Department of Medicine
CLINICAL CARE Task Focus Group

SUMMARY: STRATEGIC CLINICAL CARE CAPACITY THEMES / GOALS

DOM – Aspirational Patient OUTCOMES
○ Patients experience excellent healthcare that meets their needs.
○ Patients receive the best care, from the right providers in the right place at the right time.
○ Patients are treated and cared for in a safe environment and protected from avoidable harm.

Supporting PRIORITIES
• Develop a Chronic Disease Prevention & Management (CDPM) Strategy for Department of Medicine
  • Definitions, data and understanding
  • CDPM model for Department of Medicine
  • Roadmap and processes; toolkit
  • Models of service delivery, such as Multi-disciplinary Ambulatory Care Clinic

• Develop a Patient-Centred Healthcare Delivery model for Department of Medicine
  • Scope of care / holistic care
  • Continuity of care (within DOM settings and transitions to community)
  • Access to care: timeliness and convenience
  • Clear pathways of care to align patients to the right service with timely access to consulting services and needed investigations
  • Collaboration between patient / family and medical team
  • Respect and communication
  • Empathy and understanding, etc.

• Build capacity to meet the evolving needs of a complex and aging population
  • Grow the CTU multi-disciplinary team, adding physicians, allied health professionals and nurse practitioners to meet demand
  • Ensure sufficient capacity (staffing, services, etc.) in CTU, 24 hours, 7 days a week, 365 days per year to meet patient demands
  • Expand deployment of the MOVE-ON project (Mobilization Of Vulnerable Elders – ONtario) and education of staff to perform mobilization duties
  • Improve our response to expanding number of patients, with delirium (i.e. approximately 29% of CTU patients present with delirium)
  • Assign leadership accountability for CTU operations to a DOM Leader
• Challenge current practices and accelerate the creation of new patient care models to optimize quality care
  • Patient / family engagement models
  • Ambulatory care clinics
  • Chronic or complex disease management
  • Community-based care
  • Person-centred medicine (care plans must be aligned to the diversity of patient needs and multiple diseases)
  • Holistic, integrated approach to clinical care
    o Develop out-patient clinics to address patients with multiple diseases / disorders
  • Decline out-of-area patient transfers when we are at full capacity for CTU beds

• Improve discharge planning and care navigation system to ensure the successful transition of patients through the healthcare system
  • Develop processes and tools that ensure seamless care transitions between internal and community providers
  • Allocate appropriate levels of care provider and resources to patient, based on need (i.e. when patient move from acute care to ALC, they do not require the care of an I/M physician; transfer to hospitalist)
  • Enhance communication pathways to strengthen the continuum of care. For example, a system to follow up, check in on patients at high risk of readmission
  • Build strong and influential relationships with CCAC, LHIN and community agencies

• Advance the quality agenda with a focus on patient-centred care, efficacy, efficiency, equity, safety and access
  • Design and implement patient experience surveys to assess care experiences at all points of interaction
  • Collect and analyze patient experience and care outcomes, with emphasis on quality improvement

• Provide hands-on community leadership to educate and optimize the health and independence of identified at-risk populations
  • Collaborate with community of London to address, prevent and reduce the impact of addictions (i.e. IV drug use) in London and area (public health issue)
  • Socio-economic determinants of health outcomes

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**FOCUS GROUP DISCUSSION – Thursday, October 30th, 2014**

• The service model for CTU’s and Emergency Department needs to change – currently, the services required for the patient are not always available or accessible.
• In order to produce excellent patient outcomes, we need to ensure we are resources effectively. For example, in CTU the patient / physician ratio is too high; we are stretched so consequently impact is not as great.
  • Hire more hospitalists; sweet spot is 15 patients per physician
  • Ensure the sub-specialties are actively involved in CTU and ER – we need an integrated structure where all specialized care types are available to meet needs of patient (i.e. Respirology)
• We need the patient to receive the right doctor and care at the right time!!
• Patients should receive the safest care, the most effective care and the most patient-centred care
• Teaching is critical – Best experience for the patient means the best experience for the trainee
• We want our patients to receive the highest level of quality care to optimize patient outcomes
• We want patients to experience the safest transitions from hospital to community
• Technology must be a strategic enabler of high quality care. If we tap into the power of technology and innovation, the patient experience and outcomes will improve.
• The more we build our skills and capacity, the better the patient outcomes will be
• We must ensure safe patient care. We can measure this through reducing healthcare induced errors

Important Questions – What outcomes will different ideas / strategies achieve?

• How do we define patient-centred care? We listen; we develop the best solutions to meet their needs; we involve the patient / family; we take action quickly, etc.
• Should we be a leader in geriatric care?
• Should we be a leader in chronic disease management? First we need a chronic disease management strategy.
  • Define what CDM is
  • Define who are the patients that need our services most; high users of resources and dollars
  • What do they need
  • How can we make the biggest impact
• Should we have a multi-disciplinary clinic?
• Should we be a leader in I.V. Drug Use population?
• Should we develop centres of excellence – ensure there is a thread that touches all divisions, such as aging or chronic disease management
• How do we measure outcomes and progress? We must have data. We need a quality improvement strategy and scorecard
  • Quality Committee to hold us accountable for achieving our metrics and to identify actions needed to close the gap

1st FOCUS GROUP DISCUSSION

Clinical Care Opportunities for DOM
CTU’s

- CTU’s are overwhelmed; a dumping ground for all patients
- Complexity of patients is increasing; feel like we are walking in quicksand
- Ineffective ratio of physicians to patients; worsened by complexity of patients who come into CTU
- Need greater capacity to support patient navigation and discharge planning
- Insufficient allied health staff resources (i.e. PT’s, social workers) and even support from other services such as radiology
  - Allied health staff and other services need to be accessible 24 hours a day, 365 days a year – we do not work on a 9-5 schedule or don’t take holidays off
  - Huge backlogs on Monday morning; very difficult to get ahead
  - Some DOM divisions seem to have good access to nurses or allied health staff, whereas CTU is lacking in this area, but our volumes are huge and constantly fluctuating
- Lack of capacity negatively impacts patient care and outcomes, resident teaching and patient / family communication and education
- We need to identify need and volumes and staff appropriately, otherwise negative impacts later in the process, such as readmissions, longer stays in hospital, etc.
- Significant focus on patient safety and managing risk of falls, therefore, it is difficult to get patients mobilized quickly as we are always waiting on the P/T – need to train other staff to perform this critical skill otherwise patients suffer – Move-ON project is helping to some degree
- Around 29% of CTU patients present with delirium and we do not handle these patients appropriately. For example, restraints only make the situation worse.
- There is a lack of appreciation of geriatric principles in the department / hospital and how to manage the care of this population.
- What is the mission of the CTU’s? To provide the best possible care to patients and to train our residents. We need leadership oversight for the CTU’s – to lead us, advocate for us and help us work more effectively as a team. Leader role must be considered a priority, full time role and not something to fit in between clinics.

Discharge Processes

- Current discharge planning and navigation processes are not effective
- Re-engineer the discharge processes to support patients to move through the continuum of care and improve patient outcomes
- We need discharge planners (ideally a nurse practitioner) to support us with assessment, family communication, education, linkages to community, setting of CCAC care plans, etc.

Standardized Clinical Pathways and Guidelines

- Standardized, one size fits all, pathways or clinical care guidelines do not consistently work, as patients have multiple disorders or diseases and we need to take a holistic approach to their care. For example, patient has CHF, plus diabetes, plus is obese. What treatment plan, medications, etc. work for this patient?
- We have to focus on the individual patient and do our best to provide evidence-based care
• Holistic approach balanced with the disease approach
• Getting patients out of hospital to the most suitable supportive care environment is important, but their health is more important so if they need to stay in hospital, that needs to be okay.

**What can we do differently or eliminate?**
• Internal Medicine physicians should not be looking after ALC patients – ineffective utilization of our skills; move to hospitalists and allied health staff
• Cognitively challenged patients should be cared for in different ways; we should consider a specialized unit or integrated approach to care for these patients
• Decline out-of-area patient transfers when we are at full capacity for CTU beds; although this is difficult when we are a regional program, such as renal
• We need more outpatient internal medicine clinics that can deal with patients who have co-morbidities; I/M could run; significant benefits related to continuum of care and follow-up with patients
• We have to evolve our hospital and care models to respond to the changing population needs – aging, multiple disorders, chronic disease; no longer just acute care
• ICU patients come back to medicine but seems like duplication of effort
• Some patient populations should not be directed to CTU (such as ‘new’ cancer patients; they need a lot of support and we do not have the expertise to support them and answer their questions)
• Give more respect to CTU and the important work we do
• Neurology uses CTU at Vic campus – this is a significant issue if the patient has a stroke. All neurology patients should go to UH neurology unit to maximize patient safety
• We need to do a better job of measuring patient outcomes; ensure assessment, diagnosis, treatment and care are all top quality. We need a quality tracking system that allows us to track tests, timelines, costs, benefits of tests, etc.
• We need more support from radiology, 24/7, – when we ask for a test, our request should be respected in a timely manner, not questioned, as this slows down diagnosis and treatment

**IV Use in London**
• The number of patients that we see that are addicted to IV drugs is excessive; appears to be an opiate epidemic in London
• Contributes to CTU volumes and complexity of our role
• We need to step forward as a member of the London community and work together to address and alleviate this issue
SUMMARY: STRATEGIC RESEARCH THEMES

STRATEGIC RESEARCH OUTCOMES
- Patient health outcomes improve through the discovery, diffusion, and utilization of research.
- DOM is a recognized leader in research collaboration, knowledge exchange and deployment.
- Better prevention strategies, better treatments contributing to broader health and community benefits.

SUPPORTING PRIORITIES
- Identify and focus on a defined number of opportunities to achieve research excellence in current and emerging areas of need
  - Clinical investigation
  - Basic science
  - Translational research
- Expand interdisciplinary research and scientific interactions and collaboration between departmental divisions and research institutes and among clinical and research faculty, students, residents and fellows.
  - Develop an Interdisciplinary Research model and strategy
  - Promote collaboration between basic scientists and clinicians, and with researchers from other divisions and faculties, as well as with CERI and research institutes (i.e. virtual research lab / hub; research days)
  - Assemble right people with the right expertise / skills to work on innovative research projects
  - Leverage and augment POEM to increase its impact
- Build and sustain the essential infrastructure and conditions to enable leading edge research productivity
  - Create an empowering and enabling workplace for research
  - Construct a powerful DOM database of patient information, that is current, accurate, complete and searchable
  - Expand access to funding resources, information, necessary space and facilities (i.e. internal funding awards)
  - Optimize the efficiency and ease of administrative processes to maximize our ability to attract and manage funding for research
  - Provide access to statistical consulting, methodological support and data management services
• Create conditions for innovation
  • Shape the culture to be one that inspires innovation and collaboration
  • Establish best-practice spaces for research and research collaboration
  • Quality measurement and improvement
• Prepare the next generation of research talent
  • Support and inspire junior faculty to attain research success
  • Expand the effectiveness of the mentorship program
  • Guide young investigators through the processes of problem formulation, literature reviews, and grant preparation
  • Improve access to resources, funding, data, training and procedural toolbox (i.e. finding funding; preparing funding applications; ethics and compliance processes, managing funding, etc.)

• Create a structure for the systematic quantification and evaluation of research output and success by the DOM faculty members.

FOCUS GROUP DISCUSSION #2

Our Funding Approach
• We should be more strategic in targeting funding opportunities. Money is limited so we should align our research focus to high priority areas of interest from research funders and networks; as well as to Western / Schulich interests
• For example, CIHR has identified five overarching priorities for the duration of the next plan's mandate:
  • Enhance patient-oriented care and improve clinical results through scientific and technological innovations;
  • Support a high-quality, accessible and sustainable health-care system;
  • Reduce health inequities of Aboriginal peoples and other vulnerable populations;
  • Prepare for and respond to existing and emerging threats to health;
  • Promote health and reduce the burden of chronic disease and mental illness.
• How do we strategically align to CIHR’s focus? SPOR Network in Chronic Disease? SPOR Network in Primary and Integrated Health Care Innovations? Etc.

Research Focus
• Should we have a narrow research focus so we can ensure excellence and greater outcomes or should we spread our focus across a variety of areas?
• Perhaps we should identify top research priorities that we want to allocate resources to because there is a thread of relevance across all divisions. Simultaneously, we would have a balance to allow for unique research interests of faculty.
• We absolutely need to work hand-in-hand with basic scientists on our DOM research priorities in order to maximize outcomes
• Action: Hold a 1 day retreat to discuss / strategize about our research priorities; to merge our thinking; to network and get to know one another's strengths, interests and capacity. Ideally, smaller research teams could be developed as a result of this retreat
• We need to raise our profile with Lawson. Are we getting a good ROI on the funds we invest into Lawson? We need to advocate for our interests and what we expect. Additionally, we require more reporting transparency from Lawson as to how funds are allocated

Clinician Scientists
• We should investigate the potential of developing Clinician Scientists — we need a strategy for how to do this and what the focus and expectations will be for Clinician Scientists
• Build expertise in core areas

Inter-disciplinary Research Collaboration
Definition: Interdisciplinary research (IDR) is a mode of research by teams or individuals that integrates information, data, techniques, tools, perspectives, concepts, and/or theories from two or more disciplines or bodies of specialized knowledge to advance fundamental understanding or to solve problems whose solutions are beyond the scope of a single discipline or field of research practice.
• We are still working in silos --- we do not effectively tap into other clinicians, basic scientists, and other Western departments; and external collaborators. This needs to shift in order to accelerate our impact.
  • Our researchers should collaborate with experts from across other DOM, other medicine departments, and other disciplines, such as dentistry, nursing, health sciences, engineering, etc.
  • Such collaboration will further enable doctors to turn discoveries into preventions, treatments and cures for diseases more quickly and efficiently.
• Develop structural models of interdisciplinary research to advance our priorities; remove obstacles and disincentives; transform the DOM culture to support this mode of research
• Are there opportunities to engage patients to a greater degree to provide input on identifying health research priorities and participate in the design and undertaking of research projects?
• Technology could enable collaboration (i.e. an APP that allows you to see who is doing what or what skills / expertise different faculty members have)

FOCUS GROUP DISCUSSION #1

What should be the Department of Medicine’s clinical research themes? Consider clinical, health services and basic components?
• Research themes are driven by individual divisions
• Currently, take an opportunistic approach to research
• What should we focus on?
• Disease based research (i.e. diabetes; molecules)
• Clinical trials
• Education based research
• Translational research to improve health and well-being of patients
  o Patient experience / quality of life
  o Patient reported outcomes: quality of life outcomes (i.e. between dialysis appointments)
  o Actively involve patients in research
• Population-based health research
• Observational studies
• Pull all the research that we are doing together
• Need the right people to come together to create great research projects

An opportunity: Infectious Diseases – Microbiome Discovery
• Microbiome discovery – growing area of research with significant human health implications
• Could we establish a Centre of Excellence in Microbiome Research?
• Cross divisional opportunity: This research would mean interactions with every discipline
• Most work is being done in animals
• Big opportunity to leverage this as we have expertise: Canada is very open to this research area
• Ability to reach out to other divisions i.e. cardio implications are huge
• Outreach to clinicians

ICES
• We should continually leverage ICES and grow our expertise
  • ICES is useful for QI studies
  • ICES could be a cornerstone of research
  • Next phase is to add basic science studies through ICES

Research Innovation
• We could create a Virtual Research Lab
  • Collaborative to foster interdisciplinary research
  • Discuss potential well thought-out research ideas / concepts
  • Feed into the people we have and their expertise to fine-tune / expand the concept
  • POEM is trying to do this in a physical environment
  • CERI is for educational research – present ideas and get feedback
• IDEAS Lab
  • Generate interesting synergies – thinking laterally
  • Share expertise

What are the Infrastructure / Capacity needs to support research?
Database
- As we move more to electronic record we will need more patient data
- We require people who are skilled at working with large databases
- Need an EMR that can go into a searchable database
- DOM could facilitate access to people who can actively manage the database; ensure accuracy and completeness
- Need processes related to privacy and confidentiality

Reduce barriers to research success
- Reduce administrative burden; red tape
- For example, the number of revisions required on a grant proposal is huge – big issue
- We need a formal structure to support research: database, confidentiality and privacy processes, people support

Hiring and supporting new faculty
- Tie into a team
- We should strategically hire for certain research interests and support them
- Link new faculty to faculty with the expertise they need to tap into
- “Effective” mentorship is critical; current processes are not optimal
- Are there 3-4 areas that new faculty could tap into and build capacity from there?
- Build an electronic / searchable database which is an inventory of faculty skills, expertise, focus, interests – excellent way to support new faculty and also to build collaboration across the department

Financial supports to enable research
- Divisions should protect faculty time for research
- Need both protected time and financial support
- Currently there is some tension between clinical vs. research
- Develop metrics to understand who should get the support and to measure outcomes
- Very difficult to win grants
- Could we expand endowments?
- Peer review funding and pharma funding – pharma funding helps keep us going
- Also require administrative support to manage workload

How should we interact with pharma?
- Work together on ‘hot’ molecules
- Unrestricted funding
- DOM could be involved in the negotiations with Pharma
- DOM could also be a benefactor; leverage the relationships
- How does foundation play into the game?
• Possibility to establish a DOM foundation
  • Could DOM provide support so we could take on unrestricted funding?
  • DOM facilitate the process

Basic Science’s role in DOM?
• There is a role for PhDs in the DOM
• Our scientists should be the mentors for faculty
• Currently silos exist between clinical and B/S; need to close the gap
  • Need an inventory to align the two areas in order to leverage the expertise and obtain synergies between research projects that are happening in both areas; reduce duplication of effort
• Goal is to support faculty to become individual contributors
• Individual rounds – presenting to one another to build understanding of skills
• We require statistical support for all these research projects
• Culture of “too busy” so this limits collaboration
• Research Days are an excellent forum – showcase what all the divisions are doing; basic science projects
• Grand Rounds should be ‘a bigger deal’ and faculty at all sites should have ability to attend via electronic means

Role of CERI and Integration with DOM
• All focus group participants are not fully aware of what CERI is and the goals / scope of work done by CERI; therefore opportunity to promote CERI’s mandate and accomplishment
• Interested in clinical translation of research
• Opportunity to set up a clinical training program to build skills, with support from CERI
• We could position ourselves as a leader in this area
• Develop platforms for training: simulation, video games, electronic simulator, licensing opportunities

Researcher Skills and Capacity
• Sizing and scoping of our researcher capacity is critical – we have to decide what we want to focus on – are we going to achieve excellence in a few key areas or do a lot of things just okay?
• What is the vision?
• We should establish research priorities for DOM – types and translational
• Are we going to be best at a few things or okay at a lot of things
• Based on our research priorities, we could then determine the skill set / interests we should be recruiting for or developing in-house
• Once we establish research priorities, we can set benchmarks / targets for success
• Now research happens at a divisional level; but we should move towards a DOM focus

Research Themes
• Clinical research - Are there areas of key development related to clinically based research
  • Diabetes
  • Molecules
  • Pockets of disease management research already exist in DOM
• Patient’s subjective experience
  • Patient reported outcomes: quality of life outcomes (i.e. between dialysis)
  • Involve patients in research
  • How do we utilize their experience at the end points?
  • For example, sleep, energy diet; compare interventions
  • Comparators between treatments and drugs
• Need outcome-based research
  • Prove than an expensive drug prevents moving to a more grave state – ROI
  • Trade-offs – standard methodologies; need someone with expertise to leverage off of this
• Knowledge translation into small communities
  • Educate community physicians
  • Assess impact
  • Stuart Harris in diabetes – moving into community
• Telemedicine and telehealth research; develop consultative services to communities; been tried but doesn’t seem to be getting a lot of traction
• Identify 5-6 specialized research areas that Canada provides more support to and go from there – we could be a leader in one of those research areas
• Ensure we innovate based on what is already in place – we need expertise and dedicated resources to be strong in any area of research
• Disease research is great for training residents

Research Institutes
• Roberts and Lawson have not found their place in supporting the DOM so POEM has done this to some degree
• We need to bet a better ROI from Lawson for the money we contribute

Use of ICES Western to Support DOM Research Strategic Plan (Amit Garg)

What is ICES Western?
• ICES Western is a SSMD / Lawson core facility with 12+ analysts, epidemiologists, a database programmer, a health geographer, a research associate with expertise in health economics, and an on-site privacy officer, who have full access to the large linked healthcare databases of Ontario. There are now 65+ linked datasets with > 20 billion records. The research personnel have substantial published expertise in cohort studies, case control studies, time series analyses, multivariable modeling including propensity score analyses, privacy, data management and data linkages
including CERNER and provincial laboratory linkages. Growing expertise in registry based randomized controlled trials, geographical spatial information analyses (through collaborations with Geography) and economic analysis. There is substantial expertise (and success) with clinical, health services and population health research grants from the CIHR and other agencies.

**How to maximize use and potential of this core facility for the benefit of entire DOM?**

- Develop a DOM ICES Western Steering Committee (or call it a Task Force), with representation from multiple Divisions, who take responsibility for this DOM Initiative. Surgery has developed such an initiative within ICES Western which DOM could emulate. Amit Garg is currently the Director of ICES Western for a 3 year term (2013-2015) and is well positioned to facilitate the development and launch of this DOM initiative so that it has a strong long-term foundation. It likely that the next Director of ICES Western will be from another Department (likely Surgery).
- Empower current DOM ICES Western Scientists and Faculty Scholars in their ICES Research; also support their mentorship role in fostering research for others within their Divisions:
  - Clinical Pharmacology: Dan Hackam
  - Endocrinology: Lisa Ann Fraser, Kristin Clemens
  - Hematology: Alejandro Lazo-Langner
  - Nephrology: Matt Weir, Arsh Jain, Amit Garg
  - Cardiology: Neville Suskin
- Continue to engage DOM Faculty from multiple Divisions in the 2-year ICES Western Faculty Scholars Training Program. Next iteration 2015-2016
- Respirology: Marcus Povitz
  - Cardiology: Lorne Gula, Pallav Garg
  - Interest from Faculty in: Gastroenterology, Infectious Diseases, Rheumatology, and Critical Care Medicine.
- Develop broad strategies for DOM engagement: have a clear intake and process for DOM led project ideas that require ICES data, analytic expertise or support. This includes supporting grants, projects, pilot data requirements for ICES.
- Finance the vision to meet projected deliverables. Primary costs are to cover research personnel time who will work on the initiative (similar to surgery model).
The Clinician Scientist in Canada: Supporting Innovations in Patient Care through Clinical Research (Royal College of Physicians & Surgeons of Canada)

Abstract
Clinician Scientists are medical doctors who have undertaken additional training in health research or basic science. As both clinicians and researchers, these individuals play an essential and distinct role in the health care system. By virtue of their integrated activities, Clinician Scientists have an opportunity to undertake key aspects of the scientific research process (including, for example, formulating and testing hypotheses) within the clinical setting. The unique position and research mandate of Clinician Scientists permits them to adopt a more complex study and develop a more thorough understanding of disease. This ultimately makes the role of Clinician Scientists — and their contribution to research and its translation to practice — critical for driving health care innovation in Canada.

Despite the importance of — and contribution made by — Clinician Scientists, they are relatively few in number, comprising a somewhat small percentage of the total profession. There are many barriers to the recruitment and retention of Clinician Scientists, including the lengthy training time, the fact that there are fewer funding opportunities available to support both training and research, delayed financial reward, lower financial remuneration, overwhelming trainee requirements, insufficient guidance in the research environment, limited mentorship opportunities, and career demands. While some potential solutions to these issues have been generated both nationally and internationally (and some have been implemented), for the most part, the solutions have been local and small in scope and, as such, their success is difficult to determine.

Barriers to changing the current status of the Clinician Scientist in Canada include a lack of understanding of — and support for — the importance of Clinician Scientists at national, provincial and institutional levels, as well as the daunting task of encouraging stakeholders (e.g., Faculties of Medicine, funding agencies, governments) to invest in a common commitment to making the necessary large-scale changes. Recommendations are put forward at the end of this paper to increase the recruitment and retention of Clinician Scientists in Canada.
Department of Medicine
TEACHING Task Focus Group

DOM – ASPIRATIONAL TEACHING OUTCOMES

- Learners acquire the essential competencies to prepare them for achieving excellence in clinical practice.
- Learners experience a collaborative, multi-faceted and supportive learning environment focused on patients and on providing the highest quality of care.
- Teachers are supported through faculty and professional development and recognized for the value of their work.

SUMMARY: STRATEGIC TEACHING THEMES / GOALS

Develop an integrated, experiential medical teaching model that provides DOM residents with a broad range of inter-professional learning experiences in diverse and distributed sites.

• Ambulatory care
• Community based care
• Acute care
• Inclusive and collaborative partnerships with community providers
• Global learning opportunities – faculty and learners; undergrads and post grads

Embrace and prepare for the new Royal College competency-based education (Competency by Design) curriculum for residents

• Appropriate resources: physicians, administrative support, funding
• Outcome-based education to promote fitness for practice and education for capability

Accelerate our ability to translate evidence-based knowledge into active practice

• Define and build a learning system that incorporates knowledge translation and information and communication technologies as effective tools.
• Technology enhanced learning opportunities will support the next generation of students and health professionals in their personal learning and clinical practice.

Foster life-long learning and the maintenance of professional competence

• Advance faculty development and our focus on learning excellence
  • Leadership development
  • Teaching and coaching development
  • Improve evaluation system for residents, teachers and faculty
• Foster the role of Clinician Teachers
• Implement a ‘new faculty’ on-boarding program
• Recognize teaching excellent and provided provide protected teaching time

Accelerate the adoption of innovative practices, approaches and modalities into all education, designed to meet the current and emerging needs of today's learners
  • Simulation training
  • Interactive learning, such as video, podcasts, forums, webcasting of grand rounds and journal clubs, social media
  • Team-based learning

Cultivate an environment that promotes and values mentorship
  • Ensure mentoring is a recognized academic activity
  • Provide consistent and helpful support and training for mentors and mentees
  • Clarify roles, responsibilities, and goals for mentors and mentees

Lead in the integration of proven quality and safety practices into the education and training of residents and faculty
  • Develop faculty resources and expertise to teach quality, safety competencies and improvement methodologies
  • Establish benchmarking and performance measurement and analysis in education

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**FOCUS GROUP #2 - DISCUSSION**

**What type of health professional are we aiming to train for DOM?**
  • Clinically well-rounded professional
    • Experienced and diverse exposure to clinical practices
    • Flexibility in skill set
    • Doctors who put patients first - working with them as partners in their own care and making their safety paramount

**How do we measure success?**
  • 100% pass rate of college exams
  • Ensuring that years one to 3 are excellent as they are the core years for determining success
  • We need an ongoing system that truly measures their competencies – we currently don’t have this but CBD will drive this
    • Should we be a pilot sit for CBD at Schulich?
    • We could be the leader; best practices and learnings be developed through DOM
    • Do we have the capacity to take this on?

**What is the DOM Learning Environment known for?**
  • Collegial and support teachers
  • Developing interpersonal skills in our residents
• Open Door policy
• Encouraging residents to work as part of a team

**What should we expect of our Faculty Teachers?**
• Medical students must be inspired to learn about medicine in all its aspects so as to serve patients and become the doctors of the future. Therefore, we need our teachers to be role models for collaboration, mentoring, curiosity and innovation
• To be inspiring and motivate students to want to learn and find the answers on their own
• Understand that learners have unique needs and customize their approach to each learner's needs – one size does not fit all
• To demonstrate excellence in everything they do
• To be patient and always improving

**We need to do more to help faculty be stronger teachers**
• Protected time for teaching and associated duties
• Appropriate compensation that encourages faculty to take on teaching assignments; recognition of efforts and success (i.e. teaching awards at different levels)
• Appropriate ratios of students to teacher, otherwise the quality of teaching erodes and student outcomes will not be optimum
• Standardized curriculum
• Workshops
• Teaching strategies for different kinds of learning settings
• Evaluation
• Learning together as a faculty – sharing of best practices in teaching
• Retreat to expand our identity as a faculty of teachers
• Match teacher’s strengths to the content they are teaching; do not assume a good teacher is effective at every subject or in every environment (i.e. good in classroom but not in a clinical setting) – align the right teachers to the right setting
• 4-squares teaching program
• Types of teaching approaches in clinical, classroom, simulation

**Quality Improvement**
• Needs to be a big focus with the teaching curriculum
• How can we continually improve our teaching strategies, content, processes to maximize student outcomes?
• Establish a QI DOM committee and ensure multi-disciplinary involvement
• Also look at technology enablers in the learning environment to advance teaching effectiveness

**Knowledge Translation**
• Knowledge translation is the synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system.” (CIHR)

• CIHR has set a policy that all research grant proposals submitted for competition require a strong KT component to demonstrate thinking and implementation approaches to accelerate the dissemination and inculcation of the knowledge generated from the research into health care practices.

• Because there are so many different disciplines within the health field there is a strong need for effective inter-group communication in order to move forward on future KT

• There is growing awareness that health related knowledge, innovations and / or research findings and not making their way into practice in a timely fashion, coupled with the current emphasis on evidence-based, cost-effective and accountable health care, has stimulated increased interest in finding ways to significantly reduce the knowledge-to-action gap.

• How does DOM improve our ability to translate evidence-based knowledge into active practice? For example:

  • Use evidence / knowledge to solve a local health problem in SWO
  • Use knowledge to improve how we deliver service (i.e. all evidence points to inter-disciplinary teamwork improving health outcomes, however medical professionals are slow to translate that knowledge into real life practice) – how do we break down the barriers?

• Perhaps we need a Knowledge Translation Working Group that identifies opportunities, develops action plans to deal with the opportunity and measures outcomes (excellent linkage to Schulich’s strategic plan)

Global Learning Opportunities
• Develop a consistent strategy for international learning experiences for residents; faculty – teaching overseas

• Develop standards and processes to support this initiative

• Establish a process to share experiences with other faculty members upon return from international assignment

• Recognize these contributions

Resident Mentorship Program
• Current mentorship program does not work well: inconsistent application; quality of mentors is not reliable; processes need improvement

• Ensure mentors embody qualities such as collaborator, communicator, teacher and manager

• Is mentoring a recognized academic activity (promotion)?

FOCUS GROUP #1 - DISCUSSION

What is our Teaching Purpose?
• To ensure residents meet Royal College objectives
To prepare future generations of physicians for academic, clinical, and leadership positions
To support residents and junior faculty at various stages along their journey
To maximize a resident’s capacity to treat and manage patients

**Quality Improvement**

- Launched a QI Methodology project which incorporates experiential doing, learning and problem solving -- very well received
- QI methodologies need to be woven into the entire department and into all process improvement practices – an awesome way to learn
- Engagement in problem solving and planning builds a culture of buy-in, improvement and learning
- We need more teaching related to quality and safety
- Need to teach learners how to measure outcomes / metrics and continuously improve
- How to make decisions from a quality standpoint
  - I.e. If we need to achieve an 11:00 discharge, what comes first ‘timely’ or ‘safely’
- We need to integrate all the silos

**Resident Evaluation**

- Drags you down as it is such a cumbersome process
- Need more consistency in how we evaluate students
- Promotions need to be supported by an effective evaluation

**New Educational Venues That We Should Invest In**

- Longitudinal clinics
  - Good care
  - Education
  - See readmissions
  - More representative of experience
- Allow learners to learn the full continuum of care – following patients through their entire experience
- Simulation training – currently it is primarily procedural
  - Opportunity to develop simulation training related to critical events, communication, multi-disciplinary teamwork, physical examination
  - Area of investment
- Electronic / digital learning opportunities
- Real-life patient learning
- C-STAR
  - Suboptimal collaboration between departments and how we utilize the equipment
  - We should define our priorities in alignment with DOM and divisional goals
  - Opportunities to work cross-divisionally to maximize the learning experience
  - How do we evaluate the outcomes from simulation training; what metrics do we use?
• International educational partnerships for faculty members and medical trainees within the DOM (see attached documents – White Paper on Globalization and International Education Opportunities document)
  • Elective programs for residents in developing countries
  • Support building health care capacity in developing countries

Competency by Design
• CBD will have a significant impact on the culture of the DOM, our processes and physician accountabilities
• Faculty will need to develop new and innovative ways to train residents and conduct effective evaluations
• Innovation is ‘difficult’ for DOM --- how do we manage the change and get faculty to buy-in and do things differently
• Need to have a plan for significant changes and how we prepare faculty; support them

Teaching Recognition
• Issues related to recognition
  • Do students know that we are not fully compensated for this role? Do they appreciate the value they are getting?
  • There is not appropriate compensation for teaching commitment
  • Teaching is not seen as ‘valued’ or as interesting as high level research or clinical work
  • Unique, leading edge or innovative teaching practices are not recognized or rewarded
  • Little protection of time for teaching commitments
  • If we are making outstanding contributions, there should be accommodations for us
  • What is our commitment to Clinician teachers

Relevance of CERI
• CERI could play a greater role in DOM but needs to become more innovative
• CERI is peripheral to us
• Greatest opportunity - CERI could advance innovation in curriculum design, teaching / learning evaluation; assessment; simulation training; collaboration

Mentorship Program Structure
• What is the purpose of mentorship? Is it just to help me get promoted or is it to help me be the best faculty I can be?
• We need to refresh / redesign the mentorship program to make it relevant and impactful and to achieve specific goals
• Current program is ‘okay’ but not exceptional or innovative or consistent in how it is delivered
• Currently, it is too dependent on the mentorship committee and the division chair role is too significant.
• Effective mentoring needs to be more about a relationship, built on trust / expertise / benefits, between mentee and mentor, with regular communication / meetings to achieve goals
• There is both formal and informal mentoring and both need to happen well
• There is confusion related to mentoring being ‘voluntary’ or ‘mandatory.’ If a new faculty member does not get involved in a mentoring relationship very quickly, it will soon slip to the bottom of the priority list and will not happen
• Huge opportunity to do more coaching as part of mentorship

**Greatest Opportunities?**

• Align education to clinical care and research --- they do not need to function in silos; they are all integrated and critical to success
• Implement better preparation and training processes to help faculty to be outstanding teachers
  • Training in teaching, design, evaluation
  • Coaching opportunities
  • More just-in-time feedback to learners
• Adapt the design of curriculum to the changing needs of our current learners (i.e. Millenials), and their learning preferences (i.e. technology based; teamwork) and communication styles
• Develop training course for faculty related to ‘innovative thinking’ and how to incorporate innovation into curriculum design and teaching
  • How do we recognize and reward faculty who are innovative? Currently, there is no benchmark or appreciation for this
• Support new faculty in their teaching role – help them to become exceptional teachers
• Reinforce and hold faculty accountable for conducting timely and valuable resident evaluations; incentives; tools
• Spend more time on celebration / communication / recognition of teaching successes and milestones
• We need more investments within the DOM
  • More physicians with protected time for teaching
  • Nurse practitioners to allocate workload to
  • Parity of pay across DOM for doing same work
• Identify performance metrics for Teaching --- for example, number of residents who pass the Royal College exams
• Improve the Resident Mentorship Program
  • Ensure we provide trainees with role models who embody qualities such as collaborator, communicator and manager; can mentees be involved in the selection process?

**Barriers to Achieving Better Results in Teaching**

• Perceived lack of time due to increasing clinical, research and administrative responsibilities
• Perceived lack of importance by faculty for mentoring if it is not a recognized academic activity (promotion)
• Limited support and training for mentors
• Faculty apathy
• Hard to change old ways of doing things
• Lack of resources
• Everyone is at full capacity; how do we achieve higher standards with no additional resources?
• Parity of pay across DOM for doing same work – for example, if I am part of the Nephrology division where compensation is shared, it is easier to commit time to the teaching role, but not same scenario in other divisions