The Rural Road Map for Action: Directions

Advancing Rural Family Medicine: The Canadian Collaborative Taskforce

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Advancing Rural Family Medicine
The Canadian Collaborative Taskforce
Faire avancer la médecine familiale rurale
Le Groupe de travail collaboratif canadien

Society of Rural Physicians of Canada
Société de la Médecine Rurale du Canada

ADVANCING RURAL FAMILY MEDICINE: THE CANADIAN COLLABORATIVE TASKFORCE

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INTRODUCTION

Canadians living in rural* communities have long had challenges obtaining equitable access to health care services. Local services are often limited, with fewer physicians and other health care professionals living and working in rural communities. Geographic, environmental, and organizational factors result in challenges accessing care outside of the community. In general, rural Canadians are older, poorer, and sicker than their urban counterparts.[1] They constitute 18% of the Canadian population but are served by only 8% of the physicians practising in Canada.[2,3] Increased urbanization and centralization of medical services have further stressed this situation. Disparities in Indigenous health and access to care for Indigenous people in rural Canada are pronounced.[4,5] In order to address the Truth and Reconciliation Commission[6] calls to action, as well as the Canada Health Act mandate to "facilitate reasonable access to health services without financial or other barriers," rural Canadians must be better served.[7]

The College of Family Physicians of Canada (CFPC) and the Society of Rural Physicians of Canada (SRPC) formed a joint taskforce (Taskforce) in 2014, with the goal to improve the health of rural Canadians by producing and sustaining an increased number of family physicians practising comprehensive rural generalist medicine. The Taskforce advocates a social accountability mandate with recommendations for a renewed approach to physician workforce planning for rural Canada. The Taskforce includes members from the CFPC, SRPC, Royal College of Physicians and Surgeons of Canada, Indigenous Physicians Association of Canada, Federal/Provincial/Territorial (F/P/T) Committee on Health Workforce, Canadian Medical Association, as well as medical school deans and practising rural physicians from across Canada.

The social accountability framework for medical schools defined by the World Health Organization in 1995 is "the obligation to direct education, research and service activities towards addressing the priority health concerns of the community, region and/or nation they have a mandate to serve."[8] The Association of Faculties of Medicine of Canada's *Future of Medical Education in Canada (FMEC): A Collective Vision for MD Education*[9] reinforces recommendations for social accountability, addressing the health needs of all Canadians, and the importance of generalism in the Canadian context. However, the imperative for timely access to quality rural health services goes beyond developing education. Education and practice must be considered together, with essential infrastructure and support to sustain comprehensive generalist practice and provide equitable access to services for rural communities.†

The Taskforce used combined expertise, background research, literature reviews, and an environmental scan to create recommendations for a well-coordinated approach to providing health care in rural communities. Four directions and 20 actions have been designed for developing a framework to improve access to care for rural communities. The goal is to strengthen a physician workforce with the competencies and skills to provide high-quality and culturally safe care, work in innovative team environments with allied health care providers, and respond to the needs of people who live in rural communities. The recommendations propose collective actions with outcomes that are measurable and sustainable, building on and enhancing existing successful initiatives to improve the health of Canadians in rural communities. They require system-wide alignment in education, practice, policy, and research. This approach has the potential to revitalize rural health care in Canada and positively affect the entire Canadian health system.

* "Rural" is defined as those communities that are geographically located in rural and remote regions of Canada and are distinctly or partly populated by Indigenous people.

† The background paper, its executive summary, publications, presentations, videos, and resources developed since 2014 will be archived on our website: **www.cfpc.ca/arfm.**

DIRECTION 1:

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

The recommendations in Direction 1 on educational pathways are essential components for producing and supporting enough rural generalist physicians to care for Canada's rural communities. They consider necessary factors, starting with early educational opportunities in rural communities continuing through medical training and into practice. The need for well-trained generalist physicians with enhanced skill sets defined by community need—working in well-supported teams—cannot be overstated. These principles apply to family physicians and other specialists alike.

There is a particular need for cultural safety education in order to serve Indigenous patients. There is also a need to identify specific competencies for rural family medicine and rural specialist medicine, and to provide support for obtaining these competencies throughout training and practice lifetimes. Not only do such measures produce appropriately trained physicians, but the inclusion of training in rural locations has also been demonstrated to be an effective recruitment and retention tool. Only by considering the entire education process can the system supply rural Canada with the physicians it needs.

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.

The recommendations in Direction 2 all deal with the need to align education with workforce planning on a policy level. Failing to consider the distribution of training positions with anticipated community needs ultimately undermines the ability to provide equitable and appropriate medical care. Producing an excess of specialists without having the infrastructure in place allowing them to actually practise in rural communities benefits no one. Producing a fit-for-purpose medical workforce requires comprehensive policies, oversight, development, coordination, and support of rural medical education for undergraduate training, postgraduate residency training, and continuing medical education. Governments, regional health authorities, physician groups, and communities must work together to educate, recruit, and retain physicians.

In the rural context, the best demonstrated approach is to produce generalist physicians with broad skill sets and provide the opportunity to acquire extra skills based on documented community need. In rural training streams, it is important to consider how best to maximize exposure to essential clinical experiences. This may require a degree of flexibility in scheduling that is not necessary in urban programs because of differences in volume. It is critical that rural medical education programs be developed, implemented, and managed with rural clinicians and rural academics. In order for this to be successful, academic career paths for rural generalist physicians must be developed.

Likewise, there are benefits to increased mobility across jurisdictions for rural physicians—the communities they can serve are widely distributed across Canada. This is particularly useful in emergency situations as rural expertise is limited to a much smaller proportion of the physician population. Currently, it is easier to do relief work overseas than to respond to emergency needs within our own country.

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 licence 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.

A number of the challenges in rural retention can be attributed to frustrations among physicians trying to access high-quality health care for their patients outside of their own community. There will always be a need for secondary and tertiary care to meet the needs of the rural patient population. Spending an inordinate amount of time arranging transfers to appropriate levels of care is a common problem in many Canadian jurisdictions. Nowhere is this more predominant than in mental health services. Inadequate resources for care in rural communities, as well as in larger centres, combined with the particular challenges of transporting unstable psychiatric patients safely make accessing care for these patients extremely challenging.

Developing patient-centred care models that provide the right care in the right place at the right time, while supporting rural family physicians and generalist rural specialists, is necessary and possible. The following recommendations confront these concerns, and propose mechanisms to address them and support physicians in practice. Specific goals include better access to care for rural patients across the continuum, and increased retention of rural health care providers.

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.

The final set of recommendations in Direction 4 tackle the need for accurate data collection and ongoing quality improvement measures. Specific rural research is currently conducted in most of Canada but it is limited and needs a well-coordinated and adequately funded national rural research network. Research, statistics, and results collected in rural communities must be returned to the communities for their benefit. Ideally, research initiatives will provide internal support for such research in communities, and increase tools and capacity for ongoing research. Current successful initiatives need to be documented, measured, and spread widely if our goal is to substantively improve rural health in Canada.

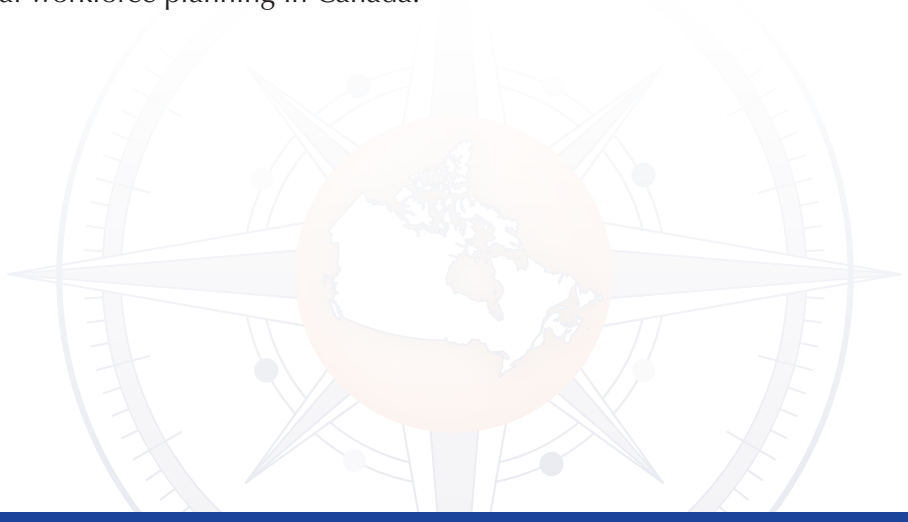
Action 16: Create and support a Canadian rural health services research network with the goal of connecting existing rural health research initiatives, and coordinating and strengthening research that enhances the health care of rural Canadians.

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.



CONCLUSION

The Rural Road Map for Action calls upon all those involved in rural health to consider future directions through a social accountability lens. The recommendations expand the rural pathway model of early repeated exposure for trainees to encompass the entire life cycle of rural physicians. Each direction focuses on one aspect of the system that must be aligned to educate, train, support, and continually improve both the professional life of rural physicians and rural health services delivery. The opportunity to address the needs of vulnerable communities through such an approach is truly exciting.

Our vision is that each rural community in Canada will be served by groups of well-supported and broadly skilled generalist family physicians and other specialists. They will be well trained, working in health care teams, and actively participating in networks of care both within and beyond their local communities. Seamless patient transfer to appropriate secondary and tertiary care will occur when needed. Rural-specific models of care will be robust and the infrastructure required supported. Education of health care professionals in rural communities will be considered essential to rural workforce planning. Teaching will be an integral part of the work of rural physicians. Priority will be placed on skills acquisition based on community needs. Rural communities and patients will be the centre of health care planning and service delivery. Our collective vision will generate a stable rural physician workforce and healthier rural communities across Canada.

The mandate is clear. Current gaps must be addressed. Collective work for improving and evolving health care delivery in rural Canada can occur only when we consider the entire system. Successful initiatives need to be identified and widely adopted. Alignment of policy and practice must be coordinated, comprehensive, and thoughtful. Only then will we truly be able to care for the needs of rural Canada.

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4 Canadian Institute for Health Information. *Disparities in Primary Health Care Experiences Among Canadians with Ambulatory Care Sensitive Conditions*. Ottawa, ON: Canadian Institute for Health Information; March 2012.

5 Health Council of Canada. *Canada's most vulnerable: Improving health care for First Nations, Inuit and Metis seniors*. Toronto, ON: Health Council of Canada; 2013.

6 Truth and Reconciliation Commission of Canada. *Honouring the Truth, Reconciling for the Future. Summary of the Final Report of the Truth and Reconciliation Commission of Canada*. 2015.

7 Government of Canada. *Canada Health Act*. R.S.C., 1985, c. C-6. Available from: http://laws-lois.justice.gc.ca/PDF/C-6.pdf. Accessed 2016 January.

8 Boelen C, Heck JE. *Defining and measuring the social accountability of medical schools.* Geneva, Switzerland: World Health Organization; 1995.

9 The Association of Faculties of Medicine of Canada. *The Future of Medical Education in Canada (FMEC): A Collective Vision for MD Education.* Ottawa, ON: Association of Faculties Medicine of Canada; 2010.