Supplementary Report

Kelowna General Hospital Paediatric Services - An Exemplar to Review
MAC Communication, Physician Recruitment and Retention, and Paediatric Service Planning

Respectfully Submitted To:

Dr. Robert Halpenny, Chair, Interior Health Board

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Introduction

In addition to reviewing cultural issues impacting paediatric service delivery at Kelowna General Hospital, this report explores opportunities to: 1) improve communication between the Medical Advisory Committees within Interior Health; 2) enhance physician recruitment and retention; and, 3) improve service planning for paediatrics within IH; using the issues involving the KGH Department of Paediatrics and paediatric service delivery as exemplars.

1. Medical Advisory Committees (MAC):

Current and former MAC Chairs at the various MAC levels were interviewed specifically as part of this review. Additional information was garnered through interviews conducted with current and previous department heads at KGH, who participated as members of the KGH LMAC.

The medical advisory committee structure within IH includes local medical advisory committees (LMACs) at each hospital, four regional medical advisory committees (RMACs - Thompson Caribou Shuswap, Okanagan, Kootney Boundary and Kootney East) and a health authority medical advisory committee (HAMAC).

A. Structure, Function and Orientation:

LMAC membership consists of the department heads (voting members), together with senior hospital medical and operations administration (voting and non-voting members). The processes to select LMAC Chairs across IH appears inconsistent. At KGH, the Chief of Staff (CoS) currently holds this position. At Royal Inland Hospital, the LMAC Chair is selected from among the hospital medical staff by the CoS based on seniority, experience and perceived abilities. Neither process appears to require LMAC members to ratify the selection of the LMAC Chair before Board approval. Selection of LMAC Chairs at the smaller hospitals was not reviewed.

The Regional Medical Advisory Committee Chairs are held by the Chiefs of Staff (CoS) for the regional hospitals within each region (KGH, RIH, KBRH, EKRH) with RMAC membership including the LMAC Chairs and CoS of the hospitals within the region and senior regional medical and operational administrative leaders. The role of the RMACs was unclear to many as most interviewed spoke of moving issues directly from the LMACs to the HAMAC. However, the RMAC meetings were seen as a valuable opportunity to discuss complex inter-site issues by the CoS who attend. However, the RMAC was not seen as having a fundamental role in the elevation

of issues from an LMAC to the HAMAC. Participation in the RMAC meetings was perceived as much less robust than at either the LMACs or the HAMAC perhaps reflecting the unclear role of the RMACs. Although, privileging recommendations from the hospitals within a region are ratified by the RMACs before proceeding to the HAMAC this was not viewed as an essential step.

The membership of the HAMAC has grown organically with a review currently underway to rationalize and formalize its membership.

Medical staff enter administrative roles with varying levels of experience at the local, and regional level. As this relates to the MACs, several of those interviewed reported a lack of orientation to their role as a MAC member or Chair and stated that they "learned on the job" and did not fully appreciate their roles, responsibilities, or accountabilities until well into their participation as a member.

Recommendations:

1. Formalize a consistent process by which LMAC Chairs are selected across IH. This could involve a small group of members or single member of the LMAC (dependent on hospital size) identifying potential candidates for consideration by the LMAC. Candidate selection can then be ratified by the LMAC and forwarded to the Board for approval.
2. Ensure that the LMAC Chairs are independent from hospital medical administrative positions such as the Chief of Staff to avoid real or perceived conflicts of interest.
3. Consider use of a small stipend for each hospital to support the LMAC Chair and incent separation of this role from other medical administrative roles.
4. Consider eliminating the current RMACs, and in their place provide opportunity for CoS of the larger "Big Six" and separately, the smaller hospitals, to meet regularly. The opportunity to discuss complex inter-site issues was seen as highly valuable particularly by the CoS of the larger hospitals.
5. Membership on the HAMAC, in addition to the Board Chair and CEO, needs to effectively represent IH geographic regions, regional versus smaller community hospitals, regional programs, as well as senior medical and operational leadership within IH. Inclusion of representatives from the non-physician medical staff within IH (e.g. dentists, nurse practitioners and mid-wives) may be of benefit. Striking a balance between HAMAC members who hold IH senior medical/operations administrative positions and HAMAC members who are selected by medical staff to represent them (for example, MSA Presidents; LMAC Chairs) is important to consider.
6. Review of existing or development of new orientation documentation and formalization of orientation processes for both members and Chairs at the various MACs is recommended.

7. Regular (for example bi-annual) quantitative (e.g. member surveys) and qualitative (terms of reference, mandate and documentation) review of the function of each MAC is recommended. This process provides additional review for members and Chairs as to their roles, responsibilities and accountabilities and facilitates more nimble adjustments to ensure optimal functioning at each level.

B. MAC Communication:

Based on those interviewed, the lack of formalized workflows and criteria for elevating issues from the LMACs to the HAMAC results in inconsistent, ad hoc and at times person dependent processes with resulting perceptions of a lack of transparency at the LMAC member level. The lack of formal processes/mechanisms to communicate HAMAC decisions/discussions back down to the LMACs further contributes to the sense of issues disappearing into an opaque process. The organic evolution of the MAC committees' roles and relationships seems to have led to the ambiguity in these communication pathways.

Furthermore, it is currently unclear how issues, outside the four major regional hospitals (Kelowna, Kamloops, Trail and Cranbrook), are raised to the attention of HAMAC as the RMAC Chairs reportedly find themselves primarily representing their own hospitals at HAMAC given the complexity of issues they are managing and the meeting time constraints.

We also heard that briefing notes (from committees and departments) required multiple levels administrative review and approval prior to submission to HAMAC and that Briefing Notes could be pulled from the HAMAC consent agenda and not tabled with no explanation given.

There was a shared desire by all to create transparent, formalized and closed loop communication between the LMACs and HAMAC generally and to have available a system to fast-track significant/crisis issues related to service delivery and quality/safety of care from the LMACs to the HAMAC.

Recommendations:

8. Create formalized pathways to identify, ratify and communicate issues in a closed loop manner between LMACs and the HAMAC.
9. Create formalized fast-track pathways to identify urgent/emergent quality/safety and service delivery issues in a closed-loop manner to the HAMAC. Establishment of weighting criteria and local/regional impact criteria may be helpful in this regard to ensure appropriate use of this system.
10. As 4 above, consider reviewing the need for the RMACs in their current role. In terms of communcation there may be more benefit in having the Chiefs of Staff from the "Big Six"

hospitals (Kelowna General Hospital, Royal Inland Hospital, Vernon Jubilee Hospital, Penticton Regional Hospital, Kootney Boundary Regional Hospital and East Kootney Regional Hospital) meet regularly as they are understood to share more in common. This type of meeting would fall outside the medical advisory committee structure. Thus, determining appropriate representation at HAMAC with the elimination of RMAC Chairs is necessary. At the same time, a similar forum for the Chiefs of Staff of the smaller hospitals to meet regularly may be of benefit for similar reasons also with a vehicle identified for representation of smaller hospitals at the HAMAC. Protection of these medical operations meetings under Section 51 legislation requires a legal opinion.

2. Paediatric Service Planning:

The Medical Directors and Program Director of the maternal, newborn and paediatric program as well as senior IH medical and operational leadership and current and former department heads of the paediatric department and other departments at KGH were interviewed. Review of existing paediatric tiers of service (ToS) documents (2018) for IH occurred – note these are currently being refreshed.

Those interviewed repeatedly emphasized the importance of access to paediatric specific data at the hospital, regional and health authority level. They also noted the challenges in obtaining data to undertake either quality improvement or service planning initiatives. Significant gaps in pediatric-specific data collection and quality frameworks were identified, hindering efforts to monitor and enhance care quality in paediatrics. Opportunities for innovation in clinic models and professional structures were highlighted, with a call for the adoption of interdisciplinary, resource-sharing approaches to optimize pediatric care within the regional hospitals.

There was a strong perception that until the recent crisis, paediatric care and service planning was not a priority for either the Ministry of Health or the health authority as evidenced by its absence in the MoH Mandate letter to the IH Board Chair and an expressed position by IH senior leadership that the mandate letter drives its focus and strategic plan. Nonetheless, planning for populations and services not specifically called out in the Mandate letter, must continue and reflect the health care needs of these populations. During this time of fiscal restraint this is a challenging but necessary task.

Those involved in paediatric care and service delivery expressed unified willingness to discuss what they perceived as necessary enhancements in paediatric services, were open to understand what IH's constraints were (fiscal and otherwise) and wanting to plan forward in partnership "what is possible now to address this issue with what we have" and "what do we need to plan for on a longer time horizon". This is a different and more collaborative conversation than "we can't do that…there is no money".

One of the positive outcomes of the crisis within paediatrics at KGH was the transition of the Maternal-Newborn-Paediatric (MNP) Network to the MNP Program. This transition has resulted in increased resources being made available, including a strategic planner, a full-time quality person, project managers, and an assistant director. There is now a Steering Committee for the Program with plans for a Paediatrics Working Group to assist with paediatric service planning for IH. The Paediatrics Working Group would benefit from representation across all appropriate ToS as well as regional subject matter expertise (i.e. department heads and operational leaders from the T3 & 4 Hospitals). The MNP program will need to engage on a regular basis with the Paediatrics Working Group and in instances where external drivers (e.g. transport; other Health Authority's needs) impact service planning feasibility there is then an opportunity to bring external partners to the table. Increased connection across the region will facilitate more comprehensive representation of the IH MNP program at provincial tables.

Recommendations:

1. Increase access to paediatric specific data to facilitate planning and quality improvement at the hospital, regional and health authority level. Currently, limited paediatric data points impact data analysis.
2. Consider a co-medical directorship or alternating medical directorship model for paediatrics within the MNP program with representation from KGH and RIH as the two Tier 4 regional hospitals.
3. Maintain the enhanced supports for the MNP program.
4. Communication of the recommendations for paediatric service planning by the MNP Program Steering Committee and its Working Groups to the IH Senior Executive Table should occur in a closed loop manner – this will enhance communication, transparency and trust.

3. Recruitment and Retention:

There was a recognized need for creative recruitment and retention strategies in the current environment of physician shortages in many specialties.

A. Recruitment:

Interior Health Physician Recruitment manages physician recruitment in partnership with the "hiring lead" (department head) with the Physician Recruitment team members reportedly collating and screening applicants and forwarding suitable candidates to the "hiring lead" (department head) for further evaluation. Over the past year, communication breakdowns during paediatric leadership transitions and turn over within the physician recruitment team resulted in lost recruitment opportunities. There was a reported lack of clarity regarding who was responsible for various aspects of the recruitment process and concerns expressed that IH Physician Recruitment was not partnering effectively with hiring leads to inform the recruitment

strategy and approach. Delays in funding approvals for site visits by potential candidates also created challenges in ensuring nimble and timely recruitments. There are perceptions on both sides that the "other side" had not done their part in terms of recruitment (i.e. appropriate leads were not followed up by Physician Recruitment and appropriate potential candidates identified by IH Physician Recruitment were not reviewed by the hiring leads). The resultant tensions, additionally informed by hiring challenges among other specialties within IH, have resulted in some senior administrators advocating to remove the responsibility of physician hiring from the department head/departments at the various hospitals and to centralize this as a function of IH Physician Recruitment within the Office of Medical Affairs. Removing the responsibility of physician hiring from the department head/department will limit the success of recruitment and runs the risk of creating challenges for newly hired physicians in terms of positive connections with their departmental colleagues and could negatively impact retention.

Recent stabilization within the physician recruitment team and the recruitment of the new paediatric department head was seen as helpful as it relates to continued hiring of paediatricians for KGH.

Recommendations:

1. Creating a cohesive partnership between the Office of Medical Affairs, IH Physician Recruitment and Department Heads (hiring leads) is essential for successful recruitment and retention of newly hired physicians. The recommended culture work will assist in facilitating this.

2. Given the current physician shortages across many specialties both nationally and globally, ensuring that IH Physician Recruitment follows up on all potential candidates in a timely manner and that the department heads follow-up and interview all appropriately screened candidates who meet their hiring criteria, is essential.

3. Having the recruiting department/hiring lead establish a priori minimum qualifications (beyond meeting requirements for licensure in BC) in advance of recruitment will aid in ensuring that candidates identified by Physician Recruitment as meeting these requirements are reviewed by the hiring lead/department and if not, serve as an audit tool for further enquiry.

4. Facilitating recruitment efforts, for example by leveraging Foundation Funding, to enable short-listed candidate visits in a timely manner will be helpful. In some situations, Foundations will make available a funding pool toward these efforts which makes this process much more efficient.

B. Contracts and Payment:

Inefficient contract and payment processes pose significant barriers to effective recruitment and retention. Physicians reported undertaking locum tenens work prior to receiving the contract and then experienced significant delays in payment. This dissuaded some from considering permanent work at KGH.

Recommendation:

5. Couple the recruitment process (regular or locum) tightly to contracts and finance to ensure that letters of offer, contracts and payments occur in a timely manner.

6. Regular monitoring of timing benchmarks by SET will assist in ensuring that inefficiencies in these processes are not contributing to physician recruitment and retention.

C. Paediatric Service Model:

The KGH department of paediatrics has grown organically relying on paediatricians with community-based practices being privileged at the hospital and providing paediatric service coverage. As KGH has evolved the required expertise in some areas (e.g. NICU and paediatric critical care) is pushing the comfort of the general community-based paediatricians. In addition, when recruiting from outside the community, province or country potential recruits want economic certainty and, in many instances, may prefer or based on sub-specialty training (e.g. NICU or paediatric critical care) want a solely hospital-based practice. Continued reliance by the department on the blended community-based model, rather than a hospitalist-based model or a blend of the two, means that if the community need for paediatricians is saturated and the number of physicians required to cover the hospital is not satisfied the department remains reliant on locums to ensure full coverage of the service. Use of locums to regularly ensure coverage creates unnecessary strain on the department head and uncertainty in the schedule. The current paediatric APP enables establishment of a hospitalist-based model which will enhance the department's ability to recruit and reduce department head turn-over due to burn-out.

Current KGH paediatric APP contracts specify a contracted hourly or shift rate and do not specify minimum work hours per physician per annum. This leads to inconsistent staffing and difficulties in scheduling as there is no lever for the department head to encourage or require a specific amount of service coverage by any individual. The value of an FTE within the department of paediatrics is currently determined by the number of paediatricians the department believes it requires to cover the services rather than by the service coverage required by the hospital. For example, if the department sees itself as functioning well with 2 shifts every 24 hours and members are happy with 1:6 call they would privilege 12 "FTE" (department members). However, each member is not obligated to a specific number of shifts or hours of work within

the hospital. The interchangeable use of the term “FTE” in this way is confusing and does not facilitate service planning for the hospital/IH.

Recommendation:

7. Consider establishing a paediatric service planning model that identifies the paediatric services required by the hospital, demand for each, the hours of coverage per annum for each and an hours-based definition for FTE. This will clarify the number of paediatricians required for each service which can then be adjusted as regional and community needs (demand) contract or expand. This type of modelling accommodates those who work part or full FTE according to hours per annum enabling flexibility and certainty in scheduling. This will require APP funding which is currently available for paediatrics and may soon be available for NICU coverage.

D. Retention:

Prioritizing retention is essential. There is current concern that despite significant efforts to recruit several new paediatricians to KGH recently, their retention is at risk.

Recommendations:

8. A focused commitment by the CEO and Board to facilitate the rebuilding of trust between physicians (in this case paediatricians) and IH senior leadership is essential.

The culture work that IH senior administration is committed to working on together with the KGH paediatricians, to rebuild trust and enable open communication will markedly enhance the likelihood of retention within the department of paediatrics. This will require a reset and letting go of the currently held narratives [for example, “physicians have lost their way and forgotten about the social contract…physicians have moved from patient focused back to physician focused” and “they [administration] do not care, do not listen and are only responsive in a crisis”]. Adopting a curious stance to understand pressures, perspectives and experiences on both sides is essential in this effort.

9. Facilitate and enable the non-monetary reasons that attract physicians to work in the hospital – this is critical particularly in settings where community-based physicians are relied on to provide hospital-based care. Engagement in quality improvement, program development, interdisciplinary care and teaching are a few examples. Financial enablers via the Shared Care Committee and Specialist Service Committee Facility Engagement funding and other Doctors of BC avenues are supportive in this regard.

10. Celebrating the activities in 2 above, within the hospital and health authority, demonstrates their importance to health authority and hospital leadership and are ways of acknowledging and showing appreciation for the work of physicians, other medical staff, nurses and allied health staff.

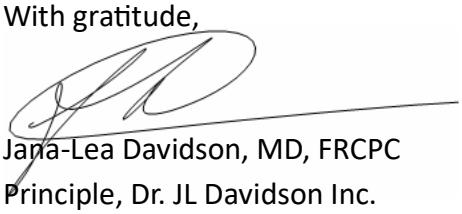
11. IH should consider the establishment of a medical staff occupational health program either on its own or in partnership with another health authority to leverage economies of scale, leveraging lessons learned by VCH and PHSA. The creation of medical staff occupational health programs within VCH and PHSA sent a clear message to medical staff that they are valued by the Health Authority. The demands placed on IH's medical staff over the past five years (COVID-19; flooding; fires; escalating workloads; resource constraints) have exacted a heavy toll. In this context a medical staff occupational health program is likely to aid in ongoing medical staff retention.

Conclusion:

It was a distinct honour and privilege to undertake this review. The passion and commitment of all those interviewed was palpable. Despite the recognized challenges, those who reside within the boundaries of Interior Health are fortunate to have such dedicated individuals working within their health care system.

I would be pleased to discuss this review and the recommendations further at your convenience.

With gratitude,



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APPENDIX A – CONCISE SUMMARY OF RECOMMENDATIONS

1. Medical Advisory Committees (MAC):

1. Formalize a consistent process by which LMAC Chairs are selected across IH.
2. Ensure that the LMAC Chairs are independent from hospital medical administrative positions such as the Chief of Staff to avoid real or perceived conflicts of interest.
3. Consider use of a small stipend for each hospital to support the LMAC Chair and incent separation of this role from other medical administrative roles.
4. Consider eliminating the current RMACs, and in their place provide opportunity for CoS of the larger "Big Six" and separately, the smaller hospitals, to meet regularly.
5. Membership on the HAMAC, in addition to the Board Chair and CEO, needs to effectively represent IH geographic regions, regional versus smaller community hospitals, regional programs, as well as senior medical and operational leadership within IH. Inclusion of representatives from the non-physician medical staff within IH (e.g. dentists, nurse practitioners and mid-wives) may be of benefit. Striking a balance between HAMAC members who hold IH senior medical/operations administrative positions and HAMAC members who are selected by medical staff to represent them (for example, MSA Presidents; LMAC Chairs) is important to consider.
6. Review existing or develop new orientation documentation and formalize the orientation processes for both members and Chairs at the various MACs.
7. Regular (for example bi-annual) quantitative (e.g. member surveys) and qualitative (terms of reference, mandate and documentation) review of the function of each MAC is recommended.
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10. As 4 & 5 above, consider reviewing the need for the RMACs in their current role.

2. Paediatric Service Planning

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3. Maintain the enhanced supports for the MNP program.
4. Communication of the recommendations for paediatric service planning by the MNP Program Steering Committee and its Working Groups to the IH Senior Executive Table should occur in a closed loop manner.

3. Recruitment and Retention

1. Creating a cohesive partnership between the Office of Medical Affairs, IH Physician Recruitment and Department Heads (hiring leads) is essential for successful recruitment and retention of newly hired physicians. The recommended culture work will assist in facilitating this.
2. Given the current physician shortages across many specialties both nationally and globally, ensuring that IH Physician Recruitment follows up on all potential candidates in a timely manner and that the department heads follow-up and interview all appropriately screened candidates who meet their hiring criteria, is essential.
3. Having the recruiting department/hiring lead establish a priori minimum qualifications (beyond meeting requirements for licensure in BC) in advance of recruitment will aid in ensuring that candidates identified by Physician Recruitment as meeting these requirements are reviewed by the hiring lead/department and if not, serve as an audit tool for further enquiry.
4. Facilitating recruitment efforts, for example by leveraging Foundation Funding, to enable short-listed candidate visits in a timely manner will be helpful. In some situations, Foundations will make available a funding pool toward these efforts which makes this process much more efficient.
5. Couple the recruitment process (regular or locum) tightly to contracts and finance to ensure that letters of offer, contracts and payments occur in a timely manner.
6. Regular monitoring of timing benchmarks by SET will assist in ensuring that inefficiencies in the processes in [5] above are not contributing to physician recruitment and retention challenges.
7. Consider establishing a paediatric service planning model that identifies the paediatric services required by the hospital, demand for each, the hours of coverage per annum for each and an hours-based definition for FTE.
8. A focused commitment by the CEO and Board to facilitate the rebuilding of trust between physicians (in this case paediatricians) and IH senior leadership is essential.
9. Facilitate and enable the non-monetary reasons that attract physicians to work in the hospital – this is critical particularly in settings where community-based physicians are relied on to provide hospital-based care.
10. Celebrating the activities in [2] above, within the hospital and health authority, demonstrates their importance to health authority and hospital leadership and are ways

of acknowledging and showing appreciation for the work of physicians, other medical staff, nurses and allied health staff.

11. IH should consider the establishment of a medical staff occupational health program either on its own or in partnership with another health authority to leverage economies of scale, leveraging lessons learned by VCH and PHSA.