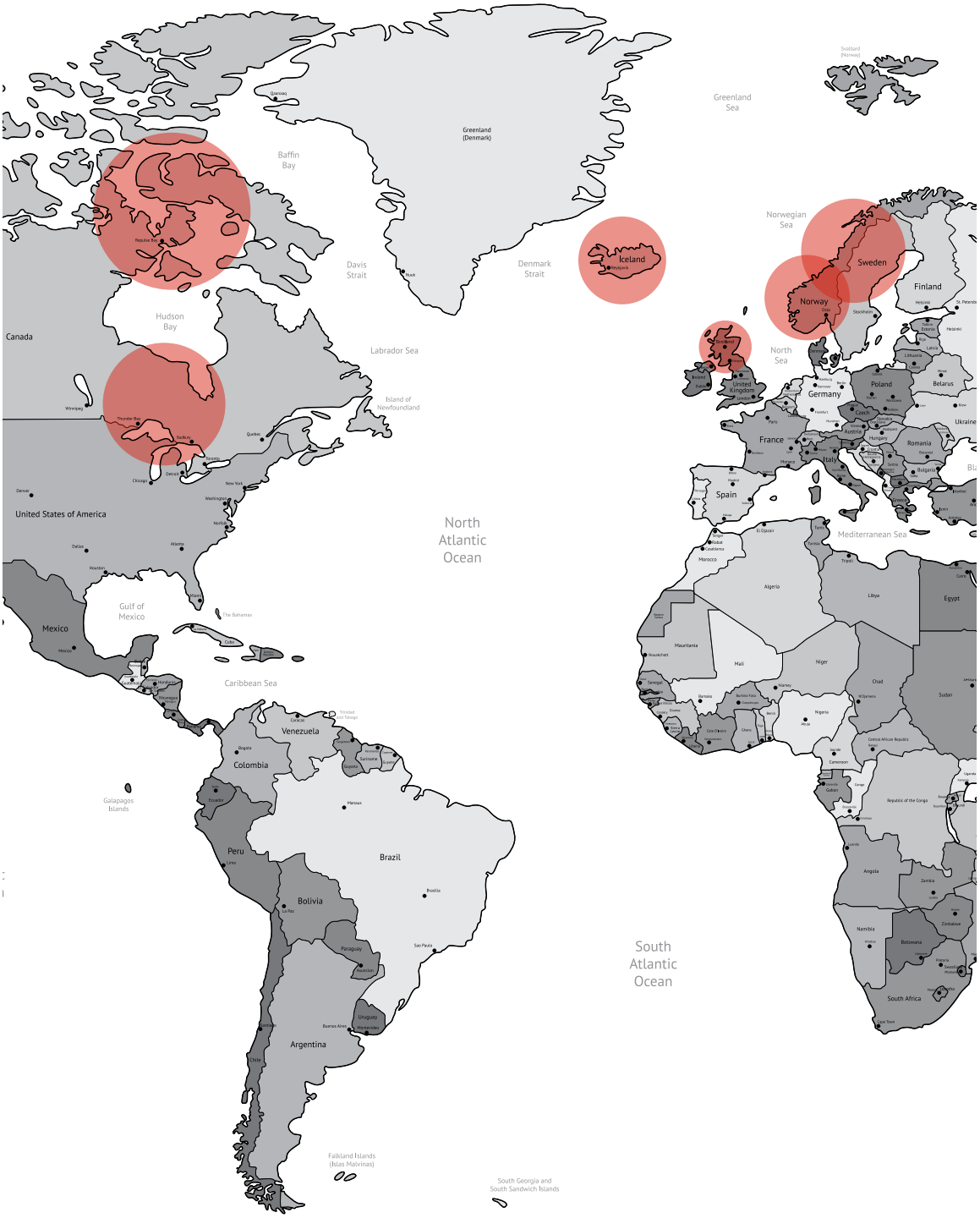
JANUARY 2019

making it work

Remote Rural Workforce Stability
Forum Report


Greenland Sea
Svalbard (Norway)
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Norway
Hudson Bay
Canada
Labrador Sea
Island of Newfoundland
North Sea
United Kingdom
Poland
Germany
Belarus
Ukraine
France
Austria
Hungary
Romania
Italy
Spain
Mediterranean Sea
North Atlantic Ocean
United States of America
Gulf of Mexico
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Caribbean Sea
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Colombia
Galapagos Islands
Peru
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Bolivia
Paraguay
Uruguay
Argentina
Chile
Falkland Islands (Islas Malvinas)
South Georgia and South Sandwich Islands
South Atlantic Ocean
Algeria
Libya
Egypt
Mauritania
Mali
Niger
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Angola
Namibia
Botswana
Zimbabwe
South Africa

Making it Work in Nunavut and Northern Ontario

The Northern Ontario School of Medicine (NOSM) was founded on the idea that if you train physicians in the North, they will stay in the North. While that strategy is making a difference, there are still many small communities struggling to maintain medical services. Established as a government strategy to address the health needs of Northern Ontarians, improving access to quality care and contributing to the economic development of the region has been a key consideration for the work being done at NOSM.

Physician recruitment and retention has long been one of the most pressing concerns in the North. That's why the School partnered with the European Union funded project titled *Recruit & Retain* from 2011-2014. The project investigated the underlying causes of challenges in recruiting and retaining health professionals in remote rural communities in the far north of northern countries in Europe. The project developed 29 solutions to the identified issues, and a business model to address them moving forward. NOSM was the only non-European partner in this project.

That work continued when NOSM partnered with the Northern Periphery and Arctic Programme on a project, titled *Recruit & Retain 2: Making it Work*. Announced in Sault Ste. Marie in 2016, the project received €2 million from the European Union over three years. The project activities focused on recruitment and retention initiatives of physicians in northern remote rural communities and developing the *Making It Work: Framework for Remote Rural Workforce Stability*, which provides a set of key areas of activity—including community engagement, supporting families, and training future professionals—that, when implemented as a holistic, integrated set of interventions, can create the conditions necessary to establish a stable and suitably skilled health-care workforce in rural and remote communities.

The *Making It Work Remote Rural Workforce Stability Forum* hosted on January 15, 2019, is the culmination of a seven-year international collaboration. Key stakeholders and partners from around the world now have a better—and evidence based—understanding of what is needed to achieve workforce stability for Northern communities. By integrating the results of the *Making It Work* partnership into the *Northern Physician Resources Action Plan*, a path forward is being created toward self-sufficiency in Northern Ontario. There will always be gaps that need to be filled, and working in partnership with communities, the gaps will be closed with skilled, competent rural generalists who have connections to the North.

Dr. Roger Strasser, AM
Dean and CEO, Northern Ontario School of Medicine

Making It Work Remote Rural Workforce Stability Forum

On Tuesday, January 15, 2019, the Northern Ontario School of Medicine hosted the *Making It Work Remote Rural Workforce Stability Forum*, an international, multi-site forum on physician recruitment and retention. The forum focused on recruitment and retention of the health workforce in rural and remote communities and the role of medical schools, health-service organizations, communities and government in creating workforce stability.

For Canadian participants, the day began with words of welcome and opening remarks from dignitaries in Sudbury, Thunder Bay, and Iqaluit. Mid-morning, each of the participating countries (Sweden, Scotland, Norway, Iceland and Canada) joined together by videoconference to present on the *Making It Work Framework for Remote Rural Workforce Stability* and case studies carried out in their respective countries.

A *Knowledge Transfer in Action* session took place in the afternoon, integrating key learnings from international rural health human resources work to the *Northern Ontario Physician Resources Action Plan* developed over the past year as a result of Summit North—a symposium in January 2018 that brought together policymakers, educators, administrators, community members and clinicians from across Northern Ontario to address the issue of health workforce recruitment and retention in rural and remote communities. The *Northern Ontario Physician Resources Action Plan* builds on existing recruitment and retention strategies across the region.

Several measures are in place at the Northern Ontario School of Medicine to support physician recruitment and retention: encouraging high-school students from rural and remote communities to see a career in health care as an opportunity that's available to them; an admissions process that favours applicants from Northern Ontario and reflects the population distribution of the region; a distinctive Distributed Community Engaged Learning model that places students in communities so they focus on responding to the health needs of the population; involving rural generalist faculty members as principal clinical teachers and role models; and, having a rural and remote First Nations stream in NOSM's family medicine residency program.

A study published in *Canadian Family Physician* found that NOSM students and graduates had a positive view of rural generalism, and their experience and exposure to rural community practice was highly influential in determining their career directions. A 2016 study examining eight communities that were successful in recruiting family doctors to their communities, found that five of those communities which had previously struggled with chronic doctor shortages had moved to a more stable situation. All participants in the study agreed that NOSM played a prominent role in physician recruitment to underserved communities in Northern Ontario.

"I cannot tell you how proud I am of what's going to happen here today. For the first time ever, Northern remote rural communities will have a body of evidence that shows how to recruit and retain health professionals in Northern Ontario and throughout the world so that we can provide equitable access to all. This is something I have been dreaming of for a long time; that brilliant people like you would put your minds together to bring solutions that makes sense in Northern remote rural communities. This is an important day! From this day on, I expect each and every one of you to push this idea forward."

France Gélinas
Member of Provincial Parliament, Nickel Belt

"We have an incredible asset in our northern and rural communities, and that's young and middle-aged people who love their communities and want to work; contribute to, and stay in their communities. Canadians across the country, who live in these areas, deserve the same level of care as everyone else but recruiting and training medical professionals can be extremely expensive. The work that you are doing to attract people to stay and work in rural and remote areas is critical. Together, we need to find a way to help people stay in their communities and contribute to their communities in meaningful ways."

Hon. Patty Hajdu
Minister of Employment, Workforce Development and Labour and MP, Thunder Bay-Superior North

The Challenge of Remote Rural Recruitment and Retention

In his introductory remarks, Dr. Roger Strasser, NOSM Dean and CEO, discussed that the partner countries have an enormous challenge for remote rural recruitment and retention.

Each community in remote rural areas of Canada and the partner countries have specific needs that differ from the larger population centres. They also experience the challenges that come with transience—the coming and going of health-care providers. This leads to a focus on filling the gaps rather than making changes that have long-term impact and change the reality for the community.

- Remote rural environments have unique health service needs.
- Impacts of transience on quality and continuity of care.
- With high turnover, HR professionals often must focus only on recruitment.
- Organizations struggle to advance strategic priorities when constantly orienting new personnel.

> "If you've seen one remote rural community, you've seen one remote rural community."
>
> **Dr. Roger Strasser**
> NOSM Dean and CEO

NOSM's Partnership with Nunavut

Dr. Roger Strasser discussed NOSM's partnership with Nunavut and Dr. Gwen Healey Akearok, Executive and Scientific Director, Qaujigiartiit Health Research Centre in Iqaluit, gave participants an introduction to Nunavut and their health care delivery model.

Nunavut's 25 communities are spread across two million square kilometres of a vast and beautiful territory, and the population is a little over 35,000 people, with 85 per cent of the population being Inuit. There are four official languages in Nunavut: Inuktitut, Inuinnaqtun, English, and French. This northern Canadian territory also has the fastest growing population in Canada, the highest birth rate, and the population is very young with more than half of the population under the age of 25.

The health care delivery model is based on a remote nursing station model that was implemented in Canada around the 1950s. In Nunavut, there are three distinct health care service regions: Qikiqtaaluk, Kivalliq, and Kitikmeot. There are 25 communities in Nunavut, located across three time zones. Supporting health care in these communities are 22 community health centers, two 'super' regional health centres in Rankin Inlet and Cambridge Bay, and then one hospital in Iqaluit.

The Northern Ontario School of Medicine approached the Government of Nunavut to explore partnership opportunities for additional residency placements, health career camps for high-school students, continuing medical education and professional development opportunities for physicians, and researching health-service models for Northern remote rural communities. The *Making it Work* funding opportunity through the Northern Periphery and Arctic Programme provided NOSM with an opportunity to work with Nunavut on initiatives that would also have relevance to Northern Ontario.

> *"We recognized similarities between Northern Ontario and Nunavut; the small communities, the vast distances… Drawing on the experiences of other countries in the arctic that are similar to Nunavut, there is much potential for collaboration."*
>
> **Dr. Roger Strasser**
> NOSM Dean and CEO

International Case Study Presentations

The *Making It Work: Framework for Remote Rural Workforce Stability* document is a result of seven years of study and research looking into lessons learned from other remote rural settings. The first *Recruit & Retain* project produced a solutions report, which included 29 tried and proven initiatives that improve retention and recruitment; the *Making it Work* project is implementing a selection of those solutions in different countries in northern Europe and in Nunavut, Canada.

Rural remote service providers and the regional authorities that support them must develop a long-range plan that ensures workforce sustainability. There is overwhelming evidence that supports a significant return on investment when educating and training rural and remote residents to become the professionals needed for service delivery in these regions. This investment may be the most important long-term strategy in workforce sustainability.

The Framework describes the necessary elements of a strategy to ensure the recruitment and retention of the right professionals to provide needed services in rural and remote locations. The ultimate purpose is to support the health and quality of life of rural and remote residents, through improved access to essential services.

> *"I want you to look in the centre. For Canadians, this is the "Timbit.®" That's the tasty bit in the middle that really counts!"*
>
> **Dr. Roger Strasser**
> NOSM Dean

The Framework consists of nine key strategic elements, grouped into three main tasks (plan, recruit, retain), with five conditions for success. Active community participation is a crucial element to the success of this Framework.

Sweden

Niclas Forsling, Executive Director, Centre for Rural Medicine; Dr. Peter Berggren, Head of Centre for Rural Medicine

Tina Kerro, Relocation Coordination Officer in Storuman, Sweden.

In Storuman, it was recognized that there was difficulty in filling job openings in their municipality, and that there were more people moving away from the community than moving in. They developed a postcard with positive messages, which was received by 1,270 young adults ages 20 to 55 who had moved away from the municipality over the past ten years. This postcard was an invitation for them to move back after spending time away from home. The postcard explained that the municipality was in a positive spending state and was able to provide a wide variety of employment opportunities and activities. In conjunction with the postcard, a form was available on the website for individuals to provide their contact details should they want to receive additional information.

> *"Relocation services have an incredibly important role to play in recruiting and retaining individuals. All activities are focused on sustainability and the notion of working together. The community is the collective spirit of those who live here. Everyone is important. Working with recruitment requires that we cooperate and head in the same direction. We understand that we need to operate not as individuals, but as a team—and that is why we will succeed."*
>
> Tina Kerro
> Relocation Coordination Officer

Scotland

Dr. David Heaney, Rossal Research and Consultancy

The Scottish presentation summarized the activities undertaken to address different components of the *Making it Work: Framework for Remote Rural Workforce Stability* in Scotland. Scotland began their work locally by looking at the conditions for success in the framework. They conducted a number of interviews with human resources, staff and community members to look at the recruitment processes. Examining community engagement and speaking with communities helped them develop local promotional material and support for new recruits and their families. Working on professional information sharing, the recruitment teams developed authentic and innovative advertising. And finally, Scotland considered professional development and team cohesion, working with educators and trainers to develop accessible learning and support for rural remote staff.

> *"There's lots of work going on in Scotland. What we're thinking about now is, how can we find a way to continue to work transnationally?"*
>
> Dr. David Heaney
> Rossal Research and Consultancy

Norway

Dr. Helen Brandstorp, Director, Norwegian Centre for Rural Medicine

Dr. Birgit Abelsen, Researcher, Norwegian Centre for Rural Medicine

The Norwegian case study consists of three municipalities that volunteered to take part in the recruitment and retention strategy: Meløy, Ådahl, and Odda. Each municipality planned and carried out their own local physician recruitment and retention project. The Norwegian Centre of Rural Medicine facilitated the local projects with up-to-date scientific knowledge on physician recruitment and retention, and arranged workshops to gather representatives from the case municipalities and other keen communities for both mutual inspiration and knowledge transfer. Many rural communities in Norway are struggling to recruit and retain physicians and, limited by budgets, are equipped with few tools. The result of the initiative has netted 11 new partners joining the project to continue the work of the three pilot municipalities.

> *"A sparsely populated and rural municipality does not automatically struggle with GP recruitment and retention. On the contrary, several rural municipalities that have had a stable physician in place for a long time provide good examples for learning. In order to attract and keep regular GPs, they use different incentives—both economic and non-economic."*

Dr. Birgit Abelsen
Researcher, Norwegian Centre for Rural Medicine

Iceland

Dr. Sigurður E Sigurðsson, Medical Director and Director of Surgical Services, Akureyri Hospital

Akureyri Hospital is a 140-bed hospital serving rural areas in the northern part of Iceland. A long-standing challenge has been to recruit and retain physicians in the hospital needed to provide services in the local and surrounding communities. This is not isolated to Iceland but a global problem. The participation in EU funded programs *Recruit & Retain* and *Making it Work* has led to new and innovative focus to solving the problems relating to the recruitment of health care personnel. Iceland set goals of recruiting seven new physicians during the Making it Work project, and 11 more in the next five years. Regular visits to medical schools in Iceland and abroad has opened up channels to larger numbers of possible candidates. Students are given a good picture of what it's like living and working in Iceland, and the sense of community that exists.

> *"The shortage of physicians is not new, both nationally and internationally.... We have a better understanding of the work of specialists and the professional isolation that may come with working in these remote rural areas. We have taken steps forward to address this problem and to help them with continuing medical education for their needs and the hospital's needs."*

Dr. Sigurður E Sigurðsson
Medical Director and Director of Surgical Services, Akureyri Hospital

Canada

Dr. Gwen Healey Akearok, Executive and Scientific Director, Qaujigiartiit Health Research Centre (AHRN-NU)

Stephen Tuitt, Territorial Director, Medical Affairs, Government of Nunavut

Jennifer Wakegijig, Senior Project Consultant, Northern Ontario School of Medicine

Nunavut was seeing many short-term, locum physicians, and that lack of continuity of care was beginning to affect patients. In the past, physician retention initiatives were not supported in terms of keeping people living and working in Nunavut. The focus was really on scrambling to locate and employ service providers. Negatively affecting physician retention, was the contract model not being quite right. The result was of a lack of continuity, and with that a risk of patients being undertreated, over-treated, and the potential for medical conditions to be missed. The Making it Work project in Nunavut had a heavy focus on changing physician contracts; continuing education for Nunavut physicians; a refresh of the Nunavut physician recruitment website; and, the introduction of a HEALTH NU app for smartphones. In addition, NOSM coordinated week-long Nunavut Youth Health Careers camp which encouraged youth from across Nunavut to consider health-care professions.

"From 2017 until now has been a time of transition, and a time when we've begun to implement some of the new things we've learned. We've opened up Nunavut to more job sharing, as we lheard from some physicians that they were interested in living in southern Canada but also coming up and providing service in Nunavut. We listened to the hundreds of physicians who support us annually. Predictability, continuity of care, and sustainability are on the horizon!"

Stephen Tuitt
Territorial Director, Medical Affairs, Government of Nunavut

Wrapping up the international presentations, Kirsti Mijnhijmer, Head of Secretariat, Northern Periphery and Arctic Secretariat, spoke from Denmark about the success of the project:

"When the first project was approved, it was already very clear that this topic of recruiting and retaining health-care professionals in remote rural communities was highly relevant to our program area. The interventions presented today demonstrate that the recruit and retain concept may take different forms depending on the context, local needs, availability of facilities, well-established links with institutions, and administrative and political support… In order to be successful, you need to adapt the concept carefully to the conditions on the ground, and keep people at the centre of everything that you do."

Kirsti Mijnhijmer
Head of Secretariat, Northern Periphery and Arctic Secretariat

Knowledge Transfer in Action

Integrating key learnings from the morning's international case study presentations, forum participants considered international rural-health human-resources work to inform the *Physician Resources Action Plan for Northern Ontario*.

In this interactive workshop, participants discussed and compared the existing *Action Plan* (solutions to build a flourishing physician workforce in rural and remote communities) with research findings and emerging workforce stability models from rural and remote regions in Northern Europe, Arctic Canada, and rural Australia.

Presenters

- Dr. Catherine Cervin, Vice Dean, Academic, Northern Ontario School of Medicine
- Dr. Sarah Newbery, Vice President, Clinical, North West Local Health Integration Network (LHIN), rural family physician and NOSM Assistant Professor
- Dr. Paul Preston, Vice President, Clinical, North East Local Health Integration Network
- Ray Hunt, Chief Operating Officer, Northern Ontario School of Medicine
- Jennifer Wakegijig, Senior Project Consultant, Northern Ontario School of Medicine

Participants in the *Making it Work* forum undertook an interactive exercise to identify the minimum requirements that would be needed to persue an effective community engagement process in Northern Ontario. Based on the input received from break-out sessions in Sudbury and Thunder Bay and participants at Ontario Telehealth Network (OTN) sites and in a WebEx space, the following key elements have been distilled.

Who to engage

- Engage a diverse group at the community level.
- Interprofessional clinical representatives. Health administrators.
- Patients and their families.
- Municipal/community leaders. Businesses, chambers of commerce.
- Cultural and linguistic diversity.
- In Indigenous communities, include the Chief and Councillors, leaders, band managers, health directors, CHRs, Elders and youth.
- Community Service Groups (Lions Clubs, Rotary Clubs).
- Include people who can make decisions and take action (as was done when advocacy took place to create NOSM).
- Be flexible about who is engaged – in some communities, municipal leadership may be very keen, but in others, the champions may be elsewhere.
- Be open to identifying both formal and informal leaders.
- Listen to all, including those whose voices are often not heard.

What to discuss

- Ask open-ended questions about the community's health priorities. Avoid asking leading questions or pre-supposing what the community needs or wants or what will fit well there.
- Consider supporting a community priority-setting exercise.
- Let topics evolve organically (follow discussion, listen to stories).
- Discuss community assets, strengths and capacity (infrastructure, human resources).
- Consider an educational component – around how the health system currently operates, health and HR related data in the region/community, to support informed dialogue.
- Consider conversations with the business community and service clubs about local and regional fund-raising needed to meet community needs.
- Quantitative data is needed.
    - Community-specific and regional health status data, health services utilization data, HHR data
    - Identify available health and Human Resources data, identify gaps.
    - Identify data held by community partners that may support priority-setting and planning
    - Ask what data communities want, and be responsive to community requests.

How to engage

- Take the time needed to get the right groups of people educated/activated/involved. True engagement is not quick and not easy.
- A sustainable, common, clear, and consistent cycle is necessary; this includes follow-through and on-going communication.
- Strive not just for engagement but active involvement that mobilizes skills in the community. Promote collaboration among partners.
- Emphasize shared leadership and priority setting, broad participation.
- Incorporate cultural and linguistic diversity respectfully, with dedicated resources for translation services as needed.
- Consider multiple mechanisms for input (web-based, in-person meetings, interviews, surveys) and open invitations for involvement.
- Acknowledge time contributions, consider offering food, honoraria, child care.
- Consider formalizing partnerships for on-going health service needs assessment, with clear roles and responsibilities among community and other partners.
- Potential Methods
    - Consider establishing community steering committees to develop the process best suited to each community.
    - Key Informant Interviews (In-person open-ended interviews to determining perspectives/ priorities of key leaders and stakeholders).

- In-person engagement has added value of seeing the community, the challenges, the distances.
- Small group facilitation with community.
- Virtual small group facilitation may also be effective.

Important Elements of the Overall Approach

- Ensure the scope and objectives of the engagement are clear.
- Take the time to understand the local context. Communicate clearly, and warmly.
- Be transparent. Be quiet and listen.
- Keep it positive and recognize what is working well – sometimes community meetings can focus on negative (why someone left) – how conversation is framed is as important as methodology.
- Dedicated resources are needed to follow up after engagement and communicate with participants as things progress. Ensure adequate resources for effective facilitation. The selection of the facilitator is important – they must be unbiased, transparent and warm.
- Challenge conventional wisdom; be solution-seeking.

Breakout Discussions on Three Themes

Community engagement remained a strong theme throughout the afternoon's break out discussions. Respondents to Theme 1 spoke to effective engagement of partners as a critical condition of success, respondents to the questions in Theme 2 discussed the importance of pentagram partners (see page 17) engaging effectively with communities, and the Theme 3 discussion touched on how community engagement can be evaluated. A summary of the questions asked and key points raised, follows.

Theme 1: Conditions for Success

All groups that discussed the conditions for success spoke to the importance of effective engagement of all pentagram partners, and hearing the voices of vulnerable populations. Participants identified that success in implementing a Physician Resources Plan is contingent on effective engagement and relationship development among the pentagram partners, that their motivation to participate be understood, and that their strengths and weaknesses in participating be recognized.

It was seen as essential that the organization's senior leadership be committed to on-going engagement. A considerable threat that was identified to the sustainability of this initiative was the change in leadership in any of the organizations. Similarly, it was seen as critical that all partners be seen as equal.

Dedicated financial resources for community engagement and for a Physician Resources Plan was seen as critical to the success of the initiative, and that changes in available funding were seen as a potential threat. One group created a visual diagram of the *WHO Pentagram Partnership Model* and added a door, windows and a chimney (see right), to highlight the importance of inclusion, of being open to change, and of the importance of a climate of warmth in the partnership.

The following strengths and potential barriers were identified for specific groups of partners.

Policy Makers

- Have an interest in health promotion/wellness and access to services.
- Often struggle with heavy bureaucratic systems.
- Can change direction when elections and leadership changes cause a change in course.
- OMA advocacy may be important to ensure rural medicine has a strong voice, and that IMGs are recognized as important allies to support health services access.

Existing Health Care Programs

- Are interested/motivated to support a physician resources plan.
- Have resources to participate. Support interprofessional collaboration.
- Often work in silos and can be difficult to engage with on broad issues.

Academic Institutions

- Can be leveraged as partners with access to data.
  - The health services compliment, HR projections and other pertinent data.
- Students need to be aware of benefits.

Communities

- Have strong interest in collaboration to increase access to services.
- Know where people are practicing. Face health threats.

Health Administrators

- Are motivated to participate.

An additional recommendation from participants was the importance of formalized partnerships or "multi-partner networks" which will create group accountability to remain engaged for follow up on shared plans.

Theme 2: Leadership Commitment

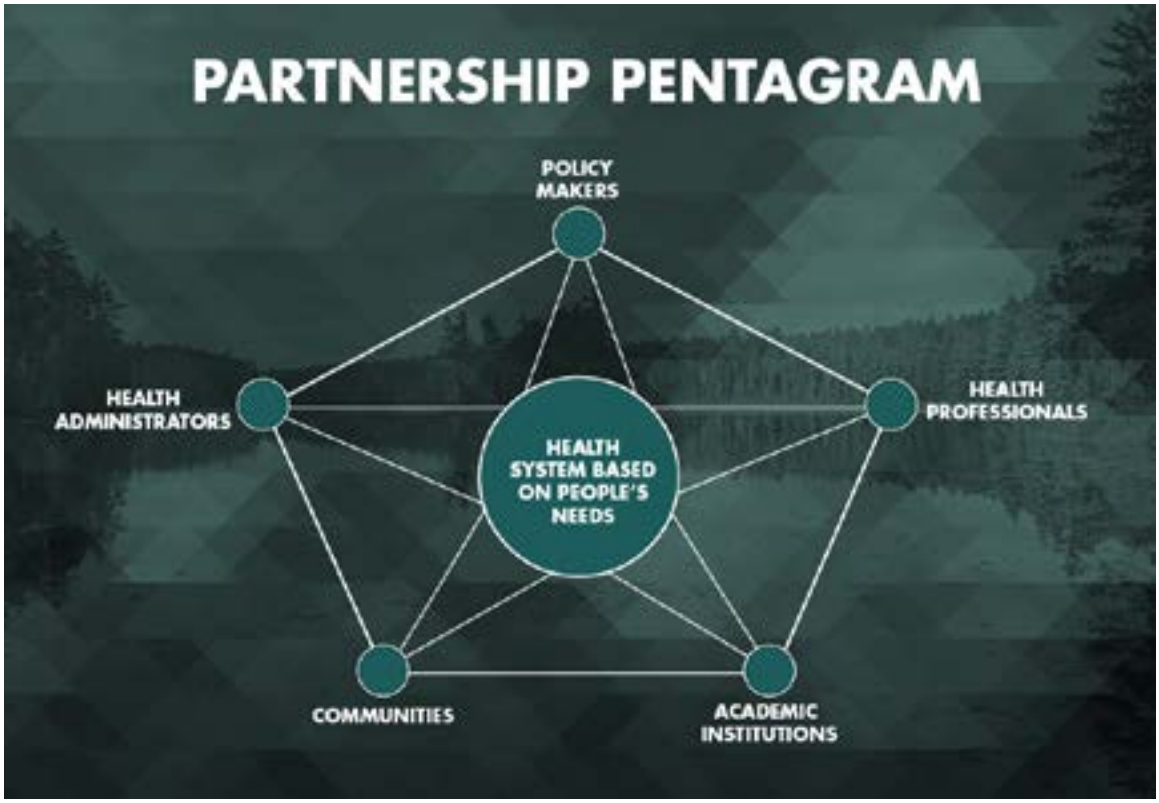
In general, in this theme, the conversation revolved around the importance of consistency and fostering positive working relationships among the leadership of partner organizations.

- NOSM and LHINs
  - Could influence funders to strengthen health services in the North.
  - Must focus on consensus building among community and regional partners regarding priorities and how to proceed in addressing them.
- In communities:
  - Local health care providers should not be relied on as leads in recruitment and retention.
  - Local providers can inform decision makers.
  - Local Service Clubs – are amazing supporters of equipment purchasing and capital projects. They need/want to know what is important to the community.
  - Schools – important partners as part of information sharing with potential recruits.
  - Recreation leadership – potential recruits want to know in what types of activities they/ their kids can be involved.
  - Community cultural organizations (Indigenous, Francophone, or other).
  - Seniors' groups.
  - First Nations – band/council, Elders, health centre leadership and staff.
- Provincial and Federal Politicians – need to recognize that workforce stability depends on additional resources.
- Importance of effective "followership" – people to implement what the leadership recommends.

Theme 3: Monitoring and Evaluation

Participants who spoke to this theme highlighted the importance of

- Identifying measurable goals and objectives.
- Evaluating the process (how the engagement went, to what extent did partners engage in the process).
- Evaluating the outcomes of the engagement (what changed).
- A draft logic model outline was provided as a visual model for elements that should be part of an evaluation strategy.



Pentagram Model Discussion

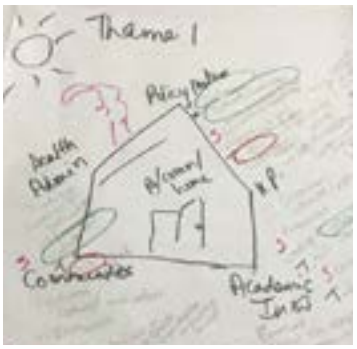
In discussing critical success factors for the implementation of a Physician Resources Plan in Northern Ontario, one of the discussion groups chose to utilize the World Health Organizations's pentagram, which also supports social accountability while engaging with communities. The description below will hopefully inspire further discussion.

Specific conditions were identified for success that must be addressed to implement an on-going physician resources plan for policy makers, health professionals, health administrators and communities. Success is dependent on the inclusion of these conditions throughout the entire engagement process, as well as the determination of their interest in physicians recruitment and retention. The question needs to be ask if each group is motivated to participate in engagement around this issue and if not, explore the reasons that might be contributing to that lack of motivation (i.e. they already have a full compliment of physicians, or there is an urgent issue that requires all resources to be allocated to other sectors). Conditions varied slightly for academic institutions. Interest and motivation was a continued theme for Learners wanting to either come/remain in the north for their education. Inclusion of Learners in the internal academic institutions dialogue on recruitment and retention issue is also necessary.

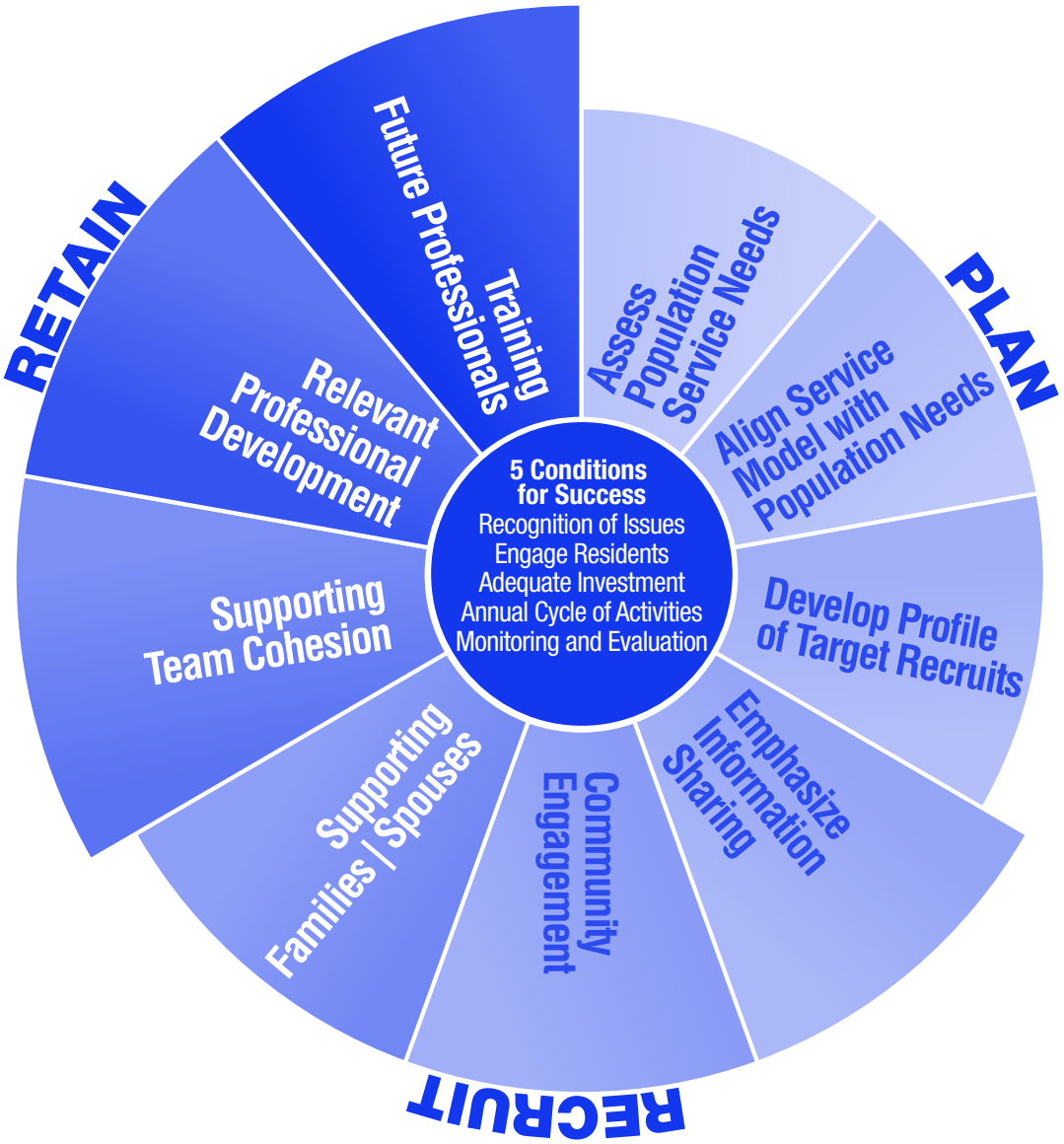
The current conditions for successful implementation that need to be supported and fostered in all areas include collaboration with academic institutions, policy makers, health professionals, health administrators and communities; collaboration also needs to occur within each of these identified groups. Common threats identified were lack of resources in each of these realms. Resources include financial, human, technological, travel, and time (as mentioned there are more

considerations to be considered and discussed). A threat to a community (example flooding, suicides, epidemic/pandemic) could also prevent policy makers, health professionals, health administrators, communities, and potentially academic institutions from coming to the table.

In the redesigned pentagram, a door, chimney and window was added. The door was to represent all ideas and voices were welcome and of equal value. It also represents the fluid nature of a theoretical framework that is needed to be open to change throughout the process. The window represents the limited lens this group had, as they were all from the world of academics and/or health-care provision. In order to expand the view, other perspectives must be brought to the table.



With only a two-dimensional lens, more windows were required with the goal of becoming a solar home! Finally, the chimney represented the need to create a climate of warmth and comfort for all those who entered and left through the door. Did every voice feel like it was treated with respect and dignity? Were those invited to the table asked in a welcoming way? When everyone came into the home, were they treated equally or were some treated with greater importance due to economic, academic, cultural, position, or socioeconomic status?



The Framework consists of nine key strategic elements, grouped into three main tasks (plan, recruit, retain) with five conditions for success.

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2014–2020

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