FELLOWSHIP PROJECT MANUSCRIPT

PHYSICIAN RECRUITMENT AND RETENTION: COLLABORATIVE MARKETING STRATEGIES FOR HOSPITALS AND COMMUNITIES

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BY

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This Case Study was prepared as an extension of my role as Chair of The Physician Recruitment and Retention Task Force and Vice President Programs at Halton Healthcare Services in Halton, Ontario and was originally submitted to the Canadian College of Healthcare Executives in February 2002. Comments received from reviewers have subsequently been incorporated as well significant policy developments such as the recommendations of the Commission on the Future of Health Care in Canada (2002). This Case Study focuses both on the physician manpower approach at HHS, and the broader policy issues of physician manpower planning and advocacy in Canada.

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TABLE OF CONTENTS

List of Tables

1.0 Description of Topic

Physician recruitment and retention of primary care physicians is a dominant issue for many community hospitals in ensuring the provision of appropriate medical care[3,13,48]. Although Hospital Boards have traditionally not taken an active role in the recruitment of family physicians, more and more hospitals are developing comprehensive physician recruitment and retention programs for primary care physicians[22,34]. Communities which have an under supply of primary care physicians frequently find that patients are unable to find a physician and hence turn to hospital emergency rooms and walk-in clinics[31,37,41,58]. Hospital resources become inappropriately utilized in the provision of primary care and difficulties in arranging medical care for unaffiliated hospital patients are encountered. Many hospitals have developed Hospitalist Programs to assist in the provision of medical care for unaffiliated patients[42,49].

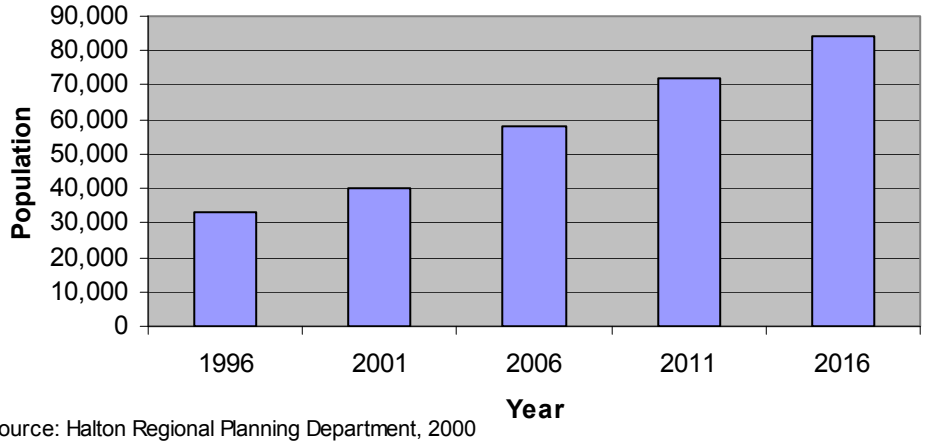
This Case Study will focus on the following key objectives:

1. To identify innovative strategies currently being utilized by hospitals and communities to recruit and retain family physicians.
2. To conduct a national and international literature review to identify successful approaches and solutions to physician recruitment.
3. To define essential elements of a collaborative physician recruitment program involving hospitals and their communities.

4. To provide a hierarchy of process steps and strategies to build a successful physician recruitment program.

Halton Healthcare Services is a community hospital comprising two hospital sites: Oakville-Trafalgar Memorial Hospital (300 beds) and Milton District Memorial Hospital (85 beds). In the fall of 2000, medical staff and administrative staff became very concerned about the shortage of family physicians in Milton and the resulting challenge of providing continued hospital services. The 14 family physicians with hospital privileges at the Milton site had closed practices and were not accepting new patients. The growing burden of unaffiliated patients presenting at the Milton Hospital placed a further demand on medical staff who were already stressed with hospital demands and busy practices. Without a proactive strategy to recruit more family physicians to the community, the Hospital was at risk of family physicians resigning hospital privileges and unable to respond to extremely significant population growth (Table 1).

Table 1: Projected Population Growth
Milton 1996-2016



Source: Halton Regional Planning Department, 2000

One of the Strategic Directions developed by the Board of Directors of Halton Healthcare Services was a strategy to attract and retain primary care physicians in both the communities of Milton and Oakville, Ontario. A Physician Recruitment and Retention Task Force was established with a mandate to recruit five family physicians for the community of Milton in 2000/2001. In the fall of 2000, the Milton community had 17 family physicians serving a population of 31,471 (2001 census). Based on the Physician Manpower Study completed by the Halton-Peel District Health Council[12], the Milton community was under-supplied by 10 family physicians, considering the Ontario College of Family Physicians'[26] benchmark 1:1,380. In the face of rapid population growth planned for Milton, the urgency for successful recruitment of primary care physicians both for the community and hospital became readily apparent.

Table 2: Physician Supply Measure, Halton-Peel and Ontario, 1991/92 and 1997/98

	Halton Peel		Ontario	
	91/92	**97/98**	**91/92**	**97/98**
Population	1,081,690	1,274,620	10,428,400	11,261,450
Active GPs per 10,000 pop.	7.12	7.06	7.82	7.82
Active Specialists per 100,000 pop.	4.73	4.93	8.10	8.10

Note: Active MDs = physicians who bill over $35k/year

Source: Institute of Clinical Evaluative Sciences ATLAS Reports - Uses of Health Services: Supply of Physician Services in Ontario, 1999

Table 2 identifies that the Active GP per 10,000 population ratio for Halton Peel fell from 7.12 in 91/92 to 7.06 in 97/98, whereas the Ontario ratio remained stable at 7.82 over the study period. In summary, the shortage of GPs serving Milton, the dramatic population growth, and relative GP to population ratio necessitated that a bold and comprehensive family physician recruitment strategy be introduced. The Physician Recruitment and Retention Task Force was established and assigned the task of developing recruitment and retention strategies to support the hospital's goal of recruiting five new primary care physicians to the Milton community in 2000/01 and developing a sustainable recruitment strategy to deal with growing family physician requirements in Milton.

This Case Study provides the reader with a summary of physician recruitment strategies obtained from both the survey tools and the literature review. Essential elements of a comprehensive recruitment and retention program are defined as well

as a hierarchy of process steps to create a comprehensive physician recruitment program.

2.0 Situation Impact Analysis

2.1 Local Mandate

The Physician Recruitment and Retention Task Force at Halton Healthcare Services was created with a mandate to focus on the recruitment of primary care physicians for the community of Milton. The overall mandate of the Task Force included the following:

1. To attract and retain the optimal number and category of physicians and other health professionals to meet the current and future health care needs of Halton Healthcare Services Corporation's (HHS) catchment area.

2. To recommend initiatives, incentives etc. to the Board and Medical Staff as required to achieve the above objective.

3. To obtain, organize and coordinate materials, information, etc. from regional, municipal and other sources to support the above objective.

4. To research the other health care organizations/municipalities' efforts to recruit and retain healthcare professionals.

Membership on the Physician Recruitment and Retention Task Force included the Chief of Staff, President & CEO, VP Programs, Chief of Family Medicine, Physician Leader, Milton Family Practice, Chief Operating Officer, Milton site and Health Promotion Coordinator. The Task Force was chaired by the VP Programs who coordinated the internal and external planning initiatives. Members of the Physician Recruitment Task Force initiated a comprehensive review of current physician recruitment and retention practices, examined Ministry of Health initiatives such as the Underserviced Program and established linkages with municipalities, chambers' of commerce and other local organizations to build support for the broader objective of family physician recruitment.

2.2 Environmental Assessment

Dr. Ben Chan, Institute for Clinical Evaluative Sciences, in his recent report entitled "Supply of Physician Services in Ontario"[5] (1999) noted that geographic maldistribution and reduced comprehensiveness in primary care services are key manpower issues that impact the provision of health services. The recent McKendry Report[22] (2000) identified that there is currently a shortage of 1300 family physicians in Ontario. However, the Ontario College of Family Physicians[58] disputes this estimate and suggests the real shortage is in the vicinity of 3,077 family physicians. Moreover, The Canadian Institute for Health Information "Physician Workforce Report"[5] of August 2000 notes that Ontario has had the second largest provincial decline in the relative number of family physicians with an 8.6% decrease from 1995

to 1999; second only to the Northwest Territories which had a decline of 9.7%, against a national average decrease of 3.1%.

Stottard[66] reports that 54 communities in southern Ontario are currently designated as underserviced for family physicians and specialists, while 33 additional communities are designated as underserviced in the north.

The physician shortage problem goes beyond Ontario and has both a national and international dimension. In May 2002, The Quebec College of Physicians reported that Quebec was short by 1,000 physicians[22]. In April 2002, the Ontario Medical Association reported that there were 900,000 people in Ontario with no family physician and that another 1585 specialists were currently needed.[22] and The Alberta Premiers Advisory Council on Health (2001), noted that Alberta needed 333 more full-time physicians today and predicted another 1329 will be needed over the next four years.

Henry Haddad, MD President of the Canadian Medical Association and Hugh Scully MD, Co-Chair, Task Force II, A Human Resource Strategy for Physicians in Canada[22], state that Canada continues to import approximately 400 MDs per year from other countries, which is the equivalent output of 4 new medical schools. International shortages have prompted the Commonwealth Health Ministers and the World Organization of Family Physicians (2001) to prepare codes of conduct for ethical recruiting of physicians. There has also been considerable media attention

lately with International Medical Graduates (IMG) and the complexities of training positions and licensure[25,26,69,70]. Ontario has moved recently to increase the number of IMG positions and hence expanded opportunities to practice medicine in Ontario. The Canadian Institute for Health Information has identified that between 1980 and 1993, the number of general practitioners for every 100,000 people in Canada increased from 76.4 to a peak of 101.5 by 1993, however the ratio consistently fell in the 1990s to 94.0 in 1999[69].

These reports collectively identify a variety of reasons for the current family physician manpower shortage; including a reduction in medical school enrollments early in the decade, changing practice patterns of physicians, the emergence of new diseases, introduction of new technologies, and the growing medical requirements of an aging population. Suggested solutions include both an expansion in supply of physician training opportunities such as the decision to create a Northern Medical School in Ontario[9], the first new medical school in Canada since the 1980's. Other initiatives include expanding the capacity to accept international medical graduates (IMGs) to work in underserviced communities[25]. Ontario has recently expanded the capacity from 46 to 90 IMGs each year. There has been considerable discussion within the media of the issues and challenges associated with practice requirements of IMGs. The Romanow Commission (2002) identified the percentage distribution of International Medical Graduates for Canada at 22.7%, with wide provincial variation (Sask.-51.4%, Ont. 24.5%, Quebec 11.3%.[56]).

The Romanow Commission[57] clearly calls for a national effort of physician and health professional manpower planning and states that “the current situation is serious and demands national solutions”(p104) Secondly, the Commission recommends that recruiting, training and retraining more nurses and doctors over the next decade are crucial strategies, particularly for rural, remote, and northern communities[57]. The Commission noted that the problem is partly a supply problem, but also involves systemic issues such as distribution, scope of practice, and the right mix of skills among various health providers and states that new primary care networks should ultimately give Canadians better access to teams of qualified health providers. Although these strategies hold considerable promise, the Commission notes that the overall transformation will be challenging and complex. Finally, the necessity to develop new approaches to education and training are needed in response to changing roles and patterns of care[57].

Broader societal trends also impact on physician productivity and concomitant manpower requirements. Hoff[30], addresses real differences in practice patterns between male and female physicians and notes that women are more likely to be employees rather than self-employed, work fewer hours per week than male physicians, and work part-time. Moreover, he identifies that female physicians emphasize marital and family roles over professional roles, while male physicians do the opposite[30]. Snyderman notes that physician productivity in the aggregate appears to be falling as a result of demographic changes, early retirements, and the increasing proportion of female practitioners. [68]

Table 3 provides a summary of the factors impacting the current family physician manpower shortage.

Table 3	Factors Impacting the Current Family Physician Manpower Shortage
1.	Reduction in medical school enrollments in the early 1990s
2.	Emergence of new diseases and the growth in demand
3.	Introduction of new technologies for diagnosis and treatment
4.	Growing care requirements of an aging population
5.	Lifestyle and worklife balance requirements of new physicians
6.	Physician productivity shifts due to demographic changes, early retirements, and the increasing proportion of female practitioners
7.	High cost of medical education and the relative earning potential of specialty medicine.

The Commission of the Future of Health Care in Canada (2002) provides an excellent summary of current policy levers employed for physician manpower planning in Canada (see, Table 4.3, Policy & Planning Responsibilities Across Canada, p.112)[57]. Policy levers for physician manpower planning take place at national, provincial, and local levels, and include data collection and monitoring, setting the number of undergraduate positions, setting tuition costs, determining education curriculum, registration and licensing standards, practice standards, scope of practice, immigration policy, system financial incentives, and recruitment and retention programs[57]. National organizations involved in physician manpower planning include the Medical Council of Canada, Royal College of Physicians and

Surgeons of Canada, College of Family Physicians of Canada, Canadian Institute of Health Information, and the Canadian Medical Association.

Provincial and local organizations focused on physician recruitment issues involve governmental ministries of health, ministries of colleges & universities, faculties of medicine, research organizations, academic health science centres, universities, regulatory bodies, professional associations, communities, chambers of commerce and community physician recruitment task forces.

Gavin and Esmail (2002) note that enticing family physicians to smaller or rural communities does not simply mean higher reimbursement[17]. Their research identifies other key factors, such as heavy workload, high demands and expectations, lack of flexibility in work arrangements, health service reorganization and training and career development issues[17].

Following the First Ministers Agreement in 2000, an 800m Primary Care Transition Fund[57,22] was created to support primary care initiatives that would provide comprehensive services to a defined population, more interdisciplinary teams with enhanced roles for nurses, pharmacists and other providers, better linkages to hospitals, specialists and community services, increase health promotion and expanded coverage to essential services 24hr/ 7 day/week. Although the Commission of the Future of Health Care in Canada recommends “fast tracking” primary care implementation in Canada, limited progress has occurred. It is difficult

to assess the real impact of this initiative on family physician manpower. It may make more efficient use of family physician skill and extend their capabilities, while expanded service requirements (24hr/7day/week) may offset these physician manpower savings.

Bruce Fried[15] suggests that physician manpower planning must be sensitive to changes in the healthcare system. He notes that although there are many studies on physician supply in the United States, the current high demand for primary care physicians and physician substitutes and the accompanying reorientation toward primary care of many specialists, was not well forecast in the United States and has put significant pressures on primary care providers.

The high cost of medical education is both a deterrent for some potential entrants to medical school and a huge challenge when dealing with the financial costs of initiating a medical practice upon graduation. Uwe Reinhart, Professor of Political Economy at Princeton University[56] advocates the introduction of innovative strategies for financing medical education. He argues that workforce policy would better align with health care needs if the current medical education subsidies were eliminated and prelaced with a federal human capital market in which medical students could borrow the funds needed to fully pay for their medical education. For example, a $200,000 loan repaid at 8% interest over a 20-year term would require an annual payment of $18,700, which could be halved if interest was tax deductible.

Innovative medical education funding strategies could eliminate some of the barriers to entry for prospective medical students in Canadian medical schools.

3.0 Review of Approaches Considered

This section will identify innovative strategies currently being utilized by hospitals and communities to recruit and retain family physicians. Secondly, it will review national and international literature to identify successful approaches and solutions to physician recruitment.

The Physician Recruitment and Retention Committee at HHS initiated a comprehensive inventory of existing strategies employed by hospitals, municipalities and District Health Councils to recruit family physicians. This inventory was prepared by contacting hospitals, municipalities, chambers of commerce, municipal economic development offices, district health councils, physician recruitment firms and consulting with the Community Development Officer, Ontario MOHLTC. Secondly, a broader literature review of recruitment and retention strategies in other jurisdictions was completed. Strategies and solutions implemented in other jurisdiction were obtained. This included other provinces in Canada, the United States, Great Britain, and Australia.

In the process of preparing the strategy inventory, we identified that the Niagara Region[41] had hired a Recruitment and Retention Coordinator for family physicians to

work closely with McMaster Medical School and the Rural Medicine Program. Other strategies included interest-free loans, reimbursement of moving expenses, community marketing packages, assistance with mortgage financing and assistance in finding jobs for spouses. West Lincoln Memorial Hospital[41] developed an innovative collaborative program whereby the Hospital; medical community and Town Councils of Beamsville, Smithville and Grimsby offer new doctors a $45,000 signing bonus to stay for three years. The city of Guelph has recently introduced a similar collaborative initiative[24] in which the municipality financially supported their Economic Development Branch attending physician recruitment fairs. Moreover, the Guelph Chamber of Commerce offers $50,000 interest-free loans to four new physicians moving to the community, repayable over four years[24]. Brantford uses money from a Charity Casino to provide $500,000 in interest-free loans[69].

Several of the hospitals surveyed[12,24,25,37,38,41,52,60,69] indicated that they had worked collaboratively with the Community Development Officer of the Underserviced Area Program, Ontario Ministry of Health and Long-Term Care. The primary mandate of the Community Development Officer is to coordinate, facilitate, establish and maintain mechanisms and strategies to recruit and retain physicians in Ontario by working with communities, including the promotion of the Underserviced Area Program, Rural Ontario Medical Program (ROMP)[60] and to act as a clearing house for successful physician recruitment and retention strategies. ROMP provides residents for the Hospital, within a designated underserviced area and includes four-month family medicine rotations, two-month specialty rotation by specialty residents

including: Emergency Medicine, Internal Medicine, Obstetrics, Paediatrics and General Surgery. The Ministry of Health and Long Term Care provides $600 per month in funding for living expenses for the Residents[60]. Hospitals often provide rental accommodation to support the residents.

The Ontario Ministry of Health and Long Term Care also provides the Underserviced Area Program with incentive grants of up to $15,000 available for physicians who relocate to eligible designated communities. Designation within the Underserviced Area Program also qualifies physicians who are applying for the defined shortage specialties to receive the tuition rebate and program of up to $40,000 from the Ministry of Health and Long Term Care. Other recruitment and retention initiatives identified through the survey included: $10,000 relocation fee, guaranteed annual minimum income, one year rental space option for new physicians, interest-free start-up loans[69,70].

Medical staff recognition was identified as an important retention strategy through the survey[41] and included the recommendation that both communities, with the specific involvement of local mayors and community leaders, plan appropriate recognition events for medical staff (i.e., physician appreciation day). Preparation of marketing information was similarly considered essential and included videos, residential and community information, hospital information, statistics, future plans, external referral centres and availability of physician office space. Several hospitals and communities also facilitated tours of both the hospital and community for prospective

physicians and their families. Spousal employment opportunities were similarly identified as a key element in physician recruitment[60]. Formalization of recruitment practices with adjacent medical schools was deemed very important and included regularly scheduled visits to medical schools and actively recruiting new physician graduates to local communities[69,70]. A presentation booth, videos and brochures were generally included in this recruitment initiative.

Table 4 Inventory of Physician Recruitment Strategies

Marketing & Promotion

- Regional/Local Physician Recruitment Coordinator
- Community promotion and marketing package
- Physician recruitment fairs
- Formalized linkages with adjacent medical schools
- Part-time physician recruiter
- Web-site promotional information and CD-Rom
- Physician recruitment firms

Incentives

- Interest free loans to assist with establishing medical practice
- Reimburse moving expenses
- Assistance with mortgage financing & spousal employment
- Providing a relocation fee
- One year free rental space option for new physicians
- Guaranteed annual income for one to three years
- Interest free loans to medical students who agree to local practice
- Interim accommodation and signing bonus
- Providing community medical clinic and apartment for visiting doctors

Community Collaboration

- Community physician recruitment task forces
- Collaborative community initiatives (i.e. business promotions, community tours, community recruitment initiatives)
- Formalized community outreach programs
- Private/public partnerships for office space

Education

- Educational assistance for rural physicians
- Interactive strategies such as video conferencing and professional association with colleagues
- Rural Physician Action Plan - Alberta (rural rotations, special skills program and student loan remission)
- Rural Medical Education Program – University of Illinois, College of Medicine at Rockford (student/peer support, community orientation and rural preceptorship).

Support Programs

- Ontario Ministry of Health – Underserviced Area Program
- Rural Ontario Medical Program (ROMP)
- Professional organizations – Medical Associations, College of Family Medicine
- Nurse practitioner programs

Dr. Doug Wilson, Professor with the Department of Public Health Sciences, University of Alberta[74], reported that Alberta's Rural Physician Action Plan has provided an integrated approach to education, recruitment and retention of physicians. This Program provides funding support for undergraduate and postgraduate medical education programs for rural rotations, special skills program, and student loan remission program. In addition, programs for practicing rural physicians include CME initiatives, enrichment program and rural locum program. Total spending for this program in 1996/97 was $3.1 million and in the evaluation survey, 35% of the 285 responding physicians indicated that the RPAP had a "critical" or "moderate" influence on their decision to move or to stay in rural Alberta[74]. In this program, rural family physicians preceptors are given a small stipend for teaching and supervision ($1000 per month for each student and $500 for each resident) and students and residents receive travel expenses and accommodation. To support practicing rural physicians, funds are provided to enhance the Regional Conference Programs and Teleconference Programs delivered to the practicing rural physicians. The Enrichment Program provides the opportunity for practicing rural physicians to upgrade their skills or grain new skills to meet the needs of their rural communities and regions and the rural locum program provides locum coverage for physicians and communities with four or fewer physicians.

The Rural Medical Education Program[65] developed by the University of Illinois College of Medicine at Rockford is an innovative program, which consists of a 4-year

longitudinal rural curriculum for family practice, student/peer support, community orientation and rural preceptorship. Sterns et.al.[65] describes an affinity model for encouraging rural health careers in family medicine. This model involves a selection process which favours physicians with rural backgrounds or significant exposure during training to rural practice settings, based on the premise that physicians choose rural practice because they find it desirable both for professional and lifestyle reasons. The Rural Medical Education Program[65] has been extremely successful in encouraging the preparation and training of family physicians to work in rural medicine. Future challenges include enhancing the rural applicant pool, increasing rural residency training opportunities and collaborating with other stakeholders to create a rural physician placement service. The R-Med Program is a comprehensive, collaborative community health oriented initiative which can be utilized in other jurisdictions.

Dr. Ian Cameron, Chief Executive Officer, New South Wales Rural Doctors' Network in Australia[4], identifies factors which both enhance and detract from physician recruitment and retention. Dr. Cameron refers to a survey of Queensland doctors who had recently left rural practice and identified that these doctors emphasized positive aspects of rural practice to be professional autonomy and support, community relationships, work variety, family lifestyle and continuity of care[4]. The negative aspects of rural practices included after hours workload, poor access to CME and locums, personality clashes and lack of family educational opportunities. While focussing on retention strategies, Hays et.al.[29] developed a conceptual model

of a balance between influences to stay or influences to leave and triggers that could shift this balance. Although personal (personality clashes and family, e.g., children's education) triggers may be difficult to assess, this model proposed professional retention strategies that could be readily addressed such as provision of CME, locum coverage, management training for doctors and educational packages for families. They also suggested that peer support and early intervention structures be developed through the divisions of general practice which exist at the local level[29].

The Penn State Geisinger Health System - Danville, Pennsylvania[61], has developed a comprehensive physician retention plan for its multi-specialty group practice of nearly 1000 physicians to reduce costs associated with ongoing physician recruitment. The Plan is organized into four phases of physician employment, including recruitment, pre-employment, and post-employment. Mr. Kirk Scott, Administrative Director, Professional Staffing and Credentialing[61], identifies that with turnover rates between 10 - 15% nationally, the annual replacement of 100 physicians requires recruitment and retention expenditures that can be in the millions of dollars. Penn State Geisinger's research[61] has shown that the most significant reasons for physician turnover include: lack of physician "fit" with partners in the practice environment, lack of clear communication of expectations to physicians during recruitment, absence of two-way communication between the physicians and practice management, failure to include physicians in the decision-making process and lack of appreciation and recognition of physicians. A focused effort on enhancing recruitment and retention meant that better recruitment practices were

introduced which included a site profile with all employment qualifications and expectations of physicians and the identification of search advisors to take a key leadership role in each search, including screening candidates for fit, clarifying mutual expectations and other areas of support such as computer, nurse, research opportunities and continuing medical education. Offering additional no-cost benefits such as discounts on fitness centres, discount on home and auto insurance and dry-cleaning pick-up service were also included. The pre-employment phase involves confirming mutual expectations and developing and implementing a formal physician orientation program and a mentor relationship. The employment phase includes ensuring two-way communication is maintained participating in a physician recognition program and provided transfer opportunities within the organization or health system. Post employment involves a formal exit interview and follow-up with any opportunities for improving the recruitment and retention process.

In identifying opportunities for hospital, municipal and community collaboration, communities, such as Burlington, Ontario, have established a Community Outreach for Family Physicians Task Force[24] which was established as a municipal task force with representation from Municipal and Provincial Leaders, Business Leaders and Economic Development Bureaus. The mandate of the Community Outreach for Family Physicians Task Force includes the responsibility to develop a plan to attract and retain family physicians in the community and report with a proposed action plan.

4.0 Management Decisions and Actions Taken

Management decisions initiated by the Physician and Recruitment Task Force at Halton Healthcare Services included obtaining a formal Underserviced Area[60] designation with the Ministry of Health and Long Term Care. The Underserviced Area status supported the travel costs for physicians interested in practice opportunities travelling to Milton. The more significant aspect of this designation was the ability to access the medical school tuition rebate of up to $40,000. In addition, HHS decided to supplement this by providing a $10,000 grant to family physicians locating in Milton who obtained hospital privileges to be utilized for office set-up and moving expenses. Moreover, a $30,000 interest-free loan was provided to interested family physicians with repayment terms negotiated over a three-year period. These incentives, combined with the Underserviced Area designation, clearly assisted the Hospital in being able to attract family physicians.

Marketing information and materials were mobilized. Brochures describing the practice opportunities available in the community, hospital information, community and lifestyle amenities were prepared and broadly distributed within the community. The Task Force asked physicians in the community to forward marketing information and brochures to interested physicians. Other marketing initiatives included advertising family practice opportunities in Medical Journals, Hospital Website, and posting on the Professional Association of Interns and Residents of Ontario (PAIRO) Website.

The Hospital also designated a staff person to be the primary point of communication, maintain the physician database, and coordinate communication with appropriate medical staff and assist with tours. This responsibility was assigned to the Health Promotions Coordinator who currently had well-established linkages within the community. Primary responsibilities for this recruitment role included:

1. Promote practice opportunities via multiple marketing strategies (i.e. medical journals, website, targeted recruitment, specific mailings, links to other websites (PAIRO), recruitment fairs, and asking current medical staff to promote opportunities with colleagues.
2. Coordinate the preparation of marketing materials, brochures, information sheets, and website pages.
3. Collaboratively work with the VP Programs (Task Force Chair) to prepare Task Force agenda and recruitment status reports.
4. Maintain the Physician Contact Database and follow-up with all requests for information.
5. Organize hospital and community tours for interested physicians and assist spouses and families with obtaining community information (.i.e. Real estate, schooling, employment)
6. Coordinate the Annual Professional Recruitment Tour at each Faculty of Medicine in Ontario.
7. Support the Region of Halton Physician Recruitment Coordinator in collaborative physician recruitment initiatives within the region.

All physicians contacted by the Hospital and those who responded to marketing initiatives were maintained in a physician communication log. We found it essential that prompt communication occur between the interested physician and appropriate Physician Leaders within the organization. The Physician Recruitment and Health Promotion Coordinator facilitates the timely communication between appropriate physicians and helps organize the hospital and community tours which follow.

The Physician Recruitment Task Force also identified community advocacy and education an important priority. The President and CEO arranged education and information meetings with key community leaders such as the Mayor of Milton, Town Council, Chamber of Commerce to communicate an awareness of the family physician shortage issue and share the results of other communities in physician recruitment. These presentations clearly helped raise awareness at the local municipal and community level. On March 21st, 2002, the Town of Milton passed a Resolution supporting the establishment of a Community-Based Physician Recruitment Task Force (Appendix A) with leadership from Halton Healthcare Services. The primary purpose of this new collaborative initiative is to develop a number of innovative recruitment and retention strategies to assist primary care physicians in establishing their practices in Milton and linking with the Hospital.

Dr. Bob Nosal, Halton Medical Officer of Health[26], recently announced the Region of Halton would designate a regional budget of $150,000 for physician recruitment initiatives. Dr. Nosal has acknowledged that there is a wide consensus that a

regional recruiter is needed to make contacts with new graduates and ensure they get connected to physicians and hospital administrators. He noted that presently the Region of Halton is short approximately 40 physicians with the largest growth anticipated in North Oakville and Milton over the next few years. Hospitals within Halton have also contributed to the Region of Halton Physician Recruitment budget by adding an additional $50,000.

Halton Healthcare Services has also participated in the Ministry of Health and Long Term Care Annual Health Professionals' Tour, held at the five Ontario Medical Schools in September 2001. HHS participated, given that the Town of Milton is designated as an underserviced for family physicians in November 2000. During this tour, 126 contacts were made with medical students, family medicine residents and family physicians.

To further enhance our recruitment opportunities for family physicians, a family practice residency program at HHS in association with McMaster Medical University was introduced. McMaster Medical University provided suggestions for involvement in postgraduate teaching and will complete an on-site visit. Medical education and training opportunities have proven to be an excellent recruitment strategy. It is the hospital's goal to become a teaching centre for family medicine residents from McMaster Medical University and to develop an effective follow-up system to encourage a long-term commitment to the community.

Faculties of Medicine and community physician recruitment task forces are also beginning to proactively promote the profession of medicine with high school students. Memorial University in Newfoundland has developed a CD ROM for interested high school students to broaden their knowledge of careers in medicine and other health professions.

The combined effect of the underserviced area designation, hospital incentives, marketing initiatives, comprehensive tours and university linkages has enabled the hospital to successfully recruit five new family physicians to the Milton community in 2001/02. Two of these physicians are relocating from other provinces and three physicians are beginning their careers in family medicine.

5.0 Analysis of Results Within Theoretical Framework

James Full, CEO St. Vincent Randolph Hospital (Wichester, Indiana)[16] utilized a four-step process hierarchy to transforming a community hospital through a comprehensive and successful physician recruitment program. The following process hierarchy for physician recruitment was utilized:

Table 5	Process Hierarchy for Physician Recruitment
1. Plan – educate Board of Trustees, Medical Staff, Employees, Community Leaders on strategic directions and physician manpower needs. 2. Locate – utilize a broad range of strategies to locate physicians (i.e. Promotional information, websites, journals, medical staff contacts, recruitment firms). 3. Screen – initial profile screening, confirming relocation potential, and credential review. 4. Promote – focusing on the critical on-site visit including meeting with, CEO, VP, Hospital Tour, Community, school, and dinner with physician and community leaders.	
Source: Full, J., "Physician Recruitment Strategies for a Rural Hospital" Journal of Healthcare Management, Vol. 46, No. 4, July/August 2001, p280.	

Full[16] summarizes the key strategies for physician recruitment and suggests essential leadership skills which must be demonstrated by health care leaders during the recruitment process to include active listening, genuine personal contact, creativity, and flexibility. When this framework is applied to the Physician Recruitment Program of Halton Healthcare Services, we see a strong correlation with each of the process steps and the specific actions of the Physician Recruitment Task Force. The following table summarizes recruitment strategies employed by the Physician Recruitment Task Force at HHS, within this framework.

Table 6	HHS Physician Recruitment Process Assessment
1.	**Plan** - Hospital Community Task Force, Halton Regional Physician Recruitment Task Force, Community Advocacy & Education, Physician Database, profiling need in medical journals, marketing information, hospital website, and associated organizations (i.e. Rural Ontario Medical Program. Unserviced Area Program, PAIRO, etc.)
2.	**Locate** – Physician Recruitment Coordinator, Regional Recruitment Coordinator, Health Professionals Recruitment Tour, Medical Staff referrals, Family Practice Residency Linkage.
3.	**Screen** – Credentialing, Referencing, and obtaining feedback from hospital, community, and physician leaders.
4.	**Promote** – Comprehensive hospital and community tours, attention to family and spousal requirements, and flexibility in terms of incentives within Board approved parameters.

HHS did experience similar physician recruitment results when compared with St. Vincents Hospital and successfully recruited 5 new family physicians to the Milton community in 2001. However, it is essential that comprehensive retention strategies be employed to ensure that the physicians which are recruited are successfully integrated and stay for the long term. In proposing physician retention strategies, Hays[14] developed a conceptual model of a balance between influences to stay and influences to leave including triggers that could shift this balance. Two important components of the model include personal factors and family factors.

Recruitment and retention strategies introduced by Halton Healthcare Services focus upon providing a tour for physician and spouse, identifying employment opportunities for the spouse and providing a comprehensive tour of the community, including lifestyle amenities. These initiatives are consistent with the conceptual model developed by Hays[29]. Other important initiatives include peer mentoring programs, the provision of CME, locum coverage and management training for doctors and educational packages for families.

Halton Healthcare Services has mechanisms in place to support the provision of CME for family physicians and provides management training for interested physicians, and focuses on creating effective mentor and peer relationships with new physicians. Some of the new physician recruits have become great allies in assisting with physician recruitment and promoting the community of Milton with other medical colleagues. Areas of support not provided by the Hospital and yet included in the conceptual model, include the provision of locum coverage for new family physicians and educational packages for families. Although these may be initiatives provided in the future, they have not been identified as primary requests for new family physicians that we have recently recruited. Other initiatives identified in the literature which may further strengthen physician recruitment include developing a formal physician orientation program, implementing physician recognition programs and completing more formal exit interviews with physicians who move or retire.

6.0 Conclusion

Halton Healthcare Services has introduced a comprehensive range of physician recruitment and retention strategies and developed community linkages with local municipal and regional governments, district health council, and government ministries to support the recruitment of five new family physicians to the community of Milton. To be successful, physician recruitment and retention initiatives must involve a collaborative effort with hospitals and their communities. Initial meetings of the Community-Based Physician and Recruitment Task Force have stimulated a number of innovative strategies to build upon and strengthen the current infrastructure for physician recruitment and retention.

In our experience, it takes approximately 18 months to develop an effective physician recruitment program. The following table summarizes the number of family physician enquiries we received while building our program.

Table 7	**Summary Schedule of Family Physician Enquiries at Halton Healthcare Services:**
	July – December, 2000 - 13 January – June, 2001 - 14 July – December, 2001 - 16 January – June, 2002 -24
Source: HHS Physician Recruitment Database, 2002	

The most significant incentive was the MOHLTC Underserviced Area Program which gave us access to the Free Tuition Program ($40,000). The Underserviced Area Program also provided access to the Annual Professional Recruitment Tour at each of the five medical schools in Ontario which was a very important contact opportunity. The next most important incentives were provided by the hospital and included a $10,000 practice initiation fund and the opportunity to access a $30,000 interest free loan. Thirdly, physician contacts obtained by the medical staff at HHS were instrumental in several of the physician recruitments which occurred. The hospital and community tours were a vital strategy and essential to complete a successful recruitment. Collaborative strategies with the community were also very important and helped to create a welcoming climate for the new physician and their family. The Hospital website and the PAIRO website were very effective tools which generated physician interest in practice opportunities in Milton. The least effective strategy was journal advertising which generated very few enquiries.

The following is a summary of the recommendations identified during this Case Study. These recommendations are oriented both to Halton Healthcare Services and the broader health care environment within which physician recruitment for family physicians occurs:

1. That HHS utilize the Hospital Community Physician Recruitment and Retention Task Force as the primary vehicle for ensuring a comprehensive,

2. That HHS collaborate and support the Region of Halton Physician Recruitment Committee and the Regional Recruitment Coordinator to optimize recruitment efforts for family physicians and identified specialty gaps.
3. That HHS encourage proactive physician manpower planning through collaborative initiatives of the MOHLTC, Institute for Clinical Evaluative Sciences, Halton Peel District Health Council, the Ontario Medical Association, Ontario Hospital Association, and Health Canada.
4. That HHS work with the Ontario Hospital Association to promote advocacy objectives including expanded medical school enrollment, integrated physician manpower planning, and endorse the Romanow Commission's call for better coordinated physician manpower planning.
5. That innovative federal provincial programs be considered to create a framework for financing medical tuition costs with reasonable repayment terms and interest deductibility.

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