Executive Summary

This document outlines the strategies for coordination of distributed medical education (DME) in Ontario communities. It updates the May 2005 document – Distributed Medical Education, a coordinated approach in Ontario. It outlines the recommendations and guidelines of engagement to provide a collaborative framework for schools of medicine, DME programs and community partner stakeholders.

Goal

To expand the delivery of medical education outside the historic Clinical Teaching Unit model of the Academic Health Science Centres through best evidence, application of accreditation standards, and removal of administrative barriers for all learners (medical students, clinical clerks, and postgraduate residents) in Ontario.

Rationale

Accreditation standards require that medical learners have clinical experience in primary care, family medicine and the general specialty disciplines. Learners must also understand all levels of health care delivery as part of the requirements for licensure. Clinical learning in rural or community practices accomplishes both of these goals. In addition, there is evidence that experience in these practice settings attracts more trainees into family medicine and general medical and surgical specialties, and increases physician recruitment to these communities.

Ontario has an excellent resource of rural and community preceptors, Ministry of Health and Long Term Care (MOHLTC) funded distributed medical education (DME) programs and university-based DME programs that organize learner placements across the province. A coordinated approach to rural/community medical education is required from these resources as faculties of medicine expand.

Collaboration across each Undergraduate and Postgraduate program within each school and across all schools and throughout the province is of paramount importance to medical education in Ontario.

The following core principles will be adhered to:

- joint collaboration amongst DME programs, the schools of medicine and communities;
- joint capacity reviews for each discipline;
- sharing and transparency of data; and
- understanding of the expectations and objectives of all stakeholders.

Context

1. DME placements are fundamental for understanding the health care system.
2. DME placements are effective in encouraging learners to consider practising in geographically undersupplied areas.
3. DME placements are critical in maintaining and further expanding training capacity in Ontario.
4. There are 6 universities and 2 non-university systems with longstanding relationships with preceptors placing learners in Ontario
5. With an expected increase in medical and other health science learners [e.g. (nurse practitioners (NPs), physicians' assistants (PAs)] in coming years, there is a clear need for establishing principles to avoid significant conflict as preceptor resources become stretched.
6. Simplification and standardization of processes will improve preceptor satisfaction and learner experiences.
7. Simplification and standardization of processes will improve undergraduate (UG) and postgraduate (PG) programs' ability to meet accreditation standards.
8. Collaboration will increase capacity.
9. Collaboration will minimize costs.

Recommended Strategies

1. **Foster established placement arrangements between the 6 schools of medicine, the Rural Ontario Medical Program (ROMP), the Eastern Regional Medical Education Program (ERMEP) and the participating communities.**
   The natural working relationships that have developed between individual schools of medicine, DME programs and communities should continue to be fostered. However, placements should be available at all sites for learners from all programs and barriers should be minimized through collaborative efforts. It is recognized that the DME programs represent a provincial resource. The DME program expertise that exists in organizing placements, recruiting, retaining and supporting local preceptors is acknowledged. Collaboration between faculties/schools of medicine and the DME programs will optimize rural/community medical education and minimize competition for resources.

2. **Outline clearly the roles and responsibilities of the schools of medicine, the community sites, and coordinating DME programs.**
   Faculties/schools of medicine have primary and ultimate responsibility for all accredited undergraduate and postgraduate medical education activities. Core rotations must meet LCME-CACMS and RCPSC/CFPC accreditation standards and electives must have educational merit.

   Faculties/schools of medicine have accreditation responsibility for credentialing faculty, providing faculty development, and evaluating practice settings in accordance with the UE:COFM and PGE:COFM Site Accreditation Checklists.

   Preceptor evaluations must be shared with:
   - The preceptors, on a schedule to be decided by each school of medicine;
   - The learner's school of medicine; and
   - The school of medicine that grants the preceptor's academic appointment.

   Schools of medicine have primary and ultimate responsibility for learner evaluation.

<u>Schools of Medicine: Key Roles and Responsibilities</u>

Ensure that accreditation standards are met, including evaluation
Provision of support through Student Affairs
Faculty appointments
Ensure appropriate faculty development is provided
Ensure infrastructure in place for distance education (e.g. videoconferencing or web conferencing equipment and arrangements)
Accommodation arrangements (where appropriate)
Community training orientation package

DME Program Key Roles and Responsibilities

- Accommodation arrangements (where appropriate)
- Transportation funding
- Accommodation stipends
- Community integration
- Facilitate Faculty development
- Facilitate evaluation mechanisms

Community Key Roles and Responsibilities

- Site coordination/capacity
- Facilitate preceptor faculty appointments
- Learner orientation and community integration
- Videoconferencing infrastructure

Joint Schools of Medicine/DME Program Key Roles and Responsibilities

- Capacity assessment
- Faculty development
- Sharing of appropriate evaluations
- Advocating appropriate preceptor stipends
- Promotion of community practice
- Learner notification re; timetables etc.
- Preceptor support through clearly delineated feedback mechanisms

3. **Place undergraduate and postgraduate learners in distributed sites at the same time.**
   The co-location of undergraduate and postgraduate learners is a strategic goal that recognizes the importance of the integrated learning team.

4. **Foster interprofessional education opportunities in distributed training sites.**
   Where possible and appropriate, community placements for medical learners should be co-located with learners from and health professional programs. This will provide opportunities for interprofessional educational experiences in line with the provincial mandate and development of the FHN/FHT model of healthcare delivery.

5. **Advocate for preceptor payments that are fair and equitable across the Province.**
   Rural/community preceptors are integral to medical education and must be valued in meaningful ways. Provincial rates of preceptor payment will be comparable across the province. When delegated by COFM, DME:COFM will play a lead role in discussing these funding levels with the MOHLTC.

6. **Standardize the reimbursement of learner expenses across the Province.**
   Learner travel/accommodation will reflect actual cost. When delegated by COFM, DME:COFM will play a lead role in discussing these funding levels with the MOHLTC.

Appendix A:

Suggested Role of COFM Committees with respect to DME Collaboration

DME:COFM Committee (see Appendix A for DME:COFM Terms of Reference) will be the forum to:

a. Develop a training capacity system to monitor and enhance community preceptor availability.
b. Develop common priority templates for learner placements.
c. Coordinate shared faculty development events.
d. Facilitate requests for placements by any Ontario learner in any site across the Province, regardless of their home program.
e. Encourage an Ontario-wide rural/regional curriculum for undergraduate core rotations.
f. Evaluate outcomes of DME collaboration efforts.

DME:COFM, UE:COFM, and PGE/PGM:COFM will work to enhance efficiencies in the system through:

- sharing rural/regional curricula;
- sharing rural and regional outcomes and evaluation approaches;
- sharing faculty development initiatives;
- sharing elective opportunities;
- supporting the strategic goal of returning learners to their home rural/community region for placements when possible;
- developing flexible opportunities for rural/community experiences to maximize student interests;
- guiding priority for rotation bookings within DME programs, first to learners in Ontario schools of medicine and second to learners in other Canadian schools of medicine, particularly those who originate from Ontario;
- monitoring site utilization and saturation rates;
- facilitating academic appointments;
- accepting of training site credentials between different Universities; and
- defining timelines for completing and sharing assessments of DME capacities in communities.

Appendix B:

DME:COFM Terms of Reference

The vision of DME:COFM is to promote a coordinated and collaborative system of distributed medical education that addresses the medical needs of communities across Ontario by providing high quality community-based education, teacher support and enhanced community recruitment and retention.

In particular:

1. Ongoing reporting to the COFM Deans on all matters and activities of DME:COFM
2. Work to enhance efficiencies in the system, including appropriate shared rural/regional curriculum and outcomes, evaluation approaches, and faculty development initiatives along with UE: COFM and PGE/PGM: COFM.
3. Support provincial collaboration activities and act as a clearinghouse for issues and developments relevant to distributed medical/health education
4. Compile statistics and reports on distributed medical education matters on a regular basis to COFM.
5. Play a lead role, when delegated by COFM, in discussing funding levels for provincial rates of preceptor payment and student travel/accommodation.
6. Receive and review annual reports from all DME programs which monitor site utilization and saturation rates.
7. Make recommendations to COFM, or the MOHLTC as delegated by COFM, which are informed by evidence and on-going evaluation.
8. Liaise with other COFM Committees, with a formal liaison with UE: COFM and PGE/PGM: COFM.

Membership:

1. One representative from each of the six Ontario medical schools. These members will represent the Dean's Office as well as the teaching programs that operate distributed medical education in Ontario.
2. Representation from each of the distributed medical education programs affiliated with the Ontario Medical Schools.
3. Ex-officio representatives from the UE:COFM, PGE/PGM:COFM, Ministry of Health and Long-Term Care, the Centre for Rural and Northern Health Research (CRaNHR), PAIRO and OMSA.
4. Additional resource people, as required.

Responsibilities of the Chair:

The Chair shall be elected by DME:COFM, then appointed by COFM for a two-year term, renewable normally to a maximum of six years.

The Chair represents DME: COFM on COFM, PGE/PGM: COFM and UE: COFM for a period coinciding with his/her term as Chair.

Meetings:
Meetings are to be held at the call and discretion of the Chair, normally three times per year.

The program administrators may meet separately to address operational issues, as required.

Voting:
In the event of a vote, each school or program receives one vote.