MOOSOMIN AND AREA NEEDS ASSESSMENT

Prepared for the
Regina Qu'Appelle Health Region (RQHR)
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1. ACKNOWLEDGMENTS

It is important to acknowledge the guidance, support and wisdom of the Moosomin Needs Assessment Project Team.

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In addition, it is important to acknowledge all the individuals who participated in the key informant interviews, community consultations and those who shared their knowledge and expertise regarding best practice models.

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3. EXECUTIVE SUMMARY

The Town of Moosomin is located in the southeast corner of Saskatchewan on Highway #1. The Town and surrounding communities have experienced population growth related to the increasing potash, oil and gas and farming industries.

A formal request was made by the The Moosomin Health Care Foundation for a needs assessment to determine if the health needs of the Moosomin and surrounding area were being met and if there were changes required to the facilities and services to better meet those needs. The original request was focused only on increasing the number of beds at the Southeast Integrated Care Centre (SEICC) in the town of Moosomin, however the decision was made to expand the scope of the project to address the broad health needs within the Moosomin and surrounding area. In the last two years, concerns regarding over capacity of the acute care and long-term care beds have been increasing due to:

- a reduction in available health services in the surrounding communities;
- the growing economy and population in Southeast Saskatchewan; and
- clients seeking care from a stable physician practice from the surrounding communities.

In October 2012, a project team was established and Laura Soparlo Consulting was engaged to assist the Regina Qu'Appelle Health Region in a comprehensive needs assessment of Moosomin and the surrounding area within a circumference of 100 kilometers. The primary aim of the assessment was to determine the current and long-range health needs of the population within this area in order to effectively determine the health services to best serve those needs now and into the future.

OUTCOMES

The outcomes of the needs assessment were to:

- determine the state of community health by reviewing current demographics of the community related to health determinants;
- examine community perspectives on the health determinants that affect the community;
- examine the effectiveness of and gaps in health services the community receives;
- identify where priority areas for improvement exist.

THE APPROACH

In accordance with the Primary Healthcare Framework, it was important to use a consultative and community development approach when working with stakeholders and communities in order to foster long-term sustainable relationships with the community partners.

THE METHODOLOGY

The methodology for the Moosomim and area needs assessment included:

- a review of area demographics and care seeking patterns;
- a situational analysis of relevant government documentation and third party research of the area within the last 5 years; and
- consultations with community members inclusive of the public, physicians, healthcare providers and Sun Country Health Region representatives.

MOOSOMIN AND AREA PROFILE, CARE SEEKING PATTERNS AND HEALTH PROVIDER INFORMATION

Area Profile

The Southeast Integrated Care Centre (SEICC) is the largest community hospital within the Regina Qu'Appelle Health Region (RQHR), with a total of 27 beds including 25 acute beds, 2 convalescent beds and 55 long-term care beds. SEICC employs approximately 260 employees and has an annual operating budget of $12.3 M. SEICC is located at the eastern end of the RQHR border, the eastern end of the Broadview/Whitewood/Moosomin corridor and 20 miles from the Manitoba border. The hospital is over two hours away from the tertiary care centres in Regina. The SEICC hospital is also in close proximity to other Regional Health Authorities:

- Sunrise Health Region to the north: Yorkton Regional Hospital (90 minutes away);
- Sun Country Health Region to the south;
- The province of Manitoba to the east (Virden Hospital).

The needs assessment area encompassed a broad service area of approximately a 100 kilometer radius of Moosomin inclusive of the towns of Whitewood, Rocanville, Wawota, Redvers, Maryfield, Elkhorn, Welwyn, Wapella, Silverwood, and Willowdale.

Local Demographic Trends

The local Potash Corporation mine employs 545 employees and currently has an additional 1,200 working the project, which will conclude this year. It is projected there will be a stable population of 600 employees, resulting in a possible 2,000 family population accessing health services within the area.

The population within the Moosomin region has increased in 2011 after years of decline. The increase has been almost as sharp as in the province as a whole, at 6.7%. From 2006 to 2011, the population increased by 6.3% within the Moosomin Region and 9.9% within the town of Moosomin.

There are a lot of seniors within the region, with 19% of the population aged 65 and over compared with the provincial average of 15%. The projection for the senior population over the next 2 years is marginal for the 75 plus age group; however, the 65 plus population will continue to grow by 6%. Within the senior population, 37% are living alone.

Based on the predicted decrease in the 75 plus age group for the Broadview and Whitewood area, both the Broadview Centennial Lodge and the Whitewood Community Health Care Centre will be "over bedded" for long-term care in the next 15 years. The SEICC in Moosomin, however, will see a modest increase in the population 75 and over, creating some pressure on the current long-term bed situation which is operating close to 100% capacity. This may be further strained as Saskatchewan has the lowest spending per capita for individuals 75 plus for home care services in Canada.

Summary of Care Seeking Patterns

Inpatient discharges have risen 4.1% over the last three years with an increase of 11.3 for 2012/13. Approximately 40% of these were non-RQHR patients from neighboring regions of Manitoba. Non-RQHR inpatient discharges have increased 8.9% over the past 3 years. Births

have decreased as the Moosomin Family Practice no longer delivers first time moms (primigravidas). Of the total inpatients for Moosomin and Broadview, the majority were within the 60 - 89 age range, with 61.6% at SEICC and 70.1% at Broadview Hospital.

There has been a steady increase in outpatients seen at SEICC over the past 5 years, with a significant increase of visits between 5 PM and 8 AM in the morning. The majority of these patients are assessed at the lowest level of urgency indicating these patients may be better served by a primary health care provider. The visits from non-RQHR patients has been relatively stable between 30-35%, however over the past year there was a 7% increase of Sun Country patients most likely due to the intermittent physician shortages in that Region.

There has been a 21% increase in the number of patients cared for by the Moosomin Family Practice Centre from 2008/09 to 2011/12, however the number of patient visits and those treated has remained stable suggesting more patients may be using the emergency services after hours if they are unable to access their physician.

Over the past few years the average length of stay at SEICC has been above the Canadian Institute for Health Information standard (CIHI); that is, people were staying longer than the recommended standard, however this fell in line for 2012/13. The average percentage of occupancy for the acute care beds has changed marginally over the past five years for SEICC, at 79% for 2012/13, however has dropped significantly at the Broadview Union Hospital, to a 23.12% occupancy for 2012/13.

The average percentage occupancy for long-term care beds is at or near maximum capacity for beds in Moosomin, Whitewood and Broadview. The waiting list to get into a long-term care bed in your home community has improved over the past 5 years,from a list of 15 with a 12 month wait, to 5 with a 2 month wait. The implementation of the Alternate Level of Care Protocol (ALC Unit) at the Broadview Hospital and the Palliative Performance Scale have helped to improve the pressure on long-term care beds.

RQHR Health Status Report 2011

The health status report confirms the growth in the rural population and individuals aged 65, with boomers remaining in their community or returning to retire. Hospitalizations were higher in rural areas than in Regina, with a higher proportion of elderly individuals in rural RQHR of which falls and injury accounted for 43% of hospitalizations. Hospitalizations due to diabetes mellitus, and the patient rate for mental illness were also higher among rural residents.

Employee Engagement

In a study by Croft 2011, it was noted that there had been a 200% employee turnover rate over the past five years which has stabilized at 17% for full-time employees and 50% for all employees for 2012/13. An employee engagement survey performed by RQHR in 2011 indicated the engagement scores were lower than the overall RQHR and the provincial score. Seventy two percent (72%) of the respondents are thinking of accepting a job with another employer. The overall job satisfaction was 59%, which was lower than the overall RQHR of 62%, and other health regions of 63%.

The RQHR also embarked on a Physician Survey in 2012 which suggested the RQHR focus on the following priorities to enhance physician engagement: foster trust and respect; demonstrate visible leadership; facilitate physician involvement in non-clinical activities; focus on impacts of the local culture on physician engagement, focus interventions on root causes of dis-

engagement; and use a sequential approach to improve engagement by tackling one or two drivers at a time.

SITUATIONAL ANALYSIS - EXTERNAL REPORTS, RESEARCH REVIEW AND INTERPRETATION

The Situational Analysis was a review of information, reports and research from third parties which further illustrates the current environment and context of how health services are provided in Moosomin and the surrounding area. It enabled the research team to better understand the external drivers impacting the situation. The situational analysis included the following areas:

1. overview of driving strategic provincial and health system priorities and initiatives;
2. analysis from Third Party Reports - review of other documents, studies and reports related to the health services and facilities in the Moosomin area over the last 5 years.

Health System Priorities and Initiatives

The Healthcare System has established a five-year plan (2012 - 2117) with four enduring goals:

- Better Health
- Better Care
- Better Value
- Better Teams

Within these goals are established improvement targets for 2017. The targets for Better Health and Better Teams will guide the recommendations arising from this assessment. Some key initiatives arising out of the five-year plan were reviewed to provide some insight into the recommendations for the improvement of health services for the Moosomin and surrounding area. The initiatives reviewed were:

- The new Framework for Primary Health Care 2012;
- Collaborative Emergency Care Centres (CEC);
- Innovation Primary Health Care Sites;
- Saskatchewan International Physician Practice Assessment (SIPPA);
- Health Human Resource Strategy;
- Focus on Rural and Remote Health;
- Patient First Review Recommendations.

Analysis of Third Party Reports

Four third party reports and research completed over the past five years, impacting the assessment area, were reviewed to identify some further insight into the care patterns and community health needs. The four reports reviewed were:

- **Bearing Point Management and Technology Consultants: Moosomin Recommendations 2008**
  This report assessed the acute care beds at Moosomin, the scope of the physician services, coordination of physician services between Moosomin, Whitewood and Broadview, and identified structures and processes that facilitated coordinated service delivery amongst the Moosomin Physican group, RQHR management and staff. Many of the findings related to acute care beds and care patterns were similar to findings found in this report. Some of the recommendations from this report were partially implemented, such as the Alternate Level of Care protocol to help patient flow in acute care and the decision to no longer deliver primigravidas at SEICC.

- **2011 -2025 Rural and LTC Master Capital Plan - Croft Planning and Design**
  In 2011, Croft Planning and Design developed a report to provide a Rural, Restorative and Long-Term Care Master Capital Plan to assist the Regina Qu'Appelle Health Region (RQHR) with future facility strategic decisions. Croft confirmed that the Broadview and District Lodge was well over capacity for long-term beds and the Broadview Union Hospital was over capacity for acute care beds now and into the foreseeable future. It was suggested downsizing capacity and options for improving patient care may be considered such as converting semi private rooms to private rooms as the demand for beds continues to decrease. It was predicted that a decrease in the population age 75 plus may reduce the demand for long-term care services in Whitewood. Croft also confirmed that the SEICC catchment area would see a minor increase in overall population and of those aged 75 and over. It also was confirmed that with the increase of non-RQHR patients using both acute and long-term care beds that SEICC may experience service pressures.

- **Sun Country Primary Health Care Plan October 24, 2011**
  In the spring of 2010 three Health Regions - Sun Country, Regina Qu'Appelle and Five Hills agreed to work together to collectively develop a sustainable plan for the delivery of primary health care in their communities. Each Region was at a different stage in the development of their model; therefore, it was agreed that phase one of the plan would be developed independently by each Region. Sun Country focused on the development of an integrated service delivery model for general practitioners in southeast Saskatchewan. Following an extensive literature review, Sun Country Health Region (SCHR) chose to focus on the Hub and Spoke alternative based on their demographic and current/future needs. Six hub and spoke options were approved by the Sun Country Board. Two of these options included communities with the Moosomin and surrounding areas: the North (Broadview/Kipling), and Northeast (Moosomin, Wawota, Maryfield).

- **Proposal for 24/7 on Site Physician Coverage at SEICC- Moosomin Family Practice**
  In 2009, the Moosomin Physician group submitted a proposal to the RQHR and the Ministry of Health outlining the need for 24/7 on-site physician coverage at SEICC Emergency Room. The overall recommendation stated that providing 24/7 on-site emergency room coverage would ultimately lead to better care for patients as well as better physician wellbeing. The ultimate outcome was safe, excellent patient care and long-term physician wellbeing and stability in the area.

COMMUNITY CONSULTATIONS

The community consultation consisted of two major components: focus groups with community stakeholders and an online survey. There were seven focus groups conducted during November 20 and December 18, inclusive of public community members and health care providers. Sessions were held in Moosomin, Rocanville, Moosomin Family Practice Clinic, SEICC, Maryfield and Weyburn (Sun Country). Overall there were forty six (46) individuals who participated in the focus groups. Of the forty six, twenty four worked in healthcare, and nineteen represented the general public. Many of the healthcare providers responded from the perspective of both a community member and healthcare profession. An online survey was developed that reflected the focus group questions. The FluidSurveys online survey tool was used to develop the survey which was open from December 15, 2012 to January 2, 2013. The survey was accessed by 165 participants and was fully completed by 66.3%.

Findings

Question 1: What do you believe makes a community healthy?

Both focus group and survey respondents identified multiple factors of what makes a community healthy. Most all the determinants of health were identified by the groups with the exception of genetic makeup. The top 2 factors cited by the focus groups were recreational facilities and a supportive community; and the top 2 cited by the survey were access to health services and doctors.

Question 2: What services do you believe are available to you in the community that supports your health?

Collectively the groups listed up to thirty different health services offered within their community. Most participants had a broad grasp of the different health services available to them ranging from standard health services like physician service and home care to supportive health services like community support groups, community recreational centers and day cares.

Question 3: Thinking about your community, what do you believe are the greatest *current* health needs?

The top responses of the focus groups were: physician access, LTC beds, health provider recruitment, acute beds, surgical and specialty care. On the whole, the health issues raised on the survey were congruent with those from the focus groups. The few health needs that were more prominent in the survey were the increase in beds or hospital size, and the need for a walk-in clinic.

Question 4
Thinking about your community, how well do you feel that your health needs are currently being met by the services offered?

In both the focus groups and the survey there is a relatively even split between those individuals who were highly satisfied or satisfied, and those who were neutral, dissatisfied, or very dissatisfied. Access to local physician services appeared to be the most significant factor as to whether respondents were satisfied or dissatisfied. The other factors cited in the survey seemed to be congruent with the focus group results.

Question 5
Looking ahead, what do you believe may change in your community that would shift the health care needs in the next 5 to 10 years?

On the whole, both the focus groups and the survey respondents cited similar trends. Growth of the population and the aging population were the top trends in both the survey and focus groups. The focus group cited trends arising from the changes in society values which were not directly raised in the survey. The survey respondents cited the factors related to physician access and shortages, which were not raised directly in the focus groups.

Question 6
Thinking about these changes, what do you believe will be the greatest health needs in your community in the next 5 to 10 years?

The top two needs cited in the focus groups were mental health issues and doctor/healthcare provider recruitment and the top two in the survey were physician access and hospital/facility bed needs. The big difference between the focus groups and the survey was that there was much more emphasis by survey respondents on the need for physician access, more hospital beds and the overall availability of services to meet the growing population needs.

Question 7: Thinking about your community, what concerns do you have about the health services currently in your community and ability to meet the future health needs?
Many focus group participants found this question similar to question 6 and did not have any new comments to add. Due to this, this question was not asked in the survey.

Question 8
If you ruled the world…or had one wish for health services in your community what would it be: Today? In the future?
The main themes of the focus groups were fairly congruent with the survey findings related to hospital expansion/Regional Hospital, healthcare provider recruitment, LTC/care home spaces, and physician access. The healthcare provider focus groups placed more emphasis on the efficient use of existing healthcare resources and the need for different models for the delivery of health services. There is a greater emphasis in the survey findings on the need for a hospital expansion or regional hospital status, physician services, and general access to a variety of health services. Also, there was significantly more emphasis on physician services for today and into the future, indicating this was a more urgent need for the survey respondents. There appeared to be a greater emphasis in the future related to expanding the types of services provided locally to encompass more specialty items such as simple surgeries, expanded diagnostics and more visiting specialists. There is an ongoing wish for more long-term care spaces, care home facilities, services for seniors, mental health, homecare and some other health services.

Question 9
Is there anything else you would like to tell us in relation to the health needs and services within your community?
Focus group respondents spoke of preventative health care measures, long-range sustainable care and service models for future, the need for collaborative discussions with Regions and the community to recruit family physicians and nurse practitioners. The top response in the survey reflected how grateful residents are for the Moosomin physician and facilities. The other top comments were around the need to address seniors' issues, expansion of services to meet the changing needs and physician concerns.

OVERALL ANALYSIS AND RECOMMENDATIONS

Based on the findings, four broad recommendations were made. Each recommendation included sub-recommendations and enabling strategies. The broad recommendations are outlined below:

I. Improve the utilization of the current beds in Moosomin, Whitewood and Broadview;
II. Enhance Primary Health Care Options within the Moosomin Area;
III. Enhance Accessible, Safe and Affordable Care Options for Seniors;
IV. Improve Health Provider Recruitment, Engagement and Retention.

i. Improve the Utilization of the Current Beds In Moosomin, Whitewood And Broadview

i. Improve the utilization of the current beds in Moosomin, Whitewood and Broadview (along the number one highway) to alleviate the pressures through achieving an average length of stay in line with the CIHI standards at the SEICC, and the expanded use of the beds, especially at Broadview Union Hospital (current occupancy of 23%). Re-examine the recommendations in the Bearing Point and Croft reports along with community stakeholders

to generate creative solutions for better bed utilization which will be supported by the community, physicians and RQHR.

ii. *Engage in conversation with the community to create awareness and understanding of the current processes that are in place to support long-term care placement.*

iii. *Continue to assess the long-term care wait times in Moosomin to determine if circumstances are changing. Monitor and benchmark the number of residents on the long-term care waiting lists, the wait time for residents to access long-term care within or near their home community, and the distances from home to where residents are being placed.*

iv. *Continue to explore the expanded role of personal care homes for residents with higher needs which would allow residents to remain closer to home.*

v. *Continue to implement the Alternate Level of Care Protocol (ALC Unit) and the Palliative Care Protocol to support residents to access care closer to home.*

ii. Enhance Primary Health Care Options within the Community and Surrounding Area

i. *Fully disclose the findings of the Moosomin and Area Needs Assessment with the community and the health providers to establish a shared understanding of the current situation and the supporting research and to establish a strong foundation built on trust for moving forward.*

ii. *Work with the communities to prioritize the findings arising from the needs assessment; identify the key gaps in health services; and, jointly agree on the strategies to pursue. Teams comprised of community members, health providers, physicians and administrators may be struck to address the specific health needs within the community and further develop the agreed upon strategies arising from this needs assessment to develop sustainable and lasting health services for the future.*

iii. *Develop robust team based primary health care services for the Mooosomin, Whitewood and Broadview area. Work with local communities, physicians and health providers to identify opportunities to utilize teams of other healthcare practitioners to offset the current load on the Moosomin Family Practice Clinic and to extend the Primary Health Care (PHC) services within the communities. Clarify roles, responsibilities and establish a commitment towards collaboration which may be documented in agreements.*

iv. *Expand access to extended hour PHC services in Moosomin and surrounding communities to decrease the need for community members to rely on Emergency services to manage everyday health needs.*

v. *Work with Sun Country Health Region (SCHR) to share the findings of their proposed PHC model with the impacted communities (Broadview and Moosomin) to create a better awareness and understanding of the model. Determine and pursue the best approach through collaborative discussions between RQHR and SCHR inclusive of community members, care providers and physicians.*

vi. *Encourage communities to identify local candidates for training who may leverage the current financial supports and bursaries offered by Government of Saskatchewan for Nurse Practitioners and Emergency Medical personnel.*

vii. *Monitor the best practices and the lessons learned from the Innovation Primary Health Care sites recently implemented within Saskatchewan to adopt and adapt practices which may benefit Moosomin and surrounding area. Identify Moosomin and the surrounding communities as a future "identified site" for PHC innovation.*

viii. *Improve the coordination and sharing of patient information across neighboring Regions and health service locations (especially RQHR and Sun Country) to enable clients to readily access their information to foster better self-care.*

ix. *Enhance and extend the supports to clients to better manage their own care through an increased access to a PHC location with a variety of health professionals.*

x. *Better leverage the clinical use of telehealth options to extend and support the health provider team, augment the services offered within the community and provide professional supports to clients who are self-managing their care.*

iii. Enhance Accessible, Safe, And Affordable Care Options For Seniors

i. *Initiate dialogue in the Moosomin and surrounding communities to explore the best options to support seniors housing and aging in place. There may be an expanded role for the local foundations to assist with the development of a model adapted from best practices to optimally serve the community needs. Moosomin and the surrounding areas have a strong commitment towards their community where community members have demonstrated the ability to work together towards a common goal, such as the capital fundraising campaign for the SEICC. This energy and drive may leverage funds to create aging in place options for the local residents.*

ii. *Support the community to explore options for the development of personal care homes to enhance the aging in place options.*

iii. *Continue to work with the Moosomin and surrounding communities and the RQHR to enhance homecare and other community supports, especially in the rural areas. Explore and generate a broader array of residential models to help individuals receive the appropriate level of services in the most appropriate and fiscally sustainable setting.*

iv. *Incorporate the findings and practices of The Five-Year Strategic Framework - Towards a Vision of Seniors Living Fall Free Lives into the recommendations for seniors aging in place and all care options for seniors within the Moosomin and surrounding communities to reduce the incident of injuries and subsequent hospitalizations for seniors.*

iv. Improve Health Provider Recruitment, Engagement and Retention

i. *The RQHR should continue to work with healthcare providers within the Moosomin and surrounding areas to enhance engagement, health provider retention and the development of collaborative care models as outlined in the engagement survey findings. Success in this area is foundational to the success of the other recommendations.*

ii. *Engage in dialogue with the Moosomin Family Practice Clinic to truly understand and appreciate their concerns and to participate in joint problem-solving efforts related to the findings and recommendations outlined in this report.*

CONCLUSION

In order for the Moosomin and surrounding communities to continue to enjoy sustainable health services, a strong primary health care model will need to be established as the foundation for healthcare. A high performing primary health care system will not happen overnight and will need the commitment and collaboration of all the stakeholders. There is no "ultimate model" but rather a model designed to address the unique needs of the community and to be flexible and responsive to the changes within communities. The Saskatchewan demographics will continue to shift over time, expanding and contracting in relation to economic forces. A robust primary healthcare framework is the best solution to provide a strong foundation for responsive health services and at the same time support physicians and healthcare providers to practice at their full scope of practice within a collaborative team environment.

Most importantly, ongoing transparent dialogue between the community, care providers and the Regional Health Authority is essential to maintain a common understanding of the local health needs to collaboratively build practical effective solutions that can be supported by all.

4. INTRODUCTION

In October 2012 Laura Soparlo Consulting was engaged to assist the Regina Qu'Appelle Health Region in a comprehensive needs assessment of the Moosomin township and the surrounding area within a circumference of 100 kilometers. The primary aim of the assessment was to determine the current and long-range health needs of the population within this area in order to effectively determine the health services to best serve those needs now and into the future.

The overall objectives of the Moosomin and area needs assessment were:

- Analysis of current data, demographics and pertinent documents.
- Community/stakeholder consultations to determine perspectives on the health determinants that affect the community.
- Determination of common themes related to trends impacting health needs, the identification of current and future health needs and potential gaps in health services.
- A final report indicating priority areas for enhancement or improvement to address community health needs.

5. BACKGROUND

Overview of Situation

The Town of Moosomin is located in the southeast corner of Saskatchewan on Highway #1. The Town and surrounding communities have experienced population growth related to the increasing potash, oil and gas and farming industries.

Moosomin Family Practice, a thriving group of seven physicians, is dedicated to the care of local residents throughout their life span. The acute care and emergency room sites in Oxbow, Arcola and Redvers (Sun Country Health Region) have experienced short-term and lengthy closures due to physician shortages. Clients from these areas are drawn to the stability of services provided by the Moosomin Family Practice Clinic. Regular clinics are held by the Moosomin Family Practice in Maryfield and Wawota (Sun Country Health Region), Elkhorn (Manitoba), and Rocanville and Whitewood (RQHR).

A formal request was made by the The Moosomin Health Care Foundation for a needs assessment to determine if the health needs of the Moosomin area are being met or if changes to facilities or services are needed for Moosomin and surrounding area.

The original request by the community was focused only on increasing the number of beds at the Southeast Integrated Care Centre (SEICC) in Moosomin. In the last two years, the issue of over capacity for acute care beds has been increasing and is likely related to:

- reduction in available services in surrounding communities;
- the growing economy / population in Southeast Saskatchewan; and
- clients seeking care from a stable physician service.

On August 15, 2012, a briefing note was submitted to the Board of RQHR for approval of a comprehensive needs assessment inclusive of a supporting budget and external consultant to aid the process. In October of 2012, a project team was established to determine the

methodology and implement the assessment of Moosomin and surrounding area. The needs assessment was to encompass a broad service area of approximately 100 kilometer radius of Moosomin.

Outcomes of Success

Outcomes are the prioritized observable and measurable end results leading to the achievement of the vision within a fixed timeframe.

In keeping with the Ministry of Health's five-year strategic priorities for the healthcare system, the needs assessment will:

- Determine the state of community health by reviewing current demographics of the community related to health determinants.
- Examine community perspectives on the health determinants that affect the community.
- Examine the effectiveness of and gaps in health services the community receives.
- Identify where priority areas for improvement exist.

Guiding Principles

Guiding principles are the primary beliefs, or principles, which drive all actions and decisions. They reflect the manner in which the vision and outcomes are achieved. They give priority to decision-making and specify acceptable actions within the organization or project.

The guiding principles of the process were:

- The process will be transparent and open.
- The findings will be communicated to the community members.
- The findings will be aligned with priorities of RQHR and the Ministry of Health and Ministry of Rural and Remote Health.
- The full continuum of care to enable a healthy community will be assessed beyond the need for enhanced health care facilities.
- The culture of Patient First is embedded in the system with ongoing client and patient input into the process and decisions.
- The principles of community development and engagement will be embraced in the process.

Deliverables

Deliverables are the tangible end product(s) of the project or initiative.

- Analysis of current data, demographics and pertinent documents including:
    - Programming and services available.
    - Demographic data identifying the client population accessing services in Moosomin.
    - Community profiles.
    - Care seeking patterns.
    - Population public health rural needs assessment.
    - Recent studies and research related to health needs of the assessment area.
    - Provincial initiatives and practices for improved care delivery in rural and remote areas.
- Community/stakeholder consultations to determine perspectives on the health determinants that affect the community.
- Determination of common themes related to trends impacting health needs, the identification of current and future health needs and potential gaps in health services.
- Final report indicating priority areas for enhancement or improvement to address community health needs.
- Communication of the findings to stakeholders to ensure transparency.

6. THE METHODOLOGY

METHODOLOGY

Step I- Define the Project (October2012)

- Define the project scope and process.
- Establish the project team to guide the process inclusive of internal and external stakeholders such as clients, Moosomin Foundation, physicians, RQHR staff.
- Identify overall outcomes and deliverables to be addressed by the strategy.

Step II- Community Consultation (November 2012, January 2013)

- Conduct focus groups with community stakeholders and a public survey to determine the community's' perception of their current and future health needs.

Step III- Situational Analysis and Data Review (January/April 2013)

- Review of other documents, studies and reports related to the health services and facilities in the last 5 years.
- Review of demographic patterns and trends within the area.
- Review of usage patterns related to current services.

Step IV-Final Report (April/May 2013)

- Draft final recommendations incorporating best practices.

The Approach

It was imperative to use a consultative and community development approach when working with stakeholders and communities. In order to foster long-term sustainable relationships with the community partners, it was important to appreciate their needs and the future vision of the communities involved.

Assumptions

Assumptions are the collective suppositions or believed truths that will form the basis for action and guide how a project will proceed.

1. The needs assessment will encompass a broad service area of approximately a 100 kilometer radius of Moosomin inclusive of the towns of Whitewood, Rocanville, Wawota, Redvers, Maryfield, Elkhorn, Welwyn, Wapella, Silverwood, and Willowdale. The radius may extend to Kipling, Arcola, Redvers, and Kenosee Lake for emergency services. The report acknowledges that there are also patients outside this boundary that may access services within the needs assessment area.

2. The level of participation for the community consultations will be at the "consultative" level; that is, obtain public opinion and feedback for the decision-makers on needs, analysis, alternatives and/or decisions.[1]

3. The recommendations will be made to the project sponsors and the Regional Health Authority of RQHR which will in turn make final recommendations to the Ministry of Health and the Ministry of Rural and Remote Health.

[1] Stakeholder Engagement - A Tool Kit. Working Towards More Effective and Sustainable Brownfield Revitalization Polices, Torfaen County Borough Council (TCBC). March 2006 http://www.revit-nweurope.org/selfguidingtrail/27_Stakeholder_engagement_a_toolkit-2.pdf (accessed Jan.23, 2013)

4. There will be an ongoing need for continued engagement of the community and other stakeholders to develop and implement meaningful solutions based on the recommendations of this report.

5. The current level of service of the SEICC as per the Saskatchewan Facilities Designation Regulations is a Community Hospital.[2] This means:
    - it must provide to in-patients and out-patients:
        - medical services;
        - basic radiography and laboratory services;
        - emergency stabilization services;
        - observation and assessment services;
        - convalescent care and palliative care; and
    - it may provide any of the following:
        - out-patient surgical services;
        - obstetrical services;
        - long-term care;
        - health assessment and screening services;
        - counseling services;
        - therapy services;
        - referral services;
        - health education services;
        - health promotion services;
        - disease and injury prevention services;
        - chronic disease management services; and,
        - disability management services.

    The SEICC is also designated as a long-term facility which provides support to individuals who are no longer able to live independently in the community, alternate levels of care to support timely discharge from acute care, and community programming to support community-based living for individuals with long-term-care needs.

7. MOOSOMIN AND AREA PROFILE AND CARE SEEKING PATTERNS

I. OUTLINE OF MOOSOMIN AND CATCHMENT AREA

RQHR provides three types of care: tertiary care in Regina; primary health which includes community health, addiction and mental health; and, restorative and continuing care. RQHR has six rural acute care facilities (community hospitals) in addition to the two tertiary care facilities in Regina. Two of these facilities are integrated care centres that combine the acute care beds and the long term care beds in a single facility. The Southeast Integrated Care Centre (SEICC) is the largest of the six facilities, with a total of 27 beds including 25 acute beds, 2 convalescent beds and 55 long-term care beds. SEICC employs approximately 260 employees and has an annual operating budget of $12.3 M.

[2] Facilities Designation Regulations. Ministry of Health. Chapter R-8.2 Reg 6 (effective December 16, 2005) as amended by Saskatchewan Regulations 22/2009 and 30/2011. http://www.qp.gov.sk.ca/documents/English/Regulations/Regulations/R8-2R6.pdf (accessed Mar.3, 2013)

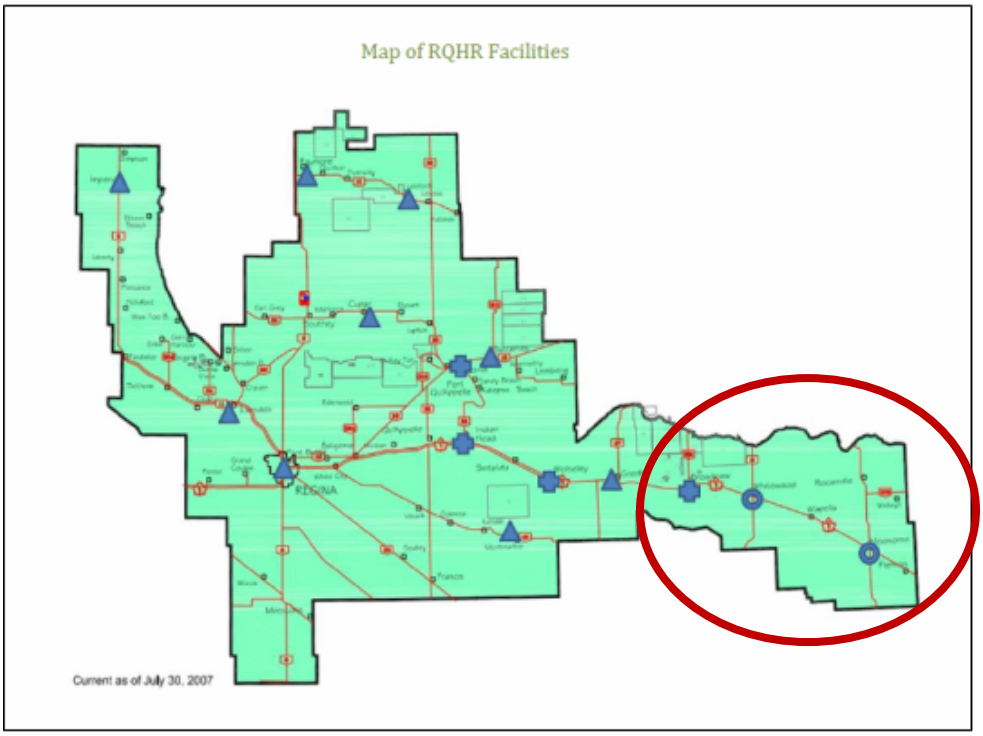
SEICC is located at the eastern end of the RQHR border, the eastern end of the Broadview/Whitewood/Moosomin corridor and 20 miles from the Manitoba border. The hospital is over two hours away from the tertiary care centres in Regina. The SEICC hospital is also in close proximity to other Regional Health Authorities:

- Sunrise Health Region to the north: Yorkton Regional Hospital (90 minutes away);
- Sun Country Health Region to the south;
- The province of Manitoba to the east (Virden Hospital).

The needs assessment area encompassed a broad service area of approximately a 100 kilometer radius of Moosomin inclusive of the towns of Whitewood, Rocanville, Wawota, Redvers, Maryfield, Elkhorn, Welwyn, Wapella, Silverwood, and Willowdale. The radius may extend to Kipling, Arcola, Redvers, and Kenosee Lake for emergency services. See Appendix A for the Facilities profile.

Health and Care Facilities servicing the area are:

- Southeast Integrated Care Centre Moosomin
- Broadview Union Hospital
- Whitewood Community Care Centre
- Broadview Centennial Lodge
- Deerview Lodge Wawota
- Kipling Memorial Health Centre
- Wawota Memorial



Covered Population Changes in Moosomin and Surrounding Area[3]

Town	2012	2008
Broadview	796	634
Carlyle	1,886	1,581
Kipling	1,279	1,102
Moosomin	2,975 + RM 176	2,550 + RM 372
Redvers	1,361	1,036
Rocanville	1,275 +RM315	1,023 + RM 418
Wawota	750	591
Whitewood	1,230	1,008
Villages		
Kenosee Lake	361	316
Maryfield	422	389
Welwyn	213	157
Elkhorn Manitoba census[4]	705 (2011)	601 (2006)

For Saskatchewan:

- Town populations rose 8.0 percent (11,224 persons) from 139,981 persons in 2006 to 151,205 persons in 2011.
- Indian Reserves also increased significantly in population between 2006 and 2011. Reserve population rose by 7,562 persons (15.7 percent) to 55,743 in 2011 from 48,181 in 2006.

Moosomin and Area:

- All the towns and villages rose in covered population from the period of 2008 and 2012.

[3] Covered Population - Zahid, Abbas RQHR, email February 2013.
[4] Manitoba Health Population Report - June 1, 2011
http://www.gov.mb.ca/health/population/3/assiniboine.pdf (accessed Feb. 22, 2013)

II. REVIEW OF DEMOGRAPHIC PATTERNS AND TRENDS

i. SaskTrends Monitor

Information from SaskTrends Monitor was used to study the demographic changes of the Moosomin area. The author states there was very little current statistical information for the population living in the Moosomin region. Some information from the 2011 census has been released but this is limited to the demographic information from the "short form". The economic statistics such as employment and education from the 2011 census won't be released for another six months. Unless otherwise indicated, the statistics in this material are derived from Statistics Canada data. Estimates and projections are, however, the responsibility of *Sask Trends Monitor*. [5] The following points were extrapolated from the report.

Saskatchewan

Birth Rates

- The natural growth rate in the province is increasing slowly after dropping for most of the 1980s and 1990s. The decline in the number of births during the 1990s was caused by lower fertility rates compounded by a drop in the number of women in the child-bearing age groups. Recent increases are the result of a) more young women in the province, and b) a slight increase in fertility rates.

International Immigration

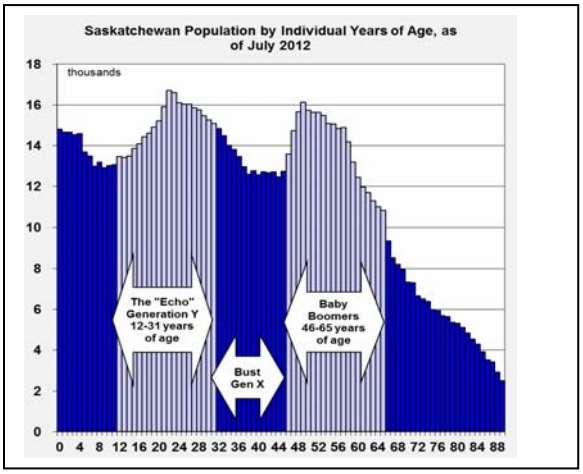
- In recent years, immigration has increased exponentially because of the Saskatchewan Immigrant Nominee Program (SINP). The number of immigrants coming to Saskatchewan is still small, however, compared with other provinces.
    - The net increase from international migration (near +11,000 for 2010-11) is now greater than the natural growth rate. The provincial government has stated that it intends to increase the number of SINP immigrants to at least 10,000 per year.
    - Retention of international immigrants has been a problem in the past. How many of these newer immigrants will stay in Saskatchewan is an open question.

Interprovincial Migration

- Interprovincial migration has been and probably will continue to be the main determining factor for the overall size of Saskatchewan population. The number of persons leaving Saskatchewan dropped after the mid-2000s and the number moving to Saskatchewan from other provinces went from levels near 15,000 per year to levels near 20,000 per year. This resulted in a positive net interprovincial flow for the first time since the early 1980s.

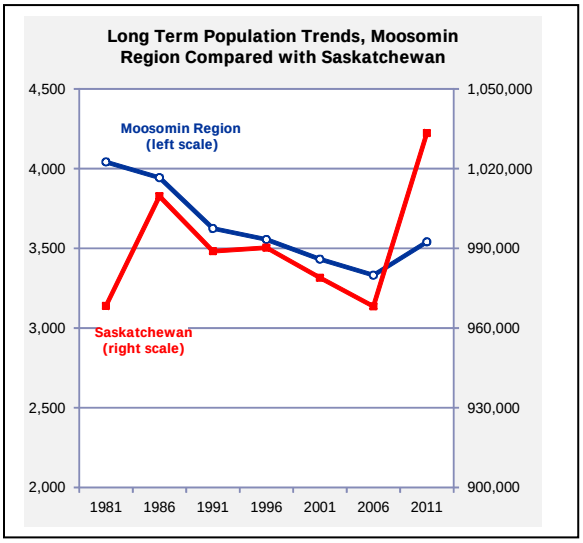
[5] Sask Trends Monitor, Doug Elliot QED Information Systems Inc., Recent Demographic and Labour Market Trends in Saskatchewan and East Central Saskatchewan, December 2012.

Provincial Trends: Age Structure of Saskatchewan Population

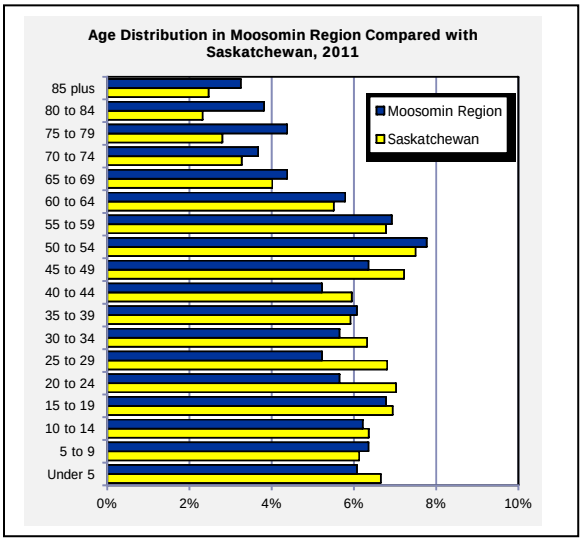


- This figure shows the age distribution of the Saskatchewan population.
- The bulge of baby boomers is nearing 65 years of age which is well past the average retirement age of 60.
- Even though they are not yet showing any signs of retiring, boomers could start doing so at any time. In 5 to 10 years, for example, the number of persons turning 60 in an average year will increase from about 12,000 now to about 15,000.
- The graph also shows the large “echo” generation that is entering the labour market age group as fast as the boomers are leaving.

Demograhic Data for the Moosomin Area



- The population in the Moosomin region increased in 2011 after years of decline.
- The increase has been almost as sharp as in the province as a whole. From 2006 to 2011, the population increased by:
  - 6.3% in the Moosomin Region; and 6.7% in the province as a whole.
  - The increase in the town of Moosomin was 9.9%.



- The region has, compared with the provincial population, relatively few young adults. In 2011, 17% of residents were 20 to 34 years of age compared with the provincial average of 20%.
- There are a lot of seniors in the region with 19% of the population 65 years of age compared with the provincial average of 15%.
- There are also a relatively large number of baby-boomers, those in the 50 to 64 age group.

Household size in 2011

- There are approximately 1,500 households (dwellings) in the Moosomin region.
- The Moosomin region has a relatively large number of single-person households – 32% of the total. This will be mainly because of the large number of seniors in the region.

Family Types in 2011

- There are approximately 1,000 families in the Moosomin region.
- Compared with the province as a whole, there are relatively few lone parents and a high proportion of couples without children.

Living Arrangements for Seniors

- Of the 635 seniors in the region, 37% live alone and 61% are living with their spouse or children.

Age of Children at Home

- Among the 990 children in the region who are still living at home, 44% are 5 to 14 years of age.

ii. Potash Corporation of Saskatchewan (PSC)

Oliver Pask, Potash Corporation (PCS) Rocanville Division, stated that currently there are 545 employees. There are an additional 1,200 workers supporting the project, however this number is projected to dwindle to approximately 200 between September to November of 2013. PSC is projecting 600 permanent employees by 2013 and approximagely 675 by the end of 2014.[6]

This indicates that there is a current transient population accessing the services of Moosomin and the surrounding area. As of September the the transient workers will be reduced, however there will remain a relatively stable PSC employee population of around 600 and their families (2,000 four member family unit) who will continue to access the services.

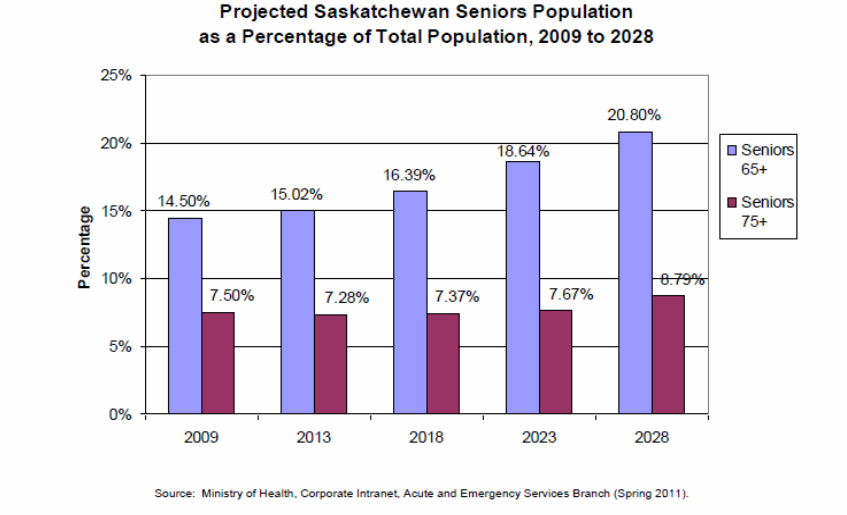
[6] Pask, Oliver J., Human Resource Superintendant Potash Corporation, Rocanville Division. Email to Holly Hodgson RQHR, April 30, 2013.

iii. Saskatchewan Seniors Mechanism May 2011[7]

Seniors Population Projection for Saskatchewan

The following outlines the population projections for seniors population as a percentage of total population form 2009 to 2028. In the next 20 years, the 75 plus will increase marginally, however the 65 plus population will increase by 6%.

Age	2009	2013	2018	2023	2028
% 65+	14.50	15.02	16.39	18.64	20.80
% 75+	7.50	7.28	7.37	7.67	8.79



[7] Saskatchewan Continuum of Care: Considerations in Developing a Seniors' Care Strategy. Government of Saskatchewan http://www.skseniorsmechanism.ca/uploads/SSM%20Annual%20Conference%20-%20May%202011.pdf (accessed Feb.27, 2013)

Long-Term Care Bed Ratio Projections[8]

	Number of Long-Term Care Beds	Long-Term Care Bed Ratio – 2010*	Long-Term Care Bed Ratio –2030†
Mamawetan Churchill River	18	41.1	22.7
Five Hills	542	96.9	83.0
Athabasca	4	97.6	70.2
Saskatoon	2,096	99.7	61.6
Prince Albert Parkland	552	105.0	80.8
Keewatin Yatthé	27	106.3	64.4
Regina Qu'Appelle	1,949	108.9	71.8
Cypress	501	116.4	99.8
Kelsey Trail	486	118.3	116.9
Heartland	519	125.1	124.0
Prairie North	516	126.9	89.8
Sunrise	899	135.5	134.1
Sun Country	715	142.3	133.5
SASKATCHEWAN	8,824	112.0	82.5

* Number of long-term care beds per 1,000 population age 75+ (figures exclude Veterans beds)

† Future number of long-term care beds per 1,000 population aged 75+ if current absolute bed numbers were to remain the same (figures exclude veterans beds)

The long-term bed ratio will be greatly reduced in the next 18 years if the number of long-term care beds per 1,000 population over 75 plus remains the same (excluding veteran beds). A reduction of 108.9 per 1,000 to 71.0 per 1,000 is projected.

The above graph illustrates that Saskatchewan is behind other provinces in regards to long-term care beds for the age 75 population. The major reduction in long-term care beds in Regina Qu'Appelle is reflective mostly of the urban or Regina area and does not reflect an accurate picture for the geographic area of this needs assessment. Another key concept that should be factored in is that in 2010 the average stay in long-term care was around 3 years. In 2013, the average stay has been reduced to 1.5 years which will greatly enhance the capacity of long-term care beds. Croft found in his study that Broadview, Whitewood and Moosomin were either at capacity or over bedded. Although the younger population is growing in Moosomin due to local industry, the boomer and older population is relatively stable or will increase marginally.

Broadview Centennial Lodge

Decreases in the long-term care beds are forecasted as the catchment area of the Broadview facility will see a modest decrease in its population for 75 years and older. The current 211 beds/1000 will increase to 220 beds /1000 people age over 75.[9]

Whitewood Community Health Centre

The Whitewood facility's catchment area will experience a substantial decrease in its 75+ population over the next 15 years (30%). The catchment currently operates 123 beds/1000 population over age 75 but that amount will shift to 175 beds/1000 population over age 75. The facility will become over bedded as the population decreases.[10]

[8] Saskatchewan Continuum of Care: Considerations in Developing a Seniors' Care Strategy. Government of Saskatchewan, presentation - slide 2, May 2011.
[9] Croft Planning and Design, 2011 -2025 RQHR Rural and LTC Master Plan, pg. 63.
[10] Croft Planning and Design, 2011 -2025 RQHR Rural and LTC Master Plan, pg. 82.

SEICC

The catchment area of the Moosomin facility will see a minor increase in its population aged 75 years and older over the next 15 years. The catchment currently operates 100 LTC beds/1000 for people over age 75 but that amount will shift to 95 LTC beds/1000 people over age 75. The facility is also utilized by residents from outside the health region, including Manitoba and Sunrise Health Region.[11]

Home Care Budget per Capita Age 75+

The figure below indicates Saskatchewan Home Care budget for the populations over 75 is less than the other provinces. This factor, along with the above factors, will greatly influence the need for accessible and affordable personal care homes now and into the future.

	Per Capita Age 75+ Home Care Budget – 2008/09
1. Manitoba	$3,179
2. New Brunswick	3,218
3. Newfoundland & Labrador	2,929
4. Nova Scotia	2,587
5. Quebec	2,446
CANADA	2,265
6. British Columbia	2,191
7. Ontario	2,114
8. Alberta	2,036
9. Saskatchewan	1,508
10. Prince Edward Island	952

Community Profile for Home Care

Saskatchewan had the third lowest (excluding the Territories) annual per capita spending on home care services at $110 per person, whereas the national average was $124 per person. In addition, Saskatchewan had the second lowest (excluding the Territories) per capita home care spending per person age 75+ at $1,429 compared to the national average of $1,976. While home care funding per capita aged 75+ is second lowest among jurisdictions, this is somewhat mitigated by the fact that the number of special-care home beds per 1,000 population aged 75+ is second highest among jurisdictions. The table below compares Saskatchewan's home care funding to the western provinces.[12]

	2006/07 Per Capita Home Care Budget	Per Capital Age 75+ Home Care Budget
Saskatchewan	$109.84	$1,429.38
British Columbia	141.42	2,100.21
Alberta	84.04	1,698.24
Manitoba	201.79	2,897.97

[11] Croft Planning and Design, 2011 -2025 RQHR Rural and LTC Master Plan, pg. 89.
[12] Focus on the Future: Long-term Care Initiative- A Report to the Honorable Don McMorris, Minister of Health, Prepared by Laura Ross, MLA Legislative Secretary to the Ministry of Health Long-term Care Initiative 2010. http://www.health.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=f26c9ea4-f96a-4c25-a7bc-4b13d447cea9&MediaID=5370&Filename=focus-on-future-ltc-initiative-2010.pdf&l=English (Accessed April 13, 2013)

III. CLIENT USAGE PATTERNS OF FACILITIES AND PHYSICIANS

i. Inpatient Activity SEICC (see appendix B)

Note: Sun Country (SC), Other Regions including Out of Province (OoP)

1. Inpatient discharges are up 4.1 % over the last three years (2009/10 to 2011/12) with a projected increase of 11.3% for 2012/13.
2. The majority of the non-RQHR inpatients are from Sun Country (29%) and out of province (14%) for 2012/13.[13] This has been the result of intermittent closures of the Arcola Health Centre and Kipling Memorial Hospital due to physician issues, and the current closure of acute beds in Redvers.
3. Inpatient discharges of non-RQHR patients are up 8.9% over the past 3 years from 2009/10 to 2012/13 and make up over 40% of all of the inpatients at SEICC.
4. New born registrations are on the increase with a spike in 2010/11 to 85 and then a drop to 66 in 2011/12 (-22%). The deliveries for 2012/13 were 41. The spike in 2010/11 may have resulted from Weyburn, in Sun Country, reducing deliveries. The drop in 2011/12 was due to the Moosomin Family Physicians stopping delivery of primigravidas (first time moms) for risk and safety reasons.
5. Overall there appears to be a leveling of the birth registrations since the spike in 2010/11. This leveling is due to the fact that the Physicians in Moosomin are no longer delivering primagravidas; however, it is predicted the overall birth rate is rising. There was a steady rise in out of province births, which dropped dramatically in 2012/13. The percentage of births from the RQHR (Moosomin area) constitutes only 50 -60% of overall births, with the remaining 40 - 50% coming from surrounding areas.

Indicator	2008/2009	2009/10	2010/11	2011/12	2012/13 projection	Variance
1. Inpatient discharges (% change per year)	1329	1,406 (up 5.8%)	1,446 (up 3%)	1,505 (up 4.0%)	1,700 (up 11.3 %)	4.1%/3 yr
2. Inpatient area of residence	RQHR-57.86% SC-21.87% OoP-18.51%	RQHR-59.53% SC-23.33% OoP-14.22%	RQHR-54.56% SC-27.07% OoP-15.88%	RQHR-53.32% SC-28.66% OoP-15.43%	RQHR-55.61% SC-27.2% OoP-14.83%	little variance
3. Non-RQHR Discharges		569 (40%)	660 (46%)	719 (48%)		8.9%/3yr
4. New born registration (% change per year)	45 (down 4.2%)	52 (up 11%)	85 (up 72%)	66 (down 22%)	41 (down 37%)	little variance
5. New born area of residence[14]	RQHR-60.0% SC-26.2% OoP-11%	RQHR - 60.0% SC-20.0% OoP-18%	RQHR - 51.0% SC-22.0% OoP-22%	RQHR – 51.0% SC-17.0% OoP-24.6%	RQHR - 56.0% SC-31.0 % OoP-12.0%	

[13] SEICC 2012/13 stats by RQHR - Appendix B - figure 1
[14] SEICC 2012/13 stats by RQHR - Appendix B - figure 3

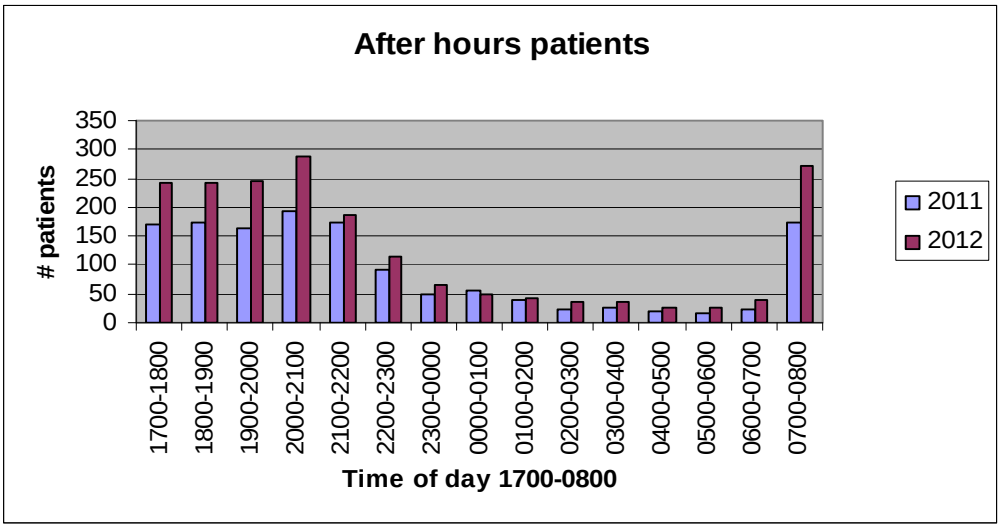
ii. Outpatient Registration SEICC

- There has been a steady increase in outpatients seen at SEICC over the past 5 years.
- The overall distribution of outpatient visits from non RQHR has remained relatively stable in the past 4 years; however outpatients residing in Sun Country have increased almost 7% (from 10.73% to 17.21% of the total outpatients seen).
- The majority (78%) of Emergency room patients are triaged at a CTAS level 4 or 5 which are the lowest levels of urgency.

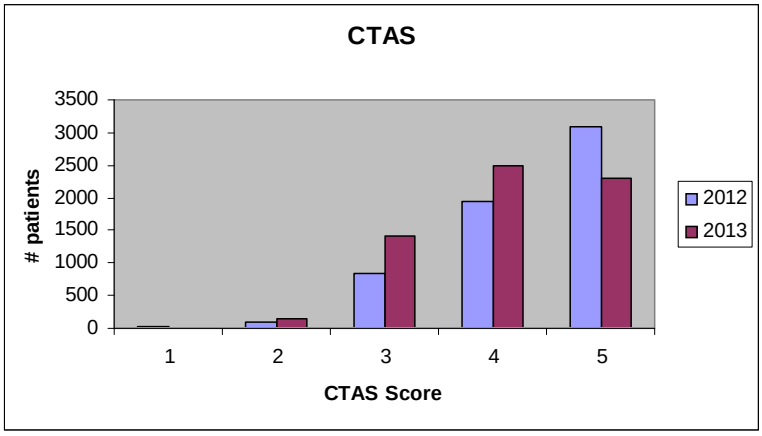
Indicator	2008/2009	2009/10	2010/11	2011/12	2012/13
1. Total Outpatients SEICC (% change per year)	14,809	17,786 (up 20%)	17,703 (down 0.47%)	19,035 (up 7.50%)	22,227 (up 16.80%)
2. Outpatient area of residence	RQHR-71.24% SC-10.73% OoP-15.22% Other regions 2.81%	RQHR-67.58% SC-12.96% OoP-16.98% Other regions 2.75%	RQHR-64.22% SC-15.03% OoP-16.98% Other regions 3.77%	RQHR-63.06% SC-16.80% OoP-16.47% Other regions 3.67%	RQHR-61.67% SC-18.63% OoP-16.50% Other regions 3.38%

iii. Patients Presenting after Regular Hours

There has been a significant increase in the patients that have been accessing the emergency room after regular hours between 1700 (5 PM) and 0800 (AM) in the morning. In addition, the CTAS scores of the patients accessing the emergency room over the past few years are at level 4 or 5, which are the lowest levels of urgency. Both of these findings suggest that more people are accessing the emergency for less acute or non-emergent issues who may be better served by their primary care provider.[15] Approximately 100 patients are accessing emergency services on the weekends.



[15] SEICC 2012/13 Stats, RQHR, Holly Hodgeson Program Director SEICC, Moosomin, May2, 2013.



iv. Moosomin Family Practice Centre Visits (Appendix C)[16]

There has been a 21 % increase in the number of patients cared for (discrete patients) at the Moosomin Family Practice Centre from 2008/09 (9,032 patients) to 2011/12 (11,163 patients). This data only reflects Saskatchewan patients. The number of physicians practicing has remained constant over this time, at seven. These numbers reflect the patients seen at the satellite clinics in the neighboring communities (see Appendix C).

Indicator	2008/2009	2009/10	2010/11	2011/12
Total Discrete patients	9,032	10,746	10,931	11,163

Moosomin Family Practice Centre Patient Visits

The following statistics show all the patient visits seen through the Moosomin Family Practice Clinic and other satellite clinics over the past 5 years. These numbers reflect the actual number of patient appointments or visits and include the patients from the RQHR, other Health Regions and Manitoba.[17] It should be noted that the jump in numbers from 2007 to 2008 reflect the addition of two more physicians (5 practicing physicians 2007 to 7 practicing physicians 2012).

Indicator	2007	2008	2009	2010	2011	2012
Visit Control Stats	39,782	52,032	57525	57,642	55,983	53,038

The above two sets of numbers suggest that the patient load (number of new patients) has been increasing at the Moosomin Family Practice Clinic, however the number of patient visits has

[16] Data source: Physician billings Ministry of Health, Government of Saskatchewan. Compiled by Bhooman Bodani
Medical Services Branch, April 18, 2013.
[17] Data Source: Moosomin Family Practice Electronic Medical Record, 2013.

declined. This suggests there are more patients using the emergency services after hours as seen in the After Hours Patient graph above.

v. Age Differential of Cases at SEICC

Of the total inpatients for 2011/12 in SEICC 61.6 % were in the 60 - 89 age range. This compares with 70.1% in Broadview Hospital and 82% in Woseley Hospital.[18] This also corresponds with Croft Planning and Design findings, "the 55 - 75 age group will represent the primary users of the acute care setting most frequently requiring access to chronic disease services, as well being managed through increased access to lab and diagnostic services."[19] The 2013 RQHR Health Status Report states from 2000 - 2009, 47.5% of all rural RQHR resident hospitalizations were 65 years of age or older and 40.3% of all Regina residents were 65 years of age or older.[20]

SEICC Hospitalizations by Age

AGE BREAKDOWN	Male		Female		Total	
	# Cases	%	# Cases	%	# Cases	%
< 14 year old	29	4.4%	19	2.2%	48	3.2%
14-19 years old	6	0.9%	25	3.0%	31	2.1%
20-29 years old	26	3.9%	124	14.7%	150	10.0%
30-39 years old	29	4.4%	64	7.6%	93	6.2%
40-49 years old	54	8.2%	62	7.3%	116	7.7%
50-59 years old	67	10.2%	73	8.6%	140	9.3%
60-69 years old	113	17.1%	143	16.9%	256	17.0%
70-79 years old	157	23.8%	141	16.7%	298	19.8%
80-89 years old	149	22.6%	153	18.1%	302	20.1%
>89 years old	30	4.5%	41	4.9%	71	4.7%
TOTAL	660	100.0%	845	100.0%	1,505	100.0%

vi. Average Length of Stay (ALOS) compared to Expected Length of Stay (ELOS) at SEICC

1. The Average Length of Stay (total cases) was 5.2 days for the last 3 years which is higher than the Canadian Institute for Health Information (CIHI) expected length of stay (ELOS) of 4.4 days for 2009/10, 4.6 for 2010/11 and 4.5 for 2011/12. These findings were consistent with the Bearing Point findings in 2008. [21] For 2012/13 the ALOS has improved and is aligned with the CIHI standard of 4.5 days.

[18] RQHR SEICC, Broadview Hospital, Woseley Hospital Annual Summary April 1, 2011 - March 31, 2012.
[19] 2011-2025 RQHR RURAL AND LTC MASTER CAPITAL PLAN, July 4, 2011, Croft Planning and Design, pg.13.
[20] RQHR Health Status Report February 2013.
[21] Moosomin Union Hospital Physician Practice Review V2, Aug. 5, 2008- Bearing Point LP, pg. 11.

Indicator	F2009/10	F2010/11	F2011/12	F2012/13
Actual Average Length of Stay (Total Cases)	5.2	5.2	5.2	4.5
CIHI Expected Average Length of Stay (Total Cases)	4.4	4.6	4.5	4.5

2. For the typical discharges the ALOS was actually lower than the ELOS (see figure below), however for the atypical discharges (approximately 20%) the ALOS was almost double the expected ELOS. This was the same finding of Bearing Point in 2008.[22] Some of the most significant diagnoses creating this variance were:
   - 3.3% due to convalescence following surgery 13.2 ALOS/2.4 ELOS
   - 2.7% Palliative care 11.3 ALOS/9.2 ELOS
   - 2.5% COPD (chronic obstructive pulmonary disease with acute respiratory infection) 7.4 ALOS/6.6 ELOS
   - 1.3% COPD (chronic obstructive pulmonary disease with acute exasperation unspecified) 9.5 ALOS/5.4 ELOS
   - 1% Bronchial pneumonia, unspecified 7.7 ALOS/4.6 ELOS

Some of the reasons for the increase in ALOS may be due to the following reasons:

- SEICC provides convalescent care for the nearby tertiary care centres such as the Regina General Hospital, Pasqua Hospital and the Brandon General Hospital. Patients receiving care in the larger centres can return to SEICC and convalesce closer to home. These patients may stay longer in a rural facility beyond the expected ELOS. It should be noted, the ALOS for SEICC is appropriate for the people that are admitted and discharged from the area who do not require tertiary care.
- Local physicians may admit sooner to the SEICC than experienced in an urban centre as there are beds available and the physician is able to monitor their care more closely.
- Some patients may stay longer in an acute bed than expected as the physicians may prefer to look after them at the SEICC and delay moving them to a palliative, convalescent or a short stay bed.[23]

Indicator	F2009/10	F2010/11	F2011/12	Variance
Typical Actual Average Length of Stay (Total Cases)	4.2	4.1	4.0	-0.1
Typical CIHI Expected Average Length of Stay (Total Cases)	4.4	4.6	4.4	-0.2
SEICC Atypcial ALOS	8.8	9.1	9.8	0.7

Excludes Newborns.

[22] Moosomin Union Hospital Physician Practice Review V2, Aug. 5, 2008- Bearing Point LP, pg. 12.
[23] Quote: Holly Hodgson Program Director SEICC, Feb. 27, 2013.

vii. Average Daily Census (ADC) and Average Percentage Occupancy (APO) Acute Beds[24]

1. The average percentage occupancy (APO) and average daily census (ADC) has remained relatively the same for the SEICC since the Bearing Point study in 2008 (2012 - ADC 21.65, APO- 79.48% vs 2008 - 20.27 ADC, 74.07% APO).
2. The Broadview Union Hospital has dropped in both ADC and APO since 2008 (2012 - ADC 3.70, APO- 23.12% vs 2008 - 6.99 ADC, 43.58% APO). This decline over the past 5 years may be due to the lack of a stable physician practice in Broadview.

   Based on the above, there appears to be some additional capacity in both facilities without increasing beds, especially at Broadview Union Hospital.

Acute Community Hospital/Health Center 2012/13	ADC Days	APO (Average Occupancy %)
South East Integrated Care Centre (SEICC) - 27 beds	21.65	79.48%
Broadview Union Hospital (BUH) - 16 beds	3.70	23.12%

viii. Occupancy of Long-term Facilities[25]

All the long-term care facilities in the area are at maximum capacity or over. For SEICC, as of April 2013 there were currently 5 individuals on the waiting list to come to Moosomin which took an average of two months to return. In April 2007 there were 15 clients on the wait list to come to Moosomin which took an average of 12 months to return. At this time, there is no collection of statistics to show how many patients passed away during their wait time. Based on these numbers it appears the situation is improving.

In addition, the RQHR has implemented the Alternate Level of Care Protocol (ALC Unit) at the Broadview Hospital, designating 4 beds for 24-hour supportive and direct personal care to patients who no longer require acute services at SEICC and cannot be immediately discharged to a long-term care facility or to a community based alternate level of care within their home community. [26] Also, there is currently a protocol in place, the Palliative Performance Scale, to help residents return home to their community if they are in the end stages of life. If the scale is 30% or less, the client has the option of returning to a facility in their home community or choosing to remain where they are. [27]

Conversations with the Manager of Deerview Lodge in Wawota stated they were at capacity with a waiting list ranging from 6 weeks to 3 months. The numberson the waiting list may vary from 1 to 10. The Manager's perception is that the average stay is becoming shorter.[28] A

[24] 2012-2013 RQHR Acute Statistics.
[25] 2012 - 2013 RQHR LTC Statistics.
[26] Broadview Union Hospital Alternate Level of Care (ALC) Unit Service Guidelines, RQHR.
[27] Quote: Holly Hodgson Program Director SEICC, April 18, 2013.
[28] Phone Quote: Manager of Deerview Lodge Wawota, Mar. 5, 2013.

conversation with a nurse at Elkhorn Manor in Elkhorn, Manitoba confirmed they are operating at 100% capacity with a waiting list.[29]

As more alternatives are available to keep individuals at home longer, the stays in long-term care facilities are becoming shorter.

LTC Facilities FY 2012/13	Total # LTC Residents % Occupancy YTD
South East Integrated Care Centre (SEICC) - 55 LTC beds, 3 short stay	98.90%
Whitewood Community Health Centre (WCHC) - 28 LTC bed, 2 short stay	99.52%
Broadview and District Centennial Lodge (BCL) - 34 LTC, 1 short stay	97.48%

IV. REGINA QU'APPELLE HEALTH REGION RURAL HEALTH STATUS REPORT 2011

The Rural Health Status Report is a report on the health status of rural Regina Qu'Appelle Health Region (RQHR) residents. The report examines a wide range of key health indicators including demographic, birth, hospitalization, external causes of injuries, leading causes of death, cancer incidence and mortality and health services utilization. The following key points were extrapolated from the above report.

Demographics

- Rural RQHR has experienced a steady growth during the past five years (except for 2010) because of the increase in number of births.
- Almost 15% of the rural population is aged 65 years or over. The aging population will increase the demand and utilization of health services.
- Rural RQHR had a larger proportion of population aged 0 to 19, 45 to 64, and 65 and older, and a smaller proportion aged between 20 and 44 years. The distribution for the 2011 rural RQHR population showed a drop in population among the 20 to 44 year age group. Baby boomers and older adults have either remained in rural communities for the majority of their adult life or are returning to rural communities to retire.
- Because many rural RQHR residents between the ages of 20 and 44 years leave the rural communities, rural RQHR has a higher dependency ratio than Regina. The dependency ratio of rural RQHR is slightly higher than that of Saskatchewan. *(**Dependency Ratio** – The ratio of the combined child population (aged 0 to 14 years) and elderly population (aged 65 years and over) to the working age population (aged 15 to 64 years).*

Births/Fertility

- The number of live births steadily increased from 2005 through to 2009 for both rural RQHR and the City of Regina.
- Teen pregnancy rates are higher in rural RQHR compared to the City of Regina.

[29] Phone Quote: Nurse, Elkhorn Manor, Elkhorn Manitoba, Mar. 5, 2013.

Hospitalization

- The age standardized hospitalization rate from 2000 to 2009 was higher among rural RQHR residents than among Regina residents. The higher rural rate can be attributed to many factors.
    - There was a higher proportion of elderly individuals in rural RQHR communities which increases the risk of falls and other accidents and accounts for 43.3% of all external cause of injury hospitalizations.
    - Rural residents are more likely to require hospitalization due to transportation accidents as they spend more time travelling. Rural males between 15-19 and 20-24 had the highest transport related injury hospitalizations. There were on average 120 transport-related injury hospitalizations per year in rural RQHR.
    - Rural residents are involved in farming, leading to more equipment and farm machinery accidents.
- Individuals 70 years of age and older were most often hospitalized due to external causes of injuries both in rural RQHR and Regina.
- Hospitalizations due to diabetes mellitus are higher among rural residents, which may be attributed to a higher Aboriginal population. Rural residents with diabetes may not have adequate access and availability to health services and may not see physicians as often as they should, which may increase the severity of the disease.[30]

Mortality

- Diseases of the circulatory system, neoplasms and diseases of the respiratory system were the three leading causes of death in both rural RQHR and Regina. These top three causes accounted for about 70% of all deaths in both rural RQHR and Regina.

Mental Health

- The discrete patient rate for mental health in rural RQHR generally increased from 2006-07 to 2010-11 and decreased slightly in Regina. The rate ranged from 11,159.3 per 100,000 rural population in 2008-09 to 11,813.4 per 100,000 rural population in 2010-11. From 2006-07 to 2010-11, the discrete patient rate for mental health was consistently higher in Regina than in rural RQHR.

Cancers

- In the previous Rural Health Status Report, it was noted that deaths from cancers in sites for which screening is available (colorectal, breast, prostate, and cervical) accounted for 30% of all cancer deaths among rural RQHR residents and for 26% of all cancer deaths among Regina residents. New data from 2006 to 2009 states deaths from cancers for which screening is available accounted for 27% of all cancer-related deaths among rural RQHR residents and for 25% of all cancer-related deaths among Regina residents. The decrease in deaths by these cancers may be attributable to improved awareness about cancer screening and prevention; however, more research must be conducted to prove this theory.

Physician Utilization

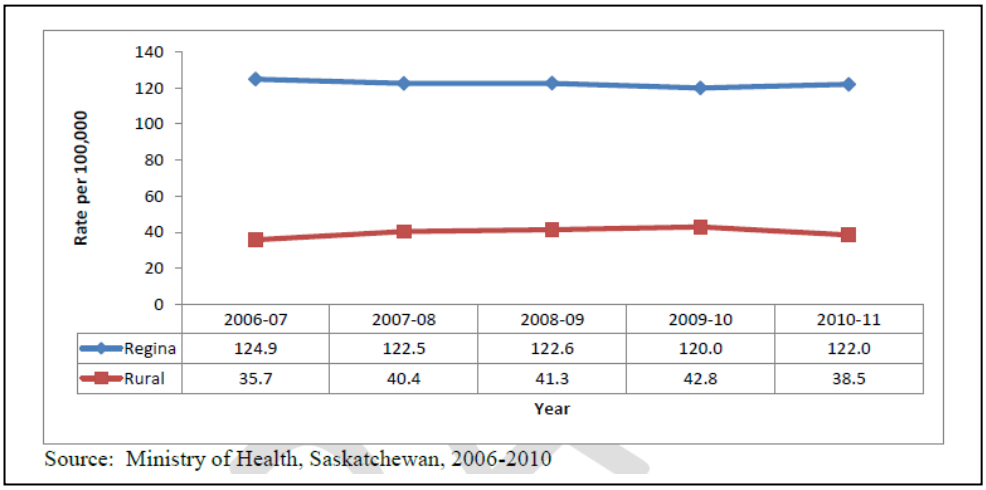
- As with many provinces, most of the physicians are concentrated in urban areas. Of the total 276 physicians in RQHR in 2010, only 23 were located in the rural areas. Based on this, 9% of general practitioners working in rural practice were responsible for the care of nearly one quarter of the population of the region. This is not a true reflection of access, as many residents in rural areas access physicians in the urban centres. As an indicator of

[30] RQHR Rural Health Status Report, January 2013, pg. 147.

access, the physician to population indicator is misleading as it assumes that residents only seek care in their own communities.

- While the rural RQHR population remains relatively stable, the discrepancy between the percentage of total general practitioners providing health care in rural RQHR and the percentage of the region's population suggests a large physician shortage in rural RQHR. Population per doctor is about three times as high in rural RQHR compared to the City of Regina.
- The physician to population rate is the number of physicians per 100,000 population. From 2006 to 2010, the average physician to population rate for rural RQHR was 39.7 physicians per 100,000 population compared to the average of 122.4 physicians per 100,000 population in Regina. There is not a universal accepted measure that relates the needs of the population with the corresponding number of physicians. The physician ratio for rural RQHR is not expected to improve in the near future as more physicians are leaving their rural positions. J. Rourke suggests, however, that there are many ways to improve the situation. Medical schools should accept more rural students as these individuals are more likely to return to their communities. Schools can also increase rural-based education and training and highlight the opportunities available in rural communities. Rural physicians should have a comprehensive team with which to work and network, a modern facility, and adequate technologies such as diagnostic imaging equipment. Finally, rural physicians should be allowed time off from the practice and provisions for their partners and dependents upon moving to the community.[31]

Physician to Population Ratio



Source: Ministry of Health, Saskatchewan, 2006-2010

V. REGINA QU'APPELLE HEALTH REGION - EMPLOYEE ENGAGEMENT SURVEY 2011

The RQHR conducted an employee engagement survey through the Saskatchewan Association of Health Organizations (SAHO) using the TalentMap Employee Engagement Index in the spring of 2011. The survey start date was May 16, 2011 and end date June 30, 2011. A snapshot report was prepared for the Moosomin Union Hospital (SEICC) in Decmember 2011.[32] The sample size was 39 of 206 staff (at the time), representing a 19% response rate.

[31] Rourke, J. Increasing the number of rural physicians CMAJ 2008; 178:3
[32] RQHR Employee Survey 2011, Snapshot Report Moosomin Union Hospital, December, 2011.

Overview of Findings (Appendix D)

The overall engagement scores were 56% favorable, which were lower than the overall RQHR score of 64% and provincial score of 63% favorable. It is troublesome to know 72% of the respondents are thinking of accepting a job with another employer. Overall job satisfaction was 59% which was lower than the overall RQHR of 62% and other Health Regions of 63%.

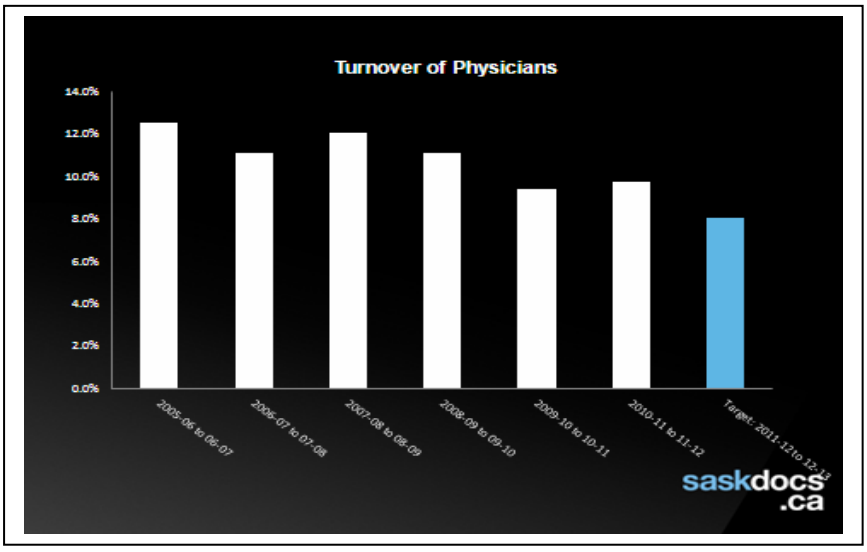
Based on the recommendations of TalentMap:

- only two areas had more favourable findings than the scores for RQHR and other Saskatchewan Health Regions - Professional Growth and Patient and Family Centred Care;
- only two areas - Work Environment and Work Place Health and Safety, fell into the good range of 70% or greater;
- only two areas - Professional Growth and Patient and Family Centred Care fell into the acceptable range requiring further follow-up of 60%;
- all remaining areas fell below 60% or within the unacceptable range.

The above findings suggest there is lots of room for improvement to enhance the engagement of the employees of SEICC. This is of great importance, as recruitment and retention of qualified health providers will be essential to sustain effective health services for the Moosomin and surrounding area in the future. In addition, almost half of the professional staff are near 50 years and older and will be due to retire in the next 15 years. Croft cited a 200% turnover in the past 5 years. In 2013 there are 260 staff employed at SEICC. The current overall turnover rate of all positions is 50% and of permanent positions 17%.

The SEICC Program Manager states "efforts to improve staff engagement have included daily visible management with opportunities for staff and managers to discuss improvement ideas and initiatives; regular visibility of senior management; and visibility wall implementation. Workplace morale and engagement continues to be a priority as engaged staff are the backbone to providing quality patient and family centred care".[33]

VI. REGINA QU'APPELLE HEALTH REGION - PHYSICIAN ENGAGEMENT SURVEY 2012



SaskDocs states "while the turnover rate has improved, that improvement has primarily been seen in the urban areas. Rural physician turnover remains quite high at somewhere around 18%" whereas the overall turnover rate is now less than 10%. The target for reduced turnover has been set for 8%.

[33] Quote: Holly Hodgson Program Manager SEICC May 2, 2013.

In 2012 RQHR performed a physician engagement survey with the aim to provide a compass for health organizations on how to best move forward with engaging physicians. It gathered evidence from multiple sources, using a variety of approaches, on what constitutes the barriers and facilitators to physician engagement at the system, organizational and individual levels. The following insights were extrapolated from the Compass for Transformation: Barriers and Facilitators to Physician Engagement (See Appendix E).[34] The findings suggested the RQHR focus on the following priorities to enhance physician engagement: foster trust and respect; demonstrate visible leadership; facilitate physician involvement in non-clinical activities; focus in on impacts of the local culture on physician engagement, focus interventions on root causes of dis-engagement; and, use a sequential approach to improve engagement by tackling one or two drivers at a time.

Moosomin Family Practice Clinic Engagement

The town of Moosomin and the surrounding communities have been very fortunate to have a stable physician practice for the past 20 years with 7 practicing physicians (5 full time, one ¾ time and one ½ time), of which two joined in 2009. They are the envy of many communities around Saskatchewan who struggle to keep even one practicing physician within the community on a consistent basis. The Practice takes pride on their clinic model which has attracted and retained physicians within the community. Over the years the practice has become disenchanted with the practice situation due to: the strain of increased patient numbers from outside the community (over a 100 K radius); the lack of staff to support chronic disease conditions and ancillary services for patients; the increased numbers of afterhours calls in emergency, and the perceived lack of involvement or engagement with Regional Health Authorities in discussing the issues and exploring alternatives. Due to new provincial regulations such as SIPPA, the physicians feel it is harder to recruit new physicians to the practice which has added to their stress. All the above factors have impacted physician engagement and increased their concerns about their ability to continue to provide patient family centred care. [35]

8. SITUATIONAL ANALYSIS - EXTERNAL REPORTS AND DATA REVIEW

The Situational Analysis is a review of information, reports and data from third parties which further illustrates the current environment and context of how health services are provided in Moosomin and the surrounding area. It enabled the research team to better understand the external drivers impacting the situation. The situational analysis included the following areas:

1) Overview of driving strategic provincial and health system initiatives.
2) Analysis from Third Party Reports - review of other documents, studies and reports related to the health services and facilities in the Moosomin area over the last 5 years.

[34] Grimes, Kellly., Swettenham, Julie. 2012. Compass for Transformation: Barriers and Facilitators to Physician Engagement. Metrics@Work Inc.
[35] Moosomin Family Practice Clinic Focus Group - November 21, 2012.

I. PROVINCIAL HEALTH SYSTEM PRIORITIES AND INITIATIVES

The review of the provincial direction illustrated the driving forces for healthcare transformation in the next 5 years. The following provincial initiatives arising from the Ministry of Health will serve as enabling factors in the development of improved health services in Moosomin and surrounding area.

i. Saskatchewan Government Throne Speech December 5, 2011[36]

The Throne outlined the Saskatchewan Government priorities related to health. The following priorities will impact the delivery of health services in rural and remote areas and should be referenced in a plan for improved services for the residents of Moosomin and surrounding areas.

- Continued attention and resources toward the stated goal that by 2014 no patient will have to wait longer than three months for surgery.
- Up to $120,000 in student loans for new physicians and up to $20,000 in student loans for new nurses and nurse practitioners will be forgiven for those agreeing to practice for five years in rural and remote communities.
- A new 20 doctor rural locum pool will be established to provide relief for existing rural doctors.
- A total of 20 new nurse practitioner training seats will be added over the next four years - a 67% increase from the 30 training seats that exist today.
- Bring the Shock Trauma Air Rescue Society emergency medical helicopter service to Saskatchewan to provide added emergency coverage and complement existing road ambulance services in our province.

ii. Saskatchewan Healthcare System Five-year plan (2012 – 2017)

The four enduring goals of the Saskatchewan Healthcare System Five-Year Plan are:

- Better Health,
- Better Care,
- Better Value
- Better Teams

The 5 - year outcomes for the Goal of ***Better Health*** are:

- By 2017, there will be a 50% improvement in the number of people who say “I can access my PHC Team for care on my day of choice either in person, on the phone, or via other technology.
- By March 2017, vulnerable populations (seniors, mental health, & communicable disease clients) will have support that will allow them to remain within their own home and progress into other care options as their needs change.

The 5 - year outcomes for the Goal of ***Better Care*** are:

- By March 2017, provide appropriate safe timely access to surgical and specialty care.

[36] Speech from the Throne December 5, 2011 Highlights http://www.gov.sk.ca/adx/aspx/adxgetmedia.aspx?docid=3810,595,594,1,documents&mediaid=4227&filename=throne+speech+2011+highlights+english.pdf (accessed February 18, 2013).

- By March 31, 2017, no patient will wait for emergency room care (patients seeking non-emergency care in the ER will have access to a more appropriate care setting).
- By March 31, 2017, a culture of safety established resulting in zero defects to patients and staff.

The 5 - year outcomes for the Goal of ***Better Value*** are:

- By March 31, 2017, the health care budget is less than the increase to provincial revenue growth.
- By March 31, 2017, the health care budget is strategically invested in IT, equipment and facility renewal.

The 5 - year outcome for the Goal of ***Better Team*** is:

- By March 31, 2017, increase staff and physician engagement scores to 80%.

Under the above framework the following provincial initiatives are relevant to the Moosomin and Area Needs Assessment:

a. Primary Health Care - Saskatchewan New Framework for Primary Health Care (PHC)

The health system hoshin for 2013/2014 is: Strengthen patient-centered PHC by improving connectivity, access and chronic disease management. The new framework for Primary Health Care outlines key steps to achieve improved PHC for the province.[37] These steps should be considered in the development of a sustainable solution to address the health needs for Moosomin and surrounding area (see Appendix F).

b. Nova Scotia Collaborative Emergency Care Centres (CEC)[38]

Nova Scotia's Collaborative Emergency Centres (CECs) are an innovative way to improve access to both primary health care and emergency care. Nova Scotia has successfully implemented the CEC model in communities which have had difficulty maintaining 24-7 emergency services. Nova Scotia CECs are open 24 hours a day, seven days a week. Services vary at each centre and reflect community needs, but they commonly offer access to primary health care by a team of professionals, including doctors and nurse practitioners, for twelve hours a day, seven days a week. At night, a team that includes a nurse and a paramedic (with physician oversight through the emergency medical services system) provide assessment, care and coordination of emergency services. This model aims to increase access to stable, reliable, predictable primary health care and emergency services and it aligns with Saskatchewan's recently announced initiative to strengthen primary health care.

c. Innovation Sites[39]

Innovation sites across the province are testing new models of service delivery using patient and community input and Lean methods to build services that best meet the needs of their patients, families and communities. Lessons learned from testing models will be shared across the province to help design models that work for their area. Health regions with innovation sites are building new models of service delivery using patient and community

[37] PHC Framework Report. http://www.health.gov.sk.ca/phc-framework-report (accessed Feb. 18, 2013).
[38] Nova Scotia Collaborative Emergency Care Centres. http://www.health.gov.sk.ca/nova-scotia-cecs (accessed Feb. 18, 2013).
[39] Innovative Sites. http://www.health.gov.sk.ca/phc-innovation-sites (accessed Feb. 25, 2013).

input and Lean methods to build services that best meet the needs of their patients, families and communities. Currently there are innovation sites in Meadow Lake, Moose Jaw, Yorkton, Regina Inner City, Lloydminster, Leader, Whitecap Dakota First Nation, and Fort Qu'Appelle, Balcarres, Lestock and All Nations Healing Hospital.

d. Saskatchewan International Physician Practice Assessment (SIPPA)[40]

In January 2011, Saskatchewan changed the method for assessing family medicine International Medical Graduates (IMGs) for readiness to practice. The Saskatchewan International Physician Practice Assessment (SIPPA) is the new process for assessing family medicine IMG's readiness to practice in Saskatchewan. This change was undertaken to ensure that physicians have the appropriate mix of academic knowledge, technical skills, and clinical judgment to provide safe patient care. SIPPA offers the opportunity for an IMG in family medicine to be assessed before they are settled in their new community. The SIPPA program comprises an orientation (2.5 weeks), centralized assessment (0.5 weeks) and clinical field assessment (6 to 12 weeks). Prior to challenging the exams and participating in the clinical field assessment, candidates participate in an orientation that is intended to provide context for the practice of family medicine in Saskatchewan as well as prepare candidates for writing their exams.

The SIPPA program will strengthen the assurance of the competency of new IMGs practicing in Saskatchewan, however the process has lengthened the time it takes to recruit new physicians to Saskatchewan (based on comments from practicing physicians). Each Health Region is offered two spots for each intake which occurs three times a year. The Region can only use the spot if all the prescreening criteria have been met.

e. Health Human Resources Strategy

Saskatchewan's 10-year Health Human Resources Strategy, released December 2011, outlines the provincial vision for a health workforce with the right mix of providers and progressive, collaborative approaches to patient care. It also provides a comprehensive, long-term assessment of Saskatchewan's health care human resource needs. The plan provides a framework for Saskatchewan health care educators and employers responsible for educating, training, recruiting, and retaining health care providers.[41]

f. Focus on Rural and Remote Health

With the recommendations of the Patient First Review and the new Ministry of Rural and Remote Health, there is a heightened priority to improve the health for citizens in rural and remote areas.

[40] Saskatchewan International Physician Practice Assessment (SIPPA) information sheet, http://www.health.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=3522cc85-549f-4622-9c57-1e48e501c19b&MediaID=6094&Filename=physician-sippa-info-sheet-may-2012.pdf&l=English (accessed Feb.25, 2013).

[41] PHC Framework Report, pg.45.

In October the results of Saskatchewan's Patient First Review performed by Commissioner Tony Dagnone was presented to Health Minister Don McMorris, calling for changes to how patients experience the health system, how health services are delivered, and how the system is administered.

Recommendation # 2 stated:[42]
That the health system develops a comprehensive and innovative strategy for rural and remote Service delivery that:

a) improves access to primary health, diagnostic and specialist services for rural and remote residents;
b) examines the cost burden of emergency transportation, including interfacility transfers; and,
c) includes a range of supports for people who must obtain health services away from their home communities.

In the fall of 2011, a new Ministry was created to focus on rural and remote health, with Honorable Randy Weekes appointed as Minister. A letter to Mr. Lloyd Boutilier, Chairperson of the RQRHA August 3, 2012 from the new Minister of Rural and Remote Health, declared his intent was to work collaboratively with the Ministry of Health to:

- Listen to people in rural and remote communities about their experiences, expectations and ideas.
- Engage, consult and build positive respectful working relationships between all partners in the healthcare field - especially between RHAs and the communities they serve.
- Identify, share, and champion innovative models in healthcare which support access to reliable, predictable, sustainable health services and meet patient needs in rural and remote communities.
- Advise and collaborate closely with the Minister of Health to achieve better alignment by viewing the quadruple aim of better health, better care, better value and better teams in rural and remote areas.

II. ANALYSIS AND INSIGHT FROM THIRD PARTY REPORTS

i. Bearing Point[43]

In the summer of 2008, Bearing Point conducted a review of Moosomin Union Hospital and related physician services. At the time of the study, the defined service area included: Rural East populations - Moosomin and the surrounding 80 kilometers (population of 40,566); and Rural East populations: Moosomin and Broadview (population of 27,688). The overall objectives of the study were to:

- assess the utilization of services at Moosomin Union Hospital and identify opportunities to enhance the utilization of inpatient beds;
- review the scope of physician services provided at Moosomin Union Hospital and identify opportunities to modify, expand and/or enhance services for safety and appropriateness;

[42] Patient First Review Recommendations: http://www.health.gov.sk.ca/patient-first-review/ (accessed Feb. 25, 2013)
[43] Akerson, Donna., Bearing Point Moosomin Recommendations (powerpoint presentation), September 9, 2008.

- identify opportunities to enhance the coordination of physician services along the Broadview/Whitewood/Moosomin corridor;
- identify technologies and other supports from RQHR which could enable the expanded/enhanced practice at Moosomin; and,
- identify the management structures and processes that facilitate coordinated planning and service delivery while enhancing the relationship between the Moosomin physician group and RQHR management and staff.

The review cited the some of the following recommendations:

- Expand the Moosomin Physician Practice model into Broadview/Whitewood replacing the retiring 3 physicians with new physicians as part of the Moosomin practice, and integrating a nurse practitioner into the practice. A new business model should be explored with the reallocation of beds in Broadview to free up acute beds in Moosomin.
- Increase obstetrical services to include low risk c-sections (c-section following a previous c-section, vaginal delivery following a previous c-section that may require c-section) and inductions (post-term pregnancy and rupture of membranes without going into labor). This required refresher training for the physicians and the additional staffing of three Registered Nurses.
- Consider building office space at the new Moosomin Hospital (Broadview model).
- Consider a 'carnival' traveling show of services that remains consistent and visits different areas on specified dates to provide technical and staff support while less expensive equipment may remain in the local area. Patients would receive care close to home with follow up by the local primary care team. This type of program would require a larger area than Moosomin alone or even RQHR alone to be efficient. Surgeons, with assistance from local general practitioners, could arrive in Moosomin and perform/supervise needed surgeries as the local physicians increase their skills. An area the size of Saskatchewan would probably be adequate in need and size.
- Leverage the use of telehealth for specialist consultations, staff training and support during interventions from practitioners within the larger centres.
- Establish specific clinics for Chronic Disease Management (e.g. COPD, Diabetes, Hypertension, Chronic Renal Disease) to be run by Nurse Practitioners with support by telehealth.
- Enhance other specialty services to the areas such as Cardiology, Gastroenterology, Orthopedics, ENT through visiting specialists or surgeons.
- Extend Physiotherapy/Occupational Therapy services using telehealth to teach other staff to support a mobile home telehealth.
- Expand mental health services through the use of holding beds in Broadview, telehealth, Nurse Practitioners and the use of Healthline for immediate information.
- Develop a group that governs the establishment of leading practices for the Rural East Corridor.
- The overall priorities for change as a result of the study were as follows.

Recommendation	1st Priority (red)	2nd Priority (blue)	3rd Priority (green)
Expand Service Area	6	0	2
Medical Offices	6	1	0
Cardiologist	4	4	1
Expand TeleHealth	3	1	1
Surgeon	2	1	2
Expand OB Services	2	2	0
ENT	1	2	8
Orthopedics	0	6	3
Carnival	0	6	3

Current Status Related to Recommended Changes

Hybrids of the care model recommended by Bearing Point were implemented, such as some of the recommendations for surgery. The Moosomin physicians chose not to continue with the delivery of primigravidas (first time mothers) due to the potential risks and safety issues to the clients. They are now referred to the larger centres. The Moosomin physicians still participate in the MORE^{OB} program to increase skill and knowledge in obstetrics, implement standards of care and obtain Ob clinical certification. Both physicians and nurses participate.

In 2010 a protocol to help patient flow in acute care was implemented. Four beds in Broadview Union Hospital were designated as Alternate Level of Care to provide quality care for those clients requiring additional convalescence or waiting for a Long Term Care Placement care until a LTC bed became available. This has eased some of the pressure on acute care beds in Moosomin.[44]

ii. 2011 -2025 Rural and LTC Master Capital Plan - Croft Planning and Design[45]

Croft Planning and Design developed a report to provide a Rural, Restorative and Long Term Care Master Capital Plan to assist the Regina Qu'Appelle Health Region (RQHR) with future facility strategic decisions. Facilities within RQHR were assessed to determine changes affecting 2025-30 demographics, the Facility Functional Assessment, the Facility Physical Assessment and the Staffing Demographics. These factors were measured and scored to assist in creating a prioritized screening process to determine facilities that may have significant issues of safety, need and sustainability (see Appendix G).

The current Saskatchewan Acute Care ratio is: 2.25 beds/1000 (note that this includes the 5 tertiary care hospitals in Saskatoon and Regina). As a guide, a 10 bed hospital should be considered as a minimum to offer a full range of community based in-patient services.

The current Saskatchewan rural LTC standard used by the Department of Health has historically been 115*/beds per 1,000 population over the age of 75.* The Ministry of Health requires a minimum of 30 residents on a sustainable basis over the next 20-25 years as a minimum number to provide LTC services as close to home as possible over the next 25 years.

[44] Quote: Holy Hodgson Program Manager SEICC, RQHR. May 2, 2013.
[45] Croft Planning and Design: 2011 - 2025 RQHR Rural and LTC Master Capital Plan, July 4. 2011.

Croft made the following recommendations related to the facilities in the Moosomin needs assessment catchment area. Croft suggested there will be increased opportunity for improved bed utilization along the number one highway corridor leveraging the beds from the Broadview and District Centennial Lodge, Broadview Union Hospital and Whitewood Community Care Centre. The key findings (see Appendix G) are summarized below:

- **Broadview & District Centennial Lodge -** Significant concern exists with the number of beds provided in Broadview; currently the number of beds exceeds the RQHR by over 200%. Further decreases are forecasted as the catchment area of the Broadview facility will see a modest decrease in its population for 75 years and older. The current 211 beds/1000 will increase to 220 beds /1000 people over age 75. Urgent attention is needed for this facility in order to provide a sustainable level of services over the next 15 years. With only 33 beds provided and a future bed need dropping below 20 beds, consideration needs to be given to investigate integration with the acute care site.

- **Broadview Union Hospital -** This facility will experience a 9% decrease in its population over 75 in the next 15 years. The catchment currently operates 5.45 beds per 1000 population and with the trending decrease in population they are projected to operate at 6.02 beds per 1000 population. Changes to the Broadview Hospital should consider the future delivery of continuing care services for residents in the Broadview area. Although the Broadview Hospital is considered to be in a sustainable state;,increasingly over time the cost per patient day is increasing. Downsizing capacity and improving patient care may consider converting semi private rooms to private rooms as the demand for beds continues to decrease.

- **Whitewood Community Health Centre -** The Whitewood facility's catchment area will experience a substantial decrease in its 75+ population over the next 15 years (30%). The catchment currently operates 123 beds/1000 population over age 75 but that amount will shift to 175 beds/1000 as the population over age 75 decreases, resulting in the facility becoming over bedded. Changing demographic trends for the Whitewood facility will also play a large part in the future of service delivery for this facility as a 30% decrease in the 75+ population will reduce the demand for services. A key concern will require a strategy to address the excess beds at the facility. Further investigation is needed to determine maintaining staff and the HR requirements over the next 15 years.

- SEICC - Croft also stated that the SEICC LTC supports the local LTC demographic including: Moosomin, Rocanville, Fleming, Wapella, RM Moosomin, RM Rocanville, and the RM Martin. The catchment area of SEICC will see a minor increase in its population aged 75 years and older over the next 15 years. The catchment currently operates 100 LTC beds for 1000 population. The ability to meet the acute care needs of out of province and out of country patients that utilize the facility is a concern as the area continues to see an increase driven by the growing oil, gas and mining operations in the area. Patients from RQHR, as well as out of province patients, skew the demographic calculations and thus the acute bed/1000 calculation is higher than the actual experience – approximately 25% of patients utilizing the facility are not residents of RQHR. There is an ongoing need for recruitment to meet the high staff turnover (498 postings over 5 years for 206 staff).

iii. Sun Country Primary Health Care Plan: Phase One (Practitioners), October 24, 2011[46]

In the spring of 2010 three Health Regions - Sun Country, Regina Qu'Appelle and Five Hills agreed to work together to collectively develop a sustainable plan for the delivery of primary health care in their communities. It became apparent that each Region was at a different stage in the development of their model, therefore it was agreed that phase one of the plan would be developed independently by each Region. Phase One of the Primary Care Health Care Plan for Sun Country focused on the development of an integrated service delivery model for general practitioners in southeast Saskatchewan.

Study Objectives

The over-arching objectives of Phase One of the Primary Health Care Plan were, as follows:

1. Estimate and project the current and future requirements for General Practitioners in southeast Saskatchewan over the next 20 years.
2. Recommend a model for organizing the delivery of general practitioner services throughout southeast Saskatchewan.
3. Identify the optimum distribution of general practitioners throughout southeast Saskatchewan, based on the recommended model, both current and future.

Following an extensive literature review, Sun Country Health Region (SCHR) chose to focus on the Hub and Spoke alternative based on their demographic and current/future needs. The Hub and Spoke model was expanded upon to include sub-spokes, as a means to extend the reach of the hub and primary spoke communities, in terms of drive access and in building the necessary underlying population as part of critical mass considerations. In Phase Two, when additional caregivers are considered, the Hub and Spoke model would be expanded upon to include other service delivery options as part of an integrated service delivery model. As well, as technology continues to improve, telehealth and telemedicine may become increasingly more viable in addressing the health care delivery needs of more remote communities and individuals.

The current and future physician requirements were calculated for each of the three participating Health Regions, since some hub-spoke scenarios relied on communities in multiple Health Regions.

The development of the Hub and Spoke plan for southeast Saskatchewan, and applied to SCHR, needed to consider all of the SCHR communities and those that are adjacent in the Five Hills and Regina Qu'Appelle Health Regions. This approach allowed communities to be included across all three Health Regions, and in calculating the service populations for each option in which a drive time area crossed a Health Region border. As a result, the total population included in the various approved options will amount to more than the SCHR population alone.

Summary of Hub-Spoke Communities

The chart below summarizes each of the SCHR Board-approved hub and spoke options including the communities in other Regional Health Authorities that fulfill the hub and spoke roles. The areas outlined in red indicate the communities impacted from the Moosomin and area needs assessment (see appendix H).

[46] Infoquest Technologies Inc., Sun Country Primary Health Care Plan: Phase One (Practitioners), October 24, 2011.

Area	Hub	Spokes and Sub-Spokes
Central	Weyburn	Radville and Bengough/Pangman
North	Broadview/Kipling	
Northeast	Moosimin	Wawota/Maryfield
Southeast	Estevan	Oxbow andCarnduff
Central East	Arcola/Carlyle	Redvers/Lampman/Stoughton
Southwest	Assiniboia	Rockglen/Coronach

At the time of the report launch (October 24, 2011), the following next steps were outlined:

1. **Phase One Implementation** - Develop an implementation plan and roadmap for each option outlined in the report.
2. **Phase One Presentation** to MoH and other Health Regions - Present findings and recommendations to the Ministry of Health, Five Hills Health Region and Regina Qu'Appelle Health Region to gain their support.
3. **Phase Two Development** - Move towards the overarching objective of developing a comprehensive Primary Health Care Plan for SCHR with FHHR and RQHR considering other healthcare providers.
4. **Hospital Service Planning Integration** - With the completion of Phase One: the general practitioner service model, monitor the impact of the model on hospital based services.
5. **Physician Resource Plan** - Develop a physician resource plan for the ongoing recruitment and retention of physicians to sustain Phase One of the model.

Current Status of SCHR PHC Plan - May 21, 2013[47]

Broadview - Kipling Area

- Locums through a private locum service have been arranged on an interim basis to serve the community with clinic service and full time call.
- A PHC site is presently being developed in Kipling.
- A Nurse Practitioner started in Kipling on April 29, 2013.
- One physician alternate payment was signed to start in June – successfully completed SIPPA May 2013 and a second physician started May following the successful completion of SIPPA.
- The SCHR and RQHR will be meeting to discuss the partnership between Broadview and Kipling with the purpose to stabilize both sites, share call and work in collaboration to achieve complete service yet shared responsibility.

Moosomin-Maryfield Area

- The Moosomin physician group continues to work in partnership with the PHC Team in Maryfield (Nurse Practitioner, office staff and regional professionals) which has been a long-standing relationship for about 20 years. At first the physicians and Nurse Practitioner worked in parallel, however over the past few years the team have been working together collaboratively.
- Maryfield shares the Electronic Medical Record out of Moosomin and they are working primarily on Chronic Disease Management.

[47] Email May 5, 2013. Wanda Miller, Regional Director Primary Health Care, Sun Country Health Region.

- SCHR and RQHR have met in regards to this, however not lately. The conversation between PHC in both regions has been ongoing in relation to RQHR understanding how SCHR has developed the relationship with this group.

iv. Proposal for 24/7 on Site Physician Coverage at SEICC

In 2009, the Moosomin Physician group submitted a proposal to the RQHR and the Ministry of Health outlining the need for 24/7 on site physician coverage at SEICC Emergency Room. The Moosomin Physician practice has been providing uninterrupted service for the last 20 years to Moosomin and the surrounding areas. The report cited the increasing pressures on the SEICC and Moosomin physician practice are mainly due to: the increase in population because of the oil pipeline; the recent Potash Corporation mine and associated construction near Rocanville; continued service interruptions of the Broadview Hospital, continued service interruptions of the Virden Hospital in Manitoba; and the potential expansion of services in Moosomin requiring further recruitment of additional physicians to the area. Other rationale cited were: the Practice was already providing 24/7 services as the only full hospital service between Regina (east) and Brandon (west) and Weyburn (south) and Yorkton (north); ongoing commitment to quality care as evidenced through the More Ob program,;ability to better attract new physicians to the area and enhance overall physician wellbeing of the current physicians.

The overall recommendation stated that providing 24/7 on-site emergency room coverage would ultimately lead to better care for patients as well as better physician wellbeing. Patients would not have to wait in the emergency room to be seen by the physician coming from the office or home, and the physcians would not have to interrupt their practice or home life to constantly travel to the emergency room. The ultimate outcome was safe excellent patient care and long-term physician wellbeing and stability in the area. [48]

9. COMMUNITY CONSULTATIONS

I. METHODOLOGY

i. Community Engagement and Development

A fundamental part of the needs assessment process was engaging in conversation with local stakeholders and obtaining input from key members of the community.

Michael Bopp (2001) describes a community as “any grouping of human beings who enter into a sustained relationship with each other for the purpose of improving themselves and the world within which they live”.

The highlights from Saskatchewan’s new Framework for Primary Health Care state:[49]

- Primary health care development in every community begins with the community’s involvement in assessing its needs and planning how to meet those needs.
- Community engagement is essential to building the trust and relationships required to successfully implement and evaluate effective primary health care.

[48] Dr. Van der Merwe, H. Schalk, on behalf of the Moosomin Physician Group 2009. Proposal for 24/7 On-site Physician Coverage at South East Integrated Care Centre Moosomin, Emergency Room.
[49] http://www.health.gov.sk.ca/phc-highlights (found Feb. 15, 2013)

- Community engagement will lead to an on-going exchange of information and ideas with health care leaders, providers, and planners.

The other fundamental principle related to community consultation is to determine the level of participation required of the group. Consultation participation can be broadly categorized into five participation goals.[50] The level of consultation chosen for the Moosomin and Area Needs Assessment by the project sponsor was the "Consult" level.

ii. Levels of Public Participation Goals

Levels of Public Participation	
Inform	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.
Consult	To obtain public feedback for decision-makers on analysis, alternatives and/or decisions.
Involve	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered in decision making processes.
Collaborate	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.
Empower	To place final decision-making in the hands of the public.

iii. Engagement Approach (see Appendix I)

The community consultation consisted of two major components:

a. Focus groups with community stakeholders:
There were seven focus groups conducted during November 20 and December 18, inclusive of public community members and healthcare providers. The groups were homogeneous in nature, that is: participants were grouped together in similar groups, for example, the public from a specific community or a group of healthcare providers.[51] Sessions were held in Moosoomin, Rocanville, Moosomin Family Practice Clinic, SEICC, Maryfield and Weyburn (Sun Country).

b. An online community survey:
In addition to the focus groups, an online survey was developed that reflected the focus group questions. The FluidSurveys online survey tool was used to develop the survey.[52] Posters were distributed to all the local RM offices, school divisions, and health facilities in the designated area of the needs assessment. Focus group participants were also asked to encourage their peers to participate by completing the survey. In addition,

[50] Stakeholder Engagement - A Tool Kit. Working Towards more effective and sustainable Brownfield Revitalization Polices. http://www.revit-nweurope.org/selfguidingtrail/27_Stakeholder_engagement_a_toolkit-2.pdf (found Jan.23, 2013)
[51] Guidelines for conducting a Focus Group. Elliot and Associates 2005, pg. 3 http://assessment.aas.duke.edu/documents/How_to_Conduct_a_Focus_Group.pdf (accessed Nov. 3, 2012).
[52] Fluid Survey Website. http://fluidsurveys.com/ (accessed Jan. 10, 2013).

paper copies of the survey were made available in the RM offices if potential respondents preferred to complete a hard copy. The survey was open from December 15, 2012 to January 2, 2013.

II. GENERAL FINDINGS

i. Focus Group Demographics (See appendix J)

Overall there were forty six (46) individuals who participated in the focus groups. Of the forty-six, twenty-four worked in healthcare, and nineteen represented the general public. Many of the healthcare providers responded from the perspective of both a community member and healthcare profession. It should be noted that the steering committee tried to organize focus groups in the Whitewood/Wapella and Elkhorn communities; however, there appeared to be little interest. The chart below outlines the times, location and participants of the focus groups.

Only 35 participants completed the demographic sheets (SCHR participants did not complete the demographic questions).

ii. Survey Demographics (See appendix J)

The survey was accessed by 165 participants and was fully completed by 66.3%.

iii. Comparison

Question	Focus Group	Survey
Gender	• Good balance of gender with 46% males and 54% females participating.	• 24% males, 76% females
Age	• Majority were age 50-65 (46%), followed by 40-50 age group (26%)	• Majority were age 50-65 (35%), followed by age 30-40 (24%), then age 65 (15%) and age 40-50 (14%)
Length in community	• Majority of participants had lived in the community 10 years or more (97%).	• Majority of participants lived in the community more than 10 years (77%), 5-10 years (12%), less than five years (10%)
Services Used	• The majority of the participants had used their family doctor (74%) or local pharmacy (71%) within the past year, with about a third (29%) accessing their local emergency, (29%) a community health professional or (29%) community hospital.	• The majority of respondents had used their local family doctor (94%), pharmacists (93%), local health clinic (74%), Emergency (50%), community hospital (50%), community health services (32%).
Self-Rated Health Status	• The majority of respondents indicated their health as excellent (26%), very good (40%) or good (23%).	• The majority of respondents indicated their health as excellent (18%), very good (48%) or good (26%).

Self-Identify	• All the participants were Canadian citizens (100%) in which 3 also stated they were Caucasian.	• The majority of the participants were Canadian citizens (99%) in which 35% also stated they were Caucasian. There was one respondent each of other citizenship and Aboriginal ancestry.

Summary

The sample population in the focus groups and survey were very similar. The key differences were:

- There were significantly more female respondents in the survey (76%).
- There was a greater age spread in the survey respondents than the focus groups.
- There were very few (1%) immigrant or Aboriginal respondents in both the focus group and survey indicating their perspective was not heard.
- Most respondents had lived in their communities over 10 years indicating they would have a longitudinal perspective, but would lack comparison with other communities.
- The majority of respondents, both in the focus groups and survey, rated their health status as very good, with the large majority (over 80%) ranging from good to excellent.

iv. Findings and Comparisons of the Focus Group and Survey Data

QUESTION 1
What do you believe makes a community healthy?

FOCUS GROUP

All groups identified multiple factors that make a community healthy which extended well beyond the availability of health services and facilities. Most all the determinants of health, with the exception of genetic makeup[53], were identified by the groups The top two factors identified by focus groups were recreational facilities (rink, gym, swimming pool, ball diamond, and soccer pits, etc.) at 14 respondents, and a supportive community (fundraising, service clubs, support groups, good volunteer base) at 12 respondents. Good health care, doctors and economic growth and business were also cited as important factors.

SURVEY

Survey respondents also indicated a large variety of responses related to the determinants of health. The difference between the survey and the focus groups was that access to services (103) and doctors (60) were the most frequent response. Supportive community (55), health facilities (43), prevention/public health (35), and lifestyle (34) were the next most frequent answers. Recreational facilities (20) and supportive community (55) were less frequent in comparison to the focus groups.

[53] What Determines Health, Public Health Agency of Canada. http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php#What (accessed Jan. 11, 2013).

Response Themes	First Response 146	Second Response 143	Third Response 135	Total 424
Access to Health Services	27	36	40	103 (24%)
Doctors	42	13	5	60 (14%)
Supportive Community	12	22	21	55 (13%)
Health Facilities	13	20	10	43 (10%)
Prevention/Public Health	4	17	14	35 (8.2%)
Life Style	13	11	10	34 (8%)
Education	17	2	8	27
Recreational Facilities		10	10	20
Emergency Care		5	6	11
Basic Needs	5	9	5	19
Economics	5	4	7	16
Spiritual/ Church Services	2	0	0	2
Other			6	6

QUESTION 2

What services do you believe are available to you in the community that supports your health?

FOCUS GROUP

Collectively the groups listed up to thirty (30) different health services offered within their community. Most participants had a broad grasp of the different health services available to them, ranging from standard health services like physician service and home care, to supportive health services like Alcoholics Anonymous, community support groups, community recreational centers and day cares. There were some differences between the number of services cited in Moosomin (26) and Rocanville (12) and Wawota (10). The two health profession groups cited (20, 22) different services respectively. The physicians cited 11. The SCHR participants did not engage in this question.

SURVEY

This question was not asked in the survey.

QUESTION 3

Thinking about your community, what do you believe are the greatest *current* health needs?

FOCUS GROUP

The frequency of responses cited were as follows: Physician Access 26, LTC Beds 13, Health Provider Recruitment and Staffing Issues 9, Acute Beds, Surgical & Specialty Care 9, Emergency Care & Services 8, Homecare 7, Mental Health 6, Adult Day Care & Care for

Seniors 4, Preventative Health 3, Palliative and Respite care 2, Therapies 2, Public Health 1, and other 4. The major categories and themes are outlined below.

Physician Access (26)
All groups cited physician access as a priority health need for their community. A key theme arising from the discussions was concern regarding the increasing strain on the physician practice in Moosomin related to the lack of physician services in the surrounding communities outside a 50 kilometer radius of Moosomin. This has increased the waiting time for the local communities normally served by the practice.

Moosomin/Rocanville Public
Both public groups noted it was taking longer to get in to see their physicians and have noted the strain on the practice.

Moosomin public - "The doctors are really busy and need a break, family appointments are taking longer to get into."

"It normally takes two weeks to get an appointment in Rocanville as the physicians get called back to Moosomin. We only have 2.5 days of doctoring - we need more days. We need to phone two weeks ahead for an appointment."

"We have extended our borders to Manitoba, Sun Country which has greatly impacted Dr. availability. We need to keep the service provision within the 50 k radius and focus on our community not needing to do anything more."

Moosomin Physicians
The physician group confirmed the pressure on their practice and were concerned with the level of fatigue of the practitioners and their ability to continue to provide quality service.

"We are concerned with our ability to maintain the family medicine practice through the clinic as we are overworking ourselves to accommodate expanded need and take on the extra burden of other districts. This is impacting our ability to provide acute care services."

Wawota
The Wawota group noted the absence of physician services in Redvers and Arcola. They too commented on the increasing amount of time to get an appointment to see the physician. They noted the new mining industry has made this part of Saskatchewan the busiest corner within the province with a huge increase in semi-truck traffic and transient population.

"Doctors in Moosomin are overloaded and we can't get an appointment the same day. This corner is the busiest corner in the province and it appears there is a lack of physicians. We need more doctor access in our community as we are dragging down Moosomin.

Healthcare Providers
Both health provider groups affirmed the thoughts of the other groups related to increased pressures on the local physician practice due to the increase in new clients. They affirmed the pressures were due to the inability to recruit new physicians in the outlying communities. They also raised the need for 24/7 physician coverage at the

South East Integrated Care Centre (SEICC) to manage the increased demands and transient population.

SCHR

The group acknowledged access to physicians or a nurse practitioner was a huge issue and spoke to the unstable physician situation in the area of SCHR around the communities such as Redvers, Wawota and Kipling. Even if a physician is recruited, patients do not come back to the community as they have established a relationship with a physician in another community and are concerned about the stability of a new physician practice.

They also cited issues related to continued and follow-up care for clients from these areas as there is uncertainty around whose patient it is, SCHR or RQHR. For example, if a Sun Country patient is seen at the Moosomin physician clinic they are considered a patient of the clinic, however if they are admitted to the SEICC, it is viewed that they are using RQHR beds and should be in SCHR. This creates tension amongst the staff in RQHR and SCHR.

There is a lack of rapport between the physicians serving Wawota and Redvers with a realistic understanding of the capacity of the solo physician in Redvers. There appears to be a breakdown in communication between practitioners. Currently SCHR has two physicians practicing 1.5 time in Arcola, 1 full-time in Redvers, 1 part-time in Carlyle, with a Nurse Practitioner, and 1 full-time in Arcola. These are all separate practices.

Long-term Care (13)

Two main themes emerged in the discussion. The first theme was the concern for enough LTC beds in the future with the increase in elderly population. All three communities perceived the LTC beds to be full with a waiting list. The second theme was that due to the lack of LTC beds, people were being shipped to other communities away from their families and loved ones.

Rocanville - *"The LTC is full, we need more lodge care for level 4".*

Moosomin - *"Approval for LTC happens on a Wednesday which blocks the acute care beds. If there were five more LTC beds that would greatly improve the amount of time individuals are away from their family and community supports. The lack affects the family. People who may need long-term care are accessing the acute services because they don't want to be shipped to another community."*

Wawota - *" We have a waiting list for level 4 beds, it has been as high 10 or 12. It seems like the patients are always moving around as people are shipped off to Sun Country, then to Carlyle and Wawota."*

Health Professional Recruitment and Staffing Issues (9)

Four groups spoke of concerns related to staffing shortages and recruitment issues related to the full spectrum of healthcare providers. Three of these groups were the healthcare provider groups. The key concerns raised were:

- the ability to maintain acute services at the SEICC due to staffing shortages;
- the lack of ancillary or follow-up care professionals like physiotherapy; and

- utilizing healthcare professionals like pharmacy and nurse practitioners to their full scope of practice.

SCHR affirmed the need to access all types of healthcare professionals on a care team. A lot of work has been done in the SCHR clinics to help manage chronic disease patients to alleviate pressure on the system. They spoke of the ability to provide follow-up care and difficulties experienced in coordinating the care once clients returned to SCHR from Moosomin,

"Just because you access the Physician in Moosomin does not mean you can't access physiotherapy in Sun Country. If Wawota patients are in the Moosomin Hospital (that was part of the original plan as part of the catchment area) they may see other professionals from another Region."

Acute Beds, Surgery and Specialty Care Services (9)
Two themes emerged from the discussion:

- the acute beds are full due to many client coming to Moosomin or the beds being utilized for non-acute patients or patients needing outpatient care;
  "example - programs offered to provide IV therapy that don't need to tie up a bed"

- The ability of the SEICC to provide more surgical services so clients do not have to travel to the cities.
  "There is a lack of OR time in the cities, but we have ORs sitting here not being used. The same surgeons can provide the services as the other sites, using our facilities. This used to be done in dentistry - All makes sense as it will minimize the cost to the RHA."

Emergency Care and Services (8)
The major themes arising from the group discussions were:

- the need for physician coverage at the emergency at the SEICC around the clock or 24/7;
- the lack of ambulance services in Redvers and the ability of training and maintaining first responders in small communities (Wawota); and
- the inappropriate use of emergency services by non-urgent patients.

Home Care (7)
The main theme arising from the groups was the lack of homecare service coverage to enable people to stay within their own homes. The perception was people needed to be institutionalized due to the lack of services. The healthcare providers commented that the assessment criterion seemed impersonal and did not appear to capture the entire client situation.

SCHR commented on the inability to provide consistent care due to staffing issues, and the difficulty to coordinate care as the clients crossed regional boundaries.

"From a Homecare community perspective, it is difficult for our clients usually seniors or the elderly as we are struggling with the staff to provide consistent HC services partly due staffing and partly due the flexibility of working with other regional staff. It is more difficult to share the care. Care becomes more tenuous and difficult when you are crossing regions practices and standards. For example, when the Home care nurse works with partners on the phone and tries to coordinate care which makes the communication more challenging".

Mental Health Counselors (6)
A variety of needs were cited such as: more counselors for children and families to deal with issues like bullying; psychologist services; timely access to mental health counselors (8 -12 week waits); and EFAP services not timely for rural staff.

Adult Day Care - Level 1 & 2 Care of Seniors (4)
Rocanville participants talked about the rising need for seniors or elder care during the day to enable residents to stay in their homes. They spoke of the loss of the former daycare program within their community and the need for something similar for residents who do not need LTC but still need level 1 or 2 assistance. The Moosomin healthcare providers raised the same concern.

> *" There is a need for private care home for those who are between LTC and Home care who need Level 1 &2, they may or may not qualify for homecare but may not be able to make it at home."*

Other (7)
Some other notable health care needs cited were:

- The need for long-term solutions, improvement and communication between stakeholders. The need for common definitions related to care.
- The disconnect between urban and rural related to the communication between the providers and the leadership within the RQHR. There is a perceived need for a better understanding of the issues and needs… "it never seems to get better".

SURVEY

Response Themes	First Response 117	Second Response 113	Third Response 106	Total 336	Comments
Physician Access	47	17	19	83(25%)	Most responses were related to access to physician care, more doctors, difficulty in getting timely appointments.
Facilities and Beds	24	24	19	67(20%)	Responses were mainly around more hospital beds, acute beds, larger hospital
LTC	7	12	8	27 (8%)	Most responses were for more LTC or LTC beds
Health Provider Recruitment and Staffing	3	13	9	25(7.4%)	Most responses related to availability of healthcare providers, a few related to competence of staff
Access to Services	8	6	6	20 (6%)	Responses were mainly timely access to a variety of services

Seniors Care	8	6	5	19(5.6%)	Reponses ranged from seniors housing, assisted living, day programs, seniors centres
Walkin clinics	7	6	6	19(5.6%)	Most responses related to walk-in clinic availability
Preventative Health Services	4	5	9	18(5.3%)	Responses ranged from education on healthy living, good food choices, physical activity
Specialty Care	3	11	4	18(5.3%)	Responses ranged from access to specialists, diagnostics, to maternity services
Emergency services	3	5	6	14(4.2%)	Most responses related to availability or close access
Other Health Services	1	4	4	9 (2.6%)	Pharmacy x3, Dentist x2, Information, Management of Fundingx2, Better care of patients
Mental Health Services	2	3	3	8 (2.4%)	Responses ranged from child and youth, inpatient, support for parents
Home Care	0	2	6	8 (2.4%)	Response were mostly increased or expanded HC services
Palliative Care	0	1	0	1	
Chronic Illness	1	0	0	1	

Comparisons
On the whole, the health issues raised on the survey were congruent with those from the focus groups. The few health needs that were more prominent in the survey were the increase in beds or hospital size, and the need for a walk-in clinic.

QUESTION 4
Thinking about your community, how well do you feel that your health needs are currently being met by the services offered?

FOCUS GROUP

Very Satisfied (6 or 15%)

- Six respondents were very satisfied with the services. Two healthcare providers stated their responses would be different from a provider perspective. Most responses were related to personal experience with the services in Moosomin.

  "I am satisfied or very satisfied because in Moosomin we have a model which is unique for the prairie province; many more communities are not as well resourced"

Satisfied (17 or 43%)

These respondents were generally satisfied but felt the system was strained. The main reasons cited were related to the SEICC not being used to its full potential: the increased demand on services from neighboring communities; and, the decrease in timely access to physicians.

Neutral (4 or 10%)

Most of these comments were that the respondent had not used the services lately or health services could be provided more efficiently.

Dissatisfied (13 or 33%)

There were a wide variety of reasons related to participant dissatisfaction. Some reasons cited were: residents being sent outside the community for LTC; physician shortages or wait times; long wait times for services like mental health, physiotherapy, podiatry; homecare access, especially in small communities; and,just a perception that there is a general erosion of the health system.

Very Dissatisfied (0)

If you feel your health care needs are being met well. Please tell us what is working well.

- The Wawota participants felt things are running smoothly with access to a physician twice a week; access to a nurse practitioner in Maryfield; and, good service from the pharmacy in Kipling.
- Kipling participants noted… with the exception of staffing shortages, the community is doing well.
- SCHR participants commented that there was a good frontline connection between the staff in SCHR and Moosomin, however the shortage in services is putting a strain on the relationships. They also commented that currently the public health services are meeting the demands.

If you feel your health care needs are not being met well. Please tell us what are the gaps in current health care services in your community.

- Wawota participants noted there was not enough homecare coverage for evenings and weekends.
- SCHR commented the primary healthcare model in Kipling needs to be improved further and to assist Moosomin when they are full. Another gap was the responsiveness for LTC placement screening. It is difficult to get clients screened in a timely manner to get them out of the bed. SCHR spoke about the use of different definitions related to care standards which causes delays or confusion between SCHR and RQHR staff. It was noted the SCHR mental health caseload is full. They also noted that community residents may be reluctant to access health services when the physician situation is unstable, as they may be concerned the services will not be there for them if they may need more.

Other Thoughts

Other comments from some healthcare providers in Moosomin were related to the concerns around the new SEICC being just a replacement facility for the old hospital. They were of the view that the facility could be used for so much more like the regional hospitals in Humboldt and Dauphin, Manitoba.

SURVEY

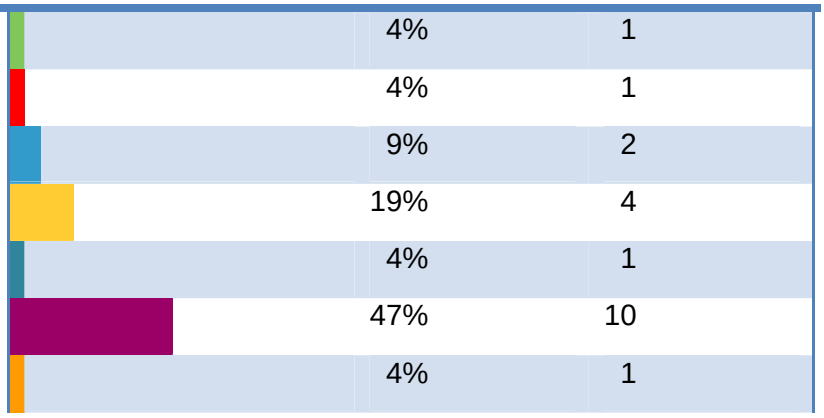
Thinking about your community, how well do you feel that your health needs are currently being met by the services offered?

Response	Chart	Percentage	Count
Very Satisfied		7%	9
Satisfied		45%	56
Neutral		29%	36
Dissatisfied		17%	21
Very Dissatisfied		2%	2
	Total Responses		**124**

You feel your health care needs are being met well. Please tell us what is working well. 53 responses

Response	Chart	Percentages	Count
Access to services when needed		15%	8
Health provider services		22%	12
Other		1%	1
Pharmaceutical care		3%	2
Physician services		71%	38

If you feel your health care needs are not being met well. Please tell us what are the gaps in current health care services in your community?
21 responses

Response	Chart	Percentages	Count
Health provider recruitment		4%	1
Homecare services		4%	1
Hospital		9%	2
LTC beds		19%	4
Other		4%	1
Physician access		47%	10
Walk-in clinic		4%	1

Comparison

In both the focus groups and the survey, there is a relatively even split between those individuals who were highly satisfied or satisfied, and those who were neutral, dissatisfied, or very dissatisfied.

Access to local physician services appeared to be the most significant factor as to whether respondents were satisfied or dissatisfied. The other factors cited in the survey seemed to be congruent with the focus group results.

QUESTION 5
Looking ahead, what do you believe may change in your community that would shift the health care needs in the next 5 to 10 years?

FOCUS GROUP

Growth of Population in Moosomin Area (19/44%)
The majority of comments referred to the exponential growth of the Moosomin population due to the local mine and new businesses. Residents commented there were "a lot of new people in town…that they do not know". The population has been stagnant until recently, when there has been a dramatic increase. Participants noted the increase in the Filipino population and other immigrant young families. It was questioned whether the current health facilities and services would be able to accommodate the recent influx of population growth into the future.

Aging Population (13/30%)
The group comments related to the impact of an aging population were: an increased need for LTC beds, senior programs and care homes; an increase in the use of healthcare services and facilities; and an increase in the incidence of illness associated with aging.

Societal Changes (10/23%)
Participants noted a variety of shifts within society that may impact the future of healthcare such as: a more mobile/global population introducing more communicable diseases; busier families leading to less volunteerism; early childhood development concerns and daycare; rent and housing issues; changes in post-secondary education; moving education into the communities; and, continued urbanization and decline of small towns.

Aging Health Care Professionals (9/21%)
Participants commented on the large number of health professionals retiring in the next 5 years and the strain it will put on health services, especially in the rural communities. The physicians also noted that their practice is aging and fewer young physicians are choosing practices in rural areas. They also noted the new SIPPA regulation makes it more difficult for immigrant physicians to come to Saskatchewan in a timely fashion.[54] SCHR also noted there is an increased reliance on foreign trained healthcare providers which adds the complexity of cultural and language challenges.

New Mines - Transient Population (9/21%)
The participants noted that with the new mines there is a different population which has created different demands on the local health system. These demands may arise from a need for afterhours emergency services, drug and alcohol issues, safety issues related to increased large transport vehicles. Although there are health services at the mines they are during the day. In addition, participants noted this population is transient and is not invested in staying within the community or giving back to the community.

Increase in Chronic Disease and Cancer (8/19%)
The participants noted an increase in diabetes, muscular sclerosis, dementia and other complex chronic diseases.

Mental Health and Addictions Issues (5/12%)
Responses from the participants suggested an increase in issues such as increased stress related disorders on the younger generation, youth depression, suicides, bullying, alcohol and drug related disorders.

Overall Complexity of Healthcare Services - Change in how we use Health Services (5/12%)
Participants spoke of the vast array of healthcare services and the need to use our resources more efficiently. They commented that communities will no longer have a physician and people will need to travel more for services, which may create transportation issues for seniors. They also noted the shift in expectations of the public regarding health care and beginning acceptance of other healthcare models.

[54] Saskatchewan International Physician Practice Assessment (SIPPA), http://www.health.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=d9637204-52a7-4962-a0f3-d55c59ead3ae&.. (accessed Jan. 26, 2013)

Other
Other trends noted were the increase in new local business, legislative changes, the lack of exercise with the increase of obesity, and the growing First Nation population.

SURVEY

Response Themes	First Response 117	Second Response 105	Third Response 92	Total 314	Comments
Growing Population	56	17	3	76 (24%)	Most comments just stated a growing population
Aging Population	32	31	9	72 (23%)	Most comments noted the aging population and people living longer
Increased Demands for Services Inside and Outside the Community	8	16	17	41 (13%)	Comments referred to the influx of patients from the surrounding communities, SCHR, Manitoba, closures, longer wait times, emergency room access
LTC/Care Home Needs	8	12	13	33 (11%)	Comments were related to the need for LTC, nursing home care, home care, housing/care for seniors.
Physician Demands	9	12	9	30 (10%)	Comments related to physician shortages, overworked, increased use of physicians
Facilities/Beds	1	4	7	12 (4%)	Comments related to the hospital full, lack of beds, acute beds
Younger Population	6	2	2	10 (3%)	Comments noted growing younger population with younger families.
Healthcare Provider Shortages	0	0	10	10 (3%)	Comments related to lack of workers, recruitment difficulties, aging staff
Increase in Chronic Disease/Cancers	0	5	3	8 (2.5%)	Comments included Alzheimer's, obesity, disease severity/complexity
Economic Business Expansion	0	1	5	6 (1.9%)	Comments related to the recent mines and increase in new local business
Special Care Needs	0	4	1	5 (1.6%)	Care for individuals with special needs, palliative, outreach programs
Mental Health Issues	2	2	1	5 (1.6%)	Comments related to additions
Transient Population	2	1	1	4 (1.3%)	Transient population with the completion of the mines

Foreign Population	1	1	1	3 (1%)	Growing number of foreign population
Other	3	4	5	12 (4%)	Comments related to increased travel for specialized care, more centralization, less funding or poor use of funds

What information or data supports your views listed in the above question?

Response	Chart	Percentages	Count
Media		25%	25
Observation, experience, word of mouth		67%	66
Professional knowledge through work		5%	5
Studies, reports		4%	4

Comparison

On the whole, both the focus groups and the survey respondents cited similar trends. Growth of the population and the aging population were the top trends in both the survey and focus groups.

The focus group mentioned trends arising from the changes in society which were not directly raised in the survey. The survey respondents cited the factors related to physician access and shortages, which were not raised directly in the focus groups.

QUESTION 6

Thinking about these changes, what do you believe will be the greatest health needs in your community in the next 5 to 10 years?

FOCUS GROUP

Mental Health (11)

Participants talked about the rising challenges related to mental health issues resulting from the shifting changes in society. One health provider group (6 responses) suggested this is a real "weak link" within the community, and a more holistic approach is needed.

Doctors, Nurses and Healthcare Professional Recruitment (10)
The major themes arising from the discussions were: the concern related to the large number of healthcare professionals retiring in the next 5 to 10 years; the need for and use of more nurse practitioners in rural communities; the difficulty sustaining traveling healthcare professionals like physiotherapists and homecare staff in rural areas;; and the ability to keep health providers current and competent in their skills.

> *"Right now we have trouble to get physiotherapists (PT) to travel out to rural areas. This is the same for Homecare. These professionals can go to other areas to get jobs. In community meetings the public want more PT. Staff push back due to the distances, the weather, and having to drive their own vehicles. This applies to all traveling professionals."*

> *"Healthcare providers now deal with wide breadth of knowledge which is hard to keep on top of it. Patient's expectations and knowledge have increased to provide good quality care."*

LTC Beds (7)
Most comments were related to the need for more beds and more level 1 and 2 care.

Acute Services and Beds (6)
Participants talked about the availability of acute services now, 20-years down the road, and the need to plan for the future. Other comments were related to more surgical procedures and the use of telemedicine for follow-up care.

> *"Either we are going to have to expand for after hour services or we are going to have to retract our services to cope and clients are going to go to Regina."*

Seniors Day Care (5)
Most participants commented on the need for creative care and supported housing options to enable seniors to stay in their home longer inclusive of light care options and addressing social needs. Comments were made about building of condos in Wawota and town houses in Redvers.

> *"The longer we can keep people viable with a little assistance in their home the better. We need the ability to meet present and future health needs."*

Home Care (5)
Comments were related to more or expanded home care services within the community to support the elderly or poorer population.

Physician Services (4)
The comments were related to the need to maintain and enhance physician services to address the demands of the recent population growth. There was also a comment about physicians being able to practice specialty skills in which they are trained or they may leave.

Emergency Care (3)
Comments reflected the ongoing need for all types of emergency care within small communities inclusive of EMTs, EMS, Fire services. They spoke of the safety issues related to the increased semi-truck traffic on the local highways.

Respite and Palliative Care (3)
The Moosomin public cited this need and percieved there was a waiting list for respite care.

Addiction Counselors (3)
Comments reflected the need for addiction services. The Moosomin public spoke about the loss of the Jamieson Foundation addiction services (founded by a local dentist) and the need for something similar.

Other Services Cited

- Public Health (2)
- Chronic Disease Care (2)
- Chemo Program (1)
- Access to Services (1)

Other Interesting Comments (8)
The following were some other comments cited in the discussion:

- The need for better collaboration between the schools and health sector.
- The need to work more collaboratively between the facilities and practices within the areas.

  "Too much turf protection or war - e.g. Broadview sitting with a daily census at 2, and Moosomin is busting at the seams. There seems to be a real challenge to work together. Perhaps we can use the open areas for dementia care. Seems to be such a disconnect between each facility. There needs to be a more integrated approach."
- The need to use our resources smarter and work more closely with the services within the city, for example, a consultation with a specialist via telehealth.
- To respect that things may work differently in rural areas and that sometimes systems that work in the city do not work in rural areas.

SURVEY

Response Themes	First Response 110	Second Response 97	Third Response 80	Total 287	Comments
Physician Access	38	22	15	75 (26%)	Comments cited - physician shortages, over extended, wait times, availability to meet growing demands, 24 hour coverage, physician burnout
Hospital/Facility Bed Needs	25	22	14	61 (21%)	Comments cited - not enough beds, tying up LTC beds, acute/emergency beds, current capacity to meet future needs
Available Services to meet Demands	17	17	15	49 (17%)	Comments cited - too much demand from surrounding areas, need to travel to city for services, lack of services to meet current and future

					needs, need for walk-in clinic
Health Provider Recruitment	9	14	11	34 (12%)	Comments cited - staffing shortages, burnout, recruitment and retention of all healthcare providers
LTC/Nursing Home	7	10	7	24 (8%)	Comments cited - waiting lists for LTC, lack of adequate LTC and care home spaces
Tertiary/Specialty Care Services	6	5	4	15 (5%)	Comments cited - waiting lists for specialists, surgery, driving to city to access services
Homecare	4	3	5	12 (4%)	Comments cited - lack of adequate homecare coverage
Mental Health	3	1	3	7 (2.4%)	Comments cited - lack of community mental health support
Care for the Elderly	0	0	5	5 (1.7%)	Comments cited - adult daycare, seniors housing, meals on wheels
Other	8	6	5	19 (7%)	Comments cited - unstable situation in SCHR, rural communities not a priority, efficiency and administration issues, funding cut backs, wait times for dental care, lack of volunteer for EMS, cost of medications

Comparison

The big difference between the focus groups and the survey was that there was much more emphasis by survey respondents on the need for physician access, more hospital beds and the overall availability of services to meet the population growing needs. A healthcare provider group weighted the emphasis on the need for mental health issues. The focus group discussion on healthcare provider recruitment/retention and the needs for LTC beds was congruent with the survey findings.

QUESTION 7

Thinking about your community, what concerns do you have about the health services currently in your community and ability to meet the future health needs?

FOCUS GROUP

Many focus group participants found this question similar to question 6 and did not have any new comments to add. Due to this, this question was not asked in the survey.

The themes arising from the focus group discussions were:

- Access to services - (5)
- Long-term Care bed needs (4)
- Recruitment and expanded scope of healthcare provider practice - e.g. nurse practitioners, pharmacists (4)
- Physician access (2)

QUESTION 8
If you ruled the world…or had one wish for health services in your community what would it be: Today? In the future?

FOCUS GROUP

Most participants did not separate their comments from their wish today and in the future. Most stated their wish was the same. Therefore the themes categorized below reflect a combination of the present and the future.

Efficient Healthcare - New Model (12)
Many comments reflected the need to utilize the current resources more efficiently such as: community healthcare satellites in smaller communities with a doctor and nurse practitioner such as the one in Maryfield; better collaboration between physician practices and other care providers; better use of empty beds in some towns such as Redvers; appropriate use of emergency services; and, the ability of residents to access the right care provider without seeing the physician first. It should be noted that most of these comments came from the health provider groups.

LTC Services/Seniors Care (11)
Comments reflected the need for more level 1 and 2 care beds to keep residents within their own community, more beds and affordable spaces; and, generally the need for more LTC beds. Most of these comments were from the public focus groups.

> *"Our seniors could stay in the community when it comes time to move out of the home. They have earned the right to be as close to the family as possible."*

Healthcare Provider Recruitment (10)
Most comments reflected the need for more healthcare providers now and into the future and, the need to find creative ways to attract healthcare providers to rural communities such as return for service agreements. These comments were from both the public and healthcare provider groups.

Regional Hospital (8)
Comments reflected the need for a Regional centre to: better meet the growing demands for services; attract healthcare providers; do more minor surgeries; and, reduce the need to access services in the city. It should be noted most of the comments were from the public.

Increase in Physician Services (4)
Comments were related to the need for more physician time in rural communities to take the pressure of the SEICC, and the ability to create a more sustainable model for physician services inclusive of other staff to support the model.

Other Services Cited

- Homecare (2)
- Access to quality health services (2)
- Respite palliative care and supports (2)
- Full or expanded scope of practice for healthcare providers (2)
- Chronic Disease Care (2)
- Mental Health Counselors (1),
- Emergency care (1)

Other Interesting Comments (8)

The following represent some other thoughts arising from the focus groups:

- Support for the children's hospital in Saskatoon to relieve the pressure from the surrounding hospital.
- Alternate affordable housing for ordinary income residents.
- The focus on community health needs should come first.
- SCHR comments…
    - The need for transportation to health service in the future as more services are centralized in hubs and the increase in elderly residents.
    - The need for more collaborative solutions between communities, Health Regions and the Ministry rather than each trying to create their own solutions. There was the perception that many good solutions and ideas are generated but politics get in the way.
    - The need for increased communication and education with the communities to promote transparency and a collective understanding of the issues with joint ownership in solving the problems.
    - Continued collaboration with the healthcare provider unions for creative recruitment strategies.

SURVEY

If you ruled the world…or had one wish for health services in your community what would it be: Today? Future?

Response Themes 110	First Response	Comments
Hospital Expansion/ Regional Hospital	29 (26%)	Comments cited - more acute beds, bigger expanded hospital
Physician Services	29 (26%)	Comments cited - increased access to physician services, shorter waiting times
Access to Services/Expanded Local Services	15 (14%)	Comments cited - quicker availability of treatments, surgery options, more local diagnostics, better 911 service direction, cancer service, better use of telehealth
Healthcare Provider Recruitment/Retention	7 (6%)	Comments cited - retaining providers in rural areas, use of professionals to their full scope of practice
Walk-in Clinic	7 (6%)	Comment cited - having or bringing back the walk-in clinic
LTC Services/Care Home	7 (6%)	Comments cited - LTC and Care home beds closer to the communities, more LTC beds
Care for the Elderly	4 (3%)	Comments cited - more service and programs to enable independent living of seniors
Mental Health	2 (2%)	Comments cited - enhanced services

Homecare	2 (2%)	Comments cited - enhanced services
Other	9 (8%)	Comments cited - more services locally to prevent travel to the city, less union involvement, promote health and wellbeing of young children

If you ruled the world…or had one wish for health services in your community what would it be: Future?

Response Themes 106	Second Response	Comments
Hospital Expansion/ Regional Hospital	25 (23%)	Comments cited - most were related to an expanded or larger facility, Regional hospital
Access to Services/Expanded Local Services	25 (23%)	Comment cited - most comments were related to more acute beds, enhanced services like diagnostics, some surgical procedures, maternity, pharmacy
LTC Services/Care Home	15 (14%)	Comments cited - more LTC beds or care home services
Physician Access	11 (10%)	Comments cited - more doctors or increased access
Specialists/Surgical Procedures	9 (8%)	Comments cited - more local procedures like colonoscopies, orthopedics, enhanced OR time, traveling specialist
Healthcare Provider recruitment/retention	7 (6%)	Comment cited - generally more healthcare providers
Care for the Elderly	7 (6%)	Comments cited - enhanced services for the elderly, e.g. assisted living, housing with meals
Mental Health	2 (2%)	Comments cited - enhanced services
Homecare	2 (2%)	Comments cited -enhanced services
Walk-in Clinic	0	
Other	10 (9%)	Comment cited - that all partners would work together to meet community health goals, reduction of administrative costs, promotion of physical activity and good nutrition x 2

Comparison

The main themes of the focus groups are fairly congruent with the survey findings related to hospital expansion/Regional hospital, healthcare provider recruitment, LTC/care home spaces, and physician access.

The healthcare provider focus groups placed more emphasis on the more efficient use of existing healthcare resources and the need for different models for the delivery of health services.

There is a greater emphasis in the survey findings both today and in the future on the need for hospital expansion or a regional hospital, physician services, and general access to a variety of health services. Also, there was significantly more emphasis on physician services for today (29) than in the future (11), indicating this was a more urgent need for the survey respondents.

There appeared to be a greater emphasis in the future related to expanding the types of services provided locally to encompass more specialty items such as simple surgeries, expanded diagnostics and more visiting specialists.

There is an ongoing wish for more LTC spaces, care home facilities, services for seniors, mental health, homecare and some other health services.

QUESTION 9
Is there anything else you would like to tell us in relation to the health needs and services within your community?

FOCUS GROUP

Additional comments:

- *Moosomin - Preventative measures are still less costly in the long run.*
- *Rocanville - Following this assessment I hope a long-range model is determined, not just focusing on what is currently needed.*
- *Health Providers - We have a really good facility and system if we could use it to full capacity. In addition to physicians, we need to look at all providers to support quality health care.*
- *Wawota -We need to have collaborative conversations on how to recruit family practices to key towns/hubs rather than lone physicians which is not sustainable. We need a similar business model as Moosomin. Physicians need collective practices to support each other. They maybe practice in different communities with the support of nurse practitioner support, but they belong to a collective practice*.
- *Wawota - Another conversation should be focused on how to train more nurse practitioners in the area. If we could get a critical mass to get a cohort in the area, could SIAST help to support a new distributed learning model?*
- Physicians
    - *"Staffing is a critical issue. It does not make sense to increase beds if there is not sufficient staff to support. For example, the practice no longer takes on primigravidas for delivery as there is not the staffing capacity to watch the moms for 6 to 8 hours and the physicians cannot go back and forth from the clinic. At one time we had the privileges to do caesarian sections, however we could not keep up with the required competencies."*
    - *"The preferred model of care would be a hub and spoke model with a centre of excellence. This is not because we have more clients… we have enough work, but it is more because we know it is sustainable. We need to provide full care, both acute and chronic, or not at all…if you don't have a backup for after 4 PM then it will not work. They have primary health care centres or models in the UK where the money is transferred to the health physician team. The physician team is responsible for coordinating the care."*
    - *"The mine has added additional pressure. Even though they have their own health staff they only work during the day. Our practice gets all the afterhours work when they come to town and drink. There was no consultation with our practice and the potential impact prior to opening the mine."*
    - *"We have provided walk in status at our clinic which has reduced the emergency statistics (may not reflect the real picture). For example, we may see an extra 60 patients per day per walk in. This may save the system approximately $300, as it cost less to see them in the clinic than it does in emergency. If they were seen in emergency it would cost more plus the other healthcare provider wages per day as well. The cost savings may be diverted into the hub model."*

SURVEY

Final Comments (last words):

A few selected comments under each heading were selected from the survey to sum up some of the general sentiments expressed in the survey.

Response Themes 60	#	Comments
Thankful for the Current Services	13/21%	• *I am very happy with the services we have right now and thankful for the Moosomin doctors and their facilities.* • *We have an amazing group of doctors who provide top-notch service. My concern is that the area's population has exploded since the new health facility was built, and the population only continues to grow. Added to this is the fact that people who live outside our region come to this facility because they know they can receive care there that they cannot receive elsewhere.* • *We have had a good experience with the Moosomin Hospital (30 min. away). LOCAL - Lab., Xray service is good, Staff are great. We do not want to lose any of these LOCAL services.*
Seniors Issues	10/16%	• *It is totally unfair if seniors are sent to another area for long term care and hospital care which creates more problems for them as well as the family. If the Health District and government people would walk in the shoes of rural seniors who have had to be moved to other areas, I know changes would be made. We always hear that funding isn't available for such services, then charge a small annual fee to all residents to cover some of these expenses. We shouldn't become a society that expects everything for free.* • *We are tired of our elderly having to move 1 to 2 hours away for level 3 and level 4 care, as Moosomin is always full. We really need level 1 and 2 care here.* • *Smaller communities are losing services like senior day care. Not enough participation is the reason but the people that did use the service really miss it and would like to see it reinstated. Possibly now that they know it will be taken away, more people will take part.*
Expansion of Services to meet Changing Needs	9/10%	• *At this point our health care services meet our needs, but I worry as more and more patients turn to the Moosomin doctors we will experience a cutback in doctor services to our community.* • *We should be able to use our own ambulance, instead of having to wait for Moosomin, it's ridiculous that we have the facility and can't use it. It is fully equipped.* • *RQHR Regina should encourage a podiatrist to resume their clinic in the community. There are two under-utilized rooms in SEICC now. Access to Mental Health workers/sessions could be looked at. It appears that there is no need, by the appointments that are kept. Is that true? Or is it that there are not enough workers to meet the needs? I believe there*

		are too many in our communities that are falling between the cracks in this field.
Physician Services	7/11%	• *The DRS are in Moosomin, they just need the green light to be able to take the existing facilities to a higher level. There is no reason this can't be done. I have seen Dr. in Moosomin for almost 20 years, it is still almost an hour away. While I understand the shortage of doctors in the rural areas, an hour away still seems like a long way away...but is still better than 2 hours away. I feel Moosomin hospital needs to be able to accommodate as much as possible. I have seen many hospitals in this area closed down. Kipling being the latest. Where are ALL these people to go???* • *We need increased physicians to cover increased population and increased needs. We need increased LTC beds so that the people who have built our community and supported it can spend their last days here without having to go elsewhere for their care. Make Moosomin a Regional Hospital.*
Enhance Collaboration between Partners	5/8%	• *It is important to keep good communications. If services have to be cancelled, residents need to be provided viable options without having increased costs or travel.* • *Let people in the know make decisions - the original proposal for the Moosomin Hospital was watered down, reducing the number of beds - now, about 5 years later we are spending many more tax dollars doing studies, surveys etc., to ultimately bring the facility up to where it should have been initially.* • *It seems those in government don't listen to the ordinary person when they express their concerns about health needs.*
Healthcare Provider Recruitment and Retention	3/5%	• *I feel that our doctors and nurses are over-worked (ie. long shifts). When surrounding communities are closing their health care facilities, then they look to Moosomin for health care. Not only do we have an increasing population due to our economy and industry but also due to surrounding communities traveling to Moosomin for health care.* • *The health care workers are all working overtime with their limited resources that have not kept up with our increased population in Saskatchewan. We are taxing our good people that are working in the hospitals and nursing homes, etc. they need more help before they all burn out and/or quit.*
Mental Health	2/3%	• *There is a huge increase in mental health issues in our communities and surrounding communities, there is a major lack of support for these issues and therefore we are seeing an increase in outpatient departments and inpatient departments having to deal with these issues and therefore taking away from the acute problems and the lack of beds available and staffing is scary.*
Walk-in Clinic	2/3%	• *The walk in clinic used to be very good. Now you have to go to emergency during the day because there is no walk in clinic. I am sure this is more costly for the government. We*

		are very fortunate to have such good doctors in this rural area.
Need for Specialty Care	1/1%	• *Recently needed care for my mother who has a brain injury from a car accident . Have found that there is NO BRAIN INJURY area for rehab in S Sask. How can this be? Also that since there is not enough room at most hospitals, rehab centres or care homes.... people are left in "no-man's land for weeks, sometimes months, in one facility taking up space others need but can't access....also making the staff at the "stalled " facility less than useful as they are not setup for the needs of the people "backed up".*
Other	8/13%	• *I believe the community would benefit from education. Healthy living education. Advertising of health services available locally. The services we have are excellent, great doctors, wonderful nurses, and beautiful facilities - there just doesn't seem to be enough to service the population in our communities.* • *I find that the travel out of our local area in order to get medical services that could be provided if we had a larger facility some of this could be eliminated. This travel is very costly for individuals. It is very hard on the elderly who may require even more travel and are required to live on a fixed income. It is a huge expense to employers as well, whose employees have to take more time away from work to seek these services that could be provided locally. One thing that is of huge concern is the time it takes to get emergency services. How many lives in the past and in the future are going to be affected by a trip that now takes a couple of hours when it could be 20 minutes?* • *As of right now it is great to be on a first name base in the health care services whether it be in the hospital or ambulances. Small towns have way of doing these things.*

10. ANALYSIS AND RECOMMENDATIONS

INTRODUCTION

Outlined below are the broad based recommendations arising from the findings in the Needs Assessment. In each of the recommendations there is an overview of the issue, the final recommendations, suggested improvement targets, and the review of the best practices and enabling strategies that were applicable. The broad recommendations are outlined below:

I. Improve the utilization of the current beds in Moosomin, Whitewood and Broadview.
II. Enhance Primary Health Care Options within Moosomin and the Surrounding Area.
III. Enhance Accessible, Safe and Affordable Care Options for Seniors.
IV. Improve Health Provider Recruitment, Engagement and Retention.

I. IMPROVE THE UTILIZATION OF THE CURRENT BEDS IN MOOSOMIN, WHITEWOOD AND BROADVIEW

The Moosomin and surrounding area needs assessment was the result of a formal request made by the Moosomin Health Care Foundation to determine if the health needs of the Moosomin area are being met or if changes to facilities or services are needed for Moosomin and the surrounding area. These perceived concerns were found again in both the focus groups and survey findings. The review of care patterns and third party reports suggested that the utilization of both acute and long-term beds in the area was not optimal with many underutilized beds in the Broadview and Whitewood facilities. In addition, it is believed the bed pressures would be further alleviated with the achievement of stable physician practices in the Sun Country Health Region and an increase of PHC sites within the area. Currently Moosomin is at the threshold level for long-term care beds at the SEICC. The situation has been improving over the past 5 years with the introduction of the Alternate Level of Care Protocol (ALC Unit) and the Palliative Care Protocol, and the reduced length of stay in long-term care beds.

Recommendation: Improve the utilization of the current beds in Moosomin, Whitewood and Broadview.

i. ***Improve the utilization of the current beds in Moosomin, Whitewood and Broadview (along the number one highway) to alleviate the pressures through achieving an average length of stay at the SEICC in line with the CIHI standards, and the expanded use of the beds especially at Broadview Union Hospital (current occupancy of 23%). Re-examine the recommendations in the Bearing Point and Croft reports along with community stakeholders to generate creative solutions for better bed utilization which will be supported by the community, physicians and RQHR.***

ii. ***Engage in conversation with the community to create awareness and understanding of the current processes that are in place to support long-term care placement.***

iii. ***Continue to assess the long-term care wait times in Moosomin to determine if circumstances are changing. Monitor and benchmark the number of residents on the long-term care waiting lists, the wait time for residents to access long-term care within or near their home community, and the distances from home of where residents are being placed.***

iv. ***Continue to explore the expanded role of personal care homes for residents with higher needs which would allow residents to remain closer to home.***

v. ***Continue to implement the Alternate Level of Care Protocol (ALC Unit) and the Palliative Care Protocol to support residents in accessing care closer to home.***

Currently the RQHR is achieving and maintaining the following standards:

- 100% of patients will have access to the 1st available long-term care bed within 1.5 hours of driving distance from their home community.
- Sustain the ratio of long-term care beds at the Saskatchewan norm of 115 beds per 1,000 population age 75 and over.

Acute and LTC Bed Improvement Targets:

- By 2015, reduce the average length of stay of the acute beds of SEICC to the CIHI standard.
- By 2015, reduce the atypical average length of stay annually by 25% through the expanded use of the Alternate Level of Care Protocol (ALC Unit).

Rationale

i. Current Bed utilization in Moosomin, Whitewood and Broadview

A review of the current care patterns and utilization data of the facilities within Moosomin and surrounding area, especially in the facilities along the number one highway (Moosomin, Whitewood and Broadview), indicates that underutilized capacity exits. These findings were confirmed by the Bearing Point report completed in 2008 and the Croft report completed in July 2011.

In view of the above findings, there is no compelling evidence that an increase in acute care beds is the wisest solution to the pressures experienced in the Moosomin and surrounding area. In the other recommendations outlined below, there are many best practices to improve and enhance health care services within the Moosomin and surrounding areas without expansion of health facilities and an increase in the physical footprint of Moosomin. Acute bed pressures may also be reduced with a more stable physician practice model in Sun Country Health Region as articulated in Phase One of their Primary Health Care Plan. Collaboration between communities, the Regina Qu'Appelle Health Region, Sun Country Health Region and local physicians should focus on the other recommendation below that is: expanding Primary Health Care options; accessible affordable housing models for seniors; and improved recruitment, engagement and retention of healthcare providers.

ii. Long-term Care Options and Services Closer to Home

The community consultations revealed that many residents were concerned about the availability of long-term care beds within their communities as they perceive there are long waiting lists. In addition, the concern was raised regarding family members being placed in long-term care facilities that were a long distance (perceived unacceptable) away from the home community. It is important to truly appreciate the actual situation within the Moosomin and surrounding area and to compare that reality with best practices.

In the past five years the wait times for long-term care placement to the patient's home community have improved (from 12 months to 2 months) and the average length of stay for a patient in long-term care has decreased from 3 years to 1.5 years. Best practices like aging in place or at home with supportive home care supports, as outlined in recommendation III, may further reduce or alleviate the need for more long-term care beds. The implementation of initiatives like the Alternate Level of Care Protocol (ALC Unit) and the Palliative Care Protocol will assist to reduce the atypical length of stay (almost double the expected length of stay) which will further reduce demand on long-term care beds. The situation will need to be monitored closely to assess if efforts are improving the situation.

Over the recent years there has been much research and advances in the area of long-term care standards and options as the above challenges are not unique to Saskatchewan. It is important to explore emerging best practices and adapt them to the local setting. Outlined below are two examples of emerging best practices that may aide both RQHR and the

community in their thinking. The Ministry of Health is supportive of clients remaining in their homes as long as possible.

Long-term Care Improvement Guide 2010[55]

Developed by Planetree Inc. in partnership with Picker Institute, the Long-Term Care Improvement Guide was created in 2010 to propel long-term care communities in their improvement efforts. The Guide features more than 250 concrete strategies for actualizing a resident-directed, relationship-centered approach and demonstrates how culture change makes an impact on operational, clinical and financial outcomes.

Close to Home: A Strategy for Long-term Care and Community Supports 2012[56]

In August and September of 2010, the Government of Newfoundland and Labrador - Department of Health and Community Services held province-wide public consultations to obtain feedback on the discussion document titled, *Close to Home: A Strategy for Long-Term Care and Community Support Services*. This document contained the proposed vision, mission and guiding principles as well as the service delivery model that forms the foundation of the provincial long-term care and community support services strategy for the next 10 years (2022). A variety of themes and strategies are outlined in the report addressing: increased support for people to remain independent in their homes; increased residential options for people to remain in their homes; improved coordination and communication amongst service providers; enhanced role for personal care homes; and, less cost for those requiring care, to mention a few. Lessons learned from the implementation of these strategies may be adapted to enhance long-term care options and services for the people of the Moosomin and surrounding communities.

II. ENHANCE PRIMARY HEALTH CARE OPTIONS WITHIN THE MOOSOMIN AREA

Best practice supports the implementation and expansion of PHC services at the community level. By implementing this recommendation within Moosomin and surrounding area, it is believed that many of the current pressures experienced by the citizens and care providers may be alleviated in a sustainable way.

The community consultations revealed that the top healthcare concerns now and into the future were: access to a physician when needed; adequate acute and long-term care beds to meet demand; healthcare provider recruitment and retention; and the access to other health services. Demographic reports and care seeking patterns confirmed that there are growing pressures on the local physician practice and healthcare centres due to population increases and more patients from outside the Region using the services.

Primary health care is defined as the foundation of the health care system; it has often been described as the “everyday care” that a person needs to protect, maintain, or restore health. It is often the first point of contact people have with a health care provider when they have a health

[55] Long-term Care Improvement Guide 2010 http://www.residentcenteredcare.org/Pages/About%20the%20guide.html (Access April 18, 2013).
[56] Close to Home: A Strategy for Long-term Care and Community Supports 2012. Government of Newfoundland. http://www.health.gov.nl.ca/health/long_term_care/ltc_plan.pdf (Accessed April 17, 2013).

concern. It may be a family physician/nurse practitioner visit, advice from the pharmacist, or information on chronic disease management.[57]

Although the physician is the most familiar provider of primary health care, and is always a member of a team, there are many other providers that can work as part of the team to meet the specific needs of the community. Team composition will vary by community type and the availability and location of provider resources will drive the service delivery model for a particular community. Service delivery models also emerge as a result of local needs, innovation, and strong partnerships between communities, providers, and Regional Health Authorities. The following recommendations are congruent and supportive of the principles outlined in the PHC Framework for Saskatchewan.

Recommendation: Enhance the Primary Health Care Options within the Community and Surrounding Area.

i. ***Fully disclose the findings of the Moosomin and Area Needs Assessment with the community and the health providers to establish a shared understanding of the current situation and supporting research and to establish a strong foundation built on trust for moving forward.***

ii. ***Work with the communities to prioritize the findings arising from the Needs Assessment, identify the key gaps in health services and jointly agree on the strategies to pursue. Teams comprised of community members, health providers, physicians and administrators may be struck to address the specific health needs within the community and further develop the agreed upon strategies arising from this needs assessment to develop sustainable and lasting health services for the future.***

iii. ***Develop robust team based primary health care services for the Mooosomin, Whitewood and Broadview area. Work with local communities, physicians and health providers to identify opportunities to utilize teams of other healthcare practitioners to offset the current load on the Moosomin Family Practice Clinic and to extend the PHC services within the communities. Clarify roles, responsibilities and establish a commitment towards collaboration which may be documented in agreements.***

iv. ***Expand access to extended hour PHC services in Moosomin and surrounding communities to decrease the need for community members to rely on ER services to manage everyday health needs.***

v. ***Work with Sun Country Health Region to share the findings of their proposed PHC model with the impacted communities (Broadview and Moosomin) to create a better awareness and understanding of the model. Determine and pursue the best approach through collaborative discussions between RQHR and SCHR inclusive of community members, care providers and physicians.***

vi. ***Encourage communities to identify local candidates for training who may leverage the current financial supports and bursaries offered by Government of Saskatchewan for Nurse Practitioners, Emergency Medical Personnel.***

[57] PHC Framework, pg.29.

vii. ***Monitor the best practices and the lessons learned from the Innovation Primary Health Care sites recently implemented within Saskatchewan to adopt and adapt practices which may benefit Moosomin and surrounding area. Identify Moosomin and the surrounding communities as a future "identified site" for PHC innovation.***

viii. ***Improve the coordination and sharing of patient information across neighboring Regions and health service locations (especially RQHR and Sun Country) to enable clients to readily access their information to foster better self-care.***

ix. ***Enhance and extend the supports to clients to better manage their own care through an increased access to a PHC location with a variety of health professionals.***

x. ***Better leverage the clinical use of telehealth options to extend and support the health provider team, augment the services offered within the community, and to provide professional supports to clients who are self-managing their care.***

Primary Health Care Improvement Targets

If this strategy is successful, the following Primary Healthcare targets (Saskatchewan Health System Five-year Plan) should be achieved for Moosomin and the surrounding communities.

- By 2017, there will be a 50% improvement in the number of people who can say "I can access my PHC Team for care on my day of choice either in person, on the phone or via other technology".
- By 2017, all Saskatchewan residents who choose to be are connected to a PHC Team that includes or is linked to a family physician.
- By 2017, 100% of primary health care teams assume responsibility for the coordination and navigation of their patients' journeys.
- By 2017, 80% of patients are receiving care consistent with provincial standards for the 6 most common chronic diseases.
- By 2017, there will be a 50% improvement in health status by focusing on prevention and management of the 6 highest impact chronic diseases (Diabetes, CAD, COPD, Depression, Congestive Heart Failure, Asthma).
- By March 31, 2017, reduce by 50% individual readmissions (mental health inpatient and acute care units).
- By 2017, people living with chronic conditions will experience better health as indicated by a 30% decrease in hospital utilization related to common chronic conditions, (Diabetes, CAD, COPD, Depression, Congestive Heart Failure, Asthma).

Outlined below are six enabling strategies which coincide with the Primary Health Care Framework of Saskatchewan:

i. Work with the communities to prioritize health needs from the needs assessment and establish collaborative decision-making towards new approaches to address health needs.
   a. Enhance Relationships;
   b. Engage Communities in Service Model Design.
ii. Work with other neighboring communities on establishing PHC sites.
iii. Engage other health providers and teams to offset the load on physician practices and facilities.
iv. Learn, adopt and adapt best practices from the innovation sites.
v. Enhance self-care options.

vi. Utilize telehealth to augment PHC services.

ENABLING STRATEGIES

i. Work with the communities to prioritize health needs from the needs assessment and establish collaborative decision-making towards new approaches to address health needs.

Enhance Relationships

The Saskatchewan primary healthcare framework suggests two key building blocks are essential for the success of a sustainable PHC model: relationships and engaging communities in the service model design. These concepts have been reinforced by other successful primary health care initiatives. Wedel (2007), notes community assessment and shared planning was one of the four key enablers to the successful implementation of a new model of primary healthcare delivery in Taber, Alberta.[58] In Australia a successful hub and spoke model was implemented in rural areas with allied health professions as a result of a collaborative approach where stakeholders at the local level identified health priorities, mapped identified gaps in service delivery and provided the context as to how services should be provided (Battye and McTaggart, 2003).[59]

During the focus groups it became apparent that there was a general relationship amongst the stakeholders i.e., citizens, health providers and administration; however, it appeared this could be strengthened by improved ongoing communication. Stakeholders did not appear to know why certain decisions were being made regarding their health services or did not clearly understand the plans related to health care services within their area, for example, the decision to discontinue the delivery of babies for first time moms at the SEICC. Both the community and the health providers perceived they have not been fully apprised of all the facts and information, and have become skeptical of the decisions regarding their local healthcare services. The PHC Framework 2012 suggests a truly engaged relationship is based on partnership and ownership; the parties are actively 'at the table'; and are empowered to make a difference at their local level; these relationships are catalysts for future change. Relationships may change over time, but are consistent and enduring.

Engage Communities in Service Model Design

Successful community engagement produces health care decisions that reflect the needs, values, and culture of the community, and makes decision-making more accountable to the community (PHC Framework 2012). [60]

It became apparent in discussion with community stakeholders that they had formulated their own opinions and ideas on how to address the health service pressures within the community, such as increased beds; changing the status of the local health centre; and other options. In other cases, community stakeholders felt their ideas were not being listened to or their ideas

[58] Wedel, R. et al. Turning Vision into Reality: Successful Integration of Primary Healthcare in Taber, Canada http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2645121/ (accessed Mar. 5, 2013).
[59] Battye, K.M., McTaggert, K. (2003) The development of a model for sustainable delivery of outreach allied health services to remote north-west Queensland Australia. http://www.rrh.org.au/publishedarticles/article_print_194.pdf
[60] PHC Framework Report. http://www.health.gov.sk.ca/phc-framework-report (accessed Feb. 18, 2013).

were being dismissed, such as the physicians at the family practice clinic. There also was a sentiment that the partners were not working collaboratively or effectively together. The PHC Report 2012 states "once the specific needs of the community are clear, communities can work with healthcare providers and Regional Health Authorities to determine how best to meet those needs". This is a critical step in determining the composition of the team and the overall service delivery model.

The PHC Report 2012 also suggests, "While communities will share many common health care needs, their distinctive demographics, geographies and other characteristics call for a primary health care model based on engagement and input from community leaders, organizations, and residents. No primary health care team or service should be established without extensive direction and input from the community it serves. This engagement process can begin with awareness campaigns that educate and inform communities about the vision for primary health care."[61]

ii. Work with other neighboring communities on establishing PHC sites

The care seeking patterns demonstrated that up to forty percent (40%) of patients using the services of the SEICC for both inpatients and outpatients were from communities outside the RQHR boundaries. In the spring of 2010 three Health Regions - Sun Country , Regina Qu'Appelle and Five Hills agreed to work together to collectively develop a sustainable plan for the delivery of primary health care in their communities. In October of 2011, Sun Country Health Region (SCHR) completed a formal Primary Health Care Plan which recommended that phase one of the plan focus on the development of an integrated service delivery model for general practitioners in southeast Saskatchewan, mainly Sun Country, prior to developing primary healthcare sites with other Regions. Following an extensive literature research, Sun Country chose to pursue the Hub and Spoke model as the service delivery model for general practitioners research.. The SCHR Board-Approved hub and spoke options included two options linked to the RQHR: the North - linking Broadview and Kipling; and the Northeast linking Moosomin with Wawota and Maryfield. Work has begun on the development of a Broadview/Kipling team. In Phase Two, it was proposed additional caregivers would be considered and the Hub and Spoke model was expanded upon to include other service delivery options as part of an integrated service delivery model.

As the moderator of the focus groups, it was perceived that key stakeholders such as community members and physicians in the Moosomin and surrounding areas had not been formally briefed on the options and had not been fully engaged (at the time of the assessment) in the implementation plans related to the proposed options with the Sun Country Health Region. Their insights and buy-in will be critical to the success of the model. The Primary Health Care Plan states "High-functioning primary health care services are the result of successful collaboration between communities, family physicians and other healthcare providers, Regional Health Authorities and the Ministry of Health. If each of these partners understands, embraces, and successfully fulfils their role, the resulting services have the best possible chance of meeting the community's needs in a reliable, sustainable, predictable manner."

[61] PHC Framework (2012) pg.12.

iii. Engage other health providers and teams to offset the load on physician practices and facilities

In the focus group in Wawota/Maryfield, the participants spoke about how pleased they were with the services of their Nurse Practitioner. They further discussed the importance of enhancing the training of local healthcare providers to become Nurse Practitioners, Paramedics and Emergency Medical Technicians. The community expressed interest in taking a more proactive role, in collaboration with the Regional Health Authority, to identify and support local practitioners to fulfill these roles.

The physicians in Moosomin were cautious to refer clients to Nurse Practitioners unless they had confidence in the provider's skill and there was good communication between the respective practices. This had been achieved with the Nurse Practitioner in Wawota/Maryfield. It was important to the physicians that they be involved in the establishment of the PHC team in which they would be working to feel confident in their abilities. It was also a concern for the physicians that the PHC practices typically do not work extended hours, and therefore after hours clients would still be accessing the physician on call.

The PHC Framework 2012 suggests "the specific services delivered by primary health care teams will vary from community to community, but nearly all of the essential functions can be placed in one of the following categories: timely access to primary health care services; diagnosis, treatment, and prescription; case management; navigation and coordination; and prevention and management of chronic disease. The configuration of practitioners, providers and others who fulfill these roles will be based primarily on the locally defined needs of the community and the assets and resources already in place. However, all teams will include, or be connected to, family physicians."[62]

The Throne speech December 5, 2011 outlined new student loans and loan forgiveness options for physicians and nurse practitioners in rural areas and the addition of 20 more nurse practitioner seats.[63] This presents a huge opportunity for communities to identify local candidates to access these loans for training to enhance the PHC teams within their own communities.

Nova Scotia's Collaborative Emergency Centres (CECs) is an innovative way to improve access to both primary health care and emergency care. Nova Scotia has successfully implemented the CEC model in communities which have had difficulty maintaining 24-7 emergency services.[64] This model may be adapted to surrounding communities within the needs assessment area to offset the load on the SEICC and Moosomin Physician practice.

iv. Learn, adopt and adapt best practices from the Innovation PHC Sites

Advancing primary healthcare within the RQHR has been a priority within RQHR for some years. It is also a Saskatchewan Health Priority and one of the 2013 -2014 Priority Areas (Hoshin) with the goal to improve access and connectivity in primary health care innovation sites. Primary Health Care Innovation Sites models the approach "learn by doing". Lessons

[62] PHC Framework, pg.25.
[63] Loan Forgiveness For Nurses and Nurse Practitioners - http://www.aeei.gov.sk.ca/loan-forgiveness-nurses (accessed April 12, 2013)
[64] Nova Scotia Collaborative Emergency Care Centres. http://www.health.gov.sk.ca/nova-scotia-cecs,(accessed Feb. 18, 2013).

learned from testing these models will be shared across the province to help design other models that will work for their area.[65] One of the RQHR breakthrough strategies for 2013 - 2014 is the implementation of Rural West PHC model and a specific target to reduce the number of CTAS presentations at All Nations Healing Hospital by 30%. Successful practices from this innovation site should be adopted and adapted in Moosomin and surrounding communities.

v. Enhance self-care options

There has been a steady increase in outpatients seen at SEICC over the past 5 years. The large majority of these visits are by individuals who are triaged at CTAS categories 4 and 5.[66] Hospitalizations due to diabetes mellitus are typically higher among rural residents, which may be attributed to rural residents with diabetes not having adequate access and availability to health services and not seeing physicians as often as they should, which may increase the severity of the disease.[67] In addition, the hospitalization for Chronic Obstructive Pulmonary Disease was higher amongst rural RQHR residents than RQHR residents in Regina.[68] The discrete patient rate for mental health in rural RQHR increased from 2006/07 to 2010/11 where it has decreased for urban RQHR residents.[69] It is known that access to PHC care teams comprised of a mix of health professionals has reduced hospitalizations.

The PHC Framework states "equipped with information and the right supports and tools, patients and families can do a great deal to manage their own health. When patients and families are at the centre of care, the primary health care team becomes a resource for them, providing information, counsel, and clinical/medical assistance as needed. Patients should always come away from an appointment with a clear plan of action for managing, maintaining, and protecting their health".[70]

Discussion arising out of the focus groups eluded to the lack of supports for both chronic disease management and mental health conditions. Enhanced PHC options closer to the community of Moosomin and surrounding communities would facilitate more self-care and reduce emergency outpatient visits and hospitalizations. With the proper supports such as diagnostic services and labs closer to home with a varied team of health professionals such as nurse practitioners, dietitians, physiotherapists, mental health workers, and social workers supporting the physician team, more residents could benefit from self-care rather than hospitalization. "It is more than just having the services in place, community residents need to know how to access and navigate the services".[71]

Practitioners need an efficient system to readily share client information at different locations and points of care (across communities and Regions) so the client has the right information at the right time to manage their care. Conversations with SCHR representatives indicated that methods of sharing client information across locations were not systematic and streamlined.

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[65] Primary Health Care Innovative Sites - http://www.health.gov.sk.ca/phc-innovation-sites (accessed April 12, 2013).
[66] Canadian Triage and acuity Scale CTAS 5 Level Triage http://emlondon.ca/pdf/CanadianTriageandAcuityScaleCodesandDefinitions.pdf (accessed April 13, 2013).
[67] RQHR Rural Health Status Report 2011, pg.71.
[68] RQHR Rural Health Status Report 2011,pg.73.
[69] RQHR Rural Health Status Report 2011, pg.92.
[70] PHC Framework, 2012, pg.27.
[71] PHC Framework, pg.27.

This may be problematic for clients who frequently access services outside their home Region (approximately 30 -35% of outpatient clients at SEICC were from outside the Region).

vi. Utilize telehealth to augment PHC services

In the Bearing Point Report, Moosomin Union Hospital Physician Practice Review Regina Qu'Appelle Health Region September 2008, there were several key recommendations about extending the services in Moosomin by the use of telehealth.[72] Telehealth has been in Saskatchewan over 10 years and was first piloted in July 1999 to help address the need for improved healthcare services and enhanced practice support in rural and remote areas of the province. Currently there are over 100 telehealth sites in Saskatchewan connecting over 2,100 patients with healthcare providers and providing over 10,000 hours of education sessions.[73] RQHR has 12 telehealth sites with one located in the SEICC. Although the telehealth site is used at the SEICC, it is mostly used to support health provider education. The site could be further leveraged to support and extend health provider services to Moosomin and area clients.

III. ENHANCE ACCESSIBLE, SAFE, AND AFFORDABLE CARE OPTIONS FOR SENIORS

The number one trend noted in the survey and the second largest trend noted in the focus groups was the growing and aging population. There was lots of discussion in the focus groups around the need for affordable housing and care options for seniors in the rural communities. Many respondents commented on the need for creative care and housing options, inclusive of light care options and other service supports, that would enable seniors to stay in their homes longer

Not unlike other communities in Saskatchewan and Canada the senior population in the Moosomin and surrounding area is growing. The seniors are living longer with less chronic illness and disability than the generations before them, however we know many seniors will have difficulty with one or more of the activities of daily living from age 65 and on. Today 42% of people age 65 and over report at least one functional limitation. Conditions such as hearing and sight loss; hip-fractures; arthritis; obesity; and Alzheimer's disease are expected to jump precipitously and exponentially with the retirement of the baby boomers in concert with the growth of this population.[74] We also know seniors, in general, and those with complex issues and chronic illness in particular, will create increased care needs for the community and the RQRH. Many seniors desire to age in place, in their own home and remain active members of their community for as long as possible.[75] Moosomin, the surrounding communities and the RQHR will need to be creative in exploring options to meet the rising senior population needs.

Recommendation: Enhance Accessible, Safe and Affordable Care Options for Seniors.

i. Initiate dialogue in the Moosomin and surrounding communities to explore the best options to support seniors housing and aging in place. There may be an expanded role for the local foundations to assist with the development of a model adapted from best practices to optimally serve the community needs. Moosomin

[72] Bearing Point, 2008.
[72] Telehealth. http://www.health.gov.sk.ca/hisc-telehealth (accessed April 12, 2013)
[73] RQHR SEICC, Broadview Hospital, Woseley Hospital Annual Summary April 1, 2011 - March 31, 2012.
[74] NORC Public Policy. www.norcs.org/page.aspx?id=160634 (accessed April 5, 2013).
[75] Focus on the Future: Long-term Care Initiative- by Laura Ross, 2010.

and the surrounding areas have a strong commitment towards their community where community members have demonstrated the ability to work together towards a common goal, such as the capital fundraising campaign for the SEICC. This energy and drive may leverage funds to create aging in place options for the local residents.

ii. Support the community to explore options for the development of personal care homes to enhance the aging in place options.

iii. Continue to work with the Moosomin and surrounding communities and the RQHR to enhance homecare and other community supports especially in the rural areas. Explore and generate a broader array of residential models to help individuals receive the appropriate level of services in the most appropriate and fiscally sustainable setting.

iv. Incorporate the findings and practices of The Five-Year Strategic Framework - Towards a Vision of Seniors Living Fall Free Lives into the recommendations for seniors aging in place and all care options for seniors within Moosomin and the surrounding communities to reduce the incidence of injuries and subsequent hospitalizations for seniors.

Options for Seniors Improvement Targets:

- By 2017, seniors will have access to supports that will allow them to age within their own home and progress into other care options as their needs change.
- By 2017, reduce the number of patient days of seniors occupying acute care beds awaiting community service supports, i.e., home care, by 50% by March 31, 2017.

Three enabling strategies with best practices and resulting recommendations are outlined below to address the rising senior population:

i. Aging in place options
ii. Increased home care supports
iii. Keep seniors safe

i. Enhance "Aging in Place options for Seniors"

The Patient First Review, completed October 2009, made the following recommendations regarding Seniors care:

For equitable care, the Ministry of Health Seniors Care Strategy should focus on strengthening:

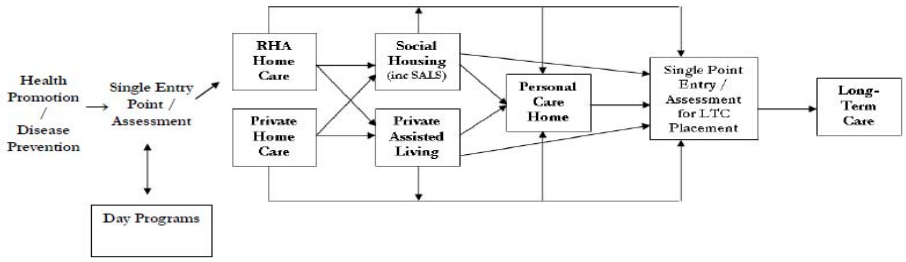
- system capacity to support independent living;
- accessibility of personal care homes by addressing the current financial barriers for low-income seniors;
- accessibility and quality of assisted living and long-term care;
- programming for seniors with extraordinary behaviours that cannot be safely managed in the general long-term care population; and,
- capacity of geriatric assessment programs to provide multidisciplinary assessments, short-term rehabilitation, day programs and a specialized outpatient clinic.

The following statements, regarding helping seniors to remain independent for as long as possible, were made in the 2012-13 Saskatchewan Health budget announcement

- Seniors will get the support they need in the community through stronger primary health care teams and home care services;
- Redesigning primary health care teams will help address the chronic and complex health care needs of seniors;
- Examine the care continuum (home care, housing, personal care homes, long term care) to identify the gaps and opportunities for further investments, including technologies like Tele-homecare and enhanced community and home-based supports;
- A new Personal Care Home Benefit will provide senior citizens with financial assistance to help them with the cost of living in a personal care home. A monthly supplement will be provided to seniors who have little or no income and who live in a licensed personal care home (benefit program administered by the Ministry of Social Services, to be launched July 2012).[76]

The term aging in place means to remain at home in familiar intergenerational neighborhoods while maintaining independence, activities and social lives. The goal of aging in place is to enable seniors to live safely and comfortably in their own homes or primary residence (Home Instead, 2011). Studies have shown that people retain greater independence and control over their lives while living in their own home, with the necessary supports such as family/friends.[77] The model below outlines the continuum of care for seniors housing and care. [78]

Saskatchewan Continuum of Care - Considerations in Developing a Seniors Strategy



Supportive housing and health service options for seniors in Saskatchewan span across a continuum of care, such as personal care homes, special care homes, home care, social housing and assisted living services. Appendix K outlines the supportive housing and services available for seniors in Saskatchewan.

Although there appears to be many options available, they may not be aligned nor appropriate to meet the needs of the seniors within Moosomin and area communities. According to a long-term care initiative conducted by Ross (April 2010), the majority of seniors in special-care homes represent a small portion (5%) of the senior population in Saskatchewan and the majority of Saskatchewan seniors desire to age in place, and remain in their own homes within

[76] Health System Transformation - Media Background, Budget 2012 - 13. http://www.finance.gov.sk.ca/Budget2012-13/HealthBackgrounder.pdf (accessed Apr. 13, 2013).
[77] Home Instead Inc. (2011). Housing Options for Seniors. (accessed April 13, 2013).
[78] Saskatchewan Continuum of Care - Considerations in Developing a Seniors Strategy http://www.skseniorsmechanism.ca/uploads/SSM%20Annual%20Conference%20-%20May%202011.pdf (Access April 13, 2013).

their own community. This indicates a great need for independent living supports or supportive housing options. Supportive housing helps seniors in their daily living by combining a physical environment that is specifically designed to be safe, secure, enabling and home-like with support services such as meals, housekeeping and social and recreational activities (Canada Mortgage and Housing Corporation 2000).[79] This allows residents to maximize their independence, privacy, dignity and decision-making abilities.

Supportive housing can be developed in many forms depending on the types and level of services to be provided, the project size desired, the types of accommodation preferred, the types of tenure wanted and the types of sponsorship available. A literature review conducted by the Aging in Place: A Saskatchewan Perspective March 2013, revealed two interesting models for consideration.: the Naturally Occurring Retirement Community - Supportive Services Program (NORC-SSP), and the Village model, the Campus-affiliated communities model, as well as programs that have a mix of supportive housing, home care and other services. Both these models have had success in communities throughout North America and may be adapted to Moosomin and surrounding areas (see Appendix L).

The Housing Strategy for Saskatchewan 2011 - 2019

On August 8, 2011 the Government of Saskatchewan released *A Strong Foundation - The Housing Strategy for Saskatchewan 2011-19* and the *2011-12 Provincial Action Plan*, which outlines government's key activities for the strategy's first year of implementation. This precedent-setting strategy involves the entire housing sector and promotes a housing environment where all Saskatchewan people have access to homes that enhance their well-being, build local communities and contribute to a growing province.[80] Innovative ideas for housing options for the Moosomin and surrounding areas may arise from the findings of this strategy.

ii. Enhance Homecare Supports

The Long-term Care Initiative 2010, authored by Laura Ross following consultation with 450 seniors in 12 Regional Health Authorities, identified the following recommendations related to homecare supports:

- There are inadequate levels of homemaking and home maintenance services available through the homecare program. Therefore, provide Regional Health Authorities with targeted funding for home supports to bring Saskatchewan in line with the national average.
- Home care clients consistently do not have a consistent provider - Healthcare workers and decision-makers should ensure they are patient and family centred in all aspects of their work.[81]

In 2012-13, the Saskatchewan Ministry of Health provided funding of approximately $140.4M, including an estimated $6.6M from homecare fees, and $2.8M to support the surgical initiative in

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[79] Canadian Mortgage and Housing Corporation (2000). Supportive Housing for Seniors. Fact Sheet. Research Highlights. Issue 56.

[80] http://www.socialservices.gov.sk.ca/housing-strategy (Accessed April 18, 2013).

[81] Focus on the Future: Long-term Care Initiative by Laura Ross, http://www.health.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=f26c9ea4-f96a-4c25-a7bc-4b13d447cea9&MediaID=5370&Filename=focus-on-future-ltc-initiative-2010.pdf&l=English (Accessed April 13, 2013)

two ways: 1) to provide funding to health regions for additional homecare services to individuals post-surgery, and 2) to establish best practice service levels for inpatient surgical specialities that require home care support (March, 2012). According to the Ministry (March 2012), planned spending for 2012-13 is $135.6M and $4.8M for grants and targeted programs.

In March 2013, the Saskatchewan government announced additional funding for seniors in the amount of an additional $3.1 million to be invested in seniors care, including funding for a Home First/Quick Response Home Care two-year pilot in Regina Qu'Appelle Health Region, allowing additional clients to receive intensive homecare supports. The investment also provides for expansion of the Alzheimer Society's First Link program and establishment of six dementia advisory networks, recognizing that 18,000 Saskatchewan individuals are affected by Alzheimer's disease or a related dementia. As well, there is operating funding for 24 additional beds at Pineview Terrace Lodge in Prince Albert (Saskatchewan Ministry of Health, March, 2013).

iii. Keep Seniors Safe

Research shows that one in three people aged 65 years and over will fall each year, and that half of these individuals will fall more than once. This increases to one in two for those aged 80 and older. Falls can be prevented and staying mobile and independent are important parts of healthy aging. Hip fractures in seniors, 90 percent of which are caused by falls, have significant associated morbidity and mortality. The RQHR Health Status Report states "there was a higher proportion of elderly individuals in rural RQHR communities which increases the risk of falls and other accidents and accounted for 43.3% of all external cause of injury hospitalizations".[82]

The Five-Year Strategic Framework (2010 - 2015) - Towards a Vision of Seniors Living Fall Free Lives has been developed by Safe Saskatchewan in an integrated and coordinated effort to reduce the impact of falls on seniors and on seniors lives. The objective of the strategic framework is to reduce the rate of fall-related injuries that result in hospitalizations by 10 percent in the 65 plus age group by December 31, 2015.[83] The framework, as well as the associated strategies, will provide guidance to the Regional Health Authorities, care providers and communities on how to keep seniors safe.

IV. IMPROVE HEALTH PROVIDER RECRUITMENT, ENGAGEMENT AND RETENTION

Having a workforce with the right number of providers with the right skills and abilities available is the key to delivering quality services within a community. The focus group and survey findings indicated concerns regarding physician and healthcare provider burnout and discontent. Physician access was the greatest current health concern in both the focus groups and survey (question 3). Healthcare recruitment and staffing issues was the third highest current health concern in both the focus groups and the fourth highest in the survey.

The review of SEICC employee recruitment and retention patterns indicated SEICC had experienced very high rates of staff turnover in the past 5 years. The employee engagement

[82] RQHR Rural Health Status Report, January 2013
[83] The Five-Year Strategic Framework (2010 - 2015) - Towards a Vision of Seniors Living Fall Free Lives - http://www.safesask.com/images/file/SFIPS_Framework%20_Revised%20May-2010_(1).pdf (accessed April 20, 2013)

scores were lower than the Saskatchewan and RQHR average in many areas, suggesting lots of room for improvement.

The Moosomin Family Practice Clinic has been a stable practice within Moosomin for almost 20 years. It currently has seven physicians. The practice is the envy of many other communities within Saskatchewan who struggle to secure just one physician for a year at a time. The residents of Moosomin and the surrounding area are highly appreciative of their physicians, however they are concerned with the increased clinic wait times and apparent strain on the physicians in the past few years. The physicians, during their focus group, alluded to the physician burnout and the lack of physician engagement toward solutions to alleviate the rising pressures.

Recommendation: Improve health provider recruitment, engagement and retention.

i. The RQHR should continue to work with healthcare providers within the Moosomin and surrounding areas to enhance engagement, health provider retention and the development of collaborative care models as outlined in the engagement survey findings. Success in this area is foundational to the success of the other recommendations.

ii. Engage in dialogue with the Moosomin Family Practice Clinic to truly understand and appreciate their concerns and to participate in joint problem solving efforts related to the findings and recommendations outlined in this report.

Recruitment and Retention Improvement Targets:

- By March 2017, increase staff and physician engagement scores to 80%.

Saskatchewan's Heath Human Resource Plan developed in 2011 provides a common vision and broad policy guidelines to inform the health human resources strategies, policies, programs and priorities of government, health regions, the Saskatchewan Cancer Agency, educational institutes, and other health organizations.[84] It has numerous strategies which may support the RQHR in the above recommendations.

11. CONCLUSION

The Town of Moosomin and the surrounding area is a thriving community in the south eastern part of Saskatchewan. The area has been the envy of many other communities as they have enjoyed a stable physician practice for 20 years and a new integrated health facility since 2009. With the recent growth in population and industry, the communities have become concerned

[84] Saskatchewan's Heath Human Resource Plan December 2011. http://www.health.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=5c66f3a8-899f-4d35-9456-72b5487caa4c&MediaID=5579&Filename=sask-health-human-resources-plan.pdf&l=English (accessed April 20, 2013).

about the increasing demand for services on the local physician practice and the availability of both acute and long-term beds.

In order for the communities to continue to enjoy sustainable health services a strong primary health care model will need to be established as the foundation for healthcare. A high performing primary health care system for Moosomin and the surrounding area will not happen overnight and will need the commitment and collaboration of all the stakeholders. There is no "ultimate model" but rather a model designed to address the unique needs of the community and to be flexible and responsive to the changes within the communities. The Saskatchewan demographics will continue to shift over time expanding and contracting in relations to economic forces. A robust primary health care framework is the best solution to provide a strong foundation for responsive health services and at the same time support physicians and healthcare providers to practice at their full scope of practice within a collaborative team environment.

Most importantly, ongoing transparent dialogue between the community, care providers and the Regional Health Authority is essential to maintain a common understanding of the local health needs to collaboratively build practical and effective solutions that can be supported by all.

12. REFERENCES

Battye, K.M., McTaggert, K. (2003). The Development of A Model For Sustainable Delivery of Outreach Allied Health Services to Remote North-West Queensland Australia. http://www.rrh.org.au/publishedarticles/article_print_194.pdf

Bearing Point Management Consultants. Moosomin Union Hospital Physician Practice Review Regina Qu'Appelle Health Region. Current state assessment, interview finding and Data Analysis. August 5, 2008.

Bedney, B.J., Goldberg, R. B., & Josephson, K. (2010). Aging in place in Naturally Occurring Retirement Communities: Transforming aging through Supportive Service Programs. Journal of Housing for the Elderly. December 2010.

Bookman, A. (2008). Innovative models of Aging in Place, Transforming our communities for an aging population. Community Work & Family, 11:4, 419-438.

Canadian Association of Emergency Physicians. Canadian Triage and Acuity Scale CTAS 5 Level Triage. http://caep.ca/resources/ctas (accessed April 15, 2013).

Canada. Government of Manitoba. Manitoba Health Population Report - June 1, 2011. http://www.gov.mb.ca/health/population/3/assiniboine.pdf (accessed Feb. 22, 2013).

Canada. Government of Newfoundland. Close to Home: A Strategy for Long-term Care and Community Supports 2012. http://www.health.gov.nl.ca/health/long_term_care/ltc_plan.pdf (accessed April 17, 2013).

Canada. Government of Ontario. Ontario Seniors Strategy Jan. 2013. http://www.health.gov.on.ca/en/common/ministry/publications/reports/seniors_strategy/docs/seniors strategy.pdf (accessed April 5, 2013).

Canada. Ministry of Health, Government of Saskatchewan. Facilities Designation Regulations. Chapter R-8.2 Reg 6 (effective December 16, 2005) as amended by Saskatchewan Regulations 22/2009 and 30/2011. http://www.qp.gov.sk.ca/documents/English/Regulations/Regulations/R8-2R6.pdf (accessed Mar.3, 2013)

Canada. Ministry of Health, Government of Saskatchewan. Focus on the Future: Long-term Care Initiative- A Report to the Honorable Don McMorris, Minister of Health, Prepared by Laura Ross, MLA Legislative Secretary to the Ministry of Health Long-term Care Initiative 2010. http://www.health.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=f26c9ea4-f96a-4c25-a7bc-4b13d447cea9&MediaID=5370&Filename=focus-on-future-ltc-initiative-2010.pdf&l=English (accessed April 13, 2013).

Canada. Ministry of Health, Government of Saskatchewan. Health System Transformation - Media Background, Budget 2012 - 13. http://www.finance.gov.sk.ca/Budget2012-13/HealthBackgrounder.pdf (accessed Apr. 13, 2013).

Canada. Ministry of Health, Government of Saskatchewan. Innovative Sites. http://www.health.gov.sk.ca/phc-innovation-sites (accessed Feb. 25, 2013).

Canada. Ministry of Health, Government of Saskatchewan. Loan Forgiveness For Nurses and Nurse Practitioners. http://www.aeei.gov.sk.ca/loan-forgiveness-nurses (accessed April 12, 2013).

Canada. Ministry of Health, Government of Saskatchewan. Moosomin Family Practice Electronic Medical Record, compiled April 18, 2013.

Canada. Ministry of Health, Government of Saskatchewan. Nova Scotia Collaborative Emergency Care Centres. http://www.health.gov.sk.ca/nova-scotia-cecs (accessed Feb. 18, 2013).

Canada. Ministry of Health, Government of Saskatchewan. Patient Centre Community Designed Team Delivered: A framework for achieving a high performing primary health care system in Saskatchewan. Saskatchewan Ministry of Health 2012. http://www.health.gov.sk.ca/phc-framework-report (accessed Feb. 18, 2013).

Canada. Ministry of Health, Government of Saskatchewan. Primary Health Care Innovative Sites. http://www.health.gov.sk.ca/phc-innovation-sites (accessed April 12, 2013).

Canada. Ministry of Health, Government of Saskatchewan. Physician billings. Compiled by Bhooman Bodani, Medical Services Branch. April 18, 2013.

Canada. Ministry of Health, Government of Saskatchewan. Saskatchewan's Heath Human Resource Plan December 2011. http://www.health.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=5c66f3a8-899f-4d35-9456-72b5487caa4c&MediaID=5579&Filename=sask-health-human-resources-plan.pdf&l=English (accessed April 20, 2013).

Canada. Ministry of Health, Government of Saskatchewan. Saskatchewan International Physician Practice Assessment (SIPPA) information sheet. http://www.health.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=3522cc85-549f-4622-9c57-1e48e501c19b&MediaID=6094&Filename=physician-sippa-info-sheet-may-2012.pdf&l=English. (accessed Feb.25, 2013).

Canada. Ministry of Health, Government of Saskatchewan. Telehealth. http://www.health.gov.sk.ca/hisc-telehealth (accessed April 12, 2013).

Canada. Ministry of Social Services, Government of Saskatchewan. Housing Strategy. http://www.socialservices.gov.sk.ca/housing-strategy (accessed April 18, 2013).

Canada. Ministry of Social Services, Government of Saskatchewan. Personal Care Home Benefit Application Guide. http://www.socialservices.gov.sk.ca/pchb-app-guide.pdf (accessed April 17, 2013).

Canada. Ministry of Social Services, Government of Saskatchewan. Seniors Programs and Services. http://www.socialservices.gov.sk.ca/seniors (accessed April 17, 2013).

Canada. Ministry of Social Services, Government of Saskatchewan. The Seniors Income Plan. http://www.socialservices.gov.sk.ca/SIP-factsheet.pdf (accessed April 15, 2013).

Canadian Mortgage and Housing Corporation (2000). Supportive Housing for Seniors. *Fact Sheet*. Research Highlights. Issue 56.

Croft Planning and Design. 2011 -2025 RQHR Rural and LTC Master Plan, July 4, 2011.

Elliot, Doug, QED Information Systems Inc. Sask Trends Monitor, Recent Demographic and Labour Market Trends in Saskatchewan and East Central Saskatchewan, December 2012.

Elliot and Associates 2005. Guidelines for conducting a Focus Group. http://assessment.aas.duke.edu/documents/How_to_Conduct_a_Focus_Group.pdf (accessed Nov. 3, 2012).

Fiessel, W., Kulyk, M., Peel, B., Pfeifer, S., Robert, J., Statler, K. Aging in Place: A Saskatchewan Perspective. Saskatchewan Institute of Health Leadership (SIHL) Group Project. March 31, 2013.

Grimes, Kellly., Swettenham, Julie. 2012. Compass for Transformation: Barriers and Facilitators to Physician Engagement. Metrics@Work Inc.

Home Instead Inc. (2011). Housing Options for Seniors. (accessed April 13, 2013).

Infoquest Technologies Inc. Sun Country Primary Health Care Plan: Phase One (Practitioners), October 24, 2011.

NORCs an Aging in Place Initiative. NORC Public Policy. www.norcs.org/page.aspx?id=160634 (accessed April 5, 2013).

Pask, Oliver J., Human Resource Superintendent Potash Corporation, Rocanville Division. Email to Holly Hodgson RQHR, April 30, 2013.

Public Health Agency of Canada. What Determines Health, http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php#What (accessed Jan. 11, 2013).

Planetree Project Team. Long-term Care Improvement Guide 2010 . http://www.residentcenteredcare.org/Pages/About%20the%20guide.html (accessed April 18, 2013).

Rourke, J. Increasing the number of rural physicians. CMAJ 2008; 178:3

Saskatchewan. Regina Qu'Appelle Health Region. Broadview Union Hospital Alternate Level of Care (ALC) Unit Service Guidelines.

Saskatchewan. Regina Qu'Appelle Health Region. RQHR Rural Health Status Report 2011. January 2013.

Saskatchewan. Regina Qu'Appelle Health Region. RQHR Employee Survey 2011, Snapshot Report Moosomin Union Hospital, December, 2011.

Safesask. The Five-Year Strategic Framework (2010 - 2015) - Towards a Vision of Seniors Living Fall Free Lives. http://www.safesask.com/images/file/SFIPS_Framework%20_Revised%20May-_ 2010_(1).pdf (accessed April 20, 2013).

Saskatchewan Seniors Mechanism. Saskatchewan Continuum of Care - Considerations in Developing a_ Seniors Strategy. http://www.skseniorsmechanism.ca/uploads/SSM%20Annual%20Conference%20-%20May%202011.pdf (accessed April 13, 2013).

Torfaen County Borough Council (TCBC). March 2006. Stakeholder Engagement - A Tool Kit. Working Towards more effective and sustainable Brownfield Revitalization Polices. http://www.revit-nweurope.org/selfguidingtrail/27_Stakeholder_engagement_a_toolkit-2.pdf (accessed Jan.23, 2013)

Wedel, R. et al. Turning Vision into Reality: Successful Integration of Primary Healthcare in Taber, Canada. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2645121/ (accessed Mar. 5, 2013).

Van der Merwe, H. Schalk, on behalf of the Moosomin Physician Group 2009. Proposal for 24/7 On-site Physician Coverage at South East Integrated Care Centre Moosomin, Emergency Room.

Zahid, Abbas. 2013. Moosomin and Area Covered Population. Email April 10, 2013.

13. APPENDICES

Appendix A : Moosomin and Area Facilities Profile

The facilities profile was compiled from the RQHR Rural 2012-21013 Acute and LTC Statistics and the 2011-2025 RQHR Rural and LTC Master Capital Plan, Croft Design and Planning, July 4, 2011.

Facility	Core Services	Catchment[85]
Broadview and District Centennial Lodge - 1982	• 34 LTC beds • 1 short stay	Broadview RM Elcapo RM Kingsley Kahkewistahaw First Nation Cowessess First Nation
Broadview Union Hospital - 1992	• Community Hospital Designation • 2 Physicians • 14 Acute beds • 2 ALC beds • Outpatient/Ambulatory Care Services, Laboratory Services, Emergency Services, Inpatient Services, and a Native Liaison Worker	Broadview RM Elcapo RM Kingsley Kahkewistahaw First Nation Cowessess First Nation
Southeast Integrated Care Centre - 2008	• Community Hospital Designation • 7 physicians • 27 Acute beds • 55 LTC beds • 3 short stay/palliative/respite • Outpatient Services, Emergency Services, Diagnostic and Laboratory Services, Mental Health Services, Physiotherapy Services, Home Care and Public Health	Moosomin Rocanville Fleming Welwyn Wapella RM Moosomin RM Rocanville RM Martin
Whitewood Community Care Center - 1985	• 28 LTC • 2 short stay • Physician Services and Outpatient/Ambulatory Care Services	Whitewood Percival RM Silverwood RM Willowdale Ochapawace First Nation
Wawota Memorial Health Centre	• Physician Clinics, • Public Health Clinic, • Diabetes Program , Dietitian Services, Emergency Medical Services (EMS), • Mental Health Services, Occupational Therapy, Palliative Care, Speech-Language Pathology • Telehealth • Volunteer Services	

[85] 2011-2025 RQHR Rural and LTC Master Capital Plan, Croft Design and Planning, July 4, 2011

Deerview Lodge Wawota	• 29 LTC • 3 Respite or Palliative beds	Maryfield Wawota Kipling Manor Langbank
Kipling Memorial Health Centre	• Community Hospital Designation (has been closed periodically) • 2 Physicians • Volunteer Services, Rehabilitation Services, Palliative Care • Mental Health Services, Home Care • Dietitian Services, Diabetes Program	Kipling Arcola Wawota Carlyle Stoughton Fillmore
Redvers	• Acute beds/emergency closed for the last few years • Lab is open • Long-term care beds	Redvers Carlyle Maryfield Bellegarde
Elkhorn Manor, Elkhorn[86]	• 24 Personal Care Home Beds or LTC beds, Community Bath Program • Itinerant Physician Clinic Services • Regional Palliative Care Program Regional Occupational and Physiotherapy Services, Regional Dietitian Services • Meals on Wheels, Public Health Services • Mental Health Services, Home Care Services	

[86] Elkhorn Manor, Manitoba. http://www.assiniboine-rha.ca/index.php/health_sites/view?id=21 (accessed Mar.4, 2013)

Appendix B: SEICC 5 year Service Utilization Statistics

Figure 1: In Patient Registration at SEICC

South East Integrated

In Patient Registration at SEICC

Health Region	2012/13		2011/12		2010/11		2009/10		2008/09	
	Total 2012/13	% 2012/13	Total 2011/12	% 2011/12	Total 2010/11	% 2010/11	Total 2009/10	% 2009/10	Total 2008/09	% 2008/09
Sun Country	492	28.94	431	28.66	392	27.07	328	23.33	292	21.97
Regina Qu'Appelle	934	54.94	802	53.32	790	54.56	837	59.53	769	57.86
Sunrise	29	1.71	32	2.13	28	1.93	37	2.63	19	1.43
Saskatoon	6	0.35	3	0.20	2	0.14	3	0.21	2	0.15
Prince Albert	2	0.12	1	0.07	2	0.14	1	0.07	0	0.00
Five Hills	2	0.12	1	0.07	0	0.00	0	0.00	1	0.08
Heartland	0	0.00	0	0.00	1	0.07	0	0.00	0	0.00
Cypress	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Kelsey Trail	0	0.00	0	0.00	3	0.21	0	0.00	0	0.00
Prairie North	1	0.06	2	0.13	0	0.00	0	0.00	0	0.00
Keewatin Yatthe	1	0.06	0	0.00	0	0.00	0	0.00	0	0.00
Out of Province/Country	233	13.71	232	15.43	230	15.88	200	14.22	246	18.51
Total	1700		1504		1448		1406		1329	
% Change over prior year	13%		3.87%		2.99%		5.79%			

Figure 2: Outpatient Registrations

Out Patient Registration at SEICC

Health Region	2012/13		2011/12		2010/11		2009/10		2008/09	
	Total 2012/13	% 2012/13	Total 2011/12	% 2011/12	Total 2010/11	% 2010/11	Total 2009/10	% 2009/10	Total 2008/09	% 2008/09
Sun Country	4142	34.44	3198	16.80	2661	15.03	2305	12.96	1589	10.
Regina Qu'Appelle	13708	114.00	12003	63.06	11369	64.22	12019	67.58	10550	71.
Sunrise	498	4.14	537	2.82	528	2.98	448	2.52	331	2.
Saskatoon	131	1.09	86	0.45	66	0.37	59	0.33	37	0.
Prince Albert	23	0.19	15	0.08	14	0.08	15	0.08	8	0.
Five Hills	36	0.30	16	0.08	21	0.12	19	0.11	26	0.
Heartland	14	0.12	3	0.02	1	0.01	6	0.03	1	0.
Cypress	9	0.07	8	0.04	9	0.05	12	0.07	3	0.
Kelsey Trail	24	0.20	19	0.10	14	0.08	2	0.01	2	0.
Prairie North	11	0.09	14	0.07	13	0.07	1	0.01	5	0.
Keewatin Yatthe	4	0.03	1	0.01	1	0.01	3	0.02	3	0.
Out of Province/Country	3627	30.16	3135	16.47	3006	16.98	2897	16.29	2254	15.
Total	22227		19035		17703		17786		14809	

Note: Out patient registration includes ER, OP, Lab, X-ray

% Change over prior year	16.80%	7.50%	-0.47%	20%

Appendix C: 5 year Physician Patterns of Care in the Moosomin and Surrounding Communities

2011-12

Physician Location	Patient Residence	# of Communities	# of Services	Discrete Patients
Moosomin	Moosomin	1	29,244	2,857
	OTHER	233	14,415	3,385
	Rocanville	1	10,474	1,167
	Whitewood	1	7,769	920
	Wawota	1	7,456	824
	Redvers	1	5,219	781
	Wapella	1	3,913	455
	Maryfield	1	3,281	424
	Welwyn	1	1,871	193
	Kennedy	1	1,094	157
Total		**242**	**84,736**	**11,163**

2010-11

Physician Location	Patient Residence	# of Communities	# of Services	Discrete Patients
Moosomin	Moosomin	1	28,935	2,790
	OTHER	204	14,060	3,214
	Rocanville	1	10,911	1,174
	Wawota	1	7,553	838
	Whitewood	1	7,619	886
	Redvers	1	4,487	811
	Wapella	1	4,026	462
	Maryfield	1	3,582	445
	Welwyn	1	1,978	207
	Fairlight	1	909	104
Total		**213**	**84,060**	**10,931**

2009-10

Physician Location	Patient Residence	# of Communities	# of Services	Discrete Patients
Moosomin	Moosomin	1	26,204	2,248
	OTHER	245	13,555	3,242
	Rocanville	1	9,121	892
	Wawota	1	5,302	502
	Whitewood	1	5,238	617
	Wapella	1	3,433	339
	RM Moosomin	1	3,243	303
	Maryfield	1	2,757	316
	RM Rocanville	1	2,699	295
	RM Walpole	1	2,205	257
	Redvers	1	2,110	524
	RM Martin	1	2,025	221
	RM Maryfield	1	2,106	242
	RM Silverwood	1	1,967	277
	RM Wawken	1	1,706	200
	RM Willowdale	1	1,232	149
	Welwyn	1	1,087	122
Total		**261**	**85,990**	**10,746**

2008-09

Physician Location	Patient Residence	# Of Communities	# of Services	Discrete Patients
Moosomin	Moosomin	1	26,805	2,197
	OTHER	219	10,376	2,456
	Rocanville	1	9,108	895
	Wawota	1	5,570	511
	RM Moosomin	1	3,597	333
	Whitewood	1	3,144	467
	Maryfield	1	3,059	288
	RM Rocanville	1	3,110	317
	Wapella	1	2,956	329
	RM Martin	1	2,297	223
	RM Walpole	1	2,051	235
	RM Maryfield	1	2,051	230
	RM Wawken	1	1,766	196
	RM Silverwood	1	1,703	242
	Welwyn	1	1,310	113
Total		**233**	**78,903**	**9,032**

1. Data Source: The Pattern of Care grouped by the physicians Residence produced from the Physicians billing data
2. The 'OTHER' row is the sum of all communities which represent less than 1 percent of the practice.

Appendix D : Regina Qu'Appelle Health Region - Employee Engagement Survey 2011

The RQHR conducted an employee engagement survey through the Saskatchewan Associations of Health Organizations (SAHO) using the TalentMap Employee Engagement Index in the spring of 2011. The survey start date was May 16, 2011 and end date June 30, 2011. A snapshot report was prepared for the Moosomin Union Hospital (SEICC) in December 2011.[87] The sample size was 39 of 206 staff (at the time), representing a 19% response rate. Currently there are 260 staff employed at SEICC. The current overall turnover rate for all positions is 50% and of permanent positions 17%.

Rating Scale Used:

- **% Favourable:** Represents the respondents who chose "Very Satisfied/Satisfied or Strongly Agree/ Agree.
- **% Unfavourable:** represents the respondents who chose "Very Dissatisfied/Dissatisfied" or "Strongly Disagree/Disagree".
- **% Neutral**: represents the respondents who chose "Neither Agree nor Disagree" or "Neutral".

Generally a % Favourable of 70 or above is considered good. A % Favourable in the 60s is acceptable and a % Favourable lower than 60 would indicate the need to investigate further.

Overview of Findings

The overall engagement scores were 56% favourable, which were lower than the overall RQHR 64 of (-8) and provincial score of 63 favourable. It is troublesome to know 72% of the respondents are thinking of accepting a job with another employer. Overall job satisfaction was 59% which was lower than the overall RQHR of 62% and other Health Regions of 63%.

Below are the overall scores for the 12 sub-engagement categories. Each category had additional indices, however for the purposes of this report, only the overall categories were cited which represents the broad sentiments of staff perceptions.

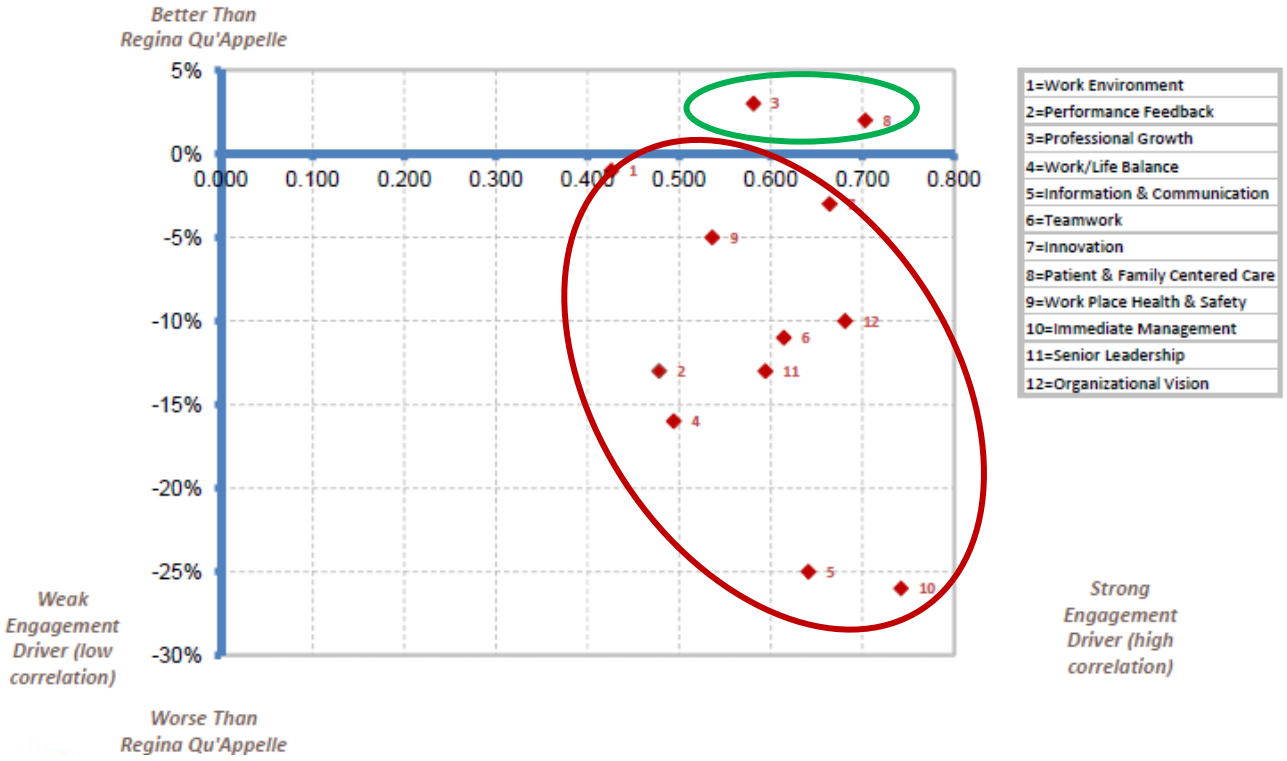
1. **Work Environment** - The overall score of (**72% favourable**) was lower than the overall RQHR 73 of (-1) and provincial score of 74 favourable.
2. **Performance Feedback** - The overall score of (**39% favourable**) was lower than the overall RQHR 52 of (-13) and provincial score of 52 favourable.
3. **Professional Growth** - The overall score of (**67% favourable**) was higher than the overall RQHR 64 of (+3) and provincial score of 64 favourable.
4. **Work Life Balance** - The overall score of (**36% favourable**) was lower than the overall RQHR 52 of (-16) and provincial score of 45 favourable.
5. **Information and Communication** - The overall score of (**20% favourable**) was lower than the overall RQHR 45 of (-25) and provincial score of 52 favourable.
6. **Team Work** - The overall score of (**49% favourable**) was lower than the overall RQHR 60 of (-11) and provincial score of 61 favourable.
7. **Innovation** - The overall score of (**59% favourable**) was lower than the overall RQHR 62 of (-3) and provincial score of 62 favourable.
8. **Patient and Family Centred Care** - The overall score of (**66% favourable**) was higher than the overall RQHR 64 of (+2) and provincial score of 65 favourable.
9. **Workplace Health and Safety** - The overall score of (**71% favourable**) was lower than the overall RQHR 76 of (-5) and provincial score of 77 favourable.

[87] RQHR Employee Survey 2011, Snapshot Report Moosomin Union Hospital, December, 2011.

10. **Immediate Management** - The overall score of (**32% favourable**) was lower than the overall RQHR 58 of (-26) and provincial score of 59 favourable.
11. **Senior Leadership** - The overall score of (**32% favourable**) was lower than the overall RQHR 45 of (-13) and provincial score of 44 favourable.
12. **Overall Vision** - The overall score of (**31% favourable**) was lower than the overall RQHR 41 of (-10) and provincial score of 42 favourable.

Based on the recommendations of TalentMap:[88]

- only two areas had more favourable findings than the scores for RQHR and other Saskatchewan Health Regions - Professional Growth and Patient and Family Centred Care;
- only two areas - Work Environment and Work Place Health and Safety, fell into the good range of 70% or greater;
- only two areas - Professional Growth and Patient and Family Centred Care fell into the acceptable range of 60%, requiring further follow-up
- all remaining areas fell below 60%, or within the unacceptable range.



[88] http://www.talentmap.com/ (accessed Feb. 23, 2013)

Appendix E: Regina Qu'Appelle Health Region - Enhancing Physician Engagement Survey 2012

In 2012 RQHR performed a physician engagement survey with the aim to provide a compass for health organizations on how to best move forward with engaging physicians. It gathered evidence from multiple sources, using a variety of approaches, on what constitutes the barriers and facilitators to physician engagement at the system, organizational and individual levels. The following insights were extrapolated from the Compass for Transformation: Barriers and Facilitators to Physician Engagement.[89]

Barriers and facilitators to physician engagement were identified through three different approaches:

- An overview of findings from a literature search on physician engagement;
- A qualitative study using telephone interviews of system, organization, and local work environment effects to identify the factors that drive, or hinder, physician engagement; and,
- A series of quantitative analyses employing physician engagement survey data to answer the questions: how engaged are physicians; are there differences in physician engagement based on physician demographics; and what health care variables are predictive of physician engagement?

The findings of this paper strongly suggested the following priorities for RQHR:

- **Foster trust and respect** - This is considered to be the strongest organizational / work environment factor affecting engagement. All leaders in the organization have a role in fostering these factors within the culture and building relationships based on this.
- **Show leadership, quite literally** - The leadership needs to be seen, visible and engaged in the conversations again, and again. It will not work if leadership is viewed as a "one hit wonder". Generally individuals need to hear a message regarding change over seven times and in a variety of ways.
- **Involve physicians** - Ask for physician opinions and input, and make it easy for them to become involved in non-clinical activities by calling meetings at appropriate times, freeing up physicians' time for non-clinical work, recognizing, compensating and/or rewarding them for their involvement.
- **Pay attention to local work environments or microclimates within an organization** - As engagement is experienced at the local environment, it is important to be aware of the local culture and to review the leadership, work environment and process at the local levels. It will be important to pay attention to areas where the scores were low.
- **Zero In** - It was suggested to go deep, not wide. This paper's findings suggest that broad-based physician interventions across a health care organization, such as general physician training events, are unlikely to succeed given the high variation among physicians. Instead, more focused interventions aimed at affecting the root causes of disengagement for that particular group of physicians are much more likely to have positive effects.

[89] Grimes, Kellly., Swettenham, Julie. 2012. Compass for Transformation: Barriers and Facilitators to Physician Engagement. Metrics@Work Inc.

- **Take it one step at a time** - The papers suggest taking a sequential approach focusing on one or two drivers of engagement at a time rather than all drivers at once. Improvement in one or two areas may cause a positive ripple effect. Identifying a "vital few" rather than trying to affect every driver is a better use of scarce resources. The evidence presented in this paper suggested the following drivers might be the most important for improving physician engagement in health organizations:
  - senior administration;
  - involvement in decisions; and,
  - relationships with department/section chiefs.

  It also suggests that these drivers are the most vital for improving engagement to the practice:
  - recognition and reward; and
  - physician cohesion and support.

A proposed framework for the RQHR suggested the following actions were needed:

1. **Collaborative Leadership** - Attracting physicians to leadership roles is a central element of health reform. Physicians should be involved in improving physician engagement and the health system.
2. **Addressing Mental Models** - Administrators and physicians are socialized differently to be effective in their roles. Each has formed certain mindsets about the other. New mindsets need to be developed around positive collaborative models. Both physicians and administrators can do this by respectfully challenging and discussing when mental models assert themselves. Practices or techniques to improve engagement must emerge from a shared attitude of "no blame" and an acceptance that the system is what it is and reform will stem from a shared understanding.
3. **Change Environment Conditions** - Environmental conditions whether structural, political or cultural need to be assessed and changed to be more empowering. Create a "change team" for engagement that involves physicians from the beginning in shaping the initiative. Review what effective practices were used in other jurisdictions and assess their alignment with RQHR's values. Also measure engagement on an ongoing basis and develop action plans to improve it.[90]

[90] Dickson, Graham., 2012. Anchoring Physician Engagement in Vision and Values: Principles and Framework.

Appendix F: Primary Health Care - Saskatchewan's New Framework for Primary Health Care (PHC)

The health system hoshin for 2013/2014 is: Strengthen patient-centered PHC by improving connectivity, access and chronic disease management. The new Framework for Primary Health Care outlines key steps to achieve improved PHC for the province.[91] These steps should be considered in the development of a sustainable solution to address the health needs for Moosomin and surrounding area.

- **Relationships as a Foundation** at all stakeholder levels, are the foundation of effective primary health care, both at the patient/provider level and at the community level.
- **Increase Patient and Family Self-Reliance** and, equipped with information and the right supports and tools, patients and families can do a great deal to manage their own health.
- **Engage Communities in the Service Model Design** by involving them in meaningful ways**.** Anything developed for the community must begin by involving the community and goes well beyond merely making information available to community members, or gathering opinions and attitudes from them. It entails the active exchange of information, viewpoints, and expectations.
- **Engage First Nations Communities and Métis Communities** to build a system that provides the best possible care, access and patient and family experience.
- **Enable Primary Health Care Teams to Flourish**:
  - Enable teams to redesign their practices and measure their results in achieving primary health care's major aims.
  - Enable teams to measure their success in achieving quality of life and job satisfaction for team members.
  - Clarify roles through agreements that delineate each team member's role and limitations (legislated or non-legislated) and enable team members to work collaboratively at the top of their scope.
  - Ensure there are mechanisms in place to help the team engage with the community.
  - Ensure funding is flexible and encourages team-based care that meets the needs of patients, families and the community.
- **Be Proactive in Preventing and Managing Chronic Disease** by coordinating efforts with population health programs and other intersectoral partners to prevent, reduce and manage chronic disease by focusing on modifiable risk factors and social determinants of health to develop a healthier Saskatchewan population.
- **Engage in Building Models that Work** by incorporating the perspectives of patients and families into the design and delivery of primary health care services and establishing a formal patient/family advisory role, and by ensuring all partners in the system.
- **Clarify the Roles of Communities, Regional Health Authorities and the Ministry of Health.**
- **Develop Policy and Accountability** to reflect a shift to health promotion, chronic disease management, team development, and innovative programming that reflects patient and family-centred care.
- **Support through the Transition** including listening to patients, community and providers to identify changes required to meet the aim, collective problem solving, tools and other supports.

[91] PHC Framework Report. http://www.health.gov.sk.ca/phc-framework-report (accessed February 18, 2013)

Appendix G: Findings of the 2011 -2025 Rural and LTC Master Capital Plan - Croft Planning and Design[92]

Croft Planning and Design developed a report to provide a Rural, Restorative and Long Term Care Master Capital Plan to assist the Regina Qu'Appelle Health Region (RQHR) with future facility strategic decisions. Facilities within RQHR were assessed to determine changes affecting 2025-30 demographics, Facility Functional Assessment, Facility Physical Assessment and Staffing Demographics. They were measured and scored to assist in creating a prioritized screening process to determine facilities that have significant issues of safety, need and sustainability. The following standards were used to guide the facility assessment:

Acute Care Demand Standards

- This was measured through a number of drivers including the population served (catchment); age sex adjusted range of services and acuity of the care provided. *A range of between 2 and 3 beds/1,000 exists throughout Canada as a benchmark.* Saskatchewan has approximately 2.25 beds per 1,000 population. As the older age demographic 55 -75 represents the primary user of acute care, diagnostic services and chronic disease services, changes in this age group may greatly influence the need for acute care beds.
- Saskatchewan: 2.25 beds / 1000 (note that includes the 5 tertiary care hospitals in Saskatoon and Regina). As a guide a 10 bed hospital should be considered as a minimum to offer a full range of community based in-patient services.

Long Term Care Demand Standards

- This is measured through a number of drivers including the populations served (catchment); total LTC beds available in RQHR; and the distance traveled to access this service. All these pose key concerns. It is important to note that over the past 15 years the province has moved from an average length of stay of 3 years towards 1.5 years. This has resulted in a doubling of the beds available for LTC at the same time as we are seeing dramatic shifts in the populations served.
- No provincial target has been set by the Department of Health however *historically a target for rural communities is 115 beds per 1,000 population over the age of 75 will be measured*. Regina, with a wider array of services for the older adult population may consider following targets closer to other larger urban communities in Saskatchewan and use lower targets of less than 105 beds/1,000 population over age 75. The Ministry of Health requires a minimum of 30 residents on a sustainable basis over the next 20-25 years as a minimum number to provide LTC services to provide beds as close to home as possible over the next 25 years.

Other Factors

Home Care and other Community based programs are also affected by the demand presented by the population served. Each of these service areas is a measured component within the population and provides a background to measure the sustainability of each health service, their space and staff requirements and the change required to correspond to the increase or decrease in the services provided. Based on the above standards, Croft Planning and Design created an assessment score and assessed the facilities using the following scale:

[92] Croft Planning and Design: 2011 - 2015 RQHR Rural and LTC Master Capital Plan, July 4. 2011

> 20% Change	5-20 % Change	0-5% Change
Urgent	***Required***	***Sustainable***
Shift resulting in under/over utilized services over the next 15 years	Increase/decrease not detrimental to the sustainability of the facility but still requires attention	Demand for the next 15 years

Broadview & District Centennial Lodge - urgent

- Built in 1982, the Broadview & District Centennial Lodge (Broadview Facility) offers long term care services. It is located in the town of Broadview which is 152 km east of Regina on the Trans-Canada Highway. The facility operates 33 LTC beds.
- Significant concern exists with the number of beds provided in Broadview; currently the number of beds exceeds the RQHR by over 200%. Further decreases are forecasted as the catchment area of the Broadview facility will see a modest decrease in its population for 75 years and older. The current 211 beds/1000 will increase to 220 beds /1000 people age over 75.
- Urgent attention is needed for this facility in order to provide a sustainable level of services over the next 15 years. With only 33 beds provided and a future bed need dropping below 20 beds, consideration needs to be given to investigate integration with the acute care site. The facility does not link with the Broadview Hospital – this further increases the cost per resident. The current bed demand does not support the 33 beds provided – consideration to examine opportunities to link these services onto the existing hospital and make functional improvements to meet minimum standards for resident care, should be considered. Renovation or replacement with a new addition onto the Broadview Hospital should be considered to address both operational and facility performance.

Broadview Union Hospital - changes required

- Built in 1992, the Broadview Union Hospital (Broadview Hospital) is a 1782m^2 facility that offers community based acute care services. The Broadview Hospital is located in the town of Broadview which is 152 km east of Regina on the Trans-Canada Highway. The facility operates 14 Acute Care Beds, 2 ALC Beds, Outpatient/Ambulatory Care Services, Laboratory Services, Emergency Services, Inpatient Services, and includes a Native Liaison Worker. The Broadview Hospital demographic catchment includes: Broadview, RM Elcapo, RM Kingsley, Kahkewistahaw First Nation, Cowessess First Nation.
- The catchment area of Broadview Hospital will experience a 9% decrease in its population over 75 in the next 15 years. The catchment currently operates 5.45 beds per 1000 population and with the trending decrease in population they are projected to operate at 6.02 beds per 1000 population. Rural acute beds and acute services require careful consideration to determine needs and creative ways to meet the needs of the population served. It was noted that this facility also regularly serves patients from the Sakimay and Ochapowace First Nations that were not included in Broadview's catchment.
- Changes to the Broadview Hospital should consider the future delivery of continuing care services for residents in the Broadview area. Although the Broadview Hospital is considered to be in a sustainable state, increasingly over time the cost per patient day is increasing. To downsize capacity and improve patient care consideration may be given to converting semi private rooms to private rooms as the demand for beds continues to decrease. Overall, the facility operates efficiently with only minor functional changes required in the lab and x-ray areas.

Whitewood Community Health Centre - changes required

- Built in 1985, the Whitewood Community Health Centre (Whitewood Facility) offers both acute care and long term care services. It is located in the town of Whitewood which is 176km east of Regina on the Trans-Canada Highway. The facility operates 28 LTC Beds, 2 Short Stay Beds, Physician Services and Outpatient/Ambulatory Care Services.
- The Whitewood facility's catchment area will experience a substantial decrease in its 75+ population over the next 15 years (30%). The catchment currently operates 123 beds/1000 population over age 75 but that amount will shift to 175 beds/1000 as the population over age 75 decreases, and, as a result the facility will become over bedded.
- The facility itself is in relatively good shape as indicated by the VFA score, however, the functionality of the building is an issue which needs to be addressed. Changing demographic trends for the Whitewood facility will also play a large part in the future of service delivery for this facility as a 30% decrease in the 75+ population will reduce the demand for services. A key concern will require a strategy to address the excess beds at the facility. Further investigation is needed to determine maintaining staff and the HR requirements over the next 15 years.

Southeast Integrated Care Centre - sustainable

- Built in 2008, the Southeast Integrated Care Centre (Moosomin Facility) offers both acute care and long term care services. It is located in the town of Moosomin 223 km east of Regina on the Trans-Canada Highway. The facility operates 27 acute care beds, 55 LTC beds as well as 3 used for palliative and respite care; Outpatient services, Emergency Services, Diagnostic and Laboratory Services, Mental Health Services, Physiotherapy Services, Home Care and Public Health.
- The Moosomin facility's LTC demographic includes: Moosomin, Rocanville, Fleming, Wapella, RM Moosomin, RM Rocanville, RM Martin. The catchment area of the Moosomin Facility will see a minor increase in its population aged 75 years and older over the next 15 years. The catchment currently operates 100 LTC beds for 1000.
- The Moosomin facility supports the needs of residents, patients and staff. The needs of these groups were well planned with well-designed and highly functional space as a clear result of careful consideration of all who are cared for and who work in the facility. The entire facility is well thought out and work flows efficiently. The ability to meet the acute care needs of out of province and out of country patients that utilize the facility is a concern as the area continues to see an increase driven by the growing oil, gas and mining operations in the area. Patients from RQHR, as well as out of province patients, skew the demographic calculations and thus the acute bed/1000 calculation is higher than their actual experience – approximately 25% of patients utilizing the facility are not residents of RQHR. There is an ongoing need for recruitment to meet the high staff turnover (498 postings over 5 years for 206 staff).

Appendix H: Sun Country Primary Health Care Plan: Phase One (Practitioners), October 24, 2011[93]

In the spring of 2010 three Health Regions - Sun Country, Regina Qu'Appelle and Five Hills agreed to work together to collectively develop a sustainable plan for the delivery of primary health care in their communities. It became apparent that each Region was at a different stage in the development of their model, therefore it was agreed that phase one of the plan would be developed independently by each Region. Phase One of the Primary Health Care Plan for Sun Country focused on the development of an integrated service delivery model for general practitioners in southeast Saskatchewan.

Study Objectives

The over-arching objectives of Phase One of the Primary Health Care Plan were, as follows:

1. Estimate and project the current and future requirements for General Practitioners in southeast Saskatchewan over the next 20 years.
2. Recommend a model for organizing the delivery of general practitioner services throughout southeast Saskatchewan.
3. Identify the optimum distribution of general practitioners throughout southeast Saskatchewan, based on the recommended model, both current and future.

Following an extensive literature review, Sun Country Health Region (SCHR) chose to focus on the Hub and Spoke alternative based on their demographic and current/future needs. The Hub and Spoke model was expanded upon to include sub-spokes, as a means to extend the reach of the hub and primary spoke communities, in terms of drive access and in building the necessary underlying population as part of critical mass considerations. In Phase Two, when additional caregivers are considered, the Hub and Spoke model can be expanded upon to include other service delivery options as part of an integrated service delivery model. As well, as technology continues to improve, telehealth and telemedicine may become increasingly more viable in addressing the health care delivery needs of more remote communities and individuals.

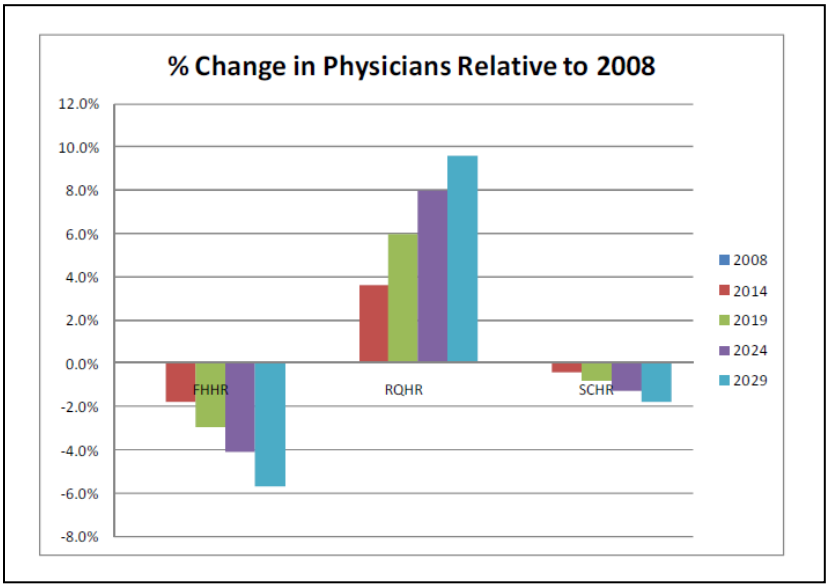
The current and future physician requirements were calculated for each of the three participating Health Regions, since some hub-spoke scenarios relied on communities in multiple Health Regions. For reference purposes, the graph on the next page illustrates the percent change in general practice requirements between Fiscal Year 2008/09 and Fiscal Year 2029/30 for each of the three Regions. The graph below shows Regina Qu'Appelle was increasing, while Five Hills and SCHR were decreasing due to the types of communities comprising each of the Regions.[94]

The development of the Hub and Spoke plan for southeast Saskatchewan, and applied to SCHR, needed to consider all of the SCHR communities and those that are adjacent in the Five Hills and Regina Qu'Appelle Health Regions. This approach allowed communities to be included across all three Health Regions, and in calculating the service populations for each option in which a drive time area crossed a Health Region border. As a result, the total population included in the various approved options will amount to more than the SCHR population alone.

[93] Infoquest Technologies Inc., Sun Country Primary Health Care Plan: Phase One (Practitioners), October 24, 2011

[94] Sun Country Primary Health Care Plan: Phase One (Practitioners), October 24, 2011, pg. 12.

Percentage Change in Physicians - FY 2008/2009 to FY 2029/30 by Health Region



Summary of Hub-Spoke Communities

The chart below summarizes each of the SCHR Board-Approved hub and spoke options, and the communities that fulfill the hub and spoke roles.

Area	Hub	Spokes and Sub-Spokes
Central	Weyburn	Radville and Bengough/Pangman
North	Broadview/Kipling	
Northeast	Moosimin	Wawota/Maryfield
Southeast	Estevan	Oxbow andCarnduff
Central East	Arcola/Carlyle	Redvers/Lampman/Stoughton
Southwest	Assiniboia	Rockglen/Coronach

Summary of Populations and Physicians by Approved Hub-Spoke Option

The chart below summarizes the populations and physician requirements for each hub and spoke option at the time of the study, October 2011.

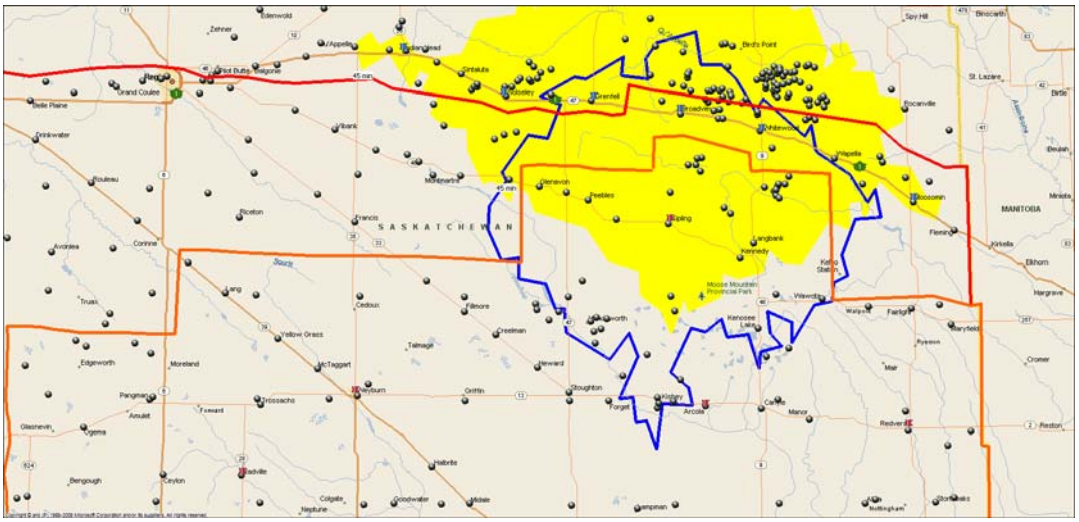
	Estimated and Projected Population*					Estimated and Projected General Practitioners				
Area	FY 2008	FY 2014	FY 2019	FY 2024	FY 2029	FY 2008	FY 2014	FY 2019	FY 2024	FY 2029
Central	17,319	17,298	17,278	17,229	17,084	15	15	16	16	16
North	8,542	8,671	8,794	8,930	9,037	6	6	6	6	6
Northeast	9,594	9,216	8,873	8,512	8,091	9	9	8	8	8
Southeast	21,629	21,428	21,202	20,916	20,528	17	17	17	17	17
Central East	12,212	11,901	11,629	11,316	10,931	9	9	9	8	8
Southwest	7,995	7,364	6,890	6,451	5,986	6	6	5	5	5
Total	**77,291**	**75,878**	**74,666**	**73,354**	**71,657**	**62**	**62**	**61**	**60**	**60**

** Includes populations in Southeast Saskatchewan - Sun Country, Five Hills and Regina Qu'Appelle Health Regions*

Approved Options Related to Moosomin and Area

The two diagrams below outline the SCHR Board approved options that impacted the Moosomin Needs assessment area; North - Broadview and Kipling and Northeast - Moosomin, Wawota, Maryfield.

i. SCHR Approved - North Kipling and Broadview



	Location	Colour
Hub	Broadview/Kipling	Yellow/Blue
Spoke		
Sub-Spoke		

Notes:
Hub cities include a 45 min. Drive. All other drives are 30 minutes.

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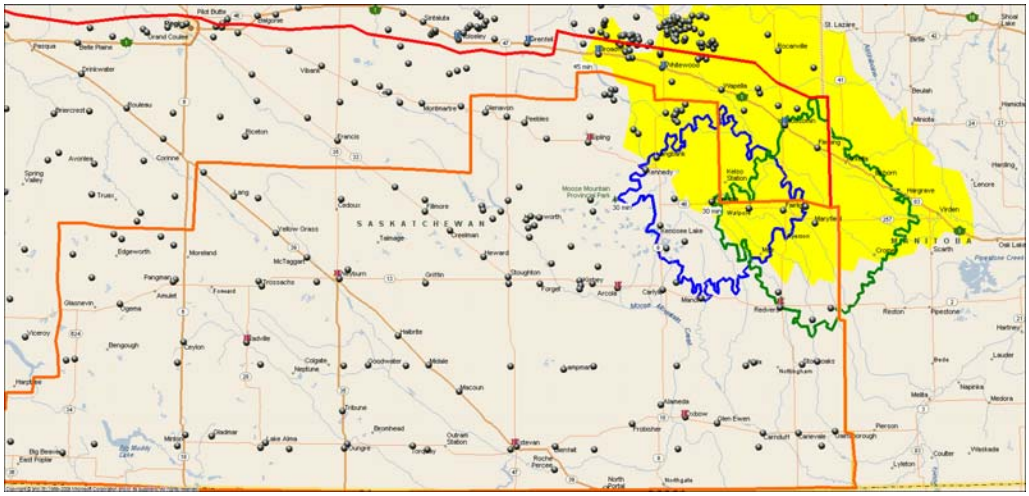
February 23, 2011

ii. SCHR Approved – North Kipling and Broadview

		Estimated and Projected Population					Estimated and Projected Family Practitioners				
Name	**Hub-Spoke**	**FY 2008**	**FY 2014**	**FY 2019**	**FY 2024**	**FY 2029**	**FY 2008**	**FY 2014**	**FY 2019**	**FY 2024**	**FY 2029**
North	**Broadview45**	4,578	4,870	5,141	5,438	5,721	3	3	3	3	3
North	**Kipling45**	3,964	3,801	3,652	3,492	3,316	3	3	3	3	3
North	**Total**	**8,542**	**8,671**	**8,794**	**8,930**	**9,037**	**6**	**6**	**6**	**6**	**6**

ii. SCHR Approved: Northeast Moosomin, Wawota, Maryfield



	Location	Colour
Hub	Moosomin	Yellow
Spoke	Wawota/ Maryfield	Blue/ Green
Sub-Spoke		

Notes:
Hub cities include a 45 min. Drive. All other drives are 30 minutes.

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January 18, 2011

		Estimated and Projected Population					Estimated and Projected Family Practitioners				
Name	**Hub-Spoke**	**FY 2008**	**FY 2014**	**FY 2019**	**FY 2024**	**FY 2029**	**FY 2008**	**FY 2014**	**FY 2019**	**FY 2024**	**FY 2029**
Northeast	**Maryfield30**	1,433	1,373	1,319	1,261	1,197	1	1	1	1	1
Northeast	**Moosimin45**	7,041	6,769	6,516	6,253	5,944	7	6	6	6	6
Northeast	**Wawota30**	1,121	1,074	1,038	998	949	1	1	1	1	1
Northeast	**Total**	**9,594**	**9,216**	**8,873**	**8,512**	**8,091**	**9**	**9**	**8**	**8**	**8**

At the time of the report launch (October 24, 2011), the following next steps were outlined:

1. **Phase One Implementation** - Develop an implementation plan and roadmap for each option outlined in the report.
2. **Phase One Presentation** to MoH and other Health Regions - Present findings and recommendations to the Ministry of Health, Five Hills Health Region and Regina Qu'Appelle Health Region to gain their support.
3. **Phase Two Development** - Move towards the overarching objective of developing a comprehensive Primary Health Care Plan for SCHR with FHHR and RQHR considering other healthcare providers.
4. **Hospital Service Planning Integration** - With the completion of Phase One: the general practitioner service model, begin to monitor the impact of the model on hospital based services.
5. **Physician Resource Plan** - Develop a physician resource plan for the ongoing recruitment and retention of physicians to sustain Phase One of the model.

PHC Plan Current Status as of May 2013[95]

Sun Country Health Region reported the following updates to the PHC Plan:

Broadview - Kipling Area:

- Locums through a private locum service have been arranged on an interim basis to serve the community with clinic service and full time call.
- A PHC site is presently being developed in Kipling.
- A Nurse Practitioner started in Kipling on April 29, 2013.
- One physician alternate payment was signed to start in June – successfully completed SIPPA May 2013 and a second physician started May following the successful completion of SIPPA.
- The SCHR and RQHR will be meeting to discuss the partnership between Broadview and Kipling with the purpose to stabilize both the Broadview and Kipling sites, share call and work in collaboration to achieve complete service yet shared responsibility.

Moosomin-Maryfield Area:

- The Moosomin physician group continues to work in partnership with the PHC Team in Maryfield (Nurse Practitioner, office staff and regional professionals) which has been a long-standing relationship for about 20 years. At first the physicians and nurse practitioner worked in parallel, however over the past few years the team has been working together collaboratively.
- Maryfield shares the Electronic Medical Record out of Moosomin and they are working primarily on Chronic Disease Management.
- SCHR and RQHR have met in regards to this, however not lately. The conversation between PHC in both regions has been ongoing and more in relation to RQHR understanding how SCHR has developed the relationship with this group.

In addition, advances have been made in other communities such as Coronach and Assiniboia, and collaboration with Five Hills Health Region to meet the needs of the communities in that area of the Region.

[95] Email May 5, 2013. Wanda Miller, Regional Director Primary Health Care, Sun Country Health Region.

Appendix I: Moosomin and Area Community Engagement Methodology - Focus Group and Survey Questions

The community consultation consisted of two major components:

i. Focus groups with community stakeholders
ii. An online community survey

i. Focus Group Methodology

The focus group methodology offers organizations an opportunity to gather more detailed and nuanced feedback than could be gleaned through a large-scale survey. "Focus groups are moderated, small-group discussions where a pre-selected group of people (usually current, past or potential customers) discuss their preferences, attitudes and opinions about products or services."[96] Focus group feedback is generally qualitative in nature, and can be combined with quantitative feedback from survey tools. Focus groups may be biased in a number of different ways:

- The sample size is small in nature; therefore, the feedback collected may not be representative of the entire customer base.
- Individual opinions may take on a greater weight due to the relatively small number of participants, with focus group participants changing their thoughts and opinions during the group.
- Participants may be reluctant to speak up on sensitive issues in a group environment.
- Questions may be leading or ambiguous which may direct or confuse the participants.[97]

Both RQHR and the moderator were aware of such biases and tried to guard against them as much as possible.

There were seven focus groups conducted inclusive of public community members and health care providers as outlined below. The groups were homogeneous in nature, that is; participants were grouped together in similar groups, for example, the public from a specific community or a group of healthcare providers.[98] Members of the steering committee, in collaboration with the Moosomin Hospital Foundation, were asked to use their community contacts to generate the focus group participants. The steering committee strived to engage participants that represented different age groups, gender, professions and length of residency within the community.

Participants in the focus groups gave consent for permission to tape record the session and a demographic profile sheet to complete. The moderator reviewed the ground rules and the process with the participants prior to the beginning of the session (Appendix II). The participants were led through the following nine questions.

[96] Focus Groups." United States General Services Administration. http://www.howto.gov/customerservice/collecting-feedback/focus-group-fact-sheet
[97] "Focus Group Best Practices-SIAST Kelsey Campus Focus Group Questions." Hanover Research Washington DC 2011.
[98] Homogeneity is key to maximizing disclosure among focus group participants. Guidelines for conducting a Focus Group. Elliot and Associates 2005.

Focus Group Questions

Ice Breaker Question
Tell us what you love about your community.

This question was not recorded and was used for the participants to introduce themselves to the other members of the group. The question also served to set a positive or appreciative tone for the conversation to follow. Participants readily shared what they loved about their community(s).

Engagement Question- Group discussion
The engagement questions were used to help the participants warm-up to the dialogue. The participants were allowed to answer using a group brainstorming format where they could build and expand on each other's thoughts.

1. What do you believe makes a community healthy?
2. What services do you believe are available to you in the community that supports your health?

Exploration Questions - Individual Answers
These questions were used to explore the specific topics related to the needs assessment.

3. Thinking about your community, what do you believe are the greatest ***current*** health needs?
4. Thinking about your community, do you believe the health needs are ***currently*** being met by the services offered? Indicate if you are highly satisfied, satisfied, neutral, dissatisfied, or highly dissatisfied. Comment further on…
    - what is working well?
    - where there may be gaps in your health services to meet the needs

5. Looking ahead, what do you believe may change in your community that would shift the health care needs in the next 5 to 10 years? What sources of information or data supports your view (e.g. media, observation, discussions with colleagues, other)?

6. Thinking about these changes, what do you believe will be the greatest health needs in your community in the next 5 to 10 years?

7. Thinking about your community, what concerns do have about the health services currently in your community and ability to meet the future health needs?

Exit Questions:
The exit questions were used to converge the participants' thinking into the areas that were most important to them and to allow them any final comments that they wished to share or expand upon.

8. If you ruled the world…or had one wish for health services in your community what would it be:
    - Today?
    - In the future?

9. Is there anything else you would like to tell us in relation to the health needs and services within your community?

If you think of something else or would like to add more information please go to our online survey.

Online Survey: http://fluidsurveys.com/s/moosomin-health/

ii. Online Survey

In addition to the focus groups, an online survey was developed that reflected the focus group questions. The FluidSurveys online survey tool was used to develop the survey.[99] Posters were distributed to all the local RM offices, school divisions, and health facilities in the designated area of the needs assessment. Focus group participants were also asked to encourage their peers to participate by completing the survey. In addition, paper copies of the survey were made available in the RM offices if potential respondents preferred to complete a hard copy. The survey was open from December 15, 2012 to January 2, 2013.

[99] fluidsurveys.com

Appendix J: Focus Group and Survey Demographics

i. Focus Group

Overall there were forty six (46) individuals who participated in the focus groups. Of the forty-six, twenty-four worked in healthcare, and nineteen represented the general public. Many of the healthcare providers responded from the perspective of both a community member and healthcare profession. It should be noted that the steering committee tried to organize focus groups in the Whitewood/Wapella and Elkhorn communities; however there appeared to be little interest. The chart below outlines the times, location and participants of the focus groups.

Group #	Date	Group & Location	Group Demographics (43)
1	Nov. 20, 2012 6:30 PM	Moosomin Public - Town Hall	7 (2 males, 5 females)
2	Nov. 21, 2012 2:00 PM	Rocanville Public Rocanville Recreation Centre	7 (3 females, 4 males)
3	Nov. 21, 2012 6:00 PM	Moosomin Family Practice Clinic, 708 Main St. Moosomin	3 doctors (3 males)
4	Nov. 22, 2012 2:00 PM	Health Care Professionals South East Integrated Care Center Moosomin	7 (1 male, 6 females) Home Care, Health Records, Administration, Dietary, Support Services, Scheduling, Laboratory
5	Nov. 22, 2012 6:30 PM	Wawota/Maryfield Public Wawota Town Office	5 (4 males, 1 female)
6	Nov. 23, 2012 10:00 AM	Health Care Professionals South East Integrated Care Center Moosomin	7 (2 males, 5 females) Maintenance, Laundry, Housekeeping, Nursing x2, Pharmacy, Dentist
7	Dec. 18, 2012 9:30 AM	Health Care Professionals Sun Country Regional Health Authority (SCHR)	7 (CEO, VP Health Facilities, Director of Home Care, Regional Director of Therapies, Manager Community Health Services Redvers, Manager Community Health Services Wawota, Manager Community Health Services Redvers (all female)

Only 35 participants completed the demographic sheets (SCHR participants did not complete the demographic questions). The following outlines the demographic information of the group:

What is your age	< 20	20-30	30-40	40-50	50-65	> 65	Male	Female		
		1/3%	4/11%	9/26%	16/46 %	4/11%	16/46%	19/54%		
How long have you been in the community	**< 5 years**	**5 to 10**	**> 10**							
		1/3%	34/97%							
What types of health services have you used in the past year?	**Emerg.**	**Fam. Doc**	**Health Clinic**	**Pharm.**	**Comm Health**	**Hosp. Comm.**	**Hosp. city**	**Home Care**	**LTC**	**Other**
	10/29%	26/74%	16/46%	25/71%	10/29 %	10/29%	3/9%	2/6%		-MD Brandon -Health Nurse
How would you rate your current Health Status	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**					
	9/26%	14/40%	8/23%	2/6%						
Self-Identification	**Can. Citizen**	**Other citizen**	**Caucas.**	**Abori.g.**	**Other VM**					
	35/100%		3/9%							

II. Survey Demographics

The survey was accessed by 165 participants and was fully completed by 66.3%. The following demographic information was obtained from the survey participants.

What is your gender?

Response	Chart	Percentage	Count
Male		24%	39
Female		76%	126
	Total Responses		**165**

What age group do you fall in?

Response	Chart	Percentage	Count
		1%	1
20-30 years		10%	17
30-40 years		24%	40
40-50 years		14%	23
50-65 years		35%	58
65 years or older		15%	25
	Total Responses		**164**

How long have you lived in this community?

Response	Chart	Percentage	Count
Less than 5 years		10%	17
5-10 years		12%	20
More than 10 years		77%	126
	Total Responses		**163**

What type(s) of Health Services have you used in the last year?

Response	Chart	Percentage	Count
Emergency		50%	83
Personal Family Doctor		94%	155
Local Health Clinic		74%	122
Local Pharmacist		93%	154
Community Health/Primary Health Services		32%	52
Community Hospital		50%	83
City Hospital (i.e., Regina or Saskatoon)		35%	58
Home Care		4%	7
Long-term Care		2%	4
Other, please specify...		7%	12
	Total Responses		**165**

How would you identify yourself?

Response	Chart	Percentage	Count
Canadian Citizenship		99%	163
Other Citizenship		1%	1
Caucasian		35%	57
Aboriginal Ancestry		1%	1
Other visible minority		1%	1
	Total Responses		**165**

How would you rate your current health status?

Response	Chart	Percentage	Count
Excellent		18%	30
Very good		48%	79
Good		26%	43
Fair		6%	10
Poor		1%	2
	Total Responses		**164**

Appendix K: Saskatchewan Supportive Housing Options for Seniors

The following supportive housing and services are available in Saskatchewan (Policy Framework and Action Plan for Older Persons, May 2003).

Private Options:

- *Own dwelling* is residing in one's own home which requires the owner to be responsible for the maintenance and upkeep. Affordable housing is available through the Saskatchewan Housing Corporation (SHC) for low-income seniors. In addition, SHC has repair programs offering loans and grants to low-income homeowners.
- *Abbeyfield housing* is a non-profit housing concept that extends affordable housing options for seniors through local volunteer agencies. Housing is developed with independence and supports in mind. Housing includes common living areas, such as a kitchen. Non-medical staff are available on-site 24 hours a day.
- *Townhouse/condominium/apartment* are owned or rented, and may qualify for services (e.g., mowing lawns, snow removal) offered by the private developer or SHC.
- *Assisted/Enriched Living (Retirement Living)* are typically large complexes where seniors live in individual suites and can access meals every day, laundry and housekeeping services as part of the rent, or other services, such as transportation. There is usually dedicated space for exercise and social activities.
- *Personal Care Homes* are privately owned and operated and are privately funded. Residents pay the full cost of care and accommodation. Residents do not need to demonstrate a need to be admitted. Services include: accommodation, meals and personal care services.
- *Home Care* assists people who need acute, palliative and supportive care in order to remain independent in their own homes. Services include: case management and assessment, nursing, therapies, personal care, home management, respite, minor home maintenance, and certain volunteer services such as visiting, security calls, and transportation.

Public Options:

- *Saskatchewan Assisted Living Services (SALS)* are affordable supportive services programs available to seniors. The program offers: coordination of social and recreational activities, one nutritional meal per day served in a common area, personal response system for unscheduled needs, and laundry and housekeeping services.
- *Special Care Homes* are long term care facilities operated by regional health authorities and funded by government. Residents are admitted on the basis of assessed need. Services may include: respite care, adult day programs, night care and palliative care.

The following programs are offered through the Ministry of Social Services to assist low-income seniors with their basic needs:

- Affordable Housing Rental Program - Makes it possible for moderate-income seniors to access suitable rental accommodations ensuring that rents are maintained at the low end of the market.
- Personal Care Home Benefit (PCHB) - The Personal Care Home Benefit (PCHB) provides seniors with monthly financial assistance to help them with the cost of living in a licensed personal care home.
- Saskatchewan Rental Housing Supplement- Seniors may access the Saskatchewan Rental Housing Supplement if they have dependent children living with them or if they have a disability which impacts their rental housing options.

- Seniors Income Plan - Provides a monthly supplement to seniors who have little or no income other than the federal Old Age Security pension and Guaranteed Income Supplement.
- Social Housing Rental Program - Provides suitable, adequate and affordable rental housing for low-income seniors and families in more than 280 communities throughout the province.[100]

In regards to accessible affordable personal care homes, it should be noted that the maximum Old Age Security Pension (OAS), Guaranteed Income Supplement (GIS) and Seniors Income Plan (SIP) is $1,382 and the approximate range of personal care home fees is $1,000 to $3,500.[101] [102] A person is eligible for The Personal Care Home Benefit (PCHB) if a resident meets all other eligibility criteria and if their monthly income is below $1,800 per month. The amount of the PCH Benefit will be $1,800 minus their monthly income (as calculated using your tax return and current OAS/GIS/SIP amounts).[103] The Laura Ross Report concluded "A subsidy is needed for residents of personal care homes with an assessed care and income need. There was almost unanimous agreement at all consultations that there is a 'gap' in the continuum of care."

Supportive housing can be developed in many forms depending on the types and level of services to be provided, the project size desired, the types of accommodation preferred, the types of tenure wanted and the types of sponsorship available. Services can be provided through a combination of on-site and off-site arrangements and can be made available to both residents and other older people living in the surrounding neighbourhood. Service-enriched supportive housing, such as assisted living, can be an alternative to living in a nursing home. Supportive housing can be developed by the for-profit, the not-for-profit, or the public sector, or by partnerships between these sectors. It can be made available in a range of tenure types, such as rentals, leaseholds, condominiums and life leases. It is also possible to combine different tenure types in individual projects. Several provinces have developed their own definitions of supportive housing that is eligible for public funding.[104]

[100] Seniors Programs And Services. http://www.socialservices.gov.sk.ca/seniors (accessed April 17, 2013).
[101] Saskatchewan Continuum of Care - Considerations in Developing a Seniors Strategy.
[102] The Seniors Income Plan - http://www.socialservices.gov.sk.ca/SIP-factsheet.pdf (accessed April 15, 2013).
[103] Personal Care Home Benefit Application Guide - http://www.socialservices.gov.sk.ca/pchb-app-guide.pdf (Accessed April 17, 2013).
[104] Fiessel, W., Kulyk, M., Peel, B., Pfeifer, S., Robert, J., Statler, K. Aging in Place: A Saskatchewan Perspective. Saskatchewan Institute of Health Leadership (SIHL) Group Project. March 31, 2013.

Appendix L: Models for Aging In Place - Review of the Literature

Models for Aging in Place - Review of Literature

A literature review conducted by the Aging in Place: A Saskatchewan Perspective March 2013, revealed two interesting models for consideration. The Naturally Occurring Retirement Community - Supportive Services Program (NORC-SSP), and the Village model, the Campus-affiliated communities model, as well as programs that have a mix of supportive housing, home care and other services.

The Naturally Occurring Retirement Community - Supportive Services Program (NORC-SSP)

The Jewish Federations of North America, pioneers of Naturally Occurring Retirement Communities (NORCs), define the NORC model as "a community-level intervention in which older adults, building owners and managers, service providers, funders, and other community partners create a network of services and volunteer opportunities to promote aging in place among older adults who live in 'naturally occurring retirement communities,' housing developments and residential areas not planned for older adults but in which large numbers of older adults reside" (Bedney, 2010).[105]

NORCs may bring together seniors within a residential area (apartment, neighborhood, town) that was not planned as senior housing, but may have over time developed a larger proportion of seniors. NORC is seen by the Jewish Federation as not only a mechanism for service delivery, to aid seniors with aging in place, but also "as a means to rewrite cultural meanings of aging" (Bedney, 2010).

Other residents living within the NORC (of all ages) interrelate with the senior resident, share skills and provide assistance as needed. The seniors also support each other and provide their experiences and skills to the younger residents. This model provides a multigenerational social relationship which benefits everyone. The NORC model has been implemented in 25 American states with 41 in New York state alone. Each NORC model has been customized to the distinct needs of the community. The common hallmarks of the NORC model are:

1) Coordination of health care and social services (some NORCs even have on staff both social workers and nurses), as well as group activities;
2) Building partnerships to unite all stakeholders, including residents, service providers, government agencies, and philanthropic organizations;
3) Engaging seniors by being responsive to their changing needs;
4) Providing seniors with program governance roles and opportunities to exchange social support among community members;
5) Filling gaps where services may not be fully coordinated or available.[106]

The above goals are potentially achieved through community engagement and empowerment, relationship building activities, and enhancing access to resources (such as transportation assistance or home repair services). NORC programs in New Jersey, in particular, have also tried to incorporate evidence-based health promotion and chronic disease management programs (Greenfield, 2012). This may help reduce the incidences of heart disease, falls, dementia, and hospitalization due to lack of self-management of chronic disease.

[105] Bedney, B.J., Goldberg, R. B., & Josephson, K. (2010). Aging in place in Naturally Occurring Retirement Communities: Transforming aging through Supportive Service Programs. Journal of Housing for the Elderly. December 2010.
[106] NORC Public Policy. www.norcs.org/page.aspx?id=160634 (accessed April 5, 2013).

Critical success factors of the model are community engagement, buy-in and local ownership from the seniors and community stakeholders. In addition, health and social service providers need to be engaged as partners which require the collaboration with different government ministries. Although many NORCs developed in the U.S. have been privately funded, they have suffered from a lack of a government role in ensuring available resources and appropriate coordination.

Village Model

The Village concept supports the continuation of aging in a home and community where people have lived most of their adult lives and allows them to remain a vital part of the intergenerational community. The Village Concept encourages and supports seniors to "age in place". This program also promotes a stronger, more vibrant community because it unites residents through volunteerism, neighborly acts and working together for the common goal of improving relationships within a community.

The biggest advantage is that older adults can maintain the lifestyle they desire by remaining in their homes. Examples of tasks provided for older residents by the Village may be assistance with security in their neighborhood or home, support in chores of daily living as needed, help with finding reliable contractors, ongoing contact through neighborhood checks to ensure well-being of the resident, social outings and assistance with transportation. Each community must determine the needs of the residents and decide on a model which would best serve them.

The Village concept is built on a "membership-driven" model where there are both volunteers and paid staff who coordinate access to affordable services including transportation, health and wellness programs, home repairs, social and educational activities, and other day to day needs thereby enabling the seniors to remain connected to the community throughout the aging process. Members of such villages can continue to live in their homes while receiving assistance that supports independent lifestyles. The arrangement provides help that bridges the gap for individuals with enough assistance from the village to remain in their homes.
A Board of Directors typically provides the governance for the village and administers the daily operations. Some villages are non-profit organizations while others have members pay annual fees depending on the structure. Membership fees may vary depending on the staffing structure and other sources of funding such as donations and grants.

The goal of a village is to offer all the benefits that would be found in an independent or assisted living facility. The hallmarks of the village model are:

1) A geographical location in neighborhoods of cities and suburbs, or rural areas;
2) A comprehensive, coordinated approach to home based and community services on a one-stop shopping basis;
3) Use of a consumer-driven organization model that requires membership fees, with some villages attempting to provide scholarships or reduced rates so as to increase access to the village of elders with low and moderate incomes;
4) Provision of information about resources and providers, and assistance with transportation and grocery shopping, are core services covered by a membership fee;
5) Home care services, home repair, and maintenance services, and other services are paid for privately on a fee for service basis, usually at a slightly (approximately 20%) discounted rate negotiated by the village on behalf of members;
6) A wide variety of community building activities, including interest groups, exercise classes, cultural and educational field trips;
7) Some degree of organized volunteerism, for members helping each other and/or helping organizations in their community. Some villages use a "time banking" model to structure their volunteer time.

Comparison of the NORC-SSP and Village Models

The table below shows a comparison of the key factors associated with the NORC-SSP and Village models (Bookman, 2008).[107] For example, NORC-SSP may be better suited for those who have lower incomes, are diverse in ethnicity and culture, services are organized and funded by government agencies, and housing is located in apartments or a condominium complex.

Model	Locale	Income	Diversity	Initiator	Funding
NORC-SSP	Urban – apartment or condo complex	Low	High	Agency	Government, Social Services
Village	Urban Neighborhood	High	Low	Seniors	Member Dues

[107] Bookman, A. (2008). Innovative models of aging in place. Transforming our communities for an aging population. *Community Work & Family*, 11:4, 419-438.