On-Site/Off-Site Model of Faculty Development

William Anderson, Ph.D.

Transcript from session.

I would like to express my thanks to the support provided for this conference by HRSA. For those of us who have been in the field of faculty development for a number of years, we realize we don't get a lot of opportunities to meet and talk about faculty development programs.

My task here this morning is to give you an overview of yet a different type of faculty development model, one that is relatively untraditional. Only a handful of programs of this kind exist in the United States, but they do train large numbers of faculty. Many, but not all, have a national focus. Some community-based medical schools use a variance of this approach to train their faculty who are not at the academic health center.

I have six major points to share with you, including 1) Definitions and examples; 2) The rationale behind an on-site/off site model; 3) A description of the program at Michigan State University; 4) Evaluations of the effectiveness of this model; 5) Conclusions we have come to over the years and issues we have faced; and, 6) directions for the future. First, I want to be sure that we all understand the concept of what an on-site/off-site faculty development program is. I will begin with a definition and give examples of programs. Then I will discuss the rationale for the model. I will tell you about our program, which has been on-going for 22 years. The program has evolved over time, but I will explain our version of the on-site/off-site faculty development model. I will also share with you some of the results that address the issue of how effective this model is. I will briefly discuss some of the conclusions we have drawn from our years of experience, including the issues we have faced. And finally, I will take a quick look at future directions.

Table 1 lists the components of on-site/off-site faculty development programs:

Table 1. The On-Site/Off-Site Model of Faculty Development: A Definition

- A faculty development fellowship program is targeted at junior, non-tenure track physician faculty from different institutions/programs
- Fellows receive on-site structured didactic/experiential training for all faculty roles
- They complete off-site assignments, readings, and a major scholarly project

As far as an operational definition, the on-site/off-site model has the following components. First, it is a fellowship program, not just a longitudinal series of trips back and forth to workshops. Generally, the appropriate group to target for such a program is junior, non-tenured faculty who come from different programs or institutions from the region or from around the country. Fellows receive structured, didactic instruction in a variety of topics and then return to their home institutions to complete assignments, readings, and a major project. On-site/off-site programs around the United States are found at the University of North Carolina, the University of Washington, the Hennepin County Medical Education Center, and the Research and Development Foundation in Waco, Texas.

In developing the rationale for our program development, we considered our institutional structure. We are a community-based medical school, which means that our faculty are not only at the mother ship in East Lansing, but also spread across six community campuses across the state. The concept of an on-site/off-site program was appropriate to this situation. We decided to target junior, entry level faculty, hoping that we could have some meaningful interaction with them before they can

be socialized to some of the more cynical views of many of their colleagues. The majority of the faculty at our place are teachers who serve as clinician educators. We started with our pool and at first recruited locally. As our program matured, we began getting requests from others outside of our region. We knew that we couldn't get people to come to the East Lansing campus for extended periods of time. We actually tried that in another program and had difficulty in recruiting participants. So we developed a model that allowed people to remain at their home institutions and come to the program for short micro-bursts of training.

Central to the concept of a fellowship program and creating continuity, we developed the concept of a longitudinal project. This has kept participants involved, connected, and interested in completing the program. Otherwise, we would have just had a series of unconnected workshops, seminars, and other activities. The project ties them into the program and also offers a "pay-back" to the participants' sponsoring programs and institutions. Participants are taken out of their home environments for awhile, but can return with new skills and with the results of their project.

In the program at Michigan State, we not only use local faculty to teach the fellows, but also faculty and role models from around the country, many of whom are sitting out in the audience and up here on the podium. And finally, we decided that, to the extent possible, we would incorporate technology to help fellows keep in contact while they were off-site. Now, at the time we started, that was Fax machines! Now, of course, we have to up the bar and are moving into other technologies. Table 2 summarizes the rationale for our model.

Table 2. Rationale for the On-Site/Off-Site Model of Faculty Development

- Target promising residents and new junior faculty
- Target non-tenure track university-based and community-based residency faculty
- Recruit locally, regionally, nationally
- Provide training for all faculty roles
- Allow fellows to remain at their home institutions
- Include a major scholarly project
- Learn from expert teachers and role models
- Emphasize primary care topics/issues
- Incorporate new technologies

The Michigan State program is a year-long, part-time fellowship program. The participants are on the Michigan State campus for a total of 24 days. The off-site time required to complete assignments and the project is an additional 48 days, for a total time commitment of 72 days. Essentially, this requires 20% release time from each fellow's home institution. Recently, this has become much more of a challenge, so we all are going to have to find more creative ways of solving time issues. To run the program we have a 1.3 FTE commitment of faculty and a 0.8 commitment of professional support. Table 3 describes the curriculum for the program with the percentage of time devoted to each topic.

Table 3. Curricular Topics

Topic	%
Teaching/ Evaluation	29%
Research	25%
Administration/Management	16%
Academic Socialization	11%
Written Communication	10%
Computing	9%

Our program is a true primary care program, supported by two HRSA grants, one for Family Medicine, and one for General Medicine and General Pediatrics, and have been training fellows since 1984. We have twenty fellows per year, 10 Family Medicine fellows, 5 General Internal Medicine fellows, and 5 General Pediatrics fellows. We have two hundred seventy-eight graduates. Prior to 1984 we had a fellowship in Family Medicine in which we have trained an additional 46 fellows, for a grand total of 324 graduates from our program. About 30% of our graduates are from minority groups. Forty-one percent work in medically under-served communities, and the gender mix is seventy/thirty males to females. Eighty-eight percent remain in academic medicine, a bit higher than the literature indicates for the national average.

The program format is as follows: Fellows are in structured didactic sessions from 7:30 in the morning until about 7:00 at night while they are on site. We feel that the time with us is very precious, so we work with them very closely, and we work them very hard. During this time they do a lot of workshops, seminars, and round tables. They do practice teaching and complete various assignments. We have computer lab time for them. We also meet in a series of mentor groups.

Then they return home, and once they get their desks cleared off, they start on a series of readings, assignments, and work on a major project. Now we can do a lot of what we call electronic mentoring, in which we talk with them not only over the phone, but also via e-mail.

The longitudinal project is an essential component of the training. Our criteria for their projects are: 1) The project must be of interest to them; 2) The project must have some utility or benefit to the fellow's sponsoring institution; 3) The project must address an object of Health People 2000; and, perhaps most important, 4) The fellow must be able to complete the project within a year. From this project, the fellow is expected to generate a manuscript, following instructions to authors from any of the academic medicine or primary care journals. They have to make a ten-minute oral presentation with slides, which is observed by national primary care role models who provide feedback.

What I would like to do now is give you a sense of what it is like to be a fellow in this type of faculty development program. We start in July with an orientation. We have a video presentation that describes not only some of the things that we have just completed, but also interviews with former fellows who give tips and strategies to survive the fellowship program. We also do either a site visit or a conference call with the fellow and the fellow's supervisor and one of our faculty. We do this to be sure that we have a common understanding of the expectations and time commitments of the program and an agreement about the major project. We ask that fellows already have their project underway prior to coming to East Lansing. They are to do an initial needs assessment and literature review. We force this interaction very early on.

The first time they come to campus is in September. They will spend a total of five weeks on campus, with the first session being two weeks. The rationale for the two-week "bolus" is that when you have twenty fellows from different institutions, they need time to get to know each other, to socialize with each other, and to come together as a group. During this time they have day-long and half-day teaching sessions. Many of these sessions are the mentor group meetings. When people elect a major project, they are paired with two other fellows and two faculty to assist them in shaping, molding and delivering their project.

When fellows return to their home institutions after the second week, they have a laundry list of things that they do. They work on their major projects. They have readings and assignments to complete prior to the next on-campus session. The majority of the time during this week, which is in November, is on their major project. We have three

tracks: curriculum, research, and administration. So while we are a group of twenty for the major project, we split up into a variety of different groups.

Fellows return for an additional week in February and one in June. What happens in those two interim sessions is a repeat of the first two. We are in constant contact with them as they complete work on a variety of assignments.

The June session does have one major difference from the others. People have been putting a lot of time and effort into their project. We decided that we would provide a realistic simulation of presenting at a national professional meeting. Most of the fellows have not had that experience before. We hold a conference at a conference center on campus and ask the fellows to present their projects. They give ten-minute presentations with slides.

We also ask fellows to write manuscripts that we bundle up and send to people like Lucy Osborn, Tom DeWitt, and Kelly Skeff and others who are sitting in this audience. They serve a very important role. They serve as a benign journal reviewer. For some of the fellows, this is one of their first attempts at writing a manuscript and receiving feedback from these national leaders is very important to them. They also get feedback from faculty at their home institutions.

Table 4 shows some of the outcome data from our program evaluation. Here you will see one of the "yellow flags" that we are concerned about. We would think that after 15 years we would have more faculty at higher academic ranks. We only have three graduates at the professor level. We have also looked at how our fellows spend their time. This tells us that our model has been effective in reaching our goals. About one third of their time is spent in instruction and about a third in patient care. They spend some time in scholarly activity, about 10%, and have many administrative responsibilities.

One of our major concerns, however, is that only about a third of our fellows publish the results of their projects. About forty percent present them at a national meeting. We must remember, however, that our trainees are in community-based residency programs. They are clinician educators. They are the worker bees of primary care and the need for publication and presentation isn't as high on their food chain as it is in the kind of academically oriented local approach that was described by Dr. Deborah Simpson.

Table 4. Program Evaluation and Outcome Data

Total number of graduates	278
Full time academic medicine	88%
Minority graduates	29.4%
Work in under-served communities	41.3%
Male/Female graduates	70%/30%
Tenure system	15.9%
Academic Rank	
Instructor	2.2%
Assistant Professor	40.9%
Associate Professor	20.5%
Professor	3.4%
Other	33%
Scholarly Activities	
Publications	34.4%
Presentations	41%
Awards	
Teaching	16.4%
Research	9.9%
(Table 4 cont.)	
Administration	2.3%
Patient Care	1.1%
Outreach/Service	8%

There are other indicators of success. Our graduates have been given honors and awards, with many at the regional or national level. They remain in their academic positions and have enjoyed success. We have concluded that we are training the right people for the right roles.

There are some issues that we face in using this model of faculty development. We have been blessed to have a Dean who is solidly supportive of the program. It would be very easy for us to get a new dean who might not support the concept of training people from other institutions. It could be hard to defend, but we know that we are making a difference.

With the attrition of faculty on the campus, it is more and more difficult for the primary care faculty to spend the amounts of time that we would like them to spend on the fellowship program. We are also seeing a slight diminishing of the fellows' pool. The reasons for both of these factors are not difficult to see. The demands on the clinical faculty and the clinical educators are ever increasing. Enforcing the release time is increasingly difficult. When fellows and supervisors sign that twenty percent agreement, there's a lot of finger crossing, blinks and smiles. This is one of the issues that is making us look at the design of the program. We are trying to shift by using the technology available to us. However, when you are dealing with a lot of people, different institutions with different kinds of e-mail systems and distance learning systems, it is tough. We have not yet solved the problems.

Where are we going in the future? We have many exciting things that we are working on. We are now teaching evidence-based medicine via the Web. We have a course on the Web so that we can have a component taught outside of the on-campus session. We are working with medical informatics, teaching our fellows how to use computer technology. We are using what we call "electronic mentoring." Finally, we are shifting to new topics, such as managed care and the care of special populations.