understanding of direction and goals that are established through dialogue.

The right to say no

Each partner has the right to say no. While there are limits to this, each party must have the ability to express views.

Joint accountability

Each partner must take responsibility and be accountable for the outcomes and success of the partnership.

Absolute honesty

The relationship depends on open communication and honesty in sharing information and decision processes.

It may be an old idea, but it is true: team approaches in complex organizations are essential.

No abdication from decisions

Once decisions have been made, both parties agree to support those decisions and not withdraw from the ongoing relationship and process.

Following this type of methodology does much to establish and maintain effective working relationships between management and medical staff.

Q

Often clinicians are tapped on the shoulder to assume nonclinical leadership positions without any formal training. Do you have any advice for young physician leaders?

RS | The health system always needs physicians who are willing to take on these non-clinical roles. Physicians are often asked to take leadership positions and to participate in hospital management and medical administration. However, many physicians often feel that they need additional training and support in taking on these responsibilities. I would encourage physicians who have leadership aspirations to endeavour to participate in formal leadership educational opportunities (most of which come with CME credits). I would also encourage them to get involved in physician networks being developed for doctors that are interested in taking on non-medical health system positions, whether full or part-time.

This journal aims to identify opportunities to address barriers in hospital-physician relationships - any other closing thoughts or considerations for administrators, physicians or other allied health professionals in the field?

It may be an old idea, but it is true: team approaches in complex organizations are essential. No single interest or group around the hospital decision-making table can claim exclusive rights. There cannot be a hospital without medical staff and medical staff cannot function in practice without the resources and services of the hospital. It is a symbiotic relationship that must constantly be nurtured. Mutual respect, open communication, honesty and integrity, common goals and fair decision processes are essential ingredients to successful long term relationships between the hospital and its medical staff. It is not just desirable, it is mandatory for future effectiveness.

Reference

Peter Bloch, <u>Stewardship, Choosing Service</u>
<u>Over Self-Interest,</u> 1993, Barrett-Koehler
Publishers Inc., San Francisco, Cal.

Why is the *Public Hospitals Act* the Third Rail of Health Policy?

While the *Public Hospitals Act* (PHA), has been in place since 1931, it is among the most intensely-criticized yet defining aspects of the health care legislative regime in Ontario.

At the heart of much of this criticism is the argument that the PHA preserves a historic, and in the eyes of some, outdated model of privileging for physicians working in hospitals. In particular, critics argue that the quasi-judicial nature of the appeals process provides few mechanisms and little flexibility for hospitals to facilitate changes to physician practice or behaviour. Disputes between hospitals and physicians over privileging often lead to years of time-consuming and costly proceedings for hospitals.

Over the last 25 years, different Ontario governments have recognized the need for PHA review and have given serious thought to reforming this legislation. However, all have ultimately shied away from substantive change. Why is this? And, perhaps more importantly, given what we know from 25 years of experience, is PHA reform ever going to materialize?

After decades of use, a review of the PHA was commissioned in the late 1980s by then-Health Minister Elinor Caplan. The report, with more than 50 recommendations, was completed and handed over to the successive New Democratic Party (NDP) government, led by then-Premier Bob Rae. This sweeping review of the

PHA touched on a wide range of hospital governance and accountability issues, including the need for fundamental reform of the privileging model. Unfortunately, by the time the report was finally completed, any impetus for change that might have existed stalled. The Rae government's relationship with organized labour and professional groups, such as the Ontario Medical Association (OMA), had soured in the face of the "Social Contract" and its unilateral intervention into collective bargaining. With a difficult election on the horizon, the report was shelved.

The Ontario Hospital Association (OHA) attempted to resurrect the PHA and a review of the privileging model in 2008. Fifteen years had passed since the previous review. During this time, significant aspects of the Caplansponsored review pertaining to the need for improved accountability between hospitals and government had been implemented by the Liberal government of Premier Dalton McGuinty. To shine a light on the challenges with the privileging model, the OHA conducted its own member-led review of the PHA. The OHA focused on a number of areas for potential reform, including the nature of the hospital-physician relationship as enshrined in the privileging model and the lengthy appeals process mandated under the Act.

Following extensive advocacy efforts by the OHA, in the 2010 Speech from the Throne, the McGuinty government promised a review of the PHA. In discussions with senior political staff in the lead-up to this commitment, it was clear that reform of the privileging model was singled out as the main objective. Discussion even took place about eminent individuals who would be qualified, impartial and able to lead a review of this nature. Despite the profile and importance of the Throne Speech commitment, the proposal was quietly abandoned. Many believe the government was split internally on the wisdom of undertaking a PHA review. Facing a general election in 2011, the government was unable, and perhaps even unwilling, to proceed.

The impetus for PHA reform has come once again into focus because of the 2016 report of the Auditor General of Ontario. The Auditor General recommended that government evaluate the long-term potential of hospitals employing physicians after concluding that the existing privileging model is costly and administratively-

cumbersome. At time of writing, there is no indication that the government intends to proceed with changes in response to these observations.

In recent years, the relationship between the OMA and government has been acrimonious. In light of the 2017 voluntary agreement to implement "binding arbitration" as the mechanism of dispute resolution between the OMA and the Government of Ontario, it is highly unlikely that the government would then go on to unilaterally seek to reform the privileging model.

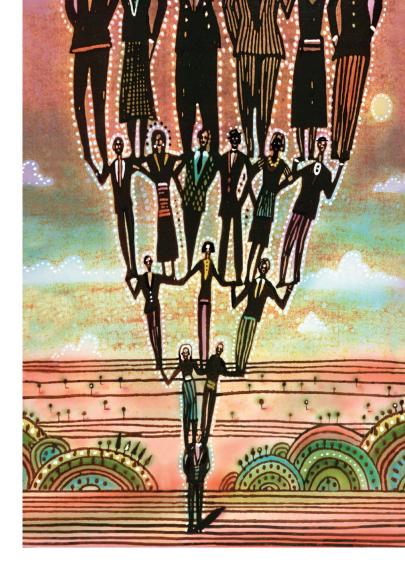
What can be learned from all of the starts and stops towards PHA reform? Arguably, Ontario's health care system has entertained 25 years of debate about how to change the legislation to improve the relationship between physicians and hospitals. But, nothing fundamental has happened.

In addition to its sheer political controversy, the most significant factor holding back reform is that privileging is inextricably linked to the fee-for-service model of remunerating physicians.

For many observers, the question is not actually if the privileging model does or doesn't work. The question is actually, what can it realistically be replaced with?

The most commonly-heard answer to this question is to move physicians from independent contractor status to hospital employees. When framed in this manner, the scale and complexity of this solution becomes far greater than simply implementing legislative and regulatory change. While many other jurisdictions outside Canada have this model in place, moving to try and achieve this in Ontario, on a systematic basis, is politically-akin to touching the third rail.

Instead of a "revolution" to replace the privileging model, Ontario has taken an "evolutionary" approach by introducing more modest reforms, such as alternate funding plans (AFPs) or alternate funding arrangements (AFAs) for specialists. An incremental approach to improving two-way accountability between physicians and hospitals implicitly recognizes the obvious sensitivities involved. However, the question remainsis it sufficient to address the needs of the health system of the future?



Given the pressure to change, the debate over the efficacy of the PHA and the privileging model will likely continue in the years ahead; yet, experience suggests that future governments are unlikely to pursue fundamental reform in a meaningful way.

Perhaps advocating for a full reform of the current privileging model is the wrong approach? Many physicians have suggested they would welcome choice in determining the type of hospital-physician relationship that makes the most sense in their own specific circumstances.

As the momentum to create new models of care increases, government, hospitals and physicians will be increasingly challenged to identify new ways of working within the existing PHA regime while introducing innovative approaches. In a rapidly changing health care system, it is essential that hospitals and physicians continue to work closely together to strengthen their relationship in order to ensure the highest possible quality-of-care for the patients of Ontario.



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