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The Social Accountability of a Northern Medical School:

Alignment of Mission and Mandate with Impact

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Dean, President and CEO
Northern Ontario school of Medicine

VISION

Innovative Education and Research for a Healthier North.

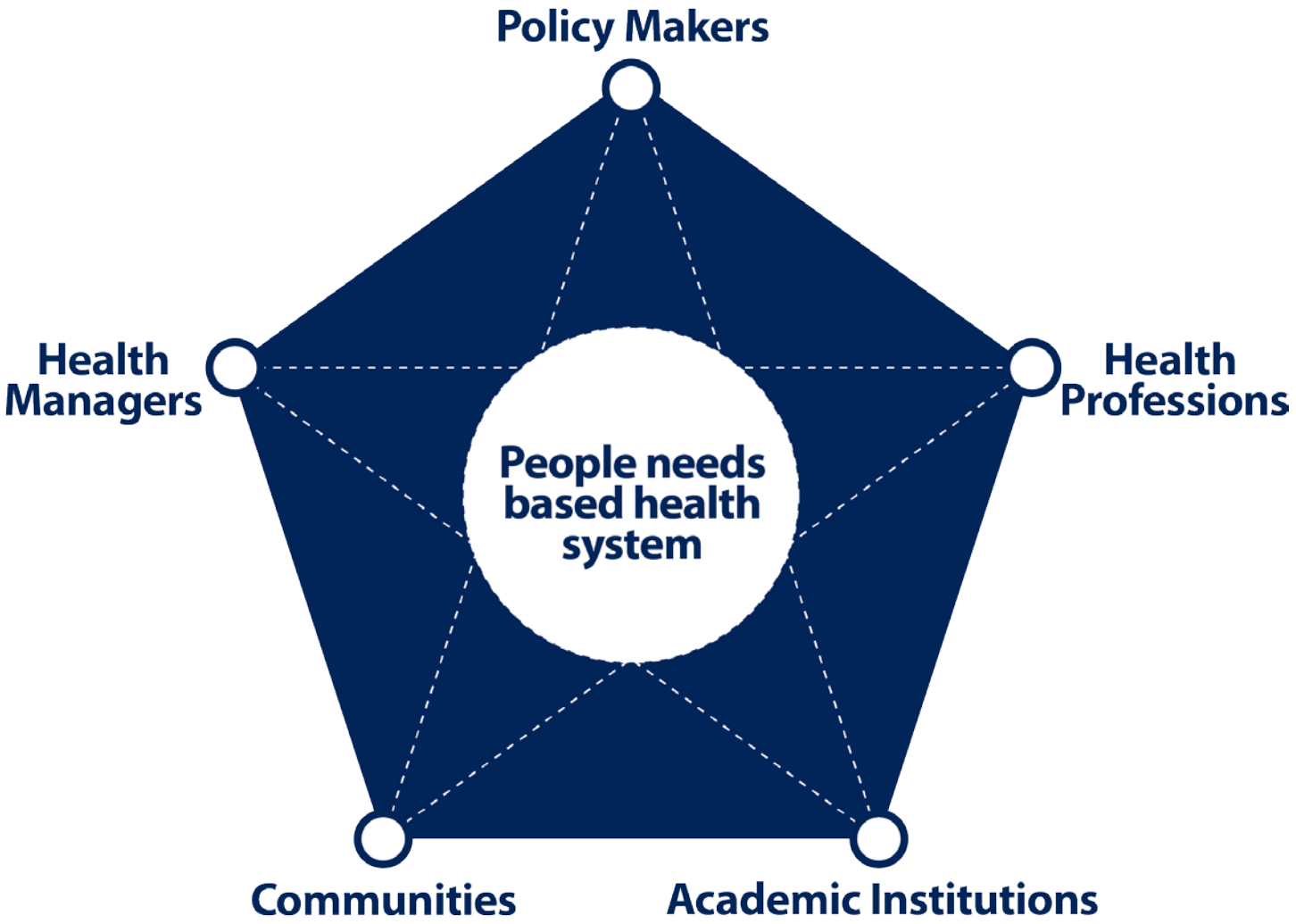
MISSION

The Northern Ontario School of Medicine (NOSM) is committed to the education of high quality physicians and health professionals, and to international recognition as a leader in distributed, learning-centred, community-engaged education and research.

VALUES

Innovation | Social Accountability | Collaboration
Inclusiveness | Respect

Social Accountability Framework



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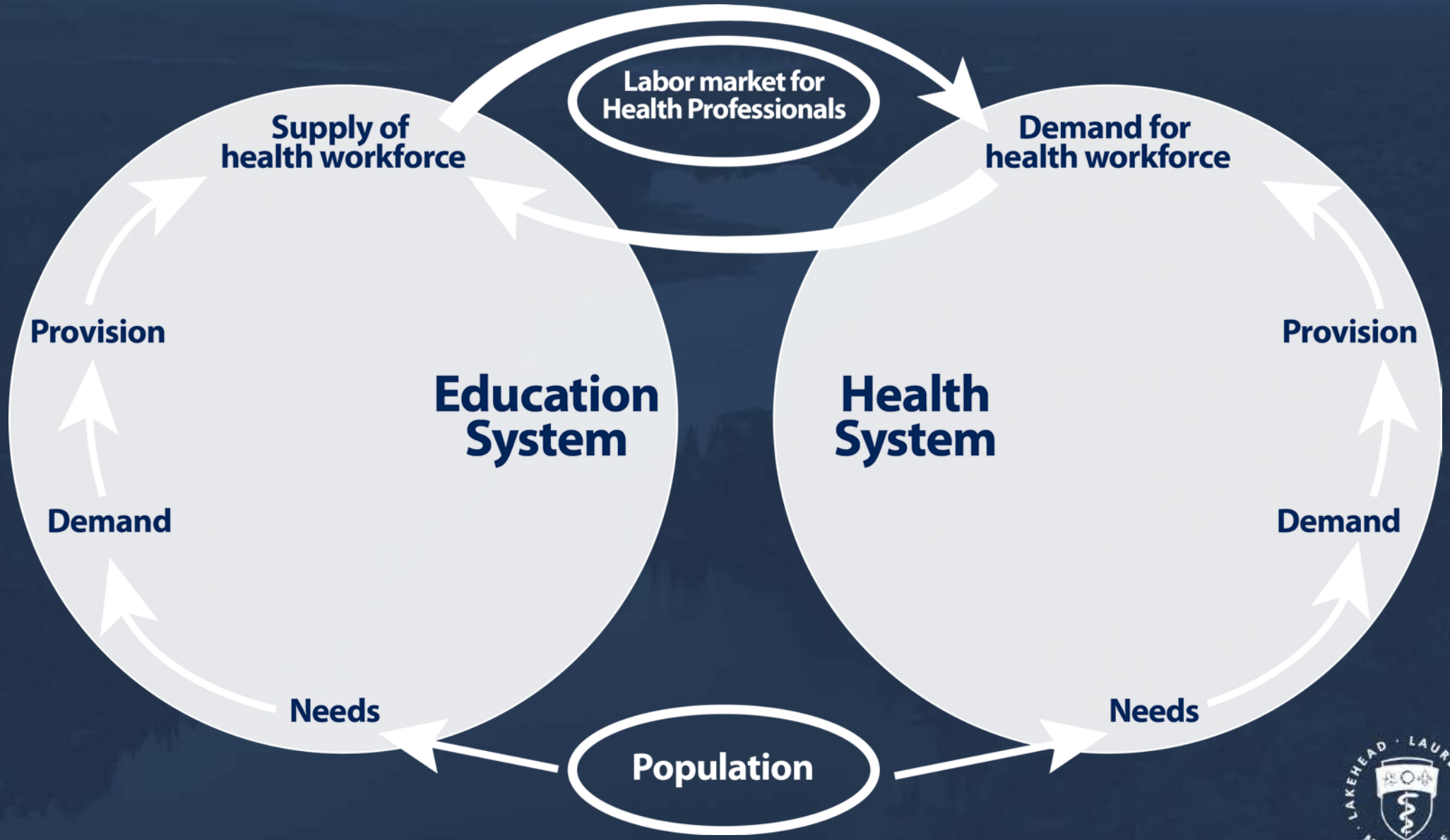
A Systems Approach

Education of Health Professionals for the 21st Century: A global independent Commission



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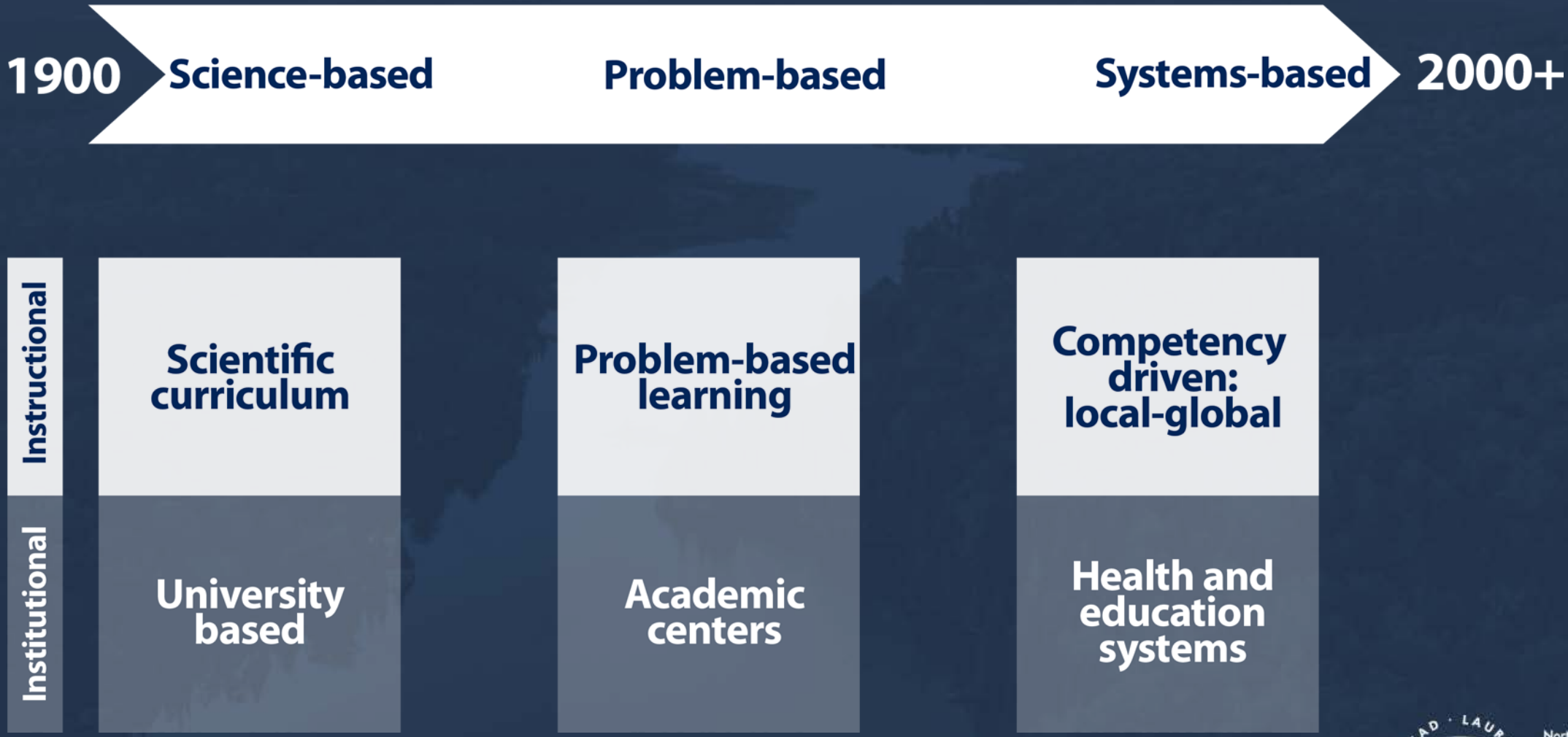
Three Generations of Reform

Education of Health Professionals for the 21st Century: A global independent Commission



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Levels of Learning

Education of Health Professionals for the 21st Century: A global independent Commission

Level	Objectives	Outcome
Informative	Information Skills	Experts
Formative	Socialzation Values	Professionals
Transformative	Leadership attributes	Change agents

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OLD WORLD

Each of our professions practice in silos as individuals

NEW WORLD

All of us work predominantly in teams

OLD WORLD

The doctor is on top of the hierarchy

NEW WORLD

Health care is part of a complex organization

OLD WORLD

Knowledge is evidence based and generalized

NEW WORLD

Knowledge is personalized and customized

OLD WORLD

Duration based education

(tea steeping)

NEW WORLD

Competency Based Education

OLD WORLD

Determinants of health were contained by geography

NEW WORLD

Health and Disease know no boundaries

What kind of health provider are we looking for?

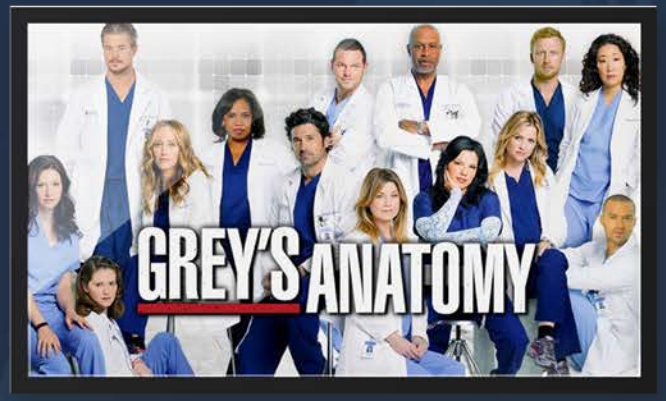

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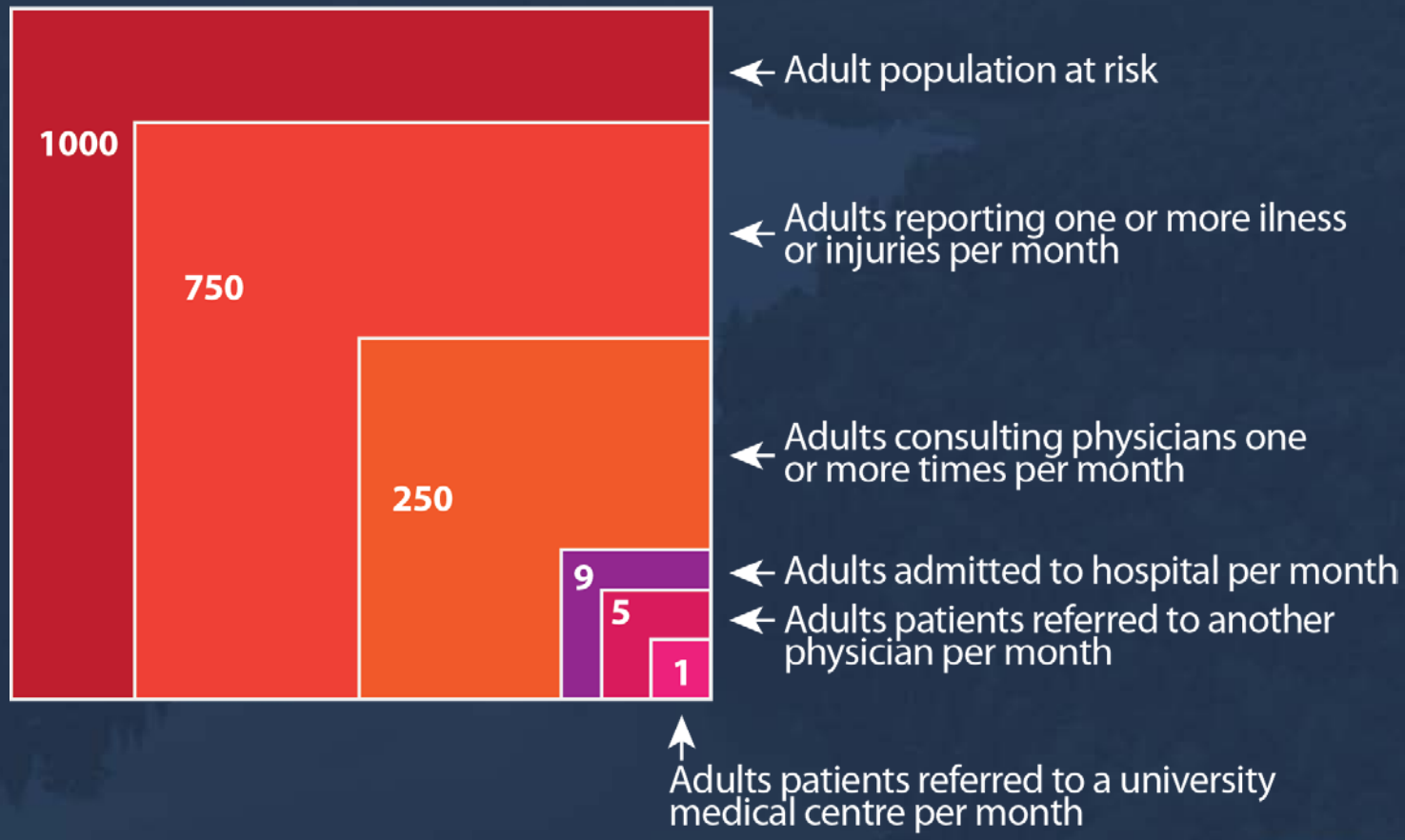
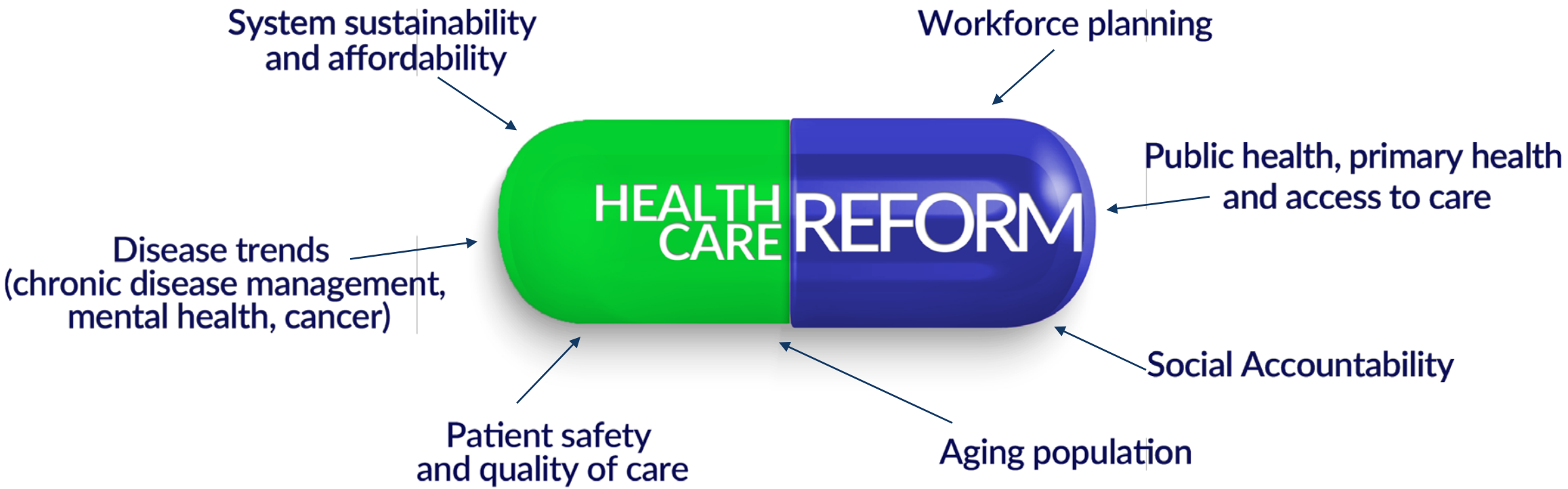
Figure 1.1 Monthly prevalence estimates of illness in the community. Roles of physicians, hospital, and university medical centres providing medical care to patients 16 years and older



Source (White et al., 1961)

Pressure on Health System to Change



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Are we training the Doctors of the Future?

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At one point it all existed in someone's imagination

And…

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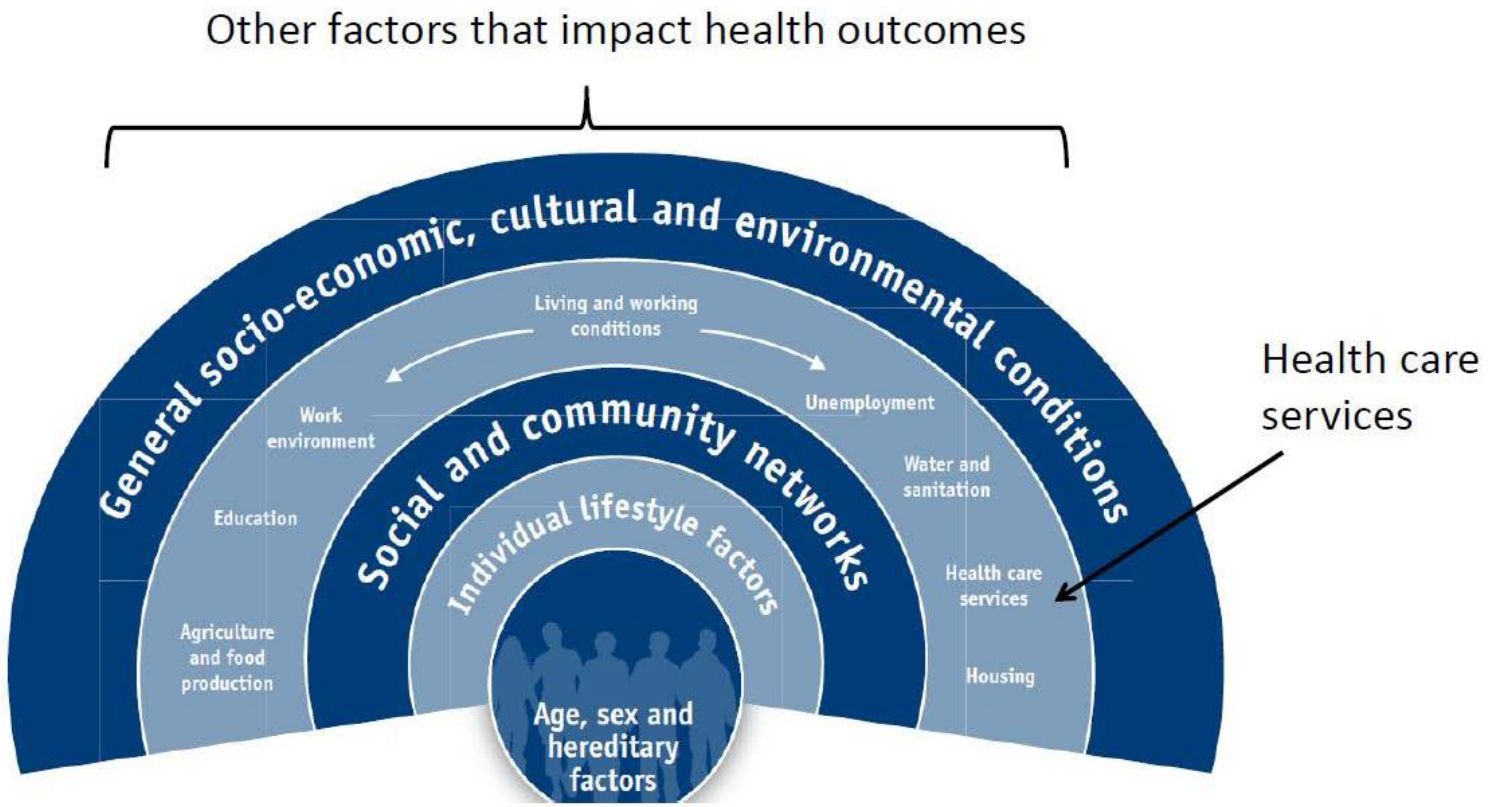
But really, is new technology relevant in your practices?

EMR, virtual CC, referral patterns, “avatar/hologram” medicine

Telederm, TeleDiagnostic Imaging…

Determinants of Population Health



Source: Butler-Jones D. The Chief Public Health Officer's report on the state of public health in Canada: Addressing health inequalities, 2008.
Adapted from: Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Stockholm: Institute for futures studies, 1991.

People in the North are more likely to die younger

- In 2014-2015, only 17% of patients in the Northwest and 21% in the Northeast saw a family doctor or psychiatrist within seven days of being discharged, compared to 30% in Ontario as a whole, and 40% in Toronto.
- In the Northwest, the potential years of life lost due to suicide are approximately 300% greater than that of Ontario. In the Northeast, the potential years of life lost due to suicide are 50% greater for men and more than 80% greater for women than in the general Ontario population

Health Quality Ontario's Equity in the North Report

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Health Inequity exists yet is barely recognized

- The Northeast and Northwest have the highest prevalence of diabetes in Ontario: 12.8% and 12.5% respectively, compared to an average of 10.2% across all of Ontario particularly high among adults living in First Nations communities, with up to 21% reportedly having been diagnosed with diabetes
- For expectant parents with complex chronic conditions living in low-income neighbourhoods in Ontario, the risk of infant mortality is 25% higher than it is for those in high-income neighbourhoods
- Prescription opioid use in pregnant women is a concern, with 28.6% of women in a rural clinic in the Northwest found to be using opioids

Health Quality Ontario's Equity in the North Report

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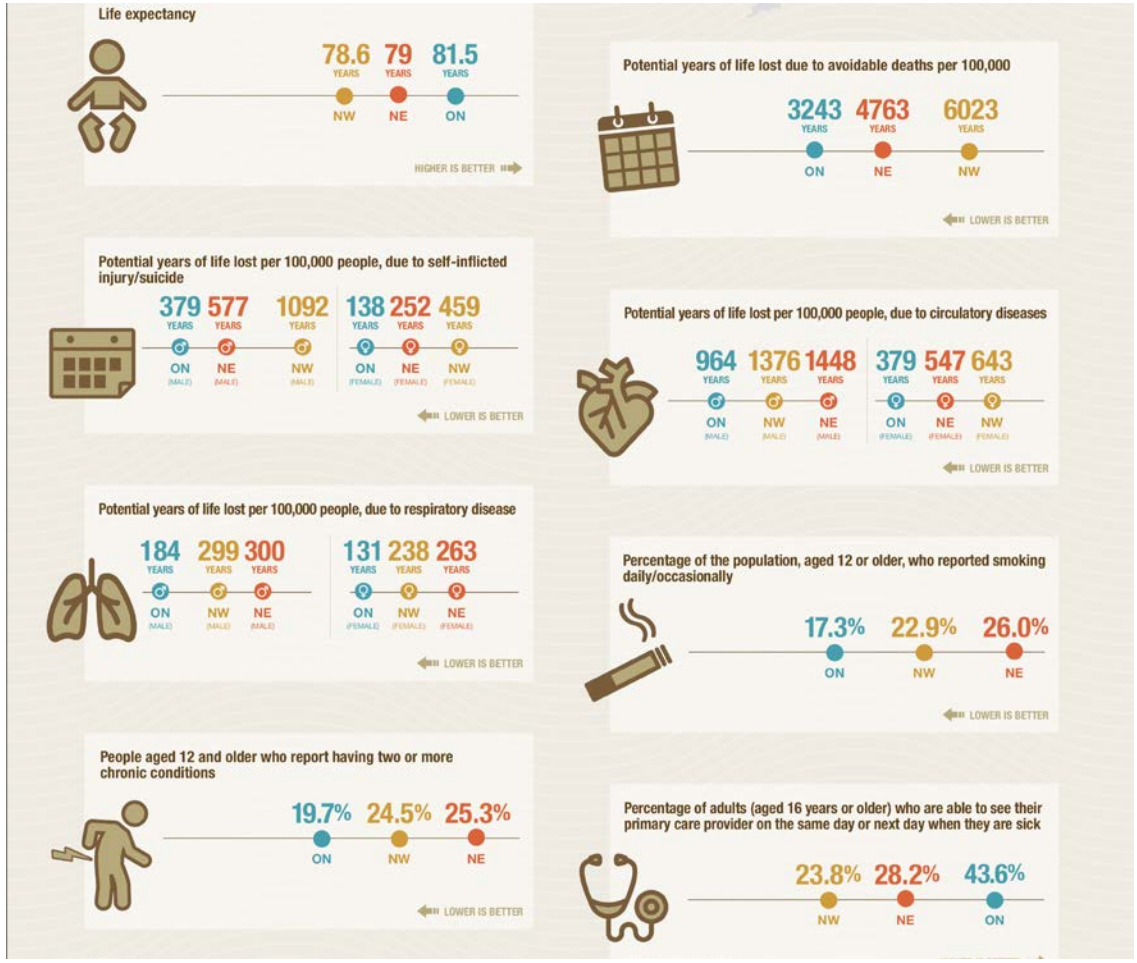
Life expectancy
78.6 YEARS
79 YEARS
81.5 YEARS
NW
NE
ON
HIGHER IS BETTER
Potential years of life lost due to avoidable deaths per 100,000
3243 YEARS
4763 YEARS
6023 YEARS
ON
NE
NW
LOWER IS BETTER
Potential years of life lost per 100,000 people, due to self-inflicted injury/suicide
379 YEARS
577 YEARS
1092 YEARS
138 YEARS
252 YEARS
459 YEARS
ON (MALE)
NE (MALE)
NW (MALE)
ON (FEMALE)
NE (FEMALE)
NW (FEMALE)
LOWER IS BETTER
Potential years of life lost per 100,000 people, due to circulatory diseases
964 YEARS
1376 YEARS
1448 YEARS
379 YEARS
547 YEARS
643 YEARS
ON (MALE)
NW (MALE)
NE (MALE)
ON (FEMALE)
NE (FEMALE)
NW (FEMALE)
LOWER IS BETTER
Potential years of life lost per 100,000 people, due to respiratory disease
184 YEARS
299 YEARS
300 YEARS
131 YEARS
238 YEARS
263 YEARS
ON (MALE)
NW (MALE)
NE (MALE)
ON (FEMALE)
NW (FEMALE)
NE (FEMALE)
LOWER IS BETTER
Percentage of the population, aged 12 or older, who reported smoking daily/occasionally
17.3%
22.9%
26.0%
ON
NW
NE
LOWER IS BETTER
People aged 12 and older who report having two or more chronic conditions
19.7%
24.5%
25.3%
ON
NW
NE
LOWER IS BETTER
Percentage of adults (aged 16 years or older) who are able to see their primary care provider on the same day or next day when they are sick
23.8%
28.2%
43.6%
NW
NE
ON

Food Security

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Water Security

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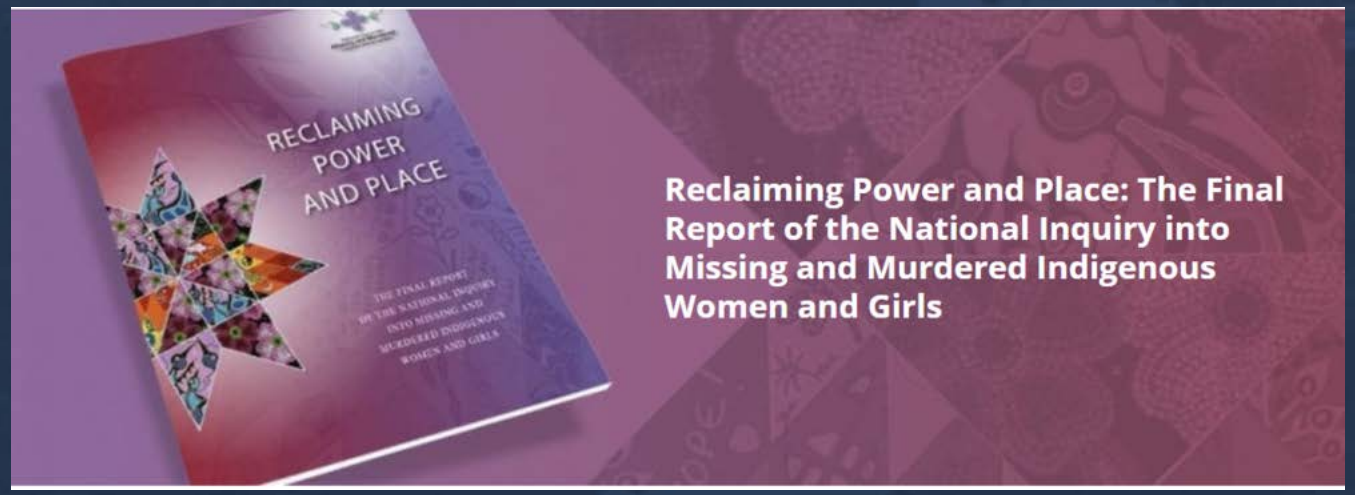
Personal Security



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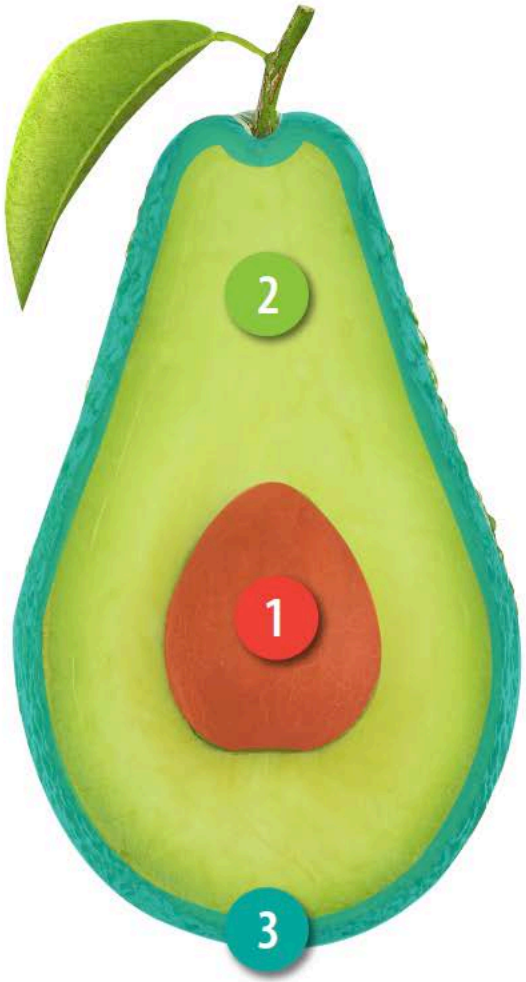
The Levels of Socially Accountable Care



1. **Micro:** The clinical environment; encompasses both the individual family physician–patient relationship and the inter-professional, team-based care setting.

One patient at a time

2. **Meso:** The local community; the geographic context in which clinical and academic medical work are situated. Includes education, training, and continuing professional development (CPD).

Into the community

3. **Macro:** The broader realm of policies and their impact on population and public health, where family physicians act as advocates for healthy public policy.

Framing the big picture

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(Goel et al., 2016; Meili et al., 2016; Woollard et al., 2016)

NOSM by the numbers

- 655 MD graduates since 2009.
  - 42 MD graduates self-identify as Indigenous.
  - 135 MD grads who self-identify as Francophone.
- 449 individuals have completed NOSM residency programs since 2008.
- In 2018, NOSM had an estimated economic impact of $125 - $137 million in Northern Ontario.
- Overall spending in 2018 was estimated to support 780 - 860 full-time equivalent jobs in the region.
- Since 2010, the Northern Ontario Academic Medical Association has awarded more than $12.6 million to NOSM clinical faculty to conduct over 248 varying health research projects in Northern Ontario.

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Doctor shortages
Allied Health Professional Shortages

Long term plan

The Making IT Work Framework

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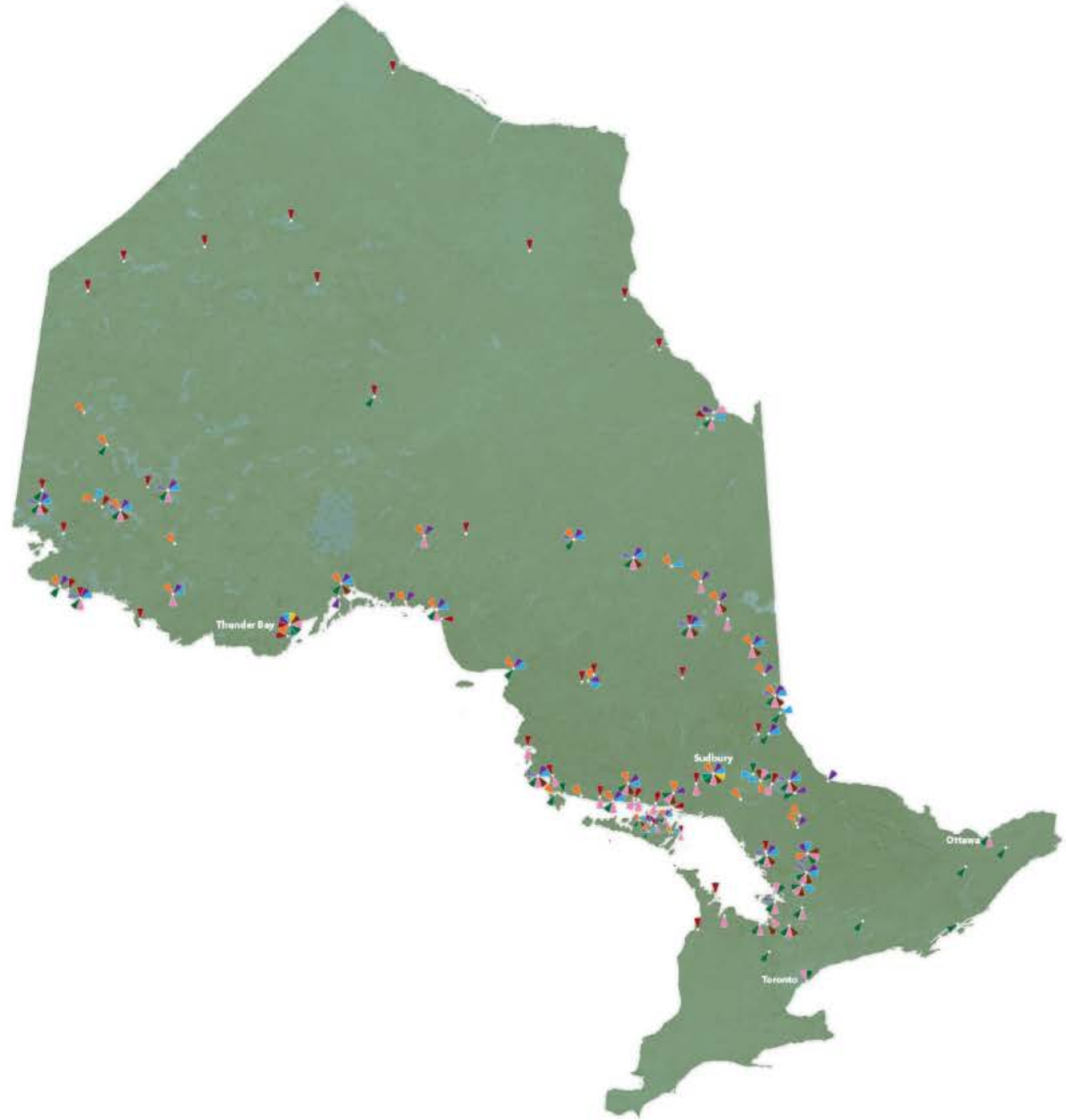
TAKING LEARNERS OUT OF THE TRADITIONAL CLASSROOM

- INDIGENOUS COMMUNITIES
- RURAL AND REMOTE COMMUNITIES
- COMPREHENSIVE COMMUNITY CLERKSHIPS (CCC)
- ROTATIONS AT ACADEMIC HEALTH SCIENCES CENTRES
- RESIDENTS
- DIETETIC INTERNS
- PHYSICIAN ASSISTANTS LEARNERS
- HEALTH SCIENCES LEARNERS
- MEDICAL PHYSICIST RESIDENTS
- VISITING MEDICAL LEARNERS



Communication and Collaboration

- Regional Sites: accreditation
- Bi-directional: one stop shopping?
- Recognition as a site; value for you?
- Local and organic research: Primary Care Research Network
- Leadership development

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IT’S A NEW WORLD

- MOH; MCU ARE LOOKING FOR LEADERSHIP
- ONTARIO HEALTH TEAMS
- ONTARIO HEALTH
- MINORITY FEDERAL GOVERNMENT
- GROUP OF SEVEN

Opportunities

- CUSTOMIZED HHR PLANNING FOR NORTHERN ONTARIO
- EXPANSION OF MED PRIGRAM AND RESIDENCY TRAINING
- ALLIED HEALTH PROGRAMS: NEW DEGREES
- CAPACITY ASSESSMENT
- CURRICULAR RENEWAL
- TECHNOLOGY AND AI
- RURAL GENARALIST PATHWAY
- POPULATION BASED RESEARCH
- AHSN- North

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Academic Health Science Networks

COLLABORATION AND GOVERNANCE

- A single governance structure and a single agreement connecting NOSM and the two AHSCs are needed.
- Laurentian University and Lakehead University, and the North East and North West LHINs must be key collaborators in this partnership.
- A broader Northern Ontario network, including other education and health organizations in Ontario was identified as a longer-term vision, with some noted concerns that form must follow function – that the purpose must be clear.
- “Getting it right” with important alignment and synergies between NOSM, HSN, and TBRHSC is a key first step.

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PROPOSED PRIORITIES

1. Clarify a unified vision for the three organizations.

2. Relationship Development:

    a. Regular contact of an “Academic Transformation Team” (3 CEOs, VPs Academic, Associate Deans).

    b. Relationship development with sites outside of Thunder Bay and Sudbury.

3. Significant progress to a unified leadership structure and a coherent and unified AFP.

4. Creation of a single collaboration agreement and new governance structure.

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Value Proposition

- AHSCs need to evolve into academic health sciences networks in which primary care, social care, community care and secondary care work in partnership, and across which clinical care, teaching and research are integrated
- While each AHSC has its own priorities and unique characteristics, they are united by a shared role and responsibility to the health system as a whole and as such, can and should work together to align priorities and pursue new opportunities for efficiency and effectiveness
- Together, a Network can treat patients, perform research, and expand clinical trials in ways individual members would not be able to do on their own
- Evidence from healthcare systems around the world shows that integrated care is better able to achieve patient and organizational goals, such as optimal clinical care pathway design and implementation; a shift in the mindset of staff to focus on the performance of the system rather than the institution, better use of resources, achievement of public health goals

NOSM: 2020-2025:
HOW WILL YOU CONTRIBUTE?

- Aside from training physicians to practice medicine in Northern Ontario, what role can or should the medical school take on to improve the health of Indigenous, Francophone, Remote and Rural communities and Northern Ontario as a whole?
- What should NOSM focus on in the next 5- 10 years in its relationships with clinical faculty? Where can NOSM improve in these relationships?
- NOSM has four main pillars: Education, Research, Partnerships (Community Relations) and Health Human Resource Supply. Are there other pillars? How should NOSM measure its performance in these key areas?
- SURVEYS, TOWNHALLS, INTERVIEWS AND ANY SUBMISSIONS TO dean@nosm.ca

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Rooted
in the North.
LAKEHEAD LAURENTIAN MEDICINE
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