Rural Site Visits Project

Community Report: June 2017- December 2018

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Rural Coordination Centre of BC
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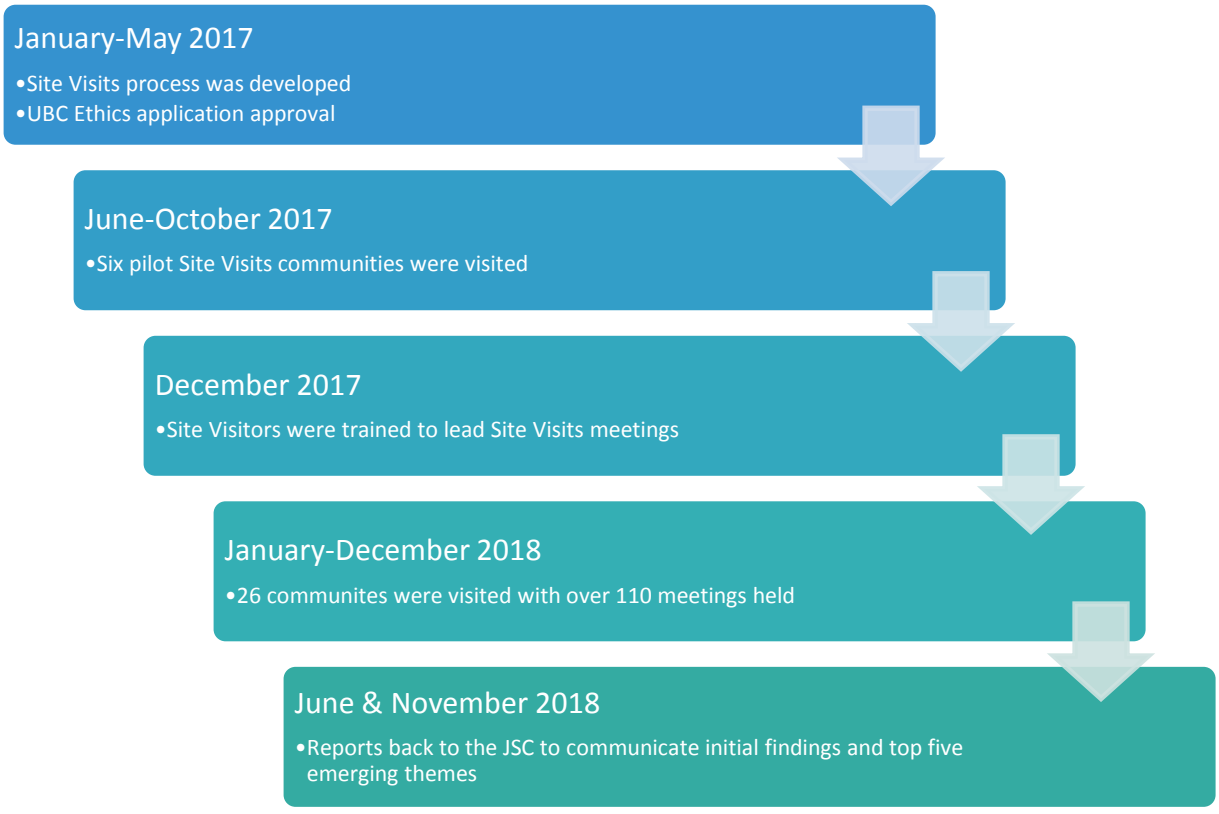
Rural Coordination Centre of BC

Overview

In 2017, the Joint Standing Committee on Rural Issues (JSC) tasked the Rural Coordination Centre of BC (RCCbc) with visiting every Rural Subsidiary Agreement (RSA) community between 2017 and 2020. These visits will connect with rural practitioners and communities to hear about the context of rural practice and health care delivery (what innovations exist, what works well, what the biggest challenges are) and feed this information back to the JSC, to better support feedback loops between rural practitioners and the programs they use.

Site Visits will engage Health Partners (Health Professionals, Health Administration, Policy Makers, Community, and Academic Institutions) within each community. From these community meetings, information is collected, anonymized and analyzed into themes to identify the major themes affecting health care delivering in rural communities in BC. As a commitment to the communities, the RCCbc will provide a bi-annual Community Feedback Report to provide updates on the project progress and share the learnings from innovative solutions found throughout the visits.

2017-2018 Timeline



Emerging Themes

A qualitative software analysis program called NVivo is used to identify and highlight emerging themes from community meeting notes. Through this process, approximately 30 communities from June 2017 until December 2018 have agreed to have their responses included.

Top 10 categories themes have been extracted from:

1. Transportation
2. Support (Collaboration and connection, community support, employee and workplace support)
3. Population (Recruitment and Retention)
4. Successful Initiatives (Models, measures, and programs)
5. Quotes
6. Physician Scope of Practice & Workload (Includes physician time off and burn out)
7. Health Authority Correspondence & Relationships
8. Finance (Physician funding, billing and pay)
9. Patient Capacity (Information relating to wait-times for services, family physician availability, and/or number of beds available within a hospital setting)
10. Demographic Focuses (Indigenous, aging, and youth)

Transportation

This category contains themes relating to both the strengths and barriers of transportation spanning five areas: distance; emergency transportation; local transportation; the Patient Transfer Network (PTN); and weather.

Our most recent presentation to the JSC (November 2018) focused on the concerns we've received regarding the PTN. Rural physicians and other health care providers spoke about PTN as an initiative that was frustrating and largely unsuccessful due to the challenges with communication, lack of geographical knowledge, and lack of efficiency – resulting in high-risk scenarios and patient delays.

"We don't know always when the ambulance is coming and we don't know who they are here for and they are equally frustrated too. We need time to know when they are actually going to arrive. They say they are coming and then they don't come until much later."

The physicians and administrators in the rural communities have identified a number of issues involving the PTN:

- Excessive time spent on the phone attempting to get a patient transferred out
- Repeating the story multiple times to different people
- Poor communication between the PTN and the physician regarding arrival time
- Poor geographical awareness by PTN staff
- Poor understanding of the local circumstances in the community. For example, weather windows, daylight issues, and staffing issues.
- Poor documentation of treatment given when a patient is repatriated

Overall, physicians strongly suggest that the PTN is not as effective as it claims to be. The initiative causes high levels of frustration contributing to some physicians' decisions to leave a rural community. Areas of opportunity include: improved communication and transparency; the addition of geographic-focused education; and improvement with regards to the timing and intentional delaying of patient transfers.

Support

Effective listening, communication, and transparency are foundational in creating supportive relationships, as identified by physicians, municipality members, Indigenous community members, and health care administrators.

Strong Relationships	Community Support	Community Collaboration	Coworker Cohesiveness	Working in close proximity
•Municipal members and health administrators value relationship with physicians	•Directly involve the community in local health care initiatives	•An essential for resource delivery, improving connectings with each other, and also other community professionals	•Coworker support and operating in sync to achieve a goal	•Improves collaboration and support

"A strong relationship [exists] between the physicians and patients and community…People talk about the doctors fairly regularly, so they are the subject of opinion makers and advocates within society and important pieces of society."

Population

Population is the third most coded-to category across all the current interview data. The four areas of population include: (1) Population Growth, (2) Recruitment, (3) Retention, (4) and Tourism.

Through this category, we have been able to begin to identify what aspects of relationship building works best for recruitment and retention and better understand factors that negatively affect recruitment and retention. One large part of successful recruitment occurred when communities had a direct or indirect influence on the recruitment process, and is briefly highlighted below:

"They had a successful recruitment initiative in the past – what would be needed to make it stick? The community engagement really worked well with trying to attract a new doc."

"Emphasis on collegiality which has brought people here."

"Marketing the wider scope of practice can help with recruitment."

"Greatest strength is the people they have been able to recruit, involvement of community in decisions, and general inclusivity."

> ***"Community needs to be involved in recruitment, it is the community's responsibility to share the things that attract people."***

Sharing Successful Initiatives

Many rural communities face unique challenges which present themselves in areas such as health care delivery, transportation, geographical isolation, and physician scope of practice. In order to overcome some of these unique barriers, communities have implemented successful measures, models, and programs that have created a beneficial impact in improving the health care of a community.

Measures

In order to provide better health care delivery for unattached, marginalized, and/or minority individuals, communities have created specific measures such as hiring a patient navigators and liaisons. Other methods that were reported to help increase health care access to vulnerable populations included the use of online web-based services.

> ***"Had a social worker working with Divisions, kind of as a patient navigator, and has been working with the vulnerable [and] marginalized population because once they [become] attached it will take less time to figure out what is going on."***

> ***"[We have a] rapid response physician in community to respond to patients with acute needs in community and the hope is that this will try to encourage attachment for those who are unattached, particularly for the frail seniors in the community."***

> ***"[We] have an APLW (aboriginal patient liaison worker) here to provide support to Indigenous clients to provide cultural support."***

> ***"[We] consult some palliative patients from their home via Webex."***

The approach of community-driven measures have allowed communities to collaborate and participate directly in health care discussions with physicians, municipality, health administrators and First Nations. This has led to successful awareness and priority setting for rural health-service delivery.

> ***'We have a health forum that holds forums 4 times a year in our communities, and people will step up and tell stories, and we try to fix them."***

> ***"[We have] community engagement meetings where [we] provide dinner for the whole community [and we] have papers for people to fill out that allow people to express their thoughts and questions…it is conducted in such a way that allows people to say what they want to say whether it is positive or negative. [We] are getting a new wellness center and that was partially brought about by these meetings."***

> ***"We created a health network to speak and hear the local problems. They meet every month [and] that's how we got a bus and telehealth. We don't overspend the money - we find better ways to use it."***

Not only did collaborative engagement strategies occur with local community members but also between municipality and the respective health authorities.

> ***"Engagement started during the time of crisis when they only had a few docs here and [nearby Community X] was also struggling, and the physicians were saying they can't even get away to get a break because they have a hard time bringing in locums because there is no housing for them. That was the beginning of the city's engagement with physicians and it's grown successfully from there."***

> ***"The Mayor does attend the MAC (Medical Advisory Council) meeting, and [Health Authority Medical Director X] is a part of that. Purpose of that has been to update and engage the local physicians on the local initiatives and issues that they are working on as well and also so they can get a sense of the water temperature of the physicians in community to see what their plans are."***

As a further outcome of collaboration and relationship building measures, direct success of physician recruitment and retention was achieved.

> ***When [Health Authority X] is looking at landing someone here we have an individual on the [municipal] council who gets engaged with them by hosting luncheons here. There was a young [physician] couple here who were soccer fanatics so they took them over and had lunch where they met some of the soccer folks. Some families have specific dietary needs so [our council member] had sourced all of the places where their dietary needs would be met. [It's] not just about landing the physician but also their families too."***

> ***"There was a medical student who wants to train as a cardiologist [and] came to the mayor saying that if the Society ([Community X] Health Services Society) is able to fund his education for the next few years to do this specialty, then he and his wife (who is training as a pediatrician) would be willing to sign a 10 year return of service contract. [They] want to make sure that they are out of the box in supporting health professionals to provide services in [Community X]. That's why they have some of the funds available for nurses and others who want to go back to school to up their skills. The intent of the society is to get out of the box in terms of how you can help sustain the services."***

> ***"In 2015 we engaged in a very tight partnership with [Health Authority X] on a doctor recruitment strategy when we were given notice that 9 physicians were leaving town. [We were] supposed to have 32 docs in the community but only had 23 and then had notice that 9 physicians were going to leave after that. We sat down with [Health Authority X] who were willing partners and we mapped out all of the system issues which causes problems in recruiting. Came up with a recruitment strategy with 12 doctors recruited after implementation."***

“During a challenging time we took on a similar approach to Obama’s campaign: ‘Obama no drama.’ When 9 physicians told us that they were leaving town, we asked ourselves ‘what are we going to do and how are we going to fix this?’ We took a more proactive approach instead of pointing fingers to the province. Asked ourselves ‘what are the system issues that are creating physicians to leave and how do we fix it?’ This was the approach that we took and it worked. Got on a path that was much more proactive than reactive. Offered free lodging and vehicles to potential physicians during this recruitment process [and] community members never knew that we were losing 9 physicians until we recruited 13 physicians. Never let one story go out about the issues, only had the stories going out about the successes. If we let the story out that a large group of physicians were leaving this would be an unwinding story. It would have made it harder to recruit new physicians to this environment.”

Models

Successful models were identified as initiatives inclusive of health services delivered in close proximity, effective communicative and team-based approaches of care, and appropriate financial models structured within communities.

> ***"[We have a] neighborhood accosted care model. Trying to look at clustering the care [we] provide to patients to a neighborhood to reduce the number of workers per client down to 5 which will help improve communication and quality of care"***

> ***"There is only one clinic located right across the road from the hospital – allows for autonomy of practice while being very easy to move into ER work when needed. Would other towns be able to buy into a single clinic model? Or do they work just as effectively in separate buildings? [This] simplifies practicing medicine and communication."***

> ***"Team based and shared model of care works well."***

> ***"Every community needs someone like [Physician X] – physicians who are willing to work with their local First Nations to build a model of care that works for them"***

> ***"[There is an] informal, cultural, expectation/agreement that you just pick up the slack when it's needed. No resentment between each other when someone is working less or more – they all take turns. They all recognize it's necessary. [This is] partially fostered by the flexible payment model – if they were all on the same contract, there would be less motivation for them to pick up slack for others… [We have] stability and sustainability of the practice [where an] agreement structure and financial structure helps. [This] agreement was written by the physician group and is modified by the group as needed."***

Programs

Youth-focused program development has allowed for easier health-service delivery for youth living in rural and remote areas. A significant benefit to some of these programs include the protection of a youth's confidentiality when discussing personal health information.

> ***"[We have found that] there is definitely a benefit of remote counselling [programs] – youth are super comfortable with virtual experience and it means that it isn't someone who lives here and is someone's auntie [or relative] so they might be more likely to talk openly [about health related matters] and not feel like word will get out"***

Another significant benefit to service delivery programs for youth include the collaboration with local school boards to talk with children and high school students directly.

> ***"There has been some work amongst the physicians to go into the schools in [Community X] for mental health."***

> ***"One of the physicians has a specific interest in children and youth and has gone to meet with the school district to discuss how they can work across silos to make sure that children are getting the best care they can provide here despite lack of services."***

Lastly, successful programs that assisted in physician recruitment and billing included using the GP for Me program and the creation of a reminder program.

> ***"Feel [now] that they are well doctored…Did have a crisis where a lot of doctors left at the same time but luckily were able to recruit quickly through Divisions and picked up ~8 more doctors. Done through [the] GP for Me [program]."***

> ***"Found that physicians were not billing for taking on unattached patients but they have a program that helps check to make sure that the physicians are including those codes. This was developed because there was a threat to cut back on supports."***

Summary

Through the information collected to date, it has been identified that relationships are a foundational part of rural health. Aspects of relationship building such as communication and transparency are necessary building blocks to maintaining a successful relationship. Where relationships and communication problems have been identified, such as the PTN, feelings of frustration have built up and contributed to poorer patient outcomes and the loss of physicians.

Good relationships result in better support networks within a community. The more supports (e.g. community, employee, other community professionals) a community had, the more successful they were likely to be with regards to recruitment and retention. As further communities are interviewed it appears likely that relationships will remain a significant aspect of successful health care models and areas of improvement moving forward.