Inspiring Improvement
Hospital Successes in Strengthening Hospital-Physician Relationships
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Introduction

It is widely recognized in the literature that physicians play an integral role in patient safety, quality improvement and health system transformation. The significant structural changes underway in Ontario’s health care system will only be successful if there are effective relationships between hospitals and physicians at all levels. This should lead to a shared objective of creating a high-performing, integrated and sustainable health care system that delivers high-quality, effective and efficient patient care.

Consequently, enhancing the relationship between hospitals and physicians will result in greater levels of satisfaction and engagement on the part of physicians working in hospitals, which will ultimately improve 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.
Quarterly Reviews with Physicians on the Progress of Corporate Objectives

Why was it implemented?
It was acknowledged by hospital leadership that physician input is important to ensuring success of corporate objectives and to implementing measures to improve quality. Hence, a decision was made to involve physician managers in the process of quality improvement.

How was it implemented?
To accelerate reaching our corporate objectives, we have instituted quarterly management reviews with coaching opportunities. This is a two-day event where all managers meet with the senior executive team to discuss progress, review courses of action, and create 90-day work plans for each manager’s area of responsibility. As part of this event, there is a session where all department heads and medical leaders work collaboratively to assess and implement how medical staff can contribute to improving performance. During these combined sessions, there has been a growing acknowledgement of the need for better communication between physicians and the non-physician leadership of the hospital, as well as the importance of setting common goals throughout the organization.

What success has been achieved to date?
As a result of involving physicians early on in the planning process, we have been able to achieve increased collaboration on a number of initiatives. Examples include shorter response time for consultants to attend the emergency department when requested, and better communication between consultants and the most responsible physician, resulting in reducing length of stay.

What were the key lessons learned?
Creating agreed upon goals with early involvement of physicians in the planning and implementation phases results in increased collaboration which makes it easier to implement change to improve quality and enhance the patient experience. In this process, it is essential to create a safe forum for physicians to discuss operational issues with non-physician leaders in a respectful way, and to ensure physicians feel that they are being heard.

As a result of involving physicians early on in the planning process, we have been able to achieve increased collaboration on a number of initiatives.
Physician-Hospital Partnership Project

Why was it implemented?
In 2012, Hamilton Health Sciences (HHS) conducted a physician and staff engagement survey providing a baseline measurement of physician engagement. In response to this, and in an effort to gain a better understanding of impeders and drivers of physician engagement, a Physician-Hospital Partnership Working Group (PHP-WG) was created. The group consisted of frontline physicians from various service areas, leaders from each clinical department, organizational development and interprofessional practice. The group set out to determine a meaningful approach to achieving cultural alignment between physicians and the hospital through shared goals, yielding stronger relationships and increased engagement.

How was it implemented?
The PHP-WG conducted an extensive literature review, identifying that organizations with highly engaged physician workforces had developed successful strategies in the following four areas: Partnership; Communication; Leadership Development; and Recognition.

Stemming from this review, the PHP-WG recommended a physician-built strategy for HHS focusing on the following four initiatives: Development of a Physician-Hospital Compact (Agreement), development of a meaningful physician communication plan, physician leadership development, and involvement of physicians in decision-making processes/projects.

The PHP-WG was transformed into an “Implementation Group” (PHP-IG) in 2014/15 and membership for the group broadened to include clinical directors. It was decided that initial efforts would be focused on the development of an enhanced communication strategy and Agreement. The overall goal of this group was to create a renewed relationship between physicians and the hospital built on trust, collaboration and respect.

In September of 2015, HHS held a series of physician-specific focus groups with 87 physicians from multiple service areas. The goal was to understand from the physicians’ perspective what the elements of an Agreement might look like.

Feedback from these physician-focus groups indicated the physicians were not ready for the immediate creation of an Agreement. It was evident more time was needed for conversations to take place elaborating on areas where mutual collaboration and understanding between the hospital and physicians would be possible.
In response to this outcome, a World Café (a large group gathering and discussion), was held in November 2015, bringing together more than 70 participants ranging from frontline physicians, physician chiefs, managers, directors, clinical directors and members of the executive team. While the objectives and experiential aims were similar to the focus groups, the desired outcome changed as the focus was no longer on creating an Agreement.

Four questions were posed to the group:

1. What makes this conversation relevant and why is a strong hospital-physician relationship so important?
2. Imagine a future where physicians and HHS leaders trust and listen to each other: what would this look like?
3. How do we measure the outcomes of an improved hospital-physician relationship? How will this look in 2 - 3 years?
4. Is there a benefit to having a document that outlines the commitment of the hospital to physicians and physicians to the hospital? If so, what would be the format?

Outcomes of this process identified four broad themes to be addressed:

- Increased physician involvement in decision-making;
- A need to develop a process to address physician issues;
- A need for better communication mechanisms; and,
- A need to better understand mutual expectations of each other.

The session resulted in a desire to continue the conversation between hospital leadership and physicians. It was recognized that there are benefits to an improved relationship and there was a willingness to consider the possibility of an Agreement in the future. However, it was appreciated that as a first step, there was the need to formulate a common vision of the foundation of this relationship before proceeding with articulation of the Agreement.

What success has been achieved to date?

Reflecting on the results from the engagement surveys, key literature, the focus group work and the World Café, the themes are fairly consistent and validate the work we have planned as next steps.

The overall goal of this group was to create a renewed relationship between physicians and the hospital built on trust, collaboration and respect.

A lot of work and energy has been invested in understanding how to enhance the relationship between hospital administration and physicians. A commitment to continued meaningful dialogue between hospital administration and physicians about the future is key to the success of this work moving forward.
Central to the success of the work to date has been raising awareness about the underlying issues among hospital leadership and physicians from the frontline to the executive team. HHS will continue this work and actively continue to solicit feedback as they work through the process.

What were the key lessons learned?

Participation from both hospital administration and physicians across all levels of the organization during the developmental phase is a key element of success. For example, an unintended outcome of holding physician-specific focus groups first was a resultant feeling of skepticism – why, when defining an Agreement which has mutual commitments, was hospital administration not present for the conversation? The joint World Café that brought both hospital and physicians together should have been the first opportunity for conversation.

A multi-pronged communication strategy providing updates on all efforts and progression to date plays an important role in the success of the project. In addition to communication, vital to gaining support is the acknowledgement that messages were both heard and understood prior to moving forward with implementation. The initial skepticism in the process was a result of a lack of intermittent communication efforts.

Rebuilding the physician-hospital relationship will take time, effort and joint understanding through many conversations to build a foundation of trust and collaboration. This must come first otherwise the relationship cannot be a partnership.
Physician Compensation Review

Why was it implemented?
The Review was implemented for several reasons. It was recognized that within two different clinical programs, there was variable remuneration amongst members of the medical staff who were providing similar amount and type of work at the hospital. Not only was this unfair for the physicians practicing within the hospital, but moving forward, the variable rates for similar roles and responsibilities created difficulty in determining stipends for new physician recruits.

After two program Reviews were conducted, the implementation of the new physician payment structures led to the creation of a Letter of Understanding between the physician groups and the hospital. This Letter outlines the expectations of working within the program and allows for more physician accountability, such as leading team conferences, accessibility for urgent consults for patients within the program, and maintaining continuing medical education requirements.

How was it implemented?
The Review focused on two clinical programs:

Clinical Program 1: Met with each physician to review finances, appropriate stipends, and re-engage their support and commitment.

Clinical Program 2: Surveyed all physicians involved to develop an alternate funding model, which would secure equitable pay structure and for some, better financial health.

What success has been achieved to date?
There have been different outcomes in each program.

Clinical Program 1: All physicians now completing similar work for equal pay; and clear expectations and transparency in the fee structure for all existing physicians and new recruits.

Clinical Program 2: All physicians are aware of the on-call budget; this allows for on-call fairness of distribution, and savings allowed for the creation of two leadership positions within the program. The Letter allows the hospital to ensure physicians are accountable to leading team conferences within their programs.
What were the key lessons learned?

When trying to implement changes impacting physicians, it is important to create a collaborative environment promoting transparency, honesty, and sharing of data. Benchmarking with similar organizations, frequent conversations with and early input of physicians in the Review, together with stressing the concept of equal pay for equal work, are examples of strategies used to attain success in the Physician Compensation Review.

Reaching out to colleagues at comparator hospitals to inquire about physician compensation and structure is crucial before communicating and implementing change. Having the right information and aligning pay structures with similar hospitals allows the physician groups to trust that administrators are honest and transparent in their research.
Introduction of the Chief Medical Information Officer Position

Why was it implemented?
The position of Chief Medical Information Officer was introduced to engage physicians throughout the planning and execution of the Electronic Medical Record (EMR) at the hospital.

How was it implemented?
The need for this position was identified through the development of the project governance structure and leadership team. A position description was prepared and a budget approved. The successful candidate had held previous leadership positions in the organization, including President of the Medical Staff, and was known to most physicians and staff.

What success has been achieved to date?
Under the leadership of the Chief Medical Information Officer, there has been excellent engagement of the medical staff throughout the process of implementing the EMR. The medical staff has enthusiastically contributed to important clinical and process decisions and has been involved in system events, such as validation and testing. Physicians have expressed interest in the super user role; have actively participated in deployment of front-end dictation in the Emergency Department; and are requesting access to online clinical documentation. This level of engagement is critical to a successful roll out.

What were the key lessons learned?
It is critical that the individual taking on this role commit to dedicated project time, and this has been enabled by the provision of an appropriate stipend by the hospital. The development of a position description results in clarity regarding role and accountabilities. The individual should have strong communication skills and abilities, and be a recognized leader in the organization. Finally for this individual to be successful, it is essential that they solicit physician input into the early planning stages and throughout the project to ensure ownership of provider workflows.
Physician Involvement with Process Improvement of Surgical Workflow

Why was it implemented?
It was recognized that there were opportunities to improve access, and decrease operating room costs as well as increase safety and convenience for patients. Consequently, this project was developed to streamline the surgical workflow from the moment of the requisition of a surgery to the discharge of the patient after the surgery.

How was it implemented?
As we progressed in our quality improvement, it was felt that we needed to address the surgical flow. After successful results in the emergency patient flow with Lean principles, we conducted a series of continuous improvement initiatives at strategic, macroscopic and operational levels. Each component involved physicians. Since those events occur over a period of up to a week, we compensated the physicians for their time, to allow participation with other members during working hours.

What success has been achieved to date?
We achieved great engagement of physicians and were able to demonstrate the value of Lean principles in achieving results, increasing productivity and improving patient access. Some of the results achieved include a reduction of operating room changeover time from 65 minutes to 45 minutes; a reduction of the number of surgery instrument kits required by 36 percent for certain types of surgeries, leading to cost and time savings as well as a reduction in instrument contamination rates from 0.89 to 0.29 percent; a reduction of the number of patient visits required, with 20 percent of pre-op interviews now taking place over the phone, mitigating the inconvenience of patient travel for in-person appointments; and improved communication by deploying a patient tracker in the waiting room to allow patients and their families to view status in real-time.

What were the key lessons learned?
Early involvement and collaboration with physicians in quality improvement initiatives facilitated the considerable success of the project. Whenever there is an expectation to involve physicians, it is important to respect their time commitment. Given the amount of time expected of physicians during the implementation of improved surgical workflow, this was accomplished by compensating physicians adequately to ensure their active participation and the ultimate success of this project.
Including the Patient’s Perspective: My Promise to Emily

Why was it implemented?
At Bluewater Health, Emily represents every patient and family we have cared for in the past, are currently caring for, and will care for in the future. Emily’s image comprises photographs of staff, physicians, volunteers, patients and families illustrating that we each have a unique role to play in the experience of care and caring. Emily appears throughout the hospital, including staff and meeting rooms where conversations include, “What would this mean for Emily?” Emily was introduced with the strategic plan in 2013 with a series of “we will” statements to indicate the initiatives the organization would undertake, or outcomes we will achieve, as a result of successfully implementing our goals. What came next was a readiness to make “I will” statements that comprise a more personal commitment – a promise, called My Promise to Emily. In 2014, Bluewater Health became one of two Canadian hospitals to participate in the Experience Innovation Network, focused on inspiring members to discover and adopt innovations that restore the human connection to health care.

How was it implemented?
To draft My Promise to Emily, more than 100 staff, physicians, volunteers, and Patient Experience Partners participated in facilitated focus groups. In small, two-hour sessions, each participant was asked to recall a time when he, she or a loved one was Emily and to reflect on their exemplary moments of care. This shared wisdom generated almost 200 possible promise statements, collected and reviewed by the hospital’s Patient- and Family-Centred Care (PFCC) Advisory Council. The promise statements needed to be applicable to everyone in the organization, memorable, actionable, and appropriate for the diversity of Emilys we care for. The original focus group participants gathered again to review the process, reflect on the criteria, and consider the then 28 promise statements. There was emotion in the room when a Patient Experience Partner expressed why the promise was such important work. “On behalf of all the Emilys you care for, thank you for your heart-given input!” As the process unfolded, consensus brought forward four statements which now comprise My Promise to Emily: I promise you and your family I will respect you as an individual on a unique health care journey; take time to address your concerns and calm your fears; involve you whenever decisions are being made about you; and be your advocate. My Promise to Emily aligns with the principles of Patient- and Family-Centred Care: dignity and respect, information sharing, participation, and collaboration. The Promise also supports the Patient Declaration of Values, during the creation of which patients and families said they valued being treated with dignity, respect...
and kindness, and honest and clear communication. My Promise to Emily is only one initiative at Bluewater Health supporting the strategic priority to embed PFCC and ultimately deliver on its mission to create exemplary health care experiences with patients and families every time.

**What success has been achieved to date?**

Participation in the focus groups personalized the statements and provided a sense of ownership. Physician participation provided an opportunity to share personal stories of exceptional care, and at the same time provided an opportunity to develop relationships among the participants. My Promise to Emily was introduced organization-wide in October 2015 at Thanksgiving breakfasts with senior leadership, sharing “I Promise” buttons and My Promise to Emily cards to post on departmental huddle boards. It is embedded within our new Quality Improvement Plan and 2016-21 strategic plan along with a ‘culture of kindness.’ With each new quality initiative, alignment is sought with My Promise to Emily. We now speak of Emily’s ‘Community of Immunity’ and ‘Choosing Wisely’ for Emily as examples. Emily and My Promise to Emily are shared when recruiting new physicians and we are now hearing about Emily during interviews. A communication and sustainability plan will help to ensure these successes continue.

**What were the key lessons learned?**

Patient, staff, and physician satisfaction are inextricably linked. There is an important connection between the patient experience, and the need and desire for health care providers to engage in meaningful work. My Promise to Emily has created an alignment of collective goals and purposeful collaboration by keeping our true north focus on the patient and family’s perspective. There is a strong emphasis on increasing the voice of patients and families as well as the need to restore the joy to health care providers.

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More Time to Care: Engaging Physicians in Continuous Quality Improvement

Why was it implemented?
Quality for most physicians is traditionally based on quality assurance where individuals, not systems, are the owners of quality; where fixing quality issues implies fixing individuals rather than the fixing of systems that lies at the heart of continuous quality improvement (CQI). As a result, the relationship of physicians to CQI can be a problematic one. Integrating physician leaders at the outset of our CQI transformation allowed them to acquire broader insight into the value of CQI and provided a new toolkit to solve non-clinical problems and issues. By so doing, we now have physician leaders who are advocates not adversaries of CQI and who have become effective and responsible leaders of CQI transformation at our hospital.

How was it implemented?
In 2012, under a new CEO, a Lean-based CQI system was implemented at NBRHC. A Vice President of Quality, a physician, was charged with mapping and overseeing the steps of this transformation (called “More Time to Care”). At the outset, visits were scheduled to Theda Care (Wisconsin) for key managers and directors, including representatives from the board. A new quality team was rolled out across the hospital programs that learned Lean methods and then the team facilitated the use of CQI tools at all levels of the hospital. Huddle boards were introduced and became standard work on all units. Metrics were developed for each unit by program and senior administration.

At the same time, a new Medical Leadership model was adopted with Chief and Medical Director positions for each of the five departments. A Theda Care trip was arranged for the new Chief of Staff and interested physicians, and the new CQI system was endorsed by the Chief of Staff at the Medical Advisory Committee (MAC) and general medical staff. The Medical Affairs team was expanded to include a dedicated Quality Coordinator, educated on Lean quality improvement tools, and charged with connecting senior physician leaders to quality initiatives and encouraging them to lead their own. The coordinator remains a high-profile resource and advocate for physicians contributing to quality at all levels of the organization including wards, programs, senior management, MAC and the board.

What success has been achieved to date?
Traditional physician problems are now solved using new CQI tools including root cause analyses and simplexity, an often lengthy problem solving exercise, which we refined to more efficiently use physician time. Medical Affairs and each medical department choose metrics as part of a medical affairs and physician
score card that is linked to the hospital Quality Improvement Plan (QIP) and organizational report card. At all monthly surgery, family practice, medicine department meetings and the MAC, the Quality Coordinator reports on current initiatives/projects. A round table quality update discussion occurs after MAC to encourage interdepartmental awareness of quality. Huddle boards were introduced into family medicine department meetings and a virtual huddle board was developed for surgery and

Driving toward achieving agreed-upon metrics is no longer viewed by physicians as a process in which they are bystanders.

Medical Affairs; these huddle boards are being utilized to focus these meetings on quality. A hospital strategy “war room” maps and prioritizes all hospital initiatives and metrics. Metrics and initiatives led by departments or medical affairs form one of four major components of this war room. A project board also identifies operational initiatives and projects in other programs that are being led by the physicians or require physician resources. Physician initiatives and metrics are transplanted from this war room on to a smaller board in the Chief of Staff’s office, allowing ongoing monitoring. Driving toward achieving agreed-upon metrics is no longer viewed by physicians as a process in which they are bystanders.

What were the key lessons learned?

Successfully integrating physicians into a new CQI system required six key ingredients and/or investments by the hospital. First, it chose to involve physicians early in the implementation of any CQI system. Second, the hospital trusted its new medical leaders in their commitment, influence and willingness to adopt CQI tools as a new way of doing business. Third, it added to the CQI team an embedded Quality Coordinator in Medical Affairs as a direct bridge between CQI and physician leaders. The choice of this coordinator is critical as this individual must have both the credibility and resolve to overcome initial skepticism of physicians and the creativity and adaptability to then tailor CQI methods to meet their needs. Fourth, the CQI team minimized the use of confusing corporate jargon intrinsic to CQI (like Lean, Green or Black Belt projects, etc.). Fifth, the hospital established a foundation where CQI became both visually and functionally an unavoidable part of the world of hospital leaders. Finally, and most importantly especially for physicians, CQI must be embraced by the Chief of Staff and the MAC, incorporated into existing processes, be adaptable to physician sensibilities, and targeted at physician priorities and needs. For NBRHC, the integration of physicians into our CQI system, “More Time to Care”, remains a work in progress but a truly rewarding one to date.
Physician Boot Camp

Why was it implemented?
The program was implemented as a means of providing physicians with ongoing educational opportunities on evolving health care/hospital issues that they may be aware of, but for which they lacked in-depth knowledge. We hoped that offering physicians this type of training would provide them with increased insight into the issues facing the hospital and going forward is likely to promote increased collaboration between the hospital and the physicians. Examples of sessions included: Understanding Hospital Finances; Our Collective Future – a presentation/discussion with the CEO; The Evolution of Health Policy and the Impact on Physicians; Patient Safety and Investigations; Physician Communication and Behaviour Styles; IT Initiatives and MyChart Readiness; and Patient Relations – The Trouble with People.

How was it implemented?
It was advertised broadly with the entire physician population, and scheduled in the afternoon immediately following the Physician Chiefs’ meeting. Each session was limited to 60 - 90 minutes in duration, and it was stressed that the sessions were meant to be a primer to give a basic understanding of a variety of important, and sometimes complex issues.

What success has been achieved to date?
To date, Boot Camp has been very well-received, with much interest and discussion. The popularity of our Boot Camp demonstrated that physicians are interested in continuous learning and are receptive to receiving education on issues not closely related to their day-to-day practice. Convenient timing of the sessions, along with the provision of an appropriate level of detail, are important factors in obtaining physician participation in this type of initiative.
Physician Involvement in Quality Improvement Initiatives

Why was it implemented?

It was recognized that a large number of quality improvement projects being initiated across the organization would benefit from the direct involvement of local physicians. To achieve the ambitious goals set by the Board’s Quality Assurance Committee, it was understood that involving the physician community, seeking their input, guidance, leadership, and participation would lead to better outcomes. Physician leaders have always been interested and actively involved as members of the Quality Assurance Committee of the Board, and have contributed to the growing culture of continuous improvement at our hospital. As such, these physician leaders were willing to be the initial champions, and to spread the engagement to peers. This was particularly true for efforts around handwashing compliance rates and the use of standardized evidence-based order sets for congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) admitted patients.

How was it implemented?

Through engagement with our Chief of Staff, it was decided that targeted quality initiatives (including the two measures mentioned above) would be brought through the Medical Advisory Committee (MAC) for discussion. The physician leads participating as committee members determined that these indicators would become a priority for physician involvement. Through the use of physician leaders, the broader physician community was engaged, using various methods of communication (meetings at rounds, emails, posters, dashboards). The physicians were very interested in their handwashing rate compliance as a group, and even took on friendly competitions with nursing staff. A very positive relationship was established between the members of the hospital’s audit team for handwashing compliance, particularly our infection control lead and the physicians.

On the order set initiative, a similar approach was taken. The physicians worked closely with clinical managers on modifying the leading practice template to best map to the operating parameters of our small hospital. Once fine-tuned with their direct input, the order sets were launched as admission algorithms. The Chief of Staff played a large role in communicating the importance of appropriate use of the tool to the professional staff.

What success has been achieved to date?

The baseline handwashing rate at the start of this effort was under 80 percent compliance. The most current data is now showing a 94 percent result. Even more dramatic improvements were demonstrated with order set use for
CHF and COPD admitted patients. The initial baseline rate of use was 28 percent. The most recent rate had climbed to 100 percent.

What were the key lessons learned?

Quality improvement initiatives can benefit greatly from direct physician participation. Communication, thoughtful engagement, being respectful of physicians’ availability, and working around their schedules (utilizing MAC and rounds, for example), are all important factors in achieving success. In addition, bringing physicians into the decision-making of selecting and launching of quality improvement efforts, and having them help craft the tools, was very beneficial. Finally, the use of physician leaders, those who have a genuine interest in the issues at hand, and who see the benefits possible with respect to quality, is seen to be crucial.
Integration of Reappointment and Training Processes for Physicians

Why was it implemented?
We wanted to ensure physicians received required training and understood evolving hospital policies in a simple, reliable and efficient manner. We ultimately aim to reduce the risk of breach of policies and need for associated disciplinary interventions.

How was it implemented?
We developed physician e-learning modules, using specific examples of issues that had occurred in our institution. Physicians participated in the development of the training materials, ensuring they were seen as meaningful and related to their practice and environment. Dissemination and completion of these materials was embedded in a web-based digital reappointment application. Single log on for all aspects of training and application completion made the process efficient and a minimal addition to an already required process. We built in an automatic documentation and notification of prior training completion, to eliminate repeated training.

What success has been achieved to date?
100 percent of physicians completed required training in one month, and the e-learning module was highly rated because of perceived relevance to local practice. The hospital has the ability to easily track and document completion and ensure physicians are provided relevant information and training so they are aware of new policies and obligations. Examples of applicability include hospital-wide processes regarding privacy, new legislative obligations and conflicts of interest. This could be utilized for departmental requirements as well.

What were the key lessons learned?
Engage physicians in the process, use materials relevant to practice environment and link, where possible, to other requirements to improve efficiency. Use of a digital format also allows for easy annual updating of materials and flexibility in topic and distribution.

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North West Regional Chiefs of Staff Council

Why was it implemented?
Prior to implementation, there was no formal process for physician leaders from the hospital settings in the North West Local Health Integration Network (LHIN) to come together to discuss issues of common concern with regards to quality and safety. Our region is really large – almost 1000 km from the hospital in the farthest east end of the LHIN to the hospital at the western end of the LHIN. With the evolution of the LHIN 14 Blueprint, a 10-year plan to transform care, and local hubs, the Chiefs of Staff anticipated a greater need for physician discussion and input regarding issues that impact the quality-of-care delivery and hospital system integration in the region. A council that included all of the Chiefs of Staff throughout the region was seen to be a reasonable way to bring this group together to try to address shared issues.

How was it implemented?
Two Chiefs of Staff – one from the regional hospital and one from a community hospital – developed the idea and tested it informally with colleagues. Together, with one other Chief of Staff, draft terms of reference were developed, reviewed by legal services of the Ontario Medical Association (OMA) and confirmed by the group. The LHIN was approached to support the initiative both for administration and the planning of four virtual meetings and one face-to-face meeting per year.

What success has been achieved to date?
To date, several initiatives have been shared through the Council allowing greater efficiency for program developers with a single point of contact. The Council has provided an opportunity for Chiefs of Staff to hear and better understand each other’s concerns, and help to identify common issues in order to support better development and implementation of regional programs.

These include:
1. Better Admissions and Transitions in Ontario’s North West (BATON) discharge planning quality improvement initiative;
2. Virtual Intensive Care Unit (ICU) rollout throughout the region;
3. Regional palliative care program; and,
4. Regional Transient Ischemic Attack (TIA) triage and referral process.

In addition, we have shared policies to standardize determination of “code status” so that documentation and patient identification is uniform from site to site. We have also begun a process to better understand gaps in repatriation
and transition from the tertiary regional hospital to all of the other 12 community hospitals in the region. We are examining time to completed repatriation data, sharing current processes and will look to develop a best practice in process across our sites. It has been identified as “the only forum for group discussion with other Chiefs of Staff… I anticipate that it will become more successful as we continue to engage one another.”

What were the key lessons learned?
There are several initiatives that have similar implications for all of our hospitals and we can support the rollout of those initiatives more effectively together. We have also shared issues like bed availability, and repatriation goals where we can support each other to work toward improvement. With limited human resources in most of our small settings, the opportunity to share policies and processes creates efficiencies, and is helping to support improvement without creating significant additional work.

There are opportunities to provide some support and mentoring to new Chiefs of Staff and create a way in which we can have a community-of-practice or network through which we can more easily ask and address questions. Other organizations and clinical program developers have benefited from having one group to which they can present and from which they can seek feedback. We will benefit from greater face-to-face meeting opportunities moving forward, but are limited by the challenge of our geography in that regard.
Executive Advisory Council

Why was it implemented?
The Senior Management Team recognized the importance of staff and physician engagement in organizational and strategic decision-making. Through direct feedback from staff and physician engagement sessions, it was recognized that the physicians were feeling somewhat disengaged from organizational strategic decision-making. While the intent for engagement was good, historical methods and processes were not yielding the needed results.

How was it implemented?
A one-hour meeting was booked quarterly and/or ad hoc that met the work time commitments of the physicians. Physician input was solicited with regard to the timing of the meetings and a time of 4:30 to 5:30 pm was chosen based on physician preference. Terms of reference and context about the rationale for having the Executive Advisory Council (Council) were provided to the group in advance. Those who attended the meeting had a good understanding of the purpose of the group and the type of engagement that was going to happen. Key concise information was presented on the topic of concern and then key questions were asked of the group. All physicians and directors were encouraged to contribute to the conversation.

What success has been achieved to date?
This format has produced robust conversations and debate. It prevents miscommunication because all relevant stakeholders are in the room at the same time having a conversation, versus one-way feedback. It has promoted enhanced perspectives and more diverse thinking. It has helped the Senior Executive Team with decision-making. It has improved physician engagement and therefore enhanced their feeling of being valued. The Council meetings are focused on one or two topics within the one-hour session thereby ensuring that the topic is allotted appropriate time and not deferred.

What were the key lessons learned?
In-person, interprofessional communication, and engagement regarding important organizational issues is vital to success. Physicians have given feedback that emails may not be the appropriate way, since they are often overwhelmed by the volume of organizational emails. The topics must be pertinent and key questions should be asked. It is important to stick to the booked time to be respectful of the physician’s time. Physicians want to give their input on strategy and they want to be involved. By creating a venue that works within their schedule and is focused and valuable, we are able to enhance physician engagement.
Enhancing the Physician and Operational Leader Partnership

Why was it implemented?
St. Joseph’s physician engagement scores for Psychiatry (as measured by the National Research Corporation Canada (NRCC) survey process) have continued to lag behind other areas in the organization. In a focus group with physician leaders within the program, they identified issues with role clarity and lack of meaningful engagement in decision-making, despite working in a co-leadership model. They identified a willingness to pilot the use of evidence-based leadership tools, recommended by the Studer Group, which had previously been rolled out to the operational leaders at St. Joseph’s.

How was it implemented?
The Site Chief (who has been involved with the city-wide physician organization partnership work) engaged the program’s Vice President (VP) and the Chief of Psychiatry to ensure a common vision of enhancing shared leadership and team performance within the mental health leadership team. A planning retreat was held with physician and operational leaders to articulate the vision and develop strategies for improving both shared leadership and team performance. An Agreement was reached to restructure the clinical leadership meetings so that physician leadership could be involved in issue resolution and decision-making earlier in the process, while trying to reduce the overall meeting time. A template was provided for physician leaders and their operational leaders to review role clarity within their respective programs. The annual work plan, to support strategic and quality improvement goals, was completed collaboratively with input from the VP and Site Chief, Directors, Coordinators, Physician Leaders and Advanced Practice Nurses. In the past, operational and physician leader work plans were completed in parallel, which often created misalignment or ambiguity regarding clinical priorities and alignment of resources. On a go-forward basis, physician leaders have been assigned weighted goals related to the organization’s strategic priorities with alignment to the workplan. Each operational and physician leader will complete 90-day plans within the Studer software system (Leader Evaluation Manager), which are visible by everyone on the team. Physician leaders will also be introduced to other tools, such as rounding on their staff, and will join their operational leaders in use of communication boards (to post progress on key metrics) and stop-light reports (to provide feedback to frontline staff and physicians on resolution of issues).
What success has been achieved to date?
Our physician leaders have provided feedback that leadership meetings are feeling much more productive and relevant to them as they are an active participant in the decision-making. There has been enhanced dialogue between operational and physician leaders regarding roles and accountability, and there is a perception that clinical initiatives are moving forward in a more timely way because everyone is clear regarding timelines, outcomes, and accountabilities. The next NRCC survey will occur in November 2016 and will determine whether the changes at the leadership level have translated to improvements at the frontline level. The other outcome we will measure is successful achievement of our strategic goals.

What were the key lessons learned?
Although we are early in our implementation plan, we have identified that it is easy to swing from too little involvement to too much involvement (i.e. asking physician leaders to take on very operational tasks). Ongoing dialogue about similarities and differences in roles and accountabilities will be important. We have also identified a lack of understanding by some hospital operational leaders regarding the academic accountabilities our physicians have which can impact their availability to the clinical team. Enhancing education and orientation will be important.

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Senior Medical Council

Why was it implemented?
The Senior Medical Council (SMC) was implemented to ensure that there was a regularly recurring meeting that deliberately connects Department/Program Leaders and the Medical Staff Association President with the Chief Executive Officer (CEO) and Chief Medical Executive. The purpose was to gain strategic input and to stimulate creativity to help enhance effective implementation of strategic decisions and to deal with thorny operational issues or challenges that arise in the health care environment. The forum focuses on creative and candid thought and dialogue.

How was it implemented?
The SMC originated many years ago at Sunnybrook, but was inactive for several years. The current hospital CEO re-implemented the SMC approximately one decade ago.

Importantly, the Chair of the SMC is one of the senior physician leaders. Generally, a Chair holds the role for one to two years. The position is rotated between a Department Chief followed by a Program Chief, e.g., Brain Sciences Program Chief, followed by Surgeon-in-Chief. The agenda is developed by the Chair of SMC but in practical terms, it is co-developed through discussion between the SMC Chair, the Chief Medical Executive and the hospital CEO.

Emphasis is placed on informality and striving to create an environment where candor and creativity are emphasized. As necessary, guest attendees (always small in number) are invited to enhance the discussion or provide expert input on content (e.g., Hospital General Counsel).

What success has been achieved to date?
This venue is deemed to be successful because it has had a very informal feel and it has provided the opportunity for thoughtful deliberation around issues with significant gravitas. Issues ranging from physician-assisted death, to hospital strategic planning, to optimizing communication between physicians and hospital management have been included in the agenda. Notably, the OMA-OHA joint advice documents lend themselves very well to discussion in this type of environment.

What were the key lessons learned?
Health care in Ontario in 2016 is fast-paced and often best described as hectic. Deliberate creation of a venue that attempts to craft thoughtful dialogue and idea generation is important to ensure we take advantage of the brain power in the organization and stay focused on the big picture. It also serves to enhance connectedness and alignment.
Connecting Physician Leadership and Operational Expertise

Why was it implemented?
Program management was used to connect physician leadership with operational expertise and accountability. Program management integrates the interprofessional and the multidisciplinary groups involved in delivering health care in specific priority areas at Sunnybrook. It highlights the role of physician leadership in key strategic and operational priorities. Program Chiefs also bring significant amounts of academic knowledge to their roles. Program management highlights the importance of physician leaders being very connected and aligned to hospital and system needs.

How was it implemented?
Program management was initially implemented at Sunnybrook more than two decades ago with the creation of the Trauma Program. In a staged fashion, we then introduced a series of other relevant programs that reflect areas of special expertise and responsibility for Sunnybrook. Other programs include the Odette Cancer Program, the Schulich Heart and Vascular Program, Women and Babies Program, Veterans and Community Program, Holland Musculoskeletal Program, Rehabilitation Medicine Program and the Hurvitz Brain Sciences Program.

What success has been achieved to date?
Programs feature dyad leadership that has a physician leader and an operational leader. The complementary skills these two individuals bring help to optimize operational and strategic success. Key features include strong linkages to the Executive Vice President (EVP) with oversight of the program portfolios. Monthly dashboard reviews occur where issues relevant to case volumes, patient flow and quality of care and finance are reviewed. Alignment to Health System Funding Reform (HSFR) and Provincial Quality Frameworks are emphasized. Additionally, quarterly reviews are held at the end of quarter two and quarter four where the program leadership and the EVP present to the Senior Leadership Team (SLT) on summaries prepared from the dashboards.
The medical leaders of the programs are members of the Strategic Planning Council (SPC) which meets on a monthly basis to help direct the overall strategy of the hospital. The SPC is the SLT plus Medical Program and Department Chiefs. Both members of the dyad are also members of the Integration and Implementation Committee (IIC).

Additionally, accountability for performance is held at the program leadership level. Results are highlighted routinely (weekly or monthly) at our three larger committees which include the Flow and Occupancy Committee, the Utilization Committee and the Quality Committee.

We look to the program leadership to facilitate and ignite system partnerships relevant to both vertical and horizontal integration in the GTA and province. Our program leaders are held jointly accountable for the development of the Sunnybrook multi-year operating plan, together with the EVP with oversight for the various programs. The program dyad helps influence and emphasizes the importance of interprofessional care.

At Sunnybrook, the medical directors are all doctors and the directors are non-physician leaders. Finally, the program leadership comes to the table to develop a multi-year medical human resource plan (MYMHRP) on a yearly basis. This process allows us to tightly align with our overall multi-year operating plan. Great emphasis is placed on aligning the MYMHRP with the strategic direction. The various programs engage in a hearty debate to ensure that we choose these physician positions most effectively.

What were the key lessons learned?
1. The model allows integration of expertise required to deliver complex, interprofessional care;
2. Physician leadership is encouraged at an operational as well as academic level; and,
3. The integrated vision of care inherent in Program Management fits well with strategic and operational priorities of a modern hospital.
Breakfast with the President

Why was it implemented?
Breakfast with the President was created to enhance physician engagement by providing an opportunity for two-way dialogue between physicians of all disciplines and the CEO. The focus is on providing physicians with the opportunity to talk about what’s important to them and to ask questions.

How was it implemented?
Breakfast with the President is open to all physicians across Osler’s two hospital sites, with one session held each quarter. Physicians submit their interest to their respective Site Chiefs, who are also encouraged to nominate high-performing physicians they feel should be considered. All nominations are forwarded by the Site Chiefs to the Vice President of Medical Affairs. In conjunction with Strategic Communications, physicians from different departments and disciplines are selected and receive formal invitations to the breakfast. Communications to physicians reinforce that there is no preset agenda, that the forum is completely open for discussion, and that the topics are driven by what is important to physicians. The breakfast forum runs for 90 minutes with about six to eight physicians attending each session. Groups are deliberately kept small and intimate to encourage open dialogue and to provide an opportunity for everyone’s voice to be heard. During the breakfast, a vibrant discussion takes place with physicians who can ask questions of the CEO and share with their peers what’s on their minds and what’s important to them. If a physician has a confidential question, or does not want it shared with the group, a form is available to leave their questions behind for follow-up. All questions are answered; any confidential questions are followed up on a one-on-one basis and the open questions are shared with the group for everyone to see.

What success has been achieved to date?
Greater engagement between hospital administration and physicians has been achieved. Since starting Breakfast with the President in September 2013, 66 physicians have attended 10 breakfast sessions. Survey results reveal that 51 physicians completed their post breakfast surveys and 100 percent agreed with the following four statements:

1. Breakfast with the CEO is an effective way to engage in two-way dialogue with the CEO;
2. I was comfortable sharing my thoughts and ideas at the table;
3. I valued spending time with my colleagues and the CEO; and,
4. I will encourage Osler physicians to participate in this program.
Comments left behind from physicians are predominantly positive. Some examples include: “Encouraging to see and to participate in such a forum.” “Great conversation, ideas sharing.” “A very good dialogue. Very informative. I would definitely recommend this be continued.” “Fantastic experience. Would love to be here again.” “Great initiative and forum to discuss pertinent issues facing physicians.” Resolutions for physician-related issues were also found following the meetings.

What were the key lessons learned?

An open dialogue where physicians are able to freely exchange ideas with the hospital CEO and their peers is a welcome forum. The sessions have also been successful in helping promote awareness of the organization and its strategic priorities, enabling more effective decision-making, and building relationships that support ongoing dialogue between the CEO and physicians. Keeping the engagement informal over coffee and breakfast allows for a think-tank like atmosphere to evolve. Highlights of the discussion are shared broadly with all physicians after each session. Sharing the questions and answers post-event with all physicians also creates a sense of transparency and openness that is important with this key stakeholder group.