ACTIVELY ENGAGING PSYCHIATRISTS IN THE MENTAL HEALTH & ADDICTIONS PROGRAM

FINDINGS AND RECOMMENDATIONS

Final Report

Submitted to HPEI Mental Health & Addictions Steering Committee
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CSI Consultancy

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EXECUTIVE SUMMARY

Mental Health and Addiction (MH&A) services are provided by Health PEI through the administrative structure of the MH&A Program. It is a province wide program which spans the spectrum of mental health and addiction services from inpatient to outpatient to community. As a province wide program that crosses the continuum, it is positioned to integrate services, reallocate resources to highest need areas and address system quality and patient safety concerns. Optimum planning, decision making and quality services require the involvement of various experts in mental health and addictions. The focus of this report is based on the concern that one group, the physicians in the program, are not adequately engaged to ensure optimum input of expertise is available to guide the program.

Health PEI contracted Corpus Sanchez International (CSI) Consultancy to assist with program planning by assessing the current state and making recommendations to improve physician engagement. The literature was reviewed and interviews were held with 13 physicians, connected with the MH & A program, either individually or in groups. The work associated with the Hillsborough Hospital project provided a further opportunity to engage other providers and over 100 people, representing all disciplines and all levels of administration were consulted.

The CSI team's work resulted in the identification of eight problem areas:

1. *Culture of separateness*: The program continues to function with a degree of separateness grounded in historical roles or sectors, with many acknowledging that they continue to operate in 'silos'. This issue is not unique to PEI, but it does make implementation of initiatives designed to lead to integration and better coordination more challenging.
2. *Physicians are disengaged:* The physicians admit to disengaging from the system for multiple reasons. Reversing this trend will require deliberate efforts by the system leadership to make physicians feel more valued, while physicians will need to make individual and collective commitments to become more active and participate more constructively in team processes.
3. *Funding, contracts and accountability:* The current contractual/funding model for psychiatrists is not always aligned to meet the need for core service needs of Health PEI and there appears to be limited ability to define/manage the contribution by psychiatrists to these same services.
4. *Change environment*; Multiple reviews, several recommendations, numerous suggestions and lots of planning committees have been unable to make significant, concrete, lasting improvements to the MH&A system. This suggests an environment whereby change will continue to be challenging.
5. *Staff withdrawal and multi-level leadership:* Given the perceived lack of action stemming from prior reviews, some staff will likely struggle to proactively participate in change efforts.
6. *Quality of care:* Quality of care can always be improved in any system or program. Efforts to strengthen a culture of quality where people can constructively participate in the quality review processes must be pursued.
7. *Team environment:* Processes related to inter-professional team communication across units and sectors and disciplines must be improved.
8. *Family input:* Families spoke with passion about their concerns and expressed a deep founded desire for the system to work better for them and their loved ones. Organized input by families to the system constraints was not readily available.

In order to address some of these items, the following recommendations are made:

- ***Recommendation #1: A province-wide Department of Psychiatry and Addiction Medicine should be created to enable advancement of professional practice within the physician community. All practicing Psychiatrists and Addiction Medicine physicians should be required to be members of the Department. Primary Care providers / family physicians, that support addictions treatment, should be offered associate status in the Department. A Division Head or Clinical Lead for Addiction Medicine should also be identified.***

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- ***Recommendation #2: A Department Head role should be created, with clearly defined province-wide leadership responsibilities and accountabilities. The Head should be part of the Provincial Medical Advisory Committee and report to the Chair of the MAC (and ultimately the Board) through the appropriate governance/leadership structures.***
- ***Recommendation #3: The process to select/appoint the Department Head (and the Division Head/Clinical Lead for Addiction Medicine) needs to be confirmed and initiated with the goal of having the Head(s) named as soon as possible.***
- ***Recommendation #4: Health PEI will need to clearly delineate/differentiate the role of the Department Head from that of the Program Medical Director, with the latter serving as Co-Director of the MH&A Program. The accountability model for the Medical Director also needs to be confirmed, including whether he/she has specific accountabilities that are distinct/separate from the Operations Director or if the two are intended to function as a dyad with collective/joint accountabilities for operational matters. The reporting relationships to executive team members for both roles also need to be confirmed.***
- ***Recommendation #5: Individual members of the Department of Psychiatry should be encouraged to participate in departmental and/or program initiatives (e.g. serving on Committees or Working Groups). This could eventually be a condition of maintaining privileges but initially it should be a voluntary model.***
- ***Recommendation #6: The Department of Psychiatry, led by the Department Head, should consider defining exactly what 'consensus' means operationally to the psychiatrist group. This would clarify and forward a more cohesive approach to decision-making and reduce the likelihood for conflict when issues are presented to the group and a collective position or decision needs to be made.***
- ***Recommendation #7: the MH&A Program should redesign its current structures and processes for quality management/improvement and identify a minimum of 1 psychiatrist to be added to the Program Quality Committee. The Department Head should also ensure that professional practice processes and structures for quality reviews are established.***
- ***Recommendation #8: the MH&A Program should review its systems and processes for including patients and families in its formal quality management processes and ensure that mechanisms for receiving and utilizing patient and family feedback as part of an integrated quality strategy are in place.***

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1.0 SETTING CONTEXT & BACKGROUND

Why the Project Was Undertaken

Health PEI is a single entity responsible for planning, implementing and evaluating operational aspects of healthcare in PEI. Health PEI works closely with the Department of Health and Wellness in the government which has responsibilities for planning, setting standards and allocating the budget to Health PEI as well as some operational oversight as taken from the Department website[1]:

- Provide leadership in maintaining and improving the health and well-being of citizens;
- Provide leadership in innovation and continuous improvement and to provide specific high quality administration and regulatory services to the health system and Islanders;
- Provide policy, program and operational leadership respecting the Island health care system; and
- Provide horizontal leadership and coordination in the implementation of Government's Healthy Living Strategy

Multiple studies of Mental Health and Addiction (MH&A) services were completed over the last few years[2,3,4,5,6,7], and while the MH&A Program leaders were working diligently to plan and implement the many recommendations, several recent media reports have raised concerns amongst politicians, residents and bureaucrats that services were not being provided in an optimal manner, and that Hillsborough Hospital specifically was not delivering care in accordance with its perceived mandate.

Given these pressures, Health PEI engaged CSI Consultancy to assist with program planning by addressing two major challenges they perceived in the provision of MH&A services:

1. The mandate of Hillsborough Hospital as a provincial resource; and
2. The engagement and accountability of the psychiatrists in planning and operation of the MH&A program.

This report deals with the *second project*.

CSI interpreted all of the above to mean that Health PEI was seeking to fully engage psychiatrists on a system wide level to ensure alignment with program needs and services, from acute inpatient mental health and addictions services and the community mental health services in the province.

This system wide perspective underscores both the Strategic Directions of Health PEI for 2013-2016 that calls for a *renewed model of home-based services; renewed model of community-based primary health care; health system enablers; and the integration of acute and facility based care* as well as the stated Vision for the Mental Health and Addictions Program to deliver "**quality services and supports which are person-centered, recovery-oriented and integrated to assist Islanders in achieving their optimal level of mental health and participation in community life "**(2009)**.**

Methodology

To meet the stated objectives in the required timeframe, CSI proposed a four-phase workplan:

- **Phase 1: Project Mobilization** to confirm the leadership model for the project, identify stakeholders to consult with, identify documents to review, interview key program leaders, and finalize the workplan.

[1] http://www.gov.pe.ca/health/index.php3?number=1037417&lang=E referenced on Feb 19, 2014.
[2] PEI Auditor General's report, 2012.
[3] Accreditation report, Health PEI, Oct. 11, 2013.
[4] Mental Health Facilities Review: comparable Canadian examples.
[5] Mental Health Facilities Review: funding.
[6] Transforming Methadone maintenance treatment to meet the growing need of Islanders. August 2012.
[7] Developing a provincial bed map. June 2013.

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- **Phase 2: Analysis, Engagement & Research** to complete data analysis, undertake stakeholder interviews during the onsite assessments, and complete an external scan and literature review to inform the concept of physician engagement and accountability.
- **Phase 3: Building Leading Care Delivery Models** by bringing stakeholders together in a Think Tank to review findings, reconfirm the overall vision for psychiatrists as a provincial resource, and debate and improve findings and draft recommendations.
- **Phase 4: Reporting and Handoff** to finalize a report of findings and recommendations related to physicians' engagement in MH&A services in PEI.

This project was ably supported by the Health PEI team of Billie-Jean and Bobbi Jo Flynn, Eileen Larkin, Dawn MacDougall, Sharon Fortier, Chris Mooney, Nadine MacLean and Kathy Lecky. Their collaborative work with the CSI team enabled the project to be completed within tight timelines.

Documentation Review and Data Analysis

A number of reviews have been conducted on aspects of the Mental Health and Addictions Programs over the past ten years, and these were made available to the CSI team including, but not limited to:

- *The Mental Health and Addictions Review, commissioned by the Department of Health and Wellness in 2012 and released in 2013*;
- *The Auditor General's Report on Community Mental Health Services*;
- *The Provincial Bed Mapping Review and Recommendations, conducted by the Hay Group in 2013;*
- *Strategic Plan for Mental Health and Addictions Services developed in 2009*; and
- *Numerous internal documents related to the MH & A program, including a project summary of initiatives/projects in various stages of implementation.*

In addition, the team was provided with current documents describing the relationship with HPEI and the Department of Health and Wellness, including Bylaws, Rules, psychiatrist contracts, and approximate billings for the psychiatry group.

Literature Review

Given the expectations and deliverables for the project, literature pertaining to physician engagement and physician accountability in general and with respect to psychiatrists in particular was sought and reviewed. Pertinent references are given below when relevant to the discussion.

Stakeholder Engagement

As outlined previously, CSI was engaged with two separate but connected MH&A projects. This facilitated the opportunity to engage many stakeholders to obtain diverse perspectives and input from other staff or family via the communication with the CSI Team, and integration between the two projects.

Initial engagement with program leaders took place on January 9th and 10th, 2014, with the goal of confirming the overall approach in mobilization. A steering committee was created to lead and provide direction to both projects. In collaboration with the Steering Committee and Health PEI project leads, key internal and external partners were identified and invited to participate in either individual or group interviews during the second week of February, 2014. Acknowledging the numerous attempts of engaging providers for input into previous reviews/ reports, the CSI team was struck by the continued interest, commitment and passion, held by providers, for clients/patients and families with mental health and/or addiction health problems.

During the on-site visit, the CSI Team was given the chance to speak to members of the leadership team, to senior and middle managers, nursing staff and physicians from the MH&A program; individuals were from acute and community, from Summerside, Charlottetown and surrounding areas, and from essentially all disciplines. Opportunities were provided for those who were unable to attend

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face-to-face meetings to have follow-up phone calls to express their points of view. The CSI team appreciated the willingness of all interviewees to share their perspectives and acknowledge that these individual views may not be shared. It is important to remember that an assessment such as this depends on the inputs provided by people through the engagement process. That said, opinions are simply that – opinions – and while we have drawn on them to complete this work, they should not be misconstrued as being 'facts or evidence'.

In total, interviews were held with over 100 staff, 17 physicians, including 13 psychiatrists and 1 addiction medicine physician, 3 members of the senior leadership team and 28 patients and/or family members. At the physician engagement Think Tank held on March 12, 2014, 10 psychiatrists were in attendance. Unfortunately all of the psychiatrists from Summerside were away at this time and as a result did not have the opportunity to participate in the discussion.

A Steering/Advisory Committee, to guide the psychiatrist project, is comprised of Dr. Nadeem Dada (Executive Medical Director HPEI), Dr. Terry Cronin, (Mental Health & Addictions Medical Director, and ad hoc member), Dr. Rob Jay (Psychiatrist with CMH and President of PEI Psychiatric Association), Eileen Larkin (Manager of Physician Services), and Margaret Kennedy (Director MH&A).

Outline of this Report

This report presents its findings recommendations as follows:

- The "Overall Landscape" which outlines contemporary approaches to program management, physician engagement and accountability (Section 2).
- The "Current State Findings" that summarizes the operating environment today and how challenges are perceived by different stakeholders (Section 3)
- "Creating a Future Vision and Planning Transition" that outlines a series of recommendations to address the main issues that resulted in the current challenges (Section 4).
- An initial "Implementation Roadmap" that provides suggestions to mobilize around the recommendations /opportunities outlined (Section 5).

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2.0 THE LANDSCAPE – PAST AND PRESENT

PEI has a population of 145,000 people and a growth rate of 0.05% between 2012 and 2013 compared to a growth rate of 1.16% in all of Canada over the same period of time.[8] The comparatively low population has several effects: the tax base is low and hence government spending must be very cautious; there are comparatively fewer skilled and experienced individuals in the work force needed to perform many of the bureaucratic and professional services that the province provides either through the public or private sector; and, as often mentioned in the interviews – "everyone knows or is related to everyone".

These concepts and others affect Health PEI's ability to meet the stated vision, mission and goals and objectives:

Vision	***One Island health system supporting improved health for Islanders.***
Mission	***Working in partnership with Islanders to support and promote health through the delivery of safe and quality health care.***
Values	***Caring - We treat everyone with compassion, respect, fairness, and dignity.*** ***Integrity - We collaborate in an environment of trust, communicate with openness and honesty, and are accountable through responsible decision-making.*** ***Excellence - We pursue continuous quality improvement through innovation, integration, and the adoption of evidence-based practices.***
Goals & Objectives	***Quality - We will provide safe, quality, and person-centered care and services.*** ***Access - We will provide access to appropriate care by the right provider in the right setting.*** ***Efficiency - We will optimize resources and processes to sustain a viable health care system.***

HR Planning – Re: Psychiatry and Addiction Services on PEI

One of the issues that Health PEI identified as the commencement of the project was the challenge associated with physician human resource planning. The Physician Resource Planning Committee, a committee established with both members from the Department of Ministry of Health and Wellness and Medical Society Association, states that each discipline will have a maximum number of positions available for the whole of PEI. A physician, or physicians, who is/are outside the maximum complement of physicians approved for the specialty, receive only 50% of the pertinent fee for service, salary, etc.

There are currently 13.5 psychiatrists in PEI and the maximum component set at 15 and a recent review of physician human resources stated there was no need to change the upper limit at this time based on population health needs.[9] Further comment on the adequacy of the current resource plan for psychiatrists in Health PEI was not within the scope of this project and as such will not be addressed in this report.

For addiction medicine, the upper limit approved is 2.0, and current staffing is the equivalent of 1.6 FTES. The 1.6 positions are filled by two physicians (one full-time and one part-time) and two others have recently been recruited to provide support 1 day per week. The part time MD states that he would likely retire if a second person is recruited although the reality of the 2.0 FTE limit may hamper recruitment because there is only a 0.5 FTE "available" at the current time. In addition to the 12 family physicians in the province that have completed the CAMH online course and can prescribe methadone, there are also family physicians contracted to provide physician support to Addictions in Montague and Prince County.

[8] http://www.gov.pe.ca/photos/original/pt_pop_rep.pdf
[9] Physician Human Reesource Report. Hay Group Health Care Consulting. August, 2010.

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The establishment of limits on the number physicians in each specialty is an absolutely necessary process that allows for a degree of cost containment and alignment of service expectations within a contractual framework but it requires strategic recruitment and the matching of positions with defined needs. But the model does have its flaws because it places critical and strict upper limits that can constrain much needed recruitment strategies to be executed effectively by Health PEI as they plan for the future delivery of MH&A services, especially as they try to transition some service areas to new models and/or manage individual issues with psychiatrists who do not contribute, or contribute less than average, within the current care delivery processes and models for MH&A services.

Stated alternatively, Health PEI must ensure that services are provided to meet the population needs and hence is highly dependent on the physician staff members within each medical department to deliver care in a manner, and in a volume, that meets defined goals. When there are issues with an individual that need to be reviewed, assessed and managed, the rigid limits on numbers and the process of having any additional physicians paid at a rate that is 50% of their colleagues, presents real challenges to the pursuit of innovative approaches to meet longer-term goals.

Health PEI's Program Management Model

The MH&A Program was the first Island-wide comprehensive clinical program to be organized under a Program Management model (2009). The goal at that time was to improve the quality, efficiency and integration of the multiple services relevant to ~12,000 adults and children served each year. The Mental Health Services Strategy, defined at that time, outlined three strategic directions: *Clarify Accountability in the Mental Health System; Enhance Service Delivery; and Address Human Resource Challenges.* Key principles identified as guiding the current mental health system's culture and priorities include:

- Person-centred
- Accessibility (in all its dimensions)
- Collaboration across providers and between providers and clients
- Accountability (who is responsible for what and to whom)
- Respect for all stakeholders
- Excellence, evidence-based practices and ongoing quality improvement
- Comprehensive continuum of support
- Recovery-oriented
- The unique role of families and others is supported, as appropriate

Reducing wait times and improving access to mental health services was identified as the priority focus in 2013-2014.

The current Program is responsible for services across the province that spans the continuum of care, from inpatient to outpatient, to community with strategies developed to enhance the delivery of these services. Current mental health inpatient services are provided in three hospitals – Hillsborough Hospital (HH), Queen Elizabeth Hospital (QEH) and Prince County Hospital (PCH) – plus the inpatient addiction unit at the Provincial Addiction facility. The budget for services within the MH&A program is approximately $36-37 million, not including costs for psychiatrists, addiction physicians and out of province cases (which reside within Medical Affairs).

A single Operations Director was appointed in 2011, and responsibilities include the oversight of the full continuum of care delivery services (e.g. inpatient, outpatient, and community services). A Medical Director was formally named in the fall of 2013 which involves the oversight of the physicians involved in MH&A services.[10] Anecdotally, the Review Team was informed that the Program Management model is meant to be a co-director model whereby both directors collaborate to plan, solve problems and implement changes for the improvement of services. In December 2013, a restructuring of Health PEI aligned the MH&A program with the acute care system, under the direction of a single Executive Director for Acute Care, Mental Health & Addictions Services.

[10] http://www.healthpei.ca/index.php3?number=1040534&lang=E

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This project did not examine Health PEI's program management model extensively, but given the need to link observations and recommendations made below in a program setting, it is important to recognize not only the program's components but also its challenges. Accordingly, suggestions that affect the MH&A Program are based on the experience of CSI's team in program management models and not on a comprehensive review of the current PEI model.

On a provincial level, an individual was appointed in November 2013, as an interdepartmental lead for mental health, within the government linked mainly with Health PEI whose responsibility includes, among others, a role in addressing policy issues between various government departments who play roles in mental health including Health and Wellness, Justice, Social Services and Housing, and Child and Youth.

What the Literature Tells Us About Program Management

Nohria (1995) stated that[11], "Organizations exist to enable a group of people to effectively co-ordinate their efforts to get things done. The structure of an organization is the pattern of its organizational roles, relationships and procedures that enable such coordinated action by its members." In other words, **organizational design allows the work of the organization to get done by defining the structures, processes and roles within which people work,** to deliver the services required by the people they individually and collectively serve.

Dr. Bryce Taylor, writing in his book *Effective Medical Leadership,* identifies some of the complexities of these structures and the organizational transitions that take place as they are introduced:

- Physician structures have typically been developed under a **Departmental Model** that is defined by the MD specialty (e.g. Medicine) and may be sub-divided into Divisions by sub-specialty (e.g. Haematology). These structures formally report to the Medical Advisory Committee and are largely focused on professional practice issues. They typically have a limited role in, or control over, resource management decisions (even though they often exert considerable informal influence over decision-making and resource allocation planning processes).
- Hospital operations have traditionally been organized under a **Functional Model** reflecting professional groupings (e.g. Nursing, Social Work, and Physiotherapy) and/or operational/service functions (e.g. Housekeeping, Food Services). In the traditional model, departments managed their own budgets and reported to a senior executive who was accountable to the CEO. Resource planning involving multiple departments required cooperation between managers and decisions could be stalled because of a lack of agreement on priorities and collective ownership of initiatives.
- Most hospitals have now shifted their managerial structures to some form of **Program Management** that reflects more of a patient orientation, rather than the more provider-centric models that existed in the functional structures. Under these models, services and staff are clustered around the common characteristics of the patient population being served, with resources deployed to the program. These models are then incorporated into some form of **Matrix Management** that creates a truly inter-professional team focused on patient populations while continuing to connect and align staff with some of the traditional structures.

Taylor notes that the transition to these new structures is not always an easy process, as all the players have to get used to new models, processes, relationships and expectations. Clarity of roles and expectations is an essential enabler, as is leadership development support to leaders as they take on new roles and responsibilities. Physicians in particular may struggle with these transitions as they may sense a loss of influence as structures and processes are more formalized. The importance of relationships, mutual personal respect, mutual support and a collective commitment to the vision, mission and values of an organization cannot be over-emphasized.

The issues noted by Taylor require further discussion because operational issues that fall under the purview of the Program often get intertwined, and confused, with program/operational issues.

[11] Glickman, S.W. et al (2007). *Promoting quality: the health-care organization from a management perspective,* International Journal for Quality in Health Care 2007 19(6):341-348

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Throughout the organization there is a lack of differentiation between psychiatry and MH & A program, and as a result issues get intertwined, leading to confusion. The need to differentiate accountabilities for program/operational matters from professional practice issues is described more fully later in the report, but the Team also realizes that it may at times present issues that reflect the underlying lack of differentiation. We have made every attempt not to do so, but note that it was challenging at times to separate the issues and concerns effectively.

What the Literature Tells Us About Physician Engagement

Physician engagement has become an important strategy for many organizations where physicians play a role in planning and operations. Hospitals[12], Health Authorities[13] and physician organizations[14] are strategizing to enhance engagement, to measure it,[15] to define it[16] and to recognize the barriers to it.[17] As many of these references are from Canadian jurisdictions, Health PEI may wish to contact them for future discussions.

But what does physician engagement mean and how is physician leadership important to make progress and improvements. Baker, in a recent presentation,[18] said:

- *"Engagement in a role refers to one's psychological presence in or focus on role activities and may be an important ingredient for effective role performance. Engagement then incorporates identification with a role and commitment to the role. Identification represents the importance or salience of the role to an individual, whereas commitment represents the individual's attachment to the role. Identification and commitment represent reasons why one might become psychologically present."*
- *"Leadership has been traditionally defined as a capacity of individuals in formal positions to influence the orientations of an organization or a group. While this role of leadership may be valuable, it is too restrictive and may not reflect the reality of leadership in health systems and organizations. Current conception of leadership suggest that leadership needs to be collective, shared, distributed or, in more general terms, plural."*

Perhaps the most comprehensive report in the literature is a review done by Denis J-L, Baker GR, Black C, *et. al.,* with key principles outlined for enhancing physician engagement.[19] The following are direct quotes from the article, with the principles applied to build recommendations for the enhancement of psychiatrists in the Health PEI MH&A program (see below).

- *"Physician leadership and physician engagement are essential elements of high-performing healthcare systems, contributing to higher scores on many quality indicators. Likewise, physician participation in hospital governance can improve quality and safety.*
- *"Although much of the literature on healthcare reforms suggests the importance of physician engagement and leadership, this literature is less explicit about the processes by which health systems and organizations can convert physicians' autonomy, knowledge and power into resources for health system performance and improvement.*
- *"Physician leadership is important at the apex of the organization, but leadership occurs at all levels of the system. Increasing attention is being paid to high-performing clinical micro-systems*

[12] https://www.ottawahospital.on.ca/wps/wcm/connect/1d84a1804da1e36dbdd2ff62660efeb4/TOH+Strategy+Report+EN+single+pages.pdf?MOD=AJPERES
[13] http://www.nhlc-cnls.ca/assets/Holmes%20and%20Chu_Final.pdf
[14] https://www.bcma.org/files/Policy-PartneringwithPhysicians-FinalJanuary212014.pdf
[15] https://www.ottawahospital.on.ca/wps/wcm/connect/1d84a1804da1e36dbdd2ff62660efeb4/TOH+Strategy+Report+EN+single+pages.pdf?MOD=AJPERES
[16] http://www.choixdecarriere.com/wp-content/uploads/2011/06/HQ_vol15_no3_Scott-Final1.pdf
[17] http://www.rqhealth.ca/inside/publications/physician/pdf_files/compass.pdf
[18] http://www.stmichaelshospital.com/pdf/research/clinical-population-rounds/baker-physician-engagement.pdf
[19] http://www.cfhi-fcass.ca/sf-docs/default-source/reports/Exploring-Dynamics-Physician-Engagement-Denis-E.pdf?sfvrsn=0

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as well as new leadership modalities (e.g. dyads of physician and manager leaders and other forms of distributed leadership) and processes (e.g. physician compacts) that are fostering what some refer to as organized professionalism.

- *"Physician engagement does not happen on its own. Organizations must use diverse strategies and initiatives to strengthen physician engagement and leadership, including (but not limited to):*
  - *"physician compacts as mechanisms that help clarify roles, expectations and accountabilities between physicians and other system leaders*
  - *"leadership that is linked to broader improvement strategies to create a receptive context for physician engagement in improving clinical outcomes*
  - *"leadership development—especially for collective and distributive leadership—to support physician engagement*
  - *"teams and team leadership—especially inclusive leadership—as a favourable context for physician engagement and leadership and performance improvement*
- *"A key variable for success in these approaches to physician involvement is trust between physicians and organizations, which can develop around these elements: open communication, willingness to share relevant data, creating a shared vision and accumulating evidence of successful collaboration.*
- *"True physician engagement and leadership begins with understanding and addressing the underlying characteristics and values of the engaged physicians.*
- *"Organizationally, physician engagement depends on a mosaic of factors and can therefore be difficult to achieve. Physician leaders may experience obstacles in assuming leadership roles in organizations and systems. Such obstacles may be partly attenuated with purposeful changes to shape the organizational culture (called cultural work).*
- *"Successful strategies to engage physicians need to go beyond, but not ignore, appeals to their economic motives. In the same vein, formalized strategic leadership positions are important but are insufficient to effect high performance. Because of the major cultural problems posed by management–professional tensions, economic and symbolic solutions do not necessarily translate into greater physician engagement. The main challenge is to bridge and integrate cultures, not buy commitment.*
- *"Developing physicians' skills and competencies to support improvements in health systems means targeting a full range of physicians rather than only individual physicians. Key core competencies for engaging and fostering physician leadership include leadership, strategic planning, systems thinking, change management, project management, persuasive communication and team building."*

One report that comes from the American literature states that "employment engages physicians."[20] This characteristic is to assist physicians to spend time in system planning and operations so as not to jeopardize their billable or family/private time. A financial relationship with the organization is not sufficient to ensure physician engagement but it is often perceived as a necessary component. Health PEI has funds to provide psychiatrists for various duties that may reflect clinical service including quality improvement and systems planning and operations, and several of the psychiatrists in the MH&A Program are on salary or contracts (see below).

What the Literature Tells Us About Physician Accountability

Physician accountability is multidimensional. They have obligations to their patients, to their colleagues and to the health care system. The Canadian Medical Association has developed a well thought out description of physicians' relationship with the health care system and created a vision that affects physicians and the system they work in. In this vision:[21]

[20] http://www.hschange.com/CONTENT/1087/#ib2
[21] http://policybase.cma.ca/dbtw-wpd/Policypdf/PD12-04.pdf

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- *"Physicians are provided with the leadership tools they need, and the support required, enabling them to participate individually and collectively in discussion on the transformation of Canada's health care system.*
- *"Physicians are provided meaningful opportunities for input at all levels of decision making, with committee and reliable partners, and are included as valued collaborators in the decision making process.*
- *"Physicians recognize and acknowledge their individual and collective obligations (as one member of the health care team and as members of the profession) and accountabilities to their patients, to their colleagues and to the health system and society.*
- *"Physicians are able to freely advocate when necessary on behalf of the patients in a way that respects the views of others and is likely to bring about meaningful change that will benefit their patients and the health care system.*
- *"Physicians participate on a regular and ongoing basis in well-designed and validated quality improvement initiatives that are educational in nature and will provide them with the feedback and skills they need to optimize patient care and outcomes.*
- *"Patient care is team based and interdisciplinary with seamless transition from one care setting to the next and funding and other models are in place to allow physicians and other health care providers to practice within the full scope of their professional activities."*

The CMA vision may not yet be fully realized but it does outline the larger roles that physicians must play in the health care system and the system's responsibilities to physicians.

To clarify the relationship between physicians and the health care organization, some have created physician compacts that outline the responsibilities of the organization and the physician. One, from Virginia Mason,[22] has been used by several organizations as a model to develop their own documents with others available in the literature[23,24] These compacts have shown themselves to positive impact the MD/Organization relationship with the key factor being that they be 'more' than pieces of paper.

Canadian examples also exist.[25] With one example being the accountability system that has developed in New Brunswick that outlines very specific expectations for psychiatrists related to performance monitoring and expected ranges of workload.[26]

Conclusions Regarding the Landscape

Health PEI has instituted several important changes over the recent years that have significant secondary affects in the provision of health services and the working environment of the physician staff. New Bylaws were passed in 2011[27] that create a province-wide medical staff system for appointment, credentialing, privileging and reappointment of members of medical staff. It supports, but does not require, the establishment of relevant programs or departments and physicians typically are members of one or the other, sometimes both. In the case of psychiatrists, currently they are members of the MH&A program as there is no department of psychiatry to which to belong.

The literature regarding program management clearly tells us that the shift to Program Management is fraught with challenges as people often resist attempts by the "program" to institute new strategies, structures and processes that changes the formal and informal power bases that were part of the previous models. With the move to program management in Mental Health & Addictions, the psychiatrists lost their secondary or matrix structure that existed under the old model and provided

[22] https://www.virginiamason.org/workfiles/HR/PhysicianCompact.pdf
[23] http://www.suttermedicalfoundation.org/images/physician-compact.pdf
[24] www.affinityhealth.org/object/affinity-physician-compact.html
[25] The CSI team is aware of physician compacts in The Ottawa Hospital and Fraser Health Authority that are worth considering should this strategy be undertaken. CSI believes however, that a physician compact should pertain to all physicians in a health authority, not just one group such as the psychiatrists.
[26] The Clinical Work Incentive (CWI) in PEI is similar (see below).
[27] http://www.healthpei.ca/photos/original/hpei_medstaffby.pdf

the organizational construct for the group of Psychiatrists with regard to professional practice issues. This has created a gap that needs to be rectified.

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3.0 CURRENT STATE FINDINGS

For this project, Health PEI was looking for a process to engage psychiatrists and addictions physicians, and assist this group to initiate planning for mental health and addiction physician services, and integrate the same within the larger Mental Health & Addictions program.

The approach undertaken to understand the current state and define potential solutions was highly consultative in order to ensure that the required, indeed critical, conversations were completed. As noted previously, the CSI Team spoke with the majority of psychiatrists/physician (13) and more than 100 stakeholders. We were extremely impressed by the willingness of all to come to the table and share their views, both positive and negative, as well as their ideas for change.

This section of the report summarizes the outputs of the stakeholder discussions and focuses on opportunities to improve service delivery, enhance communication, support a better quality of work life for the psychiatrists, and achieve a better sense of group cohesion within the psychiatry and larger mental health services community.

Listening to Stakeholders

At the end of the day, this project comes down to three things:

- Psychiatrists and Addictions Physicians feeling a sense of disenfranchisement, grounded in their perceptions that their voice is not always heard,
- Concerns from other members of the MH&A team feeling that the psychiatrists are not well integrated and/or do not function well as team members, and
- Senior Executive and Program Leadership concerns regarding physician accountability.

The convergence of these three points of view impacts the most important group - patients and families - who are sometimes poorly served by team processes that do not yield the level of integration and coordination required for optimal inter-professional care. To resolve these issues, the project team relied on significant engagement to ensure everyone's voice was heard and an integrated picture of the current state could be defined. The sections below outline the viewpoints heard.

Concerns of the Psychiatrists and Addiction Services Physicians

Psychiatrists were concerned about a number of issues, including:

- **Decision Making Processes:** As noted previously, MH&A services in PEI have been the subject of numerous reviews over the past decade, but this is the first review focused solely on the engagement of psychiatrists. Psychiatrists feel that these reviews have failed to lead to demonstrable change, despite having identified a number of consistent and ongoing themes/issues. This has helped to create a sense that "nothing ever changes" which the psychiatrists view as creating an environment characterized by a lack of political will to make decisions and implement required changes. They describe this being grounded in a fear that decisions will not be supported or will be overturned, either because of "big P" political interference from politicians/government or "small p" internal politics from individual sites or sectors. The end result is a perception that people who do not want change can do "end-runs" that prevent change.
- **Turf Issues:** Building on the above noted concerns related to decision-making processes, physicians perceive that the overall care environment is impacted by what they describe as turf-related issues between sites (PCH, QEH and HH), between disciplines (physicians and others) or between sectors (community and hospital). This leads to a sense that there is a lack of willingness to come together as one program. At the same time, psychiatrists report that decision-making processes are sometimes dictatorial because suggestions they have made are not reflected in the final decision. This raises two key issues:
    - Physicians may not understand that their ideas are simply inputs into the decision making process, and that input may be rejected when the final decision is made, and

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- Decision makers may not always communicate the rationale behind decisions, especially when input offered by key constituencies has been thoughtfully considered and rejected.

- **Operational Access and Flow Challenges:** The psychiatrists note that the turf issues create communication gaps and impact transitions of care between sites/sectors. As a result, they feel the public has learned to use the ED to enable access when other avenues have failed. They also express concerns regarding the lack of an effective interdisciplinary/collaborative care model for certain populations (e.g. Addictions).
- **Contract Issues:** The salary and contracts for the psychiatrists were also described as problematic. Contracts are designed to apply to individual physicians, meaning that if an individual physician does not live up to the expectations of the contract, they risk losing income. This is particularly a problem when a psychiatrist may be contributing to the needs of the MH&A program yet is not seen to be fulfilling some expectations of the contract (e.g. consults within the shadow billing process as outlined in the clinical work incentive portion of the Master Agreement). There is a feeling that the contract is not flexible enough to reflect situations where an individual is contributing to the system, albeit through a spectrum of activities not included in a generic format.
- **Human Resource Planning:** The future of the psychiatry group is also a point of concern as several members are very close to retirement. This, coupled with the turnover experienced in the last few years, raises concerns regarding the long-term ability to address service needs.
- **Legislative and Bylaw Changes:** There were multiple comments concerning changes to the Mental Health Act and the Health PEI Bylaws and the subsequent creation of the MH&A Program. Concerns include misunderstandings regarding the impact of changes to the Act and possible legal implications/consequences and the Bylaw changes that are seen as directly contributing to the elimination of a formal Department of Psychiatry.

Preliminary Conclusions Related to the Engagement of Physicians:

The psychiatrists generally express a sense of feeling disenfranchised, which they say has resulted in an "us versus them" environment that leads to a degree of conflict with other members of the MH&A team and administration. From the perspective of the CSI Team, we agree that the environment is sub-optimal but we have made no attempt to assign blame for the current state as this would be entirely unhelpful. That said, planning for the future must create a better atmosphere/environment for all parties.

On a positive note, the majority of psychiatrists participated actively in the interview process and those that did state that they want, and are willing to help enable, a more collaborative work atmosphere within the MH&A programs with the overall goal of making the program better in the future. One of the key barriers to this future that they identify is an absence of clarity regarding the future vision and a lack of a shared understanding regarding the actions required to get there.

In addition, psychiatrists, like many other groups we heard from, talk openly about an overarching 'immunity to change culture' in PEI that they describe as being highly resistive to change and extremely difficult to overcome. At the risk of offending some constituencies, the CSI team cannot help but feel that the ongoing sense that there is an underlying culture of resistance has become a crutch that enables people not to change. That said, the physicians have an opportunity to change their own underlying behaviours, thereby starting the process of shifting the perceived culture of resistance to change.

Concerns of the Non-Medical Staff

There are 22 sites for community mental health services in PEI and staff in the different settings have their own perceptions regarding the challenges associated with psychiatrist engagement:

- **Integration With the Broader Community Mental Health Team:** The contribution of the psychiatrists to community health services is described as variable and insufficient, the root cause of which seems to include lack of interest by some MDs and/or ineffective communication processes. At the same time, psychiatrists can get pulled to cover other service priorities on short notice, and this helps to create a sense that community services are less of a priority within the overall continuum of care.

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- **Data Sharing:** Concerns were also voiced regarding the lack of interoperability of the community mental health services IT system and the hospital system, or perhaps more importantly, the excessively restrictive access protocols that inhibit effective exchange of information between acute care staff and community based providers. While this is largely a technology issue, there is a perception that staff are resistant to sharing information between sectors. The team was informed that work is in progress to improve access between sectors. The ability to share care & treatment plans between providers is critical to ensure patients/families receive quality care.
- **Inter-Hospital Coordination:** Staff note a number of issues regarding inter-site communication. Prince County Hospital had some particular concerns:
    - They described Hillsborough Hospital as an "impenetrable fortress" and that the huge amount of time that it takes to get a psychiatrist to see a patient is viewed as an ineffective use of time. Discharge processes and discharge plans from community mental health were also described as poor and not supportive of long-term management of patients.
    - PCH had some grave concerns about the non-responsiveness of Addictions services. There is a feeling that the services are very spread out, that wait lists are growing and that services may actually be decreasing. Others have wondered why methadone induction could not be done on an outpatient basis rather than requiring all inductions to be initiated only under an inpatient model.
    - Sub-optimal pediatric mental health was a recurring theme in the review. PCH showed data indicating that the four of the top 6 most common diagnoses for admission from emergency department for 7-18 year olds were for mental health and behavioral issues. Unfortunately, comparative data for other sites was not provided so the CSI Team has no idea if this data is meaningful as it may well reflect issues that are common to many community hospitals.

Preliminary Conclusions Related to the Engagement of Non-Medical Team Members:

The theme of barriers and boundaries between PCH, QEH and HH, as well as between hospital-based team members and those working in the community reinforces many of the same issues raised by physicians. They are also consistent with themes heard by CSI when it conducted its original work at the system level 6 years ago and consistent with challenges reported as organizations move to program management. That said, the fact that this continues to be an issue, six years after the release of *One Island Health System,* and five years after the identification of MH&A as a single province-wide program is concerning. Attention to addressing these issues by establishing clear expectations regarding expected behaviours and holding leaders, physicians and staff accountable for individual and collective behaviour is required.

Concerns of the Senior Leadership Team Members

Senior leaders raised several important issues in their interactions with the CSI Team, the essence of which is as follows:

- Are people clear on the vision and mandate of the MH&A program and how they can and must contribute to that vision and mandate?
- Aare the required structures and processes in place to enable achievement of the vision and do individuals understand where they fit in the structure?
- Are individual roles and behavioral expectations adequately defined and do people understand their individual and collective accountabilities as well as the consequences if they choose not to perform and support the achievement of goals as expected?
- Do the conditions exist, or have they been created, to achieve the vision, including individual and collective supports for people as they move through the process of change?

These are all good questions and the simplistic answer to all is either no, or not consistently. And because of that simplistic answer, people have been allowed to carry on with their business in the way they choose, noting (or hiding behind) the excuse that things are simply so ambiguous that they don't know what is expected of them so they just try and do their best.

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This is reflective of a number of issues that were discussed openly with senior leaders:

- **Financial models/levers and alignment with expectations.** There are different payment models for the psychiatrists – some are on fee for service and others on salary or contract. Those on fee for service tend to be less involved in the strategic goals of MH&A services, do not have job descriptions or clear expectations and hence it is challenging to hold them accountable to the system (either with clear expectations or with negative consequences). Amongst those who have salary contracts, some contribute a considerable amount to the service needs but others do not. Consequently, the former group feels over taxed and too busy for a good work-life balance, and they harbour some resentment towards their colleagues who they view as working less hard.
- **Ability to maintain effective coverage of core services.** There are many service areas that require an active psychiatry presence, with some of the most common being direct oversight of admitted patient on mental health units, consultation liaison support to other inpatient units and the emergency departments, after-hours coverage for urgent and emergent issues and participation in the range of community programs requiring MD coverage. Decisions by individual psychiatrists to withdraw from providing coverage for some of these core services places an additional burden on a subset of the psychiatrists to provide extra service to fill the voids. If this continues, leaders fear that more psychiatrists will opt out of covering core services and this could seriously compromise the medical services required within the overall MH&A continuum of care.
- **Poor communication/engagement regarding planning and service changes.** A resounding theme throughout the review is the need for more effective communication between the psychiatrists (both individually and as a group) and leaders and staff in the MH&A system. The end result is an environment that can lead to sub-optimal accountability amongst the psychiatrists regarding their expected participation in system level processes to ensure effective care.
- **Role clarity and renewed "models of care".** Many leaders would support strategies to enhance collaborative care amongst psychiatrists, family physicians, pediatricians, NPs, community resources, etc. The concept suggests that the psychiatrists can/need to serve more of a consulting role within the larger MH&A Program.

Preliminary Conclusions Related to the Engagement of Senior Leaders:

The myriad of reviews over the past decade has yielded one common outcome – less than satisfactory traction to successfully implement the changes envisioned. The challenge for senior leaders at this time will be to enable a different outcome, by ensuring improved change management processes that will support better implementation planning for changes proposed from this project.

Concerns of the Families and Other Physicians

The Mental Health Commission of Canada (MHCC) has established the principle of "first voice" as a key principle for any planning process related to mental health services. First Voice means engaging and listening to people with first hand experience as a client of the mental health service delivery system, thus ensuring that those who use the system have a say in shaping its future. CSI fully endorses this model, as does the MH&A Program leadership in Health PEI, and as such, a number of patient and family engagement sessions were included in our process. Family physicians were also interviewed as they are uniquely positioned to discuss patient and family issues, and the impact that is felt when the specialty care system is unable to respond to access concerns in as timely a manner as requested..

While it would be inappropriate to provide specific examples of the feedback provided, some of the themes suggest (a) challenges in obtaining timely psychiatric consults and (b) issues with hand-offs between psychiatrists. The CSI Team recognizes the risk that specific cases are not necessarily representative of typical standards of care, but the examples are quoted because they represent the patient/family's perspective of what is occurring and the repetition of incidents related to the CSI Team suggests they may not be entirely uncommon.

Primary care physicians also report issues related to timely psychiatric consults as well as access to specialty services/beds at Hillsborough Hospital and community mental health services, noting that the latter routinely takes 14-16 weeks. Family physicians were also very concerned with Addiction services and the ability to get people into the program. They are particularly concerned about

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supporting people who want help but can relapse while waiting as well as the need to access services for youth with addiction issues.

The perspective on geriatric psychiatry is similar to what is described above, but there are some additional aspects to consider as older patients tend to have more difficulty traveling and only one psychiatrist provides any outreach services through a travelling clinic model. There is a Seniors Mental Health Team that is helpful, but the Team is not viewed as a provincial resource as it primarily serves seniors in Queen's County through the McGill Centre.[28]

Preliminary Conclusions Related to the Engagement of Patients, Families and Primary Care Providers:

Challenges related to timely access to care and care transitions between providers is described as problematic for patients and families, suggesting that a focus on improving communication between specialty providers, patients and primary care providers should be viewed as a high priority. Issues in this area are complex and the contributory causes are multi-faceted, but some appear to be attitudinal suggesting that a focused effort on team communication must be pursued, one that clearly defines consequences for any team member who continues to interact with his/her colleagues in a manner that is uncooperative and not focused on building a better team dynamic. Other strategies, such as more formalized care planning processes and introduction of care pathways with treatment protocols and anticipated discharge dates should also be explored and introduced. All team members should be required to follow the care plans and pathways, and required to communicate with the larger care team before any changes to the care plan are introduced.

Quality Concerns Amongst MH&A Staff

When asked about quality of care, interviewees were largely positive, although some did provide examples that suggest improvements could likely be made in some areas. Building on the conclusions presented immediately above, introduction of more formalized tools and processes to enable better, more integrated care planning and use of pathways and defined protocols will likely address many of the issues noted. The need for consequences for non-participation grounded in attitudes or behaviors that lead to sub-optimal team dynamics cannot be overstated.

MH&A does have a process to review critical incidents but some acknowledged the follow up on the recommendations is not always prompt nor completed. Incident report systems do exist but there seems to be a reluctance to use the system in that some staff stated nothing would be done anyway. For instance, the lack of responsiveness to responding to a consult could/should be a reason to submit an incident report but in most instances, this did not occur. Hence, the understanding of the magnitude of the problem is not good. MH&A leaders did acknowledge they had a suboptimal understanding of how quality data got recorded, evaluated and responded to. Specific areas that were raised during the interview process included processes and follow up to patients, presenting with violent behavior, who pose a safety risk to care providers as well as other safety concerns regarding staff safety, elopement for forensic patients and patient's smoking in rooms.

The Quality and Risk staff stated that recommendations were now being tracked and that implementation compliance was good. That said, the need to more actively engage psychiatrists in the formal quality review processes are required as they, and others, report that Psychiatrists have not been consistently involved over the years and the overall system quality system could benefit from their input and expertise.

Relevant Data

Information was provided regarding the sources of income for the psychiatrists in PEI. Psychiatrists receive funding in three major ways: salary, independent contract and fee for service. The difference between salary and contract is largely based on the benefits – contracted psychiatrists receive some overhead and support costs but do not qualify for health, pension and other benefits that the salaried (employed) psychiatrists receive. There is a small amount added in lieu of benefits to the hourly rate

[28] Health PEI Policy and Procedures Manual: Seniors Mental Health Resource Team Dated January 6, 2014.

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for some services to account for these differences.[29] Both salaried and contracted physicians are eligible to receive a Clinical Work Incentive (CWI). CWI is established to incentivize physicians to be productive and efficient. It sets minimum thresholds for the number of consultation claims and minimal fee for service equivalent submitted via shadow billing (50 claims and $40,000 respectively per quarter for psychiatrists that are prorated for those who are part time). If the psychiatrist meets those expectations in a quarter, they will receive 28% of the CWI billings above and beyond their salary or contract. If the shadow billing is less than the threshold, no CWI is paid.

For those psychiatrists on fee for service, there is no payment of any benefits or CWI. As independent practitioners, they are responsible for the office and practice overhead. Most psychiatrists receive some fee for service – from small amounts for seeing patients outside of regular working hours to several psychiatrists who are 100% on fee for service. For the last two fiscal years of April 1, 2012 to Mar 31, 22013, and for April 1, 2013 to YTD 2014 (Jan.20), one individual received over $500,000 in the last two years, 4 received between $100,000 and $500,000 in each year, 5 in 2012/13 and 3 in 2013/14 received between $50,000 and $100,000 and the remainder (8 in both 2013 and 2014) received less than $50,000 (this includes some psychiatrists on locums or who only worked part of the year). Hence there is a huge distribution of income on fee for service.

The distribution of payments to psychiatrists as of September 2013 is as follows: 5.6 FTEs on salary, 2.4 FTEs on contract and 4.2 FTEs on fee for service, for a total of 13.2 FTEs. Total annual payments to psychiatrists in the last two full fiscal years, 2011/12 and 2012/13, were $5.0 and $5.6 million respectively.

Summary of Key Issues

The following represents a summary of the major findings flagged through the process:

1. *Culture of separateness*: One overarching impression the CSI Team had after meeting with all the different disciplines was a sense of separateness grounded in historical roles or sectors, with many acknowledging that they continue to operate in 'silos'. This issue is not unique to PEI, but it does make implementation of initiatives designed to lead to improvements more challenging. A concerted effort on team building and communication is required.
2. *Physicians are disengaged:* The physicians admit to disengaging from the system for multiple reasons. Reversing this trend will require deliberate efforts by system leadership to engage physicians to make them feel more valued but will also require individual and collective commitments from the psychiatrists to become more active and make contributions that improve team processes and lead to better care for patient.
3. *Funding, contracts and accountability:* The current contractual/funding model for psychiatrists is not always aligned to meet the need for core service needs of Health PEI and there appears to be limited ability to define/manage the contribution by psychiatrists to these same services.
4. *Change environment*; Multiple reviews, several recommendations, numerous suggestions and lots of planning committees have been unable to make significant, concrete, lasting improvements to the MH&A system. This suggests an environment whereby change will continue to be challenging.
5. *Staff withdrawal and multi-level leadership:* Given the perceived lack of action stemming from prior reviews, some staff will likely struggle to proactively participate in change efforts.
6. *Quality of care:* Quality of care can always be improved in any system or program. Efforts to strengthen a culture of quality where people can constructively participate in the quality review processes must be pursued.
7. *Team environment:* Processes related to inter-professional team communication across units and sectors and disciplines must be improved.
8. *Family input:* Families spoke with passion about their concerns and expressed a deep founded desire for the system to work better for them and their loved ones. Organized input by families to the system constraints was not readily available.

[29] Master Agreement. Article C.5

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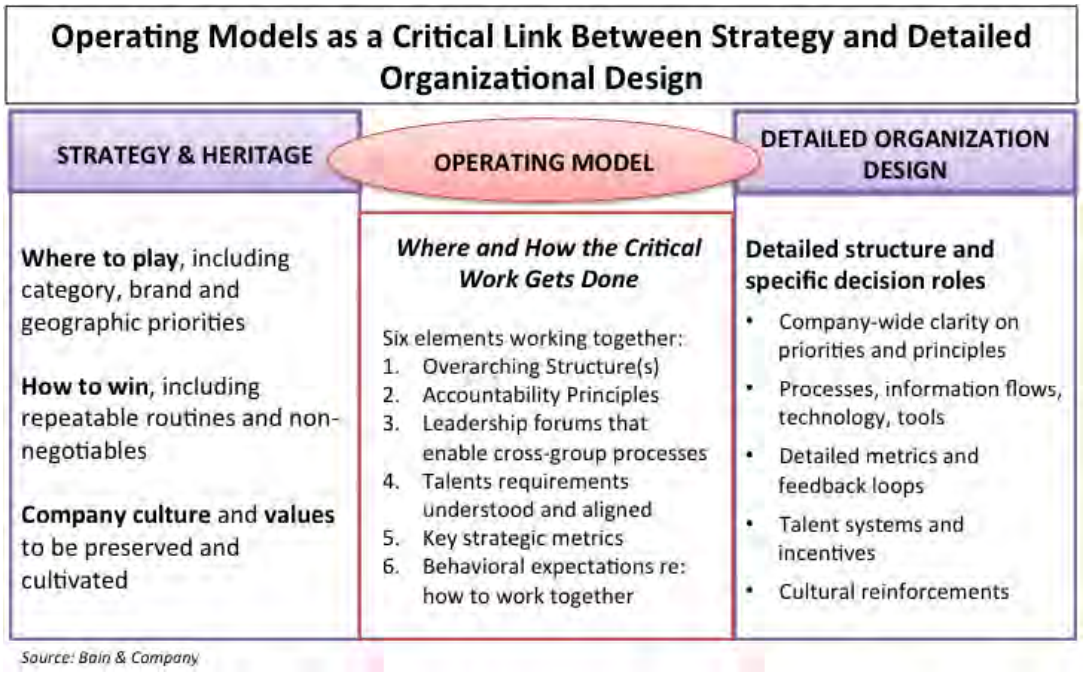
4.0 CREATING A FUTURE VISION AND PLANNING A TRANSITION

The issues summarized in the previous section have some commonalities and overlap with respect to impact as well as resolution strategies/recommendations. Accordingly, this section transitions away from the specific issues and presents a series of inter-connected "big picture" strategies that the CSI Team believes should be pursued to enable the program to pursue its desired future state.

In considering how to best frame the proposed recommendations/solutions, the Review Team decided that the overarching issue is the absence of an effective *Operating Model* within the MH&A Program. *Operating Models* are emerging as a formal tool that organizations are increasingly using to define structures, accountability frameworks/principles and organizational processes that will be consistently used to enable effective operational management and ensure success.

Bain and Company (2012), in their white paper *Winning Operating Models* note that an *operating model* "dictates where and how the critical work gets done, serving as the vital link between strategy and the detailed organization design that it puts in place to deliver on the strategy." The figure below is adapted from Bain's paper:



Applying the Operating Model framework to the issues outlined in this report, solutions are clustered under six thematic areas:

1. Leadership Structures
2. Accountability Principles/Frameworks
3. Cross-Group Processes
4. Quality Metrics
5. Patient and Family Engagement
6. Change Management Support

Each of the above is presented below with specific recommendations to aid in the implementation and achievement of change. It is important to note that ***all of the concepts and recommendations*** outlined were presented and **generally endorsed** at the Think Tank that was held on March 12th, which was attended by 10 psychiatrists, the Executive Director of Acute Care, Mental Health &

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Addictions, the ED of Medical Affairs, other senior admin representatives and leaders from the MH&A Program. Unfortunately, no addiction medicine physicians attended and the psychiatrists who practice mainly in Summerside were not present. One of the proposed strategies - *introduction of a new model for allocating resources to support medical service requirements within the MH&A Program* – was not endorsed by the Think Tank participants.

Overarching Structures

Editorial note: The discussion below uses the term Psychiatrist but is intended in almost all instances to be inclusive of Addiction Medicine physicians.

In 2009, the MH&A Program was created as Health PEI's first formal "Program" and the Department of Psychiatry was officially eliminated. As noted previously, Program Management models are typically built as *matrix management structures* that redefine the primary organizational construct by patient population, while maintaining some of the traditional structures that existed previously. The traditional structure(s) that are most often maintained reflect the need for ongoing professional practice relationships, thereby providing an ongoing community for each of the professional constituencies.

The process of understanding the importance of the above requires one to "step back" and consider the underlying theories of organizational design and program management.

- Glickman et al (2007) define organizational design as a formal, guided process for integrating the people, information, and technology of an organization – a process that serves as a key structural element that allows organizations to maximize value by matching organizational design to overall strategy. The authors go on to note that the attention to clinical quality is becoming more of a priority, suggesting that it will be essential for health care institutions to evolve organizational and management structures that design and create mechanisms for accountability related to quality of care and the pursuit of improvements in organizational performance[30].
- Other principles come from Nohria (1995) who states that[31], "Organizations exist to enable a group of people to effectively co-ordinate their efforts to get things done [recognizing] the pattern of organizational roles, relationships and procedures that enable coordinated action by its members."
- Finally, Senge (1994)[32] supports the concept of "systemic structure" that recognizes the "key interrelationships that influence behavior over time."

Building on the above references, the decision to eliminate the Department of Psychiatry when the MH&A Program was established represents a significant departure from the typical Program Management models and, in hindsight, may represent the most significant root cause for many of the issues identified in this review.

At the same time, the CSI Team is aware that a parallel review of physician structures is currently being conducted under the sponsorship of the Provincial MAC and the draft report from this review was shared with us. The report contains some excellent suggestions for change, although we were concerned with some concepts presented, most notably the suggestion presented in the draft recommendations for two separate Departments/Divisions of Psychiatry to be created - one for PCH and one for QEH/HH.

While we appreciate some of the rationale behind this recommendation (e.g. a desire to define a structure that ensures that the unique issues of each Hospital are well-represented), CSI feels strongly that implementing this model would be a mistake as it runs counter to the goals of a creating a *single* MH&A system that serves all of PEI. Indeed, we believe it will perpetuate the "silo mentality" that has prevented past efforts to build integrated solutions and set the goals of integration back for years.

Based on the feedback received, the creation of a single Department of Psychiatry with a renewed vision and effective function would be beneficial at the individual professional basis as well as for the Program. The process to create a department is outlined in the Health PEI Bylaws. Given this, we urge

[30] Nohria, N. (1995). Note on Organization Structure. Harvard Business School 1-19.
[31] Glickman, S.W. et al (2007). Promoting quality: the health-care organization from a management perspective, International Journal for Quality in Health Care 2007 19(6):341-348
[32] Senge, P. (1994). *The Fifth Discipline.* New York, New York: Currency Doubleday.

Health PEI to reconsider the organizational model and implement one that integrates clinical operations under a Program Model while understanding the importance to overlay a matrix structure that reflects the more traditional Departmental model.

Recommendation #1: A province-wide Department of Psychiatry and Addiction Medicine should be created to enable advancement of professional practice within the physician community. All practicing Psychiatrists and Addiction Medicine physicians should be required to be members of the Department. Primary Care providers / family physicians, that support addictions treatment, should be offered associate status in the Department. A Division Head or Clinical Lead for Addiction Medicine should also be identified.

Accountability Principles/Frameworks

Creation of a bifurcated structural model comprised of both a Departmental structure and Program/Operational model can create certain challenges as confusion can exist regarding which issues get addressed within which structure. To avoid this, contemporary models must clearly delineate *and differentiate* professional practice responsibilities (that fall under the purview of the Executive Director, Medical Affairs) from issues that reflect operational mandates and report (largely) to the Executive Director of Acute Care, Mental Health & Addictions.

While the Medical Director role description exists, a new role description will need to be defined for the Department Head. Key to the areas of responsibility must be a focus on providing leadership and overseeing the professionalism of departmental members. Defined responsibilities should include:

- Work with individual members of the Department to plan and support his/her professional and career development and link that to the vision and needs of the Department and program;
- Provide annual evaluations of the members of the Department (a strategy of how to evaluate psychiatrists is outlined in detail below in the discussion in Section 4.5, *Quality of care*);
- Lead the Department in the creation of departmental policies over various issues such as notification for taking holidays or attending conferences, response times for consultation, process and time for dictating patient assessments (to minimize the need for repeat second assessments and to enhance communication within the therapeutic team), responsibilities for dictating therapeutic plans for patients as inpatient and on discharge, including with whom the plans will be shared, etc.; and
- Address any sub-optimal behaviours or practices of members of the department that pertain to their professionalism as psychiatrists.

The role of the department head in a department is largely based on addressing improvement ideas for professionalism of the individual department members. It involves understanding the individual's specific career goals and objectives, and current practices as well as the team's perception of his/her knowledge and contribution to the team function.

In the past, the psychiatrists elected the Department Head. While the CSI Team has a bias to have Department Heads named/selected through a formal search committee process, election of a head by the group is also a viable option, as it would give the psychiatrists a stake in choosing their own professional practice leader. The potential downside of an election model is that it can often be seen as "drawing the shirt straw" or a "rotational job" where everyone ultimately takes their turn serving as the Head. Given the importance of this role in the overall leadership structure, it cannot be viewed as a rotational job.

Regardless of the process to select a Department Head, clear responsibilities and expectations for the Department Head must be articulated so that performance can be appropriately evaluated. Articulation of duties and formal performance management processes also help justify a stipend (which the CSI Team views as an essential part of the future leadership model).

Given the structure of a Department and Program, there will be specific expectations for leaders and Department members individually. Each individual will have clinical and professional responsibilities and expectations as outlined in their contracts for salaried or contracted staff and as found in the to-

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be-developed departmental policies.[33] Compliance to standards and quality of care must be monitored and, where necessary, acted on. It must also be clear that professional standards are to be high, that breaches will be followed up and consequences may ensue. Follow up to assess compliance will be the duty of the Program Medical Director or the Department Head depending on the issue. With the stronger group dynamic, there will also be peer pressure in the group for everyone to have high quality in a balanced work environment.

Role expectations need to be explicit and so too must be accountability. The Department Head and Program Medical Director must have clear job descriptions that define and differentiate expectations for each role. Support must come from the senior leadership who themselves must be accountable for ensuring the expectations are defined and met. Regular evaluation of the medical leaders increases their accountability and must be an expectation of senior leaders.

Recommendation #2: A Department Head role should be created, with clearly defined province-wide leadership responsibilities and accountabilities. The Head should be part of the Provincial Medical Advisory Committee and report to the Chair of the MAC (and ultimately the Board) through the appropriate governance/leadership structures.

Recommendation #3: The process to select/appoint the Department Head (and the Division Head/Clinical Lead for Addiction Medicine) needs to be confirmed and initiated with the goal of having the Head(s) named as soon as possible.

Recommendation #4: Health PEI will need to clearly delineate/differentiate the role of the Department Head from that of the Program Medical Director, with the latter serving as Co-Director of the MH&A Program. The accountability model for the Medical Director also needs to be confirmed, including whether he/she has specific accountabilities that are distinct/separate from the Operations Director or if the two are intended to function as a dyad with collective/joint accountabilities for operational matters. The reporting relationships to executive team members for both roles also need to be confirmed.

Recommendation #5: Individual members of the Department of Psychiatry should be encouraged to participate in departmental and/or program initiatives (e.g. serving on Committees or Working Groups). This could eventually be a condition of maintaining privileges but initially it should be a voluntary model.

Leadership and Decision Making

The process of decision-making within the new Department must also be considered. In health care, decisions tend to occur in a mixture of consensus, dictate or, most preferably, by the principles of organizational justice. Consensus is required mainly amongst a group of equals and most departments use consensus to reach decisions. Some departments have found that a very small portion of a group can essentially veto changes because consensus is not achieved. To avoid this, some agreement should be reached regarding what constitutes consensus. CSI has often stated that consensus reflects the majority view where the dissenters agree to live with the result.

[33] All psychiatrists irrespective of funding model are expected to comply with the Bylaws, Rules and Hospital/Department policies.

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Recommendation #6: The Department of Psychiatry, led by the Department Head, should consider defining exactly what 'consensus' means operationally to the psychiatrist group. This would clarify and forward a more cohesive approach to decision-making and reduce the likelihood for conflict when issues are presented to the group and a collective position or decision needs to be made.

Quality of Care

Optimal quality of care is clearly an overarching goal of the Program, yet staff express concerns regarding the ability to pursue quality improvement processes within a team-based model that allows for constructive discussions regarding potential operational issues or professional practice behaviors have the potential to impact quality.

Strategies to manage system quality issues are complex and the Health PEI has expert quality consultants to provide support for evaluating systems and making improvements. While a detailed discussion of the processes would not be useful in this document, we note that contemporary quality frameworks define quality along multiple dimensions and Program leaders are fully committed to advancing their internal processes to ensure a more active and focused effort is pursued/utilized.

To that end, the Program has formed a committee that studies quality and patient safety issues. The only concern noted by the CSI Team is that psychiatrists are not currently participating in this effort and that must change if a true inter-professional model is going to be leveraged.

Recommendation #7: the MH&A Program should redesign its current structures and processes for quality management/improvement and identify a minimum of 1 psychiatrist to be added to the Program Quality Committee. The Department Head should also ensure that professional practice processes and structures for quality reviews are established.

To support the implementation of the above recommendation, CSI had the opportunity of discussing strategies under development in the Vancouver Coastal Health Authority for the assessment of quality of care for psychiatrists.[34] An overview of the strategies is presented below:

1. Extraction of clinical information from specific databases[35]
2. Distribution of diagnoses, consults vs. follow ups - Over the last 12 months, determine the distribution of diagnoses/follow ups seen by each psychiatrist and determine if there are a few with a significant variation from the average. Determine if the variation is significant – e.g., based on practice differences, or if related to a practice pattern different from anticipated or desired.
3. Psychosis NOS (not otherwise specified) - The concern is that psychosis NOS may reflect an "inadequate" effort to classify the patient according to a diagnosis given there are various diagnoses under the term psychosis NOS, some with different treatments. Consequently, a psychiatrist who has a much higher percentage of psychosis NOS may be doing a disservice to his/her patients compared to colleagues.
4. Specific therapeutic interventions based on evidence.
    - Bipolar disorders should be on a mood stabilizer or a second generation anti-psychotic. Assess the percentage of patients that are not.
    - There should not be anti-depressant mono-therapy for bipolar disorders.
    - Combining 3 or more antipsychotic medications is considered poor practice.
5. Perform a 360 assessment every 3-5 years
6. Complete an annual assessment composed of some or all of:

[34] Personal communication with Dr. Lakshmi Yatham, Professor of Psychiatry, Regional Head, Department of Psychiatry, Vancouver Coastal Health and Providence Healthcare, Regional Program Medical Director, Mental Health and Addictions, Vancouver Coastal Health.

[35] The extraction of information from specific databases can be a powerful tool to find objective data but it presumes the information is collected and access is permissible. The relevant databases exist in BC.

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- attendance at rounds, Medical Staff meetings, Department meetings, continuing professional education, and contributions to committees
- a self assessment (which can be useful as a supplement to 3.c),
- review meeting with Department Head

7. Familiarity with the Mental Health Act: Given the importance of the Mental Health Act to psychiatrists, they are expected to understand their authorities and responsibilities. VCH has developed an educational package that all psychiatrists are expected to review and know for the province of BC.
8. System performance issues: For example, to assess the time taken to dictate a discharge summary, discharge plan, attendance at case conferences, etc.

These various measures can and should lead to opportunities for improvement in professional behavior and quality of care. They should not be interpreted as being critical of specific individuals but as providing opportunity to recognize what part of one's own practice might not be meeting the standards of the literature or colleagues. It is the experience of the CSI Team that presenting individual physicians with meaningful data can be a basis for improvement. Most physicians are appreciative to know of opportunities to improve care to patients. It is rare that, given good data, physicians lack insight and refuse to change their practices. Those rare cases identify individuals most groups do not want as members of their team. It goes without saying that the assessment and subsequent actions taken for all investigations must be based on due process, fairness and collaboration and, particularly the latter, will require considerable support from senior administrators.

Client and Family Role

Patient and family input into quality of care or patient safety concerns is critical for a program to be high quality. Input can be achieved in two major ways:

- General opportunity for all patients and families to describe what they liked or didn't like about the care they received; and
- Opportunity for specific input from capable individuals into committees that have responsibilities to assess and change clinical services to meet quality/patient safety demands.

Not all patients or family members can perform the latter conceptual input but all patients and family members should be able to express their concerns and know they will receive a response. Sometimes complaints are "frivolous" but all must be assessed to determine their legitimacy. If several complaints turn into a major theme then, specific action is definitely required. Some patients/family members have the ability to go beyond any personal agendas and look at the bigger picture and provide wonderful ideas. Many quality and patient safety organizations are developing specific committees to provide that input. There are examples of patient satisfaction surveys that may be used, or adapted, for the MH&A Program.

Recommendation #8: the MH&A Program should review its systems and processes for including patients and families in its formal quality management processes and ensure that mechanisms for receiving and utilizing patient and family feedback as part of an integrated quality strategy are in place.

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5.0 PLANNING FOR IMPLEMENTATION

A key issue moving forward will be a Change Management framework. Change is difficult in most environments but it is reportedly more difficult in PEI. Once a culture of resistance to change develops, it can be very difficult to move forward. There are many reasons why change efforts fail, and some of the best-known work in this area was completed by Harvard Professor Dr. John Kotter several years ago. Kotter's work[36] is too detailed to fully present here, but the 8 key stages or attributes of effective change processes he identifies are presented in the table below, along with a general summary of the actions required and pitfalls that must be avoided at each stage.

Stage	Action Needed	Pitfalls
Establish a sense of urgency	Examine organizational and system-level realities for potential crises and untapped opportunities. Convince at least 75% of your managers that the status quo is more dangerous than the unknown.	Underestimating the difficulty of driving people from their comfort zones Becoming paralyzed by risks
Form a powerful guiding coalition	Assemble a group with shared commitment and enough power to lead the change effort. Encourage the coalition to function as a team outside the normal hierarchy.	No prior experience in teamwork at the top Relegating team leadership to an HR, quality, or strategic-planning executive rather than a senior line manager
Create a vision	Create a vision to direct the change effort. Develop strategies for realizing that vision.	Presenting a vision that's too complicated or vague to be communicated in five minutes
Communicate the vision	Use every vehicle possible to communicate the new vision and strategies for achieving it. Teach new behaviors by the example of the guiding coalition.	Under-communicating the vision Behaving in ways antithetical to the vision
Empower others to act on the vision	Remove or alter systems or structures undermining the vision. Encourage risk taking and nontraditional ideas, activities, and actions.	Failing to remove powerful individuals who resist the change effort
Plan for and create short-term wins	Define and engineer visible performance improvements. Recognize and reward employees contributing to those improvements.	Leaving short-term successes up to chance Failing to score successes early enough (12 months into the change effort)
Consolidate improvements and produce more change	Use increased credibility from early wins to change systems, structures, and policies undermining the vision. Hire, promote, and develop employees who can implement the vision. Reinvigorate the change process with new projects and change agents.	Declaring victory too soon — with the first performance improvement Allowing resistors to convince "troops" that the war has been won
Institutionalize new approaches	Articulate connections between new behaviors and corporate success. Create leadership development and succession plans consistent with the new approach.	Not creating new social norms and shared values consistent with changes Promoting people into leadership positions who don't personify the new approach

As the leadership team prepares to undertake more detailed implementation planning, use of the Operating Model Framework presented previously, and a change management framework such as the one above should be used to guide the work.

[36] Leading Change: Why Transformation Efforts Fail. Kotter,JP. Harvard Business Rev, March/April 1995, pg 59.

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