rural academic health project

APPENDICES

1. Literature Synthesis
2. Inventory of Initiatives
3. Draft Discussion Paper
4. Provincial Consultation Summary
5. Draft Handbook
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BC Rural Academic Health Project

*Literature Synthesis*

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For further information see [www.health-disciplines.ubc.ca](http://www.health-disciplines.ubc.ca)
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INTRODUCTION

This discussion paper synthesises literature related to rural academic health and rural student placements/practice education. It is designed to assist in the development of a model for rural academic health across British Columbia. Three key statements are explored:

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

Interprofessional, community-oriented education is seen as an important strategy for achieving health for all (Barr, 2000). There has been a movement during the last 25 years for educational reform in the health sciences towards a person-centred, population-based model (Doyle et al., 1998). This literature review synthesizes the knowledge that has come from the rural academic health models that have been a part of this movement. The literature reviewed is international and multidisciplinary, from three key jurisdictions: Canada, the United States and Australia, as the developed countries that have shown the most interest in interprofessional education for health care professionals (Barr, 2000), all facing similar challenges regarding rural health (VanLeit, 2005).
DEFINITIONS

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

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

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

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

Interprofessional Education
When two or more professions, learn with, from and about one another in order to improve collaboration and the quality of care. (Centre for Advanced Interprofessional Education, 1997)
I. An integrated, interprofessional rural academic health setting brings benefit to communities and to learners across health professions.

Most healthcare providers, educators and administrators now agree that interprofessional education is a worthwhile, and even necessary endeavour (Stone, 2006). The increased importance of interprofessional education in rural settings is well documented (Dalton et al., 2003; Faresjo, 2006; Fertman et al., 2005; Geller et al., 2002; Marek, 2003; Shannon et al., 2005; Slack et al., 2002; Stone, 2006). An integrated, interprofessional academic health setting provides training experiences for students, encouraging them to practice in rural communities, while responding to the needs of the participating rural community (Slack et al., 2002). Evaluations of interprofessional rural programs document a range of benefits to stakeholders.

BENEFITS TO COMMUNITIES

1. Recruitment and Retention

Interprofessional rural programs are essentially designed to address issues surrounding the recruitment and retention of healthcare practitioners in rural areas. There is increasing evidence from Canada, the US, and Australia that training programs located in rural areas are more likely to produce healthcare practitioners who are interested in and willing to practise in rural areas (Collins et al., 1993; Faresjo, 2006; Pong & Russell, 2003; Slack & McEwen, 1993; Tippets & Westpheling, 1996). In Australia, rural placements have strengthened health students’ intentions to work in rural health settings after graduation (Faresjo, 2006). According to Faresjo (2006), interprofessional practice is as relevant to the Canadian context as it is to the Australian one. According to Rourke (2005), the likelihood of a graduate choosing rural practice is related to the length of the rural learning experience.

2. Capacity Building

Through the development of adequate infrastructure, interprofessional rural programs have the ability to increase a community’s capacity for supporting their own healthcare system. Adequate infrastructure is identified as a key factor in:

- Attracting healthcare practitioners to rural areas;
- Helping rural communities provide effective healthcare;
- And reducing the isolation of rural practitioners (Geller et al., 2002; Lawson et al., 2000; Mareck, 2003).

According to Goodrow and Meyers (2000), interprofessional rural programs develop action-oriented community infrastructure. The New Mexico Rural Health Interdisciplinary Program (Geller et al., 2002), the University Departments of Rural Health (Lawson et al., 2000) and the
Minnesota Rural Health School (Mareck, 2003) benefited communities by bringing infrastructure such as:

- Telecommunications technologies;
- Computer equipment;
- Medical equipment;
- Educational sessions;
- And libraries.

Programs in Canada have identified the importance of IT in facilitating learning, practice, and collaboration in remote areas (Kondro, 2006; Tesson et al., 2005; Whiteside & Newbery, 1997).

In addition to infrastructure, interprofessional rural programs have been found to expand human capital within communities:

- Promoting leadership skills among local residents (Goodrow & Meyers, 2002);
- Providing opportunities for local residents to develop professionally in a way they wouldn’t have been able to otherwise (Lawson et al., 2000);
- And improving Indigenous communities’ access to careers in healthcare (Lawson et al., 2000).

3. Community Empowerment

Goodrow and Meyers (2002) found that the development of infrastructure and human capital enable rural communities to become empowered and self-sufficient. In Del Rio, through the Graduate Health Professions Education Program, suspicion, feelings of frustration and powerlessness have given way to an empowered community that has the commitment, resources and ability to help themselves meet their own healthcare needs. Slack et al. (2002) found US interdisciplinary training programs helped disadvantaged clients develop increased self-efficacy, resulting in improved health.

4. Improved Rural Health

The presence of rural health training programs that collaborate closely with communities has improved the health status of patient populations within communities (Geller et al., 2002). Collaborative programs improve communication between health professionals and communities, further improving health outcomes for patients by fostering a multi-dimensional healthcare approach (VanLeit, 2005). Interprofessional, community-based models have been found to be effective in improving patient outcomes, increasing patient satisfaction, and decreasing health care costs (Jensen & Royeen, 2002). Rural interdisciplinary programs also reduce the health differentials between rural and non-rural communities, as well as between Indigenous and non-indigenous peoples (Lawson et al., 2000).

5. Meeting complex needs of rural communities

Interdisciplinary training programs also appear to respond well to the diversity of rural communities (Slack et al., 2002). Faced with distance from urban tertiary hospitals and limited numbers, healthcare workers, through interdisciplinary collaboration, are able to effectively address the complex, multifaceted health needs of individuals in rural communities. They do so by creating solutions to health care problems that transcend conventional, discipline-specific methods, procedures, and techniques (Fertman et al., 2005).

6. Cost Effective

It is more important than ever for healthcare professionals to work together in order to meet the increasingly complex needs of patients in rural and remote areas, where available healthcare resources are sparse (Faresjo, 2006). Interprofessional rural training programs provide efficient and cost-effective patient care (Mareck, 2003) and increase the ability of the community to
maximally use the knowledge and skills of all providers (Slack et al., 2002). Communities that recognize the cost effectiveness of rural health education programs are often willing to provide financial support to students (Worley et al., 2000).

BENEFITS TO STUDENTS

Although measuring changes in skills, knowledge and attitudes is a notoriously complex issue (Stone et al., 2002), numerous benefits to students have been reported as a result of interprofessional rural training programs. The literature supports the findings of the Vancouver Island Interprofessional Education Project (http://nursing.uvic.ca/iep/), which describes the benefits to students to be fourfold: Knowledge, Skills, Attitudes, and Behaviour.

1. Knowledge

Evaluations of students’ that participated in interprofessional rural training programs showed increases in the knowledge of:

- The roles of other health professionals (Stone et al., 2002).
- At least one rural health issue, such as high rates of diabetes faced by rural aboriginal communities (Fertman et al., 2005);
- And issues faced by the elderly due to isolation (Dalton et al., 2003);

Enabling them to:

- Work as part of a multidisciplinary team (Stone et al., 2002);
- Have a greater respect for the contribution of other health care professionals (Slack et al., 2002);
- And understand the importance of working collaboratively to achieve optimal health outcomes in rural areas (Dalton et al., 2003)

Stone et al. (2002) also found that students participating in such programs felt practitioners of other professions understood them, giving them greater confidence in interacting with other professions.

2. Skills

Many countries have identified interprofessional education programs as a means to help students prepare for rural healthcare practice by enabling them to develop the skills needed for rural health practice (VanLeit, 2005). According to Dalton et al. (2003), healthcare professionals working in rural settings need to be:

- Adaptable, in order to meet the varied demands of a rural community;
- And share similar goals with other healthcare professionals.

According to Stone et al. (2002), the ability to work as part of a multidisciplinary team is the quality most needed to effectively provide healthcare in a rural setting. Faresjo (2006) identifies interprofessional competencies as:

- The ability to cooperate with other professions;
- And knowledge and understanding of the importance, functions and roles of other professional groups.

An interprofessional education builds healthcare practitioners capacity for effective teamwork, improving the quality of the healthcare they provide as well as the sustainability of rural healthcare (Stone et al., 2002). Those that have acquired rural-relevant skills and have established social and professional connections, through extensive rural exposure, are also much more comfortable working in rural areas (Pong &
Russell, 2003). A practitioner is unlikely to choose rural medicine unless they are comfortable in a rural setting (Hutton-Czapski, 1998).

3. Attitudes

By demystifying rural primary healthcare practice (Stone et al., 2002), participation in rural training programs has been found to change students’ attitudes related to rural areas, including:

- Increased perceptions of social responsibility affect students’ intentions to work in a rural setting after graduation (Potts, 1994; Shannon et al., 2005);
- And more favourable attitudes towards rural practice (Pathman & Riggins, 1996).

4. Behaviour

Behavioural changes in students related to participation in rural practice and collaboration with other healthcare professionals have been noted throughout the literature (Fertman et al., 2005; Geller et al., 2002; Lawson et al., 2000; Parboosingh, 2003). Confidence to undertake such activities has been identified as a key factor in behavioural changes (Fertman et al., 2005; Geller et al., 2002). Participation in interprofessional rural programs has also affected students’ research interests, causing them to be more community-oriented (Lawson et al., 2000). In some cases, although students have not gone on to practice in a rural setting, program have influenced them to go into family practice, rather than specializing (Parboosingh, 2003).

BENEFITS TO OTHER STAKEHOLDERS

While interprofessional rural training programs aim to benefit communities and students, benefits to other stakeholders have been found.

1. Faculty

Through participation in rural training programs, interaction with students, and interprofessional collaboration, faculty have:

- Broadened their own research skills (Doyle et al., 1998);
- Developed their expertise related to rural health issues (Slack et al., 2002); and,
- Expanded to include graduates from rural programs who become faculty and offer expertise in rural health (Slack et al., 2002).

2. Rural Practitioners

Interprofessional rural training programs have also been found to benefit existing rural practitioners by:

- Producing additional appropriately trained rural healthcare workers, reducing burnout issues among existing practitioners (Hutton-Czapski, 1998);
- Providing practising rural healthcare workers with the opportunity to upgrade existing skills or gain new skills to meet the needs of their rural community (Pong & Russell, 2003; Wilson et al., 1998);
- Reducing the isolation of practitioners by providing a venue for rural providers to access the expertise of the associated academic institution (Slack et al., 2002); and,
- Fostering respect for rural practitioners (Worley et al., 2000).

3. Urban Practitioners

The presence of rural training has also been found to benefit urban areas through the:
- Promotion of networking between urban and rural providers (Slack et al., 2002);
- Development of a body of knowledge about rural health and the development of expertise in rural health (Slack et al., 2002);
- Creation of urban practitioners with rural experience that are available for consultation or referral, providing care that is more likely to be appropriate to rural residents (Slack et al., 2002); and,
- Availability of education, training and professional support for city-based health workers interested in continuing their professional development (Lawson et al., 2000).
II. Rural academic health approaches increase placement capacity and provide quality practice education.

It has become increasingly difficult for many schools to provide adequate clinical exposure for healthcare students at urban tertiary teaching hospitals. The clinical caseload of these hospitals has been contracting both in terms of the length of stay of inpatients and the range of cases suitable for, and accessible to, students (Worley et al., 2000). In addition, there have been repeated calls for schools to educate healthcare professionals with appropriate skills for rural practice (Pong & Russell, 2003). Rural academic health programs have been found to increase both placement capacity and the number of graduates with the skills necessary for practice in a rural setting.

INCREASED PLACEMENT CAPACITY

Around the world, interprofessional rural programs have contributed to gains in rural placements:

- The Interdisciplinary Rural Placement Program at the University of Tasmania has increased the number of undergraduate nursing, medical and pharmacy students undertaking clinical experiences in rural areas (Dalton et al., 2003);
- The New Mexico Rural Health Interdisciplinary Program has grown from 11 to 64 students per year, from five to 12 disciplines, and from 1 to 6 regional sites encompassing 12 communities throughout New Mexico (Geller et al., 2002);
- The Graduate Health Professions Education program in Del Rio has increased the number of opportunities for interdisciplinary clinical experience in a community setting (Goodrow & Meyers, 2000).

Increased rural placements in Canada, noted in the literature, have primarily been attributed to medical school initiatives:

- Memorial University has utilized the geographic characteristics of Newfoundland to train a large percentage their healthcare students in a rural setting (Tesson et al., 2005);
- The Family Medicine North Program (NOMP-FM) and the North-eastern Ontario Family Medicine Program (NOFM) have graduated over 200 family physicians with experience in a rural setting (Rourke, 2002);
- The Department of Family Practice at UBC has produced 91 physicians capable of practising competently in rural Canada¹ (Whiteside & Newbery, 1997);

¹ While other mono-disciplinary and interprofessional programs exist in Canada, the literature on these programs does not refer specifically to increases in placement capacity associated with them.
² Since its inception, the Rural Residency Program has graduated 196 residents through 17 rural community training sites and 6 regional sites around BC (http://www.familymed.ubc.ca/rural/).
- The **Rural Physician Action Plan** in Alberta has dramatically increased the number of students with experience in a rural setting, the depth of this experience, as well as number of communities affected:
  - 95% of Alberta medical students now gain experience in rural areas;
  - The number of family medicine residents doing rural rotations has doubled;
  - The length of experiences in rural practices has increased fourfold;
  - Third-year special-skills training for rural practice has expanded greatly;
  - An increasing number of participants (26 to 49) have gone on to enter rural practice;
  - More than 30 rural Alberta communities have benefited from the training of medical students and family medicine residents (Moores et al., 1998; Wilson et al., 1998).

As a result of the medical training offered in rural Canada, 99 of 684 first-year family medicine residents and 567 of 702 second year residents did some training in a rural practice (Rourke & Rourke, 1995).

## Sustainability

An important factor in sustaining these placements is student interest in participating. The increasing availability of these positions has not been matched by an increase in student interest (Topps et al., 2002). The number of postgraduate rural family medicine training stream positions in Canada has been increased, yet in 2001 and 2002 a significant number were unfilled (Rourke, 2002). Several factors have been identified as important in fostering student interest in rural placements:

1. **Faculty interest**

   According to Geller et al. (2002), having dedicated core faculty is essential. Student participation has been found to be tied to faculty leadership (Fertman et al., 2005). The **Western Maryland Area Health Education Center** accomplished this by bringing faculty together at annual workshops, creating an interdisciplinary group of allied health professionals to champion the implementation of the program within their own departments. These workshops encouraged faculty to become advocates for community-based rural experiences and to develop rural contracts and community partners for further training (Fertman et al., 2005).

2. **Community liaison**

   Geller et al. (2002) also identified the need to cultivate community relationships and support, recommending a paid community liaison or coordinator to facilitate student transition from the university setting to the local community. According to Fertman et al. (2005), a liaison can be beneficial in:
   - Recruiting both students and faculty;
   - Guiding curriculum development;
   - Facilitating community involvement;
   - And arranging logistical details (e.g., housing, meals, and transportation).

3. **Scheduling**

   One of the biggest problems in attracting students identified in the literature is scheduling (Fertman et al., 2005; Geller et al., 2002; Mareck, 2003; Dalton et al., 2003). Student participation has been tied to a program’s ability to integrate training
into their academic programs, by considering differences in schedules, course sequences, and individual program enrolments (Fertman et al., 2005). Proposed solution include:

- Ensuring students are fulfilling discipline-specific requirements while participating (Geller et al., 2002);
- Creating paid internships for certain disciplines (Geller et al., 2002);
- Implementing shorter sessions targeting specific topics (Mareck, 2003);
- Enabling students to undertake rural placements as an integrated part of their undergraduate courses (Dalton et al., 2003);
- And letting individual departments determine how credits for rural placements are assigned (i.e. academic credit or as a special project in an existing course) (Fertman et al., 2005).

4. Funding

The need for adequate funds to support students is also apparent. Transportation to rural sites, student housing within rural sites, and financial management are essential (Jensen & Royeen, 2002). Stipends allow and entice student participation (Geller et al., 2002). Orloff & Tymann (1996) identified tuition payment programs as a primary strategy to promote practice in rural communities. According to Hutton-Czapski (1998), additional monies of at least 10% of medical school and residency budgets need to be directed at training rural physicians, as training more doctors won’t help if they train to become urban specialists or urban family physicians. While federal funding is important in getting programs started, ongoing, sustainable mechanisms to fund community-centred care is necessary (Jensen & Royeen, 2002). Scholarships allow remote practitioners to study and offer more support for Indigenous and remote students (Lawson et al., 2000). According to VanLeit (2005), among the most effective interventions to increase willingness to go to rural areas are: funded student scholarships with obligations, and financial incentives.

5. An Early-Start

Encouraging students, especially rural students, to take an interest in rural health needs to be done early. According to Dalton et al. (2003), it is essential that students experience interdisciplinary teamwork at the undergraduate level. There is an increasing recognition of the importance of encouraging rural high school students to pursue a career in rural medicine. Students already participating in rural programs can help by visiting community high schools during their placement within the community (Pong & Russell, 2003). In Manitoba the situation related to rural health is better than in other provinces, in part due to guidance counsellors promoting rural medicine as a career choice to rural high school students and several “rural experience” programs for medical students that start in the first year (Hutton-Czapski, 1998). A key recommendation out of the Southwestern Ontario Rural Medicine Education program involves providing earlier and more extensive rural medicine experience for all undergraduate medical students (Rourke, 2000).

QUALITY PRACTICE EDUCATION

Students that do choose rural placements receive quality practice education that will benefit them whether or not they choose to practice in a rural setting upon graduation. An interdisciplinary curriculum has been found to complement discipline specific training (Slack et al., 2002). Mono-professional learning can create a hierarchy within the health care system, territorial disputes
and competition, preventing effective collaboration and reducing the response to consumer needs (Stone et al., 2002), while an interdisciplinary health education fosters collaboration and respect among healthcare practitioners. However, the literature indicates both interprofessional and mono-professional programs provide quality practice education when undertaken in a rural setting (Worley et al., 2000; Kondro, 2006). According to Worley et al. (2000), student who participate in rural placements benefit from:

- Following patients from diagnosis in the clinic through to hospital management and subsequent recovery at home or rehabilitation in the community;
- Longitudinal exposure to common diseases;
- Improved academic performance in comparison with that of their tertiary hospital peers’ and in comparison to their own results in previous years;
- Learning clinical decision making skills in the context of the whole patient, their family, and the available community resources;
- And development of a high level of competence in procedural skills and an increased confidence with patients.

Canada’s “distributive learning model”, which sees medical undergraduate students training at 11 “satellite learning centres” associated with 7 of the nation’s 17 established medical schools, will allow students to benefit from exposure to a broader range of patients at smaller regional facilities than those now trained in major acute care facilities in larger centres (Kondro, 2006).
III. Partnerships between rural communities, health authorities and post secondary education organizations demonstrate best practices in education, research, and service and provide a powerful model for improving rural health.

There is a definite urban bias in most medical schools across Canada: rural students are not equally represented; the majority of Canadians accepted into medical schools have grown up in an urban area; most medical training takes place in an urban setting; and training is primarily provided by physician-educators from urban areas (Barer & Stoddart, 1999). Hutton-Czapski (1998) criticizes teaching programs for turning out physicians modelled after big city medicine. University-community partnerships help to overcome this bias. Involving communities in decisions about student experiences in and out of hospital settings and modifying traditional institutional policies has created educational change (Henry, 1996). Not only does community involvement foster programs that produce practitioners better able to practice in rural areas, campus-community partnerships provide experiential, multidisciplinary education (Goodrow & Meyers, 2000). The literature identifies several key factors necessary for creating a successful partnership:

1. Involvement of many stakeholders

According to VanLeit (2005), there must be as many people as possible from all aspects of the community involved in rural training programs. This can enable alternative actions and available resources to be explored (Goodrow & Meyers, 2000). Potential stakeholders include: program staff, faculty, students, university and area health education centre administrators, community health providers, funders, and consumers living in rural communities. These stakeholders need to be unified by developing common goals, objectives, and desired outcomes (Fertman et al., 2005).

2. Common Goals

Common objectives have been sited as instrumental to the effectiveness of university-community partnerships (Goodrow & Meyers, 2000). Programs that share mutual goals with the community, such as those of recruitment and retention of healthcare providers, may attract the support of potential stakeholders within the community (Geller et al., 2002). Smaller communities that typically have the greatest health professional recruitment needs are often the most supportive of programs with a shared objective. However, the community must be large enough to provide adequate student fieldwork assignments. A regional approach, incorporating several towns in one team can make this possible (Geller et al., 2002).

3. Mutually beneficial

Successful partnerships must also be mutually beneficial. Student activities should provide needed services to community residents as well as increase the skills of the students (Slack et al., 2002). Interdisciplinary models should allow for students and faculty to provide valuable services to communities as they learn about relationship-
centred care that is personal, professional, and community sensitive (Jensen & Royeen, 2002).

4. **Degree of community involvement**

There is significant evidence in the literature that students benefit from a high degree of community interaction (Goodrow & Meyers, 2000; Fertman et al., 2005). Students tend to feel welcome in a community when they sense community investment in their program. The investment of community resources can be garnered through meetings with regional hospital CEOs, healthcare providers, public school officials, city leaders and representatives of community groups, often leading to program expansion (Geller et al., 2002).

5. **Empowerment of communities**

It is important when implementing rural training programs that communities do not feel like outsiders are coming in to serve their own interests (Goodrow & Meyers, 2000). Programs need to give communities an empowering leadership role. Giving up some control and power while gaining community support is a trade-off many university-community partnerships embrace (Henry, 1996). According to Baum (1999), a sense of community ownership or involvement in developing and implementing changes to healthcare services will sustain structural changes.

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**BEST PRACTICE**

According to Jensen & Royeen (2002), best practice is ensured through university-community partnerships, as academic institutions build meaningful authentic connections with rural communities by working together to meet community needs, while demonstrating sensitivity and respect for cultural perspectives. As a ‘best practice’ interprofessional practice is related to socio-cultural beliefs and attitudes; therefore, it is imperative that education take place in the community in which care is to be provided (Faresjo, 2006). Operational pieces such as transportation to rural sites; housing for students within rural sites; financial management; student tracking; and overall supervision of project staff and management and general project operations are essential to rural training programs. These do not insure best practice but are required to be in place in order to achieve it (Jensen & Royeen, 2002).

**Models that demonstrate best practice**

**Australia**

*University Departments of Rural Health* (Lawson et al., 2000)

- Program entails 4-6 week rural placements for undergraduate healthcare students;
- Activities include research, development, facilitation and advocacy;
- Residential accommodation for students is provided;
- Participants are supported by IT, videoconferencing and journals;
- Both activities and staff are strongly multidisciplinary;
- They are also multi-level, undertaking activities at all stages of education and practice;
- The program is collaborative, emphasising partnerships with multiple universities, rural
health organizations and services, local healthcare providers, and the community.

The Rural Interprofessional Education Project (Stone et al., 2002)
- Program consists of 2-week clinical placements in a rural primary healthcare setting;
- Includes clinical observation, interaction with patients and working with a primary healthcare team;
- Emphasises learning the principles and diverse realities of interprofessional practice through observation and participation;
- Students are from medical, nursing, pharmacy, and physiotherapy schools;
- Each student pair has two co-preceptors, one from each relevant discipline;
- Students also participate in tutorials at a regional site, facilitated by local health professionals with the support of learning packages;
- Students are encouraged to gain experience with ambulance, hospital, palliative care, hospital-in-the-home, community mental health, shire services and allied health services;
- Students accompany healthcare professionals on home visits, observe and participate in team-working activities and reflect on this interprofessional practice.

USA
The Western Maryland Area Health Education Center (Fertman et al., 2005)
- Utilizes four training venues: in-class instruction, Web-based modules, service-learning programs, and faculty development workshops;
- Implementation of the courses required the identification of a faculty liaison in each of the targeted programs at participating campuses to recruit students and to gain approval for the course within the specific program;
- Web-based modules are integrated into pre-existing courses, allowing these modules to reach far more students than separate interdisciplinary elective courses in degree programs where students have little or no room for electives;
- Rural interdisciplinary health promotion service-learning training offered in a rural location twice a year;
- Annual workshops, bringing faculty together served to generate interest for interdisciplinary team training and integrating it into departmental programs;
- A basic tenet of the model was that teams have context, structure, process, and outcomes.

Del Rio and East Tennessee State University Partnership – Graduate Health Professions Education (Goodrow & Meyers, 2000)
- Program was developed in response to concern over accessing primary care and an issue of a water born disease;
- An interdisciplinary team of health professions students and faculty worked with community leaders and residents to develop leadership skills, enhance infrastructure, and coordinate efforts to address health concerns;
- Students traveled to the community for one day per week for 12 months and also attended other community events on evenings and weekends;
- The depth and duration of student presence was a key element in the success of the project;
- Control of the program originated in and was sustained within the Del Rio community;
- Community partners were offered training in communication skills, meeting conduct,
conflict avoidance and compromise development.

The New Mexico Rural Health Interdisciplinary Program (Geller et al., 2002)
- Utilizes student-centred problem-based learning (PBL);
- Involving 12 healthcare disciplines in six communities throughout the state: medicine, physical therapy, nurse practitioner/nurse midwife, pharmacy, respiratory therapy, dental hygiene, medical laboratory science, occupational therapy, masters in public health, bachelors and associate degree nursing, social work, physician assistant and speech-language pathology;
- Students are at different points in curricula of varying lengths;
- Recruitment occurs in the fall, November orientation outlines program logistics and expectations;
- January – March teams meet weekly on campus with faculty facilitators in PBL tutorials;
- April orientation is held to introduce students to preceptors and the community;
- June and July off-campus rural component (Students resume meeting weekly);
- Uses a paid community liaison;
- E-mail and computer link-ups to library resources are used.

Canada

Alberta’s Rural Physician Action Plan (Wilson et al., 1998)
- Comprehensive, integrated and sustained program;
- Involves the participation of key stakeholders including government, the provincial medical association, the licensing authority, faculties of medicine, practising rural physicians and regional health authorities;
- Cooperative and collaborative, integrated and comprehensive with initiatives aimed at several groups;
- Programs include rural rotations for medical students, rural experience during postgraduate training, special skills training for rural practice, and student loan remission program;
- Also offers programs for practising rural physicians: expanded continuing education program, enrichment program providing practitioners with the opportunity to upgrade existing skills, and rural locum programs.

The Northern Ontario Rural Medical School (Rourke, 2002)
- A collaborative partnership between Laurentian University, Sudbury and Lakehead University, Thunder Bay;
- Patient-centred;
- Clinical problem-based;
- Systems-organized;
- Health determinant focus;
- Aboriginal health content and context;
- Small group learning;
- Distributed learning network;
- Advanced IT support.

Memorial University, Newfoundland (Tesson et al., 2005).
- Uses the geographic characteristics of Newfoundland;
- 16 week family medicine rotation;
- Electives available in isolated areas;
- Housing provided (some for couples and family);
- Based on four principles: family physicians must be skilled clinicians, family medicine is a community-based discipline, family physicians are a resource to a defined practice population, doctor-patient relationships are central to the role of the family physician.
Distributive Learning Model (Kondro, 2006; Whiteside & Newbery, 1997)
- Medical undergraduate training at 11 “satellite learning centres” associated with 7 of the nation’s 17 established medical schools;
- Uses off-site instruction with an emphasis on local needs;
- UBC opted to distribute the entire package, from basic to clinical, in partnership with Universities of Victoria and Northern BC, using its existing case-based curricula;
- UBC aims to meet the specific medial special-skills needs as identified by rural communities;
- The UBC department of Family Practice has financially supported Internet access for rural doctors and residents who are involved in the UBC training program;
- They are committed to delivering relevant, cost-effective and appropriate CME teleconferences to rural doctors and their allied health care colleagues;
- They also aim to provide community-based research.

Interprofessional Rural Program of British Columbia (Charles et al., 2006)
- Placements lasted four to 12 weeks;
- Participating disciplines: nursing, social work, medicine, physical therapy, occupational therapy, pharmaceutical sciences, speech language pathology, audiology, laboratory technology, and counselling psychology;
- Preceptors in the communities had the opportunity to receive training;
- Members of the implementation team visited participating communities to meet key stakeholders;
- A two day student orientation was conducted at UBC;
- Students were required to complete a number of assignments meant to facilitate the acquisition of interprofessional skills and attitudes;
- Students were also engaged in weekly case presentations or clinical rounds with their interprofessional team;
- Student shadowed at least two other students and/or healthcare professionals from a profession other than their own for at least two hours during the course of the placement.

CONCLUSION
Financial and related incentives are the strategies most often recommended and used in dealing with rural health workforce problems (Pong & Russell, 2003). However, there appears to be a growing awareness that rural health workforce problems are complex and must be dealt with using a multi-dimensional approach. Only a fraction of what could be done in this area of educational strategies is currently being done. Education programs remain a potentially fruitful, yet not fully exploited, policy route. According to Barer & Stoddart (1999), it is important not to approach ‘educational initiatives’ from too narrow or traditional a framework, as such initiatives offer a great deal of room for creativity and innovation.

REFERENCES


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<tr>
<th>Initiative</th>
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<tr>
<td>Aboriginal Community Based Nursing Preceptorship Curriculum Development</td>
<td><a href="http://www.health.gov.bc.ca/ndirect/ab_summary_0203_0506.html">http://www.health.gov.bc.ca/ndirect/ab_summary_0203_0506.html</a></td>
<td>To create an Aboriginal Preceptorship Program Manual, Aboriginal Community Health Module and materials for a 2 day Aboriginal Community Based Preceptor Training gathering.</td>
<td>Nursing Directorate, Ministry of Health, 250-952-3596</td>
<td>UBC Institute for Aboriginal Health, UBC School of Nursing, UBC College of Health, Disciplines, Aboriginal Nurses Association of Canada</td>
<td>Ministry of Health, Aboriginal Nursing Initiative</td>
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<tr>
<td>Aboriginal Community Based Nursing Preceptorship Program</td>
<td><a href="http://www.health.gov.bc.ca/ndirect/ab_summary_0203_0506.html">http://www.health.gov.bc.ca/ndirect/ab_summary_0203_0506.html</a></td>
<td>To give nursing students the opportunity to take part in an Aboriginal preceptorship program</td>
<td>Nursing Directorate, Ministry of Health, 250-952-3596</td>
<td>UBC Institute for Aboriginal Health, UBC School of Nursing, Aboriginal Nurses Association of Canada, UBC First Nations House, UBC College of Health Disciplines</td>
<td>Ministry of Health, Aboriginal Nursing Initiative</td>
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<td>Aboriginal health/cultural safety</td>
<td><a href="http://www2.news.gov.bc.ca/nm_news_releases/2004MAE0228-0000424-Attachment1.htm">http://www2.news.gov.bc.ca/nm_news_releases/2004MAE0228-0000424-Attachment1.htm</a></td>
<td>An online course for nurses, social workers and teachers to enable them to be able to respond effectively to the needs of aboriginal people.</td>
<td>University of Victoria, University College of the Cariboo</td>
<td>University of Victoria, University College of the Cariboo</td>
<td>Ministry of Health, Aboriginal Nursing Initiative</td>
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<td>Aboriginal Nursing Initiative</td>
<td><a href="http://www.health.gov.bc.ca/ndirect/ab_summary_0203_0506.html">http://www.health.gov.bc.ca/ndirect/ab_summary_0203_0506.html</a></td>
<td>To increase the number of nurses of Aboriginal ancestry graduating and working in Aboriginal communities in BC.</td>
<td>Nursing Directorate, Ministry of Health, 250-952-3596</td>
<td>Ministry of Health, Aboriginal Nursing Initiative</td>
<td>Ministry of Health, Aboriginal Nursing Initiative</td>
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<tr>
<td>Aboriginal Nursing Recruitment Strategy</td>
<td><a href="http://www.health.gov.bc.ca/ndirect/ab_summary_0203_0506.html">http://www.health.gov.bc.ca/ndirect/ab_summary_0203_0506.html</a></td>
<td>To create a marketing plan to encourage Aboriginal Students in Grade 10-12 to explore nursing as a career choice.</td>
<td>Nursing Directorate, Ministry of Health, 250-952-3596</td>
<td>World Native Human Resources Development, University College of the Fraser Valley, SNHRD Employment Services, School District 33</td>
<td>Ministry of Health, Aboriginal Nursing Initiative</td>
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<tr>
<td>Additional funding for speech-language pathology, physical therapy and occupational therapy in rural areas</td>
<td><a href="http://ip.med.ubc.ca/AssetFactory.aspx?id=2044">http://ip.med.ubc.ca/AssetFactory.aspx?id=2044</a></td>
<td>To support students doing pediatric placements in rural areas.</td>
<td>Dianne Drynan</td>
<td><a href="mailto:ddrynan@interchange.ubc.ca">ddrynan@interchange.ubc.ca</a></td>
<td>Ministry of Children and Family Development</td>
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<tr>
<td>Advanced Maternity Fellowship for Rural Practitioners</td>
<td><a href="http://www.bcwomens.ca/NHR/onlyres/897E2EE7-9A25-4970-B54F-7A7D71E5EE/17581/AMCFF_Application1.pdf">http://www.bcwomens.ca/NHR/onlyres/897E2EE7-9A25-4970-B54F-7A7D71E5EE/17581/AMCFF_Application1.pdf</a></td>
<td>Provides practitioners working in maternity care in rural and small urban BC communities, from family physicians to registered nurses to midwives or other allied health care providers, with intensive training in advanced maternity skills.</td>
<td>Sharon Lou-Hing</td>
<td><a href="mailto:slouhing@cw.bc.ca">slouhing@cw.bc.ca</a></td>
<td>Women’s Hospital Foundation</td>
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<tr>
<td>Advanced Skills and Training for Rural Physicians</td>
<td><a href="http://www.healthservices.gov.bc.ca/pcb/pdf/reap.pdf">http://www.healthservices.gov.bc.ca/pcb/pdf/reap.pdf</a></td>
<td>Makes funding available to increase educational opportunities for rural physicians.</td>
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<td>BCMA, REAP</td>
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</table>

Notes

Aboriginal Nursing Recruitment Strategy

To create a marketing plan to encourage Aboriginal Students in Grade 10-12 to explore nursing as a career choice.

Nursing Directorate, Ministry of Health, 250-952-3596

World Native Human Resources Development, University College of the Fraser Valley, SNHRD Employment Services, School District 33

Funding

Ministry of Health, Aboriginal Nursing Initiative

Additional funding for speech-language pathology, physical therapy and occupational therapy in rural areas

To support students doing pediatric placements in rural areas.

Dianne Drynan

ddrynan@interchange.ubc.ca

Ministry of Children and Family Development

Advanced Maternity Fellowship for Rural Practitioners

Provides practitioners working in maternity care in rural and small urban BC communities, from family physicians to registered nurses to midwives or other allied health care providers, with intensive training in advanced maternity skills.

Sharon Lou-Hing

slouhing@cw.bc.ca

Women’s Hospital Foundation

Advanced Skills and Training for Rural Physicians

Makes funding available to increase educational opportunities for rural physicians.

BCMA, REAP
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<th>Initiative</th>
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<tr>
<td>Bachelor of Social Work Program, UNBC</td>
<td>[<a href="http://www.unbc.ca/calendar/undergraduate/undergraduate">http://www.unbc.ca/calendar/undergraduate/undergraduate</a> programs/social_work.html](<a href="http://www.unbc.ca/calendar/undergraduate/undergraduate">http://www.unbc.ca/calendar/undergraduate/undergraduate</a> programs/social_work.html)</td>
<td>To prepare students for beginning level generalized social work practice with an emphasis on Social Work in northern and remote areas, First Nations, women and the human services, and community practice and research</td>
<td>UNBC 250-960-5555</td>
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<td>BC Loan Forgiveness Program</td>
<td><a href="http://www.aved.gov.bc.ca/studentaid/repay/repaymentassistance/loanforgiveness.htm">http://www.aved.gov.bc.ca/studentaid/repay/repaymentassistance/loanforgiveness.htm</a></td>
<td>BC student loans are decreased by 1/3 per year and require one year return-in-service in an underserved community for each year of loan forgiveness</td>
<td>Rural and Remote Health Initiative</td>
<td>Ministry of Advanced Education</td>
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<td>BCRRHN Mentorship Program</td>
<td><a href="http://www.bcrrhn.ca/training-mentorship.html">http://www.bcrrhn.ca/training-mentorship.html</a></td>
<td>To help students and researchers new to rural and remote health connect with those who are more experienced in the field</td>
<td>Rachel Glasby <a href="mailto:rglasby@bcrrhn.ca">rglasby@bcrrhn.ca</a></td>
<td>Michael Smith Foundation for Health Research</td>
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<tr>
<td>British Columbia Rural and Remote Health Research Institute (BCRHRRI)</td>
<td><a href="http://www.unbc.ca/ruralhealth/index.html">http://www.unbc.ca/ruralhealth/index.html</a></td>
<td>To work towards improving the health of people in rural, remote and northern populations</td>
<td>University of Northern British Columbia 250-960-6350</td>
<td>BC Ministry of Health</td>
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<tr>
<td>British Columbia Rural and Remote Health Research Network (BCRHRRN)</td>
<td><a href="http://www.bcrrhn.ca">http://www.bcrrhn.ca</a></td>
<td>To ensure the rural and remote perspectives in health research are fully identified and addressed</td>
<td>Rachel Glasby <a href="mailto:rglasby@bcrrhn.ca">rglasby@bcrrhn.ca</a></td>
<td>Michael Smith Foundation for Health Research</td>
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<tr>
<td>Building Capacity for Aboriginal and Rural Health Education</td>
<td><a href="http://www.dickharris.ca/EN/91/52764">http://www.dickharris.ca/EN/91/52764</a></td>
<td>Will produce protocols and agreements for collaborative training of students by partner universities, shared curriculum and course material for undergrad and grad and continuous learning.</td>
<td>UNBC, Lakehead University, Northern Ontario School of Medicine, Memorial University</td>
<td>Public Health Agency of Canada</td>
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<tr>
<td>Canadian Association for Rural and Remote Nursing</td>
<td><a href="http://www.carm.com/index.htm">http://www.carm.com/index.htm</a></td>
<td>To advance this unique specialty of rural and remote nursing practice through recognition, research and education, and thereby influence rural and remote health policy.</td>
<td><a href="mailto:info@carm.com">info@carm.com</a></td>
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<tr>
<td>Certificate in Rural and Northern Nursing (UNBC)</td>
<td><a href="http://www.unbc.ca/calendar/certificates/nursing.html#rnn">http://www.unbc.ca/calendar/certificates/nursing.html#rnn</a></td>
<td>Offers experienced RNs the opportunity to pursue post- diploma Undergraduate studies through a concentrated program of courses in rural and northern nursing.</td>
<td>UNBC Prince George Campus 250-960-5555</td>
<td>Rural and Remote Health Initiative</td>
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<tr>
<td>Clinical Nursing Education: Directions for the Future in Rural and Northern Health Region</td>
<td><a href="http://www.health.gov.bc.ca/ndirect/cnac_projects.html">http://www.health.gov.bc.ca/ndirect/cnac_projects.html</a></td>
<td>A project to explore how nursing education could be designed and delivered in the Northern Health Authority, which includes remote site challenges.</td>
<td>Nursing Directorate, Ministry of Health, 250-952-3596</td>
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<td>Collaboration in First Nations' Health Through Interprofessional Training and Community Engagement</td>
<td><a href="http://www.bcahc.ca/BCAHC_page.asp?pageid=850">http://www.bcahc.ca/BCAHC_page.asp?pageid=850</a></td>
<td>Immersion course integrating Aboriginal health in two aboriginal communities aimed at increasing the number of opportunities for interprofessional and Aboriginal health education for students</td>
<td>Kendall Ho <a href="mailto:Kho@cpdit.ubc.ca">Kho@cpdit.ubc.ca</a></td>
<td>UBC</td>
<td>Ministry of Advanced Education and Health - Practice Education Innovation Fund</td>
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<tr>
<td>Connecting to Rural and First Nations Communities in British Columbia: Amplifying Access of Service and Education in Health</td>
<td><a href="http://www.cpdkt.ubc.ca/Research/Completed_Projects/Connecting_to_Rural_and_First_Nations_Communities_in_British_Columbia_Amplifying_Access_of_Service_and_Education_in_Health.html">http://www.cpdkt.ubc.ca/Research/Completed_Projects/Connecting_to_Rural_and_First_Nations_Communities_in_British_Columbia_Amplifying_Access_of_Service_and_Education_in_Health.html</a></td>
<td>Explores access to health services and education among British Columbia's rural and remote First Nations communities.</td>
<td>cmeresearch@come诗句ub.ca</td>
<td>UBC Division of Continuing Medical Education</td>
<td>UBC - TELUS Strategic Alliance</td>
</tr>
<tr>
<td>Continuing and specialty education for nurses</td>
<td><a href="https://www.healthservices.gov.bc.ca/ndirect/strategies.html">www.healthservices.gov.bc.ca/ndirect/strategies.html</a></td>
<td>Provides funding for skills upgrading for nurses, and supports certification of much needed nursing specialties such as intensive care units and emergency rooms.</td>
<td>250-952-3540</td>
<td>Ministry of Health</td>
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<td>Developing a Northern Rural Environment for Medical Student Integrated Core Clerkships</td>
<td><a href="http://www.bcahc.ca/BCAHC_page.asp?pageid=850">http://www.bcahc.ca/BCAHC_page.asp?pageid=850</a></td>
<td></td>
<td>David Snadden <a href="mailto:snadden@unbc.ca">snadden@unbc.ca</a></td>
<td>UBC, Northern Medical, NHA</td>
<td>Ministry of Advanced Education and Health - Practice Education Innovation Fund</td>
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BC Initiatives
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<tr>
<td>Feeling at Home – Integrating Health Sciences Students in Northern Communities</td>
<td><a href="http://www.bcahc.ca/BCAHISTORY_PAGE.asp?pageid=850">http://www.bcahc.ca/BCAHISTORY_PAGE.asp?pageid=850</a></td>
<td></td>
<td>Dr. Ian Blue <a href="mailto:blue@unbc.ca">blue@unbc.ca</a></td>
<td>UBC</td>
<td>Ministry of Advanced Education, Ministry of Health - Practice Education Innovation Fund</td>
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<tr>
<td>First Nations and Inuit Health Branch (FNHB)</td>
<td><a href="http://www.hc-sc.gc.ca/fnih-spn/index_e.html">http://www.hc-sc.gc.ca/fnih-spn/index_e.html</a></td>
<td></td>
<td>Assistant Deputy Minister’s Office First Nations and Inuit Health Branch <a href="mailto:fnihb-dgsprn@hc-sc.gc.ca">fnihb-dgsprn@hc-sc.gc.ca</a></td>
<td>Health Canada</td>
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<td>First Year Practice Enhancement (FYPEP)</td>
<td><a href="http://www.healthservices.gov.bc.ca/pdf/reap.pdf">http://www.healthservices.gov.bc.ca/pdf/reap.pdf</a></td>
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<td>BCMA</td>
<td>REAP</td>
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<tr>
<td>Funding and Advancing Health Promotion in Rural BC</td>
<td><a href="http://www.rural.gc.ca/team/bc/newsletter/no3_e.phtml">http://www.rural.gc.ca/team/bc/newsletter/no3_e.phtml</a></td>
<td>Working with community groups and agencies in different parts of BC to develop a framework and implementation strategy for funding community-inspired health promotion initiatives</td>
<td>1-888-781-2222.</td>
<td>Canadian Rural Partnership Pilot Project Initiative</td>
<td>Government of Canada</td>
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<tr>
<td>Graduate Training Program in Public Health and the Agricultural Rural Ecosystem</td>
<td><a href="http://www.chir-irsc.gc.ca/e/19995.html">http://www.chir-irsc.gc.ca/e/19995.html</a></td>
<td>Gathering the knowledge needed to address the challenges facing rural communities as they seek a healthy, safe and sustainable lifestyle.</td>
<td>Ethel Kirychuk, <a href="mailto:kirychuk@sask.usask.ca">kirychuk@sask.usask.ca</a>.</td>
<td>Public Health and Agricultural Ecosystem (PHARE), Institute of Infection and Immunity, CIHR Institutes Cancer Research, Circulatory and Respiratory Health, Population and Public Health</td>
<td>Canadian Institute of Health Research</td>
<td>X</td>
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<tr>
<td>Health Infostructure Support Program</td>
<td><a href="http://www.rural.gc.ca/annualreport2001/report_e.phtml#4">http://www.rural.gc.ca/annualreport2001/report_e.phtml#4</a></td>
<td>To support efforts to test and assess the use of new information technologies and applications through pilot projects in areas such as public health, health surveillance, pharma, First Nations health, homecare and telehealth.</td>
<td>Rural Secretariat Agriculture and Agri-Food Canada</td>
<td>Canadian Rural Partnership</td>
<td>Government of Canada</td>
<td>X</td>
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<tr>
<td>Health Match BC</td>
<td><a href="http://www.healthmatchbc.org">http://www.healthmatchbc.org</a></td>
<td>Assists health authorities in their efforts to recruit rural physicians and nurses throughout the province.</td>
<td>Ethel Davis, Director <a href="mailto:recruit@healthmatchbc.org">recruit@healthmatchbc.org</a> 604-736-5500</td>
<td>Rural and Remote Health Initiative</td>
<td>Government of British Columbia</td>
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<tr>
<td>HSPnet</td>
<td><a href="http://www.hspbc.net/">http://www.hspbc.net/</a></td>
<td>A web-enabled system for coordinating and streamlining clinical placements for health sciences students.</td>
<td>Theresa C. Roberts <a href="mailto:theresa@toroberts.com">theresa@toroberts.com</a></td>
<td>BC Ministry of Health</td>
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<tr>
<td>Innovations in Rural and Community Health Initiative</td>
<td><a href="http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2001/2001_06bk2_e.html">http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2001/2001_06bk2_e.html</a></td>
<td>Maximize beneficial health outcomes and promotes availability and integration of health services, with a special focus on rural Canadians, addressing key issues around home and community care, access to and affordability of drugs, and integration of service delivery.</td>
<td></td>
<td></td>
<td>Government of Canada</td>
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<tr>
<td>Interprofessional Rural Program of BC</td>
<td><a href="http://www.bcahc.ca/irpbc">http://www.bcahc.ca/irpbc</a></td>
<td>To expose students to rural practice and life in a small community and revitalize the work environment for health professionals who currently practice in rural communities.</td>
<td>Kathy Copeman-Stewart, Program Manager 230-2524 <a href="mailto:irpbc@bcahc.ca">irpbc@bcahc.ca</a></td>
<td>In-BC, UBC College of Health Disciplines</td>
<td>BCAHC</td>
<td>X</td>
</tr>
<tr>
<td>Island Medical Program (UVic)</td>
<td><a href="http://imp.uvic.ca/index.php">http://imp.uvic.ca/index.php</a></td>
<td>To increase the number of physicians in BC and encourage them to practice in less populous areas of the province.</td>
<td>Dr Judy Vestrup 250-519-1828</td>
<td>UBC Faculty of Medicine, Distributed Medical Education</td>
<td></td>
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<tr>
<td>Nation First Nations telehealth research project</td>
<td><a href="http://www.hc-sc.gc.ca/htf-fass/english/projects">www.hc-sc.gc.ca/htf-fass/english/projects</a>_</td>
<td>Studies how telehealth might improve the access to health services in rural, isolate communities.</td>
<td><a href="mailto:Emin_Gal_Grande@hc-sc.gc.ca">Emin_Gal_Grande@hc-sc.gc.ca</a></td>
<td></td>
<td>Health Canada Health Transition Fund</td>
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**BC Initiatives**
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<th>Initiative</th>
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<th>Special Populations</th>
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<th>National</th>
<th>International</th>
<th>Interprofessional</th>
<th>Notes</th>
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<td>Notes</td>
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<tr>
<td>Nursing Strategy 2005/2006</td>
<td><a href="http://www.healthservices.gov.bc.ca/rural/initiative.html">Link</a></td>
<td>To year human resources plan to provide training, recruitment and retention of nursing professionals in every area of the province.</td>
<td>Rural Health Medical Services Divisions Ministry of Health 250-952-1587 <a href="mailto:HLTH.RuralHealth@bc.gov.ca">HLTH.RuralHealth@bc.gov.ca</a></td>
<td>Rural and Remote Health Initiative</td>
<td>BC Ministry of Health</td>
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<td>Office of Nursing Services</td>
<td><a href="http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnhb-dgpsrns-bsi/index_e.html">Link</a></td>
<td>Plays a vital role in the delivery of health nursing services to First Nations communities in Canada</td>
<td>Nurse Recruitment Officer, BC 604 666-1625 First Nations and Inuit Health</td>
<td>Health Canada</td>
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<tr>
<td>Partnering in Community Health Research</td>
<td><a href="http://www.pchr.net/">Link</a></td>
<td>To foster research targeted at urgent local community health needs, strengthen the links between research and policy/practice, and promote inter-disciplinary health research</td>
<td>Faye Pedersen, Training Program Manager, Institute of Health Promotion Research UBC, <a href="mailto:pchr@interchange.ubc.ca">pchr@interchange.ubc.ca</a> 604 822-8275</td>
<td>Michael Smith Foundation for Health Research, CIHR</td>
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<tr>
<td>Patients First</td>
<td><a href="http://www.in-bc.ca/projects/pf.php">Link</a></td>
<td>To optimize the quality of care provided by interprofessional teams in northern BC.</td>
<td>Katrina Ludwig 250 649-7061 <a href="mailto:Katrina.ludwig@northernhealth.ca">Katrina.ludwig@northernhealth.ca</a> Northern Health, UNBC, Carrier Sekani Family Services, Central Interior Native Health Society, In-BC</td>
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<tr>
<td>Primary Clinical Nursing Program, University of the Cariboo</td>
<td><a href="http://www.healthservices.gov.bc.ca/cpa/publications/rsp/pdf">Link</a></td>
<td>Full-time program to prepare registered nurses for work in rural hospitals, emergency settings and nursing stations.</td>
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<tr>
<td>Prince George Teaching Unit</td>
<td><a href="http://www.healthservices.gov.bc.ca/cpa/publications/rsp/pdf">Link</a></td>
<td>Two year residency in Family Medicine in a northern setting.</td>
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<tr>
<td>Promoting Aboriginal Nursing in Communities</td>
<td><a href="http://www.health.gov.bc.ca/ndirectab_summary_0203_0506.html">Link</a></td>
<td>To provide opportunities for Aboriginal and non-Aboriginal nurses on site to get further education, mentor nursing students, and act as role models to Aboriginal youth</td>
<td>Nursing Directorate, Ministry of Health, 250-952-3596 Seabird Island Band Ministry of Health, Aboriginal Nursing Initiative</td>
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**BC Initiatives** 10
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<tbody>
<tr>
<td>Proposal to Pilot Longitudinal Community-Based Clerkship in Chil-BC</td>
<td><a href="http://www.bcahc.ca/BCAHC_page.asp?pageid=850">http://www.bcahc.ca/BCAHC_page.asp?pageid=850</a></td>
<td></td>
<td>Dr. Joan Fraser/jfraser@cw.bc.ca/ Jane Eibner <a href="mailto:jeibner@meedd.med.ubc.ca">jeibner@meedd.med.ubc.ca</a></td>
<td>UBC</td>
<td>Ministry of Advanced Education and Health - Practice Education Innovation Fund</td>
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<tr>
<td>Psycho Geriatric Upgrading Course for Home Support/Resident Care Attendants (North Island College)</td>
<td><a href="http://www.accc.ca/rural/review.cfm?Targ_ID=64">http://www.accc.ca/rural/review.cfm?Targ_ID=64</a></td>
<td>To deliver Psycho Geriatric Upgrading Course in a small rural northern Vancouver Island community extended care facility for elderly residents through video and telephone conferencing.</td>
<td>Eppie Burrell, Dean, Health, Human Services &amp; Office Administration 250-923-9727 <a href="mailto:eppoe.burrell@nic.bc.ca">eppoe.burrell@nic.bc.ca</a></td>
<td>Association of Canadian Community Colleges</td>
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<tr>
<td>Recruitment Incentive Fund</td>
<td><a href="http://www.healthservices.gov.bc.ca/pch/recruitment.html">http://www.healthservices.gov.bc.ca/pch/recruitment.html</a></td>
<td>A signed bonus to physicians recruited to fill vacancies that are part of a Physician Supply Plan in communities listed under the Rural Subsidiary Agreement</td>
<td>Physician Compensation, Ministry of Health <a href="mailto:HLTH.PhysicianComp@gov.bc.ca">HLTH.PhysicianComp@gov.bc.ca</a></td>
<td>BC Ministry of Health</td>
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<tr>
<td>Rural &amp; Northern Youth Sexual Health Team</td>
<td><a href="http://www.youthsexualhealth.ubc.ca/">http://www.youthsexualhealth.ubc.ca/</a></td>
<td>An interdisciplinary research team dedicated to reducing health and social disparities for youth in rural and northern places.</td>
<td>Department of Health Care and Epidemiology <a href="mailto:info@healthcare.ubc.ca">info@healthcare.ubc.ca</a></td>
<td>CIHR</td>
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<td>Rural Academic Health Project</td>
<td><a href="http://www.health-disciplines.ubc.ca/rahp/">http://www.health-disciplines.ubc.ca/rahp/</a></td>
<td>The development of a longer term sustainable model for strengthening interprofessional student placements in rural British Columbia.</td>
<td>Kathy Copeman-Stewart, Program Manager 604 230-2524 <a href="mailto:irepbc@bcahc.ca">irepbc@bcahc.ca</a></td>
<td>UBC College of Health Disciplines</td>
<td>BC Academic Health Council - Practice Education Fund</td>
</tr>
<tr>
<td>Rural and Remote BC Post-Basic Education Phase</td>
<td><a href="https://www.healthservices.gov.bc.ca/ndirect/strategies/ns_summary_0607.html">https://www.healthservices.gov.bc.ca/ndirect/strategies/ns_summary_0607.html</a></td>
<td>Funding to support phase 2 development and implementation of a provincial, practice-driven, rural-focused, post-basic nursing education program, including the use of technology based education for nurses in remote areas.</td>
<td>Nursing Directorate, Ministry of Health, 250-952-3596</td>
<td>Nursing Directorate</td>
<td>Ministry of Health</td>
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<tr>
<td>Rural and Remote Health Initiative</td>
<td><a href="http://www.healthservices.gov.bc.ca/rural/index.html">http://www.healthservices.gov.bc.ca/rural/index.html</a></td>
<td>To improve access to health care services and enhance continuity of care in northern, rural and remote communities through the development, implementation, evaluation and coordination of effective recruitment and retention strategies.</td>
<td>Rural Health Medical Services Divisions Ministry of Health 250-952-1587 <a href="mailto:HLTH.RuralHealth@gov.bc.ca">HLTH.RuralHealth@gov.bc.ca</a></td>
<td>Rural Health Office, Ministry of Health</td>
<td>Ministry of Health</td>
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**Notes**: X indicates presence in the respective category.
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<th>Interprofessional</th>
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<tbody>
<tr>
<td>Aboriginal Nurses Association of Canada</td>
<td><a href="http://www.anac.on.ca/">http://www.anac.on.ca/</a></td>
<td>Established out of the recognition that Aboriginal people’s health needs can best be met and understood by health professionals of a similar cultural background.</td>
<td>Doris Fox <a href="mailto:dfox@anac.on.ca">dfox@anac.on.ca</a></td>
<td>Canadian Nurses Association</td>
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<td>Accessibility in Medical Education Program</td>
<td><a href="http://www.cfms.org/pre_med/aimed.cfm">http://www.cfms.org/pre_med/aimed.cfm</a></td>
<td>A project developed by medical students designed to interest high school students in a career in Medicine. AIMED works by encouraging medical students participating in electives outside of their home university city to contact a local high school and offer to give a brief presentation on the reality of a career in medicine.</td>
<td><a href="mailto:aimed@cfms.org">aimed@cfms.org</a></td>
<td>Canadian Federation of Medical Students</td>
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<tr>
<td>Annual Rural and Remote Medicine Course</td>
<td><a href="http://www.srpc.ca/">http://www.srpc.ca/</a></td>
<td>An annual meeting of rural doctors to exchange ideas and update themselves with the latest in rural medicine.</td>
<td><a href="mailto:admin@srpc.ca">admin@srpc.ca</a></td>
<td>Society of Rural Physicians of Canada</td>
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<td>Canada Health Infrastructure Partnerships Program</td>
<td><a href="http://www.hc-sc.gc.ca/hcs-sss/ehealth-esante/infrastructure/finance/chipp-spics/index_e.html">http://www.hc-sc.gc.ca/hcs-sss/ehealth-esante/infrastructure/finance/chipp-spics/index_e.html</a></td>
<td>Aimed at supporting collaboration, innovation, and renewal in health care delivery through the use of information and communication technologies.</td>
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<td>Health Canada</td>
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<td>Canadian Rural and Remote Health Association</td>
<td><a href="http://www3.telus.net/public/crrha/">http://www3.telus.net/public/crrha/</a></td>
<td>Aims to improve the health and health care of Canadians living in rural and remote areas of the country.</td>
<td>Neil Hanlon <a href="mailto:hanlon@unbc.ca">hanlon@unbc.ca</a></td>
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<td>Canadian Rural Health Research Society</td>
<td><a href="http://crhrs-scrsr.usask.ca/eng/index.php">http://crhrs-scrsr.usask.ca/eng/index.php</a></td>
<td>Facilitates research and knowledge translation aimed at understanding and promoting the health of people living in rural and remote Canada.</td>
<td><a href="mailto:CRHRS-SCRSR@usask.ca">CRHRS-SCRSR@usask.ca</a></td>
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<th>Special Population</th>
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<tr>
<td>Canadian Rural Partnership</td>
<td><a href="http://www.rural.gc.ca/crpfact_e.phtml">http://www.rural.gc.ca/crpfact_e.phtml</a></td>
<td>The key policy framework supporting federal rural policy efforts to date.</td>
<td>Rural Secretariat <a href="mailto:rs@agr.gc.ca">rs@agr.gc.ca</a></td>
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<td>Government of Canada</td>
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<td>Canadian Society of Telehealth</td>
<td><a href="http://www.cst-sct.org/en/index.php">http://www.cst-sct.org/en/index.php</a></td>
<td>Leads the transformation of health care through information and communication technology by providing a forum for advocacy, communication and sharing of resources among our communities of interest.</td>
<td>Pamela Lyons <a href="mailto:cst@eventsmgt.com">cst@eventsmgt.com</a></td>
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<td>CME Locum Project</td>
<td><a href="http://www.srpc.ca/">http://www.srpc.ca/</a></td>
<td>A system where a rural community will get a customized medical education series brought to it with associated locum coverage so that people can attend.</td>
<td>Lee Teperman <a href="mailto:bullhita@infonet.ca">bullhita@infonet.ca</a></td>
<td>Dalhousie University</td>
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<tr>
<td>Innovations in Rural and Community Health Initiative</td>
<td><a href="http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2001/2001_06bk2_e.html">www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2001/2001_06bk2_e.html</a></td>
<td>Focuses on rural and remote care; home and community care; access to and affordability of drugs; integration of service delivery.</td>
<td><a href="mailto:PHAC_Web_Mail@phac-aspc.gc.ca">PHAC_Web_Mail@phac-aspc.gc.ca</a></td>
<td>Health Canada</td>
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<td>Memorial University Faculty of Medicine</td>
<td><a href="http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2001/2001_76bk2_e.html">http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2001/2001_76bk2_e.html</a></td>
<td>Has an electronic rural medicine strategy - a national professional development effort for enhancing the retention of rural and remote physicians.</td>
<td>Fran Kirby 709-777-6653</td>
<td>Health Canada, National Rural Health Initiative</td>
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<tr>
<td>Nature of Nursing Practice in Rural and Remote Canada</td>
<td><a href="http://ruralnursing.unbc.ca/index.html">http://ruralnursing.unbc.ca/index.html</a></td>
<td>The aim of this three-year project is to examine and articulate the nature of registered nursing practice in primary care, acute care, community health, continuing care (home care), and long term care settings within rural and remote Canada.</td>
<td>Martha MacLeod <a href="mailto:macleod@unbc.ca">macleod@unbc.ca</a></td>
<td>Alberta Heritage Foundation for Medical Research, BCRRHRI, Canadian Health Services Research Foundation, CIHR, Michael Smith Foundation, Nursing Research Fund</td>
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<td>Rural and Northern Health Research (RNHR) initiative</td>
<td><a href="http://www.cihr-irsc.gc.ca/e/15871.html">http://www.cihr-irsc.gc.ca/e/15871.html</a></td>
<td>Provides an integrated and focused approach to research that contributes to health and health services in Canada's rural and northern communities.</td>
<td>Kalpana Phansalker <a href="mailto:kphansalker@cihr.gc.ca">kphansalker@cihr.gc.ca</a></td>
<td>CIHR</td>
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<td>Rural and Remote Canada Online</td>
<td><a href="http://www.rural-canada.ca/home.cfm?lang=en">http://www.rural-canada.ca/home.cfm?lang=en</a></td>
<td>A single window to knowledge, information, programs and services for and about rural and remote Canada.</td>
<td>Rural Secretariat <a href="mailto:rs@agr.gc.ca">rs@agr.gc.ca</a></td>
<td>Government of Canada</td>
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<td>Initiative</td>
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<td>Rural Critical Care Course</td>
<td><a href="http://www.srpc.ca/">http://www.srpc.ca/</a></td>
<td>An annual event hosted by the Ontario Region of the SRPC where rural doctors go to take rural specific CME.</td>
<td>Dr. Gordon Brock, Chair, SRPC RCC Committee at 819-627-3385 ext 1238 or the SRPC at 1-877-276-1549</td>
<td>Society of Rural Physicians of Canada</td>
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<td>Rural Health Online</td>
<td><a href="http://www.ruralhealth.ca/Eng">http://www.ruralhealth.ca/Eng</a></td>
<td>An online source to assist with the Rural Health Strategy is a multilevel, integrated approach for the development and implementation of strategies that will help to address some of the health needs of rural communities.</td>
<td><a href="mailto:info@torc.on.ca">info@torc.on.ca</a></td>
<td>The Ontario Rural Council</td>
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<td>Rural Information Service: Recruitment of doctors for rural and remote areas pathfinder</td>
<td><a href="http://www.rural.gc.ca/cris/recruit/recruit_e.phtml">http://www.rural.gc.ca/cris/recruit/recruit_e.phtml</a></td>
<td>A pathfinder providing information to assist rural and remote communities in the recruitment of doctors. It includes provincial and territorial government recruitment programs and a bibliography on the practice of rural medicine.</td>
<td>1-888-757-8725 <a href="mailto:cris@agr.gc.ca">cris@agr.gc.ca</a></td>
<td>Government of Canada</td>
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<tr>
<td>RuralMed</td>
<td><a href="http://www.srpc.ca/">http://www.srpc.ca/</a></td>
<td>Aims to create a network of physicians in rural practice, as well as others in universities or elsewhere with an interest in rural medicine.</td>
<td>Lee Teperman <a href="mailto:bullhits@infonet.ca">bullhits@infonet.ca</a></td>
<td>Society of Rural Physicians of Canada</td>
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<td>WONKA Rural Information Technology Exchange</td>
<td><a href="http://www.img-canada.ca/en/index.html">Www.img-canada.ca/en/index.html</a></td>
<td>Promotes the exchange and sharing of information technology amongst rural medical practitioners, and ubiquitous access to information technology resources for rural communities.</td>
<td><a href="mailto:write@cfpc.ca">write@cfpc.ca</a></td>
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ENGAGING COMMUNITIES IN INCREASING RURAL PLACEMENTS FOR HEALTH STUDENTS

The goal of the “BC Rural Academic Health Project” (RAHP) is to develop a longer term and more sustainable model for strengthening student placements in rural British Columbia, including those that involve interprofessional education. The model will effectively link the educational experience to rural health services, community needs and applied research.

A number of key considerations make this project important. Most importantly, health authorities and in particular, rural communities are facing significant and growing health human resources challenges. Hosting students is increasingly recognized as an essential recruitment strategy, particularly for rural areas.

In addition, rural communities provide a unique and powerful learning environment which fosters strong skills in assessment, decision-making, teamwork, communication, leadership and more. Students are able to experience firsthand the continuum of care, influence of culture and the broader determinants of health. This rural experience helps create a “well rounded” health professional regardless of where they practice in the longer term. In particular, this exposure to health care in a community context aligns well with the shifts in the health care system to greater emphasis on primary health care, community health, chronic disease management, etc.

Rural communities can and must play an important role in educating students. And yet, there are growing challenges given increasing numbers of students and education programs making placement requests, rural health human resources shortages and lack of education supports.

A number of initiatives are currently underway in the province relating to rural academic health. The intent of this project is to lever the lessons learned from these and from other jurisdictions, to foster dialogue across key stakeholders in applying these learnings, and to recommend an approach for moving forward.

**Purpose of discussion paper**

This discussion paper profiles the key aspects of a longer term model for rural academic health centres that would strengthen rural placements, and provides questions for engaging communities/groups/individuals in improving and building this model. It incorporates the concepts that have been gathered to date through the literature synthesis paper, key stakeholder interviews, regional consultations and provincial consultation.
Focus

The RAHP project focuses on four key areas:

1. **Benefits of rural practice education** for communities, students and the broader health and education systems
2. **Foundational principles and essential components** for expanding rural practice education
3. **Partnerships and roles** across communities, health authorities, post-secondary education institutions and others in supporting practice education linked to rural health care and applied research
4. **Action plan** for moving forward
Benefits

There are many benefits to rural communities, students and ultimately the health care system from students learning in rural communities as part of their educational experience. In British Columbia, a number of programs have been initiated over the past several years, including the Interprofessional Rural Program of BC, the Aboriginal Health Elective, and the Vancouver Island Interprofessional Health Project, in addition to the longstanding rural placements provided through most education programs.

Benefits of rural practice education include:

For rural communities
» Recruitment & retention of health professionals;
» New energy and ideas brought by the students;
» Enhanced links to academic institutions;
» Youth from rural communities inspired to pursue health careers; and
» Ultimately, improved healthcare in rural communities.

For students
» Welcoming communities, and contributions to the community;
» Opportunity to experience rural life and practice, in a supported environment;
» Broadened perspectives on health;
» Teamwork and leadership;
» Interaction with Aboriginal communities; and
» Fun!

Health & Education Systems
» Emerging health professionals oriented to the needs and realities of rural communities;
» Recruitment and retention of rural health professionals;
» Positive change levered by students;
» Improved health care and education models.

QUESTIONS
What benefits are missing from above list?
What benefits do you see for your organization/community?
What are the most important benefits?
Foundational Principles

Through feedback received to date, the following principles are proposed for the longer term model:

Community-driven

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

Partnerships

» Rural communities, health authorities, post-secondary education institutions and others are integral to supporting practice education linked to rural health care. Partnership between stakeholders is essential.

Interprofessional

» Rural health care settings, due to their very nature, must be collaborative. Learning in a rural community provides students with an interprofessional practice education that fosters teamwork skills and thus contributes to quality healthcare.

Service Learning

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

The following components of effective rural placements reflect/incorporate the knowledge generated from existing models in BC, and beyond:

For students

**Housing**

» Availability of student housing is critical for recruiting students for rural placements. Housing may be provided in a range of ways – as a designated house or apartment for students or locum staff that is available year round or for particular periods of the year, billeting, or other. Experience through the IRPbc has reinforced that shared accommodation for students provides a vital support system and opportunity to learn informally from one another. And housing provides an additional benefit in assisting the rural community to manage its HHR needs by also being available for short term locums or new hires.

» Consultations have recommended that each community work with its community partners develop and maintain a list of possible housing options for students.

» In particular, creative solutions could be explored through partnerships among industry, secondary education, government ministries, health authorities, chambers of commerce, etc. and lever local opportunities such as unused buildings, high school student project, “green building” development, other.

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

**Orientation**

» Students need orientation in advance as well as once they are in place in the rural communities. Topics to consider for orientation include: rural health, Aboriginal culture, community needs, interprofessional learning styles, teamwork, and dual relationships in rural communities.

» Currently schools/programs have a range of orientation approaches. These approaches should be shared across programs and over time become more standardized.

» Further work needs to be undertaken in exploring use of online, videoconferencing and other approaches for orientation.
Supervision

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

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

Supports e.g. travel, other

» Some programs provide remuneration for travel or weekly stipends, however, this is not consistent across programs/schools. Other supports include internet access, opportunities to access community programs (e.g. free pass for the recreation centre), dinners or workshops with preceptors, etc. These supports are important to recruiting students, making it more financially viable for students to access rural placements and fostering positive exposure to rural life and practice.

For preceptors

Training

» Continuing professional development is an essential component for rural health professionals, and particularly in preceptoring students. Topics should including preceptor training (e.g. role and responsibilities, goals and expectations of programs,) interprofessional teamwork and discipline-specific updates.

Recognition

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

Remuneration

» A critical element for rural practitioners, to undertake the additional education role and responsibilities for medical and other health sciences students. Further work is required in this area.
Local Coordination

Leadership and administrative coordination provide a critical element in supporting the rural community participation in student placements. There are two key roles involved:

» Community lead/champion solicits the community’s potential for educating students and health professionals, solves problems that arise, liaises across regional and provincial partners to help set directions, contributes to the evaluation and research, etc.

» Community coordinator provides a key role in supporting the students (aka “den mom”); communicating with faculty, preceptors and students; setting up schedules for students in the community; trouble shooting and resolving day to day issues; etc.

It is vital that these two local representatives know, understand, connect and communicate effectively within the local community – with health practitioners, elected officials, business, local clubs, etc.

Provincial Coordination Activities

The complexity of rural placements cannot be understated – given the large number of post-secondary education institutions that place students, range of health professions, existing partnerships, current gaps, number of initiatives, different funding sources, etc. There is significant need and opportunity to network stakeholders (health, education, rural communities, others) and lever initiatives, approaches etc. In particular, the following key aspects have emerged from dialogue to date:

Placement coordination across organizations

» There needs to be clear policies and processes in place to support the complex interactions across schools/programs for the placement of students. HSPnet, an online placement coordination system currently hosts placement coordination across a number of programs and regions across the province.

Marketing of rural practice opportunities

» needs to be actively undertaken. Students should be made aware of rural communities that are able to receive students, opportunities, benefits, expectations, recreational and learning opportunities, etc. This marketing could include a variety of approaches including online (e.g. HSPnet, other), brochures, presentations etc.
Network across key participants

» Rural communities in particular have reinforced the importance of networking
among themselves and with academic institutions in exchanging knowledge
relating to challenges and successes, preceptor orientation and support, ongoing
evaluation and evolution of rural practice education.

Link to rural recruitment

» Rural student placements must be integrally linked to rural recruitment
opportunities.

Evaluation and research, including knowledge translation

Rural practice education must be effectively linked to evaluation and research.
Through the RAHP processes, effort will be make to identify current initiatives and
dialogue with stakeholders regarding potential linkages, synergy and areas for future
research. Further, having students participate in active participatory research during
their placements will have an impact on rural research and leave a legacy in the
community.

In particular, there is significant knowledge about current rural practice education
programs and models such as the Interprofessional Rural Program of BC and
Aboriginal Health Elective which should be shared through this process and made
available more systematically to rural communities and education institutions.

Infrastructure and funding

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

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

Partnerships among rural communities, educators, policy makers, health authorities and government are critical to the success of a model for rural health education. The roles of each are distinctive, inter-related, and complementary:

Rural Communities

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

Students

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

Rural health care providers

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

Health authorities

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

» Profile rural practice education opportunities and information for students
» Communicate with and provide ongoing support to preceptors in rural communities
» Help select appropriate students for rural practice education

Overall Comments

1. What concerns or excites you about strengthening the role of rural communities in educating students?
2. What does your community/school/health authority/organization need in order to be an active participant?
3. What are the key next steps to move forward?
4. Other thoughts/comments

Next Steps

» Continue regional consultations with key stakeholders
» Prepare and circulate draft final report
» Present final report to decision-makers
APPENDIX

Definitions

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

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

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

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

Interprofessional Education
When two or more professions, learn with, from and about one another in order to improve collaboration and the quality of care. (Centre for Advanced Interprofessional Education, updated 2002)
Resources

» RAHP website www.health-disciplines.ubc.ca/rahp
rural academic health project

Provincial Consultation Summary

November 4, 2007
INTRODUCTION

The Rural Academic Health Project hosted a three hour provincial consultation session adjacent to the Practice Makes Perfect Conference in November 2007. The purpose of the session was to continue to build consensus on the longer term model for rural practice education in British Columbia.

Close to thirty participants in the session represented five health authorities and five post-secondary education institutions.

SETTING THE CONTEXT

The ten minute film ‘Learning Together in Rural Communities’ featuring the student team in Port McNeill BC in summer 2007 began the session and was very well received. Participants reinforced the film should be disseminated widely and used as a marketing tool.

Lesley Bainbridge, Project Lead, presented the history, purpose and process of RAHP. Lesley’s presentation showed the broad context of rural placements and the important opportunities for rural communities, students and the broader health system relating to rural practice education.

Lorinda Anderson, Director of Patient Care, Bella Coola General Hospital provided perspectives from their involvement with interprofessional student teams:

- IRPbc has facilitated Bella Coola’s goal of recruiting and retaining health care providers - five IRPbc graduates have returned to Bella Coola for locums/full time positions. Currently the community needs a pharmacist and a physiotherapist: it is hoped that recruitment will be facilitated through students coming to their community.
- Rural placements build capacity for educating students. Rural communities provide a great opportunity for students to have broad experiential learning while demystifying rural living. Rural practitioners enjoy the interaction with students which contributes to retention of rural practitioners.
- The program empowers the community and improves the health of rural communities, as students often have more time to spend with patients.
- The complex needs of rural communities are facilitated through the creative solutions students bring.

According to the Bella Coola experience and consistent with other feedback received, housing is the most critical support for student placements. In addition, housing should provide internet access. On the social side, the community loves having students and preceptors are very supportive.
DIALOGUE

Creative ideas and solutions are needed for strengthening student placements. Examples from other jurisdictions to address housing include:

- In the United States, a high school shop class built a house as a class project with materials donated by local industry. The house was moved to the hospital where it houses students, locums and people visiting the hospital from out of town.
- In China, a local village provided the labour and industry supplied the resources to build a house for the local hospital.
- Partnerships with different Ministries may offer potential solutions, for example, perhaps Ministry of Environment would support 'green' houses.

In addition to housing, community support is vital. We need to work to engage people within communities.

It was reinforced that students would be unlikely to do rural placements if they were going on their own. There are advantages to having groups of students. However, if a particular community has a reputation of welcoming students they will attract students regardless of others participating. Local coordination provides an important role in supporting and welcoming for students.

Financial support for students is important.

Small Group Discussions

I. Creative solutions for building placement capacity in rural communities:

- Key elements
  - Identify local and regional champions
  - Place emphasis on getting a student team into the community and for the community to get excited about it
  - Assess and develop community capacity for educating students – identify champions for interprofessional education and teamwork
  - Allow each community to adapt its own model/approach
  - Each community should develop/maintain a formalized list of housing options for students – e.g. house/apartment/billeting
  - Link with the community’s chamber of commerce in hiring a community coordinator

- Use active participatory research during placements that will have an impact and leave a legacy
  - Practice education experience should be interprofessional regardless of the number and type of students
  - Provide preceptor training and support
  - Recognize that student selection and timing are complex
  - Rural student placements provide an opportunity to fill the research gap that currently exists in rural communities
  - Research approach can help access funding
  - Have students work on a rural research project while in the community – identify the project, market it, brings students together on a shared community-identified project
- Evaluate outcomes
  - A qualitative/quantitative tool is being developed by medicine that compares students upon entry to a program with 5 years after graduation – this tool could be shared once it is validated. HSPnet is also developing tracking mechanism
- Coordinate across the myriad of rural initiatives

2. Development of a Handbook to strengthen rural placement capacity
- Provide relevant information – don’t overwhelm, detail information separately for different partners
- Remember each community is unique – be flexible, incorporate best practices – must be community-driven
- Engage people in ongoing up dates e.g. use managed WIKI
- Link with Rural Coordinating Centre and rural community database
- Make interactive
- Continue to evolve information after RAHP
- Attach/incorporate with clickable map
- Provide opportunity for rural communities to network
- Turn “they” into people – be specific about who we are engaging
- Engage PSE, health authorities, Ministries, professional associations
- Show ‘value-added’
- Provide community development tool
- Use faculty development tool
- #1 = Community Driven

3. Development of a Sustainable Model
- Consider timing of placements (winter and summer)
- Invite communities to participate using existing communities as a model
- Identify a provincial coordinator
- Build relationships with community health representatives
- Look for funding from Ministries
- Identify creative housing solutions such as time share, motel donate rooms, partner with industry
- Include placements for individual students and interprofessional groups
- Actively promote and market rural placements e.g. DVD
- Profile employment prospects
- Get on the political agenda
- Provide advance information so that placement coordinators have time to promote to and plan with students
- Develop a directory of communities/sites including contact information e.g. community champion
- Provide travel grants

4. Coordination across PSE and communities
- Designate rural academic centres
- Profile/market community benefits of hosting students
- Identify site champions
- Bring in people to mentor and foster expertise at new sites
- Ensure coordination at each site
- Community coordinator roles
  - liaise across community stakeholders e.g. rural practitioners, community groups/representatives
  - manage funding and resources
  - identify/coordinate housing
  - foster interprofessional approaches
- Post-secondary roles
5. Stakeholder engagement

- Confirm stakeholders – PSE, HA, rural communities, students
- Use early exposure – inform students early (including high school)
- Survey HA and PSE to identify predicted service and population needs
- Do site visits to PSE, HA and rural communities – use DVD – will be easier to get champions

SUMMARY AND NEXT STEPS

Input from the session confirmed and built on many of the concepts of the emerging RAHP model for strengthening rural practice education in British Columbia.

Next steps include:

- Additional regional/local consultations to strengthen awareness and momentum for strengthening rural practice education;
- Distribution of the Learning Together in Rural Communities DVD;
- Further refinements of the RAHP discussion paper and model, leading to a final report in March 2008.
The goal of the “BC Rural Academic Health Project” (RAHP) is to develop a longer term and more sustainable model for strengthening student placements in rural British Columbia, including those that involve interprofessional education.

But, we can’t do it without you!

This handbook provides strategies for rural communities to participate in offering a unique opportunity for students from various health professional programs to experience work and life in a rural BC community.

These strategies are based on knowledge generated from existing models in BC and beyond, and through consultation with key stakeholders and communities (front line health care providers, patients, families, senior administrators, students, and other community stakeholders).

**Principles of the Model**

*Community-driven*

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

*Partnerships*

Rural communities, health authorities, post-secondary education institutions and others are integral to supporting practice education linked to rural health care. Partnership between stakeholders is essential.

*Interprofessional*

Rural health care settings, due to their very nature, must be collaborative. Learning in a rural community provides students with an interprofessional practice education that builds effective teamwork skills, improving the quality of healthcare provided.

*Service Learning*

The ultimate goal of rural practice education is to enhance the health of communities. Initiatives allow students and faculty to provide valuable services to communities as they learn about relationship-centred care that is personal, professional, and community sensitive.
Benefits to rural communities when they support Practice Education:
- Recruitment and Retention of healthcare providers
- New energy and ideas brought by students
- Enhanced links to academic institutions
- Youth from rural communities inspired to pursue health careers
- Improved healthcare in rural communities

In a web format, users could click on the above, which would provide them with additional information in the form of a pop-up.

Recruitment and Retention of healthcare providers:

Recruitment - Evidence from around the world tells us that health care professionals who are trained in rural communities are more likely to practice in rural communities. Many communities have students return for permanent and locum positions. It is easier to attract professionals who are already familiar with the community. Students who may not choose to practice in a rural setting are still likely to become advocates for rural practice. Many students have actively shared their experience through presentations to their respective schools, journal articles, poster presentations at conferences, and through the media.

Retention - Rural health care providers are energized by the opportunity to share their knowledge with students. Existing practitioners also are presented with the opportunity to upgrade existing skills or gain new skills to meet the needs of rural communities. Students foster renewed synergy across professions within communities. Local staff feel encouragement when they hear how well they do things compared to larger centres. By producing additional appropriately trained rural healthcare workers, rural placements reduce burnout among existing practitioners.

Through the development of adequate infrastructure, communities attract more health professional, provide more effective care, and increase retention of health care professionals by reducing their isolation. Supporting student placements often presents opportunities to enhance information technology, telecommunications, computer equipment, medical equipment, and library resources.

Enhanced links to academic institutions:

There are a number of opportunities for rural practitioners to interact with faculty through site visits, planning forums, e-mail, and telephone calls. Providing practitioners with a venue to access the expertise of associated academic institutions also serves to reduce isolation of rural practitioners. There is an urban bias in most health care education. University-community partnerships help to overcome this bias.

New energy and ideas brought by students:

Student that choose to do placements in rural communities tend to be risk takers, team players and have an interest in the challenges offered by rural placements.

Students bring new energy and ideas along with an extra set of hands in providing health care.

Having students doing placements in a rural community is also cost effective. Students constitute a full-time employee when health human resources are scarce.

Improved healthcare in rural communities:

Communities become empowered and self-sufficient when they train students, improving their health care system. Communities gain the commitment and resources to help themselves meet their health care needs. Disadvantaged clients develop increased self-efficacy, resulting in improved health, due to the energy students bring.

When training focuses on collaboration, communication is improved, improving outcomes for patients. Programs also have the potential to reduce health care differentials between rural and non-rural communities, as well as between Aboriginal and non-Aboriginal peoples. Programs respond well to the complex and diverse needs of rural communities by creating solutions that transcend conventional procedures and methods.

Rural communities, by providing students with the opportunity to work closely with rural health practitioners, experience first-hand the continuum of health care, and to grow personally and professionally, contribute to the improvement of the health care system in general. Rural student placements develop a body of knowledge about rural health and expertise in rural health.

Youth from rural communities inspired to pursue health careers:

Through student presentations at local high schools and acting as role models within the community, students participating in rural placements often inspire local youth to pursue careers in health care. Programs also improve Aboriginal communities’ access to careers in health care.

Placement programs develop human capital by promoting leadership skills among local residents, providing opportunities for local residents to develop professionally in a way they might not have been able to otherwise.

Youth from rural communities inspired to pursue health careers:
## Checklist of components needed in rural communities to help build an effective sustainable model:

- Provide Housing
- Provide a welcoming environment
- Support Preceptors
- Conduct student orientations
- Identify a community coordinator
- Get your community involved
- Facilitate a range of learning and cultural activities for students

*Again, users could click on the above for additional information.*

### Housing:

#### Why
- Providing students with housing makes the program accessible - the availability of housing is critical for recruiting students for rural placements
- When students share housing it promotes informal learning and a vital support system

#### How
- Approaches to housing need to be community-specific – communities need to find a solution that works best for them within available resources
- Ideal - Shared accommodation in a furnished house or apartment close to the hospital
- Provide access to a computer and the Internet to allow students to connect with other students, faculty and preceptors
- Make sure it is available for students from all health professions
- Provide this housing at little or not rent
- Billeting is another cost-effective option

*Resources – click here to find out what other communities in BC are doing ([Link to information about other communities – lessons learned, successes, challenges, etc.](#))*

### Welcome:

#### Why
- Students can sense welcome
- Communities that have a reputation for welcoming and supporting students are more likely to attract them

#### How
- Set a positive tone early
- Meet students at the airport
- Host a welcome dinner
- Discuss learning opportunities
- Provide a tour of health facilities
- Identify activities for students
- Provide infrastructure to support their placements

*Resources – click here to find out what other communities in BC are doing*
Preceptor Support:

Why
- Preceptors support students within their profession and across professions
- It is essential that preceptors receive continuing professional development, particularly for teaching students
- It is also imperative that they receive recognition for the important work that they do

How
- Identify a range of health professional who demonstrate teamwork and love to teach
- Encourage preceptors to interact with students through formal and informal activities
- Provide orientation focusing on interprofessional learning
- Enhance education resources (e.g. books, computers)
- Facilitate interaction with faculty from post-secondary institutions
- Professional development topics should include preceptor training, IP teamwork and discipline-specific updates
- Recognition of preceptors is essential - Faculty appointments, financial remunerations, tokens of appreciation such as gift certificates for lunch, letters of thank you

Resources – click here to find out what other communities in BC are doing

Student Orientations:

Why
- Students need to feel prepared for this new experience

How
- Timing and travel need to be taken into consideration in planning
- Key topics should include rural health, Aboriginal culture, community needs, interprofessional learning
- Online orientation is becoming increasingly available
- Introduce key concepts and initiate team interaction
- Provide an opportunity to meet other students and preceptors

Resources – click here to find out what other communities in BC are doing

Community Involvement:

Why
- There should be as many people as possible from all aspects of the community involved in rural training programs
- This can enable alternative actions and available resources to be explored
- Potential community partners include: health care administrators, community health providers, funders, consumers
- Everyone needs to be united by a common goal, objectives and desired outcomes
- Students feel welcome when they sense community investment in their education

How
- Identify champions to lead the program
- It is mutually beneficial for students to be involved in the community – students can provide valuable health education and services at community events, while experiencing local culture
- Encourage rural students to become interested in health care
- Highlight your community as a place of learning

Resources – click here to find out what other communities in BC are doing
Community Coordinator:

<table>
<thead>
<tr>
<th>Why</th>
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<tbody>
<tr>
<td>➢ A community champion is needed to solicit the community’s potential for educating students</td>
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<table>
<thead>
<tr>
<th>How</th>
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<tbody>
<tr>
<td>➢ Oversees the team activities and interprofessional learning</td>
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<tr>
<td>➢ Manages logistics, schedules, travel, accommodation</td>
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<tr>
<td>➢ Beneficial in recruiting students, faculty and preceptors, and facilitating community involvement</td>
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<tr>
<td>➢ Solves problems that arise</td>
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<tr>
<td>➢ Supports students</td>
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Resources - Click here to find out what other communities in BC are doing

Learning and cultural activities:

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<th>Why</th>
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<tbody>
<tr>
<td>➢ Some of the best learning happens on an informal basis such as through shared living, outdoor activities, and casual get-togethers</td>
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<tr>
<td>➢ Fosters a positive exposure to rural life and practice</td>
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<table>
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<tr>
<th>How</th>
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<tbody>
<tr>
<td>➢ Flying to remote communities with a visiting health professional</td>
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<tr>
<td>➢ Working with the community to identify priority health concerns and strategies</td>
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<tr>
<td>➢ Participating in Aboriginal health services</td>
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<tr>
<td>➢ Promoting health care careers to local youth</td>
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<tr>
<td>➢ Participating in community events</td>
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<tr>
<td>➢ Developing health promotion material</td>
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<tr>
<td>➢ Being involved with emergency, acute and public health activities</td>
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<tr>
<td>➢ Expose students to the outdoor activities in your community – hiking, biking, kayaking, horseback riding, etc.</td>
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<tr>
<td>➢ Students shadow one another and professionals from other disciplines</td>
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<tr>
<td>➢ Travel to outlying villages</td>
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<tr>
<td>➢ Meet with community leaders</td>
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<tr>
<td>➢ Provide a free pass for the recreation centre</td>
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<tr>
<td>➢ Dinners or workshops with preceptors</td>
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</tbody>
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Resources – Click here to find out what other communities in BC are doing

Rural Communities Supporting Practice Education: (Have communities populate with information about what they are doing in the 7 categories above – share lessons learned)

- Bella Coola
- Enderby
- Hazelton
- Port McNeill
- Powell River
- Hazelton
- Communities able to add themselves and share their PE experiences

* Click on community to receive information about rural placements, the community in general, examples of housing models, etc. – this could be the resource section and provide an opportunity for networking across communities – fits in with the idea of a clickable map
Bella Coola

Location and Access
Bella Coola is the main port for the Central Coast. At the end of a magnificent long fiord, Bella Coola is situated in a mountain valley at the head of Burke Channel on the inland west coast of British Columbia. Bella Coola has highway access from the coast to the interior. It is 500 km north of Vancouver and 450 km west of Williams Lake on Highway 20. People enjoy this community’s rustic charm, pleasant climate and coastal area recreational opportunities. Turbo prop flights are scheduled daily to and from Vancouver. By car, it is six hours from Williams Lake and 12 hours from Vancouver. During summer months, BC Ferries operates a ferry between Port Hardy on Vancouver Island and Bella Coola.

History and Economy
Bella Coola has a strong Norwegian heritage resulting from settlement in the area in the 1890’s, as well as being the traditional home of the Nuxalk Nation. The economic base of the community includes fishing, tourism, logging and farming.

Population Profile
The Valley population of 2,500, includes a full range of ages, and is approximately 50% Aboriginals of the Nuxalk Nation, and the remaining 50% of the population non-native origin. The physicians in Bella Coola also serve the community of Anahim Lake on the Chilcotin Plateau.

Climate
The climate is quite moderate, with summer temperatures ranging from 10 to 30 degrees Celsius, and winter temperatures between +10 and –10 degrees Celsius. The area receives its fair share of seasonal rainfall, typical of the Pacific Northwest.

Schooling
There is a public primary, intermediate and high school serving the community. The Nuxalk operate their own community school. Community college extension courses are available in the area, and a college site in Bella Coola offers adult education and a range of other programs.

Recreation
Endless outdoor recreational opportunities include boating, kayaking, sailing, hiking, fishing, hunting, mountain and rock climbing. There are a number of active community youth groups, and the community hosts regular concerts by local bands and drama groups, as well as a Rodeo. The Bella Coola Historic Museum, housed in a pioneer schoolhouse and surveyor’s cabin, displays Hudson’s Bay Company relics and others brought by Norwegian pioneers. The Thorsen Creek Petroglyphs include over 100 native rock paintings.

Services
Services include a few small hotels, several stores including hardware and Co-op grocery store, a service station, library, credit union, pottery studio and dental services. Churches in the community include the United Church of Canada, the Seventh Day Adventist and the Pentecostal Assemblies of Canada, as well as Catholic.

Health Services
The Hospital
Bella Coola General Hospital has 10 acute care and 5 extended care beds. It has a two-bay Emergency and one Operating Room. Our occupancy rate ranges from 30-80%. Lab and x-ray services are available through the hospital, and ultrasound through the clinic. Our Pharmacy is a combined retail and hospital pharmacy. A new and modern medical clinic was opened in 1998. There are no specialists on staff at the hospital. However, services provided by the specialists who visit the community regularly include: Surgery, ENT, Pediatrics, Internal Medicine, Psychiatry, ophthalmology and Orthopedics. Most staff work 12 hour shifts. The current general practitioners in the community are able to offer limited anaesthetic and obstetrical services including C-Section capabilities. A total of three physicians staff the hospital. The facility also provides mental health services, physiotherapy/OT, and public health. The only pharmacy in the community is operated by the facility onsite. Other community services are provided under agreement with the health authority.

The Community
Within the hospital complex, we also have the Home Support/ LTC Nurse Assessor. This nurse oversees a senior’s drop-in centre in Tuesday afternoons and a Foot Clinic once monthly. Weekly Alcoholics Anonymous meetings take place in both the hospital and a location further up the valley. Across the street from the hospital are the Bella Cool Community Support Society offices. These services include: Victim Assistance Services, Alcohol and Drug Counselling, Women’s Counselling, Sexual Abuse Intervention Program, and Parent/Family Support. The Nuxalk Nation operates a health and wellness clinic staffed with local and Federal employees. Services include: Public Health Nursing, Home Support, Dental Mechanic, Audiology and Speech Pathology, Alcohol and Drug Counselling, Healthy Beginnings, and the Transition House (which is open to both native and non-native women).

Housing - A housing unit where students live together is located right across the street from the hospital.
Welcome –
Preceptor Support –
Student Orientations –
Community Coordinator –
Community Involvement –
Cultural and Learning Activities –
*Communities to provide examples and stories
Enderby

Location and Access
Enderby is a picturesque and energetic city located in the northern tip of the Okanagan Valley of British Columbia. Enderby is located on Highway 97 which is one of the main corridors to Alberta and the Rocky Mountains and the rest of the Okanagan Valley. The community is about 1 hour north of Kelowna and approximately five hours from Vancouver by highway. Air service is accessed via the Kelowna Airport and is served by WestJet, Air Canada and Horizon Air on a regular basis. Enderby is also served by Greyhound and Via Rail in Salmon Arm (about 20 minutes away by highway). Enderby is known as the Top of the Okanagan and is the largest community in the Enderby Local Health Area (area population: 7,360). The economy is dominated by agriculture, forestry, services and tourism. Located near the resort areas of Mara Lake to the north, Shuswap Lake to the northwest and Mabel Lake to the east, the population of the Enderby region swells five fold during the summer months. Winter tourism is also popular with ski areas such as Vernon’s Silver Star Mountain only 45 minutes away. Enderby enjoys several unique business enterprises such as antique stores, coffee houses, bistro and general retail merchants, some limited heavy industry and services.

History and Economy
Enderby has a rich history as a terminus for railways and paddlewheel ships at the turn of the century transferring goods from the fertile Okanagan Valley to the transcontinental railway system. Today, Enderby’s economy relies on forestry, agriculture, tourism and services. Enderby’s socio-economic status is one of the lowest in the Okanagan Valley with high levels of unemployment and poverty. For example, as of September, 2003, the percentage of Enderby and area residents aged 19 to 64 receiving federal Employment Insurance assistance was 4% compared to 3.6% in the rest of the Okanagan and 3% provincially. Similarly, the number of Enderby and area residents aged 19 to 64 receiving provincial income assistance is 80% above the Okanagan average.

Population Profile
The Enderby region, including the communities of Mara, Grindrod and Ashton Creek and the Spallumcheen Indian Band, has a population of approximately 7,360 (2005). The Enderby CHC serves the Enderby Local Health Area which is equivalent, for planning purposes, to Area F of the North Okanagan Regional District. The median age of 42.4 years of age. The largest proportion of the population is comprised of residents <20 years of age (23.6%) while the smallest proportion is residents aged >85 (2.1%). Enderby has a generally older population compared with the rest of the Interior Health Authority.

Climate
The climate is semi-arid and similar to that of the rest of the Okanagan Valley with warm summers and moderate winter temperatures. Enderby’s proximity to the Shuswap, however, moderates the climate with greater rainfall and less extreme temperatures than the central and southern parts of the valley. Typical summer high temperatures average 27 degrees Celsius while average winter daytime temperatures are -2 degrees Celsius.

Schooling
Enderby has one public elementary school and one secondary school. The Spallumcheen Indian Band operates the Shihaya Native Elementary School.

Recreation
In winter, popular pastimes include curling, hockey and snowmobiling, along with downhill and cross-country skiing at various locations including Silver Star Mountain, Larch Hills, and Sovereign Lakes. Resorts such as Sun Peaks near Kamloops and Big White in Kelowna are readily accessible. Golfing, fishing and water sports are the dominant summer activities with destination resorts and beach areas located at nearby Mara Lake, Mabel Lake, Shuswap Lake and Okanagan and Kalamalka Lakes near Vernon. The various communities in the North Okanagan area hold annual fairs and community events, especially in the spring and fall months. The neighbouring community of Armstrong hosts the Interior Provincial Exhibition in late August annually.

Services
Enderby has a number of retail, commercial and specialty stores and services plus a number of churches and numerous community and youth groups. Retailers include an IGAM Garden Market supermarket, two pharmacies, Bank of Montreal, credit union, hotels, restaurants and various clothing, mercantile and personal services retailers.

Health Services
Enderby is served by the Enderby Community Health Centre – a primary care health centre that operates Monday through Friday from 8AM to 4PM. The Health Centre has three physicians, a nurse practitioner, public health, mental health, speech language pathologist and community care nursing. The facility has an outpatient clinic and lab services. There are four additional community primary care physicians working in Enderby. Acute care services are provided in both Salmon Arm at Shuswap Lake General Hospital and Vernon Jubilee Hospital. VJH is a full service hospital with 125 acute care beds. It serves as the regional referral centre for the North Okanagan including Vernon, Coldstream, Oyama, Lumby, Armstrong, Spallumcheen and Enderby. Vernon Jubilee will also receive patients from Revelstoke, Sicamous and Salmon Arm (e.g., orthopedic cases). Interior Health operates Parkview Place, a 35 bed residential care facility in Enderby.

Housing -
Welcome –
Preceptor Support –
Student Orientations –
Community Coordinator –
Community Involvement –
Cultural and Learning Activities –
Hazelton

Location and Access
The Hazeltons are located in Northern British Columbia and named after the hazel bushes that are found along the river-carved terraces within the majestic setting dominated by the 6500 foot walls of the rugged Roche de Boule Range. People live in a number of native and non-native communities, on ranches and homesteads that are scattered over a wide region and include communities from Moricetown to Cedarvale as well as Old Hazelton, New Hazelton, South Hazelton, Two Mile, Susqua Valley, Kispiox Valley, Kitwanga, Hagwilget, Gitseukkla, Gitwangak, Gitanyow, Kispiox, Glen Vowell and Gitannax. The next closest 'neighbouring' communities are Smithers and Terrace. Smithers to the east is 150 km return by road travel, Terrace to the west is 290 km return while Vancouver in the south is 2400 km by return.

History and Economy
For centuries, the Hazelton area has been home to the Gitxsan and Wet'suwet'en people living in their extensive traditional territories. The region is renowned for its ancient culture and traditions, its totems and the famous 'Ksan Aboriginal Cultural Centre. Major pioneering efforts in land claims settlements have originated in the Hazeltons, most recently in the landmark 'Delgamuuk vs. the Queen' decision by the Supreme Court of Canada. The unquelled wilderness setting has made the Hazeltons the Historic Heartland of Northwest BC as bustling pioneer communities developed near the confluence of the Skeena and Bulkley Rivers following contact in the mid 19th century. Old Hazelton's restored heritage buildings serve as a reminder of the days when Hazelton was the commercial centre of the Northwest. Around 1890, the community was the upriver terminus for a fleet of sternwheelers that plied the wild rapids of the Skeena. People and supplies were transported to Hazelton and from there to mines, farms and far-flung settlements. To this day the Hazeltons maintain a friendly pioneer atmosphere that makes it easy to imagine the sound of riverboat whistles that would signal the arrival of supplies, settlers, and long nights of revelry. In 1914, a transcontinental rail line was constructed along the Skeena Valley with hundreds of construction workers and homesteaders in its wake. With the anticipated boom from the railroad, New Hazelton and South Hazelton were established. Forestry and fishing have always been major contributors to the local economy along with ranching and tourism as well as some past small mining operations. With recent government cutbacks and the softwood lumber dispute with the USA, local unemployment unfortunately have reached new highs.

Population Profile
The catchment area has a population of more than 7,000 people, two thirds of whom are of aboriginal descent. This includes the entire Gitxsan nation along with the western reaches of the Wet'suwet'en people. During summer months the population swells considerably because of tourism and the many available outdoor activities.

Recreation
Opportunities in the Hazeltons to discover the many riches of life in rural B.C. are many, such as fishing, hiking the alpine meadows and glaciers, white water rafting, canoeing, golfing, or attending local events like rodeo, music festivals or community gatherings. In the winter there are skiing, skating and hockey as well as participation in Community Choir and Community Concert Band.

Services
Services include various stores, restaurants, movie theatre, service stations, library, museum, bank and dental services. Churches in the community include Anglican, Roman Catholic, Salvation Army, United Church, Pentecostal, Seventh Day Adventist, Christian & Missionary Alliance and Community Gospel Chapel.

Health Services
Health care has a unique and proud history in the Hazeltons, which along with Bella Bella and Port Simpson pioneered modern medicine in NorthWestern British Columbia through its United Church mission hospitals from the close of the 19th century. The Wrinch Memorial Hospital along with the attached outpatient family practice and dental clinics are still operated under the auspices of the United Church Health Services. The hospital is fully accredited and affiliated with the University of British Columbia as well as the Northern Health Authority. Ten of its thirty beds are dedicated to acute care. Public health, pharmacy, OT, physiotherapy, diabetic teaching, radiology, ultrasound and laboratory services are all available within the facility. On active medical staff are seven family physicians and two dentists. Visiting physicians include general surgery, ENT, psychiatry, urology, and rheumatology. Local physicians provide a full range of outpatient services, inpatient services, obstetrics including C-Sections, anaesthesia and 24-hour emergency services. As well medical staff are active in community outreach activities. Medical records are fully computerized. Ambulance services are located on the hospital grounds. Over the years, Hazelton has been a model for Family Practice with its salaried, holistic and group practice philosophy. As such it has had impact on Family Medicine throughout Canada. Physicians from Hazelton such as Dr. Don Butt, Dr. Don Watt and most recently Dr. Peter Newbery have all served as presidents of the College of Family Physicians of Canada. During 2003 Dr. Peter Newbery was awarded the Order of Canada in recognition of his leadership for health and medical care in rural and remote communities in Canada. Medical Staff are also active in international health endeavours such as WONCA (World Organization of Family Doctors), Family and Community Medicine in China and with the University of Northern BC. Teaching has a time-honoured tradition at Hazelton commencing with the Nursing School that was established locally in the first part of the last century. Medical students, nursing students, other students and Family Practice residents rotate regularly through the facility. Over the years a number have returned to become permanent members of staff. Teaching, experimental training, seminars, teleconferences, video-review and trainee evaluation are actively practiced skills. Several staff physicians are involved in the annual College of Family Physicians' Certification Exams. During the past decade, the CHAC (Community Health Advisory Committee) was established with an enthusiastic and varied membership from many parts of the community, such as the Ministry of Children and Family Development, and Provincial Public Health. The outreach projects such as the ongoing programs. In turn these programs activities. At Hazelton students have along with teaching files for topics weekly clinic visits to the Gitxsan levels. Close collaboration exists Wet'suwet'en Health services, as well CHRs (Community Health Representatives). The CHAC also has a broad based and interdisciplinary approach to the community and has undertaken significant and comprehensive "Starting Smart" pregnancy outreach program, parenting programs and lifestyle programs. Hazelton also has an opportunity for trainees to be exposed to primary preventive and community interdisciplinary CHRs (Community Health Representatives) have direct contact with computers and access to the internet. An up-to-date library is on site and includes computer programs. Because of the long distances to outlying communities, medical staff make CHRs (Community Health Representatives) have the ability to travel to various other communities such as counselling, A&D workers, village consultation etc. Cultural and Learning Activities –
Port McNeill

Location and Access
Port McNeill is located within the Mount Waddington District, on Northeast coast of Vancouver Island, off the west coast of British Columbia. Port McNeill is 2 hours north of Campbell River. A coastal setting and abundant rainforest supports many species of fish and wildlife. The mild climate allows for year 'round outdoor recreational activity and is enjoyed by visitors from all over the world.

History and Economy
Port McNeill, named after the Hudson Bay Company factor, Mr. William McNeill, is situated on the North Island, some 200 kilometers north of Campbell River. Established in 1937 as a logging community by Pioneer Timer, it is the self-styled "hub of the North Island" services many of the surrounding communities. Port McNeill was the first village in Canada to be proclaimed as a town after the Canadian Charter was repatriated. The Queen’s first act, in Ottawa, after signing the Charter, was to sign the town’s Proclamation papers. The North Island has for many decades been a prime producer of natural resources, contributing greatly to the wealth of the province. More recently, these contributions have been partly reciprocated with some provincial reinvestment in infrastructure. Prime employers in the community are Weyerhaeuser Limited, Western Forest Products, Canadian Forest Products Ltd, TimberWest, Interfor Products Ltd. and LeMare Lake Logging along with numerous smaller contracting companies. Port McNeill is the center of aquaculture activity on northern Vancouver Island and is best situated to service the industry with related activities such as salmon processing (Beaver Cove) construction of net pens and floats. Surrounded by a spectacular natural environment, our Town is a prime location for tourism developments and our harbour facility is an asset for any marine-oriented operation. Increased tourism activities in the Port McNeill area now generate over $30 million annually, and opportunities in this industry continue to grow.

Population Profile
Port McNeill is a town of about 3,000 people. Right across the bay is Alert Bay, known to be the oldest community in BC. There is a healthy preservation of the tradition of Kwakuitl culture. The First Nations community is respected and encouraged by all inhabitants of the North Island. Another community rich in history and culture is Sointula, which means 'a place of harmony' in Finnish, and was settled at the turn of the century by Finnish immigrants who set out to make a Utopian society on Malcolm Island.

Climate
Northern Vancouver Island has a typical, west coast marine climate which brings cool, moist weather to the area for most of the year. Temperature variations are moderate with an average annual temperature of 8 degrees Celsius (46 degrees Fahrenheit). The summer months, May through September, are considerably drier than the winter. Temperatures average 17.4 degrees Celsius (63 degrees Fahrenheit) in July and August, with hot, sunny days and some cooler days as well.

Recreation
Port McNeill provides a full range of sports clubs and recreation facilities. There are opportunities to go fishing, hiking, sailing, windsurfing, caving, diving, canoeing, and kayaking.

Services
North Island College has five satellite campuses, one here in Port McNeill, and our senior secondary school buses and ferries students in from five communities. We have two primary schools. The downtown core offers everything your heart desires--merchants, grocers, clothing, hardware, auto parts stores, and restaurants. Churches in the community include Anglican/United Fellowship, Bahai Faith, Baptist Church, Catholic Church, Church of Jesus Christ of Latter-day Saints, Full Gospel Church, and Jehovah's Witnesses.

Health Services

Port McNeill and District Hospital is an 11 bed hospital which opened in 1979. It has an active Emergency department with 2 RNs at all times and has a full-time physiotherapy department. As well as Diabetic Education program, hospice and palliative care, home care support and a dietician. There is a visiting Occupational Therapist. The hospital provides minor surgery, low risk obstetrics and an onsite Chemical Detox program. A new psychiatric observation unit has been recently completed. The Medical Clinic provides a full service General/Family Practice with a complement of five full-time General Practitioners and one part-time. The Medical Practice was set up in 1974 by Dr. Granger Avery as a solo practice located in a small house. The practice has evolved over the years, with many attempts to integrate across the health care silos, and focus on the fundamentals of illness. Examples include:

- Mental Health and drug and alcohol rounds held weekly at the clinic
- Practice focus on aboriginal health
- Conjoint medical/nursing rounds held daily at the hospital
- Teaching of medical students and family practice residents the clinic, hospital, patient’s homes and outpost clinics
- Outreach clinics
- Integration of harm reduction with a methadone treatment program for narcotic addicts
- Approval of a psychiatric observation unit with close ties to the psychiatric unit in St. Joseph’s Hospital, Comox
- Attempts to integrate school and RCMP to address juvenile drug use and other risky behaviours
- Efforts to set up a North Island Obstetrical service incorporating a midwife.

There is a long tradition of teaching in Port McNeill medical practice and the Port McNeill hospital, with not only medical students and Family Practice Residents, but with nurses, ambulance attendants, First Nations Community Health Representatives and First Aid attendants and other small community emergency responders.
ICU: The PRGH has a 4 bed Intensive care unit staffed by specially trained RN's. On site specialists in Surgery and Internal medicine are available for consultation and a wide variety of external facilities and resources are utilized for more complex patients. The unit is well equipped with the most modern equipment and capable of looking after patients requiring short term ventilation. A state of the art helicopter pad is available for transferring the most critically ill patients to other facilities.

Operating rooms: The PRGH has two available operating theatres staffed by RN's specially trained in the skills necessary to work in the operating room. Currently the OR's are scheduled to perform procedures Monday to Thursday with on call coverage for Emergency surgeries 24 hours/day 7 day/week. We perform general, gynaecological, dental and some eye surgeries at our site.

Mental Health: the PRGH has a 5 bed inpatient psychiatry program. The unit is staffed by RN's and LPN's specially trained in dealing with Mental Health issues and a visiting Psychiatrist is on site several days/week.

Rehab: The PRGH has a very well equipped therapy department. The department is staffed by physiotherapists, occupational therapist and aids and provides service to both inpatients and outpatients Monday to Friday with some ability to provide service on the weekends.

Pharmacy: The PRGH has a well stocked pharmacy department. The department is staffed by licensed pharmacists and pharmacy techs. The service is available Monday to Friday with the mechanisms in place to access necessary medications after hours and on the weekends.

Diagnostic imaging: The PRGH has a well equipped and modern diagnostic imaging department staffed by a variety of people specially trained in performing diagnostic procedures including ultrasound, x-rays, and fluoroscopy. A radiologist is on site several days per week to interpret results of tests. The department also does Screening and Diagnostic Mammograms. All staff are registered with the CAMRT/BCAMRT and Ultrasound is registered with ARDMS. Hours of operation are 0800-1800 Monday- Friday 0900-1700 Sat Sun and Stats on call all other hours Radiologist is on site minimum of 4 days per week. Future plans include obtaining a CT scanner and implementation of a PACS system.

Laboratory: The PRGH has a state of the art lab available for performing an extensive array of tests for both inpatients and outpatients. Specially trained lab staff is available 24 hours/day, 7 days/week to perform Emergency tests.

Outpatient services: The PRGH offers a wide variety of outpatient services including a Renal Dialysis unit, an Ambulatory Care area, a Cast Clinic, Diabetic Teaching program, outpatient Mental Health services, Endoscopy and an outpatient Oncology program. Because of our geographical isolation, we often provide a more extensive list of services than you would typically find in a facility our size.

There is a wide variety of other services in our facility including Plant Operations and Maintenance, Health Records, Finance, Employee Engagement (i.e. "Human Resources"), Stores and Material Management, Sterile Processing and Laundry services. Our Nutrition Services and Housekeeping duties are performed by contractors affiliated with Vancouver Coast Health Authority.

Housing -
Welcome –
Preceptor Support –

Student Orientations –
Community Coordinator –
Community Involvement –
Cultural and Learning Activities –
Trail - The Community in Brief

Location and Access
Trail and its surrounding towns are located in the Kootenays, a mountainous region in the interior of the province of BC. Located close to the US border, Trail is 8 hours by car from Vancouver and only 200 km north of the large urban centre of Spokane, Washington. It is a very accessible community with excellent highways and an airport in neighbouring Castlegar that runs daily flights to Vancouver and Calgary. The City of Trail is one of five municipalities and two electoral areas that use the motto "The Home of Champions". The City and surrounding areas are proud of the champions in sport, industry, the arts, and education who have come from the area. This "Home of Champions" was established in 1895 when a small smelter was constructed to service the mines in nearby Rossland. Today, Teck Cominco is the world’s largest lead and zinc smelter. The steeply terraced homes and bright gardens tucked along the winding streets of "Little Italy" are evidence that the rich traditions of Italian Immigrants, who arrived here to build the railways in the 1900's, remain a celebrated part of Trail's heritage. Rossland is home to Red Mountain Ski Area, recently rated the number one resort in the world for the hard-core skier or snowboarder. Red Mountain has 1200 acres of skiable terrain spread over two mountains. Rossland also offers some of the finest cross-country skiing anywhere. Several trails start at the edge of town connecting to trails across from Red Mountain at the Black Jack X-C Ski Area with 25 km of daily machine-groomed track passing through varied terrain.

History and Economy
Trail is known as a smelter town, as its prosperity has been assured for many years by Teck Cominco, which employs many of the residents of the area. Kootenay Boundary Regional Hospital is another major employer in the community. In recent years there has been increasing economic diversity.

Population Profile
The Greater Trail community has a population of 21,000 from Fruitvale in the East to Rossland in the mountains to the West. The total West Kootenay regional population served by Trail’s hospital is approximately 85,000.

Climate
The climate is typical of the Southern BC interior. Summer temperatures range from 20 to 35 degrees Celsius, while winter temperatures fall between +10 and -10 degrees. Summers are dry and hot, while winters are usually snowy.

Schooling
Greater Trail has 8 Elementary Schools, 3 Secondary Schools, and 3 Alternate Schools. Selkirk College has campuses in Castlegar, Nelson, and Trail.

Recreation
In winter, popular pastimes include curling, hockey and snowmobiling, along with downhill and cross-country skiing at Red Mountain, in Rossland, 10 km away. Golfing, fishing and water sports are the dominant summer activities. The community has a new $4.5 million aquatic centre built for the 1996 BC Summer Games which Trail and nearby Castlegar hosted. The various communities in the Greater Trail area hold annual fairs and community events, especially in the spring and fall months.

Services
Trail has a full range of retail and commercial stores and services plus a number of churches and numerous community and youth groups.

Health Services
Kootenay Boundary Regional Hospital is a full service hospital with 75 acute care and 50 extended care beds. It serves as the regional referral centre for an immediate population of 21,000 and a regional population of 83,000. All major specialties are available on site, with the exception of neurosurgery and cardiovascular surgery. A full range of diagnostic services, including CT, are based at Kootenay Boundary Regional Hospital. Twenty-nine specialists are on staff, including two general surgeons, two obstetrician/gynaecologists, a plastic surgeon, four anaesthetists, three orthopaedic surgeons, five psychiatrists, and five internists, including an oncologist and a nephrologist. Specialized equipment includes ICU, nuclear scan, CT, US, echo and the regional laboratory. There are three radiologists and one pathologist on staff. The community is serviced by 28 general practitioners who admit patients to Kootenay Boundary Regional Hospital.
Links & Resources

Programs of the BC Academic Health Council

The Health Sciences Placement Network of BC — HSPNet (www.hspbc.net)
The Interprofessional Network of BC — In-BC (www.in-bc.ca) in conjunction with the College of Health Disciplines, UBC

Publications

Report on nursing practice in remote and rural Canada

British Columbia Health Care Authorities

Fraser Health (www.fraserhealth.ca)
Interior Health (www.interiorhealth.ca)
Northern Health (www.northernhealth.ca)
Provincial Health Services (www.phsa.ca)
Vancouver Coastal Health (www.vch.ca)
Vancouver Island Health (www.viha.ca)

British Columbia Government & Health Care Agencies

BC Ministry of Health (www.gov.bc.ca/healthservices/)
BC Ministry of Advanced Education (www.gov.bc.ca/aved/)
Health Employers Association of BC (http://www.heabc.bc.ca)
Health Match BC (www.healthmatchbc.org)

Participating Post-Secondary Education Institutions

UBC College of Health Disciplines http://www.health-sciences.ubc.ca/
UBC Community-based Rural Training Program http://www.familypractice.ubc.ca/CBRT/
UBC Faculty of Medicine http://www.med.ubc.ca/
BCIT Health Sciences http://www.health.bcit.ca/
Selkirk College http://www.selkirk.bc.ca/
Malaspina University College http://www.mala.ca/index.asp
Okanagan University College http://www.ouc.bc.ca/
University of Victoria http://www.uvic.ca/
University of Northern British Columbia http://www.unbc.ca/
North Island College http://www.nic.bc.ca/
Kwantlen University College http://www.kwantlen.ca/

British Columbia Tourism Resources

www.Britishcolumbia.com
www.Hellobc.com
www.BCRockies.com
www.CoastandMountains.bc.ca
www.Island.bc.ca
www.Landwithoutlimits.com
www.NorthernBCtravel.com
www.NorthernCentralislands.com
www.Tourism-Vancouver.org
BACKGROUND
BC Rural Academic Health Project’s (RAHP) goal is to develop a longer term sustainable model for strengthening student placements in rural British Columbia. The project builds on existing initiatives in the province, incorporates lessons from other provinces and beyond and fosters a consensus on how to enhance rural practice education.

AIMS
* Recruitment and retention of rural health practitioners
* Increased capacity for educating health professionals
* Enhanced interprofessional teamwork
* Improved health for rural communities and the broader health system

MATERIAL & METHODS
The project used a collaborative approach with strategic questions to engage key stakeholders across the province. Included in this process was a literature review and synthesis, inventory of existing initiatives and community/regional/provincial forums leading to a consensus on a model and action plan for building capacity for rural academic health in British Columbia.

1. Data-gathering & communications
   A. Project overview
   B. Literature synthesis paper
   C. Inventory of initiatives
   D. Initial consultations

2. Multi-stakeholder consultations
   A. Discursive phase
   B. Community/regional forums
   C. Policy maker interviews

3. Provincial consensus building
   A. Draft model
   B. Provincial forums
   C. Recommendations

4. Endorsement & implementation
   A. Final report & communication
   B. Communications to stakeholders
   C. Population for monitoring feedback

RESULTS
The RAHP final report (April 2008) profiles the following:
* Benefits of rural practice education
* Foundational principles and essential components
* Partnerships and roles
* Recommendations and action plan

CONCLUSION
* Rural academic health provides invaluable benefits to students, communities, and the broader health system
* There is significant complexity given the range of initiatives and stakeholders combined with growing health human resources issues in rural communities
* There is a growing imperative to support and embed rural learning experiences in health and human service education programs
* Priorities include provincial coordination, local coordination and student housing

Key Principles
* Community-driven
* Partnerships
* Community as teacher
* Service learning
* Innovation

Essential Components
For students
* Housing
* Orientation and ongoing support
* Preceptors from range of professions
* Access to computers and internet
* Opportunities to interact with the community
* Social and recreational activities

For preceptors
* Continuing professional development and preceptor education
* Recognition and/or remuneration
* Local coordination

Provincial coordination
* Placement coordination policies and processes
* Marketing
* Networking across key participants
* Linkage with rural recruitment
* Evaluation and research, including knowledge translation
* Infrastructure and funding

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