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Title

How can rural community-engaged health services planning affect sustainable health care system changes? - A process description and qualitative analysis of data from the Rural Coordination Centre of British Columbia's Rural Site Visits Project

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Abstract

Objectives

The objectives of the Rural Site Visit Project (SV Project) were to develop a successful model for engaging all 201 communities in rural British Columbia, Canada, build relationships and gather data about community health care issues to help modify existing rural health care programs and inform government rural health care policy.

Design

An adapted version of Boelen's health partnership model was used to identify each community's Health Care Partners: health providers, academics, policy makers, health managers, and community representatives. Qualitative data was gathered using a semi-structured interview guide. Major themes were identified through content analysis, and this information was fed back to the government and interviewees in reports every six months.

Setting

The 107 communities visited thus far have health care services that range from hospitals with surgical programs to remote communities with no medical services at all. The majority have access to local primary care.

Participants

Participants were recruited from the Health Care Partner groups identified above using purposeful and snowball sampling.

Primary and secondary outcome measures

A successful process was developed to engage rural communities in identifying their health care priorities, whilst simultaneously building and strengthening relationships. The qualitative data was analysed from 185 meetings in 80 communities and shared with policy makers at governmental and community levels.

Results

36 themes have been identified and three overarching themes that interconnect all the interviews, namely Relationships, Autonomy and Change Over Time, are discussed.

Conclusion

The SV Project appears to be unique in that it is physician led, prioritizes relationships, engages all of the health care partners singly and jointly in each community, is ongoing, provides feedback to both the policy makers and all interviewees on a 6-monthly basis and, by virtue of its large scope, has the ability to produce interim reports that have helped support system change.

Article Summary

- This study process has adapted Boelen's health partnership model and is unique in that it is physician led, prioritizes relationships, engages all of the health care partners singly and jointly in each community, is ongoing, provides feedback to both the policy makers and all interviewees on a 6-monthly basis.

- A successful method of engaging with rural communities and building relationships and trust across multiple stakeholder groups is described that contributed to influencing positive health care system changes.

- As all communities in one province are being visited a picture of rural health care initiatives and challenges is highly comprehensive and therefore able to influence policy.

- One of the main limitations in this study is that because the interviewers were experienced health care providers, power differentials may have existed which may have introduced bias in the discussions.

- A potential limitation is the enormous amount of data to handle and analyze in a rigorous way, which was mitigated by having two full time analysts working together to ensure consistency with frequent meeting with the research team to consider and agree emerging themes.

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Introduction

British Columba (BC), Canada, has a population of approximately 5 million. About fourteen percent (631,776) (1) are rural citizens distributed unevenly over an area of 944,738 km^2. BC is geographically diverse with a broken 27,000 km coastline and extensive mountain ranges that make for long and often dangerous travel, complicated at times by wildfires, floods, avalanches and harsh winter conditions. Access to health care services for rural citizens is often limited by the expansive geography, provider availability (2) and transportation issues (3).

Support programs for rural physicians in BC are overseen by the Joint Standing Committee on Rural Issues (JSC), a committee comprised of equal numbers of provincial Ministry of Health representatives and rural physicians. The JSC manages approximately C$150M (2020) of funding annually for programs and projects that improve health care delivery in rural BC (JSC Program Booklet). Some of this work is delivered by the Rural Coordination Centre of BC (RCCbc), which is funded by the JSC to coordinate and improve rural health care throughout the province.

The Rural Site Visits Project (SV Project) was initiated in 2017 by rural physicians with a proposal to the JSC who tasked the RCCbc with visiting 201 rural and Indigenous BC communities identified as eligible for rural benefits under the Rural Practice Subsidiary Agreement (RSA). The RSA is an agreement between the Government of BC and the Doctors of BC (a professional organization that represents 14,000 physicians, medical residents and medical students in BC).

The purpose of the SV Project was to build relationships between rural physicians, health care providers, health administrators, municipal leadership, First Nations leadership, first responders, academia and policy makers through listening and gathering data systematically about local successes, innovations and challenges relating to rural health care delivery. This data is guiding the development of JSC programs and informing government Rural Health Care policy.

In 1978 the declaration of the Alma-Ata International Conference on Primary Health Care stated that: “The people have the right and duty to participate individually and collectively in the planning and implementation of their health care” (4). Current trends in rural health services, however, aim to reduce infrastructure and support to achieve greater efficiencies through centralization of services (5, 6). Small rural communities have had to be proactive in securing local health services to resist this development (7, 8), requiring improved relationships and communication between the policy makers and communities.

Community participation has been seen as a more complete approach to health development (9) leading to culturally and contextually appropriate decisions being made about rural health services (10, 11). Relationship building between stakeholders is also seen as more effective than attempting to provide a myriad of health care services (12, 13), especially as each rural community is unique and “one size fits all” approaches are largely ineffective (6, 14). While there have been efforts by health service policy makers to align their actions with rural communities’ expressed priorities (15, 16), the processes used for community engagement have received less attention (17) and descriptions seldom include adequate documentation of the processes involved (17, 18).

The community engagement literature does not show examples of rural health projects initiated and led by physicians, even though physicians have been key partners in other research on rural community-engaged health services planning (15). Much of the research on community engagement in rural health service planning has had a specific focus, for example in improving immunization programs in Nigeria (17) or chronic disease care in the Torres Strait Islands (13). There are some examples of research focused on community participation for broader primary care reform, for example, in the Northern Health Authority region of BC (15) and the Remote Service Futures (RSF) Project in Scotland (10, 12, 16). The former has resulted in some sustained changes to date, for example the establishment of Primary Care Nurses, improved antenatal care and regional palliative care services (15). When the RSF outcomes were reviewed in 2014: "Only one direct sustained service change was found" (19). These raise the question of how best to affect sustainable beneficial rural health system changes using community engagement processes. The project described here attempts to address this issue.

Design & Methods

Theoretical Approach

The Health Partnership model described by Boelen (20) was used. This identifies five partners: health professionals, academic institutions, policy makers, health managers and citizens and recommends they meet to identify ways to improve health systems. The concept of meeting with the partners together in each community was modified to include additional separate meetings with each of the partners. Who constituted the health partners could be different in

each community, so the concept was adapted to the local context to include those present in the community. This could include others such as first responders, business and non-profit groups. It was not possible to have combined partner meetings in all communities as it was not always possible to find a date and time within the visits time line that worked for everyone.

The interviews incorporated an Appreciative Inquiry approach (21, 22) with intentional listening using a semi-structured interview guide. The interviews focused on how rural community members perceived health care delivery within their respective communities seeking successes and innovations as well as challenges. To process the large volume of qualitative data collected, qualitative content analysis (23) was used.

Patient and Public Involvement

Public input into the research project occurred during the initial pilot Site Visits to eight rural communities.

Public input was used to shape the community engagement process and the interview guide.

The initial interview guide was developed by the investigators, who had many years of rural health care experience, to elicit broad discussion about multiple health care issues. The guide was refined based on public and provider input during pilot visits. The interview format continued to be iteratively improved based on feedback from subsequent Site Visits.

Persons representing the health care partner groups in each community were recruited initially. Snowball recruitment was then used to include other valuable perspectives.

Participants were asked for feedback on the interview process and whether the time taken was appropriate.

Every six months a Community Feedback Report is circulated to all past interviewees in which the latest results are discussed. The report is in the public domain and dissemination is encouraged.

Site Recruitment

The sites identified for the SV Project were the 201 communities identified under the RSA.

Arranging Site Visits

Sites are selected six to twelve months in advance. Three to six months prior to a Site Visit, recruitment of participants commences and RCCbc staff coordinate the planning. Depending on community size and location site visits last one to three days and involve one to five communities.

Site Visits Team

A Site Visits team consists of at least one Site Visitor and one RCCbc staff member, who coordinates the visits. The Site Visitors comprise 19 rural physicians and one midwife. A one-day training session for interviewers included training in Appreciative Inquiry techniques and qualitative interviewing and cultural safety through the San'yas Indigenous Cultural Safety Training course. Site Visitors were individually mentored by the Program Leads on their first visits. On some Site Visits guests are invited. The purpose of inviting a guest is to assist urban-based allies in their understanding of how health care functions in small rural communities.

Guests have included policy makers, researchers, health care workers, administrators, and educators.

Participant Recruitment

The study population included participants who identified themselves as living or working in an RSA community and were part of one or more of the partner groups identified by Boelen (20). Participants were recruited using purposeful and snowball sampling (23) through the following methods:

- Email and phone contact through publicly available information
- Recruitment posters in doctors' lounges, hospitals, clinics, and municipal buildings
- Contacting pre-existing contacts who provide connections to potential participants
- Asking participants to suggest others who fit the inclusion criteria

Initial contact was made by telephone or e-mail with a follow-up invitation that detailed the project background, aims and goals and included a copy of the interview guide and consent form. Participants were invited to participate in one-on-one interviews or focus groups (if there was more than one person from an identified health partner group) and dates established. Interviews took place in the communities, however since March 2020, eleven virtual interviews have been trialed as a result of Covid-19 restrictions.

Data Collection

Each health partner group (between one and sixteen participants) was interviewed separately. This was followed by a combined partner focus group (between two to ten people) with a

representative from each of the health partner groups previously interviewed. A semi-structured interview guide was used which has been iteratively refined following community visits, in keeping with standard qualitative methods (supplementary file “Inteview Guide”). The guide was informed by Appreciative Inquiry and public input in order to build relationships and to better understand how rural community members perceive health care delivery within their respective communities including health care successes, innovations and challenges that inhibit their ability to access services in an equitable manner. Interviews were recorded digitally and transcribed. Interviews generally lasted one hour. Transcripts were returned to participants within four weeks for verification, alteration, or withdrawal if requested.

Data Analysis

NVivo 12 (QSR International) was used to help organize the data. Initially each interview was coded using an inductive-approach and primary cycle coding (23). This began with a close reading of the data, assigning words or phrases that captured the essence of each sentence. From this a codebook was developed (supplementary file “Code Book”), and second level codes were generated to identify emerging themes across the data. Throughout the entire analysis process data was revisited to allow for the comparison and modification of codes to fit new incoming data.

Rigor was maintained throughout by a second data analyst. Analysts coded identical interviews separately and then compared coding to promote consistency. Analysts met weekly to discuss changes and modifications needed for the coding framework. The coding framework and

emerging analysis was discussed and agreed within the research team. The data was further interpreted to identify themes connecting the data across communities (23).

Knowledge Translation

Emerging themes are disseminated to policy makers, physicians, allied health professionals, First Nations, municipality members, academics, and the general public through various knowledge translation outputs such as a six-monthly JSC and publicly available community feedback reports and newsletters, specialized (focused) reports, presentations, briefing notes, and publications. Additionally, an Innovations website has been established to share successful innovations identified by interviewees.

Ethics

The study received harmonized ethics approval from the Behavioral Research Ethics Board of the University of British Columbia. Operational approval was also received from each health authority. Informed consent is collected from all participants.

Results

Site Visits Engagement Process

Although the Covid-19 pandemic has significantly slowed down the project, 382 interviews have been carried out in 107 communities over a three-year period (Table 1). The first 4 site visits to 9 communities with 23 interviews were used to pilot and develop the methods and were not included in the analysis reported here which is based on 185 interviews with 754 participants in 80 communities. The data from the remaining 27 site visits are in process of transcription,

returning transcripts to participants and analysis. As the data is well saturated and the processes take several months it seems appropriate to report the study now.

Table 1 Partner groups and numbers of interviews

Health Partner Groups	Definition	Number of Interviews Analyzed	Number of Pilot Interviews Analyzed
Health Administrators	Health Services Administrators, health managers, hospital/clinic managers	36	4
Physicians	Majority were family physicians, but also includes residents, specialists and hospitalists	52	6
Municipal / Community Members	Mayors, Councilors, Regional District Directors and members, health organizations/societies	34 (municipal) 4 (community)	5
First Nations	First Nations Band members, elders, Chiefs, health directors, community health representatives, nurses, health coordinators	29	2
Nurse Practitioners*	Nurse practitioners (could also include students)	7	0
Midwives*	Midwives (could also include students)	4	0
First Responders*	Fire Chiefs, paramedics, community paramedics	1	0
Academics*	Clinical professors, clinical teachers, clinical researchers, medical school professors.	2	0
Combined Partners (group meeting)	Leads (or representatives/proxy's) of each health partner group such as the Mayor, hospital Chief-of-Staff, First Nations health director, fire chief.	16	6
Total number of interviews		185 (interviews analyzed to date not including pilot interviews)	23 (pilot interviews analyzed for primary codebook development)

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Number of RSA Communities visited	80
Number of interviews analysed	185
Number of participants	754

Across interviews collectively, one participant withdrew their transcript. Many participants provided feedback; highlighting their enjoyment of the direct, in-person engagement process that was used and the connections they provided:

"I think this has been very informative. Just getting to know what you guys do…and [the] supports [that exist] and establishing connections and…learning about these connections that exist that I haven't tapped into personally so, it's great." – Combined Partners

Participants further described how they felt the process allowed for their voices to be heard, and their communities to be recognized:

"I appreciate being able to talk…and to give frank feedback because that is tough at times and this is a good option to do it…some of our issues aren't really out there right? So, it's good to be able to have a voice to be able to indicate this." – Nurse Practitioner

"I want to thank you for recognizing us a 'rural,' because a lot of people don't see us as rural." – First Nations

It was commonly voiced by participants that, throughout the engagement process, they'd love to learn about what other communities have achieved.

"Would love to see information about other initiatives going on around other provinces that they might be able to learn from." – Combined Partners

"[We] would like to receive feedback about how [we] work with other communities and what works well in other communities." – Combined Partners

These requests from participants ultimately led to the creation of the Site Visits Innovations website.

Site Visits Themes

The data has become well saturated with 36 categories emerging from the data to date. The ten most common themes are presented briefly to provide context (Table 2), and these will be the subject of subsequent publications. This article reports three overarching themes that interconnect all the data: Relationships, Autonomy and Change Over Time.

Table 2: Rural Site Visits Project Table 2: List of Top 10 Themes

Themes	Definitions
Areas of Opportunity	Areas of health care that provide an opportunity to be changed or improved upon within reason. Examples range from old & damaged waiting rooms (infrastructure) to miscommunication between two or more stake holding bodies (relationship building).
Support	Areas in which direct support or additional support is requested by any health care partner in any area.
Transportation	All methods of transportation utilized by community members for local and long-distance transport. This section includes specific methods, thoughts, successes and challenges related to local transportation, emergency transportation, accessing areas far away (distance) and environmental factors/conditions.
Successful Initiatives	Initiatives such as measures, models, programs, methods, or systems that have created a beneficial impact in improving the health care and/or health service delivery of a community.
Population	Health and non-health related (i.e. community events) aspects of a population that relate to a community's population growth, recruitment, and retention
Health Authorities	Any reference to interactions with a communities HA and/or to assistance, successes, challenges brought upon a community through their HA. May also include information regarding communities that declare the presence/absence of their ties with their HA.
Scope of Practice & Workload	The entire role that physicians and/or other health professionals encompass as a rural health care provider. This may include general and or specific skill sets that are required from individuals in a given community. Other concepts included in this section are physician expectations (from self and others), physician wellbeing, and physician burnout (associated with heavy workloads, lack of time off, etc.).
Finance	Various methods of billing, funding resources, and pay models for physicians within a community. Demonstrates the variety of financial models (both successful and inadequate) utilized within communities.
Services	Any health-related service that is at risk of becoming extinct or in need because that service is (1) currently not available in the area and (2) currently in significant demand by patients and health providers.
Patient Capacity & Attachment	Information relating to wait-times for services, family physician availability, or number of beds available within a hospital setting. Includes accounts relating to patient attachment and how patients are attached/unattached in a community.

Relationships

Relationships were important in achieving successful health care outcomes and were built on communication, trust, transparency and collaboration over time. These themes were evident in every community:

"It's really groups of people coming together on committees that have people from city council, the regional district, health boards, and the non-profit societies...and I think if there's a strength in this community, it's that there are those connections and people are willing to work together to find solutions locally." – Combined Partners

Good relationships underpinned communities' abilities to successfully retain their physicians. These relationships were with the communities themselves as well as with administrators and within teams:

"Why do you think they've stayed here?" – Interviewer

"[It's] the relationship that they [the physicians] maintain with the community…It all comes down to the relationships." – Municipality

"When we went to [Health Authority X] to say, 'We're having a terrible time retaining our doctors,' - the turnover was terrible - we got no response from the system. So, the community rallied around and did what was necessary to sustain doctors in this community. But in doing that …. what we did was create relationships with our physicians that are respectful and goes [both] ways." – Community Members

Effective communication and regular "organic" contact were the foundation of these relationships and were important in building trust:

"Having all the different services all in the one building does allow for good open communication, you can pull anyone aside if you bump into them in the hallway to talk about patients. It is a very organic process rather than a formalized team-based care approach. ... It also helps retain people who work here – you build that relationship and trust of what your peers are capable of. It's not formal team-based care, but it is a team." – Combined Partners

"There needs to be trust and consistency of knowing what someone is walking into. Issues of trust [have been] a major block in [our] community to providing and receiving health services." – Health Admin

Successful collaborations that were inclusive of all partners positively impacted health care and helped reduce burnout:

"It makes it much easier working [here], because I've worked here a really long time with [colleagues X and Y] it makes it much easier when we have a group that all works together really well. And that doesn't happen everywhere. [We] are all friends so [we] tend to help each other out... being [without them] …the burnout would be terrible." – Physicians

"It's really groups of people coming together on committees that have people from city council, the regional district, health boards, and the non-profit societies that identify the problems and look at what each particular group…can provide to try to deal with the problem and…it's those

connections and people [who] are willing to work together to find solutions locally."

– Combined Partners

Conversely, poor collaboration and relationships led to adverse consequences:

"...when I meet with my doctors, I hear one thing about what the problem is and how to solve it. And then, if I talked to nurses or midwives or allied health professionals, I hear another version of what the problem is and how we would fix it. And then I sit down with [Health Authority X] and I hear their version of what the problem is and that they are fixing it. And all those voices are never in the same room at the same time..." – Municipality

Good relationships enhance problem solving, reduce the 'red tape' required to affect change and result in greater work satisfaction at all levels, positively affecting other issues such as recruitment, retention, and burnout. Local decision making (autonomy) was an important contributor to work satisfaction.

Autonomy

Autonomy within the health care context was defined in many ways. However, at its core many viewed autonomy as the ability to make reasonable decisions, sensitive to the local context, at a personal or local level that did not require the blessings of a hierarchical, top-down system. The latter stifled initiative, innovations, and satisfaction.

A sense of autonomy within the health care providers appears to improve recruitment and retention. It imbued a sense of greater 'ownership' of, or responsibility for, the local services by the community practitioners:

"Part of it is the relationship that they maintain with the community…Dr [X] has come to the council and has asked for extra room to bring in more medical professionals, and the city worked with him so that he can have the space to have another professional help out his team. The main thing is working with them and letting them grow, not dictating to the doctors." – *Municipality*

The data described a disconnect between centrally directed processes and what was practically achievable in a community:

"…I think there's kind of an issue sometimes with delivery of rural health care in that people actually in the trenches doing the job have a much better insight sometimes into what needs to be done and what is happening than the people making the decisions about how we're going to deliver the health care." – *Physicians*

The most frequent plea was that more local engagement was needed to solve local problems and how important local autonomy was in crafting enduring solutions:

"I couldn't believe that – 'we are bringing more resources and that's not working for you?' What didn't happen is there was no consultation, so it didn't really matter if we brought more resources. It was like, 'you didn't ask us what our problem is, what we need and what is our reality and you're just bringing resources and that's not how we want this to look like..." – *Health Admin*

"…locally it feels like our concerns are profoundly dismissed by the health authority, who clearly have a different idea and a different agenda" ... "We need to be kind of at least a largely autonomous community." – *Physicians*

When consultation occurred a very different attitude existed among the health care providers:

"…So, we took that learning and stepped back and took one whole year to do focus group and to follow staff to understand what they're doing, what are the challenges, the issues, to understand better the population that we serve…involving physicians along the way and after we've done all of this, we came up with another model, not really with much more budget…but it wasn't about the budget anymore and we've presented the model to the staff in March and since then, we are implementing the new model and it's working and people are just following along the process and I think that there's a lot of learning about the history of the community and how we need to do things here." – Health Admin

Local autonomy meant the ability to make rapid operational decisions on the day. Many small rural communities had extraordinary stories of unbroken 24/7 emergency coverage for many years provided by the local practitioners despite being reduced to a single physician at times. Similarly, nurses in small rural hospitals frequently did additional shifts to cover gaps when their colleagues were unable to work. These providers felt a responsibility to maintain these services in their community:

"I had a lot of autonomy about who I could hire…and so I had the ability to hire locally and so I built a big pool of people who lived here who were very committed to [the] Healthcare Centre." – Health Admin

When control of these services was elevated to a higher level outside of the community, this loyalty was reduced as local autonomy was lost, contributing to Emergency Room coverage gaps and difficulty filling nursing shifts:

"…So now we have one GP who is keeping the whole system going through being on call 24 hours a day, 7 days a week. So, it's sort of a step backwards, and I think a lot of it is just that we've lost the autonomy to be able to kind of say, "Well, this is what our community needs. This is how we can go about solving this problem." – Physicians

"...you've done a really innovative thing in adjusting your nursing lines...this is the first community we have not heard [about] nursing shortages." – Interviewer

"So, we need to start developing our rotations to make it attractive for those nurses to come…We're one of the few rural sites that have full staffing now." – Health Administrator

One example of a successful model is a 3-year trial in a region where a Health Authority granted three geographically close rural communities the autonomy to determine their priorities for improving local health care, and provided funding to support these changes:

"We had a series of engagement events for the entire community, health care providers, public, youth at one of the high schools, our Indigenous population, and the [Community X Group] and said, where would you like to spend $500,000 on services and so 5 things came to the top…". – RCCbc Video

Autonomy as defined by the local ability to make relevant health care decisions, runs through all the data as a foundational theme in supporting system improvement.

Change Over Time

"Change over time" is a prominent contextual factor that underpins all the themes within the SV Project to date. One of the biggest changes over time has been the change in community

population. Some remote and resource-based communities reported diminishing populations, however, this was much less common than those reporting increased population growth due to young families leaving cities to find affordable housing and retirees moving in. In addition, there is a growing tourism load in many communities. These factors, exacerbated by the expectations of care for those that have moved into the community, have impacted resources and funding for longstanding residents:

"…a lot of communities are struggling with what to do with a very quickly growing, aging population...we have a very strong in-migration of young families..." – Municipality

"[Our] patient population has increased… [and the] infrastructure has not changed." – Physicians

"...communities in [Region X] have been shrinking since forestry work has moved [away from Region X]." – Municipality

Participants emphasized how demographic and population changes have created local concerns that the community services are not adapted to the changing contexts; thereby causing issues that relate to capacity, patient access, staffing, service demands, manpower, and funding that do not meet the communities' needs:

"…our community is growing, like our nation is growing, but the services haven't. And so, everyone's fighting for a doc…" – First Nations

"I think we're just lacking that vision for the hospital in what is a basic level of service to serve a growing community of 21,000 that also supports 2-3 communities north of us." – Municipality

"…And trying to actually keep up from a staffing perspective, from a staff retention, everything from a budget, like it's we are playing a really hard game of catch-up because it's growing faster than we can even account for and put in services to meet the needs. That's what I think the biggest challenge is…" – Health Admin

Rural communities are dynamic and, because of their size and isolation, particularly vulnerable to changes, which may not be easily anticipated. Change is continual and only those that have the ability to find ways to adapt are able to continue to deliver effective health services.

Discussion

The Site Visit Project has strengths in the degree of its engagement and, after engaging with 107 rural communities and conducting 382 interviews, it has shown that it is possible to collect large volumes of data about local health care issues in a systematic and meaningful way in order to influence provincial health service changes. The fact that the Site Visits team travels to each community appears to have a strong influence on the relationships and trust experienced in the interviews. Many of the interviewees have informally commented on this fact, noting that they feel that the Site Visits team now understands their remoteness, available services, difficulties with transporting patients etc., and that they feel 'heard'. One limitation of this project is that it was carried out in British Columbia and supported by adequate resourcing through negotiated public funds allocated through the provincial physician organization. This means that it is specific to the context of British Columbia but may have elements transferable

to other settings. It would only be possible to replicate this project with sufficient funding supports.

The major themes are being identified and the analyzed data shared as specialized reports to both the micro and macro policy maker levels, connecting them in a manner that is resulting in some early systemic changes. Emergency transportation is one example where the provincial government have recently announced further rural emergency transport resources. The processes described have implications for policy makers in terms of rural health, ones that can be adapted to different contexts.

The three themes described in this article appear as patterns throughout the data set. They are interlinked and can be seen as foundational elements for effective functioning of health care services in rural communities. Good relationships between providers, health authority administration, external specialist services and community members were repeatedly identified as being responsible for high functioning, successful communities. This means that effort needs to be made to create the time and space to develop relationships and that these efforts are valued by all sectors. Part of the importance of relationships was linked to the concept of autonomy which in this sense meant the ability to make local decisions when needed. Autonomy impacted both the sense of wellbeing of the partners, but could also produce very practical, rapidly implemented changes with positive results, for example in the community of Hope. The exercise of autonomy however can be problematic if not carried out within an agreed framework that requires the limits of decision making to be set and agreed with health service administration and which recognizes historical power differences in health care (15, 24). Finally, change over time is recognized as being an important contextual factor in the provision

of services to small rural communities and the resilience of these communities seems related to their ability to adapt to often unexpectedly changing circumstances. Such adaptation would appear to be easier in a context of good relationships and an agreed approach to local autonomy.

There are many examples in the literature of community engagement, though the literature does not appear to contain any examples of such widespread engagement being used to support policy change at a provincial level. The SV Project benefited from the fact that it is purely about listening. It did not promise change, but rather that the information gathered would inform change. Using Boelen's Health Care Partners model at micro and macro levels (20), the results of the SV Project are being used to discuss contextually appropriate changes for rural health care. Having all the partners present at these discussions appears to increase the chances of producing successful and sustainable outcomes. The findings fit within the "five rules of Large System Transformation" described by Best et al (25) and illustrate that rural health care is a complex adaptive system. While this study does not attempt to explore complexity, it does offer a framework for engagement and data gathering that is sensitive to complexity and local contexts and may point to an example of the paradigm shift Greenhalgh and Papoutsi call for in their editorial on studying complexity in health services research (26).

Limitations

Not all partner groups existed or were available to meet in some communities. The latter was rare and virtual meetings were arranged when necessary.

Because the Site Visits teams were led by experienced health care providers, a power differential existed during the interviews which may have been inhibitory, particularly when interviewing Indigenous groups.

As the interviews were led by health care providers it is possible that they may have biased the discussions.

The data collected is specific to the geography, health system and rural context of BC and may not be fully transferable to other settings.

A potential future limitation may be disengagement by the communities from further site visits if there no beneficial changes are seen to occur.

Conclusion

By modifying Boelen's approach to partnership in health development the SV Project has demonstrated a successful way to engage rural communities and gather extensive data that can be used to inform rural health care policy in an ongoing and contextually appropriate manner. Relationships, communication and relevant data are the cornerstones that successful sustainable change is built on.

While every rural community is different, this project elicited many common themes that have linked the health care issues in rural BC. Although early changes have already occurred, further research will be needed to determine whether the changes resulting from the SV Project are beneficial and sustainable with time.

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Data Sharing

Due to the confidential nature of the interview data the raw data is not publicly available. All interim reports and innovations are available through public websites and links are embedded in the body of the text.

Competing Interests

Stuart Johnston is funded as a Director of the RCCbc. Erika Belanger and Krystal Wong are full-time employees of the RCCbc. David Snadden was the Inaugural Rural Doctors' University of British Columbia (UBC) Chair in Rural Health from 2016 to 2020, which is supported by an endowment to the UBC from the Rural Doctors' of BC through the JSC. He also sits on the RCCbc Leadership group to provide an academic perspective. He is fully funded by the Faculty of Medicine at UBC as a Professor of Family Practice. There are no other competing interests.

Author Contributions

Stuart Johnston is the project lead, has been involved in all stages of the project design, has attended visits and has helped with data analysis. He wrote the first draft of the article.

Erika Belanger is the primary analyst and developed the analytic methodology, the codebook and the initial content analysis. She has attended visits and contributed to all sections of the article.

Krystal Wong developed the Site Visits processes, attended visits, has been involved in all conversation in terms of the analysis and contributed to all sections of the article.

David Snadden developed the qualitative methodology and guided the research methodology, assisted with analysis and determining themes and contributed to all sections of the article including developing and editing the final pre-submission draft.

For researcher reflexivity statements see supplementary file “Team Reflexivity”.

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BC Rural Site Visits Program – Meeting Guide

For All Health Partners

These questions are used as a guide to facilitate our meetings for all health partner groups (unless specified below). Meetings are semi-structured and flexible, so if there are topics that are not covered in our questions we are still very interested in discussing them with you.

General

1. Tell us about your health care in your community.
    a. What are its unique features?
    b. What works well?
2. What are your connections like with other community members?
3. How does the community support local health care?

Innovations

1. Tell us about any initiatives do you offer that you feel are successful and why?
2. Tell us about any holistic initiatives that have been put in place that support a person's well-being spiritually, mentally, and/or physically?
3. Are there any unique solutions that you've developed?
4. What can other sites learn from you?

Access

1. Tell us about access to primary health care providers.
2. Tell us about access to specialists and other health care services.
3. How do patients get to their health care needs (ER, appointments, services, etc.)?
4. How is telehealth used in your community?
5. Are there any services at risk and why?
6. What health care services would you like to have/provide that would have the most impact for your community?

Cultural Awareness

1. With racism at the forefront of many conversations in health care, have you ever experienced or witnessed racism or other forms of discrimination/judgement when you or others are accessing/providing care?
2. What supports are there for Indigenous community members to promote cultural safety?
    a. Are there any supports or services in place that help promote cultural safety for staff and patients? *For example: is there a cultural space to practice ceremonies such as smudging within your hospital/clinic, is there an Indigenous liaison, are there larger spaces for families to be with the patient, etc.?*
    b. *How have these cultural safety initiatives impacted care for you/your community/your patients?*
3. **For Indigenous community members:** Tell us what would help you or a member of your community feel more culturally safe when accessing health care services?

Pick relevant partner group:

For Clinicians (physicians, NPs, midwives, etc.) and Health Admin groups only: Practice Context

1. Tell us about team-based care and/or Primary Care Networks? Describe what an ideal team-based care team would look like in your community.
2. How do health care providers in the community share the workload?
3. What workplace supports do you have (CPD, Divisions, Health Authority)?
4. How could CPD support you better?
5. Would you be interested in doing research and what supports would you need?
6. Tell us about any real-time support initiatives.
7. Tell us about any locum support in your community.

For First Responders group only

1. Tell us how you interact with the local health care providers?
2. Tell us about any locum support in your community.

For Academic group only

1. Tell us about your teaching program.
    a. How easy is it to find preceptors?
    b. How does having learners change healthcare in your community?
2. How has having an academic program in your community affected recruitment and retention?

Recruitment and Retention

1. How do you address recruitment of health care providers?
2. How do you retain health care providers in the community?
3. Are there any supports available for the spouses/family members of those being recruited to the community?

Concluding Questions

1. How has Covid-19 affected health care in your community?
2. What keeps you up at night? What is your main worry?
3. What are you proud of?
4. Have we missed anything else you would like to contribute?
5. Do you have any feedback on this process?

Site Visits Master Codebook

Developed by: Erika Belanger

Updated by: Erika Belanger + Anne Lesack on November 28 2019

Nodes\\Themes

Legend: Parent Nodes = Black
Child Nodes = Orange
Grandchild Nodes = Red

Category	Description
Advocacy	Those who advocate or stand up for the health needs of the community. Can be a community member, physician, someone from municipality, or a group of individuals who the community trusts to speak on their behalf. Typically, this individual or group of people have strong interconnected ties with the community and has an in-depth understanding of an area in health care.
Alternative Healing	Health-related services that are already offered, or wish to be offered, outside of the traditional "western-way" of medicine and service delivery. This may include services/activities that focus on mental/spiritual/cultural health that are (or can be) practiced at an individual or group level within a community.
Areas of Opportunity	Areas of health care that provide an opportunity to be changed or improved upon within reason. Examples range from old & damaged waiting rooms (infrastructure) to miscommunication between two or more stake holding bodies (relationship building).
EMR and Information Sharing	Areas of improvement which include compatibility of electronic medical records and/or paper health records. Any other information pertaining to the improvement of information sharing, monitoring and/or access of health data is included.
Education and Training	Opportunities for education and/or training for health professionals and/or health partners.
Equipment	Equipment that needs to be replaced or updated.
Funding	Areas in which funding could be allocated (e.g. health, service delivery, program implementation, etc.)
General Safety	Situations that are placing (or potentially placing) physicians, nurses, community stakeholders, or patients at risk. Includes: occupational safety, community safety, etc. *Note: situations that appear to be putting individuals in serious and/or immediate danger should be reported to RCCbc management ASAP.*

Housing	Areas where lack of housing is identified. This includes housing for general community members, medical residents, physicians, and locums.
Infrastructure	Infrastructure (buildings, roads, telecommunication services), that need to be built, replaced, fixed, or upgraded.
Manpower & Coverage	Areas where more coverage is needed and the desire exists to have another health-professional body present. Also relates to scenarios in which individuals are feeling short-staffed and stretched too thin to be performing at an optimal work-level.
Policy Change	Policies, regulations, local rules processes and measures that could be changed to improve community outcomes. (may move this node in future)
Relationship Building	Areas that demonstrate poor communication, lack of team building or connection building etc. Scenarios where individuals feel misunderstood are also included.
>Collaboration	Situations in which there is a lack of collaboration or cooperation between individuals or groups on different levels in different areas. Lack of cooperative action towards a common goal. Also includes areas where collaboration can take place between two groups to better health service delivery.
>Communication	Areas/situations where there is a lack of information exchange and/or open communication between individuals and/or groups.
>Developing Trust	Participants indicate a need for increased trust or a noted lack of trust in their relationship with an individual/partner/organization/Health Authority/ group.
>Transparency	Participants indicate desire for more/ or indicate a lack of openness, honesty and clarity in their relationship with an individual/partner/organization/Health Authority/ group.
Research	Expressions from physicians, residents, or other individuals who wish to take part in research within their community.
Support	Areas in which direct support or additional support is requested by any health care partner in any area.
Understanding Awareness and Recognition	Participants express a gap in an ones own/ individuals/ groups/ HA's, etc. understanding, awareness, recognition or knowledge regarding an aspect of health service delivery, community rurality, cultural practice, etc.
Change Over Time	Any reported change that has occurred within a community over any given period of time. This can be a health-service related change but may also be a change in community priorities, initiatives, group beliefs, relationships, finances, etc.

Confidentiality	Thoughts, feelings, perspectives and/or scenarios related to personal and/or patient confidentiality, identity, and reputation.
Demographic Focuses	Health care focuses, successes, and challenges that relate to a specific demographic within a community.
Aging	Focuses related to aged or aging individuals within a community.
Families	Focuses related to families in a community.
Youth	Focuses related to youth in a community.
Discharge Conditions	Conditions that patients are discharged into. (e.g. when leaving the hospital, when leaving a doctor's appointment or health care service outside of their own community, etc.)
Finance	Various methods of billing, funding resources, and pay models for physicians within a community. Demonstrates the variety of financial models (both successful and inadequate) utilized within communities.
Billing	All information pertaining to billing clinics, physicians, and/or patients.
Funding	All information relating to all types of funding.
Pay	All information relating to physician pay (or lack thereof). This includes information on different types of pay models (e.g. FFS or APP) and the successes and challenges that are shared about pay in general. This may also include information regarding outside funding that is given to physicians for their work.
Future Plans	Plans, initiatives, or processes that are stated to be carried out in the future. May relate to any aspect of health care.
Geographic Isolation	Comments related to geographic isolation; how community members perceive their level of isolation in a community.
Health Authority	Any reference to interactions with a communities HA and/or to assistance, successes, challenges brought upon a community through their HA. May also include information regarding communities that declare the presence/absence of their ties with their HA.
Interior Health	All comments about/directly involving Interior Health.
First Nations Health Authority	All comments about/directly involving FNHA.
Fraser Health	All comments about/directly involving Fraser Health.
Northern Health	All comments about/directly involving Northern Health.

Vancouver Coastal Health	All comments about/directly involving Vancouver Coastal Health.
Vancouver Island Health	All comments about/directly involving Island Health (also known as Vancouver Island Health, VIHA).
Health Care Approaches	Approaches that are taken in regards to service delivery, funding, etc. that is implemented in a specific manner.
Bottom Up	Initiatives that are developed by people in a community, for people in that community. Decision making on program and service development, service implementation, recruitment, and/or funding, are made directly by community members, who identify what the needs are in the community.
Top Down	Initiatives that are developed by people that do not live within a community (i.e. those that sit in higher governing bodies), that must be followed by people living in that specific community. With this approach, community members are directed to follow decisions made by those who are removed from the community – typically for things such as service delivery, funding, recruitment, etc.
Siloing	Dialogue that explicitly discusses siloing.
Centralizing	Dialogue that explicitly discusses centralizing or centralization of health services
Indigenous	All information that pertains specifically to/from First Nations.
Alternative Healing Practices	Specific comments from First Nations around health services /practices outside of the traditional “western-way” of medicine and service delivery. This may include services/activities that focus on mental/spiritual/cultural health that are (or can be) practiced at an individual or group level within a community.
Connection With Others	Connections that a group of First Nations have with eachother (in their own band/community e.g. caring circle, interprofessional teams) or that they have with other members of a community. Includes their relationships with others (good or bad), their expressed desire to have relationships with certain people/groups of people and/or connections that can be improved upon.
Cultural Safety	Includes comments around experiences, perceptions and views of cultural safety within medical and community environments.
>Needed	Participants express a need for, or a lack of cultural safety within medical or community environment. Can include comments around: racism, lack of time, lack of listening, lack of cultural awareness, etc.

>Provided	Participants express situations in which culturally safe care was delivered, experienced or demonstrated in a health or community environment.
Culture and Identity	Comments around culture and/or identity. Also includes loss/gain of culture and/or history
General	This section includes all of the “Indigenous” information that was formerly under “Demographic focuses -> Indigenous” Everything that is related to First Nations specifically that does not fall under any other category under the “indigenous” node is coded here.
Access and Service Delivery	Health care services that are offered and/or accessed within an Indigenous community. (e.g. community nurse that works with the band, community social worker specifically for the band, etc.)
Trauma	Comments around impact or experience of trauma by oneself, within a community or intergenerational trauma.
Innovations	New or unique method, idea, product or workaround that benefits a community’s health service delivery in any way.
Locums	Any information regarding the ability to bring in locums into a community, how locums contribute to a community, and the ease in which a community can access locums for any given period of time.
New to Practice Physicians and Students	Impacts, impressions, and overall effect that new physicians and/or residents and/or students establish while practicing in a rural community; this includes comments regarding perceptions of health care providers about new to practice physicians and work style. (This node was formerly known as new grads and residents)
Nursing	Any items related to nursing in the context of rural health and health care delivery.
Patient Capacity and Attachment	Information relating to wait-times for services, family physician availability, or number of beds available within a hospital setting. Includes accounts relating to patient attachment and how patients are attached/unattached in a community.
Population	Health and non-health related (i.e. community events) aspects of a population that relate to a community’s population growth, recruitment, and retention.
Decline	References of population decline within a community.
Growth	References of population growth within a community.
Recruitment	References of recruitment into a community. Recruitment successes and challenges are included.

Relocation	References of relocation into or out of a community. Relocation successes and challenges in a community are included.
Retention	References of retention in a community. Retention successes and challenges are included.
Tourism	References of tourism in a community
Proposed and Potential Solutions	Initiatives that have been proposed, suggested, or are in the beginning stages of implementation for the purpose of addressing/overcoming a challenge within a community.
Powerful Quotes	Meaningful quotes that shed light on positive, unforeseen, or unique aspects of healthcare in a community.
General	General quotes as defined by the “Quotes” category description.
Questions	Questions that participants ask as defined by the “Quotes” category description.
Stories	Stories that participants share as defined by the “Quotes” category description.
PRA’s and IMG’s	Any information that relate to PRA’s and/or International Medical Graduates (IMG’s).
Programs and Networks	Information that relates to specific programs and networks and how community members find these things either beneficial/not beneficial in their community. May also include accounts where individuals note that they have not heard about a specific network/program.
CPD	Any comments related to continuing professional development and continuing medical education.
Divisions	Any comments related to divisions of family practice. Includes both positive and negative accounts surrounding divisions; interactions, assistance, and successes brought upon a community through their respective divisions group. May also include information regarding communities that declare the presence/absence of their ties with a division.
JSC Programs/Initatives	All program information that relates to a JSC program below.
>NITAOP	Any comments related to the Northern & Isolation Travel Assistance Outreach Program (NITAOP).
>REAP	Any comments related to the Rural Education Action Plan (REAP)
>REEF	Any comments related to the Rural Emergency Enhancement Fund (REEF).

>RSON	Any comments related to the Rural Surgical and Obstetrical Networks (RSON).
>RRP	Any comments related to the Rural Retention Program (RRP).
SSC Programs/Initiatives	All program information that relates to an SSC program below.
>Facility Engagement	Any comments related to facility engagement and/or interactions with facility engagement liaisons (FELs).
PCN's	Any comments related to the Primary Care Networks (PCN's).
MOCAP	Any comments related to the Medical On Call Availability Program (MOCAP).
RCCbc Connection Points	Areas where RCCbc staff/core members are able to connect people with eachother and/or information. Includes feedback that is received on the Site Visits Project.
Follow Up's	Questions that participants have that RCCbc staff can answer and follow up on; and areas in which RCCbc staff can offer connections to other individuals or advice on a given topic.
Project Feedback	All feedback that participants share with regards to the Site Visits Project.
Resource Development	Comments that are made about resource development in a community. May include how resource development has directly/indirectly affected a community (e.g. mining, LNG project, watersheds, logging, farming, ecosystem etc.)
Rural vs Urban Perspectives	Any comparison or contrast between a rural community and another (typically urban) community that either: (i) has more services offered and/or (ii) is a larger referral community. Note: some communities may compare themselves to a larger community that is also rural. While larger rural communities are not urban, smaller rural communities may refer to these larger rural communities as so due to the above reasons.
Scope of Practice & Workload	The entire role that physicians and/or other health professionals encompass as a rural health care provider. This may include general and or specific skill sets that are required from individuals in a given community. Other concepts included in this section are physician expectations (from self and others), physician wellbeing, and physician burnout (associated with heavy workloads, lack of time off, etc).

Physician Wellbeing	Any part of a rural physician's scope of practice that relates to a physicians' well-being. Includes info that may lead (or has led) to physician burn-out
Physician Time Off	Any part of a rural physician's scope of practice that allows/does not allow adequate time off
Services	Any health-related service that is at risk of becoming extinct or in need because that service is (1) currently not available in the area and (2) currently in significant demand by patients and health providers.
At Risk	Services at risk.
In Need	Services in need (general).
>Mental Health and Addictions	Mental health and addiction services that are needed, or accounts that describe where/why such services are needed (specific).
>Obs, Gyn, and Maternity	Obstetrics, Gynecology, and/or Maternity services that are needed, or accounts that describe where/why such services are needed. (specific).
Lost	Services that were once offered but are now obsolete.
Social Determinants	Measures related to socioeconomic status that affect the health status and use of health services by individuals.
Successful Initiatives	Initiative such as measures, models, programs, methods, or systems that have created a beneficial impact in improving the health care and/or health service delivery of a community.
Measures	Measures such as having enough staff, having successful community support etc. that contributes to health care and service delivery success within a community. Includes initiatives that do not fall under the "models" or "programs" category,
Models	Models such as funding models, clinic models, etc. that contributes to health care and service delivery success within a community.
Programs	Any program that has been implemented/delivered etc. that contributes to health care and service delivery success within a community.
Support	Supports that are essential and contribute to maintaining successful health care outcomes within a community.
Collaboration & Connection	Scenarios where individuals from different areas (of profession or of geographical location) connect with each other on some level (i.e. communication, decision making) to improve an aspect of health care. Included in this section are examples of individuals or groups connecting with each other in order to: a) work together towards a common goal or outcome; or b) share ideas in a collaborative manner. Relationships that have been built between two entities may also be included.

Community Support	Support that is provided by general members within a community, or by community members that work in community-focused groups such as municipality, volunteer organizations, and/or community health organizations.
Employee Support	Support that is provided by employees towards each other in a given setting.
>Culture	Successful work-cultures that employees create within their working environment.
>Dedication	Expressions of commitment and dedication for work, delivery of services, and or towards patients/community members within a given profession.
>Teamwork	Areas in which teamwork/collegiality has been highlighted/demonstrated within the workplace.
Telehealth	Information, including successes and challenges, relating to telehealth services.
Time	Situations in which time has a significant impact or is mentioned as important in a given situation (e.g. physicians expressing they need more time with their patients, etc.)
Transportation	All methods of transportation utilized by community members for local and long-distance transport. This section includes specific methods, thoughts, successes and challenges related to local transportation, emergency transportation, accessing areas far away (distance) and environmental factors/conditions.
Alberta proximity	Information relating to successes/challenges that derive from communities that are in close proximity to the Alberta border.
Distance	Non-emergency transportation that requires an individual to travel a distance outside of their community for health care services. Examples include: needing to travel out of town for cancer appointments/dialysis/regular GP appointments, etc.
Local	Non-emergency transportation that requires an individual to travel within the community for health care services. This includes information related to the availability of taxis/buses/volunteer drivers/etc within a community.
Emergency Transport	Successes and challenges related to emergency transportation.
Environmental Factors	Environmental factors that affect the ability to transport into and/or out of a community.
>Weather	Scenarios in which weather has impacted transportation. This includes the ability to enter/leave a community.

>Wildfires	Scenarios in which wildfires have impacted transportation. This includes the ability to enter/leave a community.
>Flooding	Scenarios in which flooding has impacted transportation. This includes the ability to enter/leave a community.
Patient Transfer Network	All information pertaining to the Patient Transfer Network (i.e. successes and challenges)

Dr. C. Stuart Johnston, MSc (Civil Eng), MB, ChB, FRRMS. Director, Rural Coordination Centre of BC. Clinical Associate Professor, Department of Family Practice, UBC.

I have an Irish and Scottish cultural background, but grew up in Southern Africa before moving to South Africa to complete a Masters in civil engineering and later a medical degree at the University of Cape Town. After working in South Africa and New Zealand as a family physician, I moved to British Columbia (BC), Canada. I have lived and worked in small rural communities here for the past 29 years. During this time, I have provided primary care, surgical and maternity care and flown into remote Indigenous communities to provide health care both in BC and North of the Arctic circle in Nunavut. As a Clinical Associate Professor in the Department of Family Practice at the University of British Columbia I have been involved with teaching medical students and Residents. For the past 20 years I have worked within provincial organizations (the JSC and RCCbc) that are dedicated to improving rural health care in BC.

My experience of low resource communities in Africa and remote communities in rural Canada have shaped my views concerning the necessary resilience of these communities and the systems that impact their medical care; also, how relationships (trust) are central to well-functioning health care. I am cognizant of the health inequities that exist for those who live and work in rural areas. I have been aware of racism at times wherever I have worked, but have had the good fortune to work alongside Indigenous colleagues and patients in BC who have shaped my views on cultural safety and systemic racism.

I acknowledge that my past experiences, together with my empathy for the patients, providers, administrators and others who strive to ensure the best possible health care for their communities, will have impacted my interview techniques and data interpretation.

Krystal Wong BSc

I am Asian of Chinese and Filipino heritage, born as a second generation Canadian. I am currently located on the traditional lands of the Coast Salish Peoples, including the territories of the Musqueam, Squamish and TsleilWaututh, known as Vancouver, British Columbia.

I completed a Bachelor of Science degree in Health Sciences at Simon Fraser University and my education consisted of traditional western science views as well as a multidisciplinary approach to health. My interest to health promotion and communications led my volunteer and career experience in these areas, as well as in community development, chronic disease prevention, food insecurity in rural and urban populations, and implementation science. Currently I am a Project Coordinator for the Rural Site Visits Project (SV Project) at the Rural Coordination Centre of BC (RCCbc).

I recognize that my viewpoint shapes the way I have developed and amended the SV Project process, in particular the recruitment and data collection. My previous experience has shaped the method of the SV Project through a community development, strengths-based, and iterative approaches. I also recognize I have never lived in a rural community and my exposure to rural communities has been majority through the SV project. Meeting with participants directly in rural communities and hearing their stories and experiences of their health care services and delivery has further shaped my awareness and

understanding of rural health issues, however, I am not an expert and I have not lived through similar experiences.

Erika Belanger BSc, MSc.

I am a female Caucasian settler on this land, with both myself and my brother being the first generation to be born as Canadian in our family. My historical family roots are grounded in Denmark, where my grandparents resided for most of their lives prior to immigrating to British Columbia.

I am currently located on the Lheidli T'enneh traditional territory, known as Prince George, where I have lived and worked for the past four years. I was brought up both in Prince George, and on the Ligwiłda'xw peoples territory, known as Campbell River on Vancouver Island. From there, I moved to Victoria where I completed a Bachelor of Science degree in Psychology at the University of Victoria and returned to Prince George to complete my Master of Science degree in Health Sciences.

My undergraduate education comprised of very traditional western science views, with projects focusing primarily on quantitative data collection and analysis methods. It wasn't until I was exposed to qualitative research methodologies within the first year of my Master's degree, that I realized the importance of qualitative research; how it can contribute to policy and healthcare, and my interests in such methodology.

I believe that qualitative data, such as stories, experiences, and perspectives, should be held with equal regard to that of quantitative based research methodologies; and hope that the stigmas associated with using qualitative research as evidence, decreases over my life time as qualitative work continues to emerge. I further hold the belief that every person's perspective, and the experiences associated with such views, is valid; and recognize that multiple realities and worldviews exist outside of my own.

As a Research Coordinator and Data Analyst for the RCCbc Site Visits Project, I acknowledge that my viewpoint shapes the way in which I analyze the data of this project, and recognize that I may interpret data differently than those who chose to contribute such information. While I bring a previous lens of working in the pharmacy field, I recognize that my experience working with rural physicians and the experiences that they encounter daily, is limited and therefore my ability to pick up on certain nuances may be lesser compared to someone who has a lived experience as a rural health care provider in BC.

It is through my background, my education, and my beliefs, that I position myself in the work that I've done through the Site Visits project. The experiences I've had prior to this work have shaped the ways in which I have approached the development of the analytic methodology of this work and the experiences of meeting with participants in their communities directly, has further shaped how I've hoped to illuminate each contribution from our participants to date.

David Snadden MBChB, MClSc, MD, FRCGP, CCFP. Professor Family Practice.

I live in Prince George BC on the traditional territory of the Lheidli T'enneh. I am a first-generation immigrant to Canada. I am Caucasian of Scottish parents and grew up in India, Singapore and Scotland. I trained in undergraduate medicine at the University of Dundee and as a family practitioner in Inverness in the north of Scotland. I then practiced in a rural Highland community for 11 years. I then completed a master's degree in Family Medicine at the University of Western Ontario, Canada, returning to Academic Practice in Dundee where I completed a doctoral degree with a focus on qualitative methods and medical education. I came to Canada in 2003 to lead the establishment of the Northern Medical

Program in Prince George, BC, the Northern and Rural Distributed Campus of the UBC Faculty of Medicine. My time in BC has enabled me to visit many rural, remote and indigenous communities throughout the province and has instilled in me a deep sense of the health inequities that exists between urban and rural areas, a sense I first developed as a rural practitioner. I have been involved in qualitative research projects since 1991, firstly in the areas of patient experiences and in medical education. Subsequently my interests have evolved to rural issues in terms of recruitment and retention of rural practitioners and in health systems change. Qualitative data deepens our understanding of issues through conversations and stories and provides a rich context to help illuminate experiences, which, through careful interpretation, help deepen our understandings of important issues. I do recognize that I bring my own perspectives to the interpretation of research data and believe that to help bring changes to our systems I do need to embrace and give voice to the varied perspectives of those we talk to and to learn from them in a way that can help us together advocate for solutions and system changes that will improve rural health care.

Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

	Page/line no(s).
Title and abstract	
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	Pg. 3/lines 1-3
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	First two pages of submission, lines not numbered
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Pg. 5/lines 30-58
Purpose or research question - Purpose of the study and specific objectives or questions	Pg. 5/lines 25-29 Pg. 6/lines56-58
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	Pg. 6/lines 64-75
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	Line 453 Added as supplementary document
Context - Setting/site and salient contextual factors; rationale**	Pg. 3/lines 6-23 Pg. 8/line 92
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	Pg. 4/lines 80-85 Pg. 9/lines 109-112 Pg. 11/line 161-167
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Pg. 11/lines 156-158

Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	Pg. 6/lines 124-134
Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Pg. 9/lines 126-133
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Pg. 7/lines 141-142
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Pg. 10/lines 136-138; 143-147
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Pg. 10/lines 136-141
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Pg. 10/lines133-134 Pg. 10/lines 143-147 Pg. 14/line146

Results/findings “

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Pg. 11/lines 161-336
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Pg. 11/lines 166-333

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	Pg. 23/lines 354-403
Limitations - Trustworthiness and limitations of findings	Pg. 25/lines 406-416

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Pg. 27/lines 436-441
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Pg. 26/lines 428-430

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
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How can rural community-engaged health services planning achieve sustainable health care system changes?

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How can rural community-engaged health services planning achieve sustainable health care system changes?

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Abstract

Objectives

The objectives of the Rural Site Visit Project (SV Project) were to develop a successful model for engaging all 201 communities in rural British Columbia, Canada, build relationships and gather data about community health care issues to help modify existing rural health care programs and inform government rural health care policy.

Design

An adapted version of Boelen's health partnership model was used to identify each community's Health Care Partners: health providers, academics, policy makers, health managers, community representatives and linked sectors. Qualitative data was gathered using a semi-structured interview guide. Major themes were identified through content analysis, and this information was fed back to government and interviewees in reports every six months.

Setting

The 107 communities visited thus far have health care services that range from hospitals with surgical programs to remote communities with no medical services at all. The majority have access to local primary care.

Participants

Participants were recruited from the Health Care Partner groups identified above using purposeful and snowball sampling.

Primary and secondary outcome measures

A successful process was developed to engage rural communities in identifying their health care priorities, whilst simultaneously building and strengthening relationships. The qualitative data was analysed from 185 meetings in 80 communities and shared with policy makers at governmental and community levels.

Results

36 themes have been identified and three overarching themes that interconnect all the interviews, namely Relationships, Autonomy and Change Over Time, are discussed.

Conclusion

The SV Project appears to be unique in that it is physician led, prioritizes relationships, engages all of the health care partners singly and jointly in each community, is ongoing, provides feedback to both the policy makers and all interviewees on a 6-monthly basis and, by virtue of its large scope, has the ability to produce interim reports that have helped inform system change.

Article Summary

- This study process has adapted Boelen's health partnership model and is unique in that it is physician led, prioritizes relationships, engages all of the health care partners singly and jointly in each community, is ongoing, provides feedback to both the policy makers and all interviewees on a 6-monthly basis.

- A successful method of engaging with rural communities and building relationships and trust across multiple stakeholder groups is described that contributed to influencing positive health care system changes.

- As all communities in one province are being visited the picture of rural health care initiatives and challenges is highly comprehensive and therefore able to influence policy.

- One of the main limitations in this study is that because the interviewers were experienced health care providers, power differentials may have existed which may have introduced bias in the discussions.

- A potential limitation is the enormous amount of data to handle and analyze in a rigorous way, which was mitigated by having two full time analysts working together to ensure consistency with frequent meeting with the research team to consider and agree emerging themes.

How can rural community-engaged health services planning achieve sustainable health care system changes?

Introduction

British Columba (BC), Canada, has a population of approximately 5 million. About fourteen percent (631,776) (1) are rural citizens distributed unevenly over an area of 944,738 km^2. BC is geographically diverse with a broken 27,000 km coastline and extensive mountain ranges that make for long and often dangerous travel, complicated at times by wildfires, floods, avalanches and harsh winter conditions. Access to health care services for rural citizens is often limited by the expansive geography, provider availability (2) and transportation issues (3).

Support programs for rural physicians in BC are overseen by the Joint Standing Committee on Rural Issues (JSC), a committee comprised of equal numbers of provincial Ministry of Health representatives and rural physicians. The JSC manages approximately C$150M (2020) of funding annually for programs and projects that improve health care delivery in rural BC (JSC Program Booklet). Some of this work is delivered by the Rural Coordination Centre of BC (RCCbc), which is funded by the JSC to coordinate and improve rural health care throughout the province. The RCCbc is a networked organization that includes many rural physicians and a small number of rural health professionals in its membership.

The Rural Site Visits Project (SV Project) was initiated in 2017 by rural physicians with a proposal to the JSC who tasked the RCCbc with visiting 201 rural and Indigenous BC communities identified as eligible for rural benefits under the Rural Practice Subsidiary Agreement (RSA). The

RSA is an agreement between the Government of BC and the Doctors of BC (a professional organization that represents 14,000 physicians, medical residents and medical students in BC).

The purpose of the SV Project was to build relationships between rural physicians, health care providers, health administrators, municipal leadership, First Nations leadership, first responders, academia and policy makers through listening and gathering data systematically about local successes, innovations and challenges relating to rural health care delivery. This data is guiding the development of JSC programs and informing government Rural Health Care policy.

In 1978 the declaration of the Alma-Ata International Conference on Primary Health Care stated that: "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care" (4). Current trends in rural health services, however, aim to reduce infrastructure and support to achieve greater efficiencies through centralization of services (5, 6). Small rural communities have had to be proactive in securing local health services to resist this development (7, 8), requiring improved relationships and communication between the policy makers and communities.

Community participation has been seen as a more complete approach to health development (9) leading to culturally and contextually appropriate decisions being made about rural health services (10, 11). Relationship building between stakeholders is also seen as more effective than attempting to provide a myriad of health care services (12, 13), especially as each rural community is unique and "one size fits all" approaches are largely ineffective (6, 14). While there have been efforts by health service policy makers to align their actions with rural

communities' expressed priorities (15, 16), the processes used for community engagement have received less attention (17) and descriptions seldom include adequate documentation of the processes involved (17, 18).

The community engagement literature does not show examples of rural health projects initiated and led by physicians, even though physicians have been key partners in other research on rural community-engaged health services planning (15). Much of the research on community engagement in rural health service planning has had a specific focus, for example in improving immunization programs in Nigeria (17) or chronic disease care in the Torres Strait Islands (13). There are some examples of research focused on community participation for broader primary care reform, for example, in the Northern Health Authority region of BC (15) and the Remote Service Futures (RSF) Project in Scotland (10, 12, 16). The former has resulted in some sustained changes to date, for example the establishment of Primary Care Nurses, improved antenatal care and regional palliative care services (15). When the RSF outcomes were reviewed in 2014: "Only one direct sustained service change was found" (19). These raise the question of how best to achieve sustainable beneficial rural health system changes using community engagement processes. The project described here attempts to address this issue. Due to the complex nature of this initiative, it is presented in this article as two components. Firstly the process of engagement in terms of how communities were engaged and how information was shared with them after the visits. Secondly, as the data gathering and engagement process are entwined, information on the research methods and broad early results are included to provide a context for future more detailed publications arising from the data.

PROCESS OF COMMUNITY ENGAGEMENT

Theoretical Approach

The Health Partnership model described by Boelen (20) was used. This identifies five partners: health professionals, academic institutions, policy makers, health managers and citizens and recommends they meet together to identify ways to improve health systems. The concept of meeting with the partners in each community was modified to include additional separate meetings with each of the partners. Who constituted the health partners could be different in each community, so the concept was adapted to the local context to include those present in the community. This included First Nations and others such as, first responders, business and non-profit groups. It was not possible to have combined partner meetings in all communities as it was not always possible to find a date and time within the visits time line that worked for everyone. This process in British Columbia has become known as the pentagram plus framework. This approach does not seek representation from the various groups but seeks perspectives from those who are part of a group.

Patient and Public Involvement

Public input into the project occurred during the initial pilot Site Visits to eight rural communities and was used to shape the community engagement process and the interview guide.

The initial interview guide was developed by the investigators, who had many years of rural health care experience, to elicit broad discussion about multiple health care issues. The guide was refined based on public and provider input during pilot visits.

Participants were asked for feedback on the interview process and whether the time taken was appropriate.

Arranging Site Visits

The sites identified for the SV Project were the 201 communities identified under the RSA.

Sites are selected six to twelve months in advance. Three to six months prior to a Site Visit, recruitment of participants commences and RCCbc staff coordinate the planning. Depending on community size and location site visits last one to three days and involve one to five communities.

Site Visits Team

A Site Visits team consists of at least one Site Visitor and one RCCbc staff member, who coordinates the visits. The Site Visitors comprise 19 rural physicians and one midwife all of whom are RCCbc members and responded to a call for site visitors. A one-day training session for visitors included training in Appreciative Inquiry techniques, qualitative interviewing and cultural safety through the San'yas Indigenous Cultural Safety Training course. Site Visitors were individually mentored by the Program Leads on their first visits. On some Site Visits guests are invited. The purpose of inviting a guest is to assist urban-based allies in their understanding of

how health care functions in small rural communities. Guests have included policy makers, researchers, health care workers, administrators, and educators and all guests broaden the perspective of the visit team.

Participant Recruitment

The visits included participants who identified themselves as living or working in a RSA community and were part of one or more of the partner groups identified by Boelen (20). Participants were initially recruited from the health care partner groups by:

- Email and phone contact through publicly available information
- Recruitment posters in doctors' lounges, hospitals, clinics, and municipal buildings
- Contacting pre-existing contacts who provide connections to potential participants
- Asking participants to suggest others who fit the inclusion criteria

Initial contact was made by telephone or e-mail to members of health partner groups (physicians, administrators and allied health professional) with a follow-up invitation that detailed the project background, aims and goals and included a copy of the interview guide. The most successful method was using known contacts to identify potential participants and by asking them to pass information on to them (snowball sampling (21)). Participants were invited to participate in one-on-one interviews or focus groups (if there was more than one person from an identified health partner group) and dates established. Interviews took place in the communities, however since March 2020, eleven virtual interviews have been trialed as a result of Covid-19 restrictions. In general participants from community groups were local leaders such as local elected officials, leaders of non-profits or businesses. In First Nations communities

initial contacts were through community health centres. Coming from small rural communities everyone had a perspective as a community member in addition to their other roles. All Participants were sent consent forms and information sheets before the visit date but not obliged to sign consent forms until the start of interviews to give time to ask questions or clarify issues. Verbal re-consent was sought at the end of interviews. Framing the process as a research project also had benefits in having ethics approval which meant comprehensive informed consent processes, confidentiality and security over data storage and handling. All of which appeared to contribute to participant trust in the process.

Interview methods

Each health partner group (between one and sixteen participants) was interviewed separately. This was followed by a combined partner focus group (between two to ten people) with a representative from each of the health partner groups previously interviewed. The interviews incorporated an Appreciative Inquiry approach (22, 23) with public input to develop a semi-structured interview guide (Supplementary File 1) that would help build relationships and lead to better understanding of how rural community members perceive health care delivery within their respective communities including health care successes, innovations and challenges that inhibit their ability to access services in an equitable manner. The guide has been iteratively refined following community visits, in keeping with standard qualitative methods

Interviews were recorded digitally and transcribed. Interviews generally lasted one hour. Transcripts were returned to participants within four weeks for verification, alteration, or withdrawal if requested.

Ethics

The study received harmonized ethics approval from the University of British Columbia Behavioural Research Ethics Board with Harmonised approval in Northern, Interior, and Island Health Authorities and the University of Northern British Columbia. (Certificate H17-01591). Operational approval was also received from each health authority.

Continuing Engagement

The data collected was managed through a research process to ensure rigour of the data analysis (See Data Analysis and Results section). To continue engagement with communities emerging themes from the analysis are disseminated to all participants and communities. They are also shared with policy makers, physicians, allied health professionals, First Nations, municipality members, academics, and the general public to ensure rural communities health priorities are understood. Various knowledge translation outputs are used such as six-monthly JSC and publicly available community feedback reports and newsletters, specialized (focused) reports, presentations, briefing notes, and publications. Additionally, an Innovations website has been established to share successful innovations identified by interviewees.

Full details on the site visit process are given in the Rural Site Visits Handbook (Supplementary file 2)

DATA ANALYSIS AND RESULTS

Data Analysis

The data source were transcribed interviews, after they had been returned and agreed by participants. To process the large volume of qualitative data collected, qualitative content analysis (21) was used. NVivo 12 (QSR International) was used to help organize the data. Initially each interview was coded using an inductive-approach and primary cycle coding (21). This began with a close reading of the data, assigning words or phrases that captured the essence of each sentence. From this a codebook was developed (Supplementary File 3), and second level codes were generated to identify emerging themes across the data. Throughout the entire analysis process data was revisited to allow for the comparison and modification of codes to fit new incoming data.

Rigor was maintained throughout by a second data analyst. Analysts coded identical interviews separately and then compared coding to promote consistency. Analysts met weekly to discuss changes and modifications needed for the coding framework. The coding framework and emerging analysis was discussed and agreed within the research team. The data was further interpreted to identify themes connecting the data across communities (21).

Results

Site Visits Engagement Process

Although the Covid-19 pandemic has significantly slowed down the project, 382 interviews have been carried out in 107 communities over a three-year period (Table 1). The communities ranged in size from small communities of approximately 200 people to communities of 10-20,000 people. There was one large community of 70,000, but considered remote being 800km from major tertiary care services. The first 4 site visits to 9 communities with 23 interviews were used to pilot and develop the methods and were not included in the analysis reported here which is based on 185 interviews with 754 participants in 80 communities. The data from the remaining 27 site visits are in process of transcription, returning transcripts to participants and analysis. As the data is well saturated and as the processes take several months it seems appropriate to report the study now.

Table 1
Partner Group Interviews

Health Providers and Clinicians			
Health Partner Group	**Definition**	**# interviews analyzed**	**# pilot interviews analyzed**
Physicians	Majority were family physicians, but also includes residents, specialists, hospitalists and nurses	52	6
Midwives*	Midwives (could also include students)	4	0
Nurse Practitioners*	Nurse practitioners (could also include students)	7	0
Health Administrators			
Health Admin	Health Services Administrators, health managers, hospital/clinic managers and nurses	36	4
First Nations/Community Members**			
First Nations	First Nations Band members, First Nations community members, elders, Chiefs, health directors, community health representatives, nurses, health coordinators	29	2
First Responders*	Fire Chiefs, paramedics, community paramedics	1	0
Policy Makers			
Municipal	Mayors, Councilors, Regional District Directors and members,	34	5

	community members		
Academia Educators and Learners			
Academics*	Clinical professors, clinical teachers, clinical researchers, medical school professors	2	0
Linked Sectors Industry and Non-Profit			
Health Organizations/Societies	Community members, community health advocacy groups, hospital auxiliaries	4	0
Combined Partners (Group Meeting)			
	Leads (or representatives/proxy's) of each health partner group such as the Mayor, hospital Chief-of-Staff, First Nations health director, fire chief, community members	16	6
Total number of interviews		**185 interviews analyzed to date not including pilot interviews**	**23 (# of pilot interviews analyzed for primary codebook development)**

*Additional partner groups were added later in the study.

**Community Members are embedded throughout the groups.

The participants interviewed bring a wide variety of perspectives. Many health administrators are also nurses or other health professionals and they were able to bring those perspectives to the conversations. In addition, in the health partner group interviews nurses often came to those meetings accompanying physician colleagues. Across interviews collectively, one participant withdrew their transcript. Many participants provided feedback; highlighting their enjoyment of the direct, in-person engagement process that was used and the connections they provided:

"I think this has been very informative. Just getting to know what you guys do…and [the] supports [that exist] and establishing connections and…learning about these connections that exist that I haven't tapped into personally so, it's great." – Combined Partners

Participants further described how they felt the process allowed for their voices to be heard, and their communities to be recognized:

"I appreciate being able to talk…and to give frank feedback because that is tough at times and this is a good option to do it…some of our issues aren't really out there right? So, it's good to be able to have a voice to be able to indicate this." – Nurse Practitioner

"I want to thank you for recognizing us as 'rural,' because a lot of people don't see us as rural." – First Nations

It was commonly voiced by participants that, throughout the engagement process, they'd love to learn about what other communities have achieved.

"Would love to see information about other initiatives going on around other provinces that they might be able to learn from." – Combined Partners

"[We] would like to receive feedback about how [we] work with other communities and what works well in other communities." – Combined Partners

These requests from participants ultimately led to the creation of the Site Visits Innovations website.

Common Themes

The data has become well saturated with 36 categories emerging from the data to date. The ten most common themes are included in supplementary file 4 and these will be the subject of subsequent publications. This article reports three overarching themes that interconnect all the data: Relationships, Autonomy and Change Over Time.

Relationships

Relationships were important in achieving successful health care outcomes and were built on communication, trust, transparency and collaboration over time. These themes were evident in every community:

"It's really groups of people coming together on committees that have people from city council, the regional district, health boards, and the non-profit societies...and I think if there's a strength in this community, it's that there are those connections and people are willing to work together to find solutions locally." – Combined Partners

Good relationships underpinned communities' abilities to successfully retain their physicians. These relationships were with the communities themselves as well as with administrators and within teams:

"Why do you think they've stayed here?" – Interviewer

"[It's] the relationship that they [the physicians] maintain with the community…It all comes down to the relationships." – Municipality

"When we went to [Health Authority X] to say, 'We're having a terrible time retaining our doctors,' - the turnover was terrible - we got no response from the system. So, the community rallied around and did what was necessary to sustain doctors in this community. But in doing that …. what we did was create relationships with our physicians that are respectful and goes [both] ways." – Community Members

Effective communication and regular "organic" contact were the foundation of these relationships and were important in building trust:

"Having all the different services all in the one building does allow for good open communication, you can pull anyone aside if you bump into them in the hallway to talk about patients. It is a very organic process rather than a formalized team-based care approach. ... It also helps retain people who work here – you build that relationship and trust of what your peers are capable of. It's not formal team-based care, but it is a team." – Combined Partners

"There needs to be trust and consistency of knowing what someone is walking into. Issues of trust [have been] a major block in [our] community to providing and receiving health services." – Health Admin

Successful collaborations that were inclusive of all partners positively impacted health care and helped reduce burnout:

"It makes it much easier working [here], because I've worked here a really long time with [colleagues X and Y] it makes it much easier when we have a group that all works together really well. And that doesn't happen everywhere. [We] are all friends so [we] tend to help each other out... being [without them] …the burnout would be terrible." – Physicians

"It's really groups of people coming together on committees that have people from city council, the regional district, health boards, and the non-profit societies that identify the problems and look at what each particular group…can provide to try to deal with the problem and…it's those connections and people [who] are willing to work together to find solutions locally." – Combined Partners

Conversely, poor collaboration and relationships led to adverse consequences:

"...when I meet with my doctors, I hear one thing about what the problem is and how to solve it. And then, if I talked to nurses or midwives or allied health professionals, I hear another version of what the problem is and how we would fix it. And then I sit down with [Health Authority X] and I hear their version of what the problem is and that they are fixing it. And all those voices are never in the same room at the same time..." – Municipality

Good relationships enhance problem solving, reduce the 'red tape' required to affect change and result in greater work satisfaction at all levels, positively affecting other issues such as recruitment, retention, and burnout. Local decision making (autonomy) was an important contributor to work satisfaction.

Autonomy

Autonomy within the health care context was defined in many ways. However, at its core many viewed autonomy as the ability to make reasonable decisions, sensitive to the local context, at a personal or local level that did not require the blessings of a hierarchical, top-down system. The latter stifled initiative, innovations, and satisfaction.

A sense of autonomy within the health care providers appears to improve recruitment and retention. It imbued a sense of greater 'ownership' of, or responsibility for, the local services by the community practitioners:

"Part of it is the relationship that they maintain with the community…Dr [X] has come to the council and has asked for extra room to bring in more medical professionals, and the city worked with him so that he can have the space to have another professional help out his team.

The main thing is working with them and letting them grow, not dictating to the doctors." – *Municipality*

The data described a disconnect between centrally directed processes and what was practically achievable in a community:

"…I think there's kind of an issue sometimes with delivery of rural health care in that people actually in the trenches doing the job have a much better insight sometimes into what needs to be done and what is happening than the people making the decisions about how we're going to deliver the health care." – *Physicians*

The most frequent plea was that more local engagement was needed to solve local problems and how important local autonomy was in crafting enduring solutions:

"I couldn't believe that – 'we are bringing more resources and that's not working for you?' What didn't happen is there was no consultation, so it didn't really matter if we brought more resources. It was like, 'you didn't ask us what our problem is, what we need and what is our reality and you're just bringing resources and that's not how we want this to look like..." – *Health Admin*

"…locally it feels like our concerns are profoundly dismissed by the health authority, who clearly have a different idea and a different agenda" ... "We need to be kind of at least a largely autonomous community." – *Physicians*

When consultation occurred a very different attitude existed among the health care providers:

"…So, we took that learning and stepped back and took one whole year to do focus group and to follow staff to understand what they're doing, what are the challenges, the issues, to understand better the population that we serve…involving physicians along the way and after we've done all of this, we came up with another model, not really with much more budget…but it wasn't about the budget anymore and we've presented the model to the staff in March and since then, we are implementing the new model and it's working and people are just following along the process and I think that there's a lot of learning about the history of the community and how we need to do things here." – Health Admin

Local autonomy meant the ability to make rapid operational decisions on the day. Many small rural communities had extraordinary stories of unbroken 24/7 emergency coverage for many years provided by the local practitioners despite being reduced to a single physician at times. Similarly, nurses in small rural hospitals frequently did additional shifts to cover gaps when their colleagues were unable to work. These providers felt a responsibility to maintain these services in their community:

"I had a lot of autonomy about who I could hire…and so I had the ability to hire locally and so I built a big pool of people who lived here who were very committed to [the] Healthcare Centre." – Health Admin

When control of these services was elevated to a higher level outside of the community, this loyalty was reduced as local autonomy was lost, contributing to Emergency Room coverage gaps and difficulty filling nursing shifts:

"…So now we have one GP who is keeping the whole system going through being on call 24 hours a day, 7 days a week. So, it's sort of a step backwards, and I think a lot of it is just that we've lost the autonomy to be able to kind of say, "Well, this is what our community needs. This is how we can go about solving this problem." – Physicians

"...you've done a really innovative thing in adjusting your nursing lines...this is the first community we have not heard [about] nursing shortages." – Interviewer

"So, we need to start developing our rotations to make it attractive for those nurses to come…We're one of the few rural sites that have full staffing now." – Health Administrator

One example of a successful model is a 3-year trial in a region where a Health Authority granted three geographically close rural communities the autonomy to determine their priorities for improving local health care, and provided funding to support these changes:

"We had a series of engagement events for the entire community, health care providers, public, youth at one of the high schools, our Indigenous population, and the [Community X Group] and said, where would you like to spend $500,000 on services and so 5 things came to the top…". – RCCbc Video

Autonomy as defined by the local ability to make relevant health care decisions, runs through all the data as a foundational theme in supporting system improvement.

Change Over Time

"Change over time" is a prominent contextual factor that underpins all the themes within the SV Project to date. One of the biggest changes over time has been the change in community

population. Some remote and resource-based communities reported diminishing populations, however, this was much less common than those reporting increased population growth due to young families leaving cities to find affordable housing and retirees moving in. In addition, there is a growing tourism load in many communities. These factors, exacerbated by the expectations of care for those that have moved into the community, have impacted resources and funding for longstanding residents:

"…a lot of communities are struggling with what to do with a very quickly growing, aging population...we have a very strong in-migration of young families..." – Municipality

"[Our] patient population has increased… [and the] infrastructure has not changed." – Physicians

"...communities in [Region X] have been shrinking since forestry work has moved [away from Region X]." – Municipality

Participants emphasized how demographic and population changes have created local concerns that the community services are not adapted to the changing contexts; thereby causing issues that relate to capacity, patient access, staffing, service demands, manpower, and funding that do not meet the communities' needs:

"…our community is growing, like our nation is growing, but the services haven't. And so, everyone's fighting for a doc…" – First Nations

"I think we're just lacking that vision for the hospital in what is a basic level of service to serve a growing community of 21,000 that also supports 2-3 communities north of us." – Municipality

"…And trying to actually keep up from a staffing perspective, from a staff retention, everything from a budget, like it's we are playing a really hard game of catch-up because it's growing faster than we can even account for and put in services to meet the needs. That's what I think the biggest challenge is…" – Health Admin

Rural communities are dynamic and, because of their size and isolation, particularly vulnerable to changes, which may not be easily anticipated. Change is continual and only those that have the ability to find ways to adapt are able to continue to deliver effective health services.

Discussion

The Site Visit Project has strengths in the degree of its engagement and, after engaging with 107 rural communities and conducting 382 interviews, it has shown that it is possible to collect large volumes of data about local health care issues in a systematic and meaningful way in order to influence provincial health service changes. The fact that the Site Visits team travels to each community appears to have a strong influence on the relationships and trust experienced in the interviews. Many of the interviewees have informally commented on this fact, noting that they feel that the Site Visits team now understands their remoteness, available services, difficulties with transporting patients etc., and that they feel 'heard'. One limitation of this project is that it was carried out in British Columbia and supported by adequate resourcing through negotiated public funds allocated through the provincial physician organization. This means that it is specific to the context of British Columbia but may have elements transferable

to other settings. It would only be possible to replicate this project with sufficient funding supports.

The major themes are being identified and the analyzed data shared as specialized reports to both the micro and macro policy maker levels. The data are used by various organisations to provide a community provided rural perspective to discussions. For example, emergency transport was an issue raised by all rural communities apart from a very few within helicopter range of Vancouver. Site visit data was provided to a provincial partners' table convened by the RCCbc and discussion there informed a provincial government announcement of further rural emergency transport resources. Other examples of reports created from the data for specific issues can be found at https://rccbc.ca/rccbc/resources/documents/. The processes described have implications for policy makers in terms of rural health, ones that can be adapted to different contexts. System changes influenced by the visits data will be the subject of future publications.

The three themes described in this article appear as patterns throughout the data set. They are interlinked and can be seen as foundational elements for effective functioning of health care services in rural communities. Good relationships between providers, health authority administration, external specialist services and community members were repeatedly identified as being responsible for high functioning, successful communities. This means that effort needs to be made to create the time and space to develop relationships and that these efforts are valued by all sectors. Part of the importance of relationships was linked to the concept of autonomy which in this sense meant the ability to make local decisions when needed. Autonomy impacted the sense of wellbeing of the partners and could also produce very

practical, rapidly implemented changes with positive results. The exercise of autonomy however can be problematic if not carried out within an agreed framework that requires the limits of decision making to be set and agreed with health service administration and which recognizes historical power differences in health care (15, 24). Finally, change over time is recognized as being an important contextual factor in the provision of services to small rural communities and the resilience of these communities seems related to their ability to adapt to often unexpectedly changing circumstances. Such adaptation would appear to be easier in a context of good relationships and an agreed approach to local autonomy.

There are many examples in the literature of community engagement, though the literature does not appear to contain any examples of such widespread engagement being used to support policy change at a provincial level. The SV Project benefited from the fact that it is purely about listening. It did not promise change, but rather that the information gathered would inform change. Using Boelen's Health Care Partners model at micro and macro levels (20), the results of the SV Project are being used to discuss contextually appropriate changes for rural health care. Having all the partners present at these discussions appears to increase the chances of producing successful and sustainable outcomes. The findings fit within the "five rules of Large System Transformation" described by Best et al (25) and illustrate that rural health care is a complex adaptive system. While this study does not attempt to explore complexity, it does offer a framework for engagement, data gathering and analysis that is sensitive to complexity and local contexts and may point to an example of the paradigm shift Greenhalgh and Papoutsi call for in their editorial on studying complexity in health services research (26).

Limitations

Not all partner groups existed or were available to meet in some communities. The latter was rare and virtual meetings were arranged when necessary.

Because the Site Visits teams were led by experienced health care providers, a power differential existed during the interviews which may have been inhibitory, particularly when interviewing Indigenous groups.

As the interviews were led by health care providers it is possible that they may have biased the discussions.

The data collected is specific to the geography, health system and rural context of BC and may not be fully transferable to other settings.

A potential future limitation may be disengagement by the communities from further site visits if no beneficial changes are seen to occur.

Conclusion

By modifying Boelen's approach to partnership in health development the SV Project has demonstrated a successful way to engage rural communities and gather extensive data that can be used to inform rural health care policy in an ongoing and contextually appropriate manner. Relationships, communication and relevant data are the cornerstones that successful sustainable change is built on.

While every rural community is different, this project elicited many common themes that have linked the health care issues in rural BC. Although early changes have already occurred, further research will be needed to determine whether the changes resulting from the SV Project are beneficial and sustainable with time.

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Data Sharing

Due to the confidential nature of the interview data the raw data is not publicly available. All interim reports and innovations are available through public websites and links are embedded in the body of the text.

Competing Interests

Stuart Johnston is funded as a Director of the RCCbc. Erika Belanger and Krystal Wong are full-time employees of the RCCbc. David Snadden was the Inaugural Rural Doctors' University of British Columbia (UBC) Chair in Rural Health from 2016 to 2020, which is supported by an endowment to UBC from the Rural Doctors' of BC through the JSC. He also sits on the RCCbc Leadership group to provide an academic perspective. He is fully funded by the Faculty of Medicine at UBC as a Professor of Family Practice. There are no other competing interests.

Author Contributions

Reflective statements on author perspectives are available as Supplementary File 5

All authors contributed to and agreed the final version of the article.

Stuart Johnston is the project lead, has been involved in all stages of the project design, has attended visits and has helped with data analysis. He wrote the first draft of the article.

Erika Belanger is the primary analyst and developed the analytic methodology, the codebook and the initial content analysis. She has attended visits and contributed to all sections of the article.

Krystal Wong developed the Site Visits processes, attended visits, has been involved in all conversations in terms of the analysis and contributed to all sections of the article.

David Snadden developed the qualitative methodology and guided the research methodology, assisted with analysis and determining themes and contributed to all sections of the article including developing and editing the final version.

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BC Rural Site Visits Program – Meeting Guide

For All Health Partners

These questions are used as a guide to facilitate our meetings for all health partner groups (unless specified below). Meetings are semi-structured and flexible, so if there are topics that are not covered in our questions we are still very interested in discussing them with you.

General

1. Tell us about your health care in your community.
    a. What are its unique features?
    b. What works well?
2. What are your connections like with other community members?
3. How does the community support local health care?

Innovations

1. Tell us about any initiatives do you offer that you feel are successful and why?
2. Tell us about any holistic initiatives that have been put in place that support a person's well-being spiritually, mentally, and/or physically?
3. Are there any unique solutions that you've developed?
4. What can other sites learn from you?

Access

1. Tell us about access to primary health care providers.
2. Tell us about access to specialists and other health care services.
3. How do patients get to their health care needs (ER, appointments, services, etc.)?
4. How is telehealth used in your community?
5. Are there any services at risk and why?
6. What health care services would you like to have/provide that would have the most impact for your community?

Cultural Awareness

1. With racism at the forefront of many conversations in health care, have you ever experienced or witnessed racism or other forms of discrimination/judgement when you or others are accessing/providing care?
2. What supports are there for Indigenous community members to promote cultural safety?
    a. Are there any supports or services in place that help promote cultural safety for staff and patients? *For example: is there a cultural space to practice ceremonies such as smudging within your hospital/clinic, is there an Indigenous liaison, are there larger spaces for families to be with the patient, etc.?*
    b. *How have these cultural safety initiatives impacted care for you/your community/your patients?*
3. **For Indigenous community members:** Tell us what would help you or a member of your community feel more culturally safe when accessing health care services?

Pick relevant partner group:

For Clinicians (physicians, NPs, midwives, etc.) and Health Admin groups only: Practice Context

1. Tell us about team-based care and/or Primary Care Networks? Describe what an ideal team-based care team would look like in your community.
2. How do health care providers in the community share the workload?
3. What workplace supports do you have (CPD, Divisions, Health Authority)?
4. How could CPD support you better?
5. Would you be interested in doing research and what supports would you need?
6. Tell us about any real-time support initiatives.
7. Tell us about any locum support in your community.

For First Responders group only

1. Tell us how you interact with the local health care providers?
2. Tell us about any locum support in your community.

For Academic group only

1. Tell us about your teaching program.
    a. How easy is it to find preceptors?
    b. How does having learners change healthcare in your community?
2. How has having an academic program in your community affected recruitment and retention?

Recruitment and Retention

1. How do you address recruitment of health care providers?
2. How do you retain health care providers in the community?
3. Are there any supports available for the spouses/family members of those being recruited to the community?

Concluding Questions

1. How has Covid-19 affected health care in your community?
2. What keeps you up at night? What is your main worry?
3. What are you proud of?
4. Have we missed anything else you would like to contribute?
5. Do you have any feedback on this process?

RCCbc Rural Site Visits Project

Handbook

Prepared by Krystal Wong

May 2021

Rural Coordination Centre of BC

Enhancing rural health through education and advocacy

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Part I: Rural Site Visits Project

Introduction

The Rural Site Visit Project has been taken on by the RCCbc by the request of the JSC. The scope of the project involves visiting every Rural Subsidiary (RSA) Agreement community over a three-year period, starting in 2017. The objective of the project is two-fold:

1. **Relationship and network building** – Meet with community health partners in rural communities around BC and listen to their stories of their challenges, successes, and questions with regards to provision of care in their region

2. **Information collecting** – Build a database of information through these encounters that will provide a full overview of the current landscape of health care provision in BC that can be used to inform policy and support rural practice

To support visits to 201 RSA communities, teams consisting of a Site Visitor, an RCCbc staff and potential guest member from a partnering organization (e.g. College, Health Match BC and/or, university (e.g. Department of Family Practice, UBC RPCD)) will be joining. Each member of the team has a role to play in supporting the effectiveness of a site visit. As a Site Visitor, you will be working with staff to connect with physician leadership in the community and facilitate meetings on site.

We meet individually with the community's:

- physician group
- health administrators
- nurse practitioners; midwives
- municipal leaders and community members
- first responders
- First Nations leadership
- academia

In addition, we host a combined health partners meeting where we bring all the leads each of these groups together to open communication channels and discuss their priorities.

Key Project Milestones

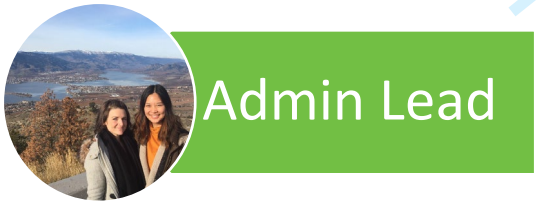
MILESTONE	DESCRIPTION	DATE
Creation of RSV Project	Proposal to JSC submitted and accepted	Fall 2016
1st SV trip (pilot)	Trip to Community X,Y	January 5, 2017
1st Site Visitor Training	Training facilitated by Paul Mohapel on appreciative inquiry	December 2017
Gained UBC ethics approval	Harmonized ethics approval	January 22, 2018
Started working with RCCbc's TRC (Truth and Reconciliation Commission of Canada) group	Presented Indigenous feedback, worked with TRC to adapt cultural safety questions on interview guide	November 2019
Introduced Maximizer	New database/trip planning online tool was introduced (removing need to plan trips on Google Sheets)	February 2020
In-person trips on hold	In-person trips were put on hold due to Covid-19	March 16, 2020
Initiated first research paper	Started first research paper with research team	April 8, 2020
Rural Site Visits and Innovations website launch	Launched website to participants and stakeholders. Presented at Core meeting.	September 11, 2020
Principal Investigator's retirement transition with new Clinical Lead	New Clinical Lead joins Site Visits team	January 2021
Incorporated a more Indigenous research methodology/two-eyed seeing approach	Created an Indigenous Research Associate role, started modifying engagement approaches	March 2021

Timeline of a Site Visit Trip

Below is a high-level summary of the Site Visits timeline.

Site Visits Team Members

Each site visit trip will include an Admin Lead and Site Visitor. At times there may be a guest(s) from the Ministry of Health, Joint Standing Committee, Health Match BC, Medical Director, etc. Also, there may be a Mentee or Admin Lead in-training.



Role of Coordinator/Admin Leads

The Site Visit Coordinator is the staff member responsible for the long-term planning, reporting and communication for site visits, and will be attending a large portion of the visits. In addition, other RCCbc staff members (Admin Leads) will also be involved in planning for individual visits and attending as administrative support.

Admin Leads assigned to a site visit will be responsible for making all the reservations, bookings, and agenda planning for the site visit. They will be working with the Site Visitor to make appropriate arrangements for travel and for initiating contact with community members in

advance of the visit. On site, staff will be responsible for setting the digital recorder for the meeting and helping ensure that all meetings run on schedule. Post-visit they will send thank you and follow-up notes, help edit the transcribed notes and assist with Site Visitor's expenses.

Role of a Site Visitor

As a Site Visitor, the primary responsibility will be to facilitate open discussion. To guide these discussions, there is a list of questions (see Appendix E) that should be used. These guides help provide a framework that covers a wide scope of topics and issues. The Site Visit Coordinator or other staff support (Admin Leads) who attend the site visit will also be able to help prompt when certain topics have not been discussed yet to help support site visitors in facilitating the discussion.

Responsibilities

1. Pre-site visit trip
    - Provide the Admin Lead with your availability to go on a trip (usually a week of flexible dates)
    - Support in making the initial contact with the Chief-of-Staff/physician to explain the Rural Site Visits project and invite them to participate. Also, to inquire about the community's health care landscape and if you can get any connections/contacts (i.e. who is the hospital administrator, are there any First Nations health services, is there a Mayor or key community health societies we should be meeting with, etc.)
    - Help with following-up with community's physicians if needed
2. During a site visit trip
    - Facilitate meetings and keep track of action items/follow-ups
    - Pay (potentially) for group meals, travel, hotel – most travel and hotel will be paid for in advance. See 'expenses' section for more details.
    - Drive or share the driving time with others on long road travels
3. Post-site visit trip
    - Debrief with the team that attended the visits (this usually occurs during the travel back home). If the team is not traveling together or if you want to highlight more feedback, a teleconference will be set up with the team and Site Visit Coordinator/Clinical Lead
    - If any partner meetings were unable to be scheduled in-person, a teleconference may be offered to them and you will need to facilitate an hour meeting
    - Action any follow-up items that arose during meetings

- Provide any clarification, revisions of the returned transcribed notes before being sent back to the community for their approval

Training for Site Visits

All Site Visitors and staff involved with the project are expected to undergo training before going on a site visit. Training consists of a session (hosted either in person or via Zoom) on facilitating dialogue. This session focuses on the theories and skill development for active listening, mindfulness, and discussion facilitation. This session also addresses how to diffuse tension that may arise during discussions. Once Site Visitors are trained, they will be mentored by the Clinical Lead for their first Site Visit trip.

We also encourage Site Visitors and Admin Leads to complete the San'yas Indigenous Cultural Safety and Humility (ICS) training which is provided online through PHSA. This training takes about 8 hours to complete in total, and you are given 8 weeks to finish the course. We recommend that Site Visitors take the ICS Health course, as this course is accredited by the College of Family Physicians of Canada. If you are an employee of a health authority training is available at no cost, for actively practicing rural physicians REAP offers reimbursement upon completion of the course (more information can be found here). RCCbc will also provide reimbursement for those who do not fall under the previously mentioned groups. More information about the training and how to register can be found here: http://www.sanyas.ca/training/british-columbia/core-ics-health

Ethics

This project has UBC ethics approval which include recording and transcribing the meetings. In our reporting, individual identities will be kept confidential and all data will be anonymized. When visiting First Nations communities, be aware of their sensitivity to being 'researched'. Some First Nations communities may have their own ethics protocols for visits where information is being gathered which we need to respect.

In introducing the ethics process, it is important to emphasize that the primary purpose of the site visits is relationship building between the JSC, RCCbc and the communities. The second purpose is to collect high-level qualitative information about the community's health care priorities. The transcription will first be sent to the participants for their review and approval. The information is owned by the community and they have the right to change, delete or request that their information is not used at all. Once you have explained the ethics process to the group and received their permission to go forward, consent forms will be handed out to all participants to sign and allow recording of the meeting.

Part II: Planning a Site Visit Trip

The Project Coordinator and Clinical Lead will work on a yearly schedule to plot potential communities to visit. Communities will be identified and made known 3-5 months in advance. The Admin Lead team will be given some preferences dependent on availability and emails will be sent out to Site Visitors to request their availability and determine who will be leading the visit to each community and identify potential dates. The Admin Lead will be assigned the trip and connected to a Site Visitor. The Site Visitor will then reach out to the physician group within that community to determine the most optimal dates for the community. Usually, an email or phone call is made to the Chief of Staff by the leading Site Visitor to explain the purpose of the project, what we are asking for, and why we would like to meet with them. Also, the Site Visitor should attempt to collect contact information for the other health partners (nurse practitioners, midwives, health administrators, First Nations, academic groups, Mayor or key community health societies) if possible.

Once the dates are chosen, the Admin Lead will extend invitations to the municipal government, health administrators, nurse practitioners and First Nations, etc.

Please note each community is unique and there is no 'one-approach' fits all. The following steps are a guideline and ways to reach out and engage will vary from trip to trip based on different circumstances.

1. Research & Plan Schedule

Once Admin Leads are assigned a visit (usually 2-4 RSA communities), they will need to research some key information to start building out the trip i.e., how many partner groups are present in the communities, how many meetings will be involved, potential travel options and how long the trip may take.

As previously mentioned, a community is usually chosen to be visited during a specific month, but the specific dates are determined by the Admin Lead for the site visit as well as the physicians of the community to be visited. Our goal is to be able to adapt to the schedules of the communities we visit so that we are not imposing a burden on the people we meet with. When asking the physician group about what dates work best for them, you will need to discuss with the clinical lead and the Project Coordinator about any potential conflicts in any of your schedules that you need to be aware of.

When setting a schedule for a site visit, it is best to work "outside – in", meaning start with looking at your options for travel before committing to any meeting times. Some communities

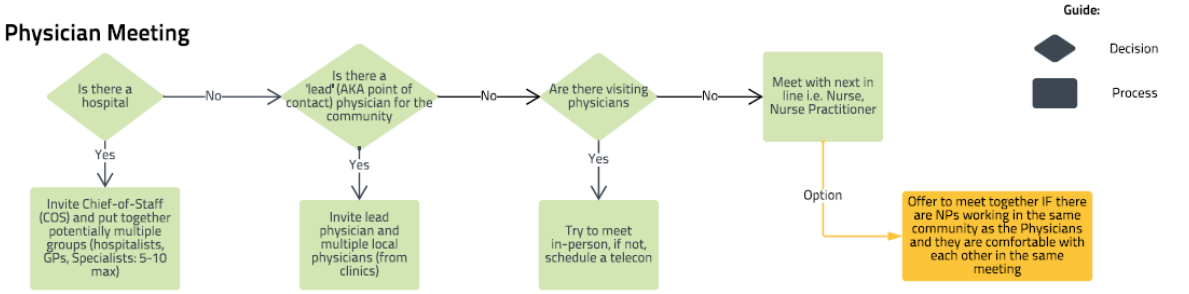
you will be able to fly directly into, some you will need to drive to, and some might be fly-in only. It is key that you map out your options and consider the travel you, the clinical lead, and any guests need to do in order to arrive in community at roughly the same time. Having this knowledge makes it a lot easier to slot in the meetings and map out where you need to be.

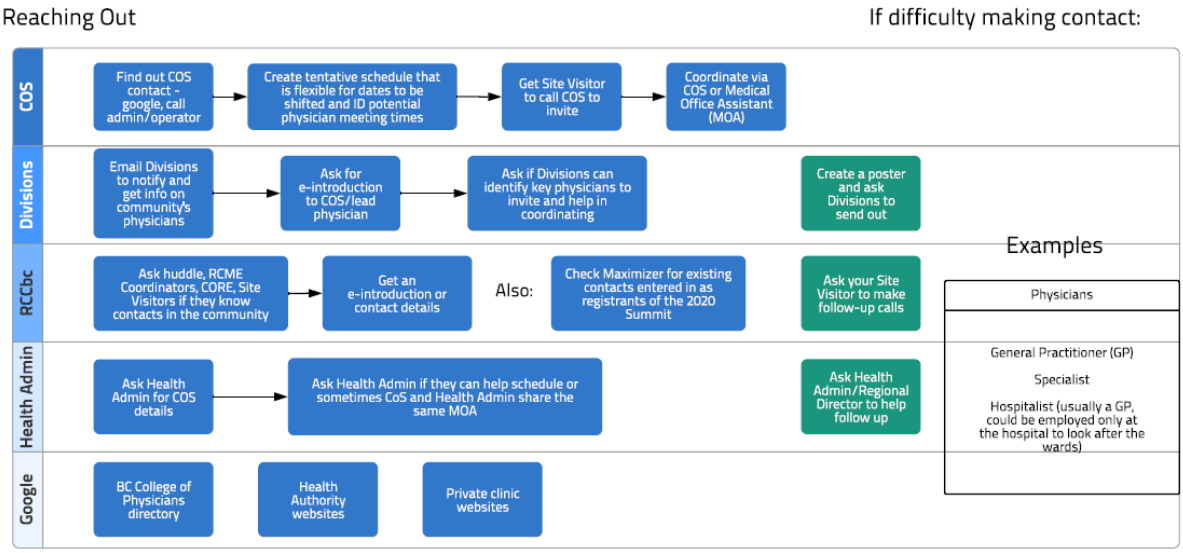
We always offer to host the physician meeting over a meal, most success has been found by hosting the meeting over dinner. This is because most of them are free once they are done clinic, and that opens up lunch time to host the Combined Partner meeting (the group meeting). Locations for meetings vary, often the physician meetings are in a clinic boardroom or in a restaurant, admin meetings usually in a meeting room in the clinic or hospital, municipal meetings are usually at city or town hall. The partner meeting is typically hosted at the clinic/hospital as well. First Nations meetings are usually hosted at their offices or clinic, and depending on where they are located may require additional travel.

Each meeting should be ~1 hour long, but leave time on either side of the meeting for travel and casual conversation (15-30 minutes on either side, depending on the context of your visit). Physician meetings often run overtime, so it is good to leave extra time after them or to plan them over dinner so they can talk freely for as long as they are willing to stay with us. If booking a meeting in a restaurant, try to book a private room if possible, to ensure privacy for the conversation. If that is not possible, try to request a quiet corner of the restaurant. Usually for the physician meetings they have a regular go-to place whether it is a restaurant or the hospital with catering – so make sure to ask them what they think would work best.

How to figure out who you should contact is different for each partner group:

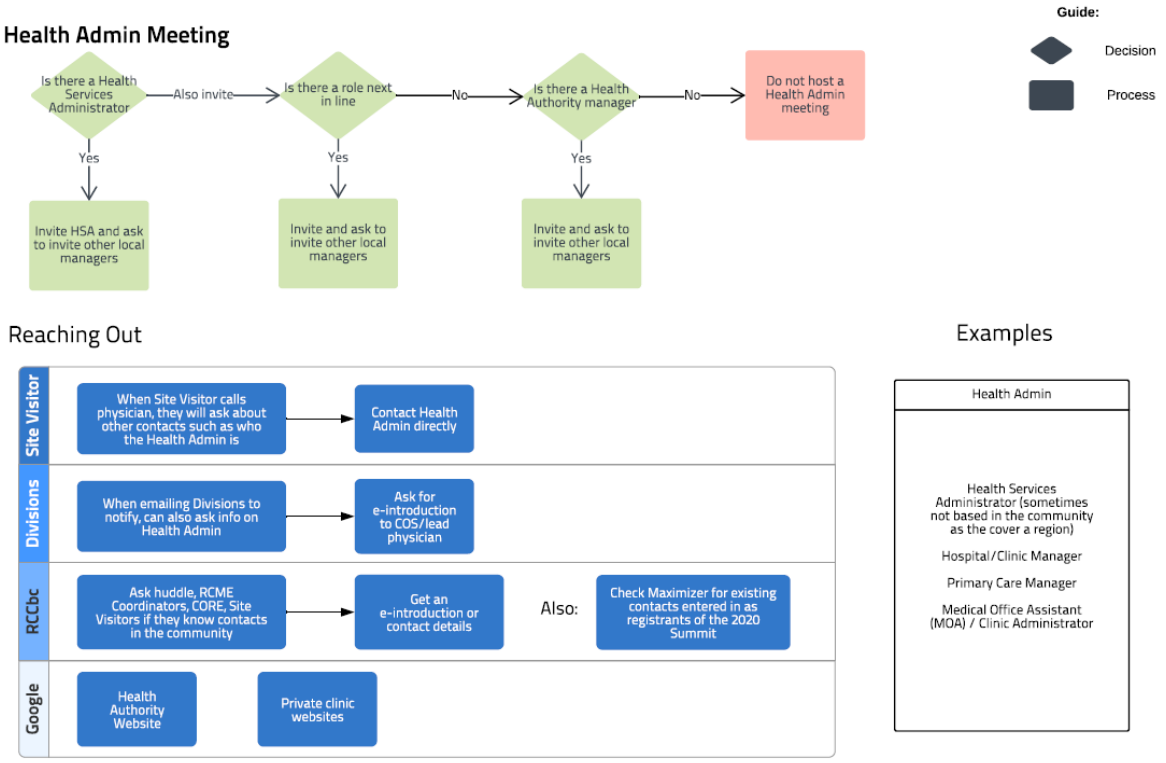
A. Physicians





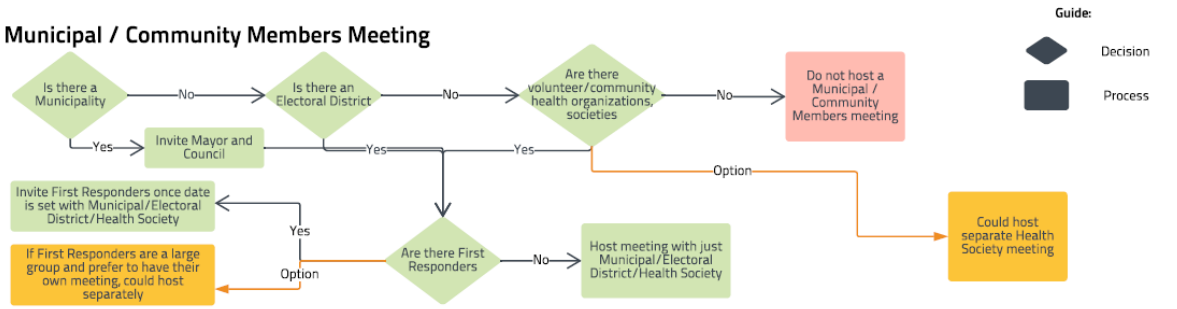
- Usually there is someone in the RCCbc office or part of the Core who knows someone (who knows someone) who works in the community you are looking to go to – try reaching out internally first to see if anyone can help.
- If the community is part of one of the Divisions of Family Practice, contacting them is usually a good place to start as well
- The BC College of Physicians and Surgeons has a directory of physicians in BC that you can search, however it isn't very accurate but helps give an idea of the number of physicians in a community
    i. https://www.cpsbc.ca/physician_search
- **Get the physician lead to reach out the physician group first – usually by a phone call directed to the chief of staff

B. Health Administration

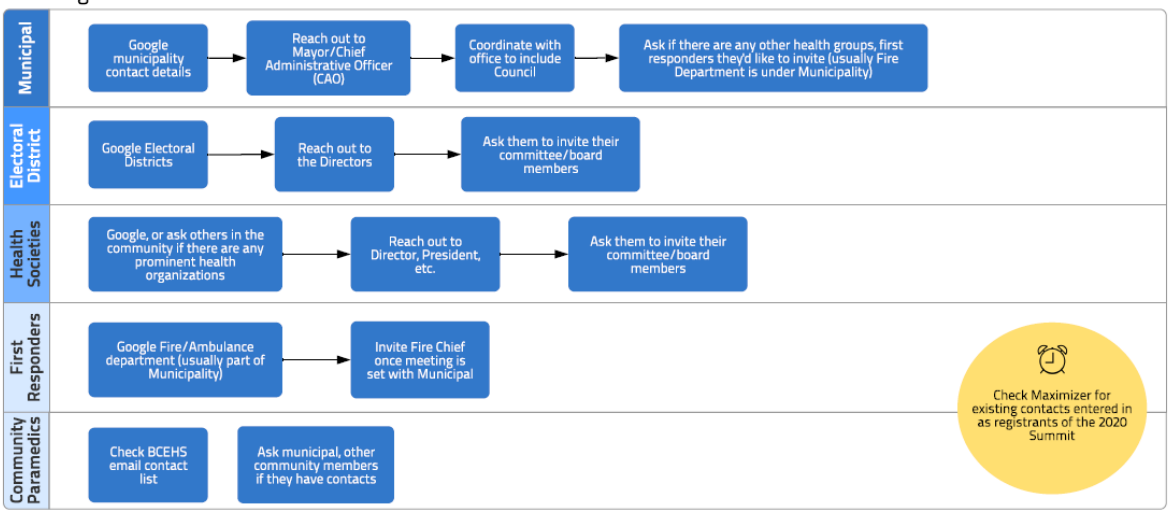


- Larger communities and health regions will have a Health Service Administrator who is an employee of health authority. You should try to connect with this person, often the physicians will be able to give you the right information.
    i. Sometimes this information is available on the HA website, but most of the time you are going to have to get the information through the physicians or through Divisions.
- With Northern Health and Interior Health, the Medical Directors have requested to be notified when a site visit is coming to their community, so they are an option for verifying who you should connect to
- When you connect with whomever the physicians say is the best to connect with, extend the offer for them to invite any program managers or nurse managers that they think should be included in the meeting. It is not uncommon for us to meet with 2-5 admin.

C. Municipal Leadership

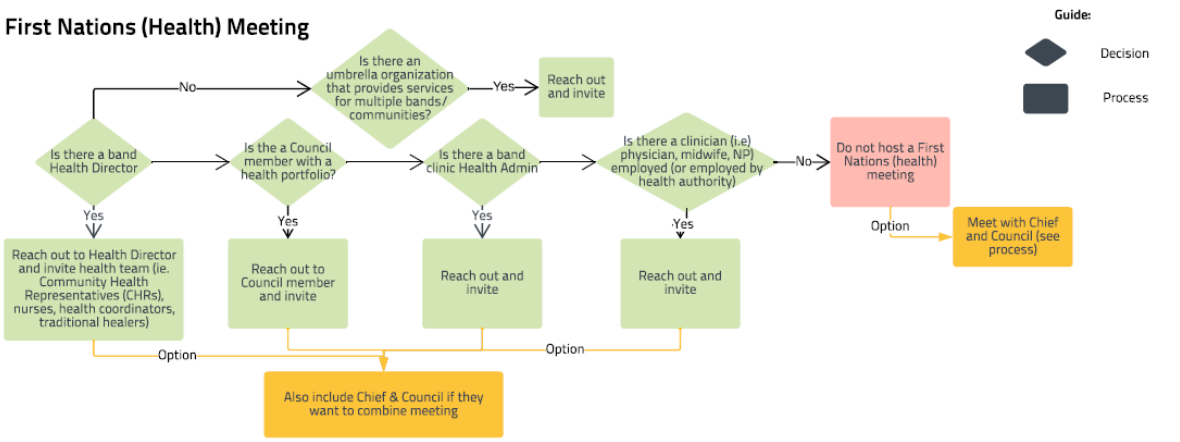


Reaching Out



- Check the municipalities' website – they all have one. They will list their current mayor and council, and often what their portfolios are.
- Best to call the office of the mayor first – they respond best to receiving an explanation of the project on the phone with email follow up.
- If you send an email to the mayor, always copy the office's administrative assistant or the Chief Administrative Officer (CAO) for the municipality. They are often the ones who manage the mayor's calendars.

D. First Nations

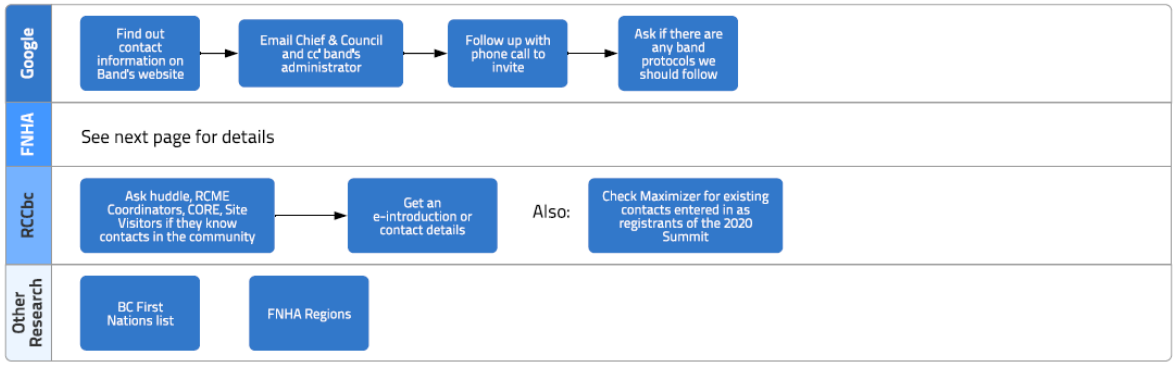


Reaching Out

Google	Find out contact information on Band's website	→ Email Health Director and cc' band's administrator	→ Follow up with phone call to invite		
FNHA	See next page for details				
RCCbc	Ask huddle, RCME Coordinators, CORE, Site Visitors if they know contacts in the community	→ Get an e-introduction or contact details	Also:	Check Maximizer for existing contacts entered in as registrants of the 2020 Summit	
Other Research	BC First Nations list	Band's Health Centre website (may be separate from Band Office website)	FNHA Regions		

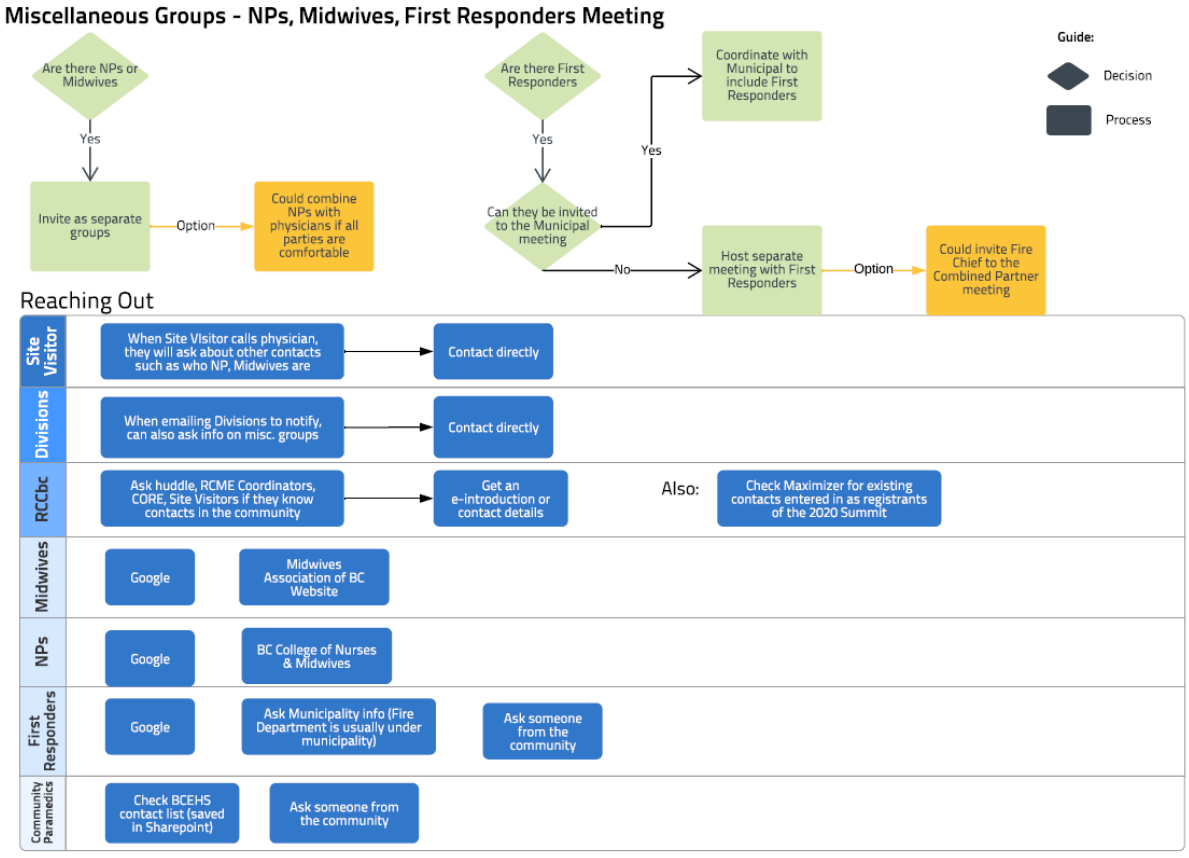
First Nations (Chief & Council) Meeting

Reaching Out

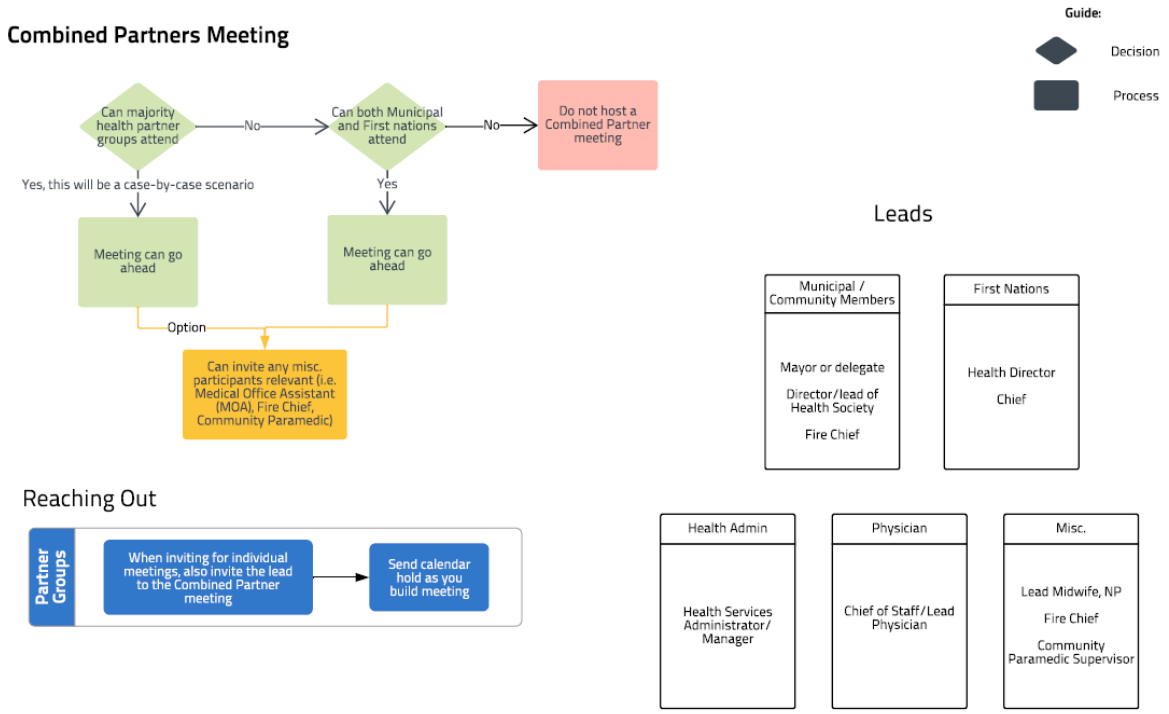


- You should try to get in contact with the Health Director or whoever is coordinating health services
- Sometimes there are multiple bands in the region you are visiting – make sure to check the RSA list and/or this map to determine who you need to be connecting with
- Most of the bands have websites with some details about what health services they have, and will usually list how to contact the band employee responsible for managing health services. If not, reach out to the general office by phone to inquire
- You can also ask health admin and the physicians, because usually someone has a relationship with the band that can help bridge the gap.

E. Miscellaneous Groups



F. Combined Partner Meeting



- The Combined Partner Meeting is the 'leads' (i.e. Mayor, Chief-of-Staff, First Nations Health Director, Fire Chief, HSA) come together to share their health care priorities with each other. In some communities, this is quite novel

2. Reaching Out

Once you've built a tentative itinerary and found contact details, send the following information and request your Site Visitor to make the first reach out to the Chief of Staff/Lead physician.

- Chief of Staff/Lead Physician or clinic's contact name and phone number
- Specific date and time for the physician meeting (could provide back-up options)
- Remind the Site Visitor to get as much community information as possible and their MOA's email (if applicable) so they can help you coordinate the meeting with physicians.

Note: We reach out to the physicians first because we need to make sure that the dates we choose work for them. If the physicians aren't available, there is no point in hosting a site visit at that time. Once you have confirmed the availability of the physicians, continue to reach out to the other partners.

It is best to contact people by phone initially and give a brief explanation to get their interest and buy-in, then follow up by email with more details and some date/time offers. Always attach the introduction letters and the meeting guides to the emails.

Physicians are a special case

With the physicians – if there is more than 3-5 in a community, it can be difficult to make sure everyone has received the invitation to meet with us. When we reach out to the physicians, usually it's just to the Chief of Staff (there may be more than one) and the president. Sometimes they will email out to their colleagues the details of the meeting, but often in those cases you will never receive confirmation of who is attending unless you ask closer to the date. Another option is asking if there is an administrative assistant who is able to send a calendar invitation to everyone and copy you into it, or you can offer to send the calendar invitation yourself. Regardless of how it happens – it is important to ensure that an invitation of some sort has been distributed.

Another piece is that in larger communities, you will have more physicians in the community than you can reasonably host at the meeting. We usually limit our meeting to 10 physicians because beyond that there are just too many people at the table, and you don't get to go deeper with the conversation as you might with a smaller group. For the larger communities, suggest that invitations are sent for a representative from each clinic in town to join, since often they will have more than 1 clinic. Prioritize GPs, but if there are specialists they are also welcome to join.

What if someone isn't available to join on the chosen dates?

If one of the partner groups is unavailable to meet during the planned site visit, always offer to connect by video or teleconference after the site visit to get their perspective. Additionally, if you are aware of another site visit to a nearby community in the near future, it is possible that a meeting could be arranged at that time.

If more than 2 of the 4 partner groups are not available, you will have to find another time to do the site visit as we won't be able to hold a successful group meeting. Similarly, if you are visiting a community that is predominantly Indigenous and you cannot secure any time with Indigenous representatives, try to find another time to have the site visit. That being said, engagement burnout is not uncommon amongst First Nations in BC – you will have to use your judgement about whether you feel you can pull them in with the right planning, or if it just too much for them at that time.

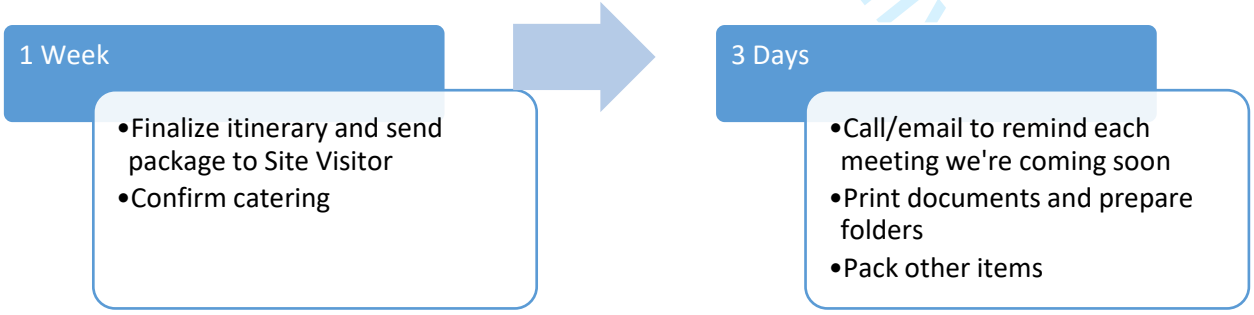
3. Booking & Confirming

The final piece is making sure all your reservations and meetings have been arranged.

- Flights are booked as soon as you have confirmed with the team what their preferred travel route is and you know when you need to be in community by.
    - Try to book these at least a month out, otherwise prices will start going up
- Accommodation is booked once you know your travel schedule. You may have to book accommodation in a few communities if you are visiting more than one so make sure you have your meeting schedule finalized before you do this
    - In some small towns they may not have great hotels or motels, in which case you can book a BnB or AirBnB
- Car rentals if needed. We have corporate accounts with Enterprise and Budget and they are usually the best for booking.
    - Be mindful of whether you need snow tires! Most rental companies won't give it to you automatically so make sure to request them if you are travelling in the winter
- Make sure that everyone you are supposed to meet with has a calendar hold. Whether it is sent by you or set up through their administrative staff doesn't matter, just make sure you have their calendar secured.
    - Include the meeting guide and the introduction letter in any calendar invitations you send so that people can easily jog their memory of what the meeting will be about.
- Restaurants – you don't need to book reservations for all your meals, just the ones that are had during a meeting. If you need to do catering, make sure that payment details are sorted out in advance.

    Most catering companies will invoice you or charge a credit card. Restaurants can also keep a card on file and charge the bill. This is useful since only Kim/Elisa/Leslie/Ray have a corporate card and these bills are usually large.

4. Preparing Final Details



Last Minute Changes

We understand that last minute changes may be necessary for personal reasons for Admin Leads or Site Visitors. In this event, we will attempt to find another Admin Lead/Site Visitor to lead the site visit.

Part III: During the Visit

During the visit, the Site Visits team with either travel together or meet up in the community. They will follow the detailed schedule created by the Admin Lead. Typically, trips can last between 2-3 days and depending on the schedule, could have 2-4 meetings per day. There should be some down time to explore the town, have coffee, and get to know the community better. The team can take turns driving – the rental will be fully insured. If road or weather conditions make it unsafe to travel, please take caution and postpone meetings, change flights, etc. If there are any emergencies, please let the office know.

When facilitating meetings, refer to the facilitation cheat sheet (Appendix A) for introductions, sharing information about the RCCbc, JSC, and the project, informing about consent, recording the meeting, etc. If you are running late, the Admin Lead has all the contact information of participants and they should let participants know if you're running late.

After the meetings, you can do a quick debrief in the car or travel back home. You'll do a more in-depth debrief once you're back home with the Site Visits Coordinator and Clinical Lead.

Taking photos and videos are encouraged throughout the trip! Please ensure you are avoiding taking any patient faces and information. Always ask participants for their permission if they'd like to be in our photos.

Part IV: After the Visit

Debrief and Follow-up

Debrief with the team that attended the visits (this usually occurs during the travel back home). If the team is not traveling together or if you want to highlight more feedback, a teleconference will be set up with the team and Site Visit Coordinator/Clinical Lead.

If any follow-up connections, sending of resources, etc. need to be made send them as soon as possible (don't wait over a week) to participants. There is a follow-up thank you email template you can send which outlines general resources and what will happen with the recordings.

If any partner meetings were unable to be scheduled in-person, a teleconference may be offered to them and you will need to facilitate an hour meeting on Zoom.

Reporting

A copy of the transcribed notes will be sent back to the community for their approval. Once approved, the notes will be inputted to NVivo, a qualitative software to be analyzed for common themes. The data is aggregated and anonymized. Additional regular 6-monthly reporting on the project to the JSC will be provided by the Site Visits Coordinator and the Clinical Lead. These reports will highlight the emerging trends from the visits done to date. As part of our commitment to the community and ethics obligations, bi-annual updates will also be sent back to participating communities to inform them of the emerging themes and notable pieces collected from Site Visits in the form of a 'Community Feedback Report'.

Sessional, Expenses and Claims

For Admin Leads

Overtime will work as per RCCbc overtime policy - please refer to this document for more details. Any dinner meetings are considered working meetings, so you are to claim overtime until the time the meeting ends. If you have any questions about what time is considered covered by overtime policies, please contact management.

All expenses for travel meals, taxis, and any other necessary expenses for the site visit will be covered by RCCbc. As per other claims, you must provide the receipts for these expenses in order to be reimbursed.

For Site Visitors

All expenses for travel, accommodation, and meals during the course of a site visit will be reimbursed by RCCbc as per our regular policy. Site Visitors will also be paid a sessional rate for the time spent in community conducting meetings. The RCCbc sessional rate is $XXX, one session equates to 3.5 hours. If a teleconference meeting with health partners in the community needs to be scheduled after the trip, they will be paid per hour ($XXX/hr) for their time. Sessional is not provided for their travel time to the community, unless there are extenuating circumstances. Reimbursements will be made within 2 weeks of submitting expenses. A photo of the itemized receipt sent to the finance assistant will be adequate.

Part V: Interviewer Facilitation

Appreciative Inquiry

Appreciative Inquiry is the study and exploration of what gives life to human systems when they are at their best. It is a positive organizational approach to development based on the assumption that inquiry into and dialogue about strengths, successes, values, hopes and dreams is itself transformational.

Four "Ds":

1. **Discovery** – asking positive questions, seeking what works, what empowers, what gives life to our community or group, when have we felt particularly energized
2. **Dream** – visioning of what could be, where we want to go
3. **Design** – making an action plan based on what we can do, and making personal commitments
4. **Delivery** – start taking actions now

Facilitation Skills

When interviewing participants, we use an open-ended approach with our questions which require some key active listening techniques.

Silence

Pause before speaking and embrace the periods of silence to allow reflection

Paraphrasing

Repeating back to the speaker what you heard, but rephrasing it into your own words

Reframing

Reflecting back the content of the speaker's message, in a way that makes the message more easily heard by the other party or in a way that neutralizes the strong emotional subtext in the message.

Empathizing

Rephrasing what the speaker said, by acknowledging and validating any feelings that was embedded in the message.

Tips:

- Be aware of your body language as well as other's in the room
- Present yourself as curious. Important to not be attached to the outcome – in this role you are supposed to be curious and not always offer potential solutions
- Avoid "why" questions as they can be perceived as judgemental
- Remember we are collecting stories and experiences, not 'data'
- Be neutral and authentic
- Bring humour

Although sharing your personal stories and experiences which relate to participants' experiences is a way to connect, it is important to allow participants enough time to speak freely. This is also important to keep the meeting to an hour to avoid going over time.

Cultural Safety and Humility

The purpose of including these questions is to generate awareness and have participants recall on their/others' experiences and practices.

The goal of **Cultural Safety*** is for all people to feel respected and safe when they interact with the health care system. Culturally safe health services are free of discrimination and racism. People are supported to draw strengths from their identity, culture and community. **"safety" is defined by those that receive the service, not provide it.*

Questions on the meeting guide:

1. With racism at the forefront of many conversations in health care, have you ever experienced or witnessed racism or other forms of discrimination/judgement when you or others are accessing/providing care?
2. What supports are there for Indigenous community members to promote cultural safety?
    a. Are there any supports or services in place that help promote cultural safety for staff and patients? *For example: is there a cultural space to practice ceremonies such as smudging within your hospital/clinic, is there an Indigenous liaison, are there larger spaces for families to be with the patient, etc.?*
    b. *How have these cultural safety initiatives impacted care for you/your community/your patients?*
3. **For Indigenous community members:** Tell us what would help you or a member of your community feel more culturally safe when accessing health care services?

Part VI: Extra Certifications Required

Course	Description	Link
San'yas Core ICS Health	San'yas: Indigenous Cultural Safety Training is a unique, on-line training program designed to enhance self-awareness, and strengthen the skills of those who work both directly and indirectly with Indigenous people. The goal of the Indigenous Cultural Safety (ICS) training is to develop understanding and promote positive partnerships between service providers and Indigenous people. You will receive a certificate upon completion.	https://www.sanyas.ca/
TPCS 2 CORE	The online tutorial (self-directed) TCPS 2: CORE (Course on Research Ethics) is an introduction to the 2nd edition of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2)*. It consists of eight modules focusing on the guidance in TCPS 2 that is applicable to all research regardless of discipline or methodology. This is a requirement to be included on UBC's BREB (Behaviour Research Ethics Board) ethics as part of our research study team. Takes approx. 3hrs to complete. You will receive a certificate upon completion.	https://tcps2core.ca/welcome **when you register, you can use UBC as your 'affiliation' if needed*

Part VII: Resources

Resource	Description	Where to find
Community Feedback Reports (CFR)	Bi-annual reports to the participant. Publicly shared.	Posted on SV website
Specialized Reports	As requested by organizations/programs. Can be publicly shared.	Posted on SV website
Map of RSA Communities completed, planning, to visit	Google map of communities visited to date, and communities left to visit.	Google Maps
List of communities visited	Check list of communities visited to date, and communities left to visit.	Link
Rural Subsidiary Agreement (RSA) List	Community eligibility for the Rural Practice Subsidiary Agreement is determined by evaluating its level of isolation. Where you can find the 200+ list of RSA communities.	Government of BC website
JSC Programs List	List of rural programs and eligibility requirements	PDF Booklet

Appendices

Appendix A: Meeting Facilitation Cheat Sheet

Site Visits – Meeting Facilitation Cheat Sheet

Time	Item
1 min	**Opening introductions for site visit meetings*:** • Introduce yourself (bio, background, etc.). • Thank participants for taking the time to meet with us. • If you are on First Nations territory, please acknowledge (i.e. We would like to begin by acknowledging that we are fortunate to be able to gather on the unceded territory of the Coast Salish People). **If in the 'Combined Health Partners' meeting – see below for separate process.*
1-2 mins	**Do a roundtable of introductions.**
1 min	**Introduce the Joint Standing Committee (JSC) and Rural Coordination Center of BC (RCCbc)** The Joint Standing Committee on Rural issues is comprised of representatives from Doctors of BC, the Ministry of Health, and the health authorities. The JSC seeks to enhance the availability and stability of physician services in rural and remote areas in BC. They provide programs to support physicians practicing in Rural Subsidiary Agreement (RSA) communities such as REAP, RCME, REEF. RCCbc is an organization that identifies the gaps and overlaps in rural health care services and seeks to foster connections and build relationships in order to improve rural health care in BC. The RCCbc works on behalf of the JSC on matters pertaining to rural medical practice.
2 min	**Introduce the Rural Site Visits project** • An initiative tasked to RCCbc by the Joint Standing Committee (JSC) – a collaborative committee of the Ministry of Health and Doctors of BC. • Visiting 201 communities in 3 years (2017+). *Purpose* of the project is to try and build relationships and channels of communication between communities and policy makers. • The information we collect will be aggregated and the major themes extracted. This information will be used to guide the modification and development of programs that support rural and inform rural health care. • The findings will be shared with the JSC on a regular basis. We will share the feedback in a community report to share the emerging themes and any successful initiatives around the province. *show copy of report as an example.

	What we are looking for is to hear about everything from what is working well, what isn't working well, your thoughts, hopes, and frustrations… all this to get a comprehensive picture of how health care services work at the community level.
1 min	**Explain the ethics/consent process and hand out consent forms (each participant must sign their own forms)** • All the information we collect will be anonymized and aggregated into the larger data set, so nothing will cause you to be identified personally – we encourage you to speak as freely and openly as you are comfortable doing. • Additionally, the notes that we record today will be shared back to you to verify that the content accurately reflects what you shared with us and that you are comfortable with all the information we have recorded. A copy of the transcribed notes will be sent to the lead/coordinator to review for accuracy and they can request if they want anything omitted, amended or completely destroyed. • You can show a copy of the 'Community Feedback Report' as an example of how the information will be presented back to communities. • Hand out consent forms and ask each participant to sign and return.
	Start recording • State the community, partner group and date – 'This is the physicians meeting in X community on X date'. • Ask everyone to re-introduce their name and title for the recording so that the transcriber can listen for voices. For virtual – ask them to say 'I consent to participating'.
60 mins max	**Use the meeting guide to facilitate** • Keep track of topics/issues as you may be able to skip questions if they've already been covered. • Write down any important themes for each group. • Stick to 1-hour max!
Important!	**Ask for feedback on our process and make sure to thank them for taking the time to meet with you and share their stories!**
	Stop the recording
	Follow-up • Let the group know the Admin Lead will send follow-up emails and a copy of their transcribed notes to approve • Provide any resources, pamphlets • Offer to make any relevant connections with RCCbc, other contacts/programs, etc. • Exchange business cards

Combined Partner Meeting

In order to make the Combined Partners' meeting more useful to the community we've elected to move towards a Pentagram Partners/Fraser Basin type approach. The goal is to demonstrate a problem-solving process that gives the community grass roots control over the solutions to their identified problems.

Potential attendees of the meeting*:

- Mayor
- Chief of Staff/lead physician
- Lead nurse practitioner
- Health Services Administrator; hospital or clinic manager
- First Nations Health Director
- First Responders

*The right people in the room will be different for each community

Pre-meeting:

Working with the full Site Visit team, compare notes and identify what appears to be common, recurring issues in the initial individual meetings with the partners. Bring these issues to the meeting and then suggest that the community might like to put together a group that will meet regularly to try and address these issues.

During meeting:

1. Thank the attendees for coming to the Combined Partners meeting.
2. Participants who have already signed the consent form will not need to sign a new consent form for this meeting. ***If there are any new participants, please still give them a brief overview of the ethics/consent process and get them to sign a consent form.**
3. You will still record and get everyone to introduce their names and roles for the recording. Please mention to the group that you'll still be recording but it may or may not get transcribed depending on whether the dialogue breaks into smaller group chats/networking time.
4. Do a brief round of introductions. Many of the folk present will already know each other.
5. Briefly reiterate the goals of the RCCbc Site Visits Project.
6. Describe why we've brought them together:
    a. Partnership Pentagram model (derived from the WHO) offers a way for all the interested parties in the community to get together in a non-adversarial way to look at ways to solve local problems. Describe how the solution must be acceptable to all of the partners, and that if anyone doesn't agree with the proposed solution then they have the right of veto.
    b. Mention the often-repeated mantra that **"the person who is not at the table is the problem".** Firstly, because whoever is not at the table tends to be blamed, and secondly a successful solution will only be found if all the players are present to agree that it will work.

c. Possibly describe a very similar 'home-grown' model in BC which is the Fraser Basin Approach. This was a collaborative series of meetings between all of the interested parties who were trying to solve the problem of declining Salmon stocks on the Fraser River. Initially each party was jealously guarded their own interests and no common ground could be found. After all sitting down at the table and agreeing that they were all ultimately after the same goal, they were able to work collaboratively towards a solution that was acceptable to all the parties. This model also incorporated the 'veto' option, i.e. if any of the proposed solutions were unacceptable to any one of the parties then it was dead. The Fraser Basin Approach has been of international interest because of its success.

7. Reiterate that successful solutions will usually come from the grass roots or community level, and that it needs to be community driven. Both models have been very successful because all of the players are at the table; and have an equal say.
8. Then sit back and watch/facilitate!

Often multiple small groups seem to form as the partners begin to explore ideas. Let them chat and circulate as needed. If you have done nothing other than plant the seed, you have had a successful meeting!

Prompts for facilitation:

- Ask about innovations/projects to share with one another and how they could collaborate.
- Ask how they might arrange future meetings together, who might attend.
- Offer the resources of the RCCbc if they need further information.

Appendix B: Physician and Health Admin Invitation Letter

Invitation to participate in Rural Site Visits Project

Rural practice has some of the most skilled people in health care, creates some of the most interesting innovations – yet not many folks seem to realize this. We want to raise the profile of rural practice and have it understood and valued throughout the province.

The Joint Standing Committee on Rural Issues (JSC) has tasked the Rural Coordination Centre of BC (RCC*bc*) with offering to visit every community that is a beneficiary of the Rural Subsidiary Agreement (RSA) between 2017 and 2020. The objective of these visits is to connect with rural practices to hear about what the context of your practice is (what innovations you have, what you are doing well, what your biggest problems are) in hopes of feeding this information back to the JSC and to better support feedback between rural practitioners and the organizations that administer the programs they use.

We are aware there are many demands on your time and that others also visit rural practices, such as the Faculty of Medicine undergraduate and postgraduate programs, researchers and CPD. We are actively working with them to streamline our visiting processes so they can be carried out in partnership.

At this point in time, we would like to ask you if you would be interested in working with us on this project by allowing us to visit your practice and your community. If you are interested, the project would involve you participating in a group and individual interview at your location that will use open-ended questions and seek your views on the areas outlined above. Because of the high volume of meetings held, we will be recording, transcribing and using a qualitative software to find the main themes heard throughout BC. Also, in our reporting, individual identities will be kept confidential and all data will be anonymized. We are happy explain further in-person the consent process. At this point in time, RCCbc does not have funds to support participation, and your attendance is voluntary. Any meals will be compensated if meetings are held over meal times. We hope that these visits bring many benefits to your community.

If you have any questions, please contact feel free to contact either Dr. Johnston.

Many thanks,

Clinical Lead
Principal Investigator/Associate Director, RCCbc
Email
Phone

Appendix C: Municipal Leadership Invitation Letter

Invitation to participate in Rural Site Visits Project

Rural practice has some of the most skilled people in health care, creates some of the most interesting innovations – yet not many folks seem to realize this. We want to raise the profile of rural practice and have it understood and valued throughout the province. We also understand that a successful healthcare practice is not support just by healthcare providers, but by the community as a whole.

The Joint Standing Committee on Rural Issues (JSC) has tasked the Rural Coordination Centre of BC (RCC*bc*) with offering to visit every community that is a beneficiary of the Rural Subsidiary Agreement (RSA) between 2017 and 2020. The objective of these visits is to connect with rural practices to hear about what the context of your practice is (what innovations you have, what are your successes, what your biggest problems are) in hopes of feeding this information back to the JSC and to better support feedback loops between rural practitioners and the programs they use.

In order to create a robust process, we are seeking input from community members to help us develop and refine it to better serve rural practice. As a community leader, you have a role in supporting healthcare practice in your community, and have an important perspective that we would greatly like to hear from. We understand that there are many demands on your time, but would greatly appreciate if you would be willing to contribute your thoughts and perspective to this project.

At this point in time, we would like to ask you if you would be interested in working with us on this project by participating in a group meeting at your location that will use open ended questions and seek your views on the areas outlined above. Your participation is completely voluntary, and you can withdraw from participation at any time. Because of the high volume of meetings held, we will be recording, transcribing and using a qualitative software to find the main themes heard throughout BC. Also, in our reporting, individual identities will be kept confidential and all data will be anonymized. We are happy to explain this consent process further in-person.

If you have any questions, please contact feel free to contact Dr. Johnston.

Many thanks,

Clinical Lead
Principal Investigator/Associate Director, RCCbc
Email
Phone

Appendix D: First Nations Invitation Letter

Invitation to participate in Rural Site Visits Project

The Rural Coordination Centre of BC (RCC*bc*) has been tasked by the Joint Standing Committee (JSC) to conduct a comprehensive site visit program that will visit each of the 201 Rural Subsidiary Agreement communities over three years in collaboration with the Health Partners (Health Professionals, Communities, Academic Institutions, Health Administrators and Policy Makers). We would like the First Nations of B.C. to be included in this collaboration so we may have a truly comprehensive understanding of the status of rural healthcare in B.C.

The objective of these visits is to connect with rural practices and community leadership to hear about what the context of health care provision is for your community in the hopes of feeding this information back to the JSC, and to better support rural health care practice. Our hope is that we can begin building stronger relationships with rural communities and the individuals who support them in addition to gaining valuable insight and information through the stories shared that can be used to bolster policy and supports for rural communities. We also hope to develop a database of communities and the various characteristics and factors (ex. Population, service level, population catchment, number of physicians, allied health professionals) that make up the face of health care within a community which can be used to identify trends across the province.

In order to ensure we capture all perspectives that go into supporting health care in community, we would like to invite you to be a part of this project if you are willing. As a community leader, you have a role in supporting healthcare practice in your community, and have an important perspective that we would greatly like to hear from. For each community visit, we meet individually with health partners (local healthcare providers, health administrators, and community leaders) as well as bring everyone together to discuss community values and priorities. At the end of all our visits, we will also seek input from those who were involved to verify the information that we gathered to ensure you feel it adequately reflects what was shared in our gatherings. Because of the high volume of meetings held, we will be recording, transcribing and using a qualitative software to find the main themes heard throughout BC. In our reporting, individual identities will be kept confidential and all information will be anonymized. We are happy explain further in-person the consent process. Please let us know if you have any ethics processes we should follow or if you'd like to discuss with further with the Band first. We will also be sharing our bi-annual reports based on the information and stories that are shared with us from other rural communities back to you and others who have taken the time to meet with us.

We highly value your input, and hope that you will be able to join us to contribute to this provincial project. If you have any questions, please contact feel free to contact Dr. Johnston.

Many thanks,

Clinical Lead
Principal Investigator/Associate Director, RCCbc
Email
Phone

Appendix E: Meeting Guide

BC Rural Site Visits Program – Meeting Guide
For All Health Partners

These questions are used as a guide to facilitate our meetings for all health partner groups (unless specified below). Meetings are semi-structured and flexible, so if there are topics that are not covered in our questions we are still very interested in discussing them with you.

General

1. Tell us about your health care in your community.
    a. What are its unique features?
    b. What works well?
2. What are your connections like with other community members?
3. How does the community support local health care?

Innovations

1. Tell us about any initiatives do you offer that you feel are successful and why?
2. Tell us about any holistic initiatives that have been put in place that support a person's well-being spiritually, mentally, and/or physically?
3. Are there any unique solutions that you've developed?
4. What can other sites learn from you?

Access

1. Tell us about access to primary health care providers.
2. Tell us about access to specialists and other health care services.
3. How do patients get to their health care needs (ER, appointments, services, etc.)?
4. How is telehealth used in your community?
5. Are there any services at risk and why?
6. What health care services would you like to have/provide that would have the most impact for your community?

Cultural Awareness

4. With racism at the forefront of many conversations in health care, have you ever experienced or witnessed racism or other forms of discrimination/judgement when you or others are accessing/providing care?
5. What supports are there for Indigenous community members to promote cultural safety?
    a. Are there any supports or services in place that help promote cultural safety for staff and patients? *For example: is there a cultural space to practice ceremonies such as smudging within your hospital/clinic, is there an Indigenous liaison, are there larger spaces for families to be with the patient, etc.?*
    b. *How have these cultural safety initiatives impacted care for you/your community/your patients?*
6. **For Indigenous community members:** Tell us what would help you or a member of your community feel more culturally safe when accessing health care services?

Pick relevant partner group:

For Clinicians (physicians, NPs, midwives, etc.) and Health Admin groups only: Practice Context

1. Tell us about team-based care and/or Primary Care Networks? Describe what an ideal team-based care team would look like in your community.
2. How do health care providers in the community share the workload?
3. What workplace supports do you have (CPD, Divisions, Health Authority)?
4. How could CPD support you better?
5. Would you be interested in doing research and what supports would you need?
6. Tell us about any real-time support initiatives.
7. Tell us about any locum support in your community.

For First Responders group only

1. Tell us how you interact with the local health care providers?
2. Tell us about any locum support in your community.

For Academic group only

1. Tell us about your teaching program.
    a. How easy is it to find preceptors?
    b. How does having learners change healthcare in your community?
2. How has having an academic program in your community affected recruitment and retention?

Recruitment and Retention

1. How do you address recruitment of health care providers?
2. How do you retain health care providers in the community?
3. Are there any supports available for the spouses/family members of those being recruited to the community?

Concluding Questions

1. How has Covid-19 affected health care in your community?
2. What keeps you up at night? What is your main worry?
3. What are you proud of?
4. Have we missed anything else you would like to contribute?
5. Do you have any feedback on this process?

Site Visits Master Codebook

Developed by: Erika Belanger

Updated by: Erika Belanger + Anne Lesack on November 28 2019

Nodes\\Themes

Legend: Parent Nodes = Black
Child Nodes = Orange
Grandchild Nodes = Red

Category	Description
Advocacy	Those who advocate or stand up for the health needs of the community. Can be a community member, physician, someone from municipality, or a group of individuals who the community trusts to speak on their behalf. Typically, this individual or group of people have strong interconnected ties with the community and has an in-depth understanding of an area in health care.
Alternative Healing	Health-related services that are already offered, or wish to be offered, outside of the traditional "western-way" of medicine and service delivery. This may include services/activities that focus on mental/spiritual/cultural health that are (or can be) practiced at an individual or group level within a community.
Areas of Opportunity	Areas of health care that provide an opportunity to be changed or improved upon within reason. Examples range from old & damaged waiting rooms (infrastructure) to miscommunication between two or more stake holding bodies (relationship building).
EMR and Information Sharing	Areas of improvement which include compatibility of electronic medical records and/or paper health records. Any other information pertaining to the improvement of information sharing, monitoring and/or access of health data is included.
Education and Training	Opportunities for education and/or training for health professionals and/or health partners.
Equipment	Equipment that needs to be replaced or updated.
Funding	Areas in which funding could be allocated (e.g. health, service delivery, program implementation, etc.)
General Safety	Situations that are placing (or potentially placing) physicians, nurses, community stakeholders, or patients at risk. Includes: occupational safety, community safety, etc. *Note: situations that appear to be putting individuals in serious and/or immediate danger should be reported to RCCbc management ASAP.*

Housing	Areas where lack of housing is identified. This includes housing for general community members, medical residents, physicians, and locums.
Infrastructure	Infrastructure (buildings, roads, telecommunication services), that need to be built, replaced, fixed, or upgraded.
Manpower & Coverage	Areas where more coverage is needed and the desire exists to have another health-professional body present. Also relates to scenarios in which individuals are feeling short-staffed and stretched too thin to be performing at an optimal work-level.
Policy Change	Policies, regulations, local rules processes and measures that could be changed to improve community outcomes. (may move this node in future)
Relationship Building	Areas that demonstrate poor communication, lack of team building or connection building etc. Scenarios where individuals feel misunderstood are also included.
>Collaboration	Situations in which there is a lack of collaboration or cooperation between individuals or groups on different levels in different areas. Lack of cooperative action towards a common goal. Also includes areas where collaboration can take place between two groups to better health service delivery.
>Communication	Areas/situations where there is a lack of information exchange and/or open communication between individuals and/or groups.
>Developing Trust	Participants indicate a need for increased trust or a noted lack of trust in their relationship with an individual/partner/organization/Health Authority/ group.
>Transparency	Participants indicate desire for more/ or indicate a lack of openness, honesty and clarity in their relationship with an individual/partner/organization/Health Authority/ group.
Research	Expressions from physicians, residents, or other individuals who wish to take part in research within their community.
Support	Areas in which direct support or additional support is requested by any health care partner in any area.
Understanding Awareness and Recognition	Participants express a gap in an ones own/ individuals/ groups/ HA's, etc. understanding, awareness, recognition or knowledge regarding an aspect of health service delivery, community rurality, cultural practice, etc.
Change Over Time	Any reported change that has occurred within a community over any given period of time. This can be a health-service related change but may also be a change in community priorities, initiatives, group beliefs, relationships, finances, etc.

Confidentiality	Thoughts, feelings, perspectives and/or scenarios related to personal and/or patient confidentiality, identity, and reputation.
Demographic Focuses	Health care focuses, successes, and challenges that relate to a specific demographic within a community.
Aging	Focuses related to aged or aging individuals within a community.
Families	Focuses related to families in a community.
Youth	Focuses related to youth in a community.
Discharge Conditions	Conditions that patients are discharged into. (e.g. when leaving the hospital, when leaving a doctor's appointment or health care service outside of their own community, etc.)
Finance	Various methods of billing, funding resources, and pay models for physicians within a community. Demonstrates the variety of financial models (both successful and inadequate) utilized within communities.
Billing	All information pertaining to billing clinics, physicians, and/or patients.
Funding	All information relating to all types of funding.
Pay	All information relating to physician pay (or lack thereof). This includes information on different types of pay models (e.g. FFS or APP) and the successes and challenges that are shared about pay in general. This may also include information regarding outside funding that is given to physicians for their work.
Future Plans	Plans, initiatives, or processes that are stated to be carried out in the future. May relate to any aspect of health care.
Geographic Isolation	Comments related to geographic isolation; how community members perceive their level of isolation in a community.
Health Authority	Any reference to interactions with a communities HA and/or to assistance, successes, challenges brought upon a community through their HA. May also include information regarding communities that declare the presence/absence of their ties with their HA.
Interior Health	All comments about/directly involving Interior Health.
First Nations Health Authority	All comments about/directly involving FNHA.
Fraser Health	All comments about/directly involving Fraser Health.
Northern Health	All comments about/directly involving Northern Health.

Vancouver Coastal Health	All comments about/directly involving Vancouver Coastal Health.
Vancouver Island Health	All comments about/directly involving Island Health (also known as Vancouver Island Health, VIHA).
Health Care Approaches	Approaches that are taken in regards to service delivery, funding, etc. that is implemented in a specific manner.
Bottom Up	Initiatives that are developed by people in a community, for people in that community. Decision making on program and service development, service implementation, recruitment, and/or funding, are made directly by community members, who identify what the needs are in the community.
Top Down	Initiatives that are developed by people that do not live within a community (i.e. those that sit in higher governing bodies), that must be followed by people living in that specific community. With this approach, community members are directed to follow decisions made by those who are removed from the community – typically for things such as service delivery, funding, recruitment, etc.
Siloing	Dialogue that explicitly discusses siloing.
Centralizing	Dialogue that explicitly discusses centralizing or centralization of health services
Indigenous	All information that pertains specifically to/from First Nations.
Alternative Healing Practices	Specific comments from First Nations around health services /practices outside of the traditional “western-way” of medicine and service delivery. This may include services/activities that focus on mental/spiritual/cultural health that are (or can be) practiced at an individual or group level within a community.
Connection With Others	Connections that a group of First Nations have with eachother (in their own band/community e.g. caring circle, interprofessional teams) or that they have with other members of a community. Includes their relationships with others (good or bad), their expressed desire to have relationships with certain people/groups of people and/or connections that can be improved upon.
Cultural Safety	Includes comments around experiences, perceptions and views of cultural safety within medical and community environments.
>Needed	Participants express a need for, or a lack of cultural safety within medical or community environment. Can include comments around: racism, lack of time, lack of listening, lack of cultural awareness, etc.

>Provided	Participants express situations in which culturally safe care was delivered, experienced or demonstrated in a health or community environment.
Culture and Identity	Comments around culture and/or identity. Also includes loss/gain of culture and/or history
General	This section includes all of the “Indigenous” information that was formerly under “Demographic focuses -> Indigenous” Everything that is related to First Nations specifically that does not fall under any other category under the “indigenous” node is coded here.
Access and Service Delivery	Health care services that are offered and/or accessed within an Indigenous community. (e.g. community nurse that works with the band, community social worker specifically for the band, etc.)
Trauma	Comments around impact or experience of trauma by oneself, within a community or intergenerational trauma.
Innovations	New or unique method, idea, product or workaround that benefits a community’s health service delivery in any way.
Locums	Any information regarding the ability to bring in locums into a community, how locums contribute to a community, and the ease in which a community can access locums for any given period of time.
New to Practice Physicians and Students	Impacts, impressions, and overall effect that new physicians and/or residents and/or students establish while practicing in a rural community; this includes comments regarding perceptions of health care providers about new to practice physicians and work style. (This node was formerly known as new grads and residents)
Nursing	Any items related to nursing in the context of rural health and health care delivery.
Patient Capacity and Attachment	Information relating to wait-times for services, family physician availability, or number of beds available within a hospital setting. Includes accounts relating to patient attachment and how patients are attached/unattached in a community.
Population	Health and non-health related (i.e. community events) aspects of a population that relate to a community’s population growth, recruitment, and retention.
Decline	References of population decline within a community.
Growth	References of population growth within a community.
Recruitment	References of recruitment into a community. Recruitment successes and challenges are included.

Relocation	References of relocation into or out of a community. Relocation successes and challenges in a community are included.
Retention	References of retention in a community. Retention successes and challenges are included.
Tourism	References of tourism in a community
Proposed and Potential Solutions	Initiatives that have been proposed, suggested, or are in the beginning stages of implementation for the purpose of addressing/overcoming a challenge within a community.
Powerful Quotes	Meaningful quotes that shed light on positive, unforeseen, or unique aspects of healthcare in a community.
General	General quotes as defined by the “Quotes” category description.
Questions	Questions that participants ask as defined by the “Quotes” category description.
Stories	Stories that participants share as defined by the “Quotes” category description.
PRA’s and IMG’s	Any information that relate to PRA’s and/or International Medical Graduates (IMG’s).
Programs and Networks	Information that relates to specific programs and networks and how community members find these things either beneficial/not beneficial in their community. May also include accounts where individuals note that they have not heard about a specific network/program.
CPD	Any comments related to continuing professional development and continuing medical education.
Divisions	Any comments related to divisions of family practice. Includes both positive and negative accounts surrounding divisions; interactions, assistance, and successes brought upon a community through their respective divisions group. May also include information regarding communities that declare the presence/absence of their ties with a division.
JSC Programs/Initatives	All program information that relates to a JSC program below.
>NITAOP	Any comments related to the Northern & Isolation Travel Assistance Outreach Program (NITAOP).
>REAP	Any comments related to the Rural Education Action Plan (REAP)
>REEF	Any comments related to the Rural Emergency Enhancement Fund (REEF).

>RSON	Any comments related to the Rural Surgical and Obstetrical Networks (RSON).
>RRP	Any comments related to the Rural Retention Program (RRP).
SSC Programs/Initiatives	All program information that relates to an SSC program below.
>Facility Engagement	Any comments related to facility engagement and/or interactions with facility engagement liaisons (FELs).
PCN's	Any comments related to the Primary Care Networks (PCN's).
MOCAP	Any comments related to the Medical On Call Availability Program (MOCAP).
RCCbc Connection Points	Areas where RCCbc staff/core members are able to connect people with eachother and/or information. Includes feedback that is received on the Site Visits Project.
Follow Up's	Questions that participants have that RCCbc staff can answer and follow up on; and areas in which RCCbc staff can offer connections to other individuals or advice on a given topic.
Project Feedback	All feedback that participants share with regards to the Site Visits Project.
Resource Development	Comments that are made about resource development in a community. May include how resource development has directly/indirectly affected a community (e.g. mining, LNG project, watersheds, logging, farming, ecosystem etc.)
Rural vs Urban Perspectives	Any comparison or contrast between a rural community and another (typically urban) community that either: (i) has more services offered and/or (ii) is a larger referral community. Note: some communities may compare themselves to a larger community that is also rural. While larger rural communities are not urban, smaller rural communities may refer to these larger rural communities as so due to the above reasons.
Scope of Practice & Workload	The entire role that physicians and/or other health professionals encompass as a rural health care provider. This may include general and or specific skill sets that are required from individuals in a given community. Other concepts included in this section are physician expectations (from self and others), physician wellbeing, and physician burnout (associated with heavy workloads, lack of time off, etc).

Physician Wellbeing	Any part of a rural physician's scope of practice that relates to a physicians' well-being. Includes info that may lead (or has led) to physician burn-out
Physician Time Off	Any part of a rural physician's scope of practice that allows/does not allow adequate time off
Services	Any health-related service that is at risk of becoming extinct or in need because that service is (1) currently not available in the area and (2) currently in significant demand by patients and health providers.
At Risk	Services at risk.
In Need	Services in need (general).
>Mental Health and Addictions	Mental health and addiction services that are needed, or accounts that describe where/why such services are needed (specific).
>Obs, Gyn, and Maternity	Obstetrics, Gynecology, and/or Maternity services that are needed, or accounts that describe where/why such services are needed. (specific).
Lost	Services that were once offered but are now obsolete.
Social Determinants	Measures related to socioeconomic status that affect the health status and use of health services by individuals.
Successful Initiatives	Initiative such as measures, models, programs, methods, or systems that have created a beneficial impact in improving the health care and/or health service delivery of a community.
Measures	Measures such as having enough staff, having successful community support etc. that contributes to health care and service delivery success within a community. Includes initiatives that do not fall under the "models" or "programs" category,
Models	Models such as funding models, clinic models, etc. that contributes to health care and service delivery success within a community.
Programs	Any program that has been implemented/delivered etc. that contributes to health care and service delivery success within a community.
Support	Supports that are essential and contribute to maintaining successful health care outcomes within a community.
Collaboration & Connection	Scenarios where individuals from different areas (of profession or of geographical location) connect with each other on some level (i.e. communication, decision making) to improve an aspect of health care. Included in this section are examples of individuals or groups connecting with each other in order to: a) work together towards a common goal or outcome; or b) share ideas in a collaborative manner. Relationships that have been built between two entities may also be included.

Community Support	Support that is provided by general members within a community, or by community members that work in community-focused groups such as municipality, volunteer organizations, and/or community health organizations.
Employee Support	Support that is provided by employees towards each other in a given setting.
>Culture	Successful work-cultures that employees create within their working environment.
>Dedication	Expressions of commitment and dedication for work, delivery of services, and or towards patients/community members within a given profession.
>Teamwork	Areas in which teamwork/collegiality has been highlighted/demonstrated within the workplace.
Telehealth	Information, including successes and challenges, relating to telehealth services.
Time	Situations in which time has a significant impact or is mentioned as important in a given situation (e.g. physicians expressing they need more time with their patients, etc.)
Transportation	All methods of transportation utilized by community members for local and long-distance transport. This section includes specific methods, thoughts, successes and challenges related to local transportation, emergency transportation, accessing areas far away (distance) and environmental factors/conditions.
Alberta proximity	Information relating to successes/challenges that derive from communities that are in close proximity to the Alberta border.
Distance	Non-emergency transportation that requires an individual to travel a distance outside of their community for health care services. Examples include: needing to travel out of town for cancer appointments/dialysis/regular GP appointments, etc.
Local	Non-emergency transportation that requires an individual to travel within the community for health care services. This includes information related to the availability of taxis/buses/volunteer drivers/etc within a community.
Emergency Transport	Successes and challenges related to emergency transportation.
Environmental Factors	Environmental factors that affect the ability to transport into and/or out of a community.
>Weather	Scenarios in which weather has impacted transportation. This includes the ability to enter/leave a community.

>Wildfires	Scenarios in which wildfires have impacted transportation. This includes the ability to enter/leave a community.
>Flooding	Scenarios in which flooding has impacted transportation. This includes the ability to enter/leave a community.
Patient Transfer Network	All information pertaining to the Patient Transfer Network (i.e. successes and challenges)

Rural Site Visits Project Table 2: List of Top 10 Themes

Themes	Definitions
Areas of Opportunity	Areas of health care that provide an opportunity to be changed or improved upon within reason. Examples range from old & damaged waiting rooms (infrastructure) to miscommunication between two or more stake holding bodies (relationship building).
Support	Areas in which direct support or additional support is requested by any health care partner in any area.
Transportation	All methods of transportation utilized by community members for local and long-distance transport. This section includes specific methods, thoughts, successes and challenges related to local transportation, emergency transportation, accessing areas far away (distance) and environmental factors/conditions.
Successful Initiatives	Initiatives such as measures, models, programs, methods, or systems that have created a beneficial impact in improving the health care and/or health service delivery of a community.
Population	Health and non-health related (i.e. community events) aspects of a population that relate to a community's population growth, recruitment, and retention
Health Authorities	Any reference to interactions with a communities HA and/or to assistance, successes, challenges brought upon a community through their HA. May also include information regarding communities that declare the presence/absence of their ties with their HA.
Scope of Practice & Workload	The entire role that physicians and/or other health professionals encompass as a rural health care provider. This may include general and or specific skill sets that are required from individuals in a given community. Other concepts included in this section are physician expectations (from self and others), physician wellbeing, and physician burnout (associated with heavy workloads, lack of time off, etc.).
Finance	Various methods of billing, funding resources, and pay models for physicians within a community. Demonstrates the variety of financial

	models (both successful and inadequate) utilized within communities.
Services	Any health-related service that is at risk of becoming extinct or in need because that service is (1) currently not available in the area and (2) currently in significant demand by patients and health providers.
Patient Capacity & Attachment	Information relating to wait-times for services, family physician availability, or number of beds available within a hospital setting. Includes accounts relating to patient attachment and how patients are attached/unattached in a community.

Dr. C. Stuart Johnston, MSc (Civil Eng), MB, ChB, FRRMS. Director, Rural Coordination Centre of BC. Clinical Associate Professor, Department of Family Practice, UBC.

I have an Irish and Scottish cultural background, but grew up in Southern Africa before moving to South Africa to complete a Masters in civil engineering and later a medical degree at the University of Cape Town. After working in South Africa and New Zealand as a family physician, I moved to British Columbia (BC), Canada. I have lived and worked in small rural communities here for the past 29 years. During this time, I have provided primary care, surgical and maternity care and flown into remote Indigenous communities to provide health care both in BC and North of the Arctic circle in Nunavut. As a Clinical Associate Professor in the Department of Family Practice at the University of British Columbia I have been involved with teaching medical students and Residents. For the past 20 years I have worked within provincial organizations (the JSC and RCCbc) that are dedicated to improving rural health care in BC.

My experience of low resource communities in Africa and remote communities in rural Canada have shaped my views concerning the necessary resilience of these communities and the systems that impact their medical care; also, how relationships (trust) are central to well-functioning health care. I am cognizant of the health inequities that exist for those who live and work in rural areas. I have been aware of racism at times wherever I have worked, but have had the good fortune to work alongside Indigenous colleagues and patients in BC who have shaped my views on cultural safety and systemic racism.

I acknowledge that my past experiences, together with my empathy for the patients, providers, administrators and others who strive to ensure the best possible health care for their communities, will have impacted my interview techniques and data interpretation.

Krystal Wong BSc

I am Asian of Chinese and Filipino heritage, born as a second generation Canadian. I am currently located on the traditional lands of the Coast Salish Peoples, including the territories of the Musqueam, Squamish and TsleilWaututh, known as Vancouver, British Columbia.

I completed a Bachelor of Science degree in Health Sciences at Simon Fraser University and my education consisted of traditional western science views as well as a multidisciplinary approach to health. My interest to health promotion and communications led my volunteer and career experience in these areas, as well as in community development, chronic disease prevention, food insecurity in rural and urban populations, and implementation science. Currently I am a Project Coordinator for the Rural Site Visits Project (SV Project) at the Rural Coordination Centre of BC (RCCbc).

I recognize that my viewpoint shapes the way I have developed and amended the SV Project process, in particular the recruitment and data collection. My previous experience has shaped the method of the SV Project through a community development, strengths-based, and iterative approaches. I also recognize I have never lived in a rural community and my exposure to rural communities has been majority through the SV project. Meeting with participants directly in rural communities and hearing their stories and experiences of their health care services and delivery has further shaped my awareness and

understanding of rural health issues, however, I am not an expert and I have not lived through similar experiences.

Erika Belanger BSc, MSc.

I am a female Caucasian settler on this land, with both myself and my brother being the first generation to be born as Canadian in our family. My historical family roots are grounded in Denmark, where my grandparents resided for most of their lives prior to immigrating to British Columbia.

I am currently located on the Lheidli T'enneh traditional territory, known as Prince George, where I have lived and worked for the past four years. I was brought up both in Prince George, and on the Ligwiłda'xw peoples territory, known as Campbell River on Vancouver Island. From there, I moved to Victoria where I completed a Bachelor of Science degree in Psychology at the University of Victoria and returned to Prince George to complete my Master of Science degree in Health Sciences.

My undergraduate education comprised of very traditional western science views, with projects focusing primarily on quantitative data collection and analysis methods. It wasn't until I was exposed to qualitative research methodologies within the first year of my Master's degree, that I realized the importance of qualitative research; how it can contribute to policy and healthcare, and my interests in such methodology.

I believe that qualitative data, such as stories, experiences, and perspectives, should be held with equal regard to that of quantitative based research methodologies; and hope that the stigmas associated with using qualitative research as evidence, decreases over my life time as qualitative work continues to emerge. I further hold the belief that every person's perspective, and the experiences associated with such views, is valid; and recognize that multiple realities and worldviews exist outside of my own.

As a Research Coordinator and Data Analyst for the RCCbc Site Visits Project, I acknowledge that my viewpoint shapes the way in which I analyze the data of this project, and recognize that I may interpret data differently than those who chose to contribute such information. While I bring a previous lens of working in the pharmacy field, I recognize that my experience working with rural physicians and the experiences that they encounter daily, is limited and therefore my ability to pick up on certain nuances may be lesser compared to someone who has a lived experience as a rural health care provider in BC.

It is through my background, my education, and my beliefs, that I position myself in the work that I've done through the Site Visits project. The experiences I've had prior to this work have shaped the ways in which I have approached the development of the analytic methodology of this work and the experiences of meeting with participants in their communities directly, has further shaped how I've hoped to illuminate each contribution from our participants to date.

David Snadden MBChB, MClSc, MD, FRCGP, CCFP. Professor Family Practice.

I live in Prince George BC on the traditional territory of the Lheidli T'enneh. I am a first-generation immigrant to Canada. I am Caucasian of Scottish parents and grew up in India, Singapore and Scotland. I trained in undergraduate medicine at the University of Dundee and as a family practitioner in Inverness in the north of Scotland. I then practiced in a rural Highland community for 11 years. I then completed a master's degree in Family Medicine at the University of Western Ontario, Canada, returning to Academic Practice in Dundee where I completed a doctoral degree with a focus on qualitative methods and medical education. I came to Canada in 2003 to lead the establishment of the Northern Medical

Program in Prince George, BC, the Northern and Rural Distributed Campus of the UBC Faculty of Medicine. My time in BC has enabled me to visit many rural, remote and indigenous communities throughout the province and has instilled in me a deep sense of the health inequities that exists between urban and rural areas, a sense I first developed as a rural practitioner. I have been involved in qualitative research projects since 1991, firstly in the areas of patient experiences and in medical education. Subsequently my interests have evolved to rural issues in terms of recruitment and retention of rural practitioners and in health systems change. Qualitative data deepens our understanding of issues through conversations and stories and provides a rich context to help illuminate experiences, which, through careful interpretation, help deepen our understandings of important issues. I do recognize that I bring my own perspectives to the interpretation of research data and believe that to help bring changes to our systems I do need to embrace and give voice to the varied perspectives of those we talk to and to learn from them in a way that can help us together advocate for solutions and system changes that will improve rural health care.

Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

	Page/line no(s).
Title and abstract	
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended – original title including qualitative description removed following reviewer feedback	Pg. 3/lines 1-3
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	First two pages of submission, lines not numbered
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Pg. 6/lines 56-58
Purpose or research question - Purpose of the study and specific objectives or questions	Pg. 6/lines 58-64
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	**Partner Group Interviews** Pg. 12 /lines 166-168
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	Pg. 28 Line 475 Added as supplementary document
Context - Setting/site and salient contextual factors; rationale**	Pg. 4 /lines 5-29
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	Pg. 9 /lines 108-110 Pg.13 /line 192 Pg. 15 /line226
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Pg. 10/lines 142-150

Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	Pg. 6/lines 124-134
Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Pg. 9/lines 126-133
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Pg. 7/lines 141-142
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Pg. 10 /lines 166-174
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Pg. 10/lines 176-180
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Pg. 9 /129-140 Pg. 10/lines 176-180

Results/findings “

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Pg.15 /lines226-229 Pg. 24/lines 405-421
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Pg. 14/lines 200-378

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	Pg. 22/lines 381-435
Limitations - Trustworthiness and limitations of findings	Pg. 25/lines 438-448

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Pg. 27/lines 468-473
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Pg. 27/lines 460-462

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
DOI: 10.1097/ACM.0000000000000388