NORTHERN HEALTH SUMMIT

PROCEEDINGS REPORT
JUNE 16 - 17, 2016

BELLE PETROLEUM CENTRE
PEACE RIVER, ALBERTA

Northern Alberta Development Council

Contents

Hosted by Northern Alberta Development Council

In Partnership with Alberta Health Services

Alberta Government

Message from the Vice-Chair

I am pleased to present you with the Summary of Proceedings for the *Northern Health Summit* hosted in Peace River on June 16 – 17, 2016.

On behalf of the Northern Alberta Development Council (NADC), I thank all the delegates who supported the event and contributed to its success through participation and valuable contributions.

In 2014, our Council hosted the Northern Leaders Summit, bringing together community leaders and government Ministers. As a result of roundtable discussions, a commitment was made to deliver an event which would identify and advance health care priorities for northern Alberta.

The NADC worked with partners in Alberta Health and Alberta Health Services, as well as with educational providers and health advocates, to follow through on this commitment. Municipal and Indigenous community leaders came together at the *Northern Health Summit* 2016 to network and participate in facilitated discussions around current northern health priorities and challenges identified by our partners. For Alberta Health, these included mental health, Indigenous health and community-based primary care. For Alberta Health Services, North Zone priorities included seniors' health and continuing care, addictions and mental health, and primary health care.

The results from these facilitated discussions have been summarized and incorporated into this Proceedings Report. The report identifies priorities, issues, progress and opportunities highlighted by community leaders across our northern communities related to these priority issues and some additional priorities that were identified during the roundtable discussions on health care.

We trust you find this report useful in continuing the dialogue towards advancing health outcomes for the northern region. Our Council will use the report to fulfill our mandate to advise government on opportunities and issues in the north, and continue to build a "stronger Alberta through a stronger north."

Brian Allen
Vice-Chair
Northern Alberta Development Council

Executive Summary

The Northern Alberta Development Council (NADC) regularly engages with northerners to identify emerging issues, opportunities and partnerships to advance the north. During the 2014 Northern Leaders' Summit, concerns related to health care were identified. Specifically, delegates discussed physician shortages, recruitment and retention issues for all health care professionals, limited access to health care professionals in Indigenous communities and ongoing communication issues with Alberta Health Services.

For the NADC, the hosting of a *Northern Health Summit* was in alignment with Council's goals of ensuring:

- Strong, vibrant northern communities
- A skilled and educated workforce
- A diversified northern economy

In order to achieve these goals, our Council understands that the social development needs of our northern region must be addressed in order to encourage sustainable growth and economic prosperity in the North. For our Council, the Summit would provided a venue to directly engage with leaders on issues of importance in their communities and gain a better understanding of the issues and impacts of current health care challenges on northern communities and residents.

As a result of these discussions, the NADC committed to hosting a *Northern Health Summit* to advance key health care priorities within the NADC region. The resulting Summit provided:

- Facilitated conversations between provincial and northern leaders, providing an opportunity to identify priority areas and challenges
- An opportunity for northern leaders to directly provide community perspectives and input into:
    - Alberta Health's ministry priorities for the north
    - Alberta Health Services North Zone priorities
- An opportunity to learn more from experts in the field on topics of interest such as physician recruitment and retention, community support for workforce development, medical education, midwifery and the establishment of healthy communities

Hosting the Summit

The NADC hosted the *Northern Health Summit* to provide an opportunity for northern communities to speak directly with Alberta Health and Alberta Health Services representatives regarding health care priorities and service delivery challenges in the region. This unique opportunity also allowed for government officials to engage directly with northern community leaders, gather input and build a shared understanding of the issues.

Each northern community was invited to send one representative. Delegates included community leaders: northern Mayors, Reeves, First Nations Chiefs and Metis Settlement Chairs. Additional attendees included: Members of the Legislative Assembly of Alberta and Members of Parliament with constituency boundaries within the NADC region, northern Regional Economic Development Alliance Chairs, northern post-secondary leaders, northern Health Advisory Councils, and experts in health. A total of 122 individuals participated in this Summit.

In preparation for the *Northern Health Summit*, northern communities were invited to participate in a survey to help the planning committee identify further health policy and access priorities for the region and topics of interest for expert panels.

From this survey emerged the following overarching themes relating to health; with further specifics identified by some participants:

- Health access challenges: seniors/aging, specialized services, transportation, facilities, centralization and cost.
- Health policy priorities: specialized services, affordability, mental health, education, improved connectivity, workforce, infrastructure.

Equipped with this information and previous engagement on health care with northern communities, the NADC arranged for key experts to share information with delegates on three theme areas:

1. Health Workforce Development in the North
2. Midwifery
3. Healthy Communities

The College of Physicians and Surgeons, University of Alberta Faculty of Medicine and Dentistry, and the Rural Physician Action Plan discussed workforce development from three differing perspectives and touch points within the physician workforce spectrum. Senior officials from Alberta Health and Alberta Health Services shared information on an emerging topic of interest, midwifery.

Dr. Dave Hepburn, an expert in health shared perspectives on health and wellbeing and the role of community in achieving positive health outcomes.

For Summit working sessions, delegates attended facilitated breakout sessions that were divided according to geographic representation. The division of geographic areas was determined by the registration list. Wherever possible,

communities were grouped together with other communities in their region where patients would naturally access services.

Delegates were asked two primary guiding questions related to each priority area. The questions and discussions are summarized in section the Alberta Health Priorities and Alberta Health Services North Zone Priorities section.

Following the facilitated breakout sessions, delegates participated in brief roundtable discussions with attending health officials, identifying community perspectives, concerns, opportunities and sharing information regarding northern Alberta's programs and services.

Roundtable discussion themes addressed by community leaders included:

- Increased funding and supports
- Senior care
- Increased mental health supports
- Cultural considerations and sensitivities
- Greater utilization of local facilities and resources
- Community engagement
- Transportation
- Technology and communication

The 2016 *Northern Health Summit* provided:

- Facilitated conversations between provincial and northern leaders to determine priorities, opportunities and strategies with respect to improving health care in northern Alberta
- Direction to strengthen the NADC's strategic and operational plans as they align with its mandate to advance the social and economic development of the north
- An opportunity for government to gather input on key health care issues impacting northern Albertans, and grow their understanding of the north's role in a prosperous Alberta

Recommendations

The NADC supports several broad recommendations resulting from the Northern Health Summit.

Council recommends that:

- A mechanism to coordinate **ongoing communication and engagement** be developed with northern municipalities and Indigenous communities to ensure health policies and services for the north are inclusive of local northern community perspectives
- The **use of technology** be explored to better serve northern residents, minimize travel for health services where possible, and support patient advocacy and quality of care
- **Gaps in transportation infrastructure** be addressed to support patients requiring access to health services
- A **distributed service delivery and funding model** for health services and education that meets the geographical, cultural and vocational realities of the north and its residents be developed
- Municipal and Indigenous leaders be engaged to **actively support health promotion** and healthy community initiatives in the north
- A **sustainable northern health workforce strategy be developed**

As a result of the Summit, our Council will:

- Share the report with:
    - All delegates who attended the Northern Health Summit
    - Government officials, including but not limited to:
        - the Hon. Rachel Notley, Premier of Alberta
        - the Hon. Sarah Hoffman, Deputy Premier and Minister of Health
        - the Hon. Deron Bilous, Minister of Economic Development and Trade, Minister responsible for the NADC
        - All northern MLAs
    - Dr. Verna Yiu, President and CEO, Alberta Health Services
    - Communities, colleges, Regional Economic Development Alliances, Health Advisory Councils and relevant stakeholders within the NADC region
- Use the information to build networks and inform future engagement opportunities and initiatives pertaining to health care in northern Alberta

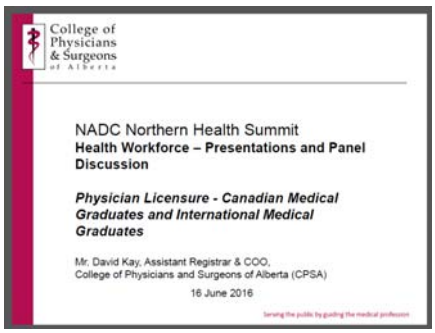
Presentations

Health Workforce Panel

The Health Workforce Panel featured a dynamic group of presentations ranging in topic from the rigors of becoming a registered physician in Alberta to the need to enhance rural and Indigenous health education in medical and dentistry programs. The final speaker circumscribed the discussion by addressing how communities can support rural physicians. The following summaries capture delegate questions and the speakers' responses.

Mr. David Kay: Assistant Registrar and COO, Alberta College of Physicians and Surgeons

Link to Presentations



David Kay presented on the regulatory role that the College of Physicians and Surgeons of Alberta (CPSA) plays in the medical workforce and how this work safeguards the public. Mr. Kay discussed the operation of the CPSA under the *Health Professions Act* and its work to guide Alberta's medical professionals by setting standards for registration and practice, registering members, overseeing the complaint process, assessing performance and accrediting both public and private facilities.

Mr. Kay outlined the process that Alberta medical students need to undergo to become registered physicians and focused on the particular process for International Medical Graduates (IMGs). Mr. Kay clarified that IMGs are students that have obtained their primary medical qualifications outside of Canada or the United States, regardless of citizenship or premedical studies. He noted that approximately 30 percent of the nearly 9,000 licensed physicians in Alberta are IMGs.

Speaker's responses to delegate questions

When asked about the difficulty that students face in gaining admission to Alberta's medical and dentistry programs, Mr. Kay indicated that the province will likely always have a surplus of qualified applicants. However, he cautioned against students obtaining medical qualifications offshore because quality assurance with foreign schools can be a concern and residency training in Canada is not always available to them following their studies. Instead, Mr. Kay suggested that students should reapply to Canadian schools.

When questioned about the governance structure of the CPSA, Mr.

Kay clarified that the role of CPSA is to safeguard the public but that its board is not publicly funded. Furthermore, when asked about the CPSA's presence in rural communities, he stated that the CPSA board plans to continue to engage with the public and arrange regional tours to talk with rural physicians, chambers and other related stakeholders. The CPSA currently hosts public dinners to learn more about how to support communities.

In the discussion, Mr. Kay emphasized that access to public health care is more than just access to physicians; it includes having access to services offered by nurses, midwives and other health care professionals. He indicated that together we must identify the needs of our communities and provide recommendations to elected government officials.

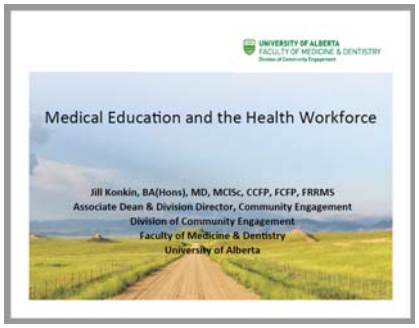
When asked about community-based health care and doctors pay rate, Mr. Kay indicated that physicians are paid on a fee-for-service basis. He explained that there is a menu of health care services paid by the Government of Alberta, and physicians currently charge the same fees and are paid the same rate regardless of location. However, he explained there was a rural and remote modifier, whereby physicians could receive additional payments if they are working in rural or remote locations.

Mr. Kay suggested that Alberta could consider introducing incentives for physicians noting examples such as retention or pension bonuses. He also discussed how Alberta could move from a fee-for-service model to an outcome or quality-based model whereby a proportion of the physician's fees are based on the outcome or satisfaction of service.

When asked about IMGs' pay rate during the Practice Readiness Assessment, which IMGs must complete prior to becoming a registered physician in Alberta, Mr. Kay responded that resident students are compensated with a stipend and assisted by CPSA for covering costs of tools. During an IMGs second assessment, a possible additional 90 days, the physician can bill the Government of Alberta and operate his/her independent practice.

Dr. Jill Konkin: Associate Dean and Division Director Community Engagement, Faculty of Medicine & Dentistry, University of Alberta

Link to Presentations



Dr. Jill Konkin presented the University of Alberta's Faculty of Medicine and Dentistry's (MD) efforts to educate students on rural and Indigenous health. Dr. Konkin indicated that both the Medicine and Dentistry programs reserve ten seats for students of rural origin and five seats for Indigenous students. In addition, the faculty offers opportunities to educate and involve medical students in rural and Indigenous health, including a clerkship program, rural residency options and clinical rotations in Indigenous communities.

Dr. Konkin's presentation also focused on encouraging rural careers in the medical profession. She asserted, "If you want physicians to take their careers to rural and Indigenous communities, then education programs need to focus

on this." To this end, Dr. Konkin discussed the University of Alberta's outreach and recruitment initiatives, which include creating a robust Office of Rural & Regional Health and providing support for rural medicine interest groups. Dr. Konkin identified that more community-engaged research projects are needed as well as a stronger voice within the Faculty of Medicine and Dentistry.

To improve rural and Indigenous health education, Dr. Konkin suggested that municipalities should partner with the Faculty of Medicine and Dentistry and Alberta Health Services to improve the recruitment of physicians who are willing to teach in the north. Dr. Konkin emphasized that rural physicians are vital to delivering rural medical education and retaining other physicians in rural communities. As such, it is important to support and recognize rural physicians willing to teach.

Finally, Dr. Konkin discussed the important role that communities can play to support and inspire learners in their communities. She stressed that communities should work with rural offices and local physicians, and that the Government of Alberta needs to provide predictable long-term funding for programs proven to be successful or innovative. She also indicated that services in the North Zone must be maintained, upgraded, re-introduced and decentralized.

Speaker's responses to delegate questions

When asked about the difficulty of gaining admission into Alberta's medical programs, Dr. Konkin clarified that the program does not accept applicants from outside of Canada. She also indicated that Alberta origin students are givien preference as well as rural and Indigenous origin students. Dr. Konkin explained that the University of Alberta has changed its admission process to attract more diverse applicants. For instance, the admissions criteria include strong consideration for applicants from Indigenous, rural and low socio-economic backgrounds.

Ms. Rebekah Seidel – Community Recruitment Consultant, Rural Physician Action Plan (RPAP)

Link to Presentations

Ms. Seidel began discussing the Alberta Rural Physician Action Plan (RPAP) by outlining its efforts to improve the quality of rural health care. To encourage education of local students, RPAP organizes high school outreach, works with students pursuing health care careers, and administers medical student awards and bursaries. To support rural physicians, RPAP offers training opportunities and resources for rural physicians as well as physician locum services. Finally, RPAP has a committee that focuses on physician attraction and retention.

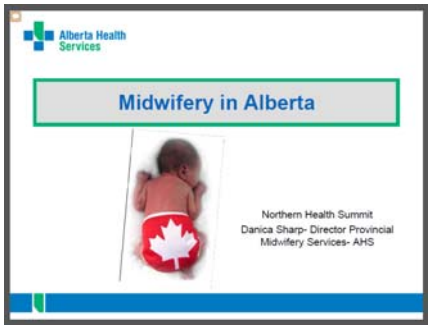
Ms. Seidel concluded her presentation with advice for introducing new physicians to rural communities. She suggested that communities should aim to make the introduction memorable for the physician, such as offering a welcome gift or providing a unique experience. She emphasized that once the community has attracted the physician it is important to help the transition into the community, particularly for International Medical Graduates or non-Indigenous individuals entering into an Indigenous community.

Midwifery in Alberta Panel

The Midwifery in Alberta panel focused on services and provided an overview of related health care spending. Subsequent summaries capture the delegates questions and the speakers' responses.

Ms. Danica Sharp, Director Provincial Midwifery Services, Alberta Health Services

Link to Presentations



Ms. Danica Sharp presented on the role of the Provincial Midwifery Services and the Government of Alberta's plan to expand access to midwives. Ms. Sharp noted that midwives are health care professionals who can offer maternity services to women with low risk pregnancies. In Alberta, 4 percent of women currently use midwife services (20 percent within Edmonton) compared to up to 30 percent in Ontario. She stated of the nearly 100 midwives in Alberta only 3 are located in the North. In terms of funding, between 2015 and 2016, over $12.7 million was allocated to midwifery services. This figure increased between 2016 and 2017 and is projected to increase again between 2017 and 2018.

Provincial Midwifery Services is responsible for both medical affairs and appointing midwives across Alberta. Midwives became publicly funded in 2009 and since January 2013 are required to be registered through the College of Midwives of Alberta, a process that involves attaining a Bachelor of Midwifery (or equivalent), in addition to completing a New Registrant year. Once privileged and appointed by the College, midwives are governed through provincial regulations. In Alberta, these are by Alberta Health Services' (AHS) bylaws and rules. However, Ms. Sharp noted that midwives are only permitted to practice in the location where they are privileged. This challenges expansion of services across the province because training new midwives requires more than one midwife in a location for supervision. This is required until one midwife has practiced in the current geographical location in Alberta for at least one year, practicing without restrictions or New Registration conditions for at least 40 births (equivalent of one year of full-time practice), and whose privileges are in good standing.

The funding model for midwifery in Alberta is based on a Memorandum of Understanding between AHS and the Alberta Association of Midwives. AHS contracts with midwifery practices (service agreements) and Primary Care Networks, rather than contracting midwives directly. Services are covered by a Course of Care and a flat rate rather than a fee for service or bill, which includes prenatal visit and services up to six weeks postpartum. According to Ms. Sharp, midwives provide approximately 40 Courses of Care per year in Alberta; each Course of Care is on average 48 hours of service.

The Canadian model of midwifery guides midwives' work using the principles of informed consumer choice, continuity of care, provision of primary care plus collaboration with other professionals as needed, and choice of birth

setting. Ms. Sharp indicated that there is a midwife in High Level who works with the Primary Care Network. This midwife is supported by nurses and can attend home births. This practice provides a suitable foundation for growth and the potential to increase equality in service allocation because the midwife is currently servicing rural, underserved and Indigenous communities. Ms. Sharp identified that there is also a midwife who operates at the William J. Cadzow-Lac La Biche Healthcare Centre and discussions are underway to provide midwifery services in Fort McMurray.

The presentation outlined alternative models, whereby midwives are not recognized by the College of Midwives. For example, in the High River model, midwives operate out of a private practice within a Primary Care Network, a collaborative low-risk clinic and midwives participate in a shared on-call rotation. Since this model does not meet the College of Midwives' requirements, the midwives are not able to do home births and can only provide services to a maximum of 10 births a year. Another model operating out of Rocky Mountain House serves and supports the local and Indigenous community.

Finally, Ms. Sharp shared considerations for growing midwifery in Alberta. She demonstrated the need for a workforce plan as well as community and facility readiness to welcome midwives. She indicated that integration of services is necessary for collaborative relationships between the midwives and clinical teams. Ms. Sharp concluded her presentation by reviewing a number of the Government of Alberta's priorities as they relate to midwifery, including: revising the three year workforce plan to be more directional, enhancing community maturity planning, creating a New Registrant program, and creating a sustainable midwifery funding model working group.

Speaker's responses to delegate questions

When questioned about expanding midwifery services to Grande Prairie, Ms. Sharp responded that this is on the workforce plan list to explore working with the College on a pilot project.

When asked about how communities can support and facilitate the process of attracting more midwives to their region, Ms. Sharp responded that Alberta Health Services is aware of the growing consumer demand for services and rely on data when implementing a business plan. She encouraged consumer involvement on committees to communicate with the Association of Midwives.

Ms. Michele Evans, Acting Assistant Deputy Minister, Professional Services and Health Benefits, Alberta Health

Link to Presentations

Ms. Evans' presentation focused on the broader context of the Government of Alberta's goals and objectives as they relate to health services. Ms. Evans noted that the Government of Alberta has consolidated $20.4 billion for Alberta Health Services. Of the total budget, the health budget comprises approximately 40 percent and has a projected 6 percent growth rate. This challenges the government to make informed choices to identify how to do

more with current resources. The Government of Alberta's primary health interests are Indigenous health, primary care, mental health and women's health. Ms. Evans indicated that the Minister of Health has a strong interest in midwifery and the Government of Alberta has committed an additional $11 million dollars over 3 years to grow midwifery services in the province. The Government of Alberta wants to focus on expansion of health care services to underserved populations, including the Indigenous, rural and low-income populations. Ms. Evans closed her presentation by outlining a number of Government of Alberta priorities including engaging in a human resource plan, improving access to health care by removing barriers, such as regulative, legislative and professional barriers, and improving the regulatory structure.

Speaker's responses to delegate questions

When questioned about expanding midwifery services to Grande Prairie, Ms. Evans stated that the Government of Alberta assesses and responds to needs and demands based on population growth.

When asked about how communities can support and facilitate the process of attracting more midwives to their region, Ms. Evans encouraged communities to work collaboratively through utilizing resources and supports, and information sharing to create an environment that attracts and retains professionals in their communities.

Alberta Health – Ministry Priorities

The Alberta Health panel speakers discussed the Ministry's priorities, which include Indigenous health, adult addiction and mental health, as well as primary care.

Indigenous Health

Ms. Lara McClelland, Executive Director, Community Based Strategic Policy Branch

Link to Presentations

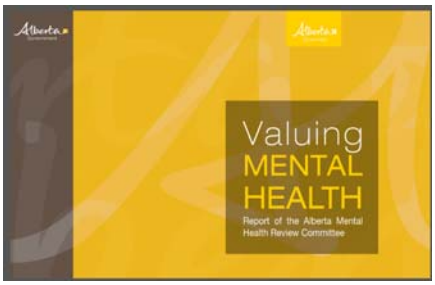
Ms. Lara McClelland presented on Indigenous health in the province as well as the work of Alberta Health's Aboriginal Health Policy Unit. This Unit works across both provincial and federal governments, with Indigenous leaders and organizations, and Alberta Health Services to improve health services and outcomes for Indigenous peoples.

There is currently a life expectancy gap between First Nations and non-First Nations people. As of 2015, the average First Nations person lives 11.9 years less than their non-First Nations counterpart in Alberta; this gap has grown since 1999.

Ms. McClelland promoted the Governments of Alberta and Canada's growing commitments towards positive changes in Indigenous health through their support of the implementation of the United Nations Declaration of the Rights of Indigenous Peoples (UNDRIP). This political commitment will provide an

opportunity to drive meaningful change in the quality of health services and Indigenous health outcomes. She addressed current initiatives of the Unit such as the Trilateral Joint Action Health Plan, Treaty 8 Protocol Agreement, and Wisdom Council among others.

In closing, Ms. McClelland noted that the limited data available on Indigenous peoples is a pressing challenge for the Unit. Nonetheless, there are opportunities to work together on innovative and creative ways to inform collaborative decision-making.



Adult Addiction and Mental Health

Ms. Shannon Berg, for Adult Addiction and Mental Health Unit

Link to Presentations

This presentation provided an overview of the review process of Alberta's addiction and mental health system, initiated in June 2015, including the findings, recommendations and actions since the review. There were 32 recommendations made based on the patient's journey, as a result of the review process.
Immediate actions resulting from the review encompass six priority recommendations:

1. Creation, development or allocation of an implementation team or governance structure
2. Child and youth mental health website
3. Performance monitoring and evaluation framework
4. Medical detox beds for adults in Lethbridge and Red Deer
5. Three social detox beds for children and youth in Calgary
6. Opioid addiction action plan

Ms. Berg spoke on the Government of Alberta's quick and decisive response to the fentanyl crisis, resulting in a tripled supply of Naloxone kits since December 2015 and over 700 Naloxone distribution sites. She concluded her presentation by addressing the Alberta Wildfire Recovery Addiction and Mental Health Response.

Community-Based Primary Care

Ms. Shannon Berg, Executive Director, Primary Health Care Branch

Link to Presentations

Ms. Shannon Berg noted that primary health care is the first place people go for health or wellness advice and programs, the treatment of a health issue or injury, or to diagnose or manage physical and mental health conditions. Per capita, Alberta spends over $800 more than the national average of $4,018 on primary care. Alberta's Primary Health Care Strategy, developed in 2014, outlined and summarized five strategic directions to transform primary health care:

1. Creating cultural change
2. Enhancing delivery of care
3. Establishing foundation for change
4. Health services design based on population needs
5. Increasing the value and return on public investment

Ms. Berg highlighted a collaborative project between Alberta Health Services and the Peace Region Primary Care Network which aims to enhance the delivery of primary health care. The four areas for service enhancement are:

1. Maternal and child health
2. Seniors' health
3. Addictions and mental health
4. Access/continuity of care for unattached individuals

Ms. Berg concluded by discussing the future and benefits of a transformed Primary Health Care in Alberta including examples such as:

- Participation in the plan
- Health services designed by population-based needs (seniors, youth, Indigenous, etc.)
- Fewer emergency department visits
- Greater connection to health, human services, education, etc.
- Improved coordination across the health system
- Access to own health information (personal record & information)
- Greater relationships with trusted providers
- Team-based approaches

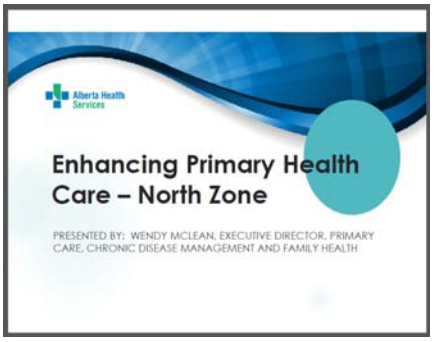
Alberta Health Services – North Zone Priorities

Speakers on the Alberta Health Services panel discussed North Zone priorities addressing initiatives, strategies, challenges and opportunities as they relate to primary health care, adult addiction and mental health, as well as continuing care.

Primary Health Care

Ms. Wendy McLean, Executive Director, Primary Care, Chronic Disease Management & Family Health

Link to Presentations



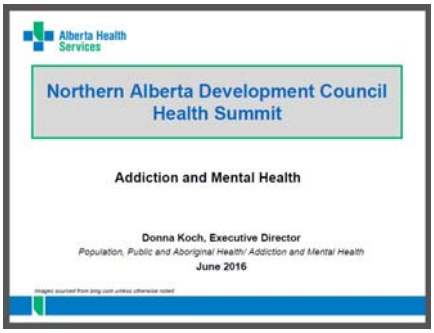
Wendy McLean discussed enhancing primary health care in the North Zone. The principles of primary health care are:

- Person-centric
- Accessible and appropriate
- Collaborative, accountable and sustainable
- Focused on a high return on public investment

According to Ms. McLean, the outcome of primary health care aims to align with the population and health needs. Primary health care is, essentially, offering the right service at the right place by the right provider at the right time. She noted that the goal of good primary health care is to be both

focused on individual and community health outcomes while ensuring that both clients and providers are satisfied. Ms. McLean highlighted that engagement and building strategic alliances among providers is necessary to advance a population health approach, including strong leadership at all levels and among all partners.

In closing, Ms. McLean outlined achievements in the North Zone, including the Slave Lake Family Care Clinic, High Prairie Community Health and Wellness Clinic, and the Peace River Enhanced Primary Health Care Project.



Addiction and Mental Health

Ms. Donna Koch, Executive Director, Addiction & Mental Health/Population Public Health & Aboriginal Health

Link to Presentations

Alberta Health Services' Addiction and Mental Health programs are offered across an individual's lifespan and range from prevention to treatment. In the North Zone, which is the third largest zone in Alberta, spanning 72 percent of Alberta's landmass and including over a half million people serviced, the needs for services vary. Ms. Donna Koch's presentation highlighted Alberta Health Services North Zone Priorities for addiction and mental health. Her presentation covered the availability of programs and services, information about the health workforce, the organization's strategic and operational plans, the response to the Fort McMurray wildfire and finally, some of the challenges and opportunities. Ms. Koch also demonstrated examples of innovations.

Addiction and mental health programs and services in Alberta are evidence-based and zone wide, meaning that they are tailored to meet the specific needs of each community; this model of operations allows resources to flow to communities in need. Ms. Koch emphasized that it is essential to pay attention to language, culture, community size and history when planning addiction and mental health support. As such, the success of innovation is dependent on addressing diversity. Ms. Koch highlighted the response to the Fentanyl crisis as an example, whereby a service was quickly provided to respond to the needs of the affected communities.

The workforce in addiction and mental health is diverse, including professionals such as Mental Health Counselors, Court Liaison Workers, Peer Support Workers and Psychiatrists. Ms. Koch emphasized the importance of partnerships and identified Health Canada, United Way, Rotary, and community organizations as existing partners.

Ms. Koch reviewed the province's addiction and mental health strategic and operational plans which include prevention and promotion, children and youth, outreach, and residential and recovery services. Innovative successes such as the Suicide Task Force, telehealth, and mobile teams and clinics such as the Man-Van (prostate and diabetes support) were also shared.

When speaking about the Fort McMurray wildfire, Ms. Koch noted nearly 25 percent of people in Fort McMurray will need addictions and mental health care, while an estimated 5 percent will require further addiction and mental health counselling. This response will be a zoned approach to accommodate people relocating. Ms. Koch noted one innovative response: the deployment

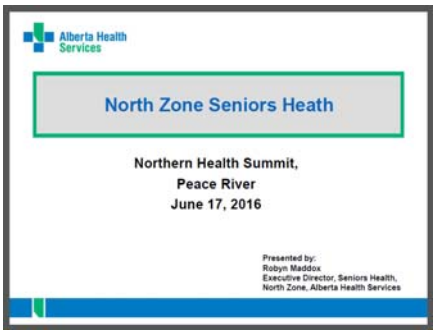
of British Columbia Dog Trauma teams which provide emotional relief.

In closing, Ms. Koch addressed challenges and opportunities for addictions and mental health in Alberta. Challenges include budget, resources and staff retention, while opportunities include the dedication of staff, an increase in psychiatrists, extended service hours (beyond 8:30 am to 4:30 pm), the ability to offer peer support services, and enhanced public addiction and mental health awareness.

Continuing Care

Ms. Robyn Maddox, Executive Director, Seniors Health

Link to Presentations



Ms. Robyn Maddox discussed three aspects of seniors health care in the North Zone. Her presentation focused on the provincial led initiatives for continuing care capacity planning, while clarifying that this planning includes finding new ways to care for people from supportive living to long-term home care, in addition to forecasting required beds. She noted that the key stakeholders in continuing care capacity planning are: Alberta Health, Alberta Infrastructure, Alberta Seniors and Housing, and Alberta Health Services.

Ms. Maddox outlined the steps involved in capacity planning. This process begins by creating a provincial demand forecast that their executive team then confirms before the Zone reviews and validates it. She noted that the Provincial Steering Committee conducts a final review prior to implementing plans.

Finally, Ms. Maddox presented the priorities of Seniors Health in Alberta specifically continuing care placement, telephone access for continuing care, and palliative care in the North.

Banquet Speaker

Dr. Dave Hepburn, author and award-winning syndicated columnist shared his experiences working as a physician, both at home in Canada and abroad. His message focused on the importance of strong community linkages with respect to individual health. He used his experiences in the island of Vanuatu and his passion for health to illustrate both the opportunities and challenges patients and physicians face as they navigate the difficult and sometimes humorous experiences of human health.

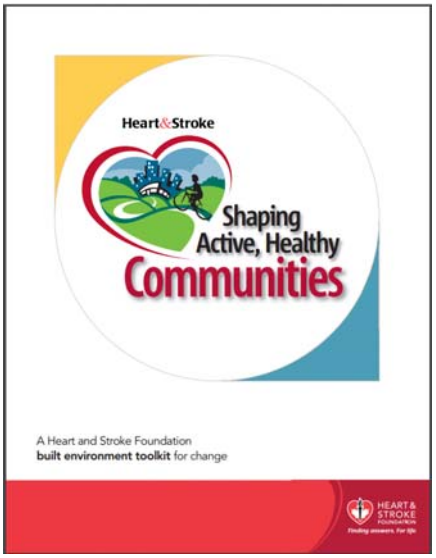
His unique experiences, coupled with an often lighthearted approach to medicine and health both inspired delegates and provided some context within which to ponder the holistic impacts of health, as individuals and within the context of community networks and relationships.

Healthy Communities Resource

Accessible communities that take an active role in supporting the healthy choices of their residents can make a huge difference in long term health outcomes for their populations.

NADC Council member, Eva Urlacher, shared with delegates the *Shaping Active, Healthy Communities Toolkit*, a resource developed by the Heart and Stroke Foundation to highlight tools and resources available to communities, as they actively engage in discussions around delivery of health services, and achievement of positive health outcomes for the northern region. The toolkit outlines practical ways in which communities can plan and design healthy communities.

The full toolkit can be found here: http://www.heartandstroke.com/atf/cf/%7B99452D8B-E7F1-4BD6-A57D-B136CE6C95BF%7D/BETK_HSF_Built_Environments_ENG.pdf



Northern Leaders Identify Priorities

Facilitated Discussions

Northern leaders were provided a unique opportunity to offer input into both ministry and Zone priorities, as identified by Alberta Health (AH) and Alberta Health Services (AHS). Leaders were divided into three groups, balancing regional service areas and the geographic representation of attendees at the Summit.

Group Geographic Representation

Northwest Peace Region
Communities north of Hwy 49 from Gordondale, to northwest of Hwy 2, to northwest of Hwy 679 to Peavine, northwest of Hwy 750 to Gift Lake to northwest of Hwy 88 to the NWT border.

Northwest Central Region
Communities northeast of Hwy 32 from Grande Cache to northeast of Hwy 751 and Hwy 658 (Fort Assiniboine), northwest of Hwy 661 to Athabasca, northwest of Hwy 44 to northwest of Hwy 2 to Slave Lake, northwest of Hwy 88 to south of Hwy 750, Hwy 679, and Hwy 49.

Northeast Central Region
Communities northeast of Hwy 36 from Frog Lake to Saddle Lake, northeast towards Goodfish Lake south of Kikino, Boyle and Rochester to northeast of Hwy 44 traveling north, to northeast of Hwy 2 towards Slave Lake, northeast of Hwy 88 including Wabasca region north to the NWT border.

Through facilitated breakout sessions, northern leaders discussed and provided community perspectives regarding challenges, potential strategies and areas for collaboration. Related to the identified priorities, the resulting discussions have been aggregated and summarized to reflect the intent of the participants.

Mental health, community based primary care and Indigenous health were priorities identified for input by AH. AHS focused on addiction and mental health, primary care and continuing care.

Questions related to the identified priority areas were developed in consultation with AH and AHS.

Roundtable Discussions

Following each facilitated discussion, a general roundtable discussion identifying additional community perspectives, concerns and opportunities was held. During the roundtables, Ministry staff was present to observe the discussions.

Alberta Health Priority

Mental Health

Lack of funding and support were cited by northern leaders as major issues in their communities. Many expressed concern that rural communities are not equipped to deal with mental health and addiction issues, especially when individuals are in crisis. Leaders reported limited funding for mental health programs and professionals resulting in unsuccessful recruitment to properly service their community's needs.

Leaders believe a lack of funding and resources has resulted in people having to **pay out of pocket for treatments** or an expectation that those seeking treatment must travel to bigger centers, which means **some people may go untreated** as they cannot afford travel costs.

Education and awareness about mental health prevention were seen as lacking. Education that focused on youth was of concern specifically related to depression, suicide and drug use/abuse in their communities. Delegates identified that youth need to get information, and concern about the ability of the family unit to provide this type of information and support their youth. There is an expressed desire for greater focus on prevention and intervention versus response to crisis.

Over-prescribing and prescription drug abuse were identified as concerns, as were **alcohol and other drug use**. Additional support and prevention services are needed.

The **family unit and support network** can be adversely affected by multiple factors within northern communities. Issues for Indigenous peoples, including a loss of culture resulting in a loss of self, could contribute to social and family unit breakdown and may result in depression or suicide.

Leaders spoke of the **downturn in the economy** and the resulting impact on mental health in the community. Less disposable income to satisfy addictions can lead to violent crimes or other mental health issues.

Concern was expressed related to the community's capacity to provide ongoing care. Patients with mental illness are sent out of town because local programming is unavailable, which disrupts the continuity of care. Leaders spoke of the **high level of inconsistency** in the mental health system and perceive it as **fragmented and hard to navigate**. The inconsistency of services, community providers and follow-up to treatment make it difficult to **build trust and rapport**.

Northern leaders are concerned about mental health issues and are eager to address **improved access to services and recruitment** of mental health professionals.

Guiding Question:

What are the most significant addiction and mental health challenges your community experiences?

Regional specific comments:

Northwest Peace Region:

- *A wide range of addictions, such as cocaine, fentanyl, alcohol, gambling and smoking were raised as concerns.*
- *Family-centric mental health services are needed in the region.*
- *Youth suicide and depression are a priority area.*

Northwest Central Region:

- *Suicidal patients are at risk when there are limited local resources; this can also place other patients and staff at risk.*
- *Jail is sometimes used when adequate treatment is not available locally.*
- *There is a high incidence of Fetal Alcohol Syndrome Disorder.*
- *More beds are needed for youth treatment.*

Northeast Central Region:

- *Residual effects of the residential school system require specific supports.*
- *There is hesitancy to admit to mental illness or struggles as a result of fear that this would lead to Child and Family Services removing children.*

Alberta Health Priority

Mental Health

Guiding Question:

What addiction and mental health system changes would have the biggest impact on improving the mental well-being and resiliency of Northern Albertans?

Regional specific comments:

Northwest Peace Region:

- *Offer continuous care to all communities in the region with a rotating professional.*
- *Use standardized diagnostic tools.*
- *Provide mental health supports for men.*
- *Offer peer mentorship for youth dealing with addictions.*

Northwest Central Region:

- *Reconstruct staffing models: mental health staff leave at 4:30pm and only work weekdays, yet statistics show influx of calls and need for support during evenings and weekends.*
- *Monitor the potential impact of marijuana legalization.*
- *Provide mandatory reconciliation training for health, mental health and RCMP staff.*

Northeast Central Region:

- *Provide navigational support and better access to shelters and other services to prevent people from falling through the cracks.*
- *Encourage greater awareness and use of telehealth.*
- *Increase communication between federal, provincial, municipal governments and Indigenous communities to provide better access to services.*

Northern leaders emphasized an **early intervention** approach towards mental health issues suggesting an increased focus on **collaborative prevention as well as earlier assessments and treatments**. **Educating children about mental health** is essential, as well as providing early information about drugs, alcohol, gambling, and other destructive behaviours. Leaders want collaborative planning between mental health professionals and schools in order to accomplish early intervention. **Communities also expressed wanting to be involved in designing local solutions**.

The idea of **a holistic approach to mental health** was emphasized. In addition to prevention and early integration, leaders identified the need for additional trauma and healing facilities, as well as aftercare supports for individuals leaving detox centers.

Intergenerational trauma was discussed, as mental health issues can span generations due to ripple effects caused by trauma. Some communities require **support groups** and a place for individuals in the community to seek mental health advice and support for what they are experiencing.

Delegates expressed a need for a **consistent approach to mental health, including ongoing education and support,** as well as reliable and consistent communication.

Concern regarding significant **staff turnover** in community service was expressed by northern leaders. Other concerns identified were **accessibility to consistent local mental health services**, availability of professionals, and transportation to access specialized services.

Alberta Health Priority

Community-Based Primary Care

Northern leaders enthusiastically described what sets rural northern Alberta apart in terms of priority areas for community-based primary care. Delegates advocated for the **decentralization of services within the north.** They were in agreement that services should be based on need and not just population density.

Utilizing existing services and facilities properly and to their fullest potential was identified as a way to manage resources more efficiently. Leaders felt that communities can improve and do better with **what already exists in order to improve services**. An example was provided around the current issue of rural **ambulances used to transport patients** to Edmonton or other larger centers for medical tests; these rural ambulances then get held up in the city leaving the northern areas without coverage. Alternate **transportation support** is needed.

The geographical location of northern communities is impacting access to services. **Maternity care, chronic disease management (in particular diabetes), home care, rehabilitation services, palliative and continuing care** were identified as lacking. Recruiting and retaining qualified health care professionals, primarily rural physicians, were raised as challenging issues.

Leaders believe that **funding should reflect the geographic realities of living in the north** and where possible, bureaucratic red tape should be reduced and adapted to reflect local realities.

Guiding Question:

Are there priority areas of focus (e.g. populations; specific issues) that are unique to Alberta's rural communities that should be considered?

Regional specific comments:

Northwest Peace Region:

- *There are challenges with providing services to Indigenous peoples if they do not have a fixed home location.*
- *Population growth adds to demand for services.*
- *There is a greater need for level 3 care for seniors.*
- *Provide mobile services, health education, and healing trauma centres for mental health issues to reduce isolation and increase access.*

Northwest Central Region:

- *Facilities are deteriorating.*
- *Better community crisis response is needed.*
- *Improve usage and accessibility of technology.*

Northeast Central Region:

- *Develop a comprehensive HUB system (including specialized services among communities) for complete services and care.*
- *There are opportunities for improved organization and usage of equipment. (e.g. Cold Lake hospital wing, use of MRI equipment and HR resources).*
- *Develop business model systems for service sustainability.*
- *Use out-of-the-box thinking, i.e. determine the capacity of local professionals to maximize service potential.*
- *Consider incentives such as loan forgiveness or interest-free loans and educate locals as health providers (e.g. partner to provide incentives to return to the community).*

Alberta Health Priority

Community Based Primary Care

Guiding Question:

In northern Alberta, what key principles and values are important to consider in the planning and delivery of community-based primary health care?

Regional specific comments:

Northwest Peace Region:

- *Consistency for dialysis/chemo service and treatment is required.*
- *Invest in long-term care facilities and senior lodges, to reduce hospitals use for long-term care and to reduce wait lists.*
- *Address transportation challenges due to geographic distances.*

Northwest Central Region:

- *Maintain cross-cultural respect and increase awareness of Indigenous protocols.*
- *Offer local specialized training and services that relate to significant local health issues (e.g. diabetes).*
- *Provide proactive and preventative education.*

Northeast Central Region:

- *Use community inter-agencies for local engagement and input.*
- *Fund ground and air ambulance with certainty.*

Leaders expressed concern that the **geographical location** of their communities was resulting in fractured care for their residents. **Respect and equal treatment in the health care system for northern citizens** was a point of concern. Questions around follow-up care and advocates to keep patients from getting lost in the system were raised. The ability to have family and community support when receiving care was also identified as a necessity.

AH and AHS need to acknowledge and define **rural north and its unique needs**, in order to provide reliable and timely care. Northern lives are equally important and funding should appropriately reflect this. Policy needs to reflect the uniqueness of communities.

Northern areas lack access to health care and services, which may impact decisions to relocate and result in decreased viability of northern communities.

Leaders identified that holistic values need to be maintained, and **local leadership needs to be engaged** by the province. **Communication** was highlighted as an important principle moving forward to improve primary care for residents. Leaders are keen to see meaningful discussion about the design and delivery of services that are action-oriented and have the specific needs of the community in mind.

Alberta Health Priority

Indigenous Health

Respect for traditions and cultural sensitivity was seen as the biggest challenge needing to be overcome. Northern leaders are eager to see mandatory cultural awareness training made available to all health care staff to achieve more understanding on both sides. Respect for local cultural traditions, values and practices, including traditional medicine and Indigenous languages, is something they hope to see more of in their communities.

Language barriers have also been identified as a discouraging factor for some patients. It was suggested that Indigenous individuals could be trained as translators to address this issue. The scope of Indigenous liaisons could also be broadened in situations where clarification is required. Indigenous peoples have a different history and association with medical care and the government, and may react differently to certain situations.

Understanding and appreciating the use of traditional Indigenous methods and medicines by health care professionals is also perceived as a barrier. Northern leaders would like to see the awareness of both types of medicine playing a role in treatment.

Integrating health care into the community may be beneficial in raising awareness for both Indigenous patients and health care staff.
It was suggested that there could be some effort made to identify community-specific teachings in order to encourage the development of relationships between the health care system and the Indigenous community. It takes time to build a **relationship of trust and respect** and this must be understood and considered when it comes to delivering cultural sensitivity training.

Guiding Question:

What does a culturally appropriate health service mean to you and how do we support this training and awareness in our health system?

Regional specific comments:

Northwest Peace Region:

- *Increase awareness around healthy eating.*
- *Offer integration workshops through Rural Physician Action Plan (RPAP) and communities.*
- *Offer career days at school through the Northern Alberta Development Council and AHS.*

Northwest Central Region:

- *Resolve issues such as fragmented services when Health Canada responsibility results in exclusion from provincial services (e.g. dental).*
- *Expand access to detox treatment services to reduce long wait times for local treatment. Allow funding to be used for traditional medicines.*

Northeast Central Region:

- *Recognize the importance of elders as teachers of future leaders.*
- *Teach about residential schools and the ripple effects within the community.*
- *Recognize and respect the international origins and diverse cultures of some residents.*
- *Leverage HUBs to access services and achieve realistic fiscal stability.*

Alberta Health Priority

Indigenous Health

Guiding Question:

What else can be done to address health inequities for Indigenous peoples? How do we engage and gather input?

Regional specific comments:

Northwest Peace Region:

- *Ensure primary care levels are equal to those available to non-Indigenous people.*

Northwest Central Region:

- *Increase collaboration and work together with services offered in Indigenous communities.*
- *Develop data and statistical information sharing agreements for better decision making and planning.*

Northeast Central Region:

- *Assess available services and gaps.*
- *Resolve unnecessary restraints and difficulties resulting from federal/provincial jurisdictional boundaries.*
- *Educate communities on service systems and expectations (i.e. STARS, rural-remote emergency care).*
- *Engage with Métis Health Board, leaders and decision makers.*
- *Change the question to "How can we make this work?"*

Northern leaders are keen to act on this priority and hope to further develop ways to improve health outcomes for Indigenous populations in the region. Various ideas were offered to address health inequities for Indigenous peoples.

Identifying existing **opportunities for collaboration** and coordinating outcomes of these efforts could be beneficial to northern communities. There are existing provincial health initiatives targeting Indigenous groups; should be offered in collaboration with communities with mutual accountability, to ensure effective service provision. A suggested first step is to conduct an **assessment** of what is currently available, to determine service accessibility for the Indigenous population.

Services that support health, such as clean drinking water and efficient sewage management were also identified as requiring attention. Leaders addressed **transportation issues** related to geographic location, **local economic development, food availability, and education** as factors affecting health.

Technology was also seen as a resource to bridge the health services gap and bring services to rural residents. Emergency situations, health link programs, and video conferencing were all identified as possible areas for increased use of technology.

Clarity and inclusion in decision making are important to northern leaders. They would like to see service providers engaging with leaders and decision makers in the Indigenous communities, and **encouraging the exchange of information to build relationships between these groups**. Leaders also expressed a need to see greater **Indigenous participation in forums** like the *Northern Health Summit*, as well as participation by Health Canada.

There was an interest in the **facilitation of additional sessions similar to the *Northern Health Summit***. Common health concerns can **bring multiple groups together to discuss those specific issues**.

Alberta Health - Roundtable Discussions

Northern leaders participated in a general roundtable discussion followed by facilitated discussions, identifying additional community perspectives, concerns and opportunities. Discussions were captured and summarized as follows:

Northwest Peace Region:

Connectivity (broadband/cellular service/technology) was identified as an issue for further discussion in terms of integration of AHS programs and services. Leaders highlighted financial issues to be examined further, such as **additional expenses incurred by northern residents to access health services**, and the **quality of services readily available in the local area**. Community leaders addressed the challenges with residing in the north and inability to access local specialized treatment care and supports. Residents are often burdened to travel great distances for this level of care and incur further expenses if more than a day trip is required. This burden on the patient includes missed time from work, expenses for accommodation, fuel, meals, etc. The group wishes to see the **inconsistency of ambulance service** wait times addressed, as well as the **rationale of the mental health therapists' rotation**.

Northwest Central Region:

Delegates expressed frustration regarding **diabetes treatment only being available in the hubs of Slave Lake and Grande Prairie**, as they have been advocating for this to be available in High Prairie for over 15 years. The High Prairie area has higher diabetes prevalence than Alberta's Geographic Peer Group average. In 2012, High Prairie ranked number 2 in hypertension, number 2 in diabetes, number 15 in ischemic heart disease and number 3 in chronic obstructive pulmonary disease among prevalence rates reported for the 132 local geographical areas in Alberta. A Diabetes Management Advocacy Group was created in High Prairie to support meaningful action to address the emergent need for a sustainable, functional and holistic diabetes management system, including dialysis, in the local area. The group hopes to enable better health outcomes and facilitate effective relationships and processes between service providers and people with diabetes.

There are **long-term financial costs and human fatigue associated with transportation to access programs and services elsewhere**. The distance and time to and from dialysis treatment affect a client's recovery and mental health. Clients currently travel to Peace River, Slave Lake, Grande Prairie or Edmonton for this service. Leaders indicated that local medical staff expressed an interest in pursuing further training. Community leaders would like to ensure decision-makers in health respond to the population health needs clearly reflected in the data and direct the establishment and provision of services in those areas.

Concern was raised about loss of services in rural areas formerly provided in Hythe and Beaverlodge, such as maternity, cardiac and acute care. Overfilled beds in Grande Prairie and additional travel time increase risks to residents.

When patients are moved between different **hospitals and care centers**, it becomes more likely for communication to breakdown among the medical staff, which compromises patient care. Leaders also felt that there can be improvements with respect to **communication and consultation with Métis Settlements** by Alberta Health. Some required services, such as addictions supports, are too far from the Settlements and are therefore inaccessible when required.

On occasion, patients have been informed that they can only discuss one issue while at doctor appointments. When patients are geographically distant from care, they **should be offered the opportunity to discuss various issues at one appointment**.

Northeast Central Region:

Northern leaders were pleased to see a health event such as the *Northern Health Summit* being held in a local area, as an opportunity to share knowledge. Leaders are **interested in taking a local perspective towards addressing health care issues** and involving services (such as education) to support health through socio-economic determinants. **Local knowledge and autonomy are essential.** Leaders expressed a need for improvements among AH policy makers to reach out and inquire with the local population about needs before implementing policy. They also pointed to the importance of health information and exposure to **health career opportunities**.

There is a desire to see **improved usage of existing facilities**, more **community-driven solutions versus outside policy-driven solutions**. This group would like clarification and consistency with **navigating through the health care system**, as it can be complex due to turnover, funding, and restructuring.

Delegates addressed the higher than usual number of suicides involving children and youth in their communities over the past three years and expressed concern for lack of continual funding and positions for child and youth Mental Health Counselors. The shortage of professional services results in the increase of client workload offered by community agencies.

Alberta Health Services - North Zone Priority:

Primary Care

Northern leaders advised that **primary care needs to be built into the community** to actively establish and maintain relationships among local providers and residents.

Primary care requires meaningful **community engagement that is action oriented** with assurance that conversations will lead to results. Community engagement among a broad population scope (seniors, youth, Indigenous, etc.) will strengthen the awareness of what is important in communities; meeting with and hearing from people who are affected will provide communities with the **ability to contribute to decision making** around local operations.

Communities expressed they would like to see the **return of local health authorities and less centralization**. Delegates spoke about the need for improved communication, awareness, advocacy, local contacts and supports. They wished for more opportunities to voice concerns and receive follow up. Health Advisory Councils were specifically referenced citing better communication and awareness is needed. This would ensure systems are in place and individuals know who to call when the system is not working. Leaders want **local advocacy and accountability**.

An aging population and limited professional resources in rural communities often contribute to added stress on extended family and friends. There was an expressed need for **increased education and support systems for family members who are primary caregivers**.

Delegates stated that community has a desire to serve and help. Primary care means **respecting how communities become engaged** (i.e. local fundraising to get hospital equipment) and being inclusive of existing partnerships.

Guiding Question:

What does citizen engagement in primary care mean to you?

Regional specific comments:

Northwest Peace Region:

- *Citizen engagement means services at the right time and right place.*
- *Community engagement should occur before service and policy changes are made.*
- *Include community representatives in physician recruitment and retention.*
- *Streamline the patient health services record system across the province.*

Northwest Central Region:

- *Meet with and hear from people who are affected.*
- *Value and listen to feedback and implement suggestions brought forward.*
- *Ensure key decision/policy makers and leaders are at the table and include others, such as FNMI partnerships.*

Northeast Central Region:

- *Need local accountability and a mechanism or system for advocacy.*
- *Patient first means having autonomy in decisions about your health care.*
- *What about prevention? Engagement means communities ensure prevention is a priority.*
- *People don't generally feel they have a voice, which results in apathy.*

Alberta Health Services - North Zone Priority:

Primary Care

Guiding Question:

How do we support citizen participation in health planning?

Regional specific comments:

Northwest Peace Region:

- *Advocate for local involvement in health advisory groups and organizations.*

Northwest Central Region:

- *Listen and support concerns raised by citizens through advocacy groups (i.e. diabetes management advocacy in High Prairie).*
- *Address ongoing challenges related to **transportation and access to services in rural areas (particularly maternity care and dialysis).***

Northeast Central Region:

- *Involve citizens in policy making decisions.*
- *Evaluate effectiveness of current policies keeping rural needs in mind.*
- *Encourage health professionals to work with natural healers and offer alternative therapies.*

Northern leaders highlighted the need for Health Advisory Councils; however, in order to be effective, they must communicate better with residents, and be heard by AHS. **Being included in the decision-making on a local level** and provided with a formal opportunity for citizens to provide feedback is important to communities (i.e. Indigenous Voice Project and the Mental Health Review).

Various discussions took place around the need for **increased communication** between AHS, municipalities and citizens. Suggestions included community mail outs, interactive websites and social media, hosting of frequent gatherings and networking events, and town hall regional meetings. Increased promotion of resource links such as Health Link (811), the mental health and seniors (1-800) resource lines were referenced.

Communities expressed the need for **greater community engagement and partnerships.** Reporting back to citizens regarding the outcomes and actions in response to engagement activities will ensure they have value.
Leaders expressed a need for **returning local and rural services back to communities**, for AHS to acknowledge the differences in rural vs urban when planning, and the need and benefit for regionalized health services. The distance for rural citizens to access urban services requires extensive travel, and often takes a day or two days for travel, being away from work and having to plan overnight arrangements. **The expenses incurred to travel and access care is a burden for the patient.**

Alberta Health Services - North Zone Priority:

Addiction and Mental Health

Northern leaders discussed ongoing **difficulties accessing services and qualified providers**, along with the recommendation to use locally delivered proactive approaches to deal with mental health and addiction.

The stigma around mental health issues remains an ongoing challenge. In the north, cross-cultural awareness training, relationship building and a holistic approach using an inter-disciplinary team is needed to ensure people know the system and "the support team is there for them."

Leaders pointed to an important role of community leadership in supporting the health system. In particular they encouraged showing concern for the mental health and well-being of residents by partnering with AHS and inviting them to Council meetings and **hosting joint community events**.

Leaders suggested AHS **consider unconventional methods** to get the word out about mental health education and awareness. Some examples included:

- The Men at Risk group in Grande Prairie - a venue to partner and supply resources and information
- Traveling education model - provided information and education on Crystal Meth
- Hope model - sharing of experiences of someone who went through rehabilitation and was successful

Leaders spoke on mental health early intervention programs which have been successful in their communities. The use of Early Childhood fairs was identified as a good initiative, showing some success. Early intervention (pre-school age) programs (i.e. Success by 6) and mental health prevention programs like "When We Are Healthy" (a Metis Settlement program funded by Family and Community Support Services), are working and supported through the involvement of the Family School Liaisons.

Wait times (up to two years) for assessments were identified as an ongoing issue and the **need for a more coordinated approach to mental health services** was identified. This includes access to and sharing of information between both the mental health specialists and health care providers and, where appropriate, the local Primary Care Network and other family and community support services. Some leaders identified a fear within their communities regarding sharing of case files, which is impacting service delivery.

Challenges with **limited scope of services available in rural and remote emergency departments** were highlighted. One community identified the 'Detroit Model' (Henry Ford Health System in Detroit) a suicide prevention system applying a standard suicide risk assessment for every behavioral patient in an emergency department, as a possible model for consideration in the north.

Guiding Question:

What are the gaps in service in the north for addiction and mental health and what are the opportunities for technology and how receptive is the community?

Regional specific comments:

Northwest Peace Region:

- *Bring services back to community; become more proactive vs reactive.*
- *Support the Primary Care Network and increase staff resources and funding.*

Northwest Central Region:

- *Fear of sharing information (i.e. case files) is paralyzing service delivery.*
- *Be willing to change how things are done and offer flexibility with service delivery.*

Northeast Central Region:

- *Support mental health during and after disasters, like Fort McMurray, which was devastated by the recent wildfires.*
- *Maintain services across the region, especially during extraordinary times.*

With varying degrees of services between regions, the use of technology is an option worth exploring, but northern leaders urged the use of face-to-face care when possible.

The gaps in broadband and cell phone service were identified as a barrier to delivering services using technology.

Limited or unreliable cell and broadband service is a reality for most communities in the north and must be considered when planning programming and services. Ideas related to use of technology include:

- AHS engage Bell as a face for mental health
- AHS create an App with GPS - individuals could text to reach out to peers for support; this would also allow providers to identify patients requiring support
- Use the 811 number
- Use videoconference

Overall, there was strong encouragement to build on success and work that has already happened. Previous work on the Mental Health Review, Indigenous Voice Project, Mental Health and Addictions Project should be used and built upon to advance outcomes.

Leaders would like to see the recommendations from the Indigenous voice Project - final results went directly to the service recipients.

Alberta Health Services - North Zone Priority:

Addiction and Mental Health

All leaders touched on the importance of community engagement, communication, education and awareness when looking at improving mental health outcomes.

Leaders suggested Alberta Health Services **engage the community** in the development of campaigns that include community role models and leaders sharing experiences and successes. Provincial health priorities must align with community priorities. In building trusting relationships with the communities, time frames and follow through are key.

Communication between health care providers, patients and families was also identified. There is a need for greater inclusion, information sharing, and education and supports for families.

Delegates spoke of the need for **increased community-based programs, education and awareness**. Northern leaders would like to see the provincial education curriculum include addiction prevention, and offer on-site supports (awareness and counselling) in the schools. Increasing community based resources, including extending after hours and post-episode supports was also suggested.

The use of technology and innovation in service delivery was discussed, particularly with respect to telehealth. Telehealth technology is available in some communities. However, some examples shared had patients travelling to urban centers to access telehealth when the equipment was available at the local center. There were questions around expectations for physicians using telehealth in their clinics.

Leaders addressed the opportunity for increased **technology use** and alternative resource supports for individuals wishing to seek one-on-one services. Some suggested greater interactive online social media-related resources and supports (such as an app) to help navigate the system and seek mental health and addiction related services.

Delegates highlighted a need for prevention, intervention and post-intervention in **Indigenous communities**. The issue of follow-up care and resources, particularly after being discharged from Edmonton facilities, was raised.

Leaders spoke about the implications and difficulties in maintaining trust and engagement among community residents resulting from **inconsistent services, sporadic programs, and high turnover of staff**. A more sustainable model that includes a 3-5 year plan with a team approach to staffing essential positions was suggested.

An important sentiment was that **"one size does not fit all"** with respect to service delivery. Recognizing the uniqueness of the individuals and communities, considering holistic healing, and having professional, culturally-aware staff is important.

Guiding Question:

How can the health system collaborate with you in improving addiction and mental health outcomes and reduce stigma?

Regional specific comments:

Northwest Peace Region:

- *Increase peer support and involvement of families in information sharing and support strategies.*

Northwest Central Region:

- *Address lack of resources, services and providers, as well as limited internet access in some areas.*
- *Offer more prevention, intervention and follow-up services in Indigenous communities.*

Northeast Central Region:

- *Offer intervention to support struggling families and increase life skills supports and education.*
- *Improve federal and provincial collaboration for access to programs and services.*

Alberta Health Services - North Zone Priority:

Seniors Health – Continuing Care

Guiding Question:

What does palliative care mean to you? What types of palliative supports would you like to have access to?

Regional specific comments:

Northwest Peace Region:

- *Communicate a standard definition of care - private, public and home.*

Northwest Central Region:

- *Increase staff (nurses, mental health and social workers) to support family members and private care nurses who can administer/train and deliver meds in the home.*

Northeast Central Region:

- *Offer a bridge between level 3 and 5 when looking at auxiliary, homecare and supportive living facilities.*
- *Address the ongoing issue of transportation needs for elderly patients.*
- *Educate local providers about the "real" community (e.g. limited access to potable water).*
- *Provide greater focus on pre-hospital intervention and supports.*

Northern leaders expressed that high standard and level of **patient care and comfort** is essential during palliative care. These included:

- Increase resources and supports for patient, family, and caregivers
- Quality of care, close to home
- Offer families more choices between home care and hospital care
- Comfort and care till end of life
- Alleviate suffering including spiritual, physical and psychosocial needs
- Respect and dignity, giving the patient the right to age and die in their community

Leaders spoke about the need for providing a **space that feels like home** (family or private room for families/patients) designed to accommodate a family setting. Additionally, they identified the need for a space between moving from senior's facility to long-term care and temporary housing for loved ones (i.e. Ronald McDonald House). In some communities, palliative care rooms are furnished by volunteers; leaders expressed that it isn't right to download this on the volunteer sector.

Cultural considerations and practices need to be respected and offered as enhanced supports, for example, drumming and smudging.

Delegates expressed a need for greater intervention and supports before families need to come to the hospital. Offering **in-home palliative care** with a **holistic care plan,** including resources for staff and community, would allow family members and caregivers to take care of palliative patients.

Caregiver training for relatives and community members, as well as **increased access to home care, auxiliary supports and respite** are required so family members don't have to leave their community. Reduced staff turnover will help to support families providing care and increased check-ins for seniors may decrease elder abuse.

Alberta Health Services - North Zone Priority:

Seniors Health – Continuing Care

A key theme throughout Northern Leader discussions was around choice. Choosing a lodge or home requires supports to be in place so families can choose which options make most sense for their loved ones and their situation.

Leaders want to ensure options are available for seniors to age in place, meaning staying in their homes as long as possible, and for families when end of life is near.

Extended home care options are essential, as are transportation services. Bringing services (i.e. paramedic) to the senior's home, thereby reducing transportation to the hospital was suggested.

Leaders expressed the increasing need for seniors' transportation, reiterating that Family and Community Support Services (FCSS) cannot fill the existing gap. The idea of provincially funded transportation was raised, with reference to transportation grants and handi-bus services being run by municipalities (e.g. Wild Rose Transportation Grant).

Delegates spoke about a greater need for ongoing review of patient delivery assessment or classification to ensure a high level of care is provided.

Seniors need to be given the choice of lodge or home and provided with other options if amenities are full or unavailable. There is a desire to see additional supports for family members in place, so seniors can stay in their homes longer, services are delivered where they are needed and couples can stay together.

Delegates addressed the need for **prevention of seniors' isolation**, affecting emotional and physical well-being.

Additional **senior social programs** and a greater AHS presence at community events for seniors would be beneficial. Social programs and activities must be affordable, utilize seniors' skills, and include programming unique to communities (e.g. Additional program topics included addressing aging at home, senior abuse awareness, and greater partnerships in local community activities, including schools).

A business model idea was shared for privately operated senior facilities, where they could host a cultural day/event, **engaging seniors** skilled in those activities where items could be sold and profits returned to facility program funds. The benefits would include greater senior engagement and interaction in activities, while sharing seniors' knowledge, skills and expertise.

Lastly, **respectful care that is culturally relevant** is needed. Partnering with Indigenous care teams to support and collaborate in case management and delivery of care should be explored.

Guiding Question:

What are the greatest needs for senior's care in your community? What types of partnerships could help us address these needs?

Regional specific comments:

Northwest Peace Region:

- *Increase senior social programs (i.e. Candy Striper Program).*

Northwest Central Region:

- *Increase facilities and program support for aging at home.*
- *Provide provincial support for patient to age in place.*
- *Increase senior engagement activities and entertainment (daytime care, recreation, etc.).*

Northeast Central Region:

- *Clarify how a local PCN fits into the governance structure of a PCN board.*
- *Support Wabasca's plans to build a regional 40 unit lodge and facility, which will attract residents from surrounding communities.*
- *Reduce Federal/Provincial red tape to facilitate First Nation partnerships.*
- *Promote the AHS North Zone '855' number and have a nurse who is located in the North answering the phones.*

Delegates spoke about the challenges and need for **funding support**:

- Seniors facilities to belong to municipal governments and not private companies (no profit margin)
- Provincial support and funding to age in place is inadequate
- Fixed income seniors have difficulty accessing hearing aids, etc.
- A need for income-based supports

Suggestions were made by Northern leaders for **greater collaboration** and flexibility. Examples include: general practitioners working together, and stronger links between AHS and municipal offices so they can share relevant health information with the local community.

Leaders noted that rules and services must be realistic and community–based, and that liability issues sometimes restrict effective solutions. Leaders expressed a need for staff to have flexibility in their position and job descriptions (e.g. support staff being able to change bandages) in order to deliver effective community services.

Alberta Health Services – Roundtable Discussions:

Following the facilitated sessions, northern leaders participated in Roundtable discussions to express and identify additional community perspectives, concerns and opportunities. For this portion, Senior Zone Leadership, Ms. Shelly Pusch and Dr. Kevin Worry addressed delegates, listened to concerns and shared information regarding current status of programs and services within the North Zone.

Northwest Peace Region:

This group of delegates highlighted issues such as a **lack of health care providers**, **affordable and accessible transportation** to health care facilities, and overall **cost of living in northern Alberta**. Leaders identified the need for health care advocates for individuals who do not have personal caregivers or require assistance navigating and accessing the health care system.

Broader **communication issues between health care planners and municipalities** were also identified by this group. Northern leaders discussed Health Advisory Councils (HAC) as a good example to bridge the gap between communities and health care planners and suggested the need for a new team whose role is to specifically communicate health care issues in the north.

The idea of **revamping secondary school curriculum** through **collaboration between school boards and Alberta Health** was proposed for a curriculum with a greater focus on health care professions and personal finances. The overall cost of living in the north and the need for **specialized allowances or other forms of compensations** was also addressed by this group.

This group concluded by addressing the **lack of involvement with Health Canada** and the need for a **specific Indigenous health program in northern Alberta**.

Northwest Central Region:

Delegates in the group addressed the need for **better public health education**, especially in relation to understanding the different functions of Alberta Health and Alberta Health Services in terms of their respective structures and how to engage with their offices. Leaders discussed the confusion experienced when trying to locate appropriate representatives to discuss their concerns with.

This group also identified the need for **better communication with communities** when there are structural changes and proposed instating an ombudsman to help rectify these issues.

Leaders addressed the topic of **accessing services in rural and remote communities**, stating that in rural and remote areas there is less access to preventative services, such as immunizations and diabetes wound care. This group discussed that health care in general is less accessible in rural communities and to receive adequate or specialized health care, rural people must travel to more populated areas. This group emphasized that the Minister of Alberta Health's notion of 'services in the right place, at the right time'

should be the focus. Reduce centralization of services and super-hubs, and bring **services to people in their geographical area** to **reduce the financial and emotional burden of travel** for individuals.

This group addressed the potential solution of having a web-based application or telehealth to address health care needs of people in rural and remote communities. However, delegates noted this would not be adequate on its own, as many people live without computers or cellphones, and that service delivery needs to match people's needs. The discussion also addressed issues encountered as a result of the **centralization of health care services** and the **need for more local autonomy** in running local facilities. This group stated it is important for **services to be reallocated to rural communities**, as they used to be, and noted if facilities were in rural locations, it may have a positive impact on recruiting physicians.

Northeast Central Region:

This group of community leaders addressed the concern for **community fundraising towards specialized health care equipment**. Leaders expressed frustration that when communities identify a need for a service and raise the funds to purchase the needed equipment, AHS does not always support the service. This results in mistrust and raises barriers to community engagement. The discussion also focused on the need for **better usage of facilities**. Many facilities have unoccupied floors and units, which can be utilized for greater specialized regional services. The discussion addressed the need for **facilities to be community-driven** and not physician-driven.

Northern leaders addressed the need to approve hiring into allocated positions within the hospitals. In many communities there are no physicians or nurse practitioners to serve a vast geographic region, and many positions are still required to be filled following staff retirement. Some municipalities established partnerships with local colleges to provide funding towards nursing training to address local workforce needs; however, **further funding is required to train local residents** to become Licensed Practical Nurses or Registered Nurses.

Ambulance services were also a topic of discussion, addressing the **inefficiencies and lack of local ambulances** as a **result of the centralized dispatch service**. Communities also noted that since the provincial takeover of ambulance services, some northern communities no longer have an EMS facility/garage, and require EMR staff to reside in hospital and occupy rooms formerly designated to long-term care beds.

Conclusion

The NADC Council members and staff extend sincere thanks to everyone involved in the planning and preparation of the Summit, and to the attendees of the *Northern Health Summit*. This event was a unique opportunity for northern leaders to share their health priorities to provincial health representatives. The roll up of discussions and priorities addressed at this event will be a valuable resource for provincial leaders and advisors. We hope northern leaders and provincial representatives will continue to work towards solutions to the issues identified.

The NADC will provide a copy of this Health Summit Proceedings report and maintain dialogue pertaining to the overarching northern health priorities with the Ministry of Health, with our northern Alberta communities and elected officials. The report will also be distributed to communities within the NADC region.

Electronic copies will be available on the NADC website. The report will also be provided to the Alberta Urban Municipalities Association (AUMA) and the Alberta Association of Municipal Districts and Counties (AAMDC).

The Council looks forward to hearing positive outcomes resulting from the *Northern Health Summit* and will continue to advocate for solutions that will work for our unique northern communities.

Appendix A

**Electronic versions are available on the NADC website: www.nadc.ca*

2016 *Northern Health Summit* Agenda Guide
NADC 2016 Health Summit Guide

Appendix B

Presentations

Workforce Panel:
Presentation: Workforce - AB College of Physicians and Surgeons - David Kay
Presentation: Workforce— Medical Education and the Health Workforce—Dr. Jill Konkin
Presentation: Workforce - Rural Physician Action Plan (RPAP) - Rebekah Seidel

Midwifery in Alberta:
Presentation: Midwifery In Alberta - Danica Sharp

Alberta Health (AH) – Ministry Priorities:
Presentation: AH Indigenous Health - Lara McClelland
Presentation: AH Adult Addiction and Mental Health - Michelle Craig
Presentation: AH Community Based Primary Care - Shannon Berg

Alberta Health Services (AHS) – Ministry Priorities:
Presentation: AHS Primary Care Priorities - Wendy McLean
Presentation: AHS Addiction & Mental Health Priorities - Donna Koch
Presentation: AHS Continuing Care Priority - Robyn Maddox

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