Department of Pediatrics

Faculty Meeting
July 25, 2017

TOPIC: Task Force 2 Update
Marc Berg, MD  
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Division of Critical Care Medicine

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Julia Chu, MD, MPH  
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Division of Stem Cell and Regenerative Medicine

Tristan Nichols, DO  
Clinical Instructor  
Division of Hospital Medicine

Ryan Padrez, MD  
Clinical Assistant Professor  
Division of General Pediatrics
Congratulations

Ann Ming Yeh, MD
• Developed the first Pediatric Integrative Medicine Fellowship in the Country

Alan Schroeder, MD
• Awarded an Intermountain-Stanford Collaboration Grant for “Optimizing Value in Bronchiolitis: the Bronchiolitis Follow-up Intervention Trial (BeneFIT).”

Carrie Rassbach, MD
• Elected Chair of the National Pediatric Hospital Medicine Fellowship Directors Council
Congratulations

Jason Wang, MD
• Launching new Innovation HABIT lab project for mobile-health tools to prevent preterm birth

Baraka Floyd
• Launching “food insecurity” screening process across LPCH, in collaboration with Nursing, Social Services, Case Management and Community Benefits

Lisa Chamberlain
• Member of the National AAP Poverty and Residency Medicaid Task Forces
In Appreciation on behalf of the Stanford Medicine Office of Medical Degree Admissions

Dharshi Sivakumar, MD
Clinical Associate Professor
Division of Neonatology

Henry Lee, MD
Associate Professor of Pediatrics
Division of Neonatology
Task Force 2: Provider-Hospital Relations

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Background

- The 2015 Department of Pediatrics climate survey identified hospital-provider relations as a key issue for providers.

- Task Force 2 was established and charged with examining the current state of provider satisfaction in their relations with the Hospital and, where problems were found, to look for solutions.
Meet the Team

Co-chairs:
Steve Alexander, Kelly Johnson

- Nominated or self-nominated
- Broad representation of major stakeholders
- Sized for optimal work

Members: Amy Chapman, Lauren Destino, Kristin Peterson, Michael Propst, Douglas Sidell, Scott Sutherland
Methods

- Confidential, one-on-one, face-to-face interviews
- Interview subjects selected by Task Force 2 members to represent faculty (MCL and CE), nurses, administrators and others in leadership roles
- Structured interview questions used to guide the interviews
- Interviews were summarized in 1-3 page narrative reports that were then read and analyzed by all members of Task Force 2
Methods

- Interviews were conducted in March, April, and May of 2017

- A total of 41 interviews from a broad sample of physicians, nurses and administrators were obtained and form the basis for this report

- All 8 Task Force 2 members contributed substantially to the writing of the report, and validate its content
Representative interview questions

- What attracted you to LPCHS, and why do you stay?
- How do you view the climate in your Division or Unit or Department?
- Does the Hospital administration seek and value your input when they make decisions?
- Can you cite a decision by the administration that helped support your ability to care for patients? A decision or lack thereof that did not help?
- Can you describe a recent case where you felt a negative climate between Hospital and providers; a case where the climate was positive?
- What do you do that is of value to LPCHS; Do you feel the LPCHS administration recognizes this value?
- What does involvement in decision making at the Hospital mean to you?
- Do you think shared decision making among providers and Hospital administration is important?
- How do you envision effective provider-Hospital collaboration?
Overview of the Report

- Report was organized into themes
- There was remarkable consistency of feedback from interview participants
- The analysis focused on identified challenges
- Recommendations target actionable items
- Recommendations are not prioritized in order to minimize bias
- Perception is reality for the individuals interviewed
General Themes from the Interviews

- There is great affection for this Hospital and Stanford School of Medicine
- LPCHS is facing broad challenges, and faculty and staff want to be part of the solutions
- Providers want to be considered thought partners, especially when decisions affect their practices and their patients
- There has been a rapid expansion of LPCHS without adequate engagement of providers
- There is much to be done to improve provider-Hospital relations
Four specific themes emerged

I. There is limited front-line provider involvement in Hospital decisions that affect strategy, operations and clinical practice

II. The “bottom line” drives most Hospital decision making

III. The Hospital infrastructure does not support the size or complexity of the organization to allow it to run efficiently or effectively: finance, outreach, strategic planning, decision making

IV. Respect and recognition for providers by the Hospital is not consistent or inclusive of non-clinical activity
Theme I: Limited front-line provider involvement in Hospital decisions that affect strategy, operations and clinical practice

Findings:

- In general, the voice of the frontline provider is not solicited or valued
- Front line providers do not have input into major decisions affecting their practice
- There is a lack of transparency and clear communication around major decisions affecting clinical services and programs
Theme I findings continued

- Frequently cited examples of “top-down” decision making where front line providers had limited involvement:
  - Gardner Clinic
  - PASC (centralized ambulatory scheduling)
  - Ambulatory Re-design
  - No ED in Packard 2.0
  - PCHA
  - Limited acute care beds in Packard 2.0
  - Overall design of Packard 2.0
Theme II: The “bottom line” drives most Hospital decision making

Findings:

- Hospital’s focus on the “margin” has led to decisions that may negatively affect long-term growth and reputation for preeminent programs.
- There is a perception that business decisions take precedence over quality, patient safety and clinical care.
- There is a perception that obligations to our local community are not fulfilled if there is no contribution to the bottom line.
- We continue to expand clinics locally and regionally despite being unable to support care needs of these patients due to limited acute care beds and OR impaction.
- Lack of adequate clinic and office space is a frustration for faculty.
- The strategy driving rapid expansion of clinical services seems to have outpaced effective operationalization of new locations or programs.
Theme III: The Hospital infrastructure does not support the size or complexity of the organization to run efficiently or effectively: finance, outreach, strategic planning, decision making

Findings:
- Current Hospital infrastructure is unclear and difficult to navigate
- Few providers know who within the Administration is directly responsible for supporting their program/practices, making the tracking of decisions challenging
- Hospital decision making is often seen as slow, disorganized, reactive and focused on short-term
- When decisions are made, there is often a lack of sufficient planning and adequate follow through
Theme III findings continued:

- There is no clear prioritization for organizational initiatives beyond the “bottom line”
- Hospital seems to have limited strategic vision for the future of the organization
- If the goal is preeminence, the focus on being the preeminent care provider in local clinical settings compromises the broader vision of national and international preeminence that attracted providers to Stanford and LPCHS
- Limited communication about strategy leads providers to see decision making as top down
Theme III findings continued:

- The current approach to medical direction and other physician involvement in Hospital leadership roles is seen as contributing to strained Hospital-provider communication

  - physicians in positions to potentially impact Hospital decisions do not fully represent front line providers’ concerns

  - medical directors suggest that the Hospital views them as conduits to convey information but otherwise peripheral to the decision-making process
Theme IV: Respect and recognition for providers by the Hospital is not apparent

Findings:

- Providers feel that the Hospital views them solely as a work force, easily replaceable
- Physicians choose to work in academic medicine and at LPCHS because it allows them to do more than “just” provide patient care
- The Hospital has a narrow focus on recognition and celebration of the value and contribution to pre-eminence of non-revenue generating work (e.g., research, education, quality improvement)
- Providers want to be viewed as partners and collaborators and in general do not feel the Hospital sees them in this role
- There is a perception that Hospital administrators have limited knowledge of and place little value on front line work
- When problems arise (e.g., lower patient/procedure volume, quality issues) the Hospital tends to blame providers
Task Force 2 Recommendations
Involve providers in all major organizational decisions before those decisions are made

- Consider front line providers as effective partners whose involvement will help the Hospital make better decisions
- Create a Clinical Leadership Council (CLC) with authority to influence Hospital decisions
  - Scope of the CLC will include timely vetting of all major Hospital decisions that impact clinical practice
  - While the Hospital Executive leadership would still be responsible for finalizing most decisions, no decision impacting clinical practice would be taken without input from the CLC
  - Details of the CLC could be developed by a working group composed of Hospital leadership and front line providers
Support non-revenue generating work

- Increase recognition and celebration of education, research, and programmatic Hospital and system improvements
- Acknowledge the value of non-revenue generating contributions
- Create an annual report to the LPCHS Board of Directors highlighting these accomplishments by providers
- Compile a quarterly report to the entire organization highlighting provider and staff accomplishments
**Improve methods of communication**

- Include a front line provider from the CLC at high level Hospital leadership meetings
- Executive leaders attend at least one meeting per year within each division/department on a regular rotation to solicit feedback on clinical program decisions
- The administrator directly responsible for the division/department/service should attend the regular monthly meetings of the services for which they are responsible
- Make detailed org charts and decision making resources available on the intranet that display the administrative chain of responsibility
Improve methods of communication, continued:

- Orient new clinicians to the administrative structure of the Hospital and the clinical settings where they are to work
- Inform all providers of paths of escalation for concerns within their clinical areas
- Continue and expand Town Halls by the CEO and other senior Hospital leaders
- Employ the principles of Gemba by establishing a regular rotation of senior hospital leadership on rounds in all units throughout Stanford Children’s Health
Re-examine Medical Direction

- Give medical directors and their dyad administrative partners the authority and responsibility to participate in decisions affecting their units
- Form a *Working Group on Medical Direction* composed of front line providers, medical directors and mid-level and senior Hospital administrators to:
  - Create a robust front line medical director/physician administrator job description
  - Develop leadership training and competencies for physician administrators at all levels
  - Evaluate the current structure for medical direction/physician administrators and make requisite changes
  - Formalize and strengthen the dyad partnerships between front line medical directors and their LPCH dyad partners