Physician Hospital Partnership

Physician-Hospital Summit:

A Discussion on Collaborative Decision-Making

April 10, 2017

Report to Participants

May, 2017

Physician Hospital Partnership

The cover design is a word cloud based on the unfiltered comments of participants recorded during the summit.

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The following report summarizes information gathered during the April 2017 Spring Summit event that brought HHS administrative leadership and physicians together to have a discussion around collaborative and transparent decision-making.

This event is one step in a journey to renew the relationship between physicians and hospital leaders. This report summarizes some tangible ways ("*actionable ways*") to improve and promote hospital decision-making that is more inclusive of physicians.

Executive Summary

On April 10th, 2017 hospital administrative leaders and physicians came together for a discussion on how we can make decision-making at Hamilton Health Sciences more collaborative, transparent and inclusive of physicians. Participants were from a comprehensive cross-section of the organization, both by department and site, with equal representation from hospital administration and physicians. A list of summit participants is provided in Appendix A.

The primary goal of the event was to understand what collaborative and transparent decision-making, inclusive of physicians, might look like and to collect the groups' perspective on the way in which we can achieve this desired state.

Participants were organized in break out sessions where they discussed, through story-telling, examples of successful involvement of physicians in decision-making. Groups were also asked to give examples where physicians weren't involved and consequential impact. The facilitators captured the types of decisions that the physicians and administrative leaders identified. The sharing of stories and ideas among the mixed group provided candid reflections on opportunities, and built a common understanding of individual roles, expectations and the challenges we face as they related to the discussion.

Individual groups were then assigned a specific type of decision to identify steps the organization could actively take to make that decision more collaborative, transparent and where applicable, inclusive of physicians.

Analysis of the information highlights operational considerations, and enablers to five (5) decision-making areas of focus. This report supports the need for the *Physician-Hospital Partnership Working Group* to continue developing ways to promote the specific deliverables outlined in this document, and encouraging leaders and physicians to share in the efforts to champion ways to improve collaborative decision-making .

Background

Hamilton Health Sciences held the first *My Voice Matters* Engagement Survey in 2012. The data provided a baseline understanding of where we stood as an organization with physician engagement levels. This information led to the development of the Physician-Hospital Partnership working group – a committee by physicians, for physicians charged with devising a strategy on physician-hospital relations

In 2014 the group reviewed literature, studied peer organizations and set the strategy & goals for the next three (3) years to enhance physician engagement. At this point the focus was on creating a *Physician-Hospital Agreement* – a set of mutual accountabilities that both physicians and the hospital collectively commit to.

In 2015 the group reflected on the direction the work was going and reached out to the physician group through a series of physician-specific focus group sessions. The PHP heard what the physicians were sharing, and listened to their feedback highlighting that physicians at HHS were not ready for an agreement – changing directions to focus on creating the foundation of a relationship built on trust and collaboration needed to happen first.

After more dialogue the work focus was shifted to: communication, partnership, decision-making, and leadership. The aim being to create a "culture of collisions" where dialogue between physicians and hospital leaders becomes inherent to every day operations.

The 2017 Spring Summit is the starting point to understand how better to involve HHS physicians in the decisions that we as an organization make at all levels.

Summit Objectives

To **identify opportunities** for greater physician involvement in decision-making

To **create actionable ways** *(tangible steps)* to make decisions more collaborative and transparent

To **gain commitment** from both hospital administrators and physicians in implementing the created actions

In addition to the evening's formal objectives, a secondary benefit of bringing leaders and physicians together is the building of new connections and enhancing or developing new relationships that foster an improved understanding of each other.

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Discussion Summary and Outcomes

Breakout Session #1 – Decision Types

Summit participants were given two (2) opportunities to provide input during the event. The first session consisted of 11 break out groups, each equally arranged with representation from both administrative leaders and physicians at varying levels of leadership. During this session participants were tasked with identifying examples of decisions that physicians were involved in successfully, unsuccessfully and potential opportunities/ways those decisions could be more collaborative. A detailed transcription of the raw data by table can be found in Appendix B.

There were multiple decision-types identified. There was an equal distribution of decisions that successfully involved the physician group and those that did not. By way of summary, the following is a snapshot list of ***decision-type*** and associated ***opportunity*** as identified by participants during this discussion:

Decision Type	Opportunity (where applicable)
Staffing Models	• Physician input into staffing numbers & models • Clarification around decision-making structures • Better communication • Shadowing to understand other's roles/perspectives
Clinical Services/Programs	• Open lines of communication with feedback loop • Physician representation must be multiple and across all sites • Ensure consultation/transparency to minimize abrupt change • Give more lead time
Resources/Procurement/ Purchasing	• Involve physicians "up-front" before decision is made • Understanding the "why" this decision is being made • Clear rules of engagement & communication
Budget	• Physicians involved in "building" options for targets; not discussing pre-determined options • Budget embedded into meetings regularly • Transparency re: resources by site/portfolio (reference bar) • Clear expectations for physician involvement
Strategy	• Involvement at the "implementation" phase but need more physician involvement at the decision-making phase • Right people at the table and make sure they can come (timing)
Operational day-to-day	• Need up-front involvement • Explicitly outline – what information do physicians need to be involved in this decision (clear parameters) • Knowing *why* decisions are being made • Know *how* committees are formed; who to go

Innovation & Technology	• Involve all stakeholders (those affected) • Communication loop-back mechanism (when feedback was sought and decision/change was made)
Space Allocation	• Earlier engagement with physicians in these decisions
Quality Improvement	• Broader dissemination of information re: performance measures and consider impact on workflow • Fatigue issues – less engaged over time • Understand *who* to go to with questions/issues – physicians get a letter "who is who"
Communication	• Committee "call for participation" to know what committees are out there and how to join • Involvement of interviewing on units • Decisions presented in "context – background – rationale" style • Connect input to outcome (close the loop mechanism) • Consider timing of meetings for physician schedules • Understand who is in which portfolio • Create opportunities for physicians to connect within/across portfolios

Breakout Session #2 – Actionable Ways

Break out session facilitators came together to review and pare down the information to the top five (5) common decision-types discovered at all, or most of the table discussions. Those five (5) decision-types were then assigned to a table for further discussion in what was called the **"Actionable Ways"** portion of the evening. The top five (5) decision-types were:

1. Budget
2. Staffing Models
3. Technology & Innovation
4. Equipment & Purchasing
5. Clinical Services & Planning

Breakout session groups were tasked with identifying tangible & concrete steps the organization could take, in an effort to make this decision more collaborative & transparent. Each table was charged with identifying the following data:

- Who should be involved in making this decision
- Tangible/actionable ways to make this decision more collaborative and transparent
- Potential barriers to making this happen
- What would need to be in place for participants/organization to commit to this change
- Immediate next steps.

The following decision-type tables represent the information gathered during this portion of the night:

Decision-Type: BUDGET

BUDGET	
Who should be involved: 1) Physicians 2) Chiefs 3) Directors 4) Executives	**Level of Involvement:** 1) Consultant – idea generation 2) Direct – bring to physicians to engage 3) Program Level – for engagement 4) Direct – high level dialogue & loop back to physicians
ACTIONS: How will we make this change more collaborative & transparent?	
1) Incentives: • Teams/units benefit from the savings it is tasked with finding • Generate ideas & incentives for teams to find/save money in their area • Ask – what are physicians/teams willing/able to 'give up' to fund item/idea x	
2) Communication & Involvement – Budget Model • Involve physicians early in the process **before** decision is made & implemented to understand the **impact** this will have • Create a feedback mechanism to ensure Chiefs & their physicians are engaged and informed • Clearly communicating physician involvement in budget model	
Additional Opportunities: ***identified during session #1 table discussions related to this decision-type***	
• Budget as an ongoing topic at meetings • Share financial reports with physician • Transparency re: distribution of resources within and among portfolios/by site (reference bar) • Hospital Funding education – tailor to physicians and offer 2 x courses through Centre for People Development	

Decision-Type: INNOVATION & TECHNOLOGY

INNOVATION & TECHNOLOGY	
Who: 1) Site Lead Physicians 2) Front Line Physicians 3) Patient Advisor – role based clarity of decision required 4) Director – Operational 5) VP – broad perspective 6) Academics/ University – training (education) 7) Learners (students/residents) 8) Procurement 9) Planning & Analysis (DSS) 10) IT 11) Front Line Staff (RN) 12) HR/OD	**Level of Involvement:** 1) Content expert/champion 2) Participant/content expert/champion 3) Consultant 4) Participant/facilitator 5) Champion 6) Participant 7) Participant 8) Consultant 9) Consultant 10) Consultant 11) Participant 12) Consultant

ACTIONS: How?

1) Theoretical Tool Kit

- Clearly define physician (and all members) roles on committees
- Set expectations of meetings to ensure time well spent & therefore value-add
- Environmental scan of how other organizations involve their physicians

2) Utilize Technology

- Explore more time efficient methods of meeting – i.e. Skype or other web based virtual meetings for group discussions

3) Innovation Lab

- Secretary of Innovation as a coordinator role
- Recruitment of idea creators with digital skillsets
- Send out a call for physician recruitment for lab
- Include physicians in selection process for lab team members

4) Innovation Committee

- Explore funding options for research & innovation
- Gather leadership (both physician & administrative), frontline physicians to identify committee structure & direction

NEXT STEPS:

1) Connect with Renato Discenza, Dr. Ralph Meyer, Dr. Steve Arora & Dr. Jan Willem Gorter

Additional Opportunities: ***identified during session #1 table discussions related to this decision-type***

- Communication feedback & close loop mechanism for technology issues (day-to-day)
- Stakeholders need to be involved earlier on – changes impact day-to-day of physicians & therefore should know what to expect

Decision-Type: CLINICAL SERVICE & PLANNING

CLINICAL SERVICE & PLANNING	
Who:	**Level of Involvement:**
1. Physicians	1. Participant
2. Patients	2. Participant
3. HCA's/Business Clerks/Phys. Admin Support/ES's	3. Advisor
4. Stock Supplier	4. Advisor
5. Nurses/Nurse Practitioners	5. Participant
6. Allied Health	6. Participant
7. University	7. Advisor
8. Supply Chain	8. Advisor
9. Community Agencies	9. Advisor
10. Decision Support	10. Advisor
11. Legal/Risk	11. Consultant
12. Quality Specialists	12. Participant
13. Learners/trainees	13. Advisor
14. Managers	14. Participant

ACTIONS: How?

1) Theoretical Tool Kit

- Clearly define physician (and all member) roles
- Set expectations for all meetings
- Onboarding checklist
- Tools for relationship building
- Develop guiding principles

2) Communication & Feedback Mechanism

- Involve physicians early in the process **before** decision is made & implemented to understand the **impact** this will have
- Create a feedback mechanism to ensure Chiefs & their physicians are engaged and informed
- Create "team boards" (virtual & for units) with names, roles, photos → understanding "who is who"
- Leverage current structures to share & gather information

NEXT STEPS

1. Guiding principles → Dr. Ryan Smith, Dr. Chris Hillis, Dr. Smita Halder & Dr. Bruce Korman agreed to be part of initiative

Additional Opportunities: ***identified during session #1 table discussions related to this decision-type***

- Know how committees are formed – getting the right voice (Quality Committees = opportunity)
- Identify physician reps with clear expectations of their role & responsibility

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Decision-Type: STAFFING MODELS

STAFFING	
Who: 1. IT 2. Interprofessional Staff (i.e. allied health, nursing etc.) 3. Patient Experience representative 4. Physicians 5. Business Clerks 6. Managers 7. Operations Groups – unit level/program level 8. Administration	Level of Involvement: 1. Advisor 2. Participant 3. Advisor 4. Participant 5. Participant 6. Participant 7. Participant 8. Participant

ACTIONS: How?

1) Theoretical Tool Kit

- Clearly define physician (and all member) roles
- Concrete description of item to be addressed by committee in meetings/by project
- Set expectations for meetings
- PDSAs → test changes on small scale before implementing across unit/program/organization
- When to hold meetings to best include participants

2) Leverage Existing Models (CQI)

- Foster local culture of CQI – ideas & opportunities welcomed from everyone
- Status sheets to improve/foster physician involvement

3) Communication & Feedback Mechanism

- Involve physicians early in the process **before** decision is made & implemented to understand the **impact** this will have
- Create a feedback mechanism to ensure Chiefs & their physicians are engaged and informed
- Transparency → staffing changes, rationale, non-negotiables
- Staffing models by unit/program → understand flow of unit staff (i.e. vacation coverage, backfilling etc).

NEXT STEPS

1) Test → include a physician volunteer on operations committee to determine involvement

Additional Opportunities: ***identified during session #1 table discussions related to this decision-type***

- Physician input into staffing numbers & models
- Clarification around decision-making structures
- Better communication
- Shadowing to understand other's roles/perspectives

Decision-type: EQUIPMENT

EQUIPMENT	
Who: 1. Current Practicing Physician 2. Physician Leader	Level of Involvement: 1. Participant 2. Participant

ACTIONS: How?

1) Theoretical Tool Kit

- Clearly define physician (and all member) roles
- Clearly defined goal of meetings (or committee) → what goal are we working to achieve?

2) Communication & Feedback Mechanism

- Involve physicians early in the process **before** decision is made & implemented to understand the **impact** this will have
- Create a feedback mechanism to ensure Chiefs & their physicians are engaged and informed
- Include physicians in communication/decision → provide context and rationale for/against equipment changes
- Open line of communication for feedback on equipment changes → are the changes going well/not well, positive feedback & opportunities for improvement
- Regularly scheduled communication → updates on upcoming/ongoing changes, rationale behind changes

NEXT STEPS:

1) Peri-operative Meeting → include physicians to watch meeting.
   - MRP: Leslie Gauthier
   - Timeline: May 2017

Additional Opportunities: ***identified during session #1 table discussions related to this decision-type***

- Involve physicians "up-front" before decision is made to purchase
- Understanding the "why" this decision is being made
- Clear rules of engagement & communication

Conclusions and Next Steps

In an effort to define what might be multi-lateral solutions, the Physician-Hospital-Partnership working group will undergo a prioritization exercise in May, 2017, to identify areas of focus and associated resource needs. Sustainability and development of this work will rely on the commitment of varying roles within the organization.

The objectives of the Spring Summit were met. Participants engaged in this process have successfully **identified opportunities** for greater physician involvement paired with **tangible ways to action** these opportunities.

A small portion of Summit participants were identified as volunteers to implement these changes; however, broader commitment will be needed to ensure success and will be sought by PHP members once the prioritization activity is complete.

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Appendix A: Summit Participant Listing

PHP: Spring Summit Registration List - Final Attendees List

NAME	DEPARTMENT
Adly, Dr. Eli	Physician, Anesthesia
Ainsworth, Dr. Craig	Physician, Critical Care
Alvarado, Kim	Director Oncology, Critical Care & Palliative Care
Armstrong, Dr. David	Physician, Medicine - Gastroenterology
Arora, Dr. Steven	Head of Service, Pediatric Nephrology
Azzam, Dr. Khalid	Site Chief, Hamilton General Hospital, Medicine
Badzioch, Lillian	Senior Public Relations Specialist
Bedini, Deb	Director Regional Cardiac & Vascular Program
Cameron, Dr. Brian	Surgeon, Pediatric Surgery
Campbell, Kelly	VP, Corporate Services & Capital Development
Campbell, Roger	Inhouse Legal Counsel
Caron, Dr. Sharine	Physician, Emergency Medicine
Centofanti, Dr. John	Physician, Critical Care/Anesthesia
Chari, Dr. Vinjamuri	Physician, Physical Medicine & Rehabilitation
Cloutier, Patrice	Manager, Communications
Collerman, Ari	Chief, Interprofessional Practice
Coupland, Mark	Manager, Seniors, Emergency & Community Medicine
Dal Cin, Dr. Arianna	Head of Service, Plastic Surgery
Davies, Dr. Tim	Surgeon, Urology
Devereaux, Dr. PJ	Physician, Cardiology
Dhamanaskar, Dr. Kavita	Physician, Diagnostic Imaging
Dietrich, Tim	Director, Quality and Value Improvement
Discenza, Renato	EVP, Strategy & Innovation
Domuracki, Dr. Kurt	Physician, Anesthesia
Doppler, Andrew	VP, Human Resources
Dorasamy, Dr. Punginathn	Physician, Medicine - Respirology
el Helou, Dr. Salhab	Head of Service, Neonatology
Elit, Dr. Laurie	Head of Service, Gynecology/Oncology - Surgery
Ellis, Dr. Peter	Head of Service, Medical Oncology

Falzon, Kelly	Director, Women & Newborn Health
Farrow, Mark	VP & Chief Information Officer
Federici, Dr. Guiliana	Head of Service, General Pediatrics
Fernandes, Dr. John	Chief, Laboratory Medicine
Finlay, Dr. Karen	Physician, Radiology
Flageole, Dr. Helene	Chief, Pediatric Surgery
Flaherty, Brenda	EVP, Clinical Operations & COO
Fleming, Dr. Adam	Physician, Pediatrics - Hematology/Oncology
Foley, Dr. Ronan	Physician, Hematology
Fox-Robichaud, Dr. Allison	Physician, Critical Care
Fuciarelli, Susan	Director, Health, Safety & Wellness
Gauthier, Leslie	Executive Director - Clinical Support Services
Gorter, Dr. Jan Willem	Physician, Pediatrics
Gulenchyn, Dr. Karen	Chief, Nuclear Medicine
Halder, Dr. Smita	Physician, Medicine
Hann, Dr. Crystal	Physician, Radiation Oncology
Hastie, Jane	Human Rights & Diversity Specialist
Hastings, Dr. Debbie	Physician, Medicine
Havers, Dr. Melanie	Physician, Anesthesia
Hewitson, Pam	Manager, Authorizing Mechanisms, Policy & Document Mgmt
Hillis, Dr. Chris	Physician, Oncology - Hematology
Hirte, Dr. Hal	Physician, Medical Oncology
Hunt, Dr. Dereck	Physician, Medicine
Hunter, Dr. Andrea	Physician, Pediatrics
Isac, Dr. Michelle	Physician, Anesthesia
Johnson, Dr. Natasha	Head of Service, Adolescent Medicine
Juergens, Dr. Rosalyn	Physician, Medical Oncology
Kelly, Dr. Stephen	Head of Service, Surgical Oncology
Kodis, Jennifer	Director, Seniors, Emergency & Community Medicine
Korman, Dr. Bruce	Head of Service, Otolaryngology
Krull, Kirsten	VP, Quality and Performance and CNE
Lacourt, David	Director of Procurement and Supply Chain
LaForce, Donna	Director, Child & Youth Acute Health Care

Lee, Dr. Stefanie	Physician, Diagnostic Imaging
Lepic, Dr. Kylie	Physician, Medicine
Levo, Aaron	VP Communications & Public Affairs
Leyland, Dr. Nicholas	Chief, Obstetrics & Gynecology
Lipman, Dr. Ellen	Chief, Child & Adolescent Psychiatry
Lloyd, Dr. Rob	Medical Director - HITS, Physician, Pediatrics
Lumb, Dr. Barry	Physician-in-Chief, Medicine
Lysecki, Dr. Dave	Physician, Pediatric Palliative Care
Lytwyn, Dr. Alice	Physician, Pathology
MacDonald, Cindy	Director of Community Programs
MacIsaac, Rob	President and CEO
MacKenzie, Dr. Jennifer	Physician, Pediatrics
Mahmood, Dr. Adeel	Physician, Family Medicine
McCaig, Dave	EVP & CFO, Finance & Integrated Health Information Services
McLean, Dr. Richard	EVP & Chief Medical Executive
Mernagh, Dr. John	Physician, Radiology
Meyer, Dr. Ralph	VP Oncology & Palliative Care
Milinovich, Lucas	Director, Urgent & Ambulatory Care
Miller, Dr. Paul	Chair of MAC, Emergency Medicine
Mondoux, Dr. Shawn	Physician, Emergency Medicine
Montgomery, Dr. Alison	Physician, Medicine - Cardiology
Morris, Beth	Chief, Interprofessional Practice
Morrison, Dr. Katherine	Physician, Pediatrics
Naus, Frank	VP, Research
Nesathurai, Dr. Shanker	Chief, Physical Medicine & Rehabilitation
Niec, Dr. Anne	Head of Service, Child Advocacy - Pediatrics
Oczkowski, Dr. Simon	Physician, Critical Care
O'Leary, Dr. Susan	Chief, Anesthesia
Owen, Dr. Julian	Physician, Emergency Medicine
Pardhan, Dr. Alim	Physician, Emergency Medicine
Patel, Dr. Ameen	Physician, Medicine
Perry, Tom	Public Relations Specialist
Pierson, Sharon	VP Community Medicine & Population Health

Porter, Katie	Director, Research Administration
Principi, Elaine	Chief of Interprofessional Practice & Spiritual Care
Prokopetz, Rosalie	Manager, HR Portfolio
Puchalski, Dr. Stephen	Physician, Anesthesia
Rand, Carol	Director Regional Cancer Programs
Raza, Dr. Samir	Physician, Medicine
Reid, Dr. Susan	Surgeon, General Surgery
Repa, Rebecca	VP Integrated Clinical Support Services & Community Surgery
Reynolds, Marie	Manager, Nursing Resources Team
Ricci, Dr. Chris	President MSA, Anesthesia
Riggs, Denise	Manager, Emergency Department, General Site
Robinson, Karen	Manager, Oncology, GI and Oncology Day Services
Ross, Dr. Catharine	Physician, Pathology
Sawchuk, Dr. Corey	Chief, Critical Care
Schabort, Dr. Inge	Physician, Family Medicine
Singhal, Dr. Nishma	Chair of PHP, Infectious Diseases
Smith, Dr. Ryan	Physician, Anesthesia
Smith, Teresa	VP, Adult Regional Care
Stacey, Dr. Michael	Surgeon-in-Chief
Timko, Dr. Julie	Physician, Family Medicine/Emergency Medicine
Veenema, Pearl	President & CEO, HHS Foundation
Williams, Amy	Director Regional Critical Care & Medicine
Williams, Dr. Dale	Surgeon, Orthopedic Surgery
Wismer, Dr. David	Surgeon, Orthopedic Surgery
Wong, Dr. Jason	Physician, Radiation Oncology
Zukotynski, Dr. Katherine	Physician, Nuclear Medicine
Walker, Dr. Irwin	Chief, Hematology Medicine
Karachi, Dr. Timothy	Physician, Critical Care
Jones, Dr. Graham	Physician, Critical Care
Parasu, Dr. Naveen	Physician, Diagnostic Imaging
Borges, Dr. Bruno	Physician, Anesthesia
Torres-Trejo, Dr. Alejandro	Physician, Neurology
Dath, Dr. Deepak	Surgeon, General Surgery

Markose, Dr. George	Physician, Diagnostic Imaging
Missiuna, Dr. Paul	Surgeon, Orthopedic Surgery
Oczkowski, Dr. Wes	Physician, Medicine

Appendix B: Summary of Breakout Group Session

TABLE #1 : Kara Campea Langdon					
top 5	Type of Decision	Example	Well	Not Well	Opportunity
	Corporate Policy	HSW i.e. Violence in Workplace (S. Fuciarelli)	√		Front line involvement up front. Physician involvement up front; (implementation involvement working well.)
	Staffing Model	Clinical Monitors (EA), there was Chief involvement; research – Craig Ainsworth	√		
	Resources	Echo machines – involvement from beginning of process (pre- RFP); not as much physician front line. – Craig Ainsworth	√		Front line involvement up front. Physician involvement up front; (implementation involvement working well.) Close relationships help make success of involvement
	Clinical Services	Stem cell (RF); admin helped with IT etc.	√		*open lines of communication helps with understanding of decisions (Craig Ainsworth)
	Operational (day-to-day)	Cath Lab – Deb Local level decisions (Shanker Nesathurai) – admin support etc.	√	√	Physician upfront in decision – making. (implementation involvement working well)
	Strategy	big picture STRATEGY – less involvement; involvement (not) x decision; (yes) √ implementation (Shanker Nesathurai)	√	√	Chief involvement (not as much front line). Implementation involvement is working well – but need physician involvement up front in decision – making.
	Engagement	PHP Agreement – contract not the right option. Need the tools		√	Need to build relations; conversation. Representation – participate or know

					representation to feel involved (*representation for decision-making)
	Strategy	Strategic direction – has Chief involvement now. Other Chiefs (division level) are at higher decision levels ie: Rehab rep. (Shanker Nesathurai)	√	√	- bottom up; frontline involvement *Parking Lot – Leadership Positions
√	**Budget**	Physicians are told decisions		√	Get involved at target phase; not at predetermined "options" – build the options.
	Bed Management	At unit level – work life + friction out of the day.		√	More consideration to work life. Physician involvement in management portion – meetings.
	Corporate Decision	Echo-balancing wait lists	√	√	Front line involve

TABLE #3 : Judy Baxter-Foreman					
top 5	Type of Decision	Example	Well	Not Well	Opportunity
	Unit-based Care (processes) #1	F3/E3/B3 @JH: interdisciplinary rounds moved rom 4 to 2 days/wk. (there was duplication); Walkabouts with physicians with IT re: 'WOWS' placement; implemented bullet rounds; white boards; referral process; resident welcome sessions	√		
	Unit-based Care (processes) #2	E3/B3 unit – scope cleaning; stem cell	√	√	Too much effort to involve – ie: time – what do "I" need?
	Resources/Procurement	• Cardiac pacemakers & ICPs – directly engaged; • trial of new microscope (too big, went for less expensive); • trial of gel foam in OR;	√ √ √		Clear communication re: rules of engagement Dr's need to understand "why's"

		• bone marrow biopsy needles – change didn't happen..told then • penlax vs. Olympus scopes; peri-op		√ √	If it's going to impact their practice – engage before
	Operational day-to-day	Practice changes (larger HHS) & hematology referral changes; co-leadership QBPs (Kirsten Krull); implementation practice changes with tracheostomy care; quality/pt safety planning process – need more started; development of hospitalist role; NSQIP role out		√	Knowing "why" decision is made; Involvement in incident management crisis
√	**Budget**	Peri-op budget cuts (BK)	√		
	Space	Move preop to UC		√	Earlier engagement with doctors
√	**Staffing**	GI on-call endoscopy– need a nurse (how did decision get made?) – hierarchy of decision making (only 1 person = the manager)		√	Shadowing to increase understanding of other perspective use context of patient story
	Other ideas for involvement not aligned to a specific example:				- transparency - integrity - impact on individual's continuum - structure of work day (electronic after hours = reality; webinar) - talk at meetings – make decisions at meeting -authentic - close the loop

TABLE #4 : Kathy Peters					
top 5	Type of Decision	Example	Well	Not Well	Opportunity
	Space	Learner space issues – sat down together; problem solved; received resources/equipment; heard from all levels	√		
√	**Staffing**	Union staff/nursing ratio – how would that impact you? This was a "fire" then money was brought in		√	Clarification around a decision-making structure Mitigate risks; pt. care; planning ahead; physicians have solutions but not contacted; talk to end user to make impact less
√	**Budget**	Lack of transparency around resources by site (perception = uneven resource allocation) = advantage vs. disadvantage programs (Ameen Patel) further – the nurse staffing ex. – money was brought in as it was a 'fire" but core/base programs haven't received new $ (complexity of care & workload increase, meeting benchmarks ie CCO)n and they are the backbone of the hospital – paternal feeling (dismissive)		√	More transparency; dissemination; realistic expectations; bring budget to meetings, incorporate into conversations regularly; bring budget with a reference bar – fairness Share budget report – clear expectations for physician rep
	Process	Changes ie: Bradma – patient safety impact	√		Know how committees are formed – getting the right voice Quality committees - opportunity
	QBPs	Research for KT; active, co-leading working group. Physician lead personally reaches out to group re: decision-making, practice (Kim A)	√		
	Clinical Decision	Order entry		√	1 physician does not represent all sites. Multiple reps at physician level.

					Continuous involvement – don't make changes without engagement
	IT/Resources	Computers – struggle to look after pts., asked unit manager, site chief etc. for 4 years – Dick & Rob come to unit to see = got results		√	Close loop of communication
	Other ideas for involvement not aligned to a specific example:				- mechanism to get grassroots messages; address them at each site; elevate themes - physician reps: clear expectations; how to disseminate; outline their role; service head meeting at site – engage by key decisions - not sure who to go to with ideas (interim outside of CQI for ex. N. Singhal) - smaller groups may be easier (eg. Critical care clinic)

TABLE #5 : Julija Kelecivic					
top 5	Type of Decision	Example	Well	Not Well	Opportunity
√	**Staffing**	Home/community outpatient program – change in RN without being involved in interviews; decreased to .5 FTE; no info re: work evaluation; logistics; 25-30 pts without nutrition		√	Interact with different parts of ors (our system?) Communication Patient experience
√	**Equipment**	Critical care – supplies/change scalpels and not able to correct monitors. Also ER/OR. Organizer perhaps informed.		√	
	Clinical Programming	1) Change in practice? Other groups GI, Surgery. Endoscopy committee - CO2. Cost/benefit	√		

		analysis PFC 2) Change outpt hours radiology – got email but changed back with engaged WLMH not knowing the pt. experience & practice		√	
	Practice Standard	How to manage type of practice – critical care, dialogue with clinical manager; dialogue with company; dialogue re: business plan; cost/benefit analysis	√		
	Site Redevelopment	@WLMH; meetings, planning; at physicians environment	√		
√	**Budget**	Structure of ORs - decrease cost; usage; came together for other options; engaged	√		Know budget info., staff plan & business plan, EB plan at Quality Council
	Other ideas for involvement not aligned to a specific example:				Central line of communication Mac ORs "location of" ie: in OR Post-correction feedback session earlier: • Not clear what questions we need to answer • Clear parameters re: decision (everything isn't as important) Know where to go – process; trust; understand role & responsibility of docs' representation

TABLE #6 : Sandra Ramelli					
top 5	Type of Decision	Example	Well	Not Well	Opportunity
	Process	Peri-op clinic – improved process & flow, involved in discussion and listened to	√		
		ICU at the JH – support for staff & physicians in making a difficult decision; admin & physician leaders seen & act as partners	√		
	Clinical Realignment	Driven by physicians; at every level of decisions there is a partnership	√		
	Communication	1) We rely on physician leader to involve physicians – frontline Not having a process to get to frontline (diversity of opinion at the frontline – individualized issues) 2) Admin/Physician leader – there needs to be a relationship or may feel under *appreciated?*		√ √	How do we engage physicians who are accountable to physicians?
	Equipment				
	Workflow	Changes to ward/clinic (clerks) - FYI			Input into staffing #s & models
√	**Innovation/Technology**	EMR; new technology			
	Policy	Transition from peds to adults			
	Other ideas for involvement not aligned to a specific example:				- Need to know who to go to – physicians get a letter "who is who" - decision-making structures "what are they?" - committees (how to get on them?) - concept – implementation – measurement: conceptualization, give input, influence, be part of the decision-making process in relation to the scope of the decision being made

TABLE #7 : Sandie Lloyd					
top 5	Type of Decision	Example	Well	Not Well	Opportunity
	Operations	• Hiring Clinical Manager (J.Kodis) • Physical planning (pre-op to urgent care) • Administrative staff hiring (R.Lloyd) • Model of care + complex hematology (Dr. Z) • Systems upgrades (Dr. KD) • Transplant capacity • Equipment purchase – ventilator (R. Repa) • Development of clinical protocols & policies • ABC - implementation • Authorizing mechanisms • Clinical Ops – corporate decision making • Outpatient EMR (R.Lloyd)	√ √ √ √ √ √ √	 √ √ √ √ √	
	Quality & Best Practice	• End of life policy (P.Miller) • Model of care + complex hematology (Dr. Z) • Accreditation – transplant (Dr. Z) • Critical Incident – root cause, always on call, presentation to committee (R. Repa) • Development of clinical protocols & policies	√ √ √ √	 √ √	

		• Outpatient EMR (R.Lloyd)			
	Safety	• Critical Incident – root cause, always on call, presentation to committee (R. Repa) • Outpatient EMR (R.Lloyd)	√ √		
	Innovation	• Model of care + complex hematology (Dr. Z) • Summit (P.Miller)	 √	√	
	Resource Allocation	• Transplant capacity (Dr. Z) • Equipment purchase – ventilator (R. Repa)	 √	√	
	Leadership	• Physician Chiefs – is there enough physician involvement in hiring?		√	
	Strategy	• ABC – implementation • Authorizing mechanisms • ELT (B.Lumb) • Board	√ √ √ √		
	Other ideas for involvement not aligned to a specific example:				- skill set in engaging physicians - timing – when is it appropriate to attend (meetings) - Selection & who - lack of administrative involvement - University acknowledgment

TABLE #8 : Kathryn Adams					
top 5?	Type of Decision	Example	Well	Not Well	Opportunity
	New Programs and Facilities	• Unit Design (Sharon) – (Not enough involvement, only selected involvement/no involvement in decision making) & (Engagement of MDs from the outset and in all aspects) • Build breast assessment centre (Carol) (didn't know what we didn't know) • Building of Ron Joyce (Wilson) – not enough lead time • Move of child & youth mental health from SJH to MUMC – did not reach out to physicians	√	√ √ √	Broader involvement More lead time Involve Senior Trainees in Our Healthy Future—they ARE the future
	Sustainability	• Finding Efficiencies (aka cuts) Stephen • Our Healthy Future (Alison, Sharon, Wilson) - Because physicians were involved (decisions impact them, engagement of MDs from the ground up – involve at the outset Q – were all MDs involved or just select group?	√	√	Identify and consult all stakeholders
	Clinical Changes	• Reorganizing OR Blocks (Stephen, Alison) • Opening and Closing Beds (All) Went well re above: because physicians were involved as decisions impact them Not well re above: were all MDs involved or just select group? Didn't know what we didn't know; not enough lead time; did not reach out to physicians	√	√	Minimize abrupt changes, ensure changes include consultation (to the extent possible) and transparency (if urgency limits consultation)

	Quality Improvement Initiatives	• Simulations GIMRAC (Alison) • Performance measures (Sharon/Steve) Went well re above: engagement of MDs from the ground up – involve at the outset Not well re above: ensure physicians are aware of the implications (ie why it's important to document the expected date of discharge – implications of not doing it)	√	√	Broader dissemination of information re performance measures and consider impact on workflow
	Supporting Learners	• Centre for People Development (Alison) • Preparing new physicians to work/make decisions (e.g., how the hospital works, policies and procedures, how equipment works) (Alison) Went well re above: listened to what is important to MDs (programs and MOC credits) Not well re above: are physicians involved in designing physician orientation?	√	√	
	Communication	• Transparency of information—are physicians aware of the opportunities to be involved in hospital decisions/projects? (Katherine) • How do physicians get involved in what they are passionate about? (e.g., what is the long term plan to replace capital equipment? How do $ allocations get made—appears all $ goes to the HGH – Stephen, Katherine) • Changes to support staff-no communication to physicians (Wilson) Not well - Gaps in communication-		√	The university puts out a call for physician participation—works well as it gives physicians the opportunity to get involved in what is important to them Transparency regarding replacement of capital equipment and decision making process Involvement in interviewing on units? At minimum-keep advised of changes

		opportunities for participation, how decisions are made, communication of changes			Put decisions in context-background and rationale Open door policy—answers to questions Committees should always be interprofessional If asking for input: LISTEN TO IT Connect input to outcome—what happened with your feedback-how was it reflected in the final decision? Consider timing when scheduling meetings that involve physicians-give enough notice, understand that they are losing income Create opportunities for physicians to know each other (including front line) within and across portfolios Which Executives have which portfolios?

TABLE #9 : Charmaine Sherlock					
top 5?	Type of Decision	Example	Well	Not Well	Opportunity
	Resource Allocation	• Dept. of Surgery – prioritization of periop/capital (Dr. Stacey): spending/operating budget; input-communication; over a few meetings; equip. • Radiology MR machine broken; looking at "new" magnet; managers & physicians agreed to get NEW • ODS input-output – physicians very vocal about what they need (phantom empty bed) • Open-hear valve (procurement), periop, hybrid OR	√ √	√	
	Clinical Services Planning & Innovation	• Hamilton centre for vascular (T. Smith): 5 different disciplines, proposal • Boris Clinic (Dr. Hunt): clinical programming, surgical, OR blocks/anesthesia/directors, physician input, pt. quality: interprofessional team/physicians;	√ √		
	Strategy	• ABC 2010 (based on 2004 blueprint): 2million because rooms weren't reconstructed properly JH Radiology; Ran oncs involved at every step; more involvement/input (Naveem)		√	Make sure the right people are at the table, patient population; Message needs to travel to peers Make sure those invited can come
√	**Operations/Budget**	• Pre-Op clinic moved (JH-MUMC); involved **a** physician, need to involve those impacted and involve EARLY; timing and "how", be transparent/frame the context.		√	

		• Re-structuring exercise – never saw the output; need feedback loop closed • Hospital/University – sometimes no decision is made, can be frustrating, no innovation happens; financial constraints/status quo (ie TAVI/mitrovalve); economics of standardization/balance		√ √	*creativity = energizing
	Quality Improvement	• Performance management/360: gap between grassroots & MAC, Chiefs & Admin, need dialogue early on (*two way communication); being heard; transparency; JK ex: the how (K. Robinson)			*sometimes the roadblock isn't clear *fatigue issue/less engaged over time

TABLE #10 : Janie Lucas					
top 5?	Type of Decision	Example	Well	Not Well	Opportunity
√	**Budget**	• Budget planning all levels • Stroke program development – separate mandate; spec. guidelines, global $, common vision/goals • Budget reductions – 2% down etc. (equity/transparency) sounds punitive; ask for suggestions	√ √	 √	Balance trust re: decisions Transparency (admin doesn't know what MDs don't know and vice versa)
	Clinical Services Planning	• Design acute care surgery program • Endo clinic MUMC • Hospitalist program implementation • Outpt. Neuroscience plans/budget/ resources/learners • APS at JH – dismantled – not included	√ √ √ √	 √	

		in decision			
√	**Staffing**	• Front line hiring practices – gaps/holes, not involved, surprises • Ambulatory setting MUMC – not involved in planning of people resources • Outpt neuro clinics (EEG) – staffing needs/scheduling		√ √ √	More collaboration
	IT	• Inefficiencies – physical locations of PCs • New Meditech pre-planning	√	√	
	Quality/Standardization	• Pre-printed order sets (all sites/specialties) • CQI huddles, improvement work • MD input, frontline consulted; MD/Learners process in place	√ √ √		
	Strategy	• Our Healthy Future – initiative, planning, discussions			
	OTHER	• PED resources (past volumes) • MAID program • Flow changes ED General • RACE team development • Irritants smaller local improvement opportunities “fixable” bureaucracy	√ √ √ √	 √	

TABLE #11 : Deb Denman					
top 5?	Type of Decision	Example	Well	Not Well	Opportunity
	Procurement/Purchasing	• Prostheses – ex. of excellence in patient care – balancing cost with good patient care; good collaboration • Bought a new bed, did not ask physician or nurse, bed not a good fit = wasted money	√	√	
	Model of Care	• MUMC – ABC, development of women's unit (obs, critical care); input from multiple sources (physician/ • nursing) - collaboration	√		
	Strategy	• Cancer Centre, strategic planning & retreat planning, involvement from the beginning & priority setting • Move to ABC and shift to MUMC to children's hospital. The consequences of this decision was not known. Long term anger & upset was a result even after the decision is long implemented.	√	√	
	Service Delivery	• Rapid cardiology referral program, (physician identified initiative), collaboration b/w ED physicians and internal cardiac • Ortho – through ABC (how to make it work) – collaborative, early involvement. Ortho/Internal Medicine – strong physician input; hospitalist model of care..(*went well isn't everyone's perspective)	√ √	√	Early engagement & transparency, context if very important & explanation of why this is important Develop deeper understanding Acknowledge input was considered – even if it wasn't followed = building trust and transparency; we don't always agree but can ensure

					understanding
	IT	• Mosaic – impacted every day life of front line health care. Big changes for physicians/nurses. Physician push back prior to implementation – front line didn't know what to expect. • Epic EMR – lack of involving stakeholders up front.		√	Involve stakeholders (those affected and those lacking responsibility)