FINAL REPORT

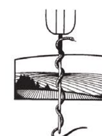
Summit to Improve Health Care Access and Equity for Rural Communities in Canada

The Rural Road Map for Action

July 2017

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

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



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

ABOUT ADVANCING RURAL FAMILY MEDICINE: THE CANADIAN COLLABORATIVE TASKFORCE

In 2014, the College of Family Physicians of Canada (CFPC) and the Society of Rural Physicians of Canada (SRPC) embarked on a joint initiative to develop a pan-Canadian framework to strengthen the rural physician workforce; provide high-quality, culturally safe care; and improve access for all people living in rural communities across Canada. Representatives on the Taskforce included members of the Royal College of Physicians and Surgeons of Canada (Royal College), the Canadian Medical Association (CMA), and the Indigenous Physicians Association of Canada (IPAC) as well as deans and educators, rural practitioners, government representatives, and community members. The Taskforce aimed to help unite educators, rural practitioners, rural communities, and health human resource planners in building a systematic approach to advance and support rural family physicians and specialists to optimize rural health care delivery in Canada through effective and sustainable health human resource planning.

ABOUT THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

The CFPC represents more than 35,000 members across the country. It is the professional organization responsible for establishing standards for the training and certification of family physicians. The CFPC reviews and accredits continuing professional development programs and materials that enable family physicians to meet certification and licensing requirements and lifelong learning interests. It also accredits postgraduate family medicine training in Canada's 17 medical schools. The College provides quality services, supports family medicine teaching and research, and advocates on behalf of family physicians and the specialty of family medicine.

ABOUT THE SOCIETY OF RURAL PHYSICIANS OF CANADA

Founded in 1992, the SRPC is the lead advocate and representative for more than 3,000 rural physicians practising in Canada. Its mission is to provide leadership for rural physicians and to promote sustainable conditions and equitable health care for rural communities. The SRPC performs a wide variety of functions, such as developing and advocating health delivery mechanisms, supporting rural doctors and communities in crisis, promoting and delivering continuing rural medical education, encouraging and facilitating research into rural health issues, and fostering communication among rural physicians and other groups with an interest in rural health care.

ADDITIONAL RESOURCES AND REPORTS OF THE TASKFORCE'S WORK CAN BE FOUND AT: www.cfpc.ca/ARFM_resources.

Publication of this report is funded by the:

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FOREWORD

We are pleased to provide this Final Report from the Summit to Improve Health Care Access and Equity for Rural Communities that was held on February 22, 2017, at the Wabano Centre for Aboriginal Health in Ottawa. Launched at the Summit by the Advancing Rural Family Medicine: The Canadian Collaborative Taskforce (the Taskforce), the Rural Road Map for Action (RRM) builds on the work that educators, rural practitioners, and governments have accomplished to improve rural health care. The goal is to produce and sustain an increased number of physicians practising comprehensive generalist rural medicine through the implementation of a set of recommendations outlined in the RRM at pan-Canadian and regional levels.

The Summit facilitated rich and engaging dialogue where participants—leaders representing various sectors from the health and education systems—articulated their perspectives in exploring strategies and sector roles to enable all physicians to practise comprehensive rural health care.

As the Summit stimulated momentum and secured the health and education sectors' involvement in continued dialogue on cross-sectoral roles to optimize rural health care delivery, it was a resounding success. Given the high momentum and positive energy, as well as the overwhelming response, there was consensus that all levels of the health care and education systems need to work together for successful implementation of the RRM. Summit participants agreed that more needs to be done to serve our rural and Indigenous communities better.

This summary frames what is to follow with ongoing collaboration. The CFPC and the SRPC have agreed to continue leading the RRM implementation and will provide a report card in 2020 on progress made. In the months ahead, the CFPC and the SRPC will begin to monitor implementation, explore collaborative opportunities with other stakeholders, and advocate where needed to advance the RRM.

We thank all stakeholders and participants who played instrumental roles in achieving the Summit goals and developing the RRM.

Sincerely,

Ruth Wilson, MD, CCFP, FCFP
ARFM Taskforce Co-chair

Trina Larsen Soles, MD, MSc, FRRMS
ARFM Taskforce Co-chair

THE RURAL JOURNEY

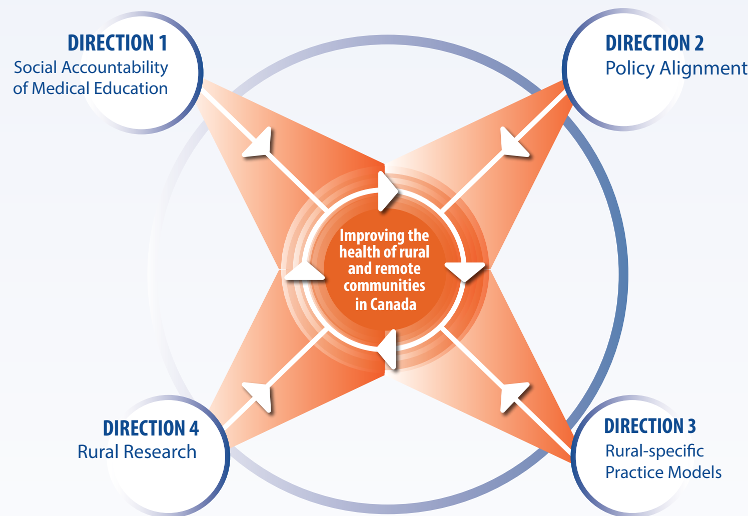
Improving access to health care in rural* Canada has been a priority across all levels of government, yet people who live in rural, remote, and isolated regions in this country still encounter challenges. Many successful initiatives have manifested change. Some communities are experiencing the benefits of having long-term health care professionals, including physicians, who have chosen to work and live in rural areas. Given these successes, the opportunity to implement a pan-Canadian strategy providing equitable health care access to rural Canadians is conceivable.

The College of Family Physicians of Canada (CFPC) and the Society of Rural Physicians of Canada (SRPC) struck the Advancing Rural Family Medicine: The Canadian Collaborative Taskforce in 2014. Using an evidence-informed approach founded on principles of social accountability, the Taskforce worked together analyzing research, reading policy papers, interviewing stakeholders, and conducting surveys to document key factors influencing physician recruitment and retention in rural Canada.

THE RURAL ROAD MAP FOR ACTION

In February 2017 the Taskforce launched 20 actions organized in four main directions (Figure 1), published in the ***Rural Road Map for Action (RRM): Directions.*** The RRM aims to: reinforce the social accountability mandate of medical schools, implement policy interventions aligning medical education and rural health care, establish rural-specific practice models and networks, and launch a pan-Canadian rural research agenda. The RRM builds on successful innovations and interventions in medical education, practice, and health policy to support the recruitment and retention of family physicians and other specialists working in rural Canada. It provides an approach that can be used systematically within and across communities, organizations, provinces, and territories.

Figure 1: The Rural Road Map for Action's four directions for improving health care in rural and remote communities in Canada

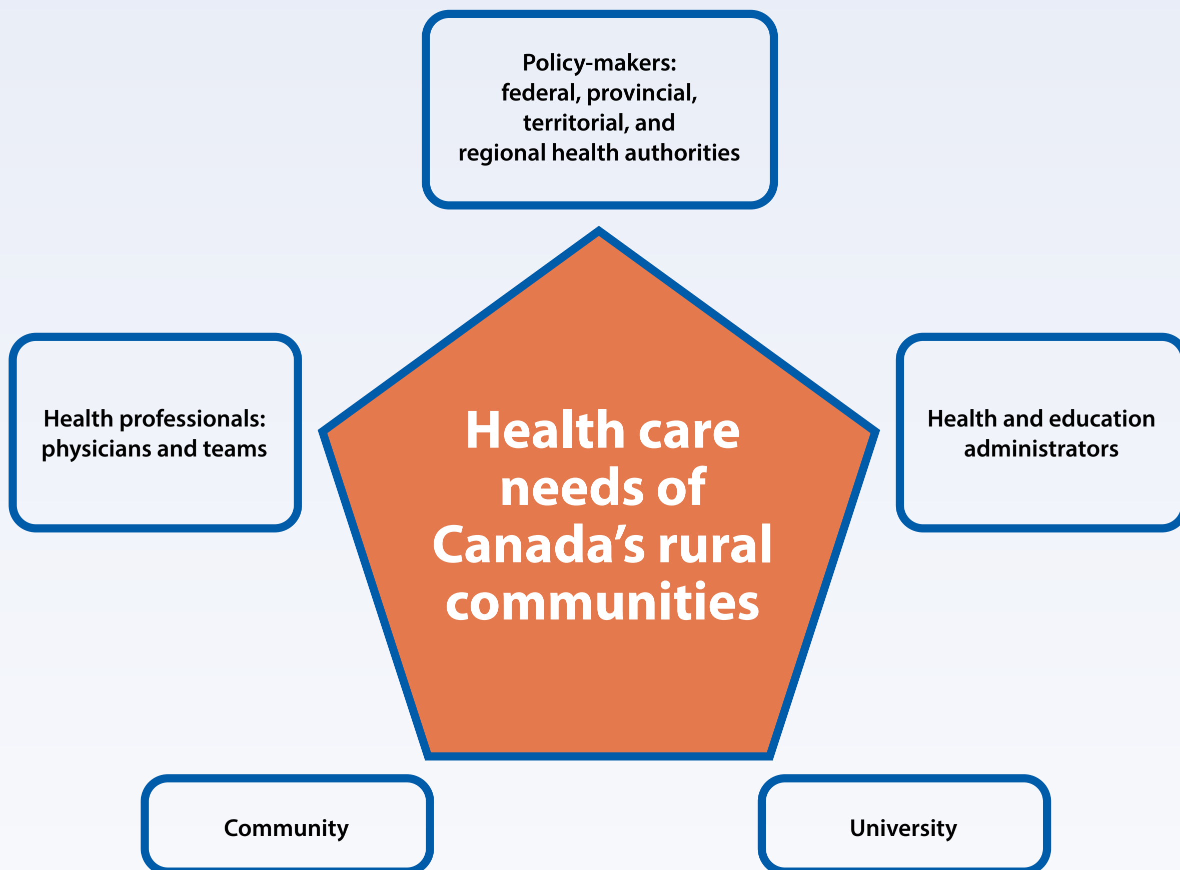


* Rural is defined as those communities that are geographically located in rural and remote regions of Canada including those distinctly or partly populated by Indigenous people.

PENTAGRAM PARTNERS – CALL FOR ACTION

The RRM stresses the need for leadership by five partners, identified as the "pentagram partners" (Figure 2). Working collaboratively these partners can enhance access to high-quality patient-centred health care for those living in rural Canada. Each has a key role to play in the implementation of the RRM. Government support and a strong commitment to collective action will enable the spread and growth of successes achieved in different parts of the country. Collaborative leadership can end the health inequities faced by rural Canadians.

Figure 2: Social accountability framework: The pentagram partners involved in implementing the Rural Road Map for Action



Adapted with permission from Boelen C. Building a socially accountable health professions school: towards unity for health. *Educ Health* 2004;17(2):223-31.

OVERVIEW OF THE RURAL SUMMIT

The Taskforce hosted an all-day Summit to Improve Health Care Access and Equity for Rural Communities in Canada to formally share the RRM with a cross section of pentagram partners. The Summit was designed to identify RRM priorities and seek opportunities for interorganizational and interprovincial/territorial collaboration. More than 140 individuals were actively engaged, representing education, government, practice, Indigenous and rural communities, and national organizations such as the Royal College, the CMA, the Canadian Nurses Association (CNA), the Federation of Medical Regulatory Authorities of Canada (FMRAC), and the Association of Faculties of Medicine of Canada (AFMC).

Allison F... ano Centre for ... ticipants and reminded ... who can make positive change so that "no one is left behind."

Algonquin Elder Barbara Dumont-Hill opened the Summit by inviting participants to consider what they could do collectively for rural and Indigenous peoples of Canada.

> *"We can all do better by collectively and collaboratively sharing ideas and best practices that are working well and innovative—such as those available through distance technology—and breaking down the silos that currently exist in our remote and Indigenous communities."—the Honourable Jane Philpott, Minister of Health*

In her opening address, the Honourable Jane Philpott, federal Minister of Health, applauded the goal of equity for all and stated that all Canadians should respond to the Final Report of the Truth and Reconciliation Commission of Canada, which calls for addressing the inequities of health care that Indigenous people experience in Canada.

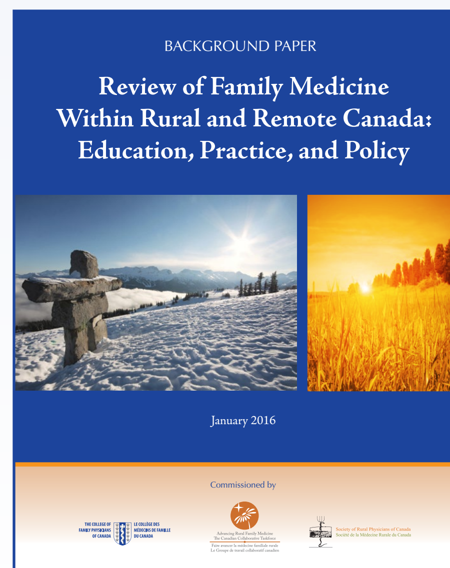
Policy and government leaders Beth Beaupre and Kevin Brown, members of the Federal/Provincial/Territorial Committee on Health Workforce (CHW), shared their personal observations regarding the RRM and the opportunity it offers to support evidence-informed and better aligned decision making for rural workforce planning in Canada. They stressed the need for continued dialogue and encouraged participants to work together to achieve the shared goal. Both reinforced the CHW's willingness to work with health/education stakeholders to enhance rural health care.

To understand more fully the intent of the RRM, participants viewed the launch of the RRM video highlighting the voices of each of the pentagram partners, emphasizing the urgency to address Canada's rural inequities, and articulating how the RRM Directions provide a way forward. With examples from different regions in Canada, the video was a powerful way to demonstrate the interdependent relationships needed by pentagram partners to ensure access to health care is provided to all in Canada.

Beth Beaupre and Kevin Brown address Summit participants at the Wabano Centre.

> *"That would be my comfort, to know that somebody is there for us and it's the same person regularly … somebody who knows my history. … That would be a great comfort to me."—Ann Meekitjuk Hanson, community member, Iqaluit, Nunavut*

The Summit focused largely on small-group activities, capitalizing on participants' expertise, to prioritize and identify concrete next steps to advance the RRM. (A list of RRM Actions can be found in **Appendix A.**) Prior to attending the Summit, all participants received preparatory material including a background paper *Review of Family Medicine Within Rural and Remote Canada: Education, Practice, and Policy*, a link to the **website** describing the development of the RRM, and specific assignments to enable dialogue at the Summit. The day was designed to gain perspectives on how to create an implementation plan for the RRM addressing national, provincial, and jurisdictional perspectives over the next two years. In small groups, participants were charged with prioritizing actions, identifying stakeholder involvement, defining key activities, and describing indicators for success. The results of the discussions are summarized in this report.



Participants formed small discussion groups that included representation from across pentagram partners.

PRIORITY ACTIONS IDENTIFIED BY PARTICIPANTS

Participants identified Actions 7, 11, 12, 5, 8, and 13 as the highest priority actions to address in the next two years (Table 1). These top priorities provide guidance for implementation of the RRM and recognize the necessity for collaboration across pentagram partners.

Table 1: RRM Actions identified as priorities for the next two years

Priority	Action
#1	**Action 7:** Establish government and university partnerships with rural physicians, rural communities, and regional health authorities that include formal agreements to strengthen the delivery of medical education in rural communities by developing and implementing specific visible rural generalist education pathways led by rural academics and rural physicians. Provide substantial ongoing funding required to support rural faculty engagement, faculty development, research, administration and community engagement.
#2 (TIED)	**Action 11**: Implement standard policies within health service delivery areas that require acceptance of timely transfers and appropriate consultations between rural medical facilities and secondary and tertiary hospitals, supported by regional training and patient care networks including generalists and specialists.
#2 (TIED)	**Action 12:** Develop specific resources, infrastructure, and networks of care within local and regional health authorities to address access issues, such as for mental health care (also general surgical or maternity care) in rural communities.
#3	**Action 5:** Educate medical students and residents about the health and social issues facing Indigenous peoples, and ensure they attain competencies to provide culturally safe care. (Supports the Truth and Reconciliation recommendations)
#4	**Action 8:** Establish programs with targeted funding from federal, provincial, and territorial governments to enable rural family physicians and other specialists, predominantly those already in practice, to obtain additional or enhanced skills training in order to improve access to health care services in rural communities.
#5	**Action 13:** Partner with rural communities and rural health professionals to develop strategies to guide implementing system-wide, coordinated, distance technology to enhance and expand local capacity, and improve access and quality health care in rural communities.

ACTIVITIES TO BE IMPLEMENTED BY RRM ACTION

Participants considered 13 RRM Actions in detail at the Summit, using small group interactive exercises to identify activities that are specific, measurable, attainable, realistic, and timely. The suggested implementable activities defining "who needs to do what" regarding specific RRM Actions can be found in **Appendix B**. These activities span local, regional, provincial/territorial, and pan-Canadian jurisdictions.

JURISDICTIONAL PRIORITIES

During the afternoon of the Summit, small group discussions were designed to prioritize the most relevant RRM Actions according to provincial/territorial or other jurisdiction affiliations. Table 2 lists the top four priorities identified for each of these jurisdictions. Many participants noted the interconnectivity of the actions and emphasized that many could not be successfully addressed in isolation (e.g., Actions 7, 3, and 4) and many needed to be performed simultaneously (e.g., Actions 11, 13, and 12).

Table 2: RRM priorities by province/region (see Appendix A for the full list of actions)

Province/Region	Priority Rank			
	#1	#2	#3	#4
British Columbia	Action 12	Action 8	Action 15	Action 14
Alberta	Action 7	Action 3	Action 6	Action 16
Saskatchewan	Action 5	Action 7	Action 12	Action 16
Manitoba	Action 12	Action 11	Action 8	Action 14
Ontario (1)	Action 5	Action 12	Action 8	Action 11
Ontario (2)	Action 14	Action 13	Action 5	Action 10
Quebec	Action 7	Action 19	Action 11	Action 13
Newfoundland and Labrador	Action 11	Action 13 & 12	Action 8	Action 7
Maritimes	Action 17	Action 12	Action 7	Action 4
Polar Arctic	Action 3	Action 7	Action 11	Action 4

SECTORAL PRIORITIES

Three specific groups prioritized actions based on their affiliations as researchers, learners, or leaders advancing enhanced surgical skills training for rural family physicians (Table 3). The researchers recommended the development of a business case for federal funding for a rural chair in all 17 departments of family medicine. Learner representatives proposed that all residency programs must have consistent wording in accreditation standards for the inclusion of mandatory rural learning experiences to emphasize the importance of exposure to rural medicine. Enhanced surgical skills' (ESS) advocates shared their need to have the scope of practice in rural settings clarified in order to define the type of training and resources required to provide general surgery and obstetrics.

Table 3: RRM priorities based on participants' affiliations (see Appendix A for the full list of actions)

Participant Affiliation	Priority Rank			
	#1	#2	#3	#4
Researchers	Action 16	Action 7	Action 17	Action 18
Learners	Action 4	Action 5	Action 16	Action 10
Enhanced Surgical Skills	Action 6	Action 8	Action 18	Action 12

PARTICIPANT PERSPECTIVES

The Summit aimed to identify priorities, catalyze agreement, and foster a spirit of collective intention around the RRM. Participants felt that the Summit achieved this vision and responded positively to the RRM (Figure 3), agreeing that the design of the Summit enabled them to contribute to the RRM's implementation strategy.

The Summit closed with a panel representing different pentagram partners sharing their perspectives on the future in a facilitated discussion.

"The development of partnerships is critical and this needs to be established between training programs and communities that include providers and patients. This includes defining a common understanding toward achieving safe care through effective engagement, consultation, and collaboration among pentagram partners."
—Panelist

Each participant was asked to commit to one action to advance the RRM. They each placed their commitment to action in a sealed envelope, which would be mailed back to them after the Summit to support continued engagement.

Figure 3: Results from participants' evaluation of the Summit

Percentage of respondents

60
50
40
30
20
10
0

The Rural Road Map (RRM) is useful for guiding the implementation of a national rural health care strategy.

Stakeholders from the realms of education, practice, policy, and research all play critical roles in advancing the RRM in Canada.

Rural communities play critical roles in supporting physician recruitment and retention strategies.

I believe the Summit effectively identified ways to address physician recruitment and retention strategies for rural communities that are relevant to my context.

I believe the Summit effectively identified ways to address physician recruitment and retention strategies at a pan-Canadian level.

I was able to contribute ideas about how to implement RRM actions that are relevant to me.

The small group formats used in the morning and afternoon were effective in identifying ways to address the RRM's recommendations.

The speakers shared relevant information to help address equitable health care access and quality care provision in rural areas.

The video provided me with a good understanding of the RRM's intent.

The pre-planning consultation paper was useful in preparing me for the Summit deliberations.

The Summit's large group debriefing sessions effectively captured key actions that need to be done in the next three years.

I believe the Summit invited the right stakeholder groups to discuss opportunities to advance the RRM.

I believe the Summit effectively identified a set of next steps for the implementation of the RRM.

There is commitment from those who attended the Summit to move the RRM forward.

I will share the RRM in the contexts in which I work to advance its implementation.

Strongly disagree
Disagree
Agree
Strongly agree

Total participants = 140
Evaluations submitted = 52
(37 per cent response rate)

Many participants expressed ongoing interest in participating in post-Summit RRM implementation activities (**Figure 4**). There was interest in all four directions (**Figure 5**), with representative voices from pentagram partners indicating willingness to participate in the implementation phase.

> *"The next steps of the RRM are crucial. Public engagement and grassroots voices will be essential for long-term success."*
> *—Community leader*

Figure 4: Levels of participants' interest in post-Summit activities

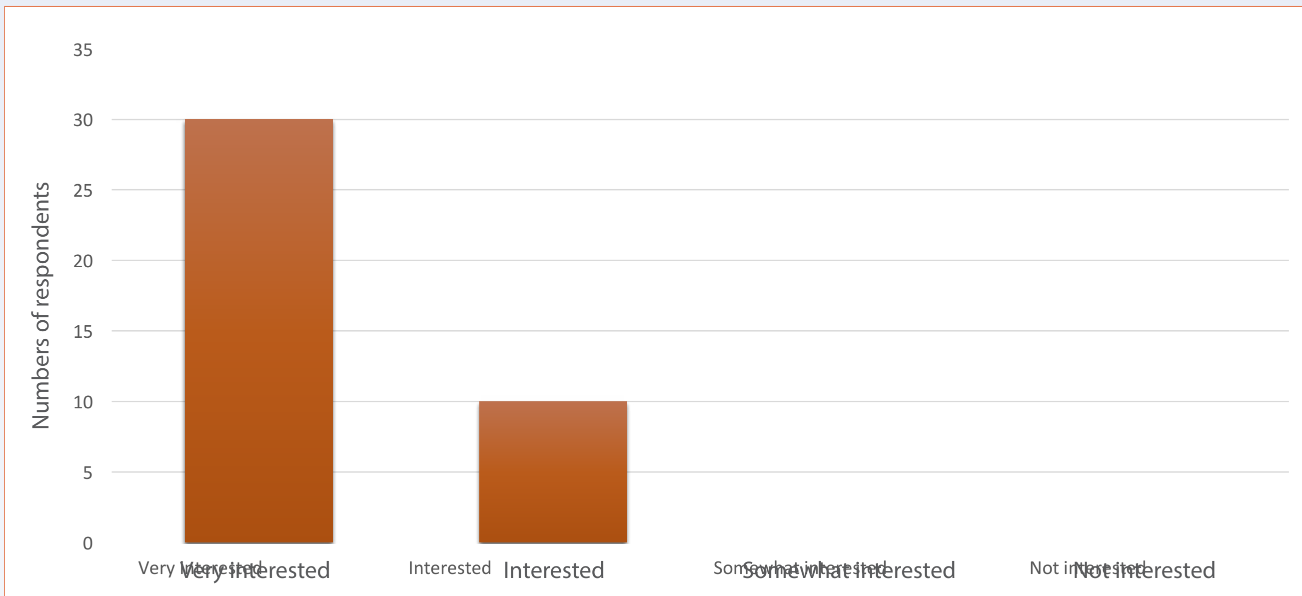
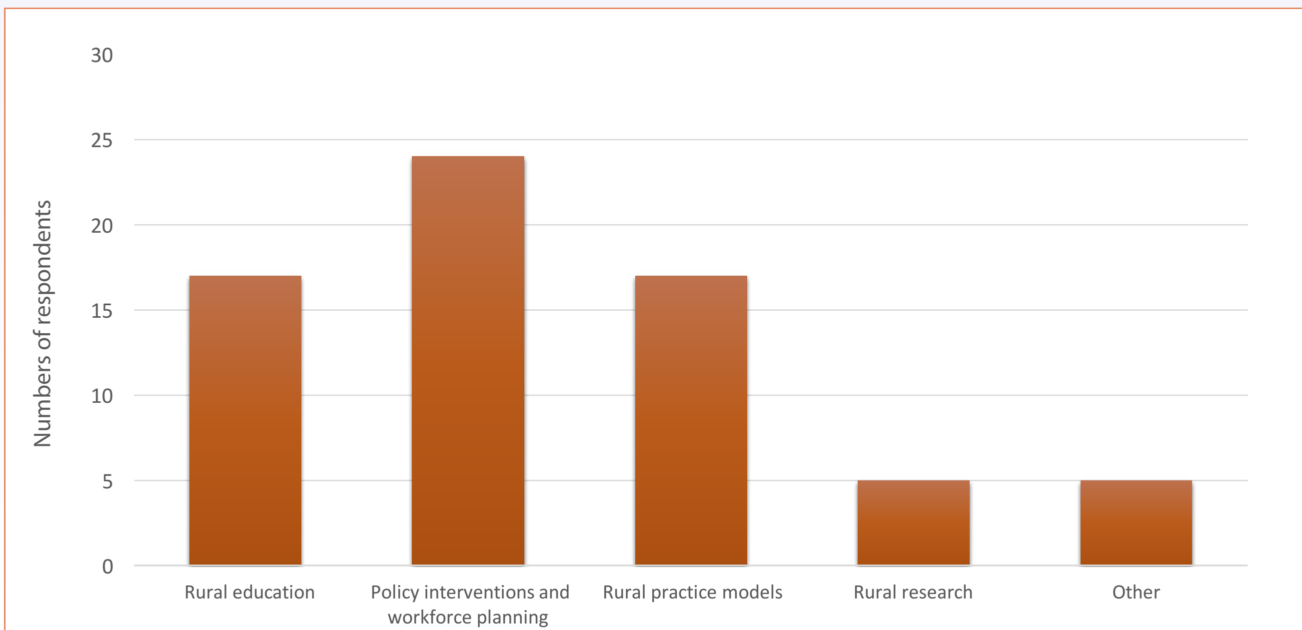


Figure 5: Areas of participants' interest in post-Summit activities



NEXT STEPS: RURAL ROAD MAP IMPLEMENTATION

On the heels of their successful collaboration that led to creating the RRM and co-hosting the rural Summit, the CFPC and the SRPC have pledged their leadership to continue working together to support the implementation of the RRM over the next two years. The two organizations thank the Taskforce members (see page 15), particularly Co-chairs Dr. Ruth Wilson and Dr. Trina Larsen Soles, for the time and energy they dedicated to creating this unprecedented pan-Canadian rural strategy built on a social accountability premise. Uptake of the RRM has already begun, with different organizations signalling a willingness for continued participation. A Collaborative will be formed in late 2017 to enable all those involved in implementing activities related to the RRM to share their successes and challenges. A Steering Committee composed of representatives from the CFPC, the SRPC, and other key organizations will spearhead monitoring the RRM's implementation and provide advocacy where needed. A 2020 Rural Road Map Report Card will highlight progress to date, celebrate successes achieved, and identify further steps to be taken.

The aim of the RRM is to improve equity and health care access for rural Canadians. The status quo is no longer acceptable. Evidence of success will come when we see improved health outcomes for those in rural Canada. Collective commitment is needed. The CFPC and the SRPC are optimistic for what lies ahead. The journey to implement the RRM has begun. The destination is within reach.

ARFM TASKFORCE

EXECUTIVE MEMBERS

Dr. Ruth Wilson, Queen's University, Ontario (co-chair)
Dr. Trina Larsen Soles, Rural family physician, British Columbia (co-chair)
Dr. Braam de Klerk, Rural family physician, Northwest Territories (SRPC past president)
Dr. Kathy Lawrence, University of Saskatchewan (CFPC past president)
Dr. Francine Lemire (CFPC Executive Director and Chief Executive Officer)
Dr. Tom Smith-Windsor, University of Saskatchewan (SRPC President)
Dr. John Soles, Rural family physician, British Columbia (SRPC Past President)

MEMBERS

Dr. Stefan Grzybowski, University of British Columbia
Dr. Ken Harris, Royal College of Physicians and Surgeons of Canada
Dr. Darlene Kitty, Rural family physician, University of Ottawa
Dr. Jill Konkin, University of Alberta
Ms. Rachel Munday, Nurse, Northwest Territories (SRPC public member)
Dr. Colin Newman, Rural family physician, Nova Scotia
Dr. Alain Papineau, University of Montreal
Dr. Jim Rourke, Memorial University of Newfoundland
Dr. Karl Stobbe, McMaster University
Dr. Roger Strasser, Northern Ontario School of Medicine
Dr. David White (CFPC President)/Dr. Jennifer Hall (CFPC Past President)
Dr. Granger Avery (Canadian Medical Association observer)
Mr. Paul Clarke (Federal/Provincial/Territorial Committee on Health Workforce, Health Canada observer)

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ACKNOWLEDGEMENTS

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APPENDIX A: RURAL ROAD MAP FOR ACTION — RECOMMENDATIONS

DIRECTION	RECOMMENDED ACTION
Direction #1: Reinforce the social accountability mandate of medical schools and residency programs to address health care needs of rural and Indigenous communities.	**Action 1:** Develop and include criteria that reflect affinity and suitability for rural practice in admission processes for medical school and family medicine residency programs. **Action 2:** Establish and strengthen specific policies and programs to enable successful recruitment of Indigenous and rural students to medical school and family medicine residency training, with established targets and measures of effectiveness. **Action 3:** Support extended competency-based generalist training in rural communities to prepare medical students and residents to be capable of and confident in providing broad-based generalist care in these settings. **Action 4:** Provide high-quality rural clinical and educational experiences to all medical students and family medicine residents that support experiential learning, enabling medical learners to feel comfortable with uncertainty and to gain clinical courage. **Action 5:** Educate medical students and residents about the health and social issues facing Indigenous peoples, and ensure they attain competencies to provide culturally safe care. **Action 6:** Establish a collaborative among medical schools, residency education accrediting bodies, and physician-based organizations (including the Society of Rural Physicians of Canada and the Indigenous Physicians Association of Canada) to ensure that physicians acquire and maintain specific competencies required to provide health care to rural communities. Support the Royal College of Physicians and Surgeons of Canada in identifying and equipping specialists with generalist competencies required to support rural communities.
Direction #2: Implement policy interventions that align medical education with workforce planning.	**Action 7:** Establish government and university partnerships with rural physicians, rural communities, and regional health authorities that include formal agreements to strengthen the delivery of medical education in rural communities by developing and implementing specific visible rural generalist education pathways led by rural academics and rural physicians. Provide substantial ongoing funding required to support rural faculty engagement, faculty development, research, administration and community engagement. **Action 8:** Establish programs with targeted funding from federal, provincial, and territorial governments to enable rural family physicians and other specialists, predominantly those already in practice, to obtain additional or enhanced skills training in order to improve access to health care services in rural communities. **Action 9:** Establish contracts for residents working in rural settings that maximize their clinical and educational experiences without compromising patient care or the residents' rights in their collective agreements. **Action 10:** Establish a Canadian rural medicine service to provide a skilled workforce of rural family physicians and generalist specialists ready and able to work across provincial and territorial jurisdictions, enabled by the creation of a special national locum licence designation.

Direction	Actions
Direction #3: Establish practice models that provide rural and Indigenous communities with timely access to quality health care that is responsive to their needs.	**Action 11:** Implement standard policies within health service delivery areas that require acceptance of timely transfers and appropriate consultations between rural medical facilities and secondary and tertiary hospitals, supported by regional training and patient care networks including generalists and specialists. **Action 12:** Develop specific resources, infrastructure, and networks of care within local and regional health authorities to address access issues, such as for mental health care in rural communities. **Action 13:** Partner with rural communities and rural health professionals to develop strategies to guide implementing system-wide, coordinated, distance technology to enhance and expand local capacity, and improve access and quality health care in rural communities. **Action 14:** Engage communities in developing and implementing recruitment and retention strategies to strengthen the integration of physicians and their families into communities. **Action 15:** Establish and support the development of formal and informal mentorship relationships to support rural family physicians and other specialists in the practice of comprehensive care.
Direction #4: Institute a national rural research agenda to support rural workforce planning aimed at improving access to patient-centred and quality-focused care in rural Canada.	**Action 16:** Create and support a Canadian rural health services research network with the goal of connecting existing rural health research initiatives, and coordinating and strengthening research that enhances the health care of rural Canadians. **Action 17:** Develop an evidence-informed definition of what constitutes rural training to support educational policy and funding decisions, and to offer clear, accurate, and comparable information about rural family medicine training programs and sites. **Action 18:** Develop a standardized measurement system, with clear indicators that demonstrate the impact of rural health service delivery models for improving access and health care outcomes. **Action 19:** Develop metrics based on environmental factors to identify and promote successful recruitment and retention programs, using a measure of five years of service in a rural community as one goal for continuity of care. **Action 20:** Promote and facilitate the use of research-informed evidence by all organizations participating in rural workforce planning in Canada.

APPENDIX B: RURAL ROAD MAP PRIORITIES IDENTIFIED BY ACTION

Please refer to Appendix A for explanations of acronyms

DIRECTION 1: SOCIAL ACCOUNTABILITY OF MEDICAL EDUCATION

ACTION 2: Establish and strengthen specific policies and programs to enable successful recruitment of Indigenous and rural students to medical school and family medicine residency training, with established targets and measures of effectiveness.

Priority Action	Stakeholder Role	1-2 Year Implementation	Indicator for Success
» Establish outreach, national process, and tools, including career gap management, to encourage and mentor rural and Indigenous learners to pursue careers as rural health care professionals	» Funders » Key education leaders (local high schools, colleges and universities, including relevant faculties) » Relevant levels of government (from regional health authorities to provincial, territorial, and federal governments) » Rural health professionals (as role models, mentors, and teachers) » Rural and Indigenous community leaders, including local community influencers and champions » Learners at all levels (high school, college, university, health professional, and residency)	» Create an inventory of what exists and is effective with respect to rural career planning, and the medical education infrastructure needed, to support students living in rural communities in each province/territory » Produce baseline data for indicators to be used for success, e.g., mentorship programs and applications by rural and Indigenous students across health professional programs » Develop a Health Professional Code of Ethics detailing expectations for mentorship at all stages of the learning continuum for rural and Indigenous students	» Increased numbers of active mentorship programs identified and implemented across high schools, colleges, and universities for rural and Indigenous learners to support their educational transitions » Increased numbers of applicants from rural and Indigenous communities to all health professional programs » Increased numbers of seats and/or admission criteria for rural and Indigenous students applying to health professional programs that reflect the realities rural and Indigenous students face » Increased numbers of successful applicants for the seats allotted for rural and Indigenous students in health professional programs » Increased numbers of organizations using the Health Professional Code of Ethics as a resource for their employees

ACTION 3: Support extended competency-based generalist training in rural communities to prepare medical students and residents to be capable of and confident in providing broad-based generalist care in these settings.

Priority Action	Stakeholder Role	1-2 Year Implementation	Indicator for Success
» Increase the number of established satellite campuses, i.e., rural training sites, with infrastructure that provides significant learning experience through encouraging exposure to rural multidisciplinary networks of care in every province/territory	» All levels of government, including regional health authorities and municipal authorities » Medical schools and affiliated health professional faculties » Undergraduate, postgraduate, and CPD medical education and health professional education leaders in charge of curriculum » Practising rural health care professionals including physicians (CFPC and Royal College members) who teach/supervise » Local hospitals and community/health service agencies » Community members as engaged patients » Medical regulatory authorities per province/ territory	» Identify the number of satellite rural/remote medical education campuses, using a consensus-driven definition » Co-create and achieve consensus on developing a set of accreditation standards that links the type of training provided on rural and remote campuses with outcome data supporting evidence to address skill development specific to rural practitioners » Establish a pan-Canadian group that develops strategies to advocate for funding, including protected funding for newly developed satellite campuses. Use data to demonstrate return on investment, e.g., MD recruitment and retention data; community/faculty/ learner satisfaction; quality indicators such as improved access, continuity of care, and enhanced patient health outcomes for rural communities affiliated with rural satellite campuses	» Increased numbers of satellite rural/remote medical education campuses compared with baseline » Increased satisfaction rates among learners/students, community, and faculty in the learning provided, teaching support offered, and health outcomes/ experiences of patients/ communities » Development of a network of rural satellite campuses that leverages the AFMC's Distributed Medical Education group to better coordinate and share key issues and resources for better advocacy

ACTION 5: **Educate medical students and residents about the health and social issues facing Indigenous peoples, and ensure they attain competencies to provide culturally safe care.**

Priority Action	Stakeholder Role	1-2 Year Implementation	Indicator for Success
» Development of a mandatory postgraduate cultural competency/ proficiency holistic model of training that is context- and community-specific in defining culturally safe care based on an established undergraduate medical school education on Indigenous health	» Indigenous communities (chiefs, elders, bands) » Medical Schools – Undergraduate Medical Education/Postgraduate deans and associate deans » Other professional groups involved in rural practice, including but not limited to: rural nursing, midwives, holistic practitioners » Postgraduate accrediting bodies including the Royal College, CFPC, and CMQ » Learner organizations (e.g., CFMS, FMRQ, RDoC) » Educators/advocates/ experts from the TRC	» Create and/or stimulate opportunities to engage and support Indigenous groups/communities to consult with medical educators on expected competencies and learning experiences that align with the provision of culturally safe care by learners, faculty, and practitioners » Develop a recommendation for medical schools to provide protected time to establish an adequate Indigenous health (IH) curriculum guided by best approaches for teaching with community participation » Implement a mechanism to support sharing best practices across medical schools, residency programs, and organizations/ communities to identify useful, effective tools and resources for IH and the teaching of cultural safety and competence » Develop assessment tools to measure competencies expected of an IH curriculum, including culturally safe care » Develop recommendations for medical schools and residency programs to use in demonstrating the utility and impact of IH and cultural safety training	» Development of an IH curriculum in medical schools, with mandatory participation supported through accreditation standards » Provision of mandatory postgraduate competency-based learning based on consensus-driven competencies that focus on culturally safe care leveraging an IH curriculum in undergraduate education » Implementation of evaluation programs in medical schools and residency programs to collect data to determine the impact and utility of an IH curriculum and learning experiences » Increased recruitment and retention of physicians working with Indigenous communities » Greater feeling of safety among Indigenous patients receiving care » Expectation of positive patient experiences in the long term » Long-term health disparities addressed with improved outcomes » Evidence of patient/ community engagement and leadership in teaching learners about cultural safety

ACTION 6: **Establish a collaborative among medical schools, residency education accrediting bodies, and physician-based organizations (including the Society of Rural Physicians of Canada and the Indigenous Physicians Association of Canada) to ensure that physicians acquire and maintain specific competencies required to provide health care to rural communities. Support the Royal College of Physicians and Surgeons of Canada in identifying and equipping specialists with generalist competencies required to support rural communities.**

Priority Action	Stakeholder Role	1-2 Year Implementation	Indicator for Success
» Mandate a national collaborative (or rural medical education network) to focus on the development of, application and decision making for a rural health care delivery model that includes rural competencies, standards, assessments, and education; includes mandating provinces and territories to implement models for rural health care and education regionally	» CFPC » SRPC » Royal College » CMQ » FMRAC » MCC » F/P/T governments » Rural practitioners » Patient and community groups » Regional health authorities	» Establish a secretariat to oversee the mandate of a national collaborative with funding leveraged from F/P/T governments and other sources » Advocate for the development and application of rural-specific competencies within lifelong medical training, learner assessments, maintenance of competence and program accreditation » Explore enforced or legislative opportunities to ensure implementation and sustainability of rural-specific health care models and education tied to improved health outcomes » Establish performance indicators that include tools to evaluate the collaborative's impact	» National agreement on rural competencies, standards, assessments, and accreditation for rural health education to align with community and provider needs » National agreement on rural standards of care for health care delivery that reflects team-based networks of care to align community and provider needs » Identification of rural medicine education streams across medical schools and residency programs, with pan-Canadian sharing and dissemination of best practices to enable a coordinated approach to national implementation with regional variation » Increased numbers of physicians choosing to practise rural medicine at any time in their career » Increased MD-retention rates of more than five years in rural communities » Increased access to specialty care, virtual critical care, and diagnostics » Increased positive health outcomes through reduced patient transfers to urban centres

DIRECTION 2: POLICY ALIGNMENT

ACTION 7: Establish government and university partnerships with rural physicians, rural communities, and regional health authorities that include formal agreements to strengthen the delivery of medical education in rural communities by developing and implementing specific visible rural generalist education pathways led by rural academics and rural physicians. Provide substantial ongoing funding required to support rural faculty engagement, faculty development, research, administration, and community engagement.

Priority Action	Stakeholder Role	1-2 Year Implementation	Indicator for Success
» Develop flexible funding models for generalist training based on and defined by community/ provider needs, with emphasis on partnership and greater system integration that would include all health professions	» F/P/T governments » Regional health authorities » Accreditation bodies (CFPC, Royal College, CMQ) » Medical Schools – AFMC » SRPC » CMA » Rural practitioners/ learners » Rural communities	» Develop stakeholder-partnership opportunities to dialogue and reach consensus on the paths to rural generalist training and modes of financial support that can be relevant to all physicians in any phase of their careers	» Recognition of generalist training as a strategy for funding as part of rural physician workforce policy and planning at provincial and territorial levels » Clearly worded, defined accreditation standards that support learner training within rural contexts, with clear indicators as to the amount of time, curriculum, type of infrastructure, and faculty resources needed to meet program requirements that address rural education aimed at improving rural health care » Increased rural and Indigenous physician retention of 20% in five years and 30% in 10 years » Acceptance of generalism teaching as a core standard for medical training

ACTION 8: Establish programs with targeted funding from federal, provincial, and territorial governments to enable rural family physicians and other specialists, predominantly those already in practice, to obtain additional or enhanced skills training in order to improve access to health care services in rural communities.

Priority Action	Stakeholder Role	1-2 Year Implementation	Indicator for Success
» Develop a venue for stakeholders to meet regularly to develop additional competency-based training opportunities for residents and practising physicians, informed by data and based on rural community health service delivery needs	» Royal College » CFPC » CMQ » AFMC » CPD stakeholders » FMRQ » Regional hospital/health system administrators » Rural communities » Regional health authorities » Provincial governments » Health administrators/ leaders from rural communities	» Identify which enhanced/ advanced skills training opportunities exist and evaluate their effectiveness » Organize meetings with stakeholders to establish an approach to identify, advocate, and develop additional appropriate enhanced/advanced skills-training opportunities and processes necessary to respond to community and provider needs (i.e., service gaps)	» Increased access to needed medical training enabling physicians and residents to meet community-specific health care needs » Improved access to local care and patient satisfaction with care provided by family physicians with enhanced skills training » Enhanced clinical health service planning resulting in cost reductions, given local provision of care

ACTION 10: Establish a Canadian rural medicine service to provide a skilled workforce of rural family physicians and generalist specialists ready and able to work across provincial and territorial jurisdictions, enabled by the creation of a special national locum licence designation.

Priority Action	Stakeholder Role	1-2 Year Implementation	Indicator for Success
» Undertake a pilot project to determine what constitutes a national locum licence and its application regionally (i.e., ER and telemedicine) » Advocate for federal government support to convene provinces/ territories to explore change in legislation to enable national licensure locum capabilities	» FMRAC » F/P/T governments » Universities/learners » MRAs » Medical associations - » MCC/CFPC/Royal College » RDoC	» Hold a meeting with representatives from provincial/territorial governments, CHW, and the Physician Resource Planning Advisory Committee to encourage provinces/territories to develop legislation enabling national portable licensure that demonstrates effective long-term patient/ system outcomes » Develop consistent approaches that model standards for locum licensure used by all provinces/territories » Explore shared scope of practices/competencies for family medicine and specialty care » Reach a bilateral agreement among F/P/T for health human resources on portability across Canada; look for examples of current locum programs that are flexible and seem to work » Regulators select a province to take a leadership role in drafting legislation for national licensing, including scope of practice within a rural-competencies context, with consultation among other jurisdictions and stakeholders » Develop an approach on standards for locum licence; build an educational licence that is portable for residents to gain exposure (i.e., Australia/US model) gain exposure (i.e., Australia/US model)	» Removal of barriers prohibiting portable licensure for rural practice; practice demand addressed » Increased rural MD retention beyond five years » Ready availability of locum physicians in rural communities » Reduction in number of complaints to regulators » Reduction in number of vacant positions for rural MD placements » Increased patient satisfaction » Increased satisfaction with locum licence provider » Decrease in the number of communities in crisis requiring physician coverage

DIRECTION 3: RURAL SPECIFIC PRACTICE MODELS

ACTION 11: Implement standard policies within health service delivery areas that require acceptance of timely transfers and appropriate consultations between rural medical facilities and secondary and tertiary hospitals, supported by regional training and patient care networks, including generalists and specialists.

Priority Action	Stakeholder Role	1-2 Year Implementation	Indicator for Success
» Develop no-refusal policies between organizations to support transfer of care from rural physicians when needed, and demonstrate implementation of such policies across provinces/ territories » Conduct environmental scans that identify effective collaborative partnerships and networks of care with a description of local champions and IT/ financial/infrastructure supports demonstrating improved care delivery for those living in rural and remote communities » Understand the factors that influence improved access to services and health providers that are external to communities	» F/P/T governments » EMS providers » Educators, providers, trainees, community and patient representatives » Regional health authorities » Local hospitals, » CIHI/CFHI – data collection and knowledge transfer » Health Standards Organization/ Accreditation Canada (standards/assessment)	» Establish national data sources and a baseline for the current state of the system related to acceptance of care in communities and regions, providing a way to measure change and a goal to strive toward for consistency » Identify, develop, and reach consensus on ways to collect data on referral-acceptance rates to be analyzed and potentially used at interprovincial/ inter-regional/ interterritorial levels » Create evidence-informed clinical-transfer protocols/ pathways to facilitate transfers and measure outcomes » Develop evidence-informed standards and common indicators to support timely rural transfers that can be reviewed and improved upon	» Increased satisfaction of patients/clinicians » Increased patient consultations around referrals » Increased number of e-referrals and a decrease in number of transfers to urban centres

ACTION 12: Develop specific resources, infrastructure, and networks of care within local and regional health authorities to address access issues, such as for mental health care in rural communities.

Priority Action	Stakeholder Role	1-2 Year Implementation	Indicator for Success
ESS Focus			
» Develop training standards by accrediting bodies to allow for consistency in competency acquisition for learners enrolled in ESS training » Identify individuals and teams willing to provide the teaching needed to support ESS competency attainment across regions » Explore and define an evaluation strategy that will demonstrate quality of care » Establish regional ESS training programs centred in regional-based hospitals to provide core training for ESS learners » Support ESS training programs that demonstrate exceptional training and assessment methodologies to graduate competent rural GP surgeons	» National societies (anesthesia, obstetrics, surgery) » Provincial college registrars » Royal College – specialists/generalists » CFPC » Universities » Hospitals » Regional health authorities » Governments	» Elevate ESS and ESS-obstetrics training programs to Category 1 status for family medicine » Support the provision of excellent training in obstetrics and surgical skills required by rural GPs, with health professional teams coordinated in the regions » Establish principles around a locum-relief pool of physicians who can fill in the gaps required for surgical/ obstetrics services when needed » Use data to determine where ESS training would be most successful » Establish collaborative standards for both educational and practice settings to implement training and deliver surgical care in rural/ regional-based hospitals	» Accreditation standards for ESS and obstetrical care training for rural medicine agreed upon by all stakeholders, including CFPC and the Royal College » Definition of competencies for ESS by the CFPC, the SRPC, and the Royal College, and their adoption » Classification of ESS programs as Category 1 programs at the CFPC, including both the ESS and ESS-Obstetrics streams » Develop accreditation standards that support rural generalist training including ESS training » Increased staff at regional hospitals providing general surgery for patients and a hub for rural ESS training sites affiliated with university-based training programs

Priority Action	Stakeholder Role	1-2 Year Implementation	Indicator for Success
Mental Health Focus			
» Devise, advocate and reach consensus on a community-driven vision and implementation process for quality of care as part of the vision addressing the TRC » Establish common goals and responsibilities fundamental to a stakeholder-led mental health strategy » Provide clarity and establish accountabilities for specific community-driven processes to address mental health access » Advocate for a community-driven vision and process to address mental health access » Advise on appropriate, equitable, accountable funding models to support effective mental health services for rural and remote communities	» Health authorities » Communities » Providers » Residents » Governments » Regulators » Mental health providers » Family health teams » Health care professional groups » CIHI » Statistics Canada	» Establish formal groups of key stakeholders who can advance a rural mental health workforce planning strategy based on an environmental scan that identifies: • Effective team-based approaches • Innovative ways to cross the geographic divide using technology or other methods • Resource plans in local, regional, provincial, and territorial areas • Effective networks of care with defined responsibilities, partnerships, and agreements • Key points of leverage for advocacy within the health care system » Share this environmental scan with key stakeholders, including government and other mental health leaders, to identify key next steps	» Shared vision and national benchmarks in place » Establishment of metrics related to numbers of mental health networks that show evidence of increase » Improved outcome of mental health indices using CIHI statistics » Harmonized policies across provinces and territories » Use of metrics/measures for comparison across provinces/territories and regions » Increased access to mental health services, with decreased wait times » Increased patient and provider satisfaction » Greater access to care within the community, with less transfer out » Adoption of resources, infrastructure, and networks by all providers and stakeholders » Evidence of community involvement in determining models of health care delivery, and evidence of delivery of care within a community through well-functioning networks » Collaboration among providers and development of accountable pathways to care

ACTION 13: Partner with rural communities and rural health professionals to develop strategies to guide implementing system-wide, coordinated, distance technology to enhance and expand local capacity, and improve access and quality health care in rural communities.

Priority Action	Stakeholder Role	1-2 Year Implementation	Indicator for Success
» Advocate for systems and technology that have full capability and function to be in place wherever providers are working in rural communities » Improve Internet speed for rural areas to allow for teleconsultation	» Government » Physicians » Advocacy groups (including patient and community groups) » Telecommunications companies » e-health programs » Broadband network providers » Canada Health Infoway	» Build a business case while leveraging existing infrastructures to engage key partners and increase awareness of inoperability of IT systems in rural communities » Identify potential infrastructure investment opportunities for technology, broadband, and telehealth networks » Leverage existing telehealth/ telecommunications programs and networks supported by F/P/T governments » Ensure clinician engagement in planning	» Increased access to and effective utilization of systems and technology by rural health care providers that improve patient access to care and satisfaction » Greater research opportunities exploring patient experiences with distance technology » Establishment of infrastructures across all provinces and territories to systematically monitor effectiveness of distance technology, with reporting mechanisms that provide annual indices of utility and impact » Increased use of telehealth networks and clinical/ educational sessions using video conferencing » Increased integration of telehealth in rural medical practices

ACTION 14: Engage communities in developing and implementing recruitment and retention strategies to strengthen the integration of physicians and their families into communities.

Priority Action	Stakeholder Role	1-2 Year Implementation	Indicator for Success
» Develop guide for physician integration and community engagement	» Universities » Regional health authorities » Community members » CMA/MD practice management » Recruiters » Physicians/families	» Define an approach to describe stakeholders' roles and responsibilities in establishing networks between physicians and community leaders to support recruitment and retention strategies » Develop a template for providing a memorandum of understanding or "charter" for communities to use as part of community-engaged recruitment and retention strategies » Develop a universal template that can be used across the country to track results in community engagement and physician support	» Improved recruitment and retention rates in communities » Increased community/ provider engagement satisfaction identified through settlement surveys

ACTION 15: Establish and support the development of formal and informal mentorship relationships to support rural family physicians and other specialists in the practice of comprehensive care.

Priority Action	Stakeholder Role	1-2 Year Implementation	Indicator for Success
» Promote mentorship as a standard of professionalism and as a fundamental role in the profession to be shared with all levels of medical education	» National and provincial medical associations and colleges » Local teaching sites » Communities	» Conduct an environmental scan of rural mentorship programs across the country and their effectiveness » Identify, share and encourage uptake and adaptation of existing mentorship programs to be included in recruitment and retention initiatives and planning	» Definition of mentorship included in medical-education and practice standards » Increased physician-retention rates in rural communities as a result of mentorship programs » Increased funding and resources for mentorship programs across all provinces and territories » Recognition and awards for mentorship included as part of CPD credits and celebrated by the CFPC and the SRPC

DIRECTION 4: RURAL RESEARCH

ACTION 17: Develop an evidence-informed definition of what constitutes rural training to support educational policy and funding decisions, and to offer clear, accurate, and comparable information about rural family medicine training programs and sites.

Priority Action	Stakeholder Role	1-2 Year Implementation	Indicator for Success
» Achieve a pan-Canadian consensus on a definition for rural training in consultation with communities and used by CaRMS and the AFMC	» Communities » Faculties » Governments	» Establish a working group of medical educators involved in medical education to work with communities and to devise a consultation plan, background literature review, and environmental scan to develop parameters and definitions related to using the term "research" in education and training	» Definition of rural training used and applied by all involved in medical education and across all stakeholders » More accurate definition and categorization of training-site lists for use by researchers and evaluators » Yearly identification of numbers of trainees matched to rural-specific sites or training in rural training sites

APPENDIX C: GLOSSARY OF ACRONYMS AND ABBREVIATED TERMS

AFMC	Association of Faculties of Medicine of Canada
ARFM	Advancing Rural Family Medicine
CaRMS	Canadian Residency Matching Service
CFHI	Canadian Foundation for Healthcare Improvement
CFMS	Canadian Federation of Medical Students
CFPC	College of Family Physicians of Canada
CHW	Committee on Health Workforce
CIHI	Canadian Institute for Health Information
CMA	Canadian Medical Association
CMQ	Collège des médecins du Québec
CNA	Canadian Nurses Association
CPD	continuing professional development
EMS	emergency medical services
ESS	Enhanced Surgical Skills
FMRAC	Federation of Medical Regulatory Authorities of Canada
FMRQ	Fédération des médecins résidents du Québec
F/P/T	Federal/Provincial/Territorial
GP	general practitioner
IH	Indigenous health
IPAC	Indigenous Physicians Association of Canada
MCC	Medical Council of Canada
MRAs	Medical Regulatory Authorities
RDoC	Resident Doctors of Canada
Royal College	Royal College of Physicians and Surgeons of Canada
RRM	Rural Road Map for Action
SRPC	Society of Rural Physicians of Canada
TRC	Truth and Reconciliation Commission