South West **LHIN** | **RLISS** du Sud-Ouest

Grey Bruce Health Forum Report

April 2019

HealthForceOntario

Schulich MEDICINE & DENTISTRY Western

Ontario

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Executive Summary

Grey Bruce, the most northern and rural Sub-Region of the South West LHIN struggles with the delivery of primary care services due to an ongoing shortage of health human resources, namely primary care physicians.

The South West LHIN and HealthForceOntario committed to hosting a Forum on April 9, 2019 in Owen Sound to bring together participants key to designing and implementing change to support rural recruitment that will meet the needs of the region.

The Rural Roadmap for Action[1] states that the health care needs of rural communities is optimized by five partners working together to plan and recruit needed Health Human Resources. These five partners include: policymakers, university, health and education administrators, and health professionals, physicians, and teams. Approximately 70 participants attended the Grey Bruce Health Forum, representing all five of the key partners.

This Forum is our collective start at tackling the persistent issue of adequate physician recruitment and retention in Grey Bruce.

The inaugural Forum started with an emphasis on physicians as they are essential for delivering rural hospital services in Grey Bruce. Delivery of primary care and recruitment efforts have been focused on physicians and Grey Bruce has traditionally struggled to recruit and retain an adequate supply. A review of the current landscape, including medical education, primary care physician and interprofessional health team distribution, recruitment efforts and locum program usage was presented. Team care, utilizing health care professionals and teams (Family Health Teams, Community Health Centres, Nurse Practitioners, Registered Nurses, Registered Practical Nurses, and Physician Assistants) to their full scope, and other best practices were brought forward as potential solutions. The workshop allowed participants to reflect on the current situation and to look for solutions that may bring more stability to the region.

Key themes and priorities were highlighted by participants with the intent that a task force will emerge to move the priorities forward to address primary care recruitment and retention challenges in Grey Bruce.

Background

Grey Bruce, the most northern and rural Sub-Region of the South West LHIN struggles with the delivery of primary care services due to an ongoing shortage of health human resources, namely primary care physicians. Currently there are 105 physicians providing comprehensive care. An additional 66 family physicians work in hospitals as locums or in focused practices. Most communities or hospitals are engaged in physician recruitment by financially supporting recruiters, offering incentives, or providing capital for clinics. There is disparity across the region in access to resources. It has been suggested that Grey Bruce look to regional strategies to improve the success rate of recruitment and retention and innovations in primary care delivery in order to sustain and enhance the delivery of primary care services now and in the future.

Action

The South West LHIN and HealthForceOntario committed to hosting a Forum on April 9, 2019 in Owen Sound to bring together key participants to design and implement change to support rural recruitment that will meet the needs of the region.

The Rural Roadmap for Action[1] states that the health care needs of rural communities is optimized by five partners working together to plan and recruit needed health human resources. Knowledge of the current environment and best practices will be shared while allowing participants to bring their expertise and a new understanding of the issues and opportunities to the group. These valuable discussions will help to develop solutions that can be implemented locally.

Participants

Over 70 key stakeholders attended the Forum. Representatives from all five pentagram partners participated:

- University – Schulich School of Medicine & Dentistry, Rural Ontario Medical Program (ROMP), and McMaster
- Health and Education Administrators – Family Health Team (FHT), Community Health Centre (CHC), Aboriginal Health Access Centres (AHAC), HealthForceOntario (HFO), Long Term Care (LTC), Community Support Services (CSS), Local Health Integration Network (LHIN), and hospitals
- Health Professionals – Physicians, Nurse Practitioners, and teams
- Community – Recruiters, patients, and mayors
- Policymakers – Members of provincial Parliament (MPP), LHIN

Objectives

1. Develop a shared understanding of the health human resource challenges and needs of the communities in Grey Bruce. The focus will be on family physician resources.
2. Explore and discuss innovative models with the purpose of designing and implementing strategies that will create and sustain a workforce and services tailored to community and population needs.
3. Commit to strategies (immediate, short, medium and long term) that are within the control of organizations and people attending the Forum and that will address the health human resource needs.

Presentation Summaries

The Grey Bruce Health Forum opened with an Indigenous land acknowledgement and Francophone welcome.

Grey Bruce Health Forum: Ensuring a Primary Care workforce to meet the needs of Grey Bruce – Dr. Keith Dyke, Grey Bruce Clinical Lead, South West LHIN

Introductions and a review of the emerging themes around barriers to primary care recruitment and retention, as reported by participants were presented. The major themes identified by participants include the role of medical education in recruitment of new physicians, physician workload in rural practices, the issues of attracting new physicians to rural communities and the lack of a regional recruitment strategy in Grey Bruce.

Perspectives on Rural Generalism – Dr Peter Wells, Rural Ontario Medical Program

While the majority of Canadian geography is rural, there is a disparity in the number of physicians that are trained for and locate in rural areas. Rural communities need generalists, but there is a trend toward increasing specialization and mentorship in urban centres.

Rural communities need to involve everyone: doctors, hospital administration, municipal leaders, and community members (patients) to recruit and retain the health workforce they need. Train learners locally, connect with medical schools to showcase your communities, collaborate, be innovative and persistent to ensure your needs are being met.

Dr. George Kim, Dean Distributed Education, Schulich School of Medicine and Dentistry – Distributed Medical Education and Recruitment

Medical education must understand the direct needs of their communities when it comes to the training of future physicians. As a main part of a healthy health human resource pool for many communities, having physicians that understand the needs of patients and their families in the communities that they live is essential in supporting the development of the physician resource. A number of expert opinions from the *Future of Medical Education in Canada* (2015) from the Association of Faculties of Medicine to the Rural Road Map (2018) endorsed by the College of Family Physicians of Canada and the Society of Rural Physicians of Canada support the critical direction of medical schools to fully partner with their local communities in the training of physicians.

Community engagement as early as possible will ensure that a steady flow of trainees from across the learning life cycle will experience first-hand the richness of clinical practice in communities of all sizes.

Medical schools must not just engage but involve our community partners in the full spectrum experience of medical education. Our community partners can assist in the training by supporting their local community of physician teachers as recruitment is only as successful as retention.

Physician Supply and Local Need in Grey Bruce – Jane Tillmann, Regional Advisor, HealthForceOntario

There are currently 105 family physicians providing comprehensive care in 18 communities throughout Grey Bruce. 70% of physicians have access to team care resources. Six of the 18 communities and their physicians do not have access to team care resources. Family physicians are essential to staffing the 11 Emergency Departments throughout the region. This is an ongoing challenge and requires support from the Emergency Department Locum Program (EDLP) financed by the Ministry of Health and Long Term Care (MOHLTC).

While there is no firm data on the number of patients needing a family physician, data from HealthCareConnect and individual communities indicate that almost every community in Grey Bruce is currently in need of additional or replacement physicians.

I love it here – Dr. Shaun Dooley, Owen Sound physician

Dr. Dooley chose Owen Sound to practice over urban centres. A rural or small centre is often associated with misconceptions; including lack of culture and things to do, distance from the city, a perception that it is not a good place to raise a family, as well as a lack of medical supports such as specialists. Dr. Dooley dismissed these misconceptions and provides the rationale of why he chose Owen Sound and what recruiters and communities should focus on to encourage new physicians to establish practices in the area.

Team approach in a time of crisis - Gerry Glover, CEO, Kincardine Family Health Team

The community of Kincardine was faced with a sudden loss of three physicians resulting in 3500 patients losing their physician. Multiple stakeholders came together to create a short and long term plan to ensure that patients were cared for until new physicians could be recruited to the community. Working with the Kincardine physicians, Family Health Team (FHT), hospital, recruiter, municipality and HealthForceOntario, various strategies were implemented to ensure continuity of care.

The tenets of this successful strategy were: Avoiding physician burnout, Emergency Department diversion for conditions best managed in primary care, utilization of Nurse Practitioners (NP) in place of family physicians, maintenance of the standard of care, transparent communication with the community, and a recruitment ready plan. An in-depth explanation of how the strategy was deployed and the success results were presented.

Northwestern Ontario Health Recruitment Association (NOHRA) - Jamie Sitar, Regional Advisor, HealthForceOntario

The North West LHIN, with a population of 236,000 and the largest land mass of all the LHINs, has unique physician recruitment challenges. Chronic physician shortages throughout the region instigated the need to look at how recruitment is done. Each community had its own strategy which was inconsistent across the region. Resource allocation and physician experience through the recruitment phase varied widely. The scarcity of physicians and high cost of recruitment led to a competitive and protective environment. In order to improve the results of recruitment efforts, the NOHRA was founded in 2018. The association aims to improve recruitment results by aligning resources and best practices and to work with health providers interested in the region to find the right fit for improved recruitment and retention results.

Regional Locum Approaches - Kevin McLeod, Regional Advisor, HealthForceOntario

Grey Bruce depends on locum physicians to ensure delivery of primary care whether as respite for family physicians in their clinics, in the hospital or as a stop gap where there are no local physicians to provide coverage. Traditionally individual communities have recruited for their own locums. There may be strategic recruitment advantages to look at the locum pool from a regional perspective. Kevin explores the data behind locum use and how HealthForceOntario jobs can now be used to encourage locums to stay in a region by booking multiple neigbouring communities.

A New Digital Connection to Quality Improvement and Office Efficiencies - Dr. Paul Gill, Digital Clinical Lead, South West LHIN, Clinical Lead, Huron Perth

Digital advances can help to address the issue of physician workload and burnout in rural areas. There are an overwhelming number of products and agencies that physicians need to know about and connect with to optimize patient care and office efficiency. This takes time and expertise, and if not optimally organized can lead to further frustration by the physician, and poor uptake or quality. The South West LHIN has formed the Digital Coalition (DC) to support the development of digital health human resources to begin addressing capacity, quality and consistency issues identified regionally. In addition, the DC will assist in the deployment of regional digital health priorities such as: imbedding referral forms into Electronic Medical Records, and supporting the deployment of digital tools (such as eConsult and MyChart).

Pre-Forum Work: Barriers to Primary Care Recruitment and Retention in Grey Bruce

In preparation for the Grey Bruce Health Forum, participants were asked to describe the main barriers to recruitment and retention in Grey Bruce. From these responses, four main themes emerged:

1. **Medical training**
   There is a need for more physicians to be trained rurally and comprehensively so that they are prepared and confident in their skills as generalists. Potential strategies included: linking training and recruitment, reflecting on the changing needs of a new generation of physicians, and ensuring that residents interested in rural practices get to train in Grey Bruce.

2. **Physician wellbeing: supportive practice environment, workload**
   As a region, Grey Bruce has been chronically underserviced with physicians, creating a workload that may be unsustainable. Ensuring that the current workforce is supported and healthy is key to long-term delivery of primary care in our region. Team based care, digital solutions and system navigation support were suggested as tools to support a healthy and optimal practice for both physicians and patients.

3. **Rurality**
   Rural living has its challenges: lack of employment for partners, geographic isolation, and housing and facility needs. However, there are many positive aspects that, as a region, Grey Bruce can capitalize on.

4. **Regional/Systemic recruitment strategy**
   Of all the Sub-Regions in the South West LHIN, Grey Bruce is the most active when it comes to physician recruitment. Financial incentives both provincially and locally have been a mainstay of recruitment efforts. Is this a time to look at what can be done differently? Do incentives work? Does competition between communities help or hinder recruitment to the region and what would a regional plan look like?

Workshop Activity: Priorities and Themes

The Rural Roadmap for Action[1] recommends including five core partners in the planning and recruitment of health human resources: Policymakers, University, Health and Education Administrators, Health Professionals, Physicians and Teams, and Community. Table assignments for the Grey Bruce Health Forum ensured the best possible cross representation of these partners at each table.

Below are summaries of the main themes and priorities that emerged from the workshop discussion. Please see Appendix C for a complete summary of recommended actions from the activity.

What are some suggestions to promote and recruit primary care providers in our region?	
Emerging themes	• Consider a regional recruitment strategy • Education and training • New recruitment strategies • Payment and funding for health professionals • Infrastructure • Rural life attributes • Supportive practice models for family physicians • Digital solutions

How do we retain primary care providers in Grey Bruce?	
Emerging themes	• Supportive practice models for family physicians • Physician wellbeing • Community partnerships • Payment and funding models for health professionals • Education • Retention strategies • New provider integration

Participant Feedback

The majority of survey respondents (N=41) indicated that the Grey Bruce Health Forum met or exceeded their expectations.

Top three most helpful things about the Forum:

1. *Networking*
2. *Dr. Kim's presentation*
3. *Break-out Session/Strategic placement of skill-set at each table for group exercise*

100% of respondents stated that they:

- learned something new that they could apply in their work, community, or team setting; and,
- would like to see this Forum offered again in the future

Opportunities for improvement:

- recruitment and retention plans (i.e. Goderich plan)
- implication of Ontario Health Teams
- more physician attendance
- impact of allied health recruitment/retention on primary health care
- Missing from Forum: youth, public health, nursing
- Follow-up from Forum and update on implementation

Recommendations

The following recommendations are based on outcomes from the Grey Bruce Health Forum 2019.

1. Develop a task force to move priority actions forward
    a. Create Terms of Reference
    b. Commit to strategies (immediate, short, medium and long term) that are within the control of organizations and people attending the Forum, and that will address the health human resource needs
2. Plan for Forum follow-up
    a. Continue primary care health human resource discussion, i.e. leverage existing platforms to allow participants to interact and continue discussions started at the Grey Bruce Health Forum
    b. Organize future Forums or engagement sessions
    c. Address opportunities for improvement, as per participant feedback

References

1. Advancing Rural Family Medicine: The Canadian Collaborative Taskforce. (2017). *The Rural Road Map for Action – Directions.* Mississauga, ON: Advancing Rural Family Medicine: The Canadian Collaborative Taskforce. Retrieved from: https://www.cfpc.ca/uploadedFiles/Directories/Committees_List/Rural%20Road%20Map%20Directions%20ENG.pdf
2. Northern Physician Resources Task Force. (2018). *Building a flourishing physician workforce: Summit North 2018.* Retrieved from: https://www.nosm.ca/our-community/nprtf/building-a-flourishing-physician-workforce-summit-north-2018-full-report

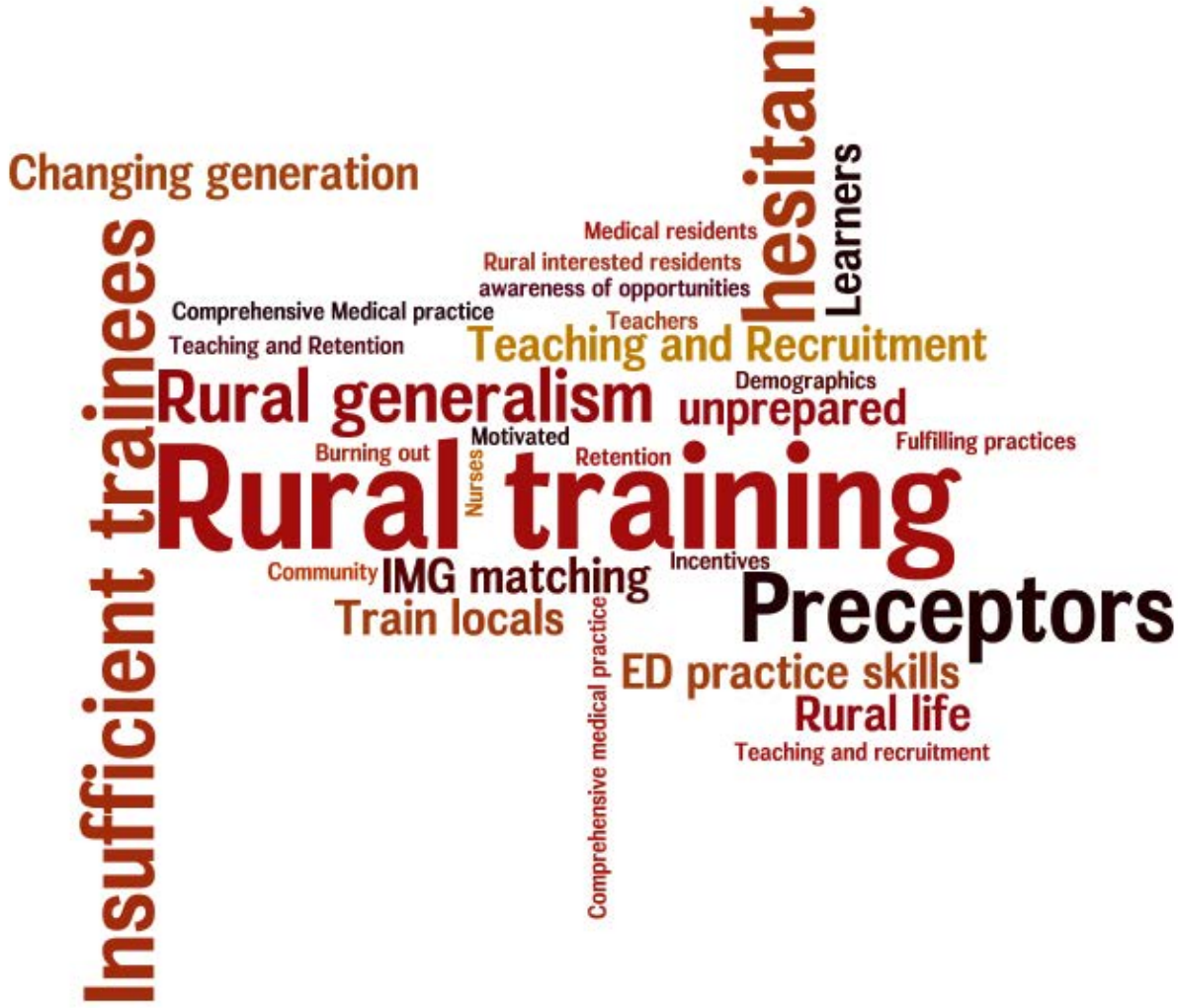
Appendices

Appendix A: Agenda

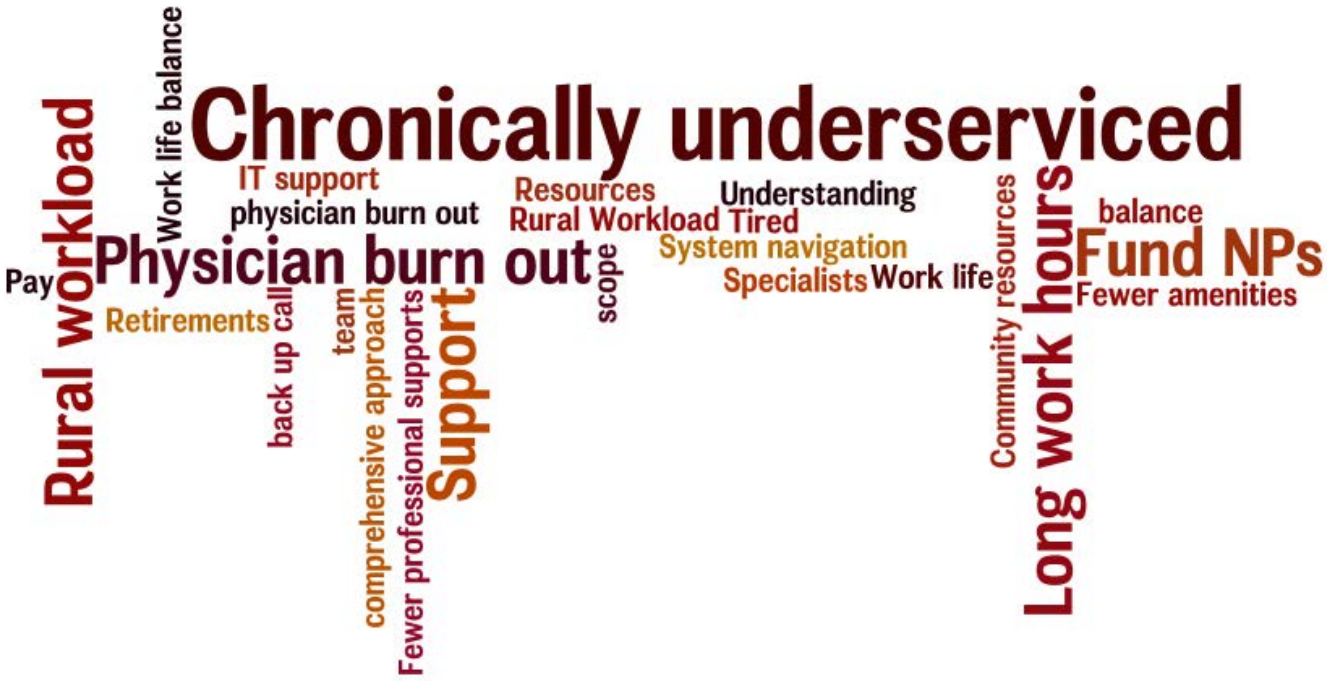
Time	Topic	Presenter(s)/Facilitator
9:30 – 10:00	Registration	Bay Room, Bayshore Community Centre
10:00 – 10:10	Introduction	Dr. Keith Dyke, Grey Bruce Clinical Lead, South West LHIN
10:10 – 10:25	Welcome	Renato Discenza, CEO, South West LHIN
10:25 – 10:45	Perspectives on Generalism in Rural Practice	Dr. Peter Wells, Executive Director, Rural Ontario Medical Program
10:45 – 11:45	Distributed Medical Education and Recruitment	Dr. George Kim, Dean Distributed Education, Schulich School of Medicine and Dentistry
11:45 – 12:00	Physician Supply and Patient Need in Grey Bruce	Jane Tillmann, Regional Advisor, HealthForceOntario
12:00 – 12:45	**Lunch**	
12:45 – 1:00	"I love it here!"	Dr. Shaun Dooley, Owen Sound
1:00 – 2:00	Innovative Practices Panel	• Gerry Glover, Executive Director, Kincardine FHT • Jamie Sitar, Regional Advisor, HealthForceOntario • Kevin McLeod, Regional Advisor, HealthForceOntario • Dr. Paul Gill, Digital Clinical Lead, South West LHIN
2:00 – 2:15	**Break**	
2:15 – 3:30	Solutions for Grey Bruce	Jennifer Kehoe, Grey Bruce Health System Planner, South West LHIN
3:30 – 4:00	Wrap-up and next steps	Samantha Colwell-Castles, Director Integration and Planning – Grey Bruce, South West LHIN

Appendix B: Pre-Forum Emerging Themes

Medical Training



Physician Wellbeing: Supportive Practice Environment, Workload



Rurality


Partner employment
Isolation
Community resources
Family supports
Collegiality
Lack of candidates
Travel
Access to Supports
Lifestyle
Social Networks
Cultural diversity
Access to supports
Geographic isolation
Rural living
Team supports
Government funding
Resources
Technology
Transportation
Financial
Infrastructure
Medical facilities
Housing
Specialist supports
Recreational facilities

Regional/Systemic Recruitment Strategy

Appendix C: Forum Workshop Themes and Priorities

Note: Suggestions prioritized by the tables are highlighted in yellow

What are some suggestions to promote and recruit primary care providers in our region?

Payment

- HOCC bundling for regional sites (2)
- $ Platforms – EDLP/NRRRI
- NP Support
- Need to compensate local doctors more so that locums and emergency department only docs commit to family practice and communities
- Benefits for physicians
- Standardize funding models in team based care – some have funding some do not
- Invest in Nurse Practitioners/ support staff
- Provincial funding for Nurse Practitioner program
- Funding and collaboration between hospitals and primary care
- Compensation
- Funding model choices
- Standardize wage/pay grid
- Municipal or Ontario Health Team funding

Regional Recruitment Strategy

- Recruiters should get together and create a regional repository
- Need a whole village – A standardized regional strategy
- Manpower to develop a strategy and focus
- Regional promotional tools
- Annual match making tool – single source of truth for who does staffing in entire region
- Survey possible candidates – what are they looking for – can we identify a match
- Recruiters meet more often and work collaboratively
- Inventory of Health Care Resources from all communities (2)
- Coordinated regional effort or community recruitment
- Make it more than just incentives – promote the area as the place to be
- Regional job bank
- Recruiters working more collaboratively together
- Regional human resources recruitment
- Group of physician champions (peer support) within region
- Have practices available - choice
- Regional strategy on-going man power
- Common material development i.e. ROMP: data catalogue
- Physician wish list/characteristics shared regionally
- Framework/network developing – opportunities to lead/innovate

- Better communication between community health centres and local providers (sharing students)
- Regional Locum Pool

Infrastructure

- High speed internet throughout Grey Bruce
- Town to support learner needs with accommodations
- Established infrastructure
- Housing – locum housing, shared housing for support
- Affiliated with rental support
- Growing communities, political support and access
- Two hospital groups/One independent hospital
- Invest in facilities
- Invest in high speed internet

Education and Training

- Upstream engagement – get to the students at the beginning of the cycle
- More rural residency positions
- Promote Indigenous Health rotations
- Business piece in school is missing
- Start recruiting early in training process and continuing throughout
- Find more physicians to take on medical students/residents (4)
- Increase capacity to help physicians teach
- Decentralized education model – local delivery
- Support for learner rotations in community where capacity is limited
- Shared education committee
- Get involved in education at different levels
- Allow Canadians studying abroad to do residency in local communities with a return of service
- Medical schools should take more rural students
- Increasing number of residencies (2)
- More local supports for medical education
- Increase contact with students
- Match trainees with the community and skill sets needed
- More flexibility/control by region on selecting candidates
- Fellowship programs for Obstetrics/Emergency department training to support rural practices
- Partner with other groups/sectors – collaborative approach to mentoring and teaching for residents
- Emergency department mentorship opportunities
- Get involved in Discovery Week
- More spots open for applicants to programs from underserviced areas

Rural Life

- Spousal employment opportunity
- Selling the lifestyle – work with Counties to partner and promote our area marketing
- Promote Community – Environmental Scan
- Highlight lifestyle, culture, recreation and community life
- Connectivity – medical/social/cultural
- Lifestyle (2)
- Social activities/networking Forums
- Cost of living
- Family friendly, healthy environment
- Spousal/Family support (3)
- Spousal employment opportunities

Recruitment Strategy

- High school students – promotion of health careers, co-op rotations to expose to other areas in hospital
- Leverage those health care providers who have lived the experience – what brought and kept you?
- Develop from within region
- Turnkey practice
- Support local students going to medical school to come back to the area
- Get to population of possible physicians early – like MedQUEST
- Get community members involved – what does the community need?
- Attendance at recruitment events
- HealthForceOntario ads on website
- Work with recent recruited physicians to encourage potential recruits
- Leverage current health care professional experience
- Start-up support
- Recruiting a family, not just a physician
- More help at start-up – i.e. billing/administration
- Orientation/welcome days (2)
- Local scholarships
- Support locals going to medical school
- Promote hospital more to keep emergency department going
- What supports are available around them (orientation), i.e. Public Health
- True turnkey – what's included in practice
- Engage local community
- Build a system where you can come and join a community
- Include more than just physicians – registered nurses, personal support workers, nurse practitioners
- Get into the schools and provide bursaries

Practice Models

- Specialists available – supports/programs
- More team services – i.e. nurse practitioners and specialists
- Nurse Practitioner functioning as stop gap funding
- 55% of physicians are female – female care providers can't work same hours as males (maternity leave) need to think about this – how do we support this?
- Practice management supports – knowledge that it is there
- Better work/life balance for emergency department/family physicians
- Better communication/education to doctors about what the family health team staff can do; including realistic expectations of full team working to scope
- Decrease workload to aid in increasing experience
- Improve integration of system – electronic medical record, communications, etc.

Digital Solutions

- One electronic medical record – streamline
- Digital supports – make practice more appealing

How do we retain primary care providers in Grey Bruce?

Practice Models

- Team-based care – better use of resources, less burnout
- Diversity of care within team
- Access to specialized services – i.e. nurse practitioners with gerontology, occupational therapists
- More mental health and addiction support, personal support workers, home care, allied health
- Shared care i.e. inpatients/obstetrics
- Robust health care system that supports the physician – work well as a system in Grey Bruce with navigation support
- Team based care for all
- Regionalization of team supports
- Sharing or creating more access to allied health
- Disparity in team based care
- Opportunity for regionalization – i.e. really evaluate emergency department usage
- Support the physicians ability to practice, i.e. access to mental health services, specialist referrals, resources in the emergency department
- Community based setting
- More nurse practitioners and other primary care physicians
- More robust integrated, consolidated electronic medical record and patient portal with IT support – improve population health capabilities

New Provider Integration

- Training about community and regional services
- New primary care provider orientation to support engagement

- Community supports to insure integration
- Listening to physician's practice wants (accommodate)
- Welcome/support/orientation/community engagement

Physician Well Being

- Planning for various phases of their life – early family, later in life, etc.
- Surround doctors with more support – teams, practice management, back office; billing, information technology, human resources
- Work life balance focus
- Emergency department back-up solutions
- Respite/vacation/sabbatical relief/coverage
- Consider partner input/needs
- Support life cycle of physician in our communities – stages of practice
- Stipend/relief coverage for primary care
- Flexible work models (.5 FTE vs 1 FTE) to accommodate family, etc.
- Hospitalist program – Emergency department: big stress and many vacancies, more options on how to obtain and to prevent burn out
- On-call frequency options
- Be aware of and support the life cycles and life changes throughout physician career
- Social events – team building
- Doctor appreciation
- Spousal/family support
- Social integration for physician and family
- Like the people you work with improves the functioning of a team
- Evening and weekend solutions
- Promote benefits of being a generalist but support so not burn out

Payment Models

- Nurse practitioner funding – long term operating stability
- Standardized pay grid remuneration for physicians and regulated health professionals
- Standardized pay grids
- Legislation/policies to match funding models, i.e. Long Term Care Home, Registered Nurse/Registered Practical Nurse per beds
- Equitable considerations and compensation

Community Partnerships

- Investing in communities/infrastructure – schools, pools, facilities, etc.
- Making the connection with physician and family; trips to do fun stuff
- Good services and family support – working with the municipalities
- Rural areas function better with connections and solid relationships
- Create a social network
- Selling lifestyle – promoting area with municipalities

- Good social network to offset isolation
- Create Medical Advisory Committee (MAC) region-wide with community based support
- Family settles into community
- Promote local culture
- Have passes to activities to show them different things to do
- Share or reduce electronic medical record cost
- Commitment of community/political/ organizational
- Turnkey practices (i.e. no overhead, infrastructure set up) – physicians do not want to be business person – want to provide care
- Hospital/capital investments
- Reduce isolation
- Social events
- Physician events – dinner/drinks
- Enhance cultural ties
- Promote the area more
- Physician appreciation events
- With IT advances, funding is an issue – potential for community/business support?

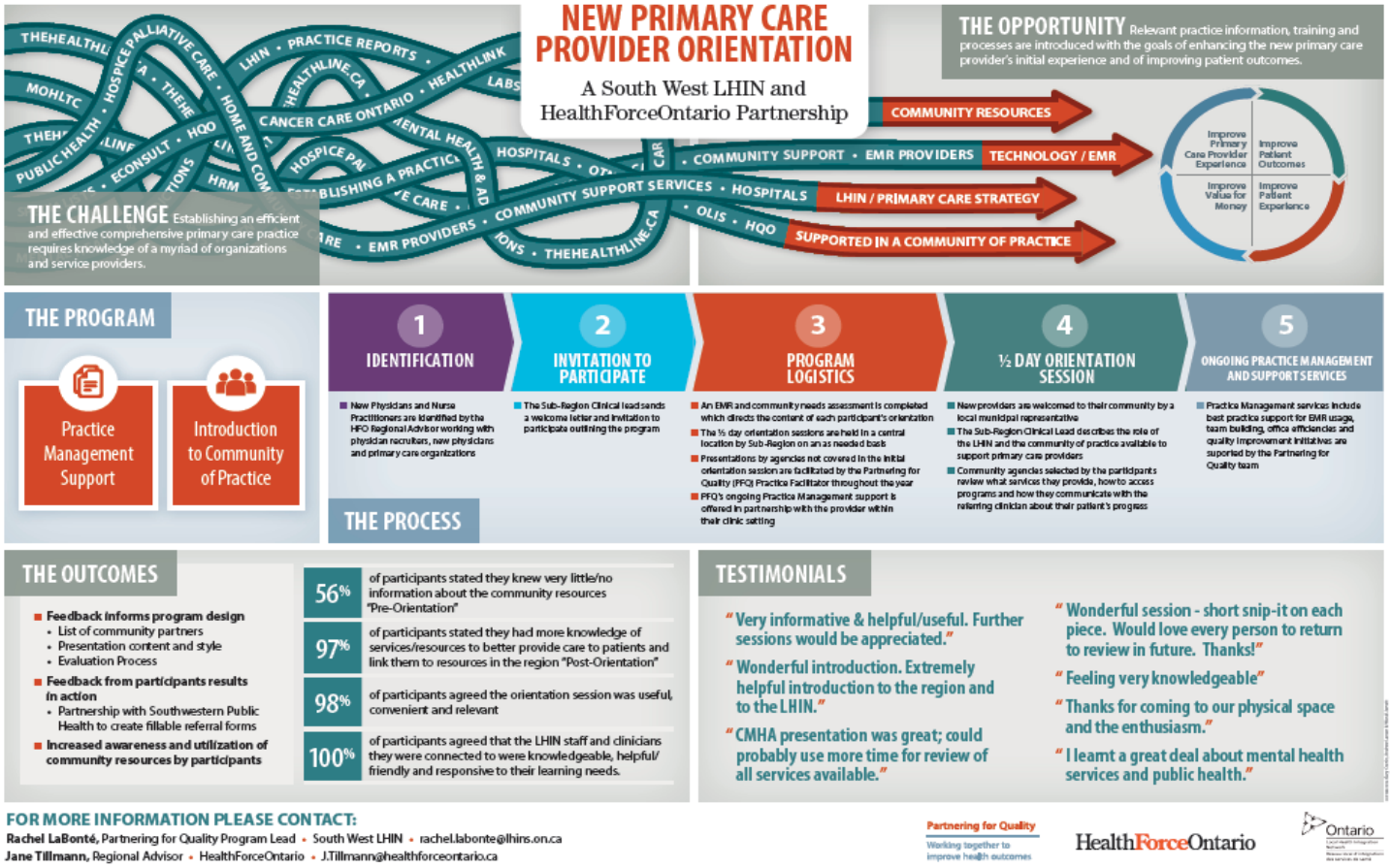
Education

- Educational opportunities/ preceptorships/research
- High risk obstetrics – ongoing education as a group, regional continuing medical education program
- Professional development closer to home – more robust
- Physician education/leadership fully paid for
- Continuing medical education events – Grey County Medical Society
- Educational support: financial enablers/support for education, e-learning

Retention Strategies

- Succession planning and ongoing recruitment
- Job is not done after recruitment – need incentives for retention – consult and include current practitioners with meaningful engagement
- Annual stipend or other financial incentive
- Long term vision/direction to avoid crisis
- Collegiality – involve with retention/recruit
- Governance, funding roles, defining results on recruitment and retention
- Better understanding of multigenerational mindsets – values of Gen X, Z etc.

Appendix D: New Primary Care Provider Orientation



Appendix E: Glossary of Terms

1. **FHT** – Family Health Team - A Family Health Team (FHT) is an approach to primary health care that brings together different health care providers to co-ordinate the highest possible quality of care. Designed to improve and expand access to primary care, most Family Health Teams consist of doctors, nurses, nurse practitioners, social workers, dietitians and other health care professionals who work collaboratively, each utilizing their experience and skills so that you receive the very best care, when you need it, as close to home as possible. http://www.health.gov.on.ca/en/pro/programs/fht/fht_understanding.aspx

2. **CHC** – A Community Health Centre (CHC) delivers primary care services in combination with health promotion and illness prevention services. In addition to promoting the health of individuals and families, CHCs mount initiatives that address social, economic and environmental problems negatively impacting people's health. https://www.allianceon.org/community-health-centres
3. **NP** – Nurse Practitioner - A nurse practitioner (NP) is a registered nurse with advanced university education who provides personalized, quality health care to patients. Ontario nurse practitioners provide a full range of health care services to individuals, families and communities in a variety of settings including hospitals and community based clinics in cities and smaller towns in Ontario. We work in partnership with physicians, nurses and other health care professionals such as social workers, midwives, mental health professionals and pharmacists to keep you, your family and your community well. https://npao.org/about-npao/what-is-a-np/
4. **RN** – A registered nurse (RN) has received several years of schooling and has also earned a four-year bachelor's degree in nursing from an Ontario university. Registered nurses have extensive knowledge in their field, which allows them to help patients with more complex health issues. Registered nurses provide care in many establishments, such as hospitals, emergency crisis centres and emergency rooms, clinics, etc. Registered nurses may also decide to specialize in a field of their own choosing, however, specialization is voluntary. Common specializations include neonatal, gerontology, emergency care, and community health. https://rnao.ca/about/types-nursing
5. **RPN** - Registered practical nurses (RPN) are college-taught professionals who use their skills, education, and common sense to assist patients with general or straightforward health conditions. Registered practical nurses commonly work in hospitals, schools, clinics, and the community to provide safe and general care to people of all ages. While they study from the same source of knowledge as registered nurses, an RPN can obtain their diploma faster. https://rnao.ca/about/types-nursing
6. **PA** – Physician Assistants (PA) support physicians in a range of health care settings and work alongside physicians, nurses and other members of interprofessional health care teams to provide patient care. http://www.healthforceontario.ca/en/Home/Health_Providers/Physician_Assistants
7. **AHAC** – Aboriginal Health Access Centre (AHAC) is an indigenous community-led, primary health care organizations. They provide a combination of traditional healing, primary care, cultural programs, health promotion programs, community development initiatives, and social support services to First Nations, Métis and Inuit communities. There are currently ten AHACs in Ontario, providing services both on and off-reserve, in urban, rural and northern locations. https://www.allianceon.org/aboriginal-health-access-centres
8. **LHIN** – Local Health Integration Network (LHIN) The role of LHINs is to plan, integrate and fund local health care as well as deliver and coordinate home and community care. The South

West LHIN covers an area from Lake Erie to the Bruce Peninsula and is home to almost one million people. http://www.southwestlhin.on.ca/aboutus.aspx

9. **HFO, HFO MRA** – HealthForceOntario Marketing and Recruitment Agency (HFO MRA) supports the government's health workforce objectives and contributes to the planning, recruitment, retention, transition, and distribution of health practitioners in Ontario. http://www.healthforceontario.ca/en/Home
10. **HFO Jobs** – HealthForceOntario Jobs is an online job board that connects health care organizations, communities and employers to health care professionals seeking employment. As Ontario's most extensive job-search tool dedicated to physician, nursing and other health profession opportunities in the province, HFOJobs offers job seekers. https://hfojobs.healthforceontario.ca/en/map/?p=1&t=7
11. **LTC** – Long Term Care (LTC) - Long term care homes are places where adults can live and receive
help with most or all daily activities and access to 24-hour nursing and personal care. https://www.ontario.ca/page/about-long-term-care
12. **CSS** – Community Support Services (CSS)are services for seniors or those living with a disability to help live comfortably in their own home. Some services are offered by not-for-profit organizations funded by government, and others may be operated by private organizations. Some services may be paid for by government, and some services are provided for a fee. https://www.ontario.ca/page/community-support-services
13. **EDLP** - Emergency Department Locum Program (EDLP) - The Emergency Department Locum Program provides urgent Emergency Department (ED) locum coverage as an interim measure of last resort to designated hospitals that are facing significant challenges covering ED shifts.
http://www.healthforceontario.ca/en/Home/All_Programs/Emergency_Department_Locum_Program
14. **NRRRI** –The Northern and Rural Recruitment and Retention Initiative (NRRRI) offers taxable financial incentives to each eligible physician who establishes a full-time practice in an eligible community of the province.
http://www.health.gov.on.ca/en/pro/programs/northernhealth/nrrr.aspx
15. **HOCC** – The Hospital on Call Coverage (HOCC) program provides incentives to physicians for the additional burden that on-call service provision places on them and their lifestyles. https://www.oma.org/sections/member-benefits/other-programs-initiatives/hospital-on-call-coverage-program/
16. **MedQUEST** - The MedQUEST Health Career Exploration Program is a clinical teaching elective that was designed by the Southwestern Ontario Medical Education Network (SWOMEN) at Western's Schulich School of Medicine & Dentistry to provide first and second year medical students with a unique opportunity to experience living, learning, and working within rural and regional communities in Southwestern Ontario.
https://www.schulich.uwo.ca/schulichhome/articles/2011/07/08/medquest-far-more-than-a-summer-camp.html

Appendix F: Forum Presentation

Grey Bruce Health Forum

Ensuring a Primary Care workforce to meet the needs of Grey Bruce

Ontario
South West Local Health Integration Network
Réseau local d'intégration des services de santé du Sud-Ouest

Schulich MEDICINE & DENTISTRY
Western

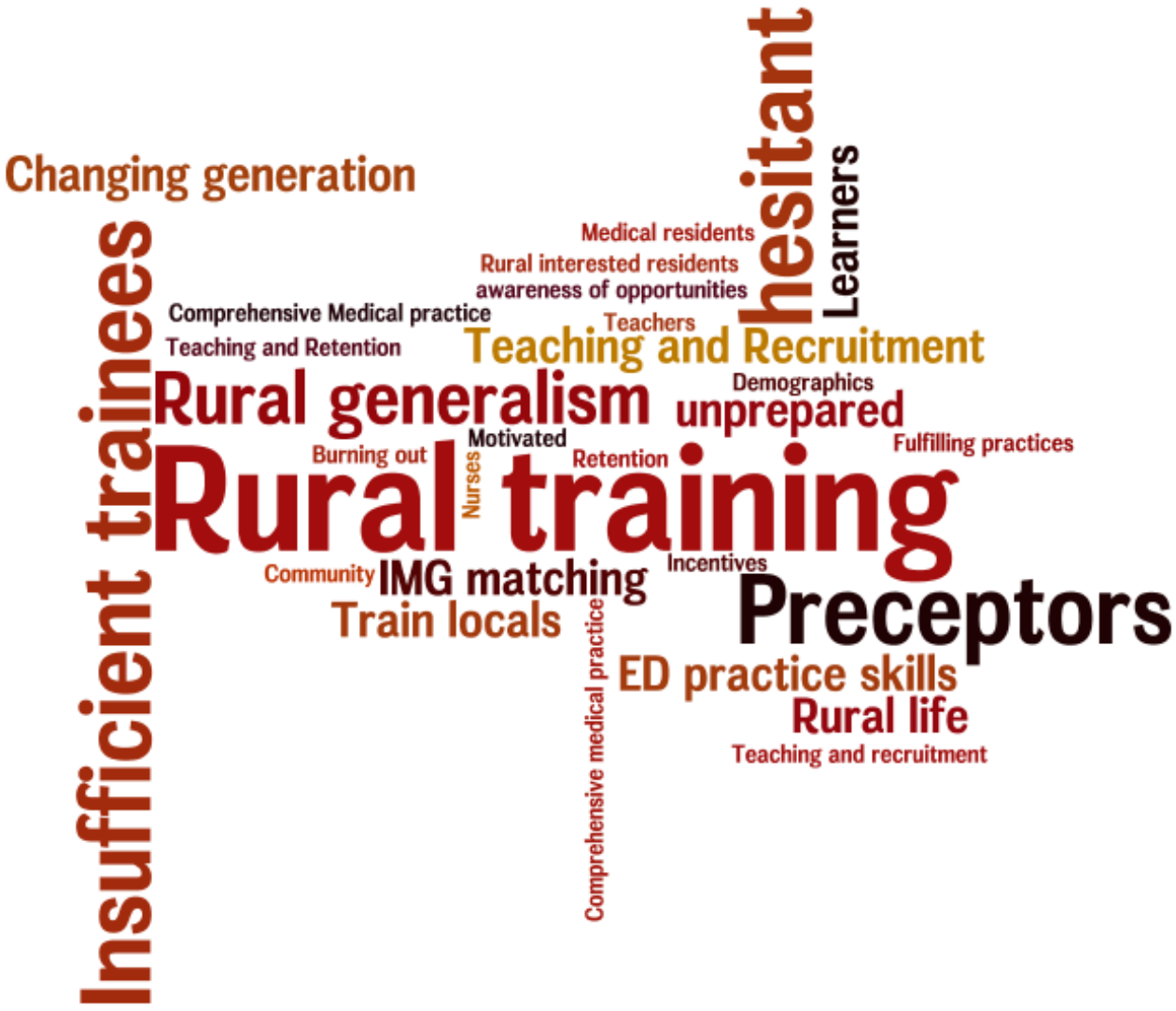
Ontario
HealthForceOntario Marketing and Recruitment Agency
Agence de promotion et de recrutement de ProfessionsSantéOntario

Pentagram Partnership: Social Accountability Framework

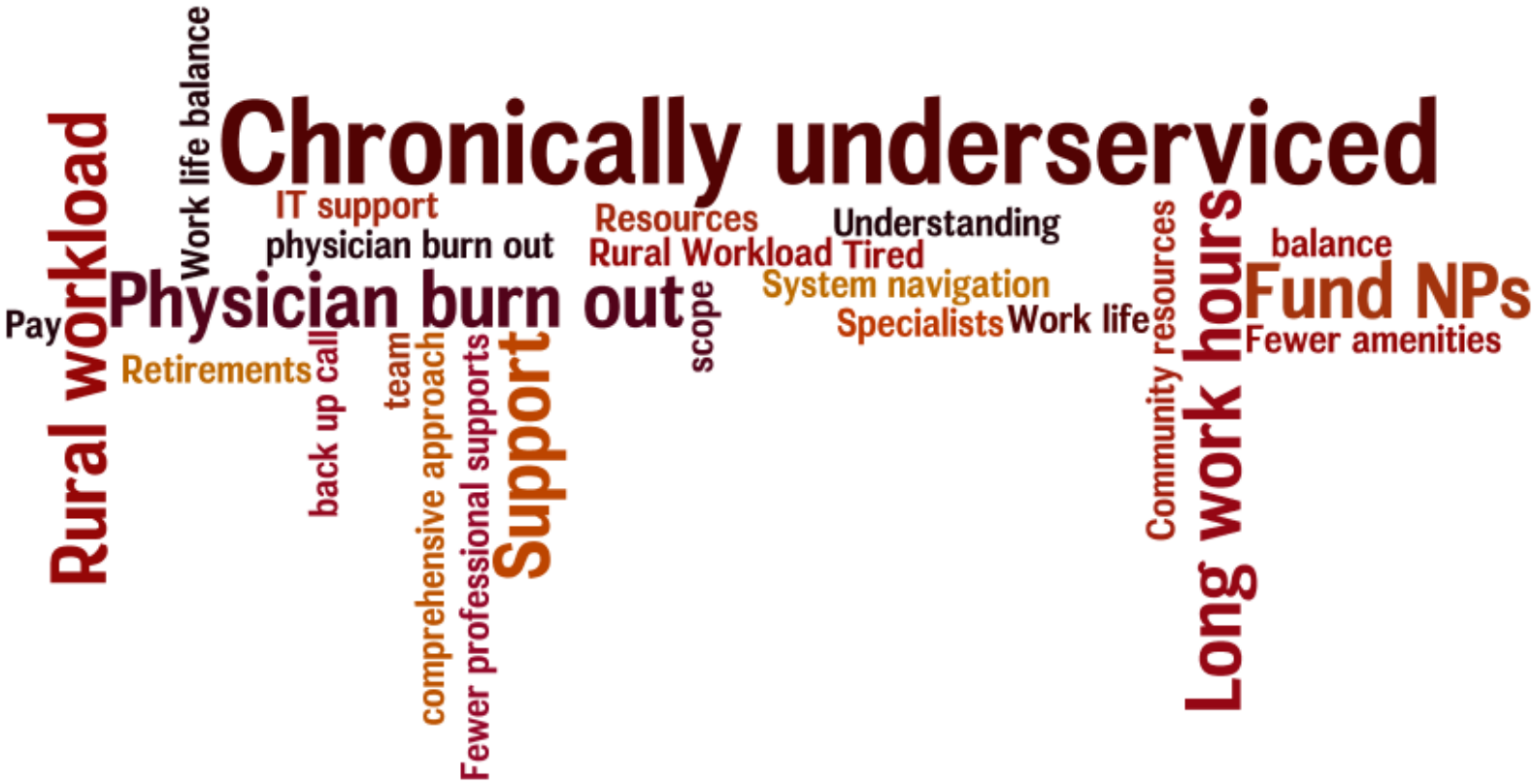
Barriers to Primary Care: Recruitment and Retention in Grey Bruce

What we heard from you

Medical Training



Physician Wellbeing: Supportive Practice Environment, Workload



Rurality


Partner employment
Isolation
Community resources
Family supports
Collegiality
Lack of candidates
Travel
Access to Supports
Lifestyle
Social Networks
Cultural diversity
Access to supports
Geographic isolation
Rural living
Team supports
Government funding
Resources
Technology
Transportation
Medical facilities
Financial
Infrastructure
Housing
Specialist supports
Recreational facilities

Regional/Systemic Recruitment Strategy

Agenda

- Presentations from experts on:
  - Medical Education
  - Health Human Resource Planning
  - Local and Regional Recruitment Strategies
  - Local Data
  - Innovative Ideas
- Listening to your ideas and priorities to create solutions for Grey Bruce

Welcome

Renato Discenza, CEO, South West LHIN

Ontario
South West Local Health Integration Network
Réseau local d'intégration des services de santé du Sud-Ouest

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Keynote

Dr. Peter Wells, Executive Director, Rural Ontario Medical Program

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Perspectives on Rural Generalism

Dr Peter Wells,
Rural Ontario Medical Program

Grey Bruce Forum
April 9, 2019

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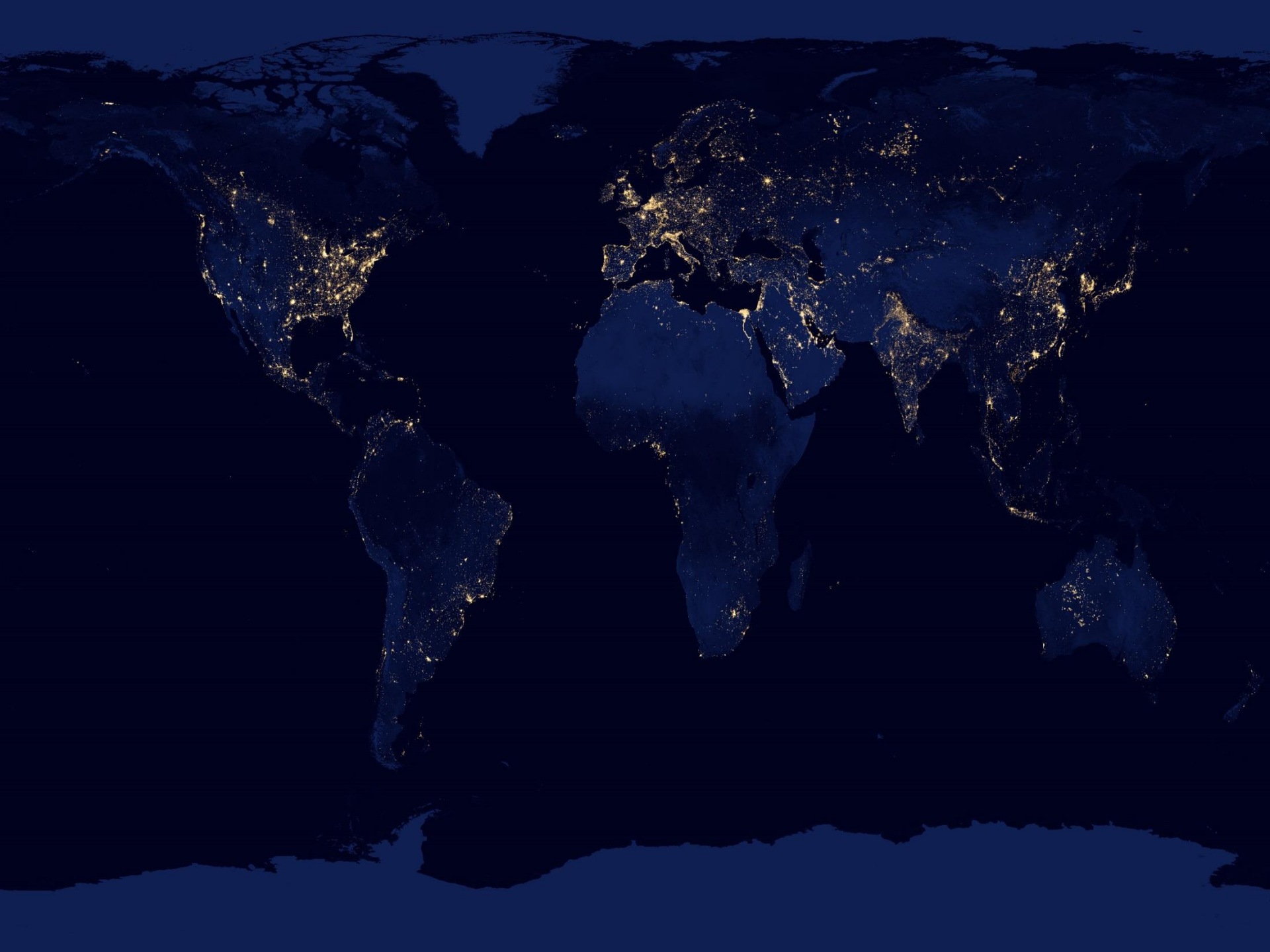
Who I am

a Rural Generalist

Disclosure

No Conflicts to Disclose



- 25% of total population; entire workforce tends to jack-of-all-trades
- Older, sicker, poorer, accident prone
- 90% local health care by generalists
- Significant limitations to travel, telemedicine

Figure 1

generalism: ˈʤɛnərəlɪz(ə)m

- **generalism*:** is a professional philosophy of practice, distinguished by a commitment to holistic, integrated, person-centered care, the broadest scope of practice within each discipline and collaboration with the larger health care team in order to respond to patient and community health needs.

- Definition adapted from the Royal College of Physicians and Surgeons of Canada and the Royal College of General Practitioners in the UK

Who is a generalist?

A primary care physician

An emergency medicine physician

An internal medicine physician

An obstetrics and gynaecology physician

A paediatrics physician

A psychiatry physician

A general surgery physician

A day in the life of a generalist…

Challenges

Increasing specialization

Mentoring in Urban/Academic Centres

Little Primary Care exposure

Public perception

Key themes

Short term:

Make you community recruit ready

Involve everyone: doctors, hospital administration, municipal leaders, and community members (patients)

Key themes

Medium term:

Promote your community and its unique resources (medical and non-medical) to current trainees (help us present to programs ie general surgery) at medical schools

Most of them will have no idea what fascinating work your community has to offer

Key themes

Long term:

Advocacy

Potential for designated generalist residency positions

Talk to MPP, schools, help design programs for offering this kind of training

Initiatives underway “Rural Roadmap for Action”

Final Thoughts

- The reason for hope for rural generalism
- Community-based teaching, closer to community as possible.
- Collaboration is key! (field practioners, universities and governments
- New models of teaching (NOSM, UBC North)

Rural Ontario Medical Program

Collingwood General &Marine Hospital
459 Hume Street
Collingwood, Ontario L9Y 1W9
Phone: (705) 445-7667
Toll Free (877) 445-7667

www.romponline.com

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Medical Education and Recruitment Lessons Learned over 20 Years

Dr. George Kim, Dean Distributed Education, Schulich School of Medicine and Dentistry

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Schulich

MEDICINE & DENTISTRY

Medical Education and Recruitment – Where now?

April 9, 2019
Owen Sound, Ontario

George Kim, MD, MClSc(FM), CCFP, FCFP
Assistant Dean Rural/Regional Community Engagement
Schulich Medicine
Western University

Schulich MEDICINE & DENTISTRY

Western

Acknowledgement

- Staff from Schulich Medicine
- Dean Cheng, Vice Dean Rosenfield
- McMaster and Western FM PG Programs
- All of you

Medical Education

- Overview

  - 6 Ontario Schools
  - UME and PGME (fellowships)
  - Urban/Regional/Remote training sites
  - Core and Elective Training
  - Many years

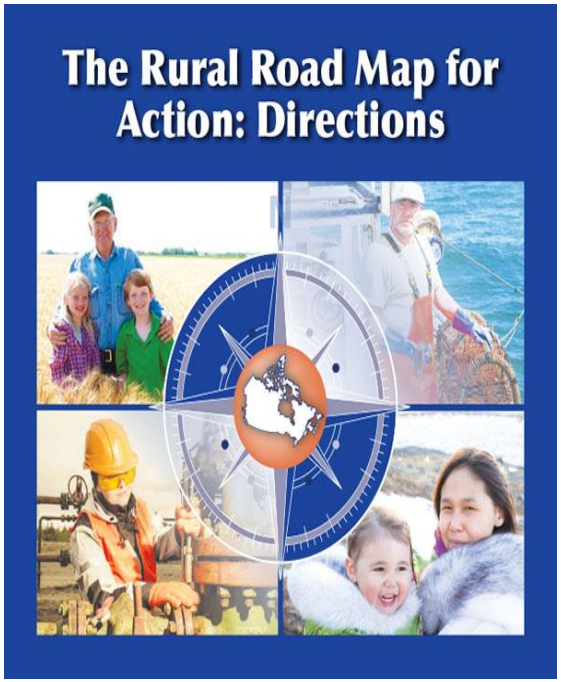
FLEXNER to FMEC

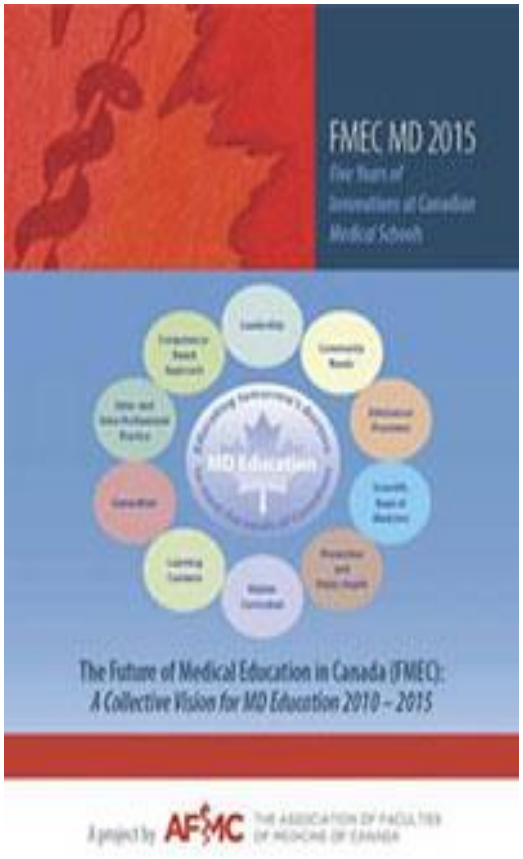

MEDICAL EDUCATION
IN THE
UNITED STATES AND CANADA

A REPORT TO
THE CARNEGIE FOUNDATION
FOR THE ADVANCEMENT OF TEACHING

BY
ABRAHAM FLEXNER

WITH AN INTRODUCTION BY
HENRY S. PRITCHETT

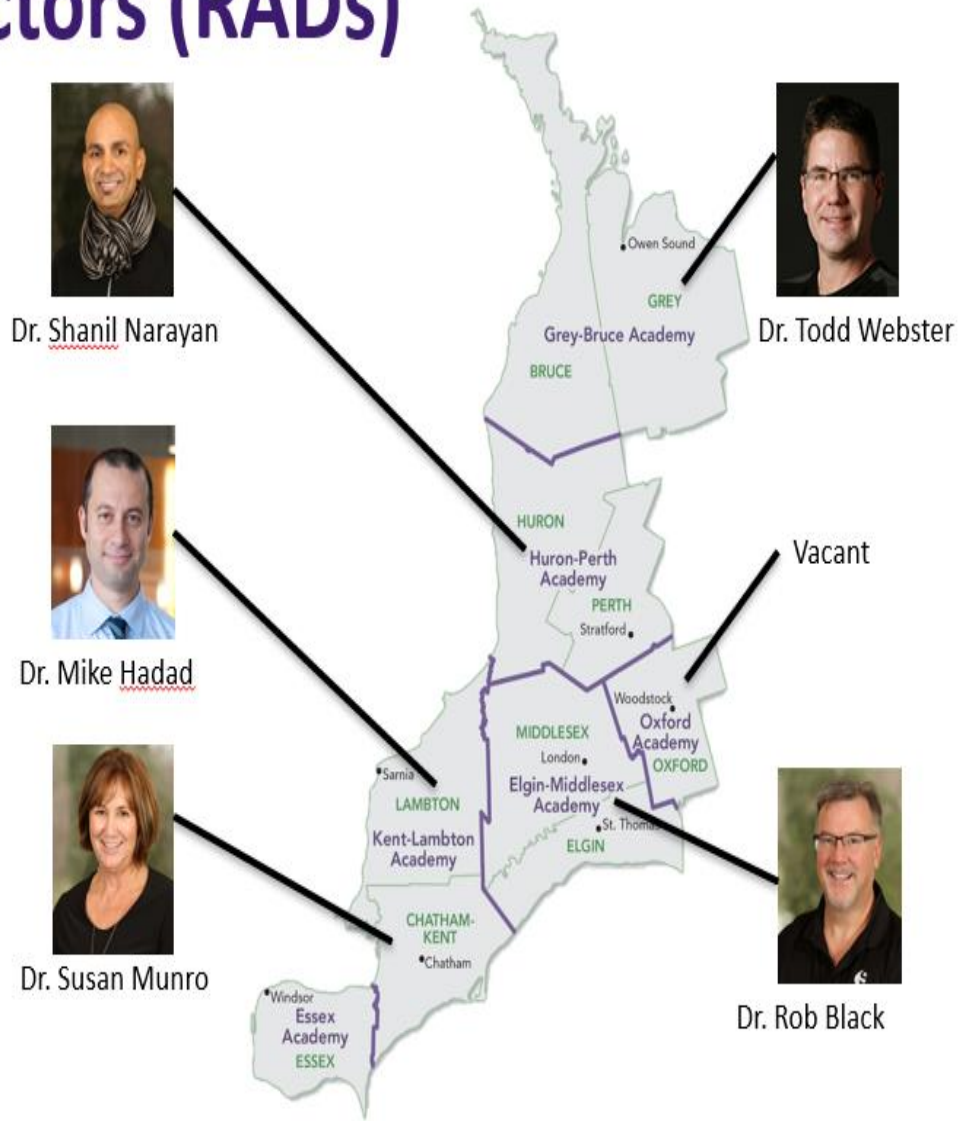




The Schulich Story

- SWORM/SWORRM
- SWOMEN
- DEN
- ODE
- DE
- Integrated Medicine

Academies and Regional Academic Directors (RADs)



The Trainees…

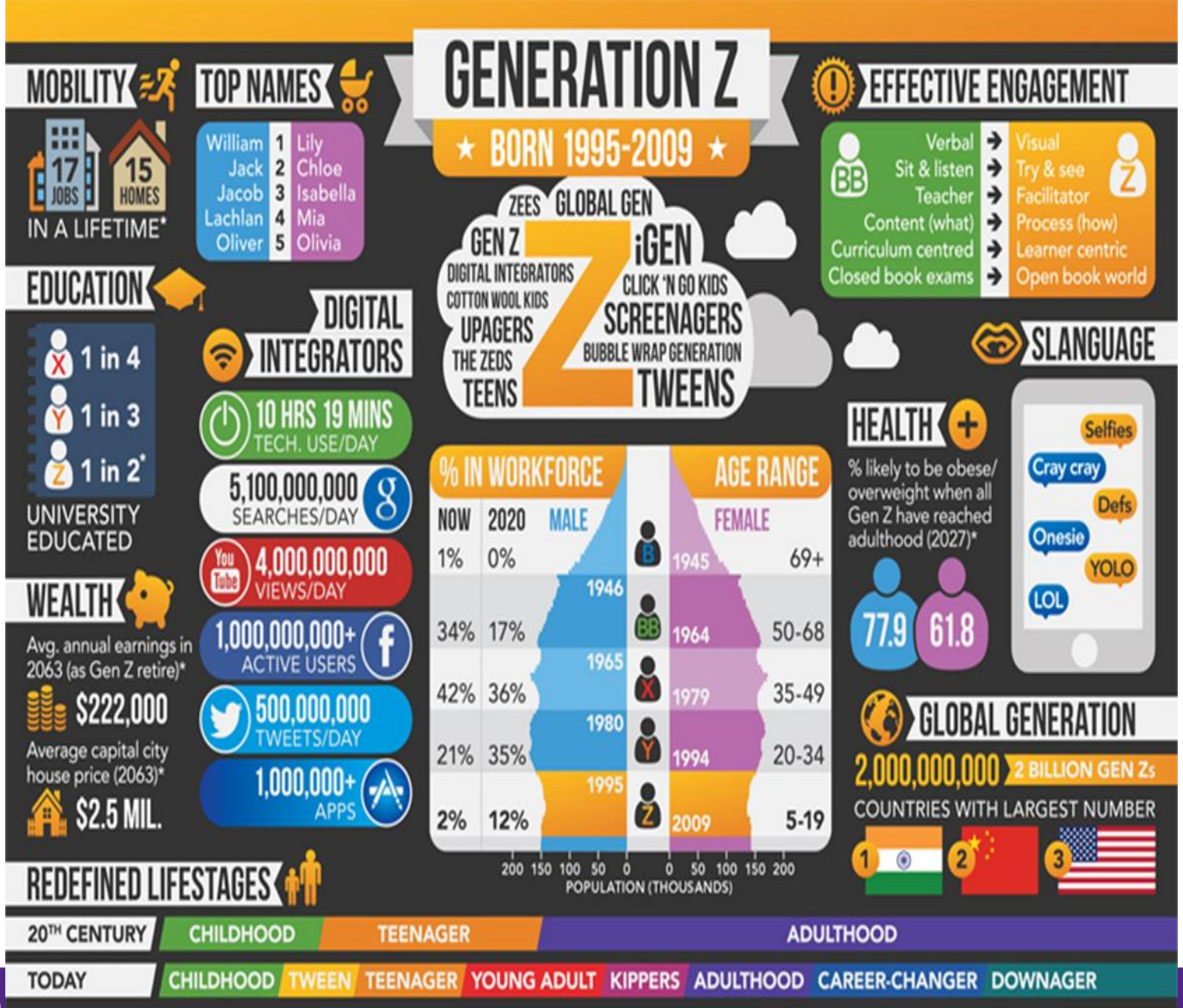
Statistics - Meds 2021

Home Province	
AB	3
BC	10
MB	2
ON	155
QC	1
	171

Non-SWO	116	68 %
SWO	55	32 %

Female	70
Male	101

Average Age – 23.16



mccrindle
FORECASTS • STRATEGY • RESEARCH

www.mccrindle.com.au | www.generationz.com.au

*Future forecasts
Source: ABS, McCrindle
© McCrindle 2014

The Program

Undergraduate Education

- Year I Program
  - ITM, INFECTION/IMMUNITY, MSK, RESP/AIRWAY, HEART/CIRCULATION, BLOOD SKIN
- Year II Program
  - Endo, GI, GU, Repro, Key Topics in FM, NEE, Psych, ER
- Community Health, PCCIA, Clinical Methods
- Year III Program
  - Clinical Clerkship
- Year IV Program
  - Transition Period
  - Clinical Sciences

New Curriculum

- Integrated
- Longitudinal Experiences
- Interdisciplinary
- Community-based

Postgraduate Education

- CFPC
- FRCPS(C)
- Minimum 2 years…and then some
- Rural Experiences

Why Rural Medicine?

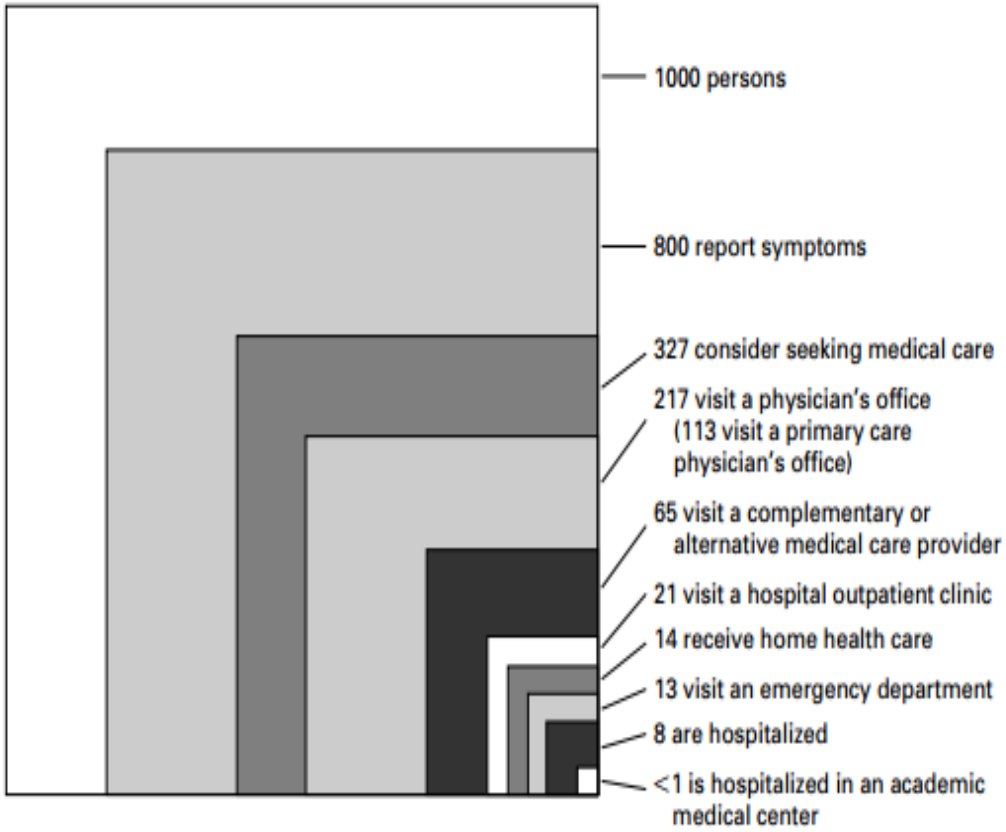
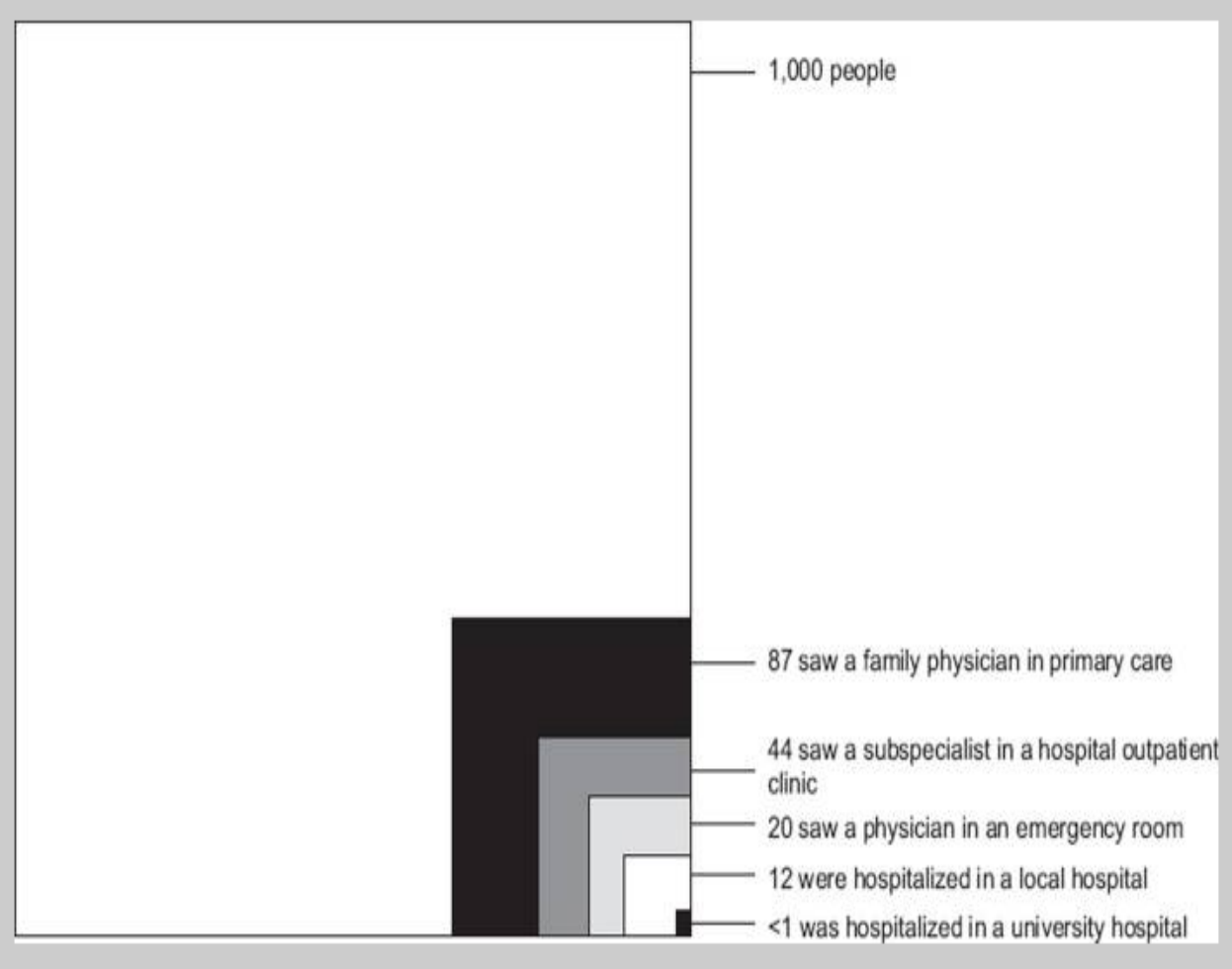
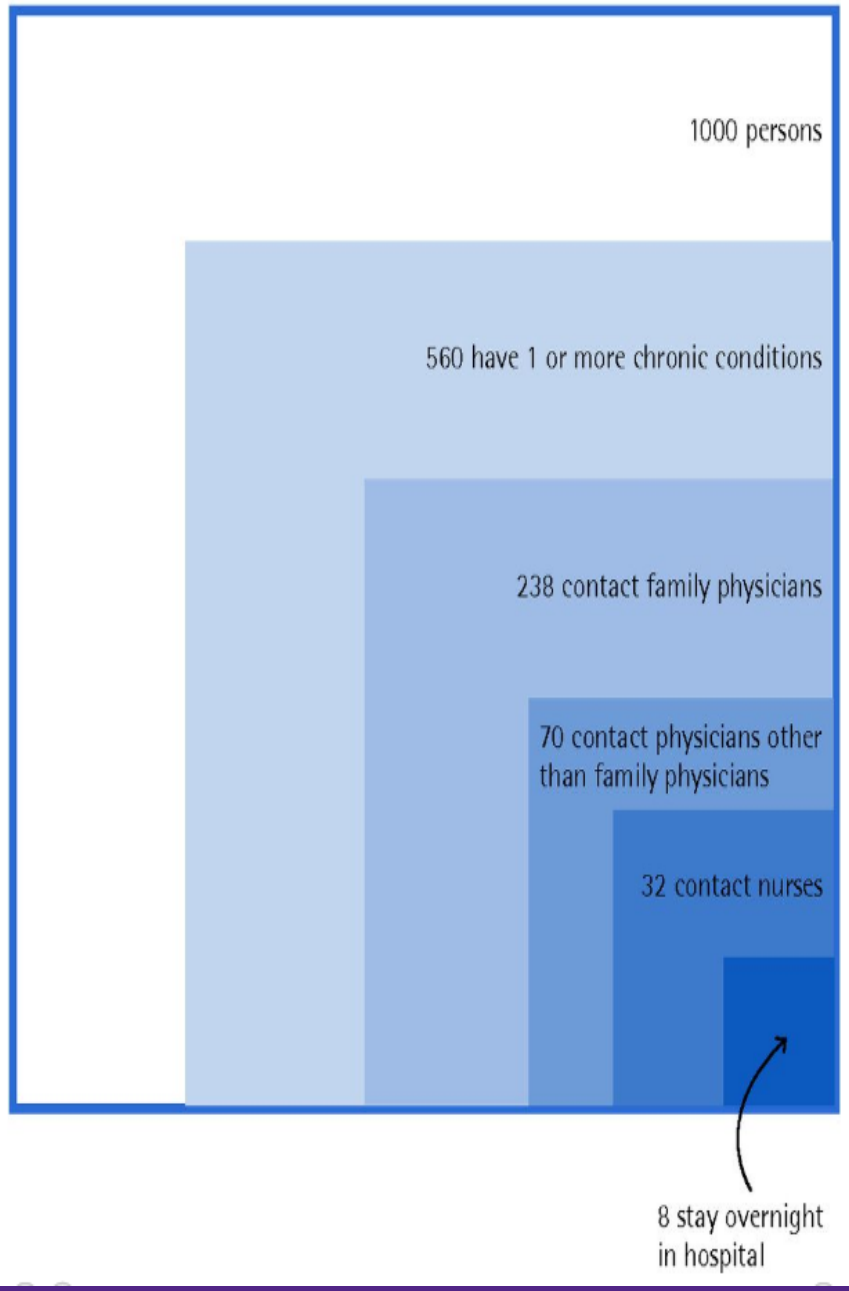


Figure 2. Results of a Reanalysis of the Monthly Prevalence of Illness in the Community and the Roles of Various Sources of Health Care.

Each box represents a subgroup of the largest box, which comprises 1000 persons. Data are for persons of all ages.


1,000 people
87 saw a family physician in primary care
44 saw a subspecialist in a hospital outpatient clinic
20 saw a physician in an emergency room
12 were hospitalized in a local hospital
<1 was hospitalized in a university hospital


1000 persons
560 have 1 or more chronic conditions
238 contact family physicians
70 contact physicians other than family physicians
32 contact nurses
8 stay overnight in hospital

How long to “grow” a physician…

Programs

- Discovery Healthcare
- Discovery Week
- Summer Elective
  - Research vs Clinical
- Clerkship
  - Block vs LIC
- Residency Elective
- Fellowship

What are we learning…

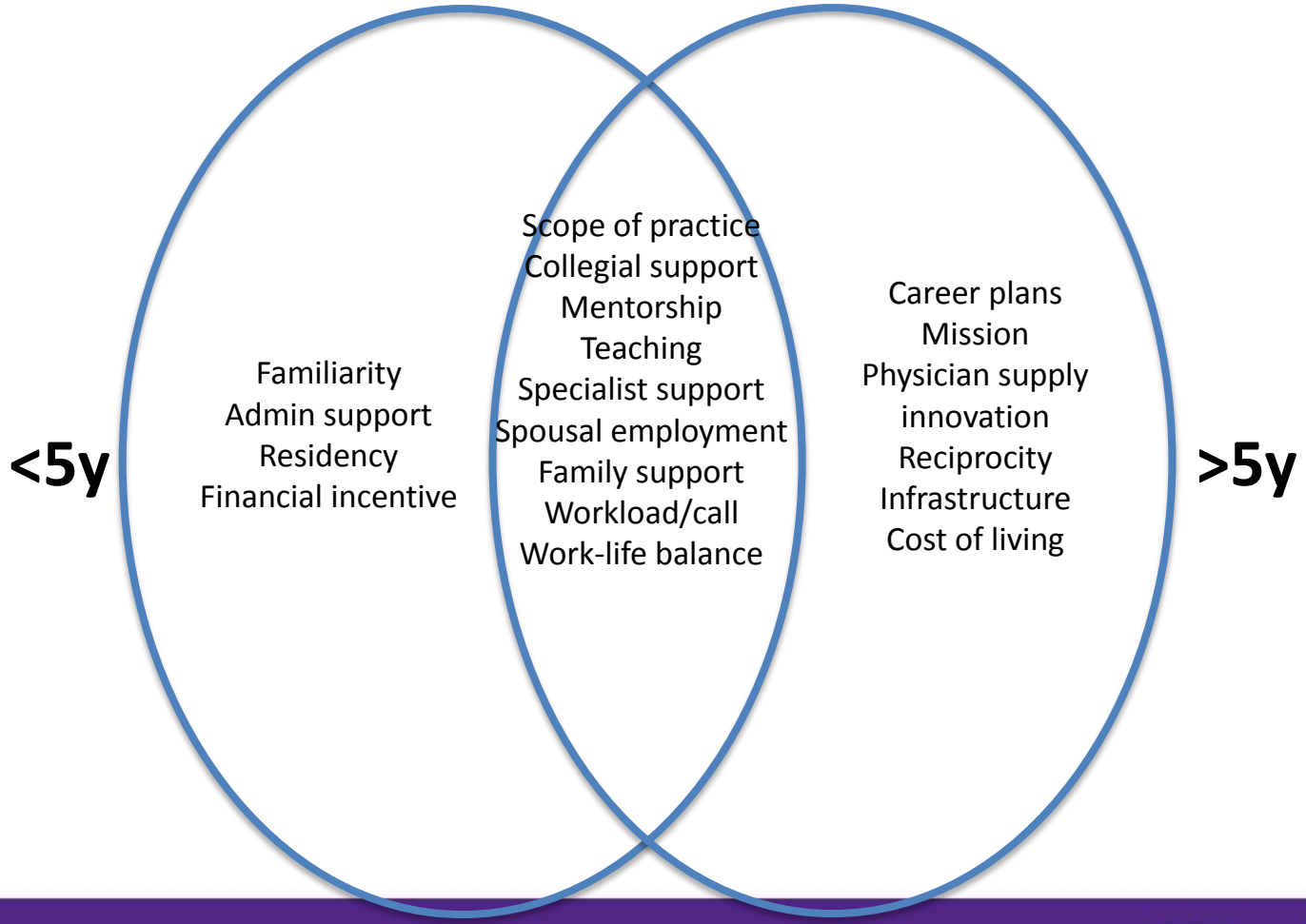
- Rural Medical Education
- Recruitment and Retention
- Engagement
- Interdisciplinary Care Teams

RME-the “stream”

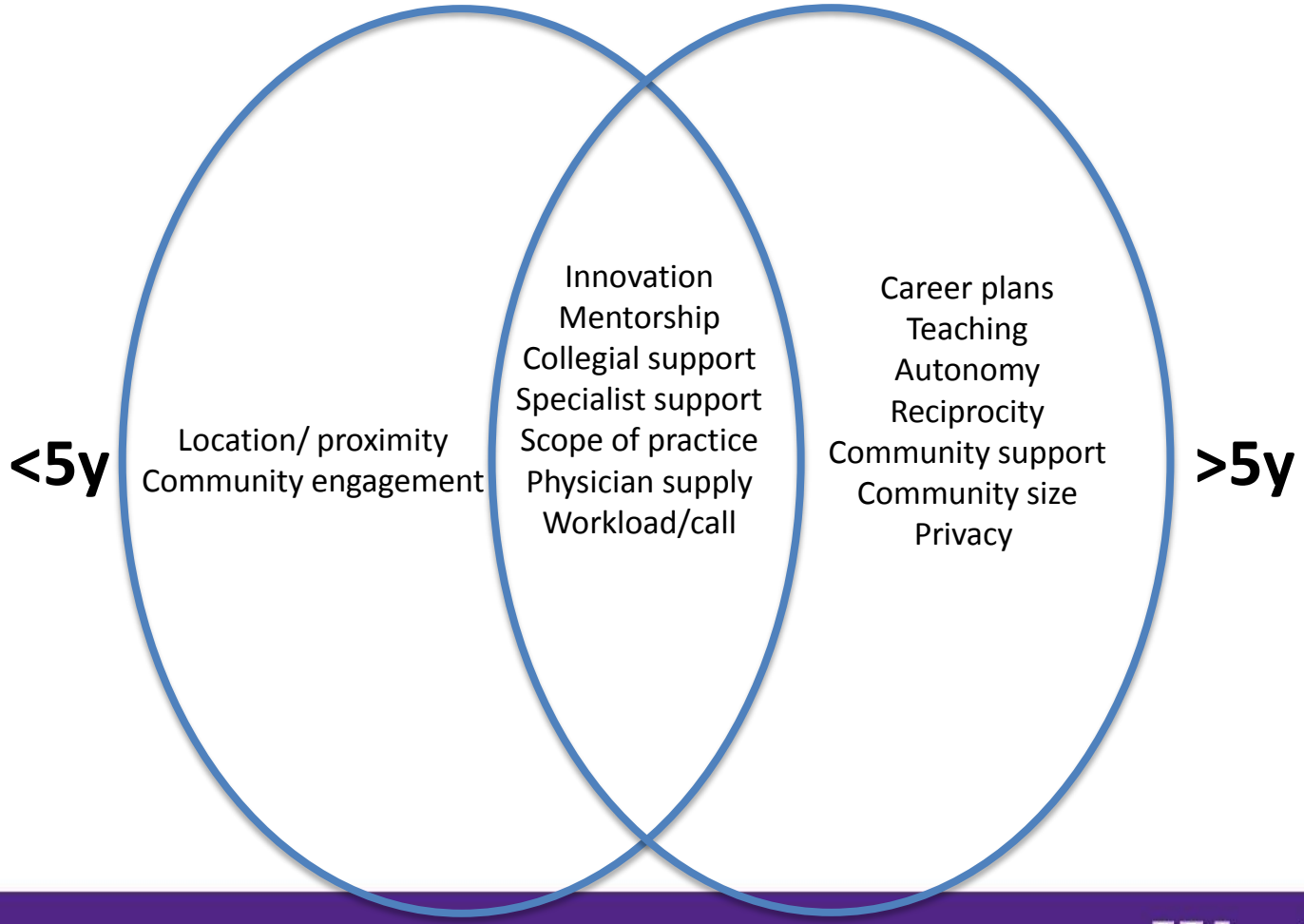
- Starts Before Admissions
- Admissions Criteria
- Training Opportunities
- “Hidden Curriculum”
- More Opportunities
- Mentors

Recruitment/Retention

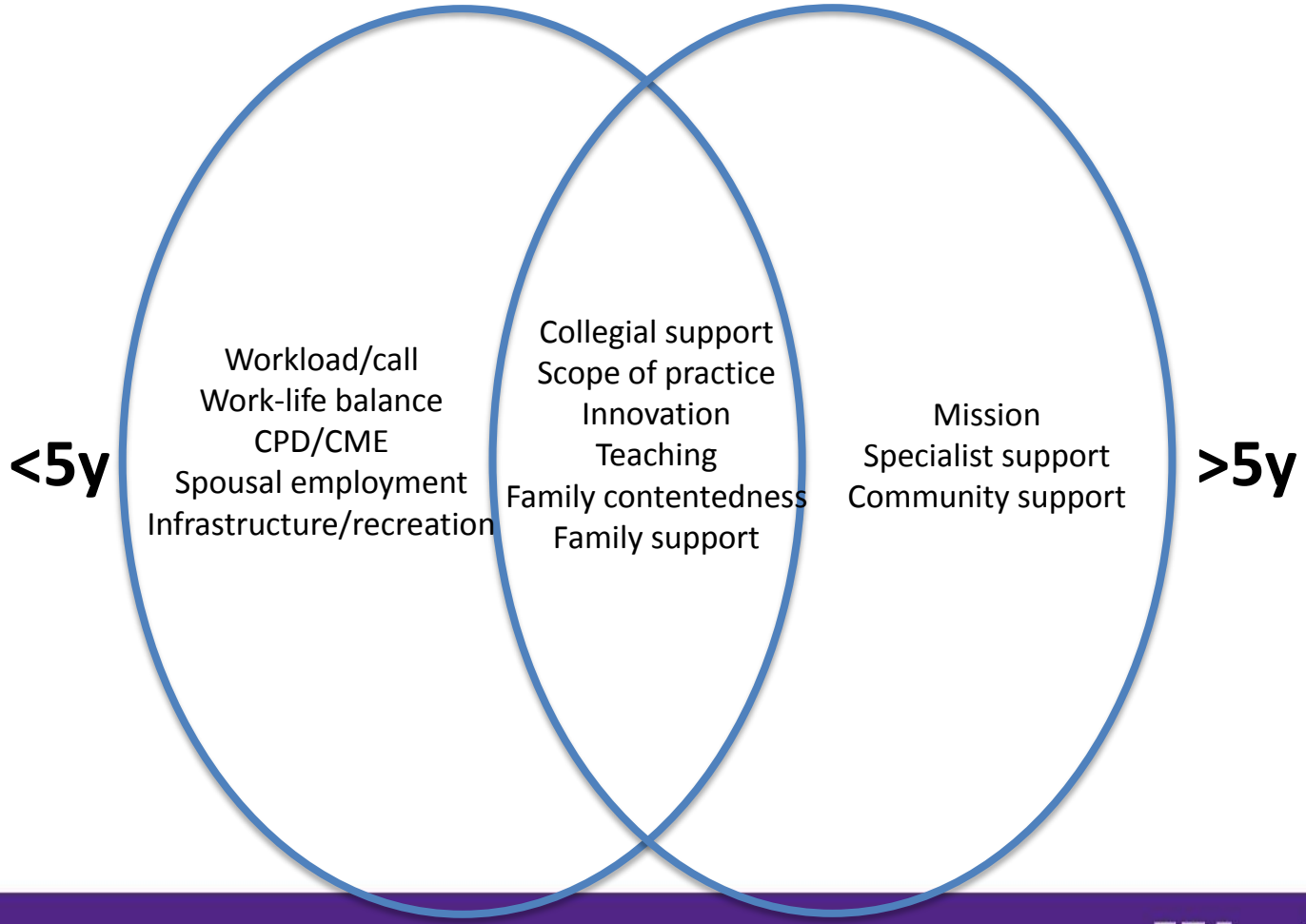
Initial Choice to Locate



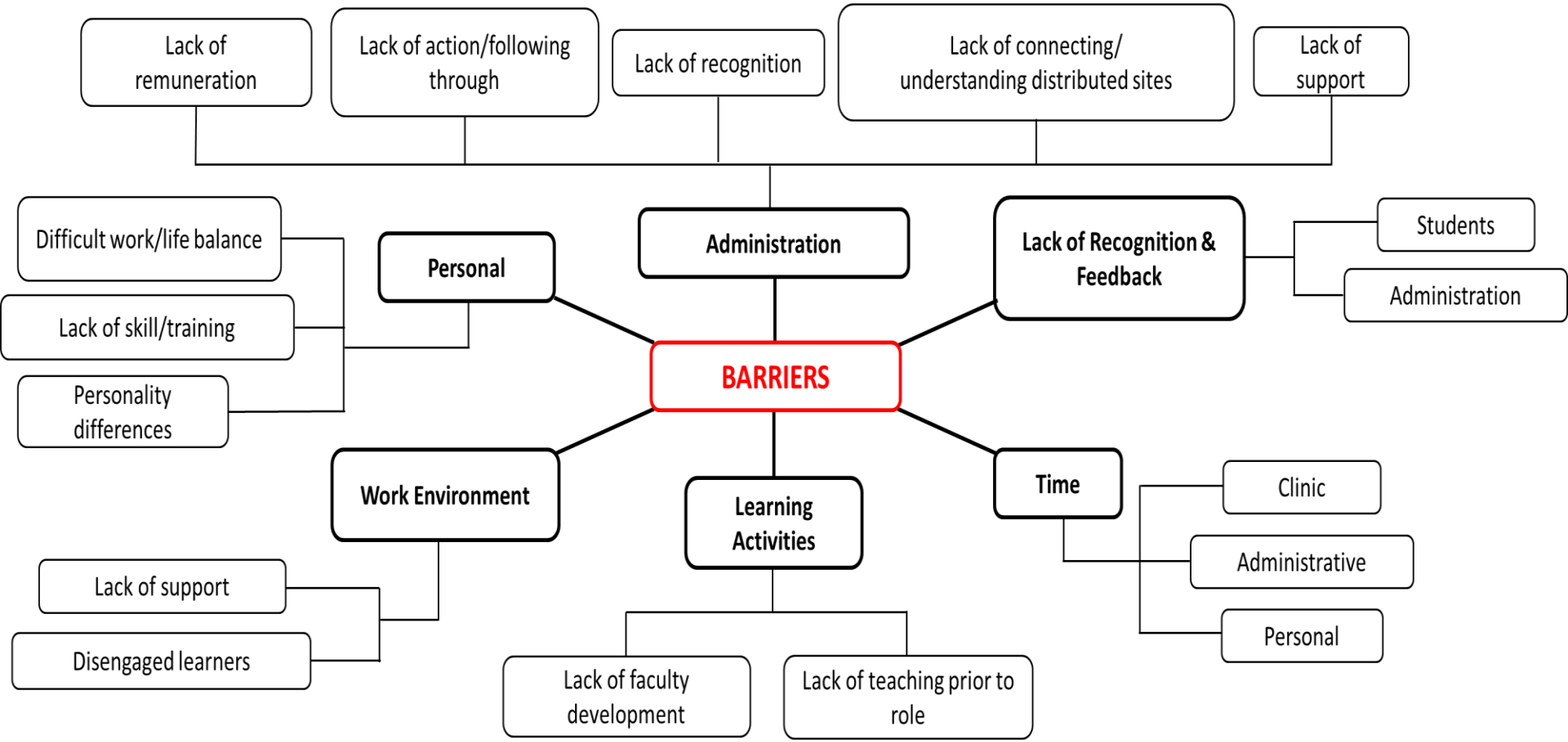
+/-ves of Current Practice

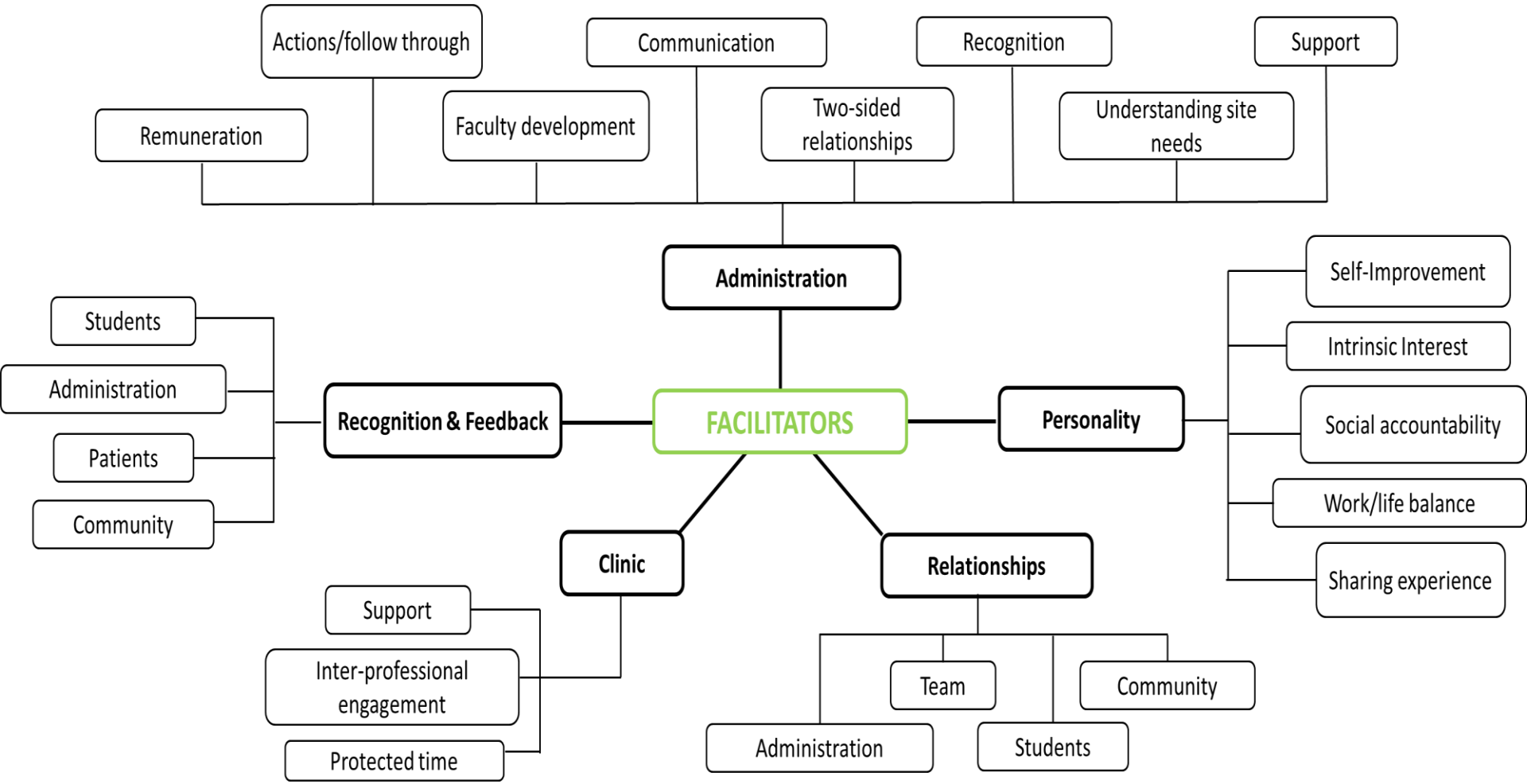


Retention Factors



Engagement


Lack of remuneration
Lack of action/following through
Lack of recognition
Lack of connecting/ understanding distributed sites
Lack of support
Difficult work/life balance
Lack of skill/training
Personality differences
Personal
Administration
Lack of Recognition & Feedback
Students
Administration
BARRIERS
Work Environment
Learning Activities
Time
Clinic
Administrative
Personal
Lack of support
Disengaged learners
Lack of faculty development
Lack of teaching prior to role


Actions/follow through
Communication
Recognition
Support
Remuneration
Faculty development
Two-sided relationships
Understanding site needs
Administration
Students
Administration
Patients
Community
Recognition & Feedback
FACILITATORS
Personality
Self-Improvement
Intrinsic Interest
Social accountability
Work/life balance
Sharing experience
Clinic
Relationships
Support
Inter-professional engagement
Protected time
Team
Community
Administration
Students

Interprofessional Education

- It takes a team to deliver healthcare
- How do we build the team?
- IPE Day

So Now What…

- What has worked?
- What can be different?
- Short term vs Long term
- Family Medicine, Royal College Physicians, Allied Health Professionals
- Integration vs Individual


1878
Western
UNIVERSITY · CANADA

Physician Supply and Local Need in Grey Bruce

Jane Tillmann, Regional Advisor, HealthForceOntario

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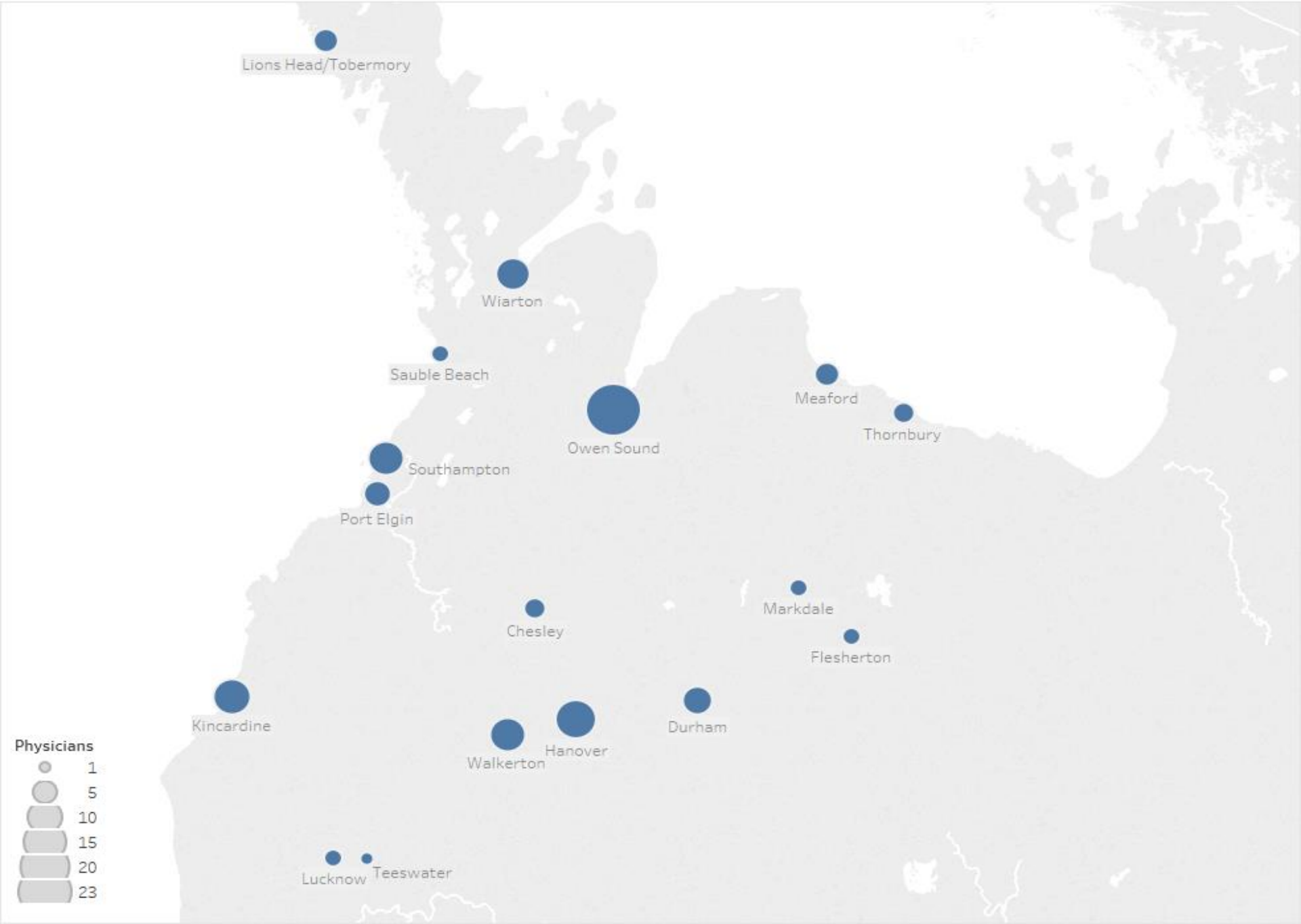
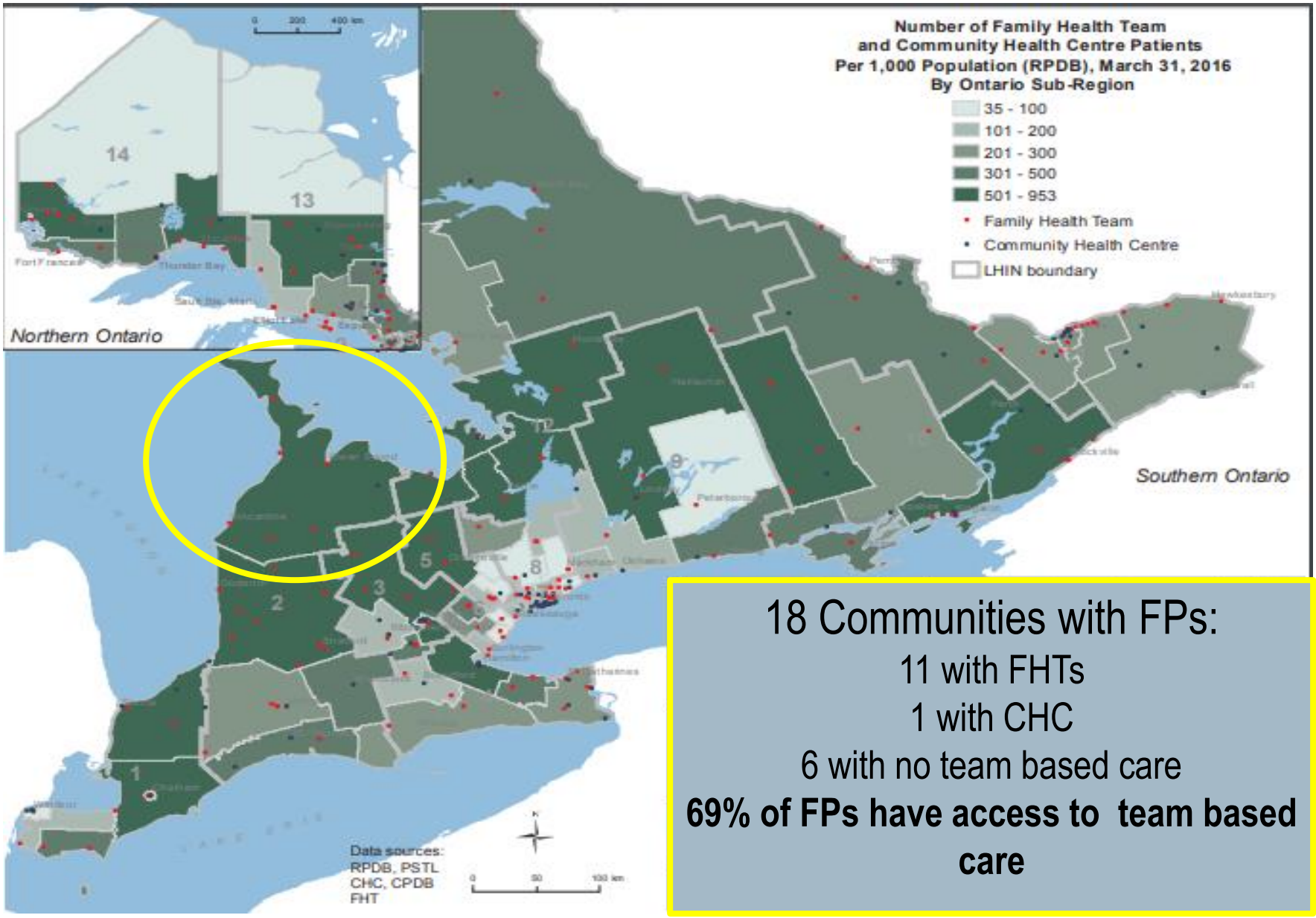
Family Physicians
Family Practice

Comprehensive Care Physicians in Grey Bruce



Grey Bruce Sub-Region



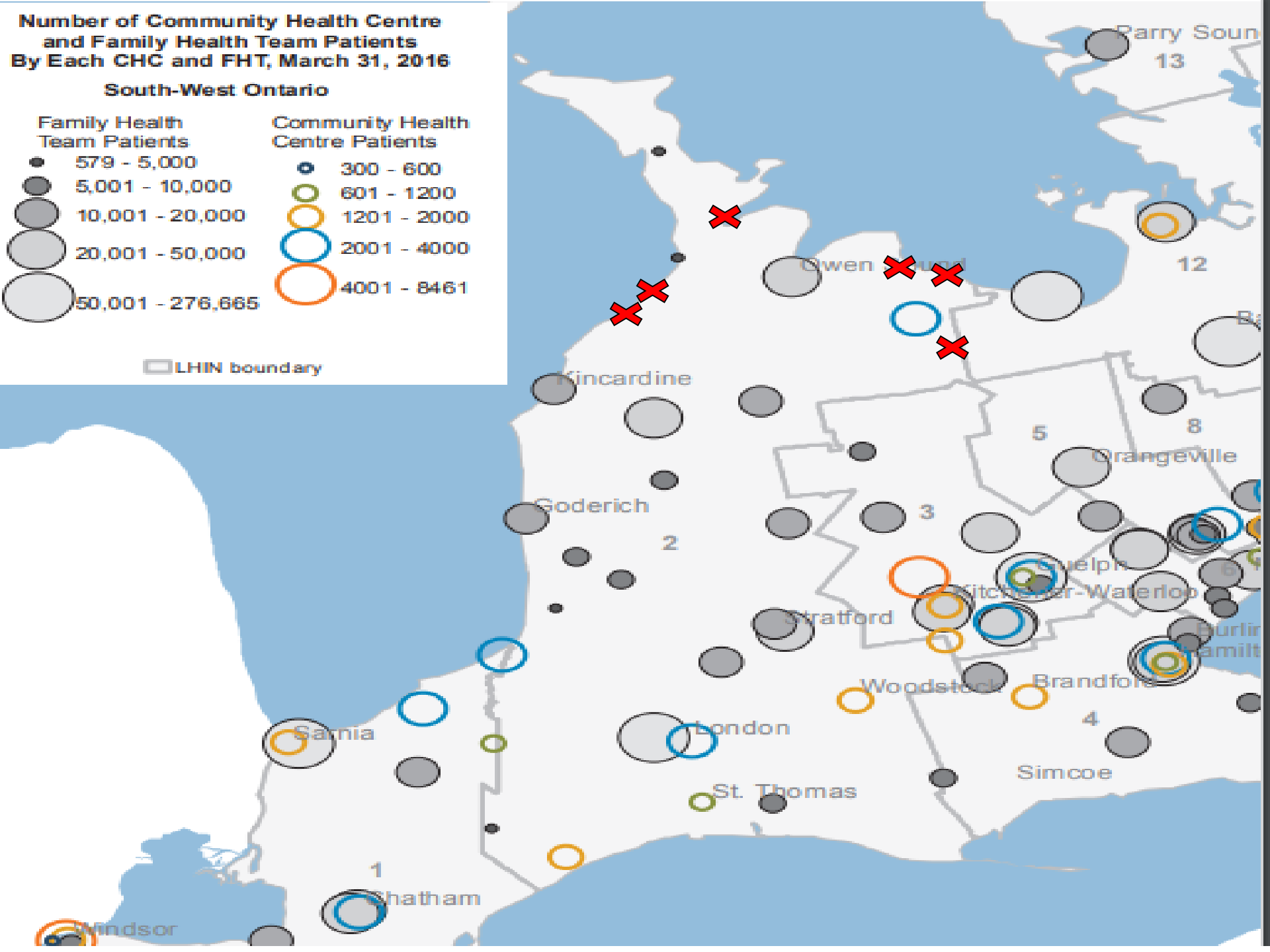
18 Communities with FPs:

11 with FHTs

1 with CHC

6 with no team based care

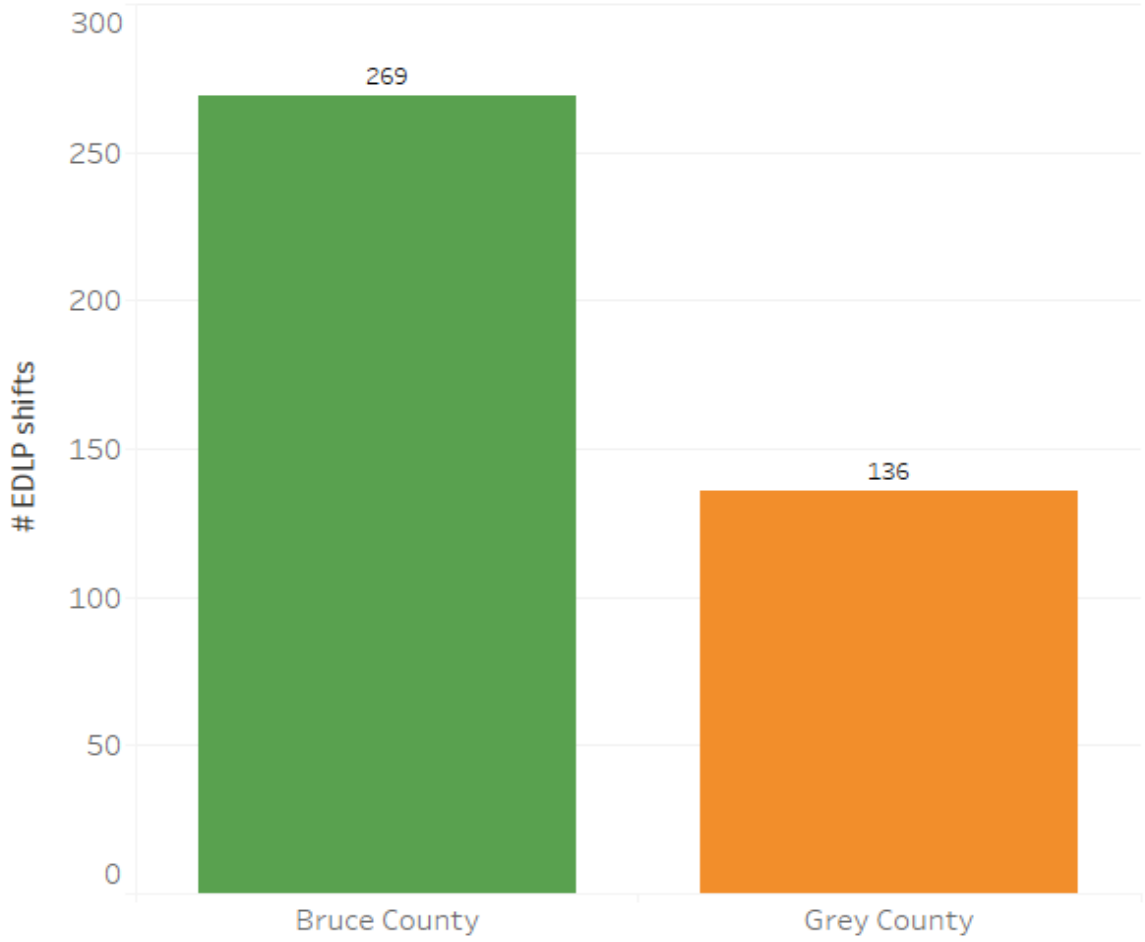
69% of FPs have access to team based care


Number of Community Health Centre and Family Health Team Patients By Each CHC and FHT, March 31, 2016
South-West Ontario
Family Health Team Patients
579 - 5,000
5,001 - 10,000
10,001 - 20,000
20,001 - 50,000
50,001 - 276,665
Community Health Centre Patients
300 - 600
601 - 1200
1201 - 2000
2001 - 4000
4001 - 8461
LHIN boundary
Parry Soun
13
12
Owen Sound
Kincardine
Goderich
Stratford
Sarnia
London
St. Thomas
Simcoe
Woodstock
Brandford
Orangeville
Guelph
Kitchener-Waterloo
Chatham
Windsor
1
2
3
4
5
8

Family Physicians
Emergency Department Coverage

EDLP Activity in Grey Bruce

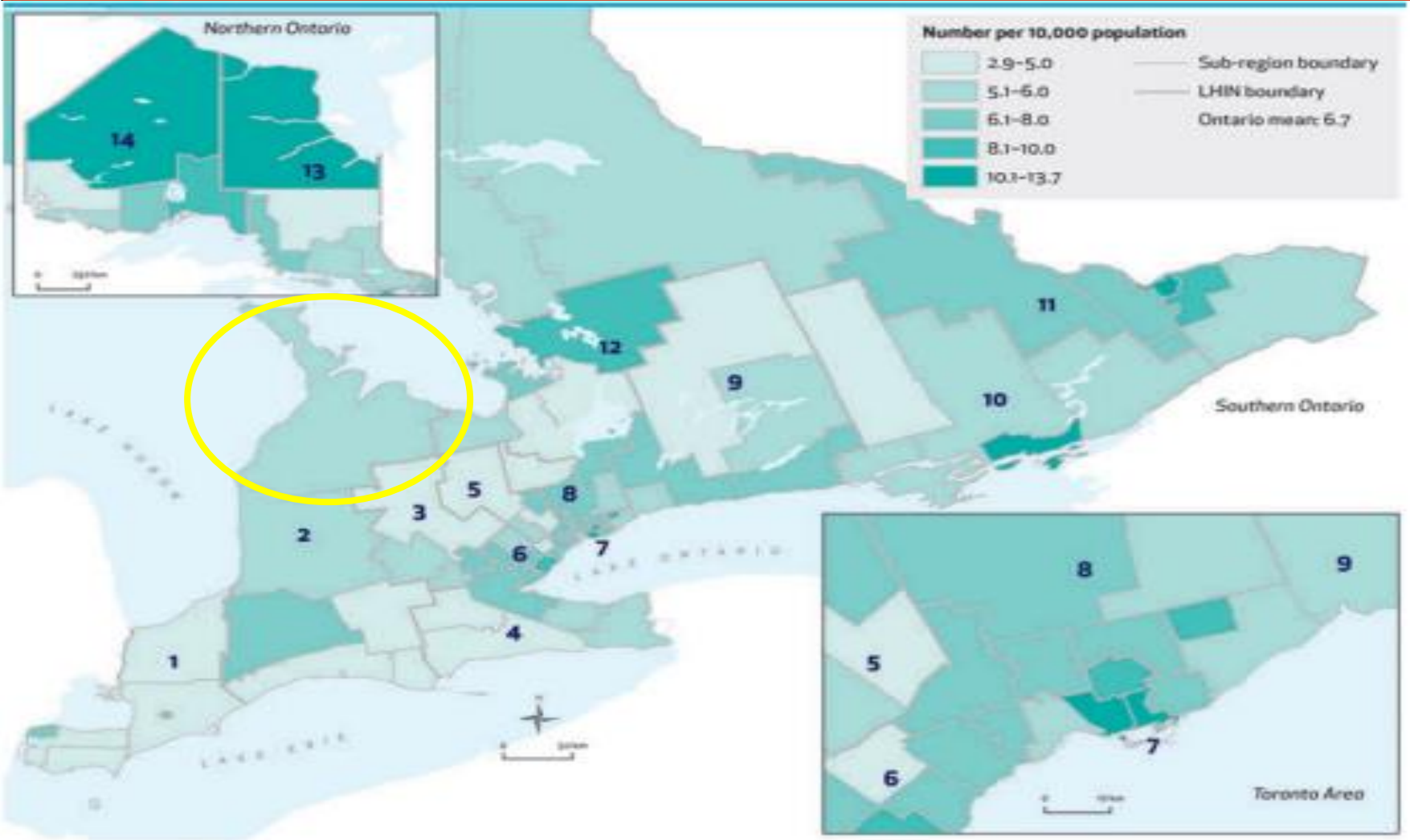
ED Shifts Covered and Closures Averted in 2018-19



Closures Averted

Closure Averted is defined as a shift that is filled within four days of the shift date.

What Does the Data Tell Us?



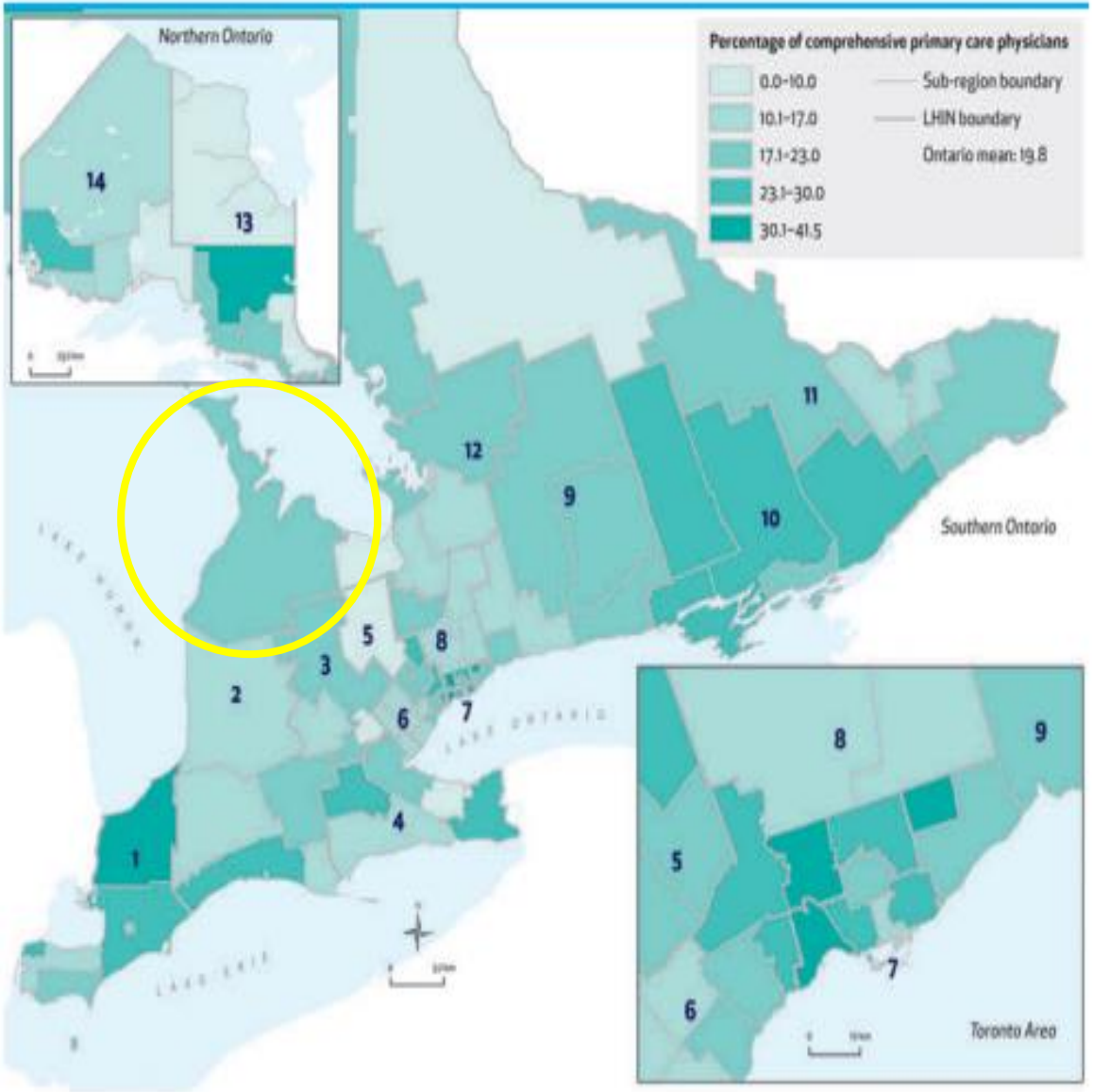
Data sources: CPDB; iPDB; OHIP; RPDB.
Note: Comprehensive primary care physicians form a subset of all primary care physicians. Primary care comprehensiveness is based on a primary care physician's fee-for-service and shadow billings that are used to track the scope of services provided (see Appendix B). Some primary care physicians provide comprehensive care for patients of all ages across multiple settings (e.g.,

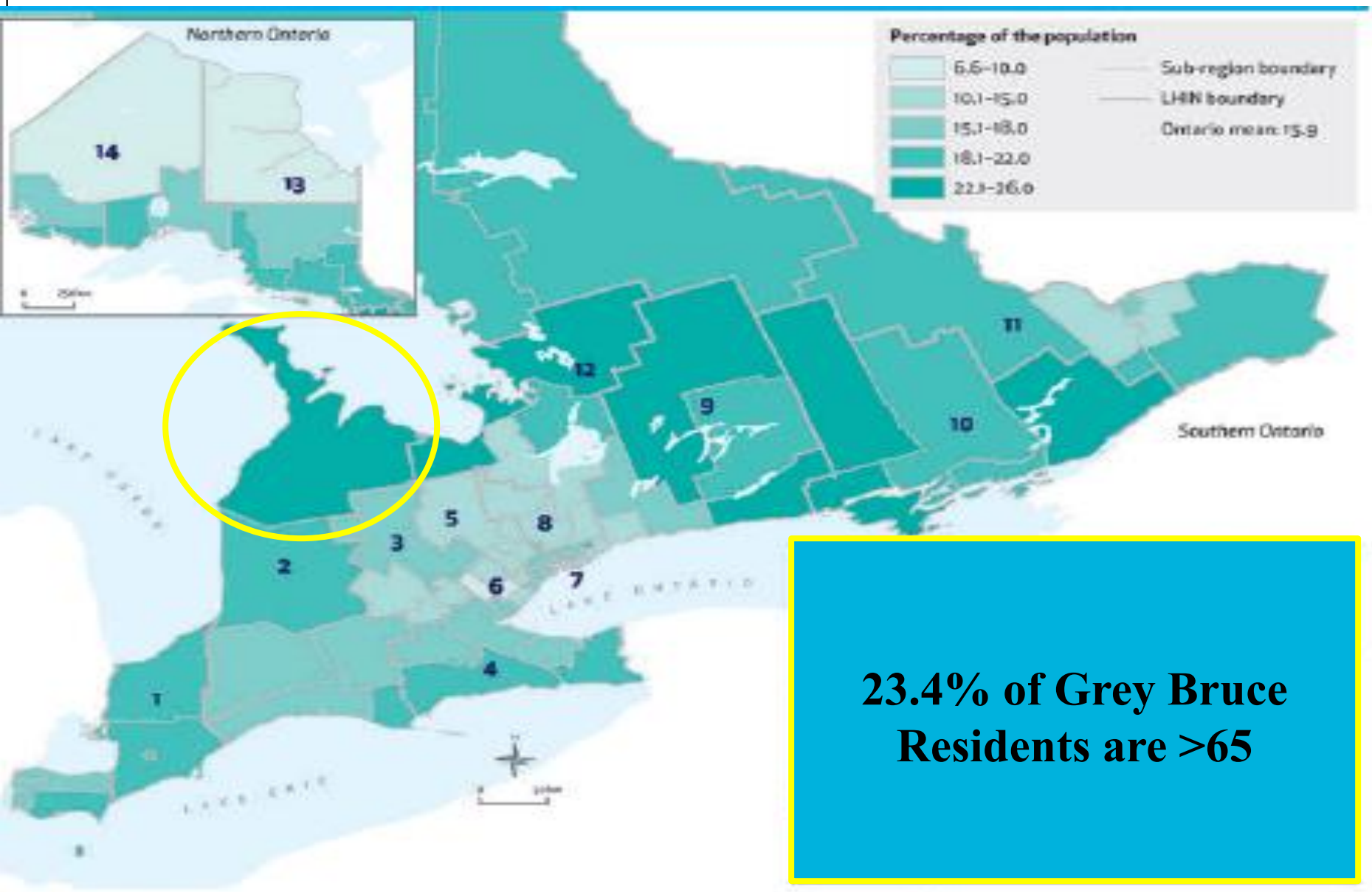
EXHIBIT 5.4 Number of comprehensive primary care physicians per 10,000 population, by sub-region, in Ontario, 2015/16

EXHIBIT 56 Percentage of comprehensive primary care physicians who were aged 65 and older, by sub-region, in Ontario, 2015/16

Key Messages

- In Ontario, 1,807 (19.8%) of comprehensive primary care physicians were aged 65 and older and 7,330 (80.2%) were younger than 65.
- The Lambton, Cochrane, Scarborough North, West Toronto and North York West sub-regions had the highest proportion of physicians aged 65 and older.





23.4% of Grey Bruce Residents are >65

Are there enough physicians in Grey Bruce?

How many residents are looking for a Primary Care Provider?

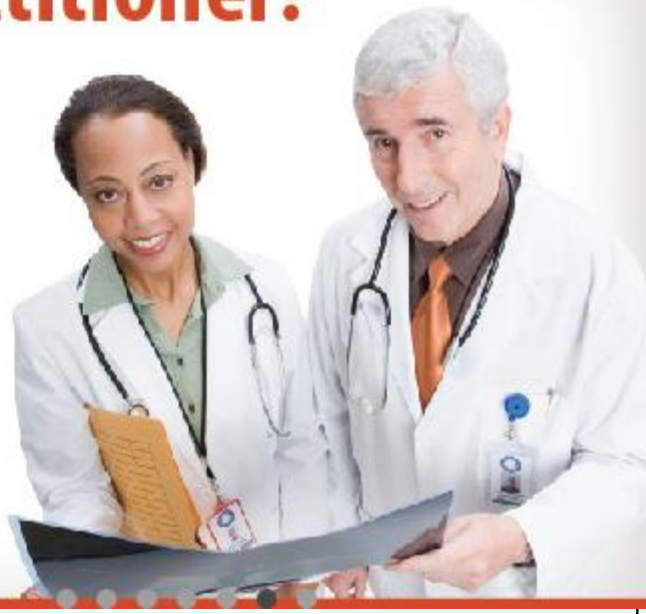
Need a family doctor or nurse practitioner?

Your new family health care provider might be just a phone call away.

Our team of Care Connectors identifies doctors and nurse practitioners in your community who are accepting new patients and links them with people who are looking for a health care provider.

Health Care Connect makes it easy. Register today.
1-800-445-1822 | www.ontario.ca/healthcareconnect

Health Care Connect



As of February 27, 1913 people were registered with HCC in Grey Bruce

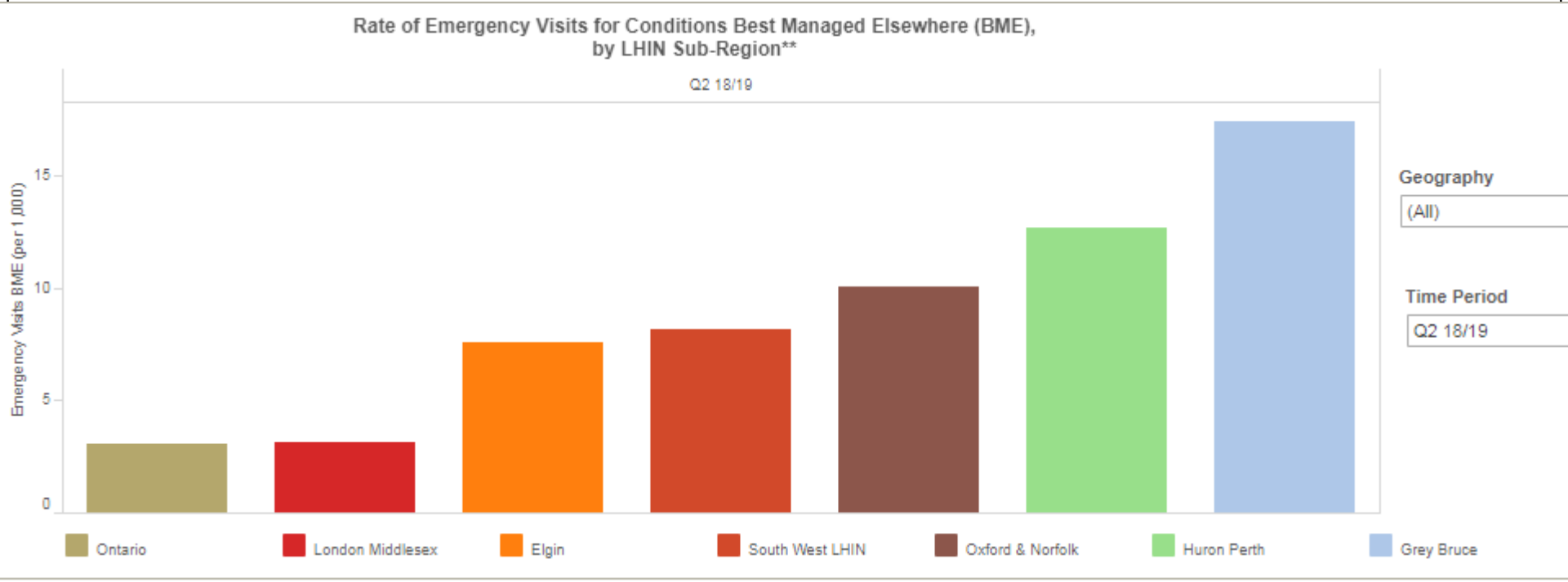
Issue - System

- Very difficult to determine true number of patients searching for a Health Care Provider.
- Many do not register knowing that there are no physicians taking patients in their area
- Many are not on the HCC list as they continue to be followed by a Physician several hours away.
- Must de roster from a physician before registering on HCC
- Lack of walk in clinics in the area.

Issues - Patients

- Patients reporting that they are waiting for hours and hours in the ER for prescription refills and being pressured by them to find a Primary care provider.
- Many Newborns unable to secure Primary Care therefore using the walk in clinic in Owen Sound
- Patients failing to have Preventative checks as do not have a Primary Care Provider
- Many moving to the area and are very frustrated with the lack of Providers accepting new patients
- Several patients have moved to the area from Out of Province and therefore unable to be followed by their previous physician until able to secure a local doctor

Emergency Visits for Conditions Best Managed in Primary Care Settings



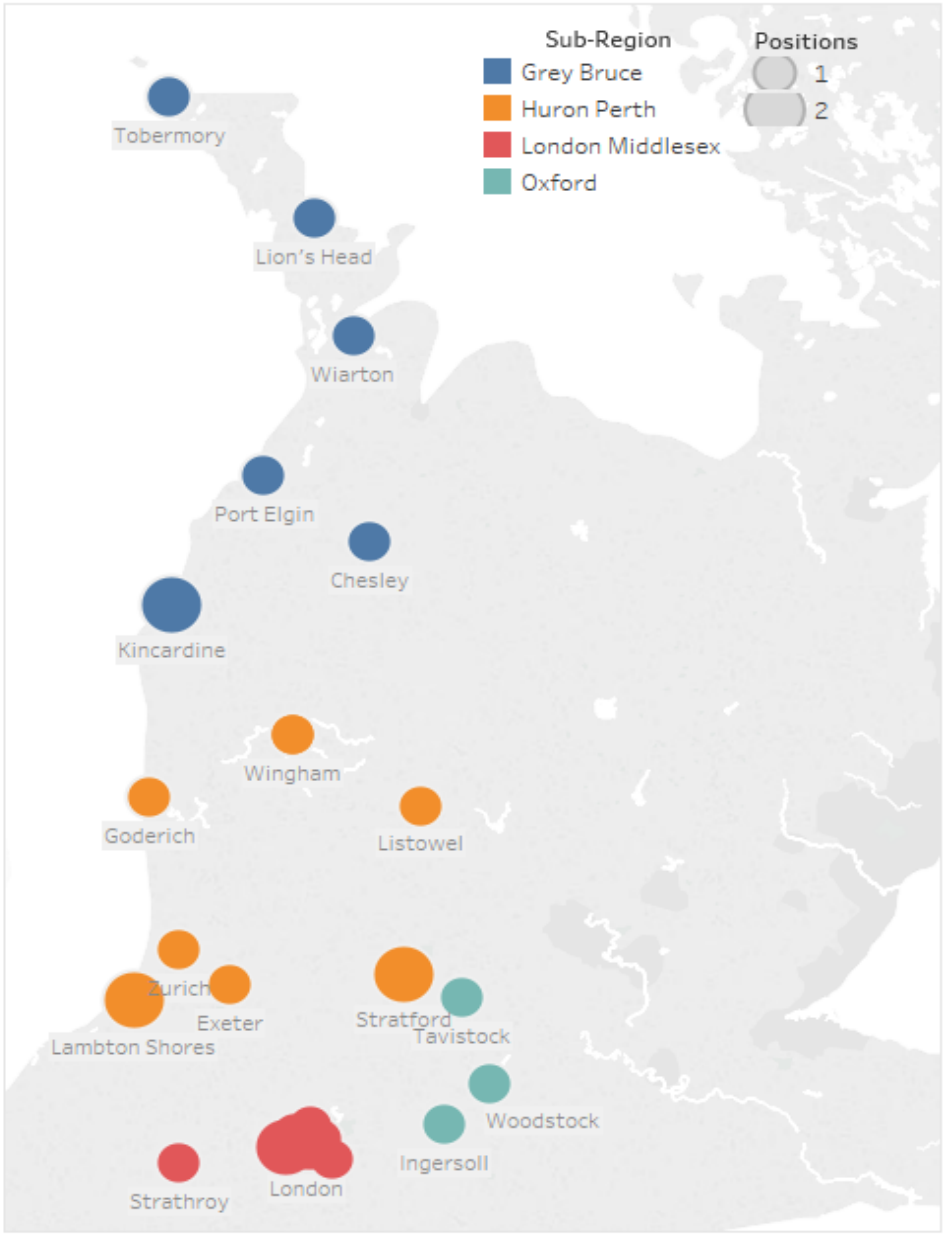
Issues - Providers

- Almost all communities in Grey Bruce are currently recruiting for additional physicians
- Physicians and teams are working at or beyond capacity
- Very few physicians or nurse practitioners work with HCC to take new patients

Recruitment Efforts

Full-Time Family Medicine Positions in the South West LHIN

Active on HFOJobs as of April 2, 2019



Positions by Community and Practice Type

		Clinic only	Comprehensive	Family Practice Anaesthesia	Hospitalist only	Grand Total
Grey Bruce	Chesley		1			1
	Kincardine		2			2
	Lion's Head		1			1
	Port Elgin		1			1
	Tobermory		1			1
	Wiarton		1			1
	Total		7			7
Huron Perth	Exeter		1			1
	Goderich			1		1
	Lambton Shores		2			2
	Listowel		1			1
	Stratford		1		1	2
	Wingham		2			2
	Zurich	1				1
	Total	1	7	1	1	10
London Middlesex	London	9			1	10
	Strathroy		1			1
	Total	9	1		1	11
Oxford	Ingersoll	1				1
	Tavistock		1			1
	Woodstock		1			1
	Total	1	2			3
Grand Total		11	17	1	2	31

Summary

- The exact number of physicians needed is unknown
- Almost every community is currently recruiting physicians to care for unattached patients and patients whose provider is not located nearby
- The need for additional physicians will continue to grow due to expected retirements and community growth and aging
- The need for generalist physicians is strong in Grey Bruce due to a large number of hospitals requiring ED and in hospital coverage

Grey Bruce Health Forum

Lunch Break

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I love it here.

Dr. Shaun Dooley, BScH, MBBS, FRACGP, CCFP
Signatory physician at OS FHO

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Narrative

- Probably worth read later when you have time
- Ill touch on the major points here
- Essentially it came down to a choice between GTA and Owen Sound
- I think this could be applicable to many centers – London / Hamilton / Toronto etc vs. Owen Sound
- These are the places we'd be trying to 'lure' physicians from (as I see it)

Barriers to retention

- Perceived lack of ‘things to do’
- Perceived lack of culture
- Perceived distance from the city
- Perceived lack of support (specialists / etc)
- Perception that Owen Sound is not a nice place to live / is rough
- Perception it is not a good place to raise a family / poor longitudinal opportunities for children

Why I love it here

- Its not the GTA
- There is SPACE
- There is CULTURE (if you look for it)
- The income is good
- My work life balance is the best it's ever been
- I have time for hobbies
- My kids are in a good school
- We have incredible friends
- Good recreational activities – skiing, skating, restauranting, markets, hiking, camping, boating, music festivals, Harrison Park etc etc
- The clinic is great to work at…we had an 'awkward' summer, but other than that it has been great

Strategies?

- Money talks – incentives
  - Maybe worth discussing this with local businesses/ campgrounds / ski hills / restaurants etc
  - ? An annual rural incentive bonus – similar to Australias RA system / Modified Monash Rurality Index
- Attractive locum positions – good way to get physicians to 'try before they buy'
- Make the location attractive to FAMILIES – recreational activities for kids
- Assistance with finding spouses / partners jobs
- How this gets rolled out – I'm not sure.
- I'm happy to show new physicians around / wine and dine them etc
- Emphasize the FHO income – we have a few physicians who are probably going to be retiring soon / reducing practice size and we will need some fresh blood – one of the things that really got my interest piqued was the remuneration available here and relative cost of living
- The healthcare connect list is NOT a list of people who were undesirable and unable to keep a doctor / got fired. I've got about 800 people from HCC who were simply orphaned by retiring physicians. This list continues to grow and we will need help with getting physicians to take these people on – this is a BIG misconception. I would also suggest there is a LARGE incentive to take on these patients as they are eligible for some high paying Q codes (Q350…which pays $350 for taking complex patients). Number to date in incentives is close to about $40 000 for myself by rostering about 800 patients. That's hard to argue with!

Innovative Practices

Team Approach in A Time of Crisis

Gerry Glover, CEO, Kincardine Family Health Team

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Overview

- Community of Kincardine was faced with the sudden closure of three family medicine practices, months within each other
- 3500+ patients were impacted and the physician shortage threatened to destabilize emergency department coverage at the local hospital
- Roundtable lead by the Kincardine Family Health Team introduced Nurse Practitioner Diversion proposals consisting of Emergency Department Diversion (ER-D) and General Practice Diversion (GP-D)

Objective

- **SHORT-TERM GOALS**
  - Develop communication strategy
  - Patient notification
  - Identify vulnerable population groups
  - Maintain continuity of care
  - Insulate local family medicine physicians from fatigue
  - Initiation of an integrated, nurse practitioner-led model of care
  - Stakeholder engagement (i.e.: nurse practitioners, Family Health Organization (FHO) physicians group, pharmacies, Long-Term Care, local hospital, Ministry of Health)
  - Identify available supports (HealthForceOntario, physician recruitment)

Objective

- **LONG-TERM GOALS**
  - Maintain patient-centred care approach
  - Recruitment of additional family medicine physicians
  - Maintain the standard of care patients expect
  - Integrate an interdisciplinary team approach
  - Remain recruitment ready (keep affected practices intact)
  - Application for Group Enrolment Model (batch transfer of patients)
  - After-Hours Clinic (Pilot)

Response

PATIENT NOTIFICATION

- Be transparent
- Dedicated phone line established for affected practice patients, to call and receive the most up-to-date recorded information.
- We employed a series of communication strategies utilizing an array of platforms such as: social media, print media, radio and mail.
- Ministry of Health guidance related to notification expectations and timelines to communicate with affected patients in keeping with CPSO directives
- Signage in ER to notify patients of wait times and of the NP FAST CLINIC option

Response

MAINTAIN CONTINUITY OF CARE

- Manual review of unidentified patient data, based on diagnosis, was extracted from the electronic medical records (EMR) to identify those most vulnerable (i.e.: pregnancy, uncontrolled diabetes, complex conditions, cancer et.)
- Assignment of interim-patients, by random selection, to a primary care provider (physician or nurse practitioner)
- Patient notification of interim provider assignment and *opt-out* information
- Piloted an after-hours nurse practitioner-led clinic
- Provide are to rostered and un-rostered patients

Response

MINIMIZE PHYSICIAN BURNOUT

- Liaised with HealthForceOntario to solicit locum physician assistance through the Rural Family Medicine Locum Program (RFMLP) and the Emergency Department Locum Program (EDLP) to mitigate fatigue among family practice physicians also taking extra shifts in ER to fill the void created by the practice closures

NURSE PRACTITIONER RECRUITMENT

- Recruitment of two additional NP's to assist in our efforts to respond to the physician shortage

- Utilized one NP to take on a practice delivering primary care and two other NPs operating a fast track clinic, to divert patients away from the emergency department. This led to the initiation of our diversion protocol

Response

EMERGENCY ROOM (ERD) AND GENERAL PRACTICE DIVERSION (GPD)

- ERD protocol would voluntarily divert patients presenting at the Kincardine ER that had been triaged a CTAS 4 or 5 (to ensure ER remained available for patients presenting with more acute conditions)

- GPD was initiated in parallel to ERD, to ensure patients not able to access their primary care providers office within 24/48 hours of their choosing, could be diverted to the FHT-NP Clinic

- FHT developed the protocol and met with stakeholders for presentation on the diversion algorithm which the hospital accepted and adopted

Response

ENGAGEMENT: STAKEHOLDER

- Engaged stakeholders from the onset – hospital (protocol), municipality (circumstance), physician recruiter (recruitment), physicians, nurse practitioners and the Ministry of Health

- Patients were notified of practice closures, followed by notification that recruitment efforts are ongoing and until a permanent resolve is determined, and to ensure continuity of care, patients would be assigned, on an interim basis to another physician. Patients also had the option to 'opt-out'.

PHYSICIAN RECRUITMENT

- All-hands on deck approach to physician recruitment – contacting all recruitment leads, attending medical conferences, posting opportunities on HFOJobs, Physician Quest, Social Media (Facebook, LinkedIn), medical schools

Response

MAINTAIN STANDARD OF CARE

- We compiled a team of existing FHT staff, skewed schedules to allow for accommodation planning of this large-scale project
- Initiated a manual review of affected patients to determine complexity of illness (i.e.: pregnant, uncontrolled diabetes/complex condition, cancer et) to ensure affected patients continuity of care did not fall through the cracks
- Worked with remaining FHO physicians to determine capacity within each of their practices to '*be assigned, on an interim basis*' affected patients. Each practice accepted an additional 250-400 patients, on an interim basis.

Response

REMAIN RECRUITMENT READY

- Liaised with the Ministry of Health for approval to deviate from our Enrolment Model to make application for consideration of a Group Enrolment Model – to assist with batch de-rostering and re-rostering of thousands of patients to multiple physicians, on an interim basis until a permanent assignment was possible (physician recruitment dependent)

- Maintained record of a patients interim rostering in excel spreadsheets to keep practices intact to allow for recall following successful physician recruitment

- Discussions with largest local employer, Bruce Power, about availability for spousal employment

The Process

- **Physician Stakeholder Engagement**
  Acceptance of increasing capacity for additional patients

- **Ministry of Health – Primary Care Branch – Family Health Team Unit**
  Received permission to allocate projected surpluses and residual position funding to fund a second FHT-NP

- **Ministry of Health – Blended Models Unit**
  Permission to transition to Batch Group Enrolment Model (this facilitated smoother patient re-rostering and negated the need to have patients complete rostering forms)

- **Manual Review of Data**
  Ensure all patients were re-assigned and those with complex needs experienced no or limited disruption to continuity of their care during our transition

The Process

- **Medical Directive Management**
  - Development of medical directives for any tests and/or procedures
  - Physician consultant identified
  - FHO physicians unanimously sign-off on medical directives

- **Nurse Practitioner Service**
  - ER and GP Diversion Programs
  - Rostered and Non-Rostered
  - Interdisciplinary collaboration (HTN, OT, Diabetes, SW referral)
  - Specialist referrals
  - FAST CLINIC (10-15 minute appointments)
  - Cardiac and Neuro-rehab Program Leads

- **Nurse Practitioner Afterhours Service**
  - Operated as a pilot program for 3 months
  - Same volume in three hours that the office had seen all day

Challenges – Unintended Consequences

- **Locum Recruitment**
  - Not sustainable model
  - Amazing collaboration in the face of adversity
- **Nurse Practitioner Recruitment**
  - Open recruitment to new graduates
  - Patient awareness and education of nurse practitioners
- **Accommodation**
  - Patient Request to Change Interim Assignment
- **Group Enrolment Model**
  - Model not an option during our first practice closure and was successful into subsequent practice closures
- **Nurse Practitioner After Hours Clinic**
  - Afterhours clinic saw the same volume in three hours as in office

Results and Measurements

- **Medical Landscape**
  Redefined (++ interdisciplinary collaboration)

- **Success**
  Not having to revert to re-instatement of the Orphan Clinic
  Utilization of locum and HealthForceOntario physicians, NP's
  Proactive Team collaboration and engagement
  Patient Education and Awareness
  Recruitment of three physicians and retention of two NP's

- **Retention of Nurse Practitioner Clinic**
  Core community service
  Nurse Practitioner-led ER and GP-Diversion
  Cardiac and Neuro-Rehab Program-leads
  EarlyON Collaboration
  Rapid Access and Addiction Medicine (RAAM) Site-Partner
  Nurse Practitioner Clinic annual diversions (2,500)*

Northwestern Ontario Health Recruitment Association - NOHRA

Jamie Sitar, Regional Advisor, HealthForceOntario

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The Region

- Largest geography of all LHINs
- Covering 47 per cent of Ontario's total land mass
- Lowest population with just 235,900 residents
- Largest proportion of Aboriginal people of all Ontario LHINs - 21.5% of population
- One Regional Health Sciences Centre
- 14 Communities, 32 + Remote Access
- Manitoba border
- One Medical School

The Needs

- **Chronic Physician Shortages**
  - High usage of EDLP, NSLP and RFMLP
  - 60+ FTE openings for Family Physicians in Jan 2019
  - Stability at risk
  - FPA and other focused practices

- **Variety of Communities**
  - Population (ranges from >100 to 100,000+)
  - Patient population serviced (old vs. young)
  - Medical services available (surgery, obs. etc…)
  - Patient Enrollment Models (FHG, FHO, AHPs)
  - Physician Services Agreements (RNPGA, SLRPSI)
  - Extended Health Services (Mental Health, Allied Health)
  - Transportation options to Referral Centres

- **Regional Problems**
  - Unreliable data for planning
  - Bad experiences can effect whole region through word of mouth
  - Recruitment experience inconsistent from community to community
  - Missed cost savings (locum extensions, economies of scale)

The Recruitment Picture

- **Recruitment landscape is different in each community**
  - Different funding arrangements
  - Resource allocation
  - Percentage of time focused on recruitment
  - Relationships with medical schools
  - Polarizing results

- **Led to some overall characteristics:**
  - Competitive
  - Scarcity mindset
  - Protective
  - Lack of trust

Change Was Needed

- **Same Problems:**
  - Hard to find good fit
  - Expensive to recruit
  - Lack of coordination increases costs
  - Unreliable data sharing leads to poor regional planning
- **Sense of Urgency Understood:**
  - First meeting
  - Problem sharing
  - Finding common ground
  - Sharing best practices
  - Collegial

NOHRA is Formed

- **Commitment to Work Together:**
  - Terms of Reference included broader healthcare needs
  - Win for stakeholders
  - Conference Attendance
  - Privileging and Locum Sharing
  - Resident Support

- **Communication Tool:**
  - LHIN has direct contact with key stakeholder group
  - Data collection and validation to inform planners
  - Developing and vetting best practice initiatives
  - Quick turnaround for unexpected situations

Success Stories / Results

- Introduction of LHIN and HFO Welcome Letters in the NW
- HFO's Onboarding and Orientation Guide
- Conference Collaboration
- Locum Coverage
- Robust Data Development
- Housing Alignment

Where NORHA is Headed

- Locum Experience Standardization
- Advocating for North West
- Funding Applications
- Advise Local Communities on HHR Planning
- Cost Sharing Recruitment Tools
- Regional locum pools

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Regional Locum Approaches

Kevin McLeod, Regional Advisor, HealthForceOntario

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RFMLP Usage
Grey Bruce/South Bruce

Based on 2018 Calendar Year

Eligible Physicians	Respite Days Available	Respite Days Used	% Respite Usage based on available Respite Days	On-Call Used	% On-Call Usage to Available Respite Usage	# of Unique Locum Physicians	# of Locums that are New Grads
55	1123	782	70%	296	26%	55	17

Strategic use of locums

- Talent Pipeline
- Broad based practice
- Supporting primary, acute and community needs
- Long term focus

VS

- Randomly filling temporary vacancies
- Narrow practice focus
- Supporting individual practitioner needs
- Short term focus

Considerations for Regional Approaches

- Coordination and cooperation amongst clinics, hospitals & neighboring communities
- Ensuring locums have the skills needed for rural generalism
- Adjacent locum dates vs overlapping of dates
- Assignment to multiple communities
- Alignment of compensation rates
- Strategic use of funding (RFMLP, EDLP, Site Visit)
- Development of local locum pool accessible to all communities

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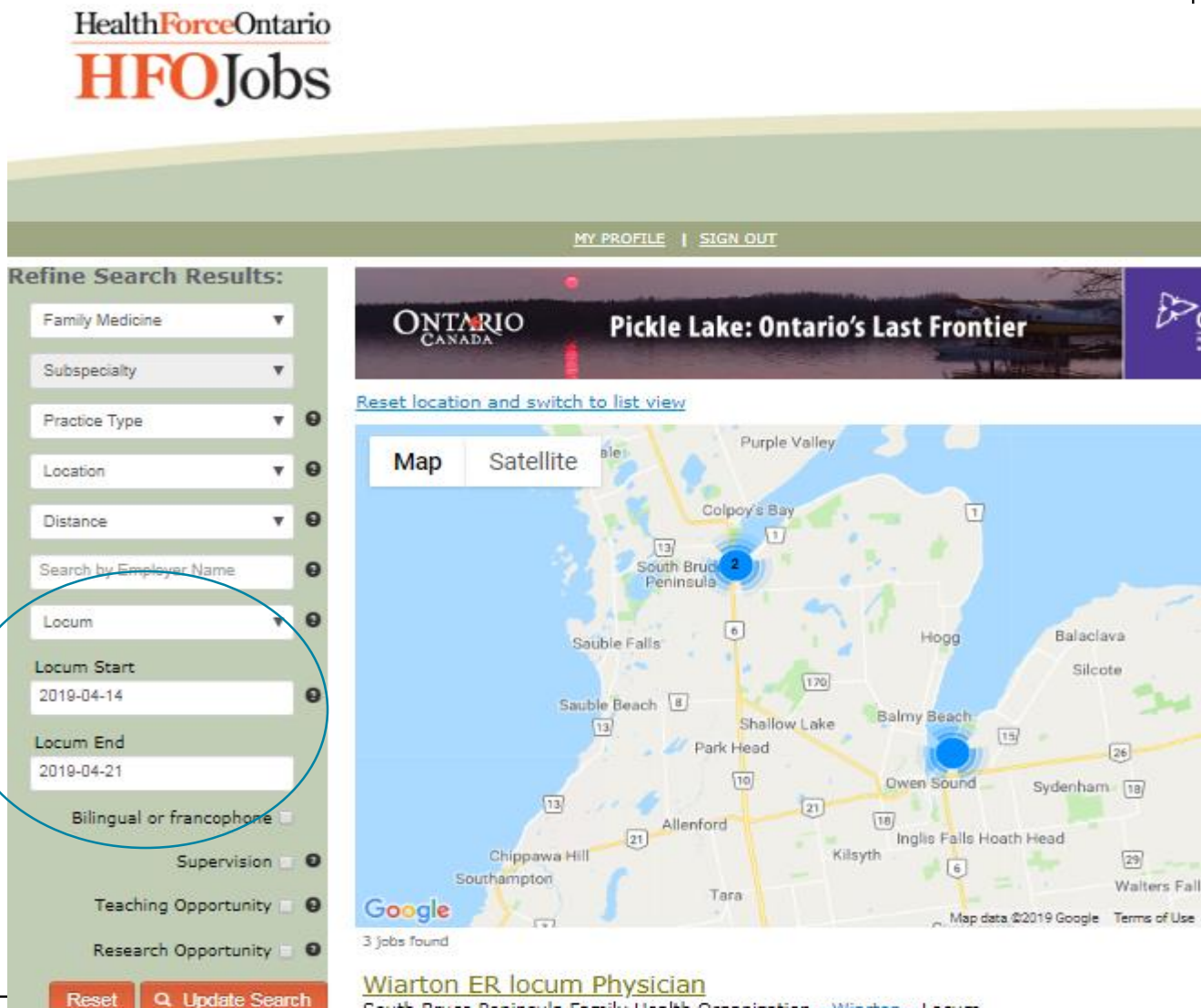
New Features on HFOJobs

New Features	Impact
Ability to search by locum dates and improved features for adding and managing postings	• Improved locum scheduling and reduced administrative burden for employers and job seekers
Job seeker receives strategically recommended locum opportunities by region/date	• Ability to schedule longer locum assignments in multiple communities in a region.
Employers are made aware of similar locum opportunities in their region, including the dates that coverage is needed	• Ability to coordinate locum opportunities regionally and align incentives as appropriate • Reduces competition and optimizes regional locum capacity

Improved Search Functions

Search by date range



A New Digital Connection to QI and Office Efficiencies

Dr. Paul Gill, MSc MD CCFP FPA
Digital Clinical Lead, SW LHIN
Clinical Lead, Huron Perth

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DIGITAL
COALITION

What you said…

Digital Tools to Support Rural Practices
Theme: Physician Well Being: Supportive Practice Environment, Workload
Updating staff with IT support. I know people who chose to stepdown due to lack in confidence in learning new IT
a rural area with fewer amenities for potential physicians and fewer professional supports than exist in more urban areas.
An understanding of local needs and a comprehensive approach that puts a focus on the broader team, rather than just the "doc"
Needing to work closely with the community resources isn't always as easy as it would seem (who to reach out to and how to access them easily)
Not feeling supported in the work they are doing
For us we are so low staffed the main one is physician burn out and no back up call coverage.
Many looming retirements due not only to age but due to prolonged contract disputes with the government and the resulting attempts to vilify physicians. Working a crazy amount of hours per week in a chronically under serviced area - with no end to shortage in sight -
Full scope practice isn't how everyone wants to practice these days. So many hours, rounding on inpatients 7 days per week isn't conducive to work life balance.
Life work balance
Workload; most of the residents we teach can find easier employment with less ER and less on-call responsibilities.
Working rural ER and not feeling well supported by regional centre and specialists. Specialists at regional centre are overworked and tired.
Pay, resources, rural aspect, workload and scope
Rising overhead costs coupled by government funding reductions
low physician complement in rural communities leading to physician burnout
Rural physicians expectations (ie: working in clinic practice, cover ER, enhanced evenings/weekends) - leading to burnout (working more for less pay)


PrescribeIT™
CANADA'S ELECTRONIC PRESCRIPTION SERVICE

eNotifications
HRM


CONNECTING SOUTH WEST ONTARIO
ClinicalConnect™


1. REQUEST
Requesting Clinician
eCONSULT
2. RESPONSE
Specialist

Patient Portals


ST file photo

eHealth Ontario

cean

cSWO
CONNECTING SOUTH WEST ONTARIO

South West LHIN

MyPractice
Primary Care
A tailored report for quality care

Partnering for Quality
Working together to improve health outcomes

OntarioMD

eHealth
CENTRE OF EXCELLENCE

PS SUITE EMR

otn
Care. Connected.

Health Quality Ontario
Let's make our health system healthier

afhto

ACCURO®
Electronic Medical Records

The Burning Platform For Change

In Primary Care

- Health Human Resource Capacity (physical # of people to support the work)
- Variable technical skills within primary care settings
- Variable 'quality' standards with tools/forms (workflows, ease of use, EMR compatibility)
- Volume of forms/tools (over 500 forms and unknown amount of custom tools)
- Clinics report between 3-5hrs/week are spent building/editing forms
- Overall forms management within each primary care clinic varies significantly

Hospital/Public Health/Mental Health & Addictions/Home & Community Care, Community Support Agencies

- Quality of referrals received (distorted faxed forms)
- No mechanism for feedback from users
- Uptake of 'most current' form low
- Missing information or illegible forms is received
- Limited understanding of primary care EMR functionality

Practice Facilitation

South West LHIN

cean

eHealth Ontario

MyPractice Primary Care
A tailored report for quality care

OntarioMD

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eHealth Centre of Excellence

afhto

cSWO Connecting South West Ontario

Health Quality Ontario
Let's make our health system healthier

Change Management

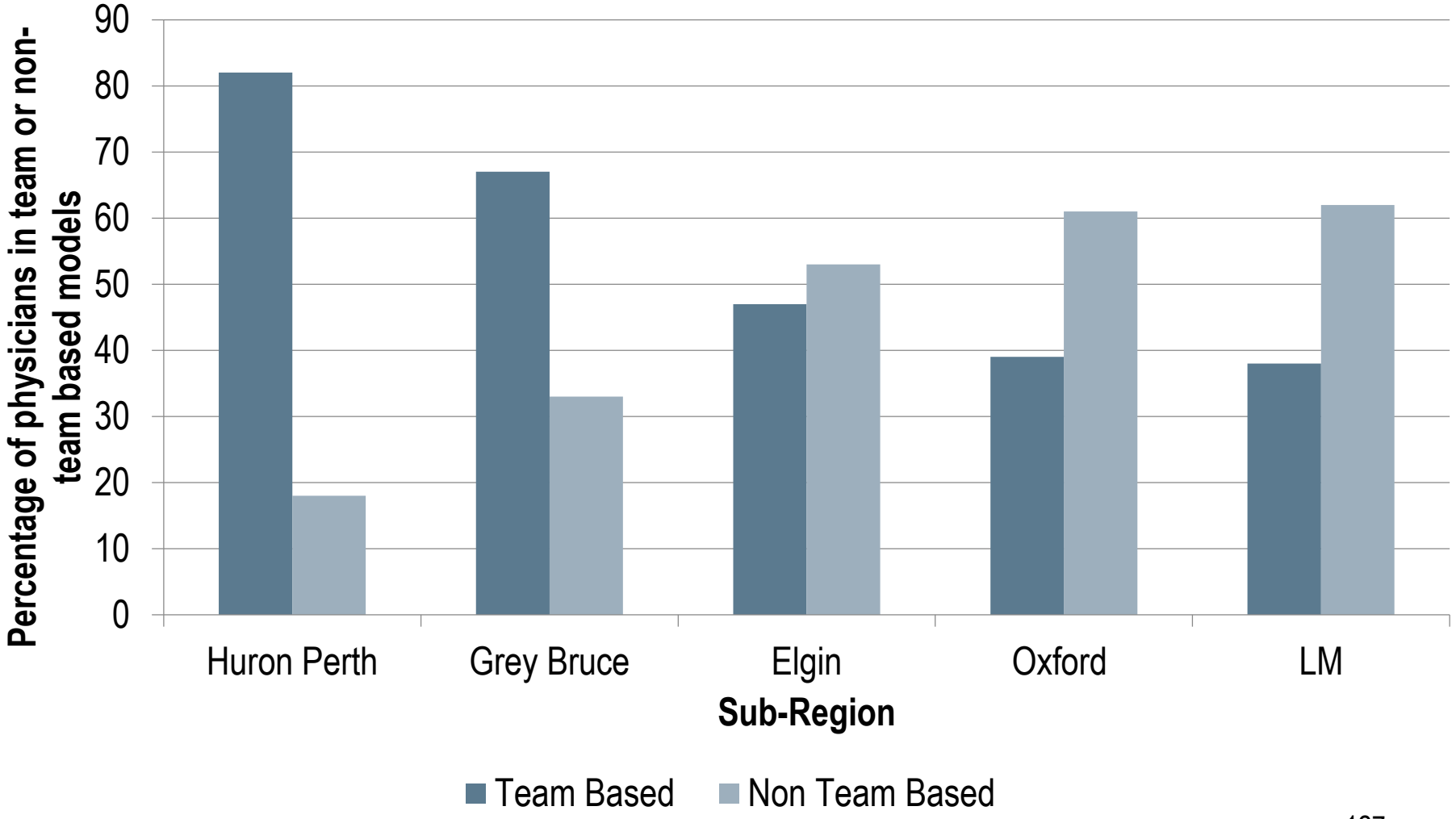
Partnering for Quality
Working together to improve health outcomes

IT Lead
FHT

PS SUITE EMR

ACCURO Electronic Medical Records

Primary Care Distribution in the South West (access to team based care)



How we got here

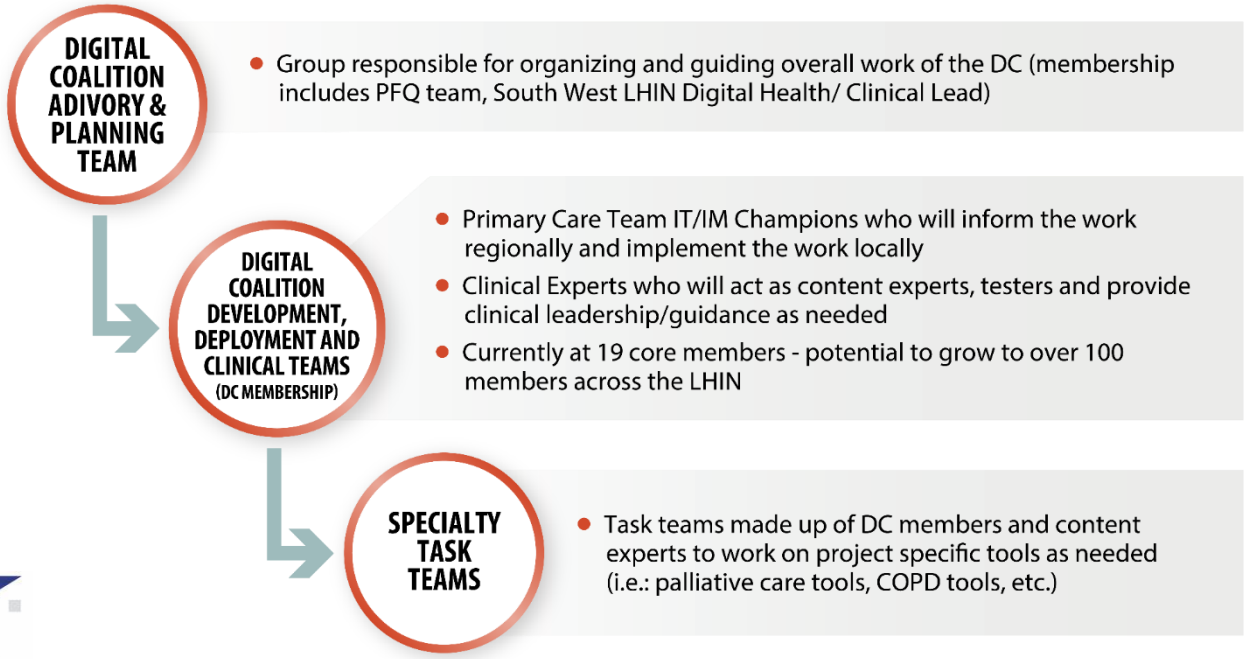
-PCN

SW Primary Care Alliance - model

Leads
Monthly newsletter
Q2mo regional web enabled engagement (CME, LHIN initiatives)
-70% newsletter engagement

Digital Coalition (PCA model for IT)

The Digital Coalition (DC) will support the *development of digital health human resources* to begin *addressing capacity, quality and consistency issues identified regionally*. In addition to assisting in deployment of regional digital health priorities such as imbedding referral forms into EMR, supporting deployment of digital tools (eConsult, MyChart etc.)



DIGITAL COALITION

Acknowledgements to date

Clinton FHT

Stratford FHT

London Health Sciences Centre

North Huron FHT

London FHT

North Perth FHT

East Elgin FHT

Thames Valley FHT

Thehealthline.ca

Saugeen Shores Medical

Brockton and Area FHT (Chesley)

St. Thomas Elgin General Hospital

South West Regional Wound Care Program

South Huron FHO

Happy Valley FHT

Huron Community FHT

London & Region Medical Referrals

St. Joseph's Health Care London

Maitland Valley FHT

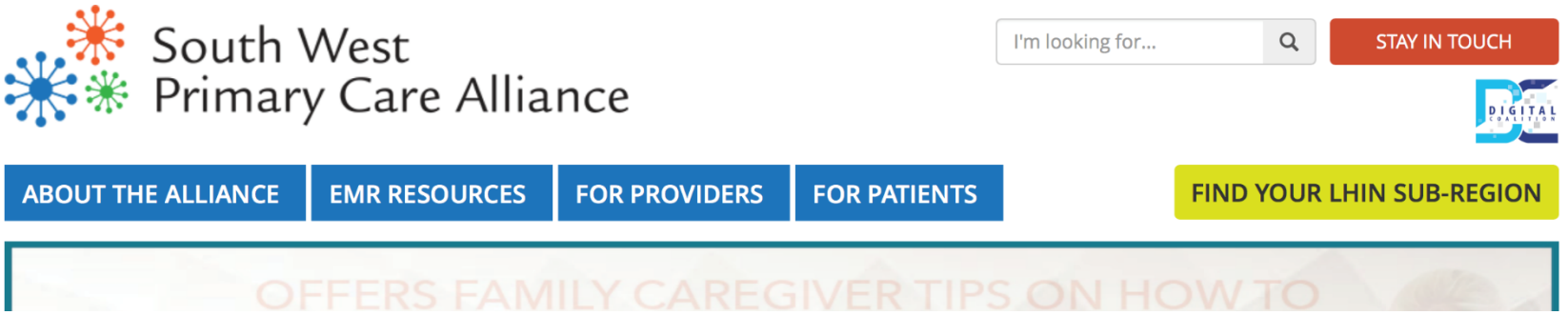
London Lambeth FHO

Partnering for Quality staff

South West LHIN Clinical Leads

Huron/Perth QIDSS

Dr. Rachel Orchard (Oxford)



Patient's First…swpca.ca (for patients button)

- Internet home for
- -SW EMR tools
- -patient friendly "handouts"
- -patient friendly "norms"

Since Nov ’18 – CoDesigned with standards

- **# of forms supported* by DC to date**
- *Support includes:
- consultation on design and clinical content development of new forms with EMR-specific considerations
- support on re-design of existing forms
- conversion from PDF to EMR-compatible version
- EMR functionality testing in two live EMR systems
- Communication and dissemination of completed new or updated forms to primary care network (Digital Coalition membership)
-
- Forms posted to the original SWPCA website pre-Digital Coalition: 18
- Forms posted to Digital Coalition repository since DC launch: 36
- **Total = 54**
- 3 Provincial forms
- 15 Regional (LHIN wide) forms
- 5 multi-site (eg. SJHC+LHSC) forms
- 31 single organization forms
- Includes Acute Care, Home Care, Mental Health/Addictions, Public Health and other specialist
-
- **8-12 currently in Forms Queue at various stages of development**

South West

Musculoskeletal

Rapid Access Clinic

Location of Assessors

REGIONAL TEAM

2 Advanced Practice Leads:

- Rhonda Butler (Hip/Knee)
- Ravi Rastogi (Low back pain)

8 Advanced Practice Providers for the region (population based allocation):

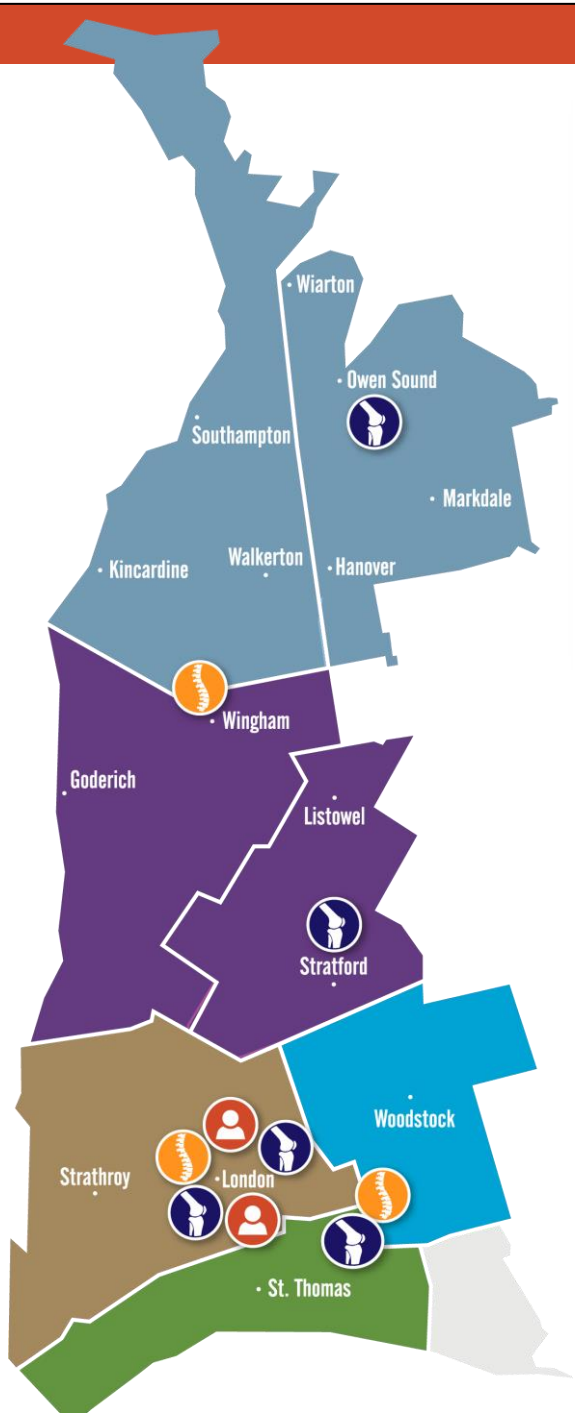
- 3 Low back pain (London, Wingham, St.Thomas/Woodstock)
- 5 Hip/Knee (London, Woodstock/St. Thomas, Huron Perth, Strathroy, Owen Sound)

Advanced Practice Lead

Hip/Knee Assessor

Low back pain (ISAEC) Assessor

*** Advanced Practice Leads provide additional assessment supports across the region where needed*



What's Next For You, Our Primary Care Partners

1. Go to http://www.isaec.org/isaec-registration.html to submit your ISAEC registration and complete the 20 minute, online training module.

2. **On April 15**, download the Hip and Knee referral form, and start using the form. Do same with the Low Back Pain referral form as soon as the training module is complete.

3. Advise your patients that waitlisted patients are being assessed prior to new referrals. The South West Rapid Access Clinics will advise when all waitlisted patients have been seen and the standard, four-week turnaround for assessments will be met

4. Provide feedback on your experiences with the onboarding process and the program to:
   a) Your Primary Care Lead
   b) MSK Primary Care Champion: Tatiana.Jevremovic@lhsc.on.ca
   c) Advanced Practice Leaders:
      Hip and Knee: Rhonda.Butler@lhsc.on.ca
      Low Back Pain: Ravi.Rastogi@lhsc.on.ca
   d) Central Intake: MSK_CentralIntake@lhsc.on.ca

5. A patient information brochure is in development.


QUESTION &
ANSWER

Grey Bruce Health Forum

Break

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Group Discussion: Solutions for Grey Bruce

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Question 1

- **What are some suggestions to promote and recruit primary care providers in our region?**

Question 2

- **How do we retain primary care providers in Grey Bruce?**

Top Priorities in Grey Bruce

- **Tables share their top priorities**

Grey Bruce Health Forum

Closing remarks

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What's Next?

- Continue today's great discussion!
- Evaluation Forms
- Grey Bruce Health Forum Report
- Task Force