

Ontario/Queensland Knowledge Transfer Project *(Moving from Fragility to Flourishing)*

The Northern Physician Resources Task Force

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Ontario/Queensland Knowledge Transfer Project

- Summit North keynote speaker, **Dr. Denis Lennox** (Queensland, Australia), shared insight on a ***Rural Generalist Program/Service and Workforce Design Model*** that he developed/refined over the past 18 years.
- The Model resulted in a significant increase in the recruitment and retention of physicians to rural Queensland and has the potential to help solve Northern Ontario's health services (and physician recruitment/retention) challenges.
- Following Summit North, (with MOHLTC assistance) NOSM retained Dr. Lennox to explore the feasibility of adapting a similar model in Northern Ontario

Ontario/Queensland Knowledge Transfer Project

- Dr. Lennox visited Northern Ontario between May 18 and June 8, 2018 to study Ontario's healthcare system to help inform the creation of a potential new model for Northern Ontario.
- Met with seven Northern Ontario communities (and key stakeholders) during an intensive three week period.
- Gathered information including, but not limited to:
 - Physician payment models;
 - use of e-health/technology;
 - how physicians work in rural areas;
 - resources available in the communities to support recruitment;
 - unique issues/challenges affecting Northern communities.

Queensland Rural Generalist Model

- Analyzes the local population health needs to determine:
 - ✓ complexity of care;
 - ✓ what services should be available locally and/or aggregated/pooled in regional delivery mechanism
- Applies a multiplier/factor to recognize local population “equivalency” to determine number (and type) of physicians required.
- Features a rural generalist “pathway” that creates a “supply-line” of physicians to work in rural/northern communities. The “pathway” encompasses undergraduate and post-graduate training resulting in a rural “specialty”.
- Establishes a new physician payment model that recognizes enhanced specialty of a Rural Generalist physician.

Designing a New Model (context for change)

- Workforce burnout exists in the North – physicians work excessive hours trying to maintain services in a model that is outdated
- A new Northern medical school was created, but the rural workforce/design model was not changed...still based on a historical urban design
- Disconnect exists with matching aspirations of future physicians with expectations of communities
- Not a one-size-fits-all approach – in developing a new model, key is establishing principles that are aligned with aspirations of new breed of physician workforce (e.g. protected time/balance between clinical, academic, research and leadership)
- Need to create over-supply/capacity (redundancy) to reduce dependency on “urgent” locums but increase “respite” coverage self supplied by local physicians

4 Components of Queensland Rural Generalist Model

1. Recognition of RGM as a medical specialist (or sub-specialty)

- In late 20th century, GPs began practicing less than “full scope” of PHC
- This was the practice style that new docs learned as “full scope” (but it wasn’t full “generalist” scope)
- Consequently, rural communities were recruiting “full-scope generalists” that no longer existed
- Hence, creation of new RGM medical specialty.

2. Valuing the specialty status with an appropriate payment model

- RGM docs income doubled after implementation of new RGM “specialty” designation – making it more financially desirable to work in rural settings
- 5 weeks vacation and 3.5 weeks CME included

4 Components of Queensland Rural Generalist Model

3. Creation of a “supply line” of physicians through unique medical education/residency training “pathway”

- Old system was like trying to catch a certain (rare) fish species in the ocean. RGM is like looking for that same fish, but now in a small lake
- RGM has integrated all the parts into one (UME, PGE, physician remuneration/contracts, recruitment – including a physician career navigation service) – Ontario’s current system built on “disparate” parts.
- Starts with admissions process – important those selected into RGM training are well suited to cope with rural life (NOSM has demonstrated success in that the majority of NOSM learners stay in the North)

4 Components of Queensland Rural Generalist Model

4. Service and Workforce Design based on community healthcare needs and infrastructure (data driven)

- Determines right mix and number of physicians for communities – goal to create over capacity
- Design yields more physicians/1,000 population – translates to better work-life balance enabling better quality of life for physicians
- Queensland physicians spend 70% of their time providing comprehensive PHC, and 30% on other (e.g. hospital, academic, leadership, CME, etc.)

Final Thoughts

- Status quo is not sustainable...System change is needed in order to yield improvements in Northern rural/remote, recruitment and retention
- Caution to not try to make Queensland Model work in Ontario...better to find commonalities/key elements of both systems that will best suit Northern Ontario
- Make change a “value proposition” – it’s not about asking for more compensation...it’s about investing in an appropriate number of doctors rendering “full scope” comprehensive PHC in rural communities thus reducing overall costs to system (lower transportation costs/travel grants, elimination of urgent locums, improved health outcomes, etc.)

Next Steps

- Northern Physician Resources Task Force (NPRTF) to oversee the work of Dr. Lennox
- Draft report anticipated February 2019.
- Following NPRTF review, report will be submitted to MOHLTC and others (Spring 2019) for consideration of any possible change(s) in policy and/or reallocation of resources, etc.

Thank You, Merci, Miigwetch

Questions/Comments?

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