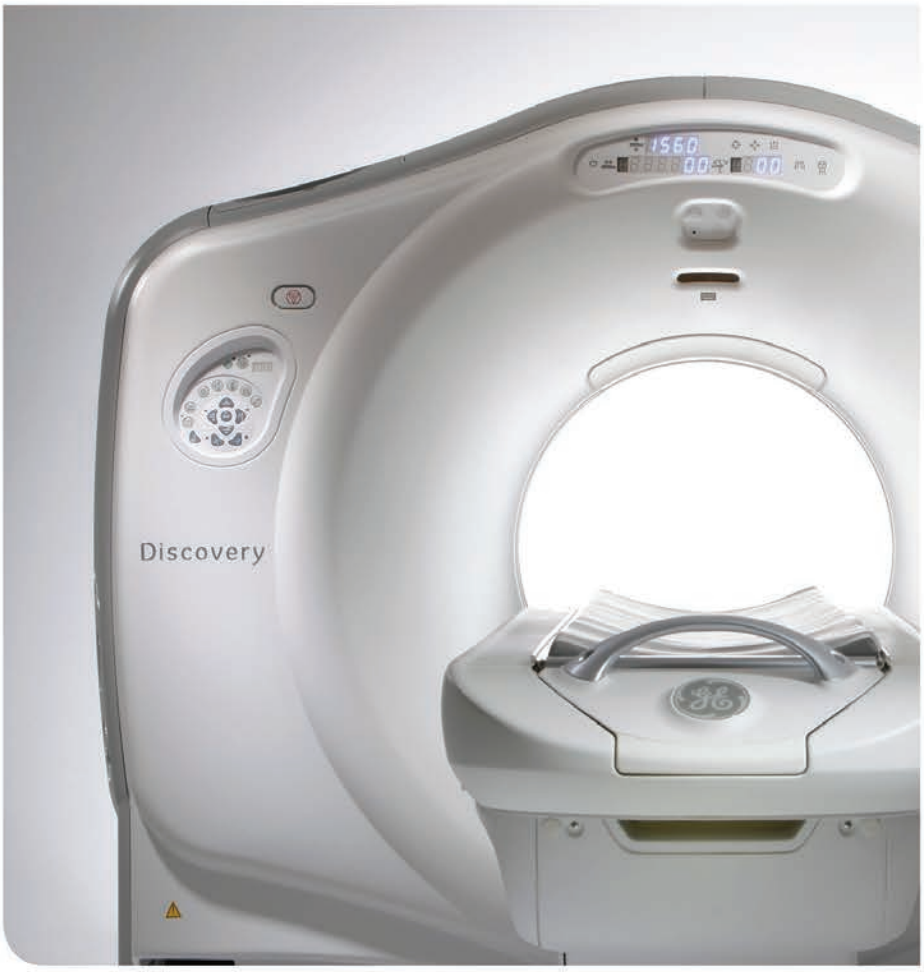
ZONE MEDICAL
STAFF ASSOCIATIONS
OF ALBERTA
April 2015

VITAL SIGNS

COMMUNICATING WITH PHYSICIANS IN ALBERTA

Patients First

President's Message: A Season of Challenges
PARAdime: A Small Venture in Community Wellness
4 Questions
Community Involvement: The Personal Touch
Twinkle, Twinkle, Little Resident…
District 9



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VITAL SIGNS

A CALGARY & AREA MEDICAL STAFF SOCIETY PUBLICATION

April 2015

CAMSS
CALGARY AND AREA MEDICAL STAFF SOCIETY

ADVOCATING
FOR PHYSICIANS,
CARING FOR PATIENTS

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SUBMISSIONS:
Vital Signs welcomes submissions (articles, notices, letters to the editors, announcements, photos, etc.) from physicians in Alberta. Please limit articles to 600 words or less.

Please send any contributions to: Spindrift Design Studio Inc. Hellmut Regehr, hregehr@studiospindrift.com

Vital Signs reserves the right to edit article submissions and letters to the editor.

The deadline for article submissions for the next issue of Vital Signs is April 15, 2015.

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ACH MSA Nominations

ACH MSA is holding it's nominations for Physician of Exellence.
Forms will be sent to all ACH members. Nominators should send their completed form to Warren Yunker, President or Sally Knight by April 30, 2015.

Save the dates! CAMSS 2015 Meetings

CAMSS Council meetings may be attended via video conference from the AMA SAO Conference Room (Suite 350 708 11th Ave SW, Calgary.)

Please email camss@camss.ca to request security access to the room.

CAMSS ZAF
April 8, 2015 | Room 1003, 10301 Southport Lane SW – 5:30-8:30 pm

CAMSS council
May 13, 2015 | ACH 07 – 5:30-8:30 pm

CAMSS AGM
June 10, 2015 | Location TBA – 5:30-9:00 pm

CAMSS council
September 9, 2015 | ACH 01 – 5:30-8:30 pm

CAMSS ZAF
October 14, 2015 | Room 1003, 10301 Southport Lane SW – 5:30-8:30 pm

CAMSS AGM
November 11, 2015 | Location TBA – 5:30-9:00 pm

CAMSS council
December 9, 2015 | ACH 01 – 5:30-8:30 pm

President's Message:

A Season of Challenges

Dr. Steve Patterson,
CAMSS President
Phone: 403-943-5554

To borrow a phrase from popular culture, "winter is coming." By this, I do not mean the season of winter we are just escaping, but rather a healthcare season of scarce resources and intense competition. There will be a temptation for groups of physicians to feel that they will "get a better deal" by forming their own organizations to represent them. This is exactly what the government is waiting for – a chance to splinter the profession and pit groups against each other. We as physicians must continue to be united under the AMA banner and put our patients first. A united profession that is focused on patient care is our best option to survive the "winter" intact and relevant.

I recently attended the spring AMA Representative Forum (RF). Much of the discussion was centred on the upcoming budget. Other topics included strengthening primary care and an update on the work done by the Physician Compensation Committee (PCC). The results of the PCC's fee deliberations will be released shortly. The RF is also a time to talk to fellow physicians across the province about issues that affect them. Residents and medical students are very worried about their future employment prospects, rural areas are worried about coverage and call obligations, and specialists are concerned about the lack of infrastructure coupled with the ever increasing demands. It is heartening to hear from so many motivated and engaged physicians. I can also state with no reservations that I have complete faith in the AMA leadership and senior staff. We are well led.

This column is being written before the budget will be announced, but I will guarantee cuts in many areas. Front line services are supposed to be protected, but changes in how we work is a certainty. We must be involved in these decisions before they are announced. AHS must work with the affected physicians before announcing program changes, and physicians must be willing to participate in these discussions at an early stage. If we have ideas about how services can be delivered more efficiently, now is the time to get involved. If we do not participate in the discussions we should not be surprised if our protests are ignored after the fact. This budget may be the "burning platform" that forces AHS and physicians to work together toward a common goal. The status quo is no longer a viable option and physician disengagement now will have a major consequence for our future.

The physician services budget is around ten percent of the government's total expenditures. Our last agreement with Alberta Health contained the line that Alberta Health would be responsible for the costs associated with increased utilization. As the province grows by two percent per year in population and continues to age, the number of services will continue to rise. The costs will continue to increase. Our fee for service system is based upon trust. Alberta Health trusts that we delivered a service, we trust that we will be paid the agreed-upon amount for that service. We must uphold that trust and hold to our part of that bargain. Creative billing is not creative, it is fraud. We are all tarnished by the actions of a few.

The Zone Medical Staff Associations represent all physicians in their zone both locally and provincially on a number of committees. We exist as an integral part of the Medical Staff Bylaws and Rules. We are supported by your medical staff dues collected by the AMA and by a grant from the AMA. We receive additional support from AHS and we are beholden to no organization. We try very hard to be your unique voice. Let us know how we are doing.

Vital Signs will become a provincial publication in April. I would like to welcome Edmonton and North Zone. I hope you find our provincial medical staff association magazine interesting. I would like to welcome any prospective authors to discuss their ideas with the managing editor. His email is hregehr@studiospindrift.com. We would especially like physicians from zones other than Calgary to contribute. Letters are very welcome. We hope to hear from you soon.

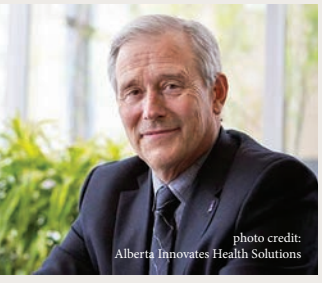


photo credit:
Alberta Innovates Health Solutions

Dr. Cy Frank

Dr. Cy Frank passed away on March 5 2015 at the age of 65. There is so much left unsaid by these simple facts. He was a warm and gracious man who touched the lives of so many colleagues, friends and patients. He was a talented surgeon and teacher. As an anesthetist, I watched many times as he soothed anxious patients or gently corrected residents. He was widely acknowledged for his innovative research and he was a particularly brilliant and visionary leader, a true renaissance man. I was privileged to work with Dr. Cy Frank for over 25 years. There are some people who can truly never be replaced and he was one of those. My sincere condolences to his family.

Dr Steve Patterson
CAMSS President

PARAdime:

A SMALL VENTURE IN COMMUNITY WELLNESS

Dr. Nicole Delaney, Resident Physician U of A Anatomical Pathology

As physicians, we see the consequences of illness on the well-being of our patients every day. We see the difference having a safe place to live, access to healthy food, quality education, and social support networks play in our health and well-being. Over and over, doctors see the relationship between these social determinants of health and the development of disease. People without access to the basic necessities of life, such as a warm bed to sleep in or enough food to eat, are much more likely to become ill. Those in poverty often face additional challenges in the event of illness – where taking medication takes a back seat to finding a place to sleep or food to eat.

As health care providers, we are motivated to help people — whether by offering our patients solutions to prevent illness or lending a hand to those facing challenges in their lives. Although doctors traditionally treat disease, it is equally important to proactively help people live healthy, happy, and fulfilling lives. By getting directly involved in our communities, we have an opportunity to help create a safe, happy, and healthy society.

As resident physicians in Alberta, we are attempting to connect with others in our communities to help our patients and our neighbours through our annual PARAdime campaign. For the past six years, resident physicians have collected backpacks filled with everyday necessities and donated them to various shelters throughout the province. Participating in PARAdime continues to be a great way for us to get involved with our communities and to assist people in overcoming some of the challenges preventing them from living safe, healthy lives.

This annual event is coordinated by resident physicians through their professional association (PARA). This year residents collected donations for the Youth Empowerment and Support Services (YESS) in Edmonton, the Calgary Drop-In and Rehabilitation Centre, the Safe Habour Society in Red Deer, the Rotary House in Grande Prairie, the Wood's Homes in Lethbridge, and the Salvation Army Family Support Services in Medicine Hat.

YESS is a wonderful organization that focuses on providing safe housing, healthy food, and social supports to at-risk youth in Edmonton. For the last two years, I have participated by donating a backpack to YESS always mindful to pack it with essentials that I hope will brighten someone's day. By participating in the actual drop-off of donations, I have been able to see first-hand how much the donations are needed and heard stories about the excitement of the youth opening the backpacks to see what was inside them.

While many of us face our own challenges, most of us have social and financial supports that help us cope with adversity. My sincere hope is that the PARAdime donations help make life a little easier for someone going through a difficult time that might not have the same supports we take for granted. Although this year's campaign has come to a close, you can still donate directly to the charity in your community at the links included here.

Regardless of how you choose to get involved, I encourage all of you to aspire finding ways to make life better in your local communities. In the words of Charles Dickens: "No one is useless in this world who lightens the burdens of another."

CHARITY LINKS:

Youth Empowerment and Support Services (Edmonton): **www.yess.org**

Calgary Drop-In and Rehabilitation Centre (Calgary): **www.thedi.ca**

Safe Harbour (Red Deer): **www.safeharboursociety.org**

Rotary House (Grand Prairie): **www.rotaryhouse.ca**

Wood's Homes (Lethbridge): **www.woodshomes.ca**

Salvation Army Family Support Services (Medicine Hat): **www.salvationarmy.ca**

Dr. Delaney and Dr. Logie

4 Questions

In discussing the Supreme Court of Canada's recent decision regarding Physician Assisted Death, Dr. Jessica Simon, Dr. Leonie Herx, and Dr. Martin Labrie – all Palliative Care Consultants in Calgary – provided some personal answers around four key questions.

1 What did the Supreme Court of Canada (SCC) say?

The SCC decided, *"the prohibition on physician-assisted dying is void insofar as it deprives a competent adult of such assistance where (1) the person affected clearly consents to the termination of life; and (2) the person has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition."*[1] The court also noted: "*Irremediable*," it should be added, *does not require the patient to undertake treatments that are not acceptable to the individual.* The court provided a 12 month suspension on this declaration before the invalidity of the sections of the criminal code on consent to death and assistance in suicide will come into effect.

2 Is this considered part of palliative care?

You might be surprised to learn the answer is "No!" The majority of Canadian Society of Palliative Care physicians (75%) feel this act should not be part of palliative care.

Palliative care seeks to prevent and relieve suffering, affirms life and regards dying as a normal process and intends **neither to hasten or postpone death** (World Health Organization definition.)[2] The SCC decision, which frames the assistance in terminating the life of a consenting person as a medical act challenges this philosophy.

The language used by the SCC, "physician assisted dying" also worries many palliative care physicians. This is because we already provide assistance to those who are dying in the form of symptom relief and emotional support but we do not intentionally kill people (euthanasia) or provide the means for people to kill themselves (assisted suicide). Language matters in this discussion — it can be polarizing, it can be dramatic and it can be sanitizing. It can also cause confusion for healthcare professionals and patients.

If the people of Alberta pursue organization around "assisted death" we would suggest that a separate service be created to provide for this act. We may all benefit from a clear separation between medical care aimed at cure, healing or care for a person until death and the act of a person receiving help in using a lethal agent with the intention to become dead. If individuals (including physicians) wish to participate in that separate service, that should be up to them, without coercion to participate or exclusion if they do. This would allow palliative care and other medical services to avoid potential conflict of interest in physician-patient relationships, and mitigate hurt to other staff and to patients and families who are choosing to live until their natural death. It does not mean that we would abandon patients and their families in the care, conversations, bereavement and decision-making that comprise the complex journey near the end of life.

3 Who normally seeks this mode of death?

Many people naturally fear death and fear dying in pain. Many people at some point will think about or request help in hastening the end of their lives, many physicians will have encountered such requests. However these feelings are usually fleeting,[3] particularly when people have access to appropriate supports or adjust to new

circumstances. In Oregon where self-administered lethal dose of an agent is legal less than 1% of deaths are through that method, and around two thirds of those signing-up for "assisted death" actually end up terminating their lives through the administration of the lethal agent.[4] The reasons given in Oregon are overwhelmingly about existential distress — primarily loss of autonomy (91.5%), fear of dependency, and worries about loss of dignity and are much less frequently about pain or fear of pain.[5]

What impact will the decision have on CAMSS physicians?

You'll have noted that the SCC provided a broad definition of who could seek the assisted mode of death and it is not limited to those who are considered terminally ill. This is different from Oregon and Washington where physician-assisted death is available only to competent adults who have a terminal illness, defined as six months or less to live, and is more akin to the less restrictive position in the Netherlands. For patients who are not approaching natural death, it is chronic pain, psychiatry, physiatry, neurology, geriatrics and others managing chronic disease who can all anticipate having to address questions about assisted death.

We would like to suggest to CAMSS physicians that you read the SCC decision, think about your personal position and reflect on your skills to relieve suffering and address the existential distress of those you treat. Being able to explore with a person why they are contemplating ending their life and to describe alternatives to hastened death, the sorts of symptom control and the care of families during natural death have become more important than ever in light of the SCC decision. We have also found the article "Dignity, Death, and Dilemmas: A Study of Washington Hospices and Physician-Assisted Death"[6] enlightening for a framework of questions that can help physicians as they contemplate the complexity of service provision in a time and place where the act maybe legal. Chat with your colleagues, this should be a lively area for dialogue in the months ahead!

FOOTNOTES:

[1] scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do (accessed March 16, 2015)

[2] www.who.int/cancer/palliative/definition/en/WHO Definition of Palliative Care (accessed March 15, 2015)

[3] Guy M and Stern T. The Desire for Death in the Setting of Terminal Illness: A Case Discussion Prim Care Companion J Clin Psychiatry. 2006; 8(5): 299-305.

[4] public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf (accessed March 16, 2015)

[5] Gazini L, Goy E, Dobscha SK. Why Oregon patients request assisted death: family members views. J. Gen Intern Med 2008;23(2):154-7

[6] Campbell C. and Black M. Dignity, Death, and Dilemmas: A Study of Washington Hospices and Physician-Assisted Death J Pain Symptom Manage 2014; 47:137e153

Community Involvement: The Personal Touch

Vanda Killeen

It's like a *Mastercard* advertisement … If your patients see you jogging down the road or, say, leading an AMA Youth Run Club warm-up at their children's school, the effect would be "priceless."

Physicians practicing what they preach, physicians demonstrating interest in and dedication to the health of their communities and playing an active role in the development and education of that health: that's priceless.

As a physician, you counsel your patients in making healthy lifestyle choices: staying active, eating nutritiously and caring for mental health, spirit and soul. Patients look to their physicians for advice and guidance and at the same time, they're often observing their physician's health and attitude and wondering, "Does my doc walk the walk and talk the talk?"

Physicians as role models and active participants in their communities is not a new concept, particularly on the Canadian prairies.

"The doctors of earlier periods did not confine their activities to only the practice of medicine. They became actively involved in community affairs, playing an important role in prairie settlement. They involved themselves in politics, banking, real estate, many other businesses and cultural activities." (*Saskatchewan:* A History by John Archer).

Time and progress have marched on and this is no longer a practical, realistic or feasible portrayal of modern medical practice. And medicine is not alone in its necessary movement away from such a community focus. Education, journalism, libraries, marketing and sales…many, many industries have gone from significant investments of time and resources in person-to-person (and door-to-door) contact to more distanced, isolated, yet (mostly) efficient methods and processes. It's both futile and irrelevant to bemoan progress and the advent of technology and its effect on society and our relationships; it's very clear that the benefits *far* outweigh the disadvantages and costs.

There's an undeniable energy to the YRC, as anyone involved with it can attest.

Still, there's an almost wistful attraction to this physician of earlier times and places, who had opportunities to relate to her patients and the community on a more casual, personal level, in comfortable, non-threatening environments.

Physicians recognize that getting involved with the health of their communities — informing and positively influencing the activity levels and health-related decisions of children and adults — could have a reciprocal effect on their practices. As you get out the door and into your community, leading children and/or adults in healthy activities and choices, you start to notice fewer patients coming back through your office door with conditions relating to inactivity or poor nutrition. Slowly, but surely!

Many Hands™

Many of the Alberta Medical Association's physician members already know and have experienced this reciprocal (or snowball) effect of community involvement and through Many Hands™, the AMA celebrates the volunteer contributions of physicians.

In addition to celebrating physician's volunteer work in communities locally, nationally and abroad, one of the initial goals of the Many Hands™ initiative was to establish an Alberta-based opportunity for physicians to get involved in their communities. The result: the AMA's Youth Run Club (YRC).

AMA's Youth Run Club

In partnership with Ever Active Schools (EAS), the YRC was launched in spring 2013 as a primarily elementary school-based run/walk program. Currently in 216 schools, with about 11,000 participants — students, coaches and leaders (including a few physician champions) — the YRC program has evolved and developed over the past two years and this fall, introduced two program Ambassadors:

Olympic triathlete Paula Findlay and Olympic racewalker Tim Berrett. *(Paula and Tim talked about their experience with the YRC and what it means to kids, with the Alberta Doctor's Digest—view the video clip at albertadoctors.org and read the article in the January-February 2015 issue.)*

YRC Participant Evaluation

There's an undeniable energy to the YRC, as anyone involved with it can attest. But the kids (and the facts and stats) speak for themselves. In an assessment of the YRC conducted jointly with EAS in May-June 2014, Dr. Jonathan McGavock PhD, Associate Professor of Medicine at the University of Manitoba and CIHR Applied Public Health Chair in Resilience and Childhood Obesity, used publically accessible figures to compare levels of physical activity in YRC participants to physical activity levels measured in youth from various districts in Alberta and Canada. They found that, on average, the YRC participants were 40-50% more physically active and took an additional 1,300 steps daily (6% of 5 to 17 year-olds in Canada take at least 12,000 steps daily). A related participant survey revealed the following:

- 95% of YRC participants will keep running after the program has ended
- 65% watched less television
- 77% felt less stressed
- 75% felt they did better in school
- 86% felt supported to make healthier choices
- 67% felt more connected to classmates

While the avenues through which physicians can engage with their communities have changed and become more global — from the "politics, banking, real estate and many other business and cultural activities" of the early prairies to today's re-building of disadvantaged communities locally and internationally, providing medical services as part of disaster relief efforts or helping communities recover from war — the rewards of volunteer work are still the same: the chance to influence and to help improve and restore a quality and love of life.

ALBERTA MEDICAL ASSOCIATION

Ever Active Schools

Rockyview General Hospital Medical Staff Association Members

Please save the date: Tuesday, June 2, 2015, 6:00-9:00 p.m.

This year, the Rockyview General Hospital Medical Staff Association Annual General Meeting is going to take place on Tuesday, June 2, 2015 from 6:00 to 9:00 p.m. at Heritage Park's Railway Orientation Centre situated in the Towne Square.

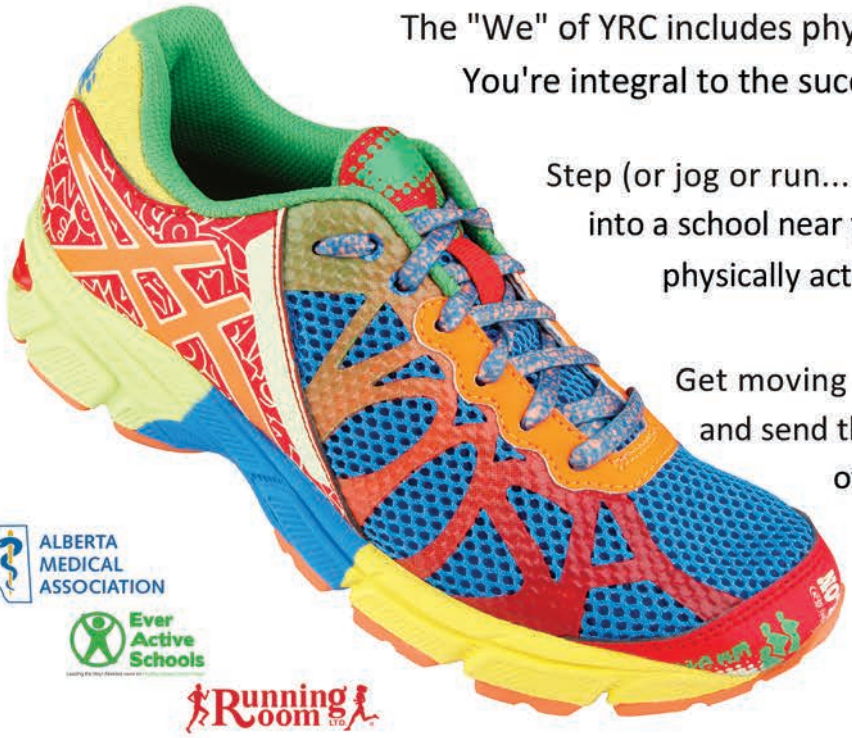
Please join us for a fabulous evening which includes wonderful entertainment, a delicious meal and heart warming physician recognition to our outstanding Rockyview General Hospital Physicians.

Your Rockyview General Hospital Medical Staff Association Membership includes 2 tickets (one for your and one for your partner) to the Rockyview General Hospital Medical Staff Association Annual General Meeting.

More information will be available in the coming weeks.

Dr. David Kent, President, Rockyview General Hospital Medical Staff Association
Stella Gelfand, Administrative Assistant, Rockyview General Hospital Medical Staff Association
stella.gelfand@albertahealthservices.ca

We help get students up and running.



The "We" of YRC includes physician champions.
You're integral to the success of YRC.

Step (or jog or run... whatever you prefer!) into a school near you and walk the talk of a physically active, healthy role model.

Get moving with Alberta's children and send them home with messages of activity, good nutrition and healthy lifestyle.

ALBERTA MEDICAL ASSOCIATION

Ever Active Schools

Running Room

We have the schools, the kids, the ambassadors, the partners, the AMA... We just need *you*!

It's easy! Many great physician champion resources -- videos, a presentation, tip sheets and more -- are featured on the Alberta Medical Association website.

If you're interested in being a Youth Run Club physician champion, call Vanda Killeen, AMA Public Affairs at 780.482.0675 or email vanda.killeen@albertadoctors.org.

www.albertadoctors.org/youth-run-club
www.everactive.org/alberta-medical-association-youth-run-club

In October 2013, the Alberta Medical Association and Ever Active Schools launched the AMA Youth Run Club, a free, school-based running program to promote physical activity in children and youth. By June 2014, 233 schools and more than 11,000 children and teachers were involved.

Twinkle, Twinkle, Little Resident…

Dr. Rithesh Ram

Resident physicians often struggle to adequately define their individual identity during residency training. For the majority of us, we spend the first year bouncing between the different specialties, while dealing with the need to successfully complete LMCC Part 2. Then as we transition into our final years (or months in the case of family medicine) of training, we are weighed down by the stress of passing our licensing exams, and navigating the job market. The ongoing discussions around physician resource management only add to the stress.

At some point, most of us come to realize… it's a game. Medicine, becoming a physician, is a game — often a very stressful one. I remember being told by a mentor during my first year of medical school, that becoming a physician is "a marathon not a sprint." Yet the need to win morphs the marathon into a series of sprints. And if you are bold enough to refuse to compete in the race — you are informed that you are not doing your best.

There are so many other things to deal with during residency — patient care, learning, on-call, family, kids — it's no surprise that many residents become burnt out, disillusioned, willing to pursue other careers, or are more than happy not to work full time upon completing residency. Like so many of my colleagues, I began to wonder: "Is this what I really want to do?" The simple mantra of pre-meds, "I just want to help people" seemed so far removed from where I was.

Is there any hope once we become disillusioned?

I consider myself one of the lucky ones. It was a single experience, a single rotation that brought life back into residency. My time in rural Alberta, specifically in Drumheller, made me love medicine again. It made me realize, beyond anything else that I have experienced in my training, that the simple pre-med mantra is real — it is alive and kicking. I remember my wife saying very plainly after my first week in Drumheller, "You seem different? You actually like what you are doing again. You have that twinkle in your eye again." And that twinkle has not left. My time in Drumheller made medicine meaningful again.

Some residents have this experience. Something career and life changing, that leads them in a specific direction or confirms the direction that they are going.

For those still waiting, there is resident wellness week. It is a time in May, organized by PARA, to help residents find balance, meaning, and time to de-stress from the medical training game. It encompasses events both adult focused and family friendly in nature. From personal experience, I can say they absolutely live up to their goal. For those still searching for that twinkle, resident wellness week will definitely scintillate.

DISTRICT 9

Dr. Kevin Hay

On March 18th we received widespread – and somewhat vague – announcements that there will be between 8-10 **'Operational Districts'** in Alberta. We are told they will improve *"local input into resource allocation at the community, site and program level; enhance local decision-making; and streamline timely and effective decisions."*

What The Districts Are Not:

They are NOT the long overdue replacement Governance Board for Alberta Health Services.

What Are The Districts?

…That's a wee bit uncertain. Most of the recommendations from the Rural Health Review Committee are appended below. (Abbreviated to those most relevant for doctors because of length. There is a link to the full document.) Many of these recommendations seem to be 'apple pie' …but there are some serious meanings behind many of them — read carefully.

We are being told that the Districts will not replace the current administrative Zonal Structures nor the Medical Representative structures (ZMSA's) ….BUT our administration has said that the Zone will not be the *'zone as we know it'* as of July 1#.

Structures:

1. Area:

"The proposed boundaries of the operational districts will be determined by a number of principles, including the natural pathways for client and patient referral; location of programs, services, hubs and hospitals; and road access that supports safe, timely and efficient patient flow."

This means that the boundaries have not been decided...or at least that is what we are being told. It is most logical and functional if the Districts follow the Zonal or old RHA geographical lines. Imagine the enormous administrative problems which will arise from a District boundary crossing a current zonal boundary…

2. Membership:

Each operational district will have a Local Advisory Committee of between 10 and 15 members comprised of *'community leaders, representatives of Health Advisory Councils, patients, families, and AHS area leaders.'* This totals 80-150 people throughout the province, most without experience of allocating resources.

3. Frequency of Meetings:

Quarterly: *How is this enough for anyone to understand and keep up-to-date on AHS issues to make an informed decision?* An important question is who will decide which information the committees are fed?

4. Reporting Channels:

Even though the Districts are specifically designed to help *'local decision making'* they will report to Northern Alberta administration (North & Edmonton Zones) and the Central & Southern Alberta administration (Central, Calgary & South Zones.) *Really local, Eh!*

Function:

The big question…

Central ZMAC was informed on March 18th that the Districts will have no legislative or fiduciary responsibilities and are *'advisory only.'* That is curiously conflicting with the media reporting today: *"They will be responsible for delivering local health services and meeting performance objectives."*

They are reported as having input into *'resource allocation and capital budgets for repairs and renovations.'* The District mandate will exclude decision-making for new capital builds, introduction of new technology, and corporate functions including finance, budgeting, human resources and communications.

Sadly this all adds up to the usual '*Divide & Conquer*' scenario we have grown to love over the past 25 years. The system is changed just as the last one is starting to come together… though we seem to lose more and more ground each time. We had hospital boards go to 15 RHA's, which were reduced to 9 RHA's, trimmed to 5 Zones, later modified to 2 main areas (North/South) comprising 2 main Zones of Edmonton/Calgary and the 3 minor zones. Don't forget the Pièce de Résistance of the AHS Board fired en masse in 2013!

Has anyone asked yet why we are not getting a Governance Board before this district stuff? A bit like the movie, we are forcibly moved to another administrative structure and treated like alien *'prawns'* yet again.

Perhaps we should form 8 districts and just rename Alberta **'DISTRICT 9.'**

FOOTNOTES

Abbreviated Recommendations From The Rural Health Services Review Final Report.

General

- Require health service planners to engage at the community level and work with communities on identifying their priority health service gaps. Service plans must be integrated across the current silos of service, and designed to meet the health care needs of the community.

Recommendations – Primary Health Care

- Implement Alberta's Primary Health Care Strategy (2014) without delay.
- Allocate funding to models of remuneration that support team-based primary health care, and enable the recruitment and deployment of other providers such as nurse practitioners, midwives and physician assistants in rural Alberta.
- Create accountabilities and flexible incentives for providing accessible, continuous and comprehensive, multidisciplinary team-based primary health care that integrates the health services in each rural community.
- Remove legislative and regulatory barriers that prevent health care providers from working to their full scope of practice and inhibit team based primary care.
- Harmonize the regulatory processes for health care professionals to facilitate all practitioners to work to their full scope of practice.
- Identify and address remaining shortcomings thwarting the full implementation of a seamless "one person, one record" province-wide electronic health record.
- Support and expect rural participation in currently available quality improvement/change management programs that teach providers about advanced access, measurement, and how to work in teams.

Recommendations – Mental Health and Addictions

- Fully implement the "Rural Capacity and Access" plan outlined in Section 3.2 of the *Creating Connections: Alberta's Addictions and Mental Health Strategy 2011-16*. Continue building on progress made thus far in rural community capacity building and implementation of an integrated service delivery framework.
- Expand availability of mental health and addictions services to rural communities through increased access to counselling and psychiatry services, either by resident or visiting caregivers or via increased use of tele-mental health.
- Provide enhanced opportunities for mental health and addictions training, including crisis intervention and management, for all rural acute care and emergency staff.
- Establish cooperative partnerships between mental health workers, addictions treatment personnel, social service and law enforcement agencies to reduce the prevalence of cyclic care

Recommendations – Continuing Care

- Increase resources dedicated to home care, respite care, and supports for caregivers. Encourage caregivers to offer (where appropriate) the option of services or care to be provided in a home setting (e.g. dialysis, chemotherapy).
- Acknowledge that family members often act as care providers and allow program eligibility/ criteria to support this role both financially and emotionally.
- Establish future living facilities that have flexibility to allow resident to age in place as care needs change/increase. Work with existing lodge/ continuing care facilities to explore potential for offering additional capacity to care for patients at the SL3, SL4 and SL4D levels of care.
- Encourage communities to share best practices to enhance non-medical social supports to assist seniors to age in place.
- Increase the coordination and availability of mobile services in the community and primary care services being available on scheduled days within a facility.
- Provide additional options for community-based end of life care through increased palliative care and hospice capacity.

Recommendations – Specialized Services

- Create incentives to improve linkage between primary health care and specialty care in rural Alberta. Enhance skills of primary care teams in priority specialized service areas to facilitate the provision of higher complexity services within the community primary health care framework.
- Identify opportunities for and encourage visiting or rotating specialists to travel to rural Alberta, providing locally prioritized (specialized) services.
- In the medical record clearly identify clients from remote rural areas, to improve coordination of specialized appointments, procedures and tests needed when patients travel to urban areas.
- Provide transportation via non-ambulance transfer to specialized services when no other option or opportunity exists to provide services remotely or via technology.

Recommendations – EMS

- Develop and implement operational practices that mandate ambulance crews to discharge transported patients within one hour of arrival at the ER. Prioritize this practice for crews whose home base is farther from the facility.
- Issue a directive that rural ambulances are to return to their home community directly and not be diverted for calls outside their region.
- Ensure that rural communities are adequately staffed with emergency personnel with training commensurate with the degree of remoteness and the time required to reach the nearest emergency care facility.
- Develop EMS access, response and performance standards. Measure, monitor and report EMS response times. Ensure that performance standards form the basis of future service planning decisions.
- Implement a system of non-emergency transport vehicles and reserve the use of ambulance crews to situations clearly designated as emergencies.
- Provide support for additional training of community volunteer first responders and work with the Alberta College of Paramedics to implement reduced fees for training and licensure of volunteers.
- Expand the AHS Volunteer Emergency Medical Response programs implemented in southern Alberta.

Recommendations – Telehealth and Transportation

- Develop an overarching patient-centered strategy focused on minimizing the need for patients to travel to receive specialty consultation. Encourage patient care planning to include greater consideration of distance between caregiver and patient as well as the patient's ability to travel.
- Re-evaluate currently utilized options for patients to travel back to their community and actively discourage unnecessary use of ambulance transfers for this purpose.
- Mandate that PCNs provide services closer to patients as opposed to using a single centralized location to serve large geographic areas.
- Examine various models in use for publicly accessible transportation and consider support for regional or community-based public transportation systems.
- Monitor, measure, and incent increased utilization of telemedicine technology. Investigate developing technologies for in-home communication and monitoring. Remove current barriers preventing increased utilization of telemedicine as an option for linking rural residents with needed health care services.

Recommendations – Accountability

- Re-launch AHS as a cohesive health care service delivery agency with province-wide standards and expectations delivered through locally autonomous districts. Establish which functions will remain controlled and managed centrally.
- Respecting historical travel and trading patterns, establish 8-10 health districts and corresponding Health Advisory Councils with clear mandates and responsibilities. Develop clear and direct reporting structures and establish expectations for communication and feedback with stakeholders.
- Empower local site managers with full authority over all day-to-day operations of their facilities and direct accountability, communication and reporting to District Directors.
- Establish a clear path of communication and feedback for patients, families, caregivers and community members to address concerns quickly and effectively.

Recommendations – Infrastructure

- Conduct a full inventory of existing facilities province wide and, in consultation with communities, evaluate their potential for re-purposing or optimized utilization to enhance health care service delivery for local residents.

www.albertahealthservices.ca/11087.asp

www.cbc.ca/m/touch/canada/edmonton/story/1.2999958

www.albertahealthservices.ca/hac.asp

www.albertahealthservices.ca/HealthAdvisoryCouncils/wf-hac-map.pdf

www.health.alberta.ca/documents/Rural-Health-Services-Review-2015.pdf

EZMSA 2015 AWARD/AGM

PHYSICIAN of the YEAR	Dr. Asifa Riaz
RESEARCHER of the YEAR	Dr. Sara Davison
INNOVATOR of the YEAR	Drs. Nigel Flook & Karen Kroeker
Champion Award for Young Leader	Dr. Jeff Toreson
Life Achievements – Medal of Service	Dr. Paul Greenwood

CONGRATULATIONS to all the NOMINEES:

Physician of the Year: Dr. Bob Simard, Dr. Fraser Armstrong, Dr. Marjan Abbasi
Researcher of the Year: Dr. Georg Schmoelzer
Innovator of the Year: Dr. Jaggi Rao, Dr. Marjan Abbasi
Champion Award for Young Leaders: Dr. Alma Bencivenga, Dr. Trevor Day
Life Achievements – Medal of Service: Dr. D.C. Reid, Dr. Paul Humphries, Dr. Alan Carroll

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