

Faculty of Health Sciences

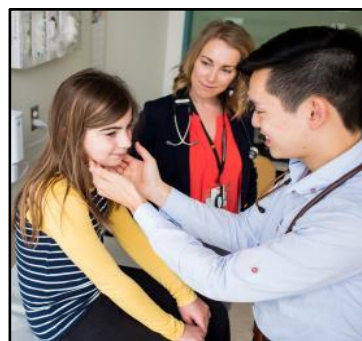


Regional Education in the School of Medicine **Strategic Plan 2017-2022**

Introduction

In September 2016, the Queen's Regional Education office launched a strategy development process to identify future priorities, choices and directions to anchor and guide the organization's future activities.

The work involved a number of planning workshops with the unit, three sessions with the project's Strategic Planning Team, and several stakeholder interviews and consultation sessions with site leads and teams through July 2017.



The review covered a close look at the organization's mission, vision and values, as well as discussion of key issues, new trends, evolving expectations and forces for change requiring strategic choices by Queen's Regional Education. Many of these sessions explored the dynamics of medical education, the role of distributed medical education within it, and relationships with community partners and the Ministry of Health and Long-Term Care.

The team considered what those involved in the program are passionate about doing, what they are best at, and where the Regional Education office can continue to excel. It looked at how the needs of learners might change in the future, how best to support faculty/preceptors and sites, together with what capabilities should be put in place to stretch the organization.

The following strategies are the product of that work.

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Consulting Support provided by Rob Wood, 8020Info Inc.

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Vision, Mission & Values

Working from a Queen’s Vision for Distributed Medical Education:

Regional Education’s priorities, goals and strategies serve a higher overall vision for distributed medical education at Queen’s — where learners develop a well-rounded understanding of practice gained through community experiences. More specifically, Regional Education’s “destination postcard” for its distributed medical education program is focused on creating and supporting opportunities, structures, and experiences that:

- 1 CONTINUALLY ENRICH LEARNER OPPORTUNITIES**
Help provide medical residents and clerks with a full range of rich learning opportunities (both depth and breadth) that effectively develop their skills, expertise and preparation for the transition to a career in medicine.
- 2 ACTIVELY CONNECT WITH & ENGAGE FACULTY**
Engage, develop, support and recognize faculty and preceptors in their academic roles as experts and enthusiastic teachers of the next generation of medical practitioners.
- 3 ENHANCE CAPACITY THROUGH A CLOSE NETWORK OF PARTNERS**
Develop a mature and integrated regional network of academic settings throughout Southeastern Ontario that advance the capacity of Queen’s and its partners as required to meet needs and achieve both shared and individual goals.
- 4 FULLY ACHIEVE THE BENEFITS OF COORDINATION**
Promote and support coordination across Queen’s programs, and with regional sites hosting distributed medical education. Desired outcomes include improved quality of experiences, efficiencies, leveraged capacity and reduced risk.
- 5 ADVANCE THE QUEEN’S MEDICAL EDUCATION BRAND**
Advance Queen’s presence, competitive appeal and strategic positioning throughout the region through DME programs, research collaborations, partner protocols, marketing/communications, faculty engagement & relationships.
- 6 DEEPEN DME’S RESILIENCE & ADAPTIVE ABILITIES**
Invest time and resources for organizational, program and network development so that robust structures and relationships are well developed, suitably resourced, and supported with a culture of practice that seizes opportunities and adapts to new challenges with agility.

Note: The vision for distributed medical education programs is framed by the new School of Medicine Strategic Plan, which emphasizes innovative education, collaborative research, partnerships with the community, and patient-centredness.

The Mission/Mandate for Queen’s Regional Education:

All strategy is framed by an organization’s mission – its purpose or reason for being. The creation of distributed education at Queen’s (including both Royal College specialties and Family Medicine programs) was driven initially by the need to build capacity beyond Kingston to serve growing programs, and also to distinguish Queen’s from the alternatives. The context and conditions for the program have broadened since then.



For 2017-2022, the focus of *Regional Education* will be:

To provide proactive leadership, coordination and support to ensure that learners and their needs are well matched with medical education experiences at regional sites. This will be accomplished by actively engaging partnering organizations and faculty in a network aligned with a shared academic mission.

Program Function:

The Regional Education Office in the School of Medicine at Queen’s University works collaboratively with other Ontario medical schools and regional providers to assist Ontario Undergraduate and Postgraduate medical learners doing rotations in regional sites across Ontario. It serves 16 clinical departments, 15 of which are Royal College specialties in addition to Family Medicine, and undergraduate programs.

Regional Education provides accommodation, travel reimbursement, cable TV and hi-speed Internet connection for clerks and residents while they are completing mandatory rotations outside of Kingston. Learners are also provided with electronic access to their course material and to Bracken Library through their home base in Kingston.

Regular faculty development sessions are offered at each major site and are also available through videoconferencing and Kingston-based sessions. Live online seminars for Undergraduate and Postgraduate learners are presented weekly, as are discipline-specific Grand Rounds and Subspecialty Rounds for regional faculty and learners.

Regional Education currently manages 25 houses and apartments (61 beds) in communities across Southeastern Ontario, including Brockville, Quinte/Belleville, Lakeridge Health/Durham Region, Peterborough, Markham/Stouffville, Toronto and Ottawa.



Background Issues & Forces for Change:

Regional Education's mission is accomplished in a complex operating environment involving scores of learners, faculty and site partners across many disciplines, approaches and locations with different expectations, funding contexts, priorities, policies and professional cultures. It also operates alongside an active distributed medical education program delivered by the Department of Family Medicine.

Many influential forces for change, specific issues and opportunities are detailed in the appendix to this strategy, which documents scores of points raised in consultations supporting the development of this strategic plan. Some of the major themes that emerged speak to:

- **The dynamic nature of the operating environment:**

The program must continually adapt to fluctuating demand and capacity issues. The challenge is to optimize a delicate "mix and match" balance — between the supply of learners at different levels and their educational needs vs. the number and variety of sites, the capacities of those sites, and related issues of logistics, scale/critical mass, academic commitment, faculty recruitment/engagement and quality.



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- **The need to design approaches within a constrained environment:**

The program functions within a variety of policy, funding and structural constraints. The freeze on Royal College residency numbers, for example, makes it difficult to accommodate sites that need more residents. Other conditions emerge by way of University and Faculty priorities, funding pressures and mechanisms, structural issues, political priorities at a provincial level, expectations for research and critical mass, concerns about social accountability, diversity/inclusion and more.

- **Ontario's health transformation agenda:**

An increasing proportion of academic service delivery will be moving out of the hospital environment and into community settings. The South East LHIN and SEAMO are also responding to an "integration imperative" for the regional health care system. New initiatives like *Healthcare Tomorrow*, with its thrust to create regional systems of integrated care, mean it will be important for departments to seek and enhance a unified regional model of care and education. It will also affect the type and location of settings available to learners.

- **The need to focus on relationships at the level of disciplines:**
Executive-level agreements are important, as are the efforts of site leads and the Regional Education team. But the pivotal connections for a functionally effective DME network are those between Queen’s program directors and their discipline-level counterparts.
- **Enhancing the value proposition for preceptors:**
Non-financial benefits are critical to recruitment and engagement of strong preceptors. Faculty development programs and the evaluation process play key roles in these regional partnerships.
- **Presenting a common front:**
The program has opportunities to better position Queen’s and share its brand with regional sites. This also builds on improving alignment and coordination with Family Medicine’s distributed education program.
- **Focus on the learner:**
Consultations identified concerns about wellness issues for learners (isolation, stress, mental health issues) along with needs for technology and videoconferencing capabilities. The learner remains the focus of the enterprise.





Five Strategic Pillars for Queen's Regional Education

□ Develop and Formalize a Robust Model for Queen's DME

The success of distributed medical education at Queen's depends almost entirely on the framework, working relationships and collaborative resources coordinated through the network. Regional Education must also keep step with changes in the needs of learners, programs, funding, regulations and Queen's priorities, all within a system evolving to offer learners more and richer opportunities and individualized choices.

Strategic objectives to achieve this goal include:

- **Develop a mature long-term structural model for the DME program.**

A dynamic balance between Kingston and distributed sites is needed, together with an ongoing, coordinated effort to maintain optimum matches for various disciplines / specialties and configurations to manage capacity, volumes, and critical mass at sites.

The following 4 categories provide some "bones" for understanding the topology of the network and managing the structure of the Distributed Medical Education program:

- 1) Queen's/Kingston-based Teaching Hospitals

These sites serve as the base for the program, with overarching responsibility for Undergraduate and Postgraduate medical education. This category incorporates Regional Education, led by the Assistant Dean, Distributed Medical Education.

- 2) Regional Academic Hubs

This type of site provides a full spectrum of medical education activities (PostGrad, UnderGrad and inter-professional, nursing, rehab and so on) and includes Satellite FM Residency, Comprehensive Integrated Clerkship, Multiple Clinical Teaching Units as well as Clinical Research. Support is provided to other major learning hospitals or nearby community hospitals. A Regional Director of Clinical Education leads it, with support from Queen's administration.

- 3) Major Community Partners

This category includes key sites for the Department of Family Medicine (satellite FM residency programs) and focused RCPS and/or UGME core rotations, with leadership provided by Regional Education Leads.

- 4) Community Teaching Sites

These sites at other hospitals, Family Medicine clinics and so on serve Family Medicine community residency rotations and core UGME rotations (primarily FM) and integrated clerkships.

Community Teaching Sites:

Kingston Health Sciences Centre (formerly KGH & Hotel Dieu) and Providence Care are considered part of Category 1 — Kingston-based Teaching Hospitals.

Lakeridge Health / Durham Region, is a Category 2 site — a Regional Academic Hub.

Humber River, Quinte Health Care, Peterborough, Brockville, Markham/Stouffville, and Weeneebayko Area Health Authority (Moose Factory) are currently Major Community Partners — Category 3.

It should be noted that ERMEP (Eastern Regional Medical Education Program) and ROMP (Rural Ontario Medical Program) are key partners.

Other strategic elements of the model:

- **Align this framework with the School of Medicine Strategic Plan**, particularly with respect to Partnership Priorities (i.e., “to advance targeted alliances and collaboration opportunities with regional academic and health system partners”).
- **Incorporate responses to social accountability priorities** as outlined by the Ministry of Health and Long Term Care. (This places emphasis on training medical learners in practice settings associated with under-serviced communities and with priority populations and patient groups — e.g. Frail and Elderly, Indigenous People, LGBTQ2S, French-language, low-income, rural/remote and northern communities, vulnerable populations and people receiving Palliative Care.) The model will also need to adapt to the shifting priorities and new initiatives of the South East LHIN.

The model should also strive to incorporate recommendations at Queen’s on **Truth & Reconciliation** as well as **Racism, Diversity & Inclusion**.
- **Enhance and formalize strategic alliances, charters and protocols with individual sites and programs** (like ROMP & ERMEP). Articulate, negotiate and confirm commitments with partners prepared to serve as academic learning sites.
- **Work closely to coordinate with Family Medicine and other programs** involved with regional sites and partners. While formal integration may not be a desirable/feasible goal (needs tend to vary from program to program, site to site), Queen’s and its brand would benefit from presentation of a common front. DME should pursue “opportunistic collaborations” to coordinate efforts or share resources. Joint planning approaches and ongoing communications will be essential.
- **Develop opportunities for new research relationships and partnerships** between Queen’s (Kingston) and the regional sites/distributed faculty (e.g. Lakeridge Health/Durham Region and Humber River Hospital). Examples include research rounds, joint research grants and potential sites for clinical trials.

□ Actively champion the value and need for Queen’s DME

DME’s operating environment involves a complex web of partners, learner needs, program needs, faculty/preceptor interests, research opportunities, working relationships, site and departmental priorities, mandates, brands, regulations, accountabilities, funding arrangements, timetables, community infrastructure, emerging technologies, and resource constraints.

The fortunes of Distributed Medical Education depend significantly upon a sustained effort to enlist stakeholder support — an ongoing campaign to eliminate barriers, generate engagement/momentum and sustain stakeholder motivation.

Strategic objectives to achieve this goal include:

- **Build support by advocating for the value and benefits of the DME program with all key decision-makers** within Queen’s as well as externally with various programs and regional sites, their boards and senior staffs, faculty/preceptors, program leads, community partners and so on.
- **Work with the Dean’s Office to enable options and ensure alignment** for distributed medical education approaches within the overall frameworks and priorities for the School Of Medicine, Faculty of Health Sciences, Queen’s, and various stakeholder governance bodies.
- **Make the case for strategic investments in DME** — for example, in technology, to enhance MEdTech for online evaluation of learners and regional preceptors, or the Common Credentialing System database of preceptors to know “who’s where”. Other strategic initiatives that may need investment to enable them include learner supports, faculty development activities, and/or building relationships with sites.
- **Promote Queen’s profile in DME settings** in ways that strengthen the Queen’s brand, lend prestige to regional sites, or help with learner or faculty recruitment.

TIMEFRAME: 2017–2022

Plans take on a different scope and flavour depending on the timeframe that applies. The perspective adopted for this plan is a timeframe of 3-5 years for the goals and priorities for the strategic plan, developed within a vision spanning 7 or 8 years.

❑ Forge close relationships in support of sites & faculty/preceptors

Without the convenience of close working relationships and nearby settings in Kingston, Distributed Medical Education must conquer and bridge the spaces that grow naturally with geographic distance, different traditions, identities, workplace cultures, contacts and contexts in distributed settings. A special effort is needed to ensure learner and faculty experiences at regional sites are delivered on a par with those in Kingston, close to the “mothership”.

Strategic objectives to achieve this goal include:

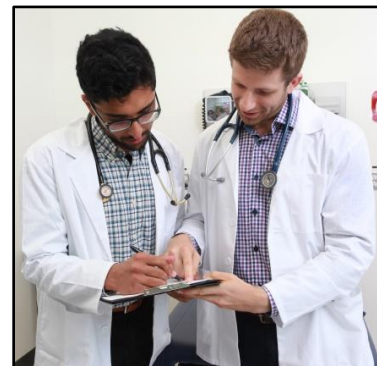
- **Develop strong program-level connections & working relationships**
It is critical to have close working relationships and strong, trusted connections at the level of individual disciplines and leads/program directors. This is where common interests and planning align, and operational opportunities, problems and most concerns are addressed in practice, with support from others on site. It would be further enabled by integration of distributed faculty within clinical departments.
- **Support the program-level connection with executive sponsorship**
While the glue of operational relationships exists at the program level, it requires the scaffolding of executive sponsorship — clear direction, high-level strategic leadership and support from site leadership/governance, Department Heads, Decanal Team and the Dean’s Office.
- **Increase visible “in-person” presence on site**
Personal on-site presence by departmental leadership, program directors and clerkship course directors needs to be elevated as a priority. Personal relationships, which are key to success, are built face-to-face. They are then more easily sustained by phone or digital means. The objective here is to reduce barriers (e.g. job mandates, travel expenses) and increase the number of annual visits to DME sites.
- **Provide more active support to education/program leads at DME sites**
Needs will vary from site to site, but examples include orientation manuals, awards & recognition, making connections to experts/specialists at Queen’s, providing DME program information and contacts, supporting site efforts to “sell” operational adaptations, investments and commitments to support learners, providing assistance with wellness supports for students (stress, mental health issues, isolation etc), along with helping community partners with succession and recruitment of preceptors and staff interested in education.
- **Improve infrastructure (especially technology) serving sites**
Increasingly, distance relationships require effective technology links for learners, preceptors, faculty in Kingston and DME staff. This will require continuing consultation and investment to keep up with expectations.

□ Make action on faculty engagement/development a priority

While learners are at the centre of the enterprise, those teaching make the experience work. They don't do it for the money (only a token stipend) and lose clinical practice time to their medical education role. Queen's (and the DME program) must do all it can to deliver on other benefits that appeal, motivate, develop and engage faculty at DME sites. It is important to work with distributed sites to develop a teaching environment that mitigates earnings losses and also offsets them with other benefits (such as sharing best practices from other sites).

Strategic objectives to achieve this goal include:

- **Outreach to connect with, engage and support faculty at distributed sites.**
Work with site leads, clinical leadership and hospital/site administration to support their engagement activities. Ideally, physicians are recruited for teaching roles from the outset: Work collaboratively to clarify the "value proposition" for preceptors and support their recruitment. Open up contacts at Queen's and opportunities to connect at various levels on research work.
- **Support ongoing efforts to design and adapt approaches that advance faculty / preceptor development**
(e.g. in terms of the amount, type, frequency, scheduling and focus of development activities). Respond to faculty learning needs identified by site leads and preceptors (e.g. around specific needs/topics of interest to the discipline, or pedagogical development to be more effective teachers). Deploy technology in effective ways to support changing development contexts and needs. Integrate faculty development activities as part of a broader engagement strategy.
- **Develop solutions that will provide faculty and preceptors with more timely feedback from learners.** This will likely require developing a modified policy and practices that will allow preceptors to receive timely feedback on their performance. It may involve another look at ways to handle confidentiality or providing easy options for learners to release their feedback. Directors and others may address trouble spots discreetly, diplomatically, and professionally.



□ Enhance DME’s organizational capacity, agility & resilience

Distributed Medical Education at Queen’s must continue to be a key strategic asset for the university and the School of Medicine. It contributes to quality, type and range of learning experiences, promotes the Queen’s brand, and supports student and faculty recruitment. It is a cornerstone for sustaining programs now, and would be the only real option for expanding capacity if and when enrolments grow.



If the Regional Education office is to contribute effectively in this important role, it must be fit for the challenge.

Strategic objectives to achieve this goal include:

- **Develop new/additional sources of funding, resources and support**
All opportunities should be explored, both internally within the School and also externally through new funding programs, project grants and sponsorships, leveraging partnerships, finding efficiencies and additional earned revenues. Options for Ministry funding through HOC (hospital operating costs) and HAC (hospital academic costs) —currently frozen— may open up at some later date.
- **Enhance databases and tools to track faculty and support evaluation**
Knowing “who’s where” and online evaluation tools must be priorities for distributed medical education. There are many opportunities that should be pursued to bring Regional Education systems up to standard, starting with database information tools, and administrative, communications and learning management systems.
- **Explore new options for collaborative service delivery**
Continue regular dialogue with internal Queen’s partners such as Family Medicine, Undergraduate and Postgraduate medical education offices, program directors and clerkship course directors to share a common approach to regional partners, solve emergent problems at regional sites, and leverage each other’s strengths to achieve efficiencies whenever opportunities present themselves.
- **Staff training and development; access to outside expertise as required**
Ongoing changes in policy, pedagogy, technology, social mores and approaches at various regional sites will require a continuing investment in expertise.
- **Make provision for succession/backup for risk at “single points of failure”.**
Manage the operational risks that attend thin staffing in a small office by acting on opportunities to build collaborative arrangements with other groups and offices, building “bench strength” to back up the members of the Regional Education office and ensure continuity. Some emphasis should also be placed on cultivating a pool of potential candidates to meet standard succession needs.

Measures of Success

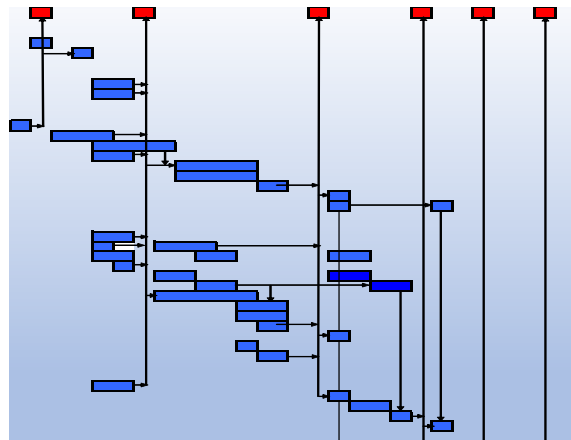
Measures of success relate to people being happy with the rotations — both learner satisfaction and also faculty/preceptor satisfaction. (In the shorter term, learner evaluations influence expectations for the regional experience, and bad experiences have a big impact.) The longer term contribution of learning experiences in community settings is to be found in the subsequent career success of Queen’s residents and clerks.

Implementation

Strategy is activated through operational plans that provide more specific direction for the work and identify responsibilities and timelines

— detailing who will do what by when.

Regional Education will be developing **specific workplans** to respond to the future challenges and opportunities outlined in this document and translating these strategic priorities into the ongoing activities and initiatives of the program.



It is expected that a high-level operational plan describing **implementation phases** will be presented to the Dean’s Office for review. Initially, they are likely to focus on:

- organizational and system infrastructure to support and manage growth,
- revitalizing the network of partnering sites, and
- marketing communications to position and promote the organization and its services effectively.

A successful roll-out of this strategic plan will depend on **effective two-way communications** and related efforts to develop understanding of its implications, both by internal audiences at Queen’s as well as community partners and the Ministry.

Related best practices in the areas of change management, capacity building, partnership relations and policy development will also be employed.

As with any well-managed implementation, progress on these strategic priorities will be reviewed regularly. **Operational plans will be updated** when necessary (as will the strategic plan itself, as appropriate from time to time).

This will help ensure the organization continues to anchor its activities in DME’s mission and vision, adapt to the latest evidence and best practices, and respond effectively to circumstances as they may change through 2022 and beyond.