

Alberta Rural Physician Action Plan (RPAP)



Proceedings from the

Rural Alberta Community Physician Recruitment and Retention Workshop

April 23 & 24, 2008
Nisku, Alberta



Northern
Alberta
Development
Council

Alberta
Government

Acknowledgement

Community representatives were asked to bring items to the provincial workshop which highlighted the value of their respective communities. These items were then to be introduced to the workshop participants and auctioned off (using “funny money” to purchase them).

The workshop organizers wish to give a huge thank you to participating communities for donating such fabulous items for the auction, thus further reinforcing the tremendous value of life in rural Alberta communities.



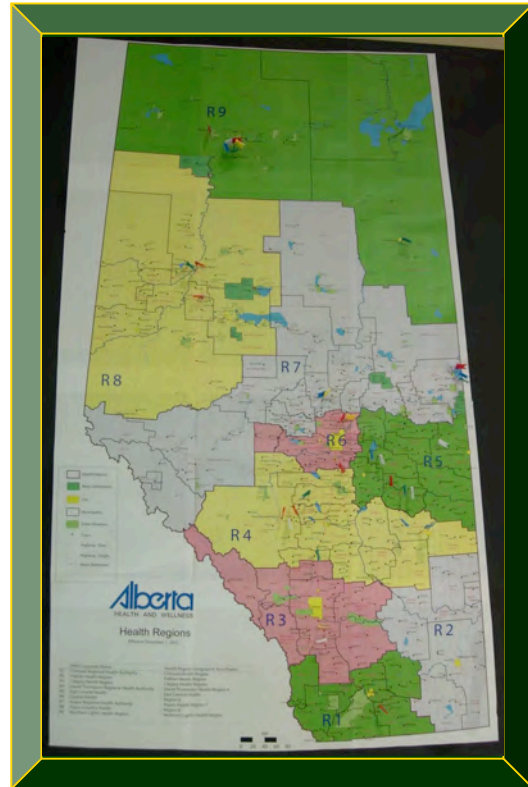
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1. Introduction – The Seeds of the Conference

Through the course of its work with Alberta communities, RPAP has received many inquiries from community members asking about the activities and situations in other communities around physician recruitment and retention. How were other committees and towns dealing with the challenges of recruiting and retaining physicians? What were those challenges? What was working? As a method of responding to these questions and to begin to develop an understanding of the cross-community situation, RPAP began to collect community stories about the development, functioning and challenges facing community-based health committees involved in recruitment and retention activities. From these stories grew the idea of holding a workshop that would serve to bring together those individuals actively involved in recruitment and retention in their communities in order to share their experiences.



The idea of a provincial workshop was also discussed as follow up to previous workshops hosted in partnership with the Northern Alberta Development Council (NADC) in Falher and Lac La Biche in 2007. The NADC is a regional development council with a focus on advancing the development of the northern economy. The mission of the NADC is to identify and implement measures that will advance northern development, as well as advise government on opportunities and issues. Since the 2006 Challenge North Conference, the NADC Health Committee has worked with northern stakeholders to advocate for northern health issues. Northerners indicated that recruitment and retention of health professionals was priority issue in the region, affecting northern communities. NADC involvement and support of a provincial workshop was evidence of their support for initiatives that will advance the development of the region.

Alberta Culture and Community Spirit, in its role to provide services that enhance the capacity of community leaders and organizations to address their goals, has been working with communities and RPAP in the development of health

committees. Their support has focused on helping organizations and communities to: work together to develop and sustain relationships; to identify and solve problems and make collective decisions; to collaborate effectively, to identify goals and to get the work done; and, to identify strengths and help build the momentum for further success in community projects and initiatives. Alberta Culture and Community Spirit's involvement in the workshop was a natural extension of the work they had already done.

The provincial workshop, attended by more than 55 people from 22 communities across 7 health regions, took place April 23 and 24, 2008 in Nisku. The format of the conference was such that it would encourage participation, dialogue and networking between practitioners, those community members working on physician recruitment and retention in their communities. Participants were members of community health committees, municipal and county politicians, business representatives, and community volunteers.

2. WEDNESDAY, APRIL 23

Exposing Possibility: Creative Ways to Explore (Ian Prinsloo, facilitator)

Ian Prinsloo, actor and artistic director, led the group in a series of activities designed to help them “think outside the box” and look at situations in different ways so that they might identify new approaches and solutions to their situations. Ian engaged the group in thinking about “What if...?” with respect to health and our communities.



With workshop participants working in small groups, “What ifs?” were generated in a brainstorming session where no idea was rejected or edited. The exercise generated responses like

- “What if we did nothing”
- “What if it wasn’t about money?” and
- “What if we thought about health in a different way?”
- “What if we tried an old idea with a new twist?”
- “What if we let doctors doctor and we, the community, do the rest?”
- “What if we weren’t a rich province?”
- “What if immigration processes/standards change?”

Participants acknowledged that there were some things they could really do nothing about, like “what if no one grew old”. And, rather than getting stuck on those, groups were asked to choose one idea that they could possibly do something with and to begin to expand on that one idea by addressing the question “What would need to happen to make it a reality?” This question generated great discussion in the small groups and the ideas were brought back to the group as a whole.

This opening session was energizing and that energy generated a creativity that led to an expanded, collective understanding of the situations that communities are experiencing. The approach that Ian introduced in this session, brainstorming solutions rather than problems, allowed participants to see their situations in a new light and perhaps shed some insight on how a problem might be newly identified and subsequently solved in a different way. Participants were

encouraged to keep this question “What if...?” in their mind throughout the conference as a way to “step outside the box”.

For a list of “What ifs” please refer to Appendix A.

Community Story Collection Presentation (Carmen Plante, Presenter)

Although a brief, non-interactive session, this PowerPoint presentation set the context for the workshop sessions that followed. The Retention and Recruitment Story Collection Project was initiated by RPAP in response to the recruitment and retention comments/questions they were receiving from the communities consultants were working with. Community groups were wanting to know what was happening elsewhere in the province. What were other communities experiencing? How successful were their strategies? Was there something that a community could do differently that would yield better results? There was keen interest shown in understanding and learning from other committees involved in the recruitment and retention of physicians for their communities. The resulting story collection project included ten communities across Alberta involved in recruitment and retention activities in some manner. The stories, and the information that they provided, helped form the contextual framework for this community based conference.



As the stories were gathered themes began to emerge. Communities that felt themselves successful in their recruitment and retention activities identified that they:

- Approached recruitment & retention as a community issue, not just an issue for the clinic;
- Involved various stakeholders from across the community, like business, government, physicians, the health region, community members;
- Had organized an on-going core community health group, supported more broadly by community members; and,
- Had developed a good working relationship and communication between the community health group, local physicians, and the RHA.

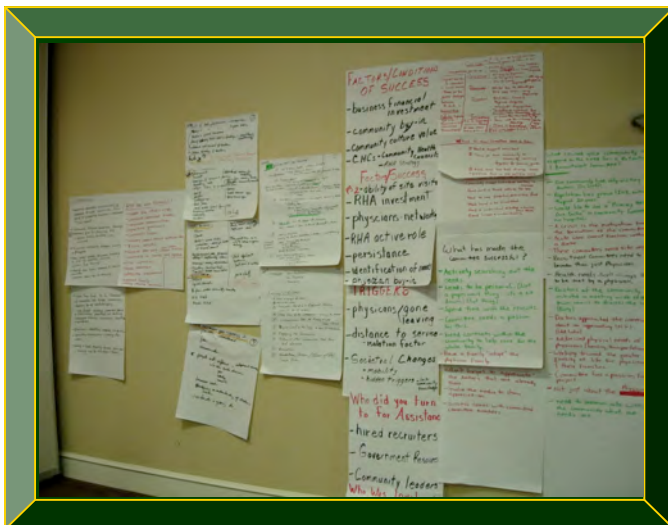
Communities were also using multifaceted approaches to address the complex problems. These approaches included:

- Community development strategies;
- Marketing of their community's assets;
- Incentive packages;
- Multi-pronged recruitment strategies, and
- Long-term, community involved retention strategies.

Through this presentation participants came to see that there were commonalities of experience in recruitment and retention. They were also introduced to some of the successful approaches communities were using to address their need for physicians.

For a copy of the PowerPoint presentation and the stories please refer to Appendix B and Appendix C respectively.

Session 1: Community Plan of Action



This first session was designed to take a look at how communities developed their recruitment and retention committees and what made them successful. Working in small groups participants shared their stories about how and why their committees came into being. In many communities the committee was a response to a crisis or a stressor such as a shortage of physicians or the hospital's

emergency room becoming the local health clinic. In other communities the committee was formed out of concern for the future health needs of community, in anticipation of what might occur if nothing was done or in response to projected population growth. Physicians, other health professionals and/or community members initiated the first discussions.

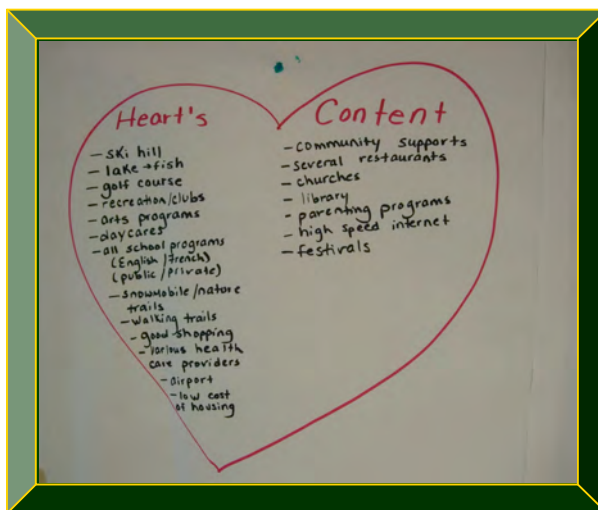
When asked to explore what has made those committees successful participants identified things such as:

- clearly understanding the problem
- understanding of the health care system
- committed committee members
- involvement by local physicians, business, town or municipality, media and the Health Region as well as citizens. Committees drew on expertise from both inside their community as well as outside to help them get organized.

Notes from this session can be found in Appendix D.

[Resources that were made available for participants to use included: the Recruitment and Retention resource guide; and, handouts on how to form a committee and how to build a committee]

Session 2: Marketing Strategies and Incentives



In the process of deciding where they will settle and practice most physicians look not only at the nature of the work environment but also at the community in which they and their families will be living. “What is it like to live there?”

In this session participants were again assigned to small working groups, giving them an opportunity to meet and share with people that hadn't necessarily met previously.

They were provided with a scenario, comprised of a potential physician profile and a brief description of a rural town, and given the task of developing a marketing strategy and incentives for their community. The strategy included identification of community assets to promote in a community profile and a list of possible incentives that would work to attract the potential physician to the community.

Through the discussion participants worked to understand the possible needs of their “physicians”, identifying community assets that would be attractive to them

as well as identifying incentives that would assist in strengthening the “fit” between physician need and community offering.

Profiles were created for communities such as ‘Hearts Content’, ‘Plunketville’, ‘Sunnyskies’ and ‘Clearwater’, Alberta. The profiles highlighted the assets in each community; such things as:

- natural attractions such as lakes, mountains, forests;
- community facilities and programs like the library, theatres, symphony, and the sports centre;
- school offerings;
- community based services such as homecare and daycare;
- available shopping;
- annual special events or attractions;
- the economy and real estate;
- population size and demographics.

Incentives included basic items such as:

- help with accommodation on arrival;
- orientations to the community;
- assistance with credit/loans, and signing bonuses.

Participants also thought ‘outside of the box’ and identified incentives particular to the individual needs of their candidates:

- financial planner services;
- provision of potential work contacts for spouses;
- a free berth at the local marina;
- a turnkey clinic, mentorship;
- education incentives;
- housekeeping services; and,
- matchmaking services.

A representative from each small group presented their fictional community to the larger group. These scenarios were kept to be used the following day in the session on retention strategies.



A broader description of community assets and recruitment incentives can be found in Appendix E.

[Resources available for this session included: Recruitment and Retention resource guide, developing a community profile handout, examples of incentives across Canada]

1. THURSDAY, APRIL 24

Session 3: Retention Strategies: site visits, settling in, and ...?

Site Visits

This morning session built on the work that small groups had undertaken the night before. First, participants were to develop a site visit for the fictional doctor (and/or their family) coming to meet their fictional town. Facilitators for this session began by asking the group what they thought should be included in a site visit. Some of the things identified by communities for consideration in a site visit were:



- the length of the visit;
- what information and how much information should be presented to the visitors;
- who should be involved; and,
- how does the community follow-up the visit with the candidate.

Participants shared their site visit experiences: the preparation and the event itself. Strategies that worked and had successful results had been:

- well planned, and
- designed to illustrate but not overwhelm.

They also ensured that there were “activities for the children”.

Settling In

The second part of this session focused on helping new physicians and their families to settle into the community. Highlighted in this discussion were issues related to family quality of life and family integration. Some of the ways in which communities/committees having been helping new physicians become settled and integrated have included:

- physically helping them move in;
- helping them to get 'up and running' with groceries, bank accounts, driver's licenses, insurance, etc.
- helping with social introductions
- providing a key community contact or 'buddy', particularly for the spouse

Participants determined that the degree of quality of life was related to the level of family integration in the community. And the key to keeping a physician in the community was to be able to provide the feeling of belonging they were looking for.

All participant comments from this session can be found in Appendix F.

[Resources for this session: Recruitment and Retention resource guide, site visit handouts, settling-in handouts, Physician Retention Survey 2006 Executive Summary]

Session 4: Ensuring Cross Cultural Success: International Medical Graduates

Cross-cultural Adaptation



In the process of recruitment more and more communities are finding themselves receiving international medical graduates, physicians coming from different parts of the world quite different from rural Alberta. In situations such as these cross cultural adaptation becomes a more pronounced component in the settlement and retention

of these physicians and their families in the community. To help highlight some of the important things to consider in cross-cultural adaptation, workshop participants watched a video clip and then discussed some of the issues to be aware of when a community is welcoming an IMG:

- access to transportation
- ties to their country of origin
- issues pertain to the settlement of children
- religious differences
- prejudice

Following this discussion, participants returned to their small groups and shared amongst themselves their community's experience in welcoming a physician from another country. Facilitators noted on flipcharts participants' identification of the important points to consider. From the collective list created by the larger group, some of these important points included:

- helping families to manage the weather and its impact;
- separation from extended family and lack of a familial support system;
- different foods, systems, and ways of doing things; and
- differing expectations in the culture
- community support for their interests
- cultural adaptation is not one-directional; the community needs to learn about the culture that the IMG is coming from.

Communities have helped IMGs with cross-cultural adaptation through:

- introductions to families of similar cultural background
- introductions to businesses and services in the community
- ensuring that someone stays in touch with the family after the first three months
- helping to make them feel important and a part of the community
- ensuring that there is someone who can meet their needs on a personal level
- understanding that there may be language barriers

The Immigration Process

In the second half of this session Kelly Lyons from RPAP spoke about Canada's immigration process, walking participants through the steps that are undertaken to bring IMGs to Canada and talking about the time needed for the process from start to finish. This information was particularly useful to communities as many times there is frustration and misunderstanding about the length of time it is taking to have a physician arrive in their community. Participants shared their



experiences with one another, particularly what did work well in their relationship with their regional recruiter, as well as where further work needs to occur around collaboration between the communities and the recruiter.

Some of the issues highlighted by participants were:

- the time delay in getting changes to work permits
- the time it takes in filling out work permit forms
- what support is there from the provincial government
- practice based assessments – requirement for IMGs and need to have doctors to do assessment

Points discussed in these discussions were compiled by the facilitators and can be found in Appendix G.

[Resources available to participants in this session included: DVD presentation, immigration process outline, cross-cultural adaptation handout)

List of participants

NAME	TITLE	ORGANIZATION
Corinne Cornell	Senior Admin/Physician Recruitment	Aspen Health
Eva Urlacher	co-Chair	CLR3
Hubert Rodden	councillor	City of Cold Lake
Katherine Chubbs	Healthcare Centre Mngr	Aspen RHA - Cold Lake
Lynn Crump	Career & Employment	AB E&I
Michelle Bourdon	ED	Cold Lake Chamber of Commerce
Sandy Jalonen	commanding officer	health services centre
Tracy Gagnier	citizen volunteer	Cold Lake Chamber of Commerce
Andrea Taylor	regional recruiter	Calgary rural
Melissa Scaman	EDO	Town of High River
Darla Cote	Project Coordinator	Capital Health
Brian Vos	Chair R&R cttee	Town of Gibbons
Gary Spitzig	Director Marketing & Development	Town of Gibbons
Gary Devloo	Mayor	Town of Castor
Marilyn Weber	Executive Director	Our Lady of the Rosary Hospital
Mike Faught	Board member	Our Lady of the Rosary Hospital
Brian Bunbury	councillor	County of Paintearth
John Rush	councillor	Town of Coronation
Keith Griffiths	citizen rep	
Lynne McKenzie	Family Physician	
Ted McKenzie	citizen rep	
Walter Weber	councilor	County of Paintearth

NAME	TITLE	ORGANIZATION
Lynda Kelly	Physician Recruiter	DTHR
Bob Long	councillor	Kneehill County
Kathryn Kane-Upton	Director	St. Mary's Health Care Centre
Marion Knudsen	Chair & R&R team member	St. Mary's Health Care Centre
Maureen Malaka	CAO	Town of Trochu
Mel Giles	Chair, community lifestyles cttee	Olds Inst. Community & Reg'l Dev
Donald Verhesen	councillor	Town of RMH
Ernie Murias	Town Councillor	Town of RMH
Jim Bague	Mayor	Town of RMH
Larry Kowatch	councillor	Clearwater County
Pat Alexander	Councillor	Clearwater County
Sheila Mizera	Councillor	Town of RMH
Tammy Burke	Program Assistant	RMH PCN
Todd Becker	Director Special Projects	Town of RMH
Holly Dudley	Admin Assistant	Wetaskiwin Hospital & Care Centre
Jim Martin	Councillor	Town of Daysland
Brian Match	Health Services Coordinator	ECH
Heidi Marcin	Medical Services Assistant	ECH
Barbara Lambert	Chair	Tofield & Area Health Services Fdn
Diane Gordon	councillor	Town of Killam
Geraldine Clark	CEO	Killam Health Care Centre
Darren Erickson	Owner, Medical Clinic/Pharmacy	Tofield Health Centre
Nabil Chehayeb	Mayor	Town of Tofield
Kim Thompson	Health Centre Coordinator	ECH

NAME	TITLE	ORGANIZATION
Sylvia Kennedy	community member	High Level
Ann Knelsen		La Crete Municipal Nursing Assoc
Gerald Archibald	consultant	Archibald Research & Planning
John Unger		La Crete Municipal Nursing Assoc
Joyce Fehr		La Crete Municipal Nursing Assoc
Ruth Unger		La Crete Municipal Nursing Assoc
Michelle Janes	Physician Recruiter	NLHR
George Brightwell	councillor	MD Peace
Brian Allen	Mayor	Town of Grimshaw
Ray Johnson	Director Health Services	PCH
Tanya Cox	Recruitment Advisor	PCH
Julie Gour	Chairperson	Peace River & District CHC
Barbara Mader	Director Health Services	PCH

Appendix A: “What if...?”

- the provincial government offered “forgivable” student loans based on service returned to rural Alberta communities?
- There was a sustainable plan for overall health care services promoting healthy living
- There were Nurse practitioners
- There were Women’s clinic
- Diabetes instruction was offered through RNs (and other areas of health promotion)
- There was a place where physicians had extra support
- Other health professions could help (efficiency)
 - (Road blocks – payment mechanism for health profession, defined scope of responsibility, communication and care management to increase effectiveness, community acceptance, common charting)
- We tried an old idea and it worked
- We tried an old idea with a new twist
- We ask physicians what they need
- We identified what their families need
- educational opportunities were offered in community to retain physician and / or families
- the community got involved
- we asked children what they would do to recruit
- we went to the university and asked what would attract you?
- We made an effort to learn from old mistakes?
- What if we did more brain storming at conferences
- What if we consult with neighbouring communities
- What if we make it impossible to leave because of community fellowship
- What if doctors working in rural areas got better pay incentives to work there – not necessarily incentive to come!
- The doctors had houses
- What if we didn’t have to drive 2 hours
- the Health Region asked the community to be a partner in recruitment
- we let doctors doctor and we, the community, do the rest
- Doctors always showed up on clinic days
- we can create a good home atmosphere / place for the doctors and families to help recruit

- you do everything
- The government gave us more money
- they hadn't cut back a few years ago
- we had more finances for incentives
- We bring in South African doctors to teach doctors
- The employers told the employees what to do and not the other way around
- The College of Physicians was more supportive of everyone's needs, not what is good for doctors
- We had all the staff we needed
- If no one grew old
- The community never got involved with recruitment
- There were no stories
- There were no sick people
- There were no well people
- We never took a chance on a resume
- We took a chance on every resume
- We didn't do anything
- We talked to each other more often
- We had 1 region
- We weren't a rich province
- We worked together
- Physicians were government employees
- Immigration processes/standards change
- Education was more accessible in rural areas
- We didn't do anything
 - (definition of we = community, hospital, generational differences)
- We get so focused on physicians that we lose sight of the bigger picture
 - (what are our assumptions about the healthcare system? What picture are we trying to create?)
- We had so many applicants that we could pick and choose
- There were about 9,000 solutions
- People worked together as a team in rural Alberta
 - ("people" expanded to include all levels of governments, all professions, right down to kids. Problem is regional, thus the solution has to also become regional. Boils down to the strength has to be in members. Try to influence the trend of recent graduates flocking to bigger centres even

in rural areas. Try to put more emphasis on local value of rural life.
Putting aside historical differences.)

- There were no prickly situations
- History had all the answers
- Governments listened
- we could retain all Canadian trained doctors
- we could turn back time
- We don't find any doctors come to our communities
- We expand current scope of practice for existing disciplines
- built common clinics
 - (depending where you live, space is premium cost)
- there were more walk in clinics
 - (reduce the number of emergency visits)
- there is a way to address the number of physicians who are currently in Canada but cannot access further training that is required to do practice
- we lobby government for continuing education opportunities for nurse practitioners and IMGs which are accessible with the province and which will allow them (IMGs) to practice / expand current scope of practice (NP)
- Everyone came to work with a big smile
- Physicians got along
- We got the whole community on the same page
- All communities were treated equally
- Communities worked together
- There was an abundance of staff and physicians
- The community understood the doctors and the doctors understood the community
- Government made more funds available
- You didn't have to wait to see a doctor
- Everyone communicated effectively
- There were more Tim Horton's gift certificates
- There was no snow
- Attitudes were checked at the door
- Physician were employees
- There were so many doctors they had to sell themselves to us instead of the reverse
- Every community actively became involved in medical profession recruitment & retention

- (to make the professional feel welcome, a valued member of the community. To find out what their family's needs are and try to meet them. Involve everyone from the local business person to children in the schools)
- We used operating rooms that are vacant / not being utilized in small communities
- We lived close to Edmonton, Calgary, Red Deer
- We could fly out
- We flew doctors in not women out
- Doctors knew where we were
- Doctors knew what we were about
- Regional offices were in rural Alberta
- A doctor did not have to do everything
- we had more control over the College of Physicians and doctor relocation
- We could restructure the system so we could put doctors where they are needed
 - (pay all university fees to give 5 years of working in community)
- you let everyone in a company work where they want – what would you get?
 - (shortages in some areas, over supply in others)
- the process for bring in doctors to communities wasn't so difficult
 - (College of Physicians, immigration, dictation of where doctors can or can't go)
- We had unlimited time, resources and no immigration issues
- there were fully sustainable clinics
- There was ample space
- There was no problem
- Community involvement meant there was no problem
- Health regions got along
- There was no competition
- It wasn't about money
- Doctors in the community didn't have to work long hours
- Our health system wasn't changing all the time
- Everyone was open to change
- People said what they meant
- People didn't think so much
- People leave
- Rural communities were not dying and aging

- What if there was not a problem
- We could retain doctors
- There were enough doctors to do the work
- There was an increase in the number of doctors because people are living longer
- Everyone was involved
- We identified with physicians as people
- We knew the needs of family
- We create a sense of community to strengthen bonds
- Facilities were there to support doctors in their role
- There were no operational restraints
- We had an alternate delivery process
- Every patient was not necessarily seen by a doctor
- Society had the will to stand up for change
- Public perception was supportive
- Media was supportive
- Recruitment was done regionally
- We stopped all financial recruiting incentives
- We co-located specialty services across rural locations (regionally)
- Pharmacists were able to play more involved role by renewing and prescribing
- We develop a matrix of deliverables by others (who, how, what)
- There was an electronic Health Records database
 - (Where will these alternative processes reside)
- We had a built in triage process for medical priority services
- We establish pilot programs of change
- retention was not a problem
- recruitment was not a problem
- We trained local physicians
- All our communities were desirable
- everyone was healthy
- payment for service was not an issue
- There were other ways to deliver service
- There were more spaces
- There was community financial support for potential local physicians
- Incentives for retiring doctors to teach

What would need to happen to make it a reality?

- 1) we didn't have to wait
 - Other health care providers (midwives, NP's Pharmacists, alternative medicine) did doctors work
 - Recruitment of all professionals
 - Expand training programs at earlier stage
 - Tap into PHC funding
 - New way to do business – telehealth, AIM
 - Overcome barriers, i.e., insurance coverage, liability
 - Better educated public so they did not need to see doctor
 - Easier access to health resources

- 2) Everyone in community actively became involved in medical profession recruitment and retention
 - Form a core committee to mentor and contact individuals in the community who can work towards the common goal of retaining health care professionals through personal friendships and meeting the family's needs (whatever they may be)

Appendix B: PowerPoint presentation – Life Support: Community Stories of Physician Recruitment and Retention in Rural Alberta

Life Support:

**Community Stories of
Physician Recruitment and
Retention in Rural Alberta**

Purpose of the Project

- Story collection project initiated to address community identified need to “know what others are doing and encountering” with respect to recruitment and retention of physicians
- RPAP would use the findings to better support communities:
 - networking, conference design, information sharing

Design of the Project

- 10 communities identified
- Open-ended telephone interviews conducted
- Themes identified through interview material
- Stories written about each community
- Matrix created correlating with RPAPs 10 success factors

Strategic Underpinnings:

- Recruitment & retention is a community issue
- Various stakeholders are affected/involved
- On-going core community health group, R & R committee
- Good working relationship/communication between R & R committee, local MDs, and RHA

Multi-faceted Approach:

1. Community development:

- Stemming from the community

2. Marketing:

- Externally and internally

3. Incentives

- Help to address some of the barriers encountered by physicians for movement to rural areas; incentives can be helpful but won't keep an unhappy physician in the community

(Multi-faceted Approach cont.)

4. Recruitment Strategies:

- Consistent, on-going communication with candidate
- Understanding needs of physician and their family
- Site visits
- Courting locums, students, residents, IMGs
- Always recruiting



(Multi-faceted Approach cont.)

5. Retention Strategies

- Focus on fit – Family satisfaction is key factor
- High level of physician/family/community support & involvement; key contact person for information
- Cultural adaptation
- Social connections
- Support during times of crisis



(Multi-faceted Approach - Retention Strategies cont.)

- Update/maintain physician skills
- Physician appreciation events
- Help to improve working conditions for physicians
- Help to arrange locums

Succession Planning

- Anticipate MD turnover, i.e retirement, changing family need
- Developing a vision/plan re: healthcare in your community (eg. other professionals, facilities)
- Scholarships for community members wanting to study; “growing their own”
- Helping physicians to build skill levels
- Developing your community so that it is more attractive to future candidates

Challenges Identified:

- Sustainability of local committee; coordination
- Length of time for candidate immigration
- Accessing locum coverage
- Need for a new clinic/expanded facilities
- Recruiting female MDs (lifestyle needs/partner needs)
- Needs are different for IMGs & new graduates
- Convincing the community to be involved in the work
- Strengthening working relationships between communities and RHAs

Appendix C: Community Stories of Physician Recruitment and Retention in Rural Alberta

Interview with Russ Robertson – Communities Leading Regional Recruitment and Retention, Cold Lake

Cold Lake is situated in northeast Alberta relatively close to the Saskatchewan border. The population of Cold Lake is approximately 13,000 known residents but like most towns in Alberta on the edge of oil and gas development it has a 'shadow population' of transient workers who come and go from the town. The region served by Cold Lake has a population of between forty and fifty thousand people. Other industry in the area includes the Canadian and foreign military, tourism and agriculture.

The Communities Leading Regional Recruitment and Retention (CLR3) coalition was formed in the fall of 2006. It grew out of a situation where people were waiting between six and eight weeks to see a physician while one of the specialists and some physicians in the hospital were considering leaving. One of the doctors took the initiative to write to the Mayor and to the president of the Regional Chamber of Commerce asking for help in dealing with the situation. The Chamber of Commerce took the lead bringing together all of the stakeholders impacted by the challenges of the medical system. A meeting was held, facilitated by non-community resource support members, which included stakeholders from regional municipal government, provincial government representatives, members of business and large corporations, hospital representatives, physicians, pharmacy and anyone else that might be impacted. The group decided that a committee needed to be formed, and that action was required. The coalition was formalized and they decided to 'test the waters to see what was available to them'. An organizational committee was created to address work required to move the efforts forward and report back to the governing stakeholders.

The coalition decided that they needed to take a look at the whole community to determine what the situation was. What they discovered was the entire community was greatly affected – doctors and hospital staff were overworked and under appreciated, businesses were having difficulty recruiting young families with children because of a less than optimal health care system, citizens had to go to the emergency department because they weren't able to find a family doctor. As the coalition looked more closely at the system they saw that some doctors and medical staff were preparing to leave due to retirement or burnout. The physicians were experiencing a great deal of stress and strain.

There were a number of causes for the stress and strain that the doctors were experiencing. The community was growing, which meant more patients. Doctors were getting older; many had been working in the community for quite a while. There were some who were wanting to leave the community because of their children's education. The physicians were so caught up in having to work that they felt there was no appreciation for them in the community either, and they were having a hard time amongst themselves as well. There did not seem to be time to develop solutions to the challenges at hand.

The coalition undertook a project to help address the issue of stress for the physicians and hospital staff. They initiated a project for the upgrading of the doctors' sleeping quarters and their lounge, as well as the staff lounge, at the hospital. The facilities at the hospital were inadequate and the hospital didn't have the resources to upgrade them due to budgetary and resource restraints. The coalition worked with the hospital administration in having the facilities painted and new furniture brought in. Now the doctors and staff have a welcoming place to retreat to that is comfortable and relaxing. There was also a Mayoralty award created to recognize the service of long-term resident doctors. As a result of these efforts the doctors and staff realized that the community did/does appreciate them; interactions were bettered between the doctors themselves and the doctors and their patients.

The coalition is also active in the recruitment and retention of physicians. In one case they became involved in the process of acquiring a locum for a physician taking maternity leave. Not only were they active in finding the locum a place to live, members of the community were on hand to help him physically move in. They helped him find the equipment as well as personal accoutrements that he needed and helped expedite bringing his family to Canada. The result was that the doctor who arrived as a locum wound up staying and establishing a specialist practice to serve the entire region. To date the CLR3 has been active in the integration of four doctors, several medical staff and their families into the community. They have also worked diligently to retain current doctors, staff and families.

The efforts that have been most effective are those strategies that support physicians and staff on a day to day basis. They have included such efforts as providing support to the spouse of the physician, connecting people to social networks, religious networks, with others who share similar hobbies, sharing kid services, or even inviting someone out for a walk. It initially looks at connecting newcomers with a buddy; after a while people find their own way and form their own friendships. The CLR3 acts as a referral service for newcomers, it helps them to sort out their challenges. "It's the little stuff that makes all the difference.

That's the weaving of the social fabric to make people feel warm in a cold climate".

The work of the coalition has resolved some of the issues. There are still problems, nothing is perfect but the CLR3 has been involved in meetings around everything from provincial health funding formulas to discussing alternatives in regional cooperation. One of the ideas is the creation of a more regionalized service so that people would not need to be sent to Edmonton, which involves travel, hotels, disruption in employment, and in family routines. This idea is still in its infancy where the CLR3 has "touched base" with some of the communities and many organizations that are working throughout the area.

Like many community committees, the CLR3 is facing the challenge of keeping volunteers enthusiastic, connected and involved in the work. Thousands of volunteer hours have gone into putting together ideas, actions, research, documentation, presentations and funding applications. There exists the risk of burning out the volunteers. The coalition has identified the need for a more permanent person to take the lead in the coordination of the activities of the coalition. There is not always a call for services/assistance on a day to day basis so the challenge is to form an entity that can be brought up to speed as required. A more permanent staff person would help to maintain the continuity of the work of the coalition. Funding for such a position is difficult to find.

Another challenge is to convince a community that they need to support doctors as the doctors are businesses that make substantial money by comparison to most. Unlike most businesses, the doctor often cannot pick and choose when, where or how long they will be involved with a patient or situational need. People need to realize that without a doctor and medical staff, there will be no medical service and without medical service the community will not long survive. There has been some movement in this area; one major company in the area initially didn't want to be involved in the coalition, but it found that in trying to recruit people to work, many refused to move to the local community because they felt there were inadequate medical services in the community. The company needed to take the community's medical situation into account in the health of their business.

Interview with Bev Crabsen – Drumheller Health Centre, Drumheller

Drumheller, population 8000, is situated in the east central part of the province, within the David Thompson Health Region (DTHR). The catchment area is about 30,000 residents. The Drumheller Health Centre is a new facility housing acute care, continuing care, a 24-hour emergency, community care, public health, mental health and other related services all on-site. CT-scan, Dialysis, and a Community Cancer Centre are also part of the hospital.



An employee of DTHR, Bev Crabsen works as the Team Lead at the Drumheller Health Centre. She is responsible for the recruitment of physicians for the hospital, although the recruitment and retention of physicians is not her primary function. She works to support the needs of the physicians, keep them informed as to what is taking place in the community and to connect the community to the doctors. She has also taken over the orientation process for new physicians, developing an orientation manual and spending an entire day with them prior to their spending time with the physicians. The initial orientation is followed up in two to three weeks as an opportunity for the new physician to ask additional questions.

The Chief of Staff at the Drumheller Health Centre plays a key role in the recruitment and retention of new doctors. He has been particularly active in the area of settlement, opening his house to new physicians and their families as they are looking for housing and becoming familiar with the community. He has also assisted with arrangements for car loans and mortgages, as many newcomers to Canada don't have credit ratings. He has worked to create a team atmosphere within the Health Centre that is welcoming to everyone. One candidate had expressed concerns about being a black doctor in a predominantly white community. She was unsure how she might be received. The Chief of Staff invited another black physician to speak to her about his experience of settling into and being accepted by the community. Her concerns were eased.



Dr. Olfert and family

One of the recruitment strategies used by the Health Centre is the targeting of South African doctors. This decision has been based on the fact that the physicians are well trained, all have a sub-specialty and they are able to pass the CPSA exams. With common backgrounds the doctors who have been here longer

support the newly arrived physicians and their families. The medical clinic where the doctors base their practice also provide settlement support through potluck lunches and an established “family buddy system”. The physicians have been well received by the broader community.

Retention practices have been related to finding additional support for the doctors, understanding the areas where they may need help. For one physician this meant understanding his learning style and making that information available to both the nurses and his supervisors so that they may be better equipped to assist him. The Team Lead acts as a conduit between the doctors and the Chief of Staff. She is able to monitor what is taking place within the hospital environment and provides feedback to the Chief as to where the new physician may need assistance.

There is not an active broad community based committee assisting with the settlement and integration of new physicians, to help with understanding and navigating the systems and cultural nuances. The Team Leader feels that it is important that there be someone available to help newcomers set up bank accounts, mortgages, loans, financial security, taxes, their health care, become familiar with our cultural nuances and help to negotiate the differences. In some Albertan communities the community based Recruitment and Retention committees help individuals through this learning but Drumheller doesn't have those people in place to help out. It is a bit of a “catch 22” situation as the Team Lead doesn't have time to take on this piece of work herself, nor does she have the time to look for those people who might be able to help.

One of the broader challenges that Bev would like to see addressed is the need for a broader orientation for new physicians. There is a fair deal of financial pressure for them to begin their practice immediately, needing to cover clinic expenses as well as personal living expenses. She believes the community and

the clinics would be better served if there was a manner in which to support them for a period of time (4-6 weeks) so they might receive a more extensive orientation which would include: mentoring with other physicians to see how our systems work; and, an opportunity to become familiar with patients with mental health issues and geriatric issues that they may not be familiar with.

Interview with Tammy Syrnyk – East Central Health, East Central Alberta

What does it mean to “grow your own” health professionals? Well, just like in farming or growing a garden it entails planting a seed and providing it with the opportunity to grow, nurturing its development along the way. East Central Health has continued to develop a program to “grow their own” for four years. Originally involved with the Careers and Next Generation provincial program for high schools students, the Region has extended this opportunity to university level students through the “East Central Health Opportunity” (ECHO) program.

The ECHO program provides an opportunity for university students who are graduates of the Careers and Next Generation program to become involved in a twelve week internship program with East Central Health. Students are placed in areas of their interest where they are able to explore healthcare in more depth. The intent of the program is to provide them with the opportunity to see and meet health care leaders, decision-makers, as well as frontline workers. They are able to meet professionals in the field who will nurture them in leadership, public speaking skills, and help them in their understanding of where they might fit within a multidisciplinary healthcare focus.

Students are not limited in the number of years they may participate, as long as they are post-secondary students, or to the areas they might investigate. They can be involved in everything from palliative care to bicycle safety, emergency care to mental health. They have participated in roundtable multidisciplinary discussions where they have an opportunity to share information and their views. Students have the opportunity to explore the development of healthcare, strategies to sustain healthcare, financial issues, political issues, and ideas on where does the profession go from here?

All research supports that one of the determinants of retention of professionals is the level of connectedness between an individual and the community. The ECHO program is about building relationships and supporting the next generation of healthcare professionals for our communities. The participants of the ECHO program are well received by the professionals with whom they have been placed and with whom they interact. The mentors and healthcare workers have commented that the students’ energy, curiosity, enthusiasm, and ambition have a positive impact on the community in which they are placed.

One of the challenges of the program is that of expansion. There is desire to increase the capacity of the program. East Central Health was able to increase the program by two seats last year but is looking to the future needs of the area.

East Central Health is looking at options to continue building the program and developing relationships with the students.

The ECHO program is currently in its fourth year so it is still early in the cycle; students that have participated since its inception are finishing up their undergraduate degrees, preparing for graduate work in a related field or moving into medicine. As such there is not yet long term information available as to how many of the ECHO participants will be remaining to live/work in the East Central Health Region. The hope held those involved in the administration of the ECHO program is that even if past participants decide not to remain with East Central Health they might well remain in rural communities in the province to work.

East Central Health also receives/hosts medical students completing a rural rotation. Some of the urban raised students have stated that they had never really considered a rural community lifestyle/rural practice as an option for themselves. Their perspective and understanding of rural health care is quite different from their rural raised counterparts. ECHO students who have been raised in a rural setting and who have had the opportunity to explore the rural health setting have a better understanding of how it operates and how they might best fit within and affect the structure.

The East Central Health serves a population based of approximately 110,000 people. Its boundaries encompass an area ranging from Camrose and Bashaw in the west, to Lamont in the north, Provost in the south and Lloydminster on the Saskatchewan border. Included within those boundaries are 13 health centres/hospitals, 16 public health/home care/rehab offices, and 9 community mental health clinics. Its economic base includes oil and gas, and farming.

Interview with Nona Elliott – High Prairie Recruitment and Retention Committee, High Prairie

“This is the most important thing that we can do in our community – it really is”

— Nona Elliott

High Prairie is a small town of about 3000 people in northern Alberta, a “little town on the edge of everything”, located approximately 4.5 hours northwest of Edmonton or 2.5 hours northeast of Grande Prairie. The area it serves includes not only the town itself but five Aboriginal reserves and three Metis settlements.

It was while attending a community health forum put on by Peace Country Health that Nona Elliott, the High Prairie Community Health Council Chair, heard about RPAP and the work being done concerning the recruitment and retention of physicians for rural communities. She decided that there was a need in High Prairie for a committee even though they were not in a crisis situation. She approached a couple of doctors, the town of High Prairie and any interested people who wanted to attend and the High Prairie Recruitment and Retention Committee was formed. The group decided that they needed a project to undertake and get things moving. They looked at all the health care needs in the community.

The question that came up was “How do we keep our physicians that are already in our community?” The Recruitment and Retention Committee decided that they needed to look at opportunities for physicians to keep and develop their skills. And, while there was not an immediate need at that point in time, there would come a time when the Committee would need to address the issue of attracting new physicians to the community. They acknowledged that they would be losing doctors in the future: two of the current doctors had thirty years of service in the community, one between ten and fifteen years of service, and four had been there less than three years.

One of the local doctors had a vision to obtain a CT Scan for the proposed Learning and Health Centre. The purchase of the CT Scan for the new health clinic would provide them with a way to attract new doctors to the area as well as offer opportunities for the doctors already there to maintain their skills or develop new ones. The committee also wanted to address a major issue that the



High Prairie R&R committee

community experiences which is transportation to the service. Typically town residents need to travel to other areas for treatments – the proposed new health centre and subsequent services would eliminate the need to travel to other communities.

The decision to pursue the purchase of the CT Scan has led to the creation of the High Prairie and District Community Health Foundation. The purpose of the Foundation is to assist the High Prairie community in developing the community amenities that will attract and retain physicians – new facilities, modern equipment and training enhancement opportunities. The first project of the Foundation will be the purchase of the CT Scan.

The Foundation's fundraising activities are being used to educate the community about the role doctors play in the health of a community, not just its citizens. Getting key people involved is also creating awareness and pride and common purpose in the community. "It is difficult in communities because often municipal governments and local governments think that this is not their problem. We need to see the ideas in such a way as to let them know that it is everyone's problem. It's about the health of the community. If you don't have doctors, if you don't have a health facility, your community dies." But one of the challenges is getting people involved and selling the idea.

The Recruitment and Retention Committee wanted broad representation from the community. Currently the committee has representatives from the Peace Country Health Board of Governors, the High Prairie Community Health Council, the Town of High Prairie, the MD of Big Lakes as well as the two doctors' clinics. There has also been representation from the Sucker Creek First Nation and the Committee is looking for ways to involve youth in the Committee's work.

The Committee is aware they are in need of a plan of action beyond raising the funds for specialized equipment for the health centre. They are working closely with their health region and the plan for the region in developing their strategies for recruitment and retention. Their first action in this area will be helping one of the doctors arrange a four month locum. Even though it is usually the responsibility of the clinic to make arrangements for a locum the Committee agreed to assist under the banner of "we will do whatever we need to make our doctors happy". In these arrangements the Town of High Prairie has agreed to help with accommodation for the locums as available, rental housing is an issue for the community. The Committee is also involved in more informal ways of integrating/including new members to the community. There have been invitations to Thanksgiving dinners and baby showers but the Committee acknowledges that its role will change and grow as they discover what the doctors and the community are needing.

Update: The Recruitment and Retention Committee is now working to avert a crisis. Two doctors are currently on medical leave and a third on holiday. The Committee, by partnering with the HP Golden Age Club, Town of High Prairie, M.D. of Big Lakes and Peace Country Health have organized a 'Meet and Greet' event for a prospective doctor and her husband in late November.

Interview with Jaqui Joys – David Thompson Health Region, Central Alberta

The David Thompson Health Region (DTHR) includes 300 physicians, 34 communities, approximately 300,000 residents and a secondary hospital. Within DTHR the individual responsible for recruitment of physicians was hired specifically to work with communities to develop recruitment committees within those communities. Over the 3.5 years that Jaqui Joys has been involved in this work she has developed working relationships with 80% of the communities in the Region. In some of the remaining 20% of the communities there has not been a need to date, although one community has decided to set up a committee proactively. Most retention and recruitment committees have started/formed as a result of a crisis in the community.

In the area of recruitment and retention both of these activities hold equal weight. If there is a crisis the focus is on finding doctors but if the community is having difficulty in finding doctors the focus shifts to the retention of those they currently have. If recruitment is done effectively then the retention issues can be solved more easily. For example, the DTHR has 'tightened up' its process, not circulating a CV until they know the candidate is eligible to practice.

Recruitment is a retention strategy – the community needs to keep in mind that they are recruiting not only the physician but the physician's family. Often the community is not aware of that the physician needs or what is happening for the family. Some of the more common issues being experienced by new physician families are the need for work for the physician's spouse and childcare. These are two areas where the community can help in identifying potential resources and contacts. Some of the other issues that new physicians encounter include housing, access to credit in order to buy into a practice or purchase a house or a vehicle.

As a recruiter, Jaqui refers to herself as a matchmaker: bringing together interested candidates and physicians/communities. What the communities and the candidates choose to do with the information is their choice; it is their decision whether or not the fit is appropriate. The hope is that there will be a union that will last long term. The recruiter is also available for support, supporting the efforts of the community through its Retention and Recruitment Committee. She helps to keep the community going in the direction it had set for itself. The recruiter can help temper activities or relationships as well as 'ramp them up' if needed. This may take place in activity, communication or decision-making arenas.

One of the challenges emerging is that competition for doctors is becoming greater and greater; the competition is international, not just local. Physicians are reviewing options in other countries, as well as Canada. There are issues in the immigration process; if it goes well it can take eight to nine months, if not it will take longer. Another factor that may affect the amount of time it takes is the ability of the physicians to respond; very much a “catch-22” situation. They may find themselves, due to physician shortages, quite busy without the time it takes to review applications and respond to the candidates. At the same time physicians on both ends of the recruitment line are frustrated by the amount of time it is taking to fill the physician need. There is a real need for all three components – the recruiter, the physicians, and the community to support each other in the process and work together, each doing their part.

Another challenge has been to find people to step forward to volunteer and in particular to identify themselves as a “point person” to drive the activity in the community. That individual could be anyone but it is best if the individual is a representative of the town such as the mayor or a town councillor, or a member of the local chamber of commerce for example. An individual such as this has the ability to bring together the other stakeholders who are able to make decisions on behalf of the broader community and has resources to bring to the work. Based on her experience in working in multiple communities throughout the DTHR Jaqui has learned that each community requires different levels of teaching, different strategies, different methods of coaching.

Some communities may be experiencing a philosophical shift as they realize that they have a role to play in the recruitment and retention of physicians for their communities; particularly around the integration and settlement of these individuals into the communities. In the past physicians and their families have found themselves isolated, which may have been a factor in their staying or leaving the community. Today this issue is of particular relevance with more international physicians coming to rural Albertan communities where they will experience issues arising from cultural difference.

There is also a need for more communication between the regions and more opportunities for recruiters to come together. Those opportunities would provide for recruiters to share notes, experiences and stories and support each other’s efforts. As well the development of strong, reciprocal relationships may assist Regions more specifically in the need to meet candidate assessment needs, and a greater sharing of candidates’ information. Working together may help navigate more easily the requirements and systems involved in recruitment; sharing may ease the workload in trying to identify potential candidates.

Afterword: The original interview was completed October 2, 2007. As of January 1, 2008 physician recruitment will become a function of the Human Resources department of DTHR rather than working within the portfolio of the Vice President of Medicine. It is uncertain at this time whether the focus on community involvement/development of recruitment and retention committees will be continued.

Interview with Bonnie Paulovich – Recruitment and Retention Coalition, Manning

The Context:

Manning, population 1,293 (2006), is located on the McKenzie Highway one hour north of Peace River, or approximately seven hours from Edmonton. A part of the Peace Country, its diversified economic base can be found primarily in forestry, oil and gas, and agriculture. This is supplemented by tourism; the area is visited for its hunting and fishing, and retail service. Like most northern communities Manning is perceived to be an isolated, backwoods community with few services and facilities. In 2003 a new Community Health Centre was opened in Manning.



Manning and Notkiwan River

The Crisis:

In February 2006 the town of Manning found itself facing a health crisis. One of their doctors had left his practice and the second one had served notice for the end of March of that year. The Town of Manning was going to be left without a resident physician. Some of the obstacles and challenges that the community was going to need to overcome were: there were no doctors available to help them recruit; the geographical location of Manning; competition for doctors in a province where physician shortages were common in rural areas; a shortage of housing stock, both ownership and rental, in the area; and no local incentive package to attract physicians.

The Response:

The Community Health Council rallied to address the immediate need through the identification of locums. The Chair of the Council worked closely with the Town of Manning, the Municipal District (MD) of Northern Lights, the Director of Health Services of the Manning Community Health Centre, Peace Country Health recruitment personnel and the Rural Physicians Action Plan (RPAP). The Manning and Area Economic Development officer provided promotional materials about the community and worked with the Board of Trade to prepare the welcome baskets for the locums and to highlight the issue within the community.

Every locum was treated as a recruitee – a potential permanent physician for the community. They were presented with welcome baskets and treated to a five-star

Bed and Breakfast for the length of their locum. They were toured through the community, the schools, and introduced to the churches and some of the community members. The Community Health Council felt that in order to attract new physicians they needed to understand some of the non-monetary attractions that the doctors were searching for. One doctor for example, expressed a desire for freedom to practice medicine in the way that s/he had envisioned. The Community Health Council, in its pitch, was able to address and meet that expressed need. The committee also developed an incentive package to help physicians settle in Manning. The package was designed as a lump sum on signing supplemented by a yearly bonus for a particular number of years. There had been discussion around providing housing, cars, etc. but the group decided that different people are at different stages of their lives and therefore requiring different things. It was decided to keep the incentives as simple and as flexible as possible, so that the individual themselves would decide how they could best utilize it. Through their efforts the Council welcomed three doctors: a husband and wife from South Africa, and a Zimbabwean who had previously completed a locum, in Manning in September of 2006.

One of the key issues that the community faced with the loss of their physicians was 'where would the locums practice'? The group decided that they did not want to encourage people in visiting the hospital/health centre for routine visits; they would need to keep the clinic open. The Town of Manning, the MD, and Peace Country Health agreed to take on the costs of keeping the clinic open, overhead and staff, in order to provide a work location for the locums. Where previously the clinic was owned by the doctors, the Town of Manning has since purchased the clinic.

At the same time that the adhoc committee was trying to address the day-to-day health needs of the community of Manning and area they were also considering what they would need to do for the future. The Manning Community Health Council decided that they needed to form a permanent Recruitment and Retention Coalition. They contacted Alberta Community Development to help them prepare a plan with their community. Meetings were held that also included the Northern Alberta Development Council (NADC), the Peace Country Development Corporation (PCDC), and the Peace River Economic Development Association (PREDA). Through the connection with Alberta Community Development, the Chair of the Community Health Council applied for an RPAP grant (\$10,000) to help with the provision of a part-time Coordinator for the R & R Coalition. The Town of Manning has donated office space, the Board of Trade has provided a desk, and the Manning and Area Economic Development Association has agreed to provide bookkeeping for the newly formed Coalition. The Coalition made the decision that their focus at this time would be on the retention of the physicians.

To date, the majority of the retention strategies have had the effect of helping the new doctors and their families, both are married with children, become a part of the community, feeling welcomed and supported. Opportunities to meet new people in the community have been set up. When one of the doctors lost a parent the spouse remained in town with their children and to work at the clinic. The R & R Coalition circulated an email and people in Manning provided support in the way of prepared meals for the doctor and her children. The Coalition finds itself providing suggestions and information on day-to-day living problems: they provided one doctor with information on where to find contractors to help fix a dug-out. The church as well has been instrumental in helping one family to become a part of the community quickly.

Challenges

Even though the crisis has been averted the R & R Coalition understands that their work is not finished. There are still issues and conditions that they can and are needing to work on to ensure that Manning and area have physicians as part of their healthy community. One of those challenges, perhaps the biggest challenge, is finding the volunteers in the community to work together. There is a need for someone to take the lead in the work, to act as a coordinator, in order to maintain continuity of information and to act as a “hub” for physician and community needs. The R & R Coalition is hoping that this challenge will be met with the addition of a part-time coordinator.

A second challenge that is acknowledged by the Coalition is the need to find a way for doctors coming into smaller centres to maintain or enhance their skills in specializations. Rural centres typically recruit for General Practitioners but many may come with skill set that they would like to maintain. In Manning for example, there is not an opportunity to do surgery or obstetrics (in hospital delivery). The Recruitment and Retention Coalition, along with the Community Health Council, will be taking this discussion forward to the Regional Health Authority as part of their concern around their ability to recruit and retain physicians.

The process of “needing to sell” their community has led the people of Manning to be both reflective and critical, to look at their community as a visitor might. It has helped the community to “pull up its socks and improve itself” and there has been movement on a new community pool as an attraction. Housing and childcare may also be two areas needing attention in the future in addressing supports and attracting individuals to Manning.

Interview with Michelle Janes – Northern Lights Health Region

The Northern Lights Health Region (NLHR) covers the northwest portion of the province – stretching from the Saskatchewan border on the east to the British Columbia border on the west, south from the Northwest Territories. Geographically, it is the largest health region in the province and it encompasses 20 communities, the largest of which is Wood Buffalo (Fort McMurray) with approximately 80,000 residents. Also included within the NLHR are some quite isolated/rural communities and cultural diversity. The other three major centres within the Region are the communities of: Fort Vermilion, which has a large Aboriginal population (900/3000 outlying area); High Level, with a population of approximately 4200 which provides service of up to 20,000 during high season; and La Crete, a predominantly Mennonite community of about 2000, which may serve a trading area of 7000.

As a result in the diversity of the Region there are a number of challenges in attracting and keeping physicians. Fort McMurray is an expensive place to live with average housing costs running about \$500,000+ and the availability is low. Property to put up a practice is expensive and difficult to find. Wages and availability of clinic staff need to be able to compete with other businesses in town. The more rural areas like High Level and Fort Vermilion take on different challenges. There are fewer amenities and residents need to travel to access some of the resources and services that they are requiring. That travel may mean driving to Edmonton, nine hours distant, or Grande Prairie about four hours away. Physicians may also encounter more cross-cultural challenges in the communities on the east side, more rural areas of the Region.

Some of the ways in which the challenges are being addressed include, for example, the provision of free housing to new physicians for a three month period. If they are unable to find adequate housing within that timeframe they may rent the accommodation provided by the Region. The provincial government, as well, has assisted in the retention process by helping to establish a stabilization fund whereby the costs of operating a practice are offset for physicians. That should help with skyrocketing office rental costs and clinic staff retention.

The recruiter for the Region, while new to the position, is very familiar with the process of human resources recruiting. She has found that many times physicians have “scoped out the area that they want to work in and they may have already spoken to the Chief of Staff and other physicians”. When they meet with the recruiter other questions arise and the focus becomes ‘what will this be like for my family? What can you offer my kids? What can you offer my spouse?’

What is important in the recruitment/selection process, and ultimately determines the retention rate, is the lifestyle fit between the candidate and the community.

As a result Michelle works to focus on what she terms “on-boarding”, introducing the candidate to the community and the community to the candidate; finding the fit. NLHR has recently completed a physician orientation program which includes introductions to everyone; and, anything and everything that has to do with the job. This is followed by a session on the community – what it is like to live in Fort McMurray. The community session covers schools, recreation, how to apply for Alberta Health Care, how to obtain a driver’s license, how some of our Canadian and Albertan systems work. In Fort McMurray, the site visit will take about 2.5 to 3 days and will include meeting with physicians and staff at the hospital, see where their assessment will be done, complete a tour of the community seeing where various amenities are, there will be a community dinner, they will be introduced to real estate agents, school principals, sporting clubs; whomever, depending upon the needs of the candidate and his/her family.

With the other communities in the Region Michelle works to visit each community once a month. It is important in these visits to meet with the physicians as well as the community based committee High Level/Fort Vermilion has a committee that has been active for approximately a year. Representatives from the Municipality, local business, community members, and hospital representatives participate on the committee. It is involved in monitoring the needs of the community. They are involved in greeting and meeting new physicians, accompanying them around the community, and helping them to meet other community members. In a site visit there will typically be people from the community, physicians, a member of the Region’s Board of Directors, and people from the local health facility. The community based Recruitment and Retention committee provides a context and a history to potential candidates that the recruiter cannot as she has not lived in the community.

One of the issues that quite often arises in the recruitment of physicians is the opportunities available for the spouse to work. The NLHR has developed good working relationships with local industry both in Fort McMurray and in the other communities in the Region. There is an understanding both within industry and the community that the provision of medical services within the community is critical to the overall health of the community and to the businesses operating there. Local industry will help to find employment for the physician’s spouse as appropriate.

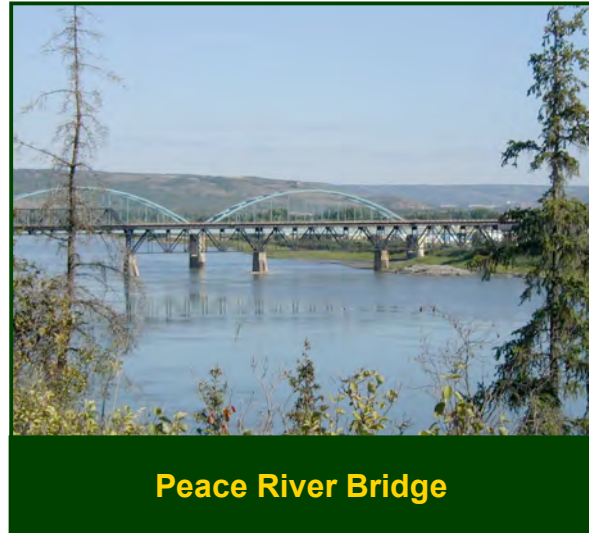
One of the challenges that have been addressed in an intriguing way has been the recruitment of five doctors for two positions in Fort Vermilion While the ultimate goal is to have doctors who live and practice in the same community it is

not always possible. In Fort Vermilion one position is split between two South African doctors who rotate every six months. The second position is shared between three South African physicians who rotate every three to six weeks depending upon their situation. This agreement provides the community with some stability and consistency of medical care and while it may not be viewed as the optimal solution it appears to be working there.

Marketing of the community and recruitment is taking place via the new doctors who have come to town. In the desire to recruit general practitioners, preferably with diplomas in surgery and anaesthesiology, current physicians are talking to others they know and are “selling the community”. Those who have been recruited and who have settled in are also participating in welcoming and introducing new physicians to others in the community.

Interview with Tanya Cox – Peace Country Health Region, Northwest Alberta

The Peace Country Health Region is one of those areas impacted by the growth of the north due to oil and gas production. At the same time it has a historical presence in northern Alberta for agriculture and pulp and paper production. Within the area of the health region there are 16 sites with the city of Grande Prairie being the largest of these. The population of the catchment area is approximately 145,000 with about 55,000 of those residents living in Grande Prairie.



Peace River Bridge

There is a need for general practitioners in the area. The current recruitment plan calls for a significant number, taking into account retirees and the new population. Family physicians are not taking new patients, getting into a walk-in-clinic is difficult and the emergency department is trying to cope with the growth in population.

Despite the fact the position of recruitment and retention is relatively new within the Region, it has been involved in the recruitment of 27 doctors in the past year. Where focus and attention need to be placed is in the area of assimilation and settlement of the recruited physicians. The function of the recruiter is to assist with the paperwork and to help coordinate the function of recruitment. She is involved in the identification of possible candidates, forwarding the curriculum vitas (CVs) that she receives to the Chief of Staff for each site, and the logistical support to the arrival of the candidates. The recruiter is also involved in arranging and accompanying candidates on site visits.

Eighty percent (80%) of all the CVs that are received are from International Medical Graduates (IMGs) although there have been lots of medical residents doing rotations in Grande Prairie to see what it is like. Recruitment is largely done via medical journals, and it is here that the process begins. Interested physicians respond by sending a copy of their CV, references, and a letter of eligibility from the College of Physicians and Surgeons of Alberta (CPSA). The recruiter will follow up with a telephone call to the physician to talk a little bit more about the type of community that they might be interested in living in and what type of lifestyle are they looking to live. These questions help to determine where the individual might best fit within the Region. It is at this point that the recruiter also inquires about the needs of the candidate's spouse and their children. She will also connect them with another physician who can speak to the issues of settling in and fitting in.

If there is interest on the part of the physicians in the Region then an all expenses paid site visit is planned. The recruiter is involved in the visit, the Vice President of medical services conducts a tour of the hospital; a real estate agent does a full city tour; the Chief of Staff of that particular service and other physicians may be involved in a supper, there is an informal interview; and tours of schools and churches appropriate for the family. Three to five days are spent on the site visit. It is while the candidate is on the site visit that the recruiter encourages the completion of a work permit application, the opening of bank accounts etc.

The Region has developed a comprehensive list of incentives that it hopes will help improve recruitment. The package has been reviewed to establish that it is comparable to that being offered in the rest of Alberta and the Canadian regions. The package includes furnished housing for three months, loans, signing incentives and relocation assistance. There is a yearly retention bonus paid plus assistance of \$5,000 if the office costs are over \$2,000 per month.

There have been some challenges in the process of recruitment lately. The length of time in getting physicians to Alberta is becoming longer. Previously there was difficulty in finding assessors able to assess candidates' abilities so candidates were left waiting, now the assessors are in place and the work permits aren't coming through quickly. Work permits are taking between four and five months; there is also a backlog of applications in overseas offices that is taking up to a year to process. The longest wait has been that of one applicant who began the process in early 2006 and is still waiting for a work permit. This delay, the lengthy wait has meant that the Region has lost four or five potential physicians as a result of the process.

Communication between the various parties throughout the Region still requires work. There are still gaps between the recruitment office and the physicians looking to recruit new doctors. There are also communication gaps between the recruitment office and the outlying communities. Communities have taken on recruitment themselves, the Region is unaware of the activity and difficulties have been encountered around issuing hospital privileges. Because of a lack of communication with other communities there is concern that the recruiting office at the Region is not being made aware of other concerns that are springing up for new recruits; communities may be dealing with them on their own. The community is in the best position to "sell" itself to potential candidates and the recruiter has not had an opportunity to become familiar with all of the 16 communities. There needs to be improved communication with the physicians and the communities around the role of the recruitment office and how it can work best for them.

Interview with Mel Giles – Recruitment and Retention in Olds

Olds is currently a community of approximately 7500 people and it continues to grow. Located about 93 kilometers north from Calgary in the Edmonton/Calgary corridor, the Town of Olds provides services and markets to over 40,000 people regionally. The economic activity of the area includes agriculture, oil and gas, service, and education with Olds College. In October of 2006 Olds was struggling with provision of physicians available to serve the rapidly growing population. With the booming economy in Alberta, particularly the growth of the cities of Calgary and Airdrie, Olds was feeling the effects of people coming to Olds to use the local emergency room and medical facilities. At the same time the town did not have a full complement of physicians, they were down four, and there had been rumours circulating that one or two others were thinking of leaving as well. It was in this context that the David Thompson Health Region (DTHR) physician recruiter wanted to present her ideas for a community based Recruitment and Retention (R & R) Committee.

In September of 2006 the recruiter for the DTHR approached the Town of Olds. The Town of Olds referred her to the Chair of Olds Institute for Community and Regional Development. The Olds Institute had been established in 2001 as the means to coordinate economic initiatives undertaken in the Town of Olds by the Olds Agricultural Society, the Olds and District Chamber of Commerce, the Town of Olds and Olds College. Today both Chinooks Edge School Division and Mountain View County are also members of the Institute. Accompanying these organizations are five members of the public at large.

The Chair of the Institute decided that they would organize a community meeting that the recruiter would speak at. The agenda was simple; hear the message and the community could decide if an R & R Committee was something that they wanted to take action on themselves. There were about 50 people in attendance for the meeting: thirty of them signed up to become involved in the development of a community based R & R Committee. Two weeks later, with the help of the DTHR recruiter, the group began in earnest.

The Committee meets monthly. In the beginning it was to determine their Terms of Reference; what were they going to do? As a sub-committee of the Institute it was necessary for them to define their role in the recruitment and retention process for physicians. In the early meetings physicians were involved and as the committee evolved they were replaced by representatives from the two medical clinics in town. While there was good community representation, good discussion and good dialogue “it was a struggle getting their heads around what

they were trying to do”. The committee had/has a lot of learning to do about the health care system itself – how physicians work, how they get paid, the abuses on the system by patients and the impact that that can have on physicians. The Committee was well supported by the DTHR representative. She “pushed them a little, pulled them a little, and there were struggles” but she was very helpful in getting them started, providing two models from other communities as examples. The Committee “just put their noses down to the ground and them buns up in the air and got to work” identifying its mandate through the development of a vision statement, a mission, a purpose and some strategies.

The first initiative undertaken by the Committee was the hosting of a hospitality room to promote the Town of Olds at a conference for medical graduates. While there was a great turnout the event did not provide as strong an outcome as the Committee desired. While not involved in the interviewing of potential candidates, the R & R Committee provides support to the clinics in the recruitment of physicians. They arrange for a community tour; connect them with realtors, schools, churches as identified; meet with candidates for dinner; talk about the community and what it is like to live there; and provide settlement support to new physicians as they begin their practice in Olds. A thank-you, accompanied by a “Welcome!” basket, is sent out by the committee to let the physician know that the community appreciates their decision to join their community.

Today, with a full complement of physicians the Committee (now shrunk to a nucleus of 12) is turning its efforts toward physician retention; working to keep the physicians now in the community. The committee is helping new physicians manage the challenges that may crop up in their settlement process. For example, one young urban-raised doctor who has just purchased an acreage is being mentored by a local member in being a successful acreage owner: understanding how living on an acreage is different that living in town. The committee has also been involved in finding alternate rental housing for a new physician whose accommodation was repossessed by the bank after problems with the builder.

The Committee, early on in its activities and its learning, conducted a two-part survey of the physicians in the community. They wanted to understand what issues were affecting the physicians and that might have an impact on their decision to stay and practice in Olds. Questions were asked about the community and about their practice: the response was very informative. The Committee learned that the physicians, unanimously, had no issues with the community; but, there were three major issues arising from the practices. Those issues that were having a big impact on the physicians included the number of hours of work, the overhead fees of the clinics, and the abuse of the emergency facilities, which had “on-call” and hours of work implications for the physicians.

With the full complement of physicians working in the community, part of the work hour issue has been addressed. The R & R Committee is now developing its working strategy for the next two years: looking at ways in which physicians' overhead fees may be reduced; and, developing a community education campaign on the appropriate use of emergency services at the hospital. It is the Committee's belief that the successful addressing of these issues will help improve the working conditions and hence, the lifestyles, of the physicians in the community, leading to higher physician retention. It is also believed that the community-based R & R Committee needs to be the organization that spearheads the discussion and the strategizing around the issue of overhead fees.

The Chair of the R & R Committee, Mel Giles believes that the complexity and nuances of the healthcare system – the bureaucracies, the standards, the protocols – are preventing communities from moving forward with recruitment and retention activities. It is necessary for communities to first understand these in order to affect change. It is also these complexities that have led to feelings of frustration and may have affected the participation levels of volunteers who are also involved in other volunteer activities in their communities. They keep going to meetings but things move forward much more slowly than they should.

Interview with Terry Danchuk – Recruitment and Retention Committee, Redwater

Redwater is a community of approximately 2200 people located about 25 minutes north of Edmonton. The Redwater Health Centre and the physicians of Redwater serve a catchment area of between 12,000 to 15,000 people. Redwater's experience with doctor recruitment and retention started about 12 years ago when the hospital was under threat of closure. They needed three doctors to keep it open – one physician had left and there was a strong indication that they were about

to lose a second doctor. A recruitment and retention committee was formed in the face of the possible loss of the hospital.



Redwater Health Centre

The committee included the town pharmacist, representatives from the towns of Redwater and Thorhild, representatives from the County of Sturgeon and the County of Thorhild, the Lakeland Health Region, politicians, and a representative from the health facility. The committee began its search locally but they were unable to find a physician interested in coming to Redwater to practice. They began to look outside of the country placing an ad in a magazine and then they engaged with the internet. There were a lot of 'hits' but no real commitment from the inquirers. They provided the interested individuals with information on the surrounding area, presenting all of the positives and the amenities of the area like hunting, fishing, proximity to Edmonton, what ever might draw someone to the town. There wasn't much time actually spent talking with the interested individuals – not like they spend now, they simply sent out the information on the area and a 'perk' package. The 'perk package' outlined the incentives that the town was offering to a physician to relocate and set up a practice in Redwater. It included a housing allowance, a car allowance, moving expenses, cost of their flights, a house stocked with groceries, and a temporary supply of furniture until theirs had arrived.

They found a doctor, and the committee made an assumption that they had recruited, the doctor had a job, and that was all that they needed to do. The doctor stayed seven months. What the committee had failed to understand was that the needs of the doctor's wife also needed to be addressed. The learning

that the committee took away was that you need to take care of the family. The physician can adapt very rapidly because s/he is working, meeting people and becoming part of the community dynamic while the spouse may not have that opportunity as readily. Settling in may be something very different for the physician's spouse.

Since their first attempt the committee has recruited four doctors and with each one they have learned something more about the retention process. They have learned that "money is helpful but it doesn't keep people in the community". With the recruitment of doctors from other countries it is important to be in touch early on with the doctor and their spouse/family and to help with day to day living because it can be very different here than where they are from. This, they have found, is one of the most critical pieces to retention – the community building, and supporting a strong relationship with the physician and her or his family.

Today members of the Recruitment and Retention committee will accompany a new doctor to help open up a bank account, help them get a mortgage so they can buy a house, set them up with a car dealer so they might buy a car, help with winter clothing and equipment shopping, take them to the schools to meet the principals so that they will understand how our education system works and where their children may fit. The committee provides assistance with understanding and working through systems like filling out forms or working with the health region for example, with which the new doctor and his/her family is not familiar. "It's important to maintain contact so that we can be aware of any red flags that might arise. That way we can address the problems before they become unsolvable".

The Committee has also been involved in involving townfolk in the retention process. The community of Redwater has responded positively. Everyone in the community understands the value of the health facility because they have faced the possibility of losing their facility. They understand the importance of working to keep physicians in the community.

In 2006 there was a social event in honour of the doctors, a way to say thank you and bring them closer to the community. It was a cross-cultural event with food and music from both the Ukrainian heritage of Redwater and the South African heritage of the doctors. Over one hundred and twenty community people attended the celebration and both the physicians and the community felt honoured.



Redwater Appreciation Event 2006



So what has worked in Redwater? A recruitment and retention committee that has current physicians involved in the process; an active health region that supports the new recruits supplying things to the doctors that the community isn't able to; a committee that is committed to the well-being of their community and the recruits; and a general community that understands the role that physicians play with respect to the health and vibrancy of their community.

So what are the challenges facing the recruitment and retention committee in Redwater? First and foremost that just because there is a 'full contingent' of doctors doesn't mean that the work stops. Retention is an on-going process, just as recruitment is. A physician's needs or those of his/her family may change over time as the family grows and changes. That may mean that they need to change their practice, perhaps from full-time to part-time or they may need to leave the

community all together. Doctors retire. The challenge for the Recruitment and Retention committee is how to maintain the volunteer committee in "down times" and then be able to "ramp up" the activity when the need arises.

One of the other challenges is the managing of relationships with other stakeholders in the physician recruitment and retention process. These would include the recruiter from the Health Region, the key individuals working with the Alberta Medical Association, and Canada Immigration, for example. As the processes and individuals change within these organizations it is necessary to keep building a good working relationship and rapport in order to more easily facilitate or expedite the work needing to be done. It is important that each stakeholder understand their role and responsibilities in the process as lengthy delays may be experienced as a result of misunderstanding, miscommunication

and a lack of clarity. Delays may mean the loss of a good, qualified MD because she or he may not be able to wait out the process.

The committee now has become a core group of about six people who meet every three months or so to see what is showing up in the community that is a concern or an issue for them to take a look at. One of the committee members has documented the recruitment process that they use so that the “ramping up” will be a bit easier as they bring on new community volunteers. This will also help ensure a smoother process should they not have the expertise of the person who has been instrumental in carrying out the majority of the tasks. Having one individual to coordinate the communication and the developments of the process helps to speed it up, with the rest of the committee kept informed and supporting the work in the community.

Interview with Roxanne Bergheim – Recruitment and Retention Task Force, St. Paul

Perhaps like in many communities, the recruitment of doctors has typically been the responsibility of the Regional Health Region or the medical clinic itself. This was the case in St. Paul, a small town in northeastern Alberta, located about 200 kilometres northeast of Edmonton.

The recruitment of physicians in St. Paul had been done by the Administrator of the medical clinic for many years; it was part of the work that she took on. She had been quite successful over the years developing relationships with the businesses and individuals in town, and within the various systems, to support the recruitment of 15 doctors over the years. But time does change all things. There are now two medical clinics in town and the clinic administrator who had taken on the coordinating function for the recruitment will be taking on new job responsibilities and unable to provide the time to the work. The thinking as well has shifted: the recruitment that needs to take place today is recruiting for the health of the community. Therefore the community needs to be involved. With the entire community involved the recruitment can be more aggressive and the retention strategies broader.

The Recruitment and Retention Task Force in St. Paul was formed in the winter of 2007. While it is still early in its development, it is comprised of Town Councillors, a County Councillor, a representative from the local Chamber of Commerce, local business owners who have an interest, and a representative from the hospital. The focus of the committee is both recruitment and retention. The committee will function as “the hub” of these two activities, hopefully helping to spread out the work so that it is not too onerous for one person. One of the challenges will be to identify who will take the lead in the coordination of this group and its function. Is the Task Force ready to take on the work of recruitment and retention without the individual who has been doing it for so many years?

Fortunately there have been many aspects already put in place. Situated on the edge of oil country, like many places in Alberta, finding housing for the doctors is difficult. There is a shortage in suitable rental property and foreign physicians new to Canada don't have an established credit rating and as such don't qualify for a mortgage. The Task Force looked at this issue and decided that it would address this problem by taking a one-year lease on a property that was for sale. The County and Town determined that they would cover the costs of the lease if the house was vacant for a period of time, in order to ensure that transitional housing was available for the next incoming physician.

Prior to the development of the Task Force all of the “upfront costs” and “settlement costs” for bringing in new physicians had been incurred by the physicians in the clinic. Now with an increase in new doctors, many of them

coming from outside of the country, there is not the same ability to provide capital support to new clinic associates. The Task Force agreed to partner with the clinic as a community contribution. A number of items for the house have been purchased with funds from the Task force and they will remain with the house after the doctor moves on to his/her own accommodations. The Lions Club has also become involved, furnishing one of the rooms. A house was determined to be the best alternative as it would meet the anticipated needs of any of the physicians coming to St. Paul. This has proven to be true, housing one family with four children and a family with two children and five pets.

Some of the other challenges related to the settlement of physicians have included obtaining vehicles – a local dealership agreed to work out a rental agreement – and, furnishings – a local furniture store provided a “don’t pay for a year” deal.

Another challenge that has been experienced by this community in its work to welcome and integrate new doctors has concerned not the physician his/herself but their spouse and children. For doctors with families the community needs to welcome the family, not just the physician. In St. Paul, involvement by community representatives involved in small business start-up and venture capital offered to help one physician’s spouse get her small design business ideas off the ground. In another instance while the physician was being courted, another organization in the community had interviewed her husband and offered him a job with them. Roxanne’s feels that recruiting female physicians may be more difficult than male physicians; in her experience they have a need for more of a work/home balance as many may have children and they may also have a partner who is also a professional wherein there may be less work opportunity for the spouse.

“A practice is a practice, but what is it like to live there?”

For single physicians the community needs to be aware as well – what are the needs of the individual? As they may not come with their family, there is a need to connect them to people within the community that share their interests and with whom they may participate in the same activities. St. Paul has been active selling its lifestyle – showing physicians with young families the array of activities available for the children, like community supported sports and music. Getting the local schools involved in the recruitment process is important if there is an interest shown by the candidate in particular educational needs for their children. If a church or a particular faith plays an important role in the life of the family getting them connected to that church in the community would be helpful as well in their integration. Physicians are coming to look for lifestyle balance and Roxanne works to make sure that the needs and wants of the physician fit with the needs and wants of the community.

One of the most effective practices undertaken by the recruiter is the process of accompaniment that is undertaken for the first two to three months of a new physician’s settling in. Roxanne arranges for their interview at the College,

makes arrangements for their assessment in another community, helps them obtain an Alberta Driver's License, housing and schooling information etc. She arranges for them to meet other people in town and helps to get them connected. The broader community and the committee also help with the orientation process.

Some of the challenges St. Paul is facing...

In St. Paul one of the challenges that the doctors and the community is facing is the need for a new clinic; it was initially started for two physicians and there are now eight under very cramped quarters. While there is pressure to build a new clinic, the newer physicians do not have the capital or access to the capital necessary to either undertake renovations or build a new facility. This becomes a community problem when the doctors are frustrated by working conditions and decide to move their practice someplace else. The doctors are looking for a community partnership to undertake the building together but it is difficult to find.

Another of the on-going challenges is keeping volunteers involved in the committee. People are interested but it is a bit of work, the committee needs a leader to help spearhead/coordinate the activities, and the committee needs to set its direction all the while learning about the needs of the foreigners coming to St. Paul.

The process of physician recruitment is becoming more complex as doctors are retiring and the demand for graduates is rising and the number available is decreasing. Recruiting doctors internationally has become a longer process, now taking nine months to a year where it used to take four to five months. Communities now need to be recruiting for the future. In St. Paul they are currently 'grooming' a doctor from South Africa, encouraging him to take courses in anaesthesiology during the processing period because St. Paul is missing an anaesthesiologist.

In thinking about the future needs of the community St. Paul is also involved in the integrated community clerkship project where doctors in training spend eight months in the rural community. Roxanne believes that the eight month period (vs. a six week rotation) is helpful in having students integrate into the community. Students who may have come from an urban environment will then become part of the community that they are working in and begin to see and understand what a rural practice really has to offer them. The community will use it as an opportunity to actively promote their town and their lifestyle.

Appendix D: Session I – Notes from Community Plan of Action

What Makes A Committee Effective/Successful?

- Community minded individuals working in unison
- Hard work and think outside the box
- Need to have direction established first
- Work hard and be committed
- Need to understand situation and resolve from there
- Good liaison - understanding
- Don't forget to "appreciate" the doctors that are already there
- Involve the media to show appreciation
- Success comes with committed committee members
- Listening
- Working with the family/kids
- Identifying needs of the doctor and family
- Communicating activity to the town
- Public appreciation of the doctors and the committee
- Recognition
- Actively searching out the needs
- Needs to be personal (Not a paper work thing... it's a sit down and chat thing)
- Spend time with the recruits
- Committee needs a passion for this
- Need contacts within the community o help care for whole family
- Have a family "adopt" physician family

What Has Been Successful?

- Support from RPAP and DTHR
- Passionate/dedicated leaders
- Structured communication
- Structured covernance
- Community support
- Industry cannot recruit without doctors

- Money from industry
- Fostered team work - team members between OR & Clinics
- Awareness of health care system
- First impression
- Keep momentum
- Physician involvement
- Recruit family
- Strong physician leadership
- Passion, commitment
- Fear
- Communication
- People with influence, interpersonal connections who can make decisions
- Business needs
- Developing an understanding of doctor's needs
- Contacts
- Doctors recognized the crisis
- Hand picked committee
- Realization that it is a regional concern - can't do it alone
- Strong ties to the community - seeing the need
- Communication between the mayor and CEO - Took charge
- Regular committee the doctors to deal with concerns
- Engaging the community
- Talking with other communities that have had success
- Education
- Guidelines/Mission/Terms of Reference
- Design roles

Why A Committee?

- Crisis/shortage
- What the future holds
- To help new physicians settle in
- Influx of people with no doctors
- Onboarding/"Settling In"
- First recruited doctor 1992, Last in 2003

- #1 handle for physician to remote/rural is family
- Loss of both physicians - unexpected 2 yr. notice
- Doctor's wives concerns
- Long standing local need and shortage
- Planned retirement of doctors
- Severe shortage of doctors
- Key people stepping forward verbalizing the concern
- 1 of 3 doctors left - crisis events
- Comm. Found to deal doc/town council, hospital board, members at large
- Retion aspect
- Doctors looking at retirement over 5 yrs
- Doctors have been difficulty on getting a LOCUM
- Our best recruiters involvement - Health Council
- Effective members of town/MDS Not just our town but wide range
- Fast growing community, 3000 people surrounding 10,000
- No services
- Visiting doctor
- Basic Need, business people, councillors, community members, community health council
- ER becoming the clinic
- Doc's RM in the hospital for Locums
- Doctors needed in community to prevent burnout and retain
- Housing incentive
- Learning for further education in urban - not returning
- Involvement of medical personal
- Committee formed March/08
- 2 town council member, 2 hospital brd. Members, 2 county members # HR to work on call
- Doctors having concerns
- Committee Formed to deal with issues
- 2 councillors, 2 community members, 2 county

What Caused Your Community To Respond To The Need For A R & R Committee?

- Our community had only visiting doctors (La Crete)
- Population has grown/50% over the past 20 years
- Would like to see a "Primary Health Care Centre" in community. Currently no hospital
- A crisis is the motivation n for the information of the committee
- Acute care cannot function without a doctor
- These committees need to be ongoing
- Recruitment committees need to be broader than just physicians
- Health needs don't always have to be met by a physician
- Doctors of the community initiated a meeting with the town council to discuss the need (Rocky)
- Doctors approached the community about an approaching crisis (Cold Lake)
- Addressed physical needs of physicians (housing/transportation)
- Working toward the greater quality of life for physicians and their families
- Committee has a passion for the project
- Not just about the physicians
- Need to communicate with the community what our needs are

Triggers

- Physicians gone, leaving
- Distance to service isolation factor
- Societal changes
- Mobility
- Hidden triggers - lack community knowledge

Who Decided?

- Town, Chamber
- Doctor's wives made presentation - asked for health at the rural summit
- Municipal nursing association
- Doctors

Initiation

- Awarded municipal sustainability incentive - community members/stakeholders group (Olds Institute)
- Community lifestyles committee developed
- Sub community who created a strategic plan for physician R & R
- Several actions identified, any initiated
- Historical relationship between community and hospital
- Town called meeting, discussed creating a plan for potential recruits (offers free housing)
- Through town council created Dr. recruitment committee
- (Committee latent - lack of continuity)
- Letter from local Dr. to chamber of commerce who called community meeting for all stakeholders
- initial mtg id'd committee, chairs & coordinators; subsequent mtgs, strategies id'd & carried out
- Physicians identified needed more help
- Committee established - looking for ideas
- County and town recently formed committee (housing may be available - duplex)

Who Made Up The Committee?

- Local nonprofit committee member
- Business reps
- Chief of staff/Healthcare manager
- Member of the town council
- Past health board members (brought list)
- Leaders in community
- School board or rep/teacher
- Community health council
- Health region rep, chamber of com., rotary club
- Pharmacist, dentist, manager of seniors
- Mayor, CEOs of 2 communities
- Nurse, pastor, college reps, doctors

- Local farmer
- Real estate agent (for whole)
- Movers and shakers
- Industry
- Advertised asking for members
- Reps from nursing
- Health services rep
- RHA board rep
- Integrated community member

Structure

- Advisory to council (informal)
- Distance from political agenda

Assistance

- RPAP
- Capital Health
- Money from individual community members
- NE HUB
- Aspen RHA
- Sponsored rural health conference
- Software
- Foundation as a way to raise and spend money
- White elephant syndrome
- Paid staff

Factors/Conditions Of Success

- Business financial investment
- Community buy-in
- Community culture value
- CHCs Community Health Councils
- RHA strategy

- Ability of site visits
- RHA investment
- Physicians networking
- RHA active role
- Persistence
- Identification of needs
- Physician buy-in

Who Did You Turn To For Assistance?

- Hired recruiters
- Government resources
- Community leaders

Who Was Involved In Decision To Start?

- Health authority, catalyst resources
- Business, pharmacists - early detection
- STP's - Same 10 people elected, informal
- Cold Lake C of C maily driven several years at this r & r
- Started for need - many retention issues
- Competition government vs. MP
- Clinic is hospital - can't expand
- Coronation - Changing dynamic
- In hospital clinic, all equipped
- Due to need, pay rentention supplied
- Clearwater - started due to shortages
- Dr's own clinic, very expensive
- Daysland - Very new (3 months)
- Regional hospital
- Looking at buying clinic
- Tentative agreement from county/other communities to support dollar wise efforts
- Grimshaw - 10 committee members
- New doctors & nurses shortage

- Clinic is subsidized
- Capital Health is interested in rural needs
- Need to be good dialogue between RHA and communities
- Tofield - 4 years ago ok
- Recruited with incentives, doesn't work
- Fit is imperative 3 clinics - politics decides where money goes
- Money issues between RHA

What Do New Committees Need To Know

- Need to support recruitment
- Need to have community to community working together for common goals
- Each area has such diverse needs and problems that no one solution works

Appendix E: Session 2 – Notes from Marketing Strategies and Incentives

Heart's Content

Profile

- Cozy community at base of Rocky Mountains wrapped in foothills with big city amenities with a small town feel
- 5,000 people
- Affordable housing
- Welcoming medical community working a stgate of the art health centre
- Community owned medccical clinic
- High quality education programs in grades K-12, English and French
- Low crime rate
- Tourism, oil and gas, farming

- Ski hill
- Lake - fish
- Golf course
- recreation clubs
- arts programs
- Daycares
- All school programs (English/French - Public/Private)
- Snowmobile/nature trails
- Walking trails
- Good shopping
- Various health care providers
- Airport
- Low cost housing
- Community supports
- Several restaurants, churches
- Library
- Parenting programs
- High speed internet
- Festivals

Incentive Package

- Personal community liaison
- \$25,000 hiring bonus (return of service)
- Free rent for 6 months
- Free rental car for 3 months
- Gift basket
- Free recreation pass
- Loan (no interest/no payments)
- Relocation assistance
- Financial planning

Plunketville

Ampen Family

Catherine - Doctor, knitting, exercise, belly dancing

John - Graphic design, golfer, reader, gourmet cook, coach

Timmy - Soccer, rollerblade, BMX hockey

Sarah - Dance, girl guides

Family - Vegetarian, outdoor hobbies, church, travel, hiking, liberals from Ghana, dog & cat

Phone Conversation

- Soccer registration - date, costs etc
- Rollerblade - great sports facility and sporting goods shop that will meet the needs of son for clothing, skateboard
- Vegetarian - talk about the farming around the community, what is fresh grown
- Other families of Ghana - meet once a week in Ghana
- Rec. Centre - Dance lessons
- Rental accommodations for 1-3 months will be at a reduced cost and transitional house
- video imaging, high speed internet information
- Soccer players write a letter, team picture
- Season ticket for sporting event - year round doctors
- Free berth at marina
- Cultural activity
- Send out resume for spouses and provide potential work contacts

Clearwater, AB, Pop 5000+ "Living Matters"

Profile

- 5,000 people - 25 mile radius
- Farming - 4 doctors, 2 planning to retire in 2 yrs
- Similar interest in communities
- Newly expanded hospital
- Doc. Trained in States - local practice 5 yrs in rural AB. Now wants to settle in one community
- Single hobby - photography
- Minimal debt

Our Town - Clearwater

- Older community established
- Tight knit
- Variety of churches
- Photographer club established
- Nature club - hiking paths, close to National and Provincial Parks
- Bird Sanctuary
- Affordable housing
- Pharmacy
- Airport - commuter flight, active flying club
- Assistance with air travel
- Active commercial and residential development
- Active retail
- Age group 35 yrs
- Hospital service - visiting specialist, EMS services
- DI & Lab, LTC, Physio
- OB Low Risk
- Sub Ca. Clijic
- Surgery
- Recreation complex - indoor pool
- 2014 expansion cor hotel will include 2nd ice rink, field house, fitness centre, xcountry skiing/sledding

- 9 hole golf course
- Active AGI society
- Clinic building established located down town
- Community health services public
- Education - schooling, stable and recruiting teachers

Incentives

- City owned house for a new doctor while looking for a permanent house
- No rent
- Furnished, allows pets
- 1 in 4 W/E on call - RPAP, AMA rural
- Active housing development
- Strong Credit Union to work with the doctor
- Cross section of recruitment committee
- banker
- car dealer
- rep medical
- Chamber member
- Rotary club
- Member access to services
- Site visit involve tour of area and virtual tours
- Foundation Co-op
- Creative alternatives around clinics practice-longer you stay the more equity you will have
- Education, videoconferencing
- Clinical conferencing, super net in Hospital and clinic
- Moving company assistance

Sunny Skies, AB

- Pop, 15, 000
- 2 hours from Grande Prairie
- Stable practice
- Low housing price
- Low taxes
- Wilderness opportunities - hunting, fishing, camping, boating

- 2 - 18 hole golf courses
- K-12 public and private schools

Incentives

- RHA housing 1 yr
- Vehicle - local dealership 1yr car, minivan
- Municipality and pharmacist built turnkey clinic: charge nominal rent (fair market) for all
- Qualified child care facilities
- Brand new recreation facilities
- Local culture
- Farmer market every Friday
- Local colony that has an abundance of locally grown and produced products
- Huge organic farms
- Multi denominational churches & service clubs
- Horse boarding, equestrian cross country, pony club, 4-H
- Mentorship - doctor on call - referral, emergency
- Community profiles
- Key contacts

Cedar Rapids, AB, Established 1897

- The home of Crystal Diamond Mines (1995)
- Town Slogan - *We appeal to every facet of your life!*
- Population base - 10,000 included mobile population
- Assets - wildlife, hiking, scenery, paved walking trails, waterfalls, affordable housing
- New recreation centre
- Bird watching & photography club
- Home to Canadian Geographic Magazines
- Camping, ice fishing, snowmobiling, cross country skiing

Incentives

- Free internet for 1 yr, cell phones, satellite TV
- Moving allowance
- Photography school (Sat outreach from Banff School of Fine Arts)
- Weekly \$50 credit at the Diamond Lil Lounge
- Service clubs - Chamber of Commerce
- Fire Services (Full time service)
- Churches, Schools K-12 French Immersion
- Soccer, baseball
- 3 financial institutions, local stores including clothing, farm implement dealer
- Women's hockey league
- Strong sense of community pride
- Year subscription to Canadian Geographic
- Matchmaking
- Telehealth, CT scanner, Mental health, primary health community
- Hospital - on call one weekend in 4
- State of the art equipment
- Physician office supplied on site in hospital included paperless office system
- Mid-wife in community
- Education incentive - skills enhancement package included OBS & Anesthetics
- Team up with local mid-wife
- Warm welcoming committee
- Night tour of Diamond Mine
- Fly her family in to meet the community
- Twice weekly housekeeping services
- A girls best friend community
- Staple agriculture community
- Canola crushing plant, bio-diesel factory, community college
- Aboriginal culture, Muck-Luck Festival
- Good restaurants
- Extra foods, Cosco, Cedar Rapids Colony, proud supplier of cedar rapids chickens and radishes
- Airport
- Volunteer base (strong and growing)
- Close knit caring community
- 1 yr pass for recreation centre

- Water front property rent free for 6 months
- Site visit - tour hospital to coincide with the Banff School of Photography show Exhibition
- Tour medical clinic, Diamond Mine - Meet/greet lunch @ Diamond Lil's
- Tour of school, rec centre, driving tour of community, farmers market
- BBQ @ picnic grounds
- Spend night in bed and breakfast
- Conclude tour with a physician luncheon
- Local gift basket
- Safety, personal testimonial, interactive slideshow

Cottage County

Steps For Committee

- Meet with local doctors
- Pre-visit questionnaire
- Set up marketing info:
- Town - history, plans for future, pros of small community involvement, financial side of MD income, cost of living
- Recreation
- School
- Equipment in health facilities
- Service clubs
- Town Website - loaded!
- Shopping/Chamber

Interview

- Daughter 8 - flute, voice, piano
- Son 10 - Computer games, karate
- MD - Walking, hiking, golf
- Husband - golf, computer, art, belong to church
- Introduce/have info on: real estate, schools, music teacher, church, banks, other of same nationality
- Female MD wants to work PT. Husband wants to work FT graphic design 2 kids 8 and 10

- MD clinic - variable hours available, would talk to all physicians to discuss options
- Husband: open work permit, tie into industry with town and other prospects, internet options - get high-speed access at home, service clubs

Family Interests

- Discuss their recreational interests with them
- Swimming
- One year free to recreation facility
- Introduce to ice fishing (stock lake)
- Golfing
- Cross country skiing
- Hiking/biking
- Camping
- Soccer

Other Support

- Clothes shopping
- Vehicle shopping/maintenance
- Community liaison

Incentives

- Housing and vehicle free for 6 months
- turnkey clinic; owned and staffed by RHA
- local MDs part of committee
- \$10,000 signing bonus
- Learning credits
- Internet connection/home computer
- Palm pilot for MD with drug database
- Professional fees
- Package options of incentives

Site Visit

- Develop a handout package/slide show info on disk for take home

- Review plan reimbursements
- Arrange for transportation for town and people
- Physician, mayor or other local dignitary as tour guide
- Pre-phone call by tour guides to introduce before visit
- Arrange rental from airport to town place to stay
- Tour hospital/clinic
- Lake - boat tour
- Trails - ride on bikes, horses
- Rec Complex
- Tour schools
- Kids tour - parallel activities
- Independent tour - candidates committee meets with doctors
- "Offer time"
- Plan to meet again
- Find out why if not interested
- Exit interview

Appendix F: Session 3 – Notes from Retention Strategies: site visits, settling in, and ...?

Site Visit

What's Important?

- Comfortable/accepted in community
- Treated as equals
- Needs to do more than an average recruit
- Rise above expectations
- Set them up for first few days
- Recognized uniqueness yet addressed in smoothly

Experiences At Table

- Recognize every family member
- 1 yr free rent – bought house
- Address accommodation needs
- Address religious needs
- Welcome basket
- Well planned, detailed site visit

Site Visit

- Hospital coordination (who, what, when)
- Welcoming committee (The right people)
- Influential people
- Continuity of familiar name
- Don't overwhelm them
- Town transportation (who, how)
- meals, cultural needs, vegetarian
- Accommodation – real estate
- Gift basket (incl. Note of appreciation)
- Contact names and number for follow-up
- Children's needs - other young people from community present
- Chamber of commerce (community guide)

- Ambassador Program – contacts, real estate, bank, school, church, business, childcare, dentist, physicians, rec centre
- Design business's, newspaper
- Transportation (sea and air)
- Farm markets, grocery stores
- Welcome package, letter, coupons, youth introductions
- MD annual report
- Accommodation recommendations
- Physician transitional house
- Meet and greet community BBQ
- 2 day itinerary (options)
- Newspaper office visit
- Spousal needs contact re: employment
- Rental care
- Real estate overview
- Neighborhood visit
- Down time!! Relax and discuss alone
- Debrief talk (30 mins)
- Tour the rec centre
- Farmers market
- Match the welcome and tour people to the visitor (ie) likes/dislikes personality
- Get a Ghanian contact to meet them
- Consult with visitor re: their priorities
- Research their culture
- Managing their expectations
- Market our assets & multiculturalism
- Who will meet them?
- Transportation, conversation
- Schools, sporting facilities
- Tour of Hospital and clinic
- Look at CMR
- Dinner with doctors/ceo's
- Accommodation - condo
- Send them an itinerary for approval
- Tour of community
- Build tour for candidate based on interview

- If IMG. - they come for 3 month locum
- Sometimes only 2 to 3 days notice that a visit is coming
- Home cooked meal with community leaders
- It's all about building a relationship
- Arrange with bank ie: mastercard/credit
- With kids - talk to whom may need a play pen
- Head by the doctors
- Meet with mayor - tour
- Most of time with doctors and touring of hospitals
- Spouse potential of business
- Success - RM available in hospital during the day
- Large groups overwhelming
- success - small groups, pick the people that fit the candidate for success
- Keep medical and business component separate
- Pre-plan - identify the time and focus on key interest
- Network with colleagues over dinner
- Greet at international airport and bring to our community
- Send CO of community to potential Doc. ID interest
- Time for self
- Vehicle for use
- Host a meet & greet 1st night
- 2nd day tour of area
- Hospital and health care services
- ID cultural sensitivities
- Meet with key people of community and medical personal
- Activity for children
- Discus financial options and how foundation works for clinical practice
- Taylor to the doctor and allow for flexibility
- Welcome gift basket at hotel
- Breakfast with RHA rep, community member 2-3 people
- Look at personal interests, outline schedule for visit
- Explore community (provide map)
- Dinner with community reps
- Physician Led Day
- Physician meet and greet
- Medical staff meeting

- meet with RHA rep, meet staff, overview programs
- Lunch with coalition, identify future needs, tie up loose ends
- Key contact to drive to meet plane
- Use time to get to know interests, needs, etc
- Check into hotel
- Stop at hospital, meet staff
- Key contact physicians department hospital go to clinic
- Give community overview
- Car so they can drive around have free time and meet at hotel for dinner theatre
- Meet certain community members
- In morning meet for breakfast answer last questions and tour any last items.

Settling In/Quality Of Life/Integration

Spouse

- Send out resume
- Home base business start up
- Potential opportunities for business start up
- Ask what concerns are – consult with them, lots of info related to incoming Dr. and spouse
- Physically help move in or assist with arranging moving company
- House warming gift (flowers, fruit basket, take casserole)
- Ask neighbours to greet new doctors (neighbours might bring something over, invite for dinners)
- Kids introduce to neighbour kids
- Introduce them or invite them to recreational activities, skiing, bowling, local games etc.
- Work with spouses, connect spouses with others
- Keep ongoing communication with spouses to find needs

Immigration

- How to use the phone system for other country calls, and where to get discount cards
- If you can, keep the spouse @ home – happy the Dr. will not have to worry
- Personal relationship building
- Ensure that there is time off – encourage this with Dr/family
- Industry – airmiles for travel out of country or long distance
- Tap into immigration resources to assist with possible needs of out of country Dr.s
- Cell phone set up plans, garbage days
- Information on income tax needs, community taxes, mill rates, utility rates and companies available

Family Integration

- Ask what they need 1st
- When they arrive – know what they need
- Can't overwhelm them – go with their schedule or pace
- Take them out to get what they need
- Once settled – introduce to: business associates, city officials, cultural/recreational, church/worship
- Define 1 person to be "key" contact
- Take it 1 step at a time to integrate grocery, school, navigate community
- Minimum 4-5 weeks till autonomous
- Check in regularly
- Welcome – town information pkg, driver's lic.

Transition Into The Community

- Accommodations – bought home/nominal rent
- Church – introduced
- Community – small scale, helpful, personal, influential people Bells & whistles, red carpet
- Help to move into house
- Other affiliations
- A furnished place to stay in
- First 6 months – cash flow, rent free, furnished, clothes shopping
- One key person as liaison who can help make arrangements

- Children – facilitate getting into soccer
- Bring warm clothes to airport
- Spend time on phone before getting to know them 2 or 3 times
- Keep up contact "maintenance schedule" encourage contact
- Invite others from home region
- Write up in newspaper
- Set up of work space, administrative needs
- Business consulting service to get set up
- Linkage to employment agencies, employees, organizations
- Orientation to town schedule & wildlife safety issues rural life
- Investment advice
- Health care help (get coverage) set up, driver license, cable
- Welcome wagon
- A checklist would be very helpful!

Quality Of Life

- Housing – realtors, condo, own house (6 months)
- Transportation – truck, industry partner 3 months, buy car
- Clinic Issues – Buy in \$150,000 signing bonus, credit union, interest free loan co-signer
- What sports available – hockey, golf, soccer, runs, someone to show trails, running club
- Quading, snowmobile clubs
- Social – dinner in young singles
- Singles club
- Social committee hospital
- CME – sponsor him for gas passer
- 1 yr salary – 5 yr return of services
- Rec. Dept – Kinsman, Lions, Elks, Photo-club, Golf
- Fish & Game
- Find a buddy in the community
- Info Package: Map, Bus. Directory, tourism info, welcome wagon

- Move in help, invite to dinner
- Phone list for food places
- How to get utilities hooked up
- High speed internet
- Build a List!

If You Have Good Family Integration Into Community, You Will Have Good Quality Of Life.

Appendix G: Session 4 – Notes from Ensuring Cross-cultural Success: IMGs

IMGs

- Willing to take them in – housing
- "Point person" contact – ensure a good match
- Introduce them to people of same nationality
- Understanding their culture
- Rural people need understanding of other cultures
- Little simple things, fruit basket, taking time to find about their interests like soccer
- Community support for their interests
- Explaining Canadian weather
- Help in getting drivers license
- Help to learn to drive in storm conditions
- Town plows out Dr.'s home 1st
- Food and food suppliers of familiar food – talk to grocery store
- Know religious food preferences
- Day's off for Sabbath days – Fridays

Video IMGs

- Prejudice
- No built in support network
- Culture shock – don't even know where to get bread
- Transportation – no car or license
- Cultural difference (i.e., Muslim)
- Need to understand their culture
- Understand the history of where they came from
- Willingness to adapt
- Religion differences
- help them connect with others that are of similar culture background in the community
- Ties to country of origin
- Credit set up, bring letters of credit from their country

- Vacations – the IMGs will need to go home sometimes
- Housing
- Credit cards
- Social network
- Kids – schooling issued, time to register, what grade do they belong in
- Activities
- What clothing to buy (recruiter took them to buy clothing)

IMG

- Vehicle – make, model, standard/automatic
- Meeting – have the same cultural residents meet income IMG
- Weather – clothing, how to drive, vehicle plug in
- Insurance re: vehicle be cautious, liability wise. Be sure you're covered if lending car
- Greet in same language if others in community
- Spouse meet other Dr. spouses in a get together
- Share interest with others in community, set up spouses with people in same interest group
- Don't neglect them 3-4 months in the difficult time, keep in contact
- Cell phones, explain plans, driving
- Help with snow shoveling, scrapper in vehicle in winter for window icing up
- Be sure to show seasonal changes
- Taylor each individual ideas and wants
- Introduce them at community events
- Some may not be interest in integration, notice their needs
- Arrival of babies, recognize their culture
- Understand culture when giving gifts, i.e., Chinese don't give clocks – means time it up
- Make them feel important
- Annual gifts – poinsettia, dessert plate at meeting
- Support staff
- Find out issues in hospital
- Have an ongoing ambassador or contact
- Financial letter from Bank for mortgage loans or vehicle purchase

Recruitment Process IMG

- Assessment recruitment – can lose recruits
- Community role for driving test time – no control over timing
- Communication is essential
- Cultural intelligence, perception, protocols
- Bringing of food, good welcome, knowing where to get it
- Transportation – credit issues, financing
- Driver training
- AHC, SIN, plan
- Clothing
- Church
- Finding someone of their culture to connect with
- Research cultural background
- Cultural night – their food
- "Shower" to help get set up
- Lack of housekeeping skills (servant to come by)
- Respect, eye contact
- Awareness of cultural differences is how people relate
- Work expectations/division of labour
- Orientation to scope of practice
- Pharmacology difference, palm pilot: epocrates
- Learn the culture of the IMGs help them be comfortable with Canadianism
- Traffic laws/customs/speeding

Cultural Considerations

- Deal with the obvious
- Introduce some familiarity
- Research personal and cultural needs
- Meet immediate needs on personal level
- Community education
- Community awareness

- Community preparedness enlightenment
- Language barriers
- Separation of extended family
- Education
- Job integration of family
- Source out cultural preferences

Transition Into Community

- Hospitality – Welcome into your home
- Welcome basket
- Access to Automobile, license, insurance, lease to vehicle, weather conditions, speed, KM vs. MP, Pedestrian right of way, signs
- Arriving with no credit – align with the bank
- Understanding the culture and beliefs
- Overwhelmed with the size of our country – distance
- Clothing for all seasons
- Housing – basements, heating systems,
- Grocery shopping – i.e., detergents
- Pre-conversation before arrival – email, phone logs
- Same nationality for relating IMG to IMG – same culture to same culture
- Introducing to the community – BBQ meet & greet

RHA Relations

- The time delay in getting changes to work permits:
 - What can be done with the Federal Gov. immigration
 - Provincial Gov. immigration support
 - Municipal Gov. ??
- Bottleneck:
 - Filling out work permit forms – some health regions help in filling in forms
- Frustration:
 - Practice based assessment for IMG & Dr. doing the assessment
 - 2 weeks to 3 month – could there be a centre set up to do this