Commentary | April 2025

What Practitioners Want:
Focus Group Findings Re: A Rural Coordinating Centre for Northern Ontario

NORTHERN POLICY INSTITUTE | INSTITUT DES POLITIQUES DU NORD

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The Office of Physician Workforce Strategy of NOSM University has, as part of its mandate a focus on identifying ways to sustain rural clinical teaching faculty in Northern Ontario as part of the educational mandate of the University.

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Summary

The work of RCCbc in British Columbia has demonstrated substantial benefits for rural healthcare, offering both precedent and promise for a Northern Ontario model, where there is not currently a cohesive strategy to support rural generalists in practice. The promise of that model for Northern Ontario has been explored in this 3 phase project. Phase 1 – the discussion paper - was endorsed by the Northern Ontario Municipalities Association as a tool of support for community based health care services. The Ontario Medical Association has identified value in the development of a coordinating body calling for it in the Stop the Crisis campaign.

This third phase has confirmed that clinicians believe that a coordinating body, like RCCbc, for Northern Ontario would help to enhance retention of rural clinicians through supporting several functions in the domains of care delivery, recruitment, academic alignment, data and information, and advocacy that would support rural physicians to better serve the rural, remote and indigenous communities of Northern Ontario.

At this time, the RCCbc model can be considered a "leading practice" in Canada that could be adopted and adapted to the priority needs identified by clinicians in this series of focus groups. The opportunity to function as a coordinating body that connects clinicians and communities across Northern Ontario's vast geography in a way that is not currently done through the OHT's and is not a mandate of Ontario Health North is an opportunity to "be a tide that lifts all boats", improving the practice lives of all Northern rural clinicians as they work to meet the needs of their communities.

With the work of this three-phase project and the general support of clinicians representing communities across Northern Ontario, the next steps should be to: convene a collaborative meeting, akin to "Summit North" in 2018 to bring together the pentagram partners of social accountability - clinicians, administrators, community members, educators and policy makers - and develop an implementation plan, support the prioritization of initiatives, determine a clinical leadership model that would align with and support OHTs and academic/education leadership, and help determine an evaluation plan for iterative improvement in service to rural Northern Ontario's clinicians and communities.

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Project Background

Northern Ontario faces a worsening doctor shortage despite efforts to recruit medical professionals. Retaining and stabilizing the rural physician workforce is critical, as systemic challenges threaten the sustainability of rural practices. To address similar challenges, British Columbia created the Rural Coordination Centre of British Columbia (RCCbc). The work of RCCbc in British Columbia has demonstrated substantial benefits for rural healthcare, offering a promising model for northern Ontario, where a comparable health and workforce strategy is needed. The promise of that model for northern Ontario has been explored in a three-phase project outlined below.

Phase 1

The project began with an **analysis and discussion paper** of the Rural Coordination Centre of British Columbia (RCCbc; https://rccbc.ca/our-work/). The paper, "Rural and Remote Physician Services Coordination in Northern Ontario: A Brief Discussion Paper on the Model from British Columbia," was released in January 2024 by Northern Policy Institute. It highlighted how the RCCbc's key role is in facilitating a network of interest holders to address gaps, issues, and solutions for improved care for patients and sustainability for care teams. It also served as the start of the discussion surrounding the idea of whether an organization similar to the Rural Coordination Centre of British Columbia could be established in Ontario.

On January 29th,2024, the Northwestern Ontario Municipal Association (NOMA) attended the Rural Ontario Municipal Association (ROMA) conference where they recommended that funding and resources be allocated to the establishment of a Rural Coordination Centre for Northern Ontario. Read the full press release here.

Phase 2

The second part of the project included an **environmental scan** of how and in what ways a coordinating centre could function in Northern Ontario based on grey literature that can be found here. This work highlighted the lack of a coordinated approach to address rural health service needs across restructured healthcare service models, and how Northern Ontario lacks an overarching workforce strategy for rural healthcare planning and evaluation. It highlighted the potential roles and services for a rural coordinating centre for Northern Ontario.

On October 16, 2024, the Ontario Medical Association (OMA) launched the Stop The Crisis campaign which included priorities for Rural and Northern Ontario. This plan included a recommendation for funding from the Provincial Government for a Rural Coordination Centre for Northern Ontario.

Phase 3

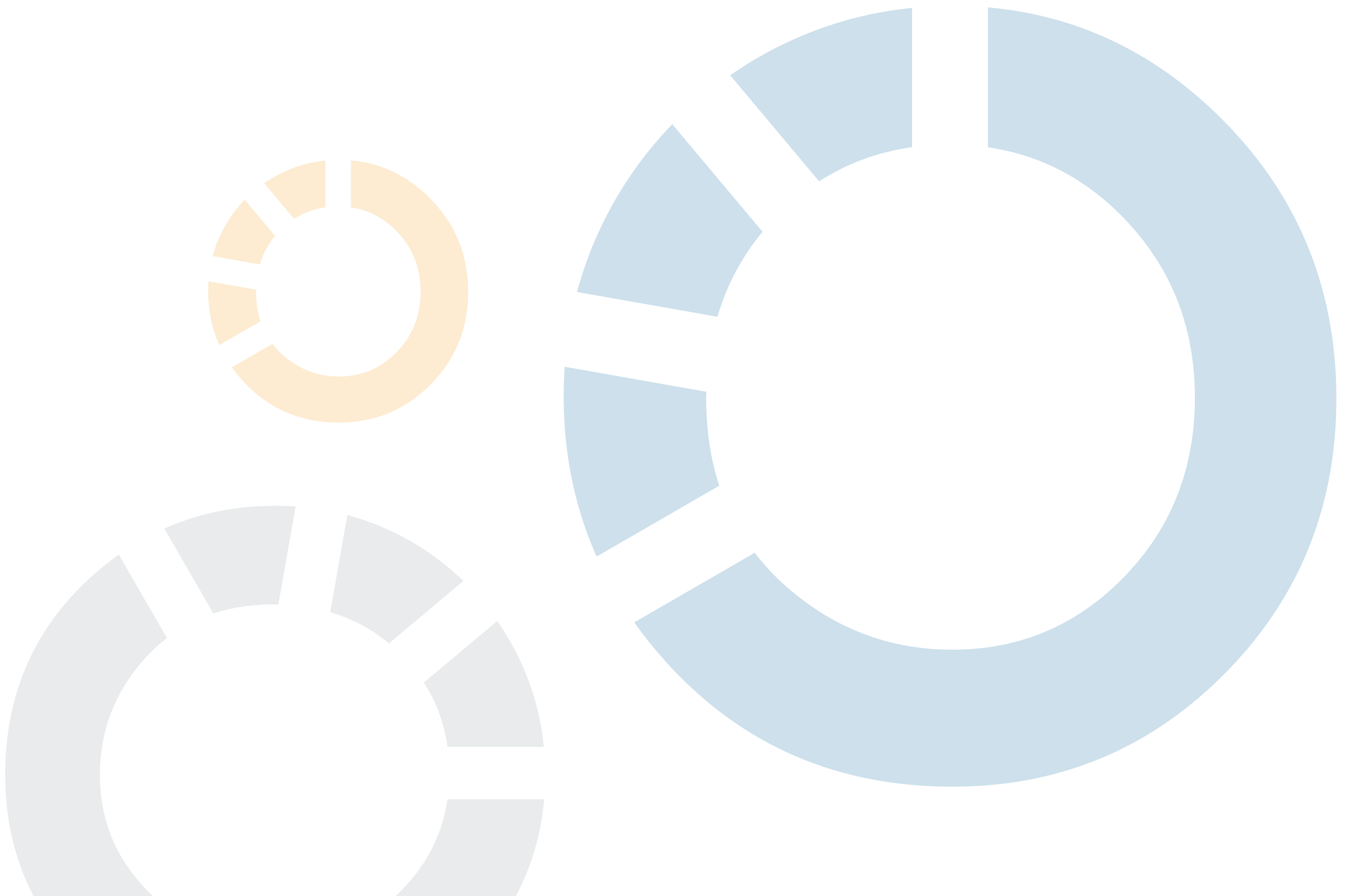
The third part, and the focus of this report, was to gather input from physicians on the greatest needs and priorities in their communities and clinical contexts to support the rural healthcare workforce now and into the future. **Focus group** questions examined challenges physicians face and the potential for a rural coordination center for our region.

This report summarizes the findings of the focus groups and explains how physicians think a rural coordination centre for Northern Ontario could serve the region. The findings show that physicians identified a need for an organization to provide solutions to the problems they face and to coordinate resources across the region. Given Northern Ontario's current workforce crisis, there are opportunities to support physicians through workforce stability, recruitment, and professional skills development.

Approach

To assess the current needs, gaps, and potential solutions for rural healthcare delivery in Northern Ontario, a series of virtual focus groups were conducted. These sessions were collaboratively organized by the Physician Workforce Strategy Unit of NOSM University led by Dr. Sarah Newbery and supported by Dr. Jullieta Lum, Northern Policy Institute represented by Patrick Berube, and the Dr. Gilles Arcand Centre for Health Equity led by Dr. Erin Cameron and supported by Angus Foster and Douglas Newhouse. The first focus group was held in late Summer of 2024 to test the format, questions, timing and survey results. Subsequent focus groups held between January and February 2025 employed purposive and snowball sampling methods, resulting in four one-hour sessions attended by twenty-four participants in total.

The transcripts of these discussions were analyzed using qualitative coding methods as indicated in Appendix B. Aligned to the themes of the questions, responses of participants are grouped in the findings below in "individual", "community" and "system" observations and needs, concluding with potential opportunities for a coordinating centre for rural and northern Ontario.



Key Findings

1. Retention: What made me stay?

Participants expressed that practicing medicine in rural communities is different and poses unique clinical challenges when compared to urban family practice. Rural generalists work with patients of all ages and are challenged with a wider variety of cases and case complexity and mentioned the wider skill set needed to address these patients. Providing care to rural communities often has physicians covering inpatients, shifts in the emergency department, and in some instances coverage for intensive care and the operating room. Participants talked about facilitators of retention on the individual level, community level, and the system level.

Individual: At a personal level participants talked about staying in rural practice because of the rural lifestyle they enjoy, the sense purpose they gain, and the flexibility they can achieve in the right situation. When they felt valued and supported in their local communities, they were more likely to remain in practice.

By far the most critical facilitator to staying as explained by the participants was having consistent and coordinated locum support. Having readily available access to locums,[1] for long and short-term coverage were all said to have "made a massive difference", "made it enjoyable again" "supported the physicians to stay in the community".

Community: The two most notable community retention factors were having a supportive team to work with and the type of work in rural practices. Participants expressed how physicians, administrators, and other allied care providers who support each other and provide strong mentorship are the most valuable aspects to working in rural communities. Participants clearly explained the role of having good colleagues and a community around them is important to them and had this to say "colleagues are what has kept me here for twenty three years", "you all rely on each other", "supportive colleagues plays a big part", and "having the support of senior administration, hospital CEO's, local municipal leaders, community members, goes a long way to not wanting to run away".

For recruitment, participants said "I think having the core group… of eclectic, amazing, intelligent, kind, and socially active people have helped with recruitment". In terms of the type of work, participants talked about the broad scope of practice they enjoy, the long-term relationships they build, and the opportunities to pursue other interests.

Other facilitators at a community level are the ability to learn together including, LEG meetings (Local Education Groups of NOSM U), SIM learning (simulation of critical clinical events) and to teach by hosting students and residents within their communities. Both facilitators – learning and teaching - helped contribute to building community among physicians, health teams, and with their local community members. Some communities attributed their currently sustainability to hosting a NOSM University rural family medicine stream that assures a community of having regular trainees, increasing retention of current clinicians, and creating opportunities for succession planning.

[1] Locums are itinerant physicians who cover for a local physician who is absent from practice. Locum support ensures that physicians can take vacation, get away for necessary and expected continuing medical education, take parental leaves and illness leaves without worrying that their patients will not receive care nor that their local ER will close, and without worry that their local colleagues will burnout with the additional work.

Supply of locums is variable, challenges for locums to get to some communities is higher than for others, and some contract models support an expected number of locum days per year, while other rural contracts do not.

System: At the system level, participants identified factors that currently support rural practices such as post graduate medical education pathways, continuity of relationships, and communication between organizations. There were a few best practices identified, such as the Remote First Nations Residency, and the new "rural generalist" health care funding model being developed and tested in the Kenora region. Tools of "virtual critical care"[2] were seen to have been important enablers of retention of rural physicians. One physician cited the Regional Critical Response Program (RCCR) as "a major reason" why he has been able to continue running his practice.

However, participants felt that factors needing more attention that could benefit the rural healthcare system were improved care coordination, enhanced sharing of best practices, intentional priority setting for rural clinicians, political advocacy, and relevant and timely feedback. As one participant said, "all the parts are pretty much here in Ontario, but they're held by different organizations and there's no unifying [body]."

2. Skills and Professional Development: How can I maintain skills as a rural generalist?

Given the scope of rural generalist family physicians and rural specialists, participants were asked about maintenance and development of clinical and non-clinical skills.

Individual: Participants talked a lot about individual confidence and competence. They noted that given the broad scope of practice there are new things that are always being learned and seen in the clinic. Participants expressed a sense of feeling "rusty" and therefore the need for ongoing skills maintenance and professional development opportunities in Northern Ontario. This is particularly true for obstetrical and critical care skills such as airway management, central lines, and chest tubes. Participants also talked about non-clinical skills that could be further developed including how to work better in teams, transitions, and resource management.

Community: Given the significant role of colleagues in rural practice, teams are finding ways to support skill-building through the sharing of clinical cases including grand rounds and fifteen-minute case presentations. Areas for future growth identified were around mentorship and teaching, with retiring clinicians as a possible source of mentorship and teaching for community-based health team resources.

System: In general, participants identified a need for more locally available and responsive request pathways for professional development. One participant said, "I asked NOSM University for elective opportunities that would allow me to gain training [for a particular clinical skill] … and the school denied my request." Participants highlighted the fact that having the clinician travel is hard for both patients and families and can be costly. "I do not like having to go away for all the courses. I want courses, but it is hard to go away." A need for better coordination and delivery of available courses relevant to rural generalists was identified. The recently piloted "Advanced Skills Training" program through the Society of Rural Physicians of Canada, (which funded the clinician acquiring the skill, the locum replacing them, and the teaching preceptor) was identified as an extremely helpful initiative that should be replicated in Northern Ontario. The CARE course (Comprehensive Approach to Rural Emergencies) an initiative of RCCbc but hosted several times in Northern Ontario communities – was also identified as a helpful example of "in community, whole team" education.

[2] Virtual critical care in the Northeast region and Regional Critical Care in the Northwest region provide a virtual video bridge from the local rural emergency room to the intensive care unit at Health Sciences North (in the northeast) and Thunder Bay Regional Health Sciences Centre to support local management of critically ill or injured patients. This has decreased the sense of isolation and enabled better supported care of patients in the emergency department.

3. Barriers: What are the biggest threats to rural practice and healthcare delivery?

The largest theme to emerge out of the research are the barriers to a sustainable practice in Northern Ontario. Participants were able to identify these on the induvial, community, and system level.

Individual: Several participants expressed specific concerns for their colleagues and themselves around the feelings of isolation and burnout. They described the challenge of managing high workloads including non-clinical responsibilities of teaching, learning, and mentoring. One participant explained "my personal experience with being a parent here was hard. I do not have any family, we could hire in help for childcare or to help cooking or cleaning, but I doctor everybody [making it hard to hire someone as they are also a patient]." New graduates have different approaches to work life balance and are not willing to be on call 24/7, presenting a new challenge to the existing workforce. One physician was quoted saying "one of the big issues for sustainability here is the inadequacy of the connective tissue around the physician" [appropriate staffing, administrative supports, structural supports].[3]

Community: The participants expressed that the largest barriers to sustainability in rural communities are staffing shortages and a lack of resources across the region. They described how everyone is forced to do more with less, creating a sense of unity amongst healthcare professionals in Northern Ontario. A healthcare system that is still suffering from colonial trauma is faced with new challenges including extensive travel requirements for patients and staff alongside increasing care needs of Northern populations. One participant went as far to say that there was moral injury on the care team based on high level calculations and decisions that were made by the system about the need for appropriate human health resources that were wrong. "We worked it out, it would've meant for each one of those 2.86 full time equivalents they would've needed to work 3062 hours or 255, 12 hour shifts a year."

System: The issue is that the current state of our healthcare system has become the norm. As described by one participant "I think a lot of it is also getting out of the mindset that the environment that we're currently working in is normal". There was a consensus that the system needs fixing. One participant explained how people that are working within the system have to hit rock bottom before they get help. Barriers at the system level are really focused on bureaucracy and ensuring that the needs of rural clinicians, and communities are met by decision makers. Participants expressed the desire for their voice to be heard, collective action to be formed, and for rural advocacy to become a top priority for administrators and policymakers.

4. Accountability: Who is responsible for rural healthcare and the needs of rural health care providers?

To the groups that this question was asked, it was met with a brief silence. An indicator that accountability throughout the healthcare system is not clearly defined.

Participants were clear: accountability throughout the healthcare system is lacking. At various levels of the system, from the local hospital to the Ministry of Health, there needs to be accountability for the conditions in which clinicians are working and support for improving them so that physicians can provide the care that communities need. Physicians were able to mention that there is a gap in the coordination and evaluation of accountability, and mentioned there is a distinction between supporting health and health service delivery and directing heath service delivery. A rural coordination centre could serve as the accountable body with structures and programs to address the needs of rural physicians to better serve the communities in our region.

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[3] For those physicians who work in practices in which the physicians are itinerant (ie. some remote first Nations practices, highly locum dependent practices) it was noted that consistency of administrative support (ie. someone who knows the patients, knows who needs to follow up, tracks what needs to be done and can hand that over to the next physician) was important for safe and effective care, and for ensuring that locums would be likely to return. Not having adequate support staff in place is a contributing to sustainability of rural practice that the region faces.

5. Going forward: What are the potential roles and impacts of a rural coordination centre in Northern Ontario?

Physicians had several ideas for possible solutions to address the barriers and for the establishment of programs that could be supported through a Northern Ontario rural coordination centre. It was recognized that clinicians in communities have much in common in terms of their challenges, but there is no organizing body that brings them together and proposes solutions. The potential roles and impacts are outlined in the following areas: addressing gaps of care, supporting community recruitment and retention efforts, aligning training programs with workforce needs, advancing critical data initiatives, and strengthening collective advocacy.

The following general functions were put forward by participants:

Delivery of Care: Coordinating improvements in transitions of care.

- Including inpatient care and the transfer of patients across sites and centers.
- Establishing and coordinating a rural locum program with recruitment and retention strategies for current Northern Ontario clinicians.

Recruitment: Supporting and advancing best practices around community-based recruitment workforce strategies in Northern Ontario.

- Supporting a distinctions-based rural practice approach, where each community and practice style is celebrated and communicated to find matches between physician preferences and community needs.

Academic: Aligning with existing academic programs and ensuring preparedness of new graduates for serving rural communities.

- Supporting distributed teaching sites through additional resources that strengthens positive learner community experiences.
- Create future opportunities for succession planning.

Data and Information: Advancing evidence-based solutions and information about workforce needs that accurately reflect the state of the industry.

- Supporting data and research initiatives that help identify the best practices for rural care needs and priorities.
- Including but not limited to clinical, leadership, teaching, and service delivery.

Advocacy: To serve as a voice of advocacy requesting evidence-based changes to the rural and northern health system.

- Support and sustain clinical services for rural communities.

A series of survey questions, detailed in the appendix were asked at the conclusion of each of the focus groups. The survey answers clearly show that, all responding participants felt that a rural coordinating centre would make them “feel better about staying in rural practice” and agreed or strongly agreed that there is a role for a body equivalent to an RCCbc for the region. There was general agreement that it should be a policy priority for the region.

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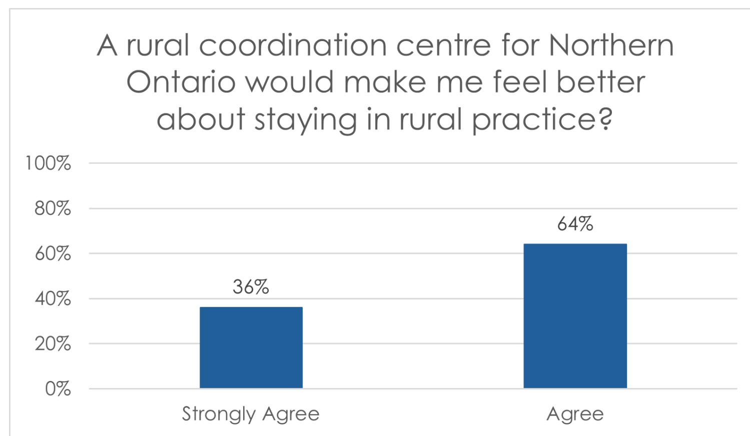
Appendix A: Survey Results

The following are results collected from the feedback survey distributed to focus group participants.

Question #1:

When asked if a rural coordination centre for Northern Ontario would make them feel better about staying in practice, sixty-four per cent of people strongly agreed, and thirty-six per cent agreed.

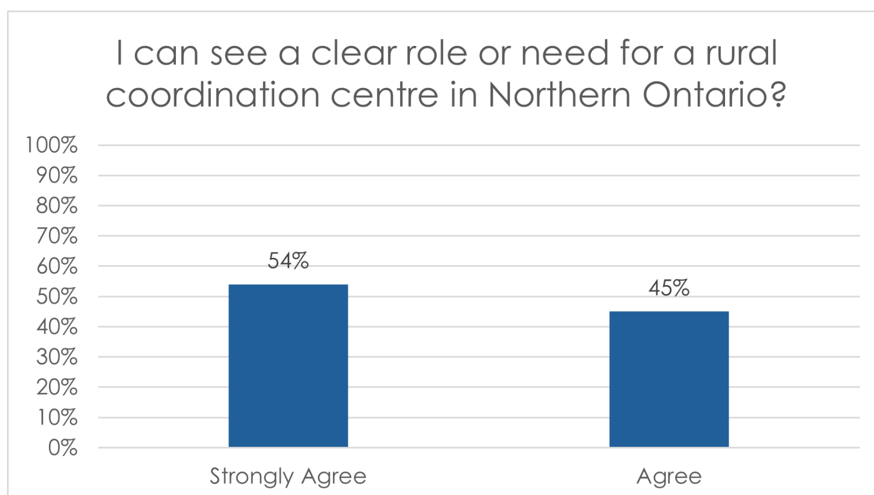
Figure 1: Exit survey question #1 responses



Question #2:

Participants were asked if they can see a clear role or need for a rural coordination centre in Northern Ontario and fifty-four per cent strongly agreed, and forty-five per cent agreed.

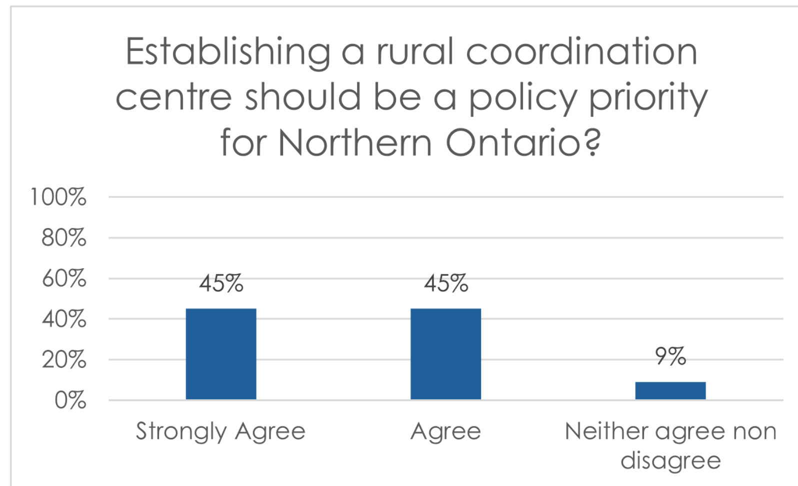
Figure 2: Exit survey question #2 responses



Question #3

Participants were asked if they thought establishing a rural coordination centre for Northern Ontario should be a policy priority for the region. Forty-five per cent strongly agreed, forty-five per cent agreed, and nine per cent were indifferent.

Figure 3: Exit survey question #3 responses



Question #5

Participants were asked if they had any additional ideas or opinions about the potential for a rural coordination centre that they were not able to share during the meeting, and they shared the following ideas:

- I would like to emphasize that having this organization support Continuing Medical Education (CME) in our local communities like the Society of Rural Physicians Canada (SPRC) funding would make it very valuable for learning in rural communities.
- Stabilization of the existing workforce.
- I think a coordinated rotation for rural skills training, with each site getting a certain number of days per year, alongside locum coverage, administered through the organization would help greatly.
- Improving locum coverage is critical to ensuring retention of existing rural generalists.
- Doctors in our entire area are struggling with burnout. The same physicians are trying to maintain the same level of care, act as specialists, teach, struggle to find locums, all while being crushed by HRMs.
- Smaller centres like the one I practice in are too overburdened to organize ourselves to achieve the kinds of systemic changes that are needed. I want to emphasize the need for adequate EMRs; technology should be a priority where geographic and cross-cultural challenges exist.

Appendix B: Methods

To assess the current needs, gaps, and potential solutions for rural healthcare delivery in Northern Ontario, a series of virtual focus groups were conducted. These sessions were collaboratively organized by the Physician Workforce Strategy Unit (led by Dr. Sarah Newbery and supported by Dr. Jullieta Lum), the Northern Policy Institute (represented by Patrick Berube), and the Dr. Gilles Arcand Centre for Health Equity (led by Dr. Erin Cameron, and supported by Angus Foster and Douglas Newhouse). A first focus group was held in the early fall of 2024 to test the format, questions, timing and survey results. Between January and February 2025, subsequent focus groups held employed purposive and snowball sampling methods, resulting in four one-hour sessions attended by 24 participants in total. In these meetings, participants were asked a series of key questions, including:

1. What factors have helped support you/make your rural practice sustainable?
2. What skills have been important in your career in a rural setting?
3. When you think about the practice/setting/community you are working in now, what has been the biggest threat to sustainable practice/healthcare delivery?
4. When you think about the community & practice that you are working in, who is accountable for understanding the needs of patients & providers in your community, and acting to address those needs?

The focus group sessions began with a short standardized overview of the project and then participants introduced themselves. The key questions and related prompts were used to guide the discussion and were displayed on the virtual computer screen. Questions were streamlined depending on available time and the degree to which the question had been touched on in prior responses. All focus groups were recorded and transcribed verbatim. The transcripts were analyzed independently by three different parties and no artificial intelligence tools were used in the analytic process. One party (PB) analyzed the data and provided unique summaries from each focus group and for each question. The other two researchers (EC, DN) used Atlas.ti a qualitative data analytic software to code and categorize the transcript data. Intercoder reliability was confirmed after analyzing one transcript. A code book was developed deductively from the questions and used to analyze the data (see table). Themes from across the transcripts were identified and helped to validate the summaries and findings.

Table 1: Codes developed from question list.

Code	Key Focus Group Questions
Facilitators	What factors have helped support you/make your rural practice sustainable?
Skills/PD	What skills have been important in your career in a rural setting?
Barriers	When you think about the practice/setting/community you are working in now, what has been the biggest threat to sustainable practice/healthcare delivery?
Accountability	When you think about the community & practice that you are working in, who is accountable for understanding the needs of patients & providers in your community, and acting to address those needs?
Centre	What are the potential roles/impacts of a future coordinated approach?

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