"Thank you for giving me the opportunity to participate in this incredible program. Being part of the IRP program was by far the best educational experience I have had in my six years of university." — pharmacy student, summer ’04
Executive Summary

The Interprofessional Rural Program of British Columbia (IRPbc) is pleased to provide this overview of the program, its progress and outcomes of the past 22 months.

We embarked on this program in February 2003 as an opportunity for rural recruitment, to model and evaluate interprofessional learning, and to provide new practice education sites for emerging health professionals. Ultimately the goal of the program is to improve the health of people living in rural communities. As a collaborative program across many health and education organizations in BC, and led by the BC Academic Health Council, it was an ambitious and challenging undertaking especially given very tight timeframes required by our funder, the Ministry of Health.

We are proud of the work that has been achieved in a very brief period – with key processes in place, champions leading the program in the rural communities and in respective educational organizations, and participants (students and rural health professionals) keen to share their stories and continue the momentum. Three placement phases have been held across five remote and rural communities. Sixty students representing 11 health professionals and eight educational institutions in BC have participated.

The achievements to date are attributed to the significant involvement, leadership and contributions by all the participants in the program. We are indebted to many – the Ministry of Health which provided us this unique opportunity; the health professionals in the rural communities who have generously welcomed and shared with the students; the College of Health Disciplines at University of British Columbia for its vision, leadership on many levels and interprofessional structures; BC Academic Health Council for its staff and structures that support networking and dissemination across health and education organizations in BC; and especially to the students who have embraced interprofessional collaboration, have been inspired by rural practice, and have enthusiastically shared their stories.

When we began the program, there were no existing models like it in Canada. With significant momentum now getting underway across the nation relating to interprofessional education for collaborative patient-centred practice, we are pleased to share our approaches and lessons learned. There is significant opportunity to adapt the program within BC (in urban, specialty settings, other rural communities) and in other provinces.

A number of recommendations are highlighted as the IRPbc shifts to a transition phase from initial “planning and development” and moves to longer term sustainability.
Introduction & Purpose

The Interprofessional Rural Program of BC (IRPbc) is an important first step for British Columbia in establishing interprofessional education which engages numerous rural communities, health authorities and post-secondary institutions. Designed to prepare students for interprofessional collaborative practice and to promote rural recruitment of health professionals, IRPbc places teams of students from a range of health professional programs into smaller British Columbia communities. The student teams experience the challenges and rewards of rural practice while developing interprofessional practice and discipline-specific skills.

The IRPbc is a provincial program, developed with funding from BC’s Ministry of Health Planning and facilitated through the BC Academic Health Council (BCAHC). IRPbc represents a partnership between rural communities, health authorities, and post-secondary institutions across the province. Pedagogical guidance and leadership is provided through the University of BC’s College of Health Disciplines. Health Match BC, a provincial public sector recruitment agency for health professionals, is an ongoing link to recruitment and retention goals.

IRPbc goals are to contribute to:

- Recruitment and retention of health professionals in rural communities;
- Modeling and evaluation of interprofessional learning\(^1\);
- Expansion of capacity to educate health professionals in BC; and
- Ultimately, the program is expected to enhance the health of people living in rural communities.

This report provides an overview of the program and its components; describes the evaluation through a program logic model; summarizes key themes from participant feedback; and makes recommendations for the future.

Background

In January 2003 the Ministry of Health Planning funded the development of a Rural Placement Program for BC with a focus on interprofessional learning. The program was conceptualized to provide a number of benefits to a range of stakeholders, including the following:

- **Health authorities** in recruiting and retaining staff;
- **Post secondary educational institutions** in increasing placement opportunities;
- **Health professionals** in promoting lifelong learning opportunities;
- **Students** through fostering interprofessional learning and practice-readiness; and
- **Rural communities** in supporting and enhancing quality care.

\(^1\) Indeed, discipline-specific learning is also enhanced as a result of learning from and teaching other professions.
The goals and objectives outlined in the funding proposal included the following:

- Increase capacity for clinical placements in rural communities
  - Develop three initial communities/sites and expanding to more communities in 2003/2004
  - Provide information to health authorities on best practices for student placements
  - Increase preceptor training and support
  - Increase support to Health Sciences Placement Network (HSPnet)
- Make rural placements more attractive to students
  - Establish criteria for student incentives
  - Explore mechanisms for sustainable funding
- Facilitate rural placements through coordination, infrastructure and linkages with other BCAHC initiatives
  - Link with HSPnet and Preceptor & Mentor Initiative for Health Sciences in BC
  - Foster links with external programs such as the UBC Faculty of Medicine Rural Training Program and Health Match BC
- Foster recruitment opportunities in rural communities
  - Investigate opportunities to improve recruitment of allied health professionals in rural communities
- Promote innovation and integrated health service delivery
  - Research and develop models of interprofessional education and delivery of health care
  - Organize workshops on interprofessional education and research in the targeted communities to learn about best practices and share experiences

Figure 1 (next page) provides an overview of the development of the IRPbc beginning with funding in early 2003 through to the completion of three phases of student placements in September 2004.
Plan

IRPbc Implementation Team
- Rural Communities
- Post-Secondary Institutions
- Health Authorities
- Ministries of Health & Advanced Education
- BCAHC

Research & background documents
Best practices, competencies, & processes
Mechanisms to communicate & coordinate
Student/preceptor orientation

IRPbc Goals
- Model & evaluate interprofessional learning
- Expand capacity for educating health professionals in BC
- Recruit & retain health professionals in rural communities

Evaluate

How does IRPbc influence competencies of students?
- Broadening perspectives
- Sharing knowledge

What supports are required for rural communities to educate students?
- Transportation, accommodation, IT, preceptor & student training and support

What is the impact of IRPbc on recruitment and retention?
- Tracking graduates that have returned to rural practice
- Renewed energy in community

Sustain

- Consolidate lessons learned
- Build regional expertise across province
- Integrate IRPbc into the health & education systems in BC

Implement

5 rural community sites; 10 health professions; 8 PSEs
3 placement phases
12 student teams = 60 IRPbc students

1 - February 2003
2 - Summer 2003
3 - January 2004
4 - Summer 2004
5 - 2004/05

Improved health care for BC’s rural communities
Implementation Team

IRPbc’s Implementation Team (Appendix A) provides strategic direction and leadership in planning and implementing the program. The 24 representatives include front-line health practitioners, managers, educators, and policy makers from rural communities, post-secondary institutions, health authorities, Ministries of Health and Advanced Education, Health Match BC, and BCAHC. The Team has met monthly which has facilitated collaboration amidst short timeframes, enabled communication/interaction across participants, and fostered program changes where required.

Each of the Implementation Team members has played a vital role in the initial implementation. In particular, the Program is indebted to the lead coordinators in each of the five rural communities who champion the program locally, and to faculty at University of British Columbia who have led the student orientation, developed the student assignments to foster interprofessional competencies, and led the evaluation. IRPbc is a true partnership.

One of the key challenges facing the IRPbc Implementation Team has been balancing perspectives across multiple post-secondary institutions particularly given the significant role of University of British Columbia (UBC). UBC has been instrumental to implementation given the community linkages with the Faculty of Medicine; the leadership of the College of Health Disciplines in interprofessional education; UBC’s multiple health professional programs, many of which are the only ones in the province; and the existing interprofessional structures such as the Practice Education Coordinators Committee.

Nursing perspectives and placements have been particularly complex given the large number of nursing programs in the province and their existing relationships with health agencies. The Nursing Education Council of BC, on behalf of the various nursing programs across BC, has provided valuable input to the Implementation Team.

PLANNING SESSIONS

Three one-day IRPbc provincial planning sessions were held April 2003, September 2003 and May 2004. The purpose of each planning session varied related to the stage of the program, but essentially were designed to foster face-to-face interaction among key participants in the IRPbc, to plan the program and to review progress. Participants in the planning sessions included Implementation Team members as well as representatives from IRPbc student teams, health authorities, and government, in order to broaden knowledge of and input to the program.

The May 2004 session was scheduled adjacent to the international interprofessional conference All Together Better Health II held in Vancouver. Thus, IRPbc participants were able to take an active role in the conference and poster presentations and learn more about interprofessional education initiatives nationally and internationally.

RESEARCH & BACKGROUND DOCUMENTS

Although similar programs have been successful in other parts of the world (in particular the United States), IRPbc is the first of its kind in Canada. In the first few weeks of the program, a literature search was undertaken and the following background documents were developed to help foster a shared understanding and vision for IRPbc:

- **Strategic Directions Working Paper** highlights key concepts and lessons from other jurisdictions;
- **Backgrounder on Interprofessional Education** summarizes lessons from other interprofessional rural programs and proposed approaches for the IRPbc including terminology, guiding principles, interprofessional competencies, team activities, and evaluation; and
- **Annotated Bibliography**.

These documents were widely distributed and are available on our website www.bcahc.ca/irpbc.
IRPbc Communities

SELECTION OF COMMUNITY SITES

Five rural communities have participated in the IRPbc to-date - Bella Coola, Hazelton, and Port McNeill were the initial sites for Phase 1/summer 2003. Two new sites – Trail and Fort St. John – were added in Phase 2/January 2004. The number of community sites was influenced by the Ministry of Health’s funding expectations and the logistics of managing across multiple sites. Given the provincial nature of the program, effort was made to disperse the sites geographically across the health authorities.

The importance of including medicine and nursing students on each interprofessional team helped shape the choice of communities. It was opportune and expedient to begin with rural communities already part of the Community Based Rural Training Program of UBC’s Faculty of Medicine. Thus the first three community sites were selected based on their existing commitment to rural medical education and strong champions for an interprofessional program.

COMMUNITY PERSPECTIVES

About IRPbc’s rural communities

HAZELTON
- Area catchment of over 7,000 people, two-thirds Aboriginal, including Gitxsan and Wet'suwet'en.
- Upper Skeena River, majestic mountains and natural beauty, renowned for ancient culture and traditions, totem poles and famous Kispiox Indian Cultural Centre.
- Northern Health Authority. A 50-bed hospital with outpatient family practice and dental clinics is operated by United Church Health Services.
- Outdoor activities: fishing, hiking, alpine meadows and glaciers, white water rafting, canoeing, and golfing.

BELLA COOLA
- Valley population: 1,500, half of whom are Aboriginal of the Nuxalk Nation.
- Situated on a mountain valley at the end of a magnificent fjord. Strong Norwegian heritage from settlement in the 1860s and traditional home of the Nuxalk Nation.
- Vancouver Coastal Health Authority. Hospital operated by United Church Health Services. 11 beds, emergency, medical clinic, physiotherapy and mental health services. Range of community services and federal health services for the Nuxalk Nation.
- Outdoor activities: boating, kayaking, sailing, hiking, fishing, mountain and rock climbing.

PORT McNEILL
- Population: 3,000.
- Mount Waddington District, on northeast coast of Vancouver Island.
- Coastal setting and abundant rainforest with many species of fish and wildlife. Across the bay is First Nations community Alert Bay, strong in the Kwakwala culture and the oldest BC community.
- Vancouver Island Health Authority. An 11-bed hospital with emergency, physiotherapy and a new psychiatric observation unit.
- Mild climate allows for year-round outdoor activities: fishing, hiking, sailing, windsurfing, cycling, diving, canoeing, and kayaking.

FORT ST. JOHN
- Population: 16,000.
- Northeast corner of BC, on the Alaska Highway.
- Wide skies, northern lights, impressive plateaus and a panoramic view of striking rivers, valleys, fertile fields, and stately forests.
- Northern Health Authority. Full-service hospital with 44 acute care beds, serving a catchment of 55,000.
- Outdoor activities: golfing, fishing, boating, swimming, horseback riding, hiking, and camping. Winter activities include curling, hockey and snowmobiling, along with cross-country skiing.

TRAIL
- Population: 21,000.
- In the Kootenays, a mountainous region in the interior of BC.
- Interior Health Authority. Regional referral hospital with 75 acute and 35 extended care beds serves a catchment of 83,000.
- Activities: downhill and cross-country skiing, golfing, fishing, water sports, curling, hockey, and a new aquatic centre.

www.bcahc.ca/irpbc
In Phase 2, site selection was led by the respective health authorities in consultation with post-secondary institutions. Criteria for Phase 2 community selection included:

- Community provides full continuum of care, with integration across continuum;
- Identified health professional to lead/champion the program in community;
- Lead organization in the rural community has demonstrated commitment to education of health professionals (students and staff);
- Available preceptors for students across a range of professions who:
  - have the right qualifications and are involved in interprofessional practice
  - are interested in students and are willing to precept
  - can provide appropriate discipline-specific as well as interprofessional learning opportunities
- Can be mobilized in short timeframe; and
- Other criteria related to: available technology, infrastructure, specific recruitment needs, and broad community support.

The five IRPbc communities vary in a number of ways, including by size and remoteness, however, all are considered “rural” under Ministry of Health Services guidelines. For example, Bella Coola with population of 2,500, about half of whom are Aboriginal has a 15 bed hospital, whereas Trail with population of 21,000, is a regional referral centre. The type of community significantly influences the types of professionals available to precept and thus the composition of an interprofessional student team.

Each of the communities has one or two designated health professional(s) who lead the program locally. In addition, several communities designated an administrative person to handle many of the logistics and schedules for students.

All five communities have provided tremendous support to the development of the program and to the student teams. Students consistently comment on the incredible welcome and support they receive, the flexibility and creativity of rural health professionals, and the breadth of learning opportunities provided.

**PRECEPTOR ORIENTATION AND SUPPORT**

A one-day IRPbc preceptor orientation session was provided onsite in four of the five community sites, and one site received two sessions. These workshops were facilitated by the IRPbc Placement Coordinator and a fieldwork coordinator from a post-secondary institution. The latter was involved to foster greater interaction between rural health practitioners and faculty.

The preceptor orientation focuses on the goals of IRPbc, interprofessional student team learning within the respective community, and generic preceptor concepts such as identifying learning needs and giving feedback.
COMMUNITY SUPPORTS AND CONTRIBUTIONS

Each of the rural communities has provided significant support to the planning, implementation and evaluation of IRPbc by creating a warm welcome and supportive learning and living environment for students. In particular, the IRPbc has benefited from:

- A “lead coordinator” who directs/champions the program within the respective community/health organization and participates on the Implementation Team. Typically, this person is a hospital administrator or physician;
- A designated “administrative coordinator” who is the conduit for information, coordination, resolving scheduling and other administrative issues; and
- Health professionals who preceptor students from their own discipline and provided a range of learning opportunities for other students on the team – individually and as a team.

IRPbc has provided financial support to participating communities for the following items:

- One-time education infrastructure, particularly related to ensuring student access to information technology (e.g. computers, LCD projectors);
- Community coordination to offset costs for the administrative workload related to IRPbc;
- Student accommodation which typically includes fully furnished suites or apartments close to the hospital;
- Travel for lead coordinator or other health professionals to attend planning sessions, international conference on interprofessional education, and orientation sessions in Vancouver;
- Preceptor support such as library resources; and
- Student activities such as a welcome dinner or education session with preceptors.

Student Teams

A number of key activities were undertaken related to the interprofessional student teams – placement timing, student selection process, composition and size of student teams, student orientation, student supports/incentives and debrief session. These are discussed below.

PLACEMENT TIMING

Two different placement times of the year have been trialed by the IRPbc – summer (June to August) and January/February. Each team was expected to have a minimum of four students representing a range of health professionals and have an overlap of minimum four weeks (the literature identifies that the ideal would be eight weeks overlap).

Unfortunately there is no time of the year that fits all programs and needs. Indeed, programs vary significantly in when placement decisions are made, the length of placement and start/end dates for the placements.

Based on a survey of all programs in BC, and from feedback from the communities, summer has been identified as “the best time” (at this point) given the greatest number of placing programs (including medicine which is vital). In addition, it provides a range of recreational activities for students to experience rural life.
STUDENT SELECTION PROCESS

IRPbc has endeavored to select senior level, strong students with an interest in interprofessional education and rural practice. Experience from other jurisdictions and from IRPbc to-date has reinforced these criteria, given the importance of active contribution to health care in the rural community and the interprofessional team activities.

The following student selection process focusing on community needs was developed through consultation with the Implementation Team and with post-secondary institutions in the province (through the provincial committee of Deans and Directors of Health Sciences, fieldwork coordinators, and others):

- Community identifies need/interest for students in particular health programs and provides preceptor contact information to BCAHC;
- BCAHC forwards community requests to respective post-secondary institutions, through their fieldwork coordinators or other designated coordinators;
- Coordinators process student applications as per the student selection criteria, contact the discipline-specific preceptor, and forward completed applications of recommended candidates to BCAHC; and
- BCAHC, in partnership with the IRPbc communities, receives/reviews/approves student applicants from post-secondary institutions.

Given multiple nursing and social work programs in BC, the following priority criteria have been used for selecting students in these health programs:

1. Traditional referring program in the geographic area (for nursing this is identified by the Nursing Education Council of BC);
2. Other programs in region; and
3. Programs outside the geographic region.

COMPOSITION AND SIZE OF TEAMS

To-date, 11 professions have participated in the IRPbc - medicine, nursing, social work, physical therapy, occupational therapy, pharmacy, speech language pathology, medical radiology, medical laboratory, counseling psychology, and audiology.

Students have represented eight post-secondary institutions across the province: British Columbia Institute of Technology, Malaspina University College, North Island College, Okanagan University College (now UBC Okanagan), Selkirk College, University of British Columbia, University College of the Cariboo, and University of Victoria.

IRPbc has endeavored to place four to five different professions including medicine, nursing and social work on each team. However, student teams have ranged from three students to seven on a team, and several have not had medical students.
There is a number of challenges regarding team composition, size, and interaction:

- The composition and size of teams is influenced by a number of factors – availability of local preceptors for students (some communities have limited range of professions\(^2\)), type of health programs placing teams at one time, timeliness of the IRPbc processes to meet selection deadlines across multiple programs, and the communities’ ability to accommodate/support students;

- Students typically arrive and depart from the community at staggered times according to their program requirements. In some cases, there has been minimal or no overlap among some team members; and

- Shift work by students (especially nursing) causes significant disruption to availability for student team meetings and activities.

**STUDENT ORIENTATION**

A two-day IRPbc orientation was conducted at the University of British Columbia for each of the three phases of student placements. The orientation includes content and team interaction focusing on personal learning styles, interprofessional team learning, rural health, Aboriginal culture, working with victims of violence, and boundary issues. In addition, health professionals from the rural communities attend the sessions to interact with students and to talk about their respective community.

Participation at the orientation and feedback from students has been excellent. Unfortunately, medical students have been unable to participate to-date given the timing of their examinations.

**STUDENT SUPPORTS & INCENTIVES**

Students have been provided shared accommodation in the rural communities near the hospital facilities. Housing has been critical not only for access to the placement, but also fosters informal interaction and learning among the students. In addition, students (other than medical students who receive funding through their own program) have been provided with the following:

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<th>Phase 1</th>
<th>Incentive</th>
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<tr>
<td></td>
<td>Travel costs up to $800 per student reimbursed through receipts</td>
<td>Matches medical students Labor intensive/impractical to continue</td>
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<tr>
<td></td>
<td>One time award of $250 per week</td>
<td>One time only, in order to attract students and the effort by students in contributing to a new program</td>
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<td>$800 for travel and other expenses per student</td>
<td>Sufficient to attract students, easy to administer</td>
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<th>Phase 3</th>
<th>Incentive</th>
<th>Comment</th>
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<tbody>
<tr>
<td></td>
<td>$500 for travel and other expenses per student</td>
<td>Sufficient to attract students, easy to administer</td>
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There has been debate over whether to continue the travel funding for future. Feedback from students indicate that they would not have participated without this incentive. We recommend that $500 in funding be continued, particularly to acknowledge the additional responsibilities and commitments, such as orientation, debrief, team assignments, evaluation interviews, and other activities above what is required in a regular placement.

\(^2\) Effort has been made to be creative identifying preceptors for students where there is not a full-time discipline-specific preceptor available. For example, students have been placed across 2 neighbouring communities or preceptored part-time by another profession, where acceptable to the program and preceptor.
DEBRIEF SESSION

A two-hour evening session is held after each placement for informal discussion with students to receive feedback about their experiences and recommendations.

STUDENT GOALS AND ACTIVITIES

During each student’s placement on an IRPbc team, a number of specific goals and activities has been outlined to allow students to achieve the interprofessional learning outcomes of the program. Within the broader goals of the program, students are expected to:

- Develop an understanding of the roles of the members of the interprofessional team including such areas as professional boundaries and areas of collaboration;
- Develop an understanding of teams and team interactions;
- Share with others what they are learning in their placements;
- Provide and seek peer support in their learning experience; and
- Identify and explore issues of common professional interest to their student team.

Students are expected to improve or develop a number of skills during their placement. These competencies are intended to complement skills needed in their professional practice but also involve understanding the “world view” of other health professions. Assignments for the interprofessional component of the learning experiences directly relate to the following six interprofessional competencies:

- **Communication** – developing an awareness of group processes such as developmental stages, social and task functions, and creative problem solving as well as having the skill to communicate effectively with colleagues and support staff, both orally and in writing;
- **Interprofessional Teamwork** – being able to facilitate interprofessional case conferences, meetings, team working and networking as well as being able to describe one’s roles and responsibilities clearly to other professionals and discharge them to the satisfaction of others;
- **Diversity** – being able to tolerate differences, misunderstandings, ambiguity, shortcomings and unilateral change in other professions as well as being able to celebrate differences and recognize similarities of team members, clients, families, and communities;
- **Ethical Practice** – developing skills to establish a mutually trusting relationship as a team as well as being able to apply and integrate ethical principles with team values;
- **Critical Thinking/Clinical Reasoning** – (relative to each student’s discipline) exploring genetics, aetiology, epidemiology and pathophysiology of the disease/injury of the client under the team’s care, as well as developing skills in interdisciplinary assessment, intervention, evaluation, and service co-ordination; and
- **Research** – sharing of relevant research articles and critiquing results as a team, being able to evaluate the effectiveness of interventions, and discussing with the team.

In addition to discipline-specific work, the students complete a number of IRPbc assignments to facilitate the acquisition of interprofessional skills and attitudes. While some portions of the work are completed individually, the majority of the assignments are team projects within which everyone is expected to contribute fully. Given different start and end dates for the students, this is at times a complicated process. The students meet together as a group for a minimum of three hours a week. Students are asked to complete daily entries into individual learning
journals throughout the course of their placement. Within the journal the students summarize insights and thoughts regarding interprofessional practice, interaction, conflict or collaboration.

Interprofessional assignments include:

- **Team Community Project**
  The team, in consultation with appropriate members of the community, identify, design, and implement a project of relevance to the local community;

- **Case Presentations/Clinical Rounds**
  Each student is expected to do a formal case presentation to their interprofessional team at least once during the placement. Using a client or relevant practice issue, each team member conducts a case conference for 30 minutes which includes relevant background, an analysis of the situation from the specific discipline perspective, interventions to-date and questions/practice dilemmas that require peer consultation;

- **Team Rules, Roles, and Rituals Exercises**
  Prior to the commencement of the placement, team members decide on group rules and roles to guide the interaction of the individual and collective team experience; and

- **Shadowing**
  Each student is expected to shadow at least two other students and/or health care professionals from a discipline other than their own for at least two hours during the course of the placement. The shadowing provides the student with the opportunity to gain a deeper understanding of the roles and responsibilities of other disciplines.

**Provincial Coordination**

The BC Academic Health Council (BCAHC) plays a facilitative role in bringing together provincial partners from rural communities, health authorities, post-secondary institutions, and government to plan, implement, and evaluate the Interprofessional Rural Program of BC. BCAHC also fulfills a number of roles including program management (led by Ms. Kathy Copeman-Stewart), placement coordination, research, administration, and financial.

Processes such as the overall workplan and timeframes, Implementation Team meetings and follow-up, selection of communities and students, and communications are administratively supported through BCAHC.

Coordinating across the number and range of organizations, particularly given the multitude of systemic issues relating to student placements, presents continuing challenges. However, IRPbc was able to build on the existing relationships, resources and activities of BCAHC to create a high quality and innovative learning experience that benefits rural communities.

**Sustainability Budget**

Funding provided by the Ministry of Health Planning in early 2003 launched the IRPbc and allowed the intensive planning and development across multiple organizations as outlined in this report. At this point, our funding is almost exhausted, however, there is significant commitment by the rural communities, post-secondary institutions, and BCAHC to maintain the momentum. Indeed, an expectation of Ministry funding was that this would become an ongoing sustainable program.

The proposed budget makes the following assumptions:

- Existing established sites continue to host student teams once a year;
- No new investment will be made, but rather we will capitalize on continued efficiencies in all aspects of the program; and
- Online curricula will be available for students and preceptors.
It is proposed that interim funding be solicited through BC’s submission to Health Canada’s Interprofessional Education for Collaborative Patient-Centred Practice as we shift from the current implementation phase and look to longer term sustainability with integration of IRPbc into health and education systems.

The next phase of student teams will link more actively with respective health authorities, with the opportunity for health authorities to integrate the student teams into a broader health authority strategy for interprofessional education for collaborative patient-centred practice. Alternatively, in the longer term, consideration should be given to shifting coordination of rural interprofessional placements with medical rural placements to foster efficiencies and integration.

### Communication and Dissemination

A communications plan was developed at the outset of the program focusing on a variety of audiences, including deans and directors of health sciences, health authorities, rural communities, students, placement coordinators, etc. Key communication vehicles for IRPbc include:

- Website developed and continually updated at [www.bcahc.ca/irpbc](http://www.bcahc.ca/irpbc);
- Periodic newsletters and articles focusing on perspectives from students, communities, and post-secondary institutions circulated by the BC Academic Health Council, health authorities, and post-secondary institutions;
- Presentations to numerous audiences by Implementation Team members; and
- Newspaper articles locally, radio (locally and nationally).

In addition, students, faculty and community representatives have taken leadership in disseminating information about the program through journal articles, interviews, and conference presentations. In summer 2003, the Minister of Health Planning traveled to Hazelton and learned first hand from the Hazelton IRPbc student team about their experiences. This same group of students went on to complete their programs, and as new graduates delivered an impressive keynote address to over 400 people at the international interprofessional conference in Vancouver.

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<tr>
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<th>4 sites</th>
<th>5 sites</th>
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<tr>
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<tr>
<td>- Existing communities</td>
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<td>- Travel</td>
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<td></td>
<td>$500/student</td>
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<td>($2,000/community)</td>
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<td><strong>Coordination</strong></td>
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<td>- Website</td>
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<td>Activities for external marketing such as brochures, posters, conferences, other</td>
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<td><strong>Total</strong></td>
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Summary of the IRPbc Experience:
Key Benefits, Success Factors & Challenges

Through formal evaluations and informal feedback from students, communities, and faculty and Implementation Team members, a number of key benefits, successes, and struggles have been identified over the first year and a half with IRPbc.

**BENEFITS**

*Student benefits* include the opportunity to work with experienced generalist practitioners across the continuum of care and the chance to interact as part of an interprofessional team. Students gain a stronger sense of their own professional identity and develop a stronger understanding of client needs. They also benefit from the experiences associated with rural practice and life in a small community. They see the link between the determinants of health (e.g., employment, housing, education) and health needs in a community.

*Local health provider benefits* include the energy and ideas of student teams and the chance to increase knowledge regarding interprofessional practice. They directly benefit from the preceptor training and support in providing health care in the community. Finally, the communities have positively changed the attitudes of students regarding rural practice and have thus recruited new staff.

*Post-secondary institutions benefits* include new placement sites for students, greater linkages with rural communities, and the opportunity to see and participate in interprofessional learning in action.

**KEY SUCCESS FACTORS**

A number of factors has fostered the progress and outcomes of the program to-date:

*Leadership* on many levels, including the many organizations represented on the Implementation Team, and in particular the local champions who put the IRPbc concepts into action. The Implementation Team has been vital in implementing the program quickly, keeping the process moving within the short timeframes, enabling communication/interaction across participants and making program changes where required. UBC College of Health Disciplines has led the student orientation as well as provided interprofessional education vision and leadership for the province.

*Strong welcoming host communities* with a long-standing commitment to health professional education and experienced *preceptors* who provide a supportive learning environment.
Interprofessional student team activities which include the community project, weekly meetings, shadowing, exposure to other professions and the student orientation.

Student incentives and support such as travel assistance, on-site administrative support and shared accommodation.

Provincial coordination by the BC Academic Health Council which facilitates the collaborative processes and ongoing communication across health and education.

**CHALLENGES**

There have been a number of significant challenges that the IRPbc has wrestled with through our processes. These include:

**Balancing perspectives** across multiple post-secondary institutions, particularly given the central role of University of British Columbia in implementing the program and in providing students from a range of professions.

**Integrating medicine** into the program, for a variety of reasons including communications; timing of orientation; different placement processes and travel funding for medical students on rural placements; and separate housing for medical residents/students in some communities.

**Complexity of nursing education in BC** given the large number of nursing programs in the province, a growing shortage of placements and the division of the province into placement ‘areas’ associated with particular institutions.

**Competing program goals** of promoting interprofessional practice, supporting rural recruitment, and expanding student placements.

**Fostering recruitment beyond medicine and nursing** is difficult given there are no existing mechanisms to link interested students to vacancies in rural communities. Indeed, some students were interested to return to the rural practice, however, there were no vacancies in their respective community, nor any mechanism to link them to other rural BC communities.

…one of the primary strengths of the program was in creating a greater understanding of the perspectives, goals and skill sets of other health professionals, which will undoubtedly aid our ability to work in a more efficient and cooperative manner in the future.

Thank you for the opportunity to participate in this encouraging and innovative program. I believe this program is a step in the right direction in creating more respect, understanding and teamwork between health care professionals. As future doctors we have benefited greatly from our involvement with the IRPbc. – medical student, summer ’03
Recommendations

1. Maintain existing communities as interprofessional rural education sites.

   Minimal investment is required with maximum benefits – policies/processes have been established, communities and preceptors across a range of professions have a high level of expertise about program, and are able to support the interprofessional teams, accommodation is in place in three communities, partnerships with faculty are well established and most importantly, these communities have experienced the benefits and are enthusiastic to continue.

   Note: in order to offer summer 2005 placements, student team selection process must get underway by November 2004.

2. Maintain focus on community-driven process in partnership with post-secondary institutions. Continue to strive towards and balance goals of interprofessional education, rural recruitment and retention, and expanding student placement capacity.

3. In the next one to two years, maintain the central coordination through the BC Academic Health Council via bridge funding. Transition these functions and expertise as appropriate out to health authorities and post-secondary education.

4. Consider establishing an interprofessional rural education site within Fraser Health.

5. Shift student orientation to an on-line format and cover both content and team interaction in advance of arriving in the respective communities. The orientation should include a component on conflict resolution. Although face-to-face interaction is very powerful, it is not sustainable to continue centralized orientation for students in Vancouver due to cost.

6. Develop a marketing strategy to recruit new students incorporating the stories/feedback received from participating students.

7. Establish recruitment mechanisms into rural health practice for participating students, possibly in conjunction with Health Match BC.

8. Consider networking opportunities with former IRPbc students to foster continued interprofessional collaboration and leadership, and assess rural practice interest.

9. Establish new evaluation methodologies in conjunction with other funding opportunities, such as Health Canada’s funding program for Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP).

10. Continue to share lessons learned with respective health authorities/western provinces/other in furthering IECPCP in BC and across Canada.
IRPbc Statistics

- Five rural BC communities have hosted interprofessional student teams – Bella Coola, Hazelton, Port McNeill, Trail and Fort St. John;
- Three placement phases with 12 student teams – summer 2003 (3 teams), January/February 2004 (five teams) and summer 2005 (four teams);
- 62 student participants to-date plus other adhoc participants (e.g. medical residents, international medical students) onsite in the respective communities;
- 50 students participated in three 2-day student orientation (12 students who did not participate were two physical therapy students for various reasons and 10 medical students due to examination conflicts) In addition, nine health professionals/senior administrators have participated in these orientation sessions. Feedback has been consistently very positive both on content and opportunity for team interaction;
- 38 rural health professionals across the five communities have served as primary preceptors for students – many others have mentored students or interacted with individual or student teams on a formal and informal basis;
- 11 health and human service professions represented by students and preceptors:
  - audiology
  - counseling psychology
  - medical laboratory
  - medical radiology
  - medicine
  - nursing
  - occupational therapy
  - pharmacy
  - physical therapy
  - social work
  - speech language pathology
- Eight post-secondary institutions:
  - University of British Columbia (audiology medicine, counseling psychology, nursing, OT, pharmacy, PT, social work, speech language)
  - British Columbia Institute of Technology (medical laboratory, medical radiology)
  - University College of the Cariboo (nursing, social work)
  - University of Victoria (nursing)
  - Selkirk College (nursing)
  - Malaspina University College (nursing)
  - North Island College (nursing)
  - Okanagan University College (now UBC Okanagan – social work)
- Approximately 50 health professionals have participated in preceptor orientation (five one day sessions) – “usefulness of session” rated to be 4.5 out of 5;
- Over $25,000 invested in education infrastructure in host communities e.g. computers, software, LCD projectors, library books;
- Website created
- Over 120 people – representing mayors, aboriginal and other community leaders, senior health administrators, post-secondary institution deans and faculty, hospital board members, media, health professionals – have been briefed on the program through site visits to the five rural communities;
- Three one day provincial planning sessions have been held with Implementation Team members and other key participants including students, health authority representatives and government;
Ten students/graduates have returned to rural communities for locum/clerkships or permanent positions

Port McNeill – social worker and laboratory technology
Bella Coola – two pharmacy (for clerkships) and two nurses (one of these also worked on locum in Hazelton)
Hazelton – nurse and speech language pathologist
Trail – nurse and social worker (to Cranbrook)

Dissemination activities undertaken by numerous participants including students, faculty, health authorities and BCAHC:

Presentations

- Children and Women’s Education Committee
- Deans and Directors of Health Sciences Committee
- International conference – four posters presented which included program overview, student/faculty and rural community perspectives, evaluation themes, Trail. Prepared through input from students, faculty, rural communities, BCAHC.
- International conference presentation with participation of rural communities, faculty and BCAHC

Professional journal articles

- Canadian Nurse, June 2004, The Interprofessional Rural Program of BC
- Pharmacy Post (national), September 2003, Teaching Teamwork
- Social work journal article underway
- The Network, Towards Unity for Health, June 2004, The Interprofessional Rural Program of BC, Kathy Copeman-Stewart

Media interviews/articles

- Interviewed Timothy George, UBC 4th year physical therapy student, and Monika Milewski,
UBC nursing graduate who currently works in Bella Coola.

− Coast Mountain News, June 19, 2003, "New Training Program for Health Care Students"

− Connections Newsletter, Vancouver Island Health Authority, summer 2003, posted on IRPbc website at: http://www.bcahc.ca/irpbc/IRPbc_News_archive.asp?pageid=683

− Interior Health Newsletter, January 21, 2004, page 6 http://www.interiorhealth.ca/MediaCentre/Newsletters/At_IInteriorHealth.htm

− Ministry of Health website http://www.healthplanning.gov.bc.ca/phc/infohcps.html

− Northeast Weekly, February 7, 2004, "Rural Health Care Program’s Focus"

− Northern Health Authority news/website http://northernhealth.ca/phs/news.asp?articleid=1038&zoneid=1

− Northern Health Notes, Vol. 2, No. 12, "Rural Training Program helps students get first-hand experience"

− Prince George television

− Rural and Underserved Community Practice Program Newsletter, UBC Family Practice Department, January 2004 http://www.med.ubc.ca/rnp/newsletter.htm


− The Bridge, The School of Social Work and Family Studies, Spring 2004, "The Interprofessional Rural Program of BC, Grant Charles"

− UBC College of Health Disciplines newsletter


− Vancouver Province – Interview of IRPbc nursing student for Nurses Week

− Vancouver Sun, Special Advertising Feature, May 8, 2004
Appendix A – Implementation Team

Alfred Laskowski, Family Medicine/Medical Education, Wrinch Memorial Hospital, Hazelton/Lead coordinator IRPbc Hazelton (phase 2 and 3)

Angela de Smit, Nurse Manager, Fort St. John Hospital/Lead Coordinator, IRPbc Fort St. John

Anne Ardiel, Executive Director, Primary Health Care and Rural Policy, Ministry of Health

Bent Hougesen, Family Medicine/Medical Education, Hazelton/Lead Coordinator, IRPbc Hazelton (phase 1)

Carl Whiteside, Director, Community-Based Rural Program, Department of Family Practice, University of BC

Cindy Aronson, Administrative Coordinator, Hazelton

Diana Herbst, Health Programs Special Advisor, Strategic Initiatives and Planning, Ministry of Advanced Education

Elizabeth MacLeod, Fieldwork Coordinator, Speech-language pathology, University of BC

Ethel Davis, Director, Health Match BC

George Eisler, CEO, BC Academic Health Council

Glen Schmidt, Associate Professor, Social Work, University of Northern BC

Granger Avery, Physician and Coordinator, UBC Community-based Rural Training Program, Port McNeill/Lead Coordinator, IRPbc Port McNeill

Grant Charles, Chair, College of Health Disciplines Fieldwork Committee/Fieldwork Coordinator, Social Work, University of BC/Lead, IRPbc Student Orientation & Assignments, Lead Investigator Evaluation

Jean Wheeler, Area Director of Rural Services, Vancouver Island Health Authority, Port McNeill/Lead Coordinator, IRPbc Port McNeill

Jocelyne Van Neste-Kenny, Department Chair, Collaborative Nursing Program, North Island College/Representative, Nurses Education Council of BC

John Gilbert, Principal, College of Health Disciplines, University of BC/Chair of Implementation Team

Lesley Bainbridge, Chair, Interprofessional Education Committee, College of Health Disciplines/Director, Rehab Sciences, School of Physical Therapy, University of BC/Presenter IRPbc Student Orientation/IRPbc Evaluation

Linda Sawchenko, Site Director, Kootenay Boundary Regional Hospital, Trail/Lead Coordinator, IRPbc Trail

Lorinda Andersen, Director Patient Care, Bella Coola General Hospital/Lead Coordinator, IRPbc Bella Coola

Mary Ellen Purkis, Director of Nursing, University of Victoria

Peter Martin, Manager of Education, Northern Health Authority

Shelley Tiffin, Clinical Coordinator, Medical Laboratory Science Program, BC Institute of Technology/IRPbc Evaluation

Brenda Sawatzky-Girling, Consultant/Background research and writing

Carol Wilson, Interprofessional Rural Placement Coordinator

Susanna Gilbert, Communications & Project Coordinator, BC Academic Health Council

Kathy Copeman-Stewart, IRPbc Program Manager
Long term outcomes – intended impact

Enhanced health care services for BC rural communities

Increased student competence to practice professionally and interprofessionally

Increased capacity for student placements

Wide range of emerging health professionals exposed to rural life and practice

Increased capacity for service delivery

Increased collaborative service delivery amongst health professionals

Increased collaborative partnerships between health service providers and PSEs

Increased rural recruitment and retention

Increased access to a broader range of health services

Incr

Increased preceptor confidence

Increased pool of health professionals to recruit

Enhanced consultation and referral mechanisms

Increased collaborative patient-centred practice among health practitioners

Advanced of interprofessional knowledge in education and practice in BC

Increased partnerships within community and with larger centres and PSEs

Interprofessional Rural Program of BC – Program Logic Model

www.bcahc.ca/irpbc

Community infrastructure and support – Student selection, incentives, and support – Provincial coordination – Mechanisms for communication and networking – Evaluation

November 2004

IRPbc Final Report
Soon after funding for IRPbc was secured, an evaluation team led by Dr. Grant Charles at UBC was assembled. The evaluation team’s main purpose was to develop methodology to assess the program’s contribution towards IRPbc’s three goals:

- Recruitment and retention of health professionals in rural communities;
- Modeling and evaluation of interprofessional learning; and
- Expansion of capacity to educate health professionals in BC.

**METHODOLOGY**

It should be noted that there are limitations to the evaluative methodology chosen for IRPbc, particularly around the program’s goal of *modeling and evaluating interprofessional learning*. The evaluation team was unable to locate in the professional and academic literature existing measures that would accurately measure the desired outcomes. Given the time restraints created by the rapid launch of the program there was insufficient time to develop the quantitative measures that would have provided “proof” of change in attitudes and behaviours in the participants. Thus a qualitative method of gathering information.

A formative method of evaluation was chosen in order to have continuous feedback. This was important so that improvements could be made as the team determined what was working and what need to be changed. While this strategy provided an effective means of quality improvement, it added to the challenge of outcome measurement as few components of the program remained static over time.

All IRPbc students (with the exception of some of the medical students) participated in individual interviews and/or debriefing sessions held at the end of each placement phase. The interviews were conducted by members of the evaluation team and followed a set of common questions. Most of the interviews were audio-taped and transcribed although a number in the first phase were recorded by hand. Preceptors and local administrators were also interviewed as part of the evaluation process.

A program logic model was chosen to align program goals, inputs and outputs to specific outcomes. While this method does not provide proof of change it does allow for the summarization of achievement.

**SUMMARY OF THE PROGRAM LOGIC MODEL OUTCOMES**

The IRPbc logic model is appended (Appendix B). The full report is available through our website. The degree of collaboration across such a range of partners is in itself a major accomplishment and speaks of the recognition throughout the province of the importance of interprofessional education and practice opportunities.

IRPbc can be deemed successful in a number of areas. For example, the program expanded the placement opportunities for students across a number of disciplines which was one of the program’s objectives. There has been involvement of health professionals who had not previously preceptored students. This is important not only because it introduces students to the possibility of rural employment but because it helps to address the shortage of placement sites currently being experienced by many health programs across the province. Each phase of the program has been able to involve post-secondary institutions and health disciplines that had not taken part in previous phases.

As expected, IRPbc contributed to the understanding by students of the unique needs of rural communities. It increased the knowledge of the students of the benefits of interprofessional practice. All students reported they have an increased knowledge and appreciation of not only the role of their own professions but also of those with whom they worked. This occurred through their...
participation in the student orientation, weekly team meetings and shadowing the students did with other team members and/or community professionals. All communities reported increased shadowing opportunities with preceptors from other disciplines. Students in three of the communities were provided ongoing opportunities for mentoring by local physicians.

The students appeared to have contributed to the well-being of the communities in which they were placed. Not only did they provide additional service to the communities while in their placements but each of the 12 teams completed community projects. The projects varied widely but often included the development of health promotion materials for use by community members. In addition many of the students have been involved in disseminating information about the program and interprofessional practice.

A further benefit of the program appears to have been the building of community capacity through the inclusion the local professions in the planning and implementation of all components of IRPbc. Health professionals from a range of health disciplines in each of the communities have been involved with the implementation team, planning sessions, orientation sessions, poster presentations at the international conference and evaluation.

a) Benefits to the Students

Students identified a number of benefits they received through the IRPbc experience. Some of the benefits were discipline-specific. The program offered them a chance to become better practitioners in ways that may not have been possible in an urban center. Rural health care offers a wider range of learning opportunities than many urban placements.

“(The best part was) being in a small hospital and able to use all of my nursing knowledge. I was also able to participate in activities I would not have been able to in the city, such as the treatment of emergency room patients.”

Students identified that they benefited through the exposure to other health and human service disciplines. They clearly developed an appreciation of the role and contribution of other professions. The power of this learning should not be underestimated. Indeed, through this and other similar endeavors we may be laying the foundation for significant systemic change.

“(It) opened my eyes to how much knowledge everybody holds … I have a new respect of how much knowledge everyone else holds and how important it is…(and) how many resources are there if you are willing to ask and how you have to know what they know in order to make use of their knowledge … Each discipline has a different approach to seeing a patient or seeing a client and when we piece it all together it can be a very powerful … healing experience….”

It is apparent that students increased knowledge of their own professions by interacting with students and professionals from other disciplines.

“(Being able) to teach them about my profession allowed me to better understand it first of all, and, get a better understanding of how I fit into that whole team atmosphere.”

One of the ways participation in the program helped the students develop an appreciation of other professions was through the breaking down of traditional stereotypes. It is through this process of understanding others that the health and human services areas will become more efficient and effective as professionals.

“This is probably one of the most significant pieces of learning for me personally and professionally. I went into the placement with a lot of preconceived ideas and biases about particularly physicians and getting to see their humanness right, and the fact that they are open to learning and open to suggestions as well, helped break down some of those stereotypes. And it’s encouraged me, I feel much more comfortable and willing to seek them out for consultations.”
Students were able to gain an appreciation of the lifestyle benefits of living in rural communities. They were exposed to living differently from larger centres.

“The community (was) geographically very beautiful. When I arrived in Smithers I was astounded when I got off the airplane and just kind of looked around at all the mountains and stuff, which I thought was quite beautiful. But then equally so (was) the drive into Hazelton along the river was just a phenomenal drive and just a beautiful place. We went for a walk my first night when I actually arrived in Hazelton. I was pleasantly surprised at the friendliness of the people even just on our walk. We stopped down at the river at one point and we were taking some photos and somebody that was just wandering out for a walk, stopped and started talking to us right away … it was that friendly small town sort of atmosphere I found right away.”

Another benefit had to do with acquiring knowledge regarding the unique nature of rural communities. Many students were surprised by the complex health care issues of people in rural settings.

“I was able to learn more about my community and some of the challenges it faces. I also had the privilege of being included in some of the support group meetings for people coping with Long QT Syndrome, an important medical issue for First Nations people in this area”.

Clearly the goal of having students consider rural practice was met. Many students had no previous exposure to rural communities. They were pleasantly surprised by their experiences.

“(Having a) rural experience was pretty interesting …I would have never ever ever thought about working in a rural setting – ever. And then I took this opportunity and now I would definitely consider it”.

“Since I never lived in a town smaller than Vancouver, I thought that I may have a hard time adjusting to living in a small town. I actually really enjoyed my time in Bella Coola. There was always something to do in the community and people are very friendly and approachable. I learned that I would enjoy living in a small community. I may pursue a rural lifestyle in the near future”.

Students acquire an appreciation of the importance of seeing the patients and clients with whom they work as being people who live in the broader community. While this approach is taught in school it is often difficult for students to translate this concept into practice.

“I could have been treating that person in the clinic and had never known that those issues were happening within that person’s family … the perspective changing is not so much on the professions but that the person that we’re treating is more of a whole person as opposed to a physical disability or a mental disability or anything like that.”

Students develop confidence and gain an appreciation of what they contribute to collaborative practice.

“(In the past sometimes) I kept my opinion to myself in order to avoid conflict but the times that I have opened up it has served the group better. I will speak my mind more freely in team settings in the future.”

“The spirit of the IRPbc program made me look at my practice from a different point of view when interacting with other professionals. I tried to take the time to find out what each person’s role was on all the teams I worked with.”
b) Benefits to the Community

[[A key principle of the IRPbc is “community drive.”

Many of the community professionals saw IRPbc as a means to attract highly competent health providers who could make a significant contribution to their communities.

“(The program) gave the community a sense of ownership of their health care in a sense. They are playing a role in training health care providers. They’ve always had this change with the medical students and the residents but I don’t think it has ever been presented to them as ‘Hey. You have this opportunity to mold health care providers of the future. There’s never been this extension into the community which there has been with IRPbc.”

“I strongly believe that northern and rural areas need creative and innovative programs to encourage professionals to consider these locations as outstanding professional possibilities. IRPbc facilitates that (process).”

It has long been known there are benefits to being a preceptor. However in rural settings there is less of a likelihood that such opportunities will occur. IRPbc provided the opportunity for an increased number of rural practitioners to precept students. The local preceptors experienced a sense of pride in rural practice and the work they did with the students. It became apparent they had a lot to offer students.

“The IRP (students) were the first students I’ve ever preceptored.”

“(preceptoring) is good because it stimulates the staff who are here … Students make you think; ‘Oh, she asked a question and I’m not quite sure what the answer is … I better start brushing up.’ So it was great for the staff to have the interaction with the students. It makes you step back and start re-thinking things sometimes.”

While rural health care practitioners work hard to stay current in their skills this can be more difficult than in urban settings due to a lack of training opportunities. The students brought fresh perspectives to the communities that in many cases benefited the local staff.

“I got to interact with somebody in the education system, has fresh knowledge and new insight and (can) update me on where things are happening in the academic world. And she did. And it was wonderful to interact with a young woman who has such self-esteem and such confidence that she could say, ‘Well, you know, this is what we’re being taught now’ and to be able to hear things and to get the feedback and appreciate the (learning).”

Rural settings appear well suited for interprofessional opportunities because of the nature of the health care settings. Their size and limited number of staff force people to work together in ways that not often happen in urban centres.

There appear to be other important benefits for the community, although they are not intended outcomes of the program.

“There is a little bit of an economic benefit to our community. I know it sounds crazy, but to have six people here who are doing things like taking riding lessons, who are buying groceries, who are going on chartered trips, all that is somehow encouraging to our community. There is more activity. So there are lots of spin-offs.”
“This program highlights rural health care. It puts us on the map. It increases the radar for where we are and what we do and how we do it, what we have to work with. As well, these students, when they come into our communities they make friends with the young people in the community. They therefore form connections, rural-city connections. It increases social opportunities for our own local young people because you know, you add five or six or seven young people to a community this size and that’s like a huge infusion of new blood! You know, it’s extra hands to help at community events, particularly in summer, not as much of that in the winter, but goodness they didn’t seem to lack social opportunities”.

Another benefit to the community was the interaction the student teams had with youth in the local school system and recreational functions. Again, while not an anticipated benefit, the IRPbc students served as role models for the young people of the area. Communities indicate this may encourage young people from the area to enter health professions in the future.

“They were very successful in putting a positive image over to the community. They went out, as a group, and attended almost every community function that happened over the summer. They presented themselves in a very positive way and the community knew who they were. So this is very good: the community seeing these students and recognizing that they will be their health care providers in the very near future. So I think it had a, a two-way impact. Both on the students but also on the community – making the community aware. It’s also a connection for students in Bella Coola to see role models very close to the level that they’re in. It was good.”

It is fitting to end this with a comment from a rural health care administrator who summarizes the biggest benefit of IPRbc to her community.

“Rural Canada, rural BC has to compete with urban Canada, urban BC for some very bright people and, of course, we don’t just want anybody, we want people that are skilled. By bringing the kind of mature students that tend to get placed, and if we succeed in interesting them in working in a rural setting that is a huge benefit… for future recruitment”.

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