Fraser Health Review:
Governance, Operational Management, and Relationships with Physicians, Staff, Divisions of Family Practice, and the Ministry of Health

Report from the FGH Working Group
March 2014
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Introduction

On October 31, 2013, the Ministry of Health issued Ministerial Order M-282: Fraser Health Authority Special Directions Regulation under the Health Authorities Act. As part of this Regulation, the Fraser Health Authority (FH) Board was directed to conduct a review of its Health Authority for purposes of creating a strategic and operational plan for the next three fiscal years. This review was conducted with the assistance of the Review Committee which is comprised of the Board Chairs of FH and Northern Health Authority, and the Associate Deputy Minister and Chief Administrative Officer, Ministry of Health.

The Regulation, in Section 4, identified eight areas to be included in scope for the review (items ‘a’ through ‘h’). Three separate working groups were constituted to address specific scope areas: Working Group ABC, Working Group DE and Working Group FGH (named after their scope from section 4(2) in the Regulation).

This report provides the findings from Working Group FGH and is the result of extensive interviews with:

1. FH Board members;
2. FH Senior leadership;
3. FH Senior medical leadership;
4. Management at four FH sites (seven focus groups in total);
   a. Surrey Memorial Hospital (SMH);
   b. Royal Columbian Hospital (RCH);
   c. Langley Memorial Hospital (LMH); and
   d. Abbotsford Regional Hospital (ARH).
5. Site leadership;
6. Senior staff at the Ministry of Health (“the Ministry”);
7. Executives from Divisions of Family Practice; and
8. Residential Care leadership (FH-owned and operated and contracted sites).
Our report contains findings and areas for consideration in each of the following areas:

1. Governance.
2. Operational Management.
4. Relationships and Engagement with Staff.
5. Engagement with Other Stakeholders: Divisions of Family Practice.
6. Relationship with the Ministry.

This report is meant to inform the FH Board of opportunities to improve the efficiency and effectiveness of its operational organization.
Governance

CONTEXT

The FH Board of Directors has a primary responsibility to foster the Authority’s short- and long-term success consistent with the Board’s responsibilities to the Government. It has leadership, stewardship and oversight responsibilities for FH. It sets the tone and direction of the organization within the authority delegated to it by the Minister. Its role is fiduciary and includes a wide range of interests and responsibilities, including strategic planning, quality, risk management, organizational and management capacity, internal control, ethics and values, and communications. The CEO provides leadership for FH under the Board’s overall guidance and direction.

Our focus on governance of FH was aimed at obtaining insights on Board processes; how information and dialogue from management assists the Board in carrying out its governance role and how the Board can better support management as it moves forward with its challenging agenda. Meetings were held with the Chair of the Board, Board Directors, and the CEO to obtain their perspectives. All were forthcoming with their views. Information gathered in management interviews also formed a part of our thinking. In addition, we conducted research into best governance practices in the public service.

THEMES

Building on the dedication to FH demonstrated by the Board and management, we identified several themes for consideration: Board/Management interactions; Board roles; Board processes; Board composition, orientation and development; evaluation and succession planning; and clinical governance.

1. Board/Management Interactions; Board Roles

- Directors have a good rapport with each other, are passionate about FH, and devote a fair amount of time to the organization through Board meetings and FH functions.

- Directors are strongly aligned with and have collegial relationships with the CEO and Executive team. Some Board members indicated that, due to this Board/management dynamic, tough questions of management were not encouraged at meetings.

- The Board recognizes the challenges facing FH. The Board feels FH - given its growth, diverse population, and limitations on options for cutting the budget - is unable to obtain the required resources to meet patient care demands. This is a matter of concern for the directors overall.
• Budget and quality issues are top of mind for the Board. However, there is insufficient focus on the strategic agenda, with some Board members not able to identify many of the strategic issues for the organization.

2. Board Processes

• There are four full Board meetings a year and a number of teleconferences on specific topics. The number of meetings and time allocated for each full board meeting is insufficient for the depth of dialogue and rigorous debate required to appreciate and address major issues - particularly given the complexity and size of FH.

• The Board is presented with voluminous material for each meeting. There are a large number of presentations. Often, underlying assumptions and rationale - which are key to understanding the information presented - are not readily available.

• FH Board meetings have a highly structured agenda that does not allow for directors to engage in creative, “upstream” thinking; it is much more practical, therefore, to ask questions about what is presented rather than test assumptions, conclusions and options explored. It is also difficult to move to strategic issues within four hours of a heavy tactical agenda.

• Not all complex material such as indicators are included in the Board Quality Performance Committee package. Often indicators, KPIs, and trend information are provided in a “live” presentation. The information is current but does not allow for Board members to review the material ahead of time and develop their thoughts and questions. It does not allow for examination of leading indicators, evaluation of trends, or assessment of action plans to adequate depth needed to foresee and address problems and prevent constant crises situations.

• The Ministry has taken on the role of the Board to initiate action when issues reach a crisis state.

3. Board Composition, Orientation and Development

• The FH Board is representative of the broader FH community. Recent Board additions bring valuable experience to the organization.

• FH is a complex organization. It takes new directors several meetings to understand the complexities and strategic issues facing an organization of this size. Given the infrequency of meetings, some directors have said it took them at least one or two years to get comfortable with the material and ask questions.
The current orientation for new directors consists of assigning a director-mentor to each new director and one-day meetings with different FH leaders.

4. Evaluation and Succession Planning

- No formal Board Chair, Committee and director evaluations are conducted with the exception of self-evaluations done under the aegis of the Accreditation process. These were last done in 2011 and are to be re-done this year. A review of the 2011 self-evaluations suggest that there were widely varying perspectives on the Board’s role and responsibilities. The Board has indicated that a more stringent and tailored evaluation process is a priority for this year.

- The objectives set for the CEO are a roll-up of all the operational objectives of the direct reports (74 operational objectives in total). The CEO does not have strategic personal and overall organizational objectives that he can be measured against.

- We understand that there is a succession planning process in place for the Board and the CEO which is discussed at the Governance & HR Committee but not at the full Board table.

- Our review suggests that a more formal CEO succession planning process cascaded to the leadership in the organization is not readily available. The Board has also indicated that CEO succession planning is a priority for this year.

5. Clinical Governance

There is limited opportunity for the Board to interact with senior medical leadership on professional affairs and quality issues. While the Board does receive regular reports from the Chair of HAMAC (Health Authority Medical Advisory Committee), the Chair of HAMAC does not always have the opportunity to be involved in Board deliberations that impact the medical community.

Please refer to “Physician Interaction with the Board” in the Relationships and Collaboration with Physicians section of this report for more detailed findings.

AREAS FOR CONSIDERATION

1. Board/Management Interactions; Board Roles

The Board should consider:

- Creating an atmosphere that promotes a healthy tension and a strategic view in testing of management’s information, assumptions and conclusions. This will lead to improved
deliberations and bring focus to critical issues, more cohesive decision-making and assist in creating different options for consideration.

- Repositioning their stance to recognize their role in implementing the Ministry’s agenda.
- Paying significant, continual attention to ensure that FH makes the best use of its resources to achieve quality within a balanced budget, consistent with its responsibilities to the government.
- Developing and/or revisiting the strategic plan annually in conjunction with management. The Board should consider monitoring progress of the agreed upon strategic agenda through regular management updates.
- Developing four or five strategic priorities upon which to focus. The focus will help FH anticipate/solve major upcoming issues. This should include two major priorities boards normally focus on: organizational capacity in the context of people; and leadership succession planning. These two areas are key strategic items at FH. Note: The Board’s focus on the “150-day challenge” and the creation of the Access & Flow Board Subcommittee are good examples of how focus assisted FH in addressing a major issue.

2. Board Processes

The Board should consider:

- Allowing maximum time in meetings for discussion, exploration and testing of information, assumptions and conclusions provided by management, and creative and “upstream” thinking, particularly on strategic items.
- Ensuring that its members have key information, including material for management presentations, ahead of time to review and prepare for in-depth dialogue at Board meetings.
- Organizing the agenda according to priorities, e.g.
  - Allocate the first part of the meeting to the strategic agenda of the Board and include a review of Key Performance Indicators. The Board will then be able to spend more time on strategy and perform its monitoring role more effectively. This section of the meeting would be followed by:
    - Decision items that the Board needs to review and deliberate upon.
    - Information items.
• Presentations for Board development (in separate sessions or included with a dinner meeting, for example).

• Adding another full two-day Board meeting annually to the four full two-day meetings and topic-specific Board teleconferences now in place. The additional meeting will allow more time for the depth of dialogue and rigorous debate required to appreciate and address the major issues to the level needed to foresee and address problems and help prevent crises from occurring. Note: Many health authorities have five or six Board meetings in addition to teleconference meetings on specific items such as credentialing or ratification of agreements.

• Reducing, re-aligning and repackaging the material presented to directors in preparation for Board meetings with a view to placing paramount importance on strategic items. This will help to ensure that directors can review critical matters thoroughly.

• Providing more input into setting agendas to ensure Board priority issues are addressed.

3. **Board Composition, Orientation and Development**

   The Board should consider:

   • Targeting candidates with experience in governance of multi-function, large, complex corporate organizations to replace Board members as they turn over.

   • Introducing a re-vamped orientation process to expedite new directors’ understanding and knowledge of the business. In addition, provide a one-day session about what it means to be a director of a public sector board in the context of its relationship with the Ministry.

   • Mandating governance education as a requirement for all directors.

   • During the recruitment process, taking into account potential directors’ governance experience.

4. **Evaluation and Succession Planning**

   The Board should consider:

   • Supplementing the Accreditation Canada Sustainable Governance Questionnaire conducted every two to three years with an annual Board self-assessment. The Board should commit to conducting regular evaluations of the Board for the Chair, Committees and individual directors. Directors should consider Including Ministry relations as one of the indicators in the evaluation process.
- Having the CEO develop four to five CEO-specific strategic objectives supplementing the CEO operational objectives. The CEO-specific strategic objectives should be reviewed and endorsed by the Board. The CEO would be accountable to the Board for delivering on these objectives.

- Ensuring the CEO evaluation, over and above the roll-up of direct report objectives, also involves a 360° feedback process and an assessment of the four to five CEO-specific objectives.

- Introducing a robust succession plan for the CEO and the leadership team.

- Discussing succession planning for the Board and the CEO at the full Board table, as well as at the Governance & HR Committee table. The Board should consider updating and presenting annually the succession plan for the CEO.

- Reviewing the “People Plan” in the same way as it reviews and approves the strategic plan to ensure that a talent management strategy is well-aligned with the future needs of FH.

5. **Clinical Governance**

   The Board should consider enhancing HAMAC Chair participation at the Board meetings. It is recognized that HAMAC is the primary vehicle for interaction between the Board and medical community on professional affairs (credentialing and discipline) and quality. As such, there needs to be significant interaction between the Board and HAMAC. There may also be some high level strategic issues that the HAMAC Chair could discuss that would guide the Board and management’s strategic priorities.
Operational Management

CONTEXT

FH is organized as a matrix. The primary organizing structures are the 17 programs, each with responsibility for its own budget and for developing a service plan to guide its activities. The programs have direct operational responsibilities at sites; Executive Directors (ED) and Program Medical Directors (PMD) have joint responsibility for Programs. Executive Directors also have responsibility for sites.

Our focus on operational management was aimed at assessing the organization’s structure and roles; the effectiveness in planning and prioritizing; the systems of reporting and accountabilities; and the relationships between programs and on-site staff.

THEMES

A number of key themes were identified in our interviews with Fraser Health’s management. They relate to leadership; planning; dealing with crises; programs; workloads; and culture.

1. Leadership

- There has been significant turnover in senior management (Vice President, Executive Director positions). FH has conducted a review of the situation and found there were multiple reasons for this turnover including retirements, resignations, and departures for career advancements either within FH or in other organizations.

- Lack of continuity in senior positions is a major issue for FH. Changes in leadership affect:
  - Relationships. For example, PMDs indicated that new EDs did not understand the role of the dyad and it took time to establish a relationship in which the new ED and PMD were working in an optimal way;
  - Progress in planning and implementation of initiatives. For example, both Divisions of Family Practice and Residential Care facilities spoke about how changes in leadership affected progress in moving forward. They commented on the need to revisit topics that were previously addressed. Several people commented that they were never sure who would attend meetings as players changed frequently; and
Decision-making. New EDs and directors are uncertain on how to address problems. This is normal but leads to a need to escalate decisions resulting in delays and increased operational burden on management.

- VPs, who must remain focused on strategic priorities and identify and address emerging issues, are focused on the operational. This is understandable in a crisis situation but should not be the norm. By staying heavily involved, they are often called upon to make decisions that EDs or directors can and should make.

2. Planning

Fraser Health’s strategic planning framework is centred on six strategic imperatives that are aligned to the Ministry’s strategic priorities:

1. Capacity;
2. Quality and Safety;
3. Integration;
4. Progressive Partnerships;
5. Research and Academic Development; and

Planning within FH occurs at both the organization level and at the program level.

The organization planning takes into account goals related to the clinical programs, the organizational structure, and the Ministry. FH considers all goals in developing its top priorities for the year.

FH currently has 74 high priority initiatives, of which 20 have been identified as top priority. All initiatives are linked to the strategic imperatives. These initiatives are reviewed and updated each quarter providing an opportunity to update/reprioritize as the year progresses.

Each program is required to prepare an annual service plan which includes a prioritized list of initiatives. In total, there are over 1,000 initiatives (many of which are inactive) across all programs. Programs are tasked with executing the organization’s top priorities with additional program-based initiatives implemented as capacity allows.
Key Findings related to Planning include:

- The VP Operations & Strategic Planning spends approximately five per cent (5%) of his time on strategic planning activities. The planning process is widely distributed which contributes to a higher number of initiatives.

- The programs are given flexibility in how they prepare their service plans. Some programs are more advanced in their development and look at demand forecasts and service models over three years, engage multiple levels of staff in the process and utilize FH project management support to facilitate planning work. Other programs simply identify their top 10 initiatives for the year and do not formally document service plans. Most program planning falls somewhere in the middle of this continuum.

- The organization recognizes that it has too many initiatives. Additional high priority initiatives arise throughout the year from the Ministry, Programs and the Executive team. One interviewee commented that “strategy is deciding what not to do”.

- Of the 20 top priorities as of February 2014, 6 were on track and 14 at risk of falling off track. The CEO Performance Report takes into account all high priority initiatives (74). Of these, 35 are on track; 31 are at risk of falling off track and 8 are off track. The number of “at risk” initiatives is an indicator that there may be too many priorities.

- Some initiatives are loosely linked to imperatives and may not align with FH priorities.

- Many managers we interviewed felt that initiatives do not always meet intended objectives. Results are not always measured and many improvements not sustained as the focus shifts to implementing the next initiative.

- Managers indicated that frontline staff at the sites feels overwhelmed by the number of initiatives.

- Programs meet to discuss their service plans. Communication gaps occur, as information cascades from senior management to the site level. Several examples were given whereby the Site Director and/or site managers only became aware of initiatives that impacted their areas after implementation had begun.

- Despite the emphasis placed on the necessity of improved integration with community services, the community-oriented programs do not engage in joint planning. For example, Divisions of Family Practice and Residential Care are not informed of FH’s plans as they affect them (e.g. Primary Care, Home Health plans, Mental Health plans). Plans are not shared across the hospital-community continuum and across the FH network.
3. **Dealing with Crises**

Several people we interviewed commented on the “Fraser factor”, a reference to staff’s “can do” attitude and ability to deal with adversity/crisis and to “get the work done”. This quality is a valued attribute for crisis situations and speaks to the culture of FH and the dedication of its staff.

- Many examples were cited where FH staff were required to deal with crises:
  - In several cases, issues had existed for a long time. FH was aware of the situations but was not addressing them.
  - In some cases, initiatives were in place to resolve the issues but were not achieving the desired outcomes, e.g. high overtime rates, congestion.
- The Ministry has had to intervene several times to resolve crises at FH. The perception is that these situations would not have been resolved had the Ministry not stepped in.
- FH staff rally when faced with a crisis and expend significant energy to overcome it (e.g. flooding).
- There exists a belief that some issues are caused by budget constraints or by other factors beyond FH’s control.
- Staff are often focused on short-term fixes and do not appear to have the skills, tools, processes, approaches or time to solve problems.
- There are often no on-site resources with sufficient responsibility and authority to sustain improvements.
- VPs spend a significant amount of time dealing with operational issues, often at the expense of the strategic agenda.

4. **Programs**

FH rolled out its current program management model approximately four years ago. Under this model, programs have accountabilities and responsibilities for services at each site (as compared to a site model where site leadership has accountability and responsibility for all programs on each site). Programs are responsible for quality, planning and budgets.

Staff are supportive of the program model. Many indicated that conversion to a program model was needed to achieve major change in the organization. It has taken time to implement and programs are at differing levels of maturity. A great deal had been accomplished in achieving benefits related to standardization of care and the ability to move patients across sites.
Programs in Relation to Sites

Key Findings are centred on how effectively the program model is operating and impacts on quality and budget.

- Early focus in implementing the program model centred on standardization benefits and implementation of new responsibilities associated with the structure. The focus was to build strength in the programs.

- Many acknowledge that this initial approach was necessary to achieve the degree of change needed. In retrospect, there was not enough focus on the importance of the site.

- FH has recognized the need to revisit site responsibilities and, as part of the “150 Day Challenge,” has moved accountability for the on-site Access and Flow and Infection Control staff to the Site Directors.

- Programs tend to operate in silos at the site level with an “us” and “them” mentality. Problems are bounced from one program to another.

- Sites rely on programs communicating their plans at Multidisciplinary Healthcare Coordinating Committee meetings. These meetings are not well-attended at some sites. In addition, programs do not communicate all initiatives and projects underway at the site.

- Site-specific plans do not exist. There is no information source that documents anticipated program changes, patient volumes and initiatives at a site. The lack of a site plan hinders the site’s ability to adequately prepare for change.

- Site Directors have limited authority to make decisions on their respective sites. The role relies on relationships and an ability to influence in order to affect the desired changes/decisions. Often this approach is a slow one, because of the need to involve many decision-makers at the director or Executive Director level.

- Site Directors do not have visibility into budgets for programs operating at their site.

- Some staff indicated that sites operate under a culture of seeking permission. As an example, one site identified an opportunity to improve discharge situations. The opportunity involved more than one program and, as such, permission had to be sought by going up the program hierarchy of both programs for approvals. This process took days to obtain authorization. Several sites had similar examples of occasions wherein they did not have the authority to make decisions of a relatively minor nature to enhance site efficiency.
Programs in Relation to Services Delivered in the Community

- Not all programs have redesigned their approach to deliver services in a way that integrates and coordinates with residential care services or community-based services. For example:
  - Home Health do not always have the resources to perform assessments in a timely way, resulting in delays in discharge to a community service;
  - Care facilities often have capacity but patient assessments have not been completed;
  - Goals across the hospital-community continuum need to be better aligned to establish effective transitions; and
  - Residential Care-ER-Residential Care transitions need to be seamless to ensure the patient returns to an appropriate facility upon discharge from the hospital setting.

- The five community-oriented programs report to three VPs Clinical Operations.

<table>
<thead>
<tr>
<th>Program</th>
<th>VP</th>
<th>ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Care</td>
<td>Colleen Hart</td>
<td>Petra Pardy</td>
</tr>
<tr>
<td>Home Health, End of Life, PATH</td>
<td>Marc Pelletier</td>
<td>Catherine Butler</td>
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<tr>
<td>Mental Health &amp; Substance Abuse</td>
<td>Lois Dixon</td>
<td>Andy Libbiter</td>
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<td>Residential Care</td>
<td>Lois Dixon</td>
<td>Keith McBain</td>
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<tr>
<td>Older Adult</td>
<td>Lois Dixon</td>
<td>Valerie Spurell</td>
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5. Workloads

- Managers’ workloads have increased as support services previously provided on site (e.g. Recruiting, Occupational Health and Safety, infection control and quality duties) are now being performed by site managers.

- Managers feel that there are too many initiatives being implemented at their sites. However, there is not enough implementation support, leading to downstream problems. Initiatives are often not achieving stated objectives.

- Managers indicate that frontline staff are becoming overwhelmed and disengaged leading to a “just tell me what to do” attitude.

- Staying in a perpetual “implementation mode” and a heavy workload contributes to a culture of firefighting with little time available for proactive issue resolution and management of staff.
• There is no overall coordinated, intentional and continual improvement program. For example, Q12 results that can be used to identify and target improvements are viewed as an HR project. Annual performance reviews are viewed as an extra task rather than as an opportunity to engage with staff.

• Many managers have more than 100 staff reporting to them (often as many as 150 or 200). It is difficult to find time to properly support the staff. This problem is exacerbated when managers have multi-site responsibilities as they often do not know some of their staff. Managers’ ability to conduct staff performance reviews becomes a challenge.

• Managers acknowledge that FH provides many courses to support professional development. Most do not sign up as they cannot afford the time off away from their units due to work demands.

• Managers do not receive adequate on-the-job “manager training” and rely on peers for guidance on how to handle day-to-day situations (whom to talk to/for what/when).

6. Culture

During our interview process, we noted recurring themes across the organization that, when viewed together, define the organization’s culture. Fraser Health’s culture impacts the way it addresses issues and performs its work. Ultimately, the culture will impact on the quality of patient care that FH provides.

Key Findings

• The “Fraser Factor”, i.e. a can-do attitude, is part of the culture.

• Managers describe their staff as passionate, caring people who are dedicated to patient care.

• Managers genuinely enjoy sessions that provide information feedback on how they are performing.

• Quarterly Business Meetings are well-received and help build teamwork across the organization.

• For some sites, the collegiality of the manager team is a meaningful benefit of their job. Other sites had relatively new managers and, accordingly, the team dynamics were in earlier stages of evolution.
• Smaller sites have less cohesion as assigned management tends to have multi-site responsibilities at all levels. As a result, management spends time at smaller sites only as time permits. It takes longer for a “team” mentality to take hold.

• There is exhaustion in the system due to high workloads, constant firefighting and lack of resources.

• Some stated that there is a culture of seeking permission at the site level where decisions need to be escalated up the program hierarchy. This aspect is viewed as disempowering.

• Managers have a high awareness of budget issues. This awareness has translated into a feeling that nothing can be done unless there is more money. This message cascades from senior management. Management consistently notes that FH is underfunded, often using Vancouver Coastal Health (VCH) as a comparison.

• Budgeting is a top-down process with managers having no input into budget decisions.

• Multi-site responsibilities at the director and manager level lead to constant double- and triple-booking for meetings. People tend to run in and out of meetings, arrive late, cancel at the last moment, and/or call in while in transit. Meeting organizers are often unsure who will show up for meetings.

• Management often identifies reasons for issues but are unable to address or resolve them.

AREAS FOR CONSIDERATION

1. Leadership

FH leadership is extremely busy dealing with complex and consuming issues such as congestion, population growth, major redevelopment projects and program priorities. Despite these demanding workloads, the organization still requires and would benefit from focusing on the strategic issues in order to be able to transition from an environment of firefighting to one of issues management and mitigation.

FH should consider the following:

• Reconsider the current executive medical leadership’s role in order to enhance medical operational leadership at the Executive table. (Note: Please refer to Relationships and Collaboration with Physicians section in this report.)

• Focus on senior leader turnover and how to retain talented people.
• Implement an ED and director readiness and succession plan. The purpose is to identify emerging leaders and determine their readiness for assuming a more senior position and the skills and competencies that they require.

• Develop a people plan that addresses organizational capacity.

• Leaders must model the behaviours they expect of others. This includes:
  o Leadership visibility;
  o On-time attendance at meetings and for the duration of meetings;
  o Acknowledging and taking accountability for problems and for addressing them;
  o A demonstrated ability to focus on the “wildly” important while ensuring that the day-to-day is handled by those closest to the situation; and
  o Appropriate delegation and ability to let go.

• Enhance the leaders’ focus on longer term strategies and track progress of these strategies.

2. Organization Focus

It is recognized that health authorities, due to their size and complexity, generally have a large number of initiatives in play. FH recognizes that the large number of initiatives is impacting its ability in achieving the “wildly” important initiatives and is contributing to exhaustion in the system. Within that context, FH Vice Presidents, led by the VP Operations and Strategic Planning, can focus the organization in the following ways:

• Define the four to five most strategic initiatives where change would have the greatest impact.

• Plan in a way that:
  o Considers both implementation and sustainment strategies for each initiative;
  o Recognizes that staff energy will still be directed largely on sustaining the day-to-day workload; and
  o Includes an engagement strategy that incorporates input from appropriate parties, including those that will ultimately be accountable for implementation.

• Consider that the VP Operations and Strategic Planning engage with each program team to add consistency to the implementation approach and to assist in better integrating planning across programs.
• Consider aligning Primary Health Care, Home Health, Mental Health, Residential Care and Older Adult programs under one VP. This should facilitate better integration and lead to reduced frustration with issues related to navigating the current program structure.

• Identify logical clusters of programs (e.g. primary care and community programs) that could plan together to achieve better cross-program integration. Involve community-based organizations in joint planning to establish closer linkages.

• Bridge the goals and activities between Residential Care, Home Health and Mental Health for the well-being of the patient as he or she transitions through the system.

3. Execution of Strategy at Sites

As described above, FH has the ability to make significant gains by focusing the organization on its top priorities. Equally important is its ability to execute these priorities. FH has had successes in implementing the program model. FH can improve execution of program strategies at the site level by taking the following measures:

• Increase accountability for decisions at the sites to promote:
  
  o More nimble decision-making. Decision-making authority negates the need for seeking permission before action is taken. It could include:
    
    ▪ Permanent authority for certain items; and
    ▪ Authority to deal with urgent situations until programs find longer term or more permanent solutions.
  
  o Improved accountability for execution and sustainment of initiatives.
  
  o Increased accountability to monitor and resolve issues before they become crises.
  
  o Enhanced staff engagement.

• Improve communication amongst programs at each site so that site staff understand program plans and any potential impacts to other areas/programs on site. RCH is in the process of developing a site plan that captures anticipated patient volumes and initiatives that will impact its site. Consideration should be given to developing similar plans for each site to promote better communication and execution.

• Encourage programs and sites to revisit the number, frequency, required attendees and content of their meeting structures with a view to maximizing value from the time spent in meetings. As an example, RCH has taken steps to improve meeting efficiency by looking at ways to reduce duplication and overlap for its site-based meetings. All site meetings now
occur on one day each month (Wacky Wednesday) and this approach has been well-received.

- FH are encouraged to review director and manager roles with a view to reducing the number of positions that have multi-site responsibilities. This will promote:
  
  - Greater stability of on-site management teams leading to greater focus on site and program efficiency and quality initiatives.
  
  - Better communication and decision-making capabilities.
  
  - Better attendance at meetings.
  
  - Reduced travel time and enhanced productivity.

4. Culture

Our findings on FH culture point to a patient-focused organization in which, in general terms, people work well together. The culture does suffer from exhaustion in the system due to the relentlessness of major issues (e.g. congestion); a focus on budget problems; the number of initiatives that add to heavy day-to-day workloads but that do not necessarily result in improvement; and a top-down decision-making process.

FH should consider the following approaches to address issues related to culture:

- Introduce an organization-wide cultural initiative, similar to the SMH culture initiative, which is tailored to each site.

- Change the messaging that comes from the most senior levels of the organization to one of “owning problems.” For example, “We have a budget issue – what are some of the things we can do with the budget we have? What are the options that will help us?” Senior leaders can deliberately create a culture to achieve specific ends.

- Engage staff in identifying solutions to problems that affect their work. Increasing engagement motivates people and unleashes ideas. FH have an abundance of collective intelligence that can be brought to bear, e.g. involve staff in finding solutions for addressing overtime issues.

- Harness the pride that FH has in working at its best during a crisis. Encourage this “can do” attitude by providing skills training and organization support for staff in order to move to a culture that handles crises well but can also make incremental improvements. Foster a ‘culture of improvement’.
Relationships and Collaboration with Physicians

CONTEXT

There are approximately 4,000 physicians practicing in the FH region, with most, although not all, having privileges with FH. Many of the physicians are independent practitioners, and as such have no contractual relationship with FH, apart from being granted privileges and having signed a Statement of Expectations. This degree of independence has a bearing on the nature of the working relationship between FH and its physicians, and must be considered in any determination of how best to engage physicians and collaborate with them.

The introduction of program management within FH is also a significant factor influencing how physicians can be engaged and become part of the decision-making processes within FH. The creation of the positions of PMDs, and their involvement in service delivery leadership throughout the organization, is an important component of the engagement process, as is the active involvement of Regional and Local Department Heads, Regional Division Heads, and Hospital Medical Coordinators (HMC) in the management process.

THEMES

We identified five key themes related to enhancing the effectiveness of senior management in engaging and collaborating with medical practitioners working in the region. They include roles and accountabilities of medical leaders in program management; senior medical leadership; physician/board interaction; engagement with independent practitioners; and physician engagement in quality oversight.

1. Delineation of roles and accountabilities of medical leaders in the program management structure

The introduction of a program management approach in FH has created the opportunity for physicians to become more actively involved in leadership throughout the organization, and to have significant influence in the decision-making processes. There is recognition that this is a complex structure, and that it requires time to develop and evolve, with the need to focus on strengthening the roles and accountabilities of medical leaders in the program management structure.
Key findings related to the effectiveness of engaging physicians in program management include the following:

- There is an opportunity for the medical community to become more actively involved in operational management through program management, but only if key responsibilities and accountabilities are clearly delineated.

- The ‘dyad’ approach of PMDs having joint leadership with Executive Directors of a FH program is an evolving one and is meaningful if the dyad works well together. The strength of this approach is highly dependent upon the working relationships developed within the dyad; to achieve a successful outcome, there is a corresponding need for greater stability in the Executive Director positions.

- There is strong support of dyads from the Clinical VPs and this provides an opportunity to influence the decision-making process at the senior management level. However, this outcome is somewhat mitigated by the lack of opportunity for the PMD to interact with the VP Medicine on operational matters.

- In programs where the positions of PMD and Regional Department Head (RDH) are separate, there is the possibility of confusion over respective roles and responsibilities, and possible duplication of effort between the two medical leaders.

- The introduction of program management at FH has resulted in a significant shift from local site/community management. This change has negatively impacted the opportunity for significant physician involvement/responsibility for addressing local issues and for being able to influence the use of resources. The introduction of HMCs at the local sites is aimed at enhancing local medical involvement, but there is a need to further strengthen the HMC role and to clarify how best this position can interact with the PMD.

2. Senior Leadership within the Medical Community

If there is to be effective engagement and collaboration between senior management and physicians, there is a need within the organization for strong medical leadership that reaches out to the medical staff and makes them part of the system.

At FH, there is acceptance that the introduction of program management has had a significant impact on medical leadership, and that this has resulted in redefined roles of the senior leaders. There is recognition that the senior medical leaders have a strong focus on quality and a desire to improve patient care throughout the organization. However, there are additional issues and concerns relating to senior medical leadership that are having an impact on the ability of senior management to collaborate with physicians:
• There is a perception of an autocratic, top-down approach to management, rather than a process whereby there is significant collaboration with physicians resulting in a more inclusive approach to decision-making.

• There are concerns about the lack of active engagement of the VP Medicine in medical operational matters, resulting in a perception of a lack of medical leadership support at the senior level when operational issues arise. (The hospitalist situation was cited as an example of late involvement by the VP Medicine. It is felt the situation may have been resolved earlier if there was more involvement from a medical operational perspective.) There is also the feeling that, without the VP Medicine’s active involvement in operational matters, there is limited opportunity to present a medical perspective in operational deliberations at the Executive level. It has been suggested that there is a need to extend the ‘dyad’ approach to program management to the Executive level, involving the VP Medicine and VPs Clinical Operations.

• There is recognition that, with the greater involvement of physicians in medical administration through the program management structure, there is a need for enhancing physician leadership skills throughout the organization, and that while management courses are available for current and aspiring leaders (e.g. the CMA’s PMI Program), this is an ongoing challenge that needs to be addressed.

3. Physician Interaction with the Board

In ensuring there is effective collaboration with physicians throughout FH, it is important that the medical community understand their opportunities to interact with not only senior management, but also with the Board of Directors.

The extent to which physician leaders interact with the Board varies considerably, with different opinions on the need for additional interaction. Of particular interest are the following findings:

• It is recognized that HAMAC is the primary vehicle for interaction between the Board and medical community on professional affairs (credentialing and discipline) and quality. As such, there needs to be significant interaction between the Board and HAMAC, and in particular HAMAC’s Chair, including more active participation of the HAMAC Chair at Board meetings. This additional engagement of the HAMAC Chair at the Board level would strengthen the opportunity for the Board to obtain physician input and advice as part of their deliberations.

• There is a mixed assessment of the value of HAMAC. Some participants believe it has become successful in focusing on quality matters (in addition to its credentialing and disciplinary responsibilities) while others believe HAMAC is too cumbersome (40+ members).
with inappropriate topics sometimes placed on the agenda, and that overall, the meetings have limited value.

- There is a perceived lack of opportunity for programs to interact with the Board, although the Board’s Quality Performance Committee has recently introduced cyclical reporting by programs to it, which should alleviate some of that concern.

4. **Engagement with Independent Practitioners**

Effective engagement with physicians is impeded by the fact that the majority of them are independent practitioners with minimal contractual relationships with FH. This type of relationship is in effect in all of the regional health authorities. The impact is not as great when physicians have an academic/research working relationship with a health authority (e.g. such as that at VCH).

Findings on this topic include:

- There has been significant engagement of general practitioners through the development of collaborative working relationships with the Divisions of Family Practice. These Divisions, even though in varying stages of development, are serving as vehicles for interaction with general practitioners in the local communities. They provide an excellent opportunity for Fraser Health and FH specialists to engage with these physicians who have limited involvement in the acute programs being offered.

- There is an ongoing need within the medical community for clarification of the roles and responsibilities of the various program and regional medical leaders, in order to foster greater interaction between the medical leadership and physicians in the region.

- The fact that many physicians at FH are independent practitioners reinforces the need for a focus on greater collaboration with the medical community.

5. **Physician Engagement in Quality Oversight**

Effective physician engagement in the FH quality improvement program is an essential ingredient of that program’s success. Key findings in this area include:

- Program management can facilitate quality oversight from a medical perspective through the program structure, if sufficient resources are available within the program to undertake quality reviews and other initiatives. Larger programs have identified the need for dedicated resources within their programs, while smaller programs could benefit from additional support being provided through the corporate Patient Care Quality Office.
• There is support for the role that HAMAC plays in quality reviews within programs, and for the opportunities for the Chair of HAMAC to present quality matters and concerns to the Board of Directors. The introduction of regular quality reporting from programs to the Board’s Quality Performance Committee is considered to be a positive step in strengthening the opportunity for physicians to interact with the Board concerning quality improvement within FH.

• There is a need to strengthen the collaboration and interaction between the PMDs and the regional/local medical leaders on quality matters, to ensure that identified issues are being addressed and that the appropriate processes are in place to oversee all physician-related quality initiatives.

**AREAS FOR CONSIDERATION**

It is recognized that physician engagement and collaboration within a health region is a complex topic that involves multiple processes and opportunities for physicians to influence future directions and decisions that are being taken. It is acknowledged that program management supports the engagement of the medical community in the management processes within FH. Within that context, there are a number of areas that the FH Board and senior management need to address to strengthen physician engagement and collaboration.

1. Achieve further enhancement through:

   • Clearer delineation of the roles and responsibilities of medical program versus medical site leaders.

   • A realignment of responsibilities to strengthen the ability of the HMCs to address site-related issues and make decisions with the Site Director.

   • Determination of the appropriate roles of PMDs and RDHs, with consideration being given to combining those roles in areas where this has not already been done.

   • Ongoing strengthening of physician leadership skills through active involvement in programs such as the Sauder School of Business Physician Leadership program.

2. Reconsider the current executive medical leadership structure with the goals of achieving greater medical operational leadership at the Executive level. Concurrently, ensure that appropriate accountabilities within the medical leadership structure are clearly delineated throughout the organization to address operational issues as they arise.
3. Address the perception of a top-down, autocratic approach to medical leadership, with a greater focus on developing collaborative working relationships and building a more inclusive approach to decision-making.

4. Consider enhancements to be made to support even greater involvement of the clinical programs in medical quality oversight. Dedicated quality resources should be made available in the larger programs (e.g. Surgery and Medicine), and additional corporate support provided to the smaller programs.
Relationships and Engagement with Staff

In order to assess staff relationships, we met with site leadership (Site Directors, HMCs) and conducted seven focus groups with managers at four sites.

- All managers indicated that they had supportive relationships with their direct leaders (directors). However, they indicated that they have little time to manage those reporting to them.

- Manager priorities are set by their respective directors. Some managers indicated they had discretion to determine their day-to-day priorities.

- Some programs involve managers in the planning process; many do not.

- Budgets are set by FH executive; site managers do not have input into budget-setting processes.

- The largest issue identified was that of heavy workloads. Managers are aware that FH is piloting a Manager Excellence program to address some of their concerns and are hoping for positive results.

- One site - SMH - introduced a culture initiative. The initiative is seen as positive and supports the relationship between on-site managers and staff.

- Managers are aware that there are a number of courses available. They are seeking guidance from their leaders on which courses would suit their professional development.

- We met with a limited number of directors. Those whom we met with indicated that their roles were manageable and that they did not experience some of the same work challenges voiced by the manager group. All managers felt that they received good support from their directors.

- At some sites, there is little senior management presence. This is particularly true when senior management has multi-site responsibilities. There is less staff engagement at those sites.

Gallup Q12 Survey

We also reviewed the Gallup Q12 engagement survey to supplement our interview and focus group findings. Overall, FH Gallup Q12 survey results were not significantly different from those of other BC
health authorities. However, the report does emphasize some areas for improvement that should be addressed. We have highlighted key staff engagement findings from the survey.

- **Staff Engagement**

  The Gallup results support the focus group findings that managers feel well supported but are unable to provide similar support to their staff:

  - 41% of managers were engaged which is a slight improvement from 37% in 2010.
  - 18% of the Bargaining Unit were engaged which is an improvement from 13% in 2010.

  The ratio of engaged to actively disengaged is at 1:1. Gallup states that the staff engagement tipping point occurs at 4.0 engaged to 1 actively disengaged. While manager engagement is higher than the Bargaining Unit and heading in the right direction, Gallup describes this score as “fragile manager engagement”.

- **“Us” and “Them” Gap**

  Gallup characterizes a Manager-Non-Manager gap as an “us” and “them” divide. Of note, there were significant gaps in rating the dimensions of progress in the last six months, my opinion counts and recognition in the past seven days:

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Management/Management Support</th>
<th>Bargaining Unit Employees</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Grand Mean</td>
<td>3.98</td>
<td>3.46</td>
<td>-0.52</td>
</tr>
<tr>
<td>Progress in last six months</td>
<td>4.16</td>
<td>2.80</td>
<td>-1.36</td>
</tr>
<tr>
<td>My opinions count</td>
<td>4.13</td>
<td>3.29</td>
<td>-0.84</td>
</tr>
<tr>
<td>Recognition in last seven days</td>
<td>3.55</td>
<td>2.83</td>
<td>-0.72</td>
</tr>
</tbody>
</table>

**AREAS FOR CONSIDERATION**

FH has developed a draft engagement plan and has committed to building survey accountability into Performance Link. This plan specifically states that “care be given to how we can work better together to deliver quality care” and recognizes the need to “increase employee involvement during change while reducing the ‘us’ and ‘them’ divide.”

Staff engagement issues have been addressed in our Areas for Consideration in the Operational Management section in this report.
Engagement with Other Stakeholders: Divisions of Family Practice

There are 10 Divisions of Family Practice within the FH region. The Divisions and FH work in partnership to achieve common goals related to maximizing use of community-based services and primary care clinics for the benefit of the patient and the health system.

Today, there are several active initiatives and all Division interviewees pointed to successes they have achieved. They have made significant progress on attachment initiatives - attracting local physicians to their Division and providing opportunities for physicians to connect amongst themselves and with specialists. There are examples of Divisions and FH together establishing a health centre (South Asian Health Centre) and a Primary Care and Seniors clinic (Chilliwack).

Currently, FH is working with Divisions on “GP for Me” and NP4BC initiatives.

FH participates in:

- Ten Collaborative Services Committees (CSC) that meet every two months. FH co-chairs these meetings. Attendance includes FH representatives (VP Clinical Operations and Executive Director), a GPSC representative and divisional guests including community agencies, municipal representatives (e.g. mayors and council members), and physicians. At times, other FH senior executive and/or staff attend meetings.

- Interdivisional Council Meetings that occur every two months. These meetings, chaired by FH, are attended by delegates from each Division and provide an opportunity to share information/learnings across all 10 Divisions of Family Practice.

Findings

- Divisions feel co-planning and collaboration with FH are crucial to the success of the Division in planning, proposal development and implementation of expanded or new initiatives.

- Divisions’ experiences with FH vary greatly across the region. At one end of the spectrum, a Division feels disenchanted as a result of getting little or no assistance and no funding; at the other end, a Division that has received substantial assistance and funding feels it has benefited from a strong, collaborative relationship with FH.
• The most common concern is the lack of continuity in FH staffing. One Division indicated that it is now experiencing a third change in FH staff this year. Lack of continuity affects progress, relationships and decision-making.

• Divisions find navigating across the FH program structure a challenge. In one instance, a small proposal for two NP positions took three months to produce because of the necessity of gaining support from three discrete programs (Home Health, Older Adults, and Mental Health).

• Not all programs have redesigned their approach to deliver services in a way that works in the Divisional model. Home Health has made some strides linking with Divisions, while working with Mental Health and Older Adult programs still present challenges for community entities.

• Divisions are unaware of FH plans in their communities.

• CSC meetings are well-attended. However, attendance at other Division meetings is less consistent. Sometimes FH staff do not attend meetings as planned, either arriving late or cancelling with little advance notice.

• Working within the FH corporate environment is difficult for a small entity. Divisions struggle with:
  o FH IT systems they use for scheduling NPs.
  o Information-sharing agreements.
  o Memorandum of Understanding.

AREAS FOR CONSIDERATION

FH should consider the following recommendations to strengthen its relationship with the Divisions of Family Practice:

• Develop alternate approaches to addressing staff continuity issues. This is a major issue and requires significant assistance from HR.

• Develop an approach for working with all 10 Divisions. FH does not have sufficient resources to effectively support all of the Divisions simultaneously on a Division-by-Division basis. FH is currently reorganizing its Primary Care team to better respond to Divisions’ needs. These changes should have a positive impact and will enable staff continuity.

• Share its plans and priorities with Divisions.
• Align the following clinical programs under one VP Clinical Operations: Primary Health Care, Home Health, Mental Health, Residential Care and Older Adult. Alignment under one VP should facilitate integration across these programs and lead to reduced frustration with issues related to navigating the current program structure.

• Continue to redefine the way FH services are delivered to align with changes underway in the Divisions of Family Practices.

• Find alternate approaches to dealing with large-system corporate requirements in a way that is manageable by a small organization such as a Division of Family Practice.
Relationship with the Ministry

We met with Ministry Executives and staff and FH Board members, executive and staff. A number of key themes relating to the working relationship between the Board, Senior Management and the Ministry executives and staff were identified. These themes revolve around the following:

- Accountability/leadership.
- Effectiveness of budget management.
- Management of issues/crises.
- Proactive planning and strategic management.
- Trust and transparency.

As noted in the following observations from the two parties, in some areas there was consensus about the current working relationships, while in others, there were different perceptions and opposing viewpoints.

- **Accountability/Leadership**

  There are differing views regarding:

  - FH Board’s level of engagement in setting directions and holding senior management accountable.
  - The degree of collaboration and CEO willingness to collaborate with the Ministry.
  - Ownership and accountability for FH issues.
  - Focus, i.e. funding versus patients.
  - FH responsiveness and transparency on Ministry requests.
  - Lack of a reference framework for the Board to evaluate CEO.

  FH recognizes the Ministry role as shareholder. However, there are opportunities to strengthen the relationships between the two organizations within this framework.
Both organizations acknowledged that significant leadership turnover at both organizations has had an impact on working relationships.

- **Effectiveness of Budget Management**

  There are differing views regarding:

  o Board’s willingness to accept deficit budgets versus living within its means and maintaining a balanced budget.
  
o Acceptable approaches to cost saving measures.
  
o What the Ministry should fund when crises arise.
  
o Degree and willingness to collaborate on developing budget management strategies (as compared to other HAs who are proactively involved).
  
o A culture within FH of always needing more versus accepting that the budget is the budget.
  
o Willingness and ability to realistically address pending issues in development of budget (e.g. realistically assessing impact of growth).

- **Management of Issues/Crises**

  The Ministry Observations

  o FH does not anticipate issues nor effectively respond to/manage issues (e.g. ambulance transfers, 48 hr. hip replacement).
  
o FH is defensive in responding to issues.
  
o FH is unwilling or unable to assume total accountability for a specific issue.

  FH Observations

  o FH recognizes that they have many issues and need better mechanisms for addressing them.
  
o The Ministry sometimes gets too involved in FH issues.
• Proactive Planning and Strategic Management

There are differing views regarding:

- The effectiveness of FH planning.
- Priority setting and determining where to place focus.
- Impact of financial constraints on planning.

Both parties acknowledge that there are too many initiatives – there is a need to simplify and limit focus.

• Trust and Transparency

The Ministry Observations

- Reluctance by FH to share information with the Ministry. Lack of trust in information provided.
- Difficult for the Ministry to understand how FH develops its budgets – lack of rationale behind the numbers.
- Information FH presents to its Board is not always accurate.

FH Observations

- “Ebb and flow” in relationship depending on the leadership (Minister and Deputy).
- FH strives to have a positive relationship.
- Need for improvement by both sides.
- FH needs to ‘get on the same page’.
- The Ministry has not always honored verbal commitments.
- FH’s desire is to operate in a world of evidence.
AREAS FOR CONSIDERATION

While any funding agency and service delivery organization will inevitably have differences in its working relationship, there are a number of key areas specific to FH that must be given further consideration and addressed. These include:

- Acceptance of accountability to be innovative in proactively introducing solutions to fiscal challenges;
- Increased collaboration between the parties and greater sharing of information and background material in addressing issues of joint interest and concern;
- The development of a more strategic approach within FH in issue management, with a focus on being proactive in anticipating problems and responding accordingly;
- Simplification of the FH approach to strategic planning, with a corresponding reduction in the number of areas of focus; and
- A commitment to transparency agreed upon by the parties through ensuring that all information presented is accurate and timely.