Primary Health Care Plan

Primary Health Care

Team Development

Regional Primary Care Planning Team

The regional Primary Health Care Steering committee has been meeting quarterly to hear updates on our existing primary health care sites, and to discuss standing agenda items of chronic disease management, the Health Quality Council Collaborative, community development and health promotion issues. Additional agenda items are welcomed.

The team is comprised of the following:
- Vice Presidents of Primary Health Services; and Integrated Health Services
- Directors of Primary Health Care; Mental/Addictions Health Services; Population Health Services; Food and Nutrition Services; Rural Facilities
- Primary Health Care Team Facilitator
- Medical Health Officer
- Saskatchewan Medical Association Representative
- Pharmacist/ Saskatchewan Pharmaceutical Association representative
- Battlefords Tribal Council Indian Health
- Regional Primary Care Consultant

Additional community input is solicited through the community advisory network and the numerous intersectoral committees in place throughout the health region.

Central Site Information – Health Centers

The following section provides the populations for each community, rural municipality and First Nation as listed. The proposed site designation, as well as timeframe for completion and number of teams estimated is included. The narrative for each speaks to the integration of health center involvement in the primary care teams. The percentage of population with access to primary care teams is based on the Saskatchewan Health definition of a primary care site, one with an alternate payment physician and nurse practitioner. Covered population statistics quoted are from the June 2004 covered population count. These statistics do not account for the large influx of tourists throughout the health region during the summer season. A cumulative table listing primary care team coverage for the health region's population is provided at the end of the site descriptions.

Please note that the majority of these communities already are served by a full team of visiting service providers (community health, mental health and addictions services) at their integrated health centers, but do not yet meet the alternate payment physician and nurse practitioner requirements.

Central Site – Loon Lake

Loon Lake	396	Central	**All completed by 04-05,**
Goodsoil	425	Satellite	2 teams
Pierceland	654	Visiting	% of population with access
Makwa	145		to PC team 6191/6191
RM – Loon Lake #561	623		or 100% to PC team
6191/6191			
RM – Beaver River #622	831		
RM – Meadow Lake #588	616		
Makwa Sahgaiechan	870		
Island Lake	968	Visiting	
Big Island Lake	663	Visiting	
Total population	**6191**		

Loon Lake – The five year review has recently been completed for this site. Although the community has experienced stable physician services over the past year, the RN-NP who resided in the community left in August and we have been unable to recruit another to date. With the departure of both the RN-NP in Loon Lake and the physician in Goodsoil, the on-call roster with Goodsoil has been discontinued. Area residents travel to Meadow Lake or Cold Lake AB for after-hours on-call services. Visiting physician services to Island Lake First Nation continue on a weekly basis, and to Goodsoil on a bi-weekly basis.

The Loon Lake team consists of the physician, RN-NP, with visiting services provided by a public health nurse, dietician, physiotherapist, mental health counsellor, addictions counsellor, and home care nurse. The facility manager is included in team planning. Additional representatives on this team who are not under the employ of PNHR are the health liaison workers from Island Lake and Makwa Sahgaiechan First Nations.

Goodsoil – Presently the community of Goodsoil is without a resident physician. As noted, the physician from Loon Lake offers a clinic in Goodsoil once every two weeks. A permanent full time RN-NP started in March 2005 and is located at the Goodsoil clinic. She offers clinics in Loon Lake once per week and in Pierceland once per week.

The Goodsoil team consists of the physician and RN-NP, with visiting services offered through a public health nurse, dietician, physiotherapist, occupational therapist, mental health counsellor, addictions counsellor, and home care nurse. The facility manager is also included in all primary health care team planning. Representatives from Big Island Lake First Nation regularly participate in the primary health care team meetings.

In light of the recruitment challenges faced in this community, a proposal has been submitted to Telehealth Saskatchewan to develop Goodsoil as a Telehealth site. This technology will help to support the RN-NP in their daily clinical practice, offer an

alternative to travel for some residents with specialist needs, as well as offer the staff in this isolated community access to education and training events.

Pierceland – The Goodsoil RN-NP presently provides service to this community one day a week. All visiting staff – including an occupational therapist, addictions counsellor, mental health counsellor, and public health nurse - are now housed under the same roof as the visiting RN-NP clinic in an effort to improve client access to service and improve continuity of care.

As the individuals providing visiting services to both Loon Lake and Goodsoil and Pierceland are largely the same, bi-monthly meetings are rotated between Goodsoil, Loon Lake, Pierceland, and the First Nations of Island Lake, Makwa Sahgaiechan and Big Island Lake to coordinate services among these communities.

Central Site – Maidstone

Community	Population	Site	Status
Maidstone	1202	Central	**All completed by 07-08**
Lashburn	1046	Visiting	1 team
Marsden	355		% of population with access
Neilburg	519	Visiting	to PC team 0/8483, 0%
Paynton	231		
Cut Knife	573	Satellite	
Little Pine FN	715		
Poundmaker FN	574	Visiting	
Sweetgrass FN	785		
Waseca	195		
Rockhaven	47		
RM – Hillsdale #440	485		
RM – Manitou Lake #442	228		
RM – Eldon #471	286		
RM – Wilton #472	658		
RM – Cut Knife #439	376		
RM – Paynton #470	208		
Total Population	**8483**		

Maidstone - Presently, the physician group in Maidstone offers visiting clinic services to Lashburn and Poundmaker, while the physician residing in Cut Knife, provides a clinic in Neilburg, so these are the logical sites to offer visiting primary care team services. On an interim basis, visiting clinics are also offered in Paradise Hill. These clinics are managed by Maidstone Municipal Health Holdings, a board comprised of representatives of the local municipal governments.

One of the physicians in this practice is taking part in the Health Quality Council Chronic Disease Management Collaborative. It is anticipated that this experience may illicit an interest in the primary health care model.

Many additional health services - public health nurse, dietician, physiotherapist (private), occupational therapist (visiting), community counsellor, addictions counsellor, emergency medical services and home care nurse - are currently being offered out of Maidstone. Our Team Facilitator will continue to work with these service providers in order to improve continuity of care for our area residents.

Planning for a new facility to replace Pine Island Lodge, and to consolidate all health care services in Maidstone, has begun. The community is very dedicated to fundraising for this facility and this may be a good time to introduce the concept of primary health care within the community.

Neilburg – Emergency medical services, public health nursing and home care and lab services are housed here. Aside from the visiting physician, visiting services are also provided by the addictions counsellor, community counsellor and dietician.

Cut Knife – Visiting services to this community to date include, addictions counsellor, community counsellor, dietician and public health nursing, while emergency medical services, home care and a resident physician are hosted at this site.

All after hours emergency services for this area are provided out of the Maidstone Hospital.

Central Site – Turtleford

Turtleford	613	Central	**All completed by 06-07**
St. Walburg	813	Satellite	2 teams
Spruce Lake	98		% of population with access
Mervin	172		to PC team 0/9993, 0%
Edam	488	Satellite	
Glaslyn	447		
Paradise Hill	630	Satellite	
Meota	480		
Cochin	267		
Thunderchild FN	921		
Saulteaux FN	583		
Moosomin FN	712		
RM – Frenchman Butte #501	1165		
RM – Mervin #499	1157		
RM – Parkdale #498	513		
RM – Turtle River #469	373		
RM – Meota #468	275		
RM – Eldon #471	286		
Total population	**9993**		

Turtleford – Category "A" on-call status was established in Turtleford for St. Walburg, Edam and Turtleford and surrounding areas last year. It is anticipated that this process will lead to the evolution of primary care teams at these sites, although interest in the alternate payment mechanism has not yet been expressed by the physicians from Turtleford.

The physicians in Turtleford (and St. Walburg and Edam) are employed by North Saskatchewan Rivers Municipal Health Holdings (NSRMHH). A brief informational meeting was held with representatives from this organization to present information on the primary health care model and its potential in Turtleford. While NSRMHH is not yet ready to consider alternate payment for their physician group, they did express some interest in the model. Communication with this group will continue.

Additional health services offered at the Riverside Health Complex in Turtleford include resident public health nursing and home care staff, and visiting physiotherapy, occupational therapy, community counsellor, dietician, addictions, podiatrist, and all other services on request. Additional non-health region personnel include a private massage therapist and a Health Liaison worker through Thunderchild First Nation.

St. Walburg – Two physicians, a husband-wife team, began to practice in St. Walburg in May 2005. In the short term absence of the Loon Lake physician in the fall 2005, the St. Walburg doctors provided “back up” support to the RN-NP in Goodsoil.

Existing visiting services to the health centre in St. Walburg include psychiatrist and community mental health nurse, community counsellor, addictions, dietician, public health nursing, physician and nurse practitioner.

Edam – 2005 also brought about a physician vacancy in this community. Visiting physician services are currently offered two times per week by the physicians from St. Walburg, and from a North Battleford physician. Visiting services to Lady Minto Health Care Center in Edam include physiotherapy, occupational therapy, public health nursing, community counsellor, dietician, and all other services on request.

Paradise Hill – While laboratory and home care services continue to be housed here, local physician services also ended in this community in 2005. Visiting community health, mental health and addictions staff continue to provide services in this community. Itinerant physician services are provided by MMHH physician group. The community is included in the “Turtleford” coverage area for now, although it is possible that it may evolve to be a component of the “Maidstone” coverage area.

Central Site – North Battleford

North Battleford	15204	Central	**2006-2009**
Maymont	199		4 teams
Ruddell	45		% of population with access
Denholm	97		to PC team 1650/23208, 7%
Battleford	4130		
RM – Meota #468	275		
RM – Glenside #377	52		
RM – Mayfield #406	313		
RM – Buffalo #409	145		
RM – Battle River #438	841		
RM – North Battleford #437	500		
Mosquito FN	652		
Red Pheasant FN	755		
Total population	**23208**		

Battlefords Family Health Centre – This site continues to provide service to a stable client population. The Physician and RN-NP work collaboratively with the clientele, and the RN-NP continues to offer targeted programming both at the site and visiting services on surrounding First Nations. Dr. Mehboob has signed a subsequent contract with Battlefords Family Health Centre to secure physician services until 2006. Dr. Neimand also provides clinic services at this site one day per week. BFHC's five year review has recently been completed.

Aside from physician and nurse practitioner services, other service providers available at this site include a licensed practical nurse, community health nursing and mental health counsellor. Programming available to clients focuses on women's wellness, diabetes prevention, sexual health clinic, and early childhood development through Kids First. This site houses the home visiting component of Kids First North Battleford, and also offers some early learning programming.

An additional primary care site is planned in North Battleford at Battlefords Union Hospital. With the recent closure of the "Medco" physician practice and the loss of several general practitioners, the opportunity to develop this site has arisen. A detailed "Team Establishment Funding Template" is being completed.

Central Site - Lloydminster

Lloydminster	9538	Central	**2008-2010**
Marshall	787		3 teams
RM – Wilton #472	658		% of population with access
RM – Manitou Lake #442	228		to PC team, 0%
RM – Britannia #502	1103		
Onion Lake FN	2652		
Total population	**14966***		

Lloydminster Community Clinic –Communication with this site is intermittent. As the physicians in this practice are paid on a fee-for-service structure, they do not meet the primary health care site criteria as set out by Saskatchewan Health.

No additional interest toward the Saskatchewan Health primary care model has been shown by physicians in this community.

*According to the 2005 City of Lloydminster census population, the Alberta side of Lloydminster is home to 15,487 residents as well. Prairie North Health Region continues to work with East Central Health Region to meet the needs of this growing population.

Shared Care Model – In the community of Lloydminster the Shared Care model of mental health services continues with two physician practices participating, and further expansion anticipated. Feedback from both physicians and clients is very favourable.

Central Site – Meadow Lake

Meadow Lake	6524	Central	**2009-2012**
Dorintosh	240		2 teams
RM – Meadow Lake #588	1232		to PC team
Flying Dust FN	545		% of population with access
Waterhen Lake FN	650		to PC team, 0%
Total population	**9191**		

Meadow Lake – Although a wide variety of health services are offered through the Northwest Health Facility – public health, mental health, addictions, and home care as well as emergency medical and acute services - the physicians in this community are yet to show an interest in the Saskatchewan Health primary care model as it is defined today. This physician practice has on occasion provided “back-up” services to the Nurse Practitioners in Loon Lake and Goodsoil, and we will continue to work with them to improve the continuity of care offered by all health care providers at this location.

To summarize, Prairie North's total population with access to a primary care team will evolve as follows:

Year	**Additional Communities Served by PC teams**	**Number of teams**	**Percentage of PNHR's total population with access to PC teams**
2004-05	Loon Lake, Island Lake, St. Walburg (visiting), Goodsoil, Pierceland, Big Island Lake, North Battleford (1)	3	7,841/72,032 = 10.9% *6191 + 1650 = 7841
2005-06	Recruitment and retention of alternate payment physicians and RN-NP's to existing sites; extensive community partnerships and early team development activities for upcoming sites	3	7,841/72,032 = 10.9% *6191 + 1650 = 7841
2006-07	Turtleford, St. Walburg (Satellite), Edam, Paradise Hill, North Battleford (+1)	6 (3 + 3)	22,834/72,032 = 31.7% *7841 + 9993 +5000 = 22834
2007-08	Maidstone, Cut Knife, Neilburg, Lashburn, Poundmaker, North Battleford (+1)	8 (5 + 2)	39,596/72,032 = 55.0% *22834 + 8483 + 8279 = 39596
2008-09	Lloydminster (1) , North Battleford (+1)	10 (7 + 2)	52,863/72,032 = 73.4% *39596 + 4988 + 8279 = 52863
2009-10	Lloydminster (+1) , Meadow Lake (1)	12 (9 + 2)	62,447/72,032 = 86.7% *52863 + 4989 + 4595 = 62447
2010-12	Lloydminster (+1), Meadow Lake (+1)	14 (11 + 2)	72,032/72,032 = 100% *62447 + 4989 + 4596 = 72032
Totals		**14**	**100%**

The level of service provision in the rural sites is evident in the number of service providers and the array of services available in the proposed sites. The need to enhance these services beyond the auspices of physician and nurse practitioner services is imperative.

Human Resources Delivery

Physicians – Aside from the actual recruitment and retention of physicians to rural Saskatchewan, the largest challenge we face with this group is the lack of a consistent contract for use both between the health region and the physician, and between the health region and the Primary Care Branch. It is anticipated that the Saskatchewan Medical Association model contract will serve to assist with this issue. On-call coverage where physician practices are partnering in the on-call roster continues to be a challenge. This has resulted in regional after-hours on-call being centered in the communities of Meadow Lake, Turtleford, North Battleford, Maidstone and Lloydminster.

Primary Care Nurses – There is an acute shortage of RN-NP's willing to relocate to other communities in the province, and thusly it is very difficult to recruit an RN-NP. We have been recruiting to a vacant full-time permanent RN-NP position for the past 6 months and have directly targeted this province's recent NP graduates and bursary recipients.

Primary Health Care Team Facilitator – A PHCTF has become an integral part of our health region's primary health care network. The Team Facilitator works with the existing primary care teams and with staff in the outlying communities who will comprise additional primary care teams. The Chronic Disease Management Coordinator reports to this position and assists in linking CDM through team development. Participation in the January 2006 facilitation training will occur for the Team Facilitator and the Director of Primary Health Care.

By working with our health region's primary health care physicians and RN-NP's, the PHCTF developed regional physician/RN-NP practice guidelines for the primary health care sites. These guidelines are meant to be a working document outlining the roles and responsibilities of the unique working relationship between an alternate payment physician and an RN-NP.

Director of Primary Health Care – This position continues to work both with staff and with community partners toward the ongoing development of primary care sites. This region, as others, includes Kids First and other community partnerships as listed below within the scope of primary care.

Community Partnerships

Chronic Disease Management/Diabetes Plan – In November 2005, a Chronic Disease Management Coordinator was hired. This position has half time dedicated to continued work with the diabetes educators from across PNRHA, as they develop one common training tool for diabetes education, and consistent regional processes. In order to facilitate this process, the reporting relationship for all Nurse Educators in the health region has been changed to report to this position. The CDM working group will be broadened to include staff from other employers (i.e., First

Nations, etc.) who provide Diabetes care so that we can share educational resources and participate in joint program planning.

Health Quality Council Chronic Disease Management Collaborative – The other half of the Chronic Disease Management Coordinator's position is dedicated to facilitating the HQC CDM Collaborative. There are 4 physician practices registered the Collaborative – 3 in North Battleford and one in Maidstone. This position will support the physician practices and act as a liaison with the health region.

Comite de liaison et d'actions en santé (CLAS) - Health Liaison and Action Committee – In November 2005 PNHR hosted a focus group to review access to health services for our health region's francophone population. The results of this day are eagerly anticipated.

In Motion – Representation on both the River Junction and Battlefords regional "In Motion" committees that are active within the boundaries of PNRHA continues. The Board of Directors of PNRHA declared our organization to be "In Motion" in 2004, and many PNRHA individual sites have adopted the "In Motion" declaration at the facility/agency level. The provincial "In Motion" staff have offered to come to North Battleford to offer training to the workplace champions throughout PNHR in 2006.

Community Development – Community development and consultation is ongoing. There are presently six formal Community Advisory Committees involved in PNHR's Community Advisory Network. Community consultations linking Primary Health Care, Population Health Promotion and regional issues are planned throughout 2006.

School^Plus^ - Participation on several school division School^Plus^ leadership teams also continues.

Lawson Foundation – A letter of intent was submitted to the Lawson Foundation proposing the development of a Diabetes prevention program in some the health region's schools. Interest and commitment from the school divisions has been solid and we await an invitation (deadline for response is December 15, 2005) from the Lawson foundation to submit a full proposal.

First Nations and Métis Organization Partnerships – The many relationships PNRHA have with neighbouring First Nations continue in many of the partnerships previously listed, as well as through Kids First and program specific initiatives. The Prince Albert Parkland model of a regional Aboriginal Community Advisory Committee is being reviewed and a similar committee for PNHR will be developed in 2006.

Cognitive Disability Strategy – The Northwest Regional Intersectoral Committee, of which Prairie North Health Region is a member and the accountable

partner, is taking the lead in implementing the provincial Cognitive Disability Strategy. This strategy focuses on providing supports to those with cognitive disabilities based on need and impact; seamless service delivery; facilitation of a shared mandate; and strengthening existing services and supports. An interim intake team, a planning committee, and a draft work plan are in place. The goal is to have a coordinator in place for April 1, 2006.

Chronic Disease Management/Diabetes Plan

A number of activities have been undertaken in 05-06 that have assisted in moving Prairie North Health Region's (PNHR) chronic disease management/diabetes strategy forward. All details are provided in the PNHR Chronic Disease Management Plan, included as Appendix A.

Physician Contracts

There are presently 2 physicians working under an alternate payment arrangement in PNHR – Dr. Mehboob in North Battleford (salary), and Dr. Bekker in Loon Lake. Also, Dr. Neimand is providing one sessional per week at Battlefords Family Health Centre in North Battleford. All of these contracts have been previously forwarded to Saskatchewan Health.

Communications Strategy

Ongoing communications with interested communities continue as the concept of primary health care is introduced and gains understanding both among staff and community members. Specifically, there have been a number of requests made by rural facility managers and by regional Directors asking for presentations on the primary health care model. Several PowerPoint presentations have been developed to meet the needs of varying audiences from the general public to specific staff groups, addressing the concept of primary health care and encouraging local discussions.

Budget

As each individual site is developed, the specific detailed budgets are submitted, including the proposed annual staffing component.

Evaluation

As mentioned, we continue to participate in Primary Care Branch evaluation activities such as site interim and five year reviews, indicator development, and evaluation workshops.

Conclusion

Primary Health Care is a topic of growing interest to our staff, our community partners and the public at large. As services continue to evolve in the northwest, we will continue to work with these groups to move the primary care agenda forward.

Appendix A – Chronic Disease Management/Diabetes Plan

Chronic Disease Management (CDM)

GOALS	OBJECTIVES	ACTIONS	INDICATORS	PLANNED OR ONGOING	Apr 1/06-Mar 31/07 TIMELINE	Diabetes Funding or Health Promotion (or shared)	ESTIMATED COST
1) To create an environment that allows people access to nutritious food. 2) To strengthen the skills and capacities of individuals, groups, organizations and communities to take action on their health. 3) To promote and support active communities.	1.) To seek out evidence based best practices and apply them in all RHA's to make healthy choices the easier choices.	• Healthy Habits for a Lifetime - An application was put forward to the Lawson foundation to run wellness program in schools in the PNRHA. • Workplace wellness programs are running several facilities in the region. Health promotion is promoting and expanding these programs. • In Motion is active in the region. • Nutrition month – presentations and news paper ads. • Midwest Foods Resources- Good Food Box. • Please note population health promotion (food securities, Active Communities)	• Number of Evidence based programs implemented • Percentage of region covered by these initiatives	Planned Ongoing	April 06		
	2.) To implement strategies that create supportive environments, strengthen community capacity for action and build community-based healthy public policies	• Francophone program- strategies i.e. focus group to enhance access for the francophone population. • Primary Health Care community development planning- PHC team facilitator, Health Promotion and Community Development to hold community stakeholder meetings.	• Number of new programs / total programs • Community development plan • Community feedback to check attitudes on community capacity.	Under review Planned	March 07 February 06		

	3.) To develop linkages to increase public awareness, social marketing and public participation about the prevention of CDM and the benefit of healthy lifestyles.	• Diabetes educational manual. The manuals are to be used for education of PNRHA staff and others. • Diabetes Nurse Educators and dieticians arrange diabetes workshops in doctor's offices. • Community partnership meetings.	• Percentage of region using the tools • Attendance at clinics • Demand for tools. • Number of new /additional physicians offices involved	Ongoing Ongoing Ongoing			
	4.) To develop support mechanisms using a holistic culturally sensible approach to increase public participation and to promote healthy lifestyles	• Battleford's tribal council involvement in the Health Quality Council Collaborative. • Primary Health Care has several first nations' partnerships. • Francophone partnership.	• Number of partnerships with first nation communities and agencies • Number of new programs developed and running	Ongoing Ongoing Ongoing			

	5.) To develop, implement and evaluate individual and community risk factor assessment and modification programs for people at risk for CDM.	• Diabetes clinics in doctor's offices. • Speak with public health nurses about a strategy to provide information to the pregnant with information on the importance of GDM screening. • Diabetes clinics in doctor's offices. • Health Quality Council Collaborative. • OBS ward staff provide GDM clients with recommendations for 6 week post-partum OGTT on discharge- Physician to do post GDM OGTT as per newest Canadian clinical practice guidelines.	• Percentage of region where testing is completed • Number or percent of client load with improvements in the health of CDM patients- with physician groups that participate in the collaborative. • Audits- Using data from the collaborative. • Number of patients being served by the clinics.	Occurring Under review Planned Ongoing Planned	March 07 March 07 June 07			

GOALS	OBJECTIVES	ACTIONS	INDICATORS	PLANNED OR ONGOING	Apr 1/06-Mar 31/07 TIMELINE		Number ESTIMATED COST
1.) To ensure every person with diabetes in Saskatchewan has: a) timely access to quality diabetes care that is client centered b) access to specialized services, as need in the diagnosis and management of diabetes and its related complications and associated conditions c) the necessary supports to achieve self-management to the best of his/her ability with inclusion of the family and support network d.) culturally appropriate care, including	1.) To create an infrastructure within each RHA, with senior leadership involvement, to support planning, financing, implementation and evaluation of optimal CDM care for persons with CDM, their families and communities.	• An interdisciplinary team that guides chronic disease management planning • Subgroups from the leadership committee to do planning. • Diabetes Nurses Educators doing clinics and education programs for staff and others. • Develop a video/power point presentation available to each health facility/community partner comprised of 15-20 min segments for each staff category. Each section of the presentation will be geared specifically to their occupation identified items they need to be aware of (insulin pen, glucometer, and testing frequency) to reinforce the national guidelines of care. Develop a written manual with mandatory readings, available to all staff in each area, to accompany the presentation.	• Systems in place • Development of the presentation • percent of PNHR care providers trained • Staff and partner evaluation of the presentation. • Percent of PNHR staff who have been provided with the manual/readings	Planned Under review Ongoing Ongoing	March 07 March 08		
	2.) To create diabetes teams to address regional diabetes care needs.	• Regional Diabetes team that will meet quarterly.	• Systems in place • percent of all disciplines in attendance at meetings	Planned	June 06		

self-management education, and support 2.) To ensure early detection of diabetes and its predisposing conditions and initiation of appropriate on-going care 3.) To reduce the impact of the human and financial costs for persons with diabetes, their families and communities	3.) To develop relationships with primary care teams to ensure quality CDM care and ongoing support for persons with CDM and their families.	• The Chronic Disease Coordinator reports to the Primary Health Care Team Facilitator- this creates a comprehensive link. • Invite Dieticians and Diabetes Nurse Educators to be part of the PHC team.	• Infrastructure developed • Percent of CDM team members on PHC teams • New CDM programming developed and operating	Ongoing Planned	 March 07		
	4.) To participate in building networks between primary care providers and teams, diabetes teams and medical care specialists.	• Diabetes team attending and taking part in clinics at doctor's office. • Dietician referrals in hospital to doctor's office. • Pamphlets and booklets. • Quarterly meetings with the diabetes team to share information and develop programming. • Invite other health professionals to the quarterly meetings.	• Referrals • Percentage of referrals to DE from all other sources to show trends	Ongoing Planned Ongoing Ongoing Planned	 March 07 March 07		
	5.) To encourage and formalize processes and systems that ensures follow-up care for all regional residents with CDM. This will require collaboration with on-reserve care providers to establish specific processes to serve First Nations on-reserve populations.	• Partnerships with Battleford's Tribal Council- They are taking part in the HQC Collaborative. Planned meetings with to discuss how we can partner and network. • Work with PHC teams who have first nation's partnerships. • Hold quarterly diabetes meetings with our intersectoral partners (i.e. Kids first, Good Food box, Community Kitchens, Native Friendship Center, and other partnerships)	• Number of aboriginal partnerships • Number of community initiatives and percentage of health region covered through these initiatives	Ongoing Planned Planned	 March 07 March 08		
	6.) To develop mechanisms to reduce barriers to optimal care.	• Working with the HQC on access. • Surveillance system for diabetes prevention, education care and treatment. • Standardized referral form.	• Use the surveillance system to collect data. Indicators from the HQC system • Development of form.	Ongoing Planned Planned	 June 06 June 06		

	7.) To use nationally recognized standards and guidelines in care planning and delivery.	• Working with the HQC to ensure best practices. • Use PDSA cycles. • Chronic Disease coordinator to research best practices in Chronic Disease Management and implement best practice research. • Use Wagners Model to as a guide to CDM planning and developing programming.	• Data collection • Number or percentage of evidence based practice implemented in the CDM programs	Ongoing Ongoing Planned			
	8.) To promote early diagnosis of 'impaired' glucose levels or diabetes and appropriate follow-up mechanisms.	• Commitment by the region to decrease the escalating costs of poorly controlled diabetes	• Rate of early diagnosis among DE clientele • Hire a Chronic Disease Coordinator	Planned Ongoing	March 07		
Awareness of diabetes to all residence of PNRHA.	9) Increase the public's accessibility to educational opportunities through partnerships and targeted advertising.	• Use wellness clinics and other drop-in support groups as a referral center to increase referrals and advertise for diabetic education opportunities and to promote life style changes. • Encourage the CDA to facilitate and support chapters in each larger centre, and approach CDA re: their fundraising strategies, to let the communities keep some of the funds raised. • Produce a standardized client teaching manual in each community including prevention component. • Reconfigure educational clinics to half basic diabetes education, half advanced modules; re-examine efficiency of satellite clinics.	• Number of wellness clinics in partnership; Tracking of referral sources • Involvement with the CDA chapters • Number or percentage or RHA covered • Number of clients served, client satisfaction	Planned Ongoing Planned Planned	March 08 March 08 March 08		
	10) Increase awareness of the health effects of diabetes	• Pre-contemplation of diabetes education posters displayed in washrooms in key public facilities.	• A survey of clients or public	Planned	June 06		

	11) Increase awareness of who should be screened for diabetes	• Posters on risk factors.	• A survey of clients or public	Planned	June 06		

Please note that we hired a ½ time Chronic Disease Coordinator on November 21, 2005. This person is still learning the position and as the person grows into the position more initiatives will be coming from her and her staff.

The Wagners Model will be used in the development and planning of all Chronic Disease Management in the Prairie North Health Region.

Appendix a Health Promotion Strategy on Accessible Nutritious Food and Active Communities

Active Communities

Key Activities	Implementation Steps:	Timelines	Internal to Regional Health Authority	External:	Resource Requirements:	Progress Measures
In motion (links to 3 other priority areas) (links to workplace wellness)	⇒ Participation in *in motion* committee work [Advisory Committee, North Battleford; Battlefords in motion committee; Lloydminster in motion committee] **Note:** * Shift from increasing awareness to more sustainable projects after 18 months of the 3-year program. Focus in year 3 will be linked to rural/urban planning. * Saskatchewan *in motion* in discussion about regional recreation association taking over after year 3. Anticipate that communities will allocate money for activity and *in motion* activators. ⇒ Examining potential opportunities to link Diabetes Working Group and Lifestyles Programs [acute care] with in motion ⇒ Health Region declared *in motion* ⇒ Initiate and foster partnerships with education, city, gyms, aquatic centers, etc. to increase awareness and promote opportunities for activity for health region staff	⇒ 2004 and on-going ⇒ 2004/2005 ⇒ 2004 and on-going	⇒ Human Resources ⇒ Public Health Nutrition ⇒ Health Promotion ⇒ Director of Intersectoral Planning ⇒ Public Health Nursing	⇒ North Battleford and Lloydminster Parks and Recreation Associations ⇒ City of North Battleford ⇒ City of Lloydminster ⇒ Education [Catholic and Public School Divisions] ⇒ Lifetime Fitness [North Battleford, Lloydminster] ⇒ Kinsmen Aquatic Centre [North Battleford] ⇒ Meadow Lake Aquatic Centre ⇒ City of Lloyd Leisure Centre ⇒ Fitness Dynamics [Meadow Lake]	⇒ Health region staff time	⇒ # of community partnerships ⇒ increase in staff activity [through survey] ⇒ opportunities for health region staff [yoga classes [North Battleford]; fitness specials [North Battleford; Lloydminster; Meadow Lake]; aquatic specials [North Battleford]
"Healthy Balance Program" ***for schools and students***	⇒ See Accessible Nutritious Food [includes education and opportunity for activity]	⇒	⇒	⇒	⇒	⇒
"Eat Smart , Move More – Stay Balanced ***for adults/parents***	⇒ See Accessible Nutritious Food [includes education and opportunity for activity]	⇒	⇒	⇒	⇒	⇒

Accessible Nutritious Food

Key Activities	Implementation Steps:	Timelines	Internal to Regional Health Authority	External:	Resource Requirements:	Progress Measures
The Good Food Box	o Continued partnership with Midwest Food Resource Project Inc. to make quality vegetables, fruit and whole grains available in at reasonable prices. o Expand program support through: ▸ access to meeting space, ▸ coverage of meeting expenses [telephone, telehealth, etc.] ▸ coverage of copying/faxing/postage expenses ▸ clerical support [copy Good Food Box newsletter] ▸ training and educational support for Midwest staff ▸ integration of volunteer appreciation with health region's volunteer appreciation event	▪ Ongoing ▪ Ongoing	▪ Public Health Nutrition ▪ Public Health Nursing ▪ Successful Mothers Support Program ▪ Community Dietitian ▪ Health Promotion ▪ Community Health	▪ Midwest Food Resource Project Inc. ▪ Other Community Partners	▪ Health Region staff time ▪ See implementation steps	▪ # Good Food Boxes **North Battleford:** [Oct. 69; Nov. 87; Dec. 122; Jan. 74; Feb. 103; Mar. 116 = **Total of 571**] **Meadow Lake:** [Oct. 41; Nov. 43; Dec. 58; Jan. 50; Feb. 93; Mar. 90 = **Total of 375**] **Lloydminster:** [Oct. 77; Nov. 67; Dec. 69; Jan. 71; Feb. 69; Mar.- = **Total of 353**]
Community Kitchens (links with 3 other priority areas)	▪ Continued partnership with Midwest Food Resource Project in the provision of Community Kitchen Services. ▪ Expand program support through: ▸ access to meeting space, ▸ coverage of meeting expenses [telephone, telehealth, etc.] ▸ coverage of copying/faxing/postage expenses ▸ training and educational support for Midwest staff ▸ integration of volunteer appreciation with health region's volunteer appreciation event ▸ development of training tools and resources to enhance community capacity [i.e. Community Kitchen Training Manuals; will incorporate "Nutrition Guidelines for Schools"]. ▸ exploring possible expansion of collective kitchen training to include healthy eating and activity components. Models after HEAL program [Saskatoon] and will be adapted from * "Eat Smart, Move More – Stay Balanced Program [See attached]. ▸ integration of Community Kitchen Services into other agencies [Battlefords Family Health Centre] and other programs [Kids First, Successful Mothers Support Program]	▪ Ongoing ▪ Ongoing ▪ Sept. 2005 ▪ April 2005 ▪ Ongoing	▪ Public Health Nutrition ▪ Public Health Nursing ▪ Community Health	▪ Midwest Food Resource Project Inc. ▪ HEAL Program, Saskatoon ▪ Other Community Partners	▪ Health Region staff time ▪ See implementation steps ▪ Community Kitchen Training Manuals [$600.00]	▪ Number of community kitchens running [North Battleford 3; 4 pending; Meadow Lake 1; Lloyd __] ▪ Community Kitchen Leadership Training and participant numbers at community kitchens ▸ 1 in North Battleford with 10 participants ▸ 1 in Meadow Lake with 9 participants. ▸ 1 in Lloyd with 4 participants.