STRATEGIC DIRECTIONS		
	1	***Empower Department members to practice according to the highest clinical standards while fulfilling their academic mission.***
	2	***Stimulate innovation in every facet and at every level of Departmental activity.***
	3	***Foster a local culture that promotes professional and personal development and that acknowledges issues of work life integration and encourages a sense of belonging to a dynamic academic community***
	4	***Enhance timely and comprehensive communication with all stakeholders of the Department according to a clearly formulated strategy.***

SPHERES	DOMAIN		ITEM		ISSUE	DESIRED OUTCOME	ACTIONS	STRATEGIC DIRECTIONS	DETAILS
CLINICAL									
	RESOURCES		*1*		The Pediatrics Department has insufficient manpower to able to sustain the clinical mission without compromising other aspects of it's mandate.	The Department will maintain excellence in delivery of clinical care without compromising its academic mission.	Create **new fellowships** to increase clinical and research capacity and preserve educational programs (subspecialty training programs).	1,2	Fund new subspecialty fellowships for Canadian CARMS 2 residents or international fellows and residents. These will be PGME approved program beyond currently funded fellowships. All Divisions will have one fellow with ER having 2 and General Pediatrics 3. All Divisions with a Fellow will co-fund with a 1% Fellows tax on their revenues as per MSSA formulas.
	RESOURCES		*2*		Clinicians dedicate too much of their time performing adminstrative duties.	Offload some administrative work from clinicians.	**Hire a Project Manager**, paid and directly reporting to the MSSA, that will see through projects outlined by the Strategic Plan.	1,3	Finance this position by imposing a cut on the MSSA administrative stipends envelope. See attached Job Description.
	RESOURCES, COMMUNICATION		*3*		For some complex patients, in the ambulatory setting, care is not well coordinated between various subspecialists	Implement new multi-disciplinary and inter disciplinary clinics that are condition/patient centered	Continue to take an active role in advocating for models care that are patient centered at the hospital level;	1,2,3,4	Continue to work with the hospital on the BFAECC Complex Care workgroup.
	CULTURE		*4*		There remain signigficant barriers to implementing quality control in the culture of day to day clinical practice despite access to significant local expertise	Seamless integration of efficiency, access and quality control in all aspects of clinical practice	**Appoint a hospital-funded Quality Control Officer** that will oversee the coordination of all aspects the quality of the medical act while promoting innovative approaches	1,2,3,4	Support the Hospital Quality Committee Ethics.
	SYSTEM		*5*		PEM restrictions increase clinical workload to the detriment of other academic goals.	In conjunction with the FMSQ and the Ministry, help at developing manpower models that reflect our academic tertiary practice, as well as demographic issues (beginning and end of practice issues, gender)	FMSQ and Ministry advocacy	1,3	The Chair and Department members should take an active role in advocating at the level of the FMSQ considering our demographic mix and our academic mission.
RESEARCH									
	GOVERNANCE		*1*		Confusion around leadership in child health research.	Coordinated strategic vision for developing and growing child health research between the Research Institute and the Department.	Develop clear and transparent job descriptions for each child health research leadership position or committee within the Department and the MUHC RI. Establish how these positions will operate and interact with each other.	2	A task force will be created to define a new governance for the research mission under the leadership of the Associate Chair (Research).
	PRODUCTIVITY		*2*		Research output insufficient in certain areas.	Increase research capacity and quality.	Continue to **hire recruits who have a strong research training** (minimum level of masters) and who are committed to an academic career as Clinician Investigators. Provide 3 years of startup salary and operation support to new Clinician Investigators. Appoint Division Heads who support and encourage research from the membrs.	1,2	Already accounted for in the current operating budget. The target is for two new recruits per year although this will vary year to year depending on PEM availability and available candidates.
	RESOURCES		*3*		Researchers lack the necessary manpower and tools to carry out research effectively	Increase accessibility to expertise that facilitates research performance.	Finance **Capacity Building Awards:** to hire expert help (ex:research coordinators) for team of investigators that share similar iresearch interests and who need logistical help in conducting their projects.	1,2,3	The department will share 1:1 the salary of this expert help.
	RESOURCES		*4*		Little access to funding for investigators who are not established.	Increase access to seed funding for all department members.	Continue to fund the **Innovation Fund** (or equivalent)	1,2,3	Already accounted for in the current operating budget.
	RESOURCES		*5*		Little collaboration between bench researchers and clinical investigators	Increase collaboration between bench researchers and clinical investigators.	Develop specific **Stimulus Funding Grants** to link basic science researchers with clinicians to jointly tackle clinical problems. These can be competitively set up to promote collaborations from the bench to the bedside within the Department and RI.	1,2,3,4	New item.
	RESOURCES		*6*		Investigators have difficulty accessing the necessary tools and services needed to be efficient and productive	Increase the accessibility to tools that help research	Increase accessibility to available tools by disseminating knowledge about available ressources and helping to access them, as needed.	2,4	Ex: Free REDCap use, biostatical and epidemiological pre-award consultation services
	COMMUNICATION		*7*		Siloing effect between researchers and clinicians	Enhace communication and colloboration between all members of the MCH research community	Implement a comprehensive **communication strategy** for the Department.	2,3,4	A facet of the Communication Strategy will concern integration of basic researchers into the Departamental community.

	COMMUNICATION		*8*		Partnerships with other local, provincial and national institutions not optimized.	Promote further linkages with HSJ, national networks, Shriner's.	**Link clinical researchers with basic science researchers** in the MUHC RI who can bring genomics, metabolomics and proteomics as diagnostic tools or biomarkers. Consider taking advantage of pan-Canadian networks where they are effective and align with your strengths. Lead a strategy to facilitate and capitalize on the relatively close geographic location to partner with HSJ's researchers.	2,3,4	Part of a comprehensive communication strategy.
EDUCATION								
	RESOURCES		*1*		Lack of supspeciality fellows threatens the accredatation of several Royal College training programs	The Department will preserve the accreditation of threatened Royal College Programs.	**Create new clinical fellowships** to increase clinical and research capacity and stimulate educational activities. Funding will be preferential to divisions that have programs that are threatened.	1	Mandate of the Project Manager under the supervision of the Chair of Pediatrics.
	CULTURE		*2*		Threatened learning environments and morale related to increasing pressures and demands being placed on faculty and residents and conflicts arising from tensions between service needs and learning needs.	Rekindle the sense of community for the Department with residents and other trainees being key participants and stakeholders in this process.	Through Departmental Discretionary Funds from the University, the Department will build the case for a partnered approach to improving professional development, physican wellness and diversity. Anticipated partners include the University and the Hospital through the Foundation.	3	Develop a systems-wide approach with the Hospital and University as partners.
	RESOURCES		*3*		Insufficient opportunities for residents to carry out research or to acquire the necessary skills to conduct and publish research.	Aim for at least one published manuscript for all general pediatric residents by the end of their residency. Enhance the productivity of sub-specialty residents as well.	Meet and greets between researchers and trainees, forum to feature ongoing research by department members, enhance access to skills necessary to conduct research (databases, epidemiology expertise, manuscript writing guidance).	2,3,4	Mandate of the Project Manager under the supervision of the Program Directors and the Associate Chair for Research.
	PRODUCTIVITY		*4*		Representation from Departmental members to teaching activities is uneven and often insufficient.	Enhance representation/participation of all divisions in the core teaching activities of the Department (academic half-days, OSCE's, STACERs, card cases)-	Impose clear expectations for the involvement of each division in the different educational activities of our Department based on division size (e.g., every member of the division of general pediatrics should participate in 1 STACER per year; the division of cardiology should contribute 2 half-days per year to OSCE supervision.	1,2,3,4	Mandate of the Project Manager under the supervision of the Program Directors and the Associate Chair (Education). The PM will create a detailed list of the annual educational needs (# of people/half-days) for their programs. Develop an 'educational calendar' to facilitate communication of educational events/needs with Departmental members.
	RESOURCES, COMMUNICATION		*5*		Faculty members are currently ill prepared to face the paradigm shift in medical education and evaluation imposed by the introduction of the Competence by Design (CBD).	Faculty members are educated about CBD and the didactic and evaluative implications. Faculty members are adequately supported during this transition period and are provided with the adequate tools to carry out their new roles.	Workshops directed towards faculty training in CBD will be organized. Key local experts that can act as resources will be idenfied and provided logistical support for their role.	1,4	Combined Mandate of the Program Directors and Associate Chair (Education) helped as needed by the PM. Development of meaningful metrics (on par with those that exist for research) to evaluate the performance of all faculty members with regards to the educational mission. Based on these metrics, faculty members need to be help accountable to meet specified bench marks of involvement in educational activities.
INFRASTRUCTURE								
	COMMUNICATION		*1*		Inadequate communication between members, external stakeholders and departmental leadership.	Improve departmental internal horizontal and vertical communication as well as interaction with community stakeholders according to a comprehensive communication strategy.	The **Project Manager** will oversee the creation and implementation of a comprehensive communication strategy for the Department. External expert consultation will be sought as needed.	1,3,4	A priority for the new Project Manager.
	RESOURCES		*3*		Insufficient manpower, skill set and time to execute strategic plan.	Execute the strategic plan according to an established timeframe.	Engage a Project Manager on a full time basis who will report to the Chair and the Ex-Co.	1,4	Hire a Project Manager, paid by the MSSA, that will see through projects outlined by the Strategic Plan. Finance this position by imposing a cut on the MSSA administrative stipends envelope.
	RESOURCES		*4*		Lack of sufficient administrative support.	Improve efficiency and decrease administrative burden for department members.	The Manager will carry out a needs analysis and propose cross-cutting solutions.	1,3,4	The emphasis will be on cross-cutting technological tools will improve the efficiency of department members. The MUHC will be engaged in a dialogue that will also consider how to best utilize current administrative manpower.
	PRODUCTIVITY		*5*		Insufficient use of informatics to streamline processes and to increase physician efficiency.	More efficient transfer of information, decreased physician workload, streamline care.	The Manager will carry out a needs analysis and propose cross-cutting solutions.	1,3,4	The emphasis will be on cross-cutting technological tools will improve the efficiency of department members. The MUHC will be engaged in a dialogue that will also consider how to best utilize current administrative manpower.
MORALE								
	COMMUNICATION		*1*		Fatigue over multiple strategic plans, confusion as to to the role of the Departamental Strategic Plan vs other strategic initiatives .	Clarify and discuss the Department Strategic Plan with all stakeholders.	Meet divisions individually to present and clarify the Strategic Plan and seek feedback, organize townhalls with all stakeholders.	3,4	The Strategic Plan will be disseminated widely to Department members. The Chair and Strategic Planning members will engage a discussion with each Division individually.

CULTURE		*2*		Lack of MCH "community spirit". Few opportunities to interact with colleagues in different silos, Divisions, etc.	Rekindle the MCH spirit and sense of belonging to a vibrant academic community.	Through Departmental Discretionary Funds from the University, the Department will build the case for a partnered approach to improving professional development, physican wellness and diversity. Anticipated partners include the University and the Hospital through the Foundation.	3	Develop a systems-wide approach with the Hospital and University as partners.
CULTURE		*3*		Issues with burnout for several deparment members.	Promote strategies of Work-Life integration that decrease the burden to deparment members.	Through Departmental Discretionary Funds from the University, the Department will build the case for a partnered approach to improving professional development, physican wellness and diversity. Anticipated partners include the University and the Hospital through the Foundation.	3	Develop a systems-wide approach with the Hospital and University as partners.
CULTURE		*4*		The concept of diversity is poorly understood and acknowledged.	Diversity education and training; workshop for all leaders reagrding gender and diversity policy and how it impacts day to day academic practice.	Through Departmental Discretionary Funds from the University, the Department will build the case for a partnered approach to improving professional development, physican wellness and diversity. Anticipated partners include the University and the Hospital through the Foundation.	3	Develop a systems-wide approach with the Hospital and University as partners.
CULTURE		*5*		There is no clear succession planning between senior and junior researchers.	Promote a dynamic and successful transition between senior and junior researchers.	**Establish a formal mentorship program**; pair senior and junior investigators; train mentors and mentees to the mentorship process. To be coordinated by the DWO.	2,3,4	Bring in expertise from the McGill Business Center to train mentors and mentees.
CULTURE		*6*		Given the demographic reality of the Department, there is poor representation of women physicians in leadership positions.	Increase leadership training for women. Aim for 80% conference attandance per year for women clinicians.	Active guidance/academic engagement for women physicians. To be coordinated by the DWO.	3	Support leadership training for women physicians.
CULTURE		*7*		The contribution of many Department members to the mission of the Department is not adequately recognized. The emphasis is on acklowledgement of research production.	Formal recognition of clincal, teaching and administrative duties.	**Ongoing recognition of contributions** that are relevant to the entire MCH community should be part of a dynamic communication strategy.	3,4	The Project Manager will assume the lead on the building on current Departmental initiative.
COMMUNITY SERVICES								
GOVERNANCE		*1*		Large number of community clinicians with atachment to MCH, no longer have close links with Department. This estrangement jeopardizes the relationship of the Department with it's community members.	Creation of Division of Community Pediatrics. This will facilitate greater Integration of service with Community physician and service providers. Commmunity should be viewed as extension of MCH.	The Chair will advocate to McGill University for the recognition of this new division and will appoint a Head.	3,4	The Chair will appoint division members who will receive official recognition of their affiliation to the Department. The Division Head will represent the interests of the community pediatricians at the departamental leadership table and will be responsible for promoting the academic agenda. Project Manager will review similar successful setups (e.g. CHOP and Harvard).
RESOURCES, COMMUNICATION		*2*		Patients with moderate complexity have poorly coordinated care between their community physician and experts in the hospital.	Improve the coordination of care between primary physicians and specialists.	Support the Complex Care Working Group in developing with Drs. Long-Gagne and Patel an intermediate clinic with excellent communication capacity.	1,2,3,4	Continue to work with the hospital at the hospital lead Complex Care workgroup. Focus on the integration of the primary physician in the care of the complex patient.
PRODUCTIVITY		*3*		Clinical material in the community is going unused by researchers.	Provide opportunities for clinical researchers and trainees to carry our community based research projects that eventually impact care delivery in this setting.	Scope out the organization of groups such as Target Kids and PROS as successful examples of community based research platforms and adapt them to the reality of our departament.	2,3,4	New models of community pediatric care that facilitate research in this setting will be privileged. These models should interfere as little as possible with the existing practices of academic community pediatricians.
RESOURCES		*4*		Glen no longer provides optimal environment to teach General Pediatrics to Trainees.	Adopt and implement an up to date curriculum for General (Community) Pediatrics that reflects the current Royal College requirements for Competency by Design (CBD).	Review of present curriculum for General Pediatrics and adapt it for CBD. Develop appropriate evaluation techniques in conjunction with the Pediatrics training program. Train the trainers (community pediatricians) in current teaching evalution methods.	1,2,3,4	Under the direction of the Project Manager, the numbers of trainees (residents and students), space, equipment and logistical help needed will be clearly defined. Discuss financial support for teachers.
COMMUNICATION		*5*		Community physicians without a PEM do not have Oacis / Inteleviewer access	Community physicians without a PEM are allowed to have Oacis / Inteleviewer access	Examine the laws with MUHC DPS which prevent this at the moment.	1,3,4	Examine the laws with MUHC DPS which prevent this at the moment.
CULTURE		*6*		The contribution of community pediatricians to the mission of the Department is not adequately recognized.	Justly recognize the role of community physicians in education, clinical and research.	The Chair and Project Manager will explore ways to promtote the integration of community pediatricians in the day to day clincal and academic activity of the Department.	3,4	The Chair and Project Manager will explore ways to promtote the integration of community pediatricians in the day to day clincal and academic activity of the Department.