Rural Health Services Review Final Report

Understanding the concerns and challenges of Albertans who live in rural and remote communities.

By the
Rural Health Services
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Section 1: Introduction

Letter from the Chair

Alberta was founded on principles of hard work, industry, and self-reliance. Our early settlers broke the land, founded communities, and established a predominantly rural way of life based on agriculture. Early on they recognized the need for health care services. Hospitals were built, doctors and nurses provided care, and communities supported their facilities and caregivers by organizing auxiliaries and foundations. Health care was a provincial responsibility but it was organized and delivered by individual communities.

As Alberta grew, populations shifted to urban centres, and other industries gained prominence. Through it all, the wealth produced from rural Alberta, through oil & gas production, agriculture, mining, forestry and tourism, has fueled the strongest economy in North America.

Rural Alberta is changing, and people who choose to live and work in rural areas of our province want to do more than accept and adapt to these changes. Rural Albertans are resourceful, energetic, and proud. Accessing high quality health care is every bit as important in rural areas as it is in larger cities.

In September 2014, Premier Prentice and Health Minister Mandel announced a review of rural health care in our province. I was asked to chair a committee of dedicated Albertans who would travel across the province to hear the concerns of rural Albertans. The first phase of this review, completed in December, examined communities with populations of less than 1250. Since late January, the focus has shifted to communities with populations between 1250 and 10,000. Committee members have traveled across the province and engaged representatives of these communities in discussions about their current health care challenges, as well as their aspirations for the future.

Our first task was to listen. And we heard a lot.

We heard about difficulties caused by geography and isolation. We heard how access to services depended on access to transportation, and how that created difficulties for many rural Albertans.

We heard about the challenge of recruiting and retaining health care professionals. We heard about ongoing efforts to attract doctors and nurses, and the challenges they faced in providing care in their communities.

We heard about frustration and anger over the loss of local services. We heard about the pride people had in their local facilities, the quality of local services, and how losing those services hurt small towns and villages.

We heard people tell us they no longer had any control of how health care was delivered in their communities, that there was no one to talk to about it, and that when they did talk to someone, their questions and concerns went unanswered.

But we didn't just hear about problems. People told us much more.

Rural Albertans are doers. They solve their own problems. They come up with common sense solutions, good ideas, simple fixes.

We heard about communities banding together to share scarce resources and provide a larger population base to support health professionals. We heard about ideas for repurposing facilities, breathing new life into old buildings by combining health care and housing for seniors. We heard about fundraising efforts for equipment and facilities, and a willingness to partner with government to provide needed services.

We heard about how important having health facilities and services are to the economic viability, indeed the survival, of small rural communities. We heard from people who refused to give up on their town.

We heard from the people on the front lines that deliver health care, and the frustrations they face as they strive to deliver care that is patient-centered. We heard from allied health professionals, and their eagerness to play a greater part in delivering care in their communities. We heard from municipal leaders who stressed the vital role health care plays in the viability of their communities.

It has been an invigorating and sometimes exhausting process. The passion, concern, frustration, and anger have been palpable. We have proposed a series of recommendations for the Minister to consider and, where feasible, implement. We have worked hard to define the problems, and to make a number of diagnoses. The time has come to treat the patient.

It won't be easy, and progress won't happen overnight. But it is our hope that this review will be the beginning of real and meaningful improvement in the way health care services are delivered in rural Alberta.

I want to thank the members of the review committee for their time, their dedication, and their commitment to this project. It has been a privilege to serve with you.

Most importantly, I want to thank everyone who came out to share their stories, frustrations, and ideas with us. You were open and brutally honest. That's what I expected from rural Albertans. It has been an honour to hear from you.

Richard Starke
MLA Vermilion-Lloydminster
Chair, Rural Health Services Review Committee

Executive Summary

Health care is fundamental to life in Alberta. All Albertans, regardless of where they live, expect high quality care delivered by skilled and compassionate professionals. As owners of the health care system, we expect services to be accessible, accountable, and sustainable. Meeting these objectives is challenging, especially in rural areas.

From the outset, the Rural Health Services Review Committee recognized a number of fundamental truths about rural Alberta. These formed the basis for guiding principles that were foundational to the consultations and subsequent recommendations. These principles recognized that while every rural community is unique, they all share fundamental characteristics—independence, generosity, perseverance, collaboration, accountability, community spirit and pride.

The Committee met with over 100 communities across our province, all with populations of less than 10,000. During the course of these engagements, a number of dominant themes emerged:

- Timely access to health care services is just as important to rural residents as it is to all other Albertans
- Rural Albertans want to have the opportunity to spend their full lives in their communities, from birth to death
- Accessing health care services largely depends on the patient traveling to the caregiver. In rural and remote areas, this depends in large measure on reliable access to transportation
- Rural EMS is a vital service that becomes more crucial as distance from an emergency care facility increases
- With variable degrees of access to acute and emergency care services, having robust, readily accessible primary health care services becomes even more critical
- Rural Albertans expect to be full partners in the planning of health care in their communities
- Having health care services readily available depends on having a cohesive team of health care professionals working in well-maintained and properly resourced facilities
- Health care services and facilities are critical components contributing to the economic viability and long term sustainability of rural communities

The Committee carefully considered the presentations from community groups as well as nearly thirty organizations deeply involved in health care in Alberta. Fifty-six recommendations are presented that address the concerns raised by communities from across the province. In general terms, these recommendations call for:

- Greater engagement, decision-making, and accountability at the community level
- Development of a robust system of team-based primary health care services
- Addressing current issues facing EMS dispatch and operations to improve response times and ensure community availability
- A coordinated approach to workforce sustainability with increased focus on development of a full spectrum of home-grown healthcare professionals
- Enhanced utilization of existing facilities to improve local access to basic health care and specialized services
- Acknowledging the crucial role of health care facilities and services in the economic viability of rural communities, and by extension, the province as a whole

Rural Albertans expect to be actively engaged in health care planning and delivery for their communities. They are eager to fully participate in implementing the recommendations of this review.

Rural Context and Guiding Principles

There are a number of fundamental truths about rural Alberta that are crucial to fully understanding the observations and recommendations that follow. For those immersed in the culture of rural Alberta, these truths will seem self-evident. They certainly are to the members of the Rural Health Services Review Committee ("the Committee"). Rural Albertans presenting to the Committee expressed these basic truths frequently and consistently throughout the course of this review. It was clear that they felt other Albertans do not always fully understand the fundamental nature of their part of Alberta.

In an effort to clearly set out the rural realities that underlie the discussion that follows, the following guiding principles were recognized and guided the work of the Committee:

1. **All Albertans deserve and require equitable access to basic health care services regardless of where they reside.** Albertans have long accepted a publicly funded universal health care system so that income or economic circumstance is not a barrier to access. In the same manner, location of residence should not cause an unreasonable barrier to equitable access to basic services.

2. **A vibrant and engaged rural Alberta is essential to the economic, social, and cultural health of Alberta as a whole.** While the majority of Albertans dwell in urban centers, much of Alberta's key economic activity (oil and gas production, agriculture, forestry, mining, tourism) takes place outside of urban centers. Even with increased automation, these activities depend on people living in the rural areas and small communities. The wealth that drives our strong economy, for the benefit of all Albertans, is generated largely in the rural areas of the province.

3. **Every rural region and community is unique in its history and development, and therefore in its needs and aspirations.** No two communities are alike. Each sees itself as distinct and unique from all other communities. Demographics, ethnicity, cultural norms, religious mores, socio-economic status, service area population, shadow population, and proximity to larger centres all have profound influence on health care needs. A "one size fits all" approach to service planning and delivery will not work for rural Alberta.

4. **It is essential that First Nations and Metis Settlements be actively engaged and included in the development and implementation of solutions and collaborative delivery models unique to the geographic area.** Recognizing and respecting our First Nations and Metis Settlements, consultations that include health care are taking place in separate processes parallel to the Rural Health Review. Moving forward, it is acknowledged that their ongoing involvement will serve to improve access to health services for their members and residents.

5. **Historical travel and trading patterns must be considered when planning service delivery.** Where travel to other communities to access services is required recognizing these historical travel patterns will contribute to greater acceptance and increased patient participation.

6. **Rural Albertans have the best understanding of their own specific needs and challenges.** Many rural Albertans are life-long residents of their communities; in many cases, residency can be traced back for generations. They have an intimate knowledge of the history and development of their own communities. It is critical that local residents be fully engaged to suggest, assess, devise and implement potential solutions for the unique and specific needs of their communities.

7. **Rural communities rely on individuals who are prepared to take responsibility for multiple tasks.** Despite having a smaller population base to draw on, rural communities must still provide residents with a wide spectrum of services. As a result, rural residents tend to be generalists, prepared to take on numerous diverse tasks within the community. This results in a fundamentally horizontal organizational structure with little or no hierarchy.

8. **Rural communities will exercise co-location, multi-purposing and re-purposing of facilities, infrastructure, and other resources to maximize use and efficiency.** With few resources to draw on, rural communities will commonly plan facilities with maximal functional flexibility to allow for the broadest possible range of uses.

9. **Geographical remoteness must be considered in making decisions regarding service delivery.** Service needs must be evaluated in the context of required travel time under varying and sometimes less than ideal seasonal weather conditions. Planning for either local provision of care or rapid patient transport must be guided by medically accepted standards for timely intervention.

10. **Consideration of population alone is a flawed approach to service planning, the broader community context must be carefully evaluated.** Remote communities will have needs and priorities that differ greatly from similar sized communities located near urban centres. The population of the community alone is not reflective of the population of the service area; in some instances very small communities serve populations many times greater than that of the town or village.

11. **The value of a service to the population must be considered to assess performance of health care delivery in more sparsely populated rural areas.** It is critical to recognize that cost comparisons between urban and rural regions will invariably favor urban communities. Decision making based solely on cost-per-patient criteria will result in services in rural areas being reduced or discontinued resulting in increased consolidation and centralization in urban centres. We must accept that there will always be a different value proposition when considering health care delivery costs in rural Alberta.

These foundational principles were reinforced in one form or another by virtually every community in every region of our province. The successful implementation of any recommendations for rural health care delivery must take these principles into account.

Review Process

The Rural Health Services Review was announced by Premier Prentice and Health Minister Mandel on Sept. 23, 2014. The purpose of the review was to further understand the needs, challenges, and concerns of Albertans living in small rural communities, defined as having populations of up to 10,000. A seven-member review committee composed of doctors, nurses, and community representatives, all with extensive rural health care experience, travelled to rural communities. Chaired by Dr. Richard Starke, the Committee listened to rural Albertans, and discussed the challenges, barriers, and potential solutions to those challenges.

Members of the Rural Health Services Review Committee were:

- Dr. Richard Starke – MLA for Vermilion-Lloydminster, Committee Chair, veterinarian with nearly 30 years of experience in rural veterinary practice, as well as past board member and Board Chair of the Lloydminster Region Health Foundation;
- Dr. Michael Caffaro – a rural family physician in Hinton, and past president of the Alberta Medical Association's Section of Rural Medicine;
- Kirsten Dupres – Certified First Nation Health Manager, Director of Health with the Kee Tas Kee Now Tribal Council, and past licensed practical nurse;
- Dr. Allan Garbutt – a rural physician in Crowsnest Pass and past-president of the Alberta Medical Association;
- Cheryl Robbins – a nurse practitioner with experience working in rural, remote, and First Nations health care, past president of the Nurse Practitioners Association of Alberta, and current Treasurer & Membership Coordinator of the Canadian Association of Advanced Practice Nurses;
- Bonnie Sansregret – long-time rural resident of Consort, Chair of the Consort and District Medical Centre Society, and current councillor on the municipal districts Special Areas Board; and
- Dr. Shannon Spenceley – current Assistant Professor in the Faculty of Health Sciences at the University of Lethbridge, and President of the College and Association of Registered Nurses of Alberta.

The Rural Health Services Review Committee focused on:

- Accessing timely, appropriate health care;
- Evaluating specialist services in rural areas;
- Optimizing the use of existing rural health facilities, ensuring patient safety, and quality services;
- Ensuring communities are engaged in health service planning and policy development;
- Recruiting and retaining health personnel in rural areas, consistent with appropriate levels of care; and
- Examining the link between rural economic development and the provision of health services within communities.

The review was originally going to be conducted in three phases. However, after the first phase was complete, Dr. Starke suggested that the second and third phases be combined because many common concerns and themes were emerging as the review progressed. In the first phase, which took place between September 23, 2014 and December 19 2014, the Committee focused its attention on rural communities with a population of 1,250 or less. In the second phase, the committee reviewed communities with a population of 1,250 to 10,000 individuals. These communities also had at least one Alberta Health Services (AHS) health facility.

Invitations were sent to community leaders, most often the Mayor and Chief Administrative Officer. Each community was allotted approximately 45 minutes to discuss their community's health

concerns and solutions with the Committee. Communities determined who would speak on their behalf, as well as the size of the delegation. Of the 155 communities invited, 109 participated in the review (Appendix 1). As part of Phase 2, the Committee also met with 25 provincial organizations (Appendix 2), including professional Colleges and Associations, municipal associations, universities, and non-profit organizations.

Health Advisory Council (HAC) chairs from each area were also invited to participate along with any interested HAC members. On Nov. 8 2014, the Committee chair made a presentation at the Province Wide Health Advisory Council Annual Conference. During the conference, the Committee chair explained the purpose and process of the review and participated in breakout sessions seeking HAC member feedback related to the questions outlined in the conversation guide.

In Phase 1, community meetings were held in six locations: Consort, Onoway, Myrnam, Falher, Bowden, and Stirling. Representatives of the 46 communities that met with the Committee in-person travelled to one of these locations. In Phase 2, community meetings took place in eleven communities: Black Diamond, Olds, High Level, Fort Vermilion, Peace River, Westlock, St. Paul, Edson, Devon, Fort Macleod and Brooks. Throughout both phases, communities were scheduled at different times throughout the day to give them a one-on-one opportunity to have their voices heard. Two conversation guides, one for each phase, were developed and used to facilitate the discussions (Appendices 3 & 4). After the meetings were over, notes from each discussion were sent back to communities to validate the information gathered. This also gave communities the opportunity to change or add any information they thought was important.

The conversation guide for Phase 1 asked about:

- *Context of health care services in rural communities*- which services were available locally, impact of health services on economy, and challenges to accessing services.
- *Solutions to address the challenges- i*deas to address the identified challenges, allow communities to become more involved, and ensure communities needs are met.

The conversation guide for Phase 2 evolved from Phase 1 to ask about:

- *Local decision making* – how communities could become more involved and represented in the health care system.
- *Moving services closer to home* – how services and equipment could be made more readily available for rural communities.
- *Increasing capacity* – ways that primary health care, mental health and continuing care could be strengthened, and opportunities for addressing transportation challenges.

Community representatives unable to attend the meetings were able to participate by written submission. Members of the public were also encouraged to submit written feedback for this project by electronic or postal mail to addresses provided on the Alberta Health website.

Section 2: What We Heard

Over the last five months, the Committee heard from over 100 communities from across the province and discussed a way forward for rural health. These communities reflected the diversity of rural Alberta — small hamlets and villages, expansive rural regions represented by counties and municipal districts, as well as larger well-established towns. Some were very remote and isolated, while others were located in close proximity to large urban centres. Although there were distinct differences between rural communities, many challenges described by small villages were also experienced by larger towns, and fully acknowledged by province wide organizations. It was striking how such a diverse group of communities shared such a common and consistent series of concerns.

Three main themes emerged out of this review, and will form the basis of this section: the importance of rural health service access, accountability and sustainability. Being able to access a range of health care services in a timely manner is essential to rural Albertans. To rural communities, accountability means having more autonomy to make decisions and govern health services in ways that make sense to them. It also means working with AHS in an open and collaborative manner. Finally, for communities to be sustainable, they need a stable health workforce, infrastructure that meets their needs and a strong economy.

"It seems like we're falling on deaf ears, we're in another study, another round table discussion. At what point in time does the government say we have enough information and help?"

Access to Health Care Services

Locally available health care services are vitally important to rural Albertans. For the most part, residents want primary health care services, EMS and continuing care services available in their communities. Mental health and addiction, and specialized services are also important, but most residents are open to other options for service delivery. During the review, communities suggested mobile services, telehealth, and rotating specialists into rural areas, as strategies that could help increase access while minimizing the hardship of travel on rural residents.

During the discussions, the desire to have as many services available locally was tempered with realism that every service could not be provided in every community. There was overall recognition that offering selected services at designated regional centres was a practical way to aggregate a sufficient number of patients required to make a given service feasible, in terms of infrastructure, equipment, and support. Communities agreed that it would be preferable to drive a much shorter distance to a neighboring community to access certain services than to travel a longer distance to a larger urban centre.

Primary Health Care

Primary health care services are the services people go to first for health care or wellness advice and programs, treatment of a health issue or injury, or to diagnose or manage physical and mental health conditions. People may receive these services in a variety of places. It may be in their own home (e.g. supportive living and long term care), in public/ community health sites, schools, workplaces, primary care clinics (e.g. doctor's offices) or the

offices of other health care practitioners. Primary health care services allow people to stay healthy, age in place, and participate meaningfully in the life of their community.

Communities were very realistic about the services they require to meet their health care needs. They understand that having specialized or the complete spectrum of acute care services in every rural area would not be possible. However, they all felt it was reasonable to expect a basic level of primary health care service that was responsive to their community's health needs. Communities emphasized that "one size does not fit all" in planning primary health care services in rural Alberta.

Some communities need more home care supports for older rural Albertans. These home care services, along with good access to primary care in their community, will make "aging in place" possible. In many communities the most pressing primary health care needs included mental health supports for children and youth, community-based public health, health promotion and disease prevention programs, and integration of chronic disease management and self-care supports. Many communities also expressed the critical need for low-risk obstetrical supports—particularly areas that were being accessed by growing Mennonite communities, and remote communities in the north.

In most rural areas, it is increasingly apparent that primary health care needs cannot be met by the traditional primary health care service approach. Sporadic physician care delivered in isolation of other health care services is not appropriate for rural communities. In many places, this approach has resulted in a "revolving door" model of locums and short-term physician recruits. These were often described as "Band-Aid solutions" for over-burdened physician practices. In many communities, the emergency department has become the default primary care service in the community, when residents cannot get in see the physician in a timely way. This was becoming increasingly common in the rapidly growing communities in the Calgary-Edmonton corridor. As ER wait times increase and primary care becomes over-burdened in urban areas, urban Albertans seek primary level services in rural areas. This adds to the problem, and stretches rural health care services to capacity. Some communities in the province have almost no access to local primary health care services. Though geographic remoteness may contribute to the problem, it was also the case for some growing communities in close proximity to major population centers.

"The patient needs to be at the center of all decisions that are made!"

In some communities, the Committee heard descriptions of well-functioning and responsive Primary Care Networks (PCN). Some PCNs have health promotion and chronic disease management programs that are well received by the community. However, in most communities the PCN was not well known or integrated into the community. The PCN was typically described as something "out there" and essentially not relevant or connected to other health services in the community.

"We have to think beyond doctors. There is more to health care than what doctors can provide. If a physician is not prepared to come and someone else is who can provide adequate care- that should be encouraged."

Some communities are taking innovative steps in the integration, design and delivery of their primary health care services. Bassano is embarking on an initiative to integrate the whole spectrum of health services in one health care campus. This will help to meet the comprehensive needs of their community. They are using an innovative funding approach to infrastructure, and using alternative payment mechanisms for physicians. All primary health care services and acute care services are being co-located on one site, where they are also

incorporating a full range of living options across the continuing care spectrum. This community-driven initiative is impressive in its attention to the principles of comprehensive primary health care service delivery. Their recommendation was to "unshackle" health service planners from their provincially driven bureaucratic structures and allow them to authentically plan with communities and innovate to meet their unique health care needs.

Recommendations – Primary Health Care

1. Implement Alberta's Primary Health Care Strategy (2014) without delay.
2. 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.
3. 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.
4. Remove legislative and regulatory barriers that prevent health care providers from working to their full scope of practice and inhibit team based primary care.
5. Harmonize the regulatory processes for health care professionals to facilitate all practitioners to work to their full scope of practice.
6. Identify and address remaining shortcomings thwarting the full implementation of a seamless "one person, one record" province-wide electronic health record.
7. 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.

Mental Health and Addiction Services

Accessing mental health and addiction services is a major challenge for many rural communities. Often there are limited mental health services available locally, both in an acute and primary health care setting. In many rural areas local needs outweigh the services available. The College of Registered Psychiatric Nurses of Alberta notes, "There is huge demand for mental health and addiction health services in rural Alberta."

While some mental health services are available for ongoing support, most communities do not have immediate access if a crisis occurs. In larger communities that have mental health therapists or psychiatrists available, these caregivers are constantly booked and have long wait lists. In areas where the need for mental health services is high but availability of treatment is low, residents feel that more preventative services would be helpful.

Addiction and mental health services are important for people of all ages but they are most in demand for youth and elderly. In rural communities, there is a pressing need to develop early identification and intervention capabilities for at-risk youth. Many communities suggested partnering with schools as a means to provide

"Access to mental health services, especially for youth, is seriously limited."

mental health education and preventative services, as well as early assessments for youth and brief interventions where necessary. These programs must be run in a way that minimizes the actual or perceived stigma attached to mental health. In general, in rural communities where residents know one another and know which services are offered in which office building, the possibility of stigma is a serious concern to residents.

Seniors, children, and single mothers have additional challenges with out-of-town mental health services. When children are referred out of the community for mental health services that are scheduled during the day, it can be difficult for parents or guardians to attend those appointments. In some cases, individuals with psychiatric illnesses who must travel to appointments choose to forego treatment, suffer relapses or become unstable, and end up in the emergency department. To make matters worse, staff at many rural hospitals report variable levels of training to deal with mental health crisis episodes.

"Demand for mental health services is growing."

Mental health services are especially important in continuing care facilities where elderly patients suffering from dementia and other mental illnesses require complex support. The need for mental health services for seniors is a growing concern throughout the province. In most long term care centres, there are no dedicated, secure dementia units. In lodges, administrators see increasing numbers of residents with early dementia, and are challenged to provide a safe environment with staff that has less training and expertise.

In some communities, there are marked increases in number of people suffering with addictions, but addiction services have not increased. There are also situations where individuals with addiction and mental illness have become aggressive and/or dangerous. In these situations, residents feel the lack of protective services for staff is a major concern. Larger communities with hospital services are experiencing a "revolving door" situation where patients are repeatedly admitted, held and then released from hospital. As a result, patients are experiencing no continuity of care and residents are concerned for community members' safety. Security in these facilities is also felt to be lacking, as well as the follow up support when individuals are released back to the community.

"Problems lie with early intervention… It's painful to have suicides occur, and addictions are an issue."

To solve these problems, many communities feel that establishing full-time in-town mental health and addiction services would be ideal. For acute crisis situations, it was recommended that secure psychiatric beds be strategically located where need had been established. Adequate facility space and staff support were also suggested. Some rural communities suggested rotating a psychiatrist into the community more often, or having a dedicated psychiatrist that residents could call for help. Many communities described successful use of tele-mental health and tele-psychiatry services and felt this could be expanded. Other communities that do not currently access services through telehealth agree that it offers a promising avenue to help increase access.

Recommendations – Mental Health and Addictions

1. 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.
2. Work with the Minister of Education to establish and coordinate school-based mental health education and early intervention programs to identify and assist youth at risk.
3. 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.
4. Provide enhanced opportunities for mental health and addictions training, including crisis intervention and management, for all rural acute care and emergency staff.
5. Establish cooperative partnerships between mental health workers, addictions treatment personnel, social service and law enforcement agencies to reduce the prevalence of cyclic care and crisis management episodes for patients with diagnosed mental health and addiction issues.

Continuing Care

Alberta's population is aging and seniors are becoming the largest segment of many rural communities. As a result, there is a need for more supportive living, home care, long term care, and supports to age in place. We The Committee often heard the term "aging in place" as a desirable goal for rural residents. What this means is that people desire the ability to live in their own homes and communities safely, independently, and comfortably, and for as long as possible. For rural residents, the Committee heard that a deep and profound sense of community lends a whole new importance to "aging in place" as a goal. To make this happen, it is necessary to accurately assess the needs of seniors in each community and create supports to meet those needs.

"We want and need to keep seniors in town so that families can visit and also provide backup support."

There are three main challenges to overcome in order to accommodate seniors needing supports in their communities—availability of care personnel (either in home care or facility-based), spaces in facilities at the appropriate level of care, and lengthy assessment wait times. For seniors with advancing care needs that cannot be met in their community, many are forced to move outside of their communities for residential support. This negatively impacts seniors and their families, as they find it traumatic to move from their homes into unfamiliar surroundings with no social or family support. In some cases, married couples have been forced to separate into facilities in different communities, based solely on the availability of beds at a particular level of care.

Staying close to their home community is important for seniors as they are more likely to receive the support of nearby family and friends, which increases their quality of life. Yet most communities expressed the concern that the home care funding and staffing levels needed to make this happen are lacking. Some observed that home care services had been reduced, and that outsourcing the contracts has had a negative impact on the community with less home care staff covering the large distances and windshield time taking away from care.

The Committee heard that distance and a lack of local transportation made staying at home even more difficult, as seniors struggled to attend

appointments. Many communities told us about their efforts to address these issues by coming together to take seniors to appointments, checking in on them at home, doing yard work and helping them around the house. The Committee heard a great deal about "citizens helping citizens." There is widespread agreement, however, that rural communities cannot do this alone. Providing mobile services or bringing more services back into the community will help address these challenges.

Overall, many people also expressed confusion with the continuing care "levels" that the government and AHS use to classify these services. In many cases, there was a mismatch between the needs of the community and the availability of appropriate services. The Committee often heard about seniors continuing to live in "lower level" settings with care needs that exceeded the care capacity of that setting. For example, in many areas the Committee heard about lodges providing care that exceeded what they were designed to provide resulting in additional strain on staff and compromised patient safety. One of the most commonly expressed concerns was the supportive living gap between lodges and long term care facilities. In community after community, the Committee heard about people waiting in acute care beds for placement into more appropriate settings. The complete lack of supportive living facilities in some areas results in patients being transferred into long term care unnecessarily.

While lodges and home care are designed to provide SL1 and SL2 level care, many people are assessed as requiring support at a SL3,SL4, or SL4D (dementia) level. For these individuals, long term care is not appropriate, but neither is lodge/home care. Several opportunities exist to build innovative models of care that help address this mismatch, such as the dementia pods attached to the Valley Lodge in Vermilion. With advanced training and support for care providers it would be possible to offer an enhanced level of home care (equivalent to SL3 and SL4) in existing facilities. Though providing this extra support would not require building a new facility or adding new beds, it may require substantial physical modifications to meet the needs of residents.

Every opportunity should be taken to increase the integration of multiple levels of continuing care in a single site. For example, lodges could also have some supportive living beds in order to accommodate residents as they age and require a higher level of care. Rural residents told us that the planning priority should be to make it possible for citizens requiring care supports to remain in the facility they are familiar with and comfortable in, especially given the negative effects associated with major transitions. Finally, increasing the access to professional home care services in the community could help healthier seniors remain at home for longer, and free up beds in facilities. AH and AHS must work more closely with communities and service providers in planning around how the "aging in place" philosophy can be realized in rural Alberta.

Many communities noted that helping seniors age in place and stay in the community involved more than just health care. Social and personal supports (e.g. snow removal, Meals on Wheels) and mobile services (e.g. hearing and vision testing) all contribute to this objective. Some communities have devised innovative solutions. Following a successful pilot project, the town of Jasper hired a community seniors' outreach worker that arranges to have various supports in place for seniors. This program is helping seniors stay healthy for longer, keeps them engaged in the community and with other seniors and has had dramatic positive results.

"There are no home care services, no Meals-on-Wheels, no public transportation. All are dependent on friends or family."

Finally, residents want to live out their full lives in their home community. In many cases, a shortage of palliative care rooms and appropriately trained staff makes this goal difficult to achieve. Increasing palliative care capacity, whether in modified existing facilities with enhanced staff training or through support for end of life hospice care, was cited as a highly desirable objective.

Recommendations – Continuing Care

1. 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).
2. Acknowledge that family members often act as care providers and allow program eligibility/criteria to support this role both financially and emotionally.
3. 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.
4. Encourage communities to share best practices to enhance non-medical social supports to assist seniors to age in place.
5. Increase the coordination and availability of mobile services in the community and primary care services being available on scheduled days within a facility.
6. Provide additional options for community-based end of life care through increased palliative care and hospice capacity.

Specialized Services

In Alberta, a specialty service is typically described as any service that requires a referral from a primary health care provider, where a specific skill-set or training is required. To most rural Albertans however, specialized services include anything that falls outside the services they receive from their doctor's office or community health centre. This could include allied health services such as occupational or physical therapy, diagnostic procedures such as X-rays or blood tests, as well as more advanced services such as dialysis and chemotherapy. Regardless of the services described, most rural residents feel that access to specialized services is an ongoing challenge and their location puts them at a disadvantage for receiving these services and treatments. Though most rural residents understand it is not practical to offer complex or advanced level services in small rural centres, many suggest using the available space in local health facilities for selected specialist procedures.

"We all have to go to Edmonton for five minute speciality consultations, if you can afford it."

In some areas, a reduction in specialized services was described as having slowly occurred over the past several years. Others described a recent, sharp decline in the availability of speciality equipment and services in their communities. For the most part, citizens reported growing frustration about an ever-increasing need to access services in large urban centres. Many communities also expressed anger about service reductions at their hospitals or health centres. Some residents described instances where an X-ray or ultrasound machine was removed when a nearby community began offering the same service. In some cases, presenters indicated that the equipment for the service in question had been purchased as a result of community fundraising initiatives.

The Committee was told of persons travelling several hours to see a specialist, only to have the appointment cancelled at the last minute, resulting in a wasted trip with all of the attendant costs. Others shared their frustration about travelling for several hours each way only to see the physician for a

consultation that lasted about 5 minutes. It was further noted that a lack of coordination and communication between caregivers sometimes forced patients to make repeated trips for tests and procedures, and many asked if it was possible to coordinate all tests to be done on a single day. It was suggested that clients from rural, certainly remote rural areas, should have their medical record flagged to enable coordination of specialized appointments, procedures and tests needed in the urban areas. Many communities expressed frustration and anger at the apparent disregard for where a patient lived, and the hardships introduced by frequent and long-distance travel for care. This became particularly evident when the discussion turned to recurring treatments such as dialysis or chemotherapy. Sadly, the Committee heard about cases where patients had chosen to discontinue treatments because of the hardships introduced – a choice that had, in some cases, resulted in premature death.

"Some go home to die rather than drive back and forth for dialysis."

Rural Albertans told the Committee that they believed it makes more sense for a specialized service provider to travel to the patient instead of the other way around. In communities where facilities, equipment, and support staff were available, the question was asked whether services could be provided by visiting specialists, at least some of the time. Some communities are already doing this successfully; they have used incentives and travel assistance to encourage specialists to see patients on a periodic basis in remote communities, often using available space in rural hospitals. Expanded use of mobile services such as MRI scanning, dialysis, and ultrasound were also suggested as possible opportunities for increasing access to specialized services.

In communities where specialists already rotated in to provide services such as orthopedics, radiology or pediatrics, residents were very appreciative of the opportunity to receive services right in their home community. Even in as little as a few days per month, OB/GYNs and psychiatrists can help address growing needs in many communities. Visiting specialists also provided additional support for people managing chronic diseases. Rotating specialized services into rural communities has the potential to eliminate thousands of trips annually by patients already stressed by illness, the financial burden of travel costs, and the prospect of driving in city traffic.

Physiotherapy, occupational therapy and rehabilitative services (e.g. speech therapy) were reported to be in high demand in many rural communities. Residents in younger, growing communities also expressed concerns about the lack of access to obstetrical services. Young families in rural communities are often unable to access basic services such as pre-natal classes or ultrasounds locally. Remote communities are even more concerned with the lack of even the most basic obstetrical services, and the Committee heard concerns about women having to drive long distances while in labour. Midwifery was advocated for as a potential solution to this service gap. The Maternity Care Consumers of Alberta Network (MCAN) expressed support for the potential role of midwives and advocated for removing barriers to midwifery practices especially in rural and remote settings.

Recommendations – Specialized Services

1. 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.
2. Identify opportunities for and encourage visiting or rotating specialists to travel to rural Alberta, providing locally prioritized (specialized) services.
3. Encourage the development of strategic partnerships between neighboring communities and visiting specialists to aggregate patients requiring care to a level where visitation by the specialist is advantageous.
4. 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.
5. Increase the use of technology to support the delivery of specialized health services. Remove barriers concerning funding and compensation models to enhance utilization of telehealth technology.
6. Provide transportation via non-ambulance transfer to specialized services when no other option or opportunity exists to provide services remotely or via technology.

Emergency Medical Services (EMS)

Dissatisfaction, frustration, and anger with the current state of rural EMS was one of the most common concerns expressed by dozens of communities. Many communities related specific incidents where some aspect of EMS had failed, others simply said, "I'm sure you've already heard about all the problems with EMS."

"EMS dispatch needs to rely less on technology and more on geography."

EMS shares the challenges of distance, travel time, and road conditions facing transportation, which will be discussed later in the report. In emergency situations, prompt accurate dispatch and rapid response times are crucial. A number of communities described situations where ambulances had a hard time finding rural addresses, which increases response times. The Alberta Association of Municipal Districts and Counties (AAMD&C) reinforced the input from their members that when EMS has dispatch problems, paramedics get lost and response times increase.

Overall, most rural Albertans perceived a marked deterioration of EMS, and blamed the consolidation of both EMS dispatch centres and EMS management. They explained that this has resulted in less responsive, frequently unavailable and poorly coordinated services. Dispatching flaws result in situations where two or three ambulances respond at once, leaving other areas without service. Residents of remote areas feel that it takes too long for EMS to reach their community. In other instances, ambulances transport people into the urban centres and are unavailable to respond to emergencies back in their "home community". Many communities described cases where ambulances would wait for hours in urban hospital bays waiting for patients to be examined or admitted. There are also frequent reports of rural ambulance crews being diverted to calls or transfers within urban centres, further delaying a return to their home community.

"There are enough ambulances in Alberta but there needs to be alternatives to that kind of transportation."

Remote communities expressed particular concern regarding response and transport times. The time interval from emergency occurrence until arrival at the emergency department is much longer than in more populated areas. Many rural residents feel that they are not receiving care within the "golden hour"*, due to their geographic location. Some people fear the distance between their home and the nearest emergency department places them at serious risk if they were to experience a life-threatening event such as a heart attack or car accident. In northern Alberta, air medevac is particularly important for transporting patients to emergency facilities, however the cost is seen as a concern.

Many communities described how the changes in EMS had placed added strain on volunteer fire departments. Some fire chiefs reported increases in medical response calls ranging from 200-500%, to a point where medical response calls constituted over 50% of their overall call volume. Volunteer first responders described situations where fire crews arrived at an emergency and had to wait over an hour for an ambulance to arrive. They also related the stress of responding to an injured neighbour, feeling powerless because of lack of training or authorization to assist, while waiting "what seemed like hours" for a lost ambulance from a neighbouring community to arrive.

The practice of using ambulances to transport in-patients and/or long-term care residents to diagnostic tests or specialist appointments, or to transfer patients between facilities, was identified as a major issue. Communities feel this is not only inefficient and expensive, but it also ties up EMS resources so they are unavailable in times of true emergency. Communities were critical of using ambulances as a "glorified taxi service". This perceived misallocation of precious resources was described by noting "a $350,000 ambulance has been transporting patients to receive treatment. A well-equipped van could have done just the same thing!" To combat this problem, members from the Alberta Urban Municipalities Association suggested that the province should add more modes of transportation for patients requiring minimal care, leaving EMS crews available for more urgent situations. AHS has already begun the implementation of this suggestion, with the placement of Non-Ambulance Transfer vans in a number of southern Alberta communities.

"Our ambulance goes to the city—and disappears into a vortex."

Many solutions were proposed to address the issues identified with EMS. Some communities suggested that management and dispatch of EMS be brought back to communities for local control. Others disagreed, recognizing that EMS is part of the health system, but suggested that better coordination is needed to meet rural needs. Operational practices that allow rural EMS crews to rapidly return to their home base were also suggested. Recognizing that response and transport times in remote areas were longer, it was suggested that these areas be staffed with paramedics with more advanced training. This would give them more capability to respond to, stabilize and transport patients that might not get to an emergency room for hours.

A number of unique local solutions to EMS challenges also emerged during the review. In Kananaskis, residents commended the EMS services they receive and felt fortunate to have such committed, responsive and advanced level care available 24-7. Because paramedics take walk-in patients at the fire hall, residents and park visitors are able to get minor urgent care when they need it. In Waterton, another busy tourism centre, paramedics provide walk-in minor urgent care. In Worsley, a joint project between AHS, the County of Clear Hills and the Worsley and District Health Promotion Society was launched where a full-time ambulance is based at the local health centre and EMS providers work alongside staff on weekdays and when not out on call.

**Golden Hour: A common term for the critical period of time between a traumatic injury and the receipt of medical attention. Chances of survival drop off steeply if medical attention is not sought within this period.*

Recommendations – EMS

1. 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.
2. Issue a directive that rural ambulances are to return to their home community directly and not be diverted for calls outside their region.
3. 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.
4. 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.
5. Implement a system of non-emergency transport vehicles and reserve the use of ambulance crews to situations clearly designated as emergencies.
6. 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.
7. Expand the AHS Volunteer Emergency Medical Response programs implemented in southern Alberta.

Barriers and Solutions to Access

Transportation

The geography of Alberta dictates that there will always be patients who are separated by long distances from caregivers. This is especially true of more remote rural locations away from the Edmonton – Calgary corridor and in the northern half of the province. For these communities, transportation is a major barrier to accessing health care services. Throughout the review, communities discussed challenges for those who do not drive, especially seniors. It was noted that the lack of access to transportation worked against the most vulnerable members of society, for whom prompt access to health services was the most critical. Communities detailed problems because of limited transportation options, distance and cost associated with accessing services outside their communities.

Considerable discussion centered on the hardships that people faced when they were required to travel to physicians or other caregivers far from their homes. The Committee heard a litany of examples where timely care was compromised because it was not possible for the patient to travel to the caregiver.

Lack of public transit (bus or taxi), dependence on friends or relatives for rides, poor weather, poor road conditions, and cost of babysitters, fuel and accommodation were all repeatedly noted as barriers to care. Loss of Greyhound service has hit some communities particularly hard. The need to take time off work, loss of productivity, loss of holidays and in some cases in loss of employment due to time required for medical appointments were all described to the Committee.

"'Younger seniors end up providing transportation to 'older' seniors, which is not always the safest option."

During the review, communities discussed the role of the municipality and the provincial government in addressing transportation barriers, but quickly noted this was not within their mandate to address. Providing publicly funded transportation options, especially

for the most vulnerable, was recommended to eliminate transportation as a barrier to accessing health services. Though some communities have tried to pay for transportation, the cost was described as being too high for the community to manage alone. Despite the challenges that most communities experienced in providing publically funded transportation services, Three Hills has established a successful seniors' outreach program. Over 200 volunteers help to drive seniors anywhere in central Alberta for appointments, and the charge is minimal or free. This program will be celebrating its 25th anniversary this summer. One unique solution to meet the community's transportation needs came from residents of Gibbons. They suggested a system where volunteers could be rewarded through tax credits or other incentives when they help transport those in need. This program could capitalize on the volunteer spirit in Alberta and help bring the community together.

Overall, rural communities expressed the belief that having to travel long distances to receive routine and necessary services creates disparity among Albertans, because some people have to spend more time and resources to obtain needed care. In some cases people who are unable to drive but who require routine care, may refrain from seeking medical attention until their condition becomes critical.

Telehealth

Telemedicine, which involves linking patients to health professionals via audio, video, and/or patient monitoring technology, was discussed by most communities. The almost universal response was that telemedicine services worked well when used, but usage was low and most use was for training or non-clinical services. Many groups explained that better use of technology would cut down on expensive, difficult and time consuming trips out of town for consultations. Receiving test results or information regarding treatment over the phone takes minutes, compared to the hours it takes to drive back and forth to the city.

"If we can increase the use of telehealth we can increase the local community access to specialist service."

A number of barriers to increased usage were noted: physicians being unwilling to assess patients without being able to physically be present with them, physicians not being allowed to bill for telemedicine consultations, lack of necessary bandwidth or cellular coverage to accurately transmit images or audio, confidentiality concerns, lack of staff to assist the patient, language/translation issues, and distrust of technology. Overall, however, telemedicine was widely accepted and greatly appreciated by those who used it. In many cases, it was described as working very well in a number of applications (tele-neo-natal care, tele-psychiatry, tele-dermatology, tele-stroke, tele-cardiology).

"Telehealth is fine, but a major problem is that there is no one with the patient who can explain the context to the health care person on the other end of the phone."

For many people, face-to-face contact with physicians is still an important aspect of their care. Having someone help explain complicated information in person and help with difficult conversations should be a key aspect to any expansion of these new technologies. As CARNA suggests "Invest in models of care that leverage technology – keeping in mind that delivery of health care is still a human endeavour." In the future, Albertans see the potential to use telehealth and Skype for discharge planning and follow-up appointments with patients with complex care needs. In order for these technologies to be successful, rural communities suggest that both patients and providers need education, support, and coordination of service options and availability.

Conclusion

In urban centres, high patient volumes and facility space limitations are key contributors to long wait times and restrictions in service access. For rural patients, a critical factor determining their access to care is their mobility; that is, their ability to access transportation to travel to the health care professional. This creates significant hardship for many rural residents, and negatively impacts vulnerable populations: seniors, persons with no vehicle, limited income, or limited flexibility in their work schedule. There is potential to decrease and eliminate the challenge of distance between rural Albertans and health care professionals in urban centers so long as the will and mechanisms to use technology are embraced

Recommendations – Telehealth and Transportation

1. 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.
2. Re-evaluate currently utilized options for patients to travel back to their community and actively discourage unnecessary use of ambulance transfers for this purpose.
3. Mandate that PCNs provide services closer to patients as opposed to using a single centralized location to serve large geographic areas.
4. Examine various models in use for publicly accessible transportation and consider support for regional or community-based public transportation systems.
5. 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.

Accountability to Rural Communities

Throughout the course of this review, in communities ranging from tiny hamlets and villages to large towns with populations of nearly 10,000, the Committee consistently heard about one issue above all others: the need for more local input into health care decision making. Speaking from years of personal involvement, many presenters outlined the history of health care governance in Alberta, starting with individual hospital boards at the community level, moving through regionalization in the 1990's, followed by centralization of decision making in urban centres. The most recent step in that process, the creation of AHS governed by a single central board, and dissolution of the regions, was criticized by representatives of nearly every community.

Assessments were pointed and voiced repeatedly - "the system is so big and complex that nobody knows what's going on", "the bureaucracy is so huge it threatens to collapse on itself", "everyone is working in silos and nobody is talking to anyone outside their silo". Communities expressed frustration and resentment about how decisions

"Bring back regional input (not one cookie cutter for everyone, but several cookie cutters for several regions)."

with profound effects on their health facilities and programs were made in "ivory towers" in Edmonton or Calgary by people who had no knowledge of their community's needs. Some presenters expressed anger that decision makers had never been to their community, never met with residents, and doubted if they even knew where their town was located.

"The zones and boundaries do not consider patient needs, only system needs."

Presenters pointed out demographic realities specific to their community that are neither known nor considered by distant decision makers. Many communities have large shadow and transient populations that significantly impact the demand for health services. This is particularly applicable to communities where large-scale construction or industrial activity is causing rapid expansion. Some communities reported an influx of young couples starting families, triggering significant population growth. Rural communities expressed the belief that these shadow populations and growth in numbers were not accurately captured and accounted for when people unfamiliar with their community make decisions. It was pointed out that health care services are provided for the large shadow and transient populations, for growing families, as well patients from urban centres who pass by on major highways.

Rural communities describe AHS as a large, complex "system" that is not easy to understand, learn about, or navigate. The AHS website was frequently described as user-unfriendly. Many presenters acknowledged that a great deal of information was available, but that specific answers or advice were difficult to find. In regions where internet access or cell phone coverage varied, obtaining information was even more difficult. Frustration with automated, menu-driven telephone answering systems was common.

The relationship between Alberta Health (AH) and Alberta Health Services (AHS) was confusing for many people. As a result, navigating the system was very difficult and frustrating. The Alberta Urban Municipalities Association (AUMA) reported that many member communities do not understand who creates the system and who is responsible for what. Residents are unsure who to follow up with, what role the Primary Care Networks (PCNs) play, and described the frequent changeovers in administration as causing "reorganization fatigue". The simple question of "Who do we talk to?" was echoed repeatedly throughout the consultation. Many communities asked for a system navigator, someone who would provide guidance to the residents who describe feeling alone and lost when dealing with a large complex organization such as AHS.

Communities recognize the need to strike a balance between local governance and more centralized control and that there are benefits to both. Rural residents feel that the health system pendulum has swung too far in the latter direction and had lost its connection with the community. Communities described that centralization had skewed the balance in favor of urban centres providing the bulk of health services in Alberta.

"The whole community needs to have a part in the (health) conversation. They are hard conversations but let's have them."

Communities expressed frustration after several failed attempts at effective health service planning engagement. Rural residents often described the one-way flow of information to AHS. Citizens are told they will be given feedback on issues, but the feedback is not received. Residents are left feeling that the loop remains unclosed when an issue is raised. In addition, communities who had taken part in consultation meetings regarding local health service planning feel that nothing is done with the information gathered. Rural communities persistently expressed that they feel left out of health service planning. They also repeatedly indicated their desire

for increased ownership of care. Communities expressed palpable frustration with the multiple layers that had to be penetrated in order to have the simplest communication with AHS.

The concern and frustration with ineffective engagement also extends to Health Advisory Councils (HACs). Most communities had no idea of the existence of the HAC in their area, while others could not name their community's representative on the HAC (if they had one). HAC members expressed frustration at an inability to bring about meaningful change in AHS policies or operating procedures. HAC members further described a lack of clear mandate for the HACs, and felt there is a lack of support for HAC members who have, for years in some cases, travelled long distances to attend meetings where the same topics and grievances were discussed again and again without apparent progress.

"Just let people do their jobs. I'm so tired of letterhead changes, and the cost of those things."

Overwhelmingly, rural Albertans want health care governance closer to home. Rural residents feel that decisions are not being made in timely manner and often do not meet local needs. The uniqueness of each community cannot be understood by far-off urban-based bureaucrats making decisions on their behalf. Where community members and health care providers once felt proud of the health services and facilities in their communities, they now feel disengaged and frustrated. Further, they feel the creation of AHS has caused Alberta's health system to lose touch with rural Alberta altogether. Communities want control over their own destinies, and residents feel like they are "begging all the time for basic services" instead of communicating effectively to better plan and deliver care. One community described the several failed attempts to health service planning engagement as "We go around the table and nothing ever gets done—we are just like a dog chasing its tail!" Both the AUMA and the AAMD&C concurred that the loss of ownership and control infuriates communities that are increasingly desperate to get some measure of ownership and control back.

"There has been some real value in doing things provincially but not when it comes to the level of giving out wheelchairs."

Communities also lamented the loss of local control over basic, day-to-day decisions. The Committee repeatedly heard about simple and routine maintenance tasks (changing light bulbs, fixing toilets, and installing new equipment) that were delayed by months and even years while awaiting approvals from "up the ladder". Site managers expressed frustration at their lack of authority to effectively manage the "whole" facility. They indicated that they had reasonably good control in the areas where they were allowed to have control (staffing, scheduling) but that a large part of facility operations (lab, food services, maintenance, laundry, housekeeping, purchasing) required obtaining approvals from a multitude of off-site managers located in various communities all over the province.

One site manager described having to obtain approvals from six different managing directors in six different communities. Acting out of frustration, site managers described proceeding without prescribed approval because they were tired of waiting months for an answer. The Committee heard that basic items (screws, band-aids, bleach) were often purchased using personal funds because the supplies were clearly needed and it would take too long to get approval, if it came at all. Every site manager that met with the Committee expressed a keen desire to actually fully manage all operations at their facility.

Many communities acknowledged that centralized control over areas like standards of care and infection control made sense. That said, communities pleaded for a return to more locally-based authority. Having a local or regional board was mentioned multiple times as a method to increase local accountability and to efficiently respond to local needs. It was felt that, "solutions are there locally, just give us the authority to implement them".

Recommendations – Accountability

1. 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.
2. 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.
3. 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.
4. Establish a clear path of communication and feedback for patients, families, caregivers and community members to address concerns quickly and effectively.

Sustainability of Rural Communities

For many rural Albertans, this review is about more than improving access to health care, it is about the viability and long term sustainability of their communities. Workforce, infrastructure, industry, education, and the economy are intricately linked together. The viability of many rural communities depends on a delicate balance of these aspects. Being able to access a range of jobs, health care services, educational opportunities, recreation and social supports helps communities grow.

Attracting and retaining a skilled workforce determines the spectrum of services provided in a community and the extent to which these services meet residents' needs. Infrastructure is also important for retaining health workforce, and providing services locally. Together both of these aspects help to stimulate the economic activity within a rural community, by creating jobs, generating local business, and attracting new residents into the area.

Recruitment and Retention

Conversations with rural communities revealed several concerns with recruitment and retention. A shortage of qualified health care personnel triggers a negative domino effect where understaffing becomes more widespread, both by location and profession. It was well understood that physicians could not do it all, and that many were burning out trying. Chronic understaffing can lead to dissatisfaction, relocation or premature retirement. Communities expressed a desire for more access to a variety of health care professionals in order to improve their access to care. This would also help improve working life for health care providers in the community, create the opportunity for some level of continuity of care for citizens, and enhance the ability to provide a range of primary level health services.

"The doctor in the ER is burned out. There are LPNs but no nurse practitioners"

In most communities general practitioners (GPs) in independent practice (not formal team based care) was prevalent and is supported by a fee-for-service compensation model. Fee-for-service creates competition among doctors by providing incentive for physicians to maintain their current caseloads and defend their volume of work. The Committee often heard accounts of the detrimental

effect on communities and on physician retention when physicians did not work well together—which unfortunately, was not uncommon. Barriers and obstacles were also discussed by the communities regarding access and funding for different types of health care practitioners. For example, the funding mechanisms available to support midwives, nurse practitioners (NPs) and other health care professionals were poorly defined by Alberta Health and AHS and thereby not understood by communities.

"We feel powerless because we have no resources to draw someone in"

It was also observed that simply recruiting physicians was not working. Such an approach sets the stage for competition rather than collaboration between communities. Smaller communities reported being unable to compete with larger communities who could provide a bigger, better incentive to physicians they are trying to attract. Some communities were quick to express that monetary compensation was not the sole draw for providers to come to, or stay in, rural Alberta. Many communities reported spending significant municipal dollars on such things as buildings, retention bonuses, housing, and relocation for physician recruitment with varying degrees of success.

One factor that was critical to the success or failure of recruitment/retention efforts was the "functionality" of the physician group within a community. More than anything else, a cooperative, collaborative attitude among physicians and other health care providers led to more successful recruitment and retention. On the other hand, in communities where health care workers historically did not "get along", recruitment and retention was a chronic and often losing battle. There was considerable variation in community experiences with the Alberta Rural Physician Action Plan (RPAP). Some communities were highly engaged and praised RPAP for its assistance in successful physician recruitment. Others had experienced limited success or were unaware of RPAP's existence.

"Attracting a physician is important, but that physician needs a team; how do we attract other health care providers?"

The Committee certainly also heard that it could not be only about physicians—that it was about recruiting and retaining providers across the professions. Many communities expressed the desire to attract and recruit NPs in particular, noting that barriers to the use of these providers needed to be removed. Many were uncertain about how they would pay an NP, and some were concerned that such recruitment would alienate the existing physician providers.

Many communities were also receptive to the idea of other health care practitioners such as physician assistants and midwives, but did not know how to access or fund these other health care providers. A small number of communities participated in a pilot program which placed physician assistants in local clinics and hospitals. This arrangement was very well accepted by patients and other health care professionals; however, residents feared the end of this pilot would result in a more pronounced lack of service to their community. Midwives were also reported as under-utilized in the rural setting, but residents are uncertain how midwives might impact other health care professionals in the community.

"The normal education process doesn't fit the rural framework at all."

Several colleges and universities offer rural placements and rural programs for nursing and allied health providers. Some barriers in these education programs include a lack of affordable accommodation, educational supports and resources. Communities indicated that there needs

to be more opportunity for distance learning so rural students can travel less, in order to receive their education, particularly students living in remote areas. Many communities are interested in providing educational opportunities and resources to their own community members, to support a "grow your own provider" approach. It was suggested that high school students who show interest in health sciences be mentored to pursue a health care career.

A community fundraising effort in Bassano allowed the purchase of a computerized mannequin patient simulator which provides high school students the opportunity to try a wide range of simulated medical interventions. Some communities, such as Westlock, host a rural skills day to bring in students from a diverse range of health care education programs to practice multidisciplinary, comprehensive team based care. This allows students the opportunity to explore the community and surrounding area. High Level has already begun work in this area though the PCN, which is starting a summer program to employ RN students. RPAP is also now bringing medical, occupational therapists, physical therapists and nursing students into the community.

"There are issues with physicians losing hospital privileges if they refuse to be on call"

Many physicians in rural Alberta want to practice to the full extent of their education, skills and training. However, if they lack privileges in the local acute care facility or there are not enough acute care beds to support a robust practice, they will not be able to do so. The Committee heard stories of communities who offered physicians the opportunity to work in an acute care facility where there was more practice potential available. In these cases, communities were able to retain physicians at a higher rate than those that did not have a local acute care facility. Retention becomes even more difficult when only part time hours are available. For example, in small communities that only require minimal home care hours, there is not enough work to support a full time, and in some cases, a part time physician.

Communities described a number of obstacles hampering successful efforts to recruit health care professionals. One community commented that residents who are looking for jobs in the health care profession experience difficulty in navigating AHS which results in a "negative impact on ongoing local workforce challenges." Further, rural Albertans feel the hiring process for physicians is too slow and the paper work onerous, which has led to communities losing interested personnel. This situation is compounded for foreign medical graduates requiring assistance with immigration issues or practitioners from other jurisdictions obtaining licensure in Alberta. If recruitment efforts are to be successful in rural Alberta, communities want the process to be straightforward and directed by local needs.

Recommendations – Recruitment and Retention

1. Re-define the mandate of the rural physician action plan (RPAP) to include province wide support and coordination for recruiting all health care providers including nurse practitioners, physician assistants, midwives, nurses, physicians and allied health providers to rural Alberta. Set specific accountabilities and performance targets for community engagement and assistance with recruitment efforts.
2. Re-direct funding for rural physician undergraduate and postgraduate medical education directly to the Rural Medical Education programs of the University of Alberta and University of Calgary medical schools.
3. Encourage post-secondary educational institutions to offer additional health care-related courses and programs through distance learning.
4. Support the development of a northern rural post-secondary facility / program for health care providers.
5. Develop specific incentives or funding for students to serve rural centers and expand the use of return for rural service agreements.
6. Establish appropriate funding mechanisms and infrastructure for nurse practitioners, physician assistants, midwives and allied health providers in rural Alberta.
7. Examine best practices from other jurisdictions and implement a concerted effort to "grow your own" health workforce, including provision for the early identification, mentoring and support for students with demonstrated aptitude and interest in the healing arts and sciences.

Infrastructure

Rural Albertans have a keen sense of ownership and pride in their community facilities—schools, hospitals, churches, libraries, community halls, arenas—and see their health care facility, and the services that it provides, as the heart of their community. Residents understand that facilities that are busy are more viable. As a result, several communities advocated for increased services or a return to previous service levels.

Larger rural communities feel they are the hub for a large service area and they need to expand infrastructure and services to meet this demand. A well-functioning emergency department that is always open is seen as being especially important for attracting physicians and meeting the needs of residents. Communities also point out that hospitals and health facilities are important for the large shadow and transient populations that the facility serves. This was particularly true for communities that have experienced rapid expansion because of oil and gas development.

Overall, rural facilities are in varying need of repair, enhancement, or replacement to meet the needs of residents. In some communities, aging facilities have been closed for years but require ongoing funding to maintain. Repairing or replacing equipment in rural communities is another common problem across the province. Many residents feel a functioning X-ray or ultrasound machine is integral to meeting their needs. Several communities also feel that their helipads are too small and can no longer accommodate the new Shock Trauma Air Rescue Society (STARS) helicopters.

The Committee heard about the problems with both over and underuse of facilities in rural Alberta. In some centres, there is room in the hospital for additional surgical or obstetrical services. Residents in other communities explained that the operating room is only being used a few days per month, which could be increased. On the other hand, some communities are experiencing service demands that outweigh their available capacity. This has resulted in concerns about overcrowding and wait lists. In

one community a resident commented, “a doctor would like to get someone into the hospital but can’t because we’re full. This is coming up more and more. The bed numbers seem to be dropping and it’s a concern to the community.”

To address some of these issues, community members discussed a wide range of solutions. Several communities see opportunities in repurposing existing space in commercial and AHS owned sites. This could include turning storage space or empty offices into patient rooms. Especially in communities with larger buildings (e.g. older long-term care facilities), residents thought the extra space could be repurposed into affordable housing for seniors. Unused space in the existing long-term care centre could be renovated and used to provide more health services for seniors. In some areas, there is a potential to renovate space in existing facilities to support seniors at all levels of care. For example, some communities suggest that opening up supportive living beds in existing facilities could also help keep families and communities intact.

“If you had an asset, why would you let it sit for 10 years?”

Communities also suggested other options for repurposing existing infrastructure. Residents in Vilna, for example, suggested that an empty 15 bed facility could be used as a training facility for health care students. High Prairie also suggested repurposing their old hospital into a medical training centre. In Nordegg, available clinic space was suggested as a satellite location for delivering services to remote areas. On the other hand, Black Diamond is dealing with substantial overflow from nearby urban centres, and proposed re-activating currently unused patient rooms to help ease the situation. In the same vein, Vermilion suggested they have room in their acute care facility that could provide space for specialist services. This would also decrease the need for residents to travel outside the community for care.

In some communities, plans are already underway to expand existing infrastructure. For example, in the County of Kneehill, a new health clinic is being built. It will be attached to the county administrative building in Three Hills. Another example is the community funded health centre in Caroline that provides co-located services (e.g. chiropractic, fitness, primary care) in partnership with a nearby clinic.

Communities are also interested in using existing infrastructure to try new ideas. Drayton Valley has two vacant operating theatres and would like to try a P3 model (Public-Private partnership) with the hospital. Residents see this model as a way explore better ways to fully use the space, making better use of an existing asset, and have it make a stronger contribution to health care in the region.

In other communities, residents felt even when they take the initiative, they still have to “jump through hoops” with the province to get things built. Despite the erosion of trust that some communities say they have experienced with health system administrators, communities want to be involved. When it came to discussions around planning and repurposing facilities in their area, communities repeatedly explained that they are ready and willing to collaborate with AHS and government to find solutions that work.

Recommendations – Infrastructure

1. 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.
2. Fully integrate long term facility usage plans in cooperation with communities as part of community health service planning.

Foundations, Auxiliaries and Trusts

Throughout the province the Committee heard about dedicated volunteers who put in thousands of hours raising funds to support health care services and facilities. These activities included everything from bake sales and quilt raffles to operating small hospital gift shops to sponsoring major fundraising galas and lotteries. Over 66 foundations, auxiliaries, and health trusts operating in Alberta raise over $100 million annually to support health care.

The vast majority of these organizations operate in rural Alberta. Virtually every facility or region has some form of committee that organizes fundraising directed at meeting the needs of that specific community. The objectives of these efforts encompassed a wide range—from patient comfort funds for blankets, pillows, books and furniture, to support for staff education and recognition, to procurement of diagnostic, surgical or therapeutic equipment, to construction of new facilities. Potential donors often raised the question, "Shouldn't the government be providing this? After all, they are responsible for health care." Government clearly is responsible for health care, but auxiliaries, foundations and trusts have historically raised funds to provide extras and enhancements. These funds are used to improve the patient experience, or actively partner with government to fund major new capital projects and clinical equipment.

"Let us build the model that works for us, wherever we are."

The Committee heard several instances where local fundraising efforts had been very successful, the target achieved, and the equipment purchased, only to find that the staffing or physical space required could not (or would not) be provided. Communities described additional hurdles such as additional engineering, often at considerable cost, that were mandated before projects could be implemented. Other communities described long and unexplained delays in the installation and commissioning of purchased equipment, in some cases even exceeding the warranty period for the item. Bathtub, therapeutic whirlpool and shower facilities were mentioned by several facilities. In a small number of extreme cases, communities described situations where equipment had been purchased, seen limited utilization, and then mysteriously disappeared from the facility.

There is a clearly expressed and sincere desire for partnership with government to provide needed facilities and services to communities. Some communities, through their foundations, even expressed a willingness to jointly fund the operational costs of facilities, equipment, and services. Communities expressed a growing distrust of government commitment to provision of services in rural areas, and expressed a willingness (sometimes reluctantly or as a last resort) to provide funding support for a service rather than see it discontinued or a facility closed. The perceived or real reluctance to form meaningful, reliable partnerships to preserve service provision was seen by many communities as a demonstration of bad faith by government.

Recommendations – Foundations, Auxiliaries and Trusts

1. Establish a joint working committee with representation from government and the provincial health philanthropy association to improve communication and coordination of effort.
2. Establish a clear process for engagement and consultation between fundraising bodies and government service planners and providers to occur before commencing fundraising on a given project. Clarify roles and responsibilities, including full costing of installation and commissioning of new equipment.
3. Investigate the feasibility of foundations entering into joint agreements for financial support of specific programs on an ongoing basis. Test this concept through a limited number of pilot projects before implementation on a wider scale.

Economic Impact

Over the course of the review, it became clear how important health facilities and services are to the economic viability of rural communities. The Alberta Association of Municipal Districts & Counties stated that "Health care is intertwined with community viability. Physicians are important to the continued sustainability of Alberta's rural communities." Communities across the province described the interconnection of health care facilities and services to other businesses within their towns. In communities with locally available services, retailers benefit from the increased traffic that regional residents provide when accessing health services in the community. Economic activity for grocery stores, hair salons, clothing stores and pharmacies all increase, providing a sense of stability for the community. The community of Boyle estimated that over $2 million is brought into the community every year due to patients visiting the health clinic alone.

"The lack of health care and emergency medical services stunts the growth of our community."

Rural Albertans emphasized that the hospital and health services function as a major building block in their communities by providing jobs, supporting growth of the community locally and attracting people into the area. When people are looking to move to smaller rural communities (both young families and seniors alike), the availability of local health services becomes a determining factor in where to live. For growing communities residents felt the availability of health services within the village is one factor that prospective residents carefully consider when deciding to purchase a home or remain in the community. This was particularly true for young families. Furthermore, communities stressed the importance of health services and facilities in attracting potential employers, especially those related to the oil and gas industry.

In several communities, the hospital is the biggest employer in town. This contributes to the economic well-being of the community and the sustainability of the local economy. Jobs in a hospital or long-term care centre are vital for many families. Rural hospitals and long-term care facilities can be especially important for women, as they make up the majority of the health workforce. Especially for single mothers, these facilities provide access to stable, well-paying jobs with benefits. For anyone employed at a health facility in their community, the salary they receive generates income for local businesses.

"I can't imagine our village without the hospital/ clinic. It's a big employer. It's the reason a lot of people live here. Without it, we'd have a hard time surviving."

Health care professionals have higher levels of education and earn above-average incomes, both of which are welcomed in small communities. Many doctors, nurses and other health care workers take on important leadership roles in their community, contributing to the overall quality of life for all residents.

Many rural communities feel that when services are moved from one area to another, the community suffers. In some areas people are moving elsewhere so they can be closer to health care services. Residents are afraid that this pattern of leaving the community for better access to services will have a negative impact on their community's long-term sustainability. On the other hand, for those communities that are considered regional hubs, the influx of people from surrounding areas has significant positive impact on the community's economic sustainability.

Communities strongly believe that a reduction in health services negatively affects their local economy. Not only does a loss of services impact the number of local jobs, but it also impacts the overall purchasing power of residents which in turn negatively affects small businesses in the community.

Finally, on the subject of economic development and viability, several rural communities stressed the significant amount of wealth they generate for the province, noting they should be entitled to timely and appropriate care that is equal to what other Albertans receive. As one community member from Consort stated, "We fuel the provincial engine that Alberta benefits from and it serves no one to reduce services to these areas." Communities were proud of the health services they did have available and strongly advocated that they be fully engaged in regional planning discussions that would impact them.

Recommendations – Economic Impact

1. Acknowledge that health care services and facilities have a vital impact on rural communities and that cost analysis of rural health care delivery must include value to the region and not be restricted to cost-per-patient.
2. Mandate that all decisions made to significantly alter services or facilities undergo a comprehensive community consultation process. This process to include full assessment of the economic and social impact on the community as well as an estimate of expenses borne by residents forced to travel elsewhere to access services.

Section 3: Recommendations

Over the course of this Review, the Committee heard from representatives of over 100 communities, nearly thirty provincial organizations with a range of involvement in health care, members of Health Advisory Councils, elected officials, and concerned Albertans. This list of recommendations to the Minister, created in large part from the presentations made, are intended to support future service planning, design, and delivery of rural health care. Overall, they describe broad changes that are intended to address the major challenges in rural health service provision. In most cases, there are many ways to go about addressing these challenges, and the recommendations are not limited to a single course of action.

Access

General

1. 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.
2. Actively engage and include First Nations and Metis communities and relevant stakeholders in collaborative service delivery planning for health care that meets community-specific needs.

Primary Health Care

1. Implement Alberta's Primary Health Care Strategy (2014) without delay.
2. 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.
3. 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.
4. Remove legislative and regulatory barriers that prevent health care providers from working to their full scope of practice and inhibit team based primary care.
5. Harmonize the regulatory processes for health care professionals to facilitate all practitioners to work to their full scope of practice.
6. Identify and address remaining shortcomings thwarting the full implementation of a seamless "one person, one record" province-wide electronic health record.
7. 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.

Mental Health and Addictions

1. 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.

2. Work with the Minister of Education to establish and coordinate school-based mental health education and early intervention programs to identify and assist youth at risk.
3. 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.
4. Provide enhanced opportunities for mental health and addictions training, including crisis intervention and management, for all rural acute care and emergency staff.
5. Establish cooperative partnerships between mental health workers, addictions treatment personnel, social service and law enforcement agencies to reduce the prevalence of cyclic care and crisis management episodes for patients with diagnosed mental health and addiction issues.

Continuing Care

1. 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).
2. Acknowledge that family members often act as care providers and allow program eligibility/ criteria to support this role both financially and emotionally.
3. 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.
4. Encourage communities to share best practices to enhance non-medical social supports to assist seniors to age in place.
5. Increase the coordination and availability of mobile services in the community and primary care services being available on scheduled days within a facility.
6. Provide additional options for community-based end of life care through increased palliative care and hospice capacity.

Specialized Services

1. 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.
2. Identify opportunities for and encourage visiting or rotating specialists to travel to rural Alberta, providing locally prioritized (specialized) services.
3. Encourage the development of strategic partnerships between neighboring communities and visiting specialists to aggregate patients requiring care to a level where visitation by the specialist is advantageous.
4. 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.
5. Increase the use of technology to support the delivery of specialized health services. Remove barriers concerning funding and compensation models to enhance utilization of telehealth technology.
6. Provide transportation via non-ambulance transfer to specialized services when no other option or opportunity exists to provide services remotely or via technology.

EMS

1. 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.

2. Issue a directive that rural ambulances are to return to their home community directly and not be diverted for calls outside their region.
3. 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.
4. 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.
5. Implement a system of non-emergency transport vehicles and reserve the use of ambulance crews to situations clearly designated as emergencies.
6. 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.
7. Expand the AHS Volunteer Emergency Medical Response programs implemented in southern Alberta.

Transportation and Telehealth

1. 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.
2. Re-evaluate currently utilized options for patients to travel back to their community and actively discourage unnecessary use of ambulance transfers for this purpose.
3. Mandate that PCNs provide services closer to patients as opposed to using a single centralized location to serve large geographic areas.
4. Examine various models in use for publicly accessible transportation and consider support for regional or community-based public transportation systems.
5. 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.

Accountability

1. 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.
2. 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.
3. 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.
4. Establish a clear path of communication and feedback for patients, families, caregivers and community members to address concerns quickly and effectively.

Sustainability

Recruitment and Retention

1. Re-define the mandate of the rural physician action plan (RPAP) to include province wide support and coordination for recruiting all health care providers including nurse practitioners, physician assistants, midwives, nurses,

physicians and allied health providers to rural Alberta. Set specific accountabilities and performance targets for community engagement and assistance with recruitment efforts.

2. Re-direct funding for rural physician undergraduate and postgraduate medical education directly to the Rural Medical Education programs of the University of Alberta and University of Calgary medical schools.
3. Encourage post-secondary educational institutions to offer additional health care-related courses and programs through distance learning.
4. Support the development of a northern rural post-secondary facility / program for health care providers.
5. Develop specific incentives or funding for students to serve rural centers and expand the use of return for rural service agreements.
6. Establish appropriate funding mechanisms and infrastructure for nurse practitioners, physician assistants, midwives and allied health providers in rural Alberta.
7. Examine best practices from other jurisdictions and implement a concerted effort to "grow your own" health workforce, including provision for the early identification, mentoring and support for students with demonstrated aptitude and interest in the healing arts and sciences.

Infrastructure

1. 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.
2. Fully integrate long term facility usage plans in cooperation with communities as part of community health service planning.

Foundations, Auxiliaries and Trusts

1. Establish a joint working committee with representation from government and the provincial health philanthropy association to improve communication and coordination of effort.
2. Establish a clear process for engagement and consultation between fundraising bodies and government service planners and providers to occur before commencing fundraising on a given project. Clarify roles and responsibilities, including full costing of installation and commissioning of new equipment.
3. Investigate the feasibility of foundations entering into joint agreements for financial support of specific programs on an ongoing basis. Test this concept through a limited number of pilot projects before implementation on a wider scale.

Economic Impact

1. Acknowledge that health care services and facilities have a vital impact on rural communities and that cost analysis of rural health care delivery must include value to the region and not be restricted to cost-per-patient.
2. Mandate that all decisions made to significantly alter services or facilities undergo a comprehensive community consultation process. This process to include full assessment of the economic and social impact on the community as well as an estimate of expenses borne by residents forced to travel elsewhere to access services.

Conclusion

The Rural Health Services Review Committee was privileged to meet individually with over 100 communities as well as with nearly thirty province-wide organizations. The Committee received verbal and written submissions, and gathered valuable input from a broad spectrum of Albertans. The information collected was carefully considered by individuals with over 200 collective years of experience working in rural health care.

Throughout these engagement sessions with individual communities, the Committee heard first-hand the concerns about increased local decision-making, increased access to health services, improved utilization of infrastructure, increased use of technology, enhanced recruitment of healthcare personnel, and the importance of health services to the local economy. What has become clear is that rural communities all have unique needs and aspirations, that they cannot be viewed in isolation, that relationships between communities must be considered and understood, and that rural Albertans expect to be full participants in developing plans and making decisions about health care in their communities.

These findings formed the basis of the recommendations made by the Committee. In many cases, the recommendations call for a fully collaborative approach between Alberta Health, AHS, and the community. In other instances, the recommendations call for continuation of programs and strategies already initiated. In every case, implementation of these recommendations must be adjusted as required to meet the unique characteristics of each rural community. This review provides a challenging way forward to ensure accessible, high-quality, accountable and sustainable health care services. Rural Albertans are eager to see action and fully participate in decisive implementation of this review.

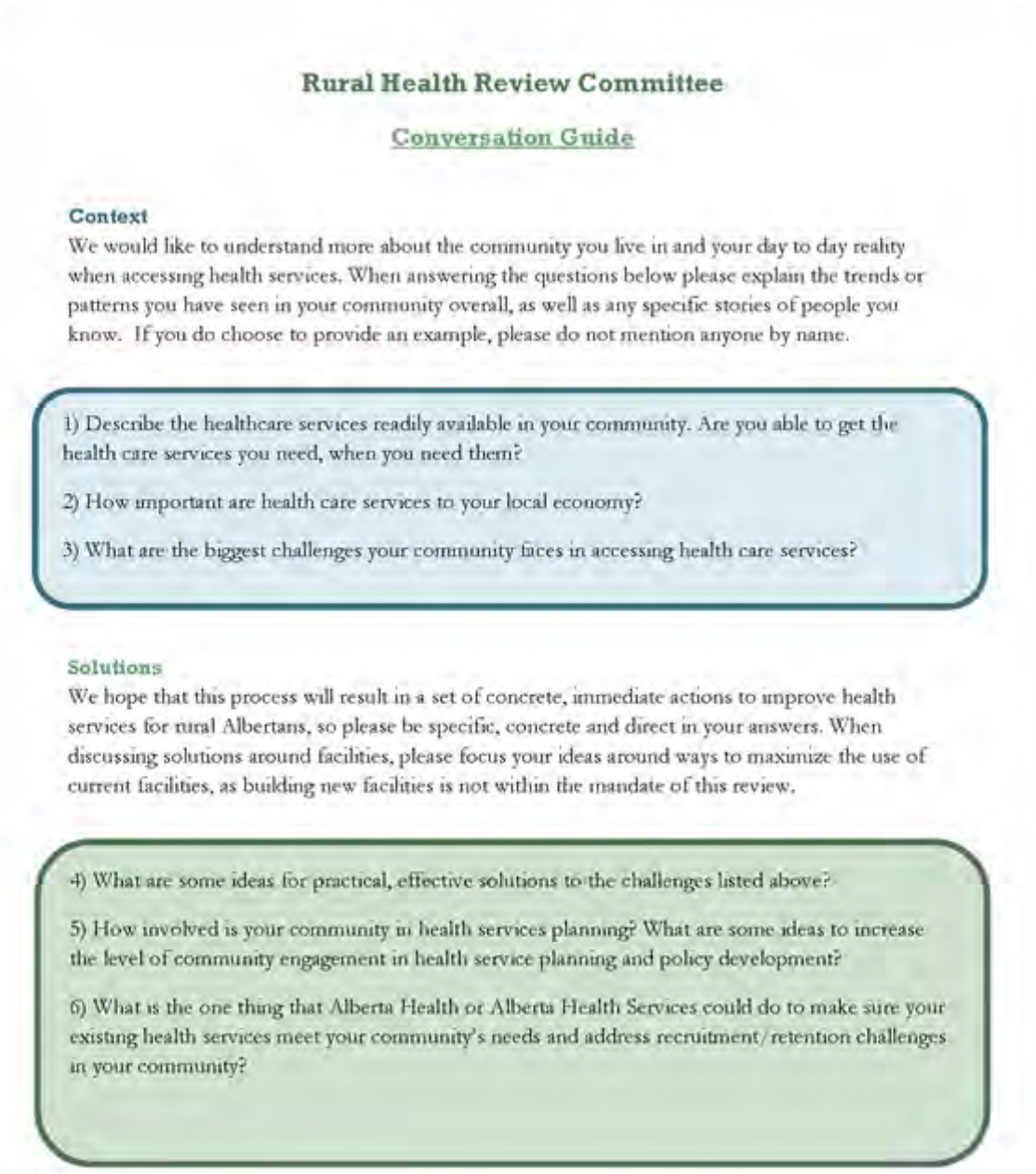
Appendix 1. List of Participating and Invited Communities in Phase 2

Date	Community/HAC Name
Wednesday, Jan 28	**Meeting in Black Diamond**
	Attended in-person
	Black Diamond
	Nanton
	Turner Valley
	Vulcan
	Banff
Friday, Jan 30	**Meeting in Olds**
	Attended in-person
	Olds
	Innisfail
	Sundre
	Three Hills
	Didsbury
	Did not attend
	Penhold
	Rimbey
	Carstairs
	Crossfield
Monday, Feb 2	**Meeting in High Level**
	Attended in-person
	High Level
	Rainbow Lake
	Meeting in Fort Vermilion
	La Crete
	Fort Vermilion
	Mackenzie County
	Provided written submission
	Zama City
Tuesday, Feb 3	**Meeting in Peace River**
	Attended in-person
	Peace River
	Grimshaw
	Valleyview
	High Prairie
	Sexsmith
	Beaverlodge
	Did not attend
	Wembley
	Fairview
	Manning
Wednesday, Feb 4	**Meeting in Westlock**
	Attended in-person
	Westlock
	Slave Lake
	Athabasca
	Morinville
	Gibbons
	Redwater
	Swan Hills
	Did not attend
	Barrhead
	Bruderheim
	Bon Accord
Thursday, Feb 5	**Meeting in St. Paul**
	Attended in-person
	St. Paul
	Two Hills
	Bonnyville
	Elk Point
	Vegreville
	Vermilion
	Provost
	Lac La Biche
	Did not attend
	Lamont
	Wainwright
Monday, Feb 9	**Meeting in Edson**
	Attended in-person
	Edson
	Jasper
	Hinton
	Tamarack Health Advisory Council
	Did not attend
	Mayerthorpe
	Fox Creek
	Grande Cache
Friday, Feb 13	**Meeting in Devon**
	Attended in-person
	Devon
	Drayton Valley
	Blackfalds
	Tofield
	Ponoka
	Millet
	Calmar
Wednesday, Feb 18	**Meeting in Fort MacLeod**
	Attended in-person
	Fort MacLeod
	Claresholm
	Pincher Creek
	Coalhurst
	Picture Butte
	Crowsnest Pass
	Oldman River Health Advisory Council
	Provided written submission
	Cardston
	Did not attend
	Magrath
	Raymond
Thursday, Feb 19	**Meeting in Brooks**
	Attended in-person
	Stettler
	Redcliff
	Vauxhall
	Bassano
	Bow Island
	Coaldale
	Drumheller
	Palliser Triangle Health Advisory Council
	Did not attend
	Hanna
	Taber

Appendix 2. List of Province Wide Organizations

Date	Province-wide Organization
Wednesday, Jan 21	University of Alberta – Faculty of Medicine University of Calgary - Faculty of Medicine Alberta Medical Association College of Physicians and Surgeons of Alberta Rural Physician Action Plan Canadian Association of Physician's Assistants University of Alberta - Faculty of Nursing Grant MacEwan - Faculty of Health & Community Studies University of Lethbridge - Faculty of Health Sciences College & Association of Registered Nurses in Alberta (CARNA) Nurse Practitioner Association of Alberta (NPAA) College of Licensed Practical Nurses of Alberta (CLPNA) College of Registered Psychiatric Nurses in Alberta (CRPNA) Alberta Pharmacist's Association (RxA) Alberta College of Pharmacists
Thursday, Jan 22	Association of Lab & X-ray Technologists Alberta Community Co-operatives Association Alberta College of Paramedics Shock Trauma Air Rescue Society (STARS) Covenant Health Association for Life-Wide Living of Alberta (ALL of Alberta) Maternity Care Advocacy Network (MCAN) Rural Obstetrics Group
Friday, Jan 23	Alberta Urban Municipalities Association (AUMA) Alberta Association of Municipal Districts and Counties (AAMD&C)

Appendix 3.
Conversation Guide: Phase 1



Rural Health Review Committee

Conversation Guide

Context

We would like to understand more about the community you live in and your day to day reality when accessing health services. When answering the questions below please explain the trends or patterns you have seen in your community overall, as well as any specific stories of people you know. If you do choose to provide an example, please do not mention anyone by name.

1) Describe the healthcare services readily available in your community. Are you able to get the health care services you need, when you need them?

2) How important are health care services to your local economy?

3) What are the biggest challenges your community faces in accessing health care services?

Solutions

We hope that this process will result in a set of concrete, immediate actions to improve health services for rural Albertans, so please be specific, concrete and direct in your answers. When discussing solutions around facilities, please focus your ideas around ways to maximize the use of current facilities, as building new facilities is not within the mandate of this review.

4) What are some ideas for practical, effective solutions to the challenges listed above?

5) How involved is your community in health services planning? What are some ideas to increase the level of community engagement in health service planning and policy development?

6) What is the one thing that Alberta Health or Alberta Health Services could do to make sure your existing health services meet your community's needs and address recruitment/retention challenges in your community?

Appendix 4.

Conversation Guide: Phase 2

Rural Health Review Committee

Phase 2 Conversation Guide

During the first phase of the review, we heard from rural communities about the challenges they face in accessing health care services. The following questions are meant to elicit specific feedback on certain topics we heard during in this first phase. We hope that this process will result in a set of concrete, immediate actions to improve health services for rural Albertans, so please be specific and direct in your answers. If you would like to respond to these questions via email, please send to rural.health@gov.ab.ca.

Local Decision Making

We heard about the disconnect between communities and those making decisions in larger urban centres. We also heard that many rural communities are unsure about where to voice their concerns, and felt that governance of the healthcare system should be moved closer to home. Health care co-operatives, which are similar to other co-operatives in that they are community owned and provide services to members and the public, may be one idea to help increase local control of health care services.

1. What does your community need to become more involved in the health care decisions that impact you?
2. What could be done to ensure more local decision making and better rural representation in the health care system?
3. What opportunities exist for setting up a health care co-operative in your community, which would be owned and operated by members of your community?

Moving Services Closer to Home

We heard that communities need more health services and equipment available locally, such as diagnostic equipment and speciality services (e.g. psychiatry). Due to infrequent clinic hours and limited health professionals, communities explained that they needed more options for accessing services when they need them.

4. How can the province make additional services and equipment available to rural communities, in a cost effective and equitable way? Are there opportunities to use Telehealth, video technology, or mobile services to bring services closer to home?
5. In the absence of local services, would a self-help line be beneficial to help members of your community access immediate help if a problem arises?

Increasing Capacity

Communities told us that they needed more support and increased capacity in primary health care, transportation, mental health services (especially for children and youth), and long term care services for seniors. Communities wanted options to help keep seniors in the same place for longer, even if their situation worsened (e.g. dementia) or they required higher levels of care.

6. What can Primary Care Networks (PCNs) do to provide more comprehensive and readily available services to your community?

7. What are some concrete, immediate solutions to help address the transportation issues that your community faces?

8. Are there opportunities to partner with existing bodies (e.g. schools) or organizations (e.g. non-profits) in your community to provide mental health services, especially for children and youth?

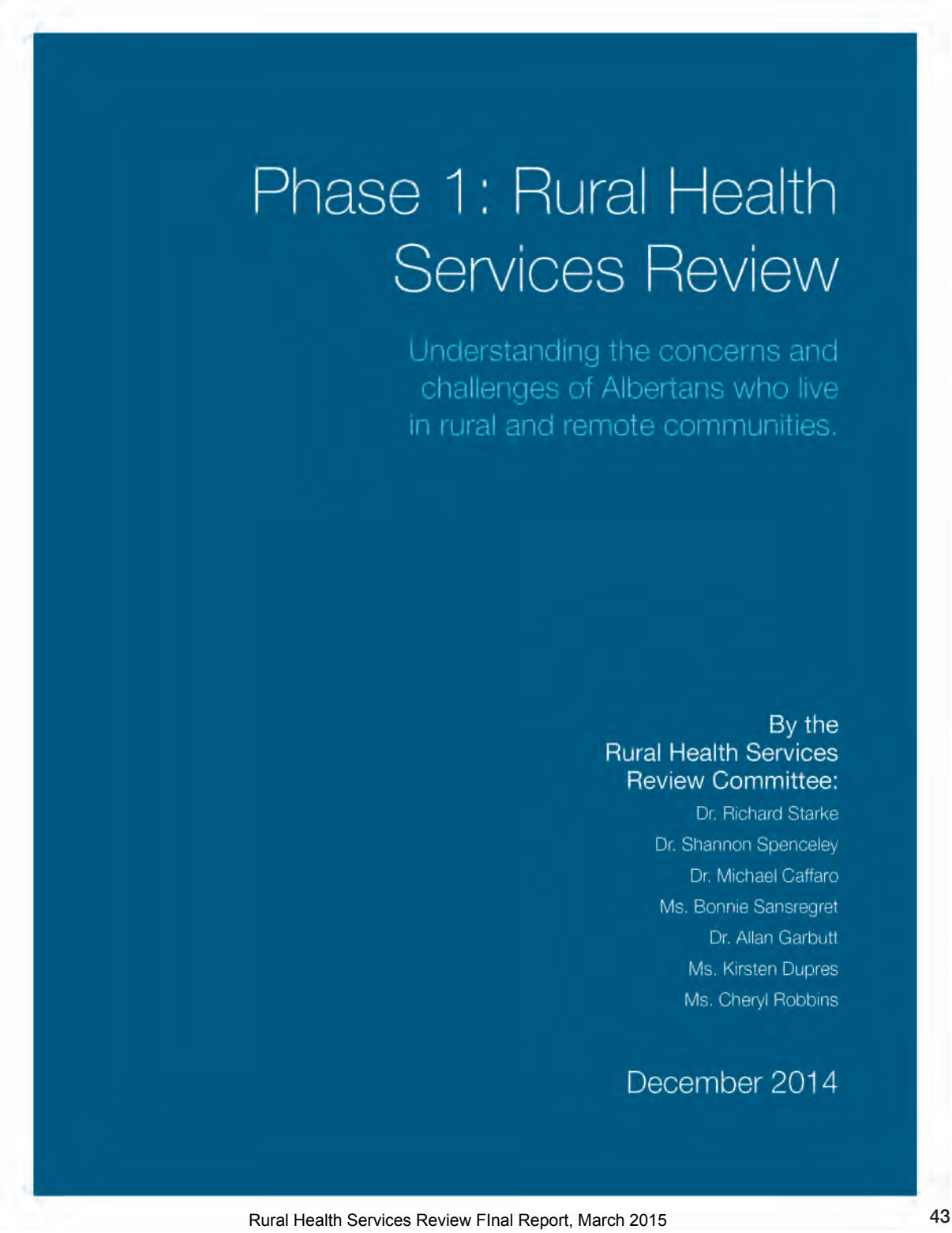
9. What are some ways the province can build on current seniors care services in your community to help seniors age in place?

Appendix 5:
Glossary of Terms

Abbreviation	Term	Definition
AH	Alberta Health	Alberta Health implements and ensures compliance with government policy. The Minister of Health, Alberta Health, and Alberta Health Services are key elements in Alberta's health care system.
AHS	Alberta Health Services	The regional health authority has a mandate to promote and protect the health of the population in Alberta. They are responsible for the assessment of health needs and the delivery of health services throughout the province.
DSL	Designated Supportive Living	Provides a higher level of health and personal care services to their residents than other supportive living accommodations and a community-based living option where 24-hour on-site (scheduled and unscheduled) personal care and support services are provided by health care aides. DSL is comprised of levels SL3, SL4 and SL4D (intended for individuals with dementia)
EMS	Emergency Medical Services	On top of being a transport service for patients, Emergency Medical Services is a critical clinical service. In an emergency situation, treatment begins as soon as the EMS team arrives and continues until the patient can be cared for in a medical facility.
HAC	Health Advisory Council	A group of volunteers who play an important role in supporting the strategic direction of Alberta Health Services by engaging their communities in public participation. There are 12 Health Advisory Councils across Alberta.
LPN	Licensed Practical Nurse	A Licensed Practical Nurse works in collaboration with other members of a healthcare team and directly cares for patients and their families. They offer practical care as they assess a patient's needs and provide treatment.
LTC	Long term care, also known as facility living	Refers to a purpose-built congregate care option for individuals with complex health conditions requiring a supervised physical environment with 24/7 Registered Nurse support.
NP	Nurse Practitioner	Nurse Practitioners are registered nurses with advanced knowledge and skills. They are trained to assess, diagnose, treat, order diagnostic tests, prescribe medications, and make referrals to specialists and manage overall care.

PA	Physician Assistants	Academically prepared and highly skilled health care professionals who provide a broad range of medical services. PAs act as health care extenders, working under the supervision of a physician, to complement existing services and aid in improving patient access to health care.
PCN	Primary Care Network	Groups of family doctors that work with Alberta Health Services and other health professionals to coordinate the delivery of primary care services for their patients. A PCN is a network of doctors and other health providers such as nurses, dietitians and pharmacists working together to provide primary health care to patients.
PHC	Primary Health Care	Primary health care is the first place people go for health care or wellness advice and programs, treatment of a health issue or injury, or to diagnose or manage physical and mental health conditions. Primary health care in Alberta includes public health, wellness, community and social supports, as well as supportive living/home care.
RN	Registered Nurse	A Registered Nurse directly cares for individuals, families, groups, and communities to be healthy and well. A Registered Nurse will coordinate patient care as part of a team with physicians and other health providers.
	Seniors Lodges	Are supportive living settings designed to provide room and board for seniors who are functionally independent with or without the assistance of community-based services.
	Specialized Services	Any service that requires a referral from a primary or secondary health care provider where a specific skill-set or training is required. It could also be for a service received during a home care referral, specialist referral, or a general practitioner's referral, etc.
SL	Supportive Living	Refers to congregate living buildings specifically designed with common areas and allow features to "age in place". Supportive services such as 24-hour monitoring, emergency response, security, meals, housekeeping, and life-enrichment activities. SL is comprised of levels SL1 and SL2.
TFW	Temporary Foreign Worker	Employees hired by Canadian employers to fill temporary labour and skill shortages.

Appendix 6. Rural Health Services Review: Phase 1 Report



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Appendices

Letter from the Chair

Alberta was founded on principles of hard work, industry, and self-reliance. Our early settlers broke the land, founded communities, and established a predominantly rural way of life based on agriculture. As Alberta grew, populations shifted to urban centres, and other industries gained prominence. Through it all, the wealth produced from rural Alberta, through oil and gas production, agriculture, mining, forestry and tourism has fueled the strongest economy in North America.

Rural Alberta is changing, and people who choose to live and work in rural areas of our province want to do more than accept and adapt to these changes. Rural Albertans are resourceful, energetic and proud. Accessing high quality health care is just as important in rural areas as it is in larger cities.

In September 2014, Premier Prentice and Health Minister Mandel announced a review of rural health care in our province. I was asked to chair a committee of dedicated Albertans who would travel across the province to hear the concerns of rural Albertans. The first phase of this review, the subject of this report, examined communities with populations of less than 1,250. In early 2015 we will continue the review, visiting communities in the 1250-2500 and 2500+ population categories. In addition, we will engage in discussions with groups that are involved in health care delivery in communities of all sizes across our province.

Our first task was to listen. And we heard a lot.

We heard about difficulties caused by geography and isolation. We heard how access to services depended on access to transportation and how that created difficulties for many rural Albertans.

We heard about the challenge of recruiting and retaining health care professionals. We heard about ongoing efforts to attract doctors and nurses, and the challenges they faced in serving their communities.

We heard about frustration and anger over the loss of local services. We heard about the pride people had in their local facilities, the quality of local services and how losing those services hurt small towns and villages.

We heard people tell us they no longer had any control of how health care was delivered in their communities, that there was no one to talk to about it, and when they did talk to someone, their questions and concerns went unanswered.

But we didn't just hear about problems. People told us much more.

Rural Albertans are doers. They solve their own problems. They come up with common sense solutions, good ideas, and simple fixes.

We heard about communities banding together to share scarce resources and provide a larger population base to support health professionals. We heard about ideas for repurposing facilities, breathing new life into old buildings by combining health care and housing for seniors. We heard about fundraising efforts for equipment and facilities, and a willingness to partner with government to provide needed services.

We heard about how important having health facilities and services are to the economic viability, indeed the survival, of small rural communities.

We heard from people who refused to give up on their town.

It has been an invigorating three months, and we still have a long way to go. The recommendations from this report will be presented to the Minister for consideration and, where feasible, implementation. We have worked hard to define the problems, to make some early diagnoses. Now we will start to treat the patient.

It won't be easy, and progress won't happen overnight. But it is our hope that this review will be the beginning of real and meaningful change in the way health care services are delivered in rural Alberta.

I want to thank the members of the review committee for their time, their dedication, and their commitment to this project. It has been a privilege to serve with you, and I look forward to the next phases of this review.

Most importantly, I want to thank everyone who came out to share their stories, frustrations, and ideas with us. You were open and brutally honest. That's what I expected from rural Albertans. It has been an honour to hear from you.

Richard Starke
MLA Vermilion-Lloydminster

Introduction

Context

Over the past few decades, Alberta has seen many changes in where people are living and how they earn a living. Despite these changes, the province's roots have continued to lie in rural Alberta and those roots form much of what it means to be Albertan. Fifty years ago, about half of all Albertans lived in rural communities and today this has dropped below 20 per cent. Part of the reason for this shift has been Alberta's young population moving from rural areas to the cities, often for educational opportunities and jobs. As a result, rural communities have struggled to preserve local businesses, attract skilled professionals, and create opportunities for young people to stay in smaller communities to build their futures.

The realities of living in rural areas are different than those in urban areas. This is important to recognize as discussions and planning for health services move forward. Rural residents have said that Alberta's policies have sometimes seemed biased by an "urban mindset" that misunderstands the rural realities. One example is the use of the internet. For those in urban settings, it may seem like second nature to use smart phones or look up information online. In rural areas there may be fewer opportunities to access information online, especially when internet service is spotty at best.

Another significant difference between Alberta's urban and rural communities is the number of health care providers and services. In an urban setting, with multiple health facilities and providers available within a short distance, there is some flexibility in where people may choose to access health services. For example, if someone cannot access the service they need at one clinic, there are often several other options nearby. In rural areas choices are limited (or non-existent) in some communities.

Travel and transportation also pose unique challenges to those living in rural areas. Whereas urban community residents can use public transportation or taxis to travel to appointments, those in more rural areas have fewer options. Rural Albertans who are unable to drive frequently rely on friends and family to take them to appointments if they are not able to drive themselves. This means that transportation becomes a significant barrier to accessing health services outside of their community.

Many of these issues were raised during the consultation and provided the Rural Health Services Review Committee (the Committee) with an understanding of the unique challenges faced by rural communities. The review process has given rural Albertans a voice to explain the challenges they face in their own words, and offer up solutions that they believe will work. The following section outlines the review process that has been underway for the past three months in communities across the province.

Process

The Rural Health Services Review was announced by Premier Prentice and Health Minister Mandel on Sept. 23, 2014. The purpose of the review was to further understand the health service needs, challenges, and concerns of Albertans living in small rural communities. A seven-member review committee composed of doctors, nurses, and community representatives, all with extensive rural health care experience, travelled to rural communities. They listened to rural Albertans, and discussed the challenges, barriers, and potential solutions to those challenges.

Members of the Rural Health Care Services Review Committee were:

- Dr. Richard Starke — MLA for Vermilion-Lloydminster, Committee chair, veterinarian with nearly 30 years of experience in rural veterinary practice, as well as past board member and Board Chair of the Lloydminster Region Health Foundation;
- Dr. Michael Caffaro — a rural family physician in Hinton, and past president of the Alberta Medical Association's Section of Rural Medicine;
- Kirsten Dupres — Certified First Nation Health Manager, Director of Health with the Kee Tas Kee Now Tribal Council, and past Licenced Practical Nurse;
- Dr. Allan Garbutt — a rural physician in Crowsnest Pass and past-president of the Alberta Medical Association;
- Cheryl Robbins — a Nurse Practitioner with experience working in rural, remote, and First Nations health care, past president of the Nurse Practitioners Association of Alberta, and current Treasurer & Membership Coordinator of the Canadian Association of Advanced Practice Nurses;
- Bonnie Sansregret — long-time rural resident of Consort, Chair of the Consort and District Medical Centre Society, and current councillor on the municipal districts Special Areas Board; and
- Dr. Shannon Spenceley — current Assistant Professor in the Faculty of Health Sciences at the University of Lethbridge, and President of the College and Association of Registered Nurses of Alberta.

The Rural Health Services Review Committee focused on:

- Accessing timely, appropriate health care;
- Evaluating specialist services in rural areas;
- Optimizing the use of existing rural health facilities, ensuring patient safety, and quality services;
- Ensuring communities are engaged in health service planning and policy development;
- Recruiting and retaining health personnel in rural areas, consistent with appropriate levels of care; and
- Examining the link between rural economic development and the provision of health services within communities.

In this first phase, the Committee was asked to focus its attention on rural communities with a population of 1,250 or less. Subsequent phases will include communities with a population of 1,250 to 2,500 and then those with a population of more than 2,500. Residents from these communities will have a chance to provide their input, which will be incorporated into the recommendations in the final report. Subsequent 'what we heard' documents will also be published at the conclusion of these two phases in 2015.

Phase 1 of the review took place between Sept. 23, 2014 and Dec. 22, 2014. Communities with a population of less than 1,250 residents and at least one Alberta Health Services (AHS) health facility were invited to participate. Invitations were sent to community leaders, most often the Mayor and Chief Administrative Officer. Communities determined who would speak on their behalf, as well as the size of the delegation. Of the 75 communities invited, 46 met with the Committee (Appendix 1).

Health Advisory Council (HAC) chairs from each area were also invited to participate along with any interested HAC members. HACs could either meet one-on-one with the Committee or sit in during the community meetings. On Nov. 8 2014, the Committee chair made a presentation at the Province Wide Health Advisory Council Meeting. During the meeting, the Committee chair explained the purpose and process of the review and participated in breakout session seeking HAC member feedback related to the questions outlined in the conversation guide.

Community meetings were held in six locations: Consort, Onoway, Myrnam, Falher, Bowden, and Stirling. Representatives of the 46 communities that met with the Committee in person travelled to one of these locations. Communities were scheduled at different times throughout the day to give them a one-on-one opportunity to have their voices heard. A conversation guide was developed and used to facilitate the discussions (Appendix 2).

The conversation guide asked about:

- The health care services that were readily available in the community, and whether the community was able to get the services they needed when they needed them;
- The importance of health care services to the local economy;
- The biggest challenges in accessing health care;
- Ideas for some practical, effective solutions;
- The extent to which the community was involved in health services planning, and what ideas could be put forward to increase community engagement in planning and policy development; and
- Ways that Alberta Health or AHS could ensure existing health services met the community's needs.

Community representatives unable to attend the meetings were able to participate by written submission. Members of the public were also encouraged to submit written feedback for this project by electronic or postal mail to addresses provided on the Alberta Health website.

Section 1: What is Working Well?

Over six days of community meetings, the Committee heard about the many challenges that rural communities experience. For the most part, communities discussed the barriers and issues they faced when trying to access health services, although they also described what was working well. The services listed below are not working everywhere; however, below are examples of when they were.

Health Services

Health services available in each community varied widely. Some towns had larger health centres with acute care services, respite care, long-term care, 24-hour emergency departments, pharmacies, dietitians, seniors programs, and community care clinics. Others had community clinics with limited hours, basic lab services and home care, while some had even fewer locally available services.

> **"Services are successful as long as we have the staff available."**
>
> Worsley

For those communities with a range of services available locally, many commented on the excellent care they receive. Over the course of the review, it became clear that rural Albertans are immensely proud of the quality services they receive, and the facilities they have in their communities.

In Vilna for example, the community expressed its satisfaction with the number of physicians, lab technicians, and nurses available. Viking also reported that it was pleased with its ability to attract several physicians despite its small size. Residents from Northern Sunrise County noted that the clinic in Grimshaw is thriving, due in part to having a nearby hospital, and believe that the rural physician action plan is working well. Despite the difficulties that many communities experience, success stories about specific facilities or health centres also pointed to care models, initiatives, and staffing aspects that were working.

Emergency Medical Services (EMS)

In most communities, residents explained that EMS services were not meeting their needs. However there were some success stories that residents attributed to the hardworking, dedicated, and creative staff.

In Boyle, community members described the 24-7 ambulance service as excellent, while residents of Willingdon felt that the services were good, with no major challenges in response times and service. Worsley and Kananaskis reported they were very pleased with the EMS services received. In Worsley, a successful project was launched through joint efforts of AHS, the County of Clear Hills and the Worsley and District Health Promotion Society. The result was a full-time, integrated ambulance service based out of the local health centre, where EMS providers can work alongside staff on weekdays and when not out on call.

In Kananaskis, residents commended the EMS services they receive, saying they were fortunate to have such committed and responsive EMS staff. Residents appreciated the advanced level care that is provided 24-7. The community also commented that there is usually an ambulance available in the community and that because paramedics take walk-in patients through the local fire hall, residents and park visitors are able to get minor urgent care when they need it.

Telehealth

Some communities were happy with the Telehealth services that exist in their communities. These services were especially important for those receiving mental health counselling and for connecting with specialists. Some communities using video technology explained it helped to improve communication with physicians and enhance patient care. Other communities discussed the importance of Telehealth services in helping them gain access to specialists that they would not otherwise be able to access. In most of the discussions around Telehealth there was a focus on building on current services, and ensuring that everyone from the region has equitable access.

Community Initiatives

Communities are doing what they can to improve and sustain services in their community. Not only are communities interested and committed to collaborating with AHS in health service planning, but many are also taking the initiative to fundraise for equipment and find local solutions to local problems.

In Castor for example, volunteers help at the hospital when the hospital is short staffed. In Killam, a local health foundation raised money for needed equipment. Residents from Boyle explained how important the Boyle Hospital Auxiliary is to the long-term survival of their hospital, noting that over the past 14 years the group has raised over $230,000 for equipment (e.g. beds, a ventilator, and ultrasound machines).

Many communities have organized committees or other working groups, and engaged in several processes to have their voices heard. For example in Consort, the Consort & District Medical Centre Society has engaged in a number of activities to bring its issues to the forefront including stakeholder meetings, meetings with Members of the Legislative Assembly and Members of Parliament and writing letters to AHS and Alberta Health.

There is widespread community involvement in physician recruitment and retention. Hardisty, Consort, Castor, Oyen, Smoky Lake, Daysland, Flagstaff, Killam, Hythe, and communities in Warner County have all formed Physician Recruitment and Retention Committees. These committees help to fund relocation costs, housing costs, vehicle rentals, office space and many other incentives to attract physicians. Many of these initiatives have been successful because of the dedication community members have shown in supporting physicians and their families to integrate into the community. Further, some communities are working hard to integrate internationally trained physicians into the community, recognizing they are "the glue" that keeps the community together.

> **"There are some good staff at AHS and we can see things that work, but we all need to have a shared vision."**
>
> Saddle Hills/ Spirit River

In other communities, residents have made efforts to attract and retain nurse practitioners (NPs). Some communities have been successful in their approach, including Onoway and Wabamun. In Wabamun, residents explained that the consistency of having a NP available has created trust in the community, which in turn has resulted in people getting better care.

> **Overall feedback from engagement sessions has been quite positive — The community is pleased with its services.**
>
> Saddle Hills

Importance of Relationships

Throughout the discussions, it became apparent how important relationships are in smaller communities, especially when it comes to health care. Rural communities are tight-knit and community members know each other well. During the discussions, communities explained that when a concern arises, they often call other members of the community for help rather than a centralized number. For example, some residents will call the EMS chief who lives in the community or the mayor at home because of the good relationships that exist.

Community members in Oyen, Trochu, Wabamun, Clearwater County and Northern Sunrise County also discussed their openness to partnering with surrounding communities to share resources and support initiatives to improve health services in the area. There were many examples of groups of communities that have collaborated to attract physicians to their region. Communities emphasized that building relationships and using existing networks will be important in order to implement solutions that will work.

> **"We have a good relationship in town and we pick up the phone to address issues."**
>
> Coronation

Section 2: What is Not Working

While participants outlined some health system strengths, they identified far more areas needing improvement. The main theme that emerged over the course of the review was timely access to a range of health care services such as primary health care, mental health and addictions, specialist access and continuing care. Communities also discussed transportation challenges that prevented access to services. Other major identified themes include workforce recruitment and retention, infrastructure, challenges with AHS including communication, governance, engagement and Health Advisory Councils (HACs), and the economic impact of health services delivery in the community.

Access to Health Services

Accessing appropriate health care services in a timely manner was seen as one of the biggest issues for most communities. Communities expressed concern about the lack of locally available services, which leads to additional challenges with transportation. Specific conversations around the importance of accessing primary health care services, specialty services and continuing care services were common during the review.

> **"The people who are making the decisions are too far away from where the services are being delivered, which creates a divide between patients and staff."**
>
> Kitscoty

Ideally, communities want access to basic diagnostic services and 24-hour emergency care. If that is not possible, most hope to have reliable, timely access to a physician or NP, or at the very least rapid access to EMS. Overall, rural Albertans felt that having equitable access to these necessary health care services was essential to their residents' well-being and the sustainability of their communities.

Transportation

For rural communities, transportation is a major barrier to accessing health services. Throughout the review, communities discussed challenges for those who do not drive. Problems identified included a lack of transportation options, the distance and cost associated with accessing services outside their communities, and the negative impact of using EMS resources to transfer patients to appointments.

Because not all services are available locally in many areas, residents are required to travel to appointments that can be hours away. Many community members are accustomed to lighter rural traffic and feel reluctant or frightened to drive to appointments in larger centres and especially in the "big city."

Bad weather in the winter, changing road conditions and increased traffic on the highways make it especially difficult for some people to travel outside of their communities for care. As a result, many communities felt the lack of transportation options, including public transportation and Handibus services, prevent people from accessing the services they required. Further, the loss of Greyhound bus services to many communities has made it even more difficult for residents to get to appointments.

Even in communities where there are some publicly funded transportation services such as a community

Handibus, a shortage of volunteer drivers results in services not being available. High costs associated with a single trip out of town may also prevent some people from accessing these services. For people without a vehicle or someone nearby who can drive, accessing needed care becomes impossible. Though some communities such as the Municipal District (MD) of Big Lakes and Willingdon have made efforts to pay for residents' transportation to health services, the cost has been too much for the community to manage alone. Overall, residents felt that having to travel long distances to receive routine and necessary services creates disparity among Albertans because some people have to spend more time and resources to remain healthy. For some, the financial burden associated with travel was extremely difficult, especially for patients requiring multiple repeated treatments (e.g. dialysis). Several communities described cases where people who were unable to drive but needed routine care, refrained from seeking medical attention until their condition became critical. Failure to access care early often resulted in a trip to a hospital emergency department and often that trip is in an ambulance. This in turn places extra pressure on the acute care system.

> **"'Younger' seniors end up providing transportation to 'older' seniors, which is not always the safest option."**
>
> Smoky Lake

Distance and travel times also raised concerns in relation to the provision of EMS. Especially in remote areas, communities commented that it takes too long for EMS to reach their community. Poorly coordinated dispatching results in cases where two or three ambulances respond at once, leaving other areas without service. Remote communities expressed particular concern regarding response and transport times. The time interval from when as emergency incident takes place until arrival at the emergency department is much longer than elsewhere in the province. As a result, some community members feel unsafe and vulnerable if and when an emergency situation occurs.

Rural residents frequently discussed the importance of the "golden hour"[1]. They expressed concern that their location and remoteness placed them at higher risk of not receiving attention within this time frame. In essence, many rural Albertans feared the distance between their home and the nearest emergency department place them at serious risk if they were to experience a life-threatening event such as a heart attack or car accident. In Milk River, residents explained that they wait more than an hour for an ambulance, noting that "the golden hour has disappeared."

In addition, communities said that transporting in-patients and/or long-term care residents by ambulance, to lab or diagnostic tests or specialist appointments is common practice. Communities felt this was not only inefficient and expensive, but also that it 'ties up' EMS resources so they are unavailable in times of "true" emergency. On several occasions, residents expressed frustration over the local ambulance often being used to transport patients to larger sites for diagnostic tests, which they believe results in no, or limited, ambulance service.

1 A common term for the critical period of time between a traumatic injury and the receipt of medical attention. Chances of survival drop off steeply if medical attention is not sought within this period.

Primary Health Care

In several discussions, community members expressed their need for more locally available primary health care services. In addition to reliable and timely EMS, many communities explained that comprehensive primary health care services were important for the sustainability of their community. Residents also saw opportunities for a range of health care professionals to provide these services.

Many communities discussed the potential of nurses, including NPs, Registered Nurses (RNs) and Licensed Practical Nurses (LPNs), in providing primary health care services. Several communities were specifically interested in discussing opportunities for NPs to lead community health clinics. Communities agreed that NPs, RNs or LPNs could play an important role in chronic disease management, health promotion and patient education, blood pressure monitoring and foot care assessments. Some communities hoped that having a primary health care clinic open a few days a week would adequately address their needs, while others such as Red Earth Creek advocated for full-time staff to keep the clinic open more often. Walk-in clinics were also suggested, as residents thought that such clinics would not only address local needs, but would also be used by residents from neighbouring communities.

In some communities, including those in Saddle Hills County, residents explained that when people do not have access to a family physician they use the emergency department instead. In these cases, community members said the emergency department becomes unnecessarily busy with non-emergency patients.

"The patient needs to be at the centre of all decisions that are made!"

Viking

While several communities discussed the important role physicians play in their area, some residents felt there were some issues with their physician's behaviour. One issue is that physicians are free to decide what services they provide and who receives those services. Residents from two communities commented this can lead to "cherry picking" patients for billing purposes, and avoiding patients with complex health problems. In some cases, communities felt they have no way to hold physicians accountable for the patients they choose to see. Other times, residents were reluctant to bring concerns forward for fear of reprisal or the physician leaving the community.

Some communities felt that because they do not have a Primary Care Network (PCN) they lack the services they require. In other communities where a PCN does exist, residents explained that it does not function adequately because there are poor relationships and/or communication between the PCN and the community. As a result, residents are unaware of the services the PCN provides or how to access those services.

Overall, communities said it was important to have stable primary care services to meet their needs. Most communities the Committee spoke with explained the impact these services have on their local economy and stressed that having more primary health care services, including access to a family physician or nurse practitioner, would help the community grow. Without access to these services, residents were afraid their community "would die" because of reduced movement into the community, a lack of jobs, and the impact on other businesses.

Mental Health and Addiction Services

Accessing mental health and addiction services is a major challenge for many communities. Several commented there are limited mental health services available locally. While some services are available for ongoing support on a weekly or bi-weekly basis, many communities do not have immediate access if a crisis occurs.

Community members often discussed how important mental health services were for children and youth. Access to early intervention services for children, including mental health reviews and follow-up in schools, was seen as a challenge. Some communities expressed concern that this lack of early intervention is leading to more youth suicides and problems within families. Having early access to residential treatment programs and long-term intensive counselling was seen as important, especially for at-risk youth. Some communities are taking specific action. For example, two community members from Stirling are advocating for a local counselling program and family supports by working with AHS, educators, law enforcement, and other community members.

> **"Access to mental health services, especially for youth, is seriously limited."**
>
> Stirling

Seniors, children, and single mothers had additional challenges with out-of-town mental health services. In Onoway, residents explained that if children are referred out of the community for mental health services that occur during the day, it is difficult for caregivers to accommodate those appointments. In one community, residents explained that those with psychiatric illnesses who must travel to appointments may choose to forego treatment and end up in the emergency department.

For communities with continuing care facilities, mental health services are especially important, as elderly patients with dementia and other mental illnesses may require more complex support. Communities noted that seniors exhibiting symptoms of dementia sometimes wait up to two weeks for an assessment. In one community, a resident of the local continuing care centre had been diagnosed with a mental illness and was becoming disruptive and a danger to other residents. Staff at the facility did not have the training or programs needed to address this resident's health concerns and the lodge was eventually forced to evict this resident. Community members felt that the system had failed this person and wished that it could have happened differently.

> **"Problems lie with early intervention... It's painful to have suicides occur, and addictions are an issue."**
>
> Northern Sunrise County

In some communities, addictions are becoming increasingly problematic. In some parts of Northern Sunrise County, residents said addiction to prescription medications appear to be increasing, while education on treatment options is not. To solve the problem, many communities felt that establishing full-time in-town mental health and addiction services would help. Acute psychiatric beds for crisis situations were also suggested, whereas others felt that rotating a psychiatrist into the community more often, or having a dedicated psychiatrist they could call would also be helpful.

Continuing Care

Several communities said their population is aging, and seniors are becoming the largest portion of the community. As a result, many stressed the need for more supportive living, home care, and supports to age in place.

> **"We want and need to keep seniors in town so that families can visit and also provide backup support."**
> Consort

Home care was seen by many as an important solution to helping seniors age in place, however communities felt that adequate funding for these services has been a challenge. Many communities struggled with the level of home care services available, including the number of staff employed. One resident from Evansburg explained that while home care nurses do a fantastic job, heavy caseloads make it difficult for nurses to manage patients.

Wait lists for supportive living beds, inadequate staffing, or a complete lack of supportive living facilities were problems experienced by many communities. In Northern Sunrise County for example, community members explained that there are not enough workers to manage the supportive living services and there is worsening shortage of accommodation. In Trochu, the community said an increased bed capacity is required to meet the needs of seniors in the area. They noted that some seniors have had to move outside of their community in order to receive appropriate care. Similarly in Worsley, community members felt the waitlist for seniors housing is too long, and while many seniors could benefit from staying in their homes there is no home care support in place.

Many communities' seniors also experience a gap between the level of supportive living care they have access to and the level of care they require. The gap between the care provided in lodges and long-term care was especially problematic. For example, Legal and Castor explained the limited availability of supportive living beds has resulted in lodges providing care that exceeds what they were designed to provide. This puts additional strain on staff and compromises the safety of residents. In other communities, patients who require a higher level of care may be sent to a hospital, which community members believe is an inappropriate use of acute care.

If seniors have advancing care needs that cannot be met in their community, they resort to seeking supportive residential care outside their community. This negatively impacts seniors and their families, as they find it traumatic to move from their homes into unfamiliar surroundings with no social or family support. In some cases, married couples have been forced to separate into different facilities in different communities, based solely on the availability of beds.

Throughout the consultations, it was clear communities were motivated and invested in supporting their seniors to age in place. To address this challenge, it was suggested that lodges should have some supportive living beds, in order to accommodate residents as they age and need a higher level of care. This would allow them to remain in the facility they are familiar with and comfortable in, while limiting the effects associated with major transitions.

Specialty Services

There was no consistent definition of what was meant by a specialty service across communities. When asked about the availability of speciality services within their communities, residents described anything that fell outside the services they receive from their family physician. This included allied health services such as occupational therapy, as well as more advanced treatments such as dialysis, X-rays, diagnostic imaging, obstetrics, and chronic disease management.

Many rural communities experienced challenges accessing a range of speciality services. Though most rural residents understood it is not practical to offer complex or advanced level services in small rural centres, there were numerous suggestions about using the available space in local health facilities for specialist procedures.

> **"Some go home to die rather than drive back and forth for dialysis."**
>
> MD Big Lakes

For some communities, a reduction in these services has slowly occurred over the past several years, while others describe a recent, sharp decline in the availability of speciality equipment and services in their communities. Communities also discussed instances where an X-ray or ultrasound machine was removed once nearby communities began offering the same services. Whereas some communities report an aging population, others are experiencing an influx of young families. For them, the loss of prenatal, post-natal and obstetric services were especially a concern.

Specialists rotate into many communities to provide services at the local hospital. For example in Daysland, two orthopedic surgeons routinely come into the hospital to perform surgeries and in Hardisty and Galahad a mobile pediatric clinic staffed with allied health professionals comes in once a month. For many other communities, residents said they must travel outside the community to access most specialty services. As discussed earlier, transportation issues prevent many people from accessing the services they need and may become a barrier for effectively managing chronic diseases.

Especially for people who require recurring treatments such as dialysis or chemotherapy, travelling in and out of the community is often a burden. Some communities discussed the financial costs associated with travelling and staying in cities for specialty treatments. For example, residents of Saddle Hills County and Spirit River explained that it can cost up to $3,000 per trip for travel and accommodations to access treatment in Edmonton, which causes significant hardship for many patients.

When discussing solutions, some residents suggested speciality services or diagnostic procedures should be reinstated within the community, especially if they had been there before. Various communities discussed that lab services, physiotherapy, and X-rays should be brought back to their community. Others felt that supporting mobile clinics or services (e.g. MRI, mammogram) and specialists to travel to rural areas would help take the burden off community members.

Another common solution discussed was to increase the use of Telehealth and other technologies in order to increase access in an economical and timely fashion. Kitscoty, Glendon and Consort all suggested various electronic methods of increasing access to specialists including video conferencing (e.g. Skype) and other apps used on tablets. One resident from Consort suggested the use of Skype could be expanded to discharge planning and follow-up for patients with complex care needs. While several communities expressed their support for these technologies, they were also quick to mention that not all areas have stable Internet access, which should be considered when determining next steps.

Workforce Recruitment and Retention

> **"We want stability in the provision of physicians. We don't want to get into a bidding war competing for physicians. The physician should want to be here because it's a good community to move to and he wants to be in the community, not because of the incentives."**
>
> Willingdon

Attracting and retaining health professionals in rural and remote communities has been, and continues to be, a significant challenge. Efforts to attract physicians, RNs, NPs, and a number of other health professionals do not always result in long-term sustainable solutions for communities. Recruitment committees have been established in many rural communities, and help by offering incentives (e.g. office space, free housing) beyond what is provided by AHS. However, several communities are worried they are getting into "bidding wars" with neighbouring areas, which will result in practitioners accepting positions in communities that can offer the most money.

Additionally, communities have experienced situations where their efforts to recruit providers were not supported by the funding or staffing arrangements offered by Alberta Health and AHS. In some communities, newly recruited doctors may be unable to generate enough revenue to remain viable. For example, in Milk River they have had several doctors come tour the community, but none have decided to set up practice. Residents believe this is a result of not having the acute care beds required to sustain a robust practice. Wabamun, Forestburg, and Evansburg all have visiting physicians that come from other communities because they cannot support a full-time physician.

In Milk River, a solution was proposed to help rural communities attract new physicians. Residents explained that visiting physicians could come into the town regularly so a new recruit would feel more supported. Currently, the community is working with neighbouring Taber to develop a model to support this practice.

Several communities also discussed issues with fee-for-service payment, which creates incentives for physicians to maintain their current case loads and defend their volume of work. Communities in the north felt current funding models do not adequately take into account the higher cost of living in some areas, and advocated for more regional adaptability in physician pay structures. A need to reassess the current physician payment model was echoed several times throughout the review. Further, some communities raised concerns over the payment model for other practitioners, such as NPs, stating it could be adapted to better meet the needs of rural communities.

It is clear communities have made a great effort to attract physicians to rural Alberta communities. For example in Trochu, residents have invested $350,000 in recruitment and retention activities. However, in some cases physicians are reluctant to remain in a community if they do not have privileges in an acute care facility where they can practice to the full extent of their education, skills and training. This is the case in Caroline and Milk River, where residents feel a lack of hospital privileges deters physicians from working in the area. When the services at rural hospitals change, communities have experienced the effects on their physician retention. In some cases, a physician may choose not to stay in that community long term because they do not feel the work they do is the best use of their training and skills.

Communities explained that some health workforce challenges are the result of interdependence of one health profession on another. For example, a local pharmacy may be an important business in a community, however part of the pharmacy's viability may be dependent on the existence of a physician office or health centre. If the physician goes on vacation or leaves the community, this has a negative impact on the number of prescriptions filled and/or the number of referrals to other services.

Overall, communities expressed their need for a consistent, stable health workforce. Several communities explained that the physicians available in their communities change often, which results in locum coverage and fragmented care. In other communities a large percentage of temporary foreign workers (TFW) in nursing positions results in staffing crises if they have to leave the community because of changes to immigration or labour laws. For example, community members in Grimshaw said 58 per cent of staff at the Stonebrook supportive living facility are TFWs and after many of them leave in the next year there will be a major impact on the ability to deliver services. Several communities noted the dependence on foreign medical graduates and called for a more concerted effort to identify, train, mentor and support Canadian doctors and nurses, encouraging them to consider practicing in rural communities.

Infrastructure

Many rural Albertans see the health care facility, and the services that it provides, as the heart of their community. As a result, several communities advocated for increased services or a return to previous service levels. One resident from Boyle said, "Our hospital of utmost importance to all residents of this village and surrounding communities!"

Residents from Milk River, Coutts, and Warner agreed that reviving services at the hospital would make a huge difference in their communities. Others pleaded for no further changes to their hospitals and services, especially without proper notification or consultation. Increasing emergency department space was also mentioned by several communities as a way to make their hospital viable for physicians and meet the needs of their residents.

Communities also said that hospitals and health facilities are important for the large shadow and transient populations that the facility serves. This was particularly true for communities that have seen rapid expansion because of oil and gas development, such as the MD of Opportunity.

The need to repair, replace, or enhance current facilities and infrastructure came up frequently throughout the discussions. In some areas there are aging facilities which have been closed for years and required ongoing funding to maintain. Other facilities that are still operating are often dated and in need of renovation or replacement. In one community, residents explained that the hospital has had major issues for the past 10 years, including unstable heating, broken floor tiles, and asbestos. Several communities also expressed concerns that important upgrades are deferred because funding is not available.

Repairing or replacing equipment was also a recurring theme, with several communities insisting that a functioning X-ray or ultrasound machine was integral to meeting their needs. Several communities, such as Viking and Boyle, also said their helipads are too small and can no longer accommodate the new Shock Trauma Air Rescue Society (STARS) helicopters.

Repurposing beds and space within seniors' lodges or facilities was mentioned several times in the discussions. In some facilities, such as in Mannville, residents suggested that space being used for storage and empty offices should be repurposed into patient rooms. In Trochu, the current residential care structure is very old and community members felt it was not capable of accommodating needed safety equipment (e.g. mechanical lifts) and should be replaced.

Some communities hoped that opening up supportive living beds in existing facilities could help keep families and communities intact. In Castor, residents felt that upgrading the current facility to allow seniors to age in place would result in more appropriate and better care. In Carmangay, the old long-term care facility is currently empty. The community sees a great need for affordable seniors housing and expressed hope that the building could be repurposed to meet that need.

> **"We need a hybrid type of rural health facility... a facility that houses all health services... We don't need a fully functioning emergency department, but enhanced services."**
>
> Onoway

When it came to discussions around infrastructure issues, communities had problems with both over- and underuse of facilities. In some places, including McLennan, hospitals are perceived to be underused and capable of being used for additional surgeries or obstetric services. Similarly in Willingdon, the seniors' lodge has vacancies that could be filled. In other communities, such as Hythe, service demands have resulted in concerns about overcrowding and wait lists.

To address some of these issues, community members discussed a wide range of solutions. Several communities discussed the opportunities that existed in repurposing existing space in commercial and AHS owned sites. Some communities also own property and provide space for their health care professionals to operate, which communities suggest could be one avenue to explore when trying to repurpose existing infrastructure. Many communities felt they had a lot of infrastructure and resources that could be updated to provide more specialist services.

Communities also suggested other options for repurposing existing infrastructure. Residents in Vilna, for example, suggested that an empty 15 bed facility could be used as a training facility for health care students. In Nordegg, available clinic space was suggested as a satellite location for delivering services to remote areas. In Evansburg and Legal, an empty physician's office and a vacant medical office building were suggested as places to house a range of services and personnel.

In some communities, plans are already underway to expand existing infrastructure. For example, in the County of Kneehill, a new health clinic is being built. It will be attached to the county administrative building in Three Hills. Another example is the community funded health centre in Caroline that provides co-located services (e.g. chiropractic, fitness, primary care) in partnership with a nearby clinic.

In other communities, residents felt even when they take the initiative, they still have to "jump through hoops" with the province to get things built. Despite the erosion of trust that some communities say they have experienced with health system administrators, communities want to be involved. When it came to discussions around planning and repurposing facilities in their area, communities repeatedly explained that they are ready and willing to collaborate with AHS and government to find solutions that work.

> **"The community is willing to participate in solving problems, but we need someone to talk to."**
>
> Myrnam

Alberta Health Services

Many rural Albertans throughout the review expressed dissatisfaction with their relationship with AHS. Some communities felt that there was a lack of communication with AHS and no clarity on the role of the HACs. A common concern throughout the discussions was the centralized nature of AHS, the resulting lack of local governance, decision making, autonomy, and accountability.

Communication

Communication issues were raised frequently over the course of this review. Communication practises and procedures were described as lacking or inconsistent between communities, AHS, HACs, and Alberta Health. Overall, communities want clear, consistent communication from AHS and health system managers.

In many communities, residents stated they were unaware of how to communicate or connect with someone on any particular issue. Some residents were unsure how or where to express their concerns or issues. Several community members described their attempts at calling a central phone number in AHS, only to be directed to an automated line. Residents in Manville described these automated systems as impersonal, and suggested having a single "number to call where people can speak directly to an individual and not have to deal with computers." Community members felt the use of automated systems can lead to confusion about where to turn for help, and are not an adequate way to ensure complaints or concerns are heard.

> **"Our solutions need to be closer to home... They (AHS) need to be more sensitive to what works for each community."**
>
> Legal

Throughout the review, individuals noted the health system is too complicated to navigate, especially for individuals who are more vulnerable, such as frail seniors requiring care. In Myrnam, one resident commented, "There is little information as to who to ask the right questions to, or where to go for additional help." Overall, Albertans want a straightforward process to ensure their voices are heard and their concerns are dealt with.

Local Decision Making

During the review, many communities expressed concerns with a loss of control over their services and facilities. This has left residents feeling the need for more local decision-making and autonomy for their local health service providers. Moving governance closer to communities was an idea that came up several times throughout the discussions. Communities felt that local representatives are more present, visible in, and knowledgeable about the community. Further, many felt that local health managers would have the best interests of the community at heart when making decisions.

Some communities thought that AHS centralization resulted in communities losing their uniqueness and limited local personal responsibility for certain facilities' success. For example, one resident from McLennan felt that many services have been lost because AHS is huge, and there has been a loss of contact at the local level. Several participants thought

> **"Bring back regional input (not one cookie cutter for everyone, but several cookie cutters for several regions)."**
>
> Northern Sunrise County

that because decisions are being made so far up the chain, local facility managers are unable to solve local problems.

Overall, communities wanted to be more involved in the decisions that impact them. They felt that people making decisions on their behalf, often in larger urban centres, do not understand the complexities of living in a rural community. Further, communities are frustrated with the apparent bureaucracy and the time it takes to make decisions and get things implemented.

Having a local board or committee was suggested multiple times as a way to improve accountability and community engagement. Local governance was also seen as an effective way to increase communication between AHS and communities. For example, residents in Smoky Lake felt the absence of a local AHS representative to discuss health concerns reduced accountability. They also felt improving communication with AHS and Alberta Health would help dispel the community's skepticism of the health care system and its capacity to implement appropriate change. Increasing collaboration with AHS was also suggested as a way to facilitate collective strategizing and improve local healthcare planning.

Engagement

Several communities expressed frustration over what they believe to be failed attempts at becoming more engaged in health service planning. For example, community members in Worsley explained there had been several consultation and engagement meetings with AHS regarding local health services but felt that nothing was ever done with the information gathered. Community members in Red Earth Creek were also upset when promises from elected officials went unfulfilled.

Even when individual community engagement activities were successful, the absence of a formal mechanism for ongoing community involvement left communities disappointed. Some communities felt they were being left out of the planning process altogether, including residents in Smoky Lake who expressed concerns over the lack of opportunity to get involved in planning discussions.

Throughout the review, communities consistently expressed their desire to become more engaged. Residents said that they would be happy to collaborate, fundraise, or partner with AHS and government to help ensure that their health services reflected local needs. Several times, residents stated that although rural and urban Albertans have similar health needs, they have distinct concerns, contexts, and challenges that need to be considered.

Health Advisory Councils (HACs)

HACs are groups of volunteers from across the province who provide advice to AHS. They are also organized by geographic area. These groups engage with the communities around them to learn about each community's health needs, concerns and services. HAC members then relay this information back to AHS and provide advice about health issues and priorities.

The relationship with the HAC, or lack thereof, was discussed by several communities during the review. Communities do not always know if they are represented on the local HAC. If they are represented on the local HAC, the purpose HACs serve in the community and what concerns or topics they can or should raise with local HAC members is unclear. Some communities are not sure if the HAC representative is there to elicit community feedback and if the feedback will go anywhere. Community members in the MD of Big Lakes were frustrated by the apparent inability of the HAC to make progress on important issues and believe that HAC members have quit because issues continue to persist without action.

Similarly, HAC members in the community who receive comments from local residents feel frustrated because they either do not know who to direct those questions to, or how to "close the loop" and provide responses back to their communities. Generally, HAC members were concerned there was inadequate communication between communities

and the HAC and between the HAC and AHS. Some HAC members feel that because the health system is so complex, it is difficult to share community concerns and ensure they are being heard. During conversations with HAC members, it was clear many were passionate about improving health care throughout their communities and were generally frustrated with their inability to make a difference. Some HAC members also expressed concerns about their poorly defined mandate, lack of administrative support, and their inadequate operating budget.

Conversely, some communities were more engaged with their HAC and thought they provided an important function in the community. For communities that had a good connection with the HAC, residents still felt better communication around the HACs' purpose and activities was required. Residents also advocated for more financial support for the HACs and better training to help HAC representatives successfully fulfill their duty to the community. Some communities were concerned that HAC members would leave these roles due to lack of support and because these individuals commit so much time and energy to their position.

> **"Bring back more local autonomy to our hospital board and more decision-making done at a local level, therefore, empowering the community to be involved where their opinions can make a difference."**
>
> Castor

Overall, increasing communication and local decision-making were seen as two of the most important changes needed to improve access to services. To do this, many communities suggested having a system navigator or an integrated site manager who would have increased decision-making ability and accountability locally—ideally, a local resident to help direct their communities concerns, complaints, and questions to the appropriate place. Reinstating more regional and local governance structures, such as hospital boards or committees, was also seen as a viable solution.

Economic Impact

Over the course of the review, it became clear how important health facilities and services are to the economic viability of rural communities. Communities across the province described the interconnection of health care facilities and services to other businesses within their towns. In communities with locally available services, retailers benefit from the increased traffic that regional residents provide when accessing health services in the community. Economic activity for grocery stores, hair salons, clothing stores and pharmacies all increase, providing a sense of stability for the community. The community of Boyle estimates that over $2 million is brought into the community every year due to patients visiting the health clinic alone.

Rural Albertans emphasized that the hospital functions as a major building block in their communities by providing jobs and attracting people into the area. When people are looking to move to smaller rural communities (both young families and seniors alike), the availability of local health services has become a determining factor in where to live. For communities such as Myrnam, current residents felt the availability of health services within the village

> **"I can't imagine our village without the hospital/ clinic. It's a big employer. It's the reason a lot of people live here. Without it, we'd have a hard time surviving."**
>
> Oyen

is one factor that prospective residents carefully consider when deciding to purchase a home or remain in the community. This was particularly true for young families. Furthermore, communities stressed the importance of health services and facilities in attracting potential employers, especially those related to the oil and gas industry.

In several communities (e.g. Oyen, Consort, Smoky Lake, McLennan) residents said the hospital is the biggest employer in town. This contributes to the economic well-being of the community and the sustainability of the local economy. Jobs in a hospital or long-term care centre are a draw for some families. Other communities such as Galahad and Consort, explained that rural hospitals and long-term care facilities are especially important for women and that they make up the majority of the health workforce in that community. Especially for single mothers, these facilities provide access to stable, well-paying jobs with benefits. For anyone employed at a health facility in their community, the salary they receive generates income for local businesses and supports the income of farming and ranching operations.

Communities felt that when services were reduced or moved from one area to another, their community suffered. In some areas people are moving elsewhere so they can be closer to health care services. Many residents expressed a fear that this pattern of leaving the community for better access to services would have a negative impact on their community's long-term sustainability.

In Forestburg for example, one resident said that some people choose to move closer to consistent care in larger centers, which creates a downward spiral of economic issues. Similarly in Legal, families and seniors have chosen to leave the community due to the lack of health services. On the other hand, for those communities that are considered regional hubs, such as Killam, the influx of people from surrounding areas has significant positive impact on the community's economic sustainability.

For some communities, there is the belief that a reduction in health services has negatively affected their local economy. Not only does a loss of services impact the number of local jobs, but it also impacts the purchasing power of residents which in turn negatively affects small businesses in the community. One resident in Consort explained it well, "The loss of medical services cannot be replaced, it cannot be overcome and the community will drastically feel its loss." One community member explained the inherent tie between the success of rural physicians and the community around them, stressing the importance of maintaining or increasing services.

"The lack of health care and emergency medical services stunts the growth of our community."
Legal

Finally, when it comes to economic development, several rural communities stressed the significant amount of wealth they generate for the province, noting they should be entitled to timely and appropriate care that is equal to what other Albertans receive. As one community member from Consort stated, "We fuel the provincial engine that Alberta benefits from and it serves no one to reduce services to these areas." Overall, communities were proud of the health services they did have available; however, some worried that without the existence of a larger facility they would be left out of regional planning discussions.

Section 3: Recommendations

Based on what was heard from communities over the past 90 days, the Committee has created a list of recommendations. These recommendations, in large part from the participants themselves, are intended to support future health service planning, design, and delivery of rural health care. Overall, these suggestions describe broad changes that are intended to help address the major problems in rural health service provision. Because there are many ways to go about solving these problems, the recommendations are not limited to one course of action.

Further, once the results from the second and third phases of this review are gathered, these recommendations can be confirmed or modified to make sure they are both relevant and feasible for larger rural communities.

1. Access to Health Services

a) EMS personnel in rural areas should have a high level of expertise, so they can adequately respond to emergencies that occur further away from major hospitals.

b) Ensure adequate coverage of EMS by limiting the use of EMS vehicles for inter-facility transfers and eliminating the diversion of rural EMS personnel when returning to their community.

c) Develop EMS access standards that outline a standard of care for response times, and ensure these standards form the basis of future service planning discussions.

d) Co-ordinate and provide transportation options for those living in rural Alberta. Albertans should not have to face undue hardship, ongoing and regular personal financial strain, or adverse health outcomes because of where they live.

e) Promote and encourage increased use of Telehealth services to support the delivery of health services. Ensure funding and compensation models are not a barrier to using Telehealth technology.

2. Workforce Recruitment and Retention

a) Create an appropriate funding mechanism that supports team-based primary health care. Teams may be comprised of a range of health care professionals including physicians, Nurse Practitioners, Registered Nurses, and Physician Assistants, depending on the needs of the community. Review a variety of compensation models, to determine which approach will work best for rural communities.

b) Develop a coordinated and focused approach to supporting health care professionals working in rural areas, especially in the early stages of their practice. This approach could include formalized programs to help health professionals become comfortable in their new setting, formal mentorship programs, health system orientation, navigation support, and a community of practice resource guide. Specifics of the approach should be tailored to each community and be coordinated with other agencies (e.g. nursing and medical schools).

c) Ensure communities have the tools and choice to recruit and retain the health professionals that best meet their needs.

d) Ensure better co-ordination of recruitment and retention programs for healthcare professionals among the many agencies and communities that support and use these programs.

e) Work with medical and nursing schools to enhance programs intended to promote rural practice as a career choice, including student and resident placement in rural communities.

f) Increase investment in home care, respite care, and supports for caregivers.

3. Infrastructure

a) Work with communities to ensure their available resources and facilities match their long-term health service needs. In areas where health facilities are underutilized, funding may be necessary to redevelop, renovate, or repurpose existing infrastructure to better align with the community's needs.

b) Explore service planning that fosters optimal usage of facilities for referral procedures that could safely and practically be performed in rural hospitals.

4. Alberta Health Services

a) Increase local input into health service planning. Empower health care providers and administrators to make decisions based on local needs. Clarify the role and authority of Health Advisory Councils. Ensure communities are actively engaged in planning the health services available in their region.

b) Improve communication within the health system, by designating individuals within Alberta Health and AHS who can act as a first point of contact for communities.

5. Economic Impact

a) Ensure the economic impact of health service delivery in rural communities is at the center of all discussions related to health service planning.

Section 4: Next Steps

Meeting individually with communities was an important opportunity to hear the first-hand experiences and challenges that rural Albertans face when accessing health care. Over the course of these meetings, it became clear that rural communities cannot be viewed in isolation.

To better understand the relationships between communities of varying sizes, including how one community impacts health care delivery in another, rural communities in Phase Two and Three will be reviewed at the same time. Communities will be grouped according to their geographic location. However, the patterns of how area residents naturally move through the region to work, shop, and enjoy other activities will also be considered. This type of review will provide the Committee with a better understanding of what services are available in different communities. More importantly it will hopefully lead to strategies on how communities, AHS, and the Government of Alberta can work together to plan and deliver more effective, patient-focused health care to rural Albertans.

In addition to meeting with communities and HACs, the Committee will also meet with First Nations and province-wide organizations. These province-wide organizations have knowledge of rural health care delivery and will include a wide range of groups representing health professional organizations, post-secondary institutions, regulatory bodies, and a variety of other interested groups that have asked to meet with the Committee. These meetings will take place over the course of Phases Two and Three, beginning in early 2015.

Input collected from the first phase of this review, along with feedback from larger rural communities, First Nations, and province-wide organizations will provide insight into improving health service delivery in rural Alberta. These findings will contribute to a final set of recommendations, which will be captured in the final report.

Appendix I. List of Invited Communities

Date	Community/HAC Name
Friday, Oct 17	**Consort**
	Castor *
	Cereal
	Chauvin
	Consort *
	Coronation *
	Czar
	Daysland *
	Forestburg *
	Galahad *
	Hardisty *
	Hughenden
	Killam *
	Oyen *
	Sedgewick
Monday, Oct 20	**Onoway**
	Alberta Beach
	Breton
	Evansburg *
	Legal *
	Me-Me-O Beach
	Onoway *
	Thorsby
	Wabamun *
	Warburg
Friday, Oct 24	**Myrnam**
	Andrew
	Boyle * •
	Elizabeth Métis Settlement
	Fishing Lake Métis Settlement
	Glendon *
	Kitscoty *
	Mannville * •
	Mundare
	Myrnam * •
	Smoky Lake *
	Two Hills County
	County of Vermilion River (Islay) *
	Viking * •
	Vilna *
	Willingdon *
	Yellowhead East Health Advisory Council †
Wednesday, Oct 29	**Falher**
	Cadotte Lake (Northern Sunrise County) *
	East Prairie Métis Settlement
	Falher *
	Gift Lake Métis Settlement
	Hythe •
	Kinuso (Big Lakes M.D.) *
	Lesser Slave Lake Health Advisory Council *
	Manning
	McLennan *
	Paddle Prairie Métis Settlement
	Peace Health Advisory Council †
	Rainbow Lake
	Red Earth Creek (M.D. of Opportunity) *
	Smith (Lesser Slave River M.D.)
	Spirit River *
	Worsley (Clear Hills County) *
Wednesday, Nov 12	**Bowden**
	Bashaw •
	Bentley
	Bowden
	Caroline * •
	Cremona
	Eckville
	Elnora •
	Irricana
	Lake Louise (I.D. No. 9)
	Linden
	Nordegg (Clearwater County) *
	Trochu *
Thursday, Nov 13	**Stirling**
	Carmangay *
	Coutts *
	Empress
	Foremost
	Glenwood
	Kananaskis (I.D.) *
	Milk River * •
	Stirling * •
	Warner *
	Waterton (I.D. No. 04) †

* Attended meeting
• Provided written submission

Appendix 2. Conversation Guide

Rural Health Review Committee

Conversation Guide

Context

We would like to understand more about the community you live in and your day to day reality when accessing health services. When answering the questions below please explain the trends or patterns you have seen in your community overall, as well as any specific stories of people you know. If you do choose to provide an example, please do not mention anyone by name.

1) Describe the healthcare services readily available in your community. Are you able to get the health care services you need, when you need them?

2) How important are health care services to your local economy?

3) What are the biggest challenges your community faces in accessing health care services?

Solutions

We hope that this process will result in a set of concrete, immediate actions to improve health services for rural Albertans, so please be specific, concrete and direct in your answers. When discussing solutions around facilities, please focus your ideas around ways to maximize the use of current facilities, as building new facilities is not within the mandate of this review.

4) What are some ideas for practical, effective solutions to the challenges listed above?

5) How involved is your community in health services planning? What are some ideas to increase the level of community engagement in health service planning and policy development?

6) What is the one thing that Alberta Health or Alberta Health Services could do to make sure your existing health services meet your community's needs and address recruitment/retention challenges in your community?

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Appendix 3: Glossary of Terms

Abbreviation	Term	Definition
AH	Alberta Health	Alberta Health implements and ensures compliance with government policy. The Minister of Health, Alberta Health, and Alberta Health Services are key elements in Alberta's health care system.
AHS	Alberta Health Services	The regional health authority has a mandate to promote and protect the health of the population in Alberta. They are responsible for the assessment of health needs and the delivery of health services throughout the province.
EMS	Emergency Medical Services	On top of being a transport service for patients, Emergency Medical Services is a critical clinical service. In an emergency situation, treatment begins as soon as the EMS team arrives and continues until the patient can be cared for in a medical facility.
HAC	Health Advisory Council	A group of volunteers who play an important role in supporting the strategic direction of Alberta Health Services by engaging their communities in public participation. There are 12 Health Advisory Councils across Alberta.
LPN	Licensed Practical Nurse	A Licensed Practical Nurse works in collaboration with other members of a healthcare team and directly cares for patients and their families. They offer practical care as they assess a patient's needs and provide treatment.
NP	Nurse Practitioner	Nurse Practitioners are registered nurses with advanced knowledge and skills. They are trained to assess, diagnose, treat, order diagnostic tests, prescribe medications, and make referrals to specialists and manage overall care.
PA	Physician Assistants	Academically prepared and highly skilled health care professionals who provide a broad range of medical services. PAs act as health care extenders, working under the supervision of a physician, to complement existing services and aid in improving patient access to health care.
PCN	Primary Care Network	Groups of family doctors that work with Alberta Health Services and other health professionals to coordinate the delivery of primary care services for their patients. A PCN is a network of doctors and other health providers such as nurses, dietitians and pharmacists working together to provide primary health care to patients.

PHC	Primary Health Care	Primary health care is the first place people go for health care or wellness advice and programs, treatment of a health issue or injury, or to diagnose or manage physical and mental health conditions. Primary health care in Alberta includes public health, wellness, community and social supports, as well as supportive living/home care.
RN	Registered Nurse	A Registered Nurse directly cares for individuals, families, groups, and communities to be healthy and well. A Registered Nurse will coordinate patient care as part of a team with physicians and other health providers.
TFW	Temporary Foreign Worker	Employees hired by Canadian employers to fill temporary labour and skill shortages.