REPORT
McGill University General Internal Medicine Retreat
27 – 28 October 2017
Saint-Sauveur, Quebec, Canada

Toward connectivity and integration aiming for GIM sustainability

PURPOSE

The purpose of the Retreat was to help the Division of General Internal Medicine to determine next steps and actions necessary to promote connectivity and integration across sites and within its clinical and academic activities with the aim of maintaining sustainable growth and innovation.

Attendees : 26 (Including Dr J. Martin, Physician-in-Chief, Dept. of Medicine and Dr L. Lalla, Associate Dean, Continuing Professional Development

24 Faculty
Jewish General Hospital : 5
Royal Victoria Hospital : 9
Montreal General Hospital : 5
St. Mary's Hospital Centre : 5

Hôpital général juif
Jewish General Hospital

Centre universitaire de santé McGill
McGill University Health Centre

Retreat Agenda

TOWARD CONNECTIVITY AND INTEGRATION: AIMING FOR GIM SUSTAINABILITY

FRIDAY October 27th	
16:00-	Hotel check in
19:00 19:30	Cocktail Dinner and social event, La Tablée Restaurant
SATURDAY October 28th	
7:00-8:45 8:45	Buffet Breakfast, La Tablée Restaurant Registration and team assignment, Aspen A Room
9:00-9:15	Welcome and introduction, Aspen A *Dr V. Tagalakis*
9:15-9:30	Department of Medicine perspective *Drs J. Martin and J. Pickering*
9:35-10:35	Working Group Session (I) What?
10:35-11:35	Debriefing-team presentations
11:35-13:00	Buffet Lunch, St. Moritz Room free time/group walk
13:00-14:30	CPD : Moving from the classroom to the clinic, Aspen A *Dr L. Lalla, McGill CPD Office*
14:30-14:45	Coffee break
14:45-15:45	Group Session (II) How?
15:45-16:45	Debriefing-team presentations
16:45-17:00	Wrap up Closing remarks *Dr V. Tagalakis*

GIM DIVISION RETREAT
OCTOBER 2017
POWER POINT PRESENTATIONS

INTRODUCTION
Vicky Tagalakis

Toward connectivity and integration aiming for GIM sustainability

The purpose of the Retreat is to help the Division of General Internal Medicine to determine next steps and actions necessary to promote connectivity and integration across sites and within its clinical and academic activities with the aim of maintaining sustainable growth and innovation.

- GIM Sustainability: What do we want to sustain?
- Important growth and development in recent years
  - 51 faculty members: 7 full professors, 6 of which are tenured; 18 associate professors, 2 of which are tenured; and 26 assistant professors
  - 10 new recruits in past 12 years
  - Deanery positions
  - Department of Medicine
  - GIM residency program

- Healthcare reform has and continues to change our clinical and academic landscape
- Emphasis has been on improving care and optimizing healthcare resource utilization
- Serious Implications to our maintaining sustainable growth and development……
  - professional autonomy
  - clinical activities
  - academic clinical programs
- Bill 130
- FC training
- PEM restrictions
- Academic recruitment
- Cross appointments
- Devaluation of GIM role
- Forced mergers, centralization—> fragmentation, competition
- Minimized MD role in healthcare planning

What you had to say:

- Across site collegiality is lackluster and not cohesive . . . this is likely to get worse given the direction of healthcare . . . superspecializing in certain centres, activities removed from other centers, limited cross appointments, push of many service outside our institution walls
- We work in silos . . . little networking and/or communication
- Divided we are not strong . . . united we have a good chance to better weather healthcare changes
- Never felt like a division; no particular tie to the division
- Many new members . . . great thing . . . what are they doing? Would like to know more . . .
- QI growing but feels fragmented
- More information on research projects . . . clinicians may want to participate/contribute to these studies
- Mentoring . . . trajectory mapping unclear to me; how does it work at the different sites?

- MUHC merger . . . many challenges to maintaining the same standard of academics across sites
- Clinical mission . . . redefine ourselves . . . cross-site clinical innovation
- CME/CPD . . . we need more, has to be GIM specific . . . focus on best practices . . . combine it with QI

- A common theme among these observations are a lack of connectivity, working in silos, and limited academic and clinical integration across sites.
- Addressing connectivity and integration within our division is key for GIM sustainability

Meeting agenda

1. Department of Medicine Perspective
2. Focus group session (I) (Research, Medical Education, Clinical activities and QI, CPD/Physician wellness)
    - What opportunities exist to build connectivity and integration across divisional sites?
    - What key items are needed to build connectivity and integration across divisional sites?
3. Focus group session (II)
    - How do you envision capitalizing on the opportunities and/or implementing the key items identified during group session 1? Timeline of implementation?
4. Wrap up, next steps

DEPARTMENT OF MEDICINE PERSPECTIVE

Jim Martin and Joyce Pickering

Department of Medicine Mission

The Department of Medicine of McGill University strives to provide innovative high quality medical care through the application of knowledge derived from cutting edge fundamental, translational and population-level research. The Department is committed to excellence in education, training and to lifelong learning. The Department commits to respect our diverse community.

Certain Operational Principles

- We are a single department across sites
- Hospital divisions should have common academic interests and objectives that are defined by their role in the McGill Department
- Common governance should serve to promote the McGill divisional objectives

Current Strengths

- Clinical teaching units
- Quality improvement
- Specialized clinical services (research)
    - Thrombosis
    - Peri-operative medicine
    - Obstetrical medicine
    - Vascular medicine
    - ? Women's health
    - Osteoporosis

EDUCATION GROUP

Team Leader: Michelle Elizov

Members: Beth Cummings, David Dawson, Jeff Segal, Jeff Wiseman, Patrick Willemot

What are we best suited at educationally that we can/should take ownership or leadership on

- GIM educational "duty/identity" vs interests
- Leads to explicit educational succession planning
    - Clinical reasoning
    - History taking
    - Bedside clinical approaches (POCUS included)
    - Physicianship
    - Learners in difficulty
    - Teaching how to teach
    - Effective use of sim
    - Assessment and CBD
- GIM program
    - Ownership and pride
    - Education research and innovation
    - Be champions at table where education decisions are made
    - IM program
    - Exam boards
    - National committees

- Need to explicitly foster/support education in division through formal mentorship and building /supporting educational leadership

How – promote connectivity, recognize centrality of teaching/education, enhance GIM teaching profile

- Explicit participation in specific education courses/activities with priority to…
    - Clinical methods course
    - TCP
    - GIM program activities
    - Core IM Sim Centre activities
- Participation in Faculty Development activities 1x/year
- Ensure representation/leadership on the following educational committees…(succession planning and educational leadership)
- Recognition of participation in education activities
    - Div award in education for excellence in teaching, leadership, innovation/scholarship

- Peer feedback of teaching (cross sites and within any of the teaching activities listed above or clinically)
    - Direct, work-based, observation and feedback with narrative assessment and do thematic analysis
    - Collegiality, Section 3 credits and scholarship
- Education subcommittee in Division to develop our CPD program that responds to our needs
- Include comment on these in annual review
    - Did you do a peer feedback, did you do a peer feedback - what did you get out of this process
    - what education course/activity did you teach in – what did you learn
    - What Fac dev activity did you participate in – what did you learn, how can you apply it to your everyday practice

RESEARCH GROUP

Team Leader: Louise Pilote

Members: Amal Bessissow, Natalie Dayan, Steven Grover, Suzanne N. Morin, Vicky Tagalakis

Challenges in Connectivity in Research

- Working in silo
- Different affiliations within research institute
- Avoid further subdivisions
- Time

The What: Strategies

- How to create connectivity amidst these many subdivisions?
- How to get researcher to become successful?
- How to find the time amidst our busy schedules

Opportunities

- Mentoring
    - Depending on stage of research career, need varies.
    - One-one mentorship program - not content specific (tips for success, regular meetings)
    - Formal method to accompany new researcher.
    - Assistance for strategies to obtain funding (Foundation)
    - Support during grant session (e.g., to present grant in front of other colleagues)
- Knowledge translation
    - Journal club and teaching rounds
    - Present research projects in Newsletter
    - Increase number of Division rounds
    - Division research seminar/rounds – failed trial in the past – worth trying another formula

How to implement connectivity in research at the divisional level

Mentorship

- Formalize one on one mentorship program
    - Specific to early career development
    - New recruit to identify mentor
    - Protocolized mentorship program
        - EBOH on mentorship, guide tools for mentor, framework for mentor/recruit
        - Meeting q X amount of time.
        - Program for 3-4 years then possibility to change mentor.
        - Clear expectations from mentor (e.g., review grant)
        - Consult other divisions about mentoring documents (e.g., respirology)
- ?Mentoring for senior colleagues
    - Invite senior researchers from other area of expertise to research seminars (career pat

Research In Progress ('RIP') meeting

- "5 à 7" meeting q 2-3 month
- Time it with grant season
- Invite all members of divisions (researcher or not)
    - Assess and enhance clinical impact & relevance of research
- Trainees to attend
- Med Ed, clin epi, QI **…**

Knowledge translation

- Research In Progress meetings
- CPAU
- Division Rounds
    - Increase frequency (4 per year)
    - centre around content areas of 'expertise'
    - Incorporate CME and platform to present relevant GIM faculty research

CLINICAL, PATIENT SAFETY, QI GROUP

Team Leader: Thomas Maniatis

Members: Gail Goldman, Laurence Green, David Hornstein, Maral Koolian, Luc Trudeau

WHAT

• QI: new hire at JGH, established leaders at MGH and RVH, CPAU at MUHC, interest to participate from St. Mary's – QI interest group for information sharing, leadership, coordination – website, cross-site M&M, integrate QI section in FOCUS on GIM

Clinical innovations: share best practices / solutions

- Inpatient (acute/complex patients – ER, GIMCS, CTU, ICU)
    -discharge processes * – share best practices / standardize
- Outpatient: Preop *
    - standardized consult template – good for data collection, standardized for GIM residents
    - database needed *
- Outpatient: MOM – site based for now
- Outpatient: Vascular Medicine
    - leadership at JGH, MGH – mixed patient pool at the other sites
    - role for redirection of patients towards dedicated clinics to
    - favour identity forming + research (database shared template)

- Outpatient: Thrombosis
    - major strength at JGH, venous thrombosis at St. Mary's and RVH, opportunity for expansion and coordination to MUHC *

- Outpatient: GIM / Complex Care
- procedures, rapid assessment units
- Role for "McGill appointment" to allow cross-site movement across hospitals

HOW

• QI:

QI interest group – champions leadership, coordination –

- website, cross-site M&M,
- integrate QI section in FOCUS on GIM
- <u>low hanging fruit:</u> what is ongoing and successful at site A to share across sites?
    - inpatient (CTUs – discharge processes) – -
    outpatient templates (preop + vascular)
    - challenge: how to share? preop MUHC, DOAC JGH

- leadership at all sites (establish internal lines of communication) + support (admin – med records)

- Clinical innovations: share best practices / solutions
  - Inpatient (acute/complex patients – ER, GIMCS, CTU, ICU)
    - low hanging fruit: discharge processes * – share best practices / standardize
      - share current tools, get interested people together (including residents), come up with standard +/- accepted variations
  - Outpatient: Preop * challenge: limited presence at JGH
    - low hanging fruit: standardized consult template that works already in use – good for data collection, standardized for GIM residents
      - database needed *
  - Outpatient: Vascular Medicine
    - leadership at JGH, MGH – mixed patient pool at the other sites
    - high hanging fruit only
- Outpatient: Thrombosis
  - medium hanging fruit: opportunity for expansion and coordination to MUHC and organizing at St. Mary's
  - DAWN already at JGH and working . . .

RECRUITING, CAREER TRACK, PHYSICIAN WELLNESS GROUP

Team Leader: Joyce Pickering
Members: Bruce Campbell, Suzanne Dubé, Ken Flegel, Suzanne T. Morin, Farzaneh Shamekh

WHAT and HOW

Dr Pickering:
On recruitment . . . we recruit with hospital allegiance first, little understanding of larger departments.

Work to do on recruiting orienting people to their university appts and issues like promotion, understanding research support, etc

On Wellness and resilience . . . It should be about skills and growth (do you want to attend on wards past 65 . . .)

Spending time on the bridge

- (Dr Flegel) Little awareness of greater structures…group evening and retreat sessions can help. Some changes in new hospital have lost some of the connections that were made over lunch etc.
- Discussion on concordance between departments and divisions in MUHC/CIUSSSs etc Dr P maps it out. Structure and personal unions

CIUSSSITIS

- New issues from mergers
  - leaders not part of day to day hospital
  - CIUSSS is like a navy with admirals and no captains on the ships
  - Fragmentation…!
  - Where is you place and who do you belong to?
  - Hospitals have personalities...it is a strength

Challenges and Ideas

- Suzanne Dube: wellness of the group depends on participation, lacking in some ways. Too many people not making the effort to be present. "Faces and Names" type activities are important. For example Dept of Med Christmas Party (cancelled for lack of funds)

- Farzaneh: How do we get people to feel like they belong. She met with Vicky and felt she belonged more and thought about her role. Make people feel half-obliged and half-comfortable that they are part of something
- What can help: common goals, part of something. A common enemy (Suzanne M).
- Building bridges through personal connections with the leadership: welcoming etc.
- NEW RECRUITS (Bruce C):
- Is there enough things focused on new recruits.
- Discussions about wellness stuff: Cleveland clinic "relationship based care". do these things last
- Balint groups: interactions with patient: personal growth

Recruiting

- Back on recruiting. Important for health of department
- Need to space out hirings
- Inevitable comparison between U of M and McGill.

Themes / Conclusions

- Support and relationship building important.
- Types of bridges
  - Electronic
  - Social
  - Personal
  - Mentoring . . . with leaders (Vicky's interviews)
  - To the future: recruiting

Role of Dept in CPD and Wellness

Beginning:

- the new recruits…meet with leadership,
- Mentoring, on billing, on practical issues etc as well as academic issues
- A more structured way to meet the new recruits / introductions to division members, "faces and names"

Middle: In their prim, i.e., everyone here

- Group "self assessment" we would like to see more
- CPD content expectations: e.g. ACLS, Med-Obs etc
- Physician wellness…we get little support and we have poor insight how much support we might need. (category 4 CPD)
- Opportunities to meet and share…excuses to meet (journal club followed by necessary complaint session, evening at the vogue, a social place identified with the department, social media, physical activity, weekly lunch, faculty only sessions)
- Adding competencies in mid-career that would be growth areas later. For example: administration, legal, advising.
- Support in case of illness or personal tragedy

Discharge planning

End of practice and retirement

- Competence, its not about age
- PEM system a huge barrier, any role for advocacy here
- Changing scope of practice / developing other areas of expertise (governance, editing etc)...this might lead back to CPD
- Division can help re-define and refine scope of practice and help with CPD

Some Suggestions

For beginners:

- Together with new recruit identify one or several mentors...co-ordinate with Division Directors (University and hospital)

In our prime:

- Looking into collective practice assessment as an easily accessible tool for members with 2 principal goals:
    - encourage assessment based CPD
    - bring site members together with a collective activity
    - provide support
- For example the Pre-Op practice review

On discharge:

- Discuss ten year plans at every performance review. Match with CPD and developing other interests

Wellness

- The fourth category of CPD . . .
- Opportunities to meet informally
- Look for practical excuses to bring division together (like this one!)
- Consider divisional rounds on the subject