



**NORTHERN  
HEALTH REGION**

**2017  
Northern Health Summit  
Final Report**



## Table of Contents

<i>Title</i>	<i>Page Number</i>
1. Introduction	3
2. Icebreaker	3
3. Diabetes in the North	4
4. Panel Discussion	5
5. Table Discussion	10
6. Gallery Walk	13
7. 25 Gets you 10	14
8. Summary	16

### *Appendix*

- a. Summit Agenda

## Introduction

The 4<sup>th</sup> Annual Northern Health Summit was a gathering of over 100 people from across the Northern Health Region (NHR). The Health Summit is an annual event hosted by the NHR Board of Directors to both share health related information and to receive feedback to help inform future direction. This year participants developed a set of recommendations around the theme **“Building Bridges to Bridge Gaps” – Diabetes in the North.**

Participants included NHR staff and Board Members, representatives from partner agencies and interested citizens.

Elder Jack Robinson opened the day with a prayer in Cree as well as in English.

Claire Betker acted as the facilitator for the day. She has worked in public health in a wide variety of roles for over 35 years and currently is the Director of the Population Health and Health Equity Unit and the Acting Executive Director of the Public Health Branch with Manitoba Health. Claire is a past president of the Community Health Nurses of Canada and is currently the president-elect of the Canadian Nurses Association.

Helga Bryant, NHR CEO brought welcome greetings on behalf of herself and the staff of the NHR. Cal Huntley, the Chair of the Board of Directors brought welcome greetings on behalf of himself and the Board of Directors most of whom were present at the event.

Following the opening remarks, Bryant reviewed the 2016 Health Summit report, reflecting on the presentation from the Southcentral Foundation in Alaska about the Nuka system of Care. She talked of how the Opaskwayak Cree Nation is implementing a similar system and encouraged all in attendance to use those lessons when they can.

The 2017 summit began with education on diabetes and it’s prevalence in the health region. The focus then moved to shared personal experiences and perspectives from people working in or associated with diabetes prevention and treatment. That set the stage for group discussion and facilitator lead sessions aimed at developing action steps to bridge gaps in diabetes prevention and treatment in the North.

Following are the details on those sessions and the recommendations the participants came up with.

## Icebreaker

To set the tone of the day, Claire Betker asked participants to write down on 2 index cards and post on a designated wall what they hoped to “Give” for the day and what they hoped to “Get” from the day. The results of the activity have been compiled below with the largest words being the ones that were mentioned most often.



*Hoped to Give*



*Hoped to Get*

## Diabetes in the North- summary of Dr. Isaac's presentation

Dr. Michael Isaac is a Medical Officer of Health (MOH) for the NHR.

He began by acknowledging that the summit was taking place on Treaty Five Territory. He also acknowledged Dr. Randy Gesell and the Manitoba Center for Health Policy for their assistance with preparing the presentation.

His presentation began with an overview of what Diabetes is and the difference between Type 1 and Type 2.

He then moved into the demographics on diabetes in the region; highlighting that Diabetes is more prevalent in this region than any other in the province. There is disparity in rates within the region as well with remote areas and First Nations having higher rates than urban communities.

Dr. Isaac outlined common complications that arise from diabetes including eye damage, kidney damage, nerve damage, heart attack/stroke and foot/skin infections. He presented information showing, in general, people in the region have more complications from diabetes than the rest of Manitoba.

Obesity, diet and physical activity were identified as primary risk factors for individuals while factors like income/poverty, food insecurity and the built environment were presented as factors at the population level. Dr. Isaac then gave risk factors that may not be as immediately obvious but which can have a strong influence such as; displacement of First Nations peoples from traditional lands, Residential schools and other policies leading to the loss of culture, loss of traditional food sources and inconsistent access to good health care.

Dr. Isaac spoke of how he feels that the Truth and Reconciliation Commission recommendations and community needs should be used to guide the work being done around health issues, adding that Jordan's Principle, Foot Care funding and changes in provincial health care and public policy are opportunities to make positive change.

He closed with the following take home messages:

1. Diabetes rates and complications in Northern Manitoba are very high.
2. The causes of diabetes are multifactorial and include both individual factors and broad factors such as colonization, and systemic racism.
3. There are opportunities for change right now when we use a common Northern voice.

## Panel discussion

In preparation for this year's Health Summit, 4 panelists were chosen by the event organizers and each was given a set of specific questions. Dr. Michael Isaac was the moderator for this part of the day's agenda. The following are summaries of each participant's unique connection to diabetes.

### Braden Vallance

Braden is a young adult man from Thompson, MB who lives with Type 1 diabetes and was diagnosed at the age of 9.

*Share your experience with diabetes especially as you have transitioned from children's services to adult services.*

After being diagnosed at 9 years old Braden spoke about having to learn what to eat, including how to count carbs. He also had to learn how and when to take insulin (5x daily) and how to test blood sugars. Because of all of these things, Braden said that he felt like the management of his diabetes took away a lot from his childhood. Until he turned 18, his care fell under the guidance of a pediatric team. This team helped to figure things out like how to get his license, apply for tax credit and as he got a little older, the team started coming up to Thompson 2 times a year for appointments. Once Braden turned 18, he switched over to adult services and as he spoke it was clear that the transition came with new challenges.

*What have been the challenges?*

He explained that now he has to go to Winnipeg for appointments and because he's over 18 he's expected to go without an escort. As well, he said, his Endocrinologist only books appointments one day a month so if an appointment has to be cancelled it can take months to re-book. Adding to that, there have been some issues with transportation. However, his biggest concern right now is that the teams in Winnipeg and Thompson don't always communicate well.

*What has worked well?*

Throughout his talk Braden was clear that when he had a team that was communicating well, he felt like he was getting the help he needed.

His final thought spoke to what would become one of the over-arching themes of the day- better communication. Not only between service providers and patients but also between service providers themselves to reduce some of the challenges of receiving care in a Northern community.

## Liz McIvor

Liz is a 37 year old woman from Cross Lake, MB who lives with type 2 diabetes and was diagnosed at the age of 18.

*Can you share your experience with diabetes?*

Liz started her story at the point of her diagnosis. At that time she said, she was overweight but had been losing weight for no reason known to her before hurting her back at work one day. She went for medical assistance and had her blood sugar tested only to find out that it was at 13- very high. This was when she was diagnosed with diabetes and was told that she had likely been diabetic for a while.

Liz was the 1st to be diagnosed in her family (her parents have recently been diagnosed) and she was unsure of where to go for support. Not knowing who to go to for help or what to do, she got her aunt to teach her how to test her blood sugars and life moved on. About 8 years later when she became pregnant and was hospitalized, she began to receive professional support. However, even though she now had professional help, things didn't instantly get better. She spoke of how frustrating it was to have to test her sugars and do ketone tests every day while also not being able to leave the hospital.

Since the birth of her daughter, things haven't always been easy either. She told a story - 5 years ago Liz was in a rush to take off her winter boots and in the rush scratched up the inside of her foot. She went to the doctor to show her foot and was told not to "baby" it. Two weeks later she ended up on crutches and with an IV because of the worsening condition of her foot. She explained that she wouldn't have even gone to get checked out had it not been for her cousin who noticed that her leg was

turning black and forced her to go to the nursing station. By the 3rd week the infection had become so bad that she was in a wheel chair and needed surgery. She said that she was later told that one more week with the infection and she would have lost her leg. Although grateful today that she still has both legs Liz explained that the trauma of this event stays with her still. She is always aware of her feet, keeping footwear on at all times and freezing at the sight of broken glass.

Liz now sees herself as an educator of sorts as people in her community ask her for guidance about their diabetes. She believes that this is a role she is destined to take on because she's been through so much that she can be helpful.

#### *What has worked well?*

Liz spoke fondly of family and how she said that as she got older she realized that her family has been there for her all along and have been important to her in caring for her health. She spoke as well of how her husband's family (mom and sister) had diabetes and that because he helped to take care of them he's also used his knowledge to help her. She also told a story of an elder who encouraged her to eat traditional foods during her pregnancy to help her baby be healthy. She took that advice to heart and as the day unfolded, using a culturally focused lens became a strong suggestion to address the theme of racial inequality.

Another thing that is working well is that Liz was connected with a diabetes nurse support in 2006 to whom she now refers to as her "BFF". They meet in person whenever they can and if face to face isn't possible, telehealth works well and does help.

Liz has learned many things about diabetes over the years like how to count carbs and how to do her best to maintain blood sugars. Her medication is now bubble packed and she's had to adjust her way of eating- she had never eaten brown rice or vegetables in the past but does try to now. Her daughter reminds her to check her sugars and she heeds advice from her nurse to eat when she takes her meds, even if she doesn't feel like eating.

#### *What about having diabetes has been a challenge for you?*

Throughout Liz's stories, it was clear to the audience that there had been and continues to be struggles related to her diabetes along the way. For example, not receiving professional services for years and then once connected to them, having those services mostly offered outside of her home community. Liz however is a truly resilient woman who framed her stories around a theme of personal growth with a message that she will never give up.



One open struggle that Liz spoke of is that along with diabetes, she also has depression and because of this, sometimes she says she doesn't care about her health. Even though she didn't want to go at first, she has seen a therapist which has helped. Liz vows that she'll continue trying to be as healthy as she can and says she won't give up because she has good people in her life who love her.

Liz's final thought was that these days, she is comfortable accessing services and she is happy with the treatment she gets. She added that over time she has learned to speak up for herself and to keep herself healthy in a way that she's comfortable- by learning about her own body.

## Maggie d'Entremont

Maggie is a Nurse Educator & Diabetes Education Coordinator in Thompson, MB.

*In your work with people experiencing diabetes what are the most significant challenges (gaps) and how do you bridge the gaps?*

Challenges that Maggie identified were: the struggle to access services and appropriate care, transportation and policies attached to getting transportation coverage, childcare when going to appointments and sometimes simply having access to a phone. As well, she added that some patients are unable to have a permanent address due to movement and/or housing issues while others are simply uncomfortable accessing services in an "institutionalized" setting.

Her ideas for solutions included working with partners to bridge gaps, going to clients if they can't/won't come to service providers or when possible, using telehealth to provide education. One idea for bridging gaps that the Diabetes Education Resource Team already employs is to try to coordinate appointments so that one trip into town can accommodate as many service needs as possible.

A strong recommendation by Maggie was that service providers need to make connections and build relationships, even when it means that an appointment never gets to a point of talking about diabetes directly. She added that addressing immediate concerns first like housing and food sometimes moves patients along, because assisting them "where they're at" can lead at some point to addressing the diabetes in a meaningful way. These suggestions all fit well as action items for the theme of increased access to service.

## Anita Crate

Anita is the Tribal Nursing Officer for Keewatin Tribal Council.

*Are there any significant gaps or challenges you would like to add?*

Anita began by acknowledging that Diabetes is a frustrating and complicated illness to look at because of the bigger issues.

She explained that in her opinion, the first challenge is around education. That up to this point education has been piecemeal because each issue has its own education protocol but she thought, a coordinated effort would work better if it went along with every aspect of the illness. Having access to an educator is vital. She said it's already difficult just to get appointments with a doctor and even when a patient does get in, that doctor may not be the one to educate. Nurses have time constraints on them as well and because of that don't always have the ability to do complete teaching. Finally, there are only about 10 people employed to specifically work on diabetes at this end of the region. Due to all those factors, she spoke of the need to use every opportunity to provide education- if someone comes in for flu shot, to ask where they're at with their illness. If nothing else she said, target pre-natal patients because their offspring is at a higher risk.

A second challenge she spoke about was addressing the social determinants of health. For example clean water for foot care. What if the patient doesn't have access to clean water? Or another example was access to healthy food. She explained that we tell people to eat healthier food but pop is cheaper than milk and white bread is cheaper than whole grains. This spoke to one of the themes that emerged through the day around food equality and access to healthy food.

Another challenge Anita mentioned was that even when there's a belief that a service will make a difference sometimes the difference is only for a small group. For example she said, foot care funding on reserve is in the works, which is great but this doesn't serve all of the people- it needs to be an insured service. There is already limited access to service, so challenges like these may not be large scale solutions. The example of having universally covered foot care services would be a small investment for a huge outcome. As well, providing services in community works well (retinal screening is an example of a similar service that has been a success) but if that is not possible at least bringing services closer would be a benefit.

Physical complications are obvious but there is a need to address the mental health of the patient and also notice that their families are affected- there are genetic components to health so service providers need to move away from laying blame. Patients can do all of the right things and still have complications.

*From a policy and planning perspective what are some of the things you are working at (or would like to work at) to address the gaps?*

Anita spoke about the ways that policies also present challenges. She gave the example that relationships are key to get people to keep coming back and sometimes policies like NPTP or non-insured travel programs don't allow for that.

Another gap around policies was that some programs limit benefits based on a policy but there is often no education to the patient about why. For example the number of test strips that are covered is limited. There is a reason for this but that reason isn't always communicated to patients.

For some areas, the policy of using EMR (Electronic Medical Records) is a good practice but those records are not accessible on reserve.

Anita's final suggestion and one of the themes of the day, was that in order to solve some of these issues, there needs to be meaningful conversation and open communication because doing nothing is not efficient or acceptable. In her opinion small investments can create great long term results by being preventative and proactive and she added that doing nothing is irresponsible, eventually costing more money by causing things such as hospitalization, surgery and rehabilitation.

## **Table discussion- Reflections on the panel discussion**

Once the panel presentations were complete, 3 more speakers were called to the stage to give reflections on what the panelists spoke about and to give some thoughts on equity. These speakers were asked:

*From an equity perspective what are the most important considerations for actions? Where are the opportunities?*

**Jim Slater** -CEO of DSM, shared health services team member

Jim began with a comment about equity perspectives. He warned that although equity is the goal, we should also be aware of the uniqueness of our communities, particularly acknowledging that we should have a strong Northern voice. As an idea for opportunity, he then issued a challenge to participants and health care providers in general to think differently about how we address diabetes. He asked, "Can health care solve this (growing diabetes rates) or is it something that communities solve?" He suggested that people in positions of community leadership come to the table with ideas about what their communities need because community needs to drive and lead and those in health care need to listen. He finished with one more suggestion saying an opportunity for action could be to stop some diagnostic testing and use that money to subsidize healthy food.

**Melanie MacKinnon** -Executive Director Ongomiizwin Health Services (Formerly the NMU) Indigenous Institute of Health and Healing Rady Faculty of Health Sciences, University of Manitoba

Melanie spoke fondly of growing up in Northern Manitoba and started her discussion with a question to participants- “Is the conversation about health care or is it about healing? Are we having the right conversation?” She observed that right now the discussion is programs and services and the dollars attached (or not attached) to them, when there is a need to be using the knowledge of elders and traditional ways of being, to direct next steps. In order to have true equity she said, Indigenous people need to be included in the conversation because talking about history and acknowledging inherent knowledge must be the priority. She reminded participants that in the health care system providers need to recognize that about 50% of those being seen are having a behavioral health issue. She further explained that this consideration is not only mental health related but also encompasses every day coping needs and finding a sense of self. So, the opportunity for action that Melanie encouraged was that relationships and how we care for each other is what will keep patients balanced and whole, and as care providers there should be a great need to respect and respond to the whole person.

**Dr. Barry Lavallee MD** - Medical Advisor, Diabetes Integration Project, Nanaandawewigamig

Answering the questions about an equity perspective, Barry began his part of the discussion reminding participants that colonization and oppression contribute uniquely to health outcomes for First Nation communities. Health Institutions and the healthcare workforce face enormous challenges in recognizing how racism presents as barriers for First Nations peoples seeking care and treatment. This structural ignorance is rooted in policies, practices and procedures that fail to address inequitable care for the communities. Indigenous health aka poor health is an investment by the system. This paradox is poorly recognized and understood in health discourse.

He explained that First Nations people have been and continue to be oppressed and are then in turn often blamed for the health outcomes of the oppression. High rates of poverty among First Nation communities drive inequities, poor access to primary care, limited resources to address preventative practices, limit access to country foods as colonization and extraction of resources continue to serve settler populations. Racism as social and economic inequities manifest in lower rates of employment and education, place First Nation peoples at risk of violence in many ways and so much so that death of First Nation peoples at higher rates is normalized. The previous federal government’s inertia to address the ongoing murder of Indigenous women in this country is exactly how death is normalized.

To contextualize this discourse in the context of type 2 diabetes and First Nation communities, it is necessary to understand intergenerational oppression as a predictor of high rates of chronic diseases like type 2 Diabetes and CKD (Chronic Kidney Disease). Geography via isolation is not a predictor of disease as most understand and articulate it to be. When First Nation peoples are held hostage under Federal systems, their health outcomes change drastically (our team is working on a publication

addressing this issue). Simply put, limited resources and opportunities are racially organized by governments so First Nation peoples suffer from one generation to the next. Conception in hostile environments, as when families conceive while forced to live in poverty, attend to racial violence, for example, and/or where high levels of glucose (Gestational and type 2 Diabetes) are found at conception, the two-cell human is primed to develop chronic diseases earlier and with greater voracity than settlers. The emerging evidence and expert opinions attest to this theory of intergenerational oppression and chronic disease patterns in First Nation communities.

Health Institutions, boards, providers and others concerned with health and First Nation communities adopting anti-Indigenous racism policies and practices hold providers and systems accountable to the Truth and Reconciliation Commission recommendations. The finer granular pathways include the adoption of a First Nation patient centered clinical approach for the training of health care providers and inclusion in the continuing medical/nursing education hold hope for supporting good and respectful practice.

The larger issue remains the uneven distribution of power wherein First Nation patients represent greater than 50% of utilization of health resources and yet do not have access to resources through equitable representation on senior management or governing boards.

To wrap up this section of the day, each speaker was given time for a last comment:

*Jim Slater*- These conversations are difficult but in order to eventually make them more comfortable there is a need to keep engaging in conversation.

*Melanie McKinnon*- What is the conversation we're supposed to be having? If things are getting worse instead of better then the conversation needs to change.

*Dr. Barry Lavallee*- The intentions of being a good provider are great however any small display of stereotype impacts care. People have to be accountable to their behavior and in order to do that they need to be self-reflective. This task is not always for an Indigenous person to teach but it's also up to non-indigenous people to teach themselves.

## Gallery Walk

<p><b>What is working?</b></p> <ul style="list-style-type: none"> <li>• Relationships are improving as far as jurisdictional issues go</li> <li>• Relationship building- service providers concerned about who you are and not just what you have</li> <li>• education and training</li> <li>• Listening to each other</li> <li>• Services are increasingly culturally appropriate</li> <li>• FN centered</li> <li>• Manitoba Indigenous and cultural safety training</li> <li>• “Nothing about us without us”</li> <li>• Circumvent barriers- acknowledging that they exist and finding ways around them or to how to avoid them</li> <li>• Telehealth in certain situations</li> <li>• Coordinated services- ex. Primary care centres</li> </ul>	<p><b>What are the factors that support it working?</b></p> <ul style="list-style-type: none"> <li>• Collaboration</li> <li>• Communication</li> <li>• Passionate and dedicated staff including diabetes educators</li> <li>• Dialogue is started</li> <li>• Board and admin support</li> <li>• Honest relationships</li> <li>• Being more creative</li> <li>• Creative resources</li> <li>• Mobile access- going to where the people are</li> <li>• Telehealth collaboration, access to health services and specialists, reducing the need to travel</li> </ul>
<p><b>What are opportunities for action?</b></p> <ul style="list-style-type: none"> <li>• Early screening for diseases</li> <li>• Shift to community health</li> <li>• Communication between health care groups/ better planning (do all appointments at one time)</li> <li>• More opportunities for Indigenous people to be in positions to develop policies</li> <li>• Addressing racism</li> <li>• Involve elders-traditional curriculum development</li> <li>• Provincial cellular network for shared services to access including other government departments</li> <li>• Advocacy for food security and food subsidies</li> </ul>	<p><b>What are the equity considerations?</b></p> <ul style="list-style-type: none"> <li>• prove access to physician services, nurse practitioners</li> <li>• Cultural safety, equality and understanding</li> <li>• Geography, transportation</li> <li>• Insured vs. non-insured , jurisdiction issues</li> <li>• Better training/ technical support for telehealth</li> <li>• Community health stations doing follow up and access to results</li> <li>• Conversations about inequity before working together to create equity</li> <li>• TRC recommendations, representative workforce</li> </ul>
<p><b>How would a “Northern voice” be strengthened?</b></p>	<p><b>What would be the impact?</b></p>

<ul style="list-style-type: none"> <li>• By including the voice of the Indigenous people (and listening)</li> <li>• Adding/including more Indigenous persons to leadership positions and the board</li> <li>• “Nothing about us without us”</li> <li>• Listen to the people</li> <li>• unify</li> <li>• Engage all levels of government</li> <li>• A board representative of the population</li> <li>• Prioritize outreach into communities to listen to their needs</li> <li>• Appreciate and recognize needs of each community</li> <li>• Provincial programs need to ask “How will this work outside of the perimeter?”</li> <li>• Communication and education</li> </ul>	<ul style="list-style-type: none"> <li>• Building trust and relationships with Indigenous people</li> <li>• More Indigenous people will access health care (earlier)</li> <li>• Lower rates of disease</li> <li>• Shift the power</li> <li>• Improved socioeconomic situations</li> <li>• Developing more opportunities</li> <li>• Wider reach</li> <li>• More northern centered care</li> </ul>
--	--

## 25 Gets you 10

For the last group activity of the day, Summit participants were each given an index card and were asked to write an idea about improving the Diabetes situation in the North and an action item that would work towards that idea. Participants were then asked to rate their idea/action combination on a scale of 1-5. The cards were then randomly passed to 4 other participants to rate on the same scale. Some cards had higher ratings than others but in the end, 6 clear themes emerged. Ranked from the most mentioned to least, the most popular themes were:

1. **Addressing racial inequity** “Nothing about us without us”

In this category, the ideas and actions all reflected the need to have more First Nations representation in all levels of health care. Action items specifically of note were:

- Address racism
- Have First Nations representation in all levels of health care including policy development positions
- Cultural safety education
- Involve elders- use a traditional curriculum
- Follow the TRC recommendations

2. **Clear communication and education**

In this category, there were calls for communication within services, between services and with those accessing service. There were suggestions for more clarity in communication, cultural safety and listening to each other. Specific action items included:

- Interact using a cultural safety lens
- Prioritize outreach into communities to listen to their needs
- To seek out and be open to having the right conversations

**3. Increased access to services**

Suggestions to make this happen were having more service providers, moving services to outlying communities or at minimum closer to those communities and creating client friendly environments. Examples of this were:

- Increase number of service providers and create client friendly environments
- Improve access to physician services, nurse practitioners
- Community health stations doing follow up and having access to those results

**4. Community Collaboration “Unity”**

Remove jurisdictions, build relationships, be inclusive and work together.

- Gain understanding- listen and learn
- Foster hope, collective understanding and further relationships

**5. Improve connectivity through technology**

Improve access to cell service, use Electronic Medical Records and telehealth and make sure that all of our systems can “talk to each other”. Specifically mentioned as well:

- Increase access to Telehealth
- Better training/ technical support for Telehealth
- use Telehealth more collaboratively - reducing the need to travel

**6. Food equality/ access**

Although mentioned less frequently, promoting and subsidizing healthy fresh foods was at times a suggestion for addressing diabetes. Suggestions on how to accomplish this were:

- Promote healthy eating
- Advocate for food security and food subsidies



## Summary

A discussion and education on diabetes intended to start Building Bridges to Bridge gaps was the focus of the Summit, but many of the recommendations grew to bridging gaps in health care as a whole with racial equality and communication between cultures, groups and providers at the heart of the discussion.

The shift happened organically as the day progressed. The broadening of focus began with first-hand accounts of living with diabetes shared by Brayden Vallance and Liz McIvor. The discussion continued to widen with provider perspectives offered by Maggie D'Entremont and Anita Crate. Finally themes began to take shape as Jim Slater, Melanie Mackinnon and Dr. Barry Lavallee offered some of their experience and expertise during the panel discussion.

The above mentioned six themes emerged from the facilitated group work informed by the various presentations and special guests and from the group work by attendees.

CEO Helga Bryant closed the day with thoughts on the presentations and the group work earlier in the day. She urged participants to “listen, listen, listen” while using the “strength of a Northern voice”, asking all to build on and carry forward the momentum and recommendations generated by the Truth and Reconciliation Report and Jordan’s Principles. She encouraged the use of those lessons in a multi-level approach across sectors, agencies and jurisdictions and concluded with a collective commitment to: gain understanding, have the right conversations, build partnerships, foster hope, collective understanding and relationships in **Building Bridges to Bridge Gaps**.

In closing she committed to another Health Summit in one year.

Elder Jack Robinson closed the day with a prayer.



## **Appendix "A"**

### **Summit Agenda**



# Northern Health Region presents 4<sup>th</sup> Annual Northern Health Summit

**“Building Bridges for Bridging Gaps”**

**Diabetes in the North**

Tuesday, October 24, 2017

St. Joseph’s Hall, Thompson

Time	Agenda Item	Speaker
<b>7:30 - 8:30 am</b>	Registration & Breakfast*	
	Opening Prayer	Elder Jack Robinson
	Opening Remarks	Cal Huntley, Board Chair Helga Bryant, CEO, Northern Health Region Kim Hutcheson, MB Health
<b>8:30 - 9:00 am</b>	Report Back on Summit 2016	Helga Bryant, CEO, Northern Health Region Cal Huntley, Board Chair
<b>9:00 - 9:30 am</b>	Ice breaker	Claire Betker
<b>9:30-9:45 am</b>	Break*	Health Fair
<b>9:45 - 10:30 am</b>	Diabetes in the North Presentation	Dr. Randy Gesell Dr. Michael Isaac
<b>10:30 – 11:30 am</b>	Panel Discussion	Dr. Michael Isaac
<b>11:30 – 12:00</b>	Lunch*	
<b>12:00 - 1:15 pm</b>	Northern Health Region Annual General Meeting	NHR Board of Directors
<b>1:15 – 1:45 pm</b>	Table Discussion	Dr. Barry Lavallee Dr. Catherine Cook
<b>1:45 - 2:00 pm</b>	Break*	Health Fair
<b>2:00 - 2:45 pm</b>	Gallery Walk	Claire Betker
<b>2:45 - 3:30 pm</b>	25 Gets You 10	Claire Betker
<b>3:30 - 3:45 pm</b>	Closing Remarks	Helga Bryant, CEO, Northern Health Region Cal Huntley, Board Chair
<b>3:45-4:15 pm</b>	Cultural Dancers	Tawipisim School of Aboriginal Dance and Music
<b>4:15 - 4:30 pm</b>	Closing Prayer	Elder Jack Robinson

*\* Health Fair open during breaks*

