Physician Resources Action Plan for Northern Ontario

Prepared by: The Northern Physician Resources Task Force

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Executive Summary

This Physician Resources Action Plan is based on the many ideas generated at *Summit North* – a conference of key stakeholders representing Northern Ontario, held January 2018 in Thunder Bay, whose primary focus was *developing short and long term solutions to help build a flourishing physician workforce, primarily family physicians[1] in rural and remote communities.* The Task Force has reviewed the *Summit North* ideas and recommendations and has created both short term action steps to move the recommendations forward as well as longer term goals and objectives. For all of the action items in the plan there is a designated lead organization with the understanding that many of the recommended strategies require input from and participation of multiple stakeholders to support their implementation.

In addition it should be noted that each action strategy will have associated tactics with detailed implementation timelines that are not listed in this document but will be developed by the individual lead and support organizations to support and direct their work.

The most important and urgent strategy is to ***Provide necessary resources to ensure there are proper needs assessments for all northern communities and targeted strategies for communities most in need using an Equity lens.*** This is necessary for establishing baseline data about the communities most in need and workforce models that will best meet their needs. Using an Equity Lens for Northern Ontario means some communities are more vulnerable in terms of population health status and more underserviced in terms of the availability and access of health and human services. It is important that these communities be identified and targeted for help. This work will need to be led by the two Northern LHINs in consultation with key partners. ***This baseline data must inform a sub-regional health human resources plan that defines needs for Family Physicians, other specialists and health care professionals.***

These are other short-term actionable priorities that can be implemented at little or no cost over the next 6 months with appropriate support from the designated Lead Organization:

[1] Recognizing that all communities need collaborative interprofessional teams. The focus is on Family Physicians because in rural communities they are the anchor for both primary and secondary care – without adequate numbers of Family Physicians, the rest of the team cannot function effectively.

NOSM AS LEAD

- ***Stream high school students interested in northern, rural and remote community health care careers and refine admission criteria that supports their admission to medical school***
    - NOSM to meet with students in the remote/Francophone and First Nations stream and the rural stream to better understand why they selected their learning stream and what the School can do to attract more students to these streams; and follow-up with graduates to better understand their community selection process in terms of preferred practice locations
    - Consult the students that dropped out and address the reasons why
    - NOSM to build strategic support for all learners (UG and PG) in rural and remote/Francophone and First Nations streams to ensure cohesion, support and continuity of path from high school to practice destination
    - NOSM to re-create and provide tangible support for RMIG (Rural Medicine Interest Group)
    - Review of successful initiatives in other jurisdictions to build the 'rural generalist path'
    - Set specific targets for intake

- ***Create more education and training options for medical students and graduates interested in a 'Rural Generalist' practice***
    - Based on Dr. Lennox's successful 3-year Rural Generalist program in Australia, define and explore options for creating Rural Generalist education and training within the current 2-year Family Medicine program and Post-Grad programs such as: (i) seeking out medical students in first year who want to be rural generalists and facilitating their career path with tailored learning experiences and possibly extra scholarships; (ii) welcoming any graduate who wants to do rural practice into the rural residency stream; (iii) reviewing and where appropriate revising the 2-year Family Medicine curriculum so that graduates are better prepared for comprehensive rural medical practice; (iv) tailored rural CME options for those who commit to rural practice (e.g. 12 months of skills-based CME over a 5-year period that is planned by the physician and based on what the community needs and what their own interests are and includes locum support)
    - Partnering with other postgrad FM departments that have rural streams or have residents interested in rural/northern practice to provide opportunities for residents to learn in Northern communities
    - Evaluate current rural and remote placements for students and residents to assess and improve effectiveness

- ***Increase elective opportunities in rural/remote communities and remove barriers to electives for all learners***
    - NOSM to improve scheduling systems for 'high-priority' electives including (i) anybody requesting an elective in an underserviced community.; (ii) any 4th year student that wants to do a residency; (iii) any final year resident who wants to do an elective
    - Promote existing financial incentives (e.g. residents get $8000 relief on their OSAP loans if they do 8 weeks in a rural area)
    - Reach out to other medical schools about elective opportunities in the North
    - Consider removing financial barriers to application to rural and remote elective experiences(i.e. waive fees for application to rural/remote placement)

HFO AS LEAD

- ***Development of regional locum pools for the North East and North West LHINs***
    - Create a formalized locum registry to support Northern Ontario. This will involve an intake process for physicians interested in providing locum coverage in the North and matching their skills and practice interests to appropriate communities and hospitals.
    - Develop a strategic communications process for targeted locum physicians to respond to urgent needs as well as communicate new opportunities and initiatives
    - Integrate the locum registry with recruitment plans/strategies that recognize locums as a critical recruitment strategy
    - Support locum planning so that opportunities within region are linked in "packages" in the North East and North West LHIN catchment areas (e.g. Marathon - 2 weeks, Manitouwadge – 1 week, Terrace Bay – 2 weeks)
    - Ensure that locums in Northern Ontario have access to and are encouraged to undertake Indigenous cultural safety training and are capable of adequately serving Indigenous communities
    - Ensure that there is a mechanism to identify a locum pool cohort that is capable of safely serving Francophone communities in French

- ***Create ways for communities to collaborate rather than compete, (e.g. "join up" recruiters) and ensure continuing professional development for recruiters***
    - Support recruitment that begins with making rural communities visible and attractive to medical students and residents as well as licensed physicians, and welcoming and supporting medical students and residents when they arrive in a community
    - Increase access to free marketing supports (i.e. increase social media presence, e-blasts to locum lists)
    - Explore the feasibility of Recruiters Association for North East Ontario
    - Explore with NAN, WAHA, Meno Ya Win, NOMA, NOFOM, RMEFNO the feasibility of shared recruitment initiatives
    - Align sub-region HHR planning with collaborative local recruitment initiatives
    - Develop branding for specific regions/the North that focuses on regional recruitment and promoting rural generalism
    - Integrate regional approach into the locum registry to reduce competition for locums

- ***Establish working group on 'Creating formal and informal mentorships' with key partners (NOSM, OMA, LHINs and others with work already underway, e.g. OCFP)***

- ***Establish working group on 'Creating recruitable communities & collaborative recruitment strategies' with key partners (NAN, FONOM, NOMA)***
    - Explore with NAN, NOMA, NOFOM the feasibility of shared recruitment initiatives

OMA AS LEAD

- ***Supportive contracts for family physicians and their primary care teams***
    - Evaluate effectiveness of payment models for rural/Northern physicians (such as RNPGA) and how they impact (or eligibility excludes) different communities
    - Revise and update the RNPGA contract to ensure that it remains competitive and attractive
    - OMA and MOHLTC to prioritize rural and Northern physician needs in negotiation
    - OMA to develop discussion paper on value of medical generalism and comprehensive rural/northern medical practice

- OMA to develop communication strategy highlighting work of rural generalists in intentional stream

- ***Establish working group on 'Intentional Approach to Physician Wellness' with key partners (HFO, NOSM, OHA and others as appropriate, e.g. HQO)***

LHINs AS LEAD

- ***Establish Collaborative Networks across practices***
  - Primary care clinical leads at both LHINs to engage primary care practices about options for strengthening communication and collaboration at both the primary and secondary care level
  - Creating and supporting a unique academic/clinical network structure that focuses on teaching and research/scholarly work as well as clinical skills/relationships

- ***Establish formalized LHIN-based Networks for referral and patient transfer***
  - North East LHIN is in the process of: (i) establishing General Surgery Network for the Cochrane Sub-Region; (ii) Rapid Access to Addiction Medicine (RAAM); and (iii) having ongoing conversations with Health Sciences North and WAHA about additional specialty care networks to serve coastal communities in the Coastal Sub-Region as part of North East Outreach Program
  - Both LHINs to review existing clinical service network models and how best to implement these network models in other parts of the LHIN geography where timely access is an issue

- ***Create single electronic health record (EHR) for the entire region to hold all hospital and other health care data***
  - Support additional hospitals to connect with CDR/Clinical Viewer
  - Long Term Care and Primary Care providers to begin contributing data to CDR and be able to connect to viewer
  - Build links through EMR to be able to access services like e-consult, Home and Community Care data, and the clinical viewer from within the EMR

In terms of next steps, the Task Force will confirm the membership and terms of reference of time-limited working groups, and what resources are required to effectively implement key strategies. It will also need to engage with the new provincial government as it establishes its health care priorities.

SECTION 1 – Introduction

This report has been developed by the **Northern Physician Resources Task Force** (see Appendix A for Membership and Terms of Reference) whose mandate is to move forward the health human resource strategies which were articulated by participants at *Summit North* – a conference of key stakeholders from Northern Ontario, held in January 2018, that focused on:

> *developing short and long term solutions to help build a flourishing physician workforce, primarily family physicians in rural and remote communities*[2].

The Task Force represents a unique opportunity to tackle the issue of chronic physician shortages in Northern Ontario because it brings together, for the first time, all the key stakeholders that hold important pieces of the puzzle but cannot solve the puzzle on their own. Many of these organizations have been working on northern physician training, recruitment and retention issues for many years. By working collaboratively and building synergies among its member organizations, the Task Force can achieve its goal of ***building a flourishing physician workforce.***

The timing of this new Action Plan is also important for the following reasons:

1. There is a new provincial government that will want to pay special attention to the health care needs of Northern Ontario residents in terms of improving access. The Task Force recognizes that all of its members have mandates and current priorities which also may need to evolve in response to new or changing government priorities. Successful implementation of this Action Plan will require alignment with the new government's health care priorities.
2. The Northern Ontario School of Medicine is committed to strengthening its social accountability mandate

[2] Recognizing that all communities need collaborative interprofessional teams. The focus is on Family Physicians because in rural communities they are the anchor for both primary and secondary care – without adequate numbers of Family Physicians, the rest of the team cannot function effectively.

3. Contract negotiations for a renewed Physician Services Agreement are underway between the Ministry of Health and the Ontario Medical Association
4. Federal and provincial governments are renewing and strengthening their relationships with Indigenous Peoples[3].
5. The Ministry of Health and Long-Term Care recently released a guide to the Obligations and Requirements Relating to French Language Health Services for Health Services Providers, LHIN, Réseau, FLHPE and the Ministry.

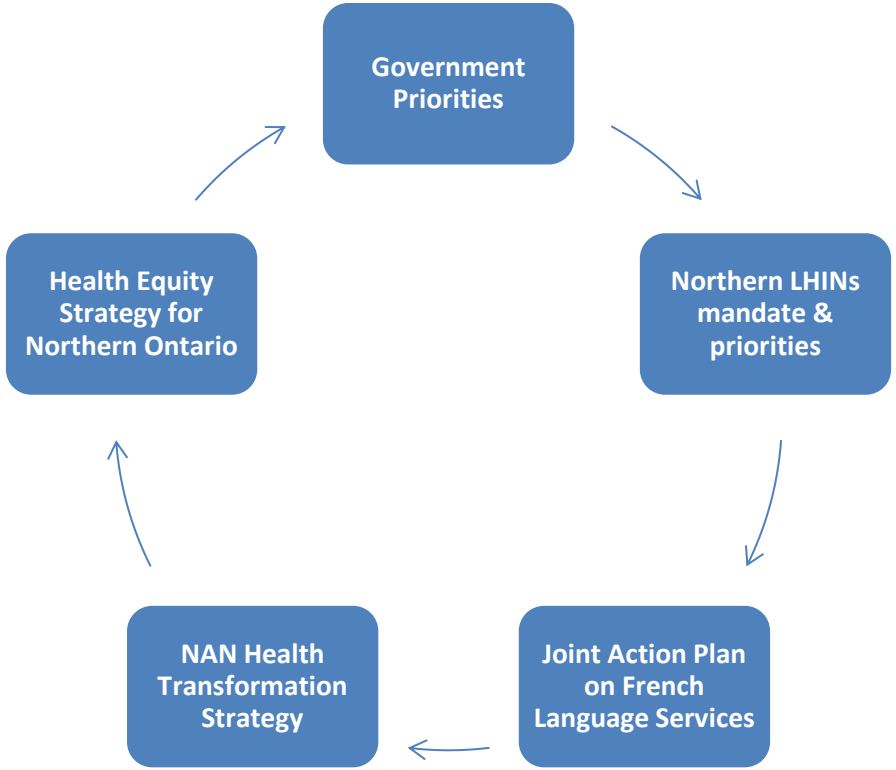
Section Two of this Plan provides more detail about this evolving provincial and regional context for a Northern Physician Resources Action Plan. Section Three outlines key components of a comprehensive health human resources strategy and how the Summit recommendations align with these components. Section Four describe the details of the various Action Plan strategies. Section Five highlights short and longer term priorities and talks about next steps.

[3] There will be an interim period as the new provincial government re-establishes its relations with First Nations leadership

SECTION 2 – The Context for a Northern Physician Resources Action Plan

Health human resources planning is complex work. Any plan must recognize that there may sometimes by overlapping roles, and that there will often be interdependency of initiatives, either in terms of funding or in terms of the logistical steps to be undertaken to enable improvement. In recognition of this, several of the actions have recommended lead and supporting organizations and some have a working group to support the details of the action planning.

Any health human resources plan for Northern Ontario also needs to be grounded in the context of evolving health policy both regionally and provincially which include:



In light of these policy reforms, a Physician Resources Action Plan for Northern Ontario needs to:

- ✓ embrace primary care and rural generalist practice as the backbone of rural/northern health services
- ✓ recognize family physicians as key members of a team of health professionals
- ✓ advance comprehensive rural generalist practice that includes emergency care, inpatient care, primary care, long term care/assisted living, palliative care and any additional domains of care to meet the needs of the community (e.g. obstetrics, anaesthesia)
- ✓ align with an evolving LHIN mandate regarding health human resource planning and sub-region focus on primary care and physician resource capacity
- ✓ be developed collaboratively with Indigenous Peoples and communities in a manner that respects their culture and approach to health & well-being
- ✓ be inclusive and supportive of the needs of Francophone learners, practitioners and the communities they serve
- ✓ be grounded in a health equity approach that targets the most vulnerable Northern communities

2.1 Government Priorities

The election of a new provincial government represents an opportunity for the Task Force to work with government as it re-establishes it health care priorities, particularly around physician supply and health care access for residents of Northern Ontario.

2.2 Northern LHINs' Priorities

As part of the implementation of the government's priority on patient access with a stronger focus on population based planning and health human resources planning, the North East and North West LHINs have introduced strong clinical responsibility at various leadership levels including:

- revised senior management teams which include physicians in Clinical VP positions
- clinical (physician) leads for specific care programs (e.g. Emergency, Critical Care, Primary Care, Chronic Disease Management)
- leads responsible for Indigenous and Francophone Affairs to ensure ongoing commitment to these important populations
- sub-region planning tables (see below), supported by LHIN staff and sub-region clinical leads, that will focus on population-based planning, performance improvement, championing of LHIN-wide health care priorities, service alignment, and integration.

Local Health Integration Network	Sub-Region Tables
North East	Algoma Cochrane Sudbury/Manitoulin/Parry Sound Nipissing/Temiskaming James and Hudson Bay Coasts
North West	City of Thunder Bay District of Kenora District of Rainy River District of Thunder Bay Northern

In terms of strategic LHIN priorities, the 2016 – 2019 Integrated Health Services Plans (IHSPs) for both LHINs are summarized below with further detail about primary care priorities and health human resources planning:

	North East LHIN	North West LHIN
Overall IHSP Priorities	✓ Improve Access and Wait Times ✓ Enhance Care Coordination ✓ Strengthen System Sustainability	✓ Improving the Patient Care Experience ✓ Improving Access to Care and Reducing Inequities ✓ Building an Integrated eHealth Framework ✓ Ensuring Health System Accountability and Sustainability
Primary Care Priorities	• Discussion Paper - *Strengthening Access, Performance and Accountability of Primary Health Care within the North East LHIN* • Health Links • Physician Office Integration Project • Timmins Francophone Primary Care Collaborative Committee • Recruitment and Retention of Health Human Resources	• Health Links • Primary Care Capacity assessment and forecasting • Expansion of interprofessional care teams in several settings across the LHIN including Indigenous primary care team expansion
Recruitment & Retention	• Partnering with NOSM and HFO on soon to be released paper *"HHR: A Primer in the Examination of the Northeastern Ontario Landscape"* • LHIN has identified the need for: (i) more current granular data to support community by community HHR discussions and the development of solutions; and (ii) localized forecasting tools to help effectively plan for HHR	• Working with HFO to ensure supports for community-led recruitment strategies • Working to determine community capacity gaps in HHR to meet the needs of communities

2.3 Joint Action Plan on French Language Services

Le Réseau de mieux-être francophone du Nord de l'Ontario (RMEFNO), in collaboration with the two Northern LHINs and its health service provider partners, have been developing strategies and toolkits and engaging with communities to improve access and equity to French language health services over the past 8 years. Le Réseau's most recent Joint FLS Action Plan with the two Northern LHINs contains the following three key priorities for action:

> *The Réseau works with health service providers and meets with them during the year to offer support and tools to improve the active offer of health services in French.*
>
> (RMEFNO)

1. **Enhance Care Coordination/Improve the Patient Care Experience** - *Improve a Francophone patient journey within the health care system through improved coordination of care.* This requires improved capture of health data on the Francophone population.
2. **Improved Access and Reduce Inequities** - *Accessible health care means receiving quality, equitable and efficient care that is culturally and linguistically sensitive in a timely manner for the Francophone population*.
3. **Strengthen System Sustainability / Leverage Technology** - *A sustainable health care system for Francophones is one that reflects a multi-level commitment to patient-centered care that is accountable and delivers better results for the patient and their families.*

2.4 NAN Health Transformation Strategy

On July 24, 2017, NAN, Ontario and Canada signed a *Charter of Relationship Principles Governing Health System Transformation in the NAN Territory* with political commitments to develop and sustain a renewed relationship to transform existing health systems (see Appendix B).

The system-wide vision for this transformation strategy would see First Nations have equitable access to quality care delivered within their community, in NAN territory, as a priority. The Parties intend the system to include holistic models of care, focusing on wellness planning, population health and health determinants.

> *Health transformation is a broad-ranging initiative to modernize and improve our health care system. Key themes necessary for health care transformation are: health promotion, effective management of illnesses, focus on quality outcomes and accountability to patients.*
>
> (Nishnawbe Aski Nation)

The system would be patient-centred, responsive to community and patient voices, and ensure that health care providers funded by federal or provincial governments would have the skills required to provide responsive, effective and culturally safe care. Communities would be engaged through 'community participation' at all levels (community workers, Elders, and youth) so that their voices are heard and incorporated into community-based programming.

2.5 Health Equity Strategy for Northern Ontario

According to Health Quality Ontario (HQO), A Health Equity Strategy for Northern Ontario is built upon four foundations:

1. addressing the social determinants of health
2. equitable access to high quality and appropriate health care services
3. indigenous healing, health and well-being
4. evidence available for equity based decision-making

> *Health equity allows people to reach their full health potential and receive high-quality care that is fair and appropriate to them and their needs,* ***no matter where they live, what they have or who they are.***
> (HQO)

To support implementation of the Strategy, HQO is creating a **Northern Network for Health Equity** that will:

- ✓ Support Northern partners to develop deeper health equity commitments within their own organizational goals
- ✓ Engage stakeholders, partners, government at all levels to collaborate inter-sectorally to develop and advance policy solutions to improve health equity
- ✓ Collaborate with Northern research groups and agencies to conduct research and surveillance in priority areas to inform health equity action
- ✓ Support Indigenous researchers to ensure research with Indigenous peoples is Indigenous-led
- ✓ Include a Francophone component to support the equity strategy

SECTION 3 – Creating a Comprehensive Health Human Resources Strategy

Comprehensive health human resources (HHR) strategies normally include the following components. Many of the issues identified in the table below are specific to Northern Ontario:

COMPONENT	KEY ISSUES
Community and Regional Needs Assessment & Workforce Planning	• Forecast of numbers/types of professionals required across the regions and within each community • Underserviced area analysis • Population health approach including equity lens • Equitable allocation of resources
Education & Training	• Rural residency streams • Lifelong cultural safety education and training (e.g. indigenous relationships) and active offer • Rural community placements for both undergraduate and postgraduate learners • Continuing medical education (CME) for new skills/knowledge including community-adaptive longer intensive training (e.g. anaesthesia, endoscopy or operative obstetric skills) • Faculty development for community based faculty to ensure adequate teaching skills and capacity
Recruitment	• Creating welcoming 'recruitable' communities and ensuring active recruitment at all stages of a physician's career from medical school to pre-retirement • Marketing and effective matching of physicians to communities • Infrastructure to support physicians and their families (e.g. housing) • Social support for families of physicians • Financial and non-financial incentives • Transitioning/mentoring support for physicians

Compensation	• Physician payment plans designed for rural/northern medical practice (e.g. RNPGA - Rural and Northern Physician Group Agreement) • Financial incentives (e.g. 5-year commitments to pay off student loans)
Retention	• Supportive communities for physicians & their families • Peer support strategies (mentoring) • Locums • IT infrastructure and supports • Access to continuing professional development including locums for time away to attend courses or community-adaptive longer intensive training (e.g. anaesthesia or operative obstetric skills) • Greater emphasis on wellness and team resilience for physicians and other health care professionals
Models of Care	• Primary care teams supporting physician practices (e.g. FHT, CHC models) and remote nursing stations • Collaborative practice models (e.g. NPs, Physician Assistants and others linked to physician resources) • Formal regional care networks for priority populations (chronic disease, OB etc) • Integrated local health systems designed for rural and northern communities (e.g. Rural Hubs) • Enablers of efficient models of care including things like: single shared EMR, timely access to specialists through clear referral paths • Effective use of digital health tools like telemedicine and e-consult in order to improve access to care while supporting local providers and infrastructure

Two foundational reports for *Summit North* which also help to inform a comprehensive HHR strategy are:

- the *Summit to Improve Health Care Access and Equity for Rural Communities in Canada (July 2017);* and
- the *Rural Road Map for Action* (see Appendix C).

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/

It should be noted that there is currently a national level committee focused on the implementation of the Rural Road Map for Action. The work of the committee will focus on identifying successful initiatives across the country for which there may be opportunity for spread and scale, and some of that work my inform how initiatives could build in the Ontario context.

The Rural Road Map contains the following four high-level strategic directions:

- DIRECTION 1: Reinforce the **social accountability mandate of medical schools** and residency programs to address health care needs of rural and Indigenous communities.

- DIRECTION 2: Implement policy interventions that **align medical education with workforce planning.**

- DIRECTION #3: Establish **practice models that provide rural and Indigenous communities with timely access** to quality health care that is responsive to their needs.

- DIRECTION #4: Institute a **national rural research agenda to support rural workforce planning** aimed at improving access to patient-centred and quality-focused care in rural Canada.

Key strategies from *Summit North* are organized below using the comprehensive HHR template:

Summit Areas of Action	N=22
Priority Actions Adapted from Rural Road Map	N=8
Big Bold Ideas[4]	N=6

There is some overlap between the Areas of Action, Priority Actions Adapted from the Rural Road Map and the Big Bold Ideas.

HHR Strategy Category	SUMMIT RECOMMENDATIONS
Community Needs & Workforce Planning	Provide resources to ensure there is **needs assessment** for each community
	Develop a proper **needs based distribution plan** for new grads
	All decisions made, and all resources **assigned by Equity**.
	Expand the role and number of **Physician Assistants 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
Education & Training	Ensure process to **review admission criteria** that supports rural/remote students and provides opportunities for rural/remote community exposure in undergraduate years
	Ensure that all postgrad family medicine residents have **rural rotations with adequate infrastructure support**
	Increase **elective opportunities**, and remove barriers to electives for all learners
	Ensure access to **community-based enhanced skills development** based on community need
	Strengthen & formalize partnerships in Northern Ontario between communities, LHINs, universities and physicians to support delivery of medical education in rural communities.
	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.
	A specialized **3-year "Rural Family Medicine" residency program** as a pilot project through NOSM.
Recruitment	Create **education for communities** regarding health human resources
	Engagement and **orientation session for each new locum** arriving in a community

[4] Big Bold Ideas were generated through small group brainstorming at *Summit North*

	Create ways for **communities to collaborate rather than compete**, (e.g. "join up" recruiters and opportunities for physicians to find "good fit" with communities)
	Ensure continuing development including **coaching and mentoring for recruitment**
	Leverage the **experience of students and residents** in communities
	Communities in Northern Ontario become more engaged and active in recruiting, retaining and strengthening the integration of physicians and their families into their communities
Retention	Development of a **regional locum pool for** North East and North West LHINs
	Intentional approach to **physician wellness**
	Create system-wide, coordinated distance technology in Northern Ontario to support local family physicians and health care teams in their clinical and academic work.
	Communities in Northern Ontario become more engaged and active in recruiting, retaining and strengthening the integration of physicians and their families into their communities
	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.
	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.
Compensation	**Supporting contracts** for physicians and their teams
	Ensure **funding models support post-residency work** in groups for new grads
Models of Care	Integrate **allied health, inter-professional learners** (including Nursing, Physician Assistants, Therapists) to train at the same time
	Establish **Networks across practices**
	Consider **specialist lead for networks** of care
	Establish **Networks for referral and patient transfer**
	Single electronic medical record (EMR) for the entire region to hold all hospital and other health care data (one patient, one record, one EMR)
	Ensure that **technology supports and enhances care** but is not central to care
	Develop **leadership capacity** and create accountability tools

	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.
	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
	An integrated "All Nations" Heath Care System designed and developed by a community driven process and which allows for integration of specialty services including **1 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.
	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

Task Force members were also interviewed about what strategies they felt were missing from the *Summit North* recommendations which generated the following list:

COMPONENT	MISSING STRATEGIES
Community and Regional Needs Assessment & Workforce Planning	✓ explicit focus on the needs of the Francophone population and the health of Indigenous Peoples and communities ✓ timely, accurate and reliable data for planning and identification of communities most in need ✓ using an Equity Lens to target specific communities – which communities are the most 'under-serviced'? ✓ do a gap analysis that is realistic – what can we achieve in next 10 years ✓ development of future practice models inclusive of team members like physician assistants ✓ development of comprehensive non-urgent transportation plan to enhance access ✓ linking the Action Plan with HQO's Northern Health Equity Plan
Education & Training	✓ improvement in the NOSM's elective program to provide opportunity for learners from all UME and PGME programs in other universities to experience Northern Ontario ✓ learner (students and residents) exposure to generalist practice in rural/remote communities during medical training ✓ system-wide recognition of the value of medical generalism
Recruitment	✓ reassessment of effectiveness of recruitment incentives to ensure both recruitment and retention
Retention	✓ a unique academic/clinical network structure that focuses on teaching and research/scholarly work as well as clinical skills/relationships
Models of Care	✓ effective use of digital health to improve access to care for local patients while still supporting local health care providers and the "patient medical home"

SECTION 4 – Building the Action Plan

The following process steps were important in the building the action plan:

Task Force members agreed to the following components of an action planning framework:

- Intended Outcomes of Strategy
- Lead Organization(s) and Key Partners
- Current Activities in Support of the Recommended Strategy
- Short-Term Action Steps
- Multi-Year Goals/Objectives
- Resources Required

For the purposes of this particular action plan, the recommended Role of the Lead Organization is:

To take responsibility for implementing strategy, in collaboration with key partners, and being prepared to commit sufficient resources (staff time, funds) as part of board-approved strategic plan and/or annual operating plan. All strategies should be implemented in a consultative and collaborative manner. For some strategies, the lead organization will need to establish a working group of appropriate partners/stakeholders to create more detailed action plans.

The remainder of this section describes the recommended action plan steps based on the various *Summit North* recommendations.

4.1 Community and Regional Needs Assessment and Workforce Planning

<table>
<tr><td>Strategy:
Provide necessary resources to ensure there are proper needs assessments for all northern communities and targeted strategies for communities most in need using an Equity lens</td><td>HHR Category:
COMMUNITY/REGIONAL NEEDS ASSESSMENT</td></tr>
<tr><td>Intended Outcomes:
✓ List of northern communities most in need that should be targeted for further investigation and support
✓ Engagement of targeted communities to develop community-specific action plans that are aligned and integrated with a regional plan</td><td>Lead Organization:
Northern LHINs with input from NAN, NOMA, FONOM, RMEFNO</td></tr>
<tr><td colspan="2">Current Activities:
• LHINs using primary care capacity planning tool to assess needs and resources at a sub-region level</td></tr>
<tr><td>Short-Term Action Steps:
• Create a needs and resources assessment template with benchmarks/targets for use by individual communities to help them assess service requirements and develop community-specific solutions, within the context of a LHIN sub-region health human resources plan
• North West and North East LHINs work with NAN’s Health Transformation strategy regarding needs assessment of northern remote communities
• North West and North East LHINs work with RMEFNO to identify francophone communities</td><td>Resources Required:
• LHIN staff time (data analysts, epidemiologists)
• NAN staff time
• Community facilitators</td></tr>
<tr><td colspan="2">Multi-Year Goals/Objectives:
• On-going engagement of targeted communities until each has a community health action plan which documents: (i) current needs & gaps in services (as defined by health status indicators, resource benchmarks and community surveys & consultations) as part of a regional health human resources plan;(ii) regional and community-designed models of care & support; and (iii) the additional health human resources required in terms of physicians and other allied health professionals
• Assess secondary care needs and capacity for those other services that are important for rural/remote communities (e.g. Anaesthesia, Obstetrics, Emergency)</td></tr>
</table>

<table>
<tr><td>Strategy:
Develop best-practice care models for rural/remote communities and related medical workforce projections</td><td>HHR Category: WORKFORCE PLANNING</td></tr>
<tr><td>Intended Outcomes:
✓ Recommended models of care that best support rural and remote communities
✓ Detailed health human resource plans for both LHINs with an initial focus on physician resources</td><td>Lead Organization:
Northern LHINs with input from OMA, NAN, NOSM, MOHLTC, RMEFNO
** working group recommended</td></tr>
<tr><td colspan="2">Current Activities:
• Ongoing review of pilot projects, e.g. rural health hubs in Blind River, Dryden, Espanola and Manitwouwadge</td></tr>
<tr><td>Short-Term Action Steps:
• LHIN develops discussion paper on relevant models of team-based primary care and comprehensive rural generalist practice that best serve smaller northern communities
• Consensus among key partners about the most appropriate team-based care models to serve rural/remote communities including appropriate FTE allocations for different sized communities and the region
• Consensus among key partners about most appropriate methodologies for workforce planning and projections
• Task Force will review Dr. Lennox Knowledge Translation Project and incorporate considerations from his model into potential models of care
• OMA to ensure needs of Northern and rural physician workforce are addressed in contract negotiations</td><td>Resources Required:
• LHIN staff time
• admin support to time-limited working group</td></tr>
<tr><td colspan="2">Multi-Year Goals/Objectives:
• Implementing best practice team-based care models for rural/remote communities
• Creating a health human resources database which can be updated annually
• Achieve sustainable funding models to support goals of sustainable care delivery
• Align team based care models in rural communities with local health hub concepts</td></tr>
</table>

4.2 Education and Training

<table>
<tr><td>Strategy:
Stream high school students interested in northern, rural and remote community health care careers and refine admission criteria that supports their admission to medical school</td><td>HHR Category: EDUCATION</td></tr>
<tr><td>Intended Outcomes:
✓ Increase the number of students from Northern rural/remote backgrounds applying to NOSM and other medical schools
✓ Increase the proportion of NOSM post-graduate trainees who select rural/remote communities in the North to establish their medical practice</td><td>Lead Organization:
NOSM with input NAN. NOMA, FONOM, RMEFNO</td></tr>
<tr><td colspan="2">Current Activities:
• NOSM sponsored tour of Northern Ontario communities for Dr. Lennox (May 2018) to be followed by a report from Dr. Lennox
• UME admissions specifically favours people with rural and northern connections and there is a specific Indigenous admissions committee that supports Indigenous applicants as well as a specific francophone admissions committee
• Post Grad admissions specifically favours people with a connection to the North and the rural stream considers suitability for rural practice which involves evidence of resilience and connection to rural
• NOSM is partnering with University of Toronto’s Psychiatric Department to create an Indigenous learning stream</td></tr>
<tr><td>Short-Term Action Steps:
• NOSM to meet with students in the remote/Francophone and First Nations stream and the rural stream to better understand why they selected their learning stream and what the School can do to attract more students to these streams; and follow-up with graduates to better understand their community selection process in terms of preferred practice locations
• NOSM to seek feedback from former Indigenous graduates on encouraging northern students to pursue health careers
• Consult the students that dropped out of NOSM (and specifically those in the rural and remote First Nation streams) and address the reasons why</td><td>Resources Required:
• NOSM staff time</td></tr>
</table>

• NOSM to build strategic support for all learners (UG and PG) in rural and remote/First Nations streams to ensure cohesion, support and continuity of path from high school to practice destination • NOSM to re-create and provide tangible support for RMIG (Rural Medicine Interest Group) • Review of successful initiatives in other jurisdictions to build the rural generalist path	
Multi-Year Goals/Objectives: • Working with NAN, WAHA, Meno Ya Win Health Centre and Indigenous communities in the North to encourage and support more Indigenous applicants • Implementing community outreach strategies that promote rural/northern medicine as a rewarding career choice for elementary and high school students in rural/remote communities (e.g. job shadowing, co-op placements at nursing stations, tours of health facilities, scholarships) • Work with Francophone interest groups (ACFO, AFNOO) to encourage and support more Francophone applicants • Establish mechanism to support and nurture learners with priority selection of rural placements • Establish Associate Dean Rural Education and Practice to support strategies in Rural Generalism • Begin monitoring for intake metrics and reporting outcomes	

Strategy: ***Create more education and training options for medical students and graduates interested in a 'Rural Generalist' practice***	HHR Category: **EDUCATION**
Intended Outcomes: ✓ New graduates who are better prepared for a comprehensive rural family practice in smaller Northern communities ✓ Increase the proportion of NOSM PGE learners who are graduates of NOSM's MD program ✓ Increased support for recently graduated physicians to enter rural generalist training stream	Lead Organization: **NOSM**
Current Activities: • NOSM currently offers a variety of additional 3rd year post-grad training programs for Family Medicine residents including: Enhanced Skills Program (PGY3) in Emergency Medicine, Family Practice Anesthesia, Maternity Care, Care of the Elderly, Palliative Care and Design-Your-Own	

Short-Term Action Steps:	Resources Required:
• Based on Dr. Lennox's successful 3-year Rural Generalist program in Australia, define and explore options for creating Rural Generalist education and training within the current 2-year Family Medicine program and Post-Grad programs such as: (i) seeking out medical students in first year who want to be rural generalists and facilitating their career path with tailored learning experiences and possibly extra scholarships; (ii) welcoming any graduate who wants to do rural practice into the rural residency stream; (iii) reviewing and where appropriate revising the 2-year Family Medicine curriculum so that graduates are better prepared for comprehensive rural medical practice; (iv) tailored rural CME options for those who commit to rural practice (e.g. 12 months of skills-based CME over a 5-year period that is planned by the physician and based on what the community needs and what their own interests are and includes locum support) • Partnering with other postgrad FM departments that have rural streams or have residents interested in rural/northern practice to provide opportunities for residents to learn in Northern communities	• NOSM staff time
Multi-Year Goals/Objectives: • Promoting the value of medical generalism through identifiable rural generalist stream • Ensure easy, funded access to Enhanced Skills training for recent graduates and other practicing physicians based on community need • Optimize enhanced skills development and ensure that practical paths exist for practicing clinicians to access enhanced skills time in line with short term actions above, but inclusive of other options for skills development; alignment of enhanced skills development with HHR planning within LHINs • NOSM to become premiere PG learning site for those interested in rural generalist practice	

Strategy: ***Ensure that all postgrad Family Medicine residents have rural rotations with adequate infrastructure support***	HHR Category: **EDUCATION**
Intended Outcomes: ✓ All Family Medicine residents experience well-supported rural rotations ✓ All Family Medicine residents at NOSM are required to do a minimum of two months in a rural community in each year (4 months over 2 years)	Lead Organization: **NOSM** with input from NOMA and FONOM

<table>
<tr><td colspan="2">Current Activities:
Postgraduate learners have considerable latitude in terms of selecting their placement communities</td></tr>
<tr><td>Short-Term Action Steps:
NOSM to review and clarify what constitutes a ‘rural community’ placement and to ensure this requirement is consistently met for all postgraduate residents of NOSM
NOSM to work with faculty to ensure that all rural faculty understand their role in supporting the “rural generalist path”
Planning and booking of rural rotations to happen earlier so that external learners seeking rural rotations in NOSM’s distributed campus can have those rotations confirmed in a timely way
Annual community capacity plan for UME and PG learners should be conducted and then matched to UME and PG learner opportunity with priority given to those learners with expressed interest in a rural generalist path
Ensure there is a formal means of matching Francophone residents at the PG level to Francophone faculty and communities, and ensure that Anglophone learners are not placed in Francophone communities</td><td>Resources Required:
NOSM staff time</td></tr>
<tr><td colspan="2">Multi-Year Goals/Objectives:
Work with NOMA and FONOM to ensure that all communities that want resident placements offer a minimum support ‘package’ including adequate housing, orientation to community and supportive local resource person
Work with Ministry of Health, key stakeholders and northern communities to establish residency hubs for northern remote First Nations communities</td></tr>
</table>

<table>
<tr><td>Strategy:
Increase elective opportunities in rural/remote communities and remove barriers to electives for all learners</td><td>HHR Category: EDUCATION</td></tr>
<tr><td>Intended Outcomes:
✓ To ensure that all electives are positive and supported experiences in support of future recruitment opportunities for all Northern, rural communities
✓ Maximize the opportunity for external learners interested in a rural/remote placement to be able to access rural placements with NOSM faculty in rural communities in a timely way
✓ Community capacity to take PG learners is matched by placement of PG learners in those communities</td><td>Lead Organization:
NOSM in collaboration with other medical schools, FONOM, NOMA</td></tr>
<tr><td colspan="2">Current Activities: NA</td></tr>
<tr><td>Short-Term Action Steps:
• NOSM to improve scheduling systems for ‘high-priority’ electives including (i) anybody requesting an elective in an underserviced or rural community.; (ii) any 3rd or 4th year student that wants to do a residency in rural family medicine; (iii) any family medicine resident from any postgraduate program who wants to do an elective
• Promote existing financial incentives (e.g. residents get $8000 relief on their OSAP loans if they do 8 weeks in a rural area)
• Reach out to other medical schools to market elective opportunities in the North
• Remove financial barriers to application to rural and remote elective experiences(i.e. waive fees for application to rural/remote placement)</td><td>Resources Required:
• NOSM staff time</td></tr>
<tr><td colspan="2">Multi-Year Goals/Objectives:
• Develop creative ways to fund housing and travel for rural electives for residents and students from southern universities, e.g. negotiated rebates on air travel</td></tr>
</table>

4.3 Recruitment

<table>
<tr><td>Strategy:
Create education for communities regarding health human resources recruitment</td><td>HHR Category: RECRUITMENT</td></tr>
<tr><td>Intended Outcomes:
✓ Communities are well-informed about strategies for successful physician recruitment</td><td>Lead Organization:
HFO with input, assistance from NAN, NOMA, FONOM, RMEFNO
** working group recommended</td></tr>
<tr><td colspan="2">Current Activities:
• HFO Regional Advisors provide consultation and advice to communities regarding physician recruitment and retention, staffing model optimization, marketing, locum utilization, immigration, licensing and supervision and succession planning
• HFO hosts annual regional recruitment forums that bring together communities to share physician recruitment best practices and deliver customized content arising from an annual needs assessment
• Online modules on the HFO website that support this work are: Recruitment Essentials, the Transition out of Practice/Succession Planning Guide, Physician Relocation Guide and the ED Toolkit</td></tr>
<tr><td>Short-Term Action Steps:
• Current HFO activities continued
• Broadly share best practices on recruitment readiness
• Most current supports are physician recruiter focused. Expand supports and services to engage all community members necessary to ensure successful physician recruitment (e.g., municipal leaders, committee members, clinical and administrative leadership)
• Refresh and more broadly disseminate existing online modules to respond to community needs identified at Summit North, with specific attention to Francophone and Indigenous communities
• Expand participation in regional physician recruiter forums to include broader representation from the ‘pentagram partners’.
• Create process to better share data (e.g., NW survey results, population need, attachment rates) with communities to support local planning and recruitment.</td><td>Resources Required:
• HFO staff time</td></tr>
</table>

Multi-Year Goals/Objectives:

- Support recruitment that begins with making rural communities visible and attractive to medical students and residents as well as licensed physicians, and welcoming and supporting medical students and residents when they arrive in a community
- Engage other organizations to identify and pursue additional opportunities (i.e. cross-sector professional recruitment tool for rural communities)

Strategy: ***Engagement and orientation session for each new locum arriving in community***	HHR Category: **RECRUITMENT**
Intended Outcomes: ✓ Locum physicians feel welcomed by the receiving community and have access to the resources and supports they need to have a successful locum experience ✓ Positive locum experiences to lead to more successful recruitment outcomes	Lead Organization: **HFO** with input, assistance from NAN, NOMA, FONOM
Current Activities: • Understanding the locum program is an important part of helping to ensure a successful locum experience. HFO currently provides welcome packages when physicians join the program that outline program guidelines	
Short-Term Action Steps: • HFO to develop enhanced locum orientation/marketing materials for physicians interested in providing locum coverage in the North. • HFO to develop and share best practices for communities on providing an orientation and support to locums to optimize recruitment and retention outcomes • Explore creating a process for locums to provide feedback and suggestions on improving their locum experiences and identifying opportunities that would support recruitment	Resources Required: • HFO staff time
Multi-Year Goals/Objectives: • Engage other organizations to identify and pursue additional opportunities	

<table>
<tr><td>Strategy:
Create ways for communities to collaborate rather than compete, (e.g. “join up” recruiters) and ensure continuing professional development for recruiters</td><td>HHR Category: RECRUITMENT</td></tr>
<tr><td>Intended Outcomes:
✓ Reduced competition between northern communities for physicians
✓ Pooling/sharing of municipal resources (recruiters and recruitment budgets) for physician recruitment
✓ Regional health human resources plan that includes strategic recruitment initiatives (e.g. to support Francophone and Indigenous populations)</td><td>Lead Organization:
HFO with input, assistance from NAN, WAHA, Meno Ya Win, NOMA, FONOM, RMEFNO
** working group recommended</td></tr>
<tr><td colspan="2">Current Activities:
• HFO currently promotes, organizes and facilitates regional recruiter forums, which bring communities together to discuss regional needs and trends and identify regional collaboration opportunities
• HFO provides physician recruiter orientation sessions for all new recruiters, develops and delivers introductory and advanced recruiter professional development sessions through the Canadian Association of Staff Physicians Recruiters (CASPR), e-blasts recruiters with updates on policy and program changes related to recruitment, provides one-on-one coaching through Regional Advisors and sits on local recruitment and retention committees
• HFO is also supporting the establishment of a Northwestern Ontario Health Recruiter’s Association (NOHRA)
• HFO represents multiple Northern communities and distributes their marketing materials at recruitment events, acting as a representative on behalf of the region as opposed to individual competing communities, including targeted newsletters, e-blasts and event attendance to support recruitment for Indigenous and Francophone populations</td></tr>
<tr><td>Short-Term Action Steps:
• HFO to increase access to free marketing supports (i.e. increase social media presence, e-blasts to locum lists)
• Explore the feasibility of Recruiters Association for North East Ontario
• Explore with NAN, WAHA, Meno Ya Win, NOMA, NOFOM, RMEFNO the feasibility of shared recruitment initiatives
• Align sub-region HHR planning with collaborative local recruitment initiatives
• Develop branding for specific regions/the North that focuses on regional recruitment and promoting rural generalism</td><td>Resources Required:
• HFO staff time</td></tr>
</table>

• Integrate regional approach into the locum registry to reduce competition for locums • For each of the above, ensure that there is opportunity for Francophone communities in both northern LHINs to share resources and 'join up' in order to optimize their opportunities to access Francophone locums	
Multi-Year Goals/Objectives: • Engage other organizations to identify and pursue additional opportunities • Establish culture of shared resources and support to neighboring communities • Ensure continuing development including coaching and mentoring for recruitment	

4.4 Compensation and Funding Models

<table>
<tr><td>Strategy:
Supportive contracts for family physicians and their primary care teams</td><td>HHR Category: COMPENSATION AND FUNDING MODELS</td></tr>
<tr><td>Intended Outcomes:
✓ Rural and Northern Physician Group Agreement (RNPGA) is made available to more northern physicians
✓ Improved governance between family physician group funding models (e.g. FHOs, FHNs) and primary care team funding models (e.g. FHTs)
✓ Broader recognition of the value of generalism as it applies to northern medical practice
✓ Broader recognition of the value of French Language Services (FLS)</td><td>Lead Organization(s):
OMA and MOHLTC</td></tr>
<tr><td colspan="2">Current Activities:
• MOHLTC-OMA negotiations on a new Physician Services Agreement underway</td></tr>
<tr><td>Short-Term Action Steps:
• Evaluate effectiveness of payment models for rural/Northern physicians (such as RNPGA) and how they impact (or eligibility excludes) different communities
• Revise and update the RNPGA contract to ensure that it remains competitive and attractive
• OMA and MOHLTC to prioritize rural and Northern physician needs in negotiation
• OMA to develop discussion paper on value of medical generalism and comprehensive rural/northern medical practice
• OMA to develop communication strategy highlighting work of rural generalists in intentional stream</td><td>Resources Required:
• OMA and MOHLTC staff time</td></tr>
<tr><td colspan="2">Multi-Year Goals/Objectives:
• Ensuring that comprehensive full scope rural practice has better remuneration than focused practice or itinerant locum work - e.g. hospitalist, ED work, urban non-comprehensive practice
• Ensuring excellence in governance, collaborative HR and budget planning between community governed FHTs and their associated physician groups
• Exploring the possibility of considering knowledge of a second official language as a specialty and that remuneration be attached to this added skill</td></tr>
</table>

4.5 Retention

<table>
<tr><td>Strategy:
Development of regional locum pools for the North East and North West LHINs</td><td>HHR Category: RETENTION</td></tr>
<tr><td>Intended Outcomes:
✓ Reliable pool of physicians (drawn from both southern and northern Ontario) prepared and oriented to provide locum services in the North
✓ Locum activity that is focused on the recruitment and retention goals of Northern communities (e.g. provided for leaves related to CME)
✓ Locum physicians and their families that feel supported including family-friendly accommodation options
✓ Locum pool identifies language capacities of Locum regarding FLS</td><td>Lead Organization: HFO</td></tr>
<tr><td colspan="2">Current Activities:
• HFO currently has 4 locum programs (Emergency Department Locum Program, Rural Family Medicine Locum Program, General Practitioner Vacancy Locum Coverage Arrangements and Northern Specialist Locum Programs) that provide centrally coordinated support to communities for vacancy coverage, respite and crisis management.
• HFO manages an urgent locum e-blast service with a network of thousands of physicians</td></tr>
<tr><td>Short-Term Action Steps:
• HFO will create a formalized locum registry to support Northern Ontario. This will involve an intake process for physicians interested in providing locum coverage in the North and matching them to appropriate communities and hospitals.
• Develop a strategic communications process for targeted locum physicians to respond to urgent needs as well as communicate new opportunities and initiatives
• Integrate the locum registry with recruitment plans/strategies that recognize locums as a critical recruitment strategy (e.g. targeted approaches to match critical skills and practice interests and to support Francophone and Indigenous populations)
• Support locum planning so that opportunities within region are linked in “packages” in the North East and North West LHIN catchment areas (e.g. Marathon - 2 weeks, Manitouwadge – 1 week, Terrace Bay – 2 weeks)</td><td>Resources Required:
• HFO staff time</td></tr>
</table>

• Ensure that locums in Northern Ontario have access to and are encouraged to undertake Indigenous cultural safety training • Ensure that there is a mechanism to identify a locum pool cohort that is capable of safely serving Francophone communities in French	

Multi-Year Goals/Objectives:

- Locum registry built up to include education and support tailored to Northern locums, which could include mentorship opportunities, continuing professional development from OCFP, clinical detailing from the Centre for Effective Practice, Indigenous cultural safety training, and Active offer training for FLS.
- Enable analytics on locum coverage trends and demographics to inform health workforce planning
- Adequate community and housing supports for locum physicians and their families

Strategy: ***Intentional Approach to Physician Wellness***	HHR Category: **RETENTION**
Intended Outcomes: ✓ Increased personal resiliency of practicing Northern physicians ✓ Systems that support physician wellness ✓ Reduced incidence of the most serious consequences of physician stress and burn-out (e.g. departure from community, substance abuse, suicide)	Lead Organization: **OMA** with input, assistance from NOSM, HFO, OHA **** working group recommended and may include others such as HQO**

Current Activities:

- NOSM's Undergraduate and Postgraduate portfolios have specific leaders dedicated to student and resident wellness and curriculum focused on wellness.
- Ontario Medical Association Physician Health Program: http://php.oma.org/
- HFO delivers Transition into Practice Services (TiPS) to medical residents around the Province, which includes promoting an online TiPS toolkit which contains a module on physician wellbeing and links physicians to available resources

Short-Term Action Steps:	Resources Required:
• NOSM to adopt the new National Standard for 'Psychological Health & Safety in the Workplace' (developed by the Mental Health Commission of Canada in partnership with the Canadian Centre for Occupational Health & Safety)	• OMA staff time

• Conduct a baseline assessment for NOSM faculty using the Standard • HFO to share physician wellness module within TiPS more broadly with Northern physicians • OMA to increase access to locum days for support for vacation leave and CME for rural/remote Northern physicians • Access to locum time for medical LOA for rural/remote Northern physicians (akin to maternity leave) to ensure support for remaining group when one member on LOA	

Multi-Year Goals/Objectives:

- Workplace wellness (using the new National Standard) becomes an accreditation standard for all health care providers in the North
- Develop a 'job description' for all physicians which recognizes and supports their comprehensive rural/northern medical practice including academic and administrative commitments and creates realistic expectations about allocation of time consistent with workplace wellness and work-life balance; align this contract obligations and funding
- Work with teaching hospitals and other clinical settings to foster healthy and supportive work environments
- Develop approach to supporting physicians through the 'system' so that responsibility for providing coverage for emergency leaves, illness leave, departure is not the responsibility of the physicians but the system through the LHINs
- Improve system responsiveness for the transfer and management of the most complex patients; and ensure adequate team based resources in communities including resources for mental health and addictions management

<table>
<tr><td>Strategy:
Create formal and informal mentorships</td><td>HHR Category: RETENTION</td></tr>
<tr><td>Intended Outcomes:
✓ All medical learners (undergraduate and postgraduate) and new graduates have supportive relationships with a more seasoned physician mentor</td><td>Lead Organization:
Clinical Leads at the LHIN with input, assistance from NOSM, OMA, HFO
** working group recommended to include other organizations that have initiated work on this issue, e.g. OCFP</td></tr>
<tr><td colspan="2">Current Activities:
• NOSM has begun to identify faculty mentors for junior faculty and indigenous faculty mentors for indigenous learners and has a ‘buddy system’ for residents
• HFO promotes mentorship as a best practice through its Regional Advisors, locum programs and through online toolkits such as ‘Recruitment Essentials’ and the ‘ED toolkit’
• Ontario College of Family Physicians (OCFP) has an initiative for Collaborative mentoring networks to launch in September 2018 for those new to rural practice and for those in “early years in practice”</td></tr>
<tr><td>Short-Term Action Steps:
• NOSM to develop training program for both mentors and mentees about how to build a successful mentoring relationship
• Clinical Leads at the northern LHINs and OMA Region Executives to welcome new graduates as they establish their northern practices and invite follow-up contact
• Best practices from OCFP project shared with partners
• Identify Francophone faculty members to ensure that Francophone learners have access to experienced Francophone physicians, and that Francophone physicians who are new to practice have a more senior physician mentor</td><td>Resources Required:
• staff time from partner organizations</td></tr>
<tr><td colspan="2">Multi-Year Goals/Objectives:
• Creating an organized way to fund local mentorships so an experienced physician gets some clinical relief (e.g. - a funded hour each day that is designed for mentoring a new grad - this would both recognize and reward the expertise of the senior physician)
• New funding source to support mentorships</td></tr>
</table>

4.6 Models of Care

<table>
<tr><td>Strategy:
Establish formalized LHIN-based Networks for referral and patient transfer</td><td>HHR Category: MODELS OF CARE</td></tr>
<tr><td>Intended Outcomes:
✓ Consistent approach to patient care and patient transfer using integrated care pathways for rural/remote patients requiring tertiary/specialized care
✓ Formal patient transfer protocols between smaller sites and tertiary centres with defined expectations and accountabilities of sending and receiving facilities
✓ Transfer protocols that take into consideration patient’s mother tongue</td><td>Lead Organization:
Northern LHINs with input, assistance from OHA and Academic Teaching Hospitals</td></tr>
<tr><td colspan="2">Current Activities:
• North East LHIN has established the following patient care/transfer networks: (i) Coastal Sub-Region mental health system care pathway between Health Sciences North and WAHA which includes a Schedule 1 Access protocol, 24/7 Crisis Intervention Assessment and Outreach Virtual Psychiatry Program; (ii) Non-Urgent Patient Transfer Regional Steering Committee; (iii) Regional Community of Practice for Medical Assistance in Dying
• North West LHIN has established the following networks: (i) Western Region Surgical Network (Dryden, Kenora, Fort Frances, Sioux Lookout); and (ii) Orthopedic Network with a specific surgical referral network for hip/knee; and (iii) Virtual Critical Care
• North East and North West LHIN had HSP complete Ozi Tool to identify FLS capacity within their regions.</td></tr>
<tr><td>Short-Term Action Steps:
• North East LHIN is in the process of: (i) establishing General Surgery Network for the Cochrane Sub-Region; (ii) Rapid Access to Addiction Medicine (RAAM); and (iii) having ongoing conversations with Health Sciences North and WAHA about additional specialty care networks to serve coastal communities in the Coastal Sub-Region as part of North East Outreach Program
• Both LHINs to review existing clinical service network models and how best to implement these network models in other parts of the LHIN geography where timely access is an issue</td><td>Resources Required:
• LHIN staff time</td></tr>
</table>

Multi-Year Goals/Objectives:
• Developing regional service networks for key priority clinical areas and underserviced communities that improve patient access and support urgent assessment and rapid transfer when required: Priority clinical areas should be Mental Health, Surgery and Obstetrics/Neonatal • Creating an Indigenous Satellite Health Service (West and East) to link and add new services for improving Indigenous health care

Strategy: ***Establish Collaborative Networks across practices***	HHR Category: **MODELS OF CARE**
Intended Outcomes: ✓ Family physicians are knowledgeable about the full range of services and supports that can benefit their patients and access to those services is coordinated & simplified ✓ Services and supports take into consideration patient's language and cultural needs	Lead Organization: **Northern LHINs**
Current Activities: • North West LHIN has been implementing its *Health Services Blueprint* over the last few years which includes the development of Local Health Hubs within its sub-regions - Local Health Hubs will integrate services across the continuum including primary care, public health, mental health, acute care, home and community care, long term care and palliative care • Dryden and Manitouwadge were designated as 'early adopter' communities as part of the MOHLTC's provincial pilot on implementing rural health hubs • within the North East LHIN, the communities of Blind River and Espanola were selected as rural health hub pilot projects	
Short-Term Action Steps: • Primary care clinical leads at both LHINs to engage primary care practices about options for strengthening communication and collaboration at both the primary and secondary care level • Creating and supporting a unique academic/clinical network structure that focuses on teaching and research/scholarly work as well as clinical skills/relationships	Resources Required: • LHIN staff time
Multi-Year Goals/Objectives: • Strengthening collaboration among primary care and rural generalist practices (FHTs, FHOs, CHCs etc) • Strengthening collaboration between primary care and other service providers	

<table>
<tr><td>Strategy:
Create single electronic health record (EHR) for the entire region to hold all hospital and other health care data</td><td>HHR Category: MODELS OF CARE</td></tr>
<tr><td>Intended Outcomes:
✓ Physicians and other providers (with approved access) have up-to-date information on patient health status, test results and health care visits and mother tongue
✓ Patients no longer required to repeat their histories for different health care visits</td><td>Lead Organization:
Northern LHINs</td></tr>
<tr><td colspan="2">Current Activities:
• Through a province-wide initiative (“Connecting Ontario”), both Northern LHINs have been working with physicians, hospitals and other health service providers to implement: (i) a Clinical Data Repository (CDR) designed to ultimately hold all relevant patient care information; and (ii) a Clinical Viewer portal to view the stored patient data
• In the North West LHIN, 10 hospitals and Home and Community Care at the LHIN are connected to the Viewer
• Many HSPs already capturing Linguistic Variable (LV) questions to identify patient’s mother tongue</td></tr>
<tr><td>Short-Term Action Steps:
• Support additional hospitals to connect with CDR/Clinical Viewer
• Long Term Care and Primary Care providers to begin contributing data to CDR and be able to connect to viewer
• Build links through EMR to be able to access services like econsult, Home and Community Care data, and the clinical viewer from within the EMR
• LV questions integrated into each patient’s EHR</td><td>Resources Required:
• LHIN staff time</td></tr>
<tr><td colspan="2">Multi-Year Goals/Objectives:
• e-Health technology supports physicians to view the patient’s total Electronic Health Record through the EMR in the physician’s office
• Ensure all nursing stations are linked to regional EHR</td></tr>
</table>

SECTION 5 – Early Wins, Short and Longer Term Priorities

5.1 Early Wins

Task Force members have identified the following *Summit North* recommendations as potential 'early wins' or ones where activity in support of the recommendation is already taking place:

POTENTIAL EARLY WINS
✓ Development of regional locum pool for North West and North East LHINs, which includes official language capacity of Locum ✓ Create formal and informal mentorship opportunities ✓ Engagement and orientation session for new locums arriving in community ✓ Ensure continuing development including coaching and mentoring ✓ Work with the Chiefs of Ontario to support the implementation of the NAN Health Transformation strategy ✓ Linguistic Variable (LV) included in the EHR
WORK ALREADY UNDERWAY
✓ Create education for communities regarding health human resources (HFO Lead) ✓ Create ways for communities to collaborate rather than compete (HFO Lead - *North West Recruiters Alliance*) ✓ Establish Networks for referral & patient transfer and provision of specialty services (Northern LHINs – some care networks exist for certain services in certain sub-regions) ✓ Ontario College of Family Physicians is developing formal mentoring network for rural physicians ✓ Single electronic health record (EHR) for entire region to hold all patient data (Norther LHINs – part of *Connecting Ontario* initiative)

5.2 Short and Longer Term Priorities

Task Force members identified the following *Summit North* recommendations as the **most important** for creating a flourishing physician workforce in the North. For some of these, action planning can begin in the short term but many of these will require a longer implementation timeframe:

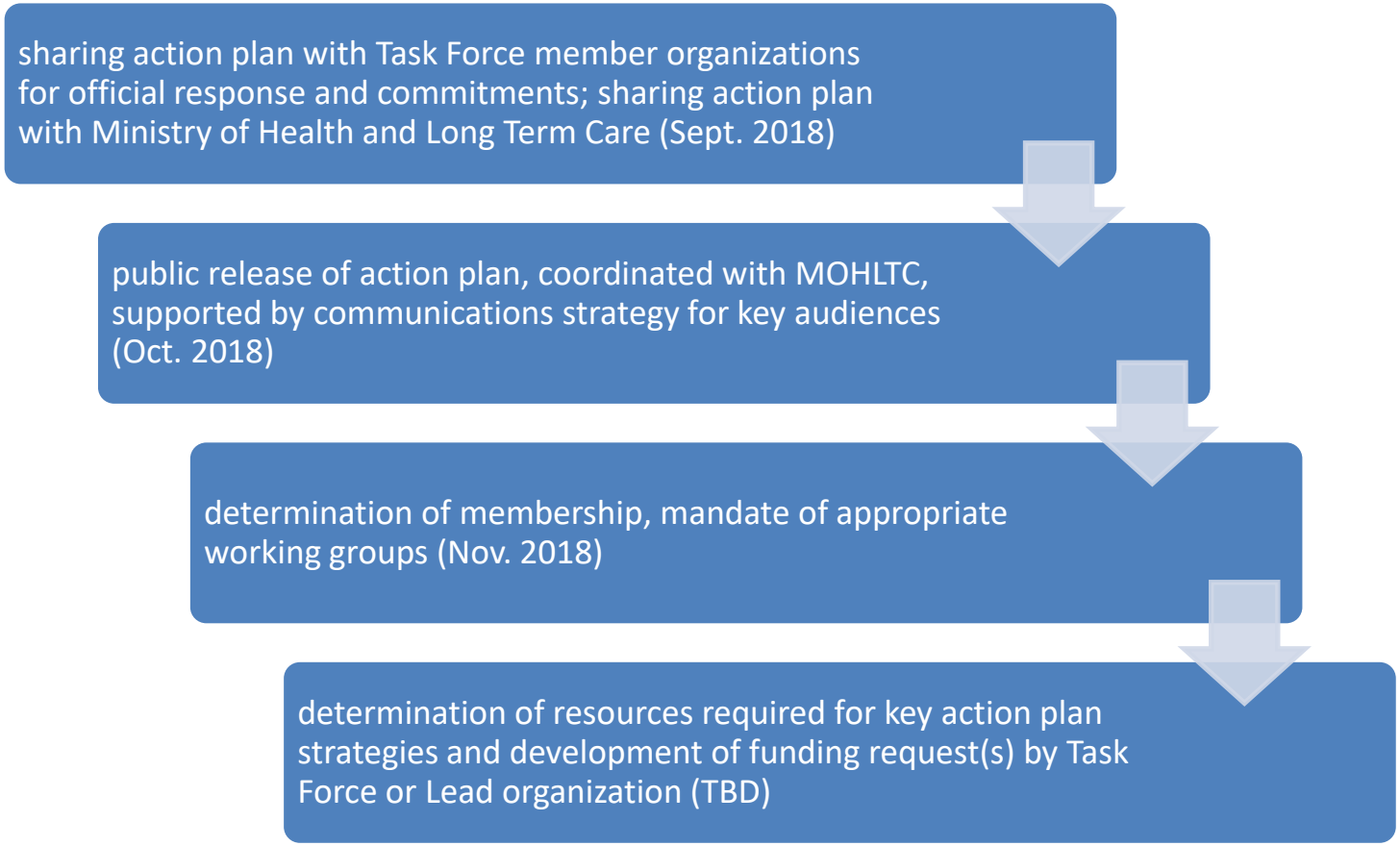
HHR COMPONENT	SUMMIT NORTH RECOMMENDATIONS
Education & Training	• Ensure process to review admission criteria that supports rural/remote students • Create specialty focus 'Rural Generalist' over 3 years Family Medicine (or realistic alternatives based on current 2-year FM residency and post-grad options)
Recruitment	• Create new, innovative ways for communities to collaborate rather than compete • Support local physician leadership as key recruitment strategy
Compensation	• Supportive contracts for family physicians and their primary care teams
Retention	• Intentional approach to physician wellness • Single electronic health record (EHR) for entire region to hold all patient data
Models of Care	• Stronger focus on the determinants of health generally and • Stronger focus on Indigenous Health consistent with the NAN health transformation strategy • Stronger focus on FLS and Francophone populations

There are a number of *Summit North* strategies that will require further Task Force discussions (see Appendix D) and/or further policy discussions with the Ministry of Health and Long Term Care such as:

- ✓ Expand the role and number of **Physician Assistants 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

5.3 Next Steps

Once the Action Plan is formally approved by the Task Force, the following are recommended next steps:



APPENDIX A – Northern Physician Resources Task Force Membership and Terms of Reference

1.0 Purpose

To bring together a multi-sectoral team to oversee the development a ***Northern Physician Resources Action Plan***, which is built on the ideas and strategies that were identified at the recent *Summit North: Building a Flourishing Physician Workforce*.

The work of the Northern Physician Resources Task Force is intended to take no longer than eight-months. Following that, members may subsequently be called upon, periodically, to review and comment on evolving initiatives that may stem from the original work of the Task Force.

2.0 Background

Following *Summit North*, a decision was made to create a multi-stakeholder *Task Force* to finalize a summary report and to ensure that the deliberations, and those actions, from the summit are realized, and momentum sustained, across Northern Ontario.

To help support the next stage of work, the Task Force will retain a consultant, of which the contract will be administered through the Northern Ontario School of Medicine (NOSM). The consultant's work will include mapping the strategic initiatives that were identified at the summit and costing some of the proposed ideas and help create a "made in the North" Action Plan.

The ultimate goal of the Task Force is to create and facilitate a model (or combination of strategies) that will help communities build health workforce capacity in the North and introducing innovative models of care will lead to more equitable access to care for patients and greater health equity for rural, remote and Indigenous communities. To that end, the task force will also support the development of a Knowledge Transfer Project (pending) which will involve the creation of a new "service and workforce design" model, built on a similar model in Queensland, Australia.

3.0 Scope and Functions

The Task Force will be responsible for:

1. Creating a draft Terms of Reference
2. Clarifying scope of project
3. Developing draft framework for categorization of Summit recommendations (short-term vs longer term, no cost vs new resources etc.)
4. Reviewing/synthesizing of recommendations and initial categorization based on framework
5. Reporting back to Summit North participants to keep them informed and updated on work of the Task Force and progression of action items.
6. Preparing draft and final Northern Physician Resources Action Plan (including initial cost estimates to implement the plan – and possible funding sources as well as natural organizational hosts for specific actions)
7. Establishing baseline data/performance indicators to help measure success
8. Planning a potential subsequent Summit North 2 (as needed)
9. Aligning with developing and emerging strategies of Government
10. Supporting the creation of a data collection and assessment tool that will aid in future HHR planning
11. Prior to close of the task force, establish a mechanism through task force organizations and the Northern Health Equity Strategy to ensure that there is sustained attention to the physician resource issue.
12. In completing its work, the Task Force should align its work with, and have regard for, other complementary initiatives and strategies currently being undertaken across the North and other jurisdictions including, but not limited to: NAN Health Transformation project, Northern Policy Institute, Northern Health Equity Strategy, Health Workforce Planning Advisory Table, etc.)
13. Ensuring a strategy is in place to facilitate appropriate and timely communications and document dissemination to Summit North participants, and others as needed (while complying with AODA requirements).

4.0 Reporting and Decision Making

The Task Force will be co-chaired by the two Local Health Integration Networks (Northeast and Northwest). Regular reports/material will be circulated by the Co-chairs in advance of meetings. Any member may table/circulate documents/information at meetings and/or via e-mail although time for advance preparation for the meeting is helpful and circulation in advance of meetings is strongly encouraged.

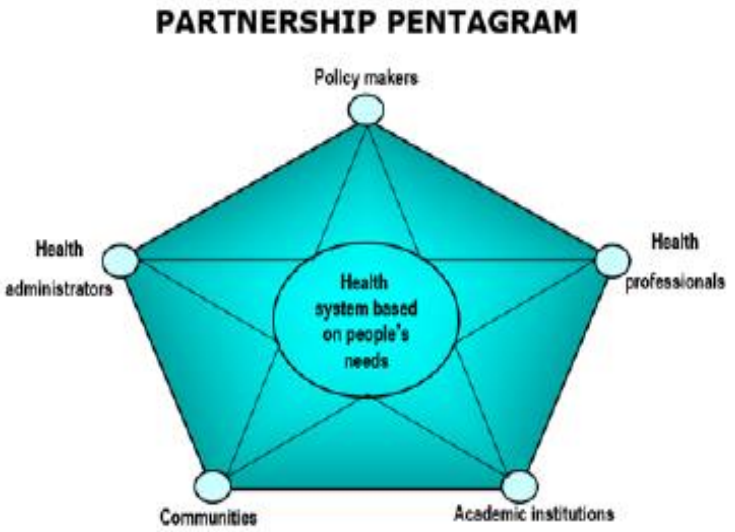
Decisions of the task force will be made by consensus, based on the members present at a meeting where decisions have been discussed. Only compelling information could result in a decision being brought back to the Task Force, of which a request for reconsideration would first be presented to the Co-Chairs.

5.0 Task Force Process

The Task Force will oversee the work of, and review material prepared by, the consultant. Much of the material would have been generated at the Summit which the Task Force will distill and formulate an action plan that is achievable and impactful in helping transform physician recruitment and retention effectiveness in those areas of the North that continue to struggle.

Time commitment to the Task Force will include reviewing material and attending about five meetings (WebEx tele/video conferencing). A possible face to face meeting may be organized at or near the end of the project to finalize recommendations and Action Plan.

6.0 Composition based on Partnership Pentagram



One representative from each of the following partner organizations:

- Northwest Local Health Integration Network (Co-chair)
- Northeast Local Health Integration Network (Co-chair)
- HealthForceOntario Marketing and Recruitment Agency
- Northern Ontario School of Medicine
- Ontario Medical Association
- Ontario Hospital Association
- Nishnawbe Aski Nation
- Federation of Northern Ontario Municipalities
- Northwestern Ontario Municipal Association
- Northern Teaching Hospital Council
- Réseau du mieux-être francophone du Nord de l'Ontario

Resources

The following individuals have served as resource persons supporting the work of the Task Force: David Lamb (Ministry of Health and Long-Term Care) and Jim Whaley (Rural Health Consultant).

NOSM will also provide additional staff resources to support the administrative/secretarial work of the Task Force. As needed, guests will be invited to attend a meeting(s) with the consensus of the group.

APPENDIX B – Charter of Relationship Principles Governing Health System Transformation in NAN Territory

THE PRINCIPLES

The Parties therefore commit to a renewed multilateral nation to nation relationship that is guided by a mutual, collaborative approach to health planning in accordance with the following principles:

1. Any new approach is intended to address health, and health care service gaps;
2. First Nations must have timely access to culturally safe health services and facilities, regardless of where they live and have a right to equitable access to health services that meet the unique needs of the communities of NAN territory;
3. Joint strategies are needed to identify and address structural barriers to health care delivery to First Nations;
4. Health transformation is a community driven process that engages the expertise of First Nations communities and health care professionals, and collaboratively increases the involvement of First Nations to ensure decision making concerning health services for communities is at the community level;
5. Any new approach for addressing health and wellness would be guided by existing health plans and community directions;
6. The system is intended to be flexible, efficient and accountable;
7. New approaches would build on First Nations' capacities and strengths with an emphasis on local control and authority over health care services;
8. Continuous evaluation is important for measuring progress and systematically assessing, evaluating and improving the structure, process and outcomes;
9. Governance and management of the system is intended to be guided by clear roles and responsibilities at all levels and incorporate First Nations ways and other best practices;
10. Health partners and communities will work together in a coordinated and collaborative manner while respecting the autonomy of tribal councils and communities. Communities will be engaged at all levels (community workers, elders and youth) so that their voices are heard and incorporated into community-based programming;
11. First Nations have an inherent right to self-government and that the relationship between Canada, Ontario and the First Nations must be based upon respect for this right; and an inherent right to self-government may be given legal effect by

specific rights recognized and affirmed by section 35 of the Constitution Act, 1982, or through negotiated agreements and legislation;

12. The jurisdiction and legal obligations of the Crown are determined by the Canadian constitutional framework, which includes common law and treaties entered into between First Nations and the Crown;
13. The Parties intend to maintain and strengthen a relationship that is based on (a) the special and the fiduciary relationship that exists between Canada and NAN First Nations; and (b) a commitment by Canada and Ontario to uphold the principles of the Canada Health Act including the accessibility criteria for First Nations people residing in the NAN Territory; and
14. This Charter is intended to strengthen the relationship between Canada, Ontario and NAN and the Parties will strive to ensure that their work together is respectful.

THE VISION: HEALTH SYSTEM TRANSFORMATION

This system-wide change would see First Nations have equitable access to quality care delivered within their community, in NAN territory, as a priority. The Parties intend the system to include holistic models of care, focusing on wellness planning, population health and health determinants. The system would be patient centred, responsive to community and patient voices, and ensure that health care providers funded by federal or provincial governments would have the skills required to provide responsive, effective and culturally safe care. Communities would be engaged at all levels (community workers, Elders, and youth) so that their voices are heard and incorporated into community-based programming.

The Parties intend to take all reasonable steps necessary to support health system transformation for the First Nations in NAN territory, including, but not limited to:

1. Supporting an alignment process that would bring decision-makers together to move health transformation forward in a deliberate, planned, and measurable way;
2. Creating a framework that would:
    a. Include an immediate process that would review the urgent health needs identified by NAN and other First Nations health entities within NAN territory, prioritize actions, and implement a joint action plan with an evaluation program for transparency;

   b. Include a joint review and implementation of commitments made by Health Canada in response to the Auditor General of Canada Spring 2015 Report on Access to Health Services for Remote First Nations Communities that are relevant for the NAN First Nations;
   c. Include a joint review of the existing health system and funding model, and work towards health system transformation guided by existing system transformation models in the NAN territory that would create new models to improve access to health services;
   d. Observe the principle that jurisdictional disputes should not prevent the timely provision of services to First Nations children.
3. Developing new approaches to improve the health and health access of First Nations people in NAN territory and associated communities, including increasing and improving services and access at the community level;
4. Supporting the ability of communities and First Nations institutions to deliver and plan health services;
5. Proposing policy reform, and considering whether legislative changes may be required, to design a new health care system for First Nations in NAN Territory that includes sustainable funding models within a new fiscal arrangement; decision making structures that provide First Nations with authority, control and oversight; and enable multi-sectoral approaches;
6. Removing barriers caused by jurisdictional, funding, policy, cultural and structural issues that negatively impact First Nations' ability to plan, design, manage and deliver quality health care services in their communities and for their members; and
7. Establishing tri-governmental political oversight such that the actions and decisions of all officials within their organization, Department or Ministry are consistent with the political commitments made by their leaders.

APPENDIX C – Recommendations from the Rural Road Map for Action (2017)

DIRECTION 1: Reinforce the social accountability mandate of medical schools and residency programs to address health care needs of rural and Indigenous communities.

Action 1: Develop and include criteria that reflect affinity and suitability for rural practice in admission processes for medical school and family medicine residency programs.

Action 2: Establish and strengthen specific policies and programs to enable successful recruitment of Indigenous and rural students to medical school and family medicine residency training, with established targets and measures of effectiveness.

Action 3: Support extended competency-based generalist training in rural communities to prepare medical students and residents to be capable of and confident in providing broad-based generalist care in these settings.

Action 4: Provide high-quality rural clinical and educational experiences to all medical students and family medicine residents that support experiential learning, enabling medical learners to feel comfortable with uncertainty and to gain clinical courage.

Action 5: Educate medical students and residents about the health and social issues facing Indigenous peoples, and ensure they attain competencies to provide culturally safe care.

Action 6: Establish a collaborative among medical schools, residency education accrediting bodies, and physician-based organizations (including the Society of Rural Physicians of Canada and the Indigenous Physicians Association of Canada) to ensure that physicians acquire and maintain specific competencies required to provide health care to rural communities. Support the Royal College of Physicians and Surgeons of Canada in identifying and equipping specialists with generalist competencies required to support rural communities.

DIRECTION 2: Implement policy interventions that align medical education with workforce planning.

Action 7: Establish government and university partnerships with rural physicians, rural communities, and regional health authorities that include formal agreements to strengthen the delivery of medical education in rural communities by developing and implementing specific visible rural generalist education pathways led by rural academics and rural physicians. Provide substantial ongoing funding required to support rural faculty engagement, faculty development, research, administration and community engagement.

Action 8: Establish programs with targeted funding from federal, provincial, and territorial governments to enable rural family physicians and other specialists, predominantly those already in practice, to obtain additional or enhanced skills training in order to improve access to health care services in rural communities.

Action 9: Establish contracts for residents working in rural settings that maximize their clinical and educational experiences without compromising patient care or the residents' rights in their collective agreements.

Action 10: Establish a Canadian rural medicine service to provide a skilled workforce of rural family physicians and generalist specialists ready and able to work across provincial and territorial jurisdictions, enabled by the creation of a special national locum license designation.

DIRECTION #3: Establish practice models that provide rural and Indigenous communities with timely access to quality health care that is responsive to their needs.

Action 11: Implement standard policies within health service delivery areas that require acceptance of timely transfers and appropriate consultations between rural medical facilities and secondary and tertiary hospitals, supported by regional training and patient care networks including generalists and specialists.

Action 12: Develop specific resources, infrastructure, and networks of care within local and regional health authorities to address access issues, such as for mental health care in rural communities.

Action 13: Partner with rural communities and rural health professionals to develop strategies to guide implementing system-wide, coordinated, distance technology to enhance and expand local capacity, and improve access and quality health care in rural communities.

Action 14: Engage communities in developing and implementing recruitment and retention strategies to strengthen the integration of physicians and their families into communities.

Action 15: Establish and support the development of formal and informal mentorship relationships to support rural family physicians and other specialists in the practice of comprehensive care.

DIRECTION #4: Institute a national rural research agenda to support rural workforce planning aimed at improving access to patient-centred and quality-focused care in rural Canada.

Action 16: Create and support a Canadian rural health services research network with the goal of connecting existing rural health research initiatives, and coordinating and strengthening research that enhances the health care of rural Canadians.

Action 17: Develop an evidence-informed definition of what constitutes rural training to support educational policy and funding decisions, and to offer clear, accurate, and comparable information about rural family medicine training programs and sites.

Action 18: Develop a standardized measurement system, with clear indicators that demonstrate the impact of rural health service delivery models for improving access and health care outcomes.

Action 19: Develop metrics based on environmental factors to identify and promote successful recruitment and retention programs, using a measure of 5 years of service in a rural community as one goal for continuity of care.

Action 20: Promote and facilitate the use of research-informed evidence by all organizations participating in rural workforce planning in Canada.

APPENDIX D – Summit North Strategies Requiring Further Discussion

AMONG TASK FORCE MEMBERS:

Strengthen & formalize partnerships in Northern Ontario between communities, LHINs, universities and physicians to support delivery of medical education in rural communities.
Ensure that **technology supports and enhances care** but is not central to 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.
Develop **leadership capacity** and create accountability tools
An integrated "All Nations" Heath Care System designed and developed by a community driven process and which allows for integration of specialty services including **1 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.
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

WITH MINISTRY OF HEALTH AND LONG TERM CARE OFFICIALS:

All decisions made, and all resources **assigned by Equity**.
Expand the role and number of **Physician Assistants 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
Integrate **allied health, inter-professional learners** (including Nursing, Physician Assistants, Therapists) to train at the same time