ENGAGE THE COMMUNITY,
RETAIN THE PHYSICIAN

4th Annual Rural Alberta Community Physician Attraction and Retention Conference Proceedings

October 26 – 28, 2011
Edmonton, AB

RPAP Community Physician Attraction & Retention

RPAP The Alberta Rural Physician Action Plan

Scotiabank

ALBERTA MEDICAL ASSOCIATION

Northern Alberta Development Council

ACKNOWLEDGEMENTS

The conference organizers would like to thank all of the participants for taking time from their busy work and family life to attend the 4rd annual Rural Alberta Community Physician Attraction and Retention (A&R) Conference. The conference has grown into a "must attend" event and it is all because of you!

We also would like to say thank you to all the community members who brought an array of great items from their communities to use as door prizes throughout the event. This special treat lets us experience a little taste of what rural Alberta has to offer.

Appreciation goes out to the Alberta Health Services (AHS) Physician Resource Planners who assisted with the facilitation of the Community Rural Planning session where challenges and creative solutions were brought forth in zone groups. Their willingness to work with the communities on recruitment efforts in their respective geographical areas of responsibility enhances the success factor in recruitment.

Finally, many thanks to the Northern Alberta Development Council (NADC), The Alberta Rural Physician Action Plan (RPAP), Scotiabank and the Alberta Medical Association (AMA) for the generous funding provided to subsidize additional costs not covered by the collected registration fees.

Back Row: Christine Hammermaster (RPAP), Audrey DeWit (NADC), Kim Pinnock (NADC)
Front Row: Donna Evans (NADC) and Laura Keegan (RPAP)

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INTRODUCTION

The 4th Annual Rural Alberta Community Physician Attraction and Retention Conference, hosted by The Alberta Rural Physician Action Plan (RPAP) and the Northern Alberta Development Council (NADC), was held October 26-28, 2011 at the Sawridge Inn – Edmonton South in Edmonton, Alberta.

There was attendance from over 100 individuals who represented over 50 communities across Alberta. Most of the participating communities have active rural Physician Attraction and Retention (A&R) Committees, which contribute significantly to supporting the successful attraction and retention of physicians to live and work in rural Alberta. There was also attendance from communities who were interested in forming or re-forming a Community Attraction & Retention Committee.

This year's Conference focused on the theme of "Engage the Community, Retain the Physician" and offered a full agenda of speakers. It also provided an opportunity for participants to network, share ideas, and take home new ideas to enhance attraction, recruitment and retention strategies within their own communities.

WEDNESDAY EVENING, OCTOBER 26

Registered conference participants had the opportunity to attend an evening "Welcome Reception" in the Gallery Room at the Sawridge Inn. The theme this year was "Alberta Night" with tasty treats with an Alberta flare!

Approximately 70 participants from various Alberta communities attended the event, enjoying an evening of networking and socializing.



THURSDAY, OCTOBER 27

MODERATORS: Christine Hammermaster

RPAP Community Physician Recruitment Consultant – South

Laura Keegan

RPAP Community Physician Recruitment Consultant- North

Welcome to the Conference

Audrey DeWit

Manager of Programs and Coordination,
Northern Alberta Development Council (NADC)

On behalf of NADC and RPAP, Audrey welcomed the large number of participants from all across the province to take advantage of the opportunity to learn, exchange stories and challenges but also to enjoy the company of old and new acquaintances.

PRESENTATION: Rural Medicine in Alberta – "The Good, The Bad and The Ugly"

Speaker: Dr. Jill Konkin, University of Alberta, Associate Dean of Community Engagement

Dr. Jill Konkin has a passion for Family Medicine and continues to inspire her students and her colleagues. She is a University of Alberta medical graduate, an academic and a rural family doctor. In 2003, she was invited to join the faculty at a new medical school, Northern Ontario School of Medicine where she was the Dean of Admissions and Student Affairs. From 2005-2010, she was the Associate Dean of Rural and Regional Health within the University of Alberta.

Jill spent sixteen years as a family doctor in Jasper and still participates in the rural locum program. She has been involved in provincial and federal organizations including the Society of Rural Physicians of Canada (SRPC) and the Admissions of Rural and Remote Students into Medical Schools Task Force and the College of Physicians and Surgeons of Alberta (CPSA).

Presentation Highlights:

Dr. Konkin's keenly intuitive statement: "**when you have seen one rural community, you've seen one rural community**," resonated with participants. Each community is unique and one model will not fit all.

Key insights into the state of rural health were shared including, Statistics Canada data related to the growing urban populations and the stay/decline in rural areas. Rural communities tend to have very young or old population extremes, and relatively little in between. Occupations are physical, but that doesn't mean we are fit and healthy as compared to our urban counterparts who participate in many physical "recreational activities." Life expectancy is approximately two years less in rural areas and even less for Aboriginal populations.

Dr. Konkin also shared information from the Romanow Report (2002), a significant health policy document that was the first to define and use "rural" as a determinant of health. Over the past several years, the definition of "rural" has been altered slightly with each change to prescribed

zones/regions. According to Dr. Konkin, rural areas have lost more than they gained during these political transitions.

Rural hospitals, although often referred to as "inefficient, ineffective and costly," are often mis-represented, and because of this have sometimes resulted in their closure. The subsequent social effects on communities are not often considered or studied.

She reminded participants that rural areas are in need of health professionals in all disciplines (physicians, nurses, and support staff) to meet the needs of the overall population. She highlighted the need to inspire our grads to come back. Canadian born or Canadian students that train abroad, are considered International Medical Graduates and must go through the same process as anyone else who is applying to work back in Canada before they can practice in Canada. Everyone needs to do a better job of letting both communities and students know about the challenges of training abroad. There is also a trend that shows that physicians stay within 100 km of where they completed medical school and/or where they completed residency.

The U of A is working hard to encourage students to practice in rural areas by providing exposure through programs like the Rural Integrated Community Clerkship Program (Rural ICC). Currently twenty 3rd year medical students are participating in the program which allows for students to train for nine months in a rural community. The U of A would like to see this number increased to thirty. Before communities can be considered as a possible ICC location, there must be a hospital offering surgery and obstetrics in order for students to gain the skills. There must also be a physician willing to be the preceptor (teaching physician) and mentor to the students

In her concluding remarks, Dr. Konkin challenged participants to look at our communities with respect to "What services are adequate?" and "What services do ALL persons need?" as urban solutions don't always fit for rural communities.

The following additional points were in response to questions from participants:

- Nurse Practitioners have not solved the problems in the US. They are a key part of the Primary Care Network (PCN) and the team approach to health care that Alberta is wanting to have moving forward.
- RPAP has an excellent cultural integration "road show" that can help with integration of new IMG's into communities.
- Compensation and training for preceptors and mentors for medical students and residents needs to be reviewed.

Appendix C: 1. Jill Konkin – "The Good, The Bad and The Ugly" Presentation

PRESENTATION: AHS: Update on Community Rural Planning Framework

"Strengthening Rural Communities……*Together*"

Speaker: Stacy Greening,

Director of Community and Rural Planning, Alberta Health Services

Stacy has an MSc in Public Health and a background in planning, research and evaluation work. Prior to her current role, she was the Decision Support and Evaluation Lead for the Urgent Care Portfolio with AHS. In her current role, Stacy leads a team that assesses the needs of local communities across the province and works with operational leaders to address those needs.

Presentation Highlights: In Sept 2010, the Community and Rural Health Planning Framework process was initiated and will continue over the next two years. Stacy updated participants as to what has happened with Community Consultations over the past year.

What is the Community and Rural Planning Framework?

- The Community and Rural Planning Framework is a planning approach that integrates both historical planning activities and current planning approaches. The Framework builds on the unique strengths inherent in each rural community.

What is a community?

- Communities are geographically defined areas that roll up into an Alberta Health Service's operational zone. There are one or more towns or cities in each of the geographic communities. There are 130 geographic communities across the province and five zones.

How are communities involved in the process?

- Communities are provided with population based health data and site utilization data. This data is presented by health leaders responsible for services in that community.
- Communities are invited to provide feedback on the data and speak to the health needs of their particular geographic community.
- Community members (those who use health services), elected officials, health staff, and physicians are all invited to participate in the process.

What are the benefits of this planning process?

- This planning process is led by operational leaders who are familiar with the community and the current services that are offered.
- Engaging community members helps to ensure that health services best meet the health needs of the local community.

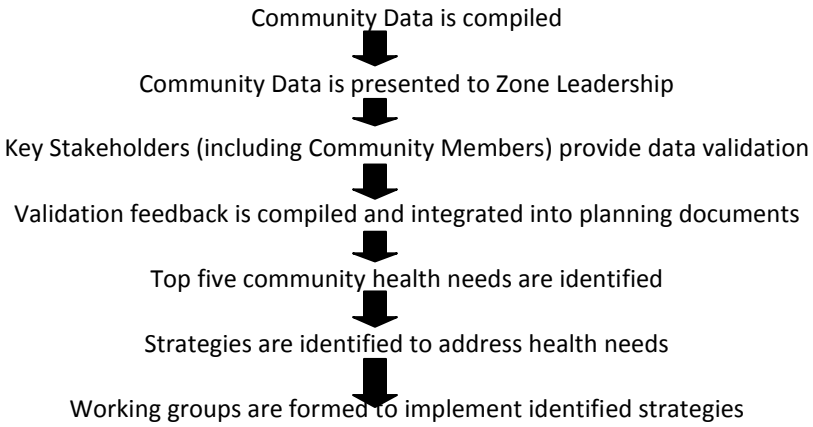
How did we do?

- We engaged approximately 600 Albertans in this last year from 22 communities across the province
- Evaluation results from community members, staff, physicians, elected officials, and local health leaders indicate that they appreciate the process and the opportunity to be involved
- We appreciate the feedback and know we have areas where we can do even better. We are working on these.

What's next?

- We are finalizing the development of 3 year plans for each of the Phase I communities. These plans will be approved by operations and the strategies contained within will be implemented.
- We will start a new round of communities in early 2012

Community and Rural Health Planning Process



For more information: http://www.albertahealthservices.ca/community&ruralplanning.asp
Stacy Greening Stacy.Greening@albertahealthservices.ca

PRESENTATION: "Working Collaboratively"

Facilitators: Laura Keegan (RPAP), Christine Hammermaster (RPAP), Audrey DeWit (NADC), Kim Pinnock (NADC), Stacy Greening (AHS), AHS Zone Recruiters – Andrea Taylor (Rural Calgary) Trudi Jersak (South), Pamela Kathol (Central), Kim Fleming (North), Susan Smith (North)

Health is more than just the treatment of illness through hospitals, doctors and nurses. After Stacy's presentation, participants broke into discussion groups. Participants shared ideas as to what a healthy Rural Alberta should look like and what is working well or has worked well regarding attraction, recruitment and retention. As the Community Consultation process moves forward, it is also important to ensure that there is appropriate representation at the community consultations – so, participants were also asked "who should be included and how to engage community".

Discussion groups were based on relative AHS zones to combine recruiters and communities within that group. It is to be noted that the trends and themes that emerged were common amongst all groupings. Summary of discussion responses:

#1. What would a Healthy Alberta look like?

- 24 Hour Access to primary care
- More doctors = increased access
- More preventative mental health (specialists)
- Circle of care
- Greyhound bus schedules that help residents get to appointments
- More advanced life support providers
- More senior services to free up beds
- More OB/GYN as there has been a loss of OBS services and increased travel to deliver
- College of Physicians and Surgeons of Alberta and Alberta Health Services rules
- Increased quality of care in rural Alberta
- Better Transportation options (for all socioeconomic and abilities)
- Coordination (One Stop Shop)
- Shorter wait times
- Better health education
- Better planning (with community involvement prior to decision making)
- Positive collaboration between services and providers (PCN's)
- Increased use of Telehealth (patient care and education)
- Improved processes result in less need for acute care
- Increased support for site manager authority (local knowledge of the situation is key)
- Better knowledge of what is available (community awareness)
- Harm reduction and healthy lifestyles
- Proactive approach
- Diversity of housing (have good housing and care from birth to death)
- Engaging the town and municipality

#2. What is Working Well?

- Community partnerships and initiatives
- Individual commitment to health
- Primary Care Networks
- Willingness to try new things to make it work, enhancing creativity
- Networking
- Telehealth (pediatrics and psychiatry) : closes the gap
- Proximity to Calgary (mountains, recreation and culture)
- Community of docs and how they relate to each other
- Learning opportunities ongoing
- Doctors recruiting doctors
- Attraction and Retention committees (meet with potential doc and family, sell the community)
- Increased level of community understanding
- Communities taking leadership and engagement
- Educational opportunities for high school students
- Intercommunity connections (conference and invites to meetings)
- Being proactive
- Building partnerships
- Cultural integration workshops
- New technologies in rural areas such as CT scanners
- Endoscopy pilot project: successful decrease in wait times
- AHS involvement in clinic operation
- Hospital auxiliary fund raising to get equipment in communities that might not have access otherwise
- RPAP, Community HAC, AHS working collaboratively

#3. Engagement of Communities:

- Awareness
- Open House: public and FCSS
- Survey
- RPAP toolkits for A&R
- Higher levels involvement such as MLA and Ministers and improved communication to community level
- Validate the community stories/data
- Delegate authority to local level
- Act on community/committee engagement meeting and follow through on action items
- Factor in shadow population (non-permanent residents)
- Speak to each community in their own media
- Talk to communities where AHS should advertise
- “Listen and React”
- Each rural community is unique
- AHS liaison for each community
- Service Clubs
- AHS going to communities (face to face)
- Interagency meetings
- Economic development

PRESENTATION: Working with the Media

Speaker: Rhonda Crooks, Consultant, Starting Points Inc.

Rhonda is an award-winning communicator with formal training in public relations, business administration and education. She has a background of experience which includes teaching, television and radio journalism, government communications, small business, consumer advocacy and public consultation. Rhonda served as Director of Communications for Saskatchewan Health in the late 80's and held the same position in Alberta Health in the early 90's. She then launched her own consulting firm, Starting Points Inc., where she designs and manages communication plans to support their business plans. From 1999-2011, Rhonda has also provided communication consultant services to RPAP.

RPAP's Rhonda Crooks shared tips and information on how communities can do to enhance their relationship with local media. Highlights include:

- Media considers timing, significance, personal and human interest events newsworthy. Communities should consider these criteria when determining whether media should be notified about their activities.
- Media is a business. Communities can't dictate what the media will cover, unless you pay them.
- The media often see themselves as purveyors of truth, so they want to get the facts right. Help them to this by being prepared when it comes time for an interview.
- Be aware of what is going on in the community, and give your local media some lead time to get prepared to share the story.
- There are a lot of "newbie" reporters in rural Alberta, many looking to get experience. They bring to the field a mixture of eager enthusiasm and sometimes inexperience. Crooks shared a personal story of working with what she termed a 'cub' reporter who changed the tense of a word in the final published version of a story. That minor error caused broken relationships between the individual who had provided the information and the organization they were representing. Communities were urged to be cautious, as once information is printed, even if a re-print occurs, the mistake can be difficult if not impossible to reverse.
- Practical tips were shared on how to prepare a media release each committee/community was encouraged to have a pre-determined media spokesperson who can speak with one voice for the group.

Rhonda concluded by saying that "when the phone rings, ask questions and remember to keep your answers brief and to the point!"

Presentation: Physician Retention

Speakers: Christine Hammermaster & Laura Keegan
RPAP Community Physician Recruitment Consultants

There are many challenges to practicing rural medicine and many factors that influence physician retention. Recruitment and retention research shows:

- The first 1-3 years are critical for retention
- Cultural fit and family are driving forces for turnover
- Part-time and flexible work options are growing in practice & importance
- Spousal happiness in a community

Through watching of some entertaining video clips of the famous Corner Gas TV series, related to hiring a new physician for the town, participants were able to reflect on the perceptions and assumptions we form. It is often those perceptions and assumptions that can affect physician and family retention.

RECRUITMENT influences RETENTION!
RETENTION influences RECRUITMENT!

Retention is better understood when categorized into three realms – professional, personal & spousal and community.

Professional Retention – these factors will influence the work/life balance for physicians which will also influence spousal and family happiness.

- The clinic / business model for practice – is it a turnkey operation, an opportunity for partnership or ownership, a solo or group practice?
- Efficient clinic management for supporting physicians with their patient scheduling, billings and overhead operations – generally, clinics that have a personable and efficient clinic manager have better retention of physicians
- Ability for physicians to have input in determining their hours of work as related to clinic hours, on call and emergency shifts
- Opportunities for continuing medical education (CME) for physicians also increases physician retention. According to Alberta research –Study conducted by Dr. Ron Gorsche, RPAP Skills Broker – "A rural physician who participates in individually focused additional skills training has a 30% greater retention rate and could be as high as 61% compared to those who do not acquire or maintain their skills. – In the untrained matched control subjects, 71% of those that left practice did so in the first 5 years. All the enrichment participants were still in practice and using their skills at 5 years."

Personal and Spousal Retention – it is a well-researched fact that there are factors that will influence the physician's choice to stay in a community.

- Flexibility for physician work hours can allow for better work/life balance that will support a happier family relationship

- Employment support for a spouse / significant other – the ability to have a second income earner in a family or just having the ability to have a job or career can affect relationships – know where you can access career and employment centers in your community
- Support for language barriers – often a spouse will not be as affluent in English as the physician and may be fearful of socializing for fear of being embarrassed and may isolate from others, which can cause stress and unhappiness in a relationship
- Ability to meet and fulfill personal interests such as sports, hobbies, theatre, recreation

Community Retention – communities are often present to help with settling and welcome activities, but forget to check-in when "reality / culture shock" set in after 3- 6 months of being in a community. A Community Physician Attraction & Retention (A&R) Committee can:

- Create a support system for follow through with new physicians and families
- Support AHS site visits to showcase the community amenities and lifestyles as well as the medical practice
- Host physician appreciation and recognition events
- Ensure there is cultural integration between the "Alberta" culture with "International" culture, both for new physician and community residents

Some RPAP supports for retention:

- Continuing Medical Education (CME) opportunities for rural physicians – Enrichment Training, Skills Enhancement, General Medical Emergency Skills (GEMS)
- Cultural Integration Workshop
- Support to new and existing Attraction & Retention (A&R) committees
- Welcome calls to new rural Alberta physicians within 3-6 months upon starting work
- Resources for specific community needs – teamwork and consensus building, asset building, setting goals for action, development of work plans
- Promotion of Doctor's Appreciation Day – March 30, a day that is currently being observed in some Canadian provinces and is noted as a National Day in some countries
- Availability of "Building on Shared Experiences" TOOLKITS for committee use – Forming a Committee, Site Visits, Promoting Your Committee, Physician Retention

Participants were given a copy of the new "Building upon Shared Experiences" TOOLKIT that reviews the above information and gives some ideas and tips for physician retention.

Appendix C: 2. RPAP Physician Retention Presentation

Scotiabank Presentation

Victoria Burgess, from Edmonton, and her counterparts from Calgary, did a brief overview of the services Scotiabank can offer to newcomers and particularly to International Medical Graduates. There is a dedicated website for newcomers in 8 languages: www.startright.scotiabank.com to assist with settlement. For any communities wishing to talk about support for physicians within their community, contact Victoria Burgess, Manager of Professional & Business Banking in Edmonton. She will facilitate the connection between your community and the closest Scotiabank representative.
victoria.burgess@scotiabank.com Telephone 780-448-7631 or 1-800-267-1234

Appendix C: 3. Scotiabank StartRight Presentation

Thursday evening – Dinner and Cultural Entertainment

A cultural dinner, including butter chicken and Irish stew, was enjoyed by all. The entertainment, sponsored by Scotiabank, followed the same theme with African drumming and Irish dancing and singing provided by WAJJO. A message from the entertainers to community – "We are trying to promote harmony and build the bridge between cultures through music."

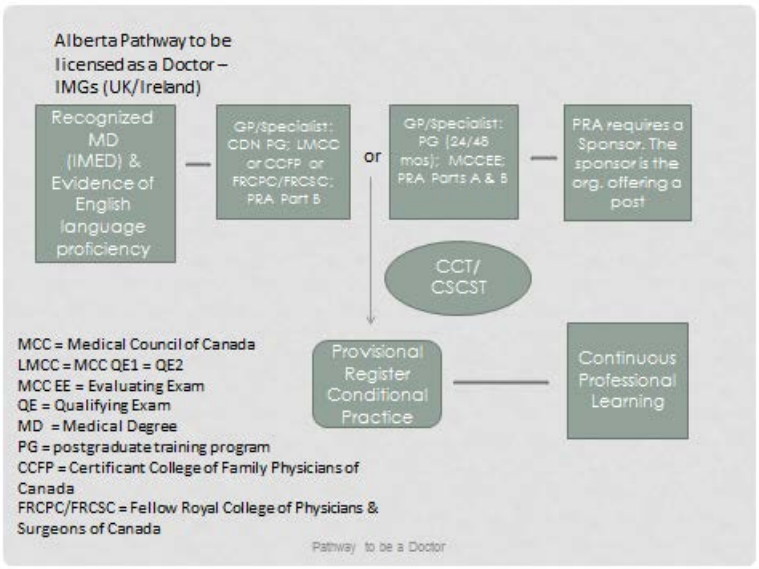
FRIDAY, OCTOBER 28

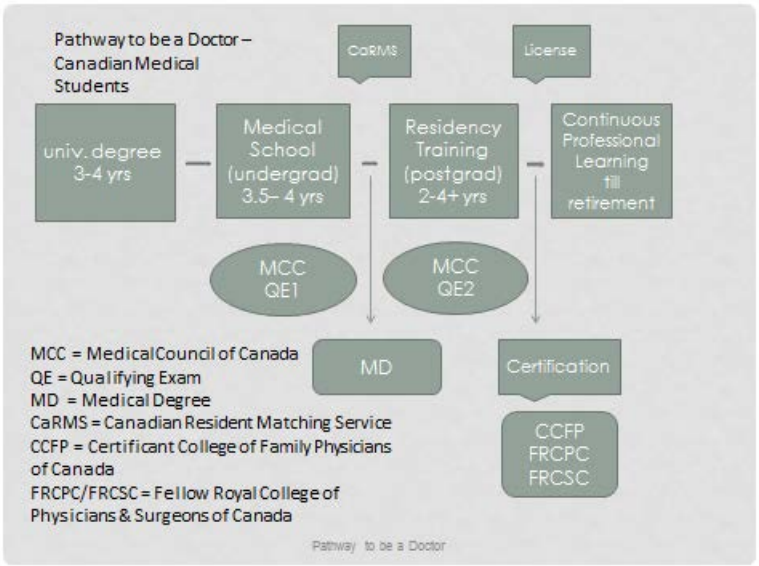

MODERATORS: Audrey DeWit & Kim Pinnock

Northern Alberta Development Council (NADC)

Welcoming Presentation: David Kay, Executive Director, RPAP

David recapped the learning's for the previous day and clarified some of the questions about the pathway to becoming a doctor.





Appendix C: 4. David Kay: Welcome Presentation

PRESENTATION: Welcoming & Inclusive Communities

Speakers: Sergio Gaggero, Alberta Human Services, Business & Industry Liaison Specialist
Todd Odgers, Norquest College, Centre for Excellence in Intercultural Education

SERGIO GAGGERO: "Welcoming and Inclusive Communities"

Sergio-- has worked in various sectors of the Government of Alberta as a Social Worker, Employment Counsellor and currently as Business and Industry Liaison Specialist in the Edmonton West community (this title should be last as it is current role), and an Economic Immigration Specialist. His diverse experience includes providing support and resources for newcomers and underrepresented groups in the workforce. He also works with employers and business associations to address their need for skilled labour while exploring a more inclusive and diverse workforce. He is a strong advocate in promoting the "Welcoming Communities" initiatives in rural Alberta.

Presentation Highlights:

Sergio presented a statistical overview of rural Canada which highlighted why immigration is important to rural communities in terms of economic development and how communities can best welcome and help these newcomers integrate into their community.

Rural Canada is largely resource-based. Communities are facing populations declines related to aging, youth outmigration and falling birthrates. Rural communities are looking at newcomers and immigrants as a means to stimulate economic development and social institutions as well as minimize population loss.

Participants were encouraged to look at all individuals who are new to the community as "newcomers," and take steps to individually break down stereotypes and barriers for the betterment of their rural communities. Small acts, both positive and negative can have larger impacts, so take the time to go the extra step in welcoming and retaining someone in your community.

Participants were introduced to the key components of a toolkit, "Attracting and Retaining Immigrants – A Toolbox of Ideas for Smaller Centres", prepared by the National Working Group on Small Centre Strategies and funded by The Government of Canada (Citizenship and Immigration Canada), 2007. It is designed to help small centres who wish to attract, welcome and retain newcomers. The toolkit provides worksheets and practical steps for implementation.
(Visit http://integration-net.ca/english/ini/wci-idca/tbo/index.htm to download or request a print copy of the toolkit)

"Welcoming communities are the reflection of the community itself and the commitment of its members to become one." – Sergio

TODD ODGERS: "From Noticing to Success"

Todd is the Director for the Centre for Excellence in Intercultural Education Division at NorQuest College. The Centre's activities support the successful integration of new Canadians into the workplace and the community.

Todd has designed customized training and facilitated a wide range of Intercultural Communication across Canada and abroad. He spent 10 years in Japan teaching and training to develop intercultural competence in colleges, universities, and with the management and staff of many of the country's best known corporations.

Presentation Highlights:

In a very powerful and energetic presentation to a captive audience, Todd engaged participants in learning.

Participants were asked to look at this picture and form their own opinions about what they saw and thought. There were many different suggestions given. He then shared the real meaning- " a Japanese tradition where when you complete a special goal, you can paint the second eye"

DESCRIPTION	INTERPRETATION	EVALUATION
What I See (only observed facts)	What I Think (about what I see)	How I Judge (what I see and think...positive or negative)

He summarized this section with the D.I.E. concept.

Todd also spoke about how the "Something's Up" model can be used as a guide for communities to evaluate their perspectives as related to cultural competence and how do they "bridge" the "cultural distance" that influences the building of a "Welcoming and Inclusive" community.

He spoke of an "Intercultural Mindset" related to the acceptance and adaptation of cultural differences" versus a "Monocultural Mindset" related to the denial and / or minimization of cultural differences.

PRESENTATION: My Life and Medical Practice in Rural Alberta

Speaker: Dr. Regan Steed

Dr. Regan Steed was born and raised in Raymond, AB. Prior to medical school, he completed a Masters Degree in Health Administration from Nova Scotia. He attended medical school at the University of Calgary. He participated in the Rural Alberta South (RAS) residency program. Upon final graduation in July 2011, he has returned to his rural home town of Raymond to practice medicine with his father.

In a very entertaining and delightful presentation, Dr. Steed captured the audience's attention as he shared his journey into medicine with some interesting facts along the way.

Presentation Highlights:

When did I know that medicine was for me?

One cannot apply to medical school directly from high school. Throughout his undergrad studies, he had a passion for medicine and was encouraged by his family and friends to apply to medical school to follow his dream. It took three times of applying before finally being accepted into the University of Calgary, Faculty of Medicine.

How did I prepare for medical school?

Regan spoke about completing the Medical College Admission Test (MCAT), volunteer and employment experiences that are all required for the application process.

Why did I take medical school in Alberta?

"I was accepted into the University of Calgary. Alberta is home. I was married and had a family and support system. It just made sense."

While in medical school, why did I choose Rural Medicine?

"My dad is a doctor in Raymond and I have watched how happy he is in his practice. I also had some good preceptors in my rural rotations that encouraged me to follow my passion." He also spoke about how "rural was presented as being cool" and RPAP's bursary support helped.

What do future doctors want when they graduate?

Key factors included career happiness and a good "fit" for balance of work and family. He also indicated that ideally, a new graduate also looks for support in the medical community and opportunities to practice their speciality. It is to be noted that Family Medicine is also recognized as a speciality of its own.

What advice would you give to help recruit persons to become a doctor?

From a high school and undergraduate perspective, Regan suggested letting students know that becoming a doctor is always an option to consider and to ensure they have information to

make informed decisions in their career journey. Medical students need to have experience in clinics to see how rewarding a rural practice can be. Don't forget about supporting the physician's spouse / partner /family, if they are considering a rural community. "It is all about the fit!" "It is all about the people".

Speaker: Dr. Johnson Fatokun

Dr. Olomide Johnson Fatokun, or better known in his community as "Dr. Johnson", shared his story of coming to Canada as an International Medical Graduate.

Dr. Fatokun had a very positive experience, arriving in the pumpkin capital of Canada – Smoky Lake, Alberta! He came to Alberta from Africa where he was working in the small desperate country of Lesotho with the US Peace Corps. After nine years of travel and constantly being away from his family, he looked into coming to Alberta. He was being actively recruited by both Calgary and Smoky Lake, but his heart was set on a small community.

He spoke of the importance of "communities raising children", and he wanted his daughter to have this experience, stating it is "the African way". It also helped that Smoky Lake was willing to wait until after the World Cup for the arrival of their newest soccer fan and doctor! In his words, "the community of Smoky Lake is big enough to accommodate us and small enough to be called home."

He spoke of how the younger generation will grow and become the ones to care for us in the future and the need to support a healthy and engaging youthful community. In under a year, he has become very involved not only in his medical practice but within the community. He has been an advocate for a new playground, continues to look at ways for rejuvenating the youth centre and swimming pool and is trying to attract an optometrist – all ways of promoting preventive and wellness health within the community without having to drive to the city. One participant stated: "The community not only hired a community doctor, they hired a community ambassador."

Appendix C: 5. Dr. Johnson on Smoky Lake Medical Clinic Before, Now and the Future

Appendix A: Agenda

4TH ANNUAL
RURAL ALBERTA COMMUNITY PHYSICIAN
ATTRACTION & RETENTION CONFERENCE

Conference Schedule

Subject to change

October 26th: Wednesday (evening)

7:00 PM	Pre-Registration and Reception (Alberta Night)

October 27th: Thursday

7:30 AM	Registration and Breakfast
8:15	**Welcoming Remarks** Audrey DeWit, Manager of Programs & Coordination, NADC
8:30	**Rural Medicine in Alberta** Dr. Jill Konkin, Faculty of Medicine & Dentistry, University of Alberta
10:30	**Update on Community Rural Planning Framework** Stacy Greening, Director Community and Rural Planning, Alberta Health Services
11:00	**Working Collaboratively** Facilitated Discussion led by RPAP and NADC
12:00 PM	Lunch
1:00	**Working with the Media** Rhonda Crooks, RPAP Communications Consultant
2:30	**Physician Retention** Christine Hammermaster & Laura Keegan, Community Physician Recruitment Consultants
4:00	**Scotiabank Presentation** Victoria Burgess, Seun Ogunsola, Vicki Underschultz
6:00	Dinner & Cultural Entertainment Wajjo drummers and Irish Dance Troupe

October 28th: Friday

7:30 AM	Breakfast
8:15	**Welcoming Remarks** David Kay, Executive Director, RPAP
8:30	**Welcoming and Inclusive Communities** Todd Odgers, Director, Centre for Excellence in Intercultural Education, NorQuest College and Sergio Gaggero, Business Industry Liaison Specialist, Alberta Human Services
12:00 PM	Lunch
1:00	**My Life and Practice in Rural Alberta** International Medical Graduate, Dr. Johnson Fatokun (Smoky Lake) and Alberta Graduate, Dr. Regan Steed (Raymond)
2:00	**Closing Remarks**

Appendix B: 2011 Conference Evaluation Summary

At the end of the conference, participants were asked to complete an evaluation form. Evaluation results are summarized below.

Demographics

As displayed by charts 1-5 below, conference community representation was diverse, both in origin and in type. The majority of participants heard about the conference through email.

Chart 1

Chart 4

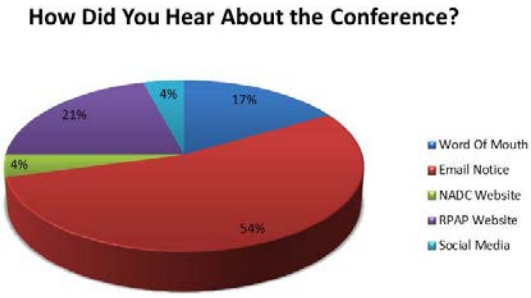


Chart 2

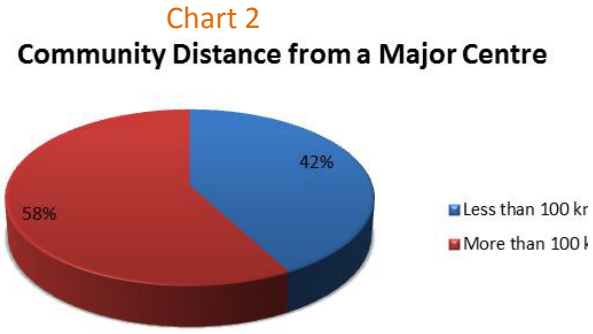
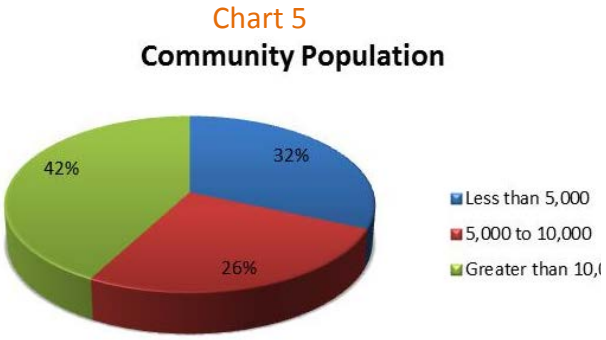


Chart 5



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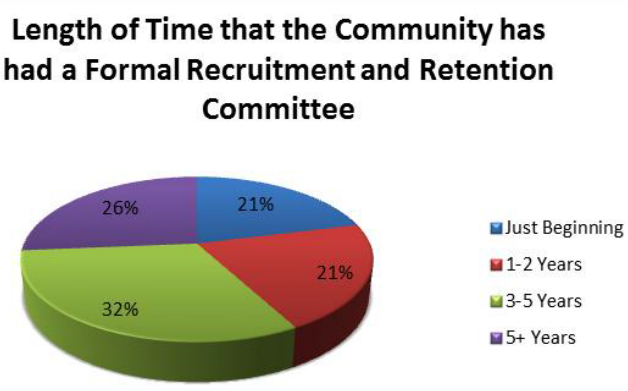


Satisfaction

- Ninety-five percent of survey respondents rated the Banquet and Cultural Entertainment as a 4 or 5 out of 5. The mode rating was a 5.

- Eighty-seven percent of survey respondents indicated that the conference met their main objectives (a rating of 4 or 5 out of 5). These objectives included, Recruitment Support, Retention Support, to Form a Committee, and Networking/Information.

- Eighty-two percent of survey respondents rated the conference sessions/presenters as a 4 or 5 out of 5. The top three sessions/presenters received high marks were for engaging the audience, using real life examples and providing interesting/relevant information.

- Ninety-one percent of survey respondents rated the conference location, format and information/material as a 4 or 5 out of 5.

- And ninety-five percent of survey respondents answered yes to the question: *Did the conference meet your overall expectations?*

Suggestions for Future Conferences

- Continue to host the conference in the fall.

- Continue to use the two day format.

- Select a venue with better food, accommodations and conference rooms.

Appendix C: Presentations

1. Jill Konkin – "The Good, The Bad and The Ugly" Presentation

The Good, The Bad and The Ugly

Just the facts ma'am!

Objectives

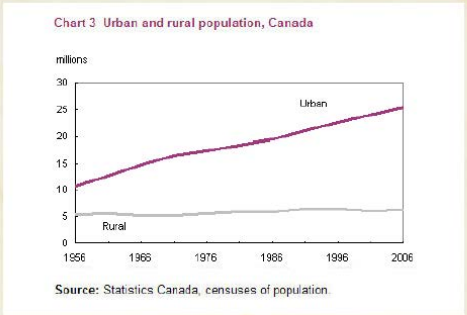
- Rural Canada & Alberta – setting the stage
- Rural health status
- Rural health service delivery
- Faculty of Medicine & Dentistry rural medical education programs

Canada

- 99.8% of Canada's 10 million sq km is rural
- ~ 37% live in rural/regional areas
  - 15.9% in larger rural and regional centres (10,000 to 100,000) served by 11.9% of physicians
  - 22.1% in towns <10,000 served by 9.4% of physicians
- 3% of specialists are rural

Rural Populations

- Range from 15% in BC and Ontario to 68% in Nunavut
- Not homogeneous
- If you see one rural community, you've seen one rural community



What is rural?

- Statistics Canada – rural includes people who live outside of communities of 1,000 people AND areas with 400 persons per square km

What is rural?

- Statistics Canada – further definitions
  - CMA – census metropolitan areas (CMAs) & CA – census agglomerations (populations of 10,000 and greater)
  - MIZ – Metropolitan Influenced Zone (based on population density and community size & commuting flow to CMA/CA)
    * Strong MIZ – 30 to <50% of workforce commute
    * Moderate MIZ – 5 to <30 %
    * Weak MIZ - >0%
    * No MIZ – no commuters

Aboriginal Communities –

Aboriginal people are 3.8% of population (2nd highest in the world)

Health Canada's 4-Level classification for remoteness:

- Type I—remote isolated (no scheduled flights or road access & minimal phone or radio service
- Type II—isolated—scheduled flights, good phone services, no road access
  Remote isolated & isolated = 22%
- Type III—semi-isolated—road access, physician services at >90 km = 14%
- Type IV—non-isolated—road access, physician access <90km = 64%

Northern Alberta Population

- 31% in Fort McMurray, Grande Prairie and Cold Lake
- 32% in smaller urban centres
- 37% in rural areas
- Over 50% of Alberta's Aboriginal Population

Northern Alberta Economic Contribution to Alberta & Canada (2006)

- 29% of Alberta Exports
- 26% Investment in Alberta
- $73 billion from 2006-2010

Information from the Northern Alberta Development Corporation

Health Status of Rural Canadians

- Most Canadian studies done on urban populations
- First pan-Canadian study of rural health status in 2006 by Canadian Institute for Health Information (CIHI)

Studies prior to 2006 CIHI study

- Different definitions of rural
- Not national in scope
- More focused on accessibility
- Less attention to other determinants of health

Characteristics of Rural Populations

- Fewer with secondary education
- Higher unemployment rates
- Lower income
- High dependency ration—i.e. significant populations of youth (0-19) and seniors (>60)
- Higher rates of smoking and obesity
- Lower rates of leisure time physical activity & other healthy behaviours

Mortality in Rural Communities

- Lower life expectancy (2 years less than AB average in North Zone)
- Increased infant mortality
- Increased all-cause mortality

Reported in the Romanow Report 2002, confirmed in CIHI Report 2006 and in 2011 AHS report

Life Expectancy, Alberta, 1999 to 2010

Year	First Nations	Non-First Nations
1999	70.95	79.55
2000	70.23	79.87
2001	69.15	80.06
2002	69.54	80.08
2003	70.20	80.25
2004	70.49	80.56
2005	69.22	80.52
2006	69.77	80.81
2007	69.24	81.00
2008	67.94	81.04
2009	69.31	81.49
2010	70.45	82.00

Infant mortality (per 1,000 live births), Alberta, 2002-2010

Year	First Nations	Non-First Nations
2002	10.84	7.04
2003	10.75	6.39
2004	9.38	5.49
2005	8.18	6.53
2006	11.72	5.16
2007	11.87	5.65
2008	13.14	5.69
2009	10.96	5.08
2010	13.26	5.40

The infant mortality rate for First Nations in 2010 is roughly the same as what the rate was for AB in 1975.

Rural Canadian Mortality Risks

Increased incidence in rural communities of:

- Circulatory disease (except Strong MIZ)
- Injuries & poisonings
- Suicide (males)
- Respiratory disease

Building on Values: The Future of Health Care in Canada

…there is an "inverse care law" in operation. People in rural communities have poorer health status and greater needs for primary health care, yet they are not as well served and have more difficulty accessing health care services than people in urban centres.

- Roy Romanow

Building on Values: The Future of Health Care in Canada

- Romanow Report 2002
- Made a "case for change" in health care delivery in rural & remote communities
- First to identify rural as a determinant of health

Romanow 2002 – issues identified

- Lack of consensus on what "adequate" access should include
- Need for effective linkages with larger centres
- Challenges of serving the smallest & most remote communities
- Focus on symptoms rather than causes
- Predominance of urban approaches applied to rural communities
- Lack of research

Principles to guide rural health initiatives

- Equity in access to health care & in health outcomes
- One size does NOT fit all
- Focus on outcomes
- Evidence-informed policies, strategies and programs
- Strategies developed for urban centres may or may not be appropriate for rural communities

Principles

- Involve community members, FPT governments, health authorities, health care providers & other stakeholders in finding solutions and taking action
- Develop a national strategy

Romanow Rural Recommendations

- Establish a national Rural & Remote Access Fund (RRAF) & use for recruitment & retention of health care providers
- Innovation in education & training programs for health care providers
- Expand telehealth approaches

Romanow Recommendations…

- Support innovative ways of delivering health care services to smaller communities and to improve the health of people in those communities

Alberta Health Care Restructuring

17 Regions -- 1994

9 Regions -- 2003

1 Region (5 Zones) -- 2008

Regionalization & Back

- Edmonton & Calgary continue throughout
- Rural Alberta health care administration changes each time
- Networks, trade patterns disrupted
- Community program gains and losses

"closing the small rural hospital is like signing a death certificate for that community"

(Curren 1993)

Closing Rural Hospitals

- Does not save money
- Has unrealized health costs
- Has unrealized social costs

James A (1999)

Closing rural hospitals: Place, Health & Social Processes

- Loss of local jobs
- Potential decline in the economy/in viability
- Elderly and children most affected
- Transportation problems
- Outmigration of local residents
- Change in sense of place & belonging
- Possible decrease in quality of life in community James A (1999)

Hospital Closures

- Realities of rural hospital closures in many provinces included:
  - unelected health boards
  - top down decision making
  - disenfranchisement of local communities
  - fails to account for the meaning ascribed to hospitals (security, identity, economic vitality)

Community based care

- Lag between increasing community care & closing hospitals
- Who are the volunteers?
- Increased social, physical and financial costs to rural women
- The challenge of home care in the country

Health Care Restructuring

- Significant consequences for rural health and rural health service delivery

Current Alberta Situation

- Approx 50% of rural physicians are International Medical Graduates
  - 30% overall for AB
  - 80% from developing world (2000-09)
- Rural Alberta needs 500 physicians (Alberta Medical Association 2010)

Not just physician shortages…

Occupation	Estimated Current Shortage	Anticipated Shortage by 2016	Current Shortage as a Percentage of Future Shortage
Nurses	1,400	6,200	23%
Pharmacists	400	1,000	40%
Speech Language Pathologists	30	100	30%
Medical Technologists	236	600	39%
Health Care Aides	2,000	5,000	40%
Physical Therapists	260	1,100	24%
Physicians	1,100	1,800	61%

Note: Data generated without information on private providers with the exception of private pharmacists and physical therapists.
Source: Government of Alberta 2006

Rural Medical Education

- Medical schools – UAlberta & UCalgary
- Expansion of programs in past 15 years
- Significant financial support from RPAP and Government of Alberta

Rural communities and the Faculty of Medicine & Dentistry

- Associate Dean, Rural & Regional Health, 2005
- Division of Community Engagement, 2011
  - Associate Dean, Community Engagement
  - Director, Rural & Regional Health

Education programs

- Undergraduate
- Postgraduate
- Continuous Professional Development

Undergraduate Medical Education

- Preclinical
  - Preclinical Networked Medical Education Pilot (PNME)
  - Shadowing, electives
- Clinical
  - Rural Integrated Community Clerkship
  - Mandatory 1 month rural family medicine rotation
  - Electives

Postgraduate (residents)

- Family Medicine
  - Rural Alberta North – 6+ months rural
  - Combined urban program – min 2 months
  - Electives
- Royal College Specialties


Community Engagement
Partnering with communities
All areas of scholarship – education, service, research


QUESTIONS???
Dr. Jill Konkin
Associate Dean, Community Engagement
jill.konkin@ualberta.ca
Dallas Dyson
Community Liaison Coordinator
dyson@ualberta.ca

Appendix C: Presentations

2. RPAP Physician Retention Presentation

Physician Retention
2011 Community Rural Conference

Presentation by:
RPAP Community Physician Recruitment Consultants
Laura Keegan – North
Christine Hammermaster – South

Today's Session

Physician Retention

- Facts & Challenges
- Perceptions
- 3 Realms of Retention
- RPAP Support for Retention

Challenges to Rural Medicine …

- Physicians tell us that practicing rural medicine can be REWARDING and/or CHALLENGING
- Many factors influence the CHOICE to stay or to leave.
- What we CAN / CANNOT Control

Some facts …

What are the 6 top factors that influence choice of first practice site?

- Significant other's wishes
- Friendliness of medical community
- Recreation and culture
- Proximity to family and friends
- Significant other's employment
- Schools for children

Some facts …

Why do physicians leave a practice?

- Career advancement
- Retirement
- Children go to university
- Spouse is unhappy

Some facts …

What does RECRUITMENT & RETENTION research show?

- First 1–3 years are critical for retention
- Cultural fit & family are driving forces on turnover
- Part-time & flexible work options are growing in practice & importance
- Spousal happiness in a community

So what we know is …

Recruitment Influences **Retention**

Retention Influences **Recruitment**

Retention Reality …

- What do we know?
- What do we believe to be?
- What do others know?
- What do others believe?

Take a look …

Discuss at your table …

- **Perceptions**: How can the perceptions of your community lead to a physician not feeling welcome- Prior to move…After move… and choosing to leave…
- **Moments of Truth**: What makes a physician and their family stay in your community?

"If you've seen one rural community, you've seen ONE rural community" Unknown

Success in a Community …

What is successful Recruitment and Retention?

- Integration into the medical practice
- Family integration into the community
- Family quality of life issues are addressed

How is this accomplished??

3 Realms of Retention …

- Professional 
-  Personal & Spousal
- Community

Professional Retention

- Clinic / business model for practice
- Clinic management
- Flexibility of work hours within the practice
- On call / shift work
- Continuing education

Professional Retention

According to Alberta research shows:

"A rural physician who participates in individually focused additional skills training has a **30%** greater retention rate and could according to the confidence interval be as high as **61%** compared to those who do not acquire or maintain their skills"

"In the untrained matched control subjects, **71%** of those that left practice did so in the first 5 years"

"All the enrichment participants were in practice and using their skills at 5 years"

Study conducted by Dr. Ron Gorsche, RPAP Skills Broker

Personal & Spousal Retention

- Flexibility in physician work hours allows for better home life balance
- Employment support for significant other
- Support for language barriers/differences
- Ability to meet / fulfill personal interests

Community Retention

- Physician Attraction & Retention Committee
- Support AHS site visits to attract physicians
- Support family settlement – Provide resources, especially for IMG and families
- Host physician appreciation & recognition events
- Involve community – schools, service clubs

RPAP Support for Retention …

- Continuing Medical Education (CME) opportunities for rural physicians – Enrichment Training, Skills Enhancement training, General Medical Emergency Skills (GEMS)
- Cultural Integration Workshop
- Support to Attraction & Retention (A&R) Committees
- Welcome calls to new rural Alberta physicians
- Resources for specific community needs

Community Physician Attraction & Retention

RPAP Initiatives …

RPAP Initiatives ...

IN DEVELOPMENT
- Consider a Career in Medicine

RPAP Initiatives

Promotion of Doctor's Appreciation Day

- **March 30** – a day that is observed in some Canadian provinces & is noted as a National Day in some countries

- What can you do in your community to celebrate this day?

RPAP Initiatives ...

"Building on Shared Experiences" TOOLKITS

NEW
- Committee Management
- Working with the Media
- Physician Retention

UPDATES to EXISTING TOOLKITS
- Site Visits – to include some evaluation tools

In closing ...

Together we can work towards:

"Having the right number of physicians in the right places, offering the right services in Rural Alberta" – RPAP Vision

Thank you

We look forward to supporting your community!!

Your Friendly Community Physician Recruitment Consultants...On the road!

Christine Hammermaster | Laura Keegan

Appendix C: Presentations

3. Scotiabank StartRight Presentation

Financial Services for Physicians

StartRight Program

Establishing a Banking relationship in Canada

Financial Services for Physicians

Challenges

- Language Barrier
- Inadequate access to Financial Services i.e. Banking accounts, Credit Cards, Investment Services, Home and Vehicle Financing
- Access to Government Services

Scotia Professional Plan

Financial Services for Physicians

Where to Start

- See Citizenship & Immigration for info on Healthcare, Education, Citizenship applications,Organisations helping Newcomers
  www.cic.gc.ca
- Human resources and Social Development Canada for info on Social Insurance Number
  www.hrsdc.gc.ca
- www.scotiabank.com/startright Available in 8 languages

Scotia Professional Plan

Financial Services for Physicians

***Scotia Professional Plan Includes*:**

- Preferred pricing on business bank accounts
- Operating lines of credit up to $75,000 as low as prime
- Term loans for equipment and leasehold improvements as low as prime with amortizations up to 7 years and interest only payments for 1st year
- No fee Scotia Gold Business VISA - $5000 limit
- Complimentary financial consultation
  - Accredited business banking advisor
  - PFP designated financial advisor

Scotia Professional Plan

Financial Services for Physicians

***StartRight* Program includes:**

- Scotia Professional Program (if applicable)
- No-fee Powerchequing account
- Credit card approval program
- Home Financing program
- Auto-loan program
- Online Western Union transfers at competitive rates

Scotia Professional Plan

Financial Services for Physicians

***StartRight* Program for Homebuyers**

- Mortgage financing with as little as 5% down on Principal Residence (Temporary and Permanent residents)
  - Maximum loan amount: 2.3 million
- Mortgage financing with 25% down payment on maximum of 1 rental property (Permanent residents only)
  - Maximum loan amount: 1 million

Scotia Professional Plan

Scotia Professional Plan

StartRight Program for Homebuyers

- Application is required within 5 years of arrival in Canada.
- Maximum amortization is 30 years.
- 0% down payment available for Permanent Residents
  - Only 5, 7, 10 year fixed rates available
  - No rate discount available
- Connecting Newcomers and Scotiabank approved Realtors.

StartRight Program for Autoloans

- 25%-40% down payment
- Depends on residency status and purchase price
- Available only at participating dealerships

StartRight Program for Autoloans

- Participating dealerships:

CHRYSLER, VOLVO, MITSUBISHI MOTORS, mazda, HYUNDAI, JAGUAR LAND ROVER, KIA

Questions???

Contacts:

Victoria Burgess
Manager Professional and Business Banking
Ph. 780.448.7631

Our Goal is to Have and Impact

- **2010**
  - 50 million in donations, sponsorships, and other forms of assistance in support of organizations/projects that make a direct, immediate difference in the communities where we live and work around the world
  - 324,000 hours of time donated by Scotiabank group employees

Community Involvement

- People in our branches are a part of the community.
- Rural branches commonly have employees who have lived and worked in the community all their lives
- Donations of time and space
  - Boardrooms, volunteers
- Fundraising is at all levels – large scale and local

Recent Community Initiatives

- Relay for Life
- Cariwest
- United Way
- Kits for Soldiers
- Juvenile Diabetes Research Foundation
- Slave Lake Fire Relief
- Local Food Banks
- Read In Week

Financial Services for Physicians

Thank you

Scotia Professional Plan
Scotiabank

Appendix C: Presentations

Appendix C: 4. David Kay: Welcome Presentation

4th Annual Rural Alberta Community Physician Attraction & Retention Conference

Family Photo

L-R Jake, Bentley, Bailey

Thank-you to:

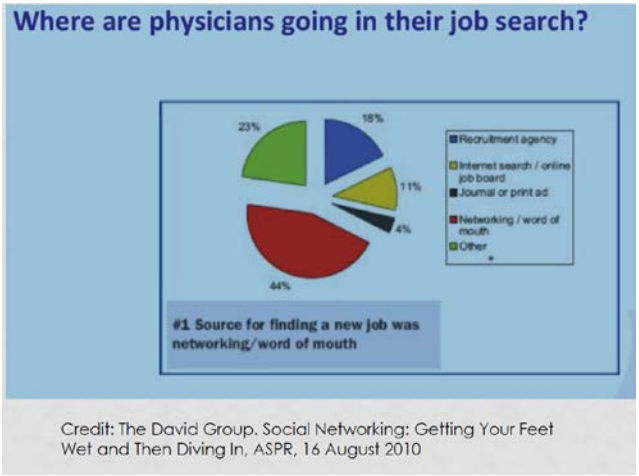
- Host staff (NADC & RPAP) for conference preparations
- Our speakers
- Sawridge Hotel
- Sponsors – Scotiabank & AMA
- AHS Physician Resource Planners for facilitating the breakout session
- And YOU! for coming, sharing and learning

Thursday's Highlights

- Jill Konkin – Rural Medicine in Alberta
  - "If you've seen one rural community, you've seen one rural community"
  - "Just the facts" on the "The Good, the Bad and the Ugly" of rural medicine in Alberta
- Stacy Greening, AHS director of community & rural planning, provided an update on the Community Rural Planning Framework
  - Delegate group discussion on healthy rural communities, successes in attraction-recruitment-retention, how to best engage communities

Thursday's Highlights

- Rhonda Crooks of Starting Points Communications shared 3 decades of experience in working with media with delegates in **Media Relations 101**
- RPAP's own Chris Hammermaster and Laura Keegan share their insights and observations on physician retention
  - Dog River SK. A&R committee
  - Delegate A&R assumptions & retention ideas
- Scotia Bank support for physician recruitment



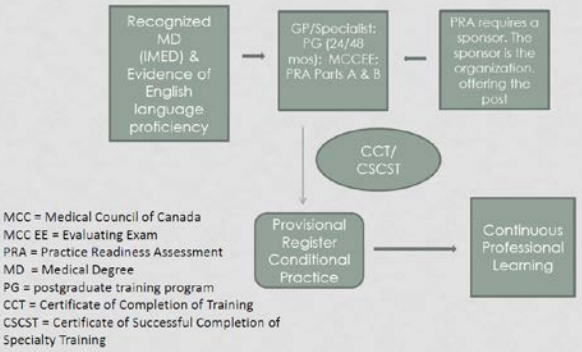
Credit: The David Group. Social Networking: Getting Your Feet Wet and Then Diving In, ASPR, 16 August 2010

Alberta Rural Community Physician Attraction and Retention Award

- City of Brooks/ County of Newell
- Caroline & District
- Fairview/North Peace Region
- Flagstaff County
- Kneehill County
- Lac Ste Anne
- Olds & District
- Smokey River Region

Presentation – ACC DM Dinner 2 Nov. 2011

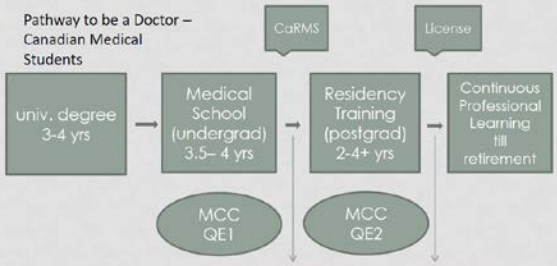
Alberta Pathway to be licensed as a Doctor – IMGs (UK/Ireland)



MCC = Medical Council of Canada
MCC EE = Evaluating Exam
PRA = Practice Readiness Assessment
MD = Medical Degree
PG = postgraduate training program
CCT = Certificate of Completion of Training
CSCST = Certificate of Successful Completion of Specialty Training

Pathway to be a Doctor

Pathway to be a Doctor – Canadian Medical Students



MCC = Medical Council of Canada
QE = Qualifying Exam
MD = Medical Degree
CaRMS = Canadian Resident Matching Service
CCFP = Certificant College of Family Physicians of Canada
FRCPC/FRCSC = Fellow Royal College of Physicians & Surgeons of Canada

Pathway to be a Doctor

Three Step Registration Process

College of Physicians & Surgeons of Alberta

There are three steps in the registration process for physicians who have not previously practiced in Alberta: the eligibility review, the application for registration, and the registration eAppointment including payment of fees as appropriate.

PRACTICE READINESS ASSESSMENT (PRA) – PARTS A & B

- Part A is a preliminary clinical assessment and Part B is a supervised practice assessment.
- The purpose of the assessment process is to determine whether or not the applicant is safe to practice independently in Alberta and is not a training experience.
- It is a pass/fail process and failure of any part of the assessment process will result in refusal of registration.
- All candidates who require an assessment must have a sponsor.

RPAP The Alberta Rural Physician Action Plan

PRACTICE READINESS ASSESSMENT (PRA) – PART A

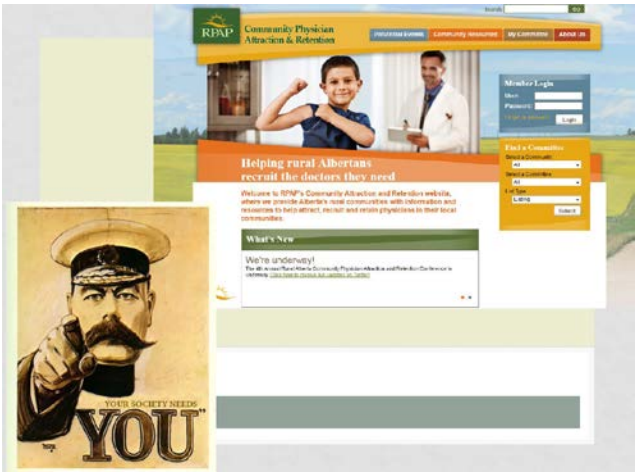
- Part A:
  - performed by independent reviewers selected & contracted by the CPSA,
  - may be of variable length depending upon the applicant's unique training & experience as well as the discipline and intended scope of practice,
  - conducted by an independent assessor typically at a location other than the recruitment location
  - followed by a period of supervised practice during which the physician will be observed in their final practice location.
  - the applicant provides patient care only while under direct supervision.
  - The duration of Part A for Family Medicine may be two weeks or three months, depending on whether training was completed in a program recognized by the College of Family Physicians of Canada (UK, Ireland, AUS, USA). The duration of the Part A for Specialists ranges from three to six months.

RPAP The Alberta Rural Physician Action Plan

PRACTICE READINESS ASSESSMENT (PRA) – PART B

- Part B:
  - A supervised practice assessment at the recruitment location is mandatory for all those entering the Provisional Register.
  - During this component of the assessment, the applicant is able to practice independently and bill Alberta Health and Wellness.
  - The duration of Part B for all applicants is a minimum of three months or as directed by the CPSA based upon results of Part A.

A PROUD DAUGHTER!



Appendix C: Presentations

5. Dr. Johnson on Smoky Lake Medical Clinic Before, Now and the Future

Smokylake
Smokylake Medical clinic
County of Smokylake

Before, Now and the future

Outline

- My community and Me
- Journey to Smokylake and Why Smokylake?
- Smokylake so far.....
- Future.....

My community and Me

- An online dating game come true!!!
- Smokylake lies between the North Saskatchewan River and the Northern boreal forest. We have two main claims to fame: as being one and October pumpkin festival
- Population of Smokylake town is about 1500 and the county about 7,000people,

Journey to Smokylake and why Smokylake

- Aggression and dedication of the recruitment committee
- Honesty, Human touch, open and genuine
- Support readily available
- Big enough to accommodate us and small enough to be called home

Smokylake so far?

- Welcome to community by RPAP
- Friendly and supportive council
- Establish a warm and computerized clinic
- Ensure adequate ER coverage
- Increase quality access to old and new patient (PCN role)
- Engage the community: School play ground, town development community
- Promoting our community: Pumpkin Capital of Alberta, Birthday town

Future

- Provide more access to quality care: Aqua-fitness centre, attract optometrist, swimming pool, rejuvenate the youth centre
- Provide opportunities for future doctors to have experience in a Rural Alberta
- Make it our home.