



Postgraduate Medical Education
UNIVERSITY OF TORONTO

Task Force on Best Practices in PGME Program Support

FINAL REPORT

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EXECUTIVE SUMMARY

Introduction

Postgraduate Medical Education (PGME) residency programs at the University of Toronto (U of T) underwent a joint accreditation survey by the Royal College of Physicians and Surgeons of Canada (RCPSC) and the College of Family Physicians of Canada (CFPC) in April 2013. In the Joint Chairs' report, it was noted that resourcing of residency programs was deficient:

“Uneven support provided to many program directors and especially program administrators requires immediate attention. Exceptions noted were the departments of Pediatrics and Radiology. (A1.3.4).”

At the Dean's request, a Task Force on Best Practices in PGME Program Support (the Task Force) was created to investigate issues related to the report's findings and make recommendations for:

- A baseline for program resourcing for Program Director and program administration support for residency programs;
- Supports and services to be provided by faculty, clinical departments or the PGME Office for program sustainability; and
- An accountability framework for funds disbursed from PGME to clinical departments.

Dr. Patrick Gullane, Past Chair, Department of Otolaryngology - Head and Neck Surgery, was appointed by the Dean of Medicine to chair the Task Force, which had representation from department chairs, vice presidents of education, program directors, program administrators and managers, business officer and medical residents.

Methods

To better understand the issues related to residency program administration and associated supports, the Task Force undertook surveys of administrators who have a role in supporting residency programs, departmental medical education activities and hospital medical education offices (response rate = 84%), program directors (56%) and department chairs (100%).

The Task Force also conducted a scan of other PGME office across Canada and developed generic role descriptions for the program administrator and program director roles.

Contextual Considerations

The Faculty of Medicine (FOM) at the University of Toronto (U of T) is the largest medical school in Canada, with 77 residency programs. These programs are integrated across nine fully affiliated hospitals, 10 large community-based affiliated hospitals and eight special care institutions, many with multi-site locations and campuses. In addition, Family Medicine and other programs place their residents in dozens of teaching practice sites and individual doctor's offices.

Trainee enrolment figures vary greatly across clinical departments ranging from less than 10 to over 200 U of T residents, plus over 700 short-term elective trainees each year from other medical schools. In addition, fellowships make up approximately 40% of the PGME enrolment total.

The sheer number of programs and the multi-site nature of these programs create challenges in the delivery of postgraduate medical education that are unique to the U of T's PGME program. Programs have adapted their strategy for supporting residency programs by adding additional roles (e.g., site coordinators, associate PDs, administrative assistants) and centralizing some activities (e.g., scheduling) where there is critical mass to support this approach.

The Task Force believes that, in considering only the resources assigned to the roles of PA and PD, the total resource complement for any program could be greatly underestimated. The Task Force further believes that by not effectively communicating the availability and contribution of these additional resources to residency programs, the residency programs may not have provided the Accreditation Team with the full picture of the available resources.

Residency Administrative Support

During the preliminary focus groups and one-on-one interviews, participants often expressed surprise at the comment in the Joint Chairs' report that the supports from the PGME Office were deficient. Indeed, many participants spoke very highly of the prompt and helpful support they received from the PGME Office across a variety of topics. This finding was supported in the more formal survey, where 62% of respondents felt that the PGME Office supported them "well" or "very well".

Through the survey, PAs told the Task Force that:

- **Many were dissatisfied with their workload, particularly in peak periods.** Only 18% said they believe they have the time they need to complete all of their responsibilities, and 18% also reported a need for additional full-time staff to assist with the responsibilities. A further 47% believed they had sufficient time to complete their responsibilities except during peak periods once or twice a year.
- **The PA role is labour intensive.** Scheduling of rotations and other educational and clinical activities (e.g., academic half days, exams, social events) and orientation of new trainees were reported to be very time consuming. The PA respondents (74%) felt that the development of an electronic, central leave tracking system to be helpful (i.e., rated 4 or 5, where 5 is "highly helpful"), and 72% felt a scheduling system would be helpful.

Program Directors

Program Directors (PDs) also reported that they have been very or extremely well supported (i.e., 4 or 5 out of 5) by the PGME office (70%), their PAs (67%) and their department chairs (67%).

Similar to the PAs, PDs told the Task Force that:

- Many were dissatisfied with the time allocated to educational responsibilities. Only nine percent said they believed they have the time they need to complete all of their responsibilities; 54% reported that they are in need of additional faculty support.
- Many felt they did not have support for protected time. Thirteen percent felt they had no support and 13% had minimal support or did not have relief from other responsibilities.
- When asked about financial remuneration, 13% reported that they had "no support" and 30% reported "minimal support".

Funding and Accountability

Based on its investigations, the Task Force made the following observations:

- **Complexity of funding.** Medical education funding in Ontario is extremely complex. Funds are provided by a variety of sources in a variety of streams, with each stream directed to a variety of players in the medical education arena (e.g., universities, hospitals, physicians). In the University of Toronto Faculty of Medicine, the Dean's office engages clinical department chairs in an annual budget process. One component of this budget includes support for residency training based on government-funded trainee enrolment. In addition to the Dean's budget process, departments receive funding and in-kind support for residency programs from a variety of sources. The financial and in-kind supports vary by department.
- **Need for accountability.** Departments are not held directly accountable for achieving the educational mandate. The Task Force believes it is important for each department and program to develop and document a formal plan of how it will achieve its educational mandate. By creating a unique template for each department, the Task Force is recognizing and honouring the distinct and unique contributions that the university, hospital sites and practice plans bring to the university's mission.
- **Need for Transparency.** The current level of support for residency programs provided by the department or external sources (financial, protected time and in-kind) is not currently known. The determination, allocation and deployment of these funds are not transparent processes. The Task Force believes that it is important for the PD and the PGME Office to understand the full extent of the resources that are being made available to the residency program and how those resources are used to achieve the educational mandate.

Conclusions

The Task Force was encouraged by the level of engagement by PAs and PDs in this activity and by their willingness to identify elements that are working as well as those that require improvements. In general, survey respondents were relatively satisfied with the level of support provided by the PGME Office and somewhat less satisfied with the supports provided by their clinical departments.

The consultations and surveys, however, did highlight a number of pressure points that require attention, especially in the resources assigned to accomplish the required responsibilities, supports to streamline and/or automate work where possible, and the high degree of variation in supports between clinical departments (e.g., allocated or protected time, financial remuneration). Many respondents expressed a desire for the PGME Office to take a more active role in advocating for needed supports.

The support structures and related funding for the U of T's residency programs are complex, and not easily compared to the more straightforward roles of program administrator and program director at other universities, which may have contributed to the Accreditation Team's statement on supports for these roles. Through improved communication, and greater transparency and accountability in the funding of supporting resources, the Task Force believes that the U of T will go a long way to address the issue of "uneven support" for these roles.

Recommendations

Recommendation 1: That each Department develop or maintain an organizational chart for each program and position descriptions (e.g., program directors, program administrators, site directors) with explicit expectations for each position.

Recommendation 2: That the PGME portfolio, in consultation with residency administrative support, program directors and department chairs, identify priority investments for supporting PAs and PDs.

Recommendation 3: Using the role description as a starting point, the department chair, division head, and hospital chief or practice plan should explicitly agree with each program director on the amount of protected time that is required to fulfill these responsibilities.

Recommendation 4: That, as part of the development of his or her role description, each program director assess, in consultation with the Chair (or Vice Chair or delegate) and Dean (or Vice Dean or delegate), the type and level of administrative support that will be required, and share this with the department chair and the division head to ensure that adequate supporting administrative resources are assigned. This process should be revisited for internal reviews and the accreditation preparation cycle.

Recommendation 5: That each program director document an academic planning cycle that is shared with the Clinical Chair or division head clearly identifying the periods during the academic year when the workload is greater than usual (e.g., preparing for internal reviews and accreditation, CaRMS) and ensure that all internal stakeholders are aware of the need for relief from other responsibilities so that the PD and PA can concentrate on these activities.

Recommendation 6: That the Dean of Medicine ask each department to develop a working group that includes a delegate of the department chair (e.g., vice chair education or equivalent) and a delegate of the Dean (e.g., from the PG office) to examine various models to support residency programs including centralization and consolidation of current funding streams and distribution of funds based on a mix of enrolment and evidence-based project submissions.

Recommendation 7: That the Program Director, as an early task after being appointed, develop and document an explicit operational plan and formal budget for PGME-related activities that is aligned with the strategic plan of the faculty and department, and PGME and aligned with accreditation standards.

1. INTRODUCTION

1.1. PGME Accreditation 2013

Postgraduate Medical Education (PGME) residency programs at the University of Toronto (U of T) underwent a joint accreditation survey by the Royal College of Physicians and Surgeons of Canada (RCPSC) and the College of Family Physicians of Canada (CFPC) in April 2013. In the Joint Chairs' report, it was noted that resourcing of residency programs was deficient:

“Uneven support provided to many program directors and especially program administrators requires immediate attention. Exceptions noted were the departments of Pediatrics and Radiology. (A1.3.4).”

Jurisdiction of this issue is under the Dean's Office and clinical department leadership. At the Dean's request, a Task Force on Best Practices in PGME Program Support (the Task Force) was created to investigate the issues related to the report's findings and make recommendations to correct the deficiency.

1.2. Task Force on Best Practices in PGME Program Support

The mandate of the Task Force was to:

- Review current levels of release time/financial support for Program Directors and/or delegates to effectively fulfill their roles in residency programs;
- Undertake a gap analysis regarding administrative support required by Program Directors and that which is provided by Departments;
- Initiate an environmental scan of current support structures and administrative practices at other Canadian PGME Offices; and
- Develop recommendations regarding:
 - A baseline for program resourcing for Program Director and program administration support for residency programs;
 - Supports and services to be provided by faculty, clinical departments or the PGME Office for program sustainability; and
 - An accountability framework for funds disbursed from PGME to clinical departments.

The terms of reference for the Task Force are provided in Appendix A.

Dr. Patrick Gullane, Past Chair, Department of Otolaryngology - Head and Neck Surgery, was appointed by the Dean of Medicine to chair the Task Force. Dr. Gullane was supported by representatives from the following roles:

- Department chair,
- Vice president education,
- Program directors (at least one representing a small and 1 representing a large program),

- Program administrators and managers,
- Business officers representative, and
- Medical resident (appointed by the Professional Association of Residents of Ontario (PARO)).

Representatives from the PGME Office, including the Vice Dean PGME, participated as ex officio members. The Task Force was supported by an external consultant.

A list of the Task Force members is provided in Appendix B.

2. METHODS

The Task Force undertook a number of surveys to better understand the issues related to residency program administration and associated supports:

- A survey of administrators who have a role in supporting residency programs, departmental medical education activities and hospital medical education offices regarding their administrative roles and their perceptions on the current and desired supports available to them in this role.
- A survey of program directors regarding their roles and perceptions of the supports available to them.
- A survey of department chairs to develop an understanding of the approach of each department to supporting its residency programs and to identify any issues related to providing that support.
- A survey of PGME offices at other medical schools across Canada.

The Task Force also developed generic role descriptions for the program administrator and program director roles.

The findings from the surveys and the role descriptions were discussed by the Task Force members to identify opportunities and challenges in supporting these administrators and to make recommendations for enhanced supports.

2.1. Surveys

2.1.1. Program Administrator Survey

As one input to the preparation of the survey for program administrators (PAs), PGME engaged a consultant to conduct focus groups and one-on-one interviews with administrative stakeholders. The findings from these consultations were documented in a report to the PGME Office in June 2013.¹

Building on the feedback from these consultations, the Task Force developed a web-based survey instrument that was sent to 117 administrators, including program administrators and representatives of medical education and business offices. The survey requested information on their program(s) and their role within the program, as well as their opinions on the time and supports available from the PGME Office, their program director and their clinical department to fulfill their responsibilities. A copy of the survey is provided in Appendix C.

A \$10 gift certificate was offered as an incentive to complete the survey. Ninety-eight administrators responded to the survey, yielding a response rate of 84%. Several surveys were incomplete; the 75 fully completed surveys yielded a response rate of 64%.

A preliminary analysis was conducted showing the simple frequencies of responses to each question. A supplementary analysis was later conducted to determine whether there was an identifiable subset of respondents that were consistently unsatisfied with the provided support. This analysis found that

¹ Focus Groups and Interviews with Administrators Supporting PGME, CONFIDENTIAL REPORT June 20, 2013.

there was no consistently “unhappy” cohort within the administrative support group. A presentation of the survey results is provided in Appendix D.

2.1.2. Program Director Survey

A second web-based survey was prepared for the Program Directors (PDs), building on the content of the PA survey. Many questions were identical to facilitate comparisons between the two groups. A copy of the PD survey is provided in Appendix E.

A preliminary analysis was conducted showing the simple frequencies of responses to each question. In addition, key questions were also analyzed based on the size of the PD’s program (i.e., number of residents currently enrolled) and how long the PD had been in the role. A presentation of the survey results is provided in Appendix F.

Seventy-nine PDs were invited to complete the survey. We received 44 completed surveys (response rate of 56%) and two partially completed surveys.

2.1.3. Chair Surveys

A short survey was prepared for the Department chairs, asking for information on the types of supports provided to the programs, and their views on areas of need and issues related to the delivery of residency education in their department. A copy of the department chair survey is provided in Appendix G.

The survey was distributed via email with a request to complete and return the email (or attached word document) to the PGME Office. All 13 department chairs responded to the survey, for a response rate of 100%. Responses to the six questions were summarized by topic, with any information removed that could identify the respondent or his or her department. The summary survey results are provided in Appendix H.

After the three surveys were analyzed and discussed during at the third Task Force meeting, it was agreed that a second survey of the chairs would be administered, asking for more detailed information on the financial and related supports (e.g., protected time) provided to program directors within each department. A copy of the second department chair survey is provided in Appendix I. Thirteen chairs responded to the survey, yielding a response rate of 100%. The summary survey results are provided in Appendix J.

2.1.4. Survey of PGME Offices

A representative of the PGME Office contacted its counterpart in each of the other 16 medical schools in Canada to solicit information on the supports provided to PAs and PDs for their residency programs. Ten of the 16 schools provided information, which is presented in Appendix K.

2.2. Role Descriptions

Building on the descriptions of their work responsibilities described by the PAs who responded to the survey and existing role descriptions for a sample of programs, the Task Force developed a generic role description for the PA role. Based on the feedback from the survey respondents, the Task Force chose to re-label this role as “Residency Administrative Support” to reflect the many different titles (e.g., program administrator, program coordinator, program administrative assistant, site coordinator) that

are currently in use for administrators involved in the residency programs. The role description is provided in Appendix L.

A role description for the position of program director was developed for the University of Toronto Faculty of Medicine residency programs in 2007. This document was revised to incorporate information provided on the PD survey and to reflect recent work that has been completed on the skills and competencies required to fulfill the responsibilities of this position. The generic role description is provided in Appendix M.

2.3. Synthesis and Analysis

The Task Force met four times from October 2013 to March 2014. During this time, the Task Force considered the results of the various surveys and, under the guidance of the Task Force Chair, developed a consensus opinion on recommendations for best practices in PGME Program Support at the University of Toronto.

3. CONTEXTUAL CONSIDERATIONS

The Faculty of Medicine (FOM) at the University of Toronto (U of T) is the largest medical school in Canada, with 77 residency programs. These programs are integrated across nine tertiary care hospitals, 10 large community-based hospitals, and eight special care institutions, many with multi-site locations and campuses. In addition, Family Medicine and other programs also place their residents in dozens of teaching practice sites and individual doctor’s offices. A list of the main affiliated teaching sites is displayed in the table below.

Table 1: Affiliated Teaching Sites, University of Toronto Faculty of Medicine, 2014

Full Affiliates	Community Affiliates	Community Affiliates – Special Care
• Baycrest Centre for Geriatric Care	• Humber River Hospital	• Bridgepoint Active Healthcare
• Centre for Addiction and Mental Health	• Lakeridge Health	• George Hull Centre for Children and Families
• Holland Bloorview Kids Rehab Hospital	• Markham Stouffville Hospital	• The Hincks-Dellcrest Centre
• Mount Sinai Hospital	• North York General Hospital	• Providence Healthcare
• St. Michael’s Hospital	• Royal Victoria Regional Health Centre	• Surrey Place Centre
• Sunnybrook Health Sciences Centre	• Southlake Regional Health Centre	• West Park Healthcare Centre
• The Hospital for Sick Children	• St. Joseph’s Health Centre	• Ontario Shores Centre for Mental Health Sciences
• University Health Network	• The Scarborough Hospital	• Waypoint Centre for Mental Health Care
• Women’s College Hospital	• Toronto East General Hospital	
	• Trillium Health Partners	

Trainee enrolment figures vary greatly across clinical departments, as well as the number of programs administered under each department structure. Although the RCPSC/CFPC accreditation concerns residency programs, fellowships make up approximately 40% of the PGME enrolment total. Some individual residency programs manage an enrolment of over 200 U of T residents, while other sub-specialty program total enrolment is less than 10. In addition, PGME programs host over 700 short-term elective trainees each year from other medical schools across Canada, which are not reflected in the enrolment data in Table 2 below.

Table 2: University of Toronto PGME Trainee Enrolment 2013-14 (Residents, Clinical and Research Fellows)

Department, Division or Interdepartmental Unit	# of programs	Fellows	Residents	TOTAL
Anesthesia	1	120	102	221
Critical Care	1	39	16	55
Diagnostic Radiology	4	104	71	172
Family Medicine	5	20	431	451
Laboratory Medicine	6	33	52	85

Department, Division or Interdepartmental Unit	# of programs	Fellows	Residents	TOTAL
Medical Genetics	1	7	13	20
Medicine	19	354	529	872
Obstetrics & Gynaecology	4	46	77	123
Ophthalmology	1	34	33	67
Otolaryngology-Head & Neck Surgery	1	24	26	50
Paediatrics	14	226	168	390
Paeds Critical Care	1	20	5	25
Palliative Medicine	1	1	5	5
Psychiatry	4	58	190	248
Public Health & Preventive Med	1	0	22	22
Radiation Oncology	1	30	31	60
Surgery	11	257	266	523
Clinician Investigator Program	1			
Total *	77	1371	2036	3386
*Totals may not add due to changes in level/program during session				

The sheer number of programs and the multi-site nature of these programs create challenges in the delivery of postgraduate medical education that are unique to the U of T's PGME program. The traditional approach of managing a residency program primarily through the efforts of a program director (PD) and program administrator (PA) cannot possibly meet the needs of many of the U of T's programs, and has been enhanced in a number of ways:

- For large, multi-site programs, an additional role of site coordinator or site director has been created. This role takes on some of the responsibilities for liaison with hospital representatives and residents, as well as managing many on-site logistics on behalf of both the PA and the PD.
- Some of the larger programs have introduced roles to assist the PA (e.g., program administrative assistant) or the PD (e.g., associate program director).
- Some programs have introduced the role of research coordinator to relieve the PA or PD of responsibilities related to research activities. Similarly, some programs have created a role of education coordinator.
- Faculty within each program might assist the PD (e.g., organizing academic half days).
- Some activities have been centralized (e.g., for Family Medicine, the rotation scheduling function is assigned to a single position).

The Task Force believes that, in considering only the resources assigned to the roles of PA and PD, the total resource complement for any program could be greatly underestimated. Accordingly, any comparison with staffing levels for PAs and PDs at other universities (per the survey of other PGME offices across Canada), is likely not meaningful.

The Task Force further believes that by not effectively communicating the availability and contribution of these additional resources to residency programs, the residency programs may not have provided the Accreditation Team with the full picture of the available resources. Indeed, it was noted that, for the Radiology Department, which was singled out in the Joint Chairs' Report as being well supported, these

additional resources were well communicated. Lack of support for the program had been identified as a weakness in the 2007 Diagnostic Radiology program review; for the 2013 review, the PD communicated the current level of support by using a map of all supports provided to the PD from the chairs program and from the hospital sites. The documentation included percentages of time from hospital site administrative assistants and extra help provided during the Canadian Resident Matching Service (CaRMS).

Recommendation 1: That each Department develop or maintain an organizational chart for each program and position descriptions (e.g., program directors, program administrators, site directors) with explicit expectations for each position.

The Task Force developed a generic role description that can be used as a starting point and tailored for each program (see Appendix L). Where these responsibilities are shared with other positions, detailed role descriptions should also be developed for each position that supports the residency program. The Task Force should also ensure that each position's contribution to the residency program and educational objectives of the department is recognized and rewarded. These materials should be used to communicate to internal and external stakeholders the department's strategy for supporting each program and its program directors, program administrators and site directors.

4. RESIDENCY ADMINISTRATIVE SUPPORT

The response rate of 64% (completed surveys only) suggests that discussions about supports in their administrative roles are important to program administrators. The Task Force was impressed by the high level of participation in the survey, as well as the thoughtful comments provided by many respondents. An analysis of the characteristics of the respondents suggests that this subset is reasonably representative of the full population of administrators.

A PowerPoint presentation showing the responses to the survey questions is provided in Appendix D. In this section, a summary of the high-level results is presented, with some analysis of the implications for the PGME Office's strategy for supporting these administrators.

4.1. PA Survey Results

4.1.1. High Level of Satisfaction with Supports Provided

During the preliminary focus groups and one-on-one interviews, participants often expressed surprise at the comment in the Joint Chairs' report that the supports from the PGME Office were deficient. Indeed, many participants spoke very highly of the prompt and helpful support they received from the PGME Office across a variety of topics.

This finding was supported in the more formal survey. Fifty (62%) of respondents felt that the PGME Office supported them "well" or "very well"; only three respondents (four percent) said they received minimal support. Similarly, 90% reported that they were well supported by their PD.

"The PGME office provides excellent support, even vague requests for information are dealt with in a timely fashion."

I have been a postgraduate coordinator for over 20 years and can wholeheartedly say that PGME has been the best resource for my work."

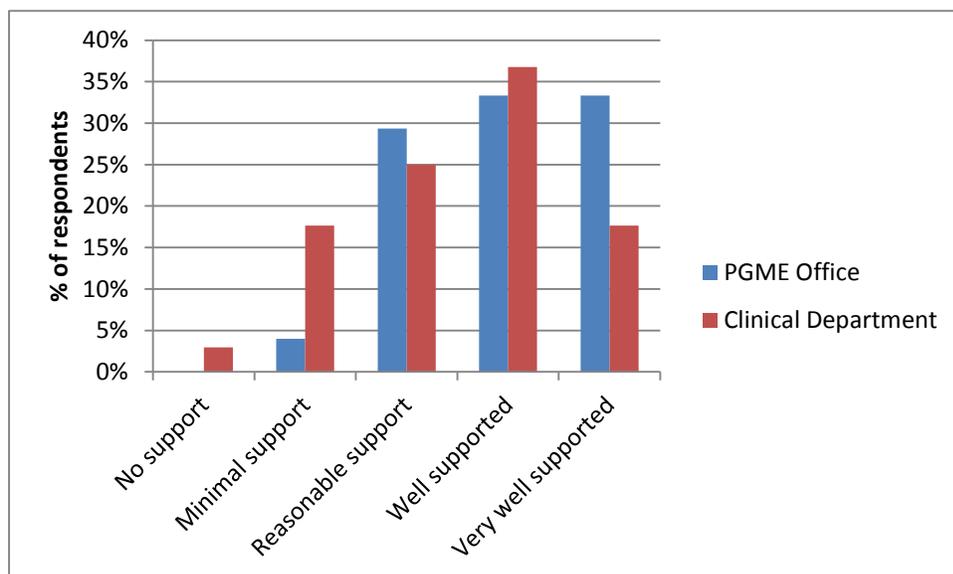
"I think the PGME office does a great job of responding to my inquiries. I have never had a problem with getting help."

PGME Administrator Survey, 2013

Administrators felt less well supported by their clinical departments, with 37% reporting that they were well or very well supported. Additional supports desired by the administrators included opportunities for training and professional development (52% rated this 4 or 5, where 5 was "fully agree" that it would be helpful); additional seasonal staff (45%) and more mentoring opportunities (44%).

A comparison of the perceptions of support from the PGME Office and the clinical departments is shown graphically in Figure 1.

Figure 1: Satisfaction with Support from the PGME Office and the Clinical Department



Source: PGME Administrator Survey, 2013

4.1.2. Dissatisfaction with Workload

When asked if the amount of their workday allocated to the residency program was sufficient, only 18% said they believe they have the time they need to complete all of their responsibilities. Eighteen percent also reported a need for additional full-time staff to assist with the responsibilities. Although the amount of time the PA is dedicated to the program is not PGME’s decision, some respondents felt that the PGME Office should establish minimum guidelines for determining the appropriate FTE allocation based on key program variables (e.g., number of residents). PG Offices at selected Canadian medical schools who have adopted such a rubric were referenced.

“The PGME office should reach out to affiliated teaching hospitals and understand the workload of the administrator and revisit the role of medical education within the community teaching hospitals.”

The PGME should advocate for the Program Assistants as well as the medical learners to ensure the learners are receiving an optimal learning experience within their residency / rotations and to also ensure the PA is not overworked.”

PGME Administrator Survey, 2013

A further 47% believed they had sufficient time to complete their responsibilities except during peak periods once or twice a year. Similarly, 45% said they need additional seasonal staff. This information is consistent with the description of the workload where managing the CaRMS match, which is concentrated in a relatively short period of time, is reported to be a significant part of annual responsibilities. Given the nature of the administrative activities, it is unlikely that providing a pool of administrators to support peak period workload would be a practical strategy due to the complexity of the tasks. The Task Force believes that a new administrator would not have sufficient time to become proficient enough during a temporary assignment to provide value to the process.

4.1.3. Required or Desired Supports

The top-rated supports that administrators would like PGME to provide were an orientation manual (90% rated it as 4 or 5 out of 5) and an orientation manual for new PAs (89%). Based on survey results, six PAs had been in the role less than a year, and 30 were in the role between one and three years. This translates into 36 in the role with less than three years of experience.

Additional desired supports from PGME were a contact list for all PDs and PAs (88%), a calendar of the PGME activities in the academic year (96%), technology tools (84%), and workshops as refreshers or to share best practices (80%). The preferred delivery strategies for supports included printed or electronic reference manuals (71%) and quarterly workshops with peers in a classroom setting (71%).

The top technology solutions (i.e., rated 4 or 5, where 5 meant “would be highly helpful”) were a colour printer (85%), enhanced reporting in POWER (85%), an on-line application system for fellows (85%), and access to additional software (83%). It was noted by the Task Force that some of the technology tools identified were outside of the scope of the PGME Office.

The top three activities, tasks and procedures that administrators thought should be delivered centrally by the PGME Office were POWER training (92%), on-line forms for the completion of pre-entry assessment program (PEAP) and assessment verification period (AVP) (84%), and professional development for administrators (81%). The Task Force was surprised that electronic support for scheduling was ranked relatively low (31% for vacation scheduling and 30% for rotation scheduling).

4.2. Role Description

Building on the feedback from the focus groups, one-on-one interviews and survey results, the Task Force developed a generic role description for residency administrative support. Based on this feedback, the role has been retitled as “Residency Administrative Support” in recognition of how many of the traditional program administrator responsibilities are shared by other members of the residency program team (e.g., site coordinators, administrative assistants), particularly in large, multi-site programs. The Task Force encourages each department to tailor the role description based on how it has organized resources to provide these services

4.3. Observations on the Survey Results

4.3.1. The PA Role Is Labour Intensive

Much of the PA’s day is consumed with labour-intensive activities that are not easily automated. For example, the scheduling of rotations – and subsequent revisions due to a variety of factors including requests for leaves – is reportedly a significant element in the PA’s workload. Scheduling of other educational and clinical activities (e.g., academic half days, exams, social events) was also reported to be very time consuming. The PA respondents (74%) felt that the development of an electronic, central leave tracking system to be helpful (i.e., rated 4 or 5, where 5 is “highly helpful”), and 72% felt a scheduling system would be helpful.

The orientation and registration for new trainees is also a labour-intensive activity, which was noted in the focus groups, one-on-one interviews and the survey as a major contributor to workload. This is especially true for the accreditation of international fellows.

As noted in the previous section, the PAs also identified a number of activities that they felt could be administered centrally by PGME, thereby reducing the PA's workload. (See Section 4.1.3.)

4.3.2. Not a "One-Size-Fits-All" Role

The survey responses described a heterogeneous group in which individual roles varied substantially depending on, for example:

- The size of the program,
- The number of programs for which support was provided,
- The work location (e.g., academic health science centre vs. campus office, inside or outside of the downtown core),
- Whether the administrator also supported fellows in addition to residents,
- The administrator's tenure in the role (ranging from less than 10 months to more than 10 years), and
- Whether support for the residency program was a full-time or part-time assignment.

It was clear from the responses that there is no "one size fits all" role description for these administrators.

Recommendation 2: That the PGME portfolio, in consultation with residency administrative support, program directors and department chairs, identify priority investments for supporting PAs and PDs.

The PGME portfolio is encouraged to use the results of the PA and PD surveys to identify the supports that would be most useful (e.g., reference materials, the streamlining or automation of some tasks, central administration of some activities, tasks and procedures, or other resources as appropriate).

See also Recommendation 1 regarding the use of generic role descriptions developed by the Task Force that can be tailored to the specific responsibilities within a program.

5. PROGRAM DIRECTORS

The response rate of 56% (completed surveys only), although slightly lower than for the administrators, still indicates that discussions about supports in the program director role are important to the respondents. An analysis of the characteristics of the respondents suggests that this subset is reasonably representative of the full population of PDs.

A PowerPoint presentation showing the responses to the survey questions is provided in Appendix F. In this section, a summary of the high-level results is presented, with some analysis of the implications for the PGME Office's strategy for supporting the PDs.

5.1. PD Survey Results

5.1.1. High Level of Satisfaction with Supports Provided

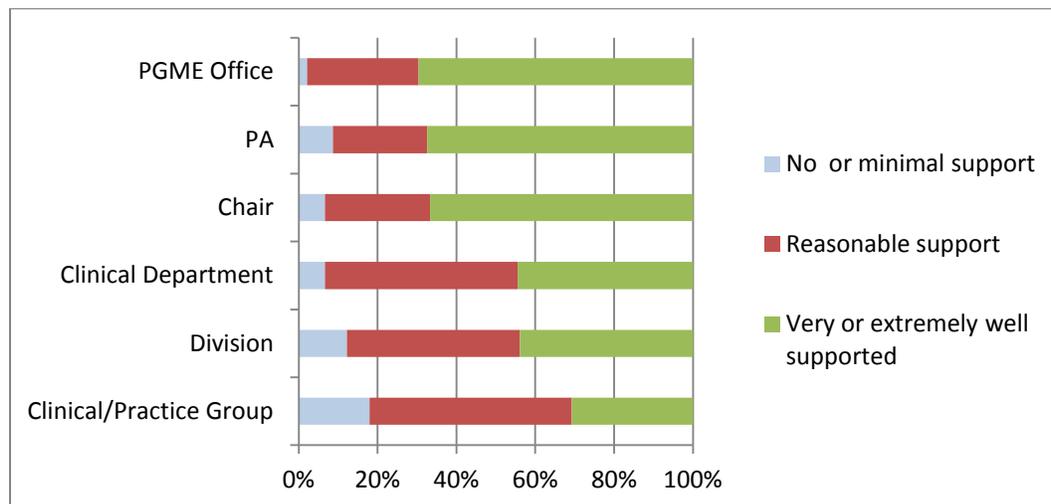
Program Directors reported that they have been very or extremely well supported (i.e., 4 or 5 out of 5) by the PGME office (70%), their PAs (67%) and their department chairs (67%). In these three groups, no respondents reported that they had no support, and only one (PGME Office) to three (PAs and Chairs) respondents reported they had minimal support.

Similar to the administrators, PDs felt less well supported by their clinical departments (44% rated very or extremely well supported), their divisions (44%) and their clinical practice groups (31%). A summary of the ratings by source of support is provided graphically in Figure 2.

An analysis of the degree of satisfaction with the various sources of support revealed that, in general:

- The larger the program, the better the PDs have felt supported by the PGME Office, their Chair, their PA and their Clinical Practice Group.
- The longer the tenure of the PD, the less well supported he or she feels (except that the reverse was reported for support from the PGME Office).

Figure 2: PDs' Perceptions of Support (rated "very or extremely well" supported)



Source: PD Survey, 2014

5.1.2. Dissatisfaction with Time Allocated to Role

When asked if the amount of their workday allocated to the residency program was sufficient:

- Only nine percent said they believed they have the time they need to complete all of their responsibilities.
- A further seven percent believed they had sufficient time to complete their responsibilities except during peak periods once or twice a year.
- Seventeen percent reported that they would have sufficient time if they had additional administrative support; 54% reported that they are in need of additional faculty support.

Many PDs also reported that they felt they did not have support for protected time (13% no support and 13% minimal support) or did not have relief from other responsibilities (13% no support and 41% minimal support).

“Relief from some of my other divisional activities would be welcome.”

“There is no additional protected time and my clinical obligations/duties remain very heavy.”

PD Survey, 2014

A further analysis of perceptions of the time available for residency program responsibilities revealed that, in general:

- PDs with programs of 10 or fewer residents were more likely to feel “very well” or “extremely well” supported with relief from other responsibilities (38%) and protected time (43%).
- PDs with three or fewer years of experience are more likely to feel “very well” or “extremely well” supported with relief from other responsibilities (33%) and protected time (33%).

There was concern expressed anecdotally by some PDs that they were not protected from clinical or other responsibilities during peak periods. When asked about constraints affecting the delivery of residency education, 11 (of 34 respondents) noted that time is a constraint, and another three noted pressures to provide services.

5.1.3. Dissatisfaction with Financial Remuneration

When asked if the financial remuneration for residency program responsibilities was sufficient, 13% reported that they had “no support” and 30% reported “minimal support”.

“Financial support doesn't really match time spent and degree of responsibility but I am not doing this for the money.”

“Need to be able to pay fair market rates for such a job.”

“PD typically do it as education is important, however, there should be common compensation across all programs. It should NOT be dependent on department and division.”

“My Division director has provided supplemental financial support which has been a help, but she should not need to do this”

PD Survey, 2014

5.1.4. Required or Desired Supports

When asked about constraints affecting the delivery of residency education, nine (of 34) reported the lack of faculty or departmental support, and seven reported a lack of administrative support.

The top-rated resources and activities (rated 4 or 5 where 5 meant “fully agree they would be helpful”) were training for remediation and residents in difficulty (77%), training in Royal College standards (67%), a work shop in curriculum planning (64%) and protected time to attend conferences (57%). In general, PDs with a program of greater than 10 residents and three or fewer years in the role were more likely to find these resources and activities helpful.

The top-rated technology solutions (rated 4 or 5 where 5 meant “fully agree they would be helpful”) were portfolios (74%), case logs (70%), electronic, central vacation and leave tracking (67%), a scheduling system (60%) and an enhanced ability to generate paper and electronic reports in POWER (59%). In general, PDs with a program of greater than 10 residents were more likely to find these resources and activities helpful.

The top three activities, tasks and procedures that PDs thought should be delivered centrally by the PMGE Office were professional development for administrators (84%), POWER training (82%), on-line pre-survey questionnaires (72%), a library of best practices (68%), on-line completion of pre-entry assessment program (PEAP) and assessment verification period (AVP) forms (67%), and evaluation and statistical reports (65%). PDs with four or more years in their role were slightly more likely to agree that central administration would be helpful for these activities.

5.2. Role Description

Building on the survey results, the Task Force developed a generic role description for program directors (see Appendix M). The duties for the program director that are included in Recommendations 3, 4 and 5 have been included in the role description.

5.3. Observations on the Survey Results

5.3.1. Need for Protected and Remunerated Time

The responses from the PDs clearly indicated that they need more time to complete their residency responsibilities. The Task Force heard anecdotal evidence that some PDs had no protected time during work hours (e.g., 9:00 am to 5:00 pm, Monday to Friday) and were expected to fulfill their program obligations on evenings and weekends.

The Task Force believes that the educational mandate is an important part of every practice's role, and should be properly resourced. The specific responsibilities for each PD, as well as the anticipated time required to execute these responsibilities should be agreed to by the department chair, division head, hospital chief or practice plan, and PD when the PD is first appointed, and reviewed whenever circumstances change.

Recommendation 3: Using the role description as a starting point, the department chair, division head, and hospital chief or practice plan should explicitly agree with each program director on the amount of protected time that is required to fulfill these responsibilities.

The Task Force developed a generic role description that can be used as a starting point and tailored for each program (see Recommendation 1 and Appendix M). Where these responsibilities are shared with other positions, detailed role descriptions should also be developed for each position that supports the residency program.

5.3.2. Need for Sufficient Administrative Support

The PA and PD work very closely together, and each relies heavily on the other for support. The PAs reported a high degree of support from their PDs, and, conversely, the PDs reported a high degree of support from their PAs. However, some PDs (17%) did note that they would have sufficient time to follow through on their program responsibilities if they had additional administrative support.

The Task Force members felt that the role of residency administrative support was critical to the success of the program director. Accordingly, it is important that the PDs have sufficient administrative support to ensure the PD's time is used effectively and efficiently.

Recommendation 4: That, as part of the development of his or her role description, each program director assess, in consultation with the Chair (or Vice Chair or delegate) and Dean (or Vice Dean or delegate), the type and level of administrative support that will be required, and share this with the department chair and the division head to ensure that adequate supporting administrative resources are assigned. This process should be revisited for internal reviews and the accreditation preparation cycle.

5.3.3. Need for an Academic Planning Cycle to Manage Peak Workloads

Both the PA and PD felt that there were peak periods in the academic year that required a greater than usual effort (e.g., CaRMS, orientation). The Task Force members felt it was important that the need for additional protected time during these periods be recognized and honoured by all stakeholders. Specifically, PDs may need additional relief from clinical and other activities during these peak times.

Recommendation 5: That each program director document an academic planning cycle that is shared with the clinical chief or division head clearly identifying the periods during the academic year when the workload is greater than usual (e.g., preparing for internal reviews and accreditation, CaRMS) and ensure that all internal stakeholders are aware of the need for relief from other responsibilities so that the PD and PA can concentrate on these activities.

6. DEPARTMENTAL CHAIRS

All 13 of the department chairs responded to both surveys. An anonymized listing of first survey responses is provided in Appendix H and of the second survey in Appendix J. As with the other two surveys, the high response rate confirms that the supports for the residency programs are an important topic of discussion for the chairs.

6.1. The Greatest Needs

According to the department chairs, the areas of greatest need for the residency programs include:

- Financial support (e.g., greater financial support from the Dean to reduce the burden on practice plans, protection from declining budgets, funding to support courses, research projects and graduate degrees, funding to attend national or international scientific meetings).
- Hospital infrastructure (e.g., equipment, human resources such as nurse practitioners, physician extenders, hospitals and technical staff, and operating room resources).
- Administrative support, to ensure that program directors are not overly burdened with administrative tasks.
- Challenges associated with changes in accreditation standards of the two colleges.
- Health human resources planning, particularly in the tension between service needs and career opportunities for graduates.

Chairs also acknowledged the constraints put on the residency programs by service demands that are creating a 'conflict' between clinical responsibilities and time for teaching (five responses) and the need for adequate administrative support, including clear expectations of administrative requirements.

Although the Task Force suspected that variability of services and equipment across training sites might be a significant issue for residency programs, only one chair felt that it was significant. Indeed, some programs felt that the variability makes a positive contribution to the learning experience.

6.2. Future Challenges

Looking forward, chairs saw a number of changes expected to affect medical education in the next five years:

- Competency-based education (mentioned by seven of the 12 chairs),
- Decentralization into community sites (three responses),
- Technology (especially simulation) (three responses),
- Reductions in resident work hours (three responses).

6.3. Support for the Program Directors

All but two programs reported that the PD is paid a stipend. The two exceptions are described as follows:

- Medical staff within one of the programs is paid through an alternative funding plan (AFP), and the department simply we adjusts the job profile description to include the duties of this role.

The PD experiences no loss of income, nor does he/she gain any income for these responsibilities.

- Within another department, the overall staffing level of physicians in each fully-affiliated hospital is sufficient to allow for the PD based at a given site to carry out his/her responsibilities in fulfillment of Royal College accreditation standards.

Based on the 25 programs that provided both the amount of the stipend paid by the department and the number of days the PD was expected to dedicate to PGME responsibilities:

- The average time dedicated to PGME responsibilities is 1.5 days (mean and median days).
- The median stipend per half day of time was \$20,000 in medical programs and \$8,667 in surgical programs.² Additional detail is provided in Appendix J.

About one-half of the chairs explicitly stated that they would support the consideration or even introduction of an algorithm to assist the departments in estimating the amount of time that would be required by each PD.

² **CAUTION.** These figures are calculated from data provided by the survey respondents. The data represent a subset of respondents who provided all required variables, and some assumptions have been made to facilitate the analysis. These numbers may not be fully representative of the entire population of programs.

7. FUNDING AND ACCOUNTABILITY

7.1. Complex Funding Arrangements

Medical education funding in Ontario is extremely complex. Funds are provided by a variety of sources (MOHLTC, MTCU, OMA Agreement, learners) in a variety of named funding types such as Geographic Full-Time Professor, Basic Income Units, Canadian Medical Graduates (Pool A), International Medical Graduates (Pool B), and Sponsored Trainees (Pool C). Each source and type of funding is directed to a variety of players in the medical education arena (universities, hospitals, physicians). Each Faculty of Medicine in turn has individual methods of calculation and distribution of its funding to the clinical departments, based on a number of factors.

In the University of Toronto Faculty of Medicine, the Dean's office engages Clinical Department Chairs in an annual budget process. One component of this budget includes support for residency training based on government-funded trainee enrolment.

In addition to the Dean's budget process, departments receive funding and in-kind support for residency programs from a variety of sources:

- The PGME Office distributes the IMG Supplementary funding (Pool B) from the Ontario Ministry of Health to departments based on enrolment.
- The PGME Office distributes a portion of the sponsored trainee funding (Pool C) to departments based on enrolment.
- Most departments support their PDs through direct financial support (e.g., either through a stipend or through protected time to manage the program responsibilities, ideally without loss of income, professional or faculty development opportunities), as well as infrastructure (e.g., office space) and administrative support.
- Through a practice plan, each service may support the PDs, again either through a stipend and/or protected time.

The financial and in-kind supports vary by department. Programs in hospitals with an alternative funding plan (AFP) that explicitly acknowledges teaching and research activities, in addition to clinical responsibilities, may offer a higher level of support (e.g., stipend or protected time) within the practice plan. For example, the Paediatrics Department was also identified as an exception in the RCPSC/CFPC Joint Chairs' report. The Task Force believes that the reported satisfaction with the level of support likely reflected the alternate funding plan (AFP) in place at SickKids Hospital. It was noted that the AFP specifically identifies responsibilities for research, teaching and administration, with articulated deliverables for directors and administrative support based on the program size.

7.2. Need for Accountability

Departments are not held directly accountable for achieving the educational mandate. The Task Force believes it is important for each department and program to develop and document a formal plan of how it will achieve its educational mandate.

Recommendation 6: That the Dean of Medicine ask each department to develop a working group that includes a delegate of the department chair (e.g., vice chair education or equivalent) and a delegate of the Dean (e.g., from the PG office) to examine various models to support residency programs including centralization and consolidation of current funding streams and distribution of funds based on a mix of enrolment and evidence-based project submissions.

By creating a unique template per department, the Task Force is recognizing and honouring the distinct and unique contributions that the university, hospital sites and practice plans bring to the university's mission.

7.3. Need for Transparency

The current level of support for residency programs provided by the department or external sources (financial, protected time and in-kind) is not currently known. The determination, allocation and deployment of these funds are not transparent processes. Often, the PD, who has overall responsibility for the development and operation of the residency program, does not know what funding has been allocated to support the program.

To prepare this operational plan and budget, the PD will need to know the source and amount of all available funding for the residency program. All education related expenses (e.g., administrative support, research coordinator support, conferences, PD stipend), should be identified and costed. This plan and associated budget could be reviewed annually.

The Task Force believes that it is important for the PD and the PGME Office to understand the full extent of the resources that are being made available to the residency program and how those resources are used to achieve the educational mandate.

Recommendation 7: That the Program Director, as an early task after being appointed, develop and document an explicit operational plan and formal budget for PGME-related activities that is aligned with the strategic plan of the faculty and department, and PGME and aligned with accreditation standards.

This plan should identify the sources and uses of the funds provided and should be reviewed on an annual basis, or when circumstances change in the program (e.g., new chair, new PD, internal review or accreditation, change in learner volumes) and provided to the Dean as part of the annual planning process.

8. CONCLUSIONS AND RECOMMENDATIONS

8.1. Conclusions

The Task Force was encouraged by the level of engagement by PAs and PDs in this activity and by their willingness to identify elements that are working as well as those that require improvements. In general, survey respondents were relatively satisfied with the level of support provided by the PGME Office and somewhat less satisfied with the supports provided by their clinical departments.

The consultations and surveys, however, did highlight a number of pressure points that require attention:

- Many PAs and PDs felt that the time they were officially allocated to their residency role was not adequate to fulfill their program responsibilities.
- The PAs, and to a lesser degree the PDs, described their role as very labour intensive, with some (albeit limited) opportunities for streamlining, automation or centralization of key tasks.
- There is a high degree of variation in supports between clinical departments (e.g., allocated or protected time, financial remuneration). Many respondents expressed a desire for the PGME Office to take a more active role in advocating for needed supports.
- The specific responsibilities within the PA and PD roles vary significantly from program to program, depending on many factors such as the size of the program, the number of sites where training is provided, and whether other positions within the department (e.g., site coordinators, research coordinators) provide support for residency activities. Although generic role descriptions have been developed, they must be tailored to reflect the unique responsibilities and resources in each program.

The support structures and related funding for the U of T's residency programs are complex, and not easily compared to the more straightforward roles of program administrator and program director at other universities, which may have contributed to the Accreditation Team's statement on supports for these roles. Through improved communication, and greater transparency and accountability in the funding of supporting resources, the Task Force believes that the U of T will go a long way to address the issue of "uneven support" for these roles.

8.2. Recommendations

As noted earlier, the mandate of the Task Force was to develop recommendations regarding:

- A baseline for program resourcing for Program Director and program administration support for residency programs;
- Supports and services to be provided by faculty, clinical departments or the PGME Office for program sustainability; and
- An accountability framework for funds disbursed from PGME to clinical departments.

Collectively, Recommendations 6 and 7 create an informal accountability framework for the funding and support of residency programs at the U of T.

A summary list of recommendations is provided below for ease of reference.

Recommendation 1: That each Department develop or maintain an organizational chart for each program and position descriptions (e.g., program directors, program administrators, site directors) with explicit expectations for each position.

Recommendation 2: That the PGME portfolio, in consultation with residency administrative support, program directors and department chairs, identify priority investments for supporting PAs and PDs.

Recommendation 3: Using the role description as a starting point, the department chair, division head, and hospital chief or practice plan should explicitly agree with each program director on the amount of protected time that is required to fulfill these responsibilities.

Recommendation 4: That, as part of the development of his or her role description, each program director assess, in consultation with the Chair (or Vice Chair or delegate) and Dean (or Vice Dean or delegate), the type and level of administrative support that will be required, and share this with the department chair and the division head to ensure that adequate supporting administrative resources are assigned. This process should be revisited for internal reviews and the accreditation preparation cycle.

Recommendation 5: That each program director document an academic planning cycle that is shared with the Clinical Chair or division head clearly identifying the periods during the academic year when the workload is greater than usual (e.g., preparing for internal reviews and accreditation, CaRMS) and ensure that all internal stakeholders are aware of the need for relief from other responsibilities so that the PD and PA can concentrate on these activities.

Recommendation 6: That the Dean of Medicine ask each department to develop a working group that includes a delegate of the department chair (e.g., vice chair education or equivalent) and a delegate of the Dean (e.g., from the PG office) to examine various models to support residency programs including centralization and consolidation of current funding streams and distribution of funds based on a mix of enrolment and evidence-based project submissions.

Recommendation 7: That the Program Director, as an early task after being appointed, develop and document an explicit operational plan and formal budget for PGME-related activities that is aligned with the strategic plan of the faculty and department, and PGME and aligned with accreditation standards.

Terms of Reference
Task Force on Best Practices in PGME Program Support
October 25, 2013

Background

In the April 2013 RCPSC/CFPC Accreditation survey of the University of Toronto residency programs, the report of the Joint Chairs stated that resourcing of residency programs is deficient: ***“Uneven support provided to many program directors and especially program administrators requires immediate attention. Exceptions noted were the departments of Pediatrics and Radiology. (A1.3.4).”***

Jurisdiction of this issue is under the Dean’s Office and clinical department leadership. At the Dean’s request, a Task Force was created to investigate the issues related to the report’s findings, and make recommendations to correct the deficiency.

Purpose

- To review current levels of release time/financial support for Program Directors and/or delegates to effectively fulfill their roles in residency programs
- To undertake a “gap analysis” regarding administrative support required by Program Directors and that which is provided by Departments
- To initiate an environment scan of current support structure and administrative practices at other Canadian PG Offices
- To develop recommendations regarding:
 - 1) a baseline for program resourcing for Program Director and program admin support for residency programs
 - 2) supports and services to be provided by the Faculty, Department or PGME Office for program sustainability
 - 3) an accountability framework for funds disbursed from PGME to Clinical Departments.

Meetings/Timelines

The Task Force will meet initially in October 2013 for discussion and task assignment. Qualitative and quantitative information will be collected via focus groups, interviews, surveys, and presentations from key stakeholders. A maximum of 3 further meetings will be scheduled ending no later than March 2014.

Deliverables

The Task Force will circulate a draft report of its findings and recommendations to relevant committees for discussion in April and final report to the Dean by June 2014

Support

The Task Force will be supported by an external consultant who will coordinate required data collection and focus groups, prepare materials for the meetings, take minutes, facilitate discussion, and coordinate with PGME regarding further technical or human resources required to undertake assigned tasks.

Chair(s) and membership

Chair – appointed by the Dean

Membership:

- 1 Department Chair
- 1 VP Education
- 4 Program Directors (at least one representing a small and 1 representing a large program)
- 4 Program Administrators/Managers
- 1 Business Officers Group representative
- 1 Medical Resident (appointed by PARO)
- 2 PGME Office representatives
- Vice Dean, PGME (ex officio)

Appendix B: Best Practice Task Force Membership

Dr. Pat Gullane (chair), Chair, Department of Otolaryngology – Head and Neck Surgery

Dr. Mark Fefergrad, Program Director, Psychiatry

Janine Hubbard, Program Coordinator, Medicine

Dr. Karl Iglar, Program Director, Family Medicine

Dr. Jacqueline James, Vice President Education, Mount Sinai Hospital

Christine Kreutzer, Business Officer, Lab Medicine

Dr. Mark Levine, Program Director, Anesthesia

Claire Mitchell, Director of Business and Administration, Medicine

Kim O’Hearn, Program Administrator, Radiation Oncology

Dr. Linda Probyn, Director, PGME

Dr. Rayfel Schneider, Associate Chair Education, Paediatrics

Dr. Donna Steele, Program Director, Obstetrics and Gynecology

Caroline Turenko, Senior Administrative Officer, Family Medicine

Tess Weber, Program Coordinator, Surgery

Dr. Kelly Winton, PARO Representative

Ex Officio

Dr. Sal Spadafora, Vice Dean, PGME

Loreta Muharuma, Director, Operations, PGME

Dr. Susan Glover Takahashi, Director, Research and Education, PGME

Lisa Bevacqua, Project Coordinator, PGME

Marcella Sholdice, Project Manager, Killarney Management Inc.

Appendix C: Program Administrator Survey

PGME Administrator Survey

Draft November 18, 2013

Introduction:

The purpose of this survey is to collect information from administrators of residency and fellowship programs to inform the Task Force on Best Practices in PGME Program Support.

All responses will be completely confidential. Only summary themes will be reported, and no responses will be attributed to individual administrators or programs. We will assume that by participating in this survey, you are providing your consent.

If you have questions about this survey or the Task Force on Best Practices in PGME Program Support, please contact postgrad.med@utoronto.ca.

A. ABOUT YOU

1. What is your title?

- a) Program Administrator (residency or fellowship)
- b) Program Coordinator (residency or fellowship)
- c) Departmental Education Coordinator
- d) Hospital Medical Education Coordinator
- e) Other (please describe) _____ (*Mariela: free text*)

2. For which type(s) of program(s) do you work (Check ALL that apply)?

- a) Family and Community Medicine
- b) Royal College certified specialty and/or subspecialty?
- c) Fellowship Programs (non RCPSC certified)
- d) Other (please describe) _____ (*Mariela: free text*)

3. a) For how many programs are you responsible?

b) For what type of PG trainees are you are responsible? (check All that apply)

- I. Residents
- II. Clinical fellows (not PGY4/5/6 etc.)
- III. Other (please describe) _____

4. How many NEW TRAINEES (e.g. CARMS PGY1 entry, CARMS PGY4 entry, PGY6 for some sub-specialties) does your program(s)/site(s) intake each year? (If you provide administrative support for clinical fellows AND residents, please combine the number of new residents and new fellows.

- a) 1-5
- b) 6-10
- c) 11-15
- d) 16-20

- e) 21-30
- f) 31-40
- g) 41-50
- h) 51-75
- i) 76-100
- j) 101 – 125
- k) 126 – 150
- l) 151-175
- m) 176-200
- n) More than 200

5. What is the current RESIDENT enrolment in your program(s)/site(s)?

- a) 1-5
- b) 6-10
- c) 11-15
- d) 16-20
- e) 21-30
- f) 31-40
- g) 41-50
- h) 51-75
- i) 76-100
- j) 101 – 125
- k) 126 – 150
- l) 151-175
- m) 176-200
- n) More than 200

6. What is the current CLINICAL FELLOW enrolment in your program(s)/site(s)?

- a) 1-5
- b) 6-10
- c) 11-15
- d) 16-20
- e) 21-30
- f) 31-40
- g) 41-50
- h) 51-75
- i) 76-100
- j) 101 – 125
- k) 126 – 150
- l) 151-175
- m) 176-200
- n) More than 200

7. How would you describe your workplace?

- a) Campus office
- b) Fully affiliated teaching hospital
- c) Community affiliated hospital within Toronto
- d) Community affiliated hospital outside of Toronto but within GTA
- e) Community affiliated hospital outside of GTA
- f) Other (please describe)_____ (*Mariela: free text field*)

Please note: GTA includes the City of Toronto and the regional municipalities of Halton, York, Peel and Durham.

8. How long have you been in this or a similar role?

- a) Less than 12 months
- b) 1 to 3 years
- c) 4 to 10 years
- d) More than 10 years

B. ABOUT THE WORKLOAD

9. How much of your workload is for postgraduate medical education (including fellowship programs)? Note that PGME responsibilities do NOT include work with students or undergraduate medical education, clinical or research support, or other site- or program-related responsibilities?

- a) 1 to 25%
- b) 26 to 50%
- c) 51 to 75%
- d) 76 to 100%

- e) I need my PD's support when managing resident requests (e.g., leaves, changes to rotation assignments).
- f) I need my PD to be more responsive to my suggestions for changes to program procedures/guidelines.
- g) I need more assistance in liaising with other faculty (e.g., follow up on evaluations, soliciting participation in academic half days).

D. ABOUT THE SUPPORT PROVIDED BY YOUR CLINICAL DEPARTMENT

13. How well are you supported by your Clinical Department?

- a) No support
- b) Minimal support
- c) Reasonable support – able to complete tasks but would like more interaction, direction and time
- d) Well supported
- e) Very well supported

14. What supports would you like to see?

- | | | | |
|--------------|---------------------------|-------------|--------------------------|
| Do not agree | Neither agree or disagree | Fully agree | N/A |
| 1 | 3 | 5 | <input type="checkbox"/> |
- a) I need more opportunities for training and professional development (includes conferences, time off to attend courses or degree completion) or protected time for same.
 - b) I need more mentoring opportunities.
 - c) I need additional full-time staff to support ongoing workload.
 - d) I need additional seasonal staff for support during peak periods.
 - e) Other (please describe) _____

E. ABOUT THE SUPPORT PROVIDED BY THE PGME OFFICE

15. How well are you supported by the PGME Office?

- a) No support
- b) Minimal support
- c) Expected level of support
- d) Well supported
- e) Very well supported

16. What are the top three reasons you would contact PGME (by phone or email)?

- a) Follow up or clarifications on policy for registrations
- b) Information or clarifications on reappointments of residents
- c) Information or clarifications regarding leaves
- d) Information or clarifications for call stipends
- e) Information or clarification related to remedial training
- f) Information or clarifications for policies not mentioned above
- g) Assistance with POWER
- h) Assistance/questions related to CaRMS
- i) Information or clarifications on VISA related paperwork

- j) Information or clarification on occupational health and safety issues (e.g., immunizations)
- k) Assistance with pre-assessment evaluation forms and AVPs
- l) Approvals for changes to ITERs
- m) Assistance related to remedial training
- n) Assistance with payroll issues
- o) Funding enquiries
- p) Other (please describe) _____

17. In a typical week, how often would you contact PGME?

- a) Once or twice a week
- b) 3 to 5 times a week
- c) 6 to 10 times a week
- d) More than 10 times a week
- e) I only contact PGME once or twice a month
- f) I only contact PGME at certain times of the year
- g) I rarely or never contact PGME
- h) If I need help, I contact my counterpart at another hospital, program or province.

18. How often do you contact the following organizations directly? *Once or twice a year; once or twice a month; once or twice a week; 3 – 5 times a week, 5 or more times a week)*

- a) The Professional Association of Residents of Ontario
- b) College of Physicians and Surgeons of Ontario
- c) Royal College or College of Family Physicians of Canada
- d) Medical Affairs office at a hospital
- e) Canadian Medical Protective Association
- f) Canadian Resident Matching Service (CARMS)

19. How satisfied are you with the support from the PGME office for each of the following?

- | Not at all satisfied
with PGME support | Acceptable support from PGME | Fully satisfied with
support from PGME | N/A |
|--|------------------------------|---|--------------------------|
| 1 | 3 | 5 | <input type="checkbox"/> |
| a) Responses to telephone and email requests | | | |
| b) Technical support and training for POWER | | | |
| c) PA Appreciation Day | | | |
| d) All PD workshops/sessions | | | |
| e) Ad hoc workshops for updates and changes to policies or practices | | | |
| f) The PGME orientation booklet | | | |
| g) Funding support to attend ICRE | | | |
| h) Other (please describe) _____ <i>(Mariela: free text field if selected)</i> | | | |

20. Rate the extent to which you would find each of the following resources and activities helpful.

- | Not at all helpful | Somewhat helpful | Highly helpful | N/A |
|--|------------------|----------------|-----|
| 1 | 3 | 5 | |
| a) Workshops on changes to policies and procedures | | | |

- b) Workshops to provide a refresher and/or to share best practices
- c) Orientation manual for new PAs
- d) Orientation workshop for new PAs
- e) Mentoring opportunities
- f) Networking opportunities
- g) A calendar of the PGME academic year with key dates
- h) A committee/interest group that meets regularly to share issues/ideas
- i) Support to join the Canadian Administrators in Medical Education Operations (CAMEO)
http://www.cameo-inc.ca/index.htm
- j) Contact list for all Program Directors and Program Administrators
- k) Technology tools to better manage the workload
- l) Other (please describe)_____ (*Mariela: free text field*)

21. What format would you find helpful to receive instruction, training or information?

- | | | | |
|--------------------|------------------|----------------|-----|
| Not at all helpful | Somewhat helpful | Highly helpful | N/A |
| 1 | 3 | 5 | |
- a) Monthly meetings
 - b) Quarterly workshops with my peers – classroom setting
 - c) Video/YouTube instruction
 - d) One-on-one training with knowledgeable PG staff or other trainer
 - e) Printed or electronic reference manual
 - f) Quick PowerPoint presentation
 - g) Quarterly newsletter
 - h) Other (please describe)_____ (*Mariela: free text field*)

22. What technology solutions do you think would help to do your job better?

- | | | | |
|--------------------|------------------|----------------|--------------------------|
| Not at all helpful | Somewhat helpful | Highly helpful | N/A |
| 1 | 3 | 5 | <input type="checkbox"/> |
- a) A scheduling system (e.g., to support the initial planning and ongoing revision of rotations)
 - b) Electronic, central vacation/leave tracking system
 - c) On-line application system for fellows
 - d) Enhanced ability to generate paper and electronic reports in POWER
 - e) Case Logs
 - f) Portfolios
 - g) Access to additional software programs (e.g., Adobe Professional)
 - h) Colour printer
 - i) Scanner
 - j) Other (please describe)_____ (*Mariela: free text field*)

23. Which of the following activities, tasks or procedures do you feel the PGME office should administer centrally?

- | Not at all helpful
1 | Somewhat helpful
3 | Highly helpful
5 | N/A
<input type="checkbox"/> |
|---|------------------------------|----------------------------|---------------------------------|
| a) Vacation scheduling | | | |
| b) Rotation scheduling | | | |
| c) Evaluation and statistical reports | | | |
| d) Professional Development for administrators | | | |
| e) POWER training | | | |
| f) FITER completion | | | |
| g) On-line pre-survey questionnaires | | | |
| h) On-line PEAP and AVP form completion | | | |
| i) Library of best practices for department processes/guidelines | | | |
| j) Other (please describe)_____ (<i>Mariela: free text field</i>) | | | |

24. Other comments or suggestions?

THANK YOU FOR YOUR INPUT

If you have questions about this survey or the Task Force on Best Practices in PGME Program Support,
please contact postgrad.med@utoronto.ca.

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Task for on Best Practices for PGME Support

PA Survey Results
December 9, 2013
DRAFT AND PRELIMINARY

University of Toronto

1

METHODOLOGY

- Draft survey created based on interviews and focus groups conducted in June
- Draft reviewed by Task Force members
- Invitation to complete web-based survey sent to 117 program administrators, medical education coordinators and other individuals with administrative responsibilities for PGME
- \$10 gift certificate offered as incentive

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2

RESPONSE RATE

- Complete surveys:
 - 75 of 117 (response rate = 64%)
- Complete and incomplete (23 surveys):
 - 98 of 117 (response rate = 84%)

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3

INCOMPLETE SURVEYS

#	Complete to end of:	Sections completed
11	Q9	"About you"
2	Q10	"About you" and % PGME workload
3	Q12	"About you" and "About workload"
2	Q15	"About you", "About workload" and "About support by clinical dept"
5	Q20	"About you", "About workload", "About support by clinical dept" and partial "About support by PGME"
23		

- None of the 23 incompletes responded to questions about preferences for additional supports and services.

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4

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About You



5

Q1. WHAT IS YOUR TITLE?

Title	Incomplete (n=98) #/%	Complete (n=75) #/%
Program Administrator (residency or fellowship)	36/37	29/39
Program Coordinator (residency or fellowship)	29/30	21/28
Departmental Education Coordinator	7/7	6/8
Hospital Medical Education Coordinator	6/6	4/5
Other - Administrative Assistant	12/12	8/11
Other - Coordinator	3/3	2/3
Other - Dual roles	4/4	4/5
Other - Manager	1/1	1/1
Total	98/100	75/100

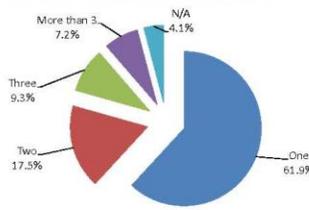
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Q2. FOR WHAT TYPES OF PROGRAMS DO YOU WORK? (CHECK ALL THAT APPLY)

Title	Incomplete (n=98) #/%	Complete (n=75) #/%
Family and Community Medicine	23/23	17/23
Royal College certified specialty and/or subspecialty	72/73	57/76
Fellowship programs (non-RCPC certified)	30/31	26/35
Other	9/9	6/8

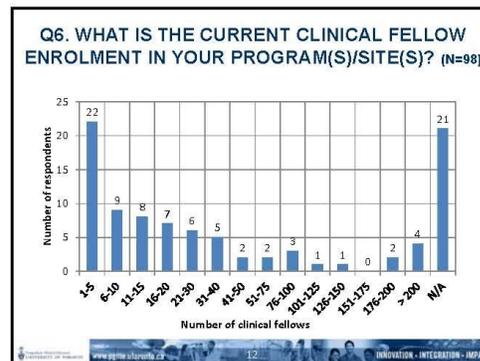
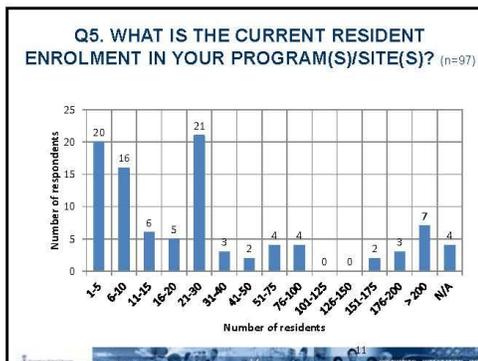
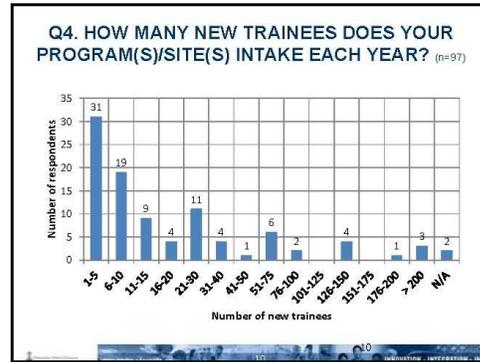
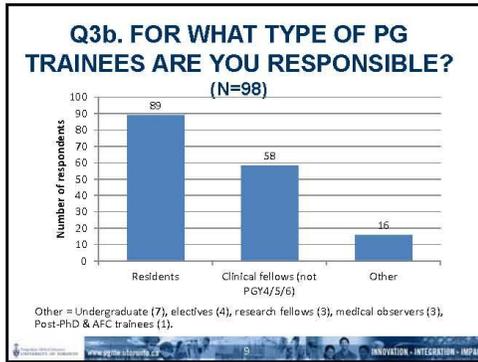
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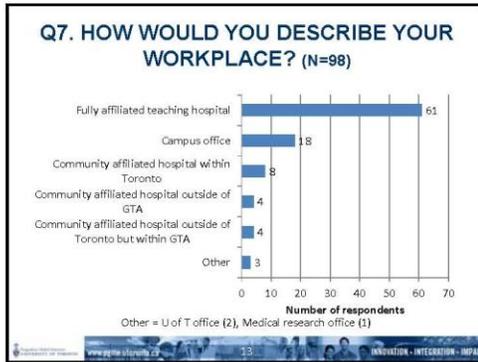
Q3. FOR HOW MANY PROGRAMS ARE YOU RESPONSIBLE? (N=97)



Number of Programs	Percentage
One	61.9%
Two	17.5%
Three	9.3%
More than 3	7.2%
N/A	4.1%

8



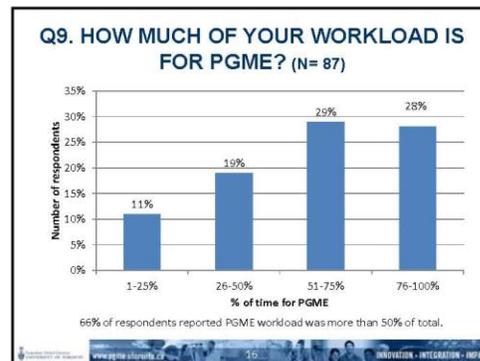


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About the Workload

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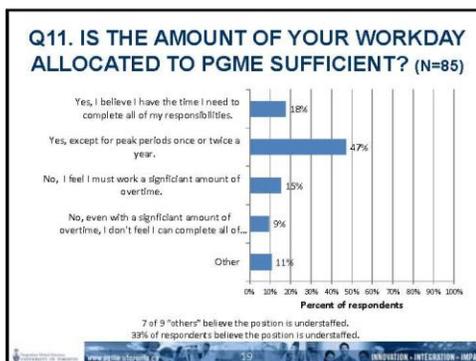
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Q10. AVERAGE % OF TIME ALLOCATED TO EACH ACTIVITY (n=84; sorted by % of time)

	Count	Average %
Other Non-PGME	66	23.0
Scheduling rotations	72	17.5
Scheduling other educational activities	73	10.7
Appointments/reappointments	74	9.2
Evaluation data re teachers	75	8.1
CaRMS match	71	7.4
Managing electives	71	7.2
Other PGME	52	6.0
Non-CaRMS applications	65	5.5
Orientation and registration for new trainees	78	5.4
Scheduling and coordinating exams	73	4.5
Managing leaves	73	4.2
Scheduling social events	66	3.8
Remediation activities	58	2.8
Training/ PD	56	2.5
Resident wellness/retreat activities	62	1.9
Call stipends	67	1.7

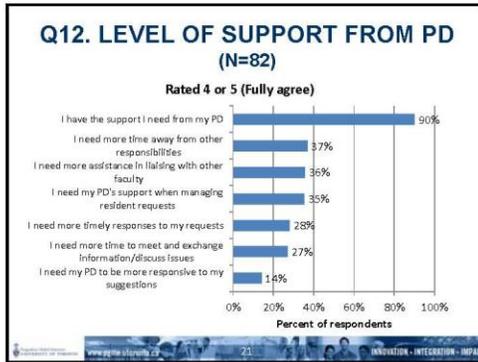
- Q10. OTHER NON-PGME ACTIVITIES (21%)**
- Duties for the Chair
 - Undergraduate responsibilities
 - Support for clinical activities
 - Other resident or fellow support
 - Financial administration (including preceptor payments)
 - Managerial or administrative duties
 - IT-related activities



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About Support by the PD

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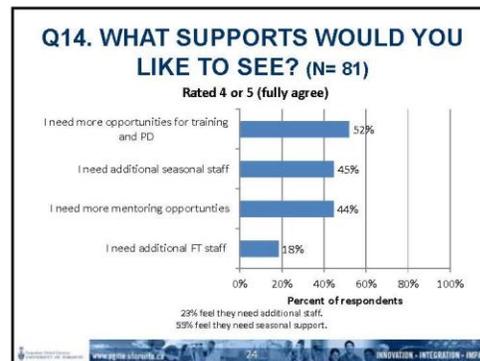
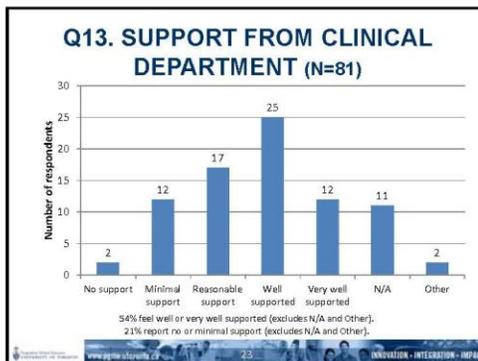


About Support by the Clinical Department

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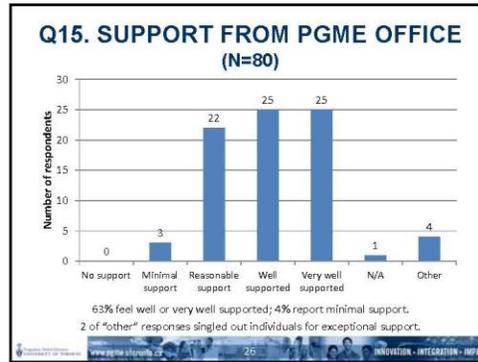
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About Support by the PGME Office

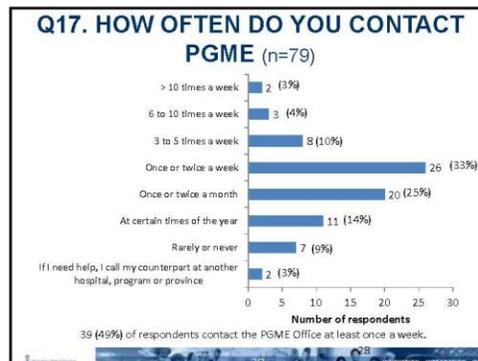

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Q16. TOP 3 REASONS TO CONTACT PGME (n=80)

Reason	% who rated as top reason	% who rated as top 3 reason
Assistance/questions related to CaRMS	51	73
Information or clarifications on visa-related paper work	18	46
Information or clarifications on reappointments of residents	6	25
Approvals for changes to ITERS	3	23
Follow up or clarification on policy for registrations	3	19
Information or clarifications regarding leaves	1	19
Information or clarifications for policies not mentioned above	5	19
Assistance with pre-assessment evaluation forms and AVPs	1	16
Assistance related to remedial training	4	13
Information or clarifications for call stipends	1	11
Funding enquiries	4	10
Assistance with POWER	-	9
Assistance with payroll issues	1	6
Information or clarification related to remedial training	1	3


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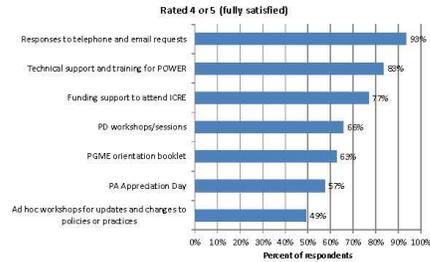


Q18. HOW OFTEN DO YOU CONTACT OTHER ORGANIZATIONS? (N=80)

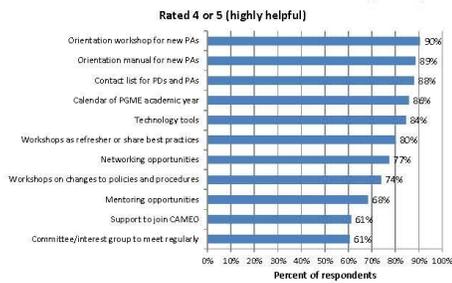
	PARO	CFPO	RCFPC or CFPC	Med Affairs	CMPA	CaRMS
1-2/year	20	32	36	24	24	48
1-2/month	10	8	6	18	3	6
1-2/week		4		2	1	
3-5/week		1		5		
5 or more/week				2		
N/A	50	35	38	29	52	26

Few PAs contact external organizations more than a couple times a month.
Results shown are number of respondents.

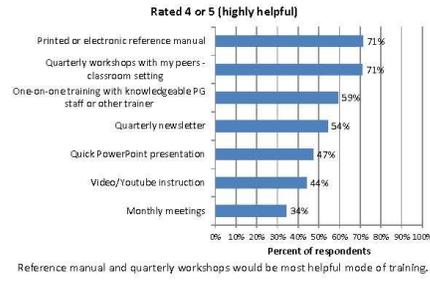
Q19. SATISFACTION WITH PGME SUPPORT (n=80)

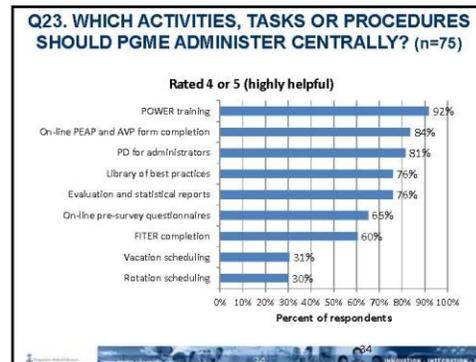


Q20. EXTENT TO WHICH RESOURCES AND ACTIVITIES WOULD BE HELPFUL (n=75)



Q21. WHAT FORMAT WOULD BE HELPFUL FOR INSTRUCTION, TRAINING OR INFORMATION? (n=75)





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Questions or Comments?

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Appendix E: Program Director Survey

PD Survey Draft January 8, 2014

Introduction:

The purpose of this survey is to collect information from Residency Program Directors to inform the Task Force on Best Practices in PGME Program Support.

All responses will be completely confidential. Only summary themes will be reported, and no responses will be attributed to individual administrators or programs. We will assume that by participating in this survey, you are providing your consent.

If you have questions about this survey or the Task Force on Best Practices in PGME Program Support, please contact postgrad.med@utoronto.ca.

1. **Are you a Family Medicine Program/Site Director or Royal College Specialty Program Director?**
 - a) Family Medicine
 - b) Royal College certified specialty and/or subspecialty?

2. **How many NEW TRAINEES (e.g. CARMS PGY1 entry, CARMS PGY4 entry, PGY6 for some sub-specialties) does your program(s) intake each year?**
 - a) 0
 - b) 1-5
 - c) 6-10
 - d) 11-15
 - e) 16-20
 - f) 21-30
 - g) 31-40
 - h) 41-50
 - i) 51-75
 - j) 76-100
 - k) 101 – 125
 - l) 126 – 150
 - m) 151 or more

3. **What is the current RESIDENT enrolment in your program(s)?**
 - a) 0
 - b) 1-5
 - c) 6-10
 - d) 11-15
 - e) 16-20
 - f) 21-30
 - g) 31-40
 - h) 41-50
 - i) 51-75
 - j) 76-100

- k) 101 – 125
- l) 126 – 150
- m) 151-175
- n) 176-200
- o) More than 200

4. How long have you been a Program Director?

- a) Less than 12 months
- b) 1 to 3 years
- c) 4 to 10 years
- d) More than 10 years

5. Do you believe that your time allocation to PGME responsibilities is sufficient?

- a) Yes, I believe I have the time I need to complete all of my responsibilities.
- b) Yes, I believe I have the time I need except for peak periods once or twice a year.
- c) No, I do not have the time to complete all of my Program Director responsibilities but would be able to do so if I had additional administrative support.
- d) No, I do not have the time to complete all of my Program Director responsibilities and am in need of more faculty support.
- e) Other (please describe)_____

6. How well do you feel supported by each of the following (rank on a scale of 1 to 5).

Scale is:

- 1- No support
- 2- minimal support;
- 3- reasonable support;
- 4- very well supported
- 5- extremely well supported
- 6- n/a

- a) by the PGME Office
- b) by your clinical department
- c) by your division, if applicable
- d) by your chair
- e) by your clinical/practice group
- f) by your program administrator

If you feel there are gaps in the financial, time, or other support you need, please describe those gaps below:

7. How well does your department or practice plan currently support you in your PD role? (rank on a scale of 1 to 5).

Scale is:

- 1- No support
- 2- minimal support;
- 3- reasonable support;
- 4- very well supported
- 5- extremely well supported
- 6- n/a

- a) Protected time
- b) Financial compensation
- c) Relief from other responsibilities
- d) Fostering a team approach to managing the program
- e) Support during a crisis
- f) Support in introducing innovation

If you feel there are gaps in the financial, time, or other support you need, please describe those gaps below:

8. Rank your top 3 issues/task which require your attention as a Program Director i.e. those which take up most of your residency-program allocated time?

1st _____

2nd _____

3rd _____

9. Do you feel the faculty development opportunities listed below would help you in your Program Director role?

Do not agree
1

Neither agree or disagree
3

Fully agree
5

- a) Protected time to attend conferences
- b) CARMS selection workshop
- c) Networking opportunities with other Program Directors at UofT or other schools
- d) Mentoring opportunities.
- e) Royal College standards training
- f) Curriculum planning workshop
- g) Remediation/residents in difficulty training
- h) Other (please describe) _____

10. How would you prefer to receive instruction, training or information to assist you in your Program Director role?

11. What technology solutions do you think would help to do your job better?

Not at all helpful
1

Somewhat helpful
3

Highly helpful
5

N/A

- a) A scheduling system (e.g., to support the initial planning and ongoing revision of rotations)
- b) Electronic, central vacation/leave tracking system
- c) Enhanced ability to generate paper and electronic reports in POWER
- d) Case Logs
- e) Portfolios
- f) Access to additional software programs (e.g., Adobe Professional)

- g) Colour printer
- h) Scanner
- i) Other (please describe)_____

12. Which of the following activities, tasks or procedures do you feel the PGME office should administer centrally?

- | Not at all helpful
1 | Somewhat helpful
3 | Highly helpful
5 | N/A
<input type="checkbox"/> |
|--|------------------------------|----------------------------|---------------------------------|
| a) Vacation scheduling | | | |
| b) Rotation scheduling | | | |
| c) Evaluation and statistical reports | | | |
| d) Professional Development for administrators | | | |
| e) POWER training | | | |
| f) FITER completion | | | |
| g) On-line pre-survey questionnaires | | | |
| h) On-line PEAP and AVP form completion | | | |
| i) Library of best practices for department processes/guidelines | | | |
| j) Other (please describe)_____ | | | |

13. What are the constraints you feel affect the delivery of residency education in your program?

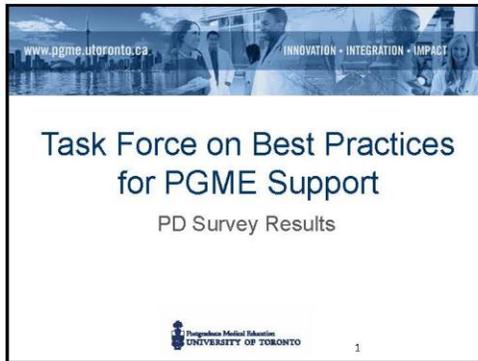
14. How significant an issue is the variability of services and equipment across training sites?

- a) Very significant
- b) Neutral
- c) Not an issue at all

15. Other comments or suggestions:

THANK YOU FOR YOUR INPUT

If you have questions about this survey or the Task Force on Best Practices in PGME Program Support, please contact postgrad.med@utoronto.ca.



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Task Force on Best Practices for PGME Support

PD Survey Results

Progressive Medical Education
UNIVERSITY OF TORONTO

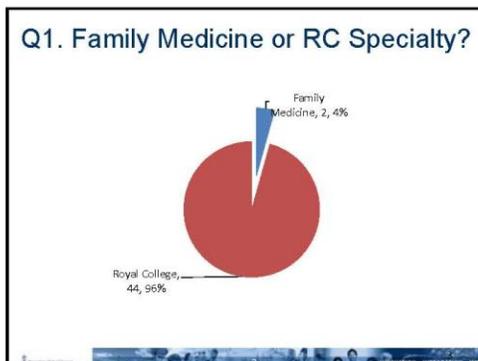
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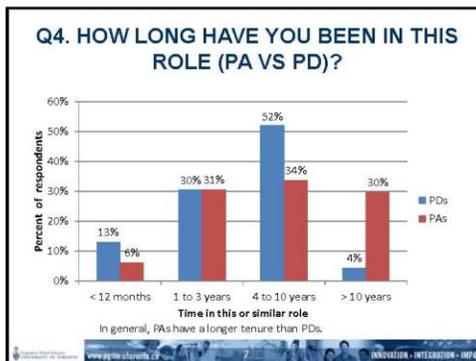
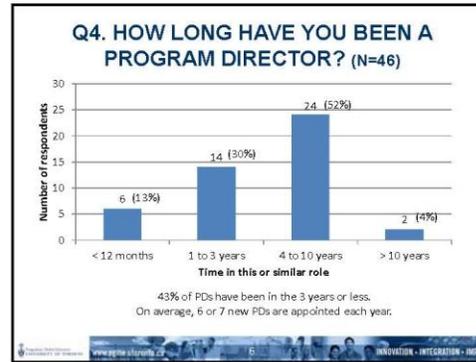
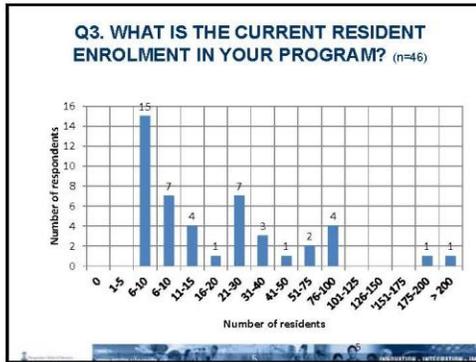
METHODOLOGY

- Draft survey built on PA survey questions
- Draft reviewed by Task Force members
- Invitation to complete web-based survey sent to 79 program directors
- Response rate:
 - 44 complete surveys (56%)
 - 2 partially complete surveys (total 46 = 58%)

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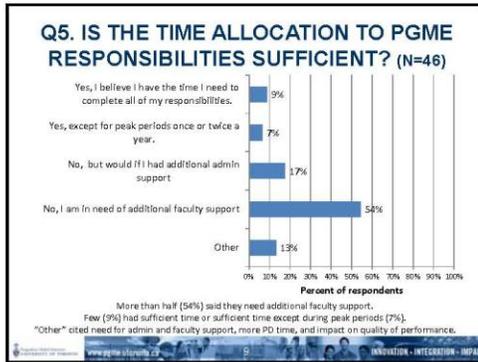


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About the Workload

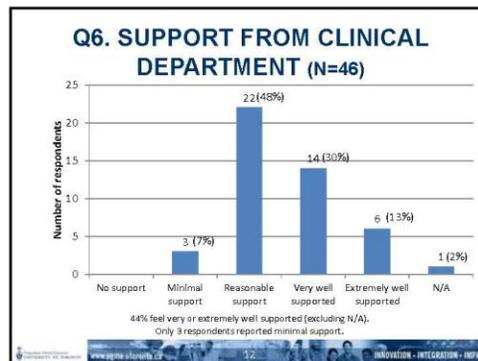
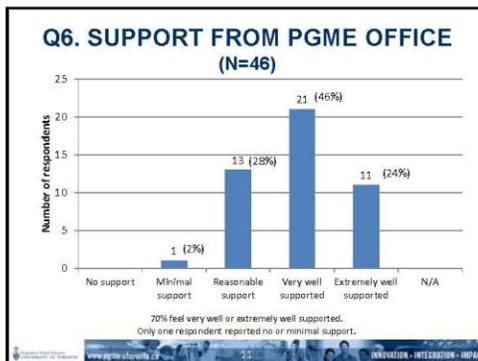
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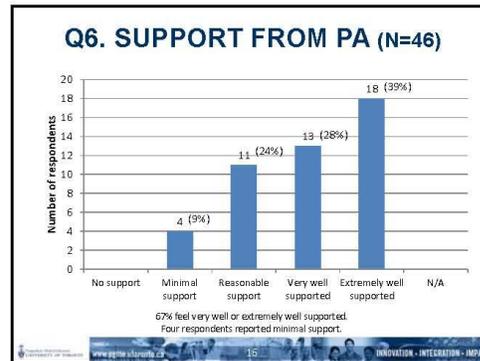
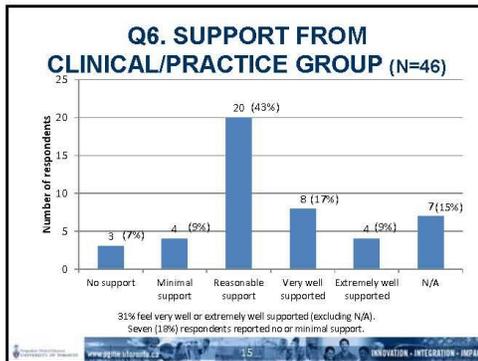
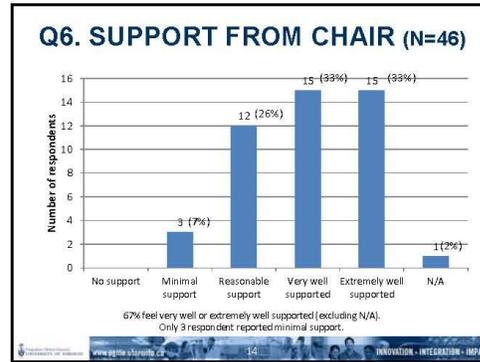
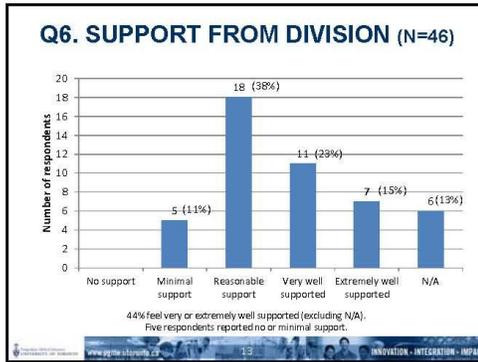


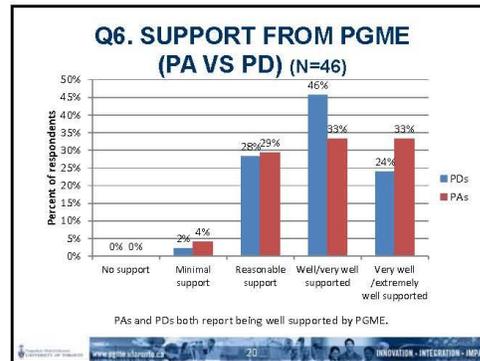
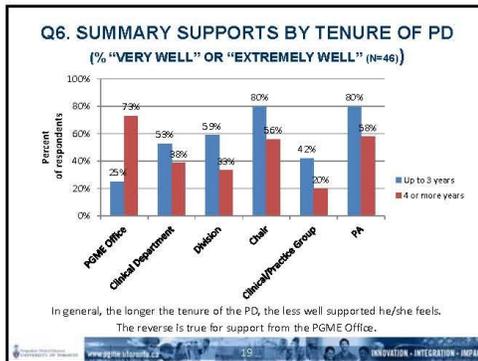
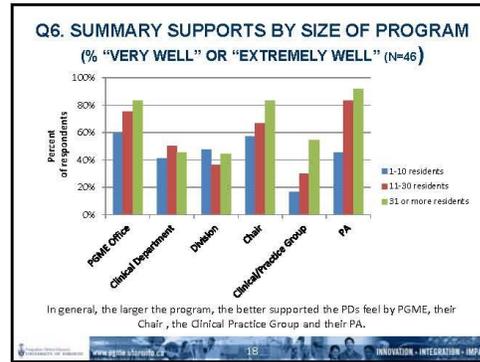
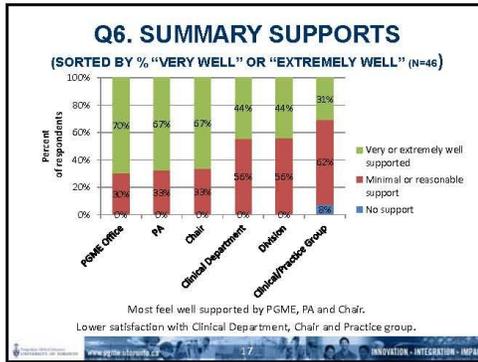
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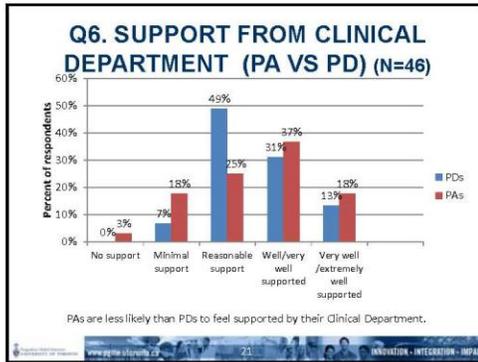
About Support

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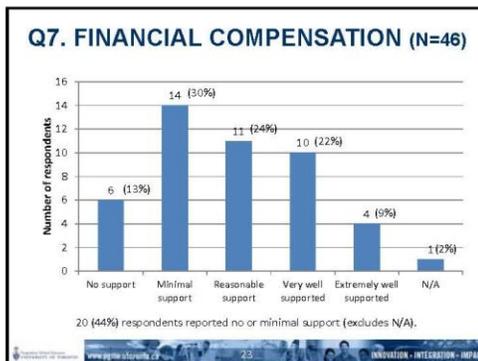






Supports from Department or Practice Plan

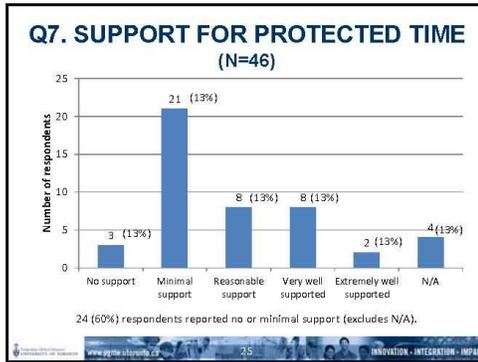
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FINANCIAL SUPPORTS

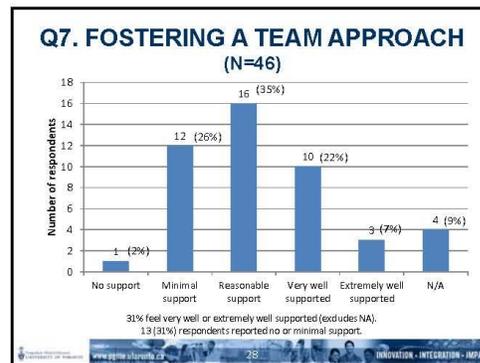
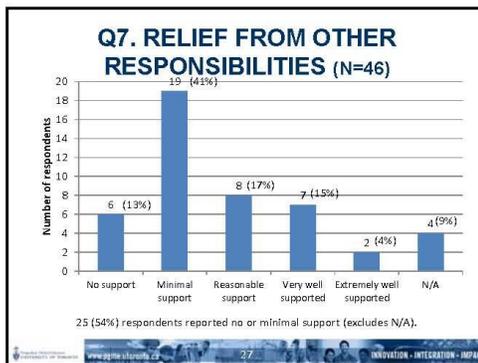
- *“Financial support doesn’t really match time spent and degree of responsibility but I am not doing this for the money”*
- *“Need to be able to pay fair market rates for such a job”*
- *“PD typically do it as education is important, however, there should be common compensation across all programs. It should NOT be dependent on department and division”*
- *“The personal support from my Division Director and Administration is superlative. My Division director has provided supplemental financial support which has been a help, but she should not need to do this”*

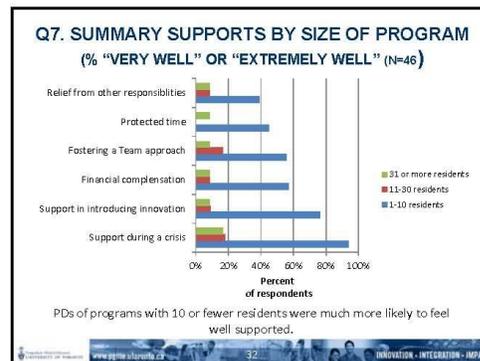
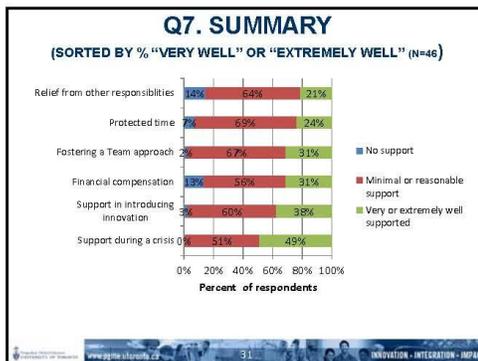
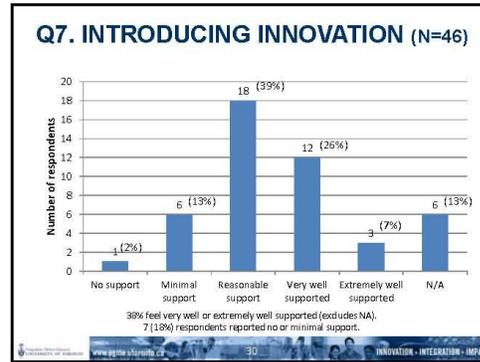
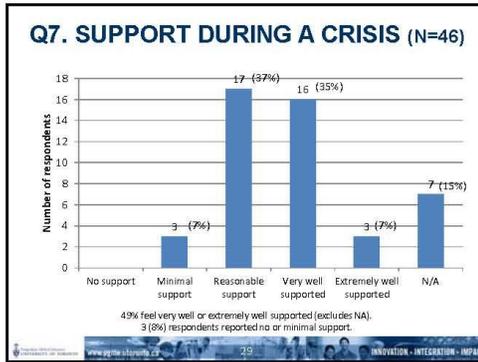
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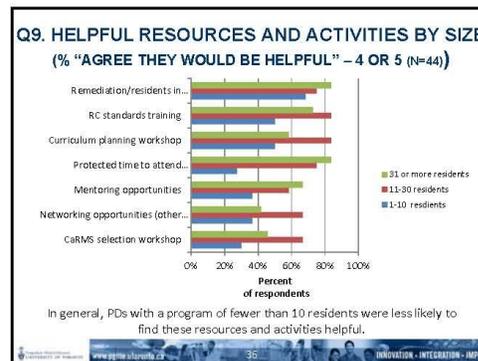
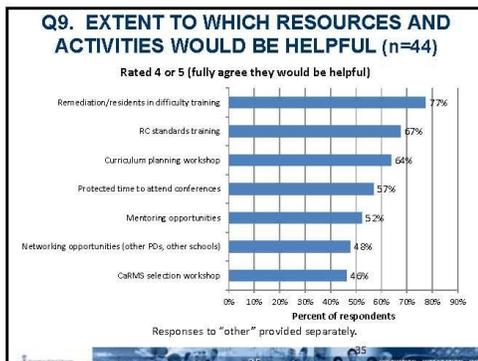
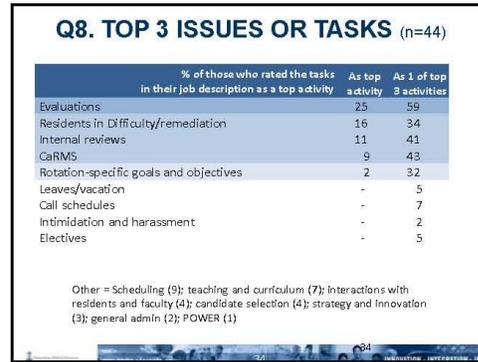
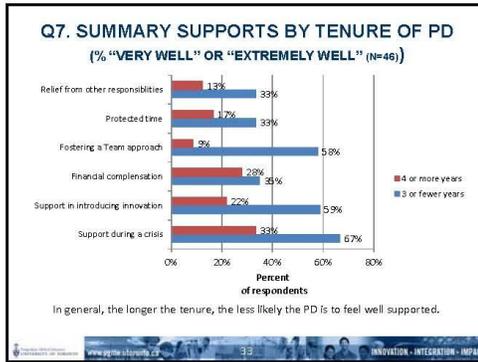


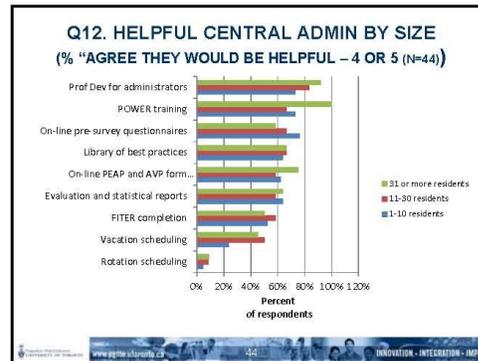
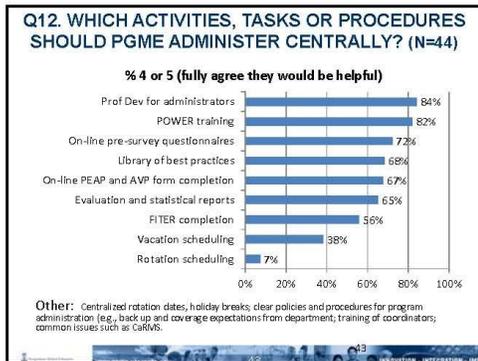
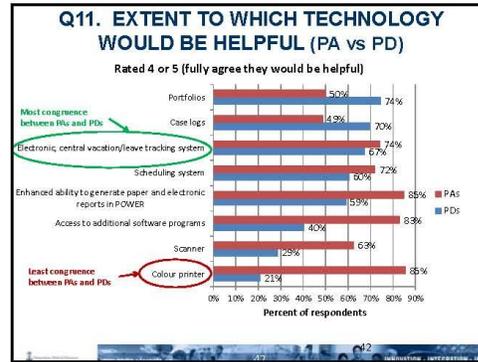
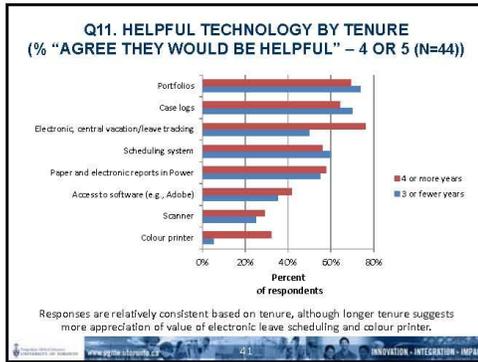
PROTECTED TIME

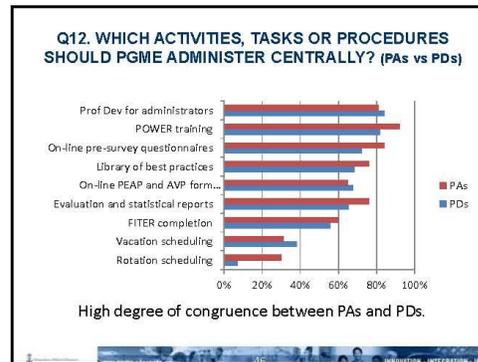
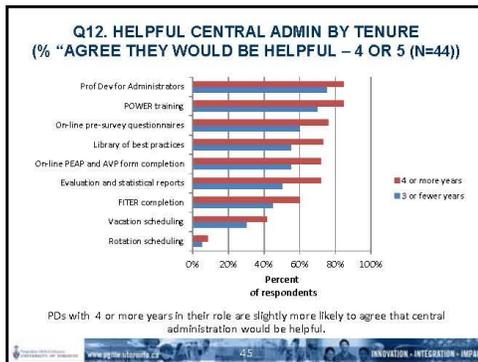
- *“Relief from some of my other divisional activities would be welcome”*
- *“There is no additional protected time and my clinical obligations/duties remain very heavy”*



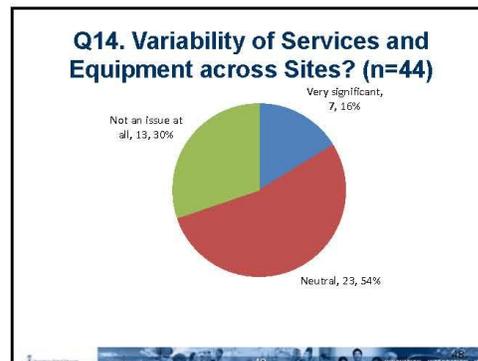








- ### Q13. CONSTRAINTS AFFECTING DELIVERY OF RESIDENCY EDUCATION (N=34)
- Time (11)
 - Faculty / Departmental support (9)
 - Administrative support (7)
 - Pressures to provide services (3)
 - Infrastructure (3)
 - Physical resources (3)



Appendix G: First Department Chair Survey

Task Force on Best Practices in PGME Program Support Survey of Clinical Chairs January 9, 2014

Introduction:

The purpose of this survey is to collect information from Clinical Department Chairs to inform the Task Force on Best Practices in PGME Program Support.

All responses will be completely confidential. Only summary themes will be reported, and no responses will be attributed to chairs or departments. We will assume that by participating in this survey, you are providing your consent.

If you have questions about this survey or the Task Force on Best Practices in PGME Program Support, please contact postgrad.med@utoronto.ca

1. Identify 2 areas of greatest need for your department's residency programs.
2. What changes in medical education do you foresee in your department in the next 5 years?
3. How would you improve Faculty Development opportunities in your department?
4. What are the constraints you feel affect the delivery of residency education in your department?
5. How significant an issue is the variability of services and equipment across training sites?
 - a) Very significant
 - b) Neutral
 - c) Not an issue at all

Comments:

6. Compensation
 - a) Some universities have adopted an algorithm that determines the resource allocation (i.e., time and stipend) required for the Program Director to support the program based on the number of trainees in the program. Does your department currently explicitly compensate your Residency Program Director(s) based on trainee enrolment? If no, do you feel that such an algorithm would be something you could support?
 - b) Name the kinds of compensation the department provides to Program Directors: (e.g., protected time, financial compensation, relief from other responsibilities, development of a team approach to supporting the program, other).

Appendix H: First Department Chair Survey Results

Task Force on Best Practices in PGME Program Support Survey of Clinical Chairs Summary Responses – By Question N=13

1. Identify 2 areas of greatest need for your department's residency programs.

Financial support:

- Increased financial support from the Dean to make protected time realistic and not a continual drain on the practice plans. As the number of residencies increase, with sub-specialisation, this problem is becoming amplified and increasingly difficult to support.
- Financial security in the face of declining budgets and other pressures.
- More funding support for the trainee education activities is needed so to have less reliance on industrial support.
- We need additional funding to continue our courses for residents, research projects and graduate degrees.
- There is no current funding support to assist the trainee to present at national or international scientific meeting.

Infrastructure support (in hospital):

- Hospital support (e.g., hospital equipment, technical staff)
- Need more support 24/7 to maintain acute care services across the hospitals, i.e., effective nurse practitioners – since resistance to create 2-tier with “hospitalists” (not academic, don't teach, not in practice plans) and realistically, no funding mechanism for their salaries (and benefits) as hospital employees.
- Physician extenders/hospitalists/nurse practitioners for assistance with service education ratio
- Improve OR resources for resident learning

Administrative support:

- Consistency in nature and amount of administrative support for programs within the Department. Continued deployment of the centralized administrative support model in the Department.
- Development of clear accountable administrative policies to ensure that program directors are not burdened by excessive administrative responsibility (for example file management, meeting management, portal management, faculty correspondence for examinations/selection, coverage and back-up etc.) It is currently unclear how standardized this is across different programs
- Adequate administrative support and resources.

Changes in standards/expectations

- Better clarity regarding new expectations from colleges

- Change in on call regulations, and therefore optimizing residents numbers vs realistic career options for the graduates
- Consistency in resident allocation to clinical sites. Changes in residency training requirements including increased involvement in ambulatory care as well as integrated medical education have placed pressure on the teaching services in our primary affiliates. Consistent allocation is needed to ensure provision of a consistent educational experience.

HHR Planning

- Health Human Resource planning (there is currently misinformation out there about job prospects, leading to incorrect perceptions that require management vis-a-vis CaRMS applicants and already-enrolled residents having correct information to guide career planning and decision-making).
- We also need to expand resident numbers if we continue to expand our clinical, teaching, and research footprints (not to mention restricted duty hours). It will be difficult to excel in all these areas without hurting our service needs. We should have more residents and the province should close other smaller programs.
- Succession planning is an issue. Our department is not a “clinical” discipline, so there needs to be greater development of career paths and funding mechanisms to support academic public health physicians to provide a “pool” of qualified, supported and sufficiently ready program directors.

Faculty Development

- Continued building of academic activities (research/education scholarship/QI) across all sites so that residents, regardless of site location of residency training have academic role models
- Greater engagement of faculty in assuming leadership roles within our residency program
- #2 faculty review that is timely, accurate and actionable

Curriculum reform:

- An effective mental health/social determinants of health curriculum
- Curriculum reform and innovation.
- #1 a sense of whether simulation is truly worth the intense effort and resources, given that it is slowly replacing patient experience; some big-picture look at the evidence (as opposed to just its popularity).

Other:

- Formal training in the latest information technologies.
- More effective infrastructure.
- Relationship between residents and fellows.

2. What changes in medical education do you foresee in your department in the next 5 years?

Competency-based education:

- Increased emphasis on competency-based education
- Our residency program is exploring a competency based curriculum over the next few years.
- Competency based education,
- Competency based education

- More competency measures in the assessment of residents
- Shift to competency-based evaluations and training programs.
- A move towards competency-based curricula in most programs.
- Likely increased talk of competency-based training - I'd rather see dialogue of how to train the best possible residents, not just how to do it in the minimal time possible.

Centralization or decentralization

- Continued building of academic activity at all sites (practice-based research network , QI initiatives and education scholarship)
- Increasingly decentralized
- There is increasing diffusion of teaching to the community

Technology

- Increased dependence on sophisticated educational technology including simulation
- Increasing dependence on technology, both educational and clinical.
- Need for more simulation,

Resident work hours

- Shift systems as opposed to the more traditionally on call systems
- Residents' duty hours reform,
- change from 24 to 12 hr shifts

Team-based learning

- Increased emphasis on team-based learning
- Team-based vs. the current "apprenticeship" model. In turn, this will build in graded responsibility during residency training (similar to what Medicine & Surgery have been doing for years)

Other

- Continued need to align our educational activities with new standards;
- CPD for development of more robust evaluation of residents, in particular to identify and effectively remediate poor performers.
- Improved delivery of CanMeds teaching and evaluation of CanMeds roles
- Shifting our core lectures to a 'Khan methodology', ie. 'flipping the classroom' where residents read ahead and the sessions are designed to test their understanding.
- Matching of highly trained personnel with opportunities in a changing work place.
- Development of a professional masters and PhD program for our residents.
- Development of the Clinical Division to address 1a and 2 a.
- Introduction of an embedded research stream (similar to the US Holman Pathway).

3. How would you improve Faculty Development opportunities in your department?

Strategies to raise profile/awareness/participation

- Tie Faculty Development to succession planning

- Improve communication of the Faculty Development opportunity.
- Look at behaviour economics for incentivizing CPD
- Entrench attendance in the job descriptions of new recruits. Practice plan incentives to attend/penalties for not attending.
- We have launched a faculty development program, which seems to be doing well. It needs time and resources. Making faculty development mandatory, particularly for new recruits, is the direction our department is going.
- There has been limited/no FD for faculty in the areas of our practice or educational scholarship. The development of a FD strategy for the program directors, faculty and residents would be a great step forward. It would be desirable to have a closer relationship between our program and CEPD.
- Enhance offerings related to academic advancement (such as the new clinical research certificate which is beginning this year)

Development of a formal Faculty Development Plan and related supports

- Actively engage individual staff of their input for need assessments. We have started doing this as we see more education topics at grand rounds. However, we could be more aggressive about encouraging our faculty to take advantage of faculty development resources - maybe we bring them to grand rounds on occasion.
- Develop a cadre of program champions in Faculty Development (there is an appetite for this)
- Continued Practice Development is identified in our strategic plan as one of the Goals of the department. We are starting from limited experience in providing this for our faculty and will be developing a three year plan to guide delivery. This will require faculty who will support this goal.
- Organizing regular faculty development workshop and seminar throughout the year.
- By offering and paying for opportunities for faculty to engage in faculty development specific
- Make Faculty Development a natural element of one's career (not a constant competition against clinical availability).

Skill development opportunities

- Need to develop increased capacity for assessment to enable the shift to competency based education
- Competency-based assessments
- Make it easy to access- consider new technology for point of care /teaching apps.
- Opportunities for in depth study/exposure in these areas.

Mentoring program

- The development of a Departmental mentoring program has been explicitly identified with in the strategic plan.

4. What are the constraints you feel affect the delivery of residency education in your department?

Service Demands

- Relentless pressures for increasing service demands from faculty (this includes trends in increasing scope of professional work to include such activities as filling out forms, etc. to ensure quality standards have been fulfilled for accreditation).
- The main constraint is the same across all educational programs in the department that being the 'conflict' between clinical demand and time for teaching. We are undertaking an internal review and will be producing a 'white paper' to try and become more explicit regarding the educational expectations. The more the Dean can help define these expectations the easier it will be to engage the department.
- Decreased faculty time for dedicated teaching due to a corresponding increased clinical load for faculty
- The increase in complexity of surgical cases, time demands of surgeons, undervaluing surgical teaching.
- Time constraints of faculty.

Administrative support:

- Adequate administrative resources.
- Complexity of funding between hospital sites, the university and partnerships. There is an optimal integration between our specialty and other specialty programs. I'm not sure how well our residents are exposed to other specialties.
- Clarity of administrative requirements and expectations leading to frustration and poor morale amongst all involved in the program

Financial constraints

- Financial
- Funding support for both trainees and teacher for the education activities, especially funding support for residents to present at major national and international meetings.

Hospital infrastructure

- Decreasing focus on ambulatory clinical care within in the AHSCs, but required for a rounded educational experience.
- OR resources at the teaching hospitals have been severely curtailed, and could be improved

Distribution of learning sites

- The geographic separation of the 5 teaching hospitals.
- Geographic dispersion of learners

Other

- We have unprecedented growth in our department, so we should pause to focus on quality rather than continued expansion.
- The limited number of full time specialists in the department. All are adjunct or status only appointments at the university. Having them covered by the clinical faculty policy would help.
- Working time directives - residents are not around patients enough

- Emphasis on simulation - drives up the perceived 'need' for simulation, and becomes a vicious (and unvalidated) cycle
- Ensure adequacy of faculty teaching - pride in same

5. How significant an issue is the variability of services and equipment across training sites?

a) Very significant: 1 response

- The residency is quite unlike the other clinical residencies and so its unique needs are often difficult to communicate in terms of securing similar resources.
- The core field rotation sites offer a variety of supports for residents which create a challenge in ensuring all sites are accessed. For example some sites cover conference costs, others not. It would be helpful to have a central fund for resident conference travel that could correct this imbalance.
- Supervisors at core sites offer a variety of teaching and assessment opportunities. In future it would be helpful to ensure all supervisors attended faculty development activities and were held accountable for program teaching expectations in their annual review. As the core supervisors are almost all adjunct faculty, this is difficult to require given their busy “day” jobs.

a-i) Somewhat significant: 1 response

b) Neutral: 6 responses.

- Royal College accreditation requirements drive much of this. Happy to discuss further.
- One program said the “neutral” response applied to “Services” (and not equipment, which was rated “not at all”).
- One program said it was “between B (neutral) and C (not at all)”. This is not a large issue, as it reflects the diverse experiences represented across the clinical sites

c) Not at all: 6 responses:

- We currently have 2 major sites for UT-DRO Residency training: PMH & Odette – which is a well-co-ordinated and harmonized program; similarly-equipped and serviced.
- One program said the “not at all” response applied to “Equipment” (and not services, which was rated “neutral”).
- One program said it was “between B (neutral) and C (not at all)”.

No rating: 1 response

- It is a minor issue. One site, UHN/TWH, consistently has issues with adequate resident equipment and resources to assess patients on-call. It is very difficult to get hospital administration to replace equipment, even something as simple as a light bulb in a slit lamp.

6. A) Does your department currently explicitly compensate your Residency Program Director(s) based on trainee enrolment? If no, do you feel that such an algorithm would be something you could support?

Explicit compensation

- Our program does not provide direct “in pocket” financial compensation to Program Directors. Instead, we put funds into a discretionary academic account for each Program Director and this funding is based on the number of trainees enrolled in his/her program.

- Not that granular. We have 4 residency programs in the department. The main program with 60 residents has a director who has 2 days per week protected time. The other three programs have between 1-4 residents. These directors have half a day per week protected.
- Given that my department is involved in a comprehensive alternate funding plan, training program directors are remunerated the same as their other colleagues in the department. The time taken to administer the program is factored into each division's academic activity.
- No to part A. Support for the program comes entirely from PGME (other than in kind IT supports office space and rooms for meetings/rounds). This support provides bare bones for the PDs, the PA and core costs such as OTN and t/c. There is no core budget for PD travel to conferences or CPD events. The program currently has put a pause on IMG/Visa revenue. The current core budget should not be reduced if the # of residents decreases, however if there is growth in future, the budget should reflect that and be increased. This has not occurred in the past when the program expanded under growth requirements to 35 residents. The program has reduced to 25 residents currently.
- The Residency Program Director receives a stipend for the role, which is not dependent on the # of residents in the program, which is reasonably stable at ~25-30 per year
- We explicitly compensate the PD (stipend, no benefits), not per resident numbers; we don't envisage a change in numbers and the \$ amount is not problematic to the practice plans (we pay the practice plan, they free up the PD for 2 days per week).

Supportive of the use of an algorithm

- I am aware of this concept, having been part of the process that developed such an algorithm at UBC a number of years ago. The algorithm was applied to all UBC postgraduate education program.
- I would be willing to support an algorithm standardized across U of T.
- An algorithm that related the amount of time (common to all specialties) per number of residents would be interesting and useful
- Yes our program does have an algorithm, however it needs to be revisited and refreshed. The formula is based on number of trainees in the program, length of the and engagement with integrated medical. Overall stipends are usually augmented or matched from the host hospital practice plans. The Stipend and pg programmatic support is arranged between the Chair and the Division Head. As often the funds flow directly to the practice plan, sometimes the program director is not aware of all of the details of the funding support.
- Our department would welcome a standardized approach to compensation for the role of program director, as the current stipends, set out in contract by the previous Chair, are significantly in excess of that being paid in other Departments; the challenge will be how to offset cuts from the department onto the practice plans. The risks are that people won't step up to these roles in practice plans that tax OHIP income, as opposed to paying for time from pooled OHIP income, as in one program. That program is seen as a model for "Resident support" but we will find it increasingly hard to keep up a high level of support as we are in an unsustainable operating deficit arising from these high levels of previously-agreed compensation from the former Chair. Finally- would there be some role for recognizing innovation and excellence? Innovative programs take more time.
- No, we don't and yes we think it would be a good idea
- We do not support based on trainee enrolment, but I agree this is a good idea to consider.

Not supportive of the use of an algorithm

- No, I don't think such an algorithm would be very useful for our department. Our department consistently has the same number of trainees, or only very minor variances. The workload does not vary significantly with these small variances.
- I do not agree with compensation based on enrolment. The paper work, meetings, committees, organizing of courses, etc. is the same if you had 5 residents or 10 residents/year.

6. B) Name the kinds of compensation the department provides to Program Directors: (e.g., protected time, financial compensation, relief from other responsibilities, development of a team approach to supporting the program, other).

All chairs said that the PD receives financial remuneration from either the department or another source (e.g., practice plan, AFP, PGME). One department said there was financial remuneration from the department and one other source.

Remuneration	# of responses
Financial compensation (Department)	9
Financial subsidy from practice plan, AFP, PGME	4
Protected time	5
Relief from clinical activities	2
Space	2
Other support	6

Protected time

- Regarding protected time, this is currently done with great reliance on the goodwill of Hospital Chiefs, but as indicated above, Chiefs face pressures to provide increased service demands by their staff physicians. I would welcome adopting best practices that would be applicable throughout PGME and be of practical utility to the situation in our program.
- The 'currency' for the individual is protected time. The home department for the individual is financially compensated though this only equates to under half the real value of the time away from the department. This is an increasing bone of contention as the demands on the practice plans increase, especially as new programs are introduced that did not previously exist.
- Protected time (1 day/week)
- We pay the practice plan, they free up the time for PD (and maintain his income as 1.0 FTE in the plan). The only issues are time (practice plan) and \$ (UT dept). In addition, the UT dept pays for modest travel (National meetings, etc).

Stipend for work

- The current approach used in our program (i.e., putting funds for Program Directors into a discretionary academic account) was started under the leadership of the former chair and continued by me in my first term.
- Support is available from the Department as well as the host hospital practice plans and therefore reflects, protected time, financial compensation, and for some programs assistant or associate program directors and site leads.
- We pay a stipend. The amount needs to be revisited as per directives from this survey, as this level of compensation cannot be sustained. We pay smaller compensations for each of the PDs in the Royal College sub-specialties; these PDs also claim variably from their practice plans, while

the Chair provides the \$\$ compensation information to the PD's site chief's to adjust practice plan compensation. These subspecialty programs fund their secretarial support at hospital level but have some core support around some of the CanMeds roles and at the time of accreditation, including preparation of PSQs etc.

- There is a stipend for the PD.
- ALTERNATE Funding plan allows for protection from other activities.
- Financial compensation.
- PD salary support is paid for by PGME.
- Financial compensation is provided from the Department for the Program Directors,

Space

- Space.
- The School provides office space for the PD, a resident room, shared space for the APDs, an open carrel for the PA and room bookings for rounds and meetings. The offices are provided with basic equipment (old computers, phones, printers, file cabinets)

Other support

- The program director is well supported with sub-specialty chiefs who organize the grand rounds schedules, and numerous volunteer staff who work as site supervisors for the residents.
- The program director is also supported by many staff who volunteer time for training, resident only lecture series, research mentoring.
- There is a RPC (Residency Program Committee) which functions as a team to address resident training issues, and resident evaluation
- Administrative resources.
- Full time administrative support.
- Budget for catering, speakers, travel.
- Supervision and mentorship from leaders in our department.
- Additional support is given as needed and upon request from the Program Directors
- Development of a team approach to supporting the program

Other comments

- I THINK THAT A MAJOR ISSUE IN PLANNING FORWARD FOR PDs IS THAT THERE IS A CONSTANT CENTRALIZATION OF EDUCATION RESPONSIBILITIES FROM THE CLINICAL DEPT TO THE PGME OFFICE ... THAT OFFICE APPEARS TO BE WELL FUNDED (CURRENTLY HIRING MULTIPLE NEW STAFF); THE RESPONSIBILITY FOR EDUCATION IS SHIFTING FROM THE BASE DEPARTMENTS TO THE PGME. THIS REPRESENTS A SHIFT FROM 'CONTENT' EXPERTISE TO 'METHODOLOGY', AND IT SOMETIMES SEEMS THAT THE VIEW OF EDUCATION ESPOUSED BY PGME IS TOWARDS A LOWEST COMMON DENOMINATOR ... IN LINE WITH RCPSC 'COMPETENCY' (AND NOT TOWARDS EXPERTISE OR EXCELLENCE).
- IN ADDITION, THE PGME SEEM TO DECIDE HOW MUCH 'TEACHING' INCOME FLOWS TO THE CLINICAL DEPARTMENTS AFTER THE PGME EXPENSES HAVE BEEN SETTLED ... SEEMS LIKE AN ADMINISTRATIVE TAIL WAGGING A TEACHING DOG!

Appendix I: Second Departmental Chair Survey

Task Force on Best Practices in PGME Program Support Survey of Clinical Chairs February 14, 2014

Introduction:

The purpose of this survey is to collect additional information from Clinical Department Chairs to inform the Task Force on Best Practices in PGME Program Support.

All responses will be completely confidential. Please be assured that the information provided will be kept strictly confidential, and will not be released except as summary statistics (e.g., mean or median level of support, minimum or maximum ranges). We will assume that by participating in this survey, you are providing your consent.

Please respond no later than Monday March 3, 2014 so that the summary information can inform the Task Force's deliberations and recommendations and be incorporated into our report to the Dean.

If you have questions about this survey or the Task Force on Best Practices in PGME Program Support, please contact postgrad.med@utoronto.ca

Please provide the following information for each program director role within your department:

1. Is the Program Director paid a stipend for his or her time that is spent on responsibilities associated with the residency program?
2. If so, what is the amount of the stipend, and by whom is it paid (e.g., practice plan, department)?
3. What level of effort is the stipend intended to reflect (e.g., one-half day per week, one full day per week)?
4. Does the PD have protected time during regular office hours (e.g., 9 to 5, Monday to Friday) for these residency responsibilities?
5. If no stipend is paid, is the PD's time covered in some other way (e.g., continued and unreduced salary or allocation from an AFP)?

Appendix J: Second Departmental Chair Survey Results

Task Force on Best Practices in PGME Program Support Survey of Clinical Chairs Summary Responses – By Question N=13

1. Is the Program Director paid a stipend for his or her time that is spent on responsibilities associated with the residency program?

All but two programs reported that the PD is paid a stipend. The two exceptions are described as follows:

- Medical staff within one of the programs is paid through an alternative funding plan, and the department simply we adjusts the job profile description to include the duties of this role. The PD experiences no loss of income, nor does he/she gain any income for these responsibilities.
- A simpler approach is used for one other department where the overall staffing level of physicians within the department in each fully-affiliated hospital is sufficient to allow for the PD based at a given site to carry out his/her responsibilities in fulfillment of Royal College accreditation standards.

2. If so, what is the amount of the stipend, and by whom is it paid (e.g., practice plan, department)?

See Table J-1 (medical programs) and Table J-2 (surgical programs) on the following pages and Table J-3 below (which provides a summary of the key statistics for medical and surgical programs).

CAUTION: The data provided in Tables J-1 to 3 are calculated from data provided by the survey respondents. The data represent a subset of respondents who provided all required variables, and some assumptions have been made to facilitate the analysis. These numbers may not be fully representative of the entire population of programs.

Table J-3: Key Statistics for Stipends by type of Program, 2013/14

	Medical Programs N=25	Surgical Programs N=14
Days dedicated to PD responsibilities		
0.5	3	-
0.67	1	-
1.0	4	2
1.5	12	11 *
2.0	2	1
3.0	2	-
3.5	1	-
Stipends per half day (paid by Department)**:		
Low	\$6,667	\$4,000
Mean	\$20,620	\$11,158
Median	\$20,000	\$8,667
High	\$30,000	\$30,000
Total stipends paid	\$1,553,500	\$457,489

* Reported as 1 to 1.5. For this analysis, we assumed 1.5 days per week

** PDs may receive additional funds from other sources.

NOTE: Table includes only those responses that provided the total stipend paid and the number of dedicated days for PD responsibilities by program.

3. What level of effort is the stipend intended to reflect (e.g., one-half day per week, one full day per week)?

See Table J-1 (medical programs) and Table J-2 (surgical programs) and Table J-3.

4. Does the PD have protected time during regular office hours (e.g., 9 to 5, Monday to Friday) for these residency responsibilities?

All but one chair indicated that PDs have protected time for these responsibilities. The one department that said the time was not formally protected indicated that this was not necessary as the overall staffing level of physicians in each fully-affiliated hospital is sufficient to allow for the Program Director based at a given site to carry out his/her responsibilities in fulfillment of Royal College accreditation standards.

5. If no stipend is paid, is the PD's time covered in some other way (e.g., continued and unreduced salary or allocation from an AFP)?

See response to Question 1 above.

Table J-1: Stipends and Protected Time by Type of Program (Medical Programs)

Stipend (\$/annum)	Days/week	Source of funds
20,000	1.5	100% from Department. May be topped up by PP
30,000	0.5	100% from Department. May be topped up by PP
30,000	0.5	100% from Department. May be topped up by PP
40,000	0.67	100% from Department. May be topped up by PP
120,000	2	100% from Department. May be topped up by PP
170,000	3 to 3.5	50% from Department and 50% by PP
Not disclosed	0.5	50% from Department, 50% from PP
Not disclosed	0.5	50% from Department, 50% from PP
Not disclosed	0.5	50% from Department, 50% from PP
Not disclosed	2	50% from Department, 50% from PP
3,000 to 65,000	depends	100% from Department, most receive 10k to 20k from PP
Unknown	2	100% PGME
\$60,000	1.5	Practice Plan
\$70,000	2	100% from Hospital
\$60,000	1.5	100% from Department
\$50,000 + HST	1	100% from Department
\$51,000	1.5	100% from Department
60,000	1.5	100% from Department
\$60,000	1.5	Shared by Department and Practice Plan
\$120,000 (shared)	3	100% from Department
\$60,000	1.5	100% from Department
\$60,000	1.5	100% from Department
\$60,000	1	100% from Department
\$70,000	1.5	100% from Practice Plan
\$120,000	3	100% from Department
\$52,500 + HST	1.5	100% from Department
\$52,500 + HST	1.5	100% from Department
\$52,500 + HST	1.5	100% from Department
\$34,000 + HST	1	100% from Department
\$17,000 + HST	0.5	100% from Department
\$34,000 + HST	1	100% from Department

Table J-2: Stipends and Protected Time by Type of Program (Medical Programs)

Stipend (\$/annum)	Days/week	Source of funds
12,000	1 to 1.5	100% from Department
15,000	1 to 1.5	100% from Department
17,000	1 to 1.5	100% from Department
18,000	1 to 1.5	100% from Department
20,000	1 to 1.5	100% from Department
25,000	1 to 1.5	100% from Department
25,000	1 to 1.5	100% from Department
27,000	1 to 1.5	100% from Department
30,000	1 to 1.5	100% from Department
37,500	1 to 1.5	100% from Department
40,000	1 to 1.5	100% from Department
45,489	1	100% from Department
60,000	1	100% by Department
\$85,500 + 8,500 benefits	2	100% from Department, PP guarantees protected time.

Appendix K: Survey Results of Other PGME Offices

Summary of support and meetings organized by PGME Offices with Program Administrators – AFMC schools – provided by PG Managers, June 2013

1. Dalhousie

- Dal's PG Office organizes an Education Day for Program Administrators and Program Directors 2x/year, 8:30 – 4:30. Breakout sessions and Learning Objectives for each topic e.g. contract issues, resident selection, curriculum development, assessment & feedback, resources & documentation, when to call for help.
- There are plans to develop a Program Director and Program Assistant “toolbox” for program issues such as effective remediation, policy setting etc.
- majority of Program Administrators are funded by the hospital
- **No set ratio for support --- clinical department jurisdiction**

2. Laval

PG Office meets with administrators approx 4x/year, plus some special training sessions on specific topics in the Fall and Winter.

There is also an administrative guide

http://www.fmed.ulaval.ca/site_fac/fileadmin/doc/formation/post_md/Guide_Admin_2012_V_05-12-2012.pdf

3. University of Montreal

The PG Dean's office does not have courses or retreats with the program assistants. Each Program Director has an assistant/secretary but this person is not necessarily a medical education administrator. The Postgraduate Medical Education office will deal with a trainee's academic issues after consultation with the Program Director.

4. McGill

- Once every 2 years meet with the program administrators to review Accreditation, Evaluation of Residents, and what our various roles are in our office.
- Breakdown of admin employer is 40% university, 60% hospital

5. University of Ottawa

- Monthly information sessions available on a variety of topics such as Rotation Scheduling, accreditation PSQ, CAMEO prep course, academic day planner, visa orientation, evaluation reporting. Registration for sessions is on-line.
http://www.med.uottawa.ca/medevents/postgradreg/clients/Events_list.asp
- Annual retreat (see attached agenda)
- Semi-annual meetings PGME and Program Administrators

6. Queen's

- PG Office organizes meetings with Program Assistants 3-4 meetings per year
- Subsidies to program assistants to attend ICRE
- Organized special training for One45 or other IT projects

- Also provide Mental Health Helping Skills course to help PAs recognize residents in distress
- Administrators employer: 50-50 hospital and university

Ratio of PD/PA to residents – see table below:

Number of Residents *	Program Director (FTE/Protected Time) **	Administrative Support (FTE)
1-15	0.20	0.40
16-30	0.30	0.75
31-50	0.40	1.00
>50	>.50	2.00

**Residents rotating through program may require additional administrative support

7. Western

- Meet with Program Administrators 3 or 4 times annually.
- See attached for agenda from March 1 2012 meeting.

8. NOSM

- Monthly meetings with Education Managers + PGE office staff where training/support of program coordinators at each meeting, e.g. sections of the B standards reviewed over the past year with Dr. Cervin
- mandatory minute-taking course at Cambrian College for all coordinators and AA's
- retreat which provided a combination of training (organizing AHD's, accreditation, CaRMS), updates and social activity.
- Writing workshop for Pre-Survey Questionnaire for PDs and administrators
- Employer: NOSM

PD/PA to resident ratio: 10 residents = 0.5 coordinator and 20-25 residents = 1.0 FTE coordinator

9. Calgary

- monthly update sessions for the program administrators. The themes/agenda based on issues raised by administrators such as evaluation, policies, registration, program reviews etc.
- Annual session organized with Alberta Health Services with new/updated information on government requirements
- Semi-annual retreat organized by PGME Office approx. 11am to 3pm. Agenda: PGME update; IMGs; demonstration/discussion of new system developments; lunch, motivational speaker (stress management, generational issues, communication, discrimination, yoga and mindfulness.
- December meeting: special breakfast and team gingerbread decorating contest --- designed to interact with administrators who did not know each other
- Majority of program administrators are employed by Alberta Health Services

- Ratio of PD:residents and PA:residents as indicated below:

Number of Residents	Program Director (FTE/Protected Time)	Administrative Support (FTE)
0	0.05	0.1
1-4	0.15	0.3
5-9	0.20	0.5
10-14	0.25	0.8
15-19	0.30	1.0
20-24	0.40	1.4
25-29	0.45	1.8
30-49	0.50	2.0
50-74	0.70	2.5
75-99	0.90	3.0
100-124	1.10	3.5

10. Saskatchewan

- Meetings with PAs every 2 months
- Orientation by PGME staff for new Program Assistants. PGME staff review processes that will require PA input. Provided with manual/guide book
- ICRE Conference – Program Admin track 5 program admins to attend each year funded by the PGME Office
- Professional development courses to upgrade skills – course funding provided by CUPE
- Employer is the University of Saskatchewan for the majority, with a few employed by health regions

Ratio of PD/PA to residents:

Number of Residents	Program Director (FTE/Protected Time)	Administrative Support (FTE)
1-4	0.20	0.3 (1 ½ days/wk)
5-9	0.20	0.5
10-14	0.25	0.8
15-19	0.30	1.0
20-24	0.40	1.4
25-29	0.50	1.8
30-49	0.60	2.0
>50	0.80	3.0



Responsibilities for Residency Administrative Support at UT PGME

DRAFT

Revised January 27 2014

Role

A Program Administrator (PA)³ for a Residency Program at the University of Toronto is responsible for supporting the Program's Director (PD), faculty and residents or clinical fellows⁴, and working with regulatory, educational and accreditation bodies as required. In most cases, the PA reports to the PD.

Program Responsibilities⁵

Scheduling

- In consultation with the PD and in collaboration with program faculty, other programs and training sites, prepare a master schedule of core and elective rotations for all residents in the program.
- Accommodate within the master schedule requests for core and elective rotations for residents from other programs or universities.
- Enter the initial rotations into POWER and update as changes are made to the initial schedule.
- In collaboration with site coordinators, oversee scheduling of vacations and other short-term leaves from residency.

Resident Registration and Orientation (Academic year begins July 1)

- Appoint new and reappoint returning residents.
- Register residents from other programs or universities for electives.
- Arrange for needed appointments and re-appointments.
- Ensure that credentials are up to date for all returning trainees and update profiles for each resident with new contact information.

³ This role may have a different name (e.g., Program Coordinator, Program Administrative Assistant); however, the responsibilities do not change. For larger programs, these responsibilities may be distributed across one or more positions (e.g., program assistants, administrative assistants, site coordinators, fellowship coordinator).

⁴ The remainder of this role description is written for residents; many of the responsibilities for fellows and for learners working towards a diploma are similar.

⁵ This role is managed as a part-time position for some programs. This role description includes only the activities related specifically to the PGME program and its residents.

- Organize resident welcome and orientation activities.
- Ensure appointments for international trainees are submitted within work visa and Pre-Entry Assessment Program timelines

Support for Residents and PDs throughout the Academic Year

- Schedule and coordinate, in consultation with the PD and program faculty, other educational and related activities (e.g., research days, academic half days, resident wellness activities, retreats). The PA's involvement in academic half-days may include logistics (e.g., finding and booking rooms, arranging for electronic equipment), identifying speakers and topics (in consultation with the PD), and may also include analyzing and reporting on feedback.
- Work with the PD in managing remediation activities.
- Manage, in consultation with the PD, changes to the initial rotation schedule (e.g., leave requests, respond to faculty or site requests).
- Assist residents with issues related to their training as they arise.
- Liaise with hospital sites regarding any issues related to resident training.
- Liaise with stakeholder organizations (e.g., Post Graduate Medical Education, hospital Medical Education office, College of Physicians and Surgeons of Ontario, Professional Association of Residents of Ontario, RCPSC/CFPC).
- Ensure residents submit their summative reports to the PD.
- Coordinate the process to select the following year's chief residents.
- Document and maintain policies and procedures for the department.

Support for Evaluation and Examination

- Schedule exams (e.g., orals, mock orals, OSCIs), which may include recruiting and booking examiners, and locating and booking rooms for the exams.
- Work with program faculty to ensure evaluations are completed on time and submitted to PGME as appropriate.
- Manage the process for Structured Assessments of a Clinical Encounter (STACERs), including organizing practice STACERs, logistic arrangements, scheduling residents and faculty, and sending the reports to the Medical Education office at the University of Toronto and to the Royal College of Physicians and Surgeons of Canada (if applicable).

Manage Financial Disbursements for Residents

- Accept and submit call stipend claims for residents (if applicable).
- Prepare reimbursements for qualifying expenses (e.g., conferences).
- Provide assistance to residents as needed to complete the forms and ensure reimbursements are received in a timely fashion.

Data and Information Management

- Ensure all resident rotations are entered accurately into POWER.
- Update faculty and coordinator list in POWER periodically.
- Provide reports from POWER as required with assistance provided by PGME POWER Helpdesk as necessary
- Liaise with PGME regarding reconciliations for reporting of medical trainee days (MTDs).

- Be familiar with relevant components of the PARO-CAHO collective agreement regarding leave, call

Information technology

- Manage electronic files.
- Manage the program's web portal for residents.
- Monitor PGCORed module completion (if applicable).

Canadian Resident Matching Service (CaRMS)

- Prepare and update program descriptions for CaRMS with detail on current program contacts, selection criteria and process, curriculum and training sites
- Gain familiarity with CaRMS on-line portal and co-ordinate with file reviewers and PGME office as necessary.
- Receive and screen applications for residencies.
- Schedule interviews, coordinating with applicants and with PAs and PDs in other programs at the University of Toronto and in other universities.
- Communicate throughout the process with the applicants.
- Provide coordination for the Resident Selection Committee.
- Collate applicants' scores from CaRMS interview process for the Resident Selection Committee, and input scores to the CaRMS site.
- Manage applications from non-CaRMS applicants.

Program Reviews (External Reviews for the Royal College of Physicians and Surgeons of Canada and College of Family Physicians of Canada as well as Internal Reviews or Audits)

- Research, retrieve, and enter data and information for the pre-survey questionnaire.
- Ensure all documents (e.g., binders, resident files) are updated and readily available for the reviewers.
- Schedule meetings for reviewers and manage logistics as required.

Supports for Residency Administrative Support

Depending on the size and nature of the residency program, the activities of residency administrative support can be shared with one or more of the following positions:

- Program coordinators,
- Administrative assistants,
- Site coordinators,
- Hospital coordinators,
- Program Director, and/or
- Department faculty.



Job Description of Program Directors at UT PGME

DRAFT

Revised January 2014

ROLE

The Program Director (PD) for a residency program at the University of Toronto (U of T) is responsible for the overall conduct, organization and accountability of the residency program.

A PD is a highly valued and pivotal leadership position in a Department and Division hosting an accredited residency program. The PD reports to the Chair of the Department and/or to the Division Chair, as well as to the Vice Dean for Postgraduate Medical Education (PGME).

The PD is the chair of the residency program committee. The PD is assisted in the execution of his/her responsibilities by the residency program committee. The Program Director is also assisted by a program administrator, site coordinators, PGME, and departmental faculty as appropriate for each residency program.

APPOINTMENT

The appointment of PDs should ideally be conjointly by the Chair, Division Chair, Chief and Vice Dean PGME. The Vice Dean must be notified of new appointments well in advance of their start so that the RCPSC or CFPC may be notified and appropriate orientation can be arranged.

RESPONSIBILITIES

Development and Operation of the Residency Program

1. **Program Development and Operation:** The development and operation of the program such that it meets the general standards of accreditation and the specific standards of accreditation of programs in the specialty or subspecialty as set forth by the accrediting colleges.
2. **Program Admissions:** The selection of candidates for admission to the program, including eligibility criteria, allocation of positions to hospitals and establishing transparent processes for all policy implementation in PGME.
3. **Rotation Scheduling:** Participation in the scheduling of components of the residency requirements (e.g., rotations, academic half days).

4. **Program Evaluation:** Participation in the ongoing review of the program and its teachers to assess the quality of the educational experience and to review the resources available in order to ensure that maximal benefit is being derived from the integration of the components of the program. The management and ongoing evaluation of the program must include:
 - a. An assessment of each component of the program to ensure that the educational objectives are being met;
 - b. An assessment of resource allocation to ensure that resources and facilities are being utilized with optimal effectiveness including the credentialing and accreditation of educational sites ensuring all affiliation agreements are transmitted through the Vice Dean's office.
 - c. An assessment of teaching in the program, including teaching in areas such as core competencies, CanMEDS roles or Four Principles of Family Medicine, biomedical ethics, medico legal considerations, teaching and communication skills, related to quality assurance/improvement, equity issues, and administrative and management issues;
 - d. An assessment of the teachers in the program either in aggregate or individual form.

The opinions of the residents must be among the factors considered in this review. Appropriate faculty/resident interaction and communication must take place in an open and collegial atmosphere so that a free discussion of the strengths and weaknesses of the program can occur without hindrance.

The PD is expected to report any significant difficulties in the conduct of the program to the Division Chair, Department Chair and Vice Dean in timely manner.

5. **Evaluation and Promotion of Residents.** Management and maintenance of an evaluation system to assess trainee performance in:
 - a. All requirements of the residency program.
 - b. All domains based on CanMEDS roles or the Four Principles of Family Medicine.
6. **Appeals Process:** Management and maintenance of an appeal mechanism and the evaluation and promotion of residents in the program in accordance with policies determined by the Faculty Postgraduate Medical Education Committee.
7. **Resident Support Services:** Establishment of mechanisms to provide career planning and counseling for residents and to deal with problems such as those related to stress and resident wellbeing.
8. **Program Innovation and Scholarship:** Engagement in innovation related to the program and encouragement of education scholarship.
9. **Program Reviews:** Leadership in preparation for and response to internal university reviews and RCPSC/CFPC reviews of the program. Contribute to the Internal Review process. Contribute to one internal review and chair one internal review in each site survey cycle.
10. **Program Representative:**
 - a. **Internal.** Participation in meetings at U of T in the appropriate committees (e.g. All PDS; PGMEAC, BOE and IRC as required).
 - b. **External.** Stay current with the requirements of the specialty and represent the residency program in RCPSC or CFPC related activities, at the CPSO and at specialty committees, hospital and university groups and international or other national bodies

especially where advocacy for the resident and the program with the University, hospital, RCPSC, CFPC, PAIRO, CPSO, CARMS may be required.

Operational and Financial Planning

1. **Operational Plan:** Early after the PD's appointment, develop and document an operational plan that is aligned with the strategic plan of the department, division, faculty and PGME and aligned with accreditation standards. This plan will identify all of the activities and resources (e.g., PD time, administrative support, appropriate committees and their support, conference attendance, professional and faculty development, space) related to the achievement of the educational mandate. This plan should be reviewed on an annual basis, or when circumstances change in the program (e.g., new chair, new PD, internal review or accreditation, change in standards).
2. **Academic Cycle:** As part of the operational plan, develop and document an academic planning cycle clearly identifying the periods during the academic year when the workload is greater than usual (e.g., preparing for internal reviews and accreditation, CaRMS) and ensuring that all internal stakeholders are aware of the need for relief from other responsibilities so that the PD and PA can concentrate on these activities.
3. **Financial Plan:** In conjunction with the development of the operational plan (see above), the PD will develop and document a formal budget for the program that documents all of the financial supports provided to the program (i.e., funding and in-kind) as well as the expenses associated with each of the activities and resources identified in the operational plan. As with the operational plan, the budget should be reviewed annually and whenever the operational plan is revised.

SKILLS⁶

PDs work in five main performance areas:

1. **Communication and Relationship Management.** Communicates clearly in a responsive manner with a diversity of individuals, groups and organizations. Establishes and nurtures – directly or indirectly – constructive and collaborative interactions with individuals, groups and organizations.
2. **Leadership.** Engages, motivates and facilitates individuals, groups and organizations to develop a shared vision and achieve related goals and objectives. Ensures that innovation and changes to the program occur within a supportive culture and are guided by a cohesive educational approach.
3. **Professionalism and Self-Management.** Aligns personal and organizational conduct with ethical and professional principles that include responsibility, service, self-reflection and self-discipline. Recognizes both personal strengths and limitations, demonstrates a commitment to improvement and lifelong learning and with integrity, leads by example.
4. **Environmental Engagement.** Monitors, seeks information from, and networks with the internal and external environments. In doing so, develops an understanding of how things work, identifies trends and priorities and builds individual and organizational relationships.

⁶ The categorization of PD skills is based entirely on the work by S Lief, S Glover Takahashi, A Zaretsky, G Bandiera, K Imrie and S. Spadafora at the University of Toronto, March 2011. Additional detail on the specific skills is available in the "Residency Program Directors Leadership Inventory" developed by these researchers.

5. **Management Skills and Knowledge.** Manages the residency program by developing, encouraging and enabling people, and effectively utilizing resources and information. Demonstrates political astuteness and good judgment about what can and cannot realistically be done.

SUPPORTS FOR THE PROGRAM DIRECTOR

A PD must be offered the following supports to do this job effectively:

- A stipend or alternate remunerative compensation during his/her term in that position,
- Adequate administrative support,
- Protected academic time, and
- Physical space.

The PD's performance should be evaluated annually through a variety of modalities.

The PD's important contribution to education in the Department should be formally recognized.