Building a Flourishing Physician Workforce

Summit North 2018

Full Report

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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 LHIN, the Northern Ontario School of Medicine (NOSM) and HealthForce Ontario (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 (ED) coverage and Family 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 indicate 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 ED shifts were covered in the preceding year by locums whose sole responsibility is to cover the local emergency department and without whose work local ED would have had to close intermittently. This number is part of a general upward trend in need for ED 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:

- Dr. 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 (HHR) 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) is based on the following five 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 (PAs) in Northern Ontario** 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 three-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 HHR

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 postgraduate 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 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.

INTRODUCTION: WHY A SUMMIT AND WHY NOW?

Access to health services, and physicians in particular, has been a longstanding challenge for citizens of Northern Ontario, and in particular for those in rural and remote communities, with the challenges of Ontario's remote Indigenous communities being the most significant. Recent evidence from Health Quality Ontario has demonstrated that in comparison to the rest of the province, Northerners experience significant inequity in both health access and health outcomes. Specifically, we know that the population of Northern Ontario has a greater burden of chronic illness, greater difficulty accessing a primary care provider on the same day or next day when sick and decreased life expectancy.

Nationally, a joint task force of the College of Family Physicians of Canada and the Society of Rural Physicians of Canada led to the publication of a report entitled R*ural Road Map for Action*. This document was launched nationally in February 2017 with representatives from across Canada including several from Ontario.

Over the years, many organizations have played a role in supporting HHR in Northern Ontario. HealthForceOntario (HFO) has created opportunities for regional and local matching of communities to physicians and locums and the Northern Ontario School of Medicine (NOSM) was created in Northern Ontario with the goal of building a physician workforce to serve the needs of the communities of northern Ontario. The Local Health Integration Networks (LHINs) have been evolving over the past decade with an increasing mandate to support HHR in order to deliver necessary health services.

While not all of the data regarding the physician human resource needs of the communities of Northern Ontario were available at the time of the Summit, information provided through the Northwest LHIN chiefs of staff highlighted significant ongoing need. It is estimated that there is a need for 56 full-time family physician in rural Northwestern Ontario to meet the primary care and hospital based needs of the rural and remote communities (including ED coverage and Family Practice anaesthesia) and approximately 12-15 available full-time family physician positions in the city of Thunder Bay.

HFO also shared data that as of October 2017, there were 106 full-time family physician vacancies being advertised through their website. In addition, almost 800 ED shifts had been covered in the preceding year by locums whose sole responsibility is to cover the local ED and without whose work local ED would have had to close intermittently due to lack of local physician availability to cover that service.

In addition to providing clinical services in Northern Ontario, physicians form the core of NOSM's distributed teaching faculty. In order then to improve health equity across Northern Ontario, sustain and improve clinical services to the rural and remote communities of the Northwest and Northeast LHIN and ensure a teaching faculty to ensure future clinicians, Summit North was envisioned as an opportunity to come together and think creatively about how to move the Northern Ontario physician workforce from "fragile to flourishing".

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 of Australia
- Deputy Grand Chief Derek Fox from Bearskin Lake First Nation
- Dr. David Gass of Nova Scotia
- Dr. Jude Kornelsen of Vancouver.

Key points shared by panelists:

1. Begin with community and population need and plan services at a regional level
2. Recognize this is a long process
3. Work in partnership with every key stakeholder
4. Base HHR forecasts and plans on accurate data
5. "Join up" communities – create networks or clusters to ensure a critical mass and volume for needed services
6. Ensure a pipeline from high school to practice to train rural generalists and support and celebrate them along that whole pipeline
7. Support family physicians with enhanced skills
8. Need vision, buy-in, engagement and energy from the provincial government level through to the local community level
9. Be creative - build new models of care and use technology to innovate with distance support, teaching
10. Evaluate

SUMMARY OF INDIVIDUAL PRESENTATIONS:

Dr. Denis Lennox

The four key success factors from Dr. Lennox's presentation are:

Joining up Medical Training and Recruitment:

Dr. Lennox described the rural generalist program in Australia and the importance of recognizing rural medicine as a distinct discipline in medical school residency training. Training must address the needs of communities and recruitment must begin early, likely in secondary school. He discussed the benefits of identifying early those who have the capacity and interest, and then providing the preparation required for practicing in rural medicine. This would require developing supportive pathways from high school, to university through undergraduate medical education to mastery of rural generalism based on specific community needs. To be successful this pathway must include endless options for training and rural experiences along the way and learners must be provided with privileged access to needed learning opportunities.

Federal, provincial and local leadership and vision:

To be successful objectives need to be set at the provincial/government level, with those in key leadership positions promoting the vision and in particular, valuing the practice of rural medicine. This requires a systematic approach with provincial-level participants and non-partisan support for rural communities. Local initiative is then necessary and may need to be prompted. There is a need to significantly increase local capacity in vision, expectations and effort to move forward. Community involvement and consultation with community leadership is critical to this success.

Joining up physicians and health service providers through Partnerships:

Success requires a strong collaborative approach among providers and health care services to develop a service model and build a culture of connection. We need to ensure that there is matching between services and community needs, and that there is a good match between needs and expectations of the communities. This also must be based on economic considerations, and an examination of rural and remote services. An important consideration is understanding the risk (personal and family) of small volume medical practices.

Key lessons from Queensland for Ontario:

Recognize that this is a long-haul project and must be elevated beyond ideology for non-partisan political support. This change is systematic and requires embedding transformative change. It is crucial to have government buy-in, as well as community involvement (e.g. politicians, community organizations).

Dr. Jude Kornelsen - BC[1]

Dr. Kornelsen's presentation touched on the following:

- Framework and component parts of BC's rural surgical obstetrical networks (RSON)
- The policy pathway that leads to creation of the networks
- The outstanding system issues that need to be resolved
- To consider the potential applicability to Northern Ontario

Her work grew out of the loss of rural obstetrical services which had a negative effect on families and women. It was quickly recognized that loss of local surgical services followed soon after. Thus Dr. Kornelsen has been working with family physicians with enhanced surgical skills and received funding to develop RSON. In Western Canada, populations of 5,000-15,000 are large enough for a small surgical program, but too small for a general surgery group.

The core assumptions of success are that rural surgical and obstetrical programs become extensions of larger referral hospital surgical programs, and that the organization of services respects the sustainability of both the regional programs and the rural programs. Also the outcomes of all surgical programs in the network are the responsibility of the referral centre as well as the local program. RSON are natural geographic catchment areas that include the regional referral centre and all community rural sites within one-hour surface travel time.

A challenge in the current climate is that there is a lack of national training standards supported by RCPSC and CFPC (e.g. a CFPC/category 1 designation for a PGY3 enhanced skills program) and a lack of ongoing CME.

1 Kornelsen J, Friesen R Building Rural Surgical Networks: An Evidence- Based Approach to Service Delivery and Evaluation HEALTHCARE POLICY Vol.12 No.1, 2016

Five pillars of the rural surgical obstetrical networks are:

Increased scope and volume:

It is important to have the volume to sustain surgical services, and RSON supports the expansion of the scope and volume of rural surgical programs to a level of sustainability

Clinical coaching:

This requires relationships among health care practitioners in the regional referral centre and the smaller communities (surgeons, family physicians with enhanced skills and operating room staff). Coaching is a two-way enedeavour with surgeons and OR staff from the regional centre travelling to smaller communities to provide on-site coaching and skill development and health professionals from the smaller centre spending time in the larger centre to enhance their skills and knowledge. This also requires introducing innovative CPD programming opportunities for rural physicians and nurses providing surgical/obstetrical care at smaller volume rural programs.

Remote presence technology (e.g. Google Glasses):

This enables teams, separated by distance and by training to stand shoulder to shoulder and operate together. The required technologies include tablets, videoconferencing carts, exam camera, self-propelled robots and optical head-mounted displays, and enables clinical coaching.

Continuous quality improvement:

The purpose is to promote the continued improvement of surgical services in rural sites and examine the activities of rural sites and the interface between rural and referral sites in real time and be able to course correct if necessary. This also allows evaluation of surgical outcomes based on validated quality improvement measured and tracking the efficacy of surgical triage and referral and transport and the potential overall effect of surgical effects

Evaluation:

It is critical to create a data platform and to conduct relevant research.

Dr. David Gass, former Physician Advisor for Nova Scotia Government:

Dr. Gass began by outlining key principles:

- Always work from and to populations and adapt to community needs
- Ensure continuous and repeated focus on engaging partners (First Nations and Indigenous peoples, Communities, Health Professionals, Regional Health Authorities, Universities and Colleges, Provincial Ministries, Professional Association
- The goal should be equity amongst communities and across the province
- In planning and evaluation use narrative and quantitative data and work to strengthen both
- Adapt and shape methods and means to goals

In order to meet the needs of communities it is essential to forecast health human resource needs and follow the forecast with an organized HHR Planning Process.

In order to plan there must be models of care at a regional (not just at a community) level (e.g. neurosurgical services). The HHR plan feeds into the structure of health professional education i.e. train the right mix of health care professional to meet the region's needs.

The work plan involves the following steps:

1. Develop HHR forecast model and reliable data sources for physician supply and community needs
2. Develop or improve models of care - Primary Care example
3. Adapt and implement models in specific clusters of communities (similar to RSON described by Dr Kornelsen)
4. Ensure adequate supply of new physicians through medical education pipeline

Develop Forecast Model and Reliable Data Sources

The forecast model and ensuring reliable data is a key provincial responsibility and may need a regional approach. In developing the forecast one of the major drivers is replacing the physicians who retire or leave. The factors to consider in determining what the replacement needs are include: the current complement of physicians, the age and gender (which predict retirement), the impact of gender on workforce participation and migration in and out of the region.

Health Human Resources Planning

The forecast is NOT a plan but provides the estimate of the need and should provide ongoing reliable data. The forecast will focus the discussion with educators and is useful for recruiters.

The plan must consider in and out migration of physicians and the specific diseases or populations within a region. Factors influencing specific population needs include demographics, aging, new or changing presentation of disease, changing models of care, quality of care requirements and equity. There may be a need to concentrate or consolidate special services and recognize and incorporate extended roles of generalist providers (e.g. Family Practice Anesthesia, Care of the Elderly)

Build new models of care **e.g.- Primary Health Care**

Key responsibility for MOHLTC, Indigenous peoples and professional associations:

- Ensure model is population based for equity and sustainability
- Be clear re: scope of model
- Identify core teams
- Clarify models of leadership governance
- Consider infrastructure including support for learners
- Adapt payment and funding to support goal including teaching
- Building technologies
- Build networks of caregivers within clusters

- Work with the willing
- Join up other systems – Emergency Health Services (EHS)

Educational supply

- Building strategies by discipline and professionals based on forecasts
- Recognize limitations of data but also strengths
- Remember lead times (it takes 10 years to train a surgeon, 6 – 7 to train a Family Physician)
- Recognize mobility of residency graduates

Nishnawbe Aski Nation Deputy Grand Chief Derek Fox:

Deputy Grand Chief Fox, who holds the Health and Education Portfolio, spoke on behalf of Grand Chief Alvin Fiddler and the 49 communities of Nishnawbe Aski Nation (NAN).

The biggest issue is infrastructure, and he noted that ORNGE is better equipped than the nursing station in most communities. 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 (e.g. pharmacies) and expensive food (a head of lettuce may cost $20).

Lobbying the government to improve social and economic determinants of health as well as health care resources is critical. There is a need to address issues of housing, education, medical access and to encourage young people to educate themselves.

RURAL ROAD MAP PRIORITIES ADAPTED AT SUMMIT NORTH 2018

There was consensus on the following priorities for action based on the *Rural Road Map,* and these priorities were identified by a broad group of Ontario representatives at the national launch of the 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.

HIGHEST RANKED 'BIG, BOLD' IDEAS FROM SMALL GROUP BRAINSTORMING

A provincial 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 **PAs in Northern Ontario** 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 three-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 Appendix.

SUMMARY OF ACTIONS:

From the three elements of the day (the panel discussion, the *Rural Road Map* and the "bold ideas" discussions) the following emerged as areas for action to ensure a flourishing workforce that can support equity in health outcomes for the population:

1. Ensuring healthy and resilient physicians and teams

- Development of a regional locum pool for Northwest and Northeast LHINS
    - Create an advisory committee to oversee locum pool and community collaboration
    - Identify coordinator role and metrics for success and evaluation of locums in pool (metrics to include cultural sensitivity)
    - Address funding and return of service (ROS) options for locum pool
        - Funding model should encourage locums, but not discourage full time commitment to a community (should be some incentive to come out of locum pool at some point)
    - Consider path for new grads to commit to locum pool perhaps as part of ROS and with expectation of rotation through communities within region
    - Consider model that includes built in co-deployment and mentorship for new grads and seasoned locums
    - Ensure orientation for locums in regional pool
        - Consider common orientation package for region
        - To include training for locums to ensure Indigenous / Francophone cultural sensitivity
        - Initiate partnership amongst Hospitals, Community/ Indigenous, Educational
    - Supporting contracts for physicians and their teams
        - Include teaching capacity in consideration of contracts for physicians
    - Intentional approach to physician wellness
        - Include ndigenous approach to wellness for physicians in communities

2. Ensuring welcoming communities

- Locums: Each community upon locum arrival; engagement and orientation session
- Collaboration: create ways for communities to collaborate rather than compete
    - "Join up" recruiters and opportunities for physicians to find "good fit" with communities

3. Ensuring skilled, competent rural generalists

- Ensure that all postgrad family medicine residents have rural rotations
- Increase elective opportunities, and remove barriers to electives for all learners
- At undergrad level: ensure process to review admission criteria (support rural / remote) and opportunities for exposure in UG years
- Create specialty focus "rural generalist" over 3 years FM- combined curriculum with training for rural generalism rather than "stand alone" PGY3 time.
- Ensure access to community based enhanced skills development based on community need
    - Leverage Local Education Groups (LEGs) funding (where possible) to hire someone to do needs assessment for each community
    - Develop education plan based on N.A. including CME, online and face to face education, faculty development, and formal advanced skills training
    - Ensure adequate infrastructure and funding
    - Ensure data for program planning and indicators for monitoring
    - Formalize partnerships between NOSM, LHINs, communities and physicians
        - Identify community priorities and gaps from ground up and work through partnership locally
        - Establish (delegate) high-level representation from organizations to work together
        - Develop shared decentralized approach to engagement and understanding of community needs to build vision/ action/ advocacy from their input
    - Integrate allied health, interprofessional learners (nursing, PA, OT/PT) to train at the same time

4. Creating local and regional networks of support

- Establish networks across practices
- Establish LHIN-based networks for referral and patient transfer
  - E-referral systems, central intake and waitlist management
  - Expand visiting specialist programs
  - Need to improve mental health networks – increase resources, improve connections and transitions in care
- Networks for regional specialty service provision (surgery, mental health, obstetrics) through which smaller communities are empowered by and supported by tertiary centre
  - Support models that are working in the region: orthopedics, surgical program, cancer care, stroke, virtual critical care
  - Leverage and expand where possible (central intake)
    - Expansion should include pediatrics, ENT, renal services
  - Alignment with academic health sciences stream to support best practices implantation
  - Enhance regional programs cancer care

5. Providing Supportive infrastructure

- EMR and IT**: pursue** single EMR through region to hold all hospital and other health care data (one patient, one record, one EMR)
  - Need to ensure data is protected and that system is robust, reliable and inclusive
  - Establish connectivity in all communities
  - Build local plans regarding use of technology that are culturally sensitive and safe
    - Ensure that technology supports/ enhances care but is not central to care
    - Consider use of things like virtual ICU vs. mobile specialist units in communities
    - Develop an evaluation framework that measures outcomes of technology / digital health support and includes performance metrics
- Governance tools
- Leadership capacity

CONCLUSIONS FROM THE DAY:

At the close of the day, there were very positive reflections and encouraging comments as well as sage advice to the task force steering committee that will carry this work forward.

The 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, with representation from organizations recommended by participants at Summit North. The 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 task force has been asked to communicate in meaningful ways about the outcomes of the day, and the next steps as well as timelines, and to report back on progress as work is undertaken.

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.

APPENDIX A: SUMMARY OF INPUT FROM TABLE GROUPS:

The following section lists by idea or action, the discussion of the table groups.

Each table of participants was assigned an Action from the *Rural Road Map for Action* and a Big Bold Idea to discuss. The two questions posed to each table were:

Question #1: In Northern Ontario, how do we move forward on this priority?

Question #2: What can be done in the short, medium and long term?

Where there was more than one table discussing an idea or action, the key actions noted have been compiled to a single list of actions and have not been differentiated into short, medium and long term.

EDUCATION: Strengthen partnerships in Northern Ontario between communities, LHINs, universities and physicians to support delivery of medical education in rural communities

- Identify priority projects to work on together, focused on community priorities
- Ensure that Residents have experience in local small communities
- LHIN – should have a role in "managed" primary care
- Develop a common set of principles for partnerships
- Address transportation/ scheduling with subsidy (low income)
    - Won't be economically viable privately
- BOLD plan to address population needs by proper distribution of new grads (three to five years…)
- Integrated "board" or cross-board appointments that drive collaboration; Infrastructure support
- Funding model to reflect community needs
- Infrastructure support for teaching needs to be more robust to adequately support this core activity
    - i.e. residency in small 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.

- The needs of the community in terms of population health need to be combined with provider level needs at the community level
- Need to determine the required infrastructure – who the teachers are, what the funding is, and what the infrastructure resources will be
- Patient safety/ CQI needs
- An educational needs assessment should be compiled to include all mechanisms of learning (face-to-face, online, hands-on, faculty development, etc)
- Evaluation and monitoring indicators need to be developed
- Consideration should be given to leveraging the *Local Education Groups* funds in each NOSM teaching community

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.

- Co-develop with patients and ensure that care is accessible and not denied based on "lack of beds"
- Evaluate where biggest needs are
- Expand the concept of critical as navigating system for available secondary and tertiary services
- Expand ORNGE: the model is insufficient for the North

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.

- Support models that are working and do so by LHIN:
  - Orthopedics
  - Obstetrics
    - C- section
    - NP/ Midwives
- Surgical program
- Leverage and expand where possible (central intake)
- Mental health challenging
  - More resources needed
  - Many disconnects
- Need to address cultural differences and should provide education on how to deal with these
  - Ex. Introduce NAN Oshki Education Program to mental health social service students
- Build relationships between primary care providers and referral centre specialists: formal regional network
- E-referral systems, central intake and waitlist management
- Expand visiting specialist programs
- Enhance regional programs and consider regional lead for

Cancer care	Stroke	Virtual critical care
Psychiatry	Obstetrics	Peds
ENT	Renal	

- Environmental scan, population health
- Administered jointly with NOSM, LHIN

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.

- Through engagement identify:
  - Community resources identified
  - Need/ current infrastructure (human and technology)
  - Local context/ locally relevant concepts/ culturally safe/ sensitive
    - Leveraging local concept to build "plans"
- Establish connectivity in communities
- Simple > single EMR or common platform hold all hospital, HC, etc. with patient portal
  - Infrastructure inventory
  - Investment > infrastructure – HR and Technology
  - Sustainability
  - Ongoing QI and evaluation framework
  - Clinical pathways
  - Ensure education training and support for technology and process for both patient and provider
- **Patient must be central to concept and activities**
- Technology enablers vs. relationships
  - Technology supports/ enhances
  - Technology is not central
- Use of virtual ICU vs. mobile specialist units in communities

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.

- Education to community re: HHR and sharing of best practices
- Stakeholder meetings
- Stakeholders to meet with prospective MDs / allied health
- Standardized regional and northern specific approach and recruitment
- Avoid competition
- Bring back CME $
- Early rural exposure with NOSM
- Stakeholder engagement
- Coaching/ mentorships
- Leverage opportunities with students and residents

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.

- Creating relationships rural-urban MDs (GP-specialist)
  - Conferences
  - Social
  - Best practices
  - Use LEGs (NOSM$)
- Increase resident exposure during NOSM FM residency to rural communities (increase back to six months)
- Inpatient/ OB/ ED formal programs
- Utilize semi or fully retired MD's to mentor
- Funding models (e. RNPGA) to support post-residency work in a new group

A specialized three-year residency program for "Rural Family Medicine" pilot project through NOSM.

- Increase elective opportunities for rural and remote communities
- Exposure as an undergrad
- Review admission criteria to ensure focus on rural/remote students
- Curriculum development to meet needs
- Review the curriculum
  - Clinical component
  - Move 108/ 110 to ?
  - Does ECC work?
- Literature review
  - Integrated community clerkships and physician practice in rural/ remote communities
- Instead of condensed in one year (PGY3) spread specialty focus "rural generalist" over three years FM- combined curriculum
  - Example: FPA/EM or EM/Obs/Gyn
- Integrate allied health, interprofessional learners to train at the same time
  - Nursing
  - OT/PT for example
  - PA
- "Community Based Co-design"
- Lobby for funds for additional community docs for base capacity for teaching
- Advocate/ drive: one patient, one record, common EMR

Provincial EMR that can be used by physicians, IHP, Home Care, Health Link partners, HQO etc.

- Local FHT/ HCC/ HAC/ CHC
- All provincially funded programs to be funded for EMR subscriptions
- Therefore, province, will through Ontario MD, choose one vender
- Physicians who are part of the above programs (FHN, FHO, HAC, CHC, etc.) would no longer bear the responsibility of sole "ownership" custodian

An integrated All Nations Heath Care System designed and developed by community-driven process and allows for integration to specialty services including one EMR but individual community focus in terms of care management programs and priorities met as close to home as possible.

The idea was rephrased to: "an integrated All Nations Health Care Program cultural safety programming designed. Delivered through community-driven process integration of specialty services. One EMR community-focused core management program close to home"

- Identify the operational community of care
  - Existing pathways and mapping of care
  - Gaps and barriers via engagement from the poorly represented groups
  - Via/ expand rural health hubs
- Outcomes – set standards and think about cultural safety indicators (ie. Space, language, Beliefs and values, physical diet, etc…)
- Evaluate case studies
- Action Driven Road Map and T+R
- Boundary setting "geography/ demographics" and social determinants for primary care
- Pathway/ care map
- Network/ community work (pantograph of engagement)

- Gather appropriate stakeholders
    - Gaps/ barriers
    - Set standards – vision
- Driven by road maps and T+R priorities
- Vision outcomes
    - Standards based on cultural safety indication
    - Space, language, beliefs/ values, physical aspects, equity
    - Priority
- Implement case study
- Evaluate
- ID patients and needs
- Reach out/ engagement (community)
- ID specialty services
- Engage providers, stakeholders, community
- User friendly integrated-web based
- Use technology for outreach services (Tele-med)
- Host community sessions for feedback

Health Equity

- Common documentation database accessible by everyone (Provincial EMR)
- Access to data
- Inventory of current available services vs. desired services
- Balance scorecard of services available by community
- LHIN-led inventory of available services
  - Evaluate community needs and current capacity
  - Collection of data
- Development of a score-card of available services vs. needs
  - Social
  - Mental
  - Physical
  - Emotional
  - Spiritual
- Access to databases
- Development of common EMR database accessible by all health care providers provincially – continuous quality improvement initiatives
- Cultural sensitivity training
- Understand local demographics and cultures
- Identify community stakeholders and engage
- Develop purpose statement and clear direction
- EMR: determine feasibility of an all-encompassing system
- Analyze effectiveness and include in HHR planning
- Funding of framework and accountabilities
- Develop provincial integration plan: funding, stakeholders, timelines, targets
- Continue to work collaboratively with all stakeholders to ensure outcomes are achieved

Integrated regional locum service.
Create 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, strives to support community. To reduce the 4Ms and increase quality and continuity of locum services, which will always be needed, even for vacation coverage.

- Create partnerships among Hospitals, Community/ Indigenous, Educational institutions
- Govt. Funded
    - Funding to support locums should not disadvantage full time local physicians
- New grads commit to locum pool;
    - Rotate through communities
- Each community upon locum arrival; engagement session
- Create network with residents and mentors
    - Co-deployment
- Create regional networks (with LHINS)
- Pool of locums of physicians near end of career or beginning
- QI Coordinator compiles feedback from each community and locum participants
- Using this feedback, we can see where we are lacking with cultural sensitivity
- Create governance structure for ownership and accountability
- Champions to advocate, "buy-in"
- Begin engagement sessions with leaders
- Create an advisory committee
- Clarify expectations > accountability
- Create pool of locums
- Stakeholders to establish consensus of priority
- Create common orientation packages

- Stop community competition
- Funding options
- Policies, administration formation
- Continue communicating engagement
- Provincial workforce planning
- Broader consideration than physicians
- Transition plan for decentralization mentorship program
- Career development/ advice mentorship

Equity: All decisions made, and all resources assigned by Equity.

- Run decisions by a community of care
  - The health hub model
- Gather information on what the inequities are. Need models of social determinants of health
- Send a fair share back to us
- Accountability > who is accountable when a decision is not equitable
  - Need a Northern lens
  - Need to travel
- Start the conversation
  - Value stream mapping
  - Care givers group
  - Gather information
- Rural and remote health accountability commissioner (like auditor general)
- Build relationships and trust
  - Bring physicians under the same contract as AHPs
- Staff the OMA and the politics

- Needs assessment and implement response measures of equity and need for framework and implement for equity
- Metrics applicable to community/ redistribution of resources
    - Geography "all in"/ $cost
    - How do the $ follow the patient?
- Define what "equity": means in healthcare
    - Given level playing field
    - What gaps prevent this (language, $, distance, etc.)
- Accurate and up-to-date image of community needs
    - Stats based (scorecard of demographics)
    - Community needs base > driven by local people
- Set standards of expectations and benchmark for care providers
    - Same level for all
- Engage all involved parties on needs, standards, benchmark
    - Policy, practitioners, communities, etc.
    - Lead committee and input sources
- Identify gaps to access from above
- Score card of stats to provide equity to community
- Organize governance to organize the info from above
- Creation of tools to help parties communicate
    - Practitioners to provide steps of care, identify expectations/ outcomes
    - Patients to identify their changing needs to others
- Ongoing feed backup
- Decisions and resources assigned with population health focus (examine need)
- Community engagement – enviro scan of needs
    - Define community- based outcomes

- Define community
- Create understanding that ways to address need will look different in other communities
- Sub region planning tables to include other sectors (use common identified outcomes to identify stakeholders)
- All decisions made and all resources assigned by equity – patients and community need
- Engaging stakeholders
    - Communities (residents, HSPs, gov'ts, education, indigenous, etc)
- Inventory/ enviro scan of current state and community wishes (outcomes)
- Health summit > ongoing dialog thru networks
- Planning tables include representation from all stakeholders
- Shift focus from "health care" to "health"
- Stop thinking like an institution – think like a community (re-allocation of funds more autonomy with books)
    - Partnerships and relationships to provide services
    - Local autonomy re: funding for more innovative projects and linkages
    - LHIN should do patient cost analysis
        - Disjointed system

INDIGENOUS SPIRITUALITY AND TRADITIONAL TEACHINGS

Introduce and integrate Indigenous spirituality and traditional teachings into wellness programs. Raise moral and sense of community of health care providers.

- To demonstrate a recognition of the role of traditional healing
- Funding would be in place for support for indigenous spirituality and traditional teaching for staff including leadership) to get wellness programs in the community (not institutions)

APPENDIX B: ADVICE TO THE STEERING COMMITTEE

At the end of the session, it was announced that a Steering Committee will take the proceedings of today and move action items towards the goal. Participants were then asked to individually write a message of advice or direction to the Steering Committee. Their advice is categorized into five main messages:

Motivational Messages - Summarized:

- Don't aim for "just enough" or "adequate." Aim for flourishing
- Don't let the pursuit of perfection get in the way of progress
- Encourage calculated risk; embrace failure as a learning opportunity
- Thank you! Thank you! For your hard work and for initiative!
- Focus on what you have influence over. Don't accept anything less than equity
- Commit to a positive and constructive solution-oriented attitude towards recruitment
- Be nice to each other
- Be open to hearing bold ideas
- Remember the client, both learners and the patients who we are here to serve
- Engage broadly and early and frequently with the actual communities for who you are making plans

Steering Committee, please consider/remember - Summarized

- Remember to ensure that each community is treated uniquely
- Continue to ensure active community participation with all other partnership pentagram members to develop a successful model in Northern Ontario for Northern Ontario
- Include Public Health in all aspects of these initiative
- Keep open to inter-jurisdictional collaboration and learning much to be gained from rural collaboration
- Remember the importance of support for the rural physician
    - Educational, social, collegial, financial, personal growth & resources

- Please don't forget to make provision of rural obstetrical area a priority
- Remember the FN communities. Don't set them aside because they supposedly fall under "federal" jurisdiction. Don't put them aside because the issues seem too difficult
- Remember communities need to be part of the entire process, including how we define what's important, methods to make change, and then to monitor and evaluate. Include allied health professionals, i.e. NPs; many physicians involved today are also key care service providers in both Northwest and Northeast LHINs. They (NPs) can help communities with primary care shortages (in the) interim until stabilized to get better physician complement where needed.
- Always keep patients top of mind; engage all stakeholders and keep an open mind
- Think about how to engage the MOHLTC. We want to be a partner in driving and bringing about change.
- Any potential solutions for physician recruitment must involve input from the medical students, residents and recent grads
- Be open to consider new ideas that provide envelope funding to communities to manage physician recruitment and retention, i.e. pool incentives, locum, etc
- The most critical component in better healthcare is a common EMR

APPENDIX C: ADDITIONAL IDEAS

FOR CLINICIANS & COMMUNITIES

- Likely offer internal mentoring to new grads
- Consideration of team-based care if unable to attract fit MD in an area. Perhaps they could get an MD to be a collaborative MD or "primary care specialist" to a team of NPs and IHPs

FOR NOSM

- Have medical learners have to commit to a couple of years in a community
- NOSM needs to improve its undergrad selection process to increase the probability of enrolling rural candidates who will go home to rural areas
- Find a way to increase selection of local and especially First Nations candidates to NOSM
- Select the clinical clerks and residents more appropriately for individual communities
- Enhance access to students/residents of NOSM
- Partners NOSM physician and teacher with IMG to push them through to residency program. Tip that resource.

FOR LHINS

- Single EMR for NorthwestLHIN
- 1 system—ownership of primary care (payment) and planning with LHIN
- Continuously push and publish that the most effective medicine for value (savings throughout the rest of the system) is every patient having a medical home and continuity with their health care provider. So let's build a system that provides that, rather than spending a ton of money on the chaos that ensure
- A coordinator for HHR in the North
- Someone who can coordinate pools of locums, students, recruitments, i.e. if someone wants to go to Atikokan and they are full, then suggest a similar community that is in need. Someone who can make introductions, pool academic resources, CMEs, teaching for MaiD, opiates, etc. Isolated communities like Manitouwadge are so busy treading water, it is so incredible to have support from other community

- Please look at funded sites which are truly turn-key and where the physicians are not excluded from the AHP group. Should all be funded together
- Advance an integrated "All Nations" Health Care System and vision for Kenora area
- More vocal and presence of Indigenous presenters to provide the Indigenous perspective to the table
- Subsidize funding for recruitment initiatives, e.g. travel; each community's needs are different
- Focus on overhauling regional governance model
- Strengthen the relationships, academic policy/funding/decision makers