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Promising practices to support retention of the healthcare workforce in northern, rural and remote communities in Canada

If you are looking for promising practices used in northern, rural, and remote communities in Canada to improve access to safe, high-quality, team-based primary care, then this promising practice will be of interest to you.

Recruitment of Permanent Part-Time Physicians – A Successful Approach to Long-Term Physician Retention

What is the promising practice?

A key strategy to promote retention within Ongomiizwin Health Services (OHS) has been to offer physicians permanent part-time positions.

Key Messages and components of the promising practice

- Ongomiizwin Health Services has been successful in recruiting and retaining physicians.
    - average retention rate of six years versus six months
    - significantly reduced vacancy rates
        - to an average of 20 percent overall (down from 70 to 80 percent)
        - from zero to five percent in three out of three hospital sites
- Committed leadership and recruitment of physicians that can commit to providing regular services in the north are two cornerstones to the success of the permanent part-time physician initiative.
- OHS physicians have shared that the permanent part-time physician approach helps to create consistency for patients. “Even though 18 of us make up eight full-time-equivalent (FTE) positions, it feels like a tight practice group that shares accountability and offers consistency to our clients.” (OHS physician)
- Although the retention and vacancy rates have improved remarkably, like all rural and remote sites, OHS continues to encounter challenges.

Context

Serving northern Manitoba and the Kivalliq, Qikiqtani and Kitikmeot regions of Nunavut, OHS is a robust interprofessional health service agency led by a team of Indigenous and non-Indigenous health professionals.

OHS has had some success in recruiting and retaining physicians practicing in rural and remote communities, but has also struggled with severe past shortages. For several years, in fact decades, physicians were expected to live in northern and remote communities on a full-time basis with perhaps one or two trips out provided per year. This may have worked well in the 1970s and 1980s but physician retention in the 1990s was beginning to waiver and nearly collapsed in the mid-2000s. By 2010, OHS (called the Northern Medical Unit at the time) had a 70 to 80 percent vacancy rate and an average retention rate of six months for more than a three-year period. There were several factors for this crisis such as provincial and national physician shortages, non-competitive remuneration packages and personal and professional physician preferences.

Some of these challenges were outside of the immediate locus of control and would take years to reconcile. We started by modernizing the antiquated “employment” model and onboarding the right fit for our practice environment. We accepted the fact that we could not recruit and retain full-time physicians and we didn’t want an inconsistent model that was serviced by non-committed locums. We were able to schedule a full-time rotation by offering multiple part-time permanent positions (as low as 0.25 FTE) and offering supports that would help sustain physician services.

Approach

The implementation and sustainability of our flexible, part-time physician model is rooted in:

- Indigenous leadership.
    - Indigenous leadership of the organization have deep and ongoing connections to community that require a high level of accountability for the quality of care.
- Recruiting physicians that want to work for communities.
- Establishment of a physician charter with a clearly stated vision and expectations that centres the needs of community.
    - "We envision a world in which all First Nations, Inuit and Métis people have achieved full and equitable access to the conditions of health including ancestral pride, cultural and language reclamation, peace, shelter, education, food, income, a stable environment, land, and resources, social justice and health services where the gifts and wisdom of First Nation, Inuit and Métis cultures are recognized as valuable, distinctive, and beautiful."
    - During our onboarding, all physicians must sign on to the charter.
- Creation of part-time permanent FTEs instead of locum positions.
    - We offer contracts of 0.25 FTE to 1.0 FTE in the community.
    - When possible we schedule consistent rotations, for example, two weeks on and two weeks off, or every other week, or the first week of the month. This allows for physicians to make a long-term commitment to a remote community while returning to a larger centre periodically.
    - The return to a larger centre enables physicians to:
        - retain skills that might wane over time
        - raise the consciousness of tertiary care systems in the south to the needs of rural and remote communities
        - maintain relationships with friends and family
- Engagement with training programs.
    - We have medical students, physician assistant trainees, family medicine residents and residents from other specialties who train in most of the communities we serve.

    - We ask medical students applying for OHS rotations to write a letter of interest to ensure their pursuits and commitment are aligned to closing health gaps for Indigenous people.

- Physician engagement.
    - OHS leadership meets with physicians to share information and address evolving concerns:
        - each week if they serve a nursing station
        - each month with hospital-based physicians
    - We have an annual two-day, in-person annual general meeting (AGM) with high levels of physician participation and engagement. These typically incorporate a combination of clinic practice sessions, ceremony and guidance from Elders and Knowledge Keepers and engagement with health system leadership.
- Interdisciplinary teams.
    - We have invested in the addition of physician assistants to our teams who have been invaluable in sharing the workload.

Results (how do we know retention is improving?)

We have some evidence to suggest the part-time physician model improves retention.

- An average physician retention rate of six years versus six months.
- Significantly reduced vacancy rates:
    - to an average of 20 percent overall (down from 70 to 80 percent)
    - from zero to five percent in three out of three hospital sites

Reports from staff

- "Being able to work part-time in a community. I love and clients I care for. It allows me to stay committed to Indigenous and community health but also to practice in other clinical environments that are important to me." (OHS physician)
- "Even though 18 of us make up eight FTEs it feels like a tight practice group that shares accountability and offers consistency to our clients." (OHS physician)
- "I couldn't relocate my family to a remote community. Being able to work one week a month allows me to balance my personal and professional priorities." (OHS physician)

Other results that may relate to improved retention rates

- 100 percent of physicians sign-on to the charter.
- Additional funding from Indigenous Services Canada for increased travel costs.
- Physician sustainability and stability allows for preceptor support for physician assistants.
- Physicians feel supported and have access to medical and administrative leadership.
- Culturally and clinically competent, committed and consistent physician coverage.

Key Success Factors

- Engaged, supported and dedicated physician community of practice.
- Secured funding for travel and logistical coordination.
- Culturally and clinically competent practitioners.
- Communities have consistent clinicians and options for provider of choice.
- Key investment in upfront provider travel costs prevents downstream exponential costs of transporting patients.
    - “Paying for more travel, almost weekly per provider, may cost more upfront but it is worth the investment because the downstream costs of transporting patients out would be significantly more.” (First Nations and Inuit Health Branch partner)

Major Challenges

Although the retention rate and vacancy rates have improved remarkably, like all rural and remote sites, we continue to encounter challenges. We are seeing high levels of physician burn-out and dissatisfaction, especially in high-volume, low-resource communities. Support is needed from health system leadership in a few key areas:

- Additional FTEs.
    - Teams are under-resourced at baseline to meet the basic needs of community.
    - A review of health human resources based on the rights of communities to access primary and emergency care.
    - A significant investment in primary care in communities.
- After-hours and weekend coverage.
    - The on-call, over-the-phone support systems and in-community weekend coverage are under-resourced and overburdened.
    - An investment is needed to expand the number of physicians providing over-the-phone call coverage and weekend in-community service to larger fly-in communities.
- Specialist support.
    - The wait times to access some specialties are too long.
    - Expansion of support for itinerant visiting specialists, virtual care, eConsult and rapid access to consultative expertise will be important.
- Tertiary care support.
    - Teams are increasingly frustrated that referral centres can’t help when they are needed. This can be due to health system overload, poor coordination (for example the run around) or lack of patient transport services.
- Transportation support.

- The air medevac system suffers from inconsistency, dyscoordination and poor access to planes and pilots overnight.
- Setting expectations for service delivery from private air medivac carriers will be critical.

We remain committed to working with our health system partners to ensure we close the significant gaps in access to physician services for Indigenous patients in Manitoba.

Cost

Additional travel cost are estimated at $500,000 per year. Other administrative and leadership costs in-kind to program support.

For more information

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