Updated August 4, 2026

Medical Trainee Days (MTD) Frequently Asked Questions

Contents

Contents 2
Introduction 6
MTD Value 7
How are hospitals classified/defined? 7
Do all hospitals benefit from MTDs? 7
Do small or specialty psychiatric hospitals still need to submit MTDs? 8
What is the difference between GEM and HBAM? 8
How much is an MTD worth? 9
MTDs in GEM Funding 9
MTD in Supplemental Funding 10
How does the Ministry allocate MTDs by care type in GEM funding? 10
Step 1: Determine the MTD days that fall under GEM funding by the following criteria: 10
Step 2: Identify MTD days by Service Code for Rehab, MH, and ER. 10
Step 3: Estimate Acute and CCC MTDs using the following approach: 11
Step 4: Allocate any Remaining (Unassigned) MTDs 12
What care type does each service code fall under? 12
Should rotations with the generic UGME service code be claimed with more specific service codes? 13
How does capping work? Why didn't my hospital get credit for all the MTDs we submitted? 14
Why might the MTD numbers not add up in the reports OPRC provides? 15
Submission Specification 17
Where can I find the current MTD Submission Specification? 17
What category/level do I use for trainees whose level changes during a particular quarter? 17
What category/level do I use for MD Extension students? 18
How does a medical trainee get a MINC? 18
How does a school find MINCs for their trainees? 18
How do I find a CPSO number for an inactive trainee? 19
How important is it that we use the right program code? 20
How important is it that we use the right service code? 20
How do you claim one rotation under more than one service code? 20

How does one decide which service to assign to a particular rotation? Is it based on the type of clinic, or on who supervises the trainees? 21
Which code should I use when the specific service or program is not listed in the MTD Submission Specification? 21
Can we create a new service code? 21
Should we claim only the exact days worked, or the entire block in which the rotation occurred? Should we claim one week as 5 or 7 days? 22
How are concurrent rotations claimed? 22
What is a longitudinal rotation? How are longitudinal rotations claimed? 23
How should a virtual rotation be claimed (when a trainee in one facility is providing services to another facility)? 23
How can I confirm the hospitals and hospital numbers my school is responsible for? 23
What about hospitals which have 'learner agreements' with more than one medical school? 24
How can I work with external partners that do not enter MTD data in our main system? 24
MTD Eligibility 25
Are pre-clerkship learners on an elective rotation eligible for MTD? 25
Do U2 CAL students get MTD credit? 25
Are UG medical trainees eligible for MTDs if they don't register using the AFMC Portal? 25
Are PEAPs and IMGs included in MTDs? 25
Are Pre-Residency Program (PRP) trainees eligible for MTDs? 26
Are Fellows included in MTDs? 26
Are we able to include Visiting Electives (ie. International Fellows) on the MTD Report? 26
Should research time be claimed? 26
Are privately funded trainees eligible for MTDs? If a fellowship is funded by a private company that operates out of the hospital, should the hospital be receiving any funding for it (since they were not the pay masters)? 26
The wrong program code was used for certain trainees – how will this impact my hospital's submission? 27
Are Mental Health rotations eligible for MTD funding? 27
Are we entitled to MTD funding now that we've amalgamated with a larger hospital? Should the school be adding the small site's MTDs to the larger hospital's report moving forward? 27

Do rotations at satellite locations or outpatient clinics for a particular hospital count for MTD? 28
Do rotations in the community count for MTD? 28
What do I do with data from organizations such as ROMP or ERMEP? 28
Submission Timelines 29
Where can I find the current MTD Data Submission Timelines? 29
What is the difference between Submissions #1-3 and FINAL data? 29
What do I do with rotations for this year that start before April 1? 30
When will we be receiving a full year's report with all quarters included for a final review? 30
Before the *Data Lock Date* deadline: 30
I found some missing records – how do I get the updated data to OPRC? 30
After the *Data Lock Date* deadline and before June 30: 31
One of our hospitals found some missing records – can I still submit them? 31
After Capped Annual File submission to Ministry on June 30: 31
What is the difference between capped and uncapped days in OPRC reports? 31
How can I view/confirm the Ministry data? 31
My hospital found errors in their data – can you adjust these? 31
What about inaccuracies based on percentages of time not being split correctly? 32
What about hospital records that never made it into our school's uploads because of a technical error? 33
What is the significance of a drop in MTDs? (Should we be concerned?) 33
Is the drop in MTDs correct? (Could it be verified?) 33
Can a drop in MTDs be changed for upcoming years? (Could it be addressed?) 34
Miscellaneous 35
How long does a medical school need to retain MTD records? 35
How long does a hospital need to retain MTD records? 35
Can UG rotations be claimed over Christmas break? 35
When do UG or PG rotations start and end? 36
COVID-19-related Situations 37
UG rotation cancellations: 37
PG redeployment / repatriation from one service or site to another: 37

Non-curricular/volunteer rotations (ie. students volunteering through OMSA) 37
Rotations affected by self-isolation/quarantine (whether student choice or program/medical requirement):..... 37
Rotations where trainees are not performing the same function as usual: 38
APPENDIX ONE..... 39
Initial Registration..... 39
Already Registered Users..... 40

Introduction

This is a compilation of questions related to Medical Trainee Days (MTDs) that have been sent to the Ontario Physician Reporting Centre (OPRC; previously known as Ontario Physician Human Resources Data Centre (OPHRDC)) and reviewed in collaboration with the Ontario Ministry of Health (the Ministry), since the 2017-18 MTD year. It is posted at https://physicianreporting.org/medical-trainee-days/, and is expected to be reviewed and updated on an annual basis.

There are often other variables to be taken into consideration, and so if a response does not make sense in a particular situation, please contact OPRC for further details or clarification.

OPRC seeks to be an independent third party, able to act as an intermediary between the Ontario Ministry of Health (the Ministry) and hospitals / medical schools under the guidance of the MTD Advisory Group.

> The purpose of the MTD Advisory Group is to ensure ongoing provision of MTD data to the Ministry that accurately reflects the resource commitment of hospitals to medical trainees' clinical education.
> 1.1 identify issues related to MTD (data collection, processing and interpretation) and if required, facilitate appropriate and timely action to address these.
> 1.2 ensure effective communications with stakeholders.
> 1.3 recommend changes to MTD policies as necessary.
> 1.4 facilitate stakeholder consultation prior to changes in MTD processes.
> *(MTD Advisory Group Terms of Reference as of November 1, 2022)*

However, the MTD process is mandated and supported by the Ministry, so they have the final say on any interpretation of the MTD Submission Specification.

Please contact OPRC for any questions or comments.

Cynthia Mech
MTD Lead
Ontario Physician Reporting Centre (OPRC)
previously known as Ontario Physician Human Resources Data Centre (OPHRDC)
MTD@PhysicianReporting.org | PhysicianReporting.org

MTD Value

Responses in this section are based on information provided by the Ministry's Hospital Sector Funding, Planning and Performance Branch, Hospital & Community Models Unit over the years. Please bring to OPRC's attention any discrepancy between information provided here and that found in other Ministry documentation.

How are hospitals classified/defined?

- For the purposes of hospital funding, hospital corporations are classified based on either their size or specialization.
- As of April 2026, the broad classifications are:
    - 60 small hospitals
    - 24 medium hospitals (including 3 medium-multisite hospitals)
    - 22 large community hospitals
    - 2 stand-alone paediatric hospitals
    - 5 stand-alone psychiatric hospitals
    - 15 teaching hospitals
    - 7 complex continuing care and rehabilitation hospital corporations
- For those hospitals that are classified based on size, it should be noted that size is not based on bed count. Instead, a hospital's annual acute inpatient and day surgery weighted cases (WC) is used to determine size.
    - Effective 2018-19, small hospitals are classified as hospitals with less than 4,000 WCs per year.
    - **Medium** hospitals are classified as hospitals with 4,000 to 12,000 WCs per year while **large** hospitals are classified as hospitals with at least 12,000 WCs per year.
    - Medium-multisite hospitals are classified as a combined total of a least 12,000 WCs per year, with each individual site having fewer than 12,000 WCs per year
    - These classifications were last updated in FY2018-19.

Do all hospitals benefit from MTDs?

In 2019, the Ontario Ministry of Health began using a new Growth and Efficiency Model (GEM) hospital funding approach. GEM is an allocation approach used to distribute new incremental investments to hospitals. The existing funding is allocated based on a combination of approaches such as Global Funding, Activity Based like QBPs and Priority Programs, capacity and performance.

MTD data directly impacts only those hospitals whose activity is modelled under GEM, the same cohort as under the Health Based Allocation Model (HBAM). GEM 2024-25 results are applied to 70 hospital corporations that reported their data separately in FY 2024-25:

- 23 Large Community
- 23 Medium (including 3 Medium-Multisite)
- 15 Teaching

- 7 Chronic/rehab
- 2 Specialty child

The remaining 67 hospitals (62 designated as "small hospitals" due to their lower activity levels, and 5 stand-alone specialty psychiatric hospitals) are excluded from the model (not included in the GEM calculations). Small and specialty psychiatric hospitals are funded on an across-the-board (ATB) basis each year. This means the number of MTDs submitted for small and specialty psychiatric hospitals, does not directly impact those hospitals' funding.

Note that the number of hospitals shown in GEM 2024-25 results is based on fiscal year 2024-25. As such, the numbers in this section are different from those listed in the previous section which are based on hospital classifications as of April 2026.

Do small or specialty psychiatric hospitals still need to submit MTDs?

Even when they do not directly impact funding, **MTDs should still be submitted for all hospitals** for a variety of reasons:

- MTD tracking benefits both hospitals and schools (i.e., preceptor payment calculations, trend reporting),
- MTDs may form part of a future revised funding model for small and specialty psychiatric hospitals,
- Hospitals that do not currently directly benefit from MTDs may merge with or grow to become a GEM-modelled hospital in the future.

Small and specialty psychiatric hospitals generally seem to value the MTD reporting process.

What is the difference between GEM and HBAM?

HBAM was the hospital funding approach used prior to the introduction of GEM in 2019. The HBAM cost model (including MTDs) is part of GEM.

From a funding allocation perspective, the key difference is that HBAM was used to re-distribute an existing ~$5.1B allocation among participating hospitals. With HBAM, any one hospital's funding was essentially 'a slice of the provincial funding pie', so the value of an MTD in any year depended on the proportion of MTDs claimed in relation to the rest of the hospitals, and the total hospital funding available that year. This resulted in some hospitals experiencing year-over-year funding increases, while others experienced decreases within the "fixed-pie" envelope.

Conversely, GEM has been used to allocate annual incremental funding to participating hospitals, such that no funding decreases are experienced. The amount of incremental funding available to allocate through GEM will vary from year to year, according to the ministry's annual

budget processes. As GEM expected unit costs (the 'price') are modelled in a similar manner to HBAM expected unit costs, MTDs have a similar price impact in either model, but **the impact of current MTDs to a hospital's funding under GEM is significantly smaller** because GEM only impacts incremental funding.

How much is an MTD worth?

There is no one answer to the value of an MTD because MTD valuation is based on multiple factors. MTDs form just one part of the overall hospital funding formula, so MTD funding is not provided as a separate piece or at a separate time. Funding is provided to the hospital by the Ministry without identifying which portion relates to MTD. It is then up to the hospital to determine how to distribute the money to their various programs. It may be of value to speak with the internal finance department to clarify how this works for a particular hospital.

Note that there is always a two-year gap between data collection to implementation for ministry funding. This allows organizations to plan for any changes before they come into effect. As an example, data from 2024-25 and the latest MOF population projections were used to calculate 2026-27 incremental growth funding.

MTDs in GEM Funding

For GEM-modelled hospitals (see earlier question, Do all hospitals benefit from MTDs?), **Incremental funding** (impacted by current MTDs, started for 2019/20 using 2017/18 MTDs):

> The core GEM formula allocates funding to modelled hospitals on a 'price x volume' basis, where the price for each hospital is determined by their respective expected unit cost across multiple care types, with a projection of annual service growth. We do not have specific dollar values but know that the formula is similar to HBAM.
>
> MTD results usually contribute to unit cost results used for GEM allocation for the following fiscal year:
> - MTD results from 2017/18 contributed to the first GEM allocation for 2019/20
> - MTD results from 2018/19 contributed to the GEM allocation for 2020/21
> - MTD results from 2019/20 contributed to the GEM allocation for 2021/22, 2022/23 and 2023/24
> - MTD results from 2020/21 and 2021/22 were not used in GEM allocations because of COVID-19 pandemic-related fluctuations (2019/20 results were used instead)
> - MTD results from 2022/23 contributed to the GEM allocation for 2024/25.
> - MTD results from 2023/24 contributed to the GEM allocation for 2025/26.
> - MTD results from 2024/25 contributed to the GEM allocation for 2026/27.

GEM expected unit costs are calculated using a weighted regression model for four care types Acute (Inpatient and Day Surgery), ER, Inpatient Rehabilitation, and Complex Continuing Care with adjustment factors specific to each care type. The teaching intensity is used in all care types and is defined as the proportion of total MTDs to total weighted services (cases or patient days). For more information on how the teaching intensity and the corresponding coefficients are calculated refer to the GEM Technical Webinar available on the HDB portal via the link below:

https://hsim.health.gov.on.ca/hdbportal/GEM_Educational_Material

For any questions related to MTD in GEM funding, please contact HSF@ontario.ca.

MTD in Supplemental Funding

Outside of GEM funding, MTD also attributes to calculating Hospital Operating Cost (HOC) and Hospital Academic Cost (HAC) funding.

1. **Supplemental funding** (where relevant, frozen at 2011/12 levels using 2009/10 MTDs): Following medical education expansion initiatives in the 2000s,, some non-Academic Health Science Centre hospitals received additional funding to help support the indirect operating costs of medical education (such as inefficiencies and supplies) as well as the additional administrative costs (such as physician leadership stipends and secretarial support). These continue to be provided.
    - Hospital Operating Cost (HOC) = $42.04 per eligible MTD
    - Hospital Academic Cost (HAC) = $97.92 per eligible MTD

    For more information on HOC and HAC, check out the **Evolution of the MTD Protocol in Ontario** from this link: https://physicianreporting.org/medical-trainee-days/ (esp. pp.19-21, 45-46).

How does the Ministry allocate MTDs by care type in GEM funding?

The core GEM formula to calculate MTDs is similar to HBAM. There are four steps to breakdown the MTD days by care type in GEM:

Step 1: Determine the MTD days that fall under GEM funding by the following criteria:

Inclusion: U2 for MAC only, U3-U6, P1-P9 and F

Exclusion: U1, U2 non-MAC, IMG and AP

Step 2: Identify MTD days by Service Code for Rehab, MH, and ER.

Rehab:

PMRE - Physical Medicine & Rehabilitation

Mental Health:

PSYC – Psychiatry,
CAPS - Child and Adolescent Psychiatry
ADDM - Addictions Medicine
FOPS - Forensic Psychiatry
GERP - Geriatric Psychiatry
FPAT - Forensic Pathology

ER: AEMG - Adult Emergency Medicine
PERG - Pediatric Emergency Medicine

Step 3: Estimate Acute and CCC MTDs using the following approach:

The Acute and CCC MTD days cannot be separated in the same way due to lack of specific Service Code related to CCC. The current approach to estimate the proportion of CCC-associated MTD in the mixed service setting is outlined as follows:

1) Calculate CCC Ratio

CCC equivalent weighted cases= CCC_RWPD * CCC Equivalent Weight Factor (~ 0.1111 in 2024-25 data)

CCC_RWPD is the Resource Utilization Group (RUG) Weighted Patient Day (RWPD) calculation, the # of days associated with a RUG classification group x the group-specific Case Mix Index (CMI) value. For more information on RWPDs refer to: https://www.cihi.ca/sites/default/files/document/ccrs-technical-document-rwpd-2017-2018-en.pdf

CCC Equivalent Weight Factor is updated annually. It is the ratio of provincial average CCC RWPD to the provincial average Acute Inpatient

Overall CCC Ratio = CCC equivalent weighted cases / Sum of (CCC equivalent weighted cases, Acute IP & DS equivalent weighted cases)

2) Identify Typical CCC-related Service Code

In mixed service setting, only some services are CCC related. A list of CCC-related MTD Service Code is identified based on the practice of standalone Chronic/Rehab facilities. The following steps outline how to derive typical CCC-related service code:

Step a: If there are no acute weighted cases, the MTDs associated to each MTD record are assigned to CCC-Related MTDs in standalone chronic/rehab facilities.

Step b: Sum up all CCC-Related MTDS by service code from step a

Step c: Calculate total CCC-Related MTDs (sum across all service codes from Step b)

Step d: Compute service-level CCC distribution:

Service-code CCC MTDs (from step b) / Total CCC MTDs (from step c)

Step e: Select service codes where their CCC distribution >= 1%.

For GEM 2024-25, five typical CCC-related Service Codes were selected:

FAMD Family Medicine
GERM Geriatric Medicine
PALM Palliative Medicine
ANEU Adult Neurology
INMG: Internal Medicine, General

Step f: For selected CCC-related Service Codes,

CCC-related MTD = Sum of (Acute, CCC) * **CCC Ratio**

Acute-related MTD= Sum of (Acute, CCC) - CCC-related MTD

Step 4: Allocate any Remaining (Unassigned) MTDs

The last step is to assign any un-distributed MTD days to the appropriate care type based on the facility type to ensure that the sum of breakdown MTD days is equal to the total MTD days.

Condition	Facility Type	Reassign MTDs To	Reset Value
No MH patient days but has MH MTDs	Chronic/Rehab	**CCC**	MH MTDs = 0
	Other facility types	**Acute**	
No CCC RWPD but has CCC MTDs	Chronic/Rehab	**Rehab**	CCC MTDs = 0
	Other facility types	**Acute**	
No Rehab weighted cases but has Rehab MTDs	Chronic/Rehab	**CCC**	Rehab MTDs = 0
	Other facility types	**Acute**	
No ER weighted cases but has ER MTDs	All facility types	**Acute**	ER MTDs = 0

What care type does each service code fall under?

Based on the above allocation, this shows which service codes belong under each of the five different care types:

- Inpatient Rehabilitation:
  - PMRE - Physical Medicine & Rehabilitation
- Inpatient Mental Health:
  - PSYC – Psychiatry,
  - CAPS - Child and Adolescent Psychiatry
  - ADDM - Addictions Medicine
  - FOPS - Forensic Psychiatry

    - GERP - Geriatric Psychiatry
    - FPAT - Forensic Pathology
- ER:
    - AEMG - Adult Emergency Medicine
    - PERG - Pediatric Emergency Medicine
- Complex Continuing Care (calculated annually, this is a typical historical assignment):
    - FAMD - Family Medicine
    - GERM - Geriatric Medicine
    - PALM - Palliative Medicine
    - UGME - Undergraduate
    - ANEU - Adult Neurology
    - ARES - Adult Respirology
- Service codes not listed above are attributed to the hospital's main care type (most often Acute Inpatient and Day Surgery).

Although we know there are differences, we do not know which care type results in a greater funding benefit.

Should rotations with the generic UGME service code be claimed with more specific service codes?

Records reported as UGME instead of a specific service code are typically allocated to Complex Continuing Care. This MAY result in a lower funding impact than desired by the hospital. If hospitals want the credit to be allocated to a different care type, a more specific service code must be provided.

We have not been able to determine the value of one care type over the other, and the process the Ministry uses to determine funding is quite complex (see earlier question).

Given the enormity of the task, if establishing a more precise service code is one of the key drivers for revamping the scheduling process, I would suggest that it is not worth the effort. I suspect that many of the rotations currently identified as UGME are actually allocated to Complex Continuing Care anyway (in that their more specific service code would be one of Family Medicine, Geriatric Medicine, Palliative Medicine, Adult Neurology, or Adult Respirology). If so, changing their service codes results in NO change to the funding outcome.

How does capping work? Why didn't my hospital get credit for all the MTDs we submitted?

The MTD process was designed to limit manual calculation of days in standard rotations. The expectation is that if a trainee works only in hospital settings, they will be claimed for 365* MTDs/year.

- Trainees are usually scheduled for blocks of 7-28+ days
- Trainees usually only work a portion of each block (d/t weekends or scheduled days off, vacation days, statutory holidays, educational leave, exam leave, etc.)
- Trainees should be claimed for their full scheduled blocks whether or not the days were actually worked, unless the trainee is on extended leave (pregnancy, parental, medical, etc.).

"All schools aim to account for 365 days per year for all trainees, given the cap applied at the end of the year accommodates acceptable short-term absences such as weekends, statutory holidays, vacations and illness—in general, periods of less than two weeks. The days missed during these short-term absences are included in MTD reporting. Longer-term absences of greater than two weeks (e.g. medical leave or maternity leave) are not included in the MTD submissions" (The Evolution of the MTD Protocol, Kathleen Clements, 2016).

When business rules were being established, it was decided that a full-time trainee could work a maximum of 275* days per year (based on the PARO contract and usual practice).

Capping is a process that accounts for claimed days in excess of 275*, bringing the total number of MTDs for any trainee to maximum of 275*:

- If uncapped total is < = 275*, no changes are made
- If uncapped total is > 275*, a formula is used to remove the same percentage from each rotation to bring the final capped total to 275*.
- Capping may reduce the value of a rotation by up to 25% if the trainee was claimed for the full 365* days.

Capping is only applied when the total number of days claimed for a trainee is greater than 275*/year, but must then be applied to all records related to that trainee in order to evenly distribute the days to all hospitals involved. Capping reduces but evenly distributes the benefit of MTDs to all hospitals at which the particular trainee worked. No more than one MTD may be counted per learner per day, and no institution (or combination of institutions) may report more than 275 MTDs for a single learner in a given year.

Capping is applied by OPRC after all quarters have completed the full submission cycle. This means that hospitals do not know exactly how many MTDs they will get credit for until the

annual cap is applied to the merged annual file at the end of June. Note that it is OPRC who applies the cap, not the Ministry of Health. The average drop in MTDs related to capping for a teaching hospital (as per Ministry classification) is 10-12%, the drop for other hospitals may be from 0-25%.

The capping formula for each of the affected trainee's records is (Number of Days/Total Number of Days) x 275*. After capping, the total number of days may be slightly less than 275* (ie. 274.98) due to rounding, but OPRC submits capped days to 4 decimal places in order to claim the maximum number of days possible.

The annual reports provided by OPRC as well as the ones published on the Ministry's HDB Web Portal use capped MTDs.

[*For a leap year, the maximum yearly claim is 366 days (instead of 365), and the capping maximum is 276 days (instead of 275).]

HISTORICAL NOTE: Capping annually rather than quarterly allows proportionate benefit to all involved hospitals in the numerous cases where trainees are not fully claimed in each quarter. The change from quarterly to annual capping increased provincially claimed days by over 10% in the 2014-15 MTD year.

Why might the MTD numbers not add up in the reports OPRC provides?

MTDs are capped at 4 decimal points, but displaying these in the chart gets very busy, so I choose to display only whole numbers.

As you will see when you click on each of the numbers, the actual value still underlies the displayed value, and normal rounding rules are used by Excel to determine the display value.

The formula for the Totals line at the end of most columns is a basic Sum. This Sum is based on the actual value of each of the preceding lines.

In the example below, if you choose to add up the whole numbers, then the changed final TOTAL (167, 757) does not match what was submitted to the Ministry. I would suggest using the table as you received it, and if anyone questions the final total, give them a similar explanation as noted above.

2021-22	ACTUAL VALUES
1112	1111.5702
3822	3821.9728
369	369.3466
966	966.1578
3207	3207.3374
3227	3226.5019
32	31.7
90460	90459.9996
3582	3582.1587
5321	5320.5381
12	11.6
61	61
543	542.7681
15672	15672.091
200881	200880.9638
7426	7425.7213
10440	10440.1202
15312	15311.6985
274	274.461
4564	4563.8834
474	473.9016
367755	**367755.492**

Submission Specification

Questions in this section relate to the MTD Submission Specification document, which is revised and republished by the Ministry by early summer each year. Proposed changes to process or standards should be communicated to OPRC in order to be evaluated by the MTD Advisory Group and submitted as a Change Request to the Ministry by early spring. Comments for the Ministry regarding corrections or clarifications to the document are accepted at any time.

Where can I find the current MTD Submission Specification?

The MTD Submission Specification document is posted by the Ministry on the MTD section of the Ministry's Health Data Branch Web Portal:
https://hsim.health.gov.on.ca/hdbportal/mtd/Standards_and_SummaryReports

The updated Specification document for the new MTD year is usually posted in the summer. See *Appendix One* for information on how to get HDB Web Portal access.

The current Specification document is also posted on the MTD page of the OPRC website:
https://physicianreporting.org/medical-trainee-days/

What category/level do I use for trainees whose level changes during a particular quarter?

There are numerous situations where a trainee transitions from one level to the next during an MTD quarter (ie. U3 to U4, P1 to P2). This creates a challenge for reporting: should the highest level category should be reported, or should the category in which the highest proportion of time was spent during that quarter be reported?

There is no difference from a Ministry perspective whether the trainee is a U3 or a U4, so long as they are a clerk. There is no difference from a Ministry perspective whether the trainee is a P1 or a P2, so long as they are a postgrad. However, there is a difference from a Ministry perspective whether the trainee is a U4 (or U3 for McMaster) or a P1.

In order to not have to manage each situation manually, OPRC has chosen to use the highest level category provided for each quarter (even if this means using P1 for some records that were submitted as U4 (or U3 for McMaster)). This may be the simplest solution for schools as well.

To make it easiest for schools, please report the student in the CAT they are in at the time of the rotation. I have a lookup table that I update with each school's UGME and PGME registration data each fall. I automatically replace the reported CAT with the expected CAT for each student, unless there is a major discrepancy between the two (i.e., reported CAT is UG and

expected CAT is PG, or vice versa). In that case, I send the record back to the school for validation.

What category/level do I use for MD Extension students?

The general policy is to use functional level rather than year # when assigning MTD categories.

Undergraduate medical students who have graduated from a UGME program but did not match in CaRMS are unable to obtain a license through CPSO and often complete additional clinical rotations in the following year(s). These are called MD Extension students and should continue to be claimed as final year undergraduate students (U4 for most schools, U3 for McMaster and Calgary). The U5/U6 designation is reserved for MD-PhD, OMFS or IMG students.

MD Extension students from the AFMC Visiting Electives Portal do not have a consistently assigned category/level. Ontario medical schools should be able to modify the academic year for visiting students in their applications without putting a service request to AFMC. Please use this option to **change MD Extension students to U4 (U3 for McMaster and Calgary) as needed**.

How does a medical trainee get a MINC?

Here are the ways to get a MINC:

- Apply for a license from their provincial/territorial college (i.e., CPSO). This applies to:
  - UGME students in other parts of Canada (they require an educational license from their provincial/territorial college),
  - PGME trainees from outside Canada who will be clinically active.
- Apply through the physiciansapply.ca site of MCC. This applies to:
  - UGME students from Ontario or from outside Canada
  - PGME students that don't already have a MINC, when they apply for a Medical Council of Canada (MCC) exam

Non-ministry funded learners who come here on an elective do not necessarily receive a MINC. MINCs actually have nothing to do with the Ministry of Health (the Ministry is not even a Licensed User of MINC). These trainees most often do not have a MINC:

- UGME students from outside Canada
- research fellows (who do not require a CPSO number)

How does a school find MINCs for their trainees?

The MINC-NIMC website includes a portal through which you can search for individual MINCs, or you can upload a file containing multiple records for which you need MINCs.

Each Ontario school is a Licensed User of MINC, so you should be able to get authorization to access the portal and the most up-to-date details on this process from:

Data Integrity Officer (Technical support)
Ms. Johane Gaudet
Email: techsupport@minc-nimc.ca

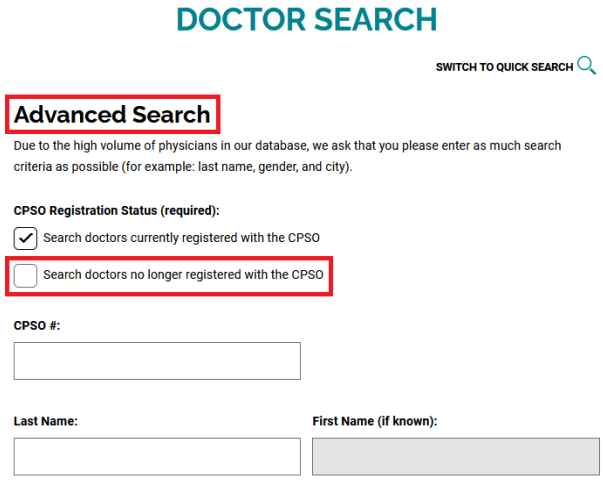
Once you have access, you can:

- search for an individual MINC using the site: https://applications.minc-nimc.ca/login.aspx.
- request a file with all of your students' MINCs:
  1. upload a file with your students' information for which they will try to find matches, or
  2. ask them to provide a file for all those who have put your university as their (anticipated) school of graduation.

How do I find a CPSO number for an inactive trainee?

The public CPSO website **Quick Search** section provides results for active physicians only. This means that postgrads who register with the CPSO for an elective can only be easily found between their official start and end dates.

However, you should still be able to find any CPSO number, you just need to switch to **Advanced Search** instead of **Quick Search**, and select the option to "Search doctors no longer registered with the CPSO" as shown here:



How important is it that we use the right program code?

Program codes are used to identify the training program in which the trainee is enrolled, based on the main accredited program lists for the Royal College of Physicians and Surgeons and the College of Family Physicians of Canada.

Program code doesn't impact funding in any way, so for UG students, UGME is the easiest and most logical option. For PG trainees, use their correct program code as much as possible to ensure that later school and hospital reports are based on accurate information.

How important is it that we use the right service code?

MTD data is used to create multiple reports for many different purposes, so it is always best to provide the most accurate data possible. From a Ministry perspective, MTDs are used to inform their care type funding model. Once the data is submitted to the Ministry, all service codes are lumped under one of five different care types:

- Acute Inpatient and Day Surgery,
- ER,
- Inpatient Rehabilitation,
- Complex Continuing Care
- Inpatient Mental Health

Records with service codes which don't directly match to one of the above care types are attributed to the hospital's main Care Type (most often Acute Inpatient and Day Surgery).

How do you claim one rotation under more than one service code?

Frequently, a single rotation can appropriately be attributed to more than one service code.

There is no need to identify exactly which days of the rotation belong to which service code. Instead, just copy the same record as many times as you have clinics, changing only the service code and number of days and keeping the same date range.

For example, a 28 day mainly Family Medicine rotation could be split like this:

SERVICE CODE	PERIOD	START DATE	END DATE	NUMBER OF DAYS
FAMD	Q1	6-Apr-21	3-May-21	20
PEDI	Q1	6-Apr-21	3-May-21	4
PSYC	Q1	6-Apr-21	3-May-21	4

How does one decide which service to assign to a particular rotation? Is it based on the type of clinic, or on who supervises the trainees?

Service Code is intended to reflect the actual department/unit the trainee worked in or the actual activity they were involved with in the hospital, so the location/activity of the rotation takes precedence over the preceptor's specialty.

As an example, for a trainee doing a rotation on a Medical CTU with a family physician preceptor, the General Internal Medicine service code should be used instead of the Family Medicine service code.

Which code should I use when the specific service or program is not listed in the MTD Submission Specification?

When there is no exact match for a service or program, the school usually determines their own internal mapping.

For example, for Newborn Screening and Metabolics, the school could consider using one of these pre-existing Service Codes:

- MGEN Medical Genetics
- NEOM Neonatal Perinatal Medicine
- PALL Pediatric Clinical Immunology & Allergy
- PEDI Pediatrics
- PENM Pediatric Endocrinology & Metabolism

Which specific code is chosen depends on the school and hospital's tracking preferences (possibly linked to care type). In the above example, no matter which of the above Service Codes the Newborn Screening and Metabolics service is mapped to, it will fall into the same Acute Inpatient and Day Surgery care type for funding purposes.

Can we create a new service code?

New or more specific service codes would likely not impact Ministry funding. As noted in the *MTD Value* section, service codes are grouped together by care type, and funding is distributed by care type, not by service code.

These are the options to revise service code:

A. If the new or more specific service code would be of benefit ONLY to internal tracking for individual school(s)/hospital(s), then those that wish could develop a custom service code that is sent to OPRC and only used for reports back to school(s)/hospital(s).
    a. The current official service code would be used in reports to the Ministry.

    b. This option could come into effect immediately.

B. If the new or more specific service codes may benefit many hospitals and should be included on official Ministry reports, then a proposal should be sent to OPRC to be brought to the MTD Advisory Group and Ministry. More specific service codes would affect all schools/hospitals since they would likely replace a previous 'general' or undifferentiated service code.
    a. If approved, the new or more specific service codes would be submitted to the Ministry in a Change Request for the MTD Submission Specification.
    b. The soonest this option would come into effect would be for the following MTD (fiscal) year.

Should we claim only the exact days worked, or the entire block in which the rotation occurred? Should we claim one week as 5 or 7 days?

The express goal in MTD is to claim each full-time trainee for 365 days/year where possible, based on program-defined rotation blocks. In this way, when the 275 days/year cap is applied, all facilities end up with a similar benefit/penalty.

The general policy is to claim the entire week or weeks in which a 'full-time' rotation was scheduled, even if the trainee does not work some of the days for any reason (facility not open, trainee not scheduled, mental health days, illness, vacation, conference, etc.). The time required to manually adjust certain rotations is not worth it, unless the trainee goes on an official leave (ie. changes their registration status).

It makes most sense for schools to make an MTD policy decision regarding how to claim rotations that applies across the board for all levels (UG, PG, F) and at all sites. In most cases, schools calculate the # of Days using a basic equation such as ([End Date] – [Start Date] + 1). The easiest practice is to claim the full week using the standard province-wide start date (Monday for UG, Tuesday for PG) and end date (Sunday for UG, Monday for PG) for each scheduled rotation.

This means that UGs who are scheduled for a Monday to Friday rotation (5 working days) should be claimed from Monday to Sunday (7 days). When those extra 2 days are added up across levels and across programs in any one school, the difference could be significant.

How are concurrent rotations claimed?

Concurrent rotations occur when one trainee is placed in more than one facility over the same time period. For these cases, allocate an appropriate portion of the whole time to each facility. MTDs are claimed under the presumption that a full week is 7 days (knowing that most learners will actually only be in the facility for 5 days each week), so it is easiest to determine the allocation based on the percentage of a full week.

For example, the learner is in one facility for 2 days a week and in other facility for 3 days a week. The first facility gets 40% of the full week (2.8 days), and the second facility gets 60% of the full week (4.2 days).

What is a longitudinal rotation? How are longitudinal rotations claimed?

Most schools define longitudinal rotations as cases where a learner is in one location for only part of the time across numerous rotation blocks. In this case, that location is assigned an appropriate fraction of the whole time. For example, a learner will be in one location for one morning each week for 3 months, and in other location(s) for the rest of the time. The first location would get 10% (½ day of a 5 day work week) of the total MTDs available in the 3 month block and the other location(s) would get the remaining 90%. Because of longitudinal rotations, it is best practice for a school's MTD database rules to allow more than one rotation to be claimed for the same time period with a percentage designation (100% is default).

How should a virtual rotation be claimed (when a trainee in one facility is providing services to another facility)?

When a medical trainee in one facility while providing services to another facility (ie. through telehealth/OTN), basic resources from both facilities are required since the videoconferencing equipment needs to be available and maintained in both locations.

MTDs are intended to capture the extent of the medical education burden that is borne by the hospital for the purpose of Ministry funding allocations, so these remote rotations should probably be split between the locations. The proportion of the split would be dependent on the investment: an even 50% split if both facilities have the same staffing and technological investment, or a more skewed split if, for example, only one of the facilities is supporting/monitoring/providing feedback to the trainee.

How can I confirm the hospitals and hospital numbers my school is responsible for?

Each medical school is responsible to submit all MTDs (no matter which school the student or trainee attends) for all facilities (hospitals) in its MTD catchment area.

This includes:

- all PG and UG rotations,
- whether they are core rotations or visiting electives, and
- whether the learner attends that medical school, another Ontario school, or an out-of-province or out-of-country school.

The Facilities list (Table 5) in the MTD Submission Specification identifies which hospitals each university is responsible for reporting on. If requested, OPRC can provide a school-specific facilities chart including site codes/names (which are not provided to the Ministry and used for internal tracking only).

With hospital mergers, OPRC submits the approved facility codes to the Ministry but schools have the option to continue to submit records to OPRC using their old facility codes.

What about hospitals which have 'learner agreements' with more than one medical school?

There are a number of hospitals which have 'learner agreements' with more than one medical school. The hospital communicates with each school about its' own rotations, but for MTD purposes the rotations are all claimed by one school.

For example, both HRH and Lakeridge have 'learner agreements' with both UofT and Queen's.

- Lakeridge is in Queen's MTD catchment, so all Lakeridge MTD rotations are currently reported to OPRC by Queen's. This means that Queen's MTD uploads include the Lakeridge rotations that were registered with UofT (and entered in UofT's MTD system).
- HRH is in UofT's MTD catchment, so all HRH MTD rotations are currently reported to OPRC by UofT. This means that UofT's MTD uploads include the HRH rotations that were registered with Queen's (and entered in Queen's MTD system).

How can I work with external partners that do not enter MTD data in our main system?

External partners often have challenges with providing the MTD data for their smaller hospitals correctly formatted and on time. You will already have the data for their hospitals for your own trainees, so the new information you receive from them will mostly be for electives.

It may be easiest to provide these external partners with the MTD template that OPRC circulates to your school each fall. This template provides acceptable options for data entry fields. It may be important to send reminders or call these partners every week until the data arrives, so that they do not delay your school's submission.

MTD Eligibility

Questions in this section relate to eligibility for MTDs. Answers are provided based on discussions with the Ministry and other medical schools.

Are pre-clerkship learners on an elective rotation eligible for MTD?

No, pre-clerkship learners of any type are not included in any MTD funding. This includes U1 learners from McMaster, and U1/U2 learners from all other schools. These rotations have never been used for funding, so for greater clarity they are no longer submitted to the Ministry (since 2015-16).

Note that U2 MAC students are considered clerks, not pre-clerks. Since McMaster's UG program is only 3 years long, these students begin their clerkship rotations earlier than students in regular 4 year programs.

Do U2 CAL students get MTD credit?

Similar to McMaster, the University of Calgary's program is also only 3 years long, but these students do not complete out-of-province electives until their third year. There is inconsistency in how students claim their level in the AFMC Visiting Elective portal, and so second year students from CAL may inadvertently mark their level as U2 when they are requesting a U3 elective. MTD records for U2 CAL students do not receive credit with the Ministry, so any U2 CAL records received by OPRC are automatically converted to U3 records.

Are UG medical trainees eligible for MTDs if they don't register using the AFMC Portal?

There is no eligibility requirement based on registration method. Out of country trainee MTD records may be submitted for visiting students from exchange programs outside of the AFMC Portal. However, note that electives should only be in a student's final or next to final year.

Are PEAPs and IMGs included in MTDs?

MTD records for PEAP and IMG trainees were submitted by hospitals but not funded by the Ministry prior to 2015-16.

From 2015-16 on, MTD records for PEAP and IMG trainees are submitted with the most closely related regular PG Category Code such as P2, P5 or F (based on the anticipated year of entry). These MTDs are then funded by the Ministry in the same way as all other PG records.

Are Pre-Residency Program (PRP) trainees eligible for MTDs?

According to the Touchstone Institute website (http://www.touchstoneinstitute.ca/education/pre-residency-program.aspx), their pre-residency programs consist solely of interactive classroom sessions and online modules. This part of the training does not involve interaction with patients or contribute to direct patient care, so it is not eligible for MTD purposes.

However, in-hospital rotations should be claimed as they are with other assessment programs (ie. AVP, PEAP) – see previous question.

Are Fellows included in MTDs?

Fellows are definitely counted in in overall MTD numbers. There are no additional restrictions on trainee type related to MTD funding such as GEM/HOC/HAC.

Are we able to include Visiting Electives (ie. International Fellows) on the MTD Report?

Visiting electives for any level should be included in your MTD report if the student registered for the elective through your school and meets the usual criteria such as valid CPSO (for fellows or residents) or student number (for clerks).

Should research time be claimed?

Every medical trainee completes an element of research. Clinical research rotations which are completed in a hospital and involve patient contact can be claimed for MTD credit. However, pure research rotations where the trainee is not involved in patient care should not be claimed.

Are privately funded trainees eligible for MTDs? If a fellowship is funded by a private company that operates out of the hospital, should the hospital be receiving any funding for it (since they were not the pay masters)?

There are multiple cases across the province where fellows are funded by organizations other than hospitals or the Ministry. A trainee's funding source is not in any way part of the MTD process. There is no direct benefit or payment for MTDs to any university or trainee funding organization.

To be clear, MTDs are intended to capture the extent of the medical education burden that is borne by the hospital for the purpose of Ministry funding allocations. So, if the trainee has a clinical appointment (has a CPSO number and will be interacting with patients, using hospital resources such as equipment and/or staff time), then their rotations in any MTD Facility should be reported.

The wrong program code was used for certain trainees – how will this impact my hospital's submission?

Unlike Service Code, the MTD Program Code does not directly affect the Ministry's valuation of MTDs. However, the Program Code may affect any internal (school) funding that is connected to MTD data (ie. for a school where preceptor payment arrangements are linked to Program Code, or where reports based on Program Code are used to impact departmental funding).

Are Mental Health rotations eligible for MTD funding?

It is important to recognize the difference between mental health **rotations** and specialty psychiatric **facilities**.

For GEM-funded hospitals, mental health **rotations** are treated like all other MTD rotations and included in GEM funding allocation calculations (aka MTD funding).

However, the 5 stand-alone specialty psychiatric **facilities** are NOT GEM-funded, so none of their MTD rotations (mental health or otherwise) influence their Ministry funding.

SUBMISSION SCHOOL	FACILITY CODE	FACILITY NAME
TOR	948	CENTRE FOR ADDICTION AND MENTAL HEALTH
MAC	601	HOMEWOOD HEALTH CENTRE
TOR	969	ONTARIO SHORES CENTRE FOR MENTAL HEALTH SCIENCES
OTT	651	ROYAL OTTAWA HEALTH CARE GROUP
MAC	972	WAYPOINT CTR FOR MENTAL HLTH CARE

Are we entitled to MTD funding now that we've amalgamated with a larger hospital? Should the school be adding the small site's MTDs to the larger hospital's report moving forward?

Yes, a small hospital (for whom MTDs do not impact funding) that amalgamates with a larger GEM-modelled hospital would then be funded through that hospital. The school should continue submitting the small hospital's MTDs to OPRC as usual – they will be included in the larger hospital's report once the merger is official. OPRC will track MTDs for the newly-amalgamated site separately from the rest of the main hospital until this is confirmed.

For Ministry purposes, mergers officially come into effect on the first day of the next fiscal year (April 1). However, the date on which a newly-amalgamated site begins to get their Ministry funding (including MTD funding) through/together with the main hospital would need to be confirmed by someone in that hospital's Finance department.

Do rotations at satellite locations or outpatient clinics for a particular hospital count for MTD?

According to the MTD Submission Standards, medical trainee rotations can be claimed for MTD purposes if worked in a hospital or hospital clinic setting. So if the location or clinic 'belongs to' the hospital, rotations at that location or clinic can be claimed.

If it is of benefit to the school or hospital to track these rotations separately, please include the site details in MTD submissions to OPRC.

Do rotations in the community count for MTD?

Community rotations are medical trainee rotations that take place in a setting not formally linked to a hospital. MTD credit is only given for time spent in hospital. Funding to compensate those settings for their time/resources spent with medical trainees is provided through other means (ie. AFPs, preceptor payments, Family Medicine program funding).

However, medical trainees in community rotations often accompany their mentor into a hospital facility for a portion of the time. This portion of time is eligible for MTD purposes, as it will likely use hospital resources to accommodate the trainee.

This means that a portion of community rotations (often 20-30%) could and should legitimately be claimed for that hospital, for MTD purposes. Schools calculate the reduced claim either manually or by algorithm based on program-specific criteria.

What do I do with data from organizations such as ROMP or ERMEP?

Organizations such as ROMP or ERMEP assist students and trainees with rural placements, connecting them with physicians in the community. Most of these physicians will have privileges at their local hospital, so it is assumed that the student or trainee will complete part of their training in that setting. In these cases, refer to the above instructions, ***Do rotations in the community count for MTD?***.

Submission Timelines

Where can I find the current MTD Data Submission Timelines?

The updated MTD Data Submission Timelines are usually posted to the MTD section of the Health Data Branch Web Portal around April 1. See *Appendix One* for information on how to get HDB Web Portal access.

The timelines are also posted on the MTD page of the OPRC website:
https://physicianreporting.org/medical-trainee-days/

What is the difference between Submissions #1-3 and FINAL data?

The MTD Annual File is of necessity a 'snapshot in time'. There is no practical way to continually update the MTD file as new information is uncovered, since the change process tends to have a cumulative impact:

- for every missed record that is discovered, there is an equal likelihood that there is a previously submitted record that should be changed or deleted,
- new records inevitably cause conflicts which involve other schools for reconciliation,
- once records have been capped across the province, any changes mean capping would need to be re-applied – which will benefit some hospitals and disadvantage others.

Prior to and during Submissions #1-3 is the time records should be added to the MTD file. Hospitals should be reminded that their key MTD review period is prior to the *Submission Deadline to University* dates for each quarter.

In fall 2022, the MTD Implementation Committee agreed that the *Data Lock Date* is the snapshot date. Hospitals are actively encouraged to review their data file to identify any missed or changed records before this *Data Lock Date*.

MTD 2024-25 Data Submission Timeline Details

as published by OPRC

	Last Day of Quarter	*Submission Deadline to University*	Submission #1 to OPRC	Submission #2 to OPRC	Submission #3 to OPRC	Final Upload to OPRC	*Approval (Data Lock Date*)*	*OPRC Submission to Ministry*	Final Data to Schools
Q1	30-Jun-24	***4-Oct-24***	29-Nov-24	17-Jan-25	7-Feb-25	21-Feb-25	***25-Feb-25***	***30-Jun-25***	11-Jul-25
Q2	30-Sep-24	***15-Nov-24***							
Q3	31-Dec-24	***14-Feb-25***	16-May-25	6-Jun-25	20-Jun-25	27-Jun-25	***30-Jun-25***		
Q4	31-Mar-25	***9-May-25***							

*No new data will be accepted after Data Lock Date (unless it meets appeal criteria).

What do I do with rotations for this year that start before April 1?

The MTD process follows strict yearly and quarterly periods as shown here:

For each MTD year:	
Q1	April 1-June 30
Q2	July 1-September 30
Q3	October 1-December 31
Q4	January 1-March 31

The current MTD year started on April 1, so any dates prior to that belong to Q4 of the previous MTD year for which data has already been collected/submitted/finalized. Because of this, the portion of any rotation that occurred before April 1 is automatically deleted/cannot be claimed.

When will we be receiving a full year's report with all quarters included for a final review?

Once the Final Annual file is approved by the Ministry in early July, OPRC will create a full year's report with all quarters included for each hospital. However, this report is only for informational purposes. Changes are NOT routinely accepted after the *Data Lock Date*. There is an appeal process if there was an issue with reporting the data that was out of the hospital/program's control, but this is rare/seldom used.

Please let OPRC know as soon as possible if this is a situation with extenuating circumstances that should be considered for appeal before the Final Annual file is created.

Before the *Data Lock Date* deadline:

I found some missing records – how do I get the updated data to OPRC?

All changes/deletes/additions for any quarter should be captured by the *Final Upload to OPRC* date. Please just change, remove, or incorporate the new records into your school's regular MTD files (don't need to be tracked separately) and upload them to OPRC at that time.

After the *Data Lock Date* deadline and before June 30:

One of our hospitals found some missing records – can I still submit them?

The expectation is that no new data will be accepted after the *Data Lock Date* deadline.

Although it is not possible to freely accept changes to the MTD data after the *Data Lock Date* deadline, please inform OPRC if changes/deletes/additions are discovered. OPRC will incorporate the revised data if the conditions for special appeal are met (see My hospital found errors below).

After Capped Annual File submission to Ministry on June 30:

What is the difference between capped and uncapped days in OPRC reports?

Uncapped days should be equivalent to the number of days submitted by hospitals/schools throughout the MTD year. The matching number of capped days may be reduced as a result of the application of the Ministry-required cap (see earlier section How does capping work?).

OPRC provides the values for both capped and uncapped days as a matter of accountability. Schools and hospitals can verify the uncapped days but do not have any easy way to verify the capped days. Providing only the capped days (which are what the Ministry uses) would give little frame of reference for comparison to source data.

How can I view/confirm the Ministry data?

OPRC provides detailed school- and hospital-specific reports to each medical school in mid-July each year. The Ministry uses the capped data submitted by OPRC for their reports posted on the MTD section of the Health Data Branch Web Portal:

1. MTD Trainee Days Summary by Service and Category (usually available in mid-July)
2. MTD Trainee Days Summary by CareType (usually available in early September).

See *Appendix One* for information on how to get HDB Web Portal access.

My hospital found errors in their data – can you adjust these?

After the data is capped, individual records can no longer be added to or removed from the MTD file – at this point, it is only major / significant issues that are appealed to the Ministry.

- Based on an appeal of the 2015-1016 MTD data, errors affecting a small number of MTDs (ie. <1000) are not likely to have an impact on a hospital's funding and so there is little value in pursuing these.

- MTDs do not impact Ministry funding for small and specialty psychiatric hospitals so there is no value in an appeal if they are the ones affected by errors in the final annual data.
- The Ministry does not use home school for funding purposes, so errors in that field would not warrant an official appeal.

However, if you discover a pattern where hundreds of days for the same hospital (that were in your school's MTD system on the *Data Lock Date* deadline) were inadvertently not submitted [or submitted in error] by your school, please inform OPRC who will certainly investigate further and submit an appeal to the Ministry if warranted.

The Ministry's appeal definition states that:

> "The Annual MTD file as submitted/approved on June 30 each year is absolutely final. However, significant errors discovered after that date should be reported to the Ministry [through OPRC,] who will take the information into consideration when assessing funding impact. Hospital errors (ie. incorrect service codes, transposed dates[, missed rotations]) will not be corrected. Non-hospital errors (ie. systematic technical issue at school level) may necessitate limited resubmission on a case-by-case basis." *(p.13, 2017-18 MTD Submission Specification)*

What about inaccuracies based on percentages of time not being split correctly?

If this is an issue between different hospital sites of the same facility, then it is of no consequence to the Ministry. Hospital site details are not submitted to the Ministry. The Ministry only deals with facilities as a whole.

If this is an issue between different facilities, then it may be of consequence. However, it would seem that significant percentage split errors are something that hospitals should have been able to pick up during their key MTD review period prior to the *Submission Deadline to University* dates for each quarter.

If over a thousand days are affected for any hospital, then it is a significant discrepancy that should be brought to the Ministry's attention. Hospitals should know that if they appeal and the Ministry agrees with the appeal, all affected records need to be resubmitted – which will likely also change the capped total MTDs for both themselves and other hospitals (not necessarily for the better).

An appeal of the 2015-16 MTD data in December of 2016 found that even with hundreds of days impacted for multiple hospitals, revising the data did not make a significant difference for any one hospital when figured into the whole HBAM funding formula.

What about hospital records that never made it into our school's uploads because of a technical error?

This is a situation which was out of the hospital's control, and so OPRC will gladly initiate an appeal to the Ministry on behalf of the hospital. Please let me know if this is what the hospital would like, as the timeline is tight and an appeal would need to be launched as soon as possible. As part of the appeal, a spreadsheet containing all the missed records will need to be uploaded so that OPRC can check for conflicts and recalculate the cap for all Ontario records.

Whether or not an appeal is launched, please ensure that your IT department is aware of the need to resolve this technical error.

What is the significance of a drop in MTDs? (Should we be concerned?)

From a Ministry perspective, only GEM-modelled hospitals are impacted by MTDs. Small or specialty psychiatric hospitals will see no impact to their Ministry funding because of a drop in MTDs. For GEM-modelled hospitals, a single year drop in MTDs will only impact their incremental funding, not their base funding. See MTD Value section at the beginning of this document for further details.

Note that a drop in MTDs may have local / school-based funding implications in addition to any Ministry funding implications (ie. for a school where reports based on MTDs are used to impact departmental funding).

Is the drop in MTDs correct? (Could it be verified?)

To find out if there was an error in the total MTD calculation, the hospital should check the Excel worksheet containing all submitted records (from the medical school/OPRC) against their in-house records and document the details of any unexpected omissions/changes. Here are the next steps:

If yes, then why is there a drop in MTDs?

If the data is correct (submitted records = in-house records), the hospital should know that a drop can occur for any number of reasons. The top of each report in the hospital data file states, "There will be year over year variability in MTD numbers, based on many factors including individualized elective selection within and outside Ontario." Because learners can choose where to do their electives, there may just have been fewer learners interested in that hospital this past year. This may be a completely random effect, or there may be larger system influences such as: school policies / supervisor recommendations / social media comments / previous learner experiences / hospital reputation / perceived benefit / financial incentives / etc. that affected those decisions.

If no, then what should be done to correct the numbers?

If the data is not correct (submitted records < in-house records), the hospital should provide their unexpected omission/change records to the school/OPRC for investigation. There are cases were an appeal to the Ministry to change the data is warranted.

Can a drop in MTDs be changed for upcoming years? (Could it be addressed?)

Depending on the reason for the drop in MTDs (see above), there is definite potential for a drop in MTDs to be reversed in upcoming years. MTDs for many hospitals fluctuate from year to year, even without any active intervention.

Miscellaneous

How long does a medical school need to retain MTD records?

In the MTD Submission Specification Appendix A: Business Rules, it states:

"6. Universities are responsible to keep the trainee's exact records for audit purposes for a minimum of 7 years and may be asked to produce [them] upon [the] Ministry's request."

For example, in 2025-26, anything from 2018-19 and earlier can be purged! It is up to the individual school to determine what constitutes the trainee's exact records for the years that must be retained.

For reference, after a couple of years, OPRC purges all earlier iterations and keeps only the final version of each quarter/year's data (which is presumably the trainee's exact final record). However, OPRC also retains that final version for ALL years to allow for evaluation of historical trends.

How long does a hospital need to retain MTD records?

The MTD Submission Specification Appendix A: Business Rules, does not specifically mention the expectation for hospital sites.

In response to this question, the Ministry has replied that each hospital has its own Record Management Department who they should work with to retain their records. This is because:

- Records from hospital sites are often manipulated within a school's MTD database in order for the records to comply with MTD submission standards and/or to resolve overlaps. This means that hospital site records may not have a clear/direct connection to the submission school (university)'s records.
- Some hospital sites do not keep their own MTD-related 'shadow records'. All of their trainees come through the medical school (university), and they obtain all their information about the trainee's identifiers and planned rotation details from the school, so it is a redundant practice for them to also keep the same records. This means not all hospital sites currently have records that could be audited.

Can UG rotations be claimed over Christmas break?

Most schools do not schedule elective rotations over the Christmas break because less formal supervision is usually available for UG students, and some medical schools have limitations on their liability coverage which may mean that rotations during the Christmas break are not covered.

However, any period of time during which an eligible trainee completes an official school-approved rotation at an Ontario hospital should be claimed for MTD credit. If a student arranges for their own experience at a hospital (independent of the school's oversight), this is considered voluntary and will not count towards any credit for their courses/education or be tracked for MTD purposes.

When do UG or PG rotations start and end?

UG rotation blocks start on Monday and end on Sunday for all medical schools in Ontario. For most schools, UG rotations start at the end of August or beginning of September and usually run through to the end of the school year in April/May/June.

PG rotation blocks start on Monday and end on Sunday for NOSM and Toronto. PG rotation blocks start on Tuesday and end on Monday for the Common Rotation Schedule shared by McMaster, Ottawa, Queen's and Western. The Common Rotation Schedule also identifies 13 4-week rotation blocks over the course of the year. For all schools, the PG rotation year starts on July 1 and ends on June 30.

COVID-19-related Situations

The COVID-19 pandemic caused a number of significant temporary changes for medical training in Ontario. Issues related to these changes were addressed at an ad-hoc meeting of much of the MTD Advisory Group in April 2020. The discussion and resolutions are recorded below.

UG rotation cancellations:

a. UG rotations and visiting electives were cancelled in mid-March 2020 for all Ontario medical schools
b. AFMC Visiting Elective Portal was also closed in mid-March 2020, which would make it difficult to validate visiting electives

→ UG rotations should be claimed as they actually occurred (ie. should probably not be any rotations claimed from mid-March through to resumption of UG rotations in June or July 2020)

PG redeployment / repatriation from one service or site to another:

a. official changes will definitely impact numbers
b. don't need to try to account for extra call, smaller cross-scheduling since they are so minor/last-minute

→ Track these official changes as much as possible in your MTD data.

Non-curricular/volunteer rotations (ie. students volunteering through OMSA)

a. these are not official rotations – not scheduled or tracked through the medical schools
b. anything that students are doing at this time is purely voluntary and will not count towards any credit for their courses/education

→ These rotations should not be captured in MTD data.

Rotations affected by self-isolation/quarantine (whether student choice or program/medical requirement):

a. MTD annual cap considers leaves of various sorts, including short-term illness/vacation which do not usually result in a change to scheduled MTD rotations
b. very difficult from a practical standpoint to accurately track changes initiated by the trainee
c. some schools are tracking these changes with school-specific codes or processes
d. blocks may be extended to accommodate required self-isolation prior to a rotation

→ Attribute the full amount of the rotation to the hospital as originally scheduled UNLESS the trainee status is changed to official medical leave.

Rotations where trainees are not performing the same function as usual:

a. trainees doing online learning instead of working in the clinical environment are not MTD eligible
b. surgical cases dramatically decreased, so trainees are in the hospital far less than usual
c. OTN/virtual appointments where patient is not in physical hospital space, but trainee is still using hospital resources for supervision and to connect with them

→ Continue to count these modified rotations if hospital resources are still being used.

APPENDIX ONE

The following text is taken from the Ministry document **HDB Website Registation_Final_v1** (current as of 22JUL2016)

Initial Registration

STEP 1 HDB Website Registration:

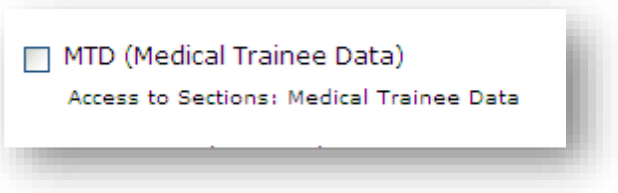
Access the Health Data Branch Web Portal | Ministry of Health and Long Term Care (gov.on.ca) at https://hsim.health.gov.on.ca/hdbportal/ and click on either Create New Account, or Register.

STEP 2 Create New Account:

On the Create New Account Page, complete the mandatory information: Username, E-mail address, Name, Organization/Sector, Department and Role, Director/Manager's Name and Telephone Number.

STEP 3: Access to Site Section

Check the MTD box the area of the site to which access is required



STEP 4: Select "User Type"

Select your user type from the pick list, and provide a brief description of your reason for requesting access to the site.

STEP 5 Create New Account:

Once you have entered the required information select "Create New Account" to submit your access request to the Health Data Branch.

You will receive a confirmation email to the email address you provided acknowledging your request.

STEP 6 Activating Your Account

Within three business days, you will receive an email from the 'HDB Web Portal' stating that your application is "approved" and along with instructions for activating your account.

- In the email received from "HDB Portal", click on the link 'Reset Password'.
- On the Reset Password page click Login and on your Edit page set a new Password; this password is unique to you; please do not share it with anyone.
- For security purposes, the HDB site will prompt you with specific requirements regarding the strength of your password if the one you choose is insufficient.
- A secure Password has a minimum of eight alphanumeric characters, upper and lower case, plus one punctuation character. Please note punctuation is not an alphanumeric character. Example: wM4k!xY5e
- Select the save button at the bottom of the page to save your password.

Already Registered Users

Forgot your user name and/or password – Please follow the steps below

- On the website-landing page, select "Request new password".
- On the User Account – Create New Password Page, enter your Username or email address and select "E-mail new password". You will receive, via email (from "HDB Web Portal"), a one-time login link to login and set a new password.
- From the received email click on the one-time "login" link and it will take you to a Reset password page. Select Log in
- At the "Account Edit" page enter and confirm your new personal Password.
- Click "Save" at the bottom of the page when finished to save your new Password.