Communicating with physicians in Alberta

May 2013

# Vital Signs

A Calgary and Area Medical Staff Society publication

## AMA and Alberta Health sign memorandum of agreement!

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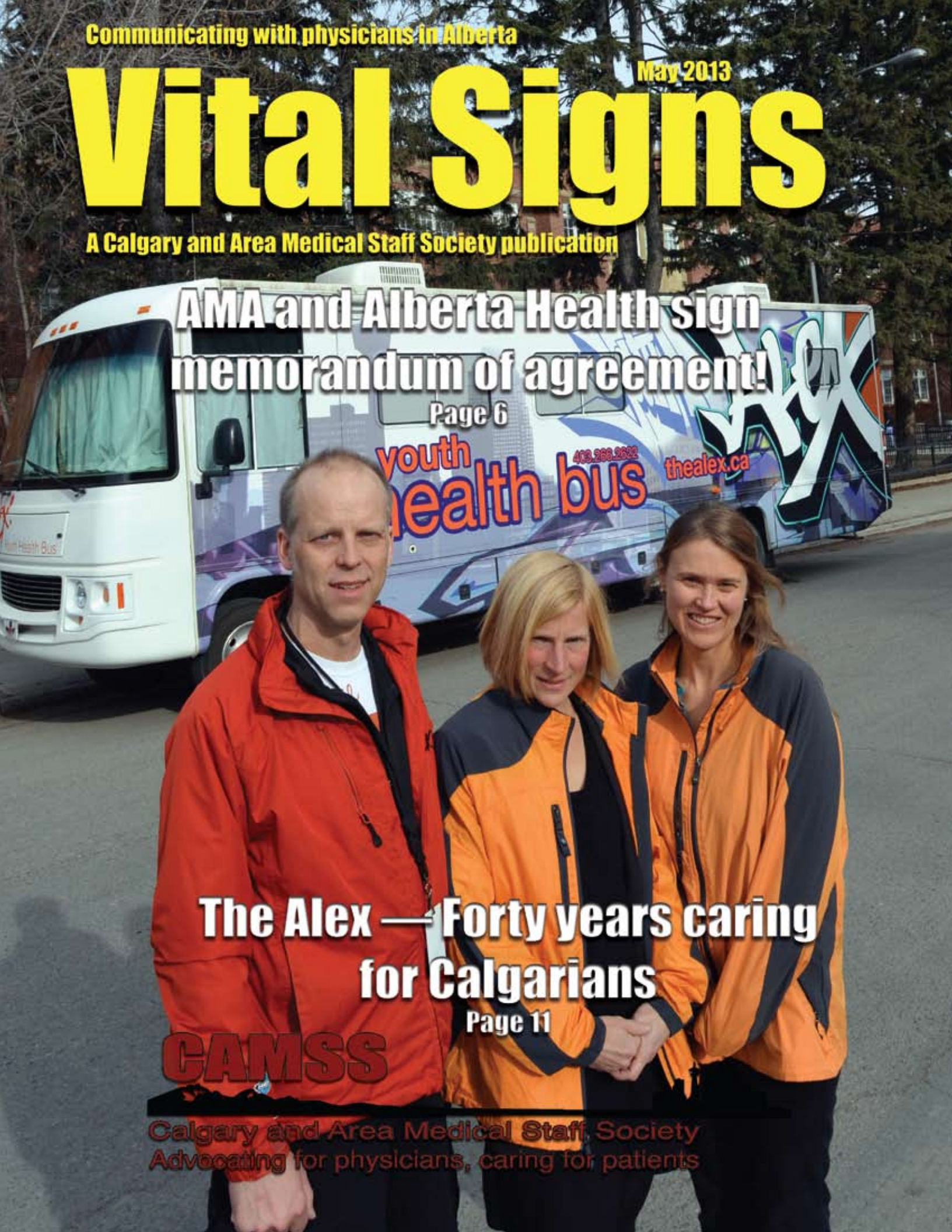


## The Alex — Forty years caring for Calgarians

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**May 2013**

***Columns:***



***Features***



# Classified



Vital Signs is published 11 times annually (not published in August) by the Calgary & Area Medical Staff Society (CAMSS) www.CAMSS.ca

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

Please send any contributions to: Dave Lowery: bethere@shaw.ca, 403-243-9498.

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

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The opinions expressed in Vital Signs do not necessarily reflect the opinions or positions of the CAMSS or CAMSS executive.

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**On the cover: The Alex youth bus with three who work on it: L to R, Lyndon Ulmer, Dr. Kerri Treherne, Danielle Deutsher, RN**
**Photo by Dave Lowery**

## The deal and the next great hurdle

**Dr. Lloyd Maybaum, CAMSS president**
**Phone: 403-943-4904**

My neck is killing me what with the constantly changing twists and turns in the negotiations landscape. First, an imposition was declared in November. An ultimatum was leveled in March. Finally, a whiplash hairpin turn on April 15th surprised us with a seven-year deal and a potential end to the acrimony. Upon hearing the announcement I immediately felt like we needed a ticker tape parade, that is, until my cynicism resurfaced. Given the games and the abrupt turn-a-rounds that have occurred thus far in negotiations, I'm not going to breathe any sigh of relief. As it has been said in the past; it ain't over till a certain lady sings. There is plenty of time for this agreement in principle to fall apart. Frankly, the process of these negotiations has left me so jaded that I won't trust that we have an agreement until the ink is dry. Despite my caution, I must say that the proposal looks promising.

I must send a hearty thank-you to the AMA, the AMA board and Dr. Michael Giuffre. I would like to say to the premier and to the health minister: let's conclude this agreement and put the last few years behind us. It is time to focus on working as a collaborative team to build the best, most efficient health care system in the country. More specifically to the premier, whom I remember as Allison from High School, I'd like to say that we were once on the same team, the Carroll Cardinals. For the sake of Albertans, the government and all of the physicians of this province need to be on the same team again. Coincidentally, Danielle Smith, the leader of the Wildrose, also attended our very same High School.

In addition to the challenges of recent negotiations another great hurdle that needs to be addressed is the schedule of medical benefits (SOMB) and the disparities that have crept within. This review is long overdue and will be pursued regardless of whatever agreement is eventually signed with the government.

As the health minister noted in a recent letter to the AMA, some specialty fee codes are misaligned compared with those of other provinces. In addition to other factors, technological advances over the past decade have significantly reduced the time and complexity required by the physician(s) to provide certain services. Thus, the AMA and the minister have agreed to establish a relative value process to recalibrate equity into the fee schedule. The proposal includes assembling a panel consisting of AMA and Alberta Health representatives, chaired by an independent party.

Fee equity is an issue that the AMA has struggled to address for a number of years because the process of resolving these difficulties might create conflicts that rend the AMA apart. Some may question whether such inequities actually exist while others feel with moral certitude that such discrepancies are prevalent and must be addressed.

Taking a look at some of the arguments surrounding fee inequity, the most basic argument surrounds the length of residency training. It has generally been accepted that physicians that pursue specialties requiring long stretches of residency training, e.g. five, eight or even more years of training should earn more than those physicians that may have trained in residency for only two years. Those latter physicians would graduate into the work force much earlier and begin earning staff incomes years sooner than the former group who would continue to toil in residency for many more years. This most definitely confers a financial advantage to the early starters but it begs the following questions. At what point do the two-year residency physician incomes balance out with the five-year (or longer) residency physicians? Should specialists be making more money every year over their entire career?

If the specialist graduates and starts making $500,000 per year from the SOMB they will come out ahead of the generalist after only a few years of practice. If the individual practices in an exceptionally high paying specialty, the amount of time required to financially 'catch-up' with the two-year trained docs would be much shorter.

There are also issues related to call. Some have suggested that specialists tend to do more call with some exceptions like rural family physicians that must endure an onerous burden of work. Other colleagues have suggested that specialists tend to work longer hours than other physicians and so deserve to be paid more; you work more — you make more. I am not sure of the validity of these claims and so, how do we rationalize and address such variations across the spectrum of physicians? Rationalizing these differences will prove to be complex.

The situation becomes even more complex when we begin to compare the possible billings from Alberta Health (the SOMB) and the opportunities for the various generalists/specialists to bill privately. We are all aware that certain specialties walk into an opportunity to pursue incredibly lucrative private work, usually procedural in nature and naturally not covered under the SOMB. Depending upon the specialty, one may be walking into incredible opportunities to make considerable income in the private market. Others are not so lucky. Should then, these opportunities to pursue private income be somehow factored into the relative value assessment of the SOMB?

We then have the argument of overhead. Some specialties have considerably higher overhead than others. Fair enough, this should be factored into the relative value of the SOMB. However, if a doc can earn a fortune in the private market then what income really pays the overhead — the rent, the light, the heat and the staff — that billed to

**Continued on page 5**

## Calgary & Area Medical Staff Society (CAMSS)

# Spring AGM notice

**Date: June 12, 2013**
**Time: 5:30 pm**
**Location: Glencoe Club, 636 - 29 Avenue S.W., Calgary**

**5:30 pm Buffet dinner**
**6:30 pm Guest speaker (TBA)**
**7:00 pm Guest speaker Dr. Michael Giuffre, AMA president**
**7:30 pm Business meeting to begin**
**8:00 pm President's report**
**8:10 pm Treasurer's report**
**8:20 pm Closing remarks**

**All CAMSS members are invited to attend. This function is open only to physicians, invited guests and invited media. Please RSVP by May 17th to Kim at: kim.Robson-Lefebvre@albertahealthservices.ca or call: 403-943-1271.**

**From the CAMSS president - Continued**

Alberta Health/SOMB or that derived from the private work? How do you tease these two apart? Herein lay some of the subterfuge and smoke and mirrors of overhead.

We then need to consider the equipment that the doc is claiming as overhead when arguing over SOMB billings and fee equity. What really is paying for that equipment — SOMB earnings or billings from private work? How much is the equipment used for public vs. private work? How much was the equipment subsidized and was it used as a tax write off? Do you allow them to claim the gross cost against their overhead costs of the after tax/after subsidy/after private use, amount? Moreover, how could anyone possibly reasonably calculate such numbers?

Some docs fear that some of their colleagues will claim SOMB poverty due to their massive overheads yet some of those very same docs may be fiscally padding their clinics with private procedures — revenue that is generally not taken into consideration when it comes time for fee equity and an analysis of the SOMB. Thus, the next great hurdle, perhaps even the greatest hurdle that will challenge our profession in the coming years, will be rationalizing specialty fee codes. As we enter into this new political chapter we must strive to maintain unity and collegiality always remembering the foundations of medicine, as underscored by Sir William Osler: "We are here to add what we can to life, not to get what we can from it."

By R. Michael Giuffre, MD, MBA, FRCP, FRCPC, FACC, FAAC, AMA president

Following several weeks of intense discussions, Minister of Health Fred Horne and I have signed a memorandum of understanding upon which negotiators will now finalize a full agreement document by April 22.

Assuming that deadline is met, the Representative Forum will review the resulting tentative agreement at a special meeting to be arranged very shortly. The Board of Directors would then direct the commencement of the ratification vote by physicians. The MOU is available online: http://bit.ly/XCNINC.and there is an executive summary below.

What physicians have been seeking

I acknowledge the solid efforts of Minister Horne in working with me to reach this MOU to address the goals of physicians in these negotiations:

- A place at the table and involvement in decision making about the health care system.
- A financial package that meets the needs of both parties and treats physicians fairly, e.g.,

1. Addressing overhead costs.
2. Covering costs of Alberta's growing population.

- A better approach to dealing with fees, programs and benefits, and finding ways to resolve disputes.

Please note that in very recent parallel discussions, Alberta Health, Alberta Medical Association and Alberta Health Services have agreed to explore opportunities to find efficiencies and savings in the health care system. I see this collaboration as a way to evolve to a "tripartite health efficiency agreement." It can be a key opportunity to advance health reform and apply the appropriate resources, policies and processes to things such as reducing the emphasis on institutional care in favor of robust community-based care. I would like to see this become my legacy project for the remaining term of my presidency.

## Finding a way forward

The drafting of a tentative agreement by April 22 still lies ahead. I am pleased with what the MOU has achieved; I also understand that physicians may be skeptical until a tentative agreement is complete and in their hands. We will keep a watching brief.

The MOU can allow a return to a structured, transparent and productive relationship with government. Working in that relationship can rebuild trust, but it will take time.

Whatever the outcome of this process, I want to thank physicians for the outstanding support demonstrated in the past two weeks. I have received copies of about 450 emails to MLAs and countless messages of support and encouragement. Members have written letters to the editor, purchased advertising and engaged local media. Such contributions could not be more valued. I know the profession will continue to advocate for what this health care system needs, albeit (I hope) under the umbrella of a long-term, stabilizing agreement with government.

Regards,

**R. Michael Giuffre, MD, MBA, FRCP, FRCPC, FACC, FAAC**
**President**

ALBERTA MEDICAL ASSOCIATION

**EXECUTIVE SUMMARY**
**MEMORANDUM OF UNDERSTANDING (MOU)**

1. Structure

- An overarching, ongoing "evergreen" agreement to address the relationship between Alberta Health (AH) and the Alberta Medical Association (AMA), e.g., joint goals, roles and responsibilities, scope, dispute resolution processes, etc.
- Schedules linked to the agreement to address details for rates and prices, financial re-openers and provisions of programs and benefits.

2. Financial term

- April 1, 2011, to March 31, 2018.

3. Programs

- Applies to and maintains:
- Fee-for-service (FFS) compensation under the Schedule of Medical Benefits (SOMB).
- Alternate relationship plans (ARPs), including the clinical component of academic ARPs.
- All current programs and benefits including continuation of the Business Costs Program and Retention Benefit.
- AH and AMA will establish a separate agreement for a new approach to a provincial electronic medical record (EMR) strategy, including a replacement strategy for the EMR completion program (formerly the Physician Office System Program) which ends as announced in March 2014.
- A separate agreement will also be established regarding primary care delivery. This is an evolving area and the agreement will identify how the parties will work together on a number of matters including, but not limited to:
- A framework for primary care network (PCN) evolution (PCN 2.0) with linkages to the broader primary care system.
- Regular review and adjustment of per capita funding for PCNs, subject to non-binding dispute resolution.
- Physician compensation elements of primary care including physician compensation mechanisms within PCNs and family care clinics.
- Yet another agreement between AH and AMA will focus on quality while taking a provincial approach toward identifying system-wide health efficiencies. Working closely with Alberta Health Services (AHS) and involving physicians from various areas in primary and specialty care (including, e.g., AMA Sections, PCNs and Strategic Clinical Networks) will be the key to our collective success.

**Continued on page 7**

4. Funding for rates, programs and benefits
- 2011-12 to 2013-14: 0%.
- 2014-15 and 2015-16: 2.5% each year.
- 2016-17 and 2017-18: Cost of living adjustment (COLA) each year.
- A one-time amount (i.e., not added to base) of $68 million paid to physicians in a manner established by the AMA. Best efforts will be made to distribute these funds within 90 days of the agreement being approved.
- Alberta Health will be responsible for funding expenditure increases for all insured services and programs beyond the rate increases, including utilization (population) increases.

5. Representation
- On written request by the AMA, AH will consider entrenching a general recognition right within legislation by which AMA is the ongoing representative of physicians for SOMB and ARP rates, and core programs with evergreen provisions (e.g., Medical Liability Reimbursement, Continuing Medical Education, Physician and Family Support Program, etc.).
- The agreement itself recognizes the AMA as the representative of physicians for any and all other programs and benefits attached to the agreement.

6. Consultation
- For health matters that are not covered by this agreement but "touch and concern physicians," AH will consult with and seek advice of AMA.

7. Arbitration and dispute resolution
- If an agreement to commence April 1, 2018, is not in place October 1, 2018, then either party can trigger arbitration, on prices only, for SOMB rates, ARP rates and funding for evergreen core programs. The ability to arbitrate this way is also an evergreen provision.
- AH and AMA may avail themselves of non-binding facilitation or mediation for all other programs and benefits.
- Disagreements about interpretation or application of the agreement can be referred to the Physician Compensation Committee (PCC) (see below), then the deputy minister and AMA chief executive officer, then the minister and president. If the dispute cannot be resolved in these ways, the minister will make a transparent and public decision.

8. Governance
- A new Physician Compensation Committee will be responsible for oversight of compensation practices and all programs (except those covered by grant agreements that address such arrangements between AMA and AH). It will consist of three representatives each from AMA and AH with an independent chair agreed upon by the minister and president. PCC responsibilities include:
- Implementing a provincial physician compensation strategy.
- Allocation of fee changes.
- Managing payment schedules (FFS and ARP).
- Reviewing and adjusting relative payment rates (FFS and ARP).
- Determining rates.
- Overseeing a relative value process.
- Oversight responsibility for the overall agreement will be between a representative of the AMA and of AH who will: ensure agreement terms are followed; receive reports from, provide guidance to and ensure sufficient resources for the PCC.

9. Approval
- The parties will make best efforts to conclude a tentative agreement on these fundamentals by April 22, 2013, prior to the respective approval processes (i.e., ratification vote by physicians).

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***Editor's note: These letters, and many other comments, phone calls and emails, were received before the settlement announced on April 15.***

*I am writing this note because I cannot sleep after a draining 36 hours — 24 of which I was on-call. My very young team of new grad nurses and our local EMT personnel have just transferred a raging drunk spitting his blood in our faces after an MVA. I have to vent.*

*Attached is a letter that we are submitting to our local press. I felt I had to let Claresholm know that we have a good thing — a good team. Like most of you, I have endured five directional changes in the delivery of healthcare by the PC's. All with the intention of making the system better. We are rewarded on the frontlines, for the most part, by grateful patients. Our patients are as confused as we are at the lack of direction from our government. We are not perfect — when we are emotionally drained we can lash out at our colleagues and patients. I have twice been a victim of an orthopedic surgeon's rant which began "after all the years that I have been in Claresholm I should be able to describe a fracture to him as well as an orthopedic resident can," even though he and I know that he can view the x-ray on PACs and that a picture is better than my stumbling description. I have endured the usual warning from the psychiatrist on-call that the patient must be medically cleared before they will see my patient with a psychiatric emergency. I know that these comments are a result of all our frustrations with the limitations of the environment that we practice. My patients and I all appreciate that specialty care is truly there when we need it.*

*Our letter to the citizen's of Claresholm was to celebrate our successes. The trilateral agreement was not just about money but it was about finding a better way. For those of us in primary care, it was facilitated by the honesty put forth by Dr. Slocombe and Dr. Comm's written support for us in Vital Signs. As a profession, we are driven by our patient's wellbeing. It is easier for me to get access to my community due to our local paper. I challenge all of us to let your patients know your own story and to celebrate your own successes. With the progress that we have made in multidisciplinary care, I do not understand why the government is being so obstreperous.*

*I have to say that I have been very appreciative of all the efforts made by Drs Maybaum, Comm and Slocombe. It has helped me know that I am not alone. I also feel admiration for Dr. Guiffre for surviving the AMA term from hell. I feel that if he had been a psychiatrist, and not a cardiologist, that he would have been better able to deal with a schizophrenic government complicated by a severe personality disorder.*

*Our patients need to speak for us — let them know how!*

***George Gish***

**Claresholm Citizens of Claresholm, Stavely, Granum, MD of Willow Creek**

Those of you who have had to use the health care system will have noted the improvement in accessibility to a healthcare provider in the last three years. While you may not see your own physician all the time, you will see a physician, if necessary 24 hours a day. We have augmented your ability to access your needs regarding care for long-term problems with the recent addition of healthcare providers with training in chronic diseases and mental health — Chelsey and Mike. You have the opportunity to have your medications reviewed by our local pharmacists or with Dusty in the Claresholm Medical Centre.

These improvements in healthcare delivery have been due to recent changes in the government's approach to primary care — that is care delivered to you when you first feel you need help. All this improvement can be attributed to the last trilateral agreement between the government, health regions and the Alberta Medical Association. With all three parties having a perspective on health care delivery, we have been able to adapt and provide care to the people that need it. The care that people need in Claresholm is not the same care that is required by the populations in Okotoks or Cochrane. Yes you just read that the government did something right.

Your Alberta government is now clamoring for more control. It feels that what is good for Calgary or Edmonton is good for you. We all know that we have to adapt. We give up some things to live here but we also enjoy things that a city person would never envision.

The government has recently extricated physicians of Alberta from any input into decisions regarding healthcare delivery. What this means is that a voice that advocates for you has been silenced. I am worried about "your" healthcare future. One size does not fit all when it comes to healthcare delivery.

Our current MLA represents Wildrose. The physicians of Claresholm have individually written the premier, the minister of health, and Mr. Stier. We received no acknowledgement about our concerns from the government but we did get a roboletter response from the Wildrose saying that they are trying to make the government aware of these issues.

I seriously think that it is time for you to give Ms Redford a call and express your concerns about her government's lack of respect for what has been accomplished in our collaborative care environment. Her boss is you, and your main voice regarding healthcare delivery has been shut out. We have always, as independents, been able to advocate for our communities because we could not be fired — well we are now not at the healthcare table — we are indeed fired. If you are concerned as I am, please call the premier – 1-780-427-2251 and leave a message or e-mail: calgary.elbow@assembly.ab.ca. If you are able, let the Alberta Medical Association know about your concern by sending them a copy of your e-mail to: amamail@albertadoctors.org.

**Physicians of Claresholm**

***More letters on page 11***

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### A dissident view of "King Ralph."

I have often used the line that, "those who don't learn from history are destined to repeat it." Current examples are the years of the late Premier Klein's reign and the current situation with today's health minister. I have Klein to thank for my Alberta Medical Association involvement. In a nutshell, I got ticked off with Klein's antics and I organized job action in Calgary. That led to my membership on the negotiating committee that crafted the, now expired, trilateral agreement in which all decisions were by consensus. Primary care networks were a product of this agreement.

I find it difficult to figure out what qualms Alberta Health Services (AHS) and Alberta health and wellness (AHW) had with this arrangement. The full agreement came in on budget when all agreed to adjustments for population, cost of living and growth were factored in. So what wasn't to like about it?

I will give you my best guess, for what it is worth (and this is only my best guess). Perhaps once you scale the lofty heights of the AHS you may, as Leonardo Dicaprio did, believe that "I truly am the king of the world." If that becomes the prevailing attitude, then instead of being partners, certain individuals such as (rhymes with thorn and rhymes with gram) may want to be king of the world!

It is a fact the AHS wants to go ahead with their plans flying in the face of no negotiated agreement. They have the ability to drag out negotiation until they have made the changes and infrastructure as an entity to themselves. It appears there is little we can do to prevent them from running roughshod over all Alberta doctors.

I fear even worse times ahead with the current mindset of the minister and a premier whose government is awash with debt and, it would seem, clueless as to how to get themselves out of the tank. Those who are nearing retirement and who have planned frugally will be okay, I would think. However I fear for those of college/university age (including my daughter) who will bear the brunt. For them, I fear, the cutbacks to education recently applied to Mount Royal University may be a foreshadowing of worse times yet to come. Once again I would love to be very wrong . . . I hope so but am pessimistic. Time will tell.

***As usual your comments, complaints, praise & poisoned darts will all be welcomed at: glenncomm@shaw.ca***

**Dr. D. Glenn Comm, CAPA past president**

## The Calgary Medical Society report

**By Dr. John Barrow**

Our Christmas event, held on Saturday November 24th 2012 from 1:00 pm to 2:00 pm at the Calgary Zoo was successful and well attended. We followed our usual format with Santa giving presents for those under 14 years of age, a play by the Winter Follies and a magic show from the amazing Soodini.

As you all know, Glenn Comm was physician of the year 2013. The dinner event was held on February 1st at the Glencoe club. There was a champagne reception and the event was semi-formal. Glenn has been the recipient of many awards. Glenn's uniqueness is his caring for others ability and in 2010 he received the Physician Advocacy award. For entertainment the evening concluded with laughs prompted by Trent McClellan, a comedian from Newfoundland who has made Calgary his home.

This year, the joint medical/legal meeting with lawyers was held at the Glencoe Club on March 19th. Approximately 50 attended and the topic chosen was bad medicine. Judge John Riley, a native-born Calgarian and retired Provincial Court Judge, gave the presentation. The judge is an outspoken advocate for better justice for aboriginal people and has written a best seller; Bad Medicine - a Judge's struggle for justice in a first nations Community.

## The Alex — Forty years caring for Calgarians

**By Dave Lowery**

Think back. Think waaaaay back. To 1973. Pierre Trudeau was Canada's prime minister, Peter Lougheed was Alberta premier, Calgary's population was less than 500,000 and the Calgary communities of Inglewood and Ramsay had problems. Those areas were far below the average socio-economic levels and, since there were no physicians in the area, primary healthcare was almost non-existent. To solve the problem, community members developed a plan to open a health clinic in the Alexandra school building. Since that time, The Alex has grown to three locations with over 120 employees and operates three motor homes, known as mobile health units, which address community, youth and dental health.

Christopher Wood, 47, is a registered nurse and says he was the first nurse practitioner in the province of Alberta in the nineties. He is currently the director of health programs and provides administrative oversight to the youth, family, seniors and mobile clinical services. He says coming to the Alex in September of 2012, from the AHS "momma ship," was a great opportunity to use his experience from several provinces and exposure to the American health system.

"There is a triad of meaningful work here," Wood says. "First, the people that we serve struggle with homelessness and poverty. Second, the Alex has just been in a significant growth phase. And third, we have an amazing team, a multidisciplinary team that provides great quality health care. But they are also very unique individuals. An example is Dr. Kerri Treherne, medical program lead, who is an exemplar of the rest of the people who work here. She lives eats and breaths her own wellness."

And though the Alex has shown a consistent and steady growth in the past 40 years, future growth is on the horizon.

"We were asked by the ministry to put in an application for a family care clinic (FCC)," Wood says. "So we have done that focusing on two

communities here in Calgary. We were told, though nothing is final until you see it in writing, that we will be getting one of the FCCs. I was involved in the FCC development in east Calgary so I'm looking forward to that opportunity."

**Community health bus (CHB)**
- Visits eight sites weekly offering free care to Calgary's most vulnerable.
- Treated 2000 patients in 2011/12
- Staffed by physican, RN, nurse practitioner and resource worker.

**Youth health bus (YHB)**
- Visits nine high schools weekly
- Initiated in 2011, the bus hosted over 1300 youth visits in the first seven months of operation. Students make the appointment themselves through high school guidance offices.
- Staffed by physician, RN and resource worker.

**Dental health bus (DHB)**
- Visits high need elementary schools
- Provides screenings, preventative oral hygiene, fluoride treatments, sealant treatments, x-rays, and minor dental services.

And though the Alex offers a multidisciplinary health care team, Wood says they also address their clients' social needs, something not done in a traditional healthcare model.

"We are way beyond just a medical clinic because we look at primary health care, the social determinants of health and also housing," he says. "We house 440 individuals who are the most complex folks who, previous to coming to us, would typically be in acute care gobbling up weeks and months of acute care services. We house them for about a tenth of what they would normally cost acute care through our assertive community care treatment model."

Though Wood says he has been impressed by what the Alex has been able to do, with what he describes as a shoestring budget, he would like to see that change in the future. He says it's sometimes difficult to pay people what they're worth given the pay grades found in the "momma ship" (AHS) and the Alex's limited resources. But the positive aspect of that is they get the team members who are passionate about what they do and want to give back to society.

"The financial resources are not enough. I would like to do a better job in that area. The people that drive the buses, nurses, physicians are the most valuable asset we have so we would like to recognize them financially and have the resources to do that."

Wood says the main thing he would like physicians in Calgary to be aware of is the Alex's mission and vision. And if they get the FCC, they will be looking to recruit family physicians and psychiatrists.

"Our mission is to deliver innovative, accessible health and social solutions to create our vision which is to create a community of healthy individuals," he says. "We can marry health care and social services in one organization so we can look at whole person care; that's what we want to focus on."

**Dr. Kerri Treherne.** I've been working here since I was a resident in 1995 and I like working with the higher needs population and the comprehensive care we can provide. If we need to spend the time with people we can and I have a team to work with to address the complex populations. I like that the Alex does creative things differently and doesn't have the same barriers that AHS has when providing services. We can outreach and come out to schools, which has never really been done before. It's great to have those freedoms.

**Lyndon Ulmer.** *Lyndon is the youth outreach worker and drives the bus. He has been with the Alex for four years.* I liked that there was a youth drop in centre for youths past age 18 for individuals that had gotten too old for other services. I thought they did really creative stuff by getting through different systems and figuring out how to work with people. The answer "yes" is typically on the edge of everyone's tongue and we do the best we can. This opening came up and I thought it was a creative way to work with kids in the health system, which I've never been able to do. I get to be part of a team that does really interesting work in really creative ways to look after kids. We get carte blanche to try different things to see what works the best. Where I worked before there were lots of constraints so this has worked really well.

**Danielle Deutsher, RN**. *With the Alex for one and a half years.* I've always enjoyed working in the community as a nurse as opposed to the hospital setting. I enjoy a proactive upstream environment and I just feel that is where my strengths lie.

**For more information about the health buses, call 403-266-2622 extension 4**

**The Family Health Centre is located at 101, 1318 Centre Street North.**
**Open Monday to Friday, 9:00am – 12:00pm and 1:00pm – 4:30pm.**
**For more information, 403-266-2622 or info@thealex.ca.**

**If you want to contribute to the Alex, they are an official charity for the Calgary marathon this year. Go to: http://calgarymarathon.com/charities/2013_official_charities/the-alex.html**

**By Dr. Maryana Duchcherer, psychiatry resident physician**

*"Coming together is a beginning. Staying together is a progress. Working together is a success"*
*-Henry Ford*

The Future of Medical Education in Canada (FMEC) project recently provided a nation-wide vision to guide the training of future generations of medical doctors based on current societal needs. According to the FMEC project, leadership is one of the key qualities that future physicians need to acquire in order to work effectively within health-care teams helping to better serve society. The Alberta Medical Association (AMA), being an exceptional leader in patient care and physician advocacy, fosters leadership development through the newly established program "Emerging Leaders in Health Promotion;" a program that funds community-based projects led by medical students and/ or resident physicians who are further supported by physician and non-physician mentors.

As a resident physician in the psychiatry program at the University of Alberta, I have gone through a number of rotations that helped me to appreciate the scope of mental illness from very early childhood to adulthood. Mental health is an area where you constantly work and interact with multidisciplinary teams made up of various health-care providers. Thus, I recognized the AMA Emerging Leaders in Health Promotion program as an excellent opportunity to translate the FMEC recommendation into a practical educational tool that directly impacts mental health care through multidisciplinary teams.

Our community project was designed to help one of the most marginalized cohort of kids who have been exposed to domestic violence. Numerous studies demonstrate how the experience of multiple traumatic events in childhood is linked to social and interpersonal dysfunction later in life. Toddlers and preschool children tend to express their traumatic stress by adopting various patterns of affect changes and distinct emotions. Early childhood identification of and intervention in these patterns can prevent and alter the developmental trajectory of potential behavioural, cognitive and psychiatric issues. Technology and multiple assisting devices are an integral part of our daily interactions and serve as tools to indicate a child's emotional state of mind, which can then enable identification. This process is particularly important for the traumatized child who can be emotionally volatile and have a significant impairment of social reciprocity among his or her peers.

**Yanina Vihovska and Dr. Maryana Duchcherer with some of the technology used in their community project "Early Intervention Strategies in Children Exposed to Domestic Violence."**

Our project "Early Intervention Strategies in Children Exposed to Domestic Violence" was aimed at giving the children an opportunity to learn how to express themselves and their emotional stresses through the use of modern technology and to gain confidence in expressing their thoughts and feelings. In addition, it concentrated on children's ability to engage in positive interactions with other peers and slowly heal with the use of technology.

Our team, in cooperation with child and youth-care leaders, worked at a shelter for women and children who escaped domestic abuse or violence in the family. We used iPods and various educational applications to create paintings, videos and melodies. Through the use of these interactive tools, children learned how to express and share their feelings and emotions, particularly those related to their personal traumas and experiences. The area of social difficulty was addressed through the use of technology in the socializing and teaching activities, and there was a significant

improvement in the behavioral status of every child. The participating children showed positive changes in their community social skills and behaviors. Furthermore, a number of extremely rewarding outcomes were detected during direct observation of the children including their improved ability to recognize and communicate emotional states that serves as a major force for the integration of healthy attachment framework.

One of the learning aspects of this experience for me was coordinating and witnessing the collaboration between the various individuals and groups who worked hard to develop this idea and transform it into a practical tool that could produce a strong change in the mental and potentially physical wellbeing of our future generation. Our team was lucky to have Yanina Vihovska as a lead-teacher; Vihovska is one of the first teachers in Elk Island Public School Board to create and implement lessons with the use of iPods in grades five and six. Vihovska has extensive knowledge and experience working with technology and multimedia tools. Her commitment and passion towards the children is truly inspiring. Dr. Rowan Scott, a staff psychiatrist, generously provided his mentorship and guidance for the project. Dr. Edna Wakene, a psychologist at the family centre in Edmonton, also generously contributed her knowledge and expertise in the design of the delivery and assessment process. Further, this idea would not have been transformed into practice without our cohesive and collaborative teamwork and without the support received from the AMA.

Our team cannot fully express our gratitude for the sponsorship of this preventive intervention that proved to be highly effective at the preliminary stages of its implementation. The experiences of the participants in this study demonstrate that this intervention has the potential to translate into significant health outcomes without the utilization of high-priced medical approaches. We strongly believe that the AMA has enabled this group of disadvantaged children to secure a strong start towards healthy development. Further, the AMA has helped identify effective prevention strategies that will help reduce the incidence and impact of mental disorders in adulthood.

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