



Final Report

June 2008

rural academic health project



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Rural communities have increasing pressure to participate in educating students in health and human services programs. The number of medical students has doubled from 128 to 256 over the past seven years. All medical students have a rural rotation in their third year, and will be able to choose rural electives in fourth year.



INTRODUCTION

There is a vital link between rural health service delivery, education of health professionals, and research into factors impacting rural health. Indeed, with rural communities across British Columbia facing critical health provider shortages, there is a growing imperative to expose emerging health professionals to rural life and practice; to support rural recruitment and retention; and to ensure sustainability of quality healthcare in rural communities.

Rural communities provide a unique and powerful learning environment which facilitates competence in assessment, decision-making, teamwork, communication, leadership and more. Students are able to experience firsthand the continuum of care, the influence of culture, and the impact of the broader determinants of health. Participating in rural life and practice fosters “well rounded” health professionals regardless of where these emerging health professionals practice in the longer term. The lessons learned through rural health professional education can be applied in all practice settings: a deeper understanding of social determinants of health, a clearer picture of rural life that improves discharge planning from urban tertiary centres, and improved communication across urban and rural settings to name a few.

Rural communities are renowned for a level of flexibility, innovation and collaboration not evident in urban centres. They therefore provide students with unique and rich learning experiences. Exposure to health services in a rural community context aligns well with shifts in the healthcare system emphasizing primary healthcare, population health, and chronic disease management.

The growing interest in rural practice education is exemplified through initiatives like the Interprofessional Rural Program of BC, Welcome Home in Northern BC, and the Aboriginal Health Elective offered through UBC among others. However, there are increasing challenges as the number of programs and students requesting rural placements grows, the critical health profession shortages in rural communities worsen, and inconsistent policies and processes across organizations and initiatives create duplication and, at times, confusion.

The goal of the “BC Rural Academic Health Project” (RAHP) was to develop a longer term sustainable model for strengthening student placements in rural British Columbia. The emerging model aims to effectively link the educational experience to rural health services, community needs and applied research by examining characteristics of successful rural health education through the literature, examples in Canada and Australia, and consultations with rural communities and post secondary education institutions in British Columbia.

DEFINITIONS

Rural

The Canadian Health Services Research Foundation describes rural as “communities based on geographic isolation, economic and labour force characteristics and availability of services and amenities”. In BC, “rural” has not been defined precisely, but is considered to be those outside the urban settings such as the Lower Mainland, Greater Victoria, Nanaimo, Kelowna, Kamloops, Penticton, Vernon and Prince George. (From BC Ministry of Health website)

Academic Health

System of activities and relationships that characterize the interface between health services, health professional education (entry-level and continuing professional development) and research (generation of new knowledge and application of evidence). (adapted from definition from BCAHC Annual Report, 2002/2003)

Capacity

The ability of rural communities, health authorities, post-secondary institutions and others to provide and support the education of health professionals, particularly at the pre-licensure level. Capacity relates to both quantity (number and mix) of students and quality of the practice education experience.

Practice Education

The terms practice education and student placements are used interchangeably in this project. Students in health and human services programs are placed in a range of healthcare settings as an integral part of their educational curriculum.

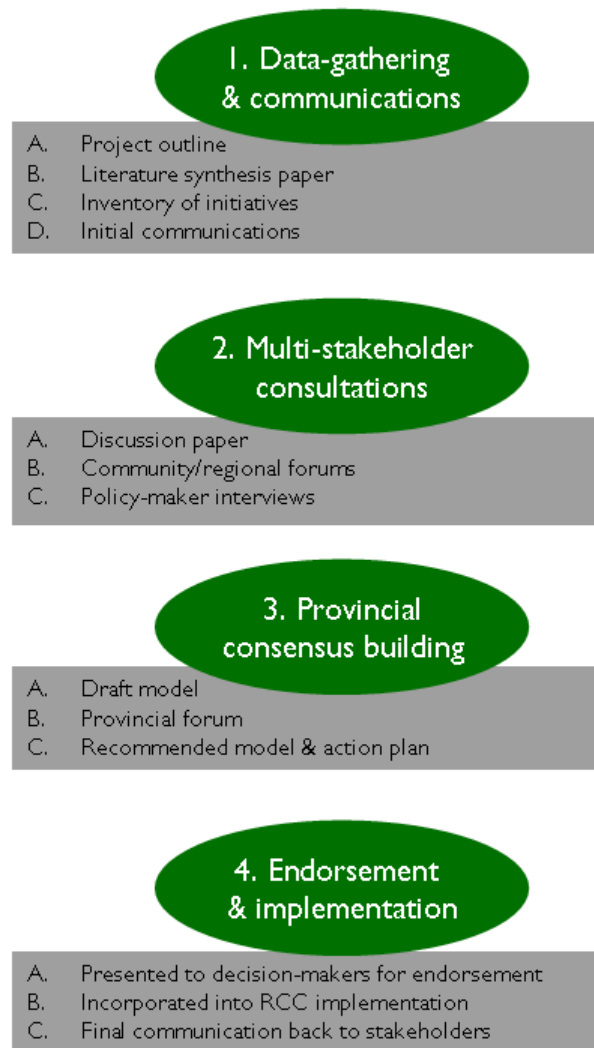
Interprofessional Education

When two or more professions, learn with, from and about one another in order to improve collaboration and the quality of care. (Centre for Advanced Interprofessional Education, 1997)

METHODS

RAHP employed a collaborative approach, using strategic questions to engage key stakeholders across the province. Questions were based on a review of the literature and on our understanding of current initiatives and what they tell us about an emerging model. Through community/regional forums and interviews with key policy-makers, this project was able to draft a model for strengthening rural academic health capacity in BC. Consensus building worked to confirm the concepts for a longer term model and an action plan for moving forward.

Figure 1 highlights the stages of RAHP.



The literature synthesis focused on three primary statements:

1. An integrated, interprofessional rural academic health setting brings benefits to communities and to learners across health professions;
2. Rural academic health approaches increase placement capacity and provide quality practice education;
3. Partnerships between rural communities, health authorities and post secondary education organizations demonstrate best practices in education, research and service and provide powerful models for improving rural health.

Major databases were searched using the key words:

- » Interprofessional and rural and academic and health
- » Interdisciplinary and rural and academic and health
- » Multiprofessional and rural and academic and health
- » Interprofessional education
- » Interdisciplinary education
- » Multiprofessional education
- » Interprofessional and practice education
- » Rural practice education
- » Rural health education
- » Rural education and best practices
- » Interprofessional education and rural

The RAHP Literature Synthesis Paper (Appendix 1) validated the three primary statements above, and concluded that “only a fraction of what could be done in this area of educational strategies [relating to rural health] is currently being done. Education programs remain a potentially fruitful, yet not fully exploited policy route.” Further it reinforced the importance of creativity and innovation in creating education strategies to support rural health.

In parallel, an inventory of current initiatives was undertaken (Appendix 2) which reinforced the wide range of programs at local, regional, provincial and national levels relating to rural health, education and research. However, on the surface there do not appear to be many opportunities for collaboration, knowledge exchange and synergy across these initiatives.

The initial RAHP phase of data-gathering prepared the way for multi stakeholder communications. The first stage of consultation was the development of a discussion paper (Appendix 3) which provided an overview of the project and the initial findings from the literature, preliminary consultations and examination of existing initiatives. The discussion paper posed a number of questions including:

1. What are (additional and important) benefits of rural practice education?
2. What critical components need to be in place to support rural practice education? What creative solutions might help address these?
3. Who are key players? What do you see as their roles and responsibilities?
4. What are some quick wins in moving forward?
5. Who needs to be contacted about this initiative?
6. What would your community need in order to participate?

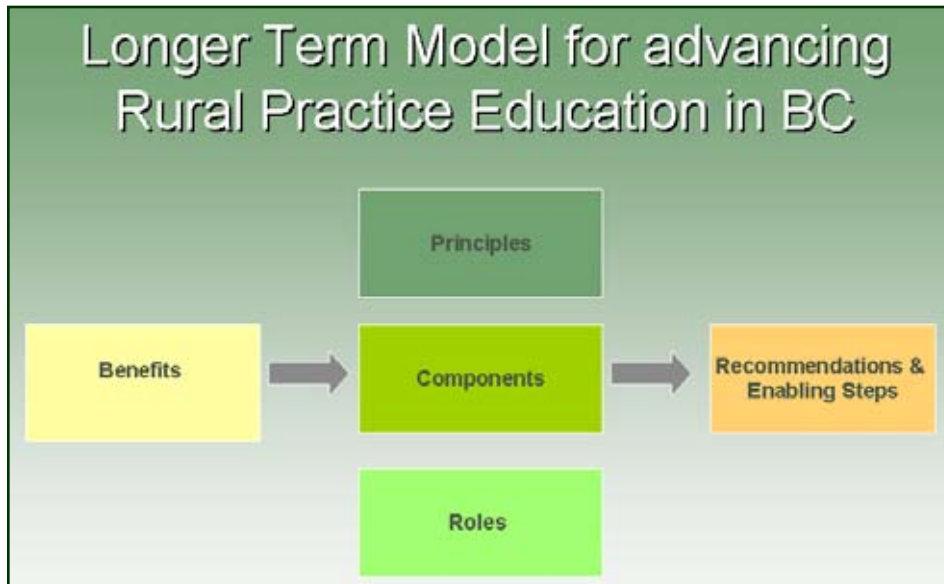
The answers to these questions were introduced into subsequent iterations of the discussion paper so that the paper reflected the main messages of the consultation process as they emerged.

A provincial forum was facilitated in concert with a large international conference “Practice Makes Perfect” (November 2007) which focused on practice education in its many forms, including in rural settings. Key stakeholders were invited to review the draft model and to provide feedback. A number of key themes emerged from the feedback:

- » *Creative solutions for building placement capacity in rural communities* included having rural communities maintain a list of housing options for students; allowing each community to develop its own approach to supporting students; and the opportunity to have students be engaged in participatory action research as part of their placement.
- » *Opportunities for community development and faculty development* emphasized the key principle of “community driven”.
- » *Development of a sustainable model* identified the need for infrastructure funding, innovation and coordination at a community and provincial level. Marketing of rural placements is a critical component.
- » *Coordination across rural communities and post-secondary education institutions* reinforced the need for leadership, direction, mandate, resources, personnel, flexibility and focus.

A 10 minute film “Learning Together in Rural Communities” featuring the Port McNeill student team in summer 2007 was debuted as part of the keynote address of the Practice Makes Perfect conference. The film is available online at www.bcahc.ca/irpbc.

This input was incorporated into the emerging model below.



During the RAHP process, a number of related initiatives were underway which have helped shape the emerging model in this report. These initiatives include:

- » *Rural Coordination Centre of BC*, launched through private funds provided to the University of Northern British Columbia. Dr. Granger Avery has been appointed Director and a number of activities are underway to advance rural academic health, in particular relating to medicine.
- » *BC Strategic Plan for Practice Education* led by the BC Academic Health Council Practice Education Committee
- » *Other projects funded by Practice Education Innovation Fund* including the development of provincial practice guidelines, preceptor education, and more See http://www.bcahc.ca/BCAHC_page.asp?pageid=807
- » *Port McNeill Interprofessional Rural Health Education Symposiums 2007 and 2008* which have brought together community members and leaders, students, rural health professionals, educators, health authorities, government and more to dialogue on the role of education in providing quality health care in rural BC

“In my six years
of university, this
[interprofessional
rural learning]
was by far the
best educational
experience I’ve had”
– pharmacy student

BENEFITS

Rural student placements benefit more than just students. There are many benefits to rural communities, students and ultimately the healthcare system. In British Columbia, communities involved in a number of programs initiated over the past several years – including the Interprofessional Rural Program of BC (IRPbc), the Aboriginal Health Elective, the Vancouver Island Interprofessional Education Project, and the longstanding rural placements provided through most education programs – have proven such benefits. These include:

For Rural Communities

- » Recruitment & retention of health professionals
- » Increased confidence and skill of rural practitioners
- » New energy and ideas brought by the students;
- » Enhanced links to academic institutions
- » Youth from rural communities inspired to pursue healthcareers
- » Ultimately, improved healthcare in rural communities

For Students

- » Warm welcome by community and opportunity to be involved in many different ways
- » Experience rural life and practice, in a supported environment
- » Broadened perspectives on health
- » Unparalleled learning opportunities
- » Teamwork and leadership
- » Exposure to Aboriginal culture;
- » Wide range of outdoor recreational activities
- » Fun!

For the Health and Education Systems

- » Emerging health professionals oriented to primary and secondary level care, population health, rural and Aboriginal communities
- » Practitioners committed to collaborative care regardless of where they choose to practice
- » Recruitment and retention of rural health professionals
- » Enhanced linkages and coordination across rural and urban settings
- » Positive change levered by students
- » Improved healthcare and education models that can be translated to other settings
- » Innovative leaders in health and education

“Having students
is our best
recruitment tool”
– Rural healthcare
manager

FOUNDATIONAL PRINCIPLES

The following key principles for strengthening rural practice education have emerged through the RAHP processes:

Community-driven

Each rural community is different, offering unique opportunities for learning. It is imperative that rural communities work with other partners to develop a model of rural practice education that meets their needs and demonstrates sensitivity and respect for their cultural perspectives.

Partnerships

Rural communities, health authorities, post-secondary education institutions and others are integral to supporting practice education linked to rural healthcare. Mutual benefits and shared ownership among stakeholders are essential.

Community as Teacher

Engaged, involved communities provide students with invaluable learning opportunities both in and out of the formal practice education setting. The Collaborative nature of rural healthcare settings provide a unique and powerful learning environment which fosters strong skills in assessment, decision-making, teamwork, communication, and leadership. Informal interaction with the host-community allows students to experience firsthand the continuum of care, influence of culture, and the broader determinants of health.

Service Learning

The ultimate goal of rural practice education is to enhance the health of communities. Initiatives allow students and faculty to provide valuable services to communities as they learn about relationship-centred care that is personal, professional, and community sensitive.

Key Components

Infrastructure needs relating to education in rural communities are different in a number of ways from urban settings. The RAHP process identified the following key components to facilitate student, preceptor, community, and wider provincial involvement in rural practice education.

Hazelton

For Students

Housing

Availability of student housing is the number one critical issue for recruiting students for rural placements. Housing may be provided in a range of ways – as a designated house or apartment for students that is available year round, a rental unit available during placement periods or billeting. Experience through the IRPbc has reinforced that shared accommodation for students provides a vital support system and opportunity to learn informally from one another. Housing provides an additional benefit in assisting the rural community to manage its health human resources (HHR) needs by also being available for locums or new hires.

Ideally, housing should be:

- » Close to healthcare facilities
- » Available for students from all health professions/programs
- » Equipped with furniture, linens, laundry facilities and computer/internet
- » Provided at no or little rent

It is recommended that each community work with its community partners to develop and maintain a list of possible housing options for students. In particular, creative solutions through partnerships among industry, secondary education, government ministries, health authorities, and chambers of commerce should be explored. Ideas to explore include partnering with secondary education on a “green building” development, /or converting an unused school building to house students and locum staff, or sharing housing with other community initiatives.

In particular, IRPbc communities have suggested that funding currently being allocated for short-term housing (typically between \$3,000 and \$6,000 for three to four months depending on the community) be offered to communities that provide



Bella Coola

matching funds. This would provide year-round housing to be available for for students, locums, and newly hired staff.

Some communities, such as Bella Coola and Hazelton, have apartments or residences available for students which support broader HHR needs.

Orientation

Students need orientation in advance as well as once they are in the rural community. Topics to consider for orientation include: rural health, Aboriginal culture, community needs, interprofessional learning styles, teamwork, and dual relationships in rural communities. Currently schools/programs have a range of orientation approaches. These approaches should be shared across programs and over time become more standardized. Further work needs to be undertaken in exploring use of online, videoconferencing and other approaches for orientation.

Supervision

Preceptoring students in rural communities can require significant creativity given that rural communities may be served by part-time staff, dual trained practitioners (e.g. physiotherapy and occupational therapy), practitioners in neighbouring communities, etc. A variety of models are being developed and lessons learned shared across programs and communities in the province.

Further work should be undertaken in exploring options for faculty support to students and rural communities, in particular across programs. Interaction with faculty varies across programs ranging from telephone and internet communication, online courses and site visits.

Travel

There are two aspects of travel costs which can be a barrier for communities and students: firstly, travel to get into the community for the placement, and secondly ongoing travel around and within the community during the placement.

Travel into rural communities is not covered by most programs, except for medical students. IRPbc has provided stipends (beginning at \$800 and now down to \$300 per student) which has helped students cover travel costs, and has been reported by students as being very important to their decision to participate. However, this creates challenges for sustainability and administration given that student needs for travel vary based on location of their school/home and which community they are placed in.

An equally important and challenging issue is travel within the community during the placement. Some students arrive with cars or bikes which help. Some

IRPbc has typically provided a one to two-day student orientation which has been powerful for connecting students and community representatives in advance of placements

communities and health authorities provide some reimbursement for gas or a bus pass.

Communities need to think creatively about how to facilitate accessible travel for students. Community approaches will vary depending on needs and opportunities.

Internet Access

Internet access is important especially given that many students research topics and/or participate in online courses and learning while on placement. Ideally, students prefer that internet access be available within student housing. However, some communities are only able to provide access within the healthcare facilities.

Other Supports

A welcoming and supportive environment make a difference for students and longer term recruitment. Community approaches range from providing a welcome basket, community information, passes to community program, hosting dinners or workshops for students, and interaction with preceptors or community members and more.

For Preceptors

Continuing Professional Development and Preceptor Training

Continuing professional development is an essential component for rural health professionals, and particularly in preceptoring students. Topics should including preceptor training (e.g. role and responsibilities, goals and expectations of programs,) interprofessional teamwork and discipline-specific updates. For example, one PEIF project developed online modules for preceptors which are available at www.practiceeducation.net.

Access to library resources within the health facilities, through the Electronic Health Library of BC (eHLbc) <http://ehlb.ca/>, conferences, workshops and other continuing education is important to make available.

Recognition

Recognition of preceptors needs to be more consistently applied across communities and professions/schools. Mechanisms need to be further explored but could include faculty appointments, financial remuneration, tokens of appreciation such as a gift certificate for lunch, or certificate/letter of thank you.

Through the phases of IRPbc, effort has been made to provide preceptors and students with a tangible “IRPbc” item to support the placement and to say thanks.

Availability of
videoconferencing in
most communities
provides for new
ways of learning
across communities
and academic
institutions

At the Port McNeill Interprofessional Health Symposium 2008, Dr. John Pawlovich profiled how alternative payments for Fraser Lake physicians and implementation of an electronic health record has supported the shift to a patient-centred model of care, collaboration across health providers, the education of students and more

Over the phases, these items have included an IRPbc shirt or vest, a backpack, a memory stick and a water bottle. In addition to saying “thanks”, these items have provided as a way to promote rural interprofessional learning.

Remuneration

A critical element for rural practitioners to undertake the additional role and responsibilities for educating medical and other health sciences students is financial remuneration. Further work is required in this area, not only for rural communities but to align with practice education across the system.

For Communities

Local Coordination

Leadership and administrative coordination provide a critical element in supporting the rural community participation in student placements. It is vital those that take on this role know, understand, connect and communicate effectively within the local community – with health practitioners, elected officials, business, and local clubs. There are two key roles involved:

- » *Community lead/champion* solicits the community’s potential for educating students and health professionals, solves problems that arise, liaises across regional and provincial partners to help set directions, contributes to the evaluation and research, etc.
- » *Community coordinator* provides a key role in supporting the students (aka “den mom”); communicating with faculty, preceptors and students; setting up schedules for students in the community; and trouble shooting and resolving day to day issues

In addition, work is being undertaken through the Interprofessional Rural Program of BC to explore the concept of an “interprofessional coach” to support the interprofessional learning of students and staff.

For the Province

Provincial Coordination Activities

The complexity of rural placements cannot be understated. The large number of post-secondary education institutions that place students, the range of health professions, existing partnerships, current gaps, the number of initiatives, and different funding sources all serve to compound communication and efficiency. There is a significant

need to find ways to network stakeholders (health, education, rural communities, and others) and initiatives, and to facilitate sharing of different approaches. In particular, several key aspects related to provincial coordination activities have emerged from dialogue to date:

- » *Placement coordination across organizations* needs to ensure that clear policies and processes are in place to support the complex interactions across schools/programs for the placement of students. HSPnet, an online placement coordination system, currently hosts placement coordination across a number of programs and regions across the province. This system can be built upon to facilitate coordination across organizations.
- » *Marketing of rural practice opportunities* needs to be actively undertaken. Students should be aware of rural communities that offer learning opportunities, and of the benefits and expectations of rural placements, as well as recreational and learning opportunities. This marketing could include a variety of approaches including online (e.g. HSPnet, other), brochures, and presentations.
- » *Networking across participants and initiatives* is vital to foster exchange of knowledge relating to challenges and successes, preceptor orientation and support, ongoing evaluation and evolution of rural practice education.
- » *Linking with rural recruitment* will ensure that rural student placements are integrally linked to recruitment and retention.

Evaluation and Research, Including Knowledge Exchange

Rural practice education must be effectively linked to evaluation and research. Through the RAHP processes, efforts were made to identify current initiatives and to communicate with stakeholders regarding potential linkages, synergy and areas for future research throughout the province. Further, having students participate in action or participatory research during their placements can have an impact on rural research and leave a legacy in the community.

In particular, during the consultation process there was an opportunity to share knowledge about current rural practice education programs and models such as the Interprofessional Rural Program of BC and Aboriginal Health Elective. Sharing these initiatives provides impetus to rural communities and educational institutions to integrate the findings of these interprofessional and rural experiences into what they offer.

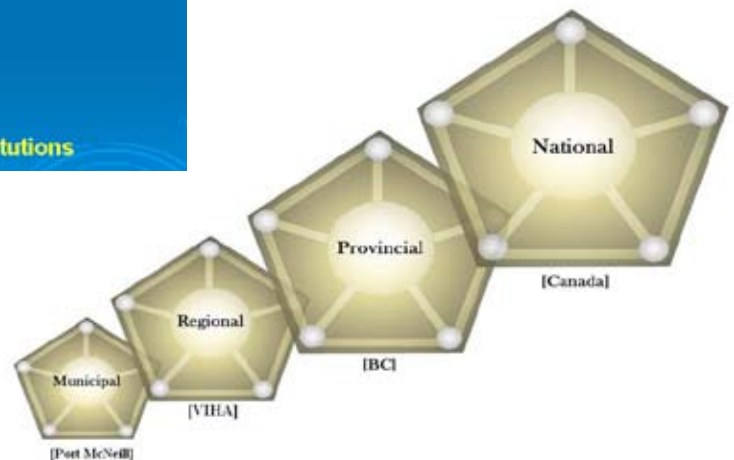
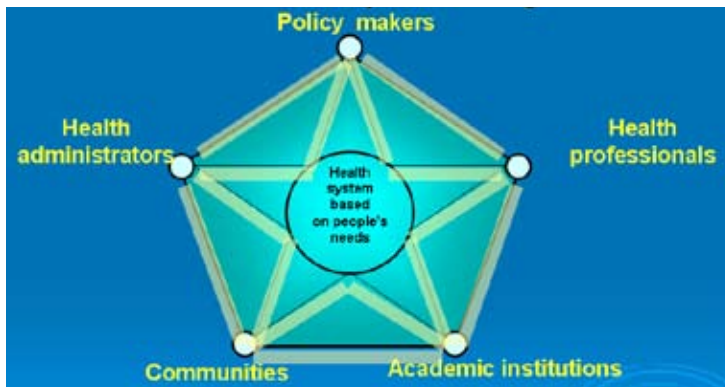
Infrastructure and Funding

There are many challenging issues relating to the infrastructure required to support rural practice education. Factors to consider include:

- » Key levers ('must haves') that support rural practice education
- » Cost-sharing mechanisms that reflect the benefits to and respective roles of key partners in rural practice education
- » Differences across health sciences programs (e.g. in whether rural placement is required as part of the educational program, funding, orientation)
- » How to allocate funds across communities/programs
- » Reporting and accountability

Partnerships and Roles

Partnerships among rural communities, health care administrators, policy makers, health professionals and academic institutions are essential for supporting and advancing rural health through education and research. The following diagrams (Dr. Robert Woollard, Port McNeill Interprofessional Health Education Symposium, 2008) depict these partnerships and linkages at the community-specific, regional, provincial and national levels.



As we move forward, we need to design structures that support these partnerships.

With respect to rural practice education, the roles of stakeholders are distinctive, inter-related and complementary as outlined below.

“It’s all about relationships,” Paul Willie, Wuikinuxv First Nations, Port McNeill symposium, June 2008

Rural Communities

- » Highlight their community as a place of learning for students and health professionals
- » Foster a welcoming and supportive environment for students
- » Provide a range of learning and cultural opportunities for students, and help “turn them on” to rural life and practice
- » Network with other rural communities to share lessons learned and support the expansion of rural placement capacity

Students

- » Actively participate with the community and rural health services
- » Take initiative in their rural learning experience
- » Contribute their skills, knowledge and experience

Rural Healthcare Providers

- » Mentor and support students both in the practice setting but also help orient them to broader rural life and practice
- » Contribute to ongoing development of policies and processes for rural practice education
- » Develop relationships with faculty at post-secondary education institutions to foster mutual support

Health Authorities

- » Recognize and support rural practice education as an integral part of their mandate
- » Integrate wherever possible the policies and processes with practice education in other sites across the regions

Post-Secondary Education Institutions

- » Participate in planning rural practice education opportunities and align curriculum
- » Profile rural practice education opportunities and information for students
- » Help select appropriate students for rural practice education
- » Communicate with and provide ongoing support to students on placement, and to rural preceptors
- » Recognize preceptors e.g. thank you, faculty appointments and continuing professional development
- » Participate in evaluation and research, knowledge translation

The above roles and responsibilities are somewhat in place to varying degrees across the system, but further work is needed to embed these across all stakeholder groups. Through this project, some of these roles and responsibilities as well as some of the innovations and promising practices in place across the system, were incorporated into a draft handbook (see appendix 3?). These concepts may be further explored in later phases of advancing rural education in the province.



RECOMMENDATIONS AND ENABLING STEPS

Based on analysis of the data gathered from the literature, multi-stakeholder consultations, and lessons learned from various provincial initiatives such as IRPbc, RAHP has identified the following recommendations and enabling steps to help implement the model outlined in this report and ultimately sustain and strengthen student placements in rural British Columbia.

Identify “rural” as a strategic priority

- » BC Ministries of Health and Advanced Education, and BCAHC Operating Committee and Council endorse “rural” as a strategic priority
- » BC Ministries of Health and Advanced Education identify Ministry Lead(s) (point people) for advancing “rural” health and education

Endorse key principles and model for Rural Academic Health

- » Present RAHP findings including key principles, proposed model and recommendations to BC Operating Committee for endorsement

Host a provincial Rural Symposium, Fall 2008

- » Host a BC rural symposium in Fall 2008 to bring together key stakeholders focusing on rural practice, education and research

Use HSPnet to help promote, profile and evaluate rural practice education

- » Enhance HSPnet’s ability to profile and facilitate rural placement activity and capacity across BC
- » Actively monitor rural practice education data from HSPnet to identify trends, confirm outcomes, and profile challenges and successes

Embed, support and recognize practice education in rural communities

- » Develop a broad engagement strategy and survey rural communities in order to foster interest in and confirm current/potential capacity for accepting students. Identify key barriers, levers and opportunities to strengthen capacity within individual communities.
- » Rural communities to develop innovative strategies for student housing which could also be used for locum and newly hired staff
- » Allocate seed funding for approaches such as cost-sharing/shared use of housing, community coordination and innovation

- » Further develop, implement and evaluate Interprofessional “Coach” concept for rural communities
- » Profile/market rural practice opportunities for students through a variety of mechanisms e.g. website, print materials, conference posters and presentations, and research publications.
- » Develop and promote a Community of Practice to engage all interested stakeholders in discussions and activities in support of stronger rural health in BC

Provincial coordination

- » Confirm provincial co-ordination mechanisms for all healthcare provider education programs
- » Ensure emerging co-ordination mechanisms provide balance of perspectives across stakeholders and in particular reflect the community voice
- » Confirm linkages/co-ordination across range of provincial stakeholders including Rural Coordinating Centre; BCAHC (Council, Operating Committee and Practice Education Committee and related initiatives), In-BC, College of Health Disciplines, Faculty of Medicine, Deans and Directors of Health Sciences, other

Evaluation and Research

- » Continue to develop a comprehensive evaluation framework that can determine enabling factors, barriers, and success stories so that future activity reflects lessons learned and builds capacity through evidence

Knowledge translation

- » Develop and maintain a website with information/links/resources on rural practice education and research
- » Develop mechanism for ongoing sharing of lessons learned
- » Develop mechanism for injecting lessons learned into provincial policies and processes

ACKNOWLEDGEMENTS

IRPbc Community Leads

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- » Lorinda Andersen, Bella Coola
- » Alfred Laskowski and Cindy Aronson, Hazelton
- » Doug Blackie, Enderby
- » Jerry Causier, Powell River

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BC Academic Health Council, Ministries of Health and Advanced Education

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Vince Verlaan, *Consultant* – process design and community engagement

APPENDICES

1. Literature Synthesis
2. Inventory of Initiatives
3. Draft Discussion Paper
4. Provincial Consultation Summary
5. Draft Handbook
6. Poster for the Sweden Conference



Solutions Panel from the Port McNeill Interprofessional Health Education Symposium 2008: Dr. Owen Heisler, Ms. Linda Sawchenko, Ms. Lesley Bainbridge, Dr. William Mackie, Honourable George Abbott, Mayor Gerry Furney, Dean Gavin Stuart, Ms. Jean Wheeler and Dr. Granger Avery.