STABILIZING THE PATIENT MEDICAL HOME IN RURAL AND REMOTE DIVISION COMMUNITIES

January 2022

Submitted To:

Rural and Remote Division of Family Practice

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PROGRAM EVALUATION & RESEARCH

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The research team gratefully acknowledges the time and energy from everyone who supported our project. Thank you to everyone who participated in interviews and completed the survey.

We also gratefully acknowledge that we live, work and play on the unceded traditional territory of the Coast Salish Peoples, including the traditional territories of xʷməθkwəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and Səl̓ílwətaɬ (Tsleil-Waututh) Nations

Background

The Rural and Remote Division of Family Practice (RRDFP) has identified several challenges to maintaining stable patient medical homes in the communities of the RRDFP Division. These include:

- Attracting and maintaining a physician workforce;
- New physicians can face challenges building a sufficient patient panel and integrating into the community;
- PRA physicians may not stay in the community, creating a burden for local physicians to train and retrain new providers; and,
- Available supports may only activate in "crisis" situations, without consideration to retirement planning and ability to have crossover between physicians to maintain continuity of care.

As well, it is understood that there are a number of different organizations with a variety of programs and services that are designed to create and maintain stable patient medical homes in rural and remote BC. However, it is not clear how well these are operating to meet the needs of current Division members, potential new physicians, and rural communities.

About the Project

The stated objectives of the project were to:

1. Develop a clear understanding of the systems designed to support a stable patient medical home in Rural and Remote communities.
2. Develop a clear understanding of the roles of the Division, Health Authorities, Provincial programs and communities to support these activities.
3. Identify where the current systems and initiatives designed to support a stable patient medical home are serving communities in the Rural and Remote Division of Family Practice.
4. Understand the opportunities for the Rural and Remote Division of Family Practice to meaningfully engage and support initiatives intended to stabilize the patient medical home including recruitment and retention activities without duplication of existing supports.
5. Investigate how the Division can support the internal readiness of patient medical homes to receive new physicians to create a stable and welcoming environment given the parameters of the existing programs and services.
6. Identify any barriers, incentives, or opportunities to access systems and initiatives established to support stable patient medical homes.
7. To develop a set of recommendations aimed at removing barriers to these initiatives in our communities with the objective of stabilizing the PMH and preparing for PCN.

Methods

The evaluation used a mixed methods approach to data collection and analysis, which included document and literature reviews, a survey and interviews with various stakeholders.

Table 1. Methods

Method	About	Response rate
Survey 	A survey was distributed via email to all current Division members to learn more about their own journey into rural and remote practice, programs and services they have accessed, and recommendations for improvement	N=26 / 120

Online/Grey Literature Review	A review of information available online about programs and services aimed at supporting Rural and Remote physicians.	n/a
Administrative Data Review 	The Rural and Remote Division membership list was cross-referenced with the College of Family Physicians website publicly available data to identify members' country of education.	n/a
Interviews 	Semi-structured interviews were conducted with a range of individuals who have different perspectives and experiences within the BC health care system.	n=12 rural/remote physicians n=10 support staff (Division of Family Practice, Health Authority, HealthMatch BC, Doctors of BC, UBC)

Limitations

Sample bias – the recruitment of participants for the interviews came primarily on recommendations of the Rural and Remote Division, based on the knowledge that the individuals would have something valuable to contribute based on the interview questions. The potential for bias in the selection was mitigated by using a snowball technique, so interviewees could further identify others to speak to, as well as an open-ended option on the survey for participants to self-identify their interest in participating.

Response bias – The survey was sent to all current Division members, however there is a risk of response bias introduced in any survey, as it may have appealed to those who have more extreme views on the subject. It was also difficult to reach some stakeholders, including a representative sample of health authority staff, for interviews.

PART ONE: THE RURAL FAMILY PHYSICIAN EXPERIENCE

1.1 Why did current family physicians start practicing rural/remote medicine?

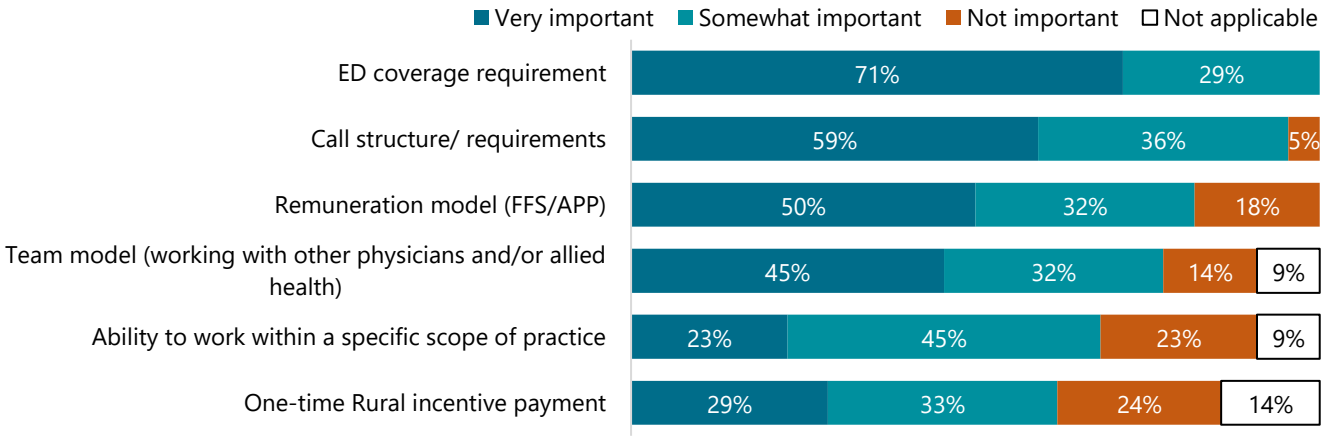
The most common driver cited by physician interviewees for becoming a rural family physician was the **scope and diversity of practice**, which some interviewees reported as the widest skill set in medicine, "*a true generalist*". Whereas in urban settings, there are opportunities to refer to other specialists more easily, or have ready access to a fully equipped hospital, rural physicians need to be able to "*do it all*." A physician interviewee commented, "*the rural aspect was appealing to do mix of emergency, clinic, and outreach clinics so I could travel to some really remote areas to do clinics there. Diversity. Every week and day is different*". Another commented, "*I feel that rural physicians are can-do physicians instead of refer-ologists*". While they admit this can feel daunting at first and be stressful at times, it was also what attracted them to rural medicine, and what they currently like about their practice.

Another key factor was **location and lifestyle**. Several interviewees noted smaller towns throughout BC "*checked the boxes*" as far as proximity to recreation opportunities, beautiful landscapes, and affordable housing[1]. Four interviewees noted that they had grown up in a rural location, and envisioned living and raising their families in a similar setting. One interviewee shared "*I'm motivated by the lifestyle. Even if I work late, I can still manage a bike ride after*."

What factors were considered when moving to a rural/remote community?

The most important work-related factors that were considered by current physicians were ED and call structure requirements, remuneration model, and team model (Fig.1)

Figure 1: All respondents said ED coverage requirement was a very or somewhat important factor in deciding which community to pratice in. (n=22, How important were the following practice/work factors when you chose your community?)



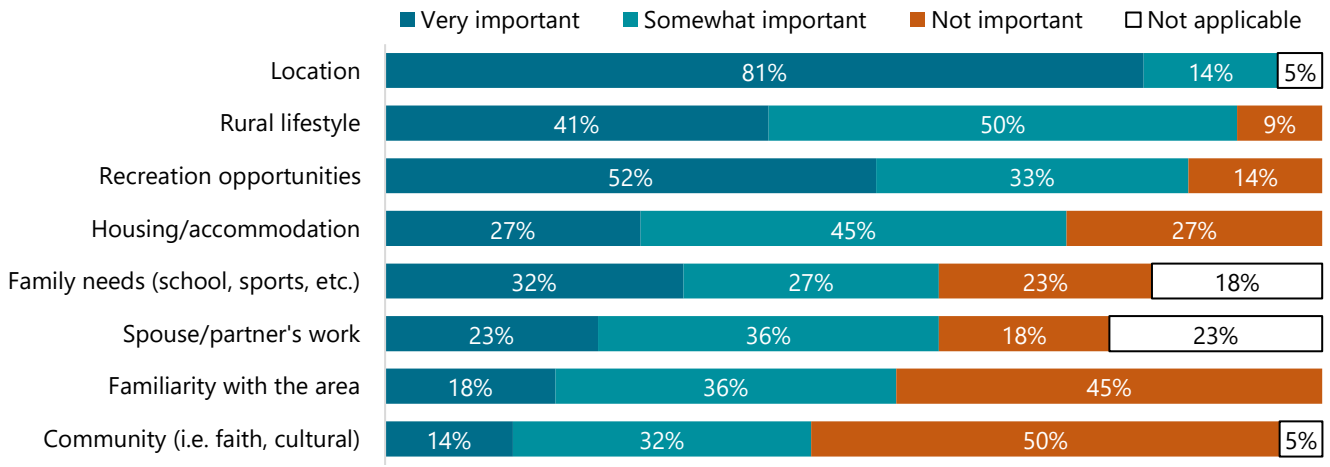
Other practice/ work factors relevant to choosing a community to work in included the collegiality among physicians (n=2), the general quality of healthcare infrastructure (n=1), the opportunity to have 30-min long appointments (n=1), the scope of practice needed in the community (n=1), the presence of underserved populations (n=1), additional ED training requirements or inadequate ED supports (n=1), leadership openings (n=1), and the flexibility of the role (n=1).

[1] Note: while housing affordability was a draw for some, lack of housing options or high cost of housing were prohibitive in other locations.

One respondent explained that they rated some factors as 'very important' because they are a deterrent to working in the community. For example, they did not want to work in a community with a requirement to do maternity care. Another respondent described how pay and call schedule are the most important factors for them, but that in their search they were satisfied with the pay and call schedules they saw across most communities. For them it was then secondary considerations, such as their sense of the collegiality between physicians, that they looked at to decide which community to practice in.

When asked about **personal factors** (ie. Not practice/ work factors) that were important for choosing the community they work in respondents rated location, rural lifestyle and the recreation activities as the most important (Figure 2).

Figure 2: 95% of respondents reported that the location of a community is very or somewhat important
(n=22, How important were the following personal factors when you chose your community?)



Other personal factors mentioned by respondents were proximity to activities and amenities (n=3), community values/ friendliness (n=2), beautiful surroundings (n=1), education opportunities (n=1), and housing (n=1).

1.2 How did current family physicians start practicing in their rural/remote community?

Physician survey respondents and interviewees shared how they were recruited to their current community. Most commonly, physicians had found the community on their own (17 of 26 survey respondents had "found the community on their own"). Three respondents cited friends or colleagues recruiting them to the region. As one interviewee explained, "*I have friends practicing who invited me there to join their practice group*" and another reported that they benefited from a medical school colleague who had moved to the area before them and gave them tips on how to navigate the immigration process as an International Medical Graduate (IMG).

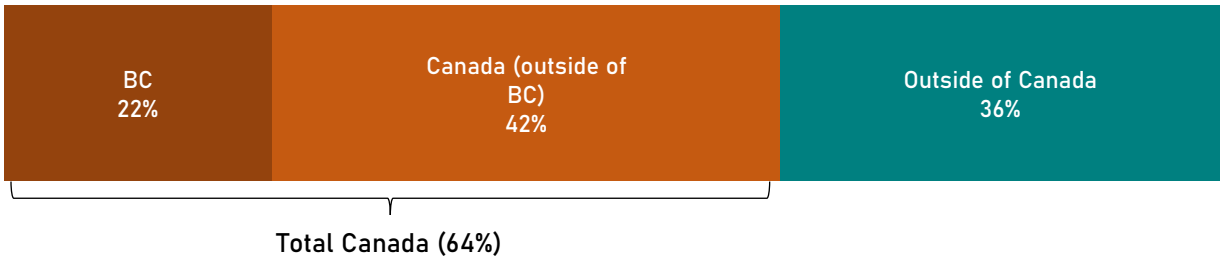
Two respondents had been recruited through HealthMatch, and an additional 2 through the local health authority.

Rural and Remote Division practitioners (family physicians and NPs) also come from a wide variety of backgrounds. Of 141 members of the Division[2], 31 graduated from medical school in BC, an additional 59 graduated from

[2] 141 of 148 members had information available on the College of Family Physicians website

elsewhere in Canada (for a total 90 Canadian graduates (64% of members)), and the remaining 51 were internationally trained (Fig. 3).

Fig. 3 - 22% of Rural and Remote Division members were trained in BC
College of Family Physicians (n=141 Rural and Remote Division physicians)



What facilitated their ability to practice in a rural/remote setting?

A key facilitator in choosing a rural and remote practice setting was **having an opportunity to visit and better yet, to test out a community** for a length of time. This was enabled through rural rotations in medical school, the rural locum program, and community visits. Two survey respondents specifically mentioned that their first impressions when visiting the community they chose were most impactful. An interviewee further shared that they would have found it very difficult to move to a new place without having visited before, or having a sense of what it felt like there.

Second, having an **opportunity to speak with local physicians** about the practice culture and know who they were going to work with. Most importantly, especially for those newer to rural practice and new grads, included the current physician's attitudes towards asking for help. As one interviewee shared, "*feeling like you have support and won't be alone is quite important to me being a new grad".* Several mentioned that the conversations they had with other physicians in the area were influential in their decision. In one example, the support received from the other physicians in the early days of her placement in the community made a difference in feeling welcome – "*there were a couple of my colleagues, they even reached out to me on my first call shift letting me know I'll be out of cell service (anywhere out of town you don't have cell service), and they stayed within service just to make sure. When they heard ambulance sirens they would text me to make sure I was ok*"

Alternative payment contracts were also cited as beneficial in choosing a rural/remote practice. These contracts enabled people to be confident that they would make enough money to cover their needs while building a practice. They were also seen as more beneficial to patient care. As one interviewee explained, *"the alternate payment structure was pretty appealing. Rather than seeing a certain number of people each day to make a living, the focus is much more on delivering certain level of care."* Two interviewees shared that they did not consider any fee for service offerings, because they did not feel it would allow them to practice optimal patient care.

> *"Without the rural locum program you won't be able to recruit people to regular positions in small communities they have never been to before. It's like the farm team."* – Rural family physician

What challenges were faced in starting to practice in a rural/remote setting?

Finding affordable, appropriate housing was the most commonly mentioned challenge facing providers looking to practice in rural and remote settings. One family has moved several times since arriving in their community, and another reported that they were unable to move to their first-choice community because there were no suitable housing options.

Those who arrived as international medical graduates (IMGs) noted that the **process for becoming licensed** in Canada was their biggest challenge. Several noted that this process is more demanding in Canada than it is for them to go to other Commonwealth countries. They reported that they have colleagues from their home countries that have selected other countries over Canada because of the additional testing (and cost of that testing) that is required here.

1.3 What do family physicians like about practicing rural and remote medicine?

In the physician member survey, 64% (14 of 22) reported being satisfied with their current rural practice. The top reason why people like rural/remote medicine mirrors the reasons they were attracted to the work in the first place.

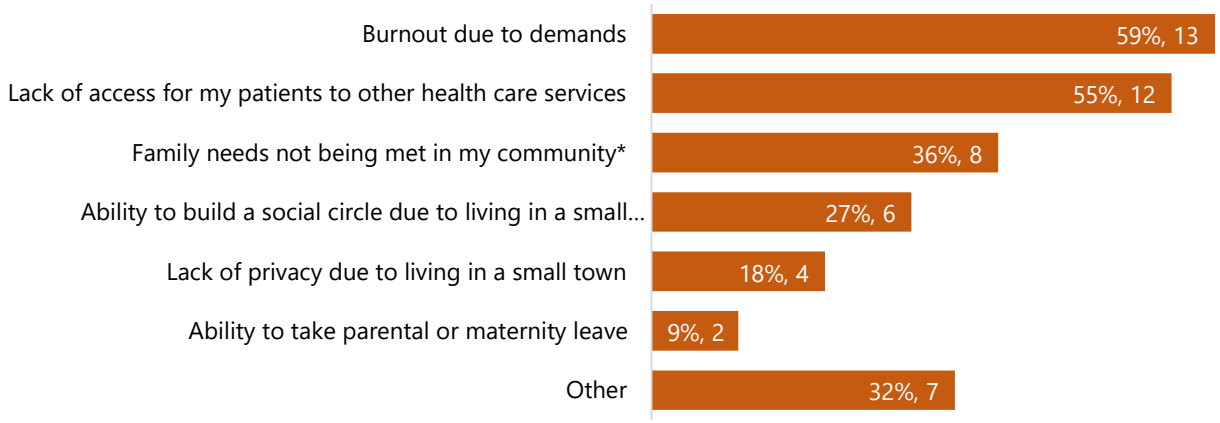
The most common factor was the diversity of the practice, and appreciation for the scope of practice they are able to utilize. In particular, having a mix of emergency and family medicine was seen as a benefit. As one provider shared, "*I'm doing more emergency medicine than I've done in many years and rediscovering that I love that*."

Third, several physicians noted that living in a rural/remote setting enables them to feel more connected with their patients and the community, and they like having the ability to be part of improving the health of their friends and neighbours.

1.4 Current challenges to maintaining a rural practice

The most common challenge reported by survey respondents to maintaining their current rural practice is burnout due to demands of the job. As one interviewee commented, "*sometimes I work 90 hrs a week and that's a lot especially if you have kids or a significant other here*".

Figure 4: Over half of respondents said their ability or desire to continue providing rural family medicine is impacted by their experience of burnout and the lack of access for patients to other health services. (n=22, Are there any challenges you are currently experiencing working as a rural physician, that may impact your ability or desire to continue providing rural family medicine? Check all that apply.)



* Family needs include a job for spouse, sports programs, etc.

Specific challenges that are contributing to burnout include a **lack of practice support**, which includes not enough rural physicians to share the workload, lack of support for on-call, OB and ED work, and lack of access to team-based care supports. It also includes challenges getting practice coverage, including locums, especially in the busier seasons, as well as long term coverage for life events such as maternity/parental leave or injuries.

Other contributing factors include the **ability to meet their family's needs**, such as access to schooling and children's recreational activities.

PART TWO: CURRENT SYSTEM OF SUPPORT FOR RURAL PHYSICIANS

Based on the evaluation findings, there were five core elements identified that form the system that is designed to support rural and remote family physician's ability to practice in their communities. They are outlined in table 2 below.

Table 2. Components of the system of support for rural physicians

Support Area	Description	Organizations/ Programs Involved[3]
Training/ Education	**Preparation to practice rural medicine, and ongoing training to improve skills.** Includes: - Formal training during medical school in rural/remote medicine - Mentorship programs - CME/CPD	**UBC**: REAP, rural CME **PRA-BC** **Health Authority**: SPLP[4] **Division of Family Practice**: CME
Medical System Support/ Navigation	**Support to provide for medical needs of the community**. Includes: - Recruitment and retirement planning/ stabilization of patient medical home (including family physicians and team-based care) - Emergency and tertiary care access - Referral pathways for specialist support/ specialized programs - Navigating the system	**HealthMatch BC** **Division of Family Practice**: recruitment, orientation, navigating the system **Health Authority**: recruitment, team supports (allied, nursing, admin) **PSP**: orientation, navigation **Community**: recruitment incentives
Practice Coverage	**Ability to have clinical duties covered for vacation time as well as longer-term coverage in special circumstances.** Includes: - Locum support - Long-term leave (maternity, parental, injury, etc.)	**Locums for BC**: Rural Locum Program
Compensation	**Financial compensation that recognizes the work of rural/remote physicians,** includes: - Incentives to practice in rural BC - Bonus funding to compensate providers working in rural BC - Additional funds available for emergency enhancement planning, travel - Alternative payment models	**JSC**: Rural incentive program **Ministry of Health**: REEF, APP contracts
Social Connection & Personal/Family Needs	**Ability to feel connected and part of a community, as well as to have family needs met.** Includes: - Connection to medical colleagues - Connection to community - Personal and family members needs met: school, work, sports, socialization, housing, transportation	**Division of Family Practice** **Community:** Health care foundations, city/town council **RCCbc**: Physician Resiliency Program **Doctors of BC**: Physician Support (i.e., Mental Health line)

[3] For more information on the different programs, please see Appendix A.
[4] Supervisors of Provisionally Licensed Physicians (SPLP) splp.pdf (gov.bc.ca)

2.1 How well are the different components of the system currently working?

Strengths and gaps are explored relative to each of the five system support areas outlined above.

2.1.1 Training/Education

There was a general sense that there is adequate training and education available for rural/remote family physicians. In particular, the 2-year UBC Rural Family Practice residency program (Prince George and Kelowna sites) was identified as a beneficial pathway for recruitment of physicians into rural practices, as was the mandatory 4-week rural rotation for the regular Family Practice program. One physician interviewee noted "*half of our physicians here were residents that worked with us*".

Interviewees also noted that ongoing CME opportunities were generally available, especially with increased accessed to virtual CME. Eighty percent of surveyed Rural and Remote Division physicians found funding available to cover CME costs useful (Fig. 6, Appendix A).

Some gaps in training/education that were identified included:

- Additional **cultural safety training**, especially for international graduates who may not be aware of the history and ongoing impacts of colonization in Canada and BC specifically.
- Coverage for **time off to access programs**/ training (linked to practice coverage, below).
- **Train-the-trainer supports**. Gaps were identified in the number of physicians available to mentor and train residents and IMGs, and in the compensation available to do so. As noted, the rural residency opportunities are a key strength in the pathway into rural practice, however this relies on current physicians being willing and available to host and train residents and IMGs.

2.1.2 Medical System Support/Navigation

Medical system support and navigation refers to the ability of the family physician to ensure their patients and community have access to the medical care they need. However, in order to do that well, they need to have a team around them, from other **team members** within the community (including other FPs, NPs and allied health or nursing staff), **administrative support and emergency and tertiary care support** both within their community and further afield.

Interviewees reported increased efforts in the past decade to support recruitment of family physicians. New physicians appreciated the effort to provide regional tours to visit multiple locations, including having accommodation and travel paid for. Recruiting physicians appreciated having Division support to help them post positions, identify candidates, and support community tours. There was also appreciation expressed for Health Match BC, which creates one place for physicians anywhere in the world to go to learn about jobs in BC.

Two examples of non-competitive recruitment collaboratives were identified in the research – Vancouver Island's Recruitment and Retention committee, which was developed during the A GP for Me initiative and mainly consists of Division representatives, and the Interior Physician Recruitment and Retention Committee (IPRR), which includes Division and Health Authority partners. These collaborative groups have seen success in jointly identifying community needs and trying to match potential candidates to the best fit, to enable long term retention.

Once physicians were in practice, **orientation support** was identified as a critical piece that, when it is prioritized, is a strength in supporting medical system navigation. Key players who are supporting orientation were the Practice Support Program (PSP), Divisions of Family Practice, and supportive colleagues.

Recent improvements in **virtual care access** also represent a benefit for system access for rural physicians, with more specialists and programs available through virtual care since the onset of COVID-19. While not a perfect solution, it does help reduce barriers to some types of care for rural/remote patients, as well as barriers to training opportunities for physicians.

Some gaps related to medical system support/navigation included:

1. **Long term recruitment planning & information about recruitment efforts**

A key aspect of a stable patient medical home in rural/remote locations relies on having enough physicians to meet patient demand, and therefore having a long-term community recruitment plan in place. Interviewees from a variety of backgrounds (physicians, Division, health authority) all remarked that understanding of long-term needs with regards to recruitment is a gap for all stakeholders, leaving the system to be more reactive than proactive in recruiting.

As well, physicians and Chapter Coordinators noted that additional information or statistics on recruitment efforts from health authorities and Health Match would help them with decision making. For example, some rural communities that are seeking new physicians are not sure if they are missing opportunities to recruit a new physician, or if there is a lack of interest in their area. Without knowing where the issue is, it is hard to develop a plan to address it. As one physician explains, "*I'm not sure whether recruits are not interested in our community or whether they (health authority, Health Match BC) are not putting our community front of mind*". Additional transparency around successes in recruitment and retention and understanding of barriers would be helpful.

2. **Support to review contracts**

Several new-to-practice physicians reported that understanding and being confident in the contracts they were signing was a key challenge they faced early in their practice. Two specifically noted seeking out legal advice prior to signing. On further investigation, Doctors of BC does offer a contract review program, however this is not broadly publicised (*see gap 4. Awareness of Programs, below*).

3. **A consistent process for orientation**

As noted, some communities have a more robust orientation process that helps new physicians understand the local medical landscape, referral pathways, tertiary care options, and other local nuances. A gap identified is that this orientation depends on the community, and some interviewees identified that a process for orientation, including who is involved, what their roles/ responsibilities are, and a checklist would be helpful. Possible participants in orientation could include clinic administrative staff and other providers, health authority, Division, PSP. To link this with Social Connection/Personal & Family Needs Support, this process could also include community members to orient the new physician to the community amenities and history.

4. **Awareness of programs**

A second gap in system navigation is awareness of available programs. Many survey respondents were not aware of the physician resiliency programs available through RCCbc (Fig. 9, Appendix A), and others reported confusion over the different training and compensation available.

> *"There are so many programs out there, navigating all of it is the tricky part. And knowing what's out there when you're so busy is the hard part."*
>
> - Rural physician

5. **Additional team supports**

While one gap identified is lack of family physicians to meet patient/community needs, another is access to team-based care supports to optimally care for their community. In several communities, social work support has been realised through Division advocacy and those Chapters are finding huge benefits to themselves and their patients. Several interviewees mentioned team supports such as RNs, occupational and physiotherapists, dentistry, massage therapy, and dietetics. Some physicians feel that the health authority has an obligation to provide equitable access to these supports in their community, and that their concerns fall on deaf ears. As one rural physician commented, "*That's one of significant issues facing retention. If people feel like the are consistently going over and above without even trying to get additional staffing in, they may well decide to walk."* Several interviewees noted that developing a team-based care approach may be facilitated by upcoming Primary Care Network collaboration and funding.

Additional administrative support was also identified as a gap, for example in Bella Coola a program to access virtual care for diabetes care currently relies on administrative support from a social worker, which cuts into their clinical time. In other areas, the amount of paperwork left at the end of the day makes a long day in clinic never-ending. Physicians with experience in other health care systems (i.e., United Kingdom) noted that physicians have pushed back on the administrative burden and have received support to reduce this aspect of their job.

2.1.3 Practice Coverage

A common need identified by physicians is the ability to obtain practice coverage when needed, for short term vacancies such as holidays, to longer term coverage including maternity/parental leave, and unexpected illness or injury. The rural locum program (RLP) was identified as a major benefit for rural providers, both as a source of recruitment (for physicians to "try out" a new area), as well as for retention (i.e., enabling physicians to take time off and reduce burnout). It was the most commonly referenced program that supports the stabilization of the rural patient medical home.

Some regions have also developed local solutions, for example Hazelton's "Provider Partners"[5] set-up, which pairs up providers to ensure patients have access to primary care when their provider is off contract or on holiday.

Gaps in practice coverage:

- A key gap in access to practice coverage is for **longer term needs**, such as maternity/parental leave, injury or an unexpected absence.

[5] See Hazelton's PMH Evaluation Summary for more details.

- Practice coverage for regions that don't meet criteria for Rural Locum Program. These communities often lose out on opportunities to sites that can offer the RLP incentives, making it even more challenging for them to find coverage.

2.1.4 Compensation

Physicians reported being generally satisfied with the amount of compensation they receive to practice rural medicine.

Some challenges were **understanding the different sources of income**, and how much to expect each year (for fee-for-service physicians). Especially in earlier years of practice, not being able to easily predict income was a source of stress for some physicians. A number of comments from interviewees also focused on **alternative payment structures** (versus the traditional fee-for-service model).

> *"Recruitment and retention fees and top ups are amazing. The income was never a problem. All those programs are very well compensated to be there. That's definitely helpful."*
>
> *"I think when I hear about people leaving rural practice its less about money and more often about lack of access to things for family and culture"*
>
> - Rural physicians

Additional gaps in compensation included:

- **Travel funding** not available (aside from northern and isolated communities which can access a travel assistance program "Northern and Isolated Travel Assistance Outreach Program" (NITAOP). Challenges with this funding was also noted, as it must be requested and it is not always an easy process to receive).
- **MOCAP funding** for on-call not available in all communities
- Equity for communities "on the cusp" of the next designation: difficult to create equity within the system, when one community will always be just shy of qualifying for the next level of benefits, or it changes yearly.

2.1.5 Social Connection, Personal & Family Needs

This is a key consideration for recruitment and more importantly retention of family physicians in rural areas. If their personal and family needs are not being met, it is unlikely they will stay, no matter how good the training, medical system support, practice coverage, and compensation are.

> *"Helping rural residents understand that even though there may be an economic and educational difference, these families are families, they need friends, social support, their children need engagement just like everyone"* – Division coordinator

> *"People who have come and stayed have done so because it fits their families. We've got a cohort of young doctors all in same age with young children, spouses who are friends. They then have created an internal retention strategy in terms of they support each other for childcare, they're all friends"* – Physician

Support for social connection and personal/family needs includes some support from the Division, as well as a variety of different approaches by different communities. What is working well is reaching out to candidates in advance of having them arrive in the community to find out what their needs are, and what their interests are, and trying to provide individualized support. However, this is not consistent across communities.

Gaps identified include:

- Lack of awareness of programs like physician resiliency program (RCCbc)
- In some locations, affordable, acceptable housing
- Information for supports (like Chapter Coordinators) to know **what to ask** of incoming physicians, such as: whether they have kids, whether they need help finding a house, do they want to be in touch with teachers. By learning this before a new recruit arrives, supports such as Chapter Coordinators can be best prepared to help.

2.2 Are there recommendations or opportunities to improve current programs and services?

The following section is divided into two sections: the first set of recommendations is targeted to the Rural and Remote Division of Family Practice, with opportunities that fall within the possible scope of the organization. They are provided for the consideration of the Division leadership. The second set are broader system recommendations that surfaced in the research. These may be aspects that the Division could advocate for within the system.

Opportunities for the Division

1. **Maintaining a database of members** to help with recruitment, retention, & retirement planning. Publicly available data on the College of Family Physicians website can provide details on location of education, year of graduation, and sex. This information can be used to identify communities that have a high percentage of providers who may be nearing retirement, or child-bearing ages who may need additional support to achieve their personal and professional goals. By tracking where providers were trained, there may be an opportunity to identify patterns of recruitment success, or identify physicians that may need additional BC-specific training (for example, on local first nation customs and practices to support cultural safety of care).

2. Clarifying (and possibly formalizing) the **chapter coordinator's role** within recruitment and retention of providers. The local coordinator role was identified as a strength for supporting a stable patient medical home by physicians as well as other system stakeholders who were interviewed. However, there were some opportunities identified to build upon this strength, including:
    - Creating a support package for local coordinators, that provides best practices in recruitment and retention, ideas for supporting new physicians, and also how to engage community partners in the recruitment and retention of providers.
    - With regards to engaging community partners, one example is to show the economic value of establishing a stable patient medical home for the community: by having enough primary care providers, a community is better able to attract and retain other professionals, therefore contributing to the overall sustainability of a rural community. Therefore, it can be viewed as a foundational responsibility of the whole community to ensure there are enough care providers (while currently the recruitment of new family physicians often falls to current physicians to replace themselves when they leave).
    - Sharing learning between chapter coordinators. Differing levels of comfort, understanding, and skills were reported between the different chapter coordinators. Enabling the sharing of best practices between chapters would support capacity building.
    - Continuing to build and develop relationships with health authority recruiters. In some regions this is occurring, however not all coordinators may be aware of the potential and value of this relationship.
    - Considering the five domains of support identified in this report to further refine opportunities for retention. Specifically, the area of social connection/family & personal needs was noted as a key area that the Division/chapter coordinators can help address due to being local and flexible in their ability to support providers.

3. Based on the provider survey, there are some programs that are less well known and utilized. **Increasing awareness of these supports** may be beneficial to providers. This could be done by increasing awareness of the Chapter coordinators of what is available and how it is accessed, and they can pass this information on to providers. Key programs that had low awareness or utilization included the RCCbc Physician Resiliency Program and Ministry of Health Physician Health Program (not rural specific).
   In addition, family physicians note that increased understanding of the different funding/ compensation supports could be helpful, for example clarifying what compensation they can expect each year, and where it is coming from.

4. **Refining role and responsibilities** in the recruitment and retention of family physicians between the different stakeholders, and potentially supporting these roles with "checklists" that can be a tool to ensure that consistent processes are being followed. Checklist examples included:

    a. Pre-arrival checklist for new providers. Components to consider include:
        - Whether the provider has a spouse/partner and what their needs are (job or otherwise)
        - Whether the provider has children
        - What their housing needs or expectations are

b. Reviewing local resources with a new provider this could be tailored based on what is learned from the pre-arrival provider check-in
    - Recreation opportunities
    - Listing of programs
    - Local history

System Improvements:

1. Improvement opportunities for recruitment of family physicians/NPs

Multiple interviewees noted that directed funding for recruitment within Divisions to support active recruitment of physicians and engagement with community and health sector partners would be a benefit. This would also include compensation to participate in regional or provincial recruitment committees to ensure equitable distribution of resources and transparency of processes.

Increased information/statistics reported from Health Match BC and health authorities to Divisions and chapters on recruitment efforts. Specific data requested by chapters included details on how many providers were recruited in the past year, where they started practicing, where they came from, how/why they chose their community, and any feedback to communities if they have not been able to recruit.

Promotion of recruitment and retention collaboratives, such as IPRR in the Interior and Vancouver Island recruitment and retention committee. This would also include incorporating more community-led collaboratives to support with recruitment of physicians.

2. Improvements for IMG & PRA programs

Several recommendations to improve the IMG & PRA programs were identified by interviewees. Additional clarity on the process from the receiving communities/practices perspective would be welcomed, as one physician commented "*There isn't a document saying 'You are getting a PRA. For more information on the program look down here. These are the steps to recruit them. These are the obligations of the health authority, the Division, the clinics, etc. Now that you have recruited, what do you do? Here are some steps along the way. If they ask questions you can connect to X or Y.'*"

Chapters would also appreciate more information on why IMGs are leaving (for example, personal or family needs, or do they not feel supported/welcomed), where do they end up practicing. More support for IMGs in training, orientation consistency, and 'selling' the benefits of rural practice were all identified as opportunities to increase IMG retention.

3. Improvement opportunities for retention

A number of interviewees noted that retention is often an overlooked aspect of stable patient medical homes, as many current "recruitment and retention" strategies are more focused on recruitment and drawing new talent, rather than on the current providers and meeting their needs to keep them in the area. Improved retention covers all five aspects of support identified in the report. Examples of retention tactics that relate to each area are included below:

Support Area	Retention Ideas identified by interviewees
 **Training/ Education**	- Ensuring providers have cultural competency training prior to practicing in rural locations. "*There's an expectation that people take cultural competency training, but no requirement that it's completed prior to practicing, especially in centres that have large indigenous populations*." – Division staff member - Train-the-trainer focus: to increase the number of sites that rural physicians can be trained at and reduce the burden on those sites that do the bulk of this work. - Extra training in emergency medicine was recommended to bolster confidence and skills in this area.
 **Medical System Support/ Navigation**	- Additional team-based care supports - Mentorship programs that link IMGs to colleagues who are not their preceptor, to provide a safe space to ask questions without feeling like they are putting their application to practice at risk. "*I wonder if there's a role for a mentor who isn't necessarily at the same site as you"* – rural physician
 **Practice Coverage**	- Maternity/parental leave was the most commonly mentioned support that rural physicians needed additional coverage for. Requests included additional time off covered, which is critical in areas that have few physicians and patients have no other options when one provider is off work. - Improved processes for covering unexpected time off for medical or other reasons. *"From a retention point of view, if there is unanticipated medical or social need, like a surgery, there'd be a gap in service. Physicians shouldn't be expected to give up vacation time to fill that gap."* – rural physician
 **Compensation**	- Exploration of different funding models (contract vs. fee-for-service) and how these relate to compensating physicians for comprehensive rural care (i.e., appreciates the additional skills needed to be a rural provider) - Ensuring contracts that rural physicians are signing are fair, especially for international physicians who may be more vulnerable. This could also be supported with additional resources to review contracts prior to signing. "*It's hard because you're in debt (finishing school) or maybe you're fleeing a bad situation. One person I met (during residency) was coming from [name of country removed], and* ***would probably sign anything"*** – FP on pitfalls of contracts. - Additional compensation available to cover maternity/parental leave, as well as maintaining access to rural benefits during maternity/parental leave (such as rural CME benefits).
 **Social Connection & Personal/Family Needs**	- Increasing community involvement in retention. Some examples include inviting providers to participate in softball/baseball teams, hosting dinners with other professionals, weekend pass to go kayaking or to a restaurant. *"Hospitality is extended to the new people, but forgotten for your current physicians, who may be feeling burnt out and would appreciate a "thanks for all you do""*- Rural physician. - Mental Health supports for physicians. Especially when there is a local tragedy, the family physicians have likely been on scene or had to support family members who were involved, and therefore could use a check-in to see how they are coping.

Conclusion

The pathways into Rural and Remote Division practices have helped shed light on how current physicians practice, what they like about rural family practice and where they face barriers. This has helped to identify 5 key areas of support that family physicians need in order to start and maintain a rural and remote practice: training/education, medical system support/navigation, practice coverage, compensation, and social connection/ personal and family needs. These domains can be used to assess current practices and identify areas for further improvement. The report has outlined key areas that the Division can consider to support its members, as well as system-wide improvements that can be advocated for.

Appendix A

There are a number of programs and services that have been developed to support physicians in rural practice. Appendix A provides an overview of these programs, and the organization responsible.

2.1 Rural Retention Program

Description: Family physicians who work in rural subsidiary agreement (RSA) locations get a bonus on top of their fee-for-service claims, depending on how rural/remote their community is classified. Interviewees shared that 20-25% of their income can be derived from this incentive.

Type of Support: Compensation

Responsibility: Administered by Joint Steering Committee on Rural Issues (JSC)

Strengths:

Interviewees valued the compensation from the Rural Retention Program and one mentioned that it meant for them income has never been a problem. Another mentioned that alongside MOCAP and REEF the RPP is a valuable piece of the rural compensation package.

Gaps/ Barriers to Use:

None mentioned.

2.2 Rural Locum Program

Description: The Rural Locum Program (RLP) provides support to physicians and specialists in rural communities to take leave from their practices for continuing medical education (CME), vacation, and health needs. To use the program as a physician you must practise full-time in an eligible Rural Practice Subsidiary Agreement (RSA) community with 7 or fewer general practitioners in the community (verified by the health authority each year) that's a minimum of 105 km from a major medical centre[6].

The RLP can assist physicians with requests for locum assistance, help locum physicians complete the application process, collaborate with health authorities in facilitating hospital privileges for locum physicians, make all travel arrangements for flights, car rental, and accommodations, provide an interactive website where host physicians can post locum opportunities; and locum physicians can review and request placement, and obtain feedback from both locums and host physicians upon completion of an assignment.

Type of Support: Practice Coverage

Responsibility: Locums for Rural BC

[6] Major medical centres are in Kamloops, Kelowna, Nanaimo, Vancouver, Victoria, Abbotsford, Prince George.

Awareness of program: Findings from the provider survey indicate widespread awareness of the program with 100% of respondents (22 of 22) reporting they are aware of the RLP.

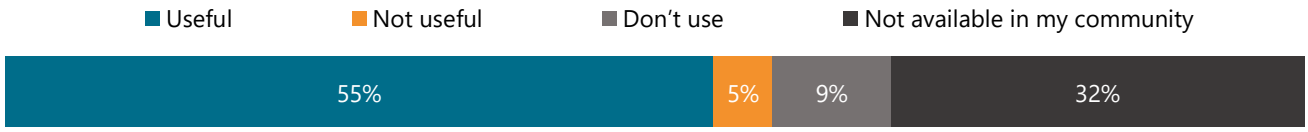
Strengths: It was seen as beneficial for both recruitment and retention of family physicians. On the recruitment side, the RLP is one way that physicians are exposed to rural practice as well as different communities. For one interviewee the RLP allowed them to visit and become familiar with several communities without taking on the cost of accommodation and travel.

On the retention side, interviewees report the RLP reduces physician workload by taking on the work of finding coverage for vacation and other time off.

> *"The rural locum program is essential for retaining physicians and recruiting them. People need to know they're going to find coverage for holiday time and isn't an extra burden on them. I think [the RLP is] the most important provincially led program to help grow communities with rural physicians."*
>
> - Rural physician

> *"The rural locum program helps keep new faces coming into the community to help with recruitment and support staff needs*
>
> - Rural physician

Figure 5: Just over half of survey respondents find the Rural Locum Program useful but nearly a third report it is not available in their community. (n=22, Do you find any of the following programs/supports useful?)



Gaps/ Barriers to Use: According to interviewees, some rural communities that are too large to qualify for the Rural Locum Program still struggle to attract a stable pool of locums. Physicians from these communities explained that they have had to compete with the RLP for locums and are disadvantaged because they may not be able to match the financial supports around accommodation and travel that the RLP provides.

Another gap identified by physicians is that long term maternity/parental leave is not covered by the RLP. Interviewees emphasized maternity/parental leave should be covered separately and not be drawn from the vacation time covered by the program. Doctors of BC does provide a maternity/parental benefit as a stipend but one interviewee noted that while this provides financial support, it does not help with finding coverage or recruiting a locum which the RLP could provide.

2.3 Rural CME Program

Description: The Rural Physician CME Program offers funding for rural physicians to meet their CME/CPD requirements.

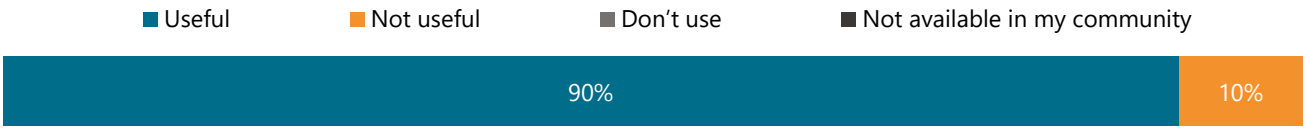
Type of Support: Compensation

Responsibility: RCCbc

Awareness of program: High

Strengths: Interviewees report that they see the CME funding being actively used in their community.

Figure 6: Over 80% of respondents report the Rural CME program/ funding is useful to them (n=21, Do you find any of the following programs/supports useful?)



Gaps/ Barriers to Use:

- While there is funding and training opportunities available, a gap is having time away from practice to take advantage of what is offered.

2.4 Rural Emergency Enhancement Fund (REEF)

Description: The Rural Emergency Enhancement Fund (REEF) is intended to support the provision of reliable, public access to emergency services in designated emergency departments in rural BC served by fee-for-service physicians.

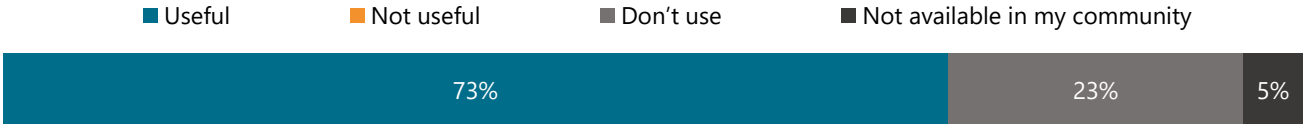
Type of Support: Compensation

Responsibility: Ministry of Health

Awareness of program: 100% of survey respondents were aware of the REEF (22 of 22).

Strengths: For one interviewee REEF amounted to a 16% top up given their rurality which to them was significant. Another interviewee explained how REEF removes disincentives to covering ER by compensating physicians adequately when they take a shift at the ER rather than going into their office.

Figure 7: Over 70% of respondents report that REEF has been useful (n=22, Do you find any of the following programs/supports useful?)



"Without REEF, people would say they can't afford to take a day off of the office [to be] in [the] ER or 'I can't afford to take [the] day off for being on call because I don't make money overnight.'"

- Rural physician

2.5 Rural Education Action Plan (REAP)

Description: The REAP program is intended to support the education and training of students/residents as well as rural physicians.

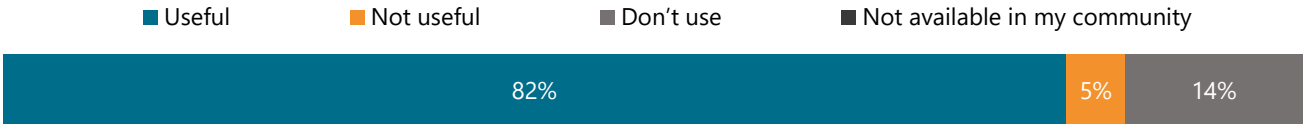
Type of Support: Training

Responsibility: UBC

Awareness of program: 100% of survey respondents were aware of the REAP (22 of 22).

Strengths:

Figure 8: **Just over 80% of respondents report the Rural Education Action Plan is useful to them** (n=22, Do you find any of the following programs/supports useful?)



Gaps/ Barriers to Use: One interviewee mentioned that the kinds of education opportunities REAP supports could be better communicated. The same interviewee also mentioned that REAP doesn't support surgery medicine. Another interviewee suggested REAP strengthen its relationships with UBC, UNBC, SMP, IMP and DSMP.

2.6 Physician Resiliency Program

Description: The Physician Resiliency program is intended to connect FP/NPs with mentorship (formal and informal), peer support, coaching, leadership, counseling, role modelling, educational programs.

Type of Support: Social connection

Responsibility: RCCbc

Awareness of program: Just over half of respondents were aware of the PRP program (55%, 12 of 22). The lowest level of awareness of the seven programs[7] surveyed in the member survey.

Strengths: While awareness and usage of the PRP is relatively low, all of the respondents who used the program said it was useful.

Figure 9: **Of respondents who knew about the PRP, 84% of respondents don't use it** (n=12, Do you find any of the following programs/supports useful?)

Gaps/ Barriers to Use:

Survey findings suggest there is relatively low awareness of the PRP and that among those who know of the program usage is low.

2.7 Health Match BC Services

Description: Health Match BC (HMBC) is a free health professional recruitment service funded by the Government of British Columbia. HMBC staff attend events, advertise digitally, research attraction methods,

[7] Rural Locum Program, Rural CME program/funding, RCCbc, REAP, REEF, PRA/IMG, Health Match BC, Division Recruitment Coordinator, Health Authority recruiters, Community Foundation, and Town Council.

and work to recruit physicians to BC. HMBC marketing is conducted internationally, such as in the US and UK, and highlights BC's quality of life.

Type of Support: Medical System Support/Navigation (Recruitment)

Responsibility: Health Match BC

Awareness of program: 83% of survey respondents who were involved in recruiting additional FP/NPs to their community (5 of 6) were aware of Health Match BC.

Strengths: IMG interviewees praised the HMBC's support as they relocated to Canada. One emphasized the value of the HMBC website especially as a platform to scan job postings across the province. Two talked about how HMBC provided valuable support at various stages of their relocation. HMBC helped them with paperwork, talked with them about the different communities they were thinking about moving to and provided insights on living in Canada. Interviewees also talked about how HMBC helped connect them to recruiters or community physicians which helped them better understand the community and whether they were a good fit.

A local physician said that HMBC was doing a good job connecting with their local Rural and Remote Division. They have seen HMBC feed candidates, including foreign grads, to their local Division whose staff could then make connections between those candidates and potential clinics.

Figure 10: 60% of respondents that were involved in recruiting new FP/NPs have found HMBC useful (n=5, Have you accessed any of the following services to support with recruitment?)

"When I was looking at jobs I was [outside Canada], I went on Health Match BC website and that worked well. It was very easy for me to make short list of places I wanted to work."

- Immigrant Rural physician

Gaps/ Barriers to Use:

One challenge for HMBC is trying to be proactive and able to match a FP/NP to a community before the need for a FP/NP in that community becomes acute. One interviewee explained that often HMBC learns about a vacancy for the first time when the opening is posted on their system. However, when vacancies are posted the need in the community is often already acute and from the time of the posting it could take 3-4 years to get a physician into that position. They also mentioned physicians often don't tell people when they'll retire or leave a community which makes it hard to try to plan ahead to fill the future vacancies.

Currently HMBC staff connect with the RRDoFP and communities to do some of this planning. With RRDoFP at quarterly meetings to talk about where the needs are and at those meetings trying to see where they can get ahead of vacancies. That said, one interviewee explained that it would be worth taking more time with the Division to map out the needs of different communities and put together a strategic plan.

According to one interviewee creating generic postings for FP/NPs in a region or set of communities, something already done for nurses in some communities, might be a way to draw physicians to an area before an acute need arises. The same interviewee explained HMBC usually advertises a specific opening or contract rather than for primary care positions in an area generally.

Another challenge is that if HMBC doesn't have a complete picture of the attachment gap in different areas it cannot use that information to advertise to FP/NPs looking to set up a practice and build a patient panel. One interviewee discussed how that information doesn't necessarily have to be shared through something formal, like an attachment forecasting report, but could also be gathered through more conversations between HMBC and local communities.

Getting feedback after a candidate turns down a position was a challenge that interviewees identified HMBC might be positioned to help address. One interviewee who was using HMBC to try and fill a position in their community explained that if a candidate ultimately decides not to come to the community, they don't have a way of learning why they that made that choice. They recommend that HMBC produce a report to give back to a community after a candidate turns down a position so that the community can better understand if there are changes they could make to better attract candidates in the future.

2.8 Practice Readiness Assessment BC

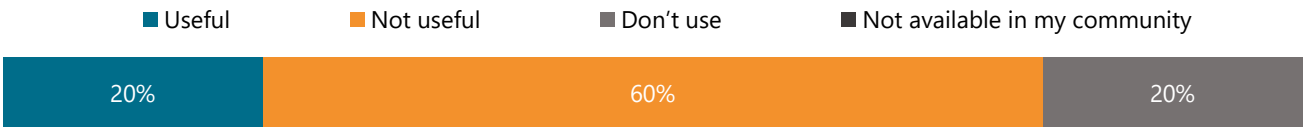
Description: The Practice Readiness Assessment (PRA) program is an assessment program for internationally educated family physicians who have completed residencies in Family Medicine outside of Canada. It provides qualified family physicians with an alternative pathway to licensure in BC.

Type of Support: Training

Responsibility: The College of Physicians and Surgeons of British Columbia and the Joint Standing Committee on Rural Issues

Awareness of program: 83% of survey respondents who were involved in recruiting additional FP/NPs to their community (5 of 6) were aware of the PRA.

Figure 11: 20% of respondents that were involved in recruiting new FP/NPs found the IMG/PRA program useful (n=5, Have you accessed any of the following services to support with recruitment?)



Gaps/ Barriers to Use: Some interviewees reported problems with unsuitable IMGs coming to communities or IMGs immediately leaving the community when their return of service was up.

One IMG interviewee mentioned that the current PRA could be more streamlined and they said that the current full registration could be pared down.