

Clinical and Administrative Integration Assessment Tool

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*Modified for Ontario/Canadian Hospital Models from the original

How to use this tool?

In Black: are dimensions along which a hospital department, or the hospital can assess itself.

In Red: are descriptions/benchmarks associated with a minimal level of successful clinical and/or administrative integration.

In Blue: are descriptions/benchmarks associated with a moderate level of successful clinical and/or administrative integration.

In Green: are descriptions/benchmarks associated with the highest level of successful clinical and/or administrative integration.

Use the tool to self-assess on these dimensions and envision how your department or hospital would look if it was more successfully integrated to achieve clinical collaboration, high patient value and high physician engagement. Use the tool to identify your areas of strength and weakness and to map out your goals in key areas.

Clinical Integration Feature	Minimally Clinically Integrated	Moderately Clinically Integrated	Truly Clinically Integrated	Comments
<p>FUNCTION</p> <p>Structure and Purpose</p>	<p><u>Within our department</u>, the docs' main purpose is to share overhead; no clinical connections or collaborations amongst clinicians- any collaborations involve traditional referral models rather than more synergistic or case-conferenced clinical models; sub-specialty clinics exist because of clinician interest and historical needs with varied practice patterns and minimal standardization. <u>Within our hospital</u>, there is minimal coordination between departments to collaboratively meet patients' needs; the main connections between departments are through conventional referral mechanisms rather than shared care, collaboration or interdisciplinary clinics based on patient needs.</p>	<p><u>Within our Department</u>, there is a sense of working together and shared problem solving and expertise beyond just offices in a row. Some of our docs prefer to be left alone to do their work but most within our department are interested in regularly identifying patient needs and altering service offerings accordingly, so long as it doesn't change the nature of their work or academic interests dramatically. <u>Within our hospital</u>, there is a sense of collegiality and general ability to call upon each other for clinical assistance but few formal connections between departments or triage algorithms to solve complex, overlapping clinical problems more efficiently to maximize patient value and reduce clinician redundancies.</p>	<p><u>Within our department</u>, there is a shared expectation that <i>the group</i> must respond to clinical imperatives collaboratively rather than in silos and that work processes and clinical practices may need to change iteratively to respond to identified patient needs and hospital and community priorities. <u>Within our hospital</u>, there is a shared expectation that departments are not stand alone entities but rather, pieces of the collective puzzle, nimbly ready to transform their services and responses within the hospital framework and community needs. There are regular processes of reviewing clinical needs and critical incidents to ensure that there is a dynamic, interdependent way of working. Business units exist to allow a framework but are contained by dotted lines only and departments are encouraged to 'think outside their boxes'.</p>	
<p>FUNCTION</p> <p>Governance and</p>	<p><u>Within our department</u> it is not entirely clear how decisions are made regarding leadership or</p>	<p><u>Within our department</u>, there is some quasi-executive or senior structure</p>	<p><u>Within our department</u>, big decisions regarding clinical services and</p>	

<p>Leadership And Physician Engagement</p>	<p>financial allocations. Leadership may be suspect or merely figurehead only but so long as everyone is meeting individual financial and career targets, there is no major dissent (or dissenters just leave). <u>Between departments/within our hospital</u>, there is minimal sense of physician engagement; docs don't really know what the strategic plan for the hospital is and also weren't really consulted on it...they notice that senior leadership changes intermittently but don't really know or care what anyone in the C-suite actually does that relates to them.</p>	<p>for decision-making, resource allocation etc. It is moderately transparent. There is no clear leadership development or succession planning but people feel confident enough in the status quo to keep it going and hope at least the Chief knows who the next Chief might be. <u>Within our hospital</u>, the board operates to try to determine some strategic priorities; they are experienced as either top down to the clinical staff or as pie in the sky goals that are out of touch with what feels currently clinically possible with the current level of integration.</p>	<p>resources and leadership of programs are openly discussed with opportunity for input and with consideration of balancing both clinician academic interests as well as the health care priorities. <u>At the hospital level</u>, there is active, bidirectional communication between clinicians, departments, the senior management and the board to help guide governance and decision-making. People feel like they really know that is going on both at the birds eye view and the worm's eye view and can and should speak up about suggestions and concerns with many forums in which to do so.</p>	
<p>FUNCTION</p> <p>Leadership and Followership</p>	<p><u>Within our department</u>, most of the control and direction is top heavy with junior docs pretty much in the dark. <u>Within our hospital</u>, a small number of docs are in the know and doing most of the committee and leadership work...the others are either not interested or not involved and/or tend to experience new programs or expectations as top down and not a priority for them, leading to moderately quiet griping and a kind of subtle obstruction with</p>	<p><u>Within our Department</u>, there is a group that feels in the know because they head up a program or a service but also a whole group of docs who feel on the margins and don't mind that till something happens that they didn't see coming. They tend to be the slower adopters to hospital wide initiatives. <u>Within the broader hospital</u>, the MAC is pretty engaged and organized around</p>	<p><u>Within departments</u>, there is strong emphasis in looking for academic chiefs who can lead both research and teaching-wise but also with respect to strategic planning, operations and other leadership skills. There is an expectation with recruitment, that physicians will participate in the growth of the overall department and its response to the hospital and community</p>	

	<p>bigger, interdisciplinary roll-outs such as safety initiatives or IT developments. People put up with credentialing expectations from 'the hospital' and that's about it. No real leadership development initiatives; leaders tend to be relatively credible clinicians/popular docs rather than leaders or visionaries and aren't supported to develop leadership skills.</p>	<p>inpatient related issues but less so re cross-disciplinary opportunities or community outreach and pretty absent a voice or a vision when it comes to ambulatory issues that could benefit from integration or synergies AND the hospital leadership doesn't itself actively foster shared approaches. The hospital has begun to sponsor some leadership development academies or growth in interested or identified physicians.</p>	<p>identified priorities. <u>Within our hospital</u>, leadership as its own skill is highly valued and mentored. THE MAC identifies opportunities for collaboration between community, ambulatory and inpatient services rather than waiting for these expectations to be imposed by government or external partners. The MAC is a proactive entity rather than a reactive final rubber stamp.</p>	
<p>FINANCE</p> <p>Business Model: Volumes, Throughput, Efficiency, Value, Productivity</p>	<p><u>Within our department</u>, value and economic success is generated primarily through fee for service payments and other entrepreneurial activities (conferences, patient education materials etc). <u>Within our hospital</u>, productivity and volumes are the main criteria for both fee for service and global payments. There are no pay for performance or pay for results incentives. There are no quality or collaboration incentives financially. The more consultants that individually consult or bill for tests or services, the better it is for the bottom line; there is no such thing as "overuse".</p>	<p><u>Within our department</u>, (depending on the specialty), there is either a mix of payment modeling that balances fee for service and quality and/or academic targets (eg academic merit funds, stipends for underserved work). Leadership is explicit regarding expecting a high percentage of unique patient OHIP codes to reflect valuing patient access and efficiency rather than just looking at overall number of visit codes. <u>Within our hospital</u>, there is a mix of fee for service payments to incentivize productivity as well as global budgeting/pay for results mechanisms</p>	<p><u>Within our department</u>, there is a mix of payment models to incentivize productivity PLUS a withhold redistributed in a bonus structure for quality improvement successes and access improvement. <u>Within the hospital's inpatient programs in particular</u>, the majority of the physician /hospital payment structure is "value driven", to reward access, efficiencies, and LOS goals (ALC efforts) and disincentivize complications. Rewards accrue to interdisciplinary efficiencies (Eg anaesth/med consults/ surgery)</p>	

		to increase quality and value.	when collaborations result in better results/better patient value.	
FINANCE Relationship with Others	<u>Within our department</u> , there is minimal cooperation or shared resources- ie my secretary is ' my secretary'. My nurse is ' my nurse'. Few economies of scale are pursued. <u>Within the hospital</u> , there is little collaboration between departments or between departments and 'corporate head office' to look for shared pursuit of vendors for equipment, IT or economies of scale optimization for similar services (billing, dictation) and mainly the departments and the central hospital services interact in a transfer price model only.	<u>Within our department</u> , sharing admin and allied health resources is the ethos. <u>Within the hospital or between departments</u> , co-management opportunities in highly interdisciplinary services are explored and there is substantial inter-department consultation regarding economies of scale or shared vendor negotiation.	<u>Within our department</u> , not only are allied health and admin resources shared as a matter of philosophy but grants and other successes in one department are regularly used in part to benefit other aspects of departmental functioning in a transparent way that both rewards success and maintains services. <u>Within the hospital and between departments</u> , the ethos is financially collaborative and financial gains are regularly recognized through bulk purchasing, larger contracts and strength in numbers negotiation for services.	
OPERATIONS Standardization, Guidelines and Protocols	<u>Within our department</u> , each doc does his or her own thing from start to finish in patient care. There are no shared expectations regarding patient care guidelines or protocols. <u>Within our hospital</u> , physicians interact according to personal practice patterns and with rotating attendings on certain service that means approach to patient care varies month-to-month or even week-to-week.	<u>Within our department</u> , we have some standardized intake assessment forms, or management algorithms for disorders but no enforcement of use and ½ the docs use them and ½ use their own forms or no form at all. Ie. Hypertension or depression might be managed 10 different ways depending on whom the patient sees. <u>Within our</u>	<u>Within our department</u> , after some consultation regarding guidelines and best practices, clinicians have standardized what is standardizable and it is a clear expectation that standardized protocols where applicable will be followed and valued to reduce poor quality variation, reduce error and allow for competent coverage in a	

		<p><u>hospital's inpatient settings</u>, there are some standardized order sets and penetration for use is about 50% with minimal expectation or programmatic attempt to move beyond that. Common medical or surgical problems can be treated differently depending on the month and the team.</p>	<p>clinician's absence. <u>Within our hospital, similarly</u>, standardizable regimens have been developed and adopted where there is a sufficient body of evidence and it is generally accepted that 'perfect is the enemy of the good' and that standardization reduces error. Standardization adherence is taken into account in credentialing and privileging.</p>	
<p><u>OPERATIONS</u> Standardization: Referrals and Care Coordination (Inter and Intra institutionally)</p>	<p><u>Within our department</u> referrals for other services (labs, other consultants, other services) are entirely each autonomous physician's choice. <u>Within our hospital</u>, referrals for other services are autonomous and <u>unguided</u> by triage or referral algorithms or a shared understanding of community resources. Discharge and community planning is variable depending on which service happens to know what about what the community offers.</p>	<p><u>Within our department</u>, referrals for other services are guided by a collaboratively developed list of qualified, reputable colleagues. <u>Within the hospital</u>, referrals are guided by the hospital director of what people do and variable knowledge of community resources. Discharge planning is informed by some informal contacts in community agencies and home care (CCAC) services</p>	<p><u>Within our department</u>, referrals for other services are guided informed quality metrics of said services (labs, diagnostics, other consultants). <u>Within the hospital</u>, referrals for other services or clinicians is guided by widely accepted triage mechanisms and algorithms (eg pancreatitis is assessed by surgery, minor strokes by medicine/major strokes by neurology/ falls by orthopedics and geriatric medicine/ dementia by geriatric medicine and dementia with behaviour disturbances by geriatric psychiatry etc. Discharge planning is informed by regularly updated</p>	

			information about community resources and community liaison practitioners whose job it is to keep discharge options up to date.	
OPERATIONS Standardization: EMR and Documentation	<u>Within our department</u> documentation lacks standardization both intra and inter clinician. There is no departmental EMR and/or one clinician might have her records on the T drive whilst another has them in a filing cabinet in their office and still another has them in a central admin office and still another just sends them to medical records. Lots of warring camps of docs regarding EMR so nothing happening yet. <u>Within our hospital,</u> there is no interdepartmental access to ambulatory records to maintain continuity of care. Initial attempts of inpatient EMR were somewhere between a nightmare and a bad dream. Lots of residue of disappointment esp with respect to physicians extracting information for their work or easily documenting it so modest uptake in using the EMR for both consultation/documentation as well as CPOE and a mix of eye rolling and irritation re both.	<u>Within our department,</u> there is standardization of documentation with respect to inclusions and form and the beginning of adopting an ambulatory EMR but little connection with respect to roll out or vendor negotiation to the hospital EMR so variable continuity of care between inpatient and ambulatory settings. <u>Within the hospital,</u> a careful EMR roll-out with substantial physician consultation is occurring. CPOE is also being rolled out. There are some cynics and late adopters and it doesn't work well for everyone but there is some growing sense that patient safety and quality efficiencies are starting to be seen.	<u>Within our department,</u> there is not only standardized documentation but it is accessible intra clinician and inter departmentally with via EMR or standard request process to enhance continuity of care, medication reconciliation and coverage both intra and inter departmentally. <u>Within the hospital,</u> there is a shared platform between the ambulatory EMR AND the inpatient EMR which dramatically improves med rec, discharge continuity and reduces error. The vendor of choice offers a level of display and functionality which helps maintain the 'narrative' of the paper chart while also increasing documentation efficiency and information extraction (eg with search tools for common concerns and patterns) that improve patient care.	
OPERATIONS Measurement and	<u>Within our department,</u> individual doc productivity is measured (if at all) via	<u>Within our department,</u> we have just started to look at collecting some basic	<u>Within our department,</u> we have a shared ethos of openness	

<p>Transparency</p>	<p>billing but no other measures (practice guideline adherence, patient satisfaction, error rate) are collected and there is no system, electronic or otherwise that is in place to collect it so it would be prohibitive to start now. There is little transparency within the physician group regarding how they measure up against each other or a shared benchmark. Credentialing and privileging takes into account egregious conduct only, not quality benchmarks. <u>Within the hospital</u>, though some LOS data and other quality data may be collected, it cannot be drilled down to individual clinicians and isn't used at that level. Specialties/Departments may have some data but that is for the physician group's eyes only and isn't shared at the MAC or elsewhere.</p>	<p>productivity, access and quality information on our docs; there is a little bit of trepidation and we aren't sure how we will use it but there is a shared consensus and understanding that even collective data can be a force for positive change. Building the infrastructure is an impediment but we are trying to put some resources towards it. <u>Within the hospital</u>, there is an expectation that departments/business units will share some quality and access metrics, maybe not at the level of individual doctors but definitely at the level of services AND that departments will be open to feedback about opportunities and needs for improvement.</p>	<p>regarding quality and access metrics and maybe even some friendly competition to improve. We focus on helping everyone to improve benchmarked against themselves and against top performers with an appreciation that depending on role, some docs will do well on some metrics better than others. <u>Within the hospital</u> there is similarly a culture of measuring and iterative quality improvement that is rewarding rather than shaming but also intolerant of major outliers. We have measurement structures in place that give relatively real-time data so ongoing learning can occur regarding reaching benchmarks. We are just about ready to decide what quality and throughput and patient satisfaction and overuse indicators are sufficiently within our control to share with the public and consider this a major commitment to accountability.</p>	
<p>FEELING Culture and Values: Teamwork</p>	<p><u>Within our department</u>, we might have a few 'jerks' who don't think they need to work with anyone but they bring grants or other goodies to the table so everyone just ignores their</p>	<p><u>Within our department</u>, teamwork is a stated value and people know they are expected to help out (eg when someone is away or there is a</p>	<p><u>Within our department</u>, teamwork is a stated value and expectation and taken into account in recruitment. A jerk will have to find</p>	

	<p>obnoxiousness or how they don't pull their weight on call or in teaching. <u>Within the hospital</u>, there are some 'disruptive physicians' but so long as no one throws a scalpel or a resident, no one is really going to lose their privileges at this hospital.</p>	<p>coverage crisis) but it is usually the same 5 people who step up and there are no real carrots or sticks involved to build teamwork and recruitment only pays lip service to it. <u>Within the hospital</u>, there is a shared belief in a collaborative culture but no one high up will really enforce the expectation when push comes to shove. There are intermittent 'team building' exercises and retreats but only modest traction.</p>	<p>somewhere else to go nobody how much grant money he or she brings in. <u>Within the hospital</u>, there are organized teams and committees and accountabilities that cut across departments AND across disciplines with components of program management to emphasize alignment of goals rather than alignment of traditional silos.</p>	
<p><u>FEELING</u> Culture and Values: Non-Physicians/ Nurse Clinicians etc.</p>	<p><u>Within our department</u>, we either don't use non-docs because it cuts into our income or because we don't accept that physician extenders/nurse clinicians can rise to our standard and/or we like the easier spectrum of our work so why would we give it up if we are already getting paid to do it ourselves?. <u>Within the hospital</u>, delegation to non-physicians is suspect and done superficially only if at all. Even where medicolegally possible, additional supervision by physicians is the hospital ethos. The docs have to be in charge.</p>	<p><u>Within our department</u>, we have built capacity through allied health and nurse clinicians some physicians are still reluctant to delegate primary non-MD responsibility, even where scope of practice would allow but it is moving in a good direction of growth. <u>Within the hospital</u>, there is variable success and experience with nurse practitioner leadership but overall some good successes that have allowed physicians to focus on work that only they can do, based on expertise and medicolegal demands..</p>	<p><u>Within our department</u>, not only have we built capacity through allied health and nurse clinician colleagues operating at the height of their scopes of practices but we have also ensured non-MD's have a role in the executive leadership of the department and in some income sharing based on collaborative and quality bonus structure. <u>Within the hospital</u>, non-MD practitioners feel fully engaged to their highest potential as part of the team, collaboratively working with staff and students, educationally utilized as mentors and co-supervisors and with leadership</p>	

			positions in key clinical areas.	
<p>FEELING</p> <p>Culture and Values: Patient Centredness</p>	<p><u>Within our clinical department</u>, we've heard the term "patient centred"-what do people THINK we've been doing till now. Patients have no idea what they need or want- that's why they need our expertise. Having them on committees will just slow us down. <u>Within our hospital</u>, we are devoted to patient care but patients are not the best experts to tell us how to run things. They have no idea how complicated everything is.</p>	<p><u>Within our clinical department</u>, we try to find ways to solicit patient opinion and input about needs. We don't want them at every meeting or executive decision but we try to think about appropriate opportunities for input. <u>Within our hospital</u>, we try to create opportunities for patient and family input but we draw the line at the board or at executive type decisions making. We have a patient council but keep patients separate from the most nitty gritty of decision-making...Too much complexity and too cumbersome to have to explain everything.</p>	<p><u>Within our clinical department</u>, we start each meeting with a patient story either told by a clinician or a patient rep to focus our attention on our core values. We are sometimes uncomfortable with having patient reps at high level meetings or retreats but see it as an important grown opportunity for us and for our patients to better collaborate. <u>Within our hospital</u>, we have patient and family representation at all levels from hospital board to the unit councils. We also send our patient reps for some education in hospital mechanics, budgeting, leadership so they can be equipped to participate and have patient rep mentors as contacts to help keep the reps up to speed and engaged. It takes a lot of work but this is our commitment.</p>	
<p>FEELING</p> <p>Culture and Values: Patient Value as a Value</p>	<p><u>Within our department</u>, we see quality care as our goal-PERIOD. Keeping costs down is not our goal or our job beyond covering our own local costs. Similarly, access and efficiency is a workforce issue not an issue for us personally. "Bending</p>	<p><u>Within our department</u>, we try to look at having responsibility for both quality outcomes AND providing care with efficiencies that maintain value and increase access but we still don't really</p>	<p><u>Within our department</u>, we are invested in the big picture of trying to do more with less; it is tempting to think we just need more money and more clinical resources to increase quality but we are focused on</p>	

	<p>the cost curve" is for management and government to figure out. <u>Within our hospital</u>, we focus on high volumes and throughputs; overuse is subjective and we won't apologize for doing more with more...we figure the government will bail us out if we can't control our costs. If patients want something, they get it- it is not for us to deny them tests they want or extra bed days. Explaining why something isn't indicated or doesn't help just takes time and brings down some of our satisfaction metrics.</p>	<p>think it is for us to take the leadership role in models that add population health type value; we still try to focus on the 1:1 satisfaction. <u>Within our hospital</u>, we recognize that this is a publically funded system and we won't get unlimited funding or bailed out just because our intentions were honourable. We feel a sense of responsibility to innovate with a view towards increasing quality while reducing costs. We have a few pilot programs aimed at reducing LOS or improving ER Wait times. We don't have a lot of formal training in lean processes or process redesign but we do try to maintain a Patient Value culture.</p>	<p>developing innovative models that maintain value, whether that is through standardization, interprofessional collaboration, group interventions, technology or patient education. We recognize that conventional models constrain our access goals and that we can probably maintain quality and increase value by 'trystorming' more and 'naysaying' less. <u>Within our hospital</u>, <u>we</u> invest in innovation by capacity building for lean and process improvement skills sets in our staff and by actively getting constraints out of the way of pilot projects and quality improvement ideas. We encourage our C-Suite leaders in IT, Quality and Safety, Nursing, Medicine and Surgery to be passionately supporting innovation and creativity in process improvements.</p>	
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