Building a Flourishing Physician Workforce

Summit North 2018

Executive Summary

Contents

Summit North: Building a Flourishing Physician Workforce
Report of January 24, 2018 Meeting
Thunder Bay

This paper documents both the inputs to, and outcomes of, Summit North 2018, a day designed to bring together groups and organizations that need to work together to ensure that rural and remote communities in Northern Ontario will have a sustainable supply of well-trained physicians to meet their health care needs.

This event was sponsored by the Northwest and Northeast Local Health Integration Networks (LHINs), Northern Ontario School of Medicine (NOSM) and HealthForceOntario (HFO), and was organized by Drs. Sarah Newbery, Catherine Cervin, and Paul Preston, and Ms. Roz Smith. With thanks to the logistics team led by Rob Barnett.

Most importantly the Summit was a success because of the energy and contributions of the 125 participants who represented the "pentagram partners" noted in the Rural Road Map for Action: policymakers, educators, administrators, and community members and clinicians from across Northern Ontario.

Executive Summary

Summit North, held on January 24, 2018, focused on short and long-term solutions to help build a sustainable physician workforce, primarily family physicians in rural and remote communities. More than 125 community and health system leaders attended with representation from Northern communities (including Indigenous and Francophone), the Northwest and Northeast LHINs, the NOSM, HFO, Ministry of Health and Long-Term Care, health professionals, hospitals and Family Health Teams, and the Ontario Medical Association.

The specific objectives of the Summit were:

1. Developing an **accurate, shared understanding** of the health human resource needs of the rural communities in Northern Ontario including the elements & dynamics which contribute to fragility of health services. The focus will be mainly on family physician resources.

2. Exploring and discussing **innovative models** that consider the elements of fragility with the purpose of designing and implementing strategies that will create and sustain a flourishing workforce and services tailored to community and population needs (including primary and secondary care).

3. **Committing to strategies** that are within the control of organizations and people attending the Summit (immediate, short, medium and long term) that will address the health human resource needs.

The Physician Resources Challenge

Physician human resource challenges in rural and Northern Ontario have been well-documented over many years.

Current data, compiled by the Northwest LHIN chiefs of staff, indicates there is an estimated need for 56 full-time family physician in rural Northwestern Ontario to meet the primary care and hospital based needs (including emergency department coverage and general practice anaesthesia) of the rural and remote communities and a need for approximately 12-15 full-time family physician positions in the city of Thunder Bay.

Data from HFO indicates that as of October 2017, across all of Northern Ontario (both the Northeast and Northwest LHINs) there were 106 full-time family physician vacancies being advertised through their website. In addition, almost 800 emergency department shifts were covered in the preceding year by locums whose sole responsibility is to cover the local emergency department and without whose work local emergency departments would have had to close intermittently. This number is part of a general upward trend in need for emergency department coverage in recent years per HFO data.

Summit Speakers and Agenda

The Summit agenda included a number of guest speakers in the morning followed by facilitated group discussions in the afternoon. The following keynote speakers provided information on health workforce models in other jurisdictions, as well as lessons learned and key ingredients for successful physician human resource recruitment and retention strategies:

- Dr. Denis Lennox, Director, Rural & Remote Medical Support, (Queensland, Australia
- Derek Fox, Deputy Grand Chief, Nishnawbe-Aski Nation, (Bearskin Lake First Nation, Kenora District)
- Dr. David Gass, Physician Advisor, Department of Health and Wellness, (Nova Scotia)
- Dr. Jude Kornelsen, Associate Professor in the Department of Family Practice and Co-director of the Centre for Rural Health Research, University of British Columbia, (Vancouver)

Background information on the key findings from the *Summit to Improve Health Care Access and Equity for Rural Communities in Canada (July 2017)* and the Rural Road Map for Action was provided in advance of the day. Both reports were released last year by the Advancing Rural Family Medicine Task Force, a joint national Task Force of The College of Family Physicians of Canada and the Society of Rural Physicians of Canada: **http://www.cfpc.ca/ARFM_What_s_New/**

Key 'take-aways' from the guest speakers included:

- Denis Lennox - The success of their **Rural Generalist Medical Program** in Queensland Australia requires both sustained provincial government support as well as extensive consultation and buy-in from rural and remote communities to ensure community needs are properly matched with the capabilities of the rural generalist physician workforce. Small communities in isolation are fragile from a human resource perspective, but opportunity exists to enhance the resilience of physician resources through "fit for purpose" training and a clear pathway to a rural generalist career as well as "joining up" services across rural communities. **https://www.youtube.com/watch?v=xm19RpdeeSw&feature=youtu.be**
- Dr. David Gass – His presentation highlighted the importance of developing accurate health human resources forecasts about the required future supply of physicians based on community needs and building robust models of primary care based on equity and sustainability.
- Dr. Jude Kornelsen – creating sustainable specialty service networks (based on the BC experience with regional surgical obstetrical networks - RSON) is based on the following 5 pillars through which regional centres support rural centres providing care:
  - Increase scope and volume for rural centres;
  - Clinical coaching and training for rural physicians;
  - Remote presence technology;
  - Continuous quality improvement; and
  - Evaluation.
- Deputy Grand Chief, Derek Fox – He emphasized the need to listen to people within the communities and understand the realities affecting First Nations health such as poor housing, small populations, lack of services and expensive food; and the need to lobby governments to improve the social and economic determinants of health

Priorities for Action

There was consensus on the following priorities for action as identified by a broad group of Ontario representatives at the national launch of the Rural Road Map in February 2017:

Education: Strengthen partnerships in Northern Ontario between communities, LHINs, universities and physicians to support delivery of medical education in rural communities.
Special Skills Development: Family physicians and other specialists need support to develop and maintain the additional or enhanced skills (Family Practice Anaesthesia, addiction medicine, obstetrical skills, surgical skills) that their communities need to improve local access to services.
Networking for Patient Care: Policies that require timely acceptance of transfers and appropriate consultations from rural communities to secondary and tertiary care across Northern Ontario could better support family physicians to access the care their patients need.
Networks for Patient Care: Infrastructure and networks of care within LHIN regions in Northern Ontario be created and used to address specific services like mental health care, surgical services, obstetrical services.
Technology: Create system-wide, coordinated distance technology in Northern Ontario to support local family physicians and health care teams in their clinical and academic work.
Community Engagement: Communities in Northern Ontario become more engaged and active in recruiting, retaining and strengthening the integration of physicians and their families into their communities.
Mentorship: The establishment of formal and informal mentorship relationships to support rural family physicians and other specialists in the practice of comprehensive care across Northern Ontario.

The highest ranked 'big, bold' ideas from small group brainstorming at the Summit were:

A provincial Electronic Medical Record (EMR) that can be used by physicians, Interprofessional Healthcare Practitioners (IHPs), Home Care, Health Link partners – Health Quality Ontario (HQO) etc. Hospitals EMRs: One patient, one health record that the patient can access, connected to every community.
An integrated "All Nations" Heath Care System designed and developed by a community driven process and which allows for integration of specialty services including **one EMR** but also has an individual community focus in terms of care management programs and health care priorities being met as close to home as possible.
Integrated regional locum service, which could be a regional non-profit locum agency that provides cultural and other regional orientation, tracks quality of service provided, maintains a pool of high quality locums committed to the region, and strives to support community. This would increase quality and continuity of locum services, which will always be needed, even for vacation coverage.
Expand the role and number of **Physician Assistants in Northern Ontario (PAs)** through targeted training in rural primary care (new or evolution of existing) PA program built along NOSM MD model) and sustainable funding model. This would complement MD recruitment and improve retention by allowing MDs to focus on highest level scope of practice.
All decisions made, and all resources assigned by **Equity**.
Introduce and integrate **Indigenous spirituality and traditional teachings** into wellness programs. Raise morale and sense of community of health care providers, since wellness is the key to recruitment, retention and flourishing. The value of indigenous knowledge is incredible in our communities for all people of all backgrounds.
A specialized 3-year **"Rural Family Medicine" residency program** as a pilot project through NOSM.

Several other ideas came forward on the day of the summit and these are noted in the final report. Please refer to Appendix C of the Summit Report for additional details.

From the three elements of the day (the panel discussion, the rural road map priorities and the "bold ideas" discussions), the following five themes for action emerged:

1. Ensuring healthy and resilient physicians and teams

a. Development of a regional locum pool for Northwest and Northeast LHINs

b. Supporting contracts for physicians and their teams

c. Intentional approach to physician wellness

d. Formal and informal mentorship opportunities (mentor with seasoned clinicians)

e. Funding models that support post-residency work in groups for new grads

2. Ensuring welcoming communities

a. Create education for communities regarding health human resources

b. Develop engagement and orientation session for each new locum arriving in a community

c. Create ways for communities to collaborate rather than compete, (e.g. "join up" recruiters and opportunities for physicians to find "good fit" with communities)

d. Ensure continuing development including coaching and mentoring for recruitment

e. Leverage the experience of students and residents in communities – what made them feel welcome?

3. Ensuring skilled, competent rural generalists

a. Ensure process to review admission criteria that supports rural/remote students and provides opportunities for rural/remote community exposure in undergraduate years

b. Ensure that all postgrad family medicine residents have rural rotations with adequate infrastructure support

c. Increase elective opportunities, and remove barriers to electives for all learners

d. Create specialty focus "rural generalist" over three years Family Medicine-combined curriculum

e. Ensure access to community-based enhanced skills development based on community need

f. Provide resources to ensure there is needs assessment for each community

g. Formalize partnerships between NOSM, LHINs, communities and physicians

h. Integrate allied health, interprofessional learners (including Nursing, PAs, Therapists) to train at the same time

i. Develop a proper needs based distribution plan for new grads (three to five years)

4. Local and regional networks of support

a. Establish networks across practices

b. Consider specialist lead for networks of care

c. Establish networks for referral and patient transfer; LHIN based and formalized

d. Establish regional networks for specialty service provision (surgery, mental health, obstetrics).

5. Supportive infrastructure

a. Single electronic medical record EMR for the entire region to hold all hospital and other health care data (one patient, one record, one EMR)

b. Technology that supports and enhances care but is not central to care

c. Enhanced leadership capacity and create accountability tools

Next Steps

At the close of the day, keynote speakers offered the following summation of the day's proceedings:

- We need to work together to solve this problem
- There is high interest for change, and genuine curiosity about options
- There is lots of energy, enthusiasm, opportunities, and today is a turning point
- There is authenticity regarding engagement with communities

The Summit North Steering Committee has now created a Northern Physician Resources Task Force whose goal is to develop a concrete Action Plan based on the ideas, strategies and priorities generated and explored by groups and panelists at the Summit. The overall goal remains unchanged – **Building a Flourishing Physician Workforce for Northern Ontario** that can support equity in health outcomes for the population of Northern Ontario.

If you would like more information about the Summit, please click here for a copy of the full report.