Edzanèk'e Gots'ǫ
Ek'èteht sodǫ
Łegehdì Kǫ

MEETING SD 48-20-24

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

THURSDAY, JANUARY 16, 2025
DET'ANCHOGH KǪ́É - EAGLE ROOM / ZOOM
7:00 PM

AGENDA

1. Call to Order

2. Prayer

3. Review and Adoption of Agenda

4. Declarations of Conflict of Interest

5. Public Matters
   a) Public Briefing on Healthcare Sustainability and Accountability with the Society of Rural Physicians Canada

6. In Camera Matters
   a) Debrief
   b) Confidential correspondence
      - 2024-12-10 Honourable Minister of Education, Culture and Employment
      - 2024-12-17 Honourable Minister of Justice
      - 2025-01-07 Honourable Minister of Justice
   c) Workplan

7. New Business
   a)

8. Date and Time of Next Meeting:
   a) February TBD

9. Adjournment

SOCIETY OF
Rural Physicians
OF CANADA

Witness Presentation:

Healthcare Sustainability and Accountability

Standing Committee on Social Development

Society of Rural Physicians of Canada

January 16, 2025

Society of Rural Physicians of Canada (SRPC)

Founded in 1992, the SRPC is the national voice of Canadian rural physicians.

The SRPC is a voluntary professional organization with over 3500 members representing rural physicians spanning the country.

Our Vision

Excellent health care close to home for all rural Canadians.

SOCIETY OF Rural Physicians OF CANADA

srpc.ca

Objectives of the Presentation

Addressing healthcare sustainability and accountability in the NWT with a focus on rural challenges.

Our recommendations:

- Advocate for Pan-Canadian Licensure
- Allocate Funding for Training
- Develop a Comprehensive Rural Health Workforce Strategy

Pan-Canadian Licensure – A Key Solution

Enabling Workforce Mobility

- Simplifies provider movement across provinces/territories.
- Addresses workforce shortages in areas like the NWT.
- Reduces administrative barriers for locums and new recruits.
- Encourages recruitment and retention of healthcare professionals.

Funding for Training – Enhancing Local Capacity

SRPC received funding to implement a National Advanced Skills and Training Program for Rural Practice.

National Advanced Skills and Training Program for Rural Practice

Optimizing rural care

Build Skills Locally

- Increases access to care
- Reduces costly patient transfers
- Supports retention

Skills and Training Program

A Rural Health Workforce Strategy

A Strategic Commitment to Sustainability

Government needs to commit to the development and implementation of a RURAL health workforce strategy.

Benefit to the NWT

Why does this matter?

- Improved access to timely and high-quality care.
- Reduced strain on rural and urban centers.
- Strengthened community health outcomes and resilience.

Collaboration is needed between governments, healthcare organizations and communities.

Thank you!

The SRPC is committed to continue to advocate and support!

SOCIETY OF
Rural Physicians
OF CANADA

RURAL PHYSICIAN PERSPECTIVES ON NATIONAL MEDICAL LICENSURE

SUMMARY REPORT

Survey Results & Analysis
April 2023

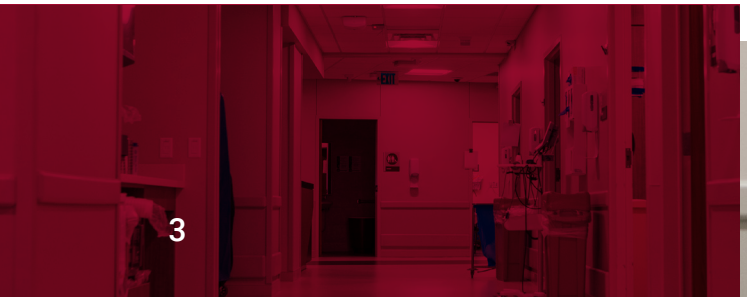
SOCIETY OF Rural Physicians OF CANADA

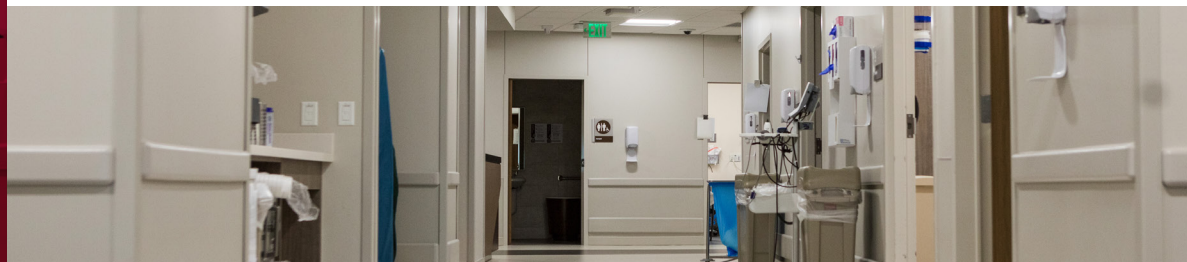
TABLE OF CONTENTS

CONTEXT

Background

There is a lot of discussion about implementing a pan-Canadian approach to medical licensure in order to overcome the barriers that prevent physicians from providing healthcare anywhere in Canada. Rural doctors face difficulties in obtaining licenses, which impedes their ability to practice in underserved and rural areas. This is a pressing issue for the Society of Rural Physicians of Canada (SRPC). Various organizations have urged the federal government to adopt a national approach to licensure to address the current shortage of healthcare professionals. However, the idea of pan-Canadian licensure has raised concerns among stakeholders and policymakers. One viewpoint suggests that implementing pan-Canadian licensure would worsen the shortage of physicians in rural Canada, as it could lead to rural doctors leaving for urban areas.





Survey Objective

In November 2022, the SRPC conducted a membership survey to determine if medical licensure is a factor that impacts a physician's decision to leave or remain in a rural community. Questions were also asked to obtain a general perspective on national licensure.

"Pan-Canadian (national) licensure is defined as the ability for physicians with full licenses to practise independently without restrictions or for medical resident trainees registered in any Canadian jurisdiction to practise or train in any other Canadian jurisdiction without having to acquire more than one license or pay additional licensing fees."

— Canadian Medical Association (CMA)

METHODOLOGY

An email was sent to 5,900 SRPC contacts asking them to complete an online survey. Out of these contacts, 33% were rural physicians practicing in rural communities. A total of 1,147 participants completed the survey, which represents a response rate of 19% of the overall distribution. Among the respondents, 1,000 indicated having a rural practice.

Out of the 1,147 participants who responded to the survey, 362 provided written responses. The data results and analysis were reviewed by the SRPC (qualitative) and the CMA (quantitative) in aggregate and de-identified form.

LAUNCH: NOVEMBER 3, 2022

CLOSE: DECEMBER 5, 2022

1,147 TOTAL RESPONSES

*Respondents identified as full-time practice, locum, clinical practice with academic appointment, retired and part-time.

KEY FINDINGS

When asked whether they had ever left rural practice to move to an urban practice due to licensure

71% of survey respondents indicated they had never left rural practice.

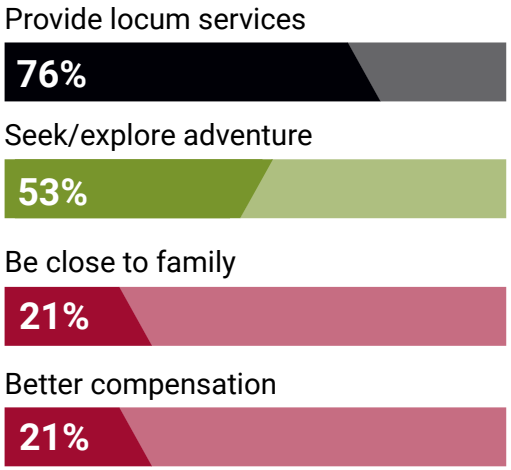
Among those who had left rural practice, the top reasons provided for moving were:

- **50%** To be closer to family and friends
- **29%** To be closer to their spouse or partners
- **26%** A more attractive community or lifestyle
- **21%** Education and professional development
- **21%** To provide locum services

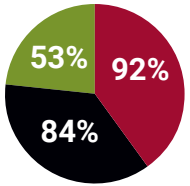
In written responses to this question, reasons for leaving included feeling burnt out, lacking support to make the practice sustainable, receiving job opportunities, needing a better lifestyle for family, and being unable to provide specialized services (e.g., anesthesia) for the rural community.

KEY FINDINGS

Top 3 reasons for applying for a license in another province



Top 3 obstacles encountered in applying for an additional license



- Length of time or process to obtain a license
- Cost of getting licensed
- Credential verification

How implementation of national licensure would affect practice

- 78% Seek locum opportunities in other provinces/territories
- 77% Practice temporarily in rural/remote areas in other provinces/territories
- 76% Relieve/assist my colleagues/other practitioners
- 75% Remain in Canada rather than seek opportunities abroad
- 69% Continue to practice part-time during retirement
- 69% Seek professional development educational opportunities

KEY FINDINGS

Several themes emerged from qualitative responses to the survey :

Restrictive licenses and administrative burdens enforced by provincial/territorial regulators (such as fees and paperwork) create challenges in attracting physicians to work in rural communities outside of their home provinces.

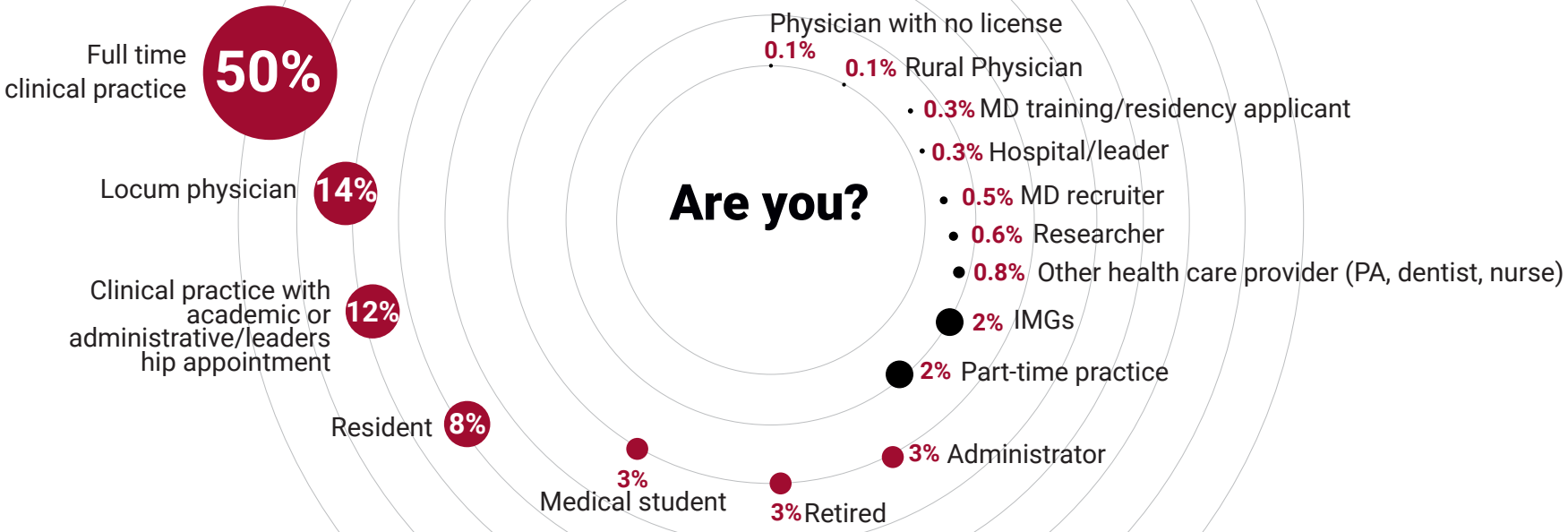
Semi-retired or retired rural doctors who are interested in doing locums have been deterred from pursuing licensure outside their home provinces because of burdensome regulatory requirements.

National licensure would help address rural physician workforce shortages by making it easier for doctors (including urban physicians) to practise in rural and underserved communities and provide locum coverage.

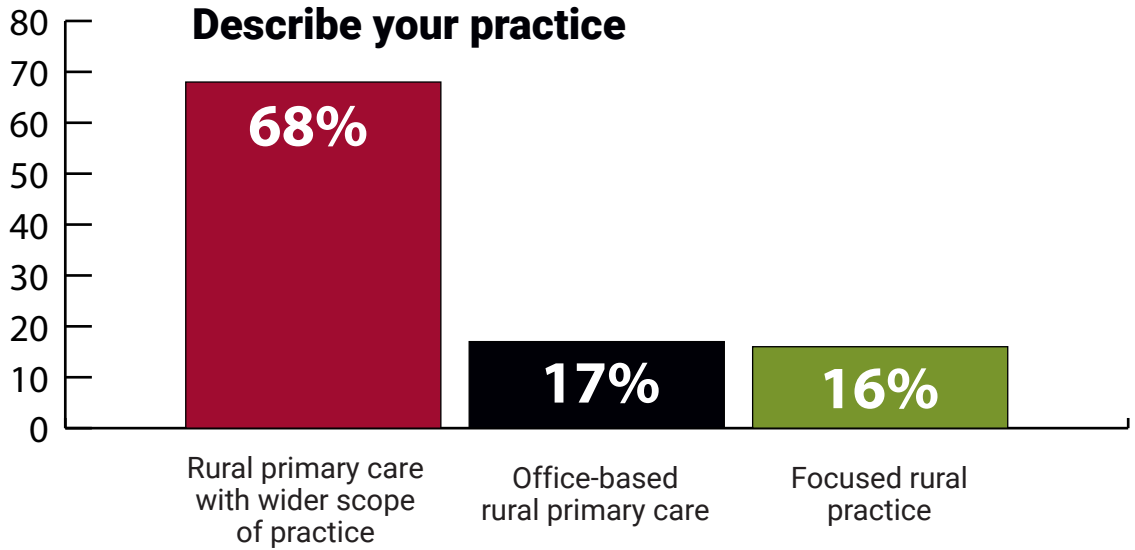
National licensure would alleviate rural physician workforce shortages by simplifying the process for doctors, including urban physicians, to practice in rural and underserved communities and offer locum coverage.

Minimal support from regulators and policy-makers is a key factor affecting the implementation of pan-Canadian licensure.

RURAL PHYSICIAN LANDSCAPE

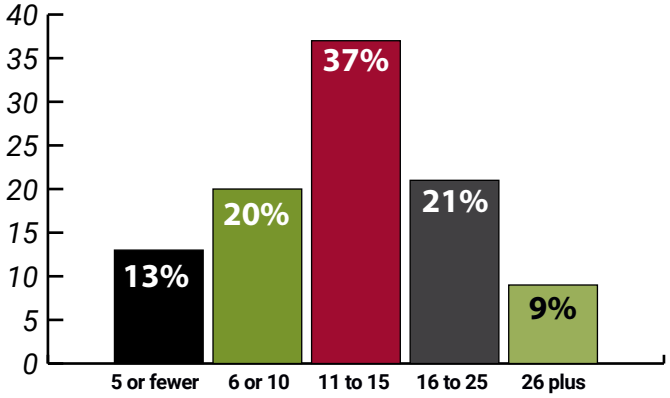


RURAL PHYSICIAN LANDSCAPE

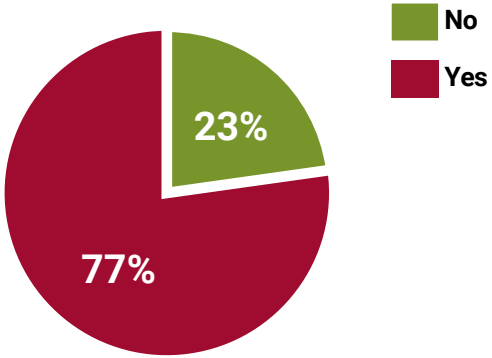


RURAL PHYSICIAN LANDSCAPE

How many full-time years have you been practising rural medicine?



Is your medical practice within 50 km of a provincial/territorial border?



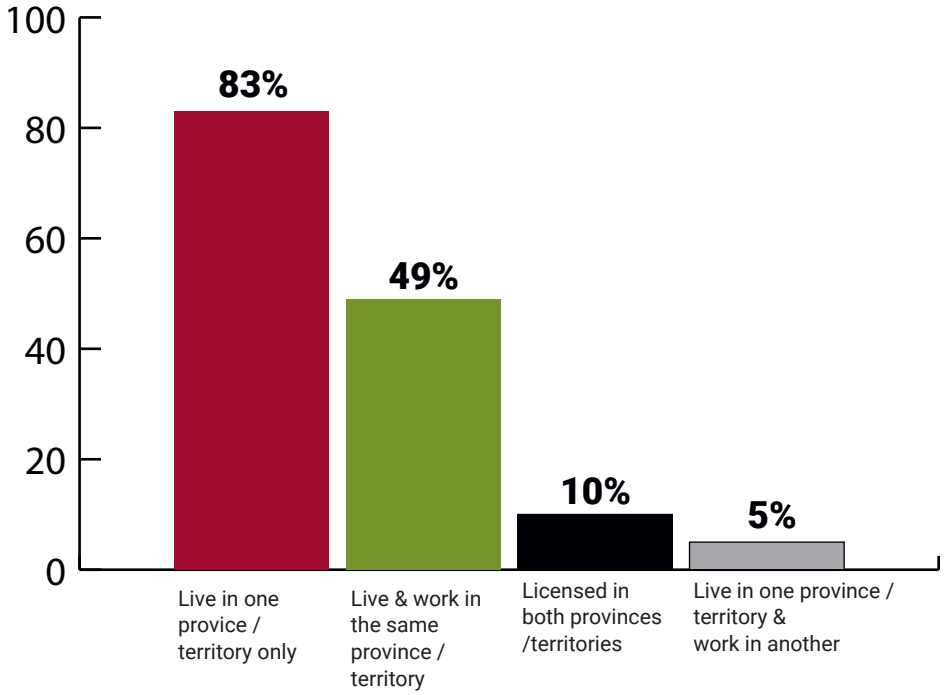
RURAL PHYSICIAN PRACTICE PATTERNS

Rural primary care with a wider scope of practice.

- **83%** Emergency medicine
- **39%** Palliative care
- **14%** Hospital
- **12%** Anesthesia
- **10%** Surgery
- **4%** Endoscopy
- **4%** In-patient care
- **4%** Other
- **3%** Long term care

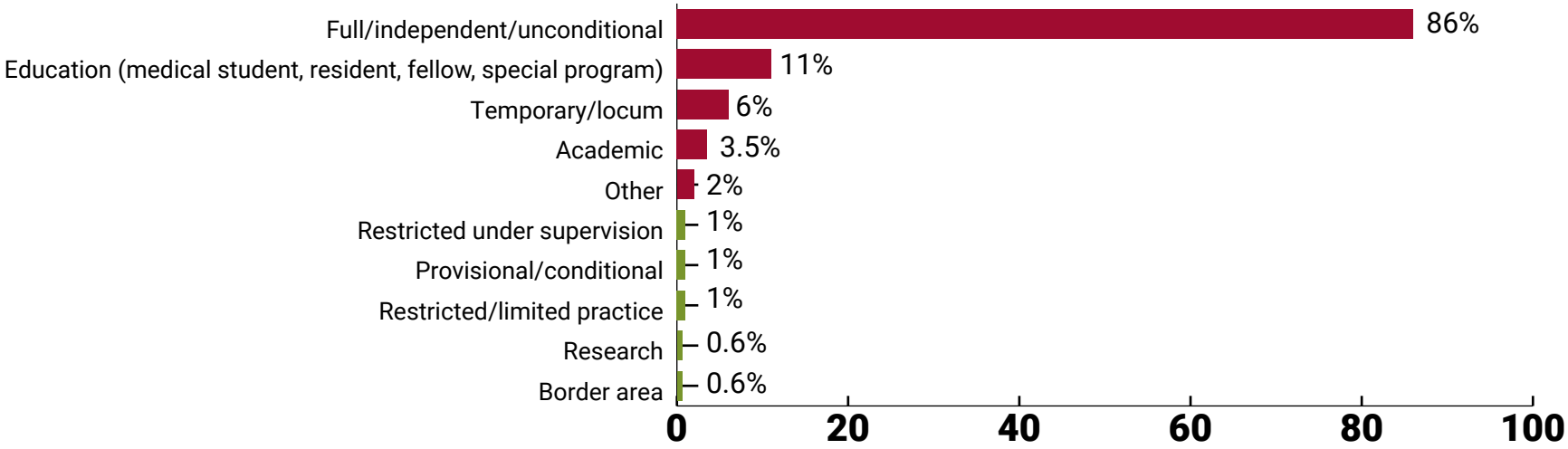
LICENSURE EXPERIENCE

Medical practice within 50 km of a provincial/territorial



TYPE OF LICENCE

Kind of medical licence(s)/registration – check that apply



HOLD ACTIVE LICENSE

Canadian jurisdiction(s) currently hold an active license

Alberta	13%
British Columbia	29%
Manitoba	7%
New Brunswick	3%
Newfoundland and Labrador	6%
Northwest Territories	12%
Nova Scotia	7%
Nunavut	7%
Ontario	33%
Prince Edward Island	2%
Quebec	3%
Saskatchewan	6%
Yukon	7%

In what province or territory do you primarily work?

Alberta	11.37%
British Columbia	25.45%
Manitoba	5.73%
New Brunswick	2.21%
Newfoundland and Labrador	5.84%
Northwest Territories	3.92%
Nova Scotia	5.73%
Nunavut	2.21%
Ontario	28.67%
Prince Edward Island	1.51%
Quebec	3.12%
Saskatchewan	5.33%
Yukon	4.43%

Survey respondents were asked in which Canadian jurisdiction(s), do they currently hold an active licence. Respondents selected more than 1 jurisdictions that applied to them directly. The results also show the home province of the respondents who completed Question 1 – "Who are they?"

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HOLD ACTIVE LICENSE

Primary Region of those who have multiple active licenses

		Frequency	%
Valid	British Columbia	68	31%
	Alberta	22	10%
	Saskatchewan	7	3%
	Manitoba	8	4%
	Ontario	51	23%
	Quebec	10	5%
	Atlantic	17	8%
	Territories	34	16%
	Total	217	100%

Total includes those who indicated having a license in multiple provinces and indicated their primary province/territory.

REASONS FOR MULTIPLE LICENCES

In holding a licensure in more than one jurisdiction, what were the top three reasons for applying for a license in another province/territory

- 76% To provide locum services
- 53% Adventure; new experiences; new horizons
- 22% Better compensation
- 22% To be closer to family and/or friends
- 20% Feeling of civic or professional duty
- 20% To provide emergency care
- 20% More attractive community or cultural diaspora or lifestyle
- 20% Education/professional development
- 17% To practice during vacation
- 16% Returning to my “home” province
- 13% To continue to practice during retirement
- 9% To be closer to spouse or partner
- 8% Career change
- 7% Living in a border community
- 4% Other(e.g. keep options open, mantain skills, benefits)
- 2% Completed my mandatory licensing requirement
- 2% Relocation for health issues

LEAVING RURAL PRACTICE

Reasons for leaving your rural practice – select any that apply.

- 50% To be closer to family and/or friends
- 29% To be closer to spouse or partner
- 26% More attractive community or cultural diaspora or lifestyle
- 21% Education/professional development
- 21% To provide locum services
- 19% Adventure; new experiences; new horizons
- 13% Career change
- 13% Better compensation
- 11% Returning to my “home” province
- 8% To provide emergency care
- 5% Other (e.g. political)
- 4% Feeling of civic or professional duty
- 4% To continue to practice during retirement
- 4% To practice during vacation
- 3.5% Relocation for health reasons
- 3% Living in a border community
- 0.8% Completed my mandatory licensing requierement

LEAVING RURAL PRACTICE

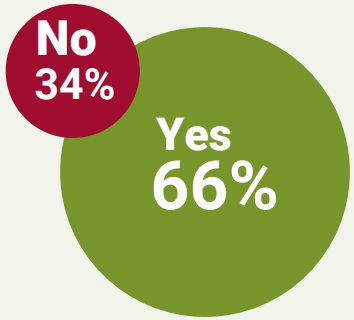
"Started a family, urban spouse, no real childcare or viable education options on small reserve."

"To provide a better education and better possibilities to our kids."

"Burnout practicing in UNDER resourced rural settings"

PRACTICING OUTSIDE JURISDICTION

Considered practicing outside home province but could not due to licensure requirements

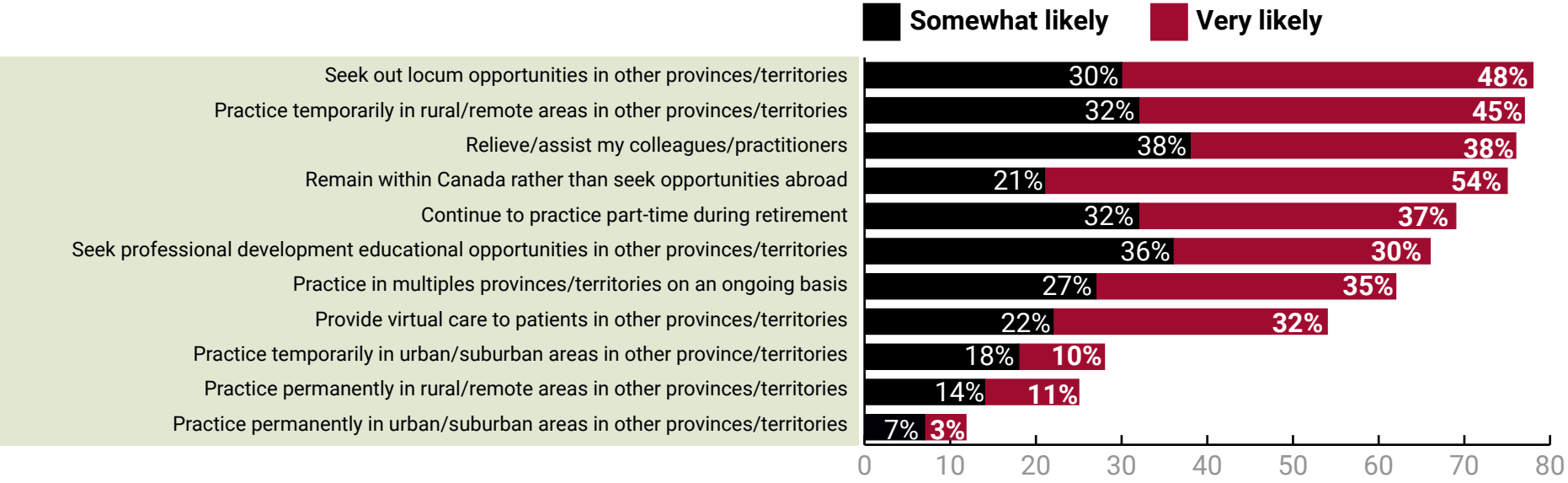


Factors identified as significant obstacles or would make physicians hesitate in applying for licensure in another province or territory

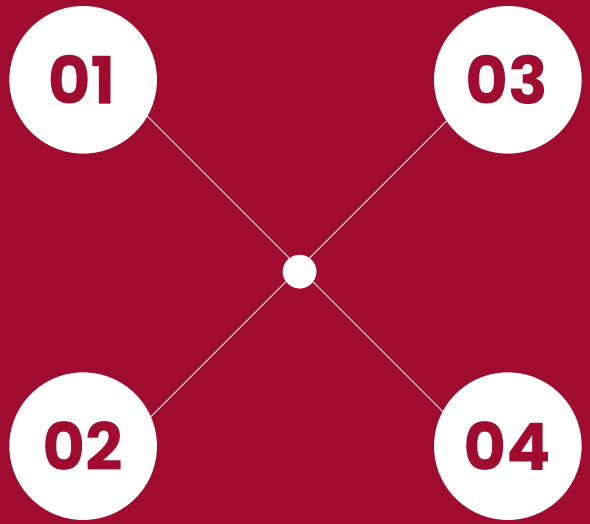
92%	Length of the process to obtain a licence in the other province or territory
84%	Cost of getting licensed in the other province or territory
53%	Obtaining credential verification/Certificate of Practice (CPC) for or from the provincial/territorial regulatory authority
32%	Obtaining reference or character letters
31%	Obtaining letter(s) of good standing from the provincial/territorial regulatory authority
25%	Obtaining police record check
3%	Other (e.g., language exam, unclear payment models, international credential verification)

SUPPORT FOR THE IMPLEMENTATION OF NATIONAL LICENSURE

% who selected somewhat likely or very likely



SURVEY LIMITATIONS



Not mandatory questions

It was not mandatory that all survey questions be answered as SRPC indicated to participants to exercise their discretion on whether to answer all or some questions.

Response rate dropped off

While there was a high response rate with some questions, it was noted that respondents skipped other questions, and mid-through the survey, the response rate dropped off. It is assumed that the survey design and its application through SurveyMonkey may not have been fully utilized.

Exclusion criteria:

Students were excluded from the analysis on questions that were practice related.

Exclusion criteria:

While 1,150 completed the survey – 2 respondents were removed as they did not complete Question 1 in identifying who they are.

RURAL PHYSICIANS HAVE THEIR SAY

Written responses to the survey provided additional insights into the potential benefits of pan-Canadian licensure. The following quotations reflect common themes expressed in favour of national licensure.

RURAL PHYSICIANS HAVE THEIR SAY

Administrative headache of licensure

"I've been licensed in 5 provinces/territories so [I am] VERY familiar with the different licensing processes, which are all duplicative! I have actively NOT worked when I could/would like to have done so in rural regions due to cost, timelines, and [the] administrative headache of licensure."

I would love to return

"I would love to return to rural locums in other provinces/territories when semi-retired if it is easier and less expensive to apply for and maintain licensing."

RURAL PHYSICIANS HAVE THEIR SAY

"During my earlier years I moved between provinces, and the administrative paperwork was a real bother. I would have been much more likely to do locums had there been easier cross-Canada licensing."

I would have been much more likely to do locums

Why on earth should we need provincial licenses?

"For us to address part of the shortage in family physicians in different regions, we need easier access to these regions, and this all starts with a national licence. Our education is nationally relatively the same, so why on earth should we need provincial licenses? … At the very least, provide an option for locums."

RURAL PHYSICIANS HAVE THEIR SAY

National licensure would greatly improve healthcare access

"National licensure would greatly improve healthcare access to people who live in areas without enough doctors. When I worked as a locum in the Northwest Territories, many of the physicians I worked with also were locums who lived in other parts of Canada. Still, there were not enough physicians to meet the needs of the territory."

I feel national licensing would enlarge our pool of potential locums.

"Our rural hospital has been on the brink of closure for many months. I feel national licensing would enlarge our pool of potential locums. We are close to a breaking point and need this to move forward."

SRPC OBSERVATIONS

While the survey revealed that medical licensure was not a factor in rural physicians' decisions to leave rural practice or rural communities, it did provide other insights about the rural physician workforce.

Based on SRPC members' perspectives, it is noted that:

Many rural physicians who are retired, semi-retired, or approaching retirement **wish to continue practising in rural communities where needed**, but they do so only when and where licensure requirements are not barriers. Rural physicians tend to go to jurisdictions with minimal or no licensure requirements.

Staffing shortages leave many physicians unable to take breaks from practice without disrupting patient care. **Improving the availability of locums would enhance rural physicians' work-life balance** and help them avoid burnout, and it could attract more physicians to rural areas.

SRPC OBSERVATIONS

While the survey revealed that medical licensure was not a factor in rural physicians' decisions to leave rural practice or rural communities, it did provide other insights about the rural physician workforce.

Based on SRPC members' perspectives, it is noted that:

A lack of administrative support and poor access to other health care services have made rural practice unsustainable for some physicians.

"Red tape" related to credentialling and privileges creates barriers for all physicians wanting to practise in rural settings, whether they are Canadian medical graduates, international medical graduates, or residents.

SRPC OBSERVATIONS

While the survey revealed that medical licensure was not a factor in rural physicians' decisions to leave rural practice or rural communities, it did provide other insights about the rural physician workforce.

Based on SRPC members' perspectives, it is noted that:

Practising rural medicine (generalism) requires having a broad skill set, including enhanced skills in areas such as emergency medicine, anesthesia, surgery, and maternity care. The survey revealed that **most rural physicians have wide scopes of practice and there was high interest in training opportunities** that would help them better serve the health care needs of their communities.

While licensure is one way to address rural physician workforce issues, **all of the above elements must be addressed** to ensure the sustainability of the rural physician workforce.

SOCIETY OF
Rural Physicians
OF CANADA

CONTACT

Dr. Kyle Sue
SRPC Lead, Ad Hoc Group on Licensure
Email: info@srpc.ca

The SRPC wishes to acknowledge CMA's support and their contributions to the quantitative analysis of the survey.

National Advanced Skills and Training Program for Rural Practice

Optimizing rural care

Society of Rural Physicians of Canada

Société de la Médecine Rurale du Canada

Équipe de soins primaires Former pour transformer

Team Primary Care Training for Transformation

Final Evaluation Report

May 23, 2024

Submitted to: Dr. Sarah Lespérance

Submitted by: Daria Parsons, Daria Parsons Consulting Inc.

Table of Contents

Executive Summary

The SRPC received $7.4M as part of the $43M *Team Primary Care Training for Transformation* project managed by the Foundation for Advancing Family Medicine (FAFM) and funded by Economic and Social Development Canada (ESDC). Team Primary Care collaborated with multiple organizations, including the SRPC, to broaden the capacity of interprofessional comprehensive primary care in Canada, in an attempt to reduce critical labour shortages and enhance labour mobility and utilization. The SRPC project's objective was to implement the *National Advanced Skills and Training Program for Rural Practice to* support training and continuing professional development programs for practicing rural family physicians to enhance their skills to meet identified rural community needs and improve access to care in rural, remote and Indigenous communities.

The response to the National Advanced Skills and Training Program for Rural Practice significantly exceeded the target number of 166 rural physicians. SRPC received 375 applications between March 2023 and March 2024 and funded training for 342 rural physicians – more than double the anticipated number. Participating physicians represented 187 communities across all provinces and territories, with at least 60 Indigenous communities benefiting from the program. Thirty percent of trainees were international medical graduates. The majority of trainees selected emergency medicine (72%) as the area of training followed by diagnostic imaging (11%), family practice anesthesia (10%) and palliative care (10%).

All key performance indicators were achieved for the project except for one - the number of participating Indigenous physicians. The success of the program was aided by the implementation of the Communication Plan. The program was promoted through emails and newsletters to SRPC membership, full page advertisements in six physician journals, and engagement with 60 provincial and national organizations and 50 provincial and regional physician recruitment organizations. A social media strategy was developed including videos and testimonials to promote the training program.

The feedback from trainees was resoundingly positive. Ninety-eight percent of participants reported that they successfully implemented their training plan and met their learning objectives. All trainees reported the training program enhanced their knowledge (100%), and 99% reported that the training program enhanced their skills, confidence and competence in providing care in their rural communities. Ninety percent of trainees indicated that the training program helped to develop their team's confidence. Eighty percent of trainees reported the training program made them feel greater connectedness to referral centres or a network of support. Eighty-two percent of participants who had a preceptor reported that

they established an ongoing relationship with them and 79% of preceptors reported the training program positively impacted their clinical practice. Ninety-seven percent of trainees reported they will be able to make evidence-informed changes to their practice as a result of the training program.

Trainees reported the self-directed nature allowed the program to suit individual physician and community needs. They described the program as well-funded, low barrier, high yield, flexible, practical, accessible, providing interactive high-quality learning opportunities.

SRPC was able to address an unmet training need for rural physicians across Canada. Participating rural physicians reported they were better equipped to offer more timely diagnosis of medical conditions in local communities, thereby reducing unnecessary transfers and wait times, increasing team-based interprofessional care, and improving communication during transfers when needed. In addition to meeting this need, 98% of trainees reported the training program helped to maintain services in the rural communities they serve.

Introduction

The Canadian healthcare system is currently facing significant challenges, as it struggles with critical shortages of skilled healthcare workers in all sectors. Efforts are underway to understand the health human resources landscape, to identify who is providing what care, to train the next generation of healthcare professionals to meet the evolving needs of a team-based healthcare system, and to capture data that will help inform the ongoing health human resource needs of this country. Meanwhile, there is an urgent need to implement practical, effective strategies to stabilize health services.

Healthcare needs are even more magnified in rural, remote and Indigenous communities. While nearly one-fifth of Canadians (18%) live in rural communities, they are served by only 8% of the physicians practicing in Canada.[1] Rural communities face ongoing challenges in recruiting and retaining family physicians resulting in critical shortages of skilled physicians. As a result, individuals in rural areas experience greater challenges accessing health care compared to their urban counterparts. Moreover, when they do access health care services, they tend to have less favorable outcomes. Access to health care close to home is of particular concern for rural Canada. Factors such as geographic isolation from urban centres, poor weather conditions impairing access to remote locations, and lack of

[1] Wilson CR, Rourke J, Oandasan IF, Bosco C; On behalf of the Rural Road Map Implementation Committee; Au nom du Comité sur la mise en œuvre du Plan d'action sur la médecine rurale. Progress made on access to rural health care in Canada. Can Fam Physician. 2020 Jan;66(1):31–6. PMCID: PMC7012120.

communication technology infrastructure have made it challenging for the Canadian health system to sustain equitable provision of quality health care services to rural and remote communities.[2]

An additional challenge is that physicians practicing in rural communities must have skills that extend beyond comprehensive primary health care e.g., emergency care, anesthesia, obstetrics, surgery, palliative care, and mental health. These core services, provided by rural generalists, are essential to ensure patients are able to access high quality care in rural communities. Unfortunately, the current rural physician workforce is not well equipped to offer the full scope of services required. While some physicians may choose to complete additional skills training prior to completion of their medical training, few opportunities exist for rural physicians to enhance their skills based on identified community needs once they are in practice. In addition, physicians interested in broadening the scope of their practice, or those who wish to relocate to rural communities, often cite a lack of confidence in various skill areas as a barrier to making such a transition.

In select regions of Canada and internationally, such as Australia, well-established programs exist that offer ongoing enhanced training opportunities for health care providers to improve their skills and knowledge continuously. Review of these programs indicated they are highly effective as part of a rural health human resources strategy to sustain services, respond to the healthcare needs of communities, and enhance retention of providers.[3,4,5]

The Society of Rural Physicians of Canada (SRPC) has been an advocate for rural healthcare providers and communities for over 30 years. To address the gaps in rural healthcare, the SRPC proposed developing the *National Advanced Skills and Training Program for Rural Practice* to increase opportunities for access to training and continuing professional development programs by providing financial support to practicing rural physicians, including international medical graduates and those in their first year of practice, to increase their skill sets based on the needs of their rural, remote, and Indigenous communities.

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[2] Soles TL, Ruth Wilson C, Oandasan IF. Family medicine education in rural communities as a health service intervention supporting recruitment and retention of physicians: Advancing Rural Family Medicine: The Canadian Collaborative Taskforce. Can Fam Physician. 2017 Jan;63(1):32-38. PMID: 28115438; PMCID: PMC5257217.

[3] https://www.health.gov.au/sites/default/files/documents/2022/03/review-of-the-rpgp-and-gpptsp-evaluation-report-review-of-the-rpgp-and-gpptsp-evaluation-report.pdf

[4] https://www.acrrm.org.au/docs/default-source/all-files/rural-procedural-grants-program-management-guidelines.pdf?sfvrsn=5d7a87eb_19

[5] https://rccbc.ca/our-work/reap/reap-research-and-evaluation/

The SRPC received $7.4M for the *National Advanced Skills and Training Program for Rural Practice* as part of the $43M *Team Primary Care Training for Transformation* project managed by the Foundation for Advancing Family Medicine (FAFM) and funded by Economic and Social Development Canada (ESDC). Team Primary Care collaborated with multiple organizations, including the SRPC, to broaden the capacity of interprofessional comprehensive primary care in Canada, in an attempt to reduce critical labour shortages and enhance labour mobility and utilization. Team Primary Care's overall objectives were to:

1. Enhance interprofessional comprehensive primary care skills of health care practitioners;
2. Improve labour market integration of Indigenous and internationally-educated health practitioners (IEHP), maximizing their utilization;
3. Support the creation of healthy work environments for diverse and resilient team members to practice at their optimal scope and capacity; and
4. Demonstrate, spread and scale leading integrated primary care workforce planning, practices, tools and resources

The objective of the SRPC's *National Advanced Skills and Training Program for Rural Practice* was to support training and continuing professional development programs for practicing rural family physicians to enhance their skills to meet identified rural community needs and improve access to care close to home in rural, remote and Indigenous communities across Canada.

Methods

Infrastructure

The SRPC assembled an Expert Advisory Committee (Appendix A) to oversee the *National Advanced Skills and Training Program for Rural Practice.* The committee included rural physicians from across Canada including an Indigenous physician and an expert from the Rural Coordination Centre of British Columbia (RCCbc), the program upon which the training program was based. A Project Manager and Coordinator were hired to develop and implement the training program.

Application Process

Interested rural physicians submitted an application through the SRPC's website portal. The portal and the reimbursement processes were established to be as simple and straightforward as possible while ensuring a paper trail for accountability purposes. In order to be considered, each application had to be accompanied by the participant's CV and a letter of support from the hospital chief of staff or regional medical director confirming that the training being proposed was needed in a rural community. Each

application was reviewed by two SRPC staff and two alternating members of the Expert Advisory Committee. Physicians who met the eligibility criteria were notified of their approval as quickly as possible. Rural physicians identified their training requirements based on community needs and had to identify or develop learning opportunities to address these needs.

Eligibility Criteria

To be eligible for the program, physicians had to:

- Have an active license to practice in Canada
- Be an SRPC member
- Have practiced in a rural community for a minimum of six months in the past year. Physicians could be practicing in more than one rural community
- Indicate their intention to return to a rural community for at least six months after training
- Identify training that could be completed by March 26, 2024 to align with funding from ESDC

Exclusions:

- Residents were not eligible to apply
- Training that began prior to approval

Rural physicians received funding for up to 30 days of training, travel, accommodation, locum expenses, preceptor stipend and overhead costs up to a maximum of $35,000. Table 1 provides a detailed summary of the available funding categories.

Table 1: Funding Reimbursement for Rural Physicians

Expense	Maximum reimbursement
Income stipend	$1,000 per day stipend to cover rural physician's income loss for up to 30 days
Travel	Up to $2,000. Additional funding was available for physicians practicing in northern and remote communities
Land travel	Mileage reimbursed at $0.55 per km
Accommodation	Up to $200 per day - receipts required ($75 per day if staying with family/friends - no receipts are required)
Locum payment or backfill physician	Up to $1,000 per day

Expense	Maximum reimbursement
Overhead	Costs paid depending on the type of practice (e.g. rent, EMR, admin staff)
Course cost	No limit set
Equipment Cost	Funded if required for course
Preceptor payment:	$250 per day

Participants were required to adhere to the following guidelines. Training:

- Could include courses that directly related to trainee's learning objectives
- Could be completed as a course or in a small-group or one-on-one training with a preceptor(s)
- Had to occur in Canada, and applicants were encouraged to seek opportunities within their referral region
- Could not be fully funded by another source
- Could only commence after approval of an application
- Could be virtual or hybrid, if appropriate

Once training was complete, physicians completed a Claim Form and submitted receipts for reimbursement. Trainees completed the evaluation survey at the time of reimbursement.

Project Timeline

Phase 1 of the project involved establishing the infrastructure in terms of hiring staff and identifying Expert Advisory Committee members. A project plan including a communications plan and evaluation plan, and promotional material were developed. Phase 2 involved the official launch of the project in March 2023 and promoting the *National Advanced Skills and Training Program for Rural Practice* to rural physicians. As most rural physicians in Canada were not members of SRPC, it was imperative to develop a multi-prong approach to increase awareness locally, provincially, and nationally. Components of the communication strategy are outlined in Table 2. Phase 3 included the reimbursement phase for participating physicians and the data analysis for the evaluation.

Table 2: Project Timeline Overview

Timeline	Activities
Months 1 to 4 Nov 2022-Feb 2023	**Phase 1: Development Phase** • Hire staff

Timeline	Activities
	• Establish SRPC's Expert Advisory Committee • Establish eligibility criteria for application approval • Develop a Project Plan outlining timelines, communication plan, stakeholder engagement plan, evaluation plan • Develop website portal content (e.g., registration data elements for trainees and preceptors) in English and French • Develop branding guidelines • Develop promotional material in English and French (e.g. invitations to participate for SRPC members and non-members, posters, 2-pagers for trainees and preceptors, FAQs, key messages, post cards, retractable banners, videos) • Develop evaluation forms for trainees and preceptors • Develop manual for successful trainees (e.g., evaluation form, claim form, letter of completion, locum and cross-covering physician payment forms, and preceptor payment receipt form) • Develop an Evaluation Framework and Evaluation Plan including the identification of data elements and data sources (e.g., a survey to trainees and preceptors, key informant interview guide, registration and reimbursement data)
Months 5 to 10 Mar 2023-Dec 2023	**Phase 2: Implementation Phase** • Media release for official launch of the *National Advanced Skills and Training Program for Rural Practice* in March 2023 and opened the portal to receive applications • Promoted the Training Program using the following platforms: ○ Email invitation to SRPC membership list, partners and committees ○ Invitation to participate mailed to all rural physicians who were not SRPC members across Canada ○ SRPC newsletters ○ Other stakeholder newsletters ○ Conference promotion ✓ SRPC – booth/session ✓ CAEP – booth

Timeline	Activities
	✓ FMF – poster ✓ NL College of FP - booth ✓ CASPR –post cards ✓ RCCbc – post cards ✓ NS College of FP Conference ○ Physician journals ✓ Canadian Family Physician (CFP) ✓ Canadian Journal of Rural Medicine (CJRM) ✓ Canadian Medical Association Journal (CMAJ) ✓ Medical Post ✓ Journal of Obstetrics and Gynecology (SOGC) ✓ Canadian Association of Emergency Physicians (CAEP) ○ Social Media including LinkedIn, X, Facebook and Instagram ○ Presentations to organizations e.g., CASPR ○ Meetings with interested stakeholders e.g. NOSM • Established process for review of applications and notification to applicants • Approval of applications (until Feb 2024)
Months 11 to 13 Jan 2024-Mar 2024	**Phase 3: Reimbursements and Evaluation** • Physician reimbursement • Start evaluation process including summarizing trainee and preceptor survey results and conducting key informant interviews
Months 14 to 17 Apr 2024-May 2024	• Develop evaluation report for approval by Expert Advisory Committee

Three sources of data were used as part of the evaluation including: 1. registration forms, 2. feedback surveys completed by trainees and preceptors, and 3. key Informant Interviews. Trainees were invited to complete a survey about their experience with the *National Advanced Skills and Training Program for Rural Practice* when they completed their claim form and an evaluation link was sent to preceptors at

the end of the project. In addition, key informant interviews were conducted with trainees and preceptors to collect more detailed information about the training program.

Results

Registration Results

Between March 2023 and March 2024, 375 physicians submitted an application for the *National Advanced Skills and Training Program for Rural Practice*. Of these, 98% were approved (n=367). Two percent of applications were not approved either because they did not meet the eligibility criteria or the proposed training occurred before or after the training program dates. Seven percent (n=25) of rural physicians whose applications were approved for training dropped out in the last month of the program. By March 2024, 342 rural physicians, representing 187 communities (60 of which were Indigenous), completed their training plan and submitted a reimbursement form to SRPC. Almost all trainees (98%) completed the evaluation survey. Forty-three percent of trainees conducted their training with a preceptor and 57% of trainees took a course, of which the highest percentage was related to enhancing ultrasound skills.

The average estimated budget on trainees' applications was $24,000 while the average actual trainee reimbursement was $15,553 which was 35% below the average estimate. Table 3 summarizes the registration results such as number of applications received and the breakdown of the type of training.

Table 3 Registration by the Numbers

Number (%)	High Level Results by the Numbers
375 (100%)	Rural physicians submitted an application
367 (98%)	Applications were approved
8 (2%)	Applications were not approved
342 (93%)	Trainees completed their training program (submitted a claim form)
25 (7%)	Trainees dropped out
334 (98%)	Trainees completed the evaluation survey of approved applications
143 (43%)	Trainees had a preceptor for their training
191 (57%)	Trainees took a course for their training
133	Physicians registered on the SRPC portal to be a preceptor
187	Rural communities involved across Canada

Number (%)	High Level Results by the Numbers
238 (70%)	Applicants joined SRPC so they could apply for funding
$24,000	Average trainee budget estimate
$15, 553	Average trainee reimbursement

The outputs and corresponding targets set for the *National Advanced Skills and Training Program for Rural Practice* are outlined in Table 4. Targets that were met or exceeded are highlighted in green and the one target that was not met is highlighted in yellow. All key performance indicators were achieved for the project except for the number of participating Indigenous physicians. Eleven Indigenous physicians participated in the training program rather than the minimum target of 25.

Table 4 Project Outputs and Targets

Output	Result	Status
Utilize existing program from RCCbc's REAP and expanded/offered at a national level	Yes	Target achieved
Number of health workers participating in new/redesigned advanced rural FM skills training	342	Target exceeded (Target was 166)
Support networks and mentorship developed between rural communities, as well as with tertiary centres of care	79% of trainees reported the training program made them feel greater connectedness to referral centres or a network of support	No target set
Number of external organizations engaged in work pertaining to rural health care delivery	60	Target exceeded x3 (Target was 20)
Number of physician recruitment agencies engaged in collaboration	50	Target exceeded x10 (Target was 5)
Number of provincial/territorial jurisdictions involved	13	Target met
Percentage of rural population captured in access to care in rural/Indigenous communities 342	22%	Target exceeded (14-18%)

Output	Result	Status
trainees x3835 avg number of patients =1,311,570/ 5,957,695=22%		
Improved access to care for rural/Indigenous communities	187 communities engaged	No target set
Increased access to training programs for Indigenous rural physicians	11	Target was missed (target was 25)
Increased access to training programs for Francophone rural physicians	8%	No target set
Number of physicians feeling more competent providing care in their rural community as they enhanced their skills	99% reported by trainees and 66% reported by preceptors	No target set
Access to training for essential health services in rural communities: anesthesia, surgery, maternity care, mental health	80% of trainees reported the training program increased access to training for essential health services in their rural community i.e., anesthesia, surgery	No target set

Table 5 shows that the SRPC met the six outcomes established for the *National Advanced Skills and Training Program for Rural Practice*.

Table 5 Outcomes for the National Advanced Training Program

Outcomes	Results	Status
Expanded skills and capacity of physicians working in rural areas	98% of trainees reported they achieved their training plan and met their learning objectives	Outcome met
Improved and new national programs/approaches to enhancing rural primary care physician skills	342 rural physicians participated	Target Exceeded
Improved relationships and communication between primary care physician and specialist physician mentors	83% of trainees reported they established an ongoing mentorship relationship with a preceptor as part of their training program	Outcome met

Outcomes	Results	Status
Increased availability of expanded clinical services to rural populations across Canada	Trainees reported the training program enhanced their knowledge (100%), skills (99%), confidence (99%) and competence (99%). Almost all trainees (98%) reported the training program helped to maintain services in rural communities they serve.	Outcome met
Developed best practice approach to developing skills	97% of trainees reported they will be able to make evidence-informed changes to their practice as a result of the training program.	Outcome met
Increased employment of IEHP and Indigenous practitioner utilization	For **trainees** who responded to the evaluation survey: • 29% were IMGs • 3% (n=11) were Indigenous • 8% (n=26) were Francophone • 4% (n=14) were Black Canadian • 28% (n=94) were another racialized group or visible minority • 7% (n=24) were newcomers to Canada For **preceptors** who responded to the evaluation survey: • 2% (n=1) were Indigenous • 11% (n=5) were Francophone • 2% (n=1) were Black Canadian • 35% (n=15) were another racialized group or visible minority • 5% (n=2) were newcomers to Canada	Outcome met

Other Trainee Results from the Evaluation Survey

Appendix B includes additional tables based on results from the evaluation surveys that are not included in the inputs and outcomes tables.

Notified About the Program

Table 6 outlines the various avenues through which trainees learned about the program. Forty-one percent of trainees heard about the program through word of mouth.

Description of Participants

Table 7 describes the trainees who participated in the project. Ninety-four percent of the trainees who participated in the program were family physicians and 6% were specialists. Almost 29% of trainees were international medical graduates. The average age of trainees was 41 years. The average years in practice was 9.5 years and the average years of training since medical school was 3.1. The reported average number of patients per practice was 3,835.

Equity Deserving Groups

Table 8 outlines the percentage breakdown of equity deserving groups.

Province

Table 9 provides the percentage breakdown of trainees by province/territory.

Area of Interest

Twenty seven percent of trainees reported they had a Certificate of Added Competency (CAC). Table 10 shows the areas of interest that trainees applied for. Emergency medicine was the most popular for training by participants (72%) followed by diagnostic imaging (11%), family practice anesthesia (10%) and palliative care (10%). Specific examples of training included vascular access, chronic pain and mobility impairment, EMS, gastroenterology, dermatology, adult pulmonary medicine, critical care medicine, orthopedics, neonatal intensive care, and gynecological oncology.

Likert Scale Results

Table 11 presents the questions trainees were asked to rate, using a 5-point Likert scale, regarding their level of agreement as part of the training program evaluation.

Offload Tasks

Table 12 shows that the majority of trainees (84%) will not offload clinical or administrative tasks to their team after completing the training program, and (50%) anticipate training may actually increase their workload.

Qualitative results from the evaluation surveys can be found in Appendix C. Suggestions on ways the application process could be improved are outlined in Appendix D. Appendix E provides examples of testimonials from trainees.

Preceptor Results – Evaluation Survey

At the end of the project, preceptors who worked with trainees were invited to complete the evaluation survey. Fifty-one (36%) preceptors completed the survey out of 143.

Table 13 shows the province/territory of preceptors. Table 14 presents a comprehensive summary of the questions preceptors were asked to rate their level of agreement with using a 5-point scale. Ninety-six percent reported that participating in the training program was a positive experience. In addition, 82% of preceptors reported that the training helped to maintain services in rural communities they serve and 75% reported the training program will increase access to training for essential health services in their rural communities. Table 15 shows that 80% of preceptors reported they established an ongoing relationship with their trainee and 70% reported the training program positively impacted their own clinical practice. Table 16 outlines self-reported equity-deserving groups. Two percent self-reported as Indigenous and 11% were Francophone.

Key Informant Interview Results

Between March 1 and March 20, 2024, 45-minute virtual interviews were conducted via zoom with nine physicians who participated in the *National Advanced Skills and Training Program for Rural Practice*. Six interviews were conducted with trainees and three were preceptors. Appendix F outlines background information on the physicians who participated in key informant interviews. Physicians provided consent to participate in the interview. There was significant alignment in the information provided during the key informant interviews and the evaluation survey results.

Preceptors

Two out of three preceptors were family physicians and one was a specialist. Preceptors' participation in the program was motivated by trainees' interests and willingness to learn, as well as their own desire to help fellow physicians gain experience. Additionally, preceptors were driven by their desire to support rural physicians attempting to address challenges encountered in their rural communities.

The program was well received by preceptors who noted that the *National Advanced Skills and Training Program for Rural Practice* provided structured learning opportunities that allowed trainees to gain valuable insights into healthcare system operations and upskill themselves. They highlighted the program's flexibility, which allowed participants to continue their practice while gaining experience. Preceptors reported that this program will improve access to care in rural areas. They advocated for the program's continuation, citing its significant impact on both preceptors and trainees, and stressed the benefits the program brought to rural communities.

Trainees

Five out of six of trainee key informants were family physicians and one was a specialist. Trainees were motivated to participate in the program for several reasons. The program provided both time and financial support to take courses as they acknowledged that cost and busy schedules are often barriers to further education. Trainees also recognized the benefits of upskilling, understanding that it could lead to savings in time, money, and unnecessary transfers for patients requiring further testing or examination (e.g., ultrasound). Trainees were cognizant of the limited availability of specialists in their region and saw the importance of expanding their own skills to meet the demand for healthcare services. They expressed a genuine interest in learning new skills and enhancing their practice, particularly in areas where they lacked recent experience. Some trainees were also influenced to sign up for the program due to the positive experiences shared by other rural physicians who had participated.

Trainees expressed deep appreciation for the *National Advanced Skills and Training Program for Rural Practice,* with one describing it as one of the best initiatives ever offered by SRPC. Physicians reported that the program encouraged them to pursue new training opportunities that they might not have considered otherwise; provided an opportunity to learn from experienced physicians; boosted their confidence in practice; and facilitated the ability to make connections, so that they now feel they have a network of support they can rely on. They highlighted that the program was easy to apply for and that the program's flexibility allowed them to tailor their learning to better meet their community needs. Key informants discussed the importance of such programs for rural physicians, emphasizing its potential to be a game changer in healthcare. Preceptors and trainees expressed an interest in participating in future skills and training programs with SRPC.

Additional results from the key informant interviews can be found in Appendix G.

Summary

In response to rural communities facing critical shortages of skilled physicians, the SRPC's *National Advanced Skills and Training Program for Rural Practice* offered support for rural physicians to access a variety of training opportunities to increase their generalist skill set to help address service gaps in rural, remote and Indigenous communities. The project was a resounding success and surpassed the targets for training opportunities to upskill practicing rural physicians, including specialists, nationwide, which enabled them to meet specific community needs and reduced the need for patient transport out of communities to receive these services, thus increasing care close to home. The program allowed for self-directed learning opportunities to improve primary care and additional community services including rural emergency, surgery, obstetrical, and anesthesia care where needed to address the health care needs of rural communities across Canada. The evaluation was intended to assess the effectiveness, impact, and overall success of the *National Advanced Skills and Training Program for Rural Practice Project*. By implementing a well-structured evaluation process, SRPC aimed to measure not only the tangible outcomes but also the intangible effects that contributed to the success of the endeavor.

Lessons Learned

- The implementation of *National Advanced Skills and Training Program for Rural Practice* was successful in demonstrating proof of concept. All trainees reported the training program enhanced their knowledge (100%), and 99% reported that the training program enhanced their skills, confidence and competence in providing care in their rural communities. Ninety percent of trainees indicated that the training program helped to develop their team's confidence. Almost all trainees (98%) and 82% of preceptors reported the training program helped to maintain services in rural communities they serve which was the primary objective of the program.
- Some trainees reported that requiring a letter of support from their regional medical director or chief of staff was a burden and significantly slowed down their application submission. In fact, a large number of trainees did not know who their regional medical director or chief of staff were. One of the intangible benefits of the program may have been establishing the relationship between rural physicians and regional medical directors and/or chiefs of staff. SRPC could have increased awareness about the *National Advanced Skills and Training Program for Rural Practice* with regional medical directors and chiefs of staff to expedite the process for trainees.

- The project was originally established for rural physicians to implement their training plan with a preceptor to encourage that relationships be established based on referral patterns. In order to meet an expressed need from rural physicians, however, the SRPC expanded the criteria to include courses in response to a demand for ultrasound skills. In addition, physicians reported that securing hospital privileges proved challenging so courses were more appealing. If future funding is secured, SRPC could promote the courses that are available across Canada and identify and promote preceptor opportunities by province to expedite the registration process. Enhanced collaboration, and raising awareness of the Program with regional health authorities could help alleviate the burden related to privileging encountered by physicians participating in the future. Because the most popular areas of interest were emergency medicine (72%) and diagnostic imaging (11%), it might be feasible to establish and promote training programs for these areas of interest. Anticipating the need for preceptors, SRPC developed a portal for physicians to register as preceptors at the start of the project and took every opportunity to match trainees with the 133 preceptors who registered. Future training could increase the number of preceptors on this list and provide more detail on the type of skills the preceptors can offer.

- Applications were approved for rural physicians in all provinces and territories for more than double the anticipated number of physicians. The success of the program was facilitated by the development and implementation of the multi-prong Communication Plan. The program was promoted through emails and newsletters to SRPC membership, other stakeholder newsletters, advertisements in physician journals, engagement with provincial and national organizations and provincial and regional physician recruitment organizations. Beyond these traditional methods of promotion, SRPC added a key component to target non-SRPC members. An invitation to participate was mailed to rural physicians who were not SRPC members. Seventy percent of trainees became SRPC members because this was a criterion for submitting an application, and given 41% of trainees learned about the training program by word of mouth, identifying new channels of communication to reach beyond SRPC membership into the informal networks of rural physicians was important to exceed the target number of trainees.

- Ninety-four percent of trainees were family physicians and six percent were specialists. The average age of trainees was 41 years (minimum age was 30 and maximum age was 59 years). The average years of practice was 9.5 years (minimum was 8 and maximum was 40 years). The average years of training since medical school was 3 years (minimum was two and maximum was 25 years). These data demonstrate that the *National Advanced Skills and Training Program for*

Rural Practice had wide appeal to international medical graduates (29%), and rural physicians across a wide range of ages, years of practice, and years of training after medical school. It was anticipated that the training program may appeal to rural physicians early in their career but it became clear that there was no typical profile for rural physicians and the training program successfully engaged a wide demographic.

- The average number of patients per practice reported in the trainee survey was 3,835 which means the *National Advanced Skills and Training Program for Rural Practice* could improve health outcomes for 1,311,570 patients across all provinces and territories.

- All key performance indicators were achieved for the project except for the number of participating Indigenous physicians. Despite repeated engagement attempts through meetings and emails with Indigenous organizations and stakeholders who were associated with SRPC and Team Primary Care, it proved difficult to engage Indigenous physicians in the *National Advanced Skills and Training Program for Rural Practice.* A future objective would be to strengthen partnership with the Indigenous Physicians Association of Canada to facilitate engagement and awareness of this program amongst Indigenous physicians.

- Although the project duration was insufficient for full evaluation of impact on attracting new rural physicians, the eligibility criteria required that rural physicians that applied for the *National Advanced Skills and Training Program for Rural Practice* had worked in rural communities for six months and promised to continue to work in rural communities for at least six more months. On a small scale, the training program increased retention of physicians in rural communities. It is likely that, similar to what has been observed in other jurisdictions [5], sustained funding could facilitate recruitment and retention of rural physicians if the program is scaled and spread.

- Notably, the actual budget ($15,533) submitted by trainees was 35% less than the average trainee approved budget ($24,000). This highlights the pragmatic approach that rural physicians took to use of the Training Program, using only the funds required to meet their needs. However, this provided budgeting challenges as many funds were allocated that then went un-used. In addition, 25 trainees were approved for training but unexpectedly dropped out in the last two weeks of the project. If SRPC secures sustainable funding, a longer timeline for project implementation could facilitate trainees completing their full training programs. Regular contact with approved participants e.g., a quarterly check-in may have provided sufficient time to

reallocate funds. In addition, explicit participation of nurse practitioners and nurses may have provided additional support to rural physicians enhancing positive outcomes.

- Demand for training outpaced funding and 95% of rural physicians who participated said they had additional training needs if funding were to extend beyond March 2024. The SRPC portal currently allows physicians to register for the wait list. With future funding, SRPC will immediately be able to promote the program to physicians who have already expressed interest in additional training.
- In addition to implementing the training program, it was important that SRPC participate in the larger Team Primary Care project by attending the Summits and sitting at a number of the tables including Alignment, Communication, Engagement and Strategy (ACES) meetings, Team Optimization and Cross-Cutting Team meetings so that successes and challenges of the National Advanced Skills and Training Program for Rural Practice could be broadly shared.

The SRPC was able to address an unmet training need for rural physicians across Canada. The SRPC successfully facilitated the delivery of training opportunities that served the needs of its rural physician members, enhancing equity in access to care for the populations they serve. Participating rural physicians reported they were better equipped to offer more timely diagnosis of medical conditions in local communities, thereby reducing unnecessary transfers and wait times, increasing team-based interprofessional care, and improving communication during transfers when needed. On the evaluation survey, trainees reported that the program:

- Gave rural physicians more status, and rendered their practices more interesting, actually enviable
- Promoted rural excellence and support for generalist practice
- Provided an opportunity to meet experienced physicians who challenged them to improve their practice
- Changed patient care e.g., ultrasound reduced the need for transport out of the community
- [Skills acquired have already been put into practice
- Allowed acquisition of important usable skills that would not otherwise be affordable or possible
- Strengthened team rapport because they completed training with non-MD clinicians
- Provided an increase in vital services to patients in rural communities
- Provided an opportunity to network with colleagues across Canada which created a greater sense of personal fulfillment with being a rural physician

The *National Advanced Skills and Training Program for Rural Practice* offers one solution that leverages the strengths, adaptability, and skills of rural healthcare providers, and provides a sustainable, practical, and proven solution to the urgent health human resource crisis in rural Canada.

As further funding was not available from Employment and Service Development Canada (ESDC) after March 2024, the SRPC seeks to secure funding to continue to support the expressed interest from rural physicians for advanced skills training in rural, remote and Indigenous communities across Canada.

Appendix A: Expert Advisory Committee Membership

Dr. Sarah Lespérance, SRPC President, Chair, Petitcodiac, New Brunswick

Dr. Elaine Blau, Tobermory, Ontario

Dr. Isabelle Cochrane, Baie-St-Paul, Quebec

Dr. Brian Geller, Regina, Saskatchewan

Lisa Hetu, Administrative Manager, Rural Education Action Plan, Vancouver, British Columbia

Dr. Stuart Iglesias, McDougall, Ontario

Dr. Sivaruban (Ruban) Kanagaratnam, Swift Current, Saskatchewan

Dr. Kàh enti:ne Maracle, SRPC Resident Member & Indigenous Representative, Tobermory, Ontario

Dr. Gavin Parker, Pincher Creek, Alberta

Dr. Sonja Poole, SRPC Resident Member, Yellowknife, Northwest Territories

Dr. James Wiedrick, Nelson, British Columbia

Staff

Jennifer Barr, Chief Operating Officer

Kristen Kluke, Project Coordinator

Daria Parsons, Project Manager

Appendix B: Trainee and Preceptor Survey Results

Additional tables from the trainee and preceptor surveys are outlined below.

Table 4 Notification about the Training Program (n=334)

Method	% (n)
Word of mouth	41% (136)
SRPC newsletter/email	30% (101)
SRPC conference	6% (20)
SRPC website	5% (16)
Other association newsletter	2% (7)
Social media	2% (7)
SRPC media release	2% (6)
Other conference	0% (1)
Other	12% (40)

Table 5 Trainee Description (n=334)

Trainee Description	% (n)
Type of physician • family physician • specialist	 94% (291) 6% (21)
International medical graduate	29% (89)
Mean age (minimum, maximum)	41 years (30, 59)
Average years of practice (minimum, maximum)	9.5 years (8, 40)
Average years of training after medical school	3.1 years (2, 25)
Average number of patients per practice	3,835

Table 6 Participants Who Self-Identify as "Equity-Deserving Groups"

ESDC's Equity-Deserving Group	% (n)
Women	47% (157)
Indigenous	2% (8)

ESDC's Equity-Deserving Group	% (n)
Francophone	8% (26)
Black Canadian	4% (14)
Another racialized group or visible minority	28% (94)
Person with a disability	2% (8)
LGBTQ2+	6% (20)
Newcomer to Canada	7% (24)

Table 7: Trainee Province/Territory of Practice (n=334)

Province/Territory	% (n)
Alberta	14% (48)
British Columbia	13% (43)
Manitoba	5% (16)
New Brunswick	0.3% (1)
Newfoundland and Labrador	5% (18)
Northwest Territories	5% (18)
Nova Scotia	3% (10)
Nunavut	2% (6)
Ontario	51% (171)
Prince Edward Island	1% (3)
Quebec	2% (5)
Saskatchewan	8% (25)
Yukon	4% (13)

Table 8 Trainee Training Area of interest (n=334)

Trainee Training Area of Interest	% (n)
Addiction Medicine	8% (25)
Care of the Elderly	7% (22)
Diagnostic Imaging	11% (37)

Trainee Training Area of Interest	% (n)
Emergency Medicine	72% (240)
Enhanced Surgical Skills	5% (18)
Family Practice Anesthesia	10% (34)
Obstetrical Surgical Skills	6% (20)
Palliative Care	10% (32)
Sport and Exercise Medicine	9% (30)
Other e.g. hospitalist, oncology, dermatology, pediatrics	29% (96)

Table 9 Trainee Evaluation Survey Likert Scale Questions

Trainee Evaluation Likert Scale Questions	Agree/Strongly Agree % (n)
Participating in the National Advanced Skills and Training Program for Rural Practice was a positive experience	98% (327)
My training plan was successfully implemented and I was able to achieve my learning objectives.	98% (327)
The training program enhanced my knowledge.	100% (333)
The training program enhanced my skills.	99% (332)
The training program enhanced my confidence.	99% (332)
This training program helped to develop my team's confidence.	88% (294)
In my opinion, the training program will make me feel more competent providing care in my rural community as I enhance skills.	99% (332)
This training program made me feel greater connectedness to referral centres or a network of support.	79% (265)
I will be able to make evidence-informed changes to my practice as a result of the training program.	97% (324)

Trainee Evaluation Likert Scale Questions	Agree/Strongly Agree % (n)
This training program helped to maintain services in rural communities I serve.	98% (326)
This training program increased access to training for essential health services in my rural community. i.e. anesthesia, surgery etc.	80% (266)
The SRPC website clearly articulated the eligibility criteria for the training program.	96% (319)
The application process was straightforward.	90% (299)

Table 10 Trainee Evaluation Categorical Questions

Trainee Evaluation Categorical Questions	% Yes (n)	% No (n)
Given your advanced skills training, will you offload clinical or administrative tasks to your team?	16% (50)	84% (259)
Do you anticipate that your additional advanced skills may increase your workload?	50% (153)	50% (156)
Did you have a preceptor as part of your training program?	43% (143)	57% (191)
I have established an ongoing mentorship relationship with a preceptor as part of my training program.	83% (118)	17% (25)
Do you have any other training needs for advanced skills if funding were to extend beyond 2024?	95% (316)	5% (18)

Table 11: Preceptor Province/Territory of Practice

Province/Territory	% (n)
Alberta	24% (12)
British Columbia	16% (8)
Manitoba	10% (5)
New Brunswick	0% (0)
Newfoundland and Labrador	2% (1)

Province/Territory	% (n)
Northwest Territories	0% (0)
Nova Scotia	6% (3)
Nunavut	0% (0)
Ontario	33% (17)
Prince Edward Island	2% (1)
Quebec	2% (1)
Saskatchewan	8% (4)
Yukon	2% (1)

Table 12 Preceptor Data with a Likert Scale

Preceptor Evaluation Data Likert Scale Questions	Combined: Strongly Agree and Agree % (n)
Participating in the National Advanced Skills and Training Program for Rural Practice as a preceptor was a positive experience.	96 % (44)
This training program helped to maintain services in rural communities I serve.	82% (36)
In my opinion, the training program will make me feel more competent providing care in my rural community as I enhance skills.	66% (29)
This training program increased access to training for essential health services in my rural community. i.e.; anesthesia, surgery etc..	75% (33)

Table 13 Preceptor Data with Categorical Data

Preceptor Results with Categorical Data	Yes % (n)	No % (n)
I have established an ongoing mentorship relationship with a trainee as part of the National Advanced Skills and Training Program.	80% (37)	20% (9)
Did the training program positively impact your own clinical practice?	70% (31)	30% (13)

Table 14: Preceptors who identify as Equity Deserving Groups

ESDC's Equity-Deserving Group	Percentage
Women	32% (14)
Indigenous	2% (1)
Francophone	11% (5)
Black Canadian	2% (1)
Another racialized group or visible minority	35% (15)
Person with a disability	0% (0)
LGBTQ2+	2% (0)
Newcomer to Canada	5% (2)

Appendix C: Qualitative Results from Survey

1. **Describe aspects of the training program that could be improved if the program funding continued beyond March 2024:**
    - Increase deadline to finish training
    - Increase promotion to rural physicians
    - Preapprove and promote existing training opportunities including courses
    - Link trainees to preceptors through hospitals and facilitate privileges
    - Administrative requests: increase meal allowance, reimburse for travel days and reimburse physicians as they complete training rather than at the end

2. **Please describe two strong features of the training program**

Trainees reported that there was good communication about the *National Advanced Skills and Training Program* and rural physicians felt supported during the application and reimbursement processes. They reported that the application process was straightforward. Physicians reported a strong feature of the training program was the unlimited range of training options, the comprehensive and intensive training programs and the relevance to their practices.

Trainees reported the self-directed nature allowed the program to suit individual physician and community needs. They described the program as well-funded, low barrier, high yield, flexible, practical, accessible, providing interactive high-quality learning opportunities. Participants reported the program made it possible to attain skills that allowed them to provide better care to their patients in their rural communities across Canada.

Physicians reported the National Advanced Skills and Training Program:

- Made training feasible
- Established new working relationships and increased connectedness/networking with colleagues in different specialties and across disciplines
- Encouraged sharing of experiences and knowledge with preceptors
- Was significant and comprehensive enough in reimbursement (stipend/travel/office expenses/locum/preceptor) for preceptors and trainees to encourage training
- Provided a structure to approach institutions/preceptors for training
- Provided excellent interprofessional collaboration
- Encouraged rural and Northern physicians to seek ways to improve patient care
- Provided an opportunity to refresh knowledge and training not used in a long time
- Offered multiple avenues to achieve advanced training (courses, preceptorships, rotations etc.)

Trainees reported the program provided an opportunity to:

- Self-identify learning objectives
- Train in a larger centre with a higher patient volume and a formal PICC insertion training program
- Learn a standard of care with a preceptor
- Engage in team-based learning e.g., with nursing, paramedics and MD group
- Train in larger centre with a higher patient volume and a formal PICC insertion training
- Learn and share experience with excellent preceptors who were very knowledgeable in rural medicine as well as specialist medicine
- To build teamwork and improve communication as part of a team which increased trust to work well together

3. What is the greatest impact your participation in this program has had on your: Community

- Increasing capacity in underserved areas
- I can reduce the strain on some rural communities
- Improved care for children
- We will be able to handle trauma cases in our rural ER
- Improved patient centred care
- Reduce wait times and travel
- Safe transfer when needed
- Better assessment in emergent cases
- Increases community capacity to retain a patient instead of transferring them out of community
- Extend services to a broader population with enhanced skills
- Extra skill for better care
- Increased access to advanced care for cardiac arrest will hopefully improve survival of cardiac arrest
- Enhances/improves care for community members, improves transfer experience
- Serving the community in a more efficient, safer, and more skilled manner
- Make our community a safer place
- Increased efficiency and speed with procedures, exams, interpretations of imaging which will allow for shorter wait times. I will be able to do more palliative care offloading some of the burden on community palliative care team.

- improving patient health and trust in me as their provider (++ important with indigenous pts) i.e. to better know when to encourage a patient to go to referral centre when they don't think it's necessary
- I can offer patients more complete care
- Pts have faster recovery and early return to work.
- A whole new skill set to reduce patient transfers
- Support ongoing provision of cancer treatments locally in-territory, allowing patients to receive care close(r) to home, in a culturally safe environment
- Improve patient care and clinical outcomes
- Reduced ER closure days
- Improved time to diagnosis
- Community members will have improved emergency and family medicine care
- Nurse and physician recruitment and retention for keeping our hospital and clinics open in an underserviced rural area
- Better equipped to deal with acute care/ trauma in the rural ED
- Reduce travel to larger centers when not needed based on more confident and informed diagnoses, faster and more efficient care for patients.
- Enhanced learner experience translates into recruitment opportunities
- There has been threat of closure and diversion: I can help obviate this.
- Provide weekly cast and minor injury clinics locally
- Better working relationships with pre-hospital and nursing staff
- Ensuring that a safe obstetrical program with full surgical back up is available in the community
- I will be able to apply to the CPSO to be designated as having a focused practice

4. **What is the greatest impact your participation in this program has had on your: Local healthcare team**
    - Improved patient access to care
    - Better communication
    - More available skills
    - Facilitates communication to assess patients
    - Increases confidence in local decision making
    - Alleviate the burden on referral centers by effectively managing more challenging cases
    - Providing higher quality care
    - Allows me to support my colleagues in their care for patients

- Added a new level of skill for the emergency department team
- Better coordination between me and the team
- More confident running codes and trauma as team leader
- Less frequent calls to specialist teams offloading burden to colleagues
- Avoid utilizing provincial healthcare resources
- Less pressure on the already resource-strapped local health clinic
- Ability to better utilize resources in both how and when
- More access after-hours to at least some imaging
- More excitement about CME
- Unity among team
- Trust in my competence
- I learned to be a team-player
- Working as a team with the same protocols, improving relationships with referring centres

5. What is the greatest impact your participation in this program has had on your: Individual practice

- Reassured me that I have the skills to practice remotely
- Increased my ability and confidence to work in remote isolated settings
- Booster confidence in using skills
- Airway management
- Enhance diagnostic skills for acute care
- Enhanced surgical skills for minor procedures
- Critical care in resuscitating unstable patients to diagnose the cause of shock
- Improved time to diagnosis and decreased ED LOS
- I will now spend 25% of my time exclusively in oncology (previously none)
- Increased confidence in my abilities and knowledge for managing various patient presentations
- Confident screening and managing clients with addiction, particularly around ETOH use disorder

6. What will your ongoing relationship with your preceptor look like?

- I keep scanning the patients and will revise them with my preceptor in the future
- Preceptor is added to my network of colleagues
- I work with a preceptor on occasion in the OR; he is open to having me practice intubations and procedures in the future

- He will be available via email/phone calls if I have any further questions
- He provides consults on every patient we are considering for treatment
- Shared care of complex patients
- I have a wonderful mentorship relationship with my preceptor who is a local anesthesiologist. He has been so quick to answer questions at any time, and has welcomed me to come back to his OR to practice. He often comes to my resuscitations in the ED and lends a hand, even when he is not on call. We have learned to work very well as a team.
- Improved interactions, collaboration and knowledge sharing as we work in the same ER
- Ability to call/text/email, hopefully some ongoing clinic shadowing and training - they were both kind enough to invite me back
- Consult discussions, referrals for services not attainable at our center, follow-up assessments for services done through the preceptor's center, and periodic in-person continued training and practice discussions.
- Consult discussions, referrals for services not attainable at our center, follow-up assessments for services done through the preceptor's center, and periodic in-person continued training and practice discussions.
- We use a discord server where all fellows and faculty are able to share and collaborate daily.
- Ability to send videos of scans for review or follow up
- Regular follow-up and hopefully working as colleagues in the future.
- They will mentor me in the delivery of rural skills
- I meet with him every 2 weeks on zoom to go over cases. We communicate by email as well in between.
- Peer support, mentorship, sharing of resources

7. How will your training improve team-based primary care e.g., interprofessional care?
    - Now on a first-name basis with prehospital staff, feel much better about working as team
    - With ability to do PoCUS as an independent practitioner, I am better able to communicate with specialists and arrange for appropriate referrals.
    - I am able to present when consulting other colleagues, and also when working with my local team to come to a diagnosis.
    - Training will foster a cohesive and synergistic team, ultimately benefiting patients through comprehensive, patient-centered care.
    - Using my skills, I will be able to help my colleagues to diagnose and treat their patient more efficiently

- Improves diagnostic clarity and ability for team to provide care in acute care settings
- Work better with other physicians but more importantly nurses, RT and allied health care in my facility by providing improved patient care.
- My training has increased my skills and knowledge which I have already passed along to my colleagues and residents/students. Better interpretation of exam findings, physical exams, splinting etc. which allows for better follow-up care or consultation when required
- I will be able to support my colleagues with bedside ultrasound skills
- Improve quality of multidisciplinary care by providing better information to nursing team and specialists
- Better understanding when to involve colleagues in care of patients
- Ultrasound is important for ER which is a team-based department (nurses, RT, etc.)
- The decisions to treat is now team-based
- OT, PT have relevant patient info sooner rather than waiting days for advanced imaging (CT, ECHOs) in admitted patients
- I have been able to work with my RT colleagues much more since my training, and we have become very collaborative. Now that I have a functional understanding of ventilation and more nuanced airway skills, we work together to optimize our challenging airway/resp patients and are both on the same page.
- Training was team based. Will help us work together as a unit
- My training in a high-volume setting has highlighted some of the rare but life potentially life-threatening situations that can arise in surgical obstetrics. By being in this setting, I was able to see how the full healthcare team worked together. I hope to have meaningful conversations and education with the obstetrical care team to plan for unexpected emergencies that can arise;
- in rural communities, primary care is multifaceted and this emergency care course brought together MDs, nurses, learners, paramedics to problem solve, self-evaluate and provide feedback to each other - improved communication

Appendix D: Application Improvements

Aspect of Program	Comments from Trainees
Application Process	• The evaluation form had questions that were not applicable to courses • More clearly identify what types of training are being approved • Ensure the application can be saved to reference later on • Some aspects of predicting costs up front are unpredictable • Clarity up-front on maximum travel and accommodation budgets e.g., inclusion of HST • I was impressed at how flexible the application process was and how they were able to increase my funding to cover more training. A very reasonable amount of paperwork considering the payoff • Improve descriptions of budget categories e.g., clarify if meals are covered • Streamline application process so there are checkboxes as you progress • Application required too much paperwork e.g., a letter of support should not be required • The application should include a built-in spread sheet to help remind physicians of things (mileage, police checks), etc. • Recognize that IT infrastructure at a rural site is not always up to urban expectations. E-forms, e-signatures and having everything digital is not realistic. Faxes are a 100% legitimate way of communicating • The application should clearly indicate that physicians had to be SRPC member to participate
Timelines	• Extend the deadline beyond March 31, 2024 e.g., a full 12 months to use the funding • Speed up approval process
Reimbursement	• Allow participants to apply for reimbursement as training is complete instead of at the end • Allow automatic access to full $35,000 • Facilitate the trainee's ability to increase the budget • Reimburse equipment costs

Aspect of Program	Comments from Trainees
	• Ensure fair allocation of funds – consider reducing the total budget of $35,000 so more physicians can participate • Simplify the reimbursement process • After completing the training, the funding could be released with the certificate of completion only. Getting all the paperwork is a lengthy process. It would be better to receive the funding up front to pay all the expenses rather than paying from our own pocket first • The receipt that the preceptor signs saying they have been paid (to complete the application) before we have paid them • Clear communication is required that changes to the estimated budget must be communicated to SRPC • Allow for a group application particularly when it is a course.
Preceptors	• Provide access to preceptors far and wide within and after the training period • The preceptors for this program should be advised on how to objectively assess their trainees • SRPC should take a lead to communicate with the preceptors before training
Eligibility Criteria	• Extend to all physicians beyond rural communities

Appendix E: Testimonials

- Best thing to happen to the SRPC in years! Exactly what rural skills training needed.
- I never in a million years would have done this course if I had to pay out of pocket but I LOVED the course and am really excited about the new skills I have. If the program is extended, I will definitely take the rest of the resuscitation ultrasound course.
- I would like to thank you so much for providing this opportunity for rural doctors to improve their skills to provide higher quality of cares to the patient. I greatly appreciate it.
- I am highly appreciative of the SRPC funding, as I would not likely have been able to do this course without the support and funding. Just to be able to concentrate on the course and the skills training was challenging enough, and not to have to worry about the funding, made the training more enjoyable and fruitful.
- My training was excellent and I really could not be happier. As a rural family physician, there are many different areas I could train in. This program was concise, direct, and practice changing.
- Thank you so much for supporting this opportunity and the improvement of access to clinical care for rural underserved populations across our vast nation!
- This was an incredible opportunity and I am grateful to have been accepted. I am optimistic the patients of our region will find the increased level of service/availability for treatment beneficial to their lives.
- This was quite literally a dream come true. I always wanted to learn POCUS but it was not integrated into our school/residency curriculum and the cost of this course was quite prohibitive. As a recent grad, it was amazing to get this skill under my belt and start using it quite literally next day in emergency. It was also such a blessing to my mental health to be able to interact with other docs in the same situation, learn about the successes and struggles of their respective practices and hospitals, and overall, the collegiality was great. I cannot

recommend this course enough to other docs. I will certainly be applying again if future funding available.

- Excellent. I am so glad I got this opportunity. I know a lot of colleagues waiting on the next opportunity. We are all on the lookout. Thank you to all involved in organizing this.
- I could not speak more highly of this program nor the access it gave me to training I could not otherwise obtain. I have already seen first-hand how it has changed the quality of care I provide to patients with tangible examples. Please work hard to obtain further funding like this in the future.
- This program was a great opportunity to improve my skills and improve care for patients, collaboration with team members and my confidence in managing patient care in rural and remote settings.
- This program was invaluable to combat burnout in my practice and gave me the confidence to continue my practice as a rural generalist. The first time I've felt like I've had real support from the government or an organization that recognized there was value in investing in me.
- I practice in a recognized rural community where I do comprehensive family medicine, including inpatient, ER, and oncology care. This program has significantly improved my skillset for my community, and improved my confidence with high acuity low occurrence scenarios. I also have incorporated ultrasound-guided musculoskeletal injections for local patients who normally have to drive 2 hours to receive the same level of care. Thank you from the bottom of my heart.
- Thank you for the funding. Definitely felt like the government went above and beyond in trying to tackle the rural physician shortage in another way.
- Thank you for the funding - it will really improve my ER care and confidence in managing some of the sickest patients in our rural ER.
- Thanks for having this program. CME is extra expensive when rural and so very needed when trying to keep up with the expectations and skills needed to be working in remote practice.

- This was an amazing experience. I was able to complete my 30 days training with a 3-month period hence had the best of both worlds. I feel better equipped to serve my community the ED despite the prior experience I got during family medicine residency.
- One great side benefit for me from the process was taking up membership in SRPC. I am at a stage in my career where I want to contribute to the recognition and continuation of this unique brand of medical practice.
- Thank you for this incredible opportunity. It is difficult to obtain extra training while living and working in a remote northern community, this program made that attainable.
- I am better equipped to offer procedures and care in my local community. Hence reducing unnecessary transfers, working with local interprofessionals to deliver local care, and improving communication during transfer when needed.
- The training improved my diagnostic skills.
- I have a renewed interest in shared care, team-based care.
- I have more confidence in rural decision making – we take on a lot of risk when we try to keep patients in the community. Ultrasound training has helped with the confidence in my team.
- The training increased my knowledge of systems, referral patterns, group norms and Canadian guidelines.
- By efficiently managing my patients, this will impact the entire health system, time spent with each patient, decrease wait lists.
- Please consider continuing this program and having it embedded in relationships between rural and urban centres to foster mentorship and longitudinal skills development. The cognitive and time efforts required to set up rotations and self-designed programs without any administrative support or existing infrastructure is a barrier to physicians seeking out new opportunities. Consider if referral centres and academic community hospitals may just be able to offer opportunities and house this in a database

Appendix F: Key Informants

Trainees	Position	Province
1	Family Physician	Manitoba
2	Family Physician	British Columbia
3	Family Physician	Newfoundland and Labrador
4	Family Physician	Alberta
5	Family Physician	Manitoba
6	Specialist	British Columbia
Preceptors	**Position**	**Province**
7	Specialist (Neonatologist)	British Columbia
8	Family Physician	Nova Scotia
9	Family physician	Alberta

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Appendix G: Key Informant Interview Summary

Question 1: Can you reflect back on some memorable learning experiences you had while participating in this program? Describe the program you participated in.

Preceptors

Memorable lessons learned during the program included the value of one-on-one hands-on learning sessions, the principle of treating each patient equitably regardless of their condition, and the critical role of clear communication between family physicians and hospital staff. Participants recognized the importance of open discussions regarding patient management and decision-making processes. A noticeable shift towards a team-based approach in patient care emerged. A preceptor reported that their trainee's handling of acutely ill patients and honing procedural skills, which are often underutilized in family practice, was found to be fulfilling. One preceptor stated that the experience of teaching a trainee with a high level of experience was unique and enriching.

Trainees

Participants thought that the exposure to diverse medical cases and various approaches to patient care provided invaluable experience and perspectives, which enhanced their understanding and approach to patient care and bolstered their confidence. Some trainees admitted initially experiencing panic during certain procedures but noted a steady increase in confidence with continued exposure. They also discussed that while they previously had to rely on specialists for confirmation, they were now more confident in their decisions (e.g., medication management). Trainees emphasized that the program underscored the importance of understanding protocols and safety measures, and highlighted the significance of collaboration among colleagues in following the same protocol, ensuring consistency in patient care and understanding among team members. Trainees felt fortunate to have had the opportunity to learn from experienced clinicians and believed that exposure to different physicians enabled them to pick the best practices from each and develop their own approach. One trainee expressed excitement about returning to hands-on work, stating that they felt almost a decade younger.

Trainees indicated the wide range of areas in which they furthered their skills some of which include gaining more experience with acute care, emergency medicine, minor surgical skills (e.g. vasectomies, colposcopy, urological procedures such as cystoscopy), pediatrics and neonatal care (e.g. resuscitation and intubation), obstetrics care (e.g., new methods of induction), and ICU-based procedures. In addition, trainees were interested in ultrasound training including ultrasound-guided injections for pain management.

Question 2: How will this enhanced training enable you to provide better care closer to home for your patients? (trainee question only)

Participants reported numerous benefits gained from the program, notably leading to better care for patients. Trainees reported that their involvement in the program enhanced their ability to address common medical issues encountered in their practice. They report that they now follow clearer guidelines which are in alignment with established protocols. This has facilitated smoother communication and explanations to patients and have improved patient understanding. Additionally, participants noted an increase in confidence and skill sets has enabled them to better manage complex or emergency cases and fostered collaboration between family physicians and specialists. The training equipped participants with skills that enabled them to offer services that patients would otherwise have to wait for or travel long distances to receive (e.g. vasectomies). One participant cited that, upon returning to practice, their newly acquired skills were immediately put to use in confirming a diagnosis in the emergency department, emphasizing the efficiency and accuracy it brought to patient care, suggesting that proficiency in skill can lead to more efficient and effective patient care.

Question 3: How will your training improve team-based primary care e.g., interprofessional care? (trainee question only)

Participants emphasized the importance of teamwork, and expressions of appreciation for the opportunity to collaborate with various healthcare professionals and observe how different roles contribute to patient care. They highlighted the importance of standardized protocols in their clinic, stating that protocols ensure consistency in patient care among colleagues. Participants stressed the value of building relationships with colleagues, involving them in patient care decisions and being on the same page stating that these elements foster a sense of teamwork and mutual support. This team-based approach represents a shift from previous practices, where communication may have been less consistent. Participants reported that they are committed to replicating these collaborative practices in their current work environment to enhance patient care and teamwork.

Question 4: Given your advanced skills training, will you offload clinical or administrative tasks to your team? If not, why? (trainee question only)

Trainees' responses were mixed regarding whether the additional training would cause them to off load work. One participant reported that they would offload follow-ups to nurses (e.g. stitches removal), whereas others reported that they had no intention to offload tasks.

Question 5: Do you anticipate that your additional advanced skills may increase your workload? Why? (trainee question only)

Trainees were mixed in their feeling that acquiring new skills led to an increase in workload. Some felt that the training would help them perform their job more effectively and allow them to make more informed decisions in their practice. One participant said that the increase knowledge did result in a shift in responsibilities rather than a straightforward increase in workload.

Question 6: Are you planning to maintain a mentoring relationship with your trainee? If so, what does it look like? (preceptor question only)

While there is currently no formal requirement or funding to support this interaction, preceptors reported a desire to continue to maintain a relationship even though the official program was over.

Question 7: Describe any challenges and opportunities for improvement

Throughout the interview both preceptors and trainees shared challenges they encounter with the training program and identified opportunities for improvement

Challenges - Preceptors

Some of the challenges encountered during the training program, included financial constraints, logistical difficulties in organizing boot camps and exams, heightened activity level of the emergency department and limited timelines for completion of the training. Additionally, preceptors noted that many colleagues were unable to participate due to time constraints and insufficient notice about the program's deadlines.

Challenges - Trainees

Trainees noted challenges with the timelines, reflecting that it was difficult to come up with a program or find a preceptor in the time allotted for the *National Advanced Skills and Training Program.*

Opportunities for Improvement - Preceptors

Preceptors emphasized the need for clear communication regarding program details, their role as preceptor (e.g. how many hours to spend with the trainee), defined goals/objectives and the value add to their practice to enhance the effectiveness and coordination of the program. Fixed dates or a schedule was also suggested to support trainees learning as some preceptors noted they had many students coming in and out and it was difficult to coordinate their learners.

Opportunities for Improvement - Trainees

Trainees recommended the development of a list of preceptors who are willing to share their skills and emphasizes the importance of facilitating connections between learners and experienced practitioners. One participant recommended the need for clarity regarding budget and another about the importance of raising awareness about training opportunities.

National Advanced Skills and Training Program for Rural Practice

Optimizing rural care

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

Équipe de soins primaires / Team Primary Care

> "I am now an independent ultrasound practitioner and can help certify other physicians."

> "I have a connection with a mentor I can now call."

Program Budget: $7.4M a portion of the $43M received as part of the Team Primary Care: Training for Transformation. Managed by the Foundation for Advancing Family Medicine (FAFM) & funded by Economic and Social Development Canada (ESDC).

The Challenge

Access to care **close to home** is a concern for those in rural, remote, and Indigenous communities in Canada.

Few opportunities exist for rural physicians to enhance their skills once in practice.

Lack of confidence is a barrier for those interested in moving to a rural area or expanding the scope of care provided.

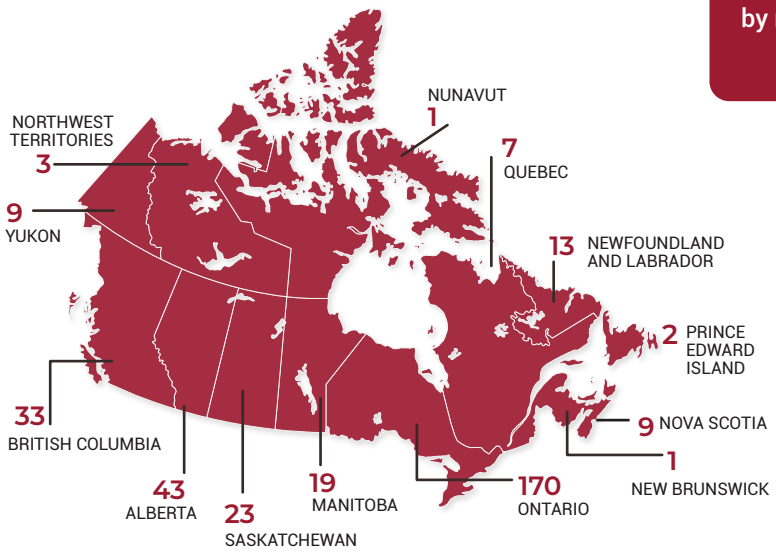
The Objective

Enhancing access to **advanced skills training** for rural physicians, to serve community needs.

Self-designed by rural

Training based on an identified community need:

- $1000 / day income reimbursement
- Travel + accommodation expenses
- Preceptor payment
- Locum payment + overhead
- Course + equipment costs



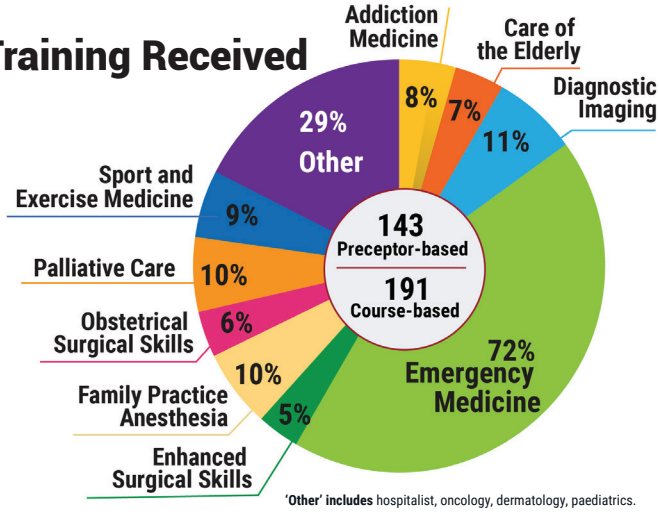
342	Rural Physicians
187	Communities
60 +	Indigenous Communities
28%	International Medical Graduates (IMGs)
8 (2.4%)	Indigenous Physicians
26 (7.8%)	Francophone Physicians

> "We can now support ongoing provision of cancer treatments locally in-territory, allowing patients to receive care close to home, in a culturally safe environment."

Potential benefit on health outcomes for 1,311,570 rural Canadians, 1 year after program start.

Based on an average of 3,835 patients per practice as reported by participants.

Training Received



'Other' includes hospitalist, oncology, dermatology, paediatrics.

Average projected expense per physician **$24K**	Average amount reimbursed **$15K** (35% less)

100% reported training **increased access** to care in their rural communities	**74%** feel a **better connection** to a network of support	**94%** still have **additional training needs**

Future program directions:

- Enhanced partnership and engagement with Indigenous physician organizations
- Ongoing, sustainable funding for continued program delivery
- Targeting under-represented communities for increased participation
- Monitoring and evaluation of long-term impact on retention and service delivery in rural Canada

Overall Outcomes:

Improved Access to Care:

- Timely diagnosis of medical conditions
- Reduction of transfers and wait times
- Increased team-based interprofessional care

Enhanced Community Services & System Resilience:

- Provision of additional services, including rural emergency, surgery, obstetrical, anesthesia care

Recruitment and Retention:

- Improved working relationships with pre-hospital and nursing staff
- Self-reported increased likelihood to stay in rural communities
- Strengthened networks of mentorship and care

For more information contact:

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