**LEG LEADS & ADMINSTRATORS MEETING**

**Friday, November 3, 2017**

**Academic Health Sciences Network in Northern Ontario**
**(Catherine Cervin, Stewart Kennedy, Jennifer Wakegijig)**

***Why is it important to teach and do research in your clinical setting?***

- What is the ultimate goal and purpose in research and teaching?
- It is important to have well trained physicians in our communities of Northern Ontario

**Action Items identified for the three organizations:**

- Develop a unified vision
- Develop a unified leadership structure
- Create a single collaboration agreement

**Important Process Recommendations:**

- Keep partners and stakeholder engaged and informed
- Ensure approach is scalable to the broader community / partners.

**Original Themes:**

1. Leadership Accountability
2. Research support
3. Administrative Support; and
4. Strategic Collaboration in governance

We have been working on a number of those themes. The overall project purpose is to define a desired future state in which academic work is thoroughly integrated throughout the Academic Health Sciences Centres. Ultimately our goal is to improve collaboration and excellence in patient care, education and research. We also heard from the symposium that it is critically important to remember all of our community partners across Northern Ontario.

**Accountability for Academic Deliverables**
What are Academic Deliverables?
What are Leadership Accountabilities?
Why does this matter?

**Questions to be addressed:**

1. Who should be accountable for your discipline for the quality of yours and your peers' clinical teaching?
2. Who should be aware and advocate for your clinical learning needs?
3. Who should ensure appropriate allocation in teaching activities?
4. Who would make sure the continuities of learning and acquisitions of competencies is addressed?
5. What mechanisms should be in place to get more people engaged in more academic work in your community?

6. Where should people from your discipline turn to report learning needs or identify needed curriculum improvement?
7. Deciding what the needed complement of physicians in your environment with clinical demands.

**Why pursue the accountability changes that the Academic Health Sciences put in place?**

There certainly is a lack of integration, lack of communication, a lack of vision, and who is responding to these needs. What we are challenged with is that most of our clinicians are so overwhelmed with their clinical load that the academic load really becomes secondary, and the research load is way down at the bottom. So how do we move forward as an academic institution to actually mitigate our positions to reduce some of the clinical loads so that we actually have the time for the academic loads? We need better coordination and better integration at the departmental level. Once we fix the academic structure we can mirror it in the community hospitals.

**How do we move this initiative forward without any real significant financial incentives?**

We have had the opportunity to interview medical school Deans of Medicine and CEO's of academic hospitals around Canada and asked them what leadership activities do you do to integrate academic work in the clinical setting. We found the answers to be are that it is important that whoever is responsible for the academic work that they actually have "clout" in the clinical setting.

At NOSM, by contrast, we have very separate organizations that are not intertwined, except at the level of physicians – who reports clinically to a "blue" clinical chief, and then report to other people entirely, by various mechanism, for any work they do that is academic. Some of these are led by LEG Leads, there are site UG and site PG coordinators, but section chairs and other roles are at arm's length, and not integrated in to the leadership structure of the clinical setting. For an academic health sciences centre, it is felt that this is too diffuse – there is no site-based leadership in each discipline that formally oversees both clinical and academic deliverables. The physicians are being pulled in two directions. One key consideration is the opportunity to map academic responsibilities onto the clinical department chief roles – they could potentially have the role of "deputy section chair".

***Breakout Session:*** ***As we redesign leadership structures at the AHSCs and potential changes in other communities / LEGs, what must we do and not do?***

**<u>PURPOSE</u>:**

1. **To evolve highly functioning Academic Health Sciences Centres in Northern Ontario**
    - **with strong regional roles, supporting excellence in patient care, education and research in Northern Ontario**
    - **well integrated with the Northern Ontario School of Medicine**
2. **To continuously strengthen collaboration to deliver excellence in patient care, education and research in Northern Ontario.**

**SUMMARY**

| | We must… |
|---|---|
| Features of Model | • Ensure new leadership model is transparent, fair, inclusive<br>• Ensure a clear, stable org. structure<br>• Design a system that is scalable and flexible<br>• Ensure coordination of research, teaching and clinical care<br>• Maintain functional academic structures<br>• Allow flexibility of level of participation by individual physicians<br>• Ensure education for educators (via various platforms rather than at an annual meeting<br>• Ensure realistic expectations and adequate support<br>• Have a fair model for grandparenting<br>• Provide appropriate local (reachable) support staff for teaching clinicians<br>• Create incubators for research (PhD)<br>• Develop Fellows/PA/AP for clinical offloading<br>• Develop a team to do research leg-work – ethics, paper reviews, publishing<br>• NOT disregard excellence in clinical teaching for the pursuit of research<br>• Streamline supports for Research REB approval (coordination/common template among NOSM, HSNRI, TBRHRI)* |
| Inclusivity of non-AHSC sites | • Integrate non-hospital settings<br>• Integrate distributed sites in rural and remote settings<br>• Design a system that is inclusive of all communities, not just TB/Sudbury (AHSCs)<br>• Be collaborative / all-inclusive<br>• Be involved at the community level to understand the function of the practice / LEGs in each<br>• NOT diminish regional providers' value<br>• NOT discourage leadership engagement of faculty in smaller communities<br>• NOT impact the autonomy of smaller places |
| Process suggestions | • Articulate evidence of intent<br>• Consult broadly<br>• Make fewer assumptions about what might work<br>• Coordinate multiple aspects of diverse academic centres<br>• Find common needs for support<br>• Feedback for all smaller sites that are similar<br>• Look into the LEGs to compose framework<br>• Remember that clinicians wear many hats when assigning new responsibilities<br>• Have realistic expectations and adequate support<br>• Define a clear road map<br>• NOT do the rural planning after the 2 AHSCs (i.e. as an afterthought) |
| Effectiveness | • Make more sense of NOSM's distributed model<br>• NOT create a less efficient and effective organization<br>• NOT make it more complicated than it already is |

**Protected Time for Academic Work**

All the leadership is very important as leaders we need to form an ASK for the OMA and MOHLTC. We will talk about the presentation that we gave to the OMA negotiating team. We put some academics behind the ASK. We came to the table asking for $75 Million for academic health.

Through NOAMA, NOSM is able to deliver its distinctive distributed, community-engaged medical and health professional education model involving over 1,000 stipendiary physician faculty working in hospitals, clinics and family practices across 90 Northern communities.

Background on the Northern Ontario School of Medicine:

**History**:

- Opened September 2005
- First MD class graduated 2009
- First NOSM residency program 2007 – now 8 residency programs plus 5 Enhanced Skills program
- CEPD
- Research
- Health Sciences students
- Digital library

**Our Success to Date**:

MD Students

- 92% from Northern Ontario
- 40% from remote and rural communities
- 7% Indigenous 22% Francophone

Career Choices

- 62% family medicine, mostly rural
- 33% general specialties
- 5% sub-specialties

Graduates

- 64% of NOSM residents stay in the North (22% remote rural)
- 94% NOSM MD plus residency in Northern Ontario (33% remote rural)
- 150 new family doctors in Northern Ontario serving approximately 178,000 patients

Economic Benefit

- $103M – financial impact of NOSM on new economic activity in the North (Draft CRaNHR report

New Remote Firs Nations Residency Stream

- 2 residents beginning Family Medicine Residency training July 2017 with a 4 year return of service to a remote f ly-in First Nations community – unique in Canada.

**Our Challenges**:

- We anticipate that up to 50% of family physicians will retire in small/rural communities in the next five years.

- We are seeing burnout among faculty as the struggle to cope with increasing clinical load, and more learners.
- At the residency level it is more difficult to recruit faculty to take on leadership positions – for one program we have been trying to find a new Program Director for 18 months with all potential candidates citing too heavy a clinical load.
- Rural faculty are expressing that they may be unable to provide quality educational experiences because of clinical overload.

**Intent of the NOAMA AFP Agreement**

- Provide funding that recognizes the unique contributions of physicians for academic activities. The funding presently is inadequate for the number of clinical physicians;
- Increase the capacity of academic physicians to provide clinical services and academic activities in an integrated manner;
- Improve the coordination and integration of the interests of the physicians, hospitals and universities that comprise NOSM. If we are to go down this route to secure funding for both leadership and protected time, we are going to have to be more coordinated;
- Facilitate the successful recruitment and retention of physicians participating in the academic mission; and
- Ensure that the funding reaches participating physicians in an open and transparent manner.

**The Case for Additional NOAMA Funding**

1. Foundation supports for academic medicine that exist in more mature AHSC environments are lacking in the North. Funding to support protected academic time and build a foundation of expertise and capacity is required to build a needed academic medicine base. With this will come a strong accountability framework including quality deliverables aligned with hospital and system priorities.
2. Unfunded growth in the teaching requirements facing NOSM clinician faculty is no longer tenable. Unfunded academic expectations on clinicians have been exacerbated by the increase clinical pressures of a growing and aging population in the North.
3. Research funding through the AFP was based on number of learners and this number has increased over time, unfunded.
4. Recruitment funding through the AFP was also based on number of learners. Given NOAMA membership has doubled since 2009, additional recruitment funding is required.

**Funding Request**

Department protected time funding has been determined by multiplying the total number of FTEs (active staff) in each Department by 20% of average billings for that specialty (ies) using provincial OHIP data.

$51M is the calculation for the 2 main campuses in Thunder Bay and Sudbury. A placeholder amount of $4M is requested to include affiliate community hospital departments as appropriate.

For the new academic funding we requested by taking most of the specialties of HSN and Thunder Bay Regional Hospital and we took the average billings in a community for General Surgery. Then we

multiplied that by 20%. Traditionally for academic schools the mode is 30% academic and 70% clinical. We had to leave out schools in North Bay and Sault Ste. Marie, as we did not have their numbers.

**Funding Allocation – Academic Base Funding Assumptions**

1. Based on 80% clinical Service, 20% Academic
2. Community Averages by Specialty – Fee for Service billings in Ontario
3. Specialty FTE's within both Health Sciences North and Thunder Bay Regional Health Sciences Centre were used for the calculation of funding ask.
4. $4,000,000 was used as a placeholder for the community hospital specialties (north Bay, Sault Ste. Marie, Timmins, Kenora)
5. Family Practice was not used in the calculation in the department structure.

**Accountability for Department Academic Base Funding**

- Allocation of funding to Departments, Divisions and sites will be based on actual academic activity. The key thing to receive this funding is working on the academic deliverables. Once the funding is in, NOAMA will be responsible for allocating the funds to specific departments.
- A comprehensive accountability framework will be developed that sets out teaching, research and quality deliverables, including funding incentives and consequences based on meeting deliverables.
- Department base funding will flow from NOAMA to TBRHSC and HSN Departments and through those Departments to respective Departments in affiliated community hospital Department sin Sault Ste. Marie, North Bay, Timmins and Kenora.
- A condition for receiving Departmental funding will be the establishment of a governance group within the Department to receive and distribute funding and oversee accountability for deliverables. Governance will have NOAMA, hospital department membership representation.

**Next Steps**

1. Await outcomes of negotiations between the OMA / MOHLTC
2. Continue to develop Academic deliverables at the department level.
3. Integrate the Leadership Structure with NOSM and the Academic Hospitals (Thun der Bay Regional Health Sciences Centre and Health Sciences North)
4. Continue to lobby the Ministry and the OMA.
5. Establish Readiness Structure.

The sustainability of NOSM is contingent on getting more funds for the organization. If funding comes in the next steps are to have NOAMA, OMA and MOHLTC sit down and discuss how it is going to be allocate it.

**QUESTIONS**:

*What constituted a placeholder community?*

It is decided through the volume of physicians.

Adam Moir stated that it is good that we already have the governing structure through the PCTA Board and members, as well as NOAMA.

Yes, we already have a governing structure with NOAMA and the PCTA.

*Where have you seen the best version of the deliverables? How far advanced are we?*

We wanted to take the time to establish what we mean by academic deliverables and also corresponding academic accountabilities. If we want to change those definitions we need a set of accountabilities. There is no real clear framework that a lot of other medical schools use. There are categories of deliverables that people tie the funding to. So this is kind of a work in progress where we will be breaking new ground. We will go into negotiations with high level academic deliverables and sounds like we will be further ahead than other traditional schools already.

*The Ministry has a lot of demands so is there a way for our LEG leads to actually get the demands from the Ministry? When we are filling out the NOAMA Academic Deliverables Report we are wondering if there is a framework or to see what other LEGs are submitting so that we may see if we are on the right track?*

The short answer is that the information is collected and we need it to meet our academic mandate for AFP purposes or if the Ministry needs the information. We did hire CRaNHR to do a LEG evaluation project to tighten up the metrics that the LEGs are delivering. Further to that, we are proposing a new system that we are working on to better collect the information and be able to populate it outwards, and be able to give feedback to the LEG leads.

The MOHLTC already has had lobbying from OHA and have come to the table already to present. Right now we are almost finished with the negotiations and going to mediation.

*NOSM is a unique medical school in the world. One of the things that you say that you need more of is family physicians in more rural communities. I wonder if you might reflect upon the language that you are using in the presentation*

We are trying to support the specialists because the more support that specialists can give to the regional family physicians, the more they will stay longer and practice with support.

*What's the timing in placing family medicine and how does it play out for these rural communities?*

This is a framing of an ASK and we didn't have the time to frame the ASK for family practice, but we did create an elevated type of ASK and the result will simultaneously work with the family practices.

**LEG LEAD & ADMINISTRATORS MEETING**

**Saturday, November 4th, 2017**

**LEG Administrators Meeting**

**(Mathieu Litalien)**

## Clinical Teaching Payment Project

Two subjects to be discussed at today's meeting are:

1. Clinical teaching payments
2. Changes made to clinical scheduling

Nick Persichino and I have been working on the payment and scheduling process for the last year. Today's Agenda has the following:

- Overview of changes
- Implementation Timelines
- Pilot – "Summary and Details"
- Pay Period Expectations – NOSM / NOAMA, LEGs
- Transition Plan
- Contact Information

### Overview of Changes

1. Retrospective payments:
   - This means that we are only going to pay once the rotation has been completed. We have now eliminated prepayments / reconciliations completely. The reason why the prepayments were initiated was because there wasn't a process for time limiting.

2. Single payment per rotation (no splitting):
   - Once a rotation ends it will be paid in the block date.

3. 13 Pay periods per year that align with PG block dates:
   - Everyone should be paid on a consistent basis and regularly which eliminates the need for prepayments.

4. Rotation pay period driven by rotation end date:
   - Our goal is to issue the payments four weeks post block. Every month you will receive a block payment.

5. No formal reconciliation process:
   - Prior to now we used to send to you for your review, this is now eliminated. If there are issues with the payments, we will be able to deal with them right away.

6. Payment based on exact weeks:
    - Used to be paid on rounded weeks; now you will be paid on exact weeks.

**Implementation Timelines**

- Collect and incorporate feedback from LEGs in May 2017. It was first presented at Northern Constellations back in April.
- Next, we received NOAMA Board of Directors approval.
- Then we had some volunteers from the Northern Constellation's conference for testing internally within NOSM from July to September 2017
- There was a Pilot process with the selected LEGs in October.
    - We applied the process of 2016-17 Block 12 to see if it would work. There were 2 sheets for the LEGs to fill out, and we received very positive feedback. There were no concerns reported from the LEGs.

- Full implementation will begin in January 2018 with the last period using prepayment / reconciliation process from October to December 2017.

**Summary – Sample**

Two major changes on this summary sheet are:

1. Broken down by program vs. electives. An elective rotation whether it be undergrad or postgrad and specialty goes to NOSM and the next amount from NOAMA.

**Details – Sample**

This form allows you to see the Rotation Discipline. All the information is pulled from Panda for consistency and accuracy.

**Pay Period Deliverables – NOSM / NOAMA**

**Pay Period Deliverables**

For each pay period you can expect from us:

1. Summary and Details PDF to be sent in the week of the pay run by NOAMA.
2. Payments to be received on the Friday, **4 weeks after the Block end date.**
    - A pay advice will be generated by NOSM Finance on the day of the payment.
3. Timely resolution to any issues / inquiries brought forward by LEGs. We do have one individual, Nick Persichino, right now for all payments and processing across the organization. Previously, we had all departments doing their own submission and now it will be handled by one person.

**Pay Period Deliverables for LEGs**

What we expect from you:

Review of payments received and to notify NOAMA if there are any discrepancies. By all accounts, it's a much easier and quicker process with this implementation.

**Transition Plan – Prepayment / Reconciliation**

The last prepayment and reconciliation period will be from October 1 to December 31, 2017 (Q3)

- Prepayment for this period was already issued on September 29, 2017.
- Reconciliation will occur after the period ends in January / February 2018.

July 1 to September 30 period (Q2) reconciliation will be issued independently prior to NOSM's winter break (December 22, 2017). These are the two outstanding items in the old process.

**Transition Plan – New Process**

- The first period of new process will be Block 7 (December 19, 2017 to January 15, 2018). Payment to be received by February 9, 2018
- Any rotation that was scheduled to end in Block 7 was removed from the last prepayment and will not be included on the reconciliation. There should be **no overlap between the new and the old processes.**

This new process should streamline everything, especially behind the scenes. With the commitment from NOSM to pay every block should alleviate the need for any prepayment.

**<u>Clinical Scheduling</u>**

**Current State (2017-18 & Previous)**

Our department is responsible for all the payments, clinical scheduling and housing. We have been made aware of several issues with regards to how we schedule and the timeliness of response, to students and residents when they apply to NOSM, especially visiting learners.

- Sequential Base which means that our undergrad goes first. Then our residency programs put their schedules into Panda second and after that it goes to NOSM electives. After that it goes in or our agreements with external universities. The problem is when we do it in this sequential order, the time it takes to get all of those entered into the system means whoever applied during that time frame has to wait until all of that is done before you can even start to process that application.

- Visiting learners apply as early as November for the 2018-19 year. Last year and the years previous we have had visiting learners as early as October. No action until the new year. All those sit and wait until that whole process takes place which can be a fairly lengthy process. The first "pull" for 2017-18 doesn't go out until March. This means that anyone who applied in November or December waited 5 months before any action was taken on their application. Within those 5 months, a good number of them have already secured rotations with other schools. So that doesn't bode well for our recruiting purposes or the communities. The worst part of that is we are not set up well operationally.

**Future State (2018-19)**

- We have been working closely with our NOSM programs to ensure that all their schedules are completed by October 31st. We can get resident application as early as October. So what we have done is we have established priority resident electives. This means that anyone who is applying in October / November will receive priority for processing.

- PGY2 Family Medicine Rural, PGY2 Family Medicine looking to match to Emergency +_1 and Royal College Programs for PGY3, will all get processed immediately. This means that anyone who applies before October 31st will all get processed immediately.

- UGY 3 & 4 begins applications for 2018-19 in mid-December and we will be immediately processing visiting learners upon receipt of their application.

**What can you expect?**

- One-off requests for resident applications between now and our first schedule request for 2018-19.
- The first scheduling requests (first "pull") for 2018-19 will be sent out in early December.
- It will feature primarily NOSM students.
- Visiting learners will be added to subsequent requests as applications are received. This should really streamline the application process. Now that we will not have operational delay with respect to visiting learners, the application process will happen immediately.

I sit on the National Electives Committee and have been getting them up to date with this new process. NOSM used to charge a $200 application fee. We have changed this as it was a deterrent to these students, as we didn't even give a refund to those learners that had applied.

We are now getting the LEG Administrators access to payment so that they can see all the rotations coming through when they want. You will have this change shortly in the new year.

With the Panda system we are able to make changes to the system if we notice there are any additions or errors. This is the first year with this new system and definitely should be better than we has gone on in the past.

Question: Can we start to keep track of what times of year that most students get refused applications; do we have that kind of data?

Answer: No we don't. Right now when we receive refusals as cancelled. We just don't know what kind of learner was refused. We have put forward a new set of criteria identifying whether it is declined or refusal and we can get that kind of information. The way our scheduling system works right now is we have capacity in our Panda system.

**Changes for Vacation Requests**

- The leave request is going through a new process through Panda. Depending on how you're set up it will go directly to the preceptor for approval, or it will go to perhaps to a centre that is assigned to manage those leave requests. The learner will go into the payment system and an email is automatically sent and goes to a specific process. This is all done automatically through the system.

**LEG Lead & Administrators Meeting**

**Saturday, November 4, 2017**

**Promoting Unity Within the North**
**(Jean Bartkowiak)**

***The purpose of this presentation will be to describe the shift of promoting unity as clinicians and researchers across Northern Ontario.***

**Introduction**

What I am going to discuss with you this morning is to a certain degree experiencing what other provinces have done in their medical departments.

Northern Ontario current clinical and academic environment:

- There is only one school of medicine currently in the North. It crosses over to regions in the North – Laurentian and Lakehead are the two universities.
- 2 LHINs
- 2 AHSCs; and
- Crosses over 40 + community hospitals.

**Current Challenges**:

- Unfortunately, although we serve our communities, there isn't that much collaboration between the regions. Collectively, the 40 hospitals in Northern Ontario spend a large portion of money on medical supplies and it all has to go through the chain provider. I would like to see that experience shared among all 40+ hospitals.
- Large geography representing two-thirds of Ontario. Some of it you cannot access by roads
- Small dispersed population of 500,000 split into 2 small regions.
- Poorest population health status of all Ontario. It doesn't seem to bother Queen's Park at all. Apparently, the Francophone population also has poor health status.
- Northern Ontario has a very large Indigenous population. It is apparent that this population is very poor and has no way to commute or access medical services.
- Relatively new academic role for NOSM and the 2 AHSCs. I have worked with University of Toronto and their AFP's have been in place for decades. I believe that we should have more collaboration between medical schools for future progress.
- I think it is time for us to create this network of collaboration and that we should meet more frequently to share our perspectives on our challenges.
- There will be 2 new presidents of the universities being appointed in the next few months.

**Opportunity**

- We have the opportunity to rethink how we interact together in all of Northern Ontario academic teaching facilities.
- Northern Ontario academic leadership will see 3 of the 5 academic institutions be new and also 2 new LHIN CEO's.

- In regards to governance of both the academic and health care systems we can capitalize on the one medical school on the 2 campuses model. I think this is an asset given the spread of the population we serve. We need to strengthen our relationship.
- There is strength in unity: one voice representing 800 thousand populations vs. 2 voices representing very small regional populations.

**Challenges of a Relatively New AHSC**

- We have similar challenges; we should have collaboration with government officials to let them know that there is a cost to serve the northern population.
- We are currently servicing 93% of our population which means only 7% of the population will need to go elsewhere for medical services. I think we are doing a tremendous job.
- From a clinician scientist or academic perspective the high clinical needs monopolize potential research time and opportunities. The demands that are placed on our clinicians results in less time for research and teaching students. We absolutely need to free up time for the clinicians.
- The clinical culture legacy of merged community hospitals is a challenge which needs to be changed.
- The other challenge is the migration of family physicians out of the AHSC;
- From a research ethics perspective one of the big challenges I was facing when I arrived at TBRHSC was research projects. I would like to think that when we start looking at projects we want to protect patients. Unfortunately, it takes a long time to process projects, so we had to change how the projects were assessed. Doctors take risks all the time with their patients, but you don't do it purposely, and they would like to try something new. A lot of people were risk avert and not taking risks. Science and research should be the same.
- The other challenge we were facing was recruitment of research participants. We have an "opt-in" approach which means we asked patients if they would allow our teams to approach them for research. Now we are going with the "opt-out" approach. The "opt-out" approach means you are told right from the start that you are going into an academic health science centre and the expectations are you will be participants in the research part, unless you tell us otherwise. I am confident that this will help in our recruitment.
- From a research and teaching funding perspective, there is a diminishing seed funding from FedNor and NOHFC. This is how we started our research centre in Thunder Bay and HSN did pretty much the same. Our research centre relies on us for funding.
- Aging infrastructure is impacting capital investments. Thunder Bay is over 10 years old. The Research Institute as well. We don't see any opportunity from a clinician's perspective should we partner and buy a new MRI machine, but they won't hear of it.
- There is another challenge regarding the absence of tradition for philanthropic support of research science in Northwestern Ontario. The foundation itself has always been keen on replacing equipment and supporting these kinds of projects that will have a tangible outcome.
- There is a competing clinical, academic and scientific priority for hospital base funding. Right now we have to foot the bill for the research institute. This is taking away from our academic mission.
- There is limited funding which hinders innovation and research program opportunities. We unfortunately do not have the funds to kick-start new projects, especially having a deficit in the budget.
- There is no funding for protected time for physicians, scientists and teachers.

**Impact of Migration of General Practitioners out of the Hospital**

- From a quality of care perspective:
    - Inappropriate admissions of frail, chronically ill or dying patients
    - Poor continuity of care
    - Increased LOS and
    - Growing cost to fund hospitals

**Contribution of Community General Practitioners**

- Family practice must be integrated back into the AHSC and community hospitals:
    - How can we foster and support better integration?
    - How do AHSC's and hospitals re-engage community primary care providers?
    - What resources do family practice clinics require to come back or stay in hospitals?

**TBRHSC Regional Programs to Support Community Hospitals**

- Existing:
    - Regional MSK Program
    - Regional ICU Program
    - Regional Pharmacy Program

What other programs would support community primary care providers?

Our MPP's are very engaged, but they are also dealing with other MPP's in the region. I am currently engaging with the MPP's to find ways of to have the funds managed from the hospital, or maybe a central agency in the North.

I believe that the staff at TBRHSC are outstanding. They are engaging, smiling, welcoming staff and I have not experienced this anywhere else I have worked. I believe that if we don't change the environment in which we operate now, we will not accomplish what we need to do.

**LEG Lead & Administrators Meeting**

**Saturday, November 4, 2017**

**LEG Presentations**

***This portion of the meeting is dedicated to LEG successes and challenges to date. Presentations from some LEGs who have put various programs and structures into place will describe their successes and challenges to date. These will be supplemented with content regarding evaluation and research resources available to LEGs.***

**Research Network**
**Sault Ste. Marie LEG**
**(Ed Hirvi / Melissa Kargiannakis)**

We were asked this year to provide an update on the research office:

- Our LEG is the largest in the Northern community at NOSM and we have a Board of Directors that helps lead our group; Dr. Tim Best, Plastic Surgeon, Dr. Luke Fera, Hospitalist, Dr. Chris Rossi, Family Medicine Program Lead, Dr. Steven Smith, Emergency physician and the local Oncologist. They work together to establish a research office in our community.
- Our LEG was established in 2012 and has taken 4 years to get off the ground and start the search for a Research Director, and it's always been our goal to activate and develop our research network locally and collaborate in partnerships between all of the major healthcare organizations within our community.
- We eventually found Melissa Kargiannakis in 2016 after an extensive search and had an office established in 2017.
- Our focus has been on teaching which is what most of the LEGs are focussing on, but we have been putting a significant emphasis on research within the last year and establishing a local office. We have also taken some initiative to develop leadership in professional development in the last year as well.
- To clarify first in regards to research we are not talking about things that happen in the laboratory; for us it's within the "clinical setting" and community-based care. We also have some retrospective chart reviews that happen which are a lot easier from a logistics standpoint, as you are not asking patients to enroll.
- A lot of it stems from quality improvement. We have been interviewing a lot of physicians, and a lot of them said the reason they do research is because they have clinical questions that matter to them, and they want to improve on their delivery of care. They are unsatisfied with the answers they find in the literature or they are not as relevant. Quality improvement is a huge foundation for research.
- Our physicians that want to do research at the Sault area hospital are not Sault area hospital employees, so we need at least 3 legal documents put in place before they can do research at the hospital. So we are trying to get all that infrastructure and process in place.
- We have broken down essentially 12 steps for research. Most research initiatives take approximately 2 years. We are trying to streamline the research to make it much simpler.
- A Research Director would be 90% strategy and 10% project operations. We found that we have coordinated so many local organizations and get the processes in place.

- The Research Coordinator is 40% strategy and 60 % project operations. The Research Assistants are more specifically tied to project funds.
- We believe that working together should be a lot better with our partnerships. What we found extremely beneficial with these partnerships is to ask for support, such as office space and the hospital being the hiring body and can get through those process hurdles such as the hiring of Research Assistants per project basis.
- When it comes to designing a study, about 2 or 3 professors from the University will sit down with the physicians and ask what their clinical question is and how to turn the questions into research questions. So from day 1 it's automatically linked to either the correct statistical test or the qualitative framework and methodology, such that data collection is done in a way that would work for the study.
- These are all the other organizations and entities that we would like to expand working with, so right now we are trying to get more external funding.
- On the theme of collaboration, we believe that LEGs who are working together certainly would be stronger. We are looking to offer a potential service provider. Further discussions in regards to the PCTA and NOSM and what they can offer to better support our associations, should be looked at.
- We have also developed a stringent process for research applications that come in and you are more than welcome to use this as templates for developing your research program.
- Currently, we are looking at how we can improve the quality of patient care in our community. A lot of our projects are quality improvement projects.

QUESTION:

If there was one thing now that you need to do research to keep the momentum going, and do you have a goal?

ANSWER

We have as many projects on the go as possible. Our limitation is finances.

**Resource Sharing and Collaboration**
**Huntsville / South Muskoka LEGs**
**(Dave McLinden / Sue Featherston)**

***Learning Objectives:***

***1) Identify different programs and structures that LEGs throughout the North are utilizing***
***2) Discuss some of the challenges associated with implementing new programs***

- We at Huntsville LEG take the "Crocodile Dundee" administrative approach to things. In Crocodile Dundee #1 there is a scene where Crocodile Dundee is in a bar in a rural place in Australia and a patron is asking him how you deal with a personal problem in a small place. His response is that he goes to the bartender and tells him my problem. Then the bartender tells everybody else in the community and comes back with an answer. So this is how we approach things like this.
- A lot of what we've done in terms of collaboration is that it all comes down to the people; who do you go to for things?

- The collaboration and recent resources that we have started to use over the last couple of years we noticed that in our LEG we are getting more and more done, with more people and less money. We largely believe it is because of our collaboration.
- These are some keys to our success:
    - Administrative support
    - Some leadership
    - Some communications; and
    - A strong framework

**Administrative Support**

- Is vital to the success of any project
- Be creative with scope of role based on the project and compensation available
- Share with another Leg
- Offer a short term contract
- Consider an independent contractor
- If unable to e stablish your own support, collaborate with a LEG that already has this in place.

So in regards to administrative support, what we are finding is that as we have added more and more administrative support, we were having trouble coordinating all of that. So what we did is that we partnered with Bracebridge LEG and hired Krista. She does the day to day administration, runs our specialty clinics that we have, arranges all of our Rounds and does all of the CME, so this has helped our LEG considerably.

**Leadership**

- We have learned that busy clinicians are not very good at the administration part. Clinicians should make sure that they are open and available for the administration, and to know who your administrative support is.

**Communication**

- Among the team is critical for success
- Choose a small committee and designate key people who can make decisions for the group
- Use available technology to facilitate communication
    - Emails
    - Teleconference
    - Doodle Polls

We have found that we have good communications between us and the committees.

**Strong Framework**

- Need to establish guidelines, a time frame and rough schedule from the beginning
- Good objectives

**Accomplishments**

- An Academic Coordinator
- A Regional Research Coordinator
- Numerous teaching activities
- A simulation lab

One of our biggest accomplishments is hiring Lisa Allen. So ourselves, Bracebridge and Parry Sound hired Lisa. What they've done is set up an informal group of people who are interested in research in these communities, and hired a Research Coordinator. We were able to push forward a lot of research that has been hanging around in these communities for a while. It is important to find the right kind of person to do that, and Lisa was the right person for us.

We have a couple of projects on the go right now; Enhanced research after surgery, a very interesting one on the Dignity of Dying which will be published soon. Also we have one with all 3 communities regarding Opioid Tapering in a Rural Setting.

**Teaching Activities**

- Surgeon Surgical Evenings
- Difficult medical conversations & patient dignity
- Observed complete history & physical
- MSK session
- EKG talks
- Suturing session

**A Simulation Lab**

- Pilot launched last year
- Huge success
- The established administrative support was vital to project's success
- Potential for expansion after just one year

**LEG Evaluation Project**
**Feedback from completed evaluations and opportunity for future evaluation**
**(James Goertzen)**

***Learning Objectives:***

***1) Describe NOSM – LEG collaborative medical educational research project***
***2) Pursue potential NOSM – LEG medical education research and QI collaborations***

NOAMA funded this project and what we were interested in were 2 questions:

1) Do LEG faculty find it relevant to delivery of a LEG FD session based on their grouped learner evaluations?
2) Can a LEG FD session lead to improvements in individual preceptor and LEG teaching activities?

- What we have done is a pilot study with 3 LEGs, 2 rural and 1 urban specialist, and we are looking for another 5 LEGs.

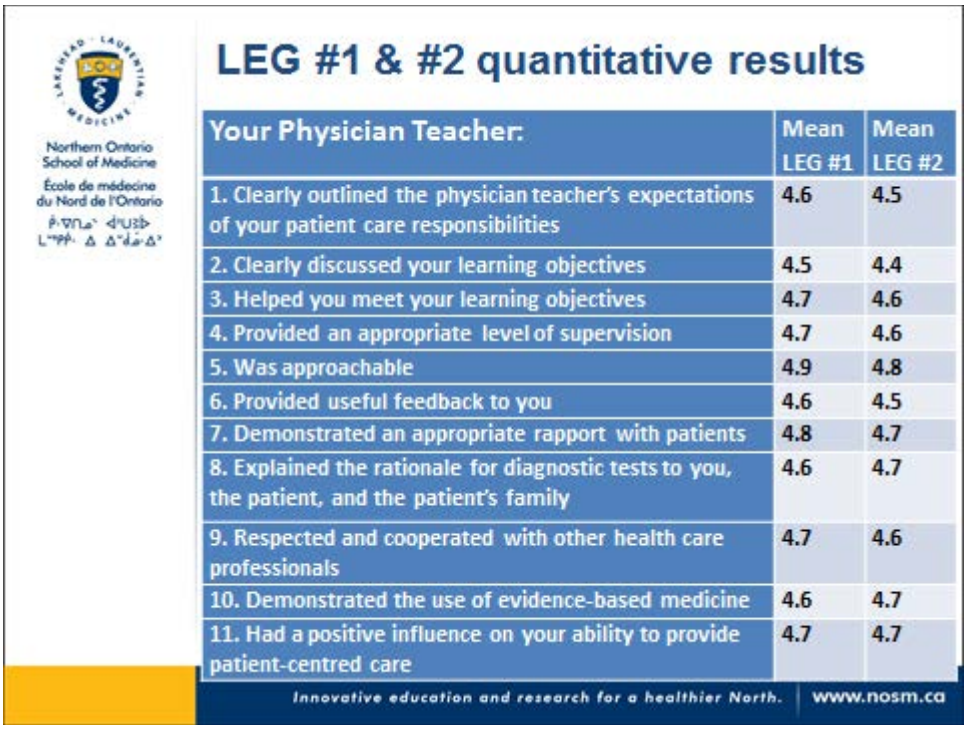
**Study Protocol:**

- We got individual consent from the LEG faculty
- Compiled anonymized faculty and program evaluations
- The evaluations were analysed
- There were LEG FD workshops created and delivered
- Faculty complete intention to change
- Post workshop impact follow-up

You give us the permission to go into the vaults at NOSM and pulled all of your faculty and program evaluations; we analyze them and say "OK we are designing a faculty workshop for you and deliver it to your community. Then we ask you as part of the workshop "what are you going to do differently because of this", and then we go back 6 months later to see if you have done anything different.

In regards to faculty evaluation data set, LEG 1 had 11 members, and LEG 2 had 12. Evaluations are the things that your learners are completing when they are working together with you. When looking at the faculty evaluations what we know from the literature is when the typical faculty member gives their evaluations it usually says "I am ever doing a good job". So with this research project we can look at how can we increase the impact of the evaluations that are being completed.

One of the LEGs has 121 evaluations and the other only has 68, which is a very interesting question. Why is that? Here are the results and are rated from 0-5:




| Your Physician Teacher: | Mean LEG #1 | Mean LEG #2 |
|---|---|---|
| 1. Clearly outlined the physician teacher's expectations of your patient care responsibilities | 4.6 | 4.5 |
| 2. Clearly discussed your learning objectives | 4.5 | 4.4 |
| 3. Helped you meet your learning objectives | 4.7 | 4.6 |
| 4. Provided an appropriate level of supervision | 4.7 | 4.6 |
| 5. Was approachable | 4.9 | 4.8 |
| 6. Provided useful feedback to you | 4.6 | 4.5 |
| 7. Demonstrated an appropriate rapport with patients | 4.8 | 4.7 |
| 8. Explained the rationale for diagnostic tests to you, the patient, and the patient's family | 4.6 | 4.7 |
| 9. Respected and cooperated with other health care professionals | 4.7 | 4.6 |
| 10. Demonstrated the use of evidence-based medicine | 4.6 | 4.7 |
| 11. Had a positive influence on your ability to provide patient-centred care | 4.7 | 4.7 |

For each of the LEGs they submitted faculty evaluations and qualitative comments.

LEG #1: 83 comments on "areas of strength" and 17 comments on "areas of improvement"
LEG #2: 97 comments on "areas of strength", 39 comments on "areas of improvement" and 21 suggestions on "areas of improvement".

<u>LEG #1 Faculty Strengths</u>:

- Approachable
- Passion for teaching
- Balances learner independence with appropriate supervision
- Exemplary physician role model
- Competent clinicians
- Rapport with patients
- Respectful learning environment
- Organized case reviews

<u>LEG #1 Faculty areas of improvement</u>:

- Feedback
- DOC opportunities (Phase 2)
- Topic teaching

LEG #2 Faculty Strengths:

- Approachable
- Commitment to teaching
- Learner centred teaching
- Balances learner independence with appropriate supervision
- Models effective patient care
- Provides diverse learning experience
- Incorporates evidence based practice
- Provides feedback

LEG #2 Faculty areas of improvement:

- Learning scheduling
- Additional independence

So what we know is that we do analysis of the comments. So the whole reason for this project is to say "how can we improve the teaching that you are doing in your LEG as it is 90% of your academic deliverables?"

The next question we have for the learners is "Have you shared this evaluation feedback with your clinical faculty teacher?", and it seems from both of the LEG groups that only not even 50% of them shared the feedback. So, what in the LEG can you change to incorporate the feedback from your learners?

We then ask to do a reflective exercise with the LEG members and what we ask you to do is to make a commitment to do something about this. What are you going to do differently now that you have this data and then we do a follow-up together with you?

**Dyad Exercise: Preceptor and LEG Educational Activities**

- What strategies could you as an individual faculty member implement to improve your role as a preceptor?
- What strategies or approaches could your LEG implement to improve teaching and educational activities?

So that is the project and what we are really looking at is how can we collaborate with LEGs as medical education research, medical education QI activity right now we are not doing anything about it.

QUESTIONS:

Q: Is there a way to deal with LEG funding resources uniquely to this area for research. How do we create new opportunities to evaluate more?

A: Because of this project we are starting to build some expertise within CEPD in terms of how do you do medical education research, how do you do research in evaluation in medical education projects.

**HSNRI & TBRHRI**
**Research Support Services**
**(Ian Lane, Shalyn Littlefield)**

***Learning Objectives:***

1. ***Identify methods to engage your LEG members in research***
2. ***Identify research support systems available to LEGs***

Both Shalyn and I have services to support you in your various research activities. There does seem to be a lot of research supports out there in Northern Ontario.

- Both Research Institutes are hospital-affiliated and are focused on healthcare innovation, discovery, translation and dissemination to communities and patients in Northern Ontario, and ascending to Canada and internationally.
- Over the past 3 years both organizations have been recognized as one of Canada's Top 40 research hospitals. A lot of this is attributed to the physician investigators, and physicians' engagement in research. They have been successful in the fact of NOAMA grants that have been awarded, as well as partnership with universities and the medical school.

**HSNRI Priorities**

- Priorities are Infection & Immunity, Cancer solutions, personalized medicine, healthy aging, and is all wrapped around Northern Indigenous Health, which is a relatively new priority of ours and have had a lot of growth in that area. We have a biologist that has a breadth and large scope of research going on right now.

**TBRHRI 2020 Strategic Plan**

**Healthier**
Enhance research to improve the health outcomes of the people of Northwestern Ontario and beyond.

**Wealthier**
Enhance philanthropic and other support and generate revenue through science and partnerships.

**Smarter**
Enhance the academic environment.

- The support services that we offer in our research institute are really all the three pillars.
- We have 5 key directions that we are following and have research active in all 5:
    - Patient Experience
    - Seniors' health
    - Comprehensive clinical care
    - Indigenous health; and
    - Acute mental health

**Partners**

Academic Partners:

- Laurentian University
- Lakehead University
- NOSM
- Northern College
- Cambrian College
- College Boreal
- Confederation College

Major Funders:

- Northern Ontario Academic Medicine Association (NOAMA)
- Northern Ontario Heritage Foundations Corporation
- FedNor
- CIHR
- Physician Services Incorporated Foundation (PSI)

Community/Public Partners:

- Greater Sudbury Economic Development Corporation
- Thunder Bay Community Economic Development Commission
- FedNor
- NOHFC

**How Grant Facilitation Works:**

**Pre-Award**

- Finding funding opportunities
- Proposal development & review
- Budget development
- Grant submission assistance
- Award, acceptance & administration

**Post-Award**

- Contract negotiation
- Project start-up
- Award management & financial tracking
- Ongoing project support
- Study close-out

We are very fortunate to have NOAMA's funding and very fortunate to have this in Northern Ontario, as I believe Southern Ontario and Atlantic provinces do not.

**Research Ethics**

Research ethics is important consideration when you are doing research:

- The following requires ethics review and approval by an REB (Research Ethics Board) before the research commences:
    - Research involving living human participants;
    - Research involving human biological materials, as well as human embryos, fetuses, fetal tissue, reproductive materials and stem cells. This applies to materials derived from living and deceased individuals.

**Other Research Facilitation Services**

- Pre-review, liaison and submission to the Research Ethics Board
- Statistical Services for sample size calculation, statistical analyses, bioinformatics and database development
- Graphics & Figures
- Research Oversight Committee with pre-review, liaison and submission
- Other services such as proofreading, business development and networking

Each organization has their own research ethics board services. So as part of our research support services we really help you navigate this system. So often we see physicians completely overwhelmed in getting research ethics approval. So what we can do is take that burden from the physician and give support throughout the process. So in addition to the research ethics office we can fill out the application for you, help you plan your study and take care of any communication you are required. After the project has been approved, we can also continue on with amendments that may be needed.

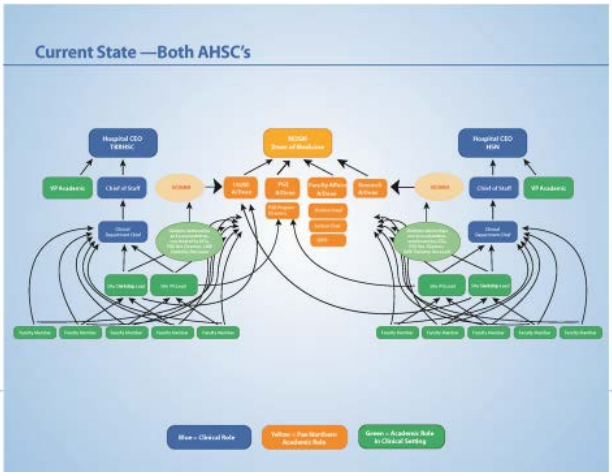
# Workshop Summary: Academic Health Sciences Network Project

## Presented to NOAMA's Local Education Group (LEG) Lead Meeting
## Toronto, November 2017

## Background

Dr. Catherine Cervin (NOSM A/Dean Postgraduate Medical Education), Dr. Stewart Kennedy (TBRHSC EVP Academic Affairs) and Jennifer Wakegijig (NOSM Manager Program Development and Strategic Initiatives), provided a presentation on the Northern Ontario Academic Health Sciences Network Project, and work underway to strengthen the integration of academic work into clinical settings at Northern Ontario's Academic Health Sciences Centres (AHSCs), which include Thunder Bay Regional Health Sciences Centre (TBRHSC) and Health Sciences North (HSN). The purpose of the project was described as follows:


In practical terms, the project seeks to replace the existing very complex accountability structure for academic work taking place in the AHSCs, described as follows…




…. With a leadership structure within the AHSCs that integrates support and accountability for both clinical and academic work.

While this project initially has a focus on the Academic Health Sciences Centres in Sudbury and Thunder Bay, the project's leadership recognized that changes in leaders' accountability for academic work at the academic centres would have implications for NOSM's partnerships with all NOSM teaching sites. Thus it is important to inform and consult with LEG leads across Northern Ontario.

## Minimum Specs Plenary Exercise

In plenary, all LEG lead meeting participants (approximately 100) undertook an interactive exercise to identify key "MUSTs" and "MUST NOTs" for the project. The following were the essential elements identified by the participants.

## As we redesign leadership structures at the AHSCs ….

| | We must… |
|---|---|
| Features of Model | • Ensure new leadership model is transparent, fair, inclusive<br>• Ensure a clear, stable org. structure<br>• Design a system that is scalable and flexible<br>• Ensure coordination of research, teaching and clinical care<br>• Maintain functional academic structures<br>• Allow flexibility of level of participation by individual physicians<br>• Ensure education for educators (via various platforms rather than at an annual meeting<br>• Ensure realistic expectations and adequate support<br>• Have a fair model for grandparenting<br>• Provide appropriate local (reachable) support staff for teaching clinicians<br>• Create incubators for research (PhD)<br>• Develop a team to do research leg-work – ethics, paper reviews, publishing<br>• NOT disregard excellence in clinical teaching for the pursuit of research<br>• Streamline supports for Research REB approval (coordination/common template among NOSM, HSNRI, TBRHRI) |
| Inclusivity of non-AHSC sites | • Integrate non-hospital settings<br>• Integrate distributed sites in rural and remote settings<br>• Design a system that is inclusive of all communities, not just TB/Sudbury (AHSCs)<br>• Be collaborative / all-inclusive<br>• Be involved at the community level to understand the function of the practice / LEGs in each<br>• NOT diminish regional providers' value<br>• NOT discourage leadership engagement of faculty in smaller communities<br>• NOT impact the autonomy of smaller places |
| Process suggestions | • Consult broadly<br>• Make fewer assumptions about what might work<br>• Coordinate multiple aspects of diverse academic centres<br>• Find common needs for support<br>• Feedback for all smaller sites that are similar<br>• Look into the LEGs to compose framework<br>• Remember that clinicians wear many hats when assigning new responsibilities<br>• Have realistic expectations and adequate support<br>• Define a clear road map<br>• NOT do the rural planning after the 2 AHSCs (i.e. as an afterthought) |

**LEG Lead & Administrators Meeting**

**Saturday, November 4, 2017**

**BREAKOUT SESSION**

**Description:**

***This portion of the meeting is dedicated to an interactive group session. Individuals will select two of the breakout sessions and have small group discussions with one of five theme champions.***

# Breakout Session – Academic Leadership and Support

On Day 2 of the LEG lead meeting, Dr. Cervin and Jennifer Wakegijig facilitated further discussion on the project at breakout sessions, and focused on questions brought by participants

Two sessions were held, each with 20+ participants. Discussion largely focused on the interests of communities outside of Sudbury and Thunder Bay, and their needs for support for academic work in their clinical and community settings.

## Key Themes and Points Raised Include

### Small Communities and Clinics Struggle with the Requirements of Academic Work and Would like More Support

- "Our distributed sites need distributed support" – NOSM current model of support doesn't work for our distributed sites.
- Smaller sites like Parry Sound and Sioux Lookout want "NOSM" to provide academic leadership and support – more robust than receiving e-mails, but coaching and PD for their LEG
- Smaller sites feel they are "barely keeping up," overwhelmed by the administrative responsibilities that come with the added academic work – need support and help.
- More one-on one support is needed, more section chairs, access to clinician educators and support to nurture a community of practice.
- The idea of appointing someone in each community as "deputy section chair" to assume a leadership role more locally was proposed, however, the general response was that they are not interested in more local roles, but they need more locally-available support.
- They need someone who will listen to their needs and act as a catalyst to help make needed connections.
- One LEG lead said "I don't get my peers' reviews and I'm not trained in giving people feedback – I would appreciate the support of someone like James Goertzen to say "here's the last 2 years of evaluations for this group – let's talk about it" – that leadership should come from NOSM. "

### Family Medicine Leadership

- "more than 2 FM sections chairs are needed"
- "Section chairs don't know everyone"
- We need a Family Medicine Chair or a "Professor of Family Medicine" – who has time for the smaller communities. FM is at the heart of what we do

- The concept of “Regional Academic Leads” who would each have responsibility for a geographic group of communities – provide leadership, faculty development, support etc. was raised

### Not all LEGs outside of Thunder Bay and Sudbury are Family Medicine

- Leads from larger communities like North Bay do not want to miss out on an opportunity to streamline and strengthen their own academic leadership and asked not to be considered as an afterthought, but to be kept informed as this initiative progresses.

### Consider Pan-Northern Specialty LEGS?

- MUST be balanced with local needs and not dismantle positive local developments with a regional approach
- Success example - Pathology Section Chair oversees the chiefs of the different regional hospitals that have that specialty.

### Concerns About how Academic Deliverables are Monitored (Quantity vs Quantity)

- “Associate Dean signs off on academic deliverables but it’s not meaningful - it’s “burgers served” “

### We Need Protected Time for Academic Work and Admin

- Admin time needs to be built in to paid work time – create roles like clinical researcher, clinician administrator, clinician educator

### Interest in Access to Information on an On-going basis as this project develops

- Interested in access to web-based information
- Keep people engaged at the PCTA board level
- Northern Constellations
- LEG videoconference