EXECUTIVE SUMMARY

Study Purpose and Approach

The study focused on assessing the current and anticipated demand for primary health care and family physician services in the Lloydminster catchment area, identifying major issues to be addressed, and recommending potential strategies. The process included: detailed analysis of demographic and utilization data; extensive consultation with a wide range of community stakeholders to understand the issues; a review of the Saskatchewan and Alberta primary health care models to ensure appropriate alignment of recommendations; and the generation and evaluation of innovative approaches to improve access to and the quality of primary health care services.

Major Findings

The major findings and conclusions of the study were:

➢ The Lloydminster catchment area for primary health care services includes about 42,279 residents as of 2009/2010 and the population is projected to continue to grow quite rapidly to 54,787 by 2020.

➢ The population within the catchment area is significantly younger than the provincial averages for Alberta and Saskatchewan; and has lower health status scores in several key areas that have implications for the provision of primary health care services.

➢ The Lloydminster area has experienced significant challenges recruiting family physicians and currently requires at least nine physicians to bring the family physician to resident ratio to recommended guidelines. These demands will increase as the population continues to grow.

➢ The stakeholder consultation process identified: access to family physicians; access to mental health services; access to chronic disease management services; and access to after-hours care as the most pressing primary health care issues that need to be addressed.
Recommendations

The major recommendations of the study were:

1. Develop a shared vision, service mandate, service-delivery model and accountability framework for primary health care for the Lloydminster area.

2. Develop a Primary Health Care Center on the Alberta side of Lloydminster that builds upon the existing Primary Care Network (PCN) and effectively co-locates, integrates and coordinates a wide range of primary health care services.

3. Build and staff a Primary Health Care, Family Practice and Teaching Center attached to the Lloydminster Hospital and aligned with the Saskatchewan Primary Care Model.

4. Develop and implement a family physician recruitment strategy designed to address short-term and longer-term requirements for family physicians for the Lloydminster catchment area.

5. Proactively address issues related to Lloydminster’s unique status as a border city with a view to ensuring residents receive timely, equitable access to primary health care services they need regardless of the province in which they reside. Specifically address issues relating to: funding shortfalls; barriers to patient access to primary health care services funded under the Alberta and Saskatchewan models; and the credentialing and certification of physicians and other health care professional staff.

6. Develop and implement mechanisms and processes to effectively engage key internal and external stakeholders and maintain effective and productive ongoing communications with them.

A common theme that emerged during the stakeholder consultations was that the community of Lloydminster and the surrounding municipalities were willing to work cooperatively with PNRHA, the Health Foundation, and physicians to help build a better primary health care system; and this work was a very high priority for residents. Lloydminster also has a very supportive business community that has demonstrated an ongoing willingness to step up and support health care projects and initiatives. It was suggested that the system should build on the strengths of both the Alberta and Saskatchewan primary health care models to develop a “made in Lloydminster, state of the art solution” that could serve as a model for Western Canada.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Title</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>i</td>
</tr>
<tr>
<td>1.0 BACKGROUND</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Project Context</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Project Objectives</td>
<td>1</td>
</tr>
<tr>
<td>2.0 PROJECT METHODOLOGY</td>
<td>2</td>
</tr>
<tr>
<td>3.0 MAJOR FINDINGS</td>
<td>4</td>
</tr>
<tr>
<td>3.1 Demographic Trends</td>
<td>4</td>
</tr>
<tr>
<td>3.2 Health Status</td>
<td>8</td>
</tr>
<tr>
<td>3.3 Physician Numbers and Emergency Department Utilization</td>
<td>13</td>
</tr>
<tr>
<td>3.4 Current Primary Health Care Services</td>
<td>16</td>
</tr>
<tr>
<td>3.5 Primary Health Care – Strengths, Challenges and Service Gaps</td>
<td>19</td>
</tr>
<tr>
<td>3.6 Physician and Health Professional Recruitment Environment</td>
<td>23</td>
</tr>
<tr>
<td>3.7 Primary Care Vision and Service Model</td>
<td>24</td>
</tr>
<tr>
<td>3.8 Saskatchewan and Alberta Primary Health Care Models</td>
<td>25</td>
</tr>
<tr>
<td>4.0 RECOMMENDATIONS AND IMPLEMENTATION CONSIDERATIONS</td>
<td>38</td>
</tr>
<tr>
<td>APPENDIX 1: LLOYDMINSTER PRIMARY HEALTH CARE CATCHMENT AREA</td>
<td></td>
</tr>
<tr>
<td>APPENDIX 2: PNRHA PRIMARY HEALTH CARE PROJECT STAKEHOLDER CONSULTATIONS RESULTS REPORT</td>
<td></td>
</tr>
<tr>
<td>APPENDIX 3: PHYSICIAN RECRUITMENT FLOW CHART AND ONBOARDING</td>
<td></td>
</tr>
</tbody>
</table>
1.0 Background

1.1 Project Context

The City of Lloydminster and the surrounding catchment area are part of the Prairie North Regional Health Authority (PNRHA). The PNRHA provides services to a large and diverse area in the northwest part of central Saskatchewan with a population of over 74,550 (PNRHA 2009 – 2010 Annual Report). The PNRHA also serves a significant population on the Alberta side of Lloydminster and the surrounding area of approximately 23,549 (Projected Primary Health Care Catchment Area).

The City of Lloydminster has grown rapidly over the last 10 to 15 years. In addition, the city has a “shadow population” as a result of economic activity in the energy industry that is not reflected in the standard demographic statistical data.

The complement of family physicians has not grown to match the needs of the expanding population. In addition, the demand for other primary health care services such as chronic disease management and mental health services has outstripped the capacity to deliver these services. As a result, the community is not being well served in terms of access to family physicians; and there is growing frustration and concern on the part of residents and key stakeholders about access to primary health care services in general.

Accordingly, the PNRHA has engaged an external consulting firm to assess the current and anticipated need for primary health care, including family physician services, and recommend potential strategies to position the region to effectively meet these needs.

1.2 Project Objectives

The specific objectives of the project are to:

➢ Complete an assessment of the current and anticipated demand for primary care and family physician services in the region;

➢ Identify strengths, weaknesses and major issues relating to access to primary care services, including the attraction and retention of family physicians;
Engage physicians, primary care representatives from Alberta and Saskatchewan, the Health Foundation and other key stakeholders in identifying issues to be addressed and potential solutions;

Identify creative options and approaches to organizing the delivery of primary care which may improve access and enhance quality; and

Evaluate options and recommend specific approaches and strategies within the context of the legislative and policy frameworks of Saskatchewan Health and Alberta Health and Wellness.

2.0 Project Methodology

The project methodology included the following key steps:

- **Steering Committee**: A project Steering Committee was established, comprising representatives from the PNRHA, Lloydminster and District Health Advisory Committee and the Lloydminster Region Health Foundation (Health Foundation), to provide overall direction and feedback to the consulting team.

- **Project Objectives and Approach**: An initial meeting was held with the Project Steering Committee to confirm project objectives, review the proposed work plan and key research questions to be addressed, identify individuals and groups to be consulted, and review the project schedule.

- **Communications**: The CEO and PNRHA communications staff developed and issued communications to affected stakeholders to provide an overview of the project and request their participation and input into the process.

- **Document Review**: A wide range of relevant documents and reports were reviewed to provide a context for the project.

- **Demographic Trends**: Available data on demographic trends within the Lloydminster catchment area were reviewed; and updated population growth projections were completed to help inform the assessment of current and anticipated demand for primary health care services.

- **Utilization Data**: Available primary health care utilization data, emergency department utilization data, family physician staffing levels, and PNRHA staffing levels for other primary health care professionals were reviewed.
- **Interviews**: Individual or group interviews were conducted with a number of key representatives and decision-makers to help provide context, identify issues and gather initial ideas for strategies.

- **Stakeholder Focus Groups**: Input from more than 150 representatives of key stakeholder groups was gathered through a series of focus groups. (Appendix 2 provides a listing of the stakeholder groups that were consulted as well as a detailed report on the results from physicians, primary care administration and front line staff, community and municipal leaders, and representatives of the public at large.)

- **Alberta and Saskatchewan Primary Care Models**: The Alberta and Saskatchewan primary health care centre models were reviewed with a view to building on the strengths of each and ensuring reasonable alignment of recommendations. The primary health centre models in Fort McMurray, Chinook, East Edmonton and the Battlefords were studied in some detail to help inform recommendations.

- **Documentation of Findings**: The results from the preceding activities were documented in the form of a draft report and used as the database to support the development of initial recommendations.

- **Steering Committee Review**: Study findings and initial recommendations were reviewed with the Steering Committee and their input and suggestions on initial recommendations sought.

- **Draft Report**: Input and suggestions from the Steering Committee review were used to support the development of the draft report, including recommendations and implementation considerations. The draft recommendations were reviewed with the CEO and the VP Primary Care Services and their input was sought regarding the proposed direction and implementation considerations.

- **Steering Committee Review of Draft Report**: The draft report was reviewed by the Steering Committee and PNRHA executive, and feedback and suggestions were noted.

- **Finalization of Report**: The consultants finalized the report, taking into consideration feedback from the Steering Committee and PNRHA Executive.
3.0 Major Findings

3.1 Demographic Trends

An understanding of the make-up of the population in the Lloydminster primary health care catchment area and a study of growth patterns are important to effective planning. The data paints a vivid picture of a region in transition, dealing simultaneously with boom-driven growth in some areas and level or slow growth populations in others. The typical demographic characteristics of a developing energy-driven urban area contrast with the diversity and unique attributes of a more stable, land-based economy.

Patterns of Population Growth

The rapid growth in the City of Lloydminster has been well documented. Between 1991 and 2006, for example, the Alberta portion of the City of Lloydminster had an annual average growth rate (3.86%) only exceeded by Grande Prairie. The Saskatchewan portion of the city had a lower average annual growth rate (0.8%) for the same period, but this compared well to its Saskatchewan counterparts (City of Lloydminster, Municipal Census, 2009).

Exhibits 1, 2 and 3 following illustrate past growth, and reflect projections that the City of Lloydminster will have a population of almost 105,000 by the year 2055.

| Exhibit 1: Lloydminster Historical Population Data |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Saskatchewan             | 7,636 | 7,840 | 8,156 | 8,118 | 8,737 |
| Alberta                  | 11,317 | 13,148 | 15,487 | 15,910 | 16,786 |
| TOTAL                    | 18,953 | 20,988 | 23,643 | 24,028 | 25,523 |

| Exhibit 2: Lloydminster Permanent Resident Population Projections |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|                          | 2009 | 2015 | 2020 | 2030 | 2045 | 2055 |
| Saskatchewan             | 9,100 | 10,345 | 11,511 | 14,254 | 19,641 | 24,320 |
| Alberta                  | 17,402 | 21,243 | 25,084 | 34,976 | 57,586 | 80,293 |
| TOTAL                    | 26,502 | 31,588 | 36,596 | 51,260 | 77,227 | 104,613 |

Source: City of Lloydminster, Growth Study 2009

The disparity of growth rates in the Alberta and Saskatchewan sides of the city will have an increasingly obvious impact over time.
In contrast to the rapid growth rate in the City of Lloydminster, it is interesting to note the population in the Battlefords and surrounding area, and Meadow Lake and surrounding area, has been relatively stable between 2003 and 2006; and the population in the remaining region has grown by 6.9% over the same period (Exhibit 4). These trends are significant in that they serve to illustrate the importance of ensuring that service planning and resource allocation decisions take into account population growth trends.

**Exhibit 4: PNRHA Population Outside the City of Lloydminster**

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>N. Battleford City</td>
<td>15,135</td>
<td>15,204</td>
<td>15,380</td>
<td>14,812</td>
<td>15,110</td>
<td>15,401</td>
<td>15,217</td>
<td>0.5</td>
</tr>
<tr>
<td>Battleford</td>
<td>4,086</td>
<td>4,130</td>
<td>4,133</td>
<td>4,037</td>
<td>4,019</td>
<td>4,102</td>
<td>4,064</td>
<td>-0.5</td>
</tr>
<tr>
<td>RM Battleford</td>
<td>531</td>
<td>500</td>
<td>484</td>
<td>463</td>
<td>453</td>
<td>446</td>
<td>451</td>
<td>-15.1</td>
</tr>
<tr>
<td>Meadow Lake Town</td>
<td>6,206</td>
<td>6,524</td>
<td>6,648</td>
<td>6,259</td>
<td>6,431</td>
<td>6,592</td>
<td>6,319</td>
<td>1.8</td>
</tr>
<tr>
<td>RM Meadow Lake</td>
<td>1,879</td>
<td>1,849</td>
<td>1,796</td>
<td>1,768</td>
<td>1,799</td>
<td>1,827</td>
<td>1,799</td>
<td>-4.3</td>
</tr>
<tr>
<td>Remaining Region</td>
<td>33,703</td>
<td>34,287</td>
<td>34,630</td>
<td>34,683</td>
<td>34,928</td>
<td>33,603</td>
<td>36,038</td>
<td>6.9</td>
</tr>
</tbody>
</table>

*Source: PNRHA Key Indicator Report, 2010-11 (amended)*
**Lloydminster Primary Health Care Catchment Area**

To effectively analyze the resources needed for a workable primary health care system for Lloydminster, it is necessary to define the area this system would serve. Based on an assessment of population numbers and already defined centres of medical service, the estimate of population to be served is outlined in Exhibit 5. A map and a detailed explanation of the area included in the catchment calculations are included in Appendix 1 of this report.

| Exhibit 5: Population Projections for Lloydminster Primary Health Care Catchment Area |
|---------------------------------------------|----------------|---------|---------|--------|
|                                             | 2009/10 | 2015   | 2020   | 2030   |
| City of Lloydminster Population             | 26,502  | 31,588 | 36,596 | 52,260 |
| Alberta Region                              | 6,147   | 6,762  | 7,371  | 8,550  |
| Saskatchewan Region                         | 9,630   | 10,208 | 10,820 | 12,064 |
| Lloydminster Regional Population            | 42,279  | 48,588 | 54,787 | 72,874 |

*Data Sources:*
- City of Lloydminster figures – City of Lloydminster, Growth Study 2009.
- Alberta/Saskatchewan Region Population Projection figures – Statistics Canada 2009/10
- Census Tract data inflated by medium growth provincial population growth projections

**Characteristics of Resident Population**

The population of the City of Lloydminster and the primary health care catchment area is generally younger than provincial comparators (Exhibit 6). Nearly 50% of the population of the City of Lloydminster is under the age of 30. Almost 30% of the population is school age (<19). The populations in the former East Central Health Region and the PNRHA are also younger than their respective provincial levels.
Education levels are lower in the Lloydminster region when contrasted with provincial scores. In the ECH\(^1\), 77.7% of the population has graduated from high school compared to 82.6% in Alberta. For PNRHA\(^*\), 71.7% are high school graduates, while the Saskatchewan rate is 80.8%.

Low income rates are similar in PNRHA and Saskatchewan as a whole (14.2%/14.2%), whereas the ECH rates are lower than Alberta’s (8.6%/12.2%).

**Percentage of Aboriginal Population**

The Aboriginal population in PNRHA is almost double the rate in Saskatchewan (29.0%/14.9%). The 2009-2010 PNRHA annual report notes that nearly a third of the population of PNRHA is of Aboriginal descent and goes on to demonstrate that the Aboriginal population is also very young when compared to the region and the province.

\(^{1}\) Lloydminster straddles two health districts and some information is drawn from the data from the Prairie North Regional Health Authority (PNRHA) and the East Central Health Authority (ECH).
By contrast, the Aboriginal population in ECH is smaller than Alberta as a whole (3.5%/5.8%).

**Exhibit 7: PNRHA First Nation Community Population by Age Groupings - 2008**

The Shadow Population

The shadow population of an economic centre like Lloydminster includes workers and business visitors who do not live in Lloydminster, but who may spend a large part of their work year in the area. The 2007 study for the Lloydminster Hospital functional program estimated the shadow population at about 1,500 persons. More recent estimates from the City of Lloydminster, Tourism and Economic Development, put the number somewhere between 1,000 and 3,000 depending on the nature of the activity in the area. No accurate survey data was found to verify these numbers.

**3.2 Health Status**

Health status indicators are increasingly valued as a reliable tool for predicting the demand on medical services of all types. Exhibit 8 below provides a detailed overview of recently released data drawn from the Alberta (the former ECH Region) and Saskatchewan (PNRHA) health authorities in which the City of Lloydminster is located.
While this information is drawn from the two health authorities as a whole, it provides useful insights into the population of the Lloydminster region and the special needs that must be successfully met in any primary health care model.

**Health Scores are Lower than Provincial Averages**

Generally, the Lloydminster area health status scores are lower than comparable province-wide numbers.

- For example, the diabetes rate in the former ECH region is almost double that of the Alberta score (9.0% compared to 4.8%). The diabetes rate for the PNRHA is also higher than the Saskatchewan provincial number (7.0% versus 5.6%). It is important to note that the Saskatchewan diabetes rates as a whole are almost 30% higher than in Alberta.

- A similar pattern is shown for rates of overweight and obesity. The former ECH region had rates higher than Alberta (61.1% versus 55.1%); PNRHA has rates higher than Saskatchewan (67.4% versus 58.6%); and Saskatchewan rates are 3.5% higher than Alberta.

**Lower Participation Rates for Preventative Health Practices**

Residents of the Lloydminster area tend to be less involved in activities that might improve their general health status:

- Fewer people describe themselves as being active or moderately active in their leisure time (ECH: 45.5% versus 56.5% in Alberta; PNRHA: 38.5% versus 51.9% in Saskatchewan).

- Immunization rates for seasonal flus are also much lower than comparable provincial patterns (ECH: 26.3% versus 30.8%; PNRHA: 18.9% versus 30.7%).

- The percentage of the population having regular pap smears is lower in the Lloydminster area than in either province, although Saskatchewan scores better than Alberta.
<table>
<thead>
<tr>
<th>Exhibit 8: Health Status Indicators</th>
<th>AB (ECH)</th>
<th>AB (Province)</th>
<th>SK (PNRHA)</th>
<th>SK (Province)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Well-being</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived health, very good or excellent (%)</td>
<td>54.1</td>
<td>61.4</td>
<td>60.7</td>
<td>58.7</td>
</tr>
<tr>
<td>Perceived mental health, very good or excellent (%)</td>
<td>67.9</td>
<td>73.8</td>
<td>68.9</td>
<td>71.7</td>
</tr>
<tr>
<td>Perceived life stress (%)</td>
<td>21.1</td>
<td>22.5</td>
<td>17.0</td>
<td>19.0</td>
</tr>
<tr>
<td><strong>Health Conditions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overweight or obese (%)</td>
<td>61.1</td>
<td>55.1</td>
<td>67.4</td>
<td>58.6</td>
</tr>
<tr>
<td>Diabetes (%)</td>
<td>9.0</td>
<td>4.8</td>
<td>7.0</td>
<td>5.6</td>
</tr>
<tr>
<td>Asthma (%)</td>
<td>11.1</td>
<td>8.5</td>
<td>7.0</td>
<td>9.0</td>
</tr>
<tr>
<td>High blood pressure (%)</td>
<td>18.3</td>
<td>14.6</td>
<td>16.6</td>
<td>18.2</td>
</tr>
<tr>
<td>Mood disorder (%)</td>
<td>9.9</td>
<td>6.8</td>
<td>......</td>
<td>7.1</td>
</tr>
<tr>
<td>Low birth weight (% of live births)</td>
<td>5.6</td>
<td>6.7</td>
<td>5.9</td>
<td>5.6</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (COPD) (%)</td>
<td>4.0</td>
<td>3.3</td>
<td>......</td>
<td>4.3</td>
</tr>
<tr>
<td>Hospitalized stroke event rate (per 100,000 population)</td>
<td>120</td>
<td>123</td>
<td>140</td>
<td>133</td>
</tr>
<tr>
<td>Hospitalized acute myocardial infarction event rate (per 100,000 population)</td>
<td>246</td>
<td>205</td>
<td>276</td>
<td>228</td>
</tr>
<tr>
<td>Injury hospitalization (per 100,000 population)</td>
<td>729</td>
<td>715</td>
<td>988</td>
<td>805</td>
</tr>
<tr>
<td><strong>Health Behaviours</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current smoker, daily or occasional (%)</td>
<td>23.1</td>
<td>23.3</td>
<td>32.4</td>
<td>21.6</td>
</tr>
<tr>
<td>Current smoker, daily (%)</td>
<td>19.0</td>
<td>17.9</td>
<td>27.1</td>
<td>17.2</td>
</tr>
<tr>
<td>Heavy drinking (%)</td>
<td>20.3</td>
<td>18.2</td>
<td>17.9</td>
<td>18.7</td>
</tr>
<tr>
<td>Leisure-time physical activity, moderately active or active (%)</td>
<td>45.5</td>
<td>56.5</td>
<td>38.5</td>
<td>51.9</td>
</tr>
<tr>
<td>Fruit and vegetable consumption, 5 times or more per day (%)</td>
<td>42.0</td>
<td>42.7</td>
<td>42.4</td>
<td>39.7</td>
</tr>
<tr>
<td>Bike helmet use (%)</td>
<td>25.4</td>
<td>48.3</td>
<td>23.6</td>
<td>22.6</td>
</tr>
</tbody>
</table>
### Exhibit 8: Health Status Indicators

<table>
<thead>
<tr>
<th></th>
<th>AB (ECH)</th>
<th>AB (Province)</th>
<th>SK (PNRHA)</th>
<th>SK (Province)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Human Function</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation and activity limitation, sometimes or often (%)</td>
<td>30.5</td>
<td>28.0</td>
<td>31.6</td>
<td>30.7</td>
</tr>
<tr>
<td>Functional health, good to full (%)</td>
<td>78.6</td>
<td>80.6</td>
<td>82.4</td>
<td>79.4</td>
</tr>
<tr>
<td><strong>Accessibility</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza immunization (%)</td>
<td>26.3</td>
<td>30.8</td>
<td>18.9</td>
<td>30.7</td>
</tr>
<tr>
<td>Mammography (%)</td>
<td>78.7</td>
<td>74.0</td>
<td>70.4</td>
<td>73.6</td>
</tr>
<tr>
<td>Pap smear</td>
<td>71.8</td>
<td>76.6</td>
<td>76.2</td>
<td>77.1</td>
</tr>
<tr>
<td>Regular medical doctor (%)</td>
<td>81.4</td>
<td>80.6</td>
<td>78.8</td>
<td>83.4</td>
</tr>
<tr>
<td>Wait time for hip fracture surgery (surgery same or next day) (Proportion)</td>
<td>40.4</td>
<td>61.4</td>
<td>33.6</td>
<td>47.1</td>
</tr>
<tr>
<td><strong>Effectiveness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory care sensitive conditions (per 100,000 population)</td>
<td>401</td>
<td>308</td>
<td>689</td>
<td>486</td>
</tr>
<tr>
<td><strong>Environmental Factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second-hand smoke, exposure at home (%)</td>
<td>6.9</td>
<td>5.8</td>
<td>10.4</td>
<td>6.9</td>
</tr>
<tr>
<td>Second-hand smoke, exposure in vehicles and/or public places (%)</td>
<td>21.4</td>
<td>15.3</td>
<td>18.6</td>
<td>13.2</td>
</tr>
<tr>
<td><strong>Deaths</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant mortality (per 1,000 live births)</td>
<td>4.3</td>
<td>5.5</td>
<td>9.6</td>
<td>6.3</td>
</tr>
<tr>
<td>Total, all causes of death (per 100,000 population)</td>
<td>580.9</td>
<td>531.9</td>
<td>626.6</td>
<td>582.7</td>
</tr>
<tr>
<td>All cancers (per 100,000 population)</td>
<td>176.2</td>
<td>153.7</td>
<td>164.2</td>
<td>161.4</td>
</tr>
<tr>
<td>Colorectal cancer (per 100,000 population)</td>
<td>21.6</td>
<td>15.0</td>
<td>12.1</td>
<td>16.4</td>
</tr>
<tr>
<td>Lung cancer (per 100,000 population)</td>
<td>41.4</td>
<td>38.6</td>
<td>43.8</td>
<td>40.5</td>
</tr>
<tr>
<td>Breast cancer (per 100,000 population)</td>
<td>10.4</td>
<td>10.8</td>
<td>12.0</td>
<td>11.4</td>
</tr>
<tr>
<td>Prostate cancer (per 100,000 population)</td>
<td>12.7</td>
<td>9.7</td>
<td>12.3</td>
<td>11.8</td>
</tr>
<tr>
<td>Circulatory disease (per 100,000 population)</td>
<td>176.2</td>
<td>167.</td>
<td>185.1</td>
<td>176.4</td>
</tr>
<tr>
<td>Ischaemic heart diseases (per 100,000 population)</td>
<td>94.7</td>
<td>96.5</td>
<td>99.5</td>
<td>91.3</td>
</tr>
<tr>
<td>Cerebrovascular diseases (per 100,000 population)</td>
<td>36.3</td>
<td>31.0</td>
<td>34.3</td>
<td>32.5</td>
</tr>
<tr>
<td>Health Status Indicators</td>
<td>AB (ECH)</td>
<td>AB (Province)</td>
<td>SK (PNRHA)</td>
<td>SK (Province)</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>----------</td>
<td>---------------</td>
<td>------------</td>
<td>--------------</td>
</tr>
<tr>
<td>All other circulatory diseases (per 100,000 population)</td>
<td>45.3</td>
<td>40.5</td>
<td>51.3</td>
<td>52.5</td>
</tr>
<tr>
<td>Respiratory diseases (per 100,000 population)</td>
<td>52.9</td>
<td>46.5</td>
<td>49.7</td>
<td>47.4</td>
</tr>
<tr>
<td>Pneumonia and influenza (per 100,000 population)</td>
<td>14.8</td>
<td>11.7</td>
<td>16.6</td>
<td>14.1</td>
</tr>
<tr>
<td>Bronchitis, emphysema and asthma (per 100,000 population)</td>
<td>3.9</td>
<td>2.3</td>
<td>7.1</td>
<td>3.5</td>
</tr>
<tr>
<td>All other respiratory diseases (per 100,000 population)</td>
<td>34.2</td>
<td>32.6</td>
<td>26.1</td>
<td>29.8</td>
</tr>
<tr>
<td>Unintentional injuries (per 100,000 population)</td>
<td>34.9</td>
<td>25.2</td>
<td>50.5</td>
<td>33.7</td>
</tr>
<tr>
<td>Suicides and self-inflicted injuries (per 100,000 population)</td>
<td>6.8</td>
<td>11.1</td>
<td>14.3</td>
<td>11.2</td>
</tr>
<tr>
<td>Human immunodeficiency virus (HIV) disease (per 100,000 population)</td>
<td>.....</td>
<td>0.8</td>
<td>.....</td>
<td>0.6</td>
</tr>
<tr>
<td>Living and Working Conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school graduates aged 25 to 29 (%)</td>
<td>77.7</td>
<td>82.6</td>
<td>71.7</td>
<td>80.8</td>
</tr>
<tr>
<td>Unemployment (%)</td>
<td>5.1</td>
<td>6.6</td>
<td>5.8</td>
<td>4.8</td>
</tr>
<tr>
<td>Low income (%)</td>
<td>8.6</td>
<td>12.2</td>
<td>14.2</td>
<td>14.4</td>
</tr>
<tr>
<td>Children aged 17 and under living in low income families (%)</td>
<td>9.7</td>
<td>13.9</td>
<td>20.2</td>
<td>17.9</td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth, under 20 years, as a proportion of total population (%)</td>
<td>26.3</td>
<td>25.0</td>
<td>31.3</td>
<td>26.3</td>
</tr>
<tr>
<td>Seniors, 65 years and over, as a proportion of total population (%)</td>
<td>15.1</td>
<td>10.4</td>
<td>12.5</td>
<td>14.7</td>
</tr>
<tr>
<td>Aboriginal population</td>
<td>3.5</td>
<td>5.8</td>
<td>29.0</td>
<td>14.9</td>
</tr>
<tr>
<td>Lone-parent families (%)</td>
<td>10.6</td>
<td>14.4</td>
<td>20.0</td>
<td>16.6</td>
</tr>
<tr>
<td>Health System</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact with medical doctor in past 12 months (%)</td>
<td>75.8</td>
<td>77.6</td>
<td>81.9</td>
<td>81.3</td>
</tr>
</tbody>
</table>

3.3 Physician Numbers and Emergency Department Utilization

A growing population places demands on the health care system to respond to the changing needs of the community. Of special interest to this study is the number of family physicians available to meet the needs of the residents of Lloydminster.

Physician Requirements for the Lloydminster Primary Health Care Catchment Area

The chart below (Exhibit 9), based on a best estimate of the resident population size for a Lloydminster-based primary health care catchment area, demonstrates the challenges ahead in recruiting and retaining an adequate number of physicians to meet current and anticipated demands. The shadow population estimates are likely understated; it would be useful for future planning exercises if a study was undertaken to measure the impact of this important variable.

<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2015</th>
<th>2020</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimate of the Resident Population Size</td>
<td>42,279</td>
<td>48,588</td>
<td>54,787</td>
<td>72,874</td>
</tr>
<tr>
<td>% Increase</td>
<td></td>
<td>14.5</td>
<td>12.6</td>
<td>31.8</td>
</tr>
<tr>
<td>Physicians Needed – Residents (1 physician: 1,500 population)</td>
<td>28.19</td>
<td>32.4</td>
<td>36.5</td>
<td>48.6</td>
</tr>
<tr>
<td>Estimate of the Shadow Population Size</td>
<td>1,000-3,000</td>
<td>1,145-3,435</td>
<td>1,289-3,868</td>
<td>1,699-5,098</td>
</tr>
<tr>
<td>Allowance for Shadow Population (1 physician: 8,000 population)</td>
<td>0.25</td>
<td>0.44</td>
<td>0.48</td>
<td>0.75</td>
</tr>
<tr>
<td>Estimated Number of Physicians Needed (1 physician: 1,500 population)</td>
<td>28.44</td>
<td>32.84</td>
<td>36.98</td>
<td>49.35</td>
</tr>
</tbody>
</table>

2011 Family Physician Numbers in Lloydminster – 19.38
2009/2010 Resident to Family Physician Ratio – 2,181/1

Data Sources:
City of Lloydminster, Growth Study 2009
Statistics Canada 2009/10 Census
Tract data inflated by medium-growth provincial population growth projections
Comparative Physician Numbers

The 2011 Statistics Canada Health Profile contains information that allows comparison of the number of family physicians and specialist physicians in the PNRHA and the former ECH region compared to provincial norms. That information, contained in Exhibit 10, highlights the shortage of family physicians and specialist physicians in the Lloydminster area relative to both Alberta and Saskatchewan.

<table>
<thead>
<tr>
<th>Exhibit 10</th>
<th>AB (ECH)</th>
<th>AB (Province)</th>
<th>SK (PNRHA)</th>
<th>SK (Province)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors Rate – General/Family Physicians (per 100,000 population)</td>
<td>89</td>
<td>112</td>
<td>80</td>
<td>93</td>
</tr>
<tr>
<td>Residents/Family Physician</td>
<td>1123</td>
<td>893</td>
<td>1250</td>
<td>1075</td>
</tr>
<tr>
<td>Doctors Rate – Specialist Physicians (per 100,000 population)</td>
<td>14</td>
<td>91</td>
<td>19</td>
<td>70</td>
</tr>
</tbody>
</table>

The City of Lloydminster and catchment area is under-resourced with respect to family physicians. There are currently 19.38 FTE family physicians providing services within the defined catchment area which currently has a service population of about 42,279. This represents a physician to resident ratio of 2,181.6 residents/family physician. In addition, it is important to recognize that family physicians have a comprehensive practice that includes hospital inpatient care, emergency room coverage and on call services which adds substantially to their workloads.

If the Lloydminster area is to achieve target ratio of 1,500 residents per family physician, which is a generally accepted ratio for family physicians operating in primary health care centres, an additional nine physicians are required immediately; and based on projected population growth in the area, an additional 13 physicians will be required within five years.

Emergency Room Usage

It is important to note the performance of the health system in terms of accessibility, patient satisfaction and other key indicators. The PNRHA estimates that 30% to 40% of its residents do not have a family physician, and there were many focus group stories of lengthy waits to see a family doctor for even routine items like prescription renewal. The Canadian College of Family Physicians notes that 85% of Canadians have a family doctor; thus the Lloydminster area is significantly underserved. Perhaps the most telling statistic in assessing the accessibility and responsiveness of the system is that of ER usage. The chart below
documents the high number of unscheduled visits to the ER, and demonstrates that over 81% of these visits are for non-emergent issues (CATS 4 and 5).

Exhibit 11a: Lloydminster Hospital ER Visits by Triage Codes

<table>
<thead>
<tr>
<th>Triage Codes</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>One &amp; Two</td>
<td>538</td>
<td>517</td>
<td>526</td>
</tr>
<tr>
<td>Three</td>
<td>5,459</td>
<td>4,995</td>
<td>5,929</td>
</tr>
<tr>
<td>Four &amp; Five</td>
<td>25,100</td>
<td>21,569</td>
<td>25,103</td>
</tr>
</tbody>
</table>

Data Source: Prairie North Regional Health Authority, Hospital Key Activity Indicators, March 16, 2011.

Exhibit 11b: ER Visits by Triage Code

Summary

The City of Lloydminster and its surrounding service area face a number of challenges in providing responsive and accessible health care. The community has been experiencing sustained growth fueled by its role as a key centre in the energy and service industries. This growth is expected to continue well into the mid-21st Century, and the boom displays a
familiar pattern of a growing shadow workforce, and a resident population showing an elevated need for primary care services when compared to the provincial populations as a whole.

The recruitment and retention of health professionals will be key to building a primary health system that responsively and effectively meets the needs of its population.

3.4 Current Primary Health Care Services

Primary health care represents the first point of contact people have with the health care system. It is where people have their everyday health care needs met usually by family physicians, nurses, mental health professionals, dieticians, pharmacists and other health care professionals. Exhibit 12 diagrammatically presents the key components of primary health care and illustrates the vital linkages to secondary and tertiary services, specialists and the Emergency Department.
In the Lloydminster area a range of services are offered that could be categorized as primary health care. These include family physician services; mental health services; community diabetes education and counseling; school immunization; child health clinics, cardiac education, home care services, and maternal/child services. Exhibit 13 following provides an overview of the full time equivalent health care professionals providing primary care services in the Lloydminster area.

<table>
<thead>
<tr>
<th>Exhibit 13: Primary Health Care Professionals – Lloydminster Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Description</td>
</tr>
<tr>
<td>Family Physician Services</td>
</tr>
<tr>
<td>Nurse Practitioner Services</td>
</tr>
<tr>
<td>Home Care Services</td>
</tr>
<tr>
<td>Assessment and Case Management</td>
</tr>
<tr>
<td>Home Nursing</td>
</tr>
<tr>
<td>Wellness Clinics</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
</tr>
</tbody>
</table>
| Diabetes                                                      | 0.69     | ➢ RHA diabetes educator and dietitian provide two monthly diabetes classes, one for those on insulin and a second clinic for those on oral medications.  
➢ Cholesterol Classes and Salt classes are also offered.  
➢ Education and support offered for diabetes education of other health care providers. |
| Cardiovascular Heart Health                                   | 0.4      | ➢ One to one client heart health education provided based on referrals.  
➢ Heart to Heart classes quarterly. |
<p>| Asthma                                                        | -        | ➢ No dedicated resources |
| COPD                                                          | 1.0      | ➢ For all program needs in Lloydminster. Respiratory Therapist supports a home exercise program. |</p>
<table>
<thead>
<tr>
<th>Service Description</th>
<th>FTE</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Other                               | 1.33| ➢ STRIDES: Chronic Disease Education and Exercise program 3 days per week. Provides coordination for stroke education and rehabilitation outpatient clinics  
➢ Living With Stroke classes offered quarterly.  
➢ Live well with Chronic Conditions offered quarterly.  
➢ CDM working to expand depression screening throughout the region. |
| Population Health                   |     |                                                                           |
| Acquired Brain Injury               | 1.0 | ➢ Provides regional services including Lloydminster for clients with brain injury, prevention of injury. |
| Speech Language Pathology           | 2.0 | ➢ Provide SLP services to children birth to 5 years in Lloydminster and area. |
| Speech Language Pathology (Adult)   | 1.0 | ➢ Adult SLP services regional including Lloydminster, to acute, long term care and community. |
| Autism Services                    | 1.0 | ➢ ASD services to children birth to age 18. Both positions based in Lloydminster |
| Physiotherapy                      | 6.6 | ➢ Services to Lloydminster Hospital, Dr. Cooke, Jubilee Home, Home care and community. Support of program STRIDES and stroke strategy. |
| Occupational Therapy               | 3.2 | ➢ Services to Lloydminster Hospital, Dr. Cooke, Jubilee Home, Home care and community. Support of stroke strategy and living well. |
| Occupational Therapy (Pediatric)    | 2 d/wk | ➢ Children birth to age 5, service delivered at Lloyd Hospital  
➢ Contractor services |
| Respiratory Therapy                | 1.0 | ➢ Service delivered to Lloydminster hospital and outpatient services. |
| Podiatry                            | 2.0 | ➢ Based in North Battleford, provides services to Lloydminster 2 times a month. |
| TIPS Coordinator                   | 1.0 | ➢ Based in North Battleford provides services to Lloydminster and area. For children birth to age 5. |
### Exhibit 13: Primary Health Care Professionals – Lloydminster Area

<table>
<thead>
<tr>
<th>Service Description</th>
<th>FTE Prof</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Childhood Psychology</td>
<td>0.4</td>
<td>Psychology services for children birth to age 5.</td>
</tr>
<tr>
<td>Public Health</td>
<td>12.75</td>
<td>Parent Mentoring Program – Volunteer Mentor program that supports at risk pregnant and new mothers, Runs Baby’s First program.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Population Health Program – supports healthy lifestyle through the 4 pillars identified by Sk Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Public Health Nursing – including Child health clinics, postnatal programming, prenatal support, school programs, teen prenatal programming and travel health program</td>
</tr>
<tr>
<td>Mental Health</td>
<td>10</td>
<td>In addition provide outpatient Psychiatry services 6 days per month.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In the process of hiring 3 FTE Addictions Workers.</td>
</tr>
<tr>
<td>Social Work</td>
<td>3</td>
<td>Social Workers in Child &amp; Youth Services.</td>
</tr>
<tr>
<td>Community Liaison</td>
<td>1.0</td>
<td>Onion Lake employee providing service to Lloydminster Hospital</td>
</tr>
</tbody>
</table>

### 3.5 Primary Health Care – Strengths, Challenges and Service Gaps

The study process included an extensive stakeholder consultation process. Input from more than 150 representatives of key stakeholder groups was gathered through a combination of interviews and focus groups. There was a high degree of convergence with respect to perceived strengths, challenges and priority primary health care service gaps that needed to be addressed.

#### Primary Health Care – Current Strengths

Stakeholder representatives identified the following as strengths of the current primary health care service.

- **Physician Support:** Physicians are dedicated and committed to providing quality care. They generally work well together and are responsive to requests for support from other...
health care professionals. Most doctors have hospital privileges and contribute to the effective operation of the hospital.

- **Community Support**: The community and residents are quite supportive of and appreciative of the work family physicians and other health care professionals do on their behalf. The community has an innovative, entrepreneurial, “can do” attitude; access to a strong economic resource base; and numerous socially conscious businesses that strongly support the hospital and are willing to get involved and provide financial support for projects.

- **Strong Health Foundation**: The community has a strong Health Foundation that does good work to raise funds and support health care service delivery.

- **Practice Environment**: Physicians identified positive working environments in their clinics and mutual respect and support among physicians and other front line health professionals as a positive feature. They also expressed strong support for a practice environment that allowed them to be independent and self-directed and do interesting and challenging work.

- **Specific Program Strengths**: Specific primary health care programs/services identified by stakeholders as working well included:
  - Home Care Services;
  - Long-term care at Jubilee and Dr. Cooke;
  - Cancer Care;
  - Maternal/Child Services;
  - Adult Wellness Clinics;
  - Supportive Living – PointsWest;
  - Palliative Care; and
  - EMS/Ambulance.

- **Quality of Care**: Several public representatives indicated that the quality of care was good once you actually got access to the system.

**Primary Health Care – Current Challenges and Issues**

Stakeholder representatives identified the following as the major issues and challenges with the current primary health care service.
Access to Family Physicians: Access to physicians is a major problem for the Lloydminster area. Many people do not have a family physician – over 40% of those coming to the ER are unattached; and wait times for attached patients to access a physician for non-emergency services range from three to six weeks. Most clinics try to provide some emergency slots for their clients, although these tend to fill up quickly. Currently not one doctor in Lloydminster is taking on new patients.

Primary Care Service Pressures: There are access and capacity issues and staff shortages in many primary care service areas including Mental Health, Chronic Disease Management, Diabetes Care, Cardiovascular Health, and Community-based Therapies.

Emergency Department: The Emergency Department is under great pressure since unattached patients and patients that cannot get quick access to their family physicians use the Emergency Department as a walk-in clinic. This results in long wait times at emergency and inefficient and inappropriate use of more expensive emergency department resources.

Physicians Workload: Work-life balance is a challenge for family physicians working in Lloydminster. Physicians are over worked and stretched so thinly it is difficult to take holidays or time off. This creates challenges with recruitment and retention. The area needs at least 8-10 additional family physicians immediately just to stabilize the system.

Service Alignment Challenges: There is some duplication of services which results in inefficiency. Clinics do not operate using a multi-disciplinary primary care team approach, resulting in sub-optimization of scarce physician resources. The coordination of home care and public health nursing services could be improved. Discharge planning and management is not managed as effectively as it should be.

Physical Space Challenges: The health region has huge staff housing/space challenges. Even if new staff and programs are approved there is no place to locate them.

Border Issues: There is confusion for physicians and the public regarding which services are delivered in which province; and different funding and service delivery models between the provinces add to the confusion. In addition, significant pay discrepancies exist between Alberta and Saskatchewan in some areas (physicians and therapists for example) create challenges keeping physicians and other health care workers in Saskatchewan. Differences in physician certification requirements between provinces are also problematic.
➢ **Funding Issues:** There is a perception among some stakeholders that Lloydminster is proportionately underfunded – both from the Alberta and Saskatchewan sides. The net deficit funding from Alberta for 2009-10 is estimated by the PNRHA to be $1.48 million. The ability of the health region to plan effectively is also severely compromised by the lack of timely information about funding levels from the Alberta government.

➢ **Onion Lake Pressures:** The physician and primary health care centre on the reserve at Onion Lake provides a very important service. With the planned retirement of the physician serving the community, there will be significant pressures placed on the Emergency Department if a replacement is not found.

➢ **Access to Specialists:** There is a shortage of specialists which makes family practice more stressful and risky. This can be a barrier to recruiting and retaining family physicians.

➢ **Health Records:** There is no integrated primary health record – not all clinics are linked for information exchange and access to patient information is impeded by different electronic health systems between provinces. Lack of access to Alberta’s Electronic Health Records for Saskatchewan service providers is problematic.

➢ **After Hours Care:** There is very limited access to after-hours care, except through the Emergency Department. There does not appear to be a systematic approach to providing timely emergent care; e.g. Christmas coverage, etc.

➢ **Service Continuity:** Services are not provided in a client-centered, seamless manner; discharge planning and follow-up need to improve; and records management and data collection systems are not integrated.

### Highest Priority Primary Health Care Service Gaps

Participants identified the following as the most significant primary care service gaps within the Lloydminster area that needed to be addressed.

➢ **Access to Family Physicians:** There is a serious shortage of family physicians; wait-times to see a physician for non-emergency care are in the three to six week range; approximately 40% of patients that present at the Emergency Department do not have a family physician; and no physicians in the area are taking on new patients.
Access to Mental Health Services: Mental health services that are available are well organized and effective; however, the demand for services was viewed as significantly exceeding current capacity to deliver.

Access to Chronic Disease Management Services: While some resources have been allocated to diabetes and cardiac education, they are not adequate to meet the demand for chronic disease management services.

24/7 Access: After-hours access to physician services and other primary health care services was identified as a major issue by all stakeholders.

Engaged and Supportive Community

A common theme that emerged during the stakeholder consultations was that the community of Lloydminster and the surrounding municipalities were willing to work cooperatively with the health region, the Health Foundation, and physicians to help build a better primary health care system. Representatives of the Chamber of Commerce, the City, and surrounding municipalities indicated they were quite prepared to work in partnership with the health region to assist with the development of PHCC and physician recruitment and retention.

It was also noted that Lloydminster had a very supportive business community that had demonstrated an ongoing willingness to step up and help fund health care projects and initiatives. It was suggested that we should build on the strengths of both the Alberta and Saskatchewan primary health care models to develop a made in Lloydminster, state of the art solution that could serve as a demonstration project and model for western Canada.

3.6 Physician and Health Professional Recruitment Environment

The national and provincial shortage of family physicians has created a very competitive environment, making it increasingly difficult to attract physicians to the Lloydminster region. Historically, the responsibility for recruiting family physicians has rested with the privately owned and operated physician clinics. Representatives of these clinics have indicated that they have been providing a range of incentives, including signing bonuses, access to housing, vehicles and relocation allowances to support their recruitment efforts; and in spite of these incentives they have had very limited success in attracting family physicians to their clinics.

It has become apparent to physicians, the PNRHA and community leaders that a more coordinated approach that brings a range of community resources to bear to support
recruitment efforts is required. Consultation with community leaders and other stakeholders suggest they would be supportive of such an approach.

Similar recruitment challenges exist across the spectrum of primary health care professionals – with mental health professionals, nurse practitioners, physiotherapists, dietitians and clinical nurse specialists being identified as particularly difficult to recruit.

These challenges are compounded by differences between Alberta and Saskatchewan relating to compensation levels for various primary care professionals, the medical services fee schedule for family physicians, and certification and licensing requirements.

### 3.7 Primary Care Vision and Service Model

While some work has been done to develop a strategic plan for primary health care services for the PNRHA, input from physicians and front line primary health care staff in Lloydminster suggests they have very limited awareness of the plan and little involvement in its development. Almost all stakeholder focus group participants identified the need to collaboratively develop a clear shared vision, service mandate, service delivery model, and accountability framework for primary health care for the Lloydminster area.

There was general agreement among physicians and primary health care administration and staff that the primary care vision and model should include the following key principles and/or elements:

- **Family/Patient Centred:** Patients and families should be at the centre of accessible, appropriate and seamlessly delivered primary health care services. Services should be integrated and coordinated across disciplines and sectors.

- **Inter-provincial Alignment:** There should be one primary health care system for the Lloydminster region that effectively accommodates patients regardless of their province of residence.

- **Multidisciplinary Teams:** Family physicians and other health care workers should function as multidisciplinary teams working to their full scope of practice.

- **Optimization of Physician Resources:** Physicians should be seeing patients with higher acuity needs and using other members the multidisciplinary team to effectively triage and manage the larger caseloads.
Co-location of Services: Co-location of a larger range of primary health professionals and services should be a priority. This “hubbing” of people and services will improve interdisciplinary collaboration, continuity of care and access.

Adequate Resources: Resourcing levels need to be matched appropriately to the primary health care service mandate, program priorities and the volume of demand for services.

Key Linkages: The program must be effectively linked to the acute care system, emergency department, specialist physicians, the continuing care program, and other community partners such as the educational system.

Leadership: Leadership, planning and accountability structures and mechanisms should facilitate effective engagement of physicians and other key stakeholders.

Data Management: Effective systems should be in place to manage and share data required to support high quality patient care (e.g., electronic charting, electronic health records, data sharing protocols, etc.).

3.8 Saskatchewan and Alberta Primary Health Care Models

Primary Health Care Context

Both Saskatchewan and Alberta have identified the provision of quality primary health care services as high priorities. Both provinces have developed and are continuing to evolve primary health care service models designed to improve access, optimize the diverse skills of physicians and other health care professionals, prevent or manage chronic disease, and focus energy and resources on other primary health care services that will have the greatest positive impact for their residents.

Why is access to quality primary health care important?

Access to quality primary health care is recognized as an essential and fundamental prerequisite to an effective and efficient health system. Individuals report higher levels of satisfaction with the patient experience when they are attached in some form to a formalized primary health care system.
In their paper *Contribution of Primary Care to Health Systems and Health*, Starfield, Shi and Macinko (2005) note the following:

**Better Health Outcomes**: In summary, the studies consistently show a positive relationship between more or better primary care and most of the health outcomes studied. Primary care was associated with improved health outcomes, regardless of the year (1980–1995), after variable lag periods between the assessment of primary care and of health outcomes, level of analysis (state, county, or local area), or type of outcome as measured by all-cause mortality, heart disease mortality, stroke mortality, infant mortality, low birth weight, life expectancy, and self-rated health.

**Lower Costs**: In addition to its relationship to better health outcomes, the supply of primary care physicians was associated with lower total costs of health services. Areas with higher ratios of primary care physicians to population had much lower total health care costs than did other areas, possibly partly because of better preventive care and lower hospitalization rates.

**Why is appropriately managing chronic diseases/conditions important?**

Chronic conditions are a major cause of health care utilization. In Alberta, for example, 30% of patients with chronic conditions are responsible for approximately 60% of costs to the health system. With appropriate support, the majority of chronic diseases can be managed effectively at a primary care level; and primary care, through health promotion, disease prevention, screening, and other upstream activities can prevent or minimize the impact of chronic disease. Therefore, it makes sense to invest in high quality, accessible primary health care services.

**Why is team-based primary health care important?**

Sharing patient care with other health professionals enables doctors to spend more time with those patients who require the special skills of a physician and allows the unique skills and knowledge of other health professionals to be applied more effectively. Primary care teams would typically comprise a group family physician practices, primary care nurse practitioner(s), home care, public health and mental health nurses. The teams often include other health care workers that may be members of more than one team (e.g., dietician, pharmacist, social worker, physical therapists, speech and language pathologists, and
psychologists). A team is usually situated at (or around) a central location and may serve a number of communities.

**Saskatchewan Primary Health Care Model**

The vision for primary health care is set out in *Saskatchewan Healthy People. A Healthy Province* (2001) as follows:

“Our health plan will co-ordinate and expand primary health care services, and improve patient care. We will begin by organizing doctors, nurses, therapists and other front-line providers into teams so that patients have better access to the most suitable health care provider. Patient care will be better co-ordinated and more personal, as providers work together to meet specific needs. These teams will diagnose and treat illness, but will also focus on preventing health problems and managing existing ones so they do not become more serious”.

*Saskatchewan’s Action Plan for Primary Health Care* (2002) identifies the following principles, goals, roles and core services with respect to primary health care:

**Principles**

- **Integration and Co-ordination of Services:** A comprehensive range of co-ordinated health promotion, prevention, primary curative care, rehabilitative and supportive services will be provided by integrated, interdisciplinary, multi-service networks of providers with care co-ordination for each high-risk client or family. This will involve further development of group medical practices and a continuous client record.

- **Community Participation:** The development of partnerships among consumers and providers will facilitate community participation in the planning, delivery and evaluation of the primary health care delivery system.

- **Community Development:** This approach involves consumers and providers working together to enhance the community’s overall capacity to address issues and needs affecting the health of the community.

- **Defined Access and Service Standards:** Access and service standards will be developed along with accountability mechanisms (outcomes, performance indicators).
Effective Partnerships with other Community Organizations: This ensures health services are continuous with and complementary to other community services and have capacity to address the social and physical environmental determinants of health.

Human Resources Continuum: A human resources continuum which:

- Uses the most effective and economically efficient health service providers;
- Ensures training/education of health service providers is consistent with the principles of primary health care; and
- Incorporates the appropriate use of and support for self-care, and informal and formal service providers.

Physician Remuneration: Physicians will be compensated using a salaried or paid sessional model.

Access Goals

The Saskatchewan Action Plan for Primary Health Care states that it will improve access to primary health care services in the following ways:

- Establish access standards for primary health care services; for example:
  - Primary Care Team locations within the RHA will be based on standards such as “95% of communities are within 30 minutes travel time of a primary health care practitioner.”
  - Establish reasonable wait times for services such as therapies (i.e., speech and language pathologist).
- Provide 24/7 access to basic services (physician and/or nurse);
- Establish a 24-hour telephone advice service;
- Improve co-ordination of referrals to other primary health care services, diagnostic services, and tertiary services; and
- Improve referrals to primary health care services by hospitals and emergency rooms.
Quality Goals

- Improve follow-up and treatment for chronic conditions based on accepted practice guidelines.
- Improve case management for clients with complex needs.
- Introduce more proactive approaches to reaching high-risk populations.
- Ensure care is provided by the professionals who can best meet the needs of the client.
- Improve screening and monitoring programs to support early detection and intervention.
- Ensure health services are continuous with and complementary to other community services.
- Support and enable self-care.

Roles

- The government will define the core services to be provided in the primary health care system and set standards and establish performance indicators.
- The RHAs will manage, operate and fund the primary health care system.
- Each RHA will have the capacity to provide the full range of core primary health care services.

Core Services

- Primary Medical Care
- Emergency Medical Services
- Community Mental Health
- Addictions
- Public Health (Population Health)
- Supportive Care (i.e. special care homes, respite care, adult day care)
- Home Care
- End-of-Life Care (Palliative Care)
- Laboratory and X-ray Services
Support for informal caregivers
Therapy Services (i.e., physio, occupational, speech and language)

RHA Primary Health Care Services Plans

The provincial *Guidelines for the Development of a Regional Health Authority Plan for Primary Health Care Services* (January 2003) states:

“The goal for primary health care is to provide quality health services delivered by appropriate staff at the appropriate time in the appropriate setting. Primary health care seeks to improve the health of the population and to modernize traditional roles of the primary care physician, primary care nurse practitioner, public health, mental health, emergency medical services and other providers, and make better use of the skills and knowledge of each team member. The goal for primary health care also includes meaningful public participation, utilization of interdisciplinary networks and intersectorial collaboration.”

Progress to Date

- Over the last seven years, 73 designated PHC teams have been established in Saskatchewan. These teams provide access to about 33% of the provincial population.
- Self-help services called Healthline and Heath Online are available 24/7.
- The province is pursuing a single automated health record for PHC and this solution is currently used at 13 PHC sites.
- Some primary health care components such as chronic disease management and mental health exist but are not integrated with family physician services.
- In the Lloydminster area, a PHC has not been established on the Saskatchewan side; a Primary Care Network (PCN) is currently being formed on the Alberta side.

Governance and Management Structure

In the Saskatchewan model, the RHA is responsible for the management, operation and funding of the primary health care system. Each RHA is charged with providing the capacity
to provide the full range of core primary health care services. Family physicians are essentially contractors and have a very limited role in the governance of PHC, except in those cases where they may manage their own clinic operations within the PHC framework. The majority of other team members are RHA employees.

Funding Model

The province of Saskatchewan provides funding comprised of the following:

➢ **PHC Funding:**

- Start-up costs: $125,000;
- Annual funding per PHC:
  - Nurse Practitioner: $143,500;
  - Clerical support: $35,000; and
  - Team Development: $50,000
  - for a total of $228,500.

- The entire cost of Electronic Medical Record (EMR).

➢ **Physician Payment:**

- Physician are paid on a sessional (e.g., $1,000/day) or an annual contract basis (e.g., 200 days x $1,000 = $200,000).
- The sessional payment or annual contract is based on the prior three to five year average of fee for service billings less a percentage deducted for overhead (e.g., 27%).
- The baseline used to form this five-year average includes all previous activities, including inpatient services, on call and ED support. PNRHA staff noted some exceptions.
- Physicians’ shadow bill (FFS) to provide support that they are in fact working at the same volume as their previous three to five year average.
- Physicians are expected to take six weeks of vacation and CME per year.
- Physicians are expected as a guideline to see 25 to 30 patients per day.
Other Health Professional: Other health professionals working within the PCH are funded by the RHA.

Facilities: The facilities are provided and/or funded by the RHA.

Service Delivery Model

The PHC model is team-based with physicians, nurse practitioners (NPs) and other health professionals working in an integrated care environment. The ratio of NPs to physicians is reported to be between one NP to three to four physicians.

NPs are a fundamental component of the Saskatchewan PHC model. NPs work as members of the care team, under the overall direction of a physician. NPs do not have an independent practice but do provide a broader range of clinical services based on two additional years of advanced training. They see patients without them having to be seen by a physician either before or after the NP visits. NPs are expected to see approximately 15 patients per day.

The primary functions of the NP include:

- Patient education – chronic disease management;
- Advanced clinical services such as spirometry and minor procedures;
- Managing group medical appointments; and
- Ordering from a pre-approved test menu, laboratory and diagnostic imaging tests.

Other health professionals round out the primary care services provided. These services may include chronic disease management, public health services, etc.

Note: The current PHC framework is under review and is expected to be completed in the spring of 2011.

Alberta Primary Care Model

In 2003, Alberta Health and Wellness, the Alberta Medical Association and Alberta’s Regional Health Authorities (now Alberta Health Services) established the Primary Care Initiative (PCI) to improve access to family physicians and other frontline health care providers in Alberta. The purpose of the PCI is to develop Primary Care Networks (PCNs) and support them in meeting the objectives of the program.
The five provincial objectives are as follows:

1. Increase the proportion of residents with ready access to primary care.

2. Provide coordinated 24-hour, seven-day-per-week management of access to appropriate primary care services.

3. Increase emphasis on health promotion, disease and injury prevention, care of the medically complex, and care of patients with chronic disease.

4. Improve coordination and integration with other health care services, including secondary, tertiary, and long-term care through specialty care linkages to primary care.

5. Facilitate the greater use of multidisciplinary teams to provide comprehensive care.

**Progress to Date**

Over the last eight years, Alberta has taken the initial steps to strengthen its primary care system. This has been done through the Primary Care Initiative and the introduction of Primary Care Networks (PCNs). It is now generally accepted that the introduction of PCNs has been a success in Alberta, and this model of care is widely regarded in the province as the preferred model over the more traditional approaches. Approximately 80% of all family physicians are part of a PCN as of 2010.

The initial success and experience of PCNs, along with other primary care innovations internationally, now provides an opportunity to improve health care delivery for Albertans. Primary Health Care continues to evolve by incorporating and embedding a broader range of co-located health services such as home care, public health, mental health and addiction services. The key responsibilities of the PCN are also evolving to include responsibility for the health of a population within a given geographic area, as well as responsibility for promoting and integrating community supports.

**Governance and Management Structure**

The PCN is a joint venture between a group of family physicians and Alberta Health Services. Decisions are made on a consensus basis with each party having veto power. Business plans are completed and submitted every three years to the Primary Care Initiative Committee (PCIC) – a trilateral group comprising AHW, AHS and AMA representatives. The PCI Project...
Management Office monitors, evaluates and reports on compliance annually. The staff provided through this additional funding is employed by the PCN.

**Funding Model**

The Province of Alberta currently provides additional funding to established PCNs based on an annual rate of $50 for each Alberta resident deemed to be part of the PCN. This funding must be applied to the provision of new or enhanced primary care services that meet established provincial criteria (i.e., Basket of Service – 16 categories). Services/functions that are eligible for funding include:

- Direct costs and/or payment for professional services associated with the provision of a new service (a new service is defined as a service that is currently not provided and is not compensated through either the Physician Services Budget and/or the AHS budget).

- Direct costs and/or payment for professionals associated with the provision of an enhanced service (an enhanced service may be defined as a service that is currently provided; however, the scope of the proposed service is broader in its application uses different personnel – health professional teams, provides a more comprehensive service, uses case/care management processes, etc.).

- Recovery of indirect costs associated with the provision of new and/or enhanced services; e.g., rent, equipment leases, etc.

**Service Delivery Model**

Service guidelines provide a clear set of enhanced service priorities (i.e., the service basket consists of 16 service areas), including chronic disease management; however, each PCN has the flexibility to prioritize service enhancements based on local need within these guidelines. The business plans outline how the additional $50 per capita is to be spent.

The primary care model emphasizes the importance of team-based care. Many PCNs support the addition of clinic nurses working under the direction of a physician(s) to improve access and streamline service delivery by making the best use of the skills of physicians, nurses and other professionals. Many PCNs also provide direct support for staff to address chronic disease, mental health, geriatric and palliative needs.
In addiction, Alberta Health Services (AHS) often co-locates elements of their primary health services and personnel within a Primary Health Care Centre (PHCC). Co-location helps support the creation of multidisciplinary teams comprising family physicians, other PCN professional staff and AHS professional staff who work collaboratively to improve the delivery of patient centred, integrated and seamlessly delivered primary health care services. Specific examples of PHCCs include Taber, East Edmonton Primary Health Centre, Sheldon Chumir – Calgary and Fort McMurray.

**Comparison of the Alberta and Saskatchewan Models**

An analysis of the relative advantages and disadvantages of each model is presented in the following tables. The analysis is based on information provided through the focus groups, individual interviews with physicians, PNRHA senior staff and the consultants’ own assessment and experience.

<table>
<thead>
<tr>
<th>Saskatchewan Primary Health Centre Model</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages</strong></td>
<td><strong>Disadvantages</strong></td>
</tr>
<tr>
<td>Service Model</td>
<td></td>
</tr>
<tr>
<td>- The service model is attractive to physicians who want to work in a practice environment that is characterized by lower patient volumes, a more controlled workload, more physician time to provide comprehensive care and use of a multidisciplinary team approach.</td>
<td>- Access to family physicians may decrease as physicians are now only expected to see 25 patients/day and there is no incentive to see more patients even if the demand exists. The NP is expected to see approximately 15 patients/day. With a ratio of one NP to three to four physicians, the additional capacity of the NP does not compensate for the lost volume/ productivity of the physician group.</td>
</tr>
<tr>
<td>- The service model will be more attractive to physicians who place a higher priority on maintaining work-life balance over optimizing income generation potential.</td>
<td>- The model relies heavily on nurse practitioners who are hard to recruit and relatively expensive compared to other nursing staff.</td>
</tr>
<tr>
<td>- The service model relies heavily on nurse practitioners who can provide a broad range of advanced nursing services which provides alternative and expanded access to those services not requiring a physician.</td>
<td>- The model does not allow monies for NPs to be substituted for other health professional services. The model is not flexible to allow for compensation for those who want to do more work – higher volume.</td>
</tr>
</tbody>
</table>
### Saskatchewan Primary Health Centre Model

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improved access from a patient perspective to comprehensive range of services provided by a team working across disciplines. Survey data (2010) indicates high levels (4.22/5.0) of satisfaction with the patient experience.</td>
<td>• There has been limited enrollment into the plan (less than 40%) on the part of physicians.</td>
</tr>
</tbody>
</table>

**Funding**

<table>
<thead>
<tr>
<th>• The guaranteed income and lack of responsibility for overhead costs provides greater financial certainty by lowering business risk – provides a “turn-key” operation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The full funding of EMR is an incentive to implement and standardize across the province. This should positively impact patient information sharing and care.</td>
</tr>
<tr>
<td>• The model helps with the recruitment of new physicians in that it provides a supportive practice environment with no initial investments required. This is quite attractive to someone coming out of university with large student loans or physicians moving to the region from out of country locations.</td>
</tr>
<tr>
<td>• The current funding model does not provide incentives or performance payments to see more patients or meet other performance targets (appropriate test utilization, etc.).</td>
</tr>
<tr>
<td>• The funding model may reduce the incentive to provide services beyond primary care such as Emergency Department coverage and inpatient services.</td>
</tr>
<tr>
<td>• The current physician compensation levels may not be competitive with the fee for services remuneration levels.</td>
</tr>
</tbody>
</table>

**Physician Engagement**

<table>
<thead>
<tr>
<th>• Physicians are contractors and are not required to be involved in setting priorities or managing the operations of the PHC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Some physicians may fear a loss of practice autonomy and the capacity to manage their own work environments</td>
</tr>
</tbody>
</table>
### Service Model

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The model is flexible with respect to the types of primary care staff that can be funded; e.g., clinic nurses, mental health counselors, social workers. The PCN can tailor its staff depending on local need. PCNs can provide performance incentives for meeting specified targets.</td>
<td>• The primary care focus of each PCN is variable based on the joint decisions made by each PCN. Therefore, there is not one consistent approach across PCNs.</td>
</tr>
<tr>
<td>• The service model is attractive to physicians who want to maintain or work in a fee-for-service environment yet want to provide comprehensive care using a team-based approach. This may support physician recruitment efforts.</td>
<td>• The RHA has less direct influence over the direction of primary care services.</td>
</tr>
<tr>
<td>• Helps support work-life balance through the expanded use of team-based care including an array of other PCN provided professional staff.</td>
<td>• The service model requires a high degree of collaboration and joint planning mechanisms that engage both family physicians and RHA personnel in establishing service priorities.</td>
</tr>
<tr>
<td>• Improved access from a patient perspective to comprehensive range of services provided by a team working across disciplines.</td>
<td></td>
</tr>
</tbody>
</table>

### Funding Model

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The model is a blended approach with a combination of fee-for-service billing and per capita payments. It encourages physicians to see patients while providing support for other primary care providers.</td>
<td>• The fee-for-services component provides incentives for physicians to see more patients even if other primary care providers could better provide some of the services clients need.</td>
</tr>
<tr>
<td>• The other provincial programs provide funding of EMR. There are four supported choices.</td>
<td>• The PCN funding model is more complex and requires the development of detailed business plans and annual monitoring to ensure compliance, which can be time consuming.</td>
</tr>
</tbody>
</table>
### Alberta Primary Care Centre Model

<table>
<thead>
<tr>
<th>Physician Engagement</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physicians are active partners in the design, and overall management of PCN priorities.</td>
<td>• Physicians and the RHA may not agree on priorities.</td>
</tr>
<tr>
<td>• Physicians maintain control over their practice environment.</td>
<td>• Governance and decision-making processes are more complex and require more collaboration.</td>
</tr>
<tr>
<td></td>
<td>• The RHA has less direct influence over the direction of primary care services.</td>
</tr>
</tbody>
</table>

### Conclusion

The Primary Health Model of Saskatchewan and Alberta have the same overall objective: to improve primary health care. The approaches are different and each model has its own advantages and disadvantages.

Each model will appeal to physicians with very different practice style preferences, income requirements, tolerance for risks and need for autonomy. Each model will evolve as Saskatchewan and Alberta continue the process of enhancing primary care.

Irrespective of the specific elements of each model, this evolution is likely to see the further integration and co-location of RHA resources and physician resources to improve comprehensive care.

### 4.0 Recommendations and Implementation Considerations

1. **Primary Care Vision:** Develop a shared vision, service mandate, service delivery model, and accountability framework for primary health care for the Lloydminster area.

   **Comments:** PNRHA leadership and staff should work in partnership with family physicians and Alberta Health Services to develop a shared vision and service delivery model for primary care for the Lloydminster service area. There was general agreement among physicians and primary health care administration and staff participating in the study that
the primary care vision and service delivery model should include the following key principles and/or elements:

- **Family/Patient Centred:** Patients and families should be at the centre of accessible, appropriate and seamlessly delivered primary health care services. Services should be integrated and coordinated across disciplines and sectors.

- **Inter-provincial Alignment:** There should be one primary health care system for the Lloydminster region that effectively accommodates patients regardless of their province of residence.

- **Multidisciplinary Teams:** Family physicians and other health care workers should function as multidisciplinary teams working to their full scope of practice.

- **Optimization of Physician Resources:** Physicians should be seeing patients with higher acuity needs and using other members of the multidisciplinary team to effectively triage and manage the larger caseloads.

- **Co-location of Services:** Co-location of a larger range of primary health professionals and services should be a priority. This “hubbing” of people and services will improve interdisciplinary collaboration, continuity of care and access.

- **Adequate Resources:** Resourcing levels need to be matched appropriately to the primary health care service mandate, program priorities and the volume of demand for services.

- **Key Linkages:** The program must be effectively linked to the acute care system, emergency department, specialist physicians, the continuing care program and other community partners such as the educational system.

- **Leadership:** Leadership, planning and accountability structures and mechanisms should facilitate effective engagement of physicians and other key stakeholders.

- **Data Management:** Effective systems should be in place to manage and share data required to support high quality patient care (e.g., electronic charting, electronic health records, data sharing protocols, etc.).

The process should build on this initial agreement to fairly quickly identify the key elements and reach agreement on and build ownership for the shared vision and model.
2. Develop a Primary Health Care Center (PHCC) on the Alberta side of Lloydminster that builds on the existing PCN and effectively integrates and coordinates a range of primary health care services depicted in Figure 2 following.

➢ **Affirm Primary Health Care Vision:** Review and confirm the vision and service delivery model for primary care which should have been completed in response to recommendation #1.

➢ **Establish Operating Principles:** Reach agreement on fundamental operating principles that are to set the parameters for the development of the project and the eventual operation of the PHCC. Operating principles should include statements such as:

- The importance of a strong partnership between family physicians, the RHA and other community stakeholders is recognized as critical to providing effective primary health care services for our residents.

- The respective contributions that various disciplines make to the provision of quality primary health care services are recognized and respected.

- Decision-making is transparent, collaborative and evidence-based.

- Members/partners demonstrate mutual respect and high degrees of professionalism.
• Ongoing transparent communications are essential to continued successful relationship building between physicians and PNRHA and AHS.

• Partners recognize the importance of balancing personal interests with common interests.

➢ Establish /Confirm Objectives: The primary objectives of the PHCC should be aligned with the key objectives of the Alberta Tri-lateral Master Agreement which provides the policy and funding framework for Primary Care Networks (PCNs) in Alberta. Specifically the goals and objectives should include:

• Increase the proportion of residents with ready access to primary health care;

• Provide 24 hour, seven day/week management of access to appropriate primary health care services;

• Increase the emphasis on health promotion, disease and injury prevention;

• Improve the care of medically complex patients and patients with chronic disease;

• Improve coordination and integration of other health care services including secondary, tertiary and long-term care, through specialty care linkages to primary care; and

• Facilitate the greater use of multidisciplinary teams to provide comprehensive primary care.

Other specific goals and priorities to respond to high priority local needs and circumstances should also be considered and integrated during this step. Once agreement is reached on these goals and priorities they should become the foundation for the development of the strategic service plan for the PHCC.

➢ Establish Programs and Services: Establish the proposed programs and services that are to be provided through the PHCC. While these would be finalized as part of the collaborative planning process they would likely include the following:

• Primary health care physician services;

• Public Health Services - Immunization Programs, STD Infection Programs, Maternal/Child Programs and School health programs;
• Home Care Services – nursing, personal care and home-making services;
• Mental Health Services – psychiatric nurses, access to psychiatrists, etc.; and
• After-hours Care – including extended hours of operation to mitigate inappropriate use of the Emergency Department; general radiology; and limited point of care laboratory testing and specimen procurement services.

➢ Establish Staffing Levels: Establish the preferred staffing levels for the PHCC. While these would be established as part of the collaborative planning process and be aligned with the established service needs/priorities, they will likely include the following:

- Family physician practices (12-15);
- PHCC Manager (1);
- Nurse Practitioners or Clinical Nurses (3-4);
- Mental Health Professionals – psychiatric nurses and addictions counselor (3);
- Chronic Disease Experts – nurse educators – diabetes, cardiac (2-3);
- Dietitian/Nutrition Counselor (.5);
- PT/OT (1);
- Public Health Nurses and Home Care Nurses would be co-located at the PHCC; and
- Formal linkages to community-based pharmacy services.

➢ Establish Facility Requirements: Once decisions have been made with regard to programs and services to be co-located at the PHCC, a physical space/programming study will need to be completed. Based on a recent study completed in Fort McMurray for the planned PHCC, approximately 2300 square meters (24,000 square feet) of space will likely be required. This space should be adequate to accommodate the services and staffing levels noted above as well as the space for diagnostic equipment and activities required to support after-hours care services.

One option would be to locate the proposed PHCC on the large tract of land on which the current Community Services Building is situated. This land is owned by the City and is large enough to accommodate a new building that would house the proposed PHCC functions as well as current City Community Services functions. The location near the current Lloydminster Clinic/PCN would support co-location, seamless access to a range of primary health care services for residents, allow continued utilization of the Lloydminster Clinic space, and expansion into the new facility as new family physicians are recruited. This type of development would require a partnership between the City and the RHA to fund and develop the site and facilities.
Establish Governance and Decision-Making Structures: The PHCC will include a combination of resources from the PCN (AHS, Physician Joint Venture) and the PNRHAA. It will be important to reach agreement on the governance and decision-making structures for the PHCC that respects the legitimate authorities and accountabilities of each of the partner organizations. Figure 3 depicts the inter-relationships between the PCN and the RHAs.

Establish the Funding Model: The Province of Alberta currently provides additional funding to established PCNs based on an annual rate of $50 for each Alberta resident deemed to be part of the PCN. This funding must be applied to the provision of new or enhanced primary care services that meet established provincial criteria (i.e., Basket of Service - 16 categories). For example, services/functions that are eligible for funding include:

- Direct costs and/or payment for professional services associated with the provision of a new service (a new service may be defined as a service that is currently not provided and is not compensated through either the Physician Services Budget and/or the RHA budget).
• Direct costs and/or payment for professionals associated with the provision of an enhanced service (an enhanced service may be defined as a service that is currently provided, however the scope of the proposed service is broader in its application: uses different personnel - health professional teams, provides a more comprehensive service, uses case/care management processes, etc.).

• Recovery of indirect costs associated with the provision of new and/or enhanced services; e.g., rent, equipment leases, etc.

Regional Health Authorities in Alberta often co-locate some of their primary care services and personnel within a PHCC. This helps support the creation of multidisciplinary teams comprising family physicians, other PCN professional staff and RHA professional staff who work collaboratively to improve patient centred, integrated and seamlessly delivered primary health care services.

The funding model for the PHCC will need to include agreement on who funds the facility capital and equipment costs, expected contribution levels from physicians to ongoing overhead costs, funding for patient information systems, and FTE staffing complement by discipline or function and related funding sources.

The potential for the Saskatchewan government or the PNRHA to provide the $50 per Saskatchewan resident registered in the Alberta PCN should be explored. This would help remove barriers to access to primary care services offered by the PCN in Alberta.

➢ Establish Physician Compensation Model: Initial input received from family physicians during the study suggests they have a strong preference for continued use of a fee-for-service model that allows them a reasonable degree of practice independence, as opposed to working for the Health Region on a fixed salary. Thus it is anticipated they would continue to bill the provincial Physician Services Budgets which fund physicians’ fees for medical services provided. PCN funding would be accessed in accordance with the policies and criteria established by the Alberta Tri-lateral Master Agreement.

In addition to the direct monetary benefits, family physicians participating in an effectively run PHCC will benefit from improved quality of life, increased satisfaction with the medical practice environment, increased support and improved linkages specialty services, increased access to tools and resources to support their practice, and access to funding to support new services and service delivery models.
➢ **Build and Commission the Facility**: Either acquire and retrofit an existing facility or acquire land and construct a new facility in accordance with the space programming plan.

➢ **Change Management Strategy**: A carefully crafted change management strategy should be embedded within the overall process.

3. **Build and staff a Primary Health Care, Family Practice and Teaching Center attached to the Lloydminster Hospital.**

**Comments**: The proposed primary health care, family practice and teaching centre (The Centre) should be developed by the PNRHA in collaboration with family physicians and other community stakeholders. Key process elements that will be required include:

➢ **Clear Vision**: Establish a clear vision for The Centre. The vision would have many of the same elements as those detailed in recommendation 2 – family/patient centred care, multi-disciplinary team approach, co-location of services, key linkages to other services, and effective leadership and governance processes. Additional elements would include support for teaching and education for both family physicians and other health care professionals; strong linkages to the hospital’s diagnostic services; effective triage between the Emergency Department and the family practice centre; provisions for after-hours care to take pressure of the Emergency Department; and strong linkages to the University Faculties of Medicine, Lakeland College, and other post-secondary institutions engaged in educating health care workers; and formal affiliation with the Onion Lake Primary Care Centre to build on existing strengths, support service integration and improve continuity of care.

➢ **Establish Operating Principles**: Reach agreement on fundamental operating principles that are to set the parameters for the development of the project and the eventual operation of The Centre. While these will be developed as part of the planning process, they should include statements such as:

- **Partnerships**: The importance of a strong partnership between the PNRHA, family physicians, Faculties of Medicine and other Health Sciences, Lakeland College, other educational institutions and other community stakeholders is recognized as critical to providing effective primary health care services.

- **Multi-disciplinary Environment**: The respective contributions that various disciplines make to the provision of quality primary health care services are recognized and respected.
• **Teaching Focus**: Teaching and mentorship is valued and rewarded. The mechanisms, processes and infrastructure required to support the teaching component of The Centre’s mission are in place.

• **Physician Engagement**: Physicians are effectively and meaningfully engaged in setting priorities for The Centre. Decision-making is transparent, collaborative and evidence-based.

• **Professionalism**: Members/partners demonstrate mutual respect and high degrees of professionalism.

➢ **Establish/Confirm Objectives**: The primary objectives of The Centre will be aligned with Saskatchewan’s Primary Care Model which provides the policy and funding framework for the development of PHCs in Saskatchewan. The specific goals and objectives of The Centre therefore include:

  • Provide access to basic services (physician and/or nurse) 24/7;
  
  • Improve co-ordination of referrals to other primary health care services, diagnostic services, and tertiary services;
  
  • Improve referrals to primary health care services by hospitals and emergency rooms;
  
  • Improve follow-up and treatment for chronic conditions based on accepted practice guidelines;
  
  • Improve case management for clients with complex needs;
  
  • Introduce more proactive approaches to reaching high-risk populations;
  
  • Ensure care is provided by the professionals who can best meet the needs of the client;
  
  • Improve screening and monitoring programs to support early detection and intervention;
  
  • Ensure health services are continuous with and complementary to other community services; and
  
  • Support and enable self-care.
Other specific goals and priorities to respond to high priority local needs and circumstances should also be considered and integrated during this step. Once agreement is reached on these goals and priorities they should become the foundation for the development of the strategic service plan for The Centre.

- **Establish Programs and Services**: Establish the proposed programs and services that are to be provided through The Centre. While these would be finalized as part of the planning process they would likely include the following:
  
  - Primary health care physician and nurse practitioner services;
  - Hospitalist services for unattached patients;
  - Emergency Department Support – physician coverage, mental health, social work, etc.;
  - Mental Health Services – psychiatric nurses, access to psychiatrists, etc.;
  - After-hours care – including extended hours of operation to mitigate inappropriate use of the Emergency Department;
  - Education and Teaching Services – field placements, mentorships, family practice residents; etc.;
  - Public Health Services - Immunization Programs, STD Infection Programs, Maternal/Child Programs and School health programs;
  - Home Care Services – nursing, personal care and home-making services;
  - Access to hospital-based diagnostic imaging and laboratory services; and
  - Formal affiliation agreement with Onion Lake Primary Health Centre.

- **Establish Staffing Levels**: Establish the preferred staffing levels for the PHCC. While these would be established as part of the collaborative planning process and be aligned with the established service needs/priorities, they will likely include the following:
  
  - Family physicians (up to 10);
  - PHC Manager (1);
  - Clinical Nurse Educator (1);
- Nurse Practitioners (3);
- Mental Health Professionals – psychiatric nurses and addictions counselor (3);
- Chronic Disease Experts – Nurse educators – diabetes, cardiac (2);
- Dietitian/nutrition Counselor (0.5);
- PT/OT (1);
- Public Health Nurses and Home Care Nurses would be co-located at the PHCC; and
- Formal linkages to community-based pharmacy services.

*Note:* For some positions RHA employees could provide support for both primary health care centres.

- **Establish Facility Requirements:** The space requirements should be established based on the proposed service and staffing mix and integrated into the functional planning for the new hospital.

- **Establish Governance and Decision-Making Structures:** The RHA is accountable for developing, maintaining and managing the program. However, it is recommended that a Joint Operations Committee be established to provide a vehicle for engaging family physicians and other key stakeholders in planning and decision-making. It will also be important to establish mechanisms and processes to annually update the strategic service plan and budget for The Centre, ensure ongoing effective communications, support collaborative decision-making, surface and resolve emerging issues and challenges, and monitor and evaluate results being achieved.

- **Establish the Funding Model:** Funding for the operation of The Centre would be based on the Saskatchewan funding model. This would include a combination of RHA-funded positions and the application of the Saskatchewan funding model for PHCs.

  The potential for the Alberta government or AHS to provide the $50 per Alberta resident registered in the Saskatchewan PHC should be explored. This would help remove barriers to access to primary care services offered by the PHC in Saskatchewan.

- **Establish Physician Compensation Model:** Physicians would be compensated on a salaried or sessional basis consistent with the Saskatchewan PHC model. Some provisions would be required to recognize the contributions of physicians engaged in mentoring or teaching activities. This physician compensation model would be quite compatible with the several of the proposed roles for physicians in The Centre – support medical
education/teaching, comprehensive family health care, hospitalist services for unattached patients, etc.

**Note:** Physician payment for Emergency Department work needs to be aligned with fee-for-service and the primary care compensation to avoid creating unintended consequences like Emergency Department work being more attractive from a compensation standpoint and work life perspectives. It is possible to create a situation where there is a dis-incentive for physicians to reduce Emergency Department visits.

- **Change Management Strategy:** The carefully crafted change management strategy should be embedded within the over all process.

4. **Develop and implement a family physician recruitment strategy designed to address short-term and longer-term requirements for family physicians for the Lloydminster catchment area.** The recruitment strategy should include the following key elements:

- **Confirm Recruitment Targets:** Based on the data there is an immediate need to recruit eight to ten family physicians for the Lloydminster catchment area, and an additional five to six family physicians within five years.

- **Support Onion Lake Physician Recruitment:** Given the size of the population and the burden of disease experienced by its residents, Onion Lake could support two family physicians. With the imminent retirement of the one family physician currently at Onion Lake, supporting efforts of the Onion Lake Community to replace the retiring physician and recruit additional physicians should be a high priority.

- **RHA and Community Engagement:** The Health Region and the community need to take more ownership in creating the environment that attracts and retains physicians. The Health Region, The Health Foundation, and municipal government partners should work in partnership with physicians to support physician recruitment and retention efforts. This could include:

  - Developing and providing incentives;
  - Stabilizing clinic overhead costs for physicians;
  - Making physicians and their families feel welcome and valued in the community;
  - Helping to create the physical infrastructure to support family practice; and
  - Increasing and supporting opportunities for family practice rotations/residency within the Lloydminster Hospital.
Establish a Clear Physician Recruitment Process: Ensure the physician recruitment process and the roles and responsibilities of various partners are clearly articulated. The process should include:

- Establish clear leadership accountability for the physician recruitment process. Appointing a physician recruiter accountable for coordinating the process and the efforts of the key players (physicians, private clinics, PNRHA medical leadership, the municipality, the Health Foundation, etc.) is recommended;

- Establish the sources for potential candidates;

- Confirm the need and the skills required;

- Develop recruiting packages, including incentives based on an understanding of the key variables that impact ability to recruit physicians;

- Conduct initial discussions with the candidate;

- Determine the candidate’s eligibility to practice in Alberta and/or Saskatchewan;

- Obtain work permits for foreign candidates;

- Complete College of Physicians and Surgeons assessments;

- Offer the position and engaging in contract negotiations;

- Finalize the contract;

- Implement the recommended physician on-boarding strategy;

- Implement the family on-boarding strategy; and

- Implement a retention strategy that includes:
  - Periodic follow-up with all primary care physicians to identify and address emerging issues and concern in a timely and constructive fashion;
  - Public and community recognition of physicians for long service; and
  - Use of exit interviews with any physician leaving to understand the reasons and mitigate problems going forward.
51.

We note: The key steps in the physician recruitment process are detailed in the attached Physician Recruitment Flow Chart in Appendix 3. A recommended Physician Onboarding process is also included in Appendix 3.

5. Inter-provincial Alignment: Proactively address issues related to Lloydminster’s unique status as a border city with a view to ensuring residents receive timely, equitable access to the primary health care services they need regardless of their province of residency. This will likely require provincial leaders and policy makers from both Alberta and Saskatchewan coming together to resolve issues in the best interests of the residents they represent. Specific recommendations in this regard include:

- **Address Funding Shortfalls:** An analysis of the population data from this study and the recommendations from a 2007 study jointly sponsored by the PNRHA and the former East Central Health Region, suggests the level of funding from Alberta does not reflect the disproportionate growth in the number of Alberta residents being served by the PNRHA. The PNRHA estimates they are being underfunded by Alberta by approximately $1.48 million per year. Population projections indicate the population growth rates on the Alberta side of Lloydminster will continue to be higher than the Saskatchewan side, thus the problem will be exacerbated over time.

In addition to issues related to funding levels, funding commitments need to be established early. For example, the commitment from Alberta for funding is not clear even during the actual operational year, making it very difficult to run an effective operation.

- **Remove Barriers to Patient Access to Alberta PCN Services and Saskatchewan PHC Services:** There needs to be provincial reciprocity with respect to funding for primary care enhancements between Alberta and Saskatchewan to allow patients to access primary health care services on either side of the boarder regardless of their province of residence. One option would be to have Saskatchewan pay $50/capita for Saskatchewan residents who are part of Alberta PCN and Alberta could pay a per capita equivalent for Alberta residents who are part of a Saskatchewan PHC. When analyzing the current funding models between the provinces the top up funding for enhanced primary care services are very similar. For example, Saskatchewan’s model provides about $228,500 for a PHC with three family physicians. If we assume each physician serves approximately 1,500 patients, this equates to 4,500 patients times $50/patient for the Alberta PCN or $225,000.

- **Credentialling and Certification Issues:** Identify and work with appropriate government and professional colleges to remove the provincial barriers relating to the certification and credentialing of family physicians and other health service professionals. Consider using
the model the Law Society uses in Lloydminster for payment of fees to the professional association, whereby 50% of the annual fee is paid to each of the Alberta and Saskatchewan Law Societies.

6. **Stakeholder Engagement and Communications:** Develop and implement mechanisms and processes to effectively engage key internal and external stakeholders and maintain good communications with them.

**Comment:** There is a need for an ongoing and sustainable commitment to transparent, timely and high quality communications with key internal and external stakeholder groups, including physicians, PNRHA employees, the municipalities, the business community, Alberta Health Services/AHW, and the public at large. Emphasis needs to be placed on a two-way flow of information. In addition to informing stakeholders and residents about strategic initiatives, there needs to be opportunities to listen to their concerns and meaningfully engage them in setting strategic directions. Multiple communications channels should be used including Web-based, social media, formal reports, customer focus groups and media releases.
APPENDIX 1:

LLOYDMINSTER PRIMARY HEALTH CARE CATCHMENT AREA
LLOYDMINSTER PRIMARY HEALTH CARE CATCHMENT AREA

The catchment area for Lloydminster was defined based on where residents typically accessed primary health care, including family physician services. Population centers with well-developed family practices were not included in the catchment calculations, since most residents accessed family physician services in their home locations. Accordingly, the catchment area for primary care services is somewhat different that the catchment area for the Lloydminster Regional Hospital. The catchment area deemed most appropriate for a Lloydminster based service is illustrated in the maps on the following pages.

The catchment area utilized for this analysis was developed as follows:

- The City of Lloydminster was included in its entirety.
- The Prairie North Regional Health Authority population from census tracts 440, 442, 471, 472, 501 and 502 were included in the Saskatchewan portion of the catchment area. Excluded from this calculation was the Town of Meadow Lake since it has its own family physician services.
- The population of the County of Vermillion River was included in the Alberta area calculations, with the exception of the Town of Vermillion. Vermillion was not included because they have their own family physician services.
- Mannville, Innisfree and Minburn, which are part of the County of Minburn, were counted in their entirety because of their proximity to Lloydminster. Fifty percent of the remainder of the County of Minburn population was included in the calculation. The Town of Vegreville was excluded. Vegreville was not part of the calculation since they have their own family physician services.
- The 2011 Registered Population of the Onion Lake Cree Nation is 5,032. However, 1,773 of this number are recorded as living off the reserve, bringing the Registered on Own Reserve population of 3,079. A substantial portion of the registered on-reserve population for Onion Lake resides in Census Tracts 501 with some residing in Census Tracts 502 and 561. In addition, since the Onion Lake Reserve straddles the Alberta and Saskatchewan border, some of the on-reserve Registered Population resides in the County of Vermillion River. (Source: Indian and Northern Affairs Canada: Registered Population as of March, 2011. Onion Lake.)
Specifically, those cities, towns, census tract areas and counties that were included were:

- The City of Lloydminster: (2009 Municipal Census Data)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Saskatchewan portion</td>
<td>9,100</td>
</tr>
<tr>
<td>Alberta portion</td>
<td>17,402</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>26,502</strong></td>
</tr>
</tbody>
</table>

- Saskatchewan Area (2006 Federal Census, inflated by 4% to match average provincial growth):
  - **Rural Census Tracts:**
    |                      |               |
    | Britannia (502)      | 1,500         |
    | Frenchman’s Butte (501) | 1,240       |
    | Manitou Lake (442)   | 590           |
    | Manitou Lake (440)   | 530           |
    | Eldon (471)          | 745           |
    | Wilton (472)         | 1,470         |
    | **TOTAL**            | **6,075 + 4% inflation = 6,318** |
  - **Towns and Villages:**
    |                      |               |
    | Paradise Hill        | 485           |
    | Marsden              | 235           |
    | Neilburg             | 395           |
    | Lashburn             | 915           |
    | Marshall             | 610           |
    | St. Walburg          | 645           |
    | **TOTAL**            | **3,185 + 4% inflation = 3,312** |

- **Alberta Area**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>County of Vermilion River*</td>
<td>3,428</td>
</tr>
<tr>
<td>County of Minburn **</td>
<td>2,719</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>42,279</strong></td>
</tr>
</tbody>
</table>
*Source: 2008 County of Vermillion Municipal Census, less Town of Vermilion. Includes the Hamlet of Blackfoot, the Hamlet of Clandonald, the Village of Dewberry, the Village of Kitscoty, the Village of Marwayne, the Hamlet of McLaughlin, the Village of Paradise Valley, the Hamlet of Rivercourse, the Hamlet of Streamstown, the Hamlet of Tulliby Lake.

**Source: County of Minburn office: Breakdown as follows:

- Mannville 761
- Innisfree 233
- Minburn 65
- 50% of County of Minburn, including Lavoy and Ranfurly 1,660

TOTAL: 2,719
Lloydminster Primary Care Catchment Area – Saskatchewan Component
APPENDIX 2:

PNRHA PRIMARY HEALTH CARE PROJECT
STAKEHOLDER CONSULTATIONS RESULTS REPORT

March 2011
Stakeholder Consultation Results

Family Physicians

Seventeen physicians provided input into the study through their participation in focus groups or through individual interviews. The key themes emerging from physician input were as follows:

- **Strengths**: Physicians identified the following as the strengths of the existing primary care service:
  - **Collegiality**: Generally physicians and front line primary care providers in the community work well together and are willing to support and help each other. Several commented about the positive working environment within their clinics and the mutual respect demonstrated for the roles and expertise of the various health care disciplines. The Home Care Program, in particular, was identified as being very effective.
  
  - **Supportive Community**: The community is quite supportive of and appreciative of the work that family physicians do on their behalf. Our patients value their relationship with their physicians. We have a strong Foundation that does good work to raise funds and support health care service delivery.
  
  - **Independent Practice**: The current practice model allows physicians to set the conditions for work. Physicians prefer being independent and self-directed; most of us would not favor working as a salaried employee.
  
  - **Interesting Work**: There is interesting work for physicians in rural areas – you see a range of patients with problems that require fairly deep skills – more than you would see in a family practice clinic in a large city.
  
  - **Connected to the Hospital**: Family physicians are all closely connected to the hospital. All have hospital privileges and share the work load required to support the effective operation of the hospital.
Weaknesses: Physicians identified the following as areas where the effectiveness of primary care could be improved:

- **Access to Family Physicians:** Access to physicians is the major problem for the region. Many people do not have a family physician – over 40% of those coming to the ER are unattached; and wait times for attached patients to be able access a physician for non-emergency services range from three to six weeks. Most clinics try to provide some emergency slots for their clients, although these tend to fill up quickly. Currently not one doctor in Lloydminster is taking on new patients.

- **Emergency Department:** The emergency department is under great pressure since unattached patients and patients that cannot get quick access to their family physicians use the Emergency Department as a walk-in clinic. This results in long wait times at emergency and inefficient and inappropriate usage of more expensive emergency department resources.

- **Physicians Workload:** Work-life balance is a challenge for family physicians working in Lloydminster. Physicians are over worked and stretched so thinly it is difficult to take holidays or time off. This creates challenges with recruitment and retention. We need six to eight additional family physicians immediately just to stabilize the system. The system is very vulnerable – if we lose more family physicians we will be in crisis.

- **Relationship with PNRH:** Physicians noted there are challenges with communications and levels of trust between the health region and family physicians. Physicians feel they need to be effectively engaged in developing the vision, plan and strategy for primary care for the Lloydminster area. For example there appeared to be not attempt by either the physicians or PNRHA to engage in a collaborative approach to the development of the new Primary Care Network on the Alberta side; and physicians indicated that were not aware of or engaged in the development of the PNRHA’s Primary Care Plan.

- **Primary Care Service Pressures:** There are access issues and staff shortages in many primary care service areas including: Mental Health, Chronic Disease Management, Diabetes Care, cardiovascular health, and community based therapies.

- **Access to Specialists:** There is a shortage of specialists which makes family practice more stressful and risky. This can be a barrier to recruiting and retaining family physicians.
• **Highest Priority Service Gaps:** Physicians identified the following as the highest priority primary care service gaps:

  - Access to family physicians – long wait times and too many unattached patients;
  - Access to Mental Health Services and supports;
  - Access to Chronic Disease Management Services – Diabetes, cardiovascular health; and
  - Access to Physiotherapy Services.

➢ **Vision for Primary Care:** Physicians identified the following as the most important elements that should be included in a new vision for primary care:

• **Family/Patient Centred:** Patients should be at the centre of the care model and be able to get the primary care services they need in a timely manner; Physicians should have increased ability to practice medicine in a more comprehensive way – time, preventative focus, follow-up, etc.

• **Inter-provincial Alignment:** A comprehensive approach which involves both Alberta and Saskatchewan is required. There should be one primary care system for the Lloydminster region.

• **Multidisciplinary Teams:** Multidisciplinary teams working to their full scope of practice should be a key component.

• **Co-location of Services:** Co-location of a large range of primary health services to improve interdisciplinary collaboration and seamless delivery should be considered.

• **Timely Access:** Mechanisms and processes need to be in place to increase the number of patients a clinic can serve to help support timely and appropriate access to services. Physicians should be seeing patients with higher acuity needs and using other members the multidisciplinary team to effectively triage and manage the caseloads. Access to key primary care services should be enhanced – Mental Health, Chronic Disease Management, Seniors Health, etc.

• **Specialist Support:** Required linkages and support from specialists should be reflected in the model.
Performance Measures: Physicians identified the following as metrics that be used to evaluate the performance of the primary care system:

- Emergency Department usage by CTAS score – appropriate use of the Emergency Department;
- Percentage of residents with a family doctor;
- Percentage of unattached patients;
- Ability/success at attracting and retaining family physicians;
- Levels of patient satisfaction with access to and quality of primary care services;
- Ability to maintain population to family physician ratios of 2000/1 or better;
- Percentage of ED patients without family physicians;
- Average time to see a family doctors;
- Ability of residents to choose who they see as a family doctors; and
- Access to therapies and other primary care service.

FNMI Clients: Physicians identified the following as key issues and considerations relating to the provision of primary care services for FNMI clients:

- Currently there are approximately 5,000 residents in Onion Lake. There is one family doctor providing family physician services at Onion Lake. He is supported by a reasonable good and well-staffed on-reserve primary care centre.

- Several physicians in Lloydminster indicated they have patients from Onion Lake on their register. In addition it was noted that the residents of Onion Lake make extensive use of the Emergency Department at the Lloydminster hospital for after-hours care.

- Concern was expressed that the family physician in Onion Lake plans to retire within the next year and this will have an overwhelming impact on the Emergency Department if a new physician is not recruited to Onion Lake.
• It was noted that residents of Onion Lake have significantly higher incidences of diabetes, high blood pressure and other chronic diseases. Maintaining a strong primary care centre with physician resources in the community needs to be a very high priority.

➢ **Barriers to Access:** Physicians identified the following as the most significant barriers to access to primary care services for residents within Lloydminster and catchment area:

• *Physician and Health Care Worker Shortages:* The severe shortage of family physicians and other primary health care workers across the primary care service continuum.

• *Resource Constraints:* Staffing and resource shortages in other key primary care areas – mental health, diabetes care, cardiovascular health, and physiotherapy;

• *Border Politics:* The border is a serious issue – different funding models, policies and political philosophy create challenges for the service. There is a strong, well-documented case to suggest Alberta funding to the PNRHA is significantly lower than it should be.

• *Resource Allocation:* PNRHA has two regional centres – Lloydminster and Battleford. Some physicians felt Battleford gets a disproportionate amount of the resources.

• *Municipal Engagement:* There is a lack of engagement of the municipality in attracting physicians to the area.

• *Physician Licensing:* There are major challenges with provincial licensing of new physicians.

• *Diagnostics:* Shortage of local diagnostic and treatment services – traveling MRI, no echo or ENT services.

➢ **Physicians’ Needs:** Physicians identified the following as what was needed to be able to have a satisfying and effective medical practice.

• *Physician Engagement:* There is a need to dramatically improve communication between the Region and the physician group; physicians need to be consulted and engaged in developing the primary care vision and strategy.
- **Support for Recruitment Efforts:** Physicians need support from the Region and the municipality with physician recruitment. Clinics currently are being forced to provide significant incentives to attract new physicians - signing bonuses, access to vehicles, access to housing, etc.

- **Work-Life Balance:** Work-life issues need to be addressed. The severe physician shortage makes it very difficult to take time off, take holidays or meet personal and family needs. This makes it difficult to recruit physicians and motivates physicians to leave the community for better working conditions.

- **Competitive Compensation:** There is a high demand for family physicians across the province and the country. To be able to attract and retain family doctors, compensations and benefits must be competitive.

- **Independent Practice Model:** Most physicians want to have reasonable control over their practice and work environment.

  ➤ **Recommended Strategies:** Physicians identified the following as potential strategies to address the major issues and challenges identified in relative to primary care services.

    - **Support Physician Recruitment:** The Health Region and the community need to take more ownership in creating the environment that attracts and retains physicians. Physicians currently feel that the entire burden for recruitment has rested with them. The Health Region and Municipal Government partners should work in partnership with physicians to support physician recruitment and retention efforts. This could include:
      - Providing incentives – vehicle, place to stay, signing bonuses;
      - Reducing and stabilizing clinic overhead costs for physicians;
      - Making physicians and their families feel welcome and valued in the community;
      - Helping to create the physical infrastructure to support family practice;
      - Using Canadian medical school graduates to support the physician recruitment process;
      - Take medical students and establish an early relationship with them – support from the region, the community and the clinics;
− Increasing and supporting opportunities for family practice rotations/residency within Lloydminster; and

− Increasing access to specialist consults/services to address emergency situation and reduce risk for family doctors.

• *Primary Health Care Centres:* Develop primary health care centres that bring together physicians and other primary care workers as a multi-disciplinary team working within the full scope of professional practice. The Region needs to do a better job of engaging the physicians in the planning for primary care services and centres. Physicians need to be engaged in developing the model and managing the centres.

• *Border Alignment/Politics:* Border politics and policies create challenges that need to be addressed. Specifically there is a need to:

  − Set up primary care in Lloydminster as a seamless integrated system that does not create artificial barriers because of province of residence;

  − Ensure a fair and equitable funding system for physicians in both provinces;

  − Resolve physician licensing issues between the two provinces; and

  − Address issues with Alberta PCN funding – currently provides funding for Alberta patients and physicians only.

• *Hospitalists:* Establish hospitalist positions to take some of the pressure of the system and better manage unattached patients.

**Primary Care Administrators and Front Line Service Providers**

Twenty-one primary care administrators and front-line staff provided input into the study process through focus groups or interviews. The key themes emerging from these groups included the following.
 Strengths: Primary care administrators and front line staff identified the following as strengths of the current primary care service:

- **Physician Support:** Physicians are dedicated and committed to providing quality care. They are generally responsive to requests for support. Most doctors have hospital privileges and contribute to the effective operation of the hospital.

- **Home Care:** Home care services are quite good. There is good communication between home care and long-term care.

- **Chronic Disease Management:** While there are still very limited resources for Chronic Disease Management services, some enhancements have been made in recent years; i.e., stroke and cardiac services are expanding and diabetes education classes are well attended.

- **Mental Health:** The shared care model being used in two of the clinics for Mental Health services is the right model – the family physician connects the patients to the Mental Health nurse, initial assessment is completed, recommendations made, and assistance provided to navigate the patient through the services available.

  There are currently two evening psychiatric emergency nurses (4pm to midnight) to support the mental health service. Streamlined processes for initial mental health screening are in place.

  The services provided are of good quality, capacity is not adequate to respond to mental health needs in a timely manner. Non-urgent wait time for Mental Health services is about four weeks.

- **Adult Wellness Clinics:** There are adult wellness clinics at various community locations – home care nurse, monitor chronic health issues, educational programs, etc.

 Weaknesses: Primary care administrators and staff identified the following as areas where the effectiveness of primary care could be improved.

- **Lack of Access:** There are serious access challenges across all primary care services. There is a serious shortage of family doctors, and those here are overwhelmed and over worked. Wait times to see a physician are too long; and a significant percentage
of the population does not have a family physician. No clinics are taking on new patients.

- **Staffing Shortages:** There is a shortage of staff across the primary care service continuum – physicians, mental health workers, social workers, therapists, etc. The system does not have adequate capacity to meet basic primary care service demands and needs.

- **Inappropriate Use of the Emergency Department:** Many people cannot get a family doctor so they use the ER as their primary care provider. As a result there is no follow-up and the ER is not being used appropriately. There is no family medicine or inpatient clinic within the hospital, although two physicians staff the ER.

- **Service Alignment Challenges:** There is some duplication of services which results in inefficiency and sub-optimal use of resources. Clinics do not operate using a multi-disciplinary primary care team approach, resulting in sub-optimization of scarce physician resources. The coordination of home care and public health nursing services could be improved. Discharge planning and management is not managed as effectively as it should be.

- **Primary Care Vision and Plan:** Many of the participating front line staff and some administrative staff had limited awareness about PNRHA’s Primary Care Plan. Most indicated they had not been actively engaged in developing the plan and many were unaware of the state of its adoption and/or implementation.

- **Border Issues:** There is confusion for physicians and the public regarding which services are delivered in Alberta and Saskatchewan; and different funding and service delivery models between the provinces add to the confusion. In addition, significant pay discrepancies exist between Alberta and Saskatchewan in some areas (physicians, therapists for example) creating challenges keeping physicians and other health care workers in Saskatchewan. Differences in physician certification requirements between provinces are also problematic.

- **Onion Lake Pressures:** The physician and primary health care centre on the reserve at Onion Lake provides a very important service. With the planned retirement of the physician serving the community, there will be significant pressures placed on the Emergency Department if a replacement is not found.
• Health Records: There is no integrated primary health record – not all doctors clinics are linked for information exchange and access to patient information is impeded by different electronic health systems between provinces. Lack of access to Alberta’s Electronic Health Records for SK service providers is problematic.

• Communications: Communications between physician clinics and PNRHA primary care services need to improve significantly.

• Space Challenges: The Region has huge staff housing/space challenges. Even if new staff and programs are approved there is no place to locate them.

• Regional Resource Allocation: Some questions were raised about whether or not Lloydminster was getting an appropriate share of regional resources.

• Mental Health: The Mental Health shared care model needs more resources and needs to be broadened to include all clinics. This will not be possible until we are able to provide timely services and address the long wait lists. Wait times – Mental Health Clinics – urgent immediate; non-urgent – six weeks; Psychiatric Assessments – child and youth three to six months.

• Addictions Services: In-patient addictions services are provided through the Thorpe Recovery Centre which is a separate entity. This creates challenges for service coordination and integration.

• Access to Specialists: There is limited local access to specialists. The lack of a pediatrician in Lloydminster is a problem

• Access to After Hours Care: Assess to after-hours care is a challenge.

• Administrative Structure: The administrative structure could be improved to more effectively facilitate integrated primary care service delivery.

➤ Vision for Primary Care: Primary care administrators and front line staff identified the following as the fundamental principles and parameters that should be reflected in any proposed primary care service delivery model:

• Patients should be at the centre of accessible, appropriate and seamlessly delivered primary care services.
• Services should be integrated and coordinated across disciplines and sectors.

• The administrative and accountability structure should ensure service integration is supported.

• Effective systems should be in place to share data; e.g., electronic charting, electronic health records, data sharing protocols, etc.

• Colocation of primary care services should be encouraged and supported to increase collaboration.

• Effective staff training and development should be in place to ensure informed practice

➢ **Performance Metrics:** Primary care administrators and front line staff noted the following with respect to evaluating the effectiveness of primary care services.

• Currently there is no uniform formal performance measurement system is in place for primary care services within the health region.

• Some tracking by department does take place on items such as:
  
  – Time from referral to being seen;
  – Wait times for services;
  – Immunization levels for public health;
  – Wound care audits;
  – Nursing hours; and
  – Surveys of client satisfaction.

• Participants noted that a formal evaluation system should be focused on key efficiency and outcome measures based on establish objectives.

➢ **Primary Care Program Alignment:** The group noted the need to align the following primary care services operating within Lloydminster and catchment area with any proposed primary care plan.
• **Chronic Disease Management Services:**
  
  – STRIDES – cardiac rehab and stroke program (1 FTE);  
  – One day/week of cardiac education; and  
  – Diabetes Education – one on one and group classes (0.69 FTE diabetes nurse educator backed up by home care nurses).

• **Mental Health:** Primary program, adult, child psychiatric rehab (3 FTE nurses; added two nurses to do assessments and support through emergency – no in-patient beds).

• **Home Care Program**

• **Palliative Care:** 1 FTE – good support from other professionals – inpatient and community focus – physician with palliative specialty skills would be helpful, no social worker access, no designated mental health time for bereavement support.

• **Nutrition Services:** two part-time dietitians.

• **Public Health:** Gaps in sexual health clinics and services in Lloydminster; increased focus needed on education and prevention.

• **Community based PT/OT:** Capacity issues; lack of early intervention creates chronic problems.

➢ **FNMI Clients:** Primary care administrators and front line staff identified the following as key issues and considerations relating to the provision of primary care services for FNMI clients:

• Onion Lake has a well-run primary care centre supported by a full time physician clinic on site.

• There is very limited interaction between PNRHA and Onion Lake.

• The Onion Lake primary care centre has limited capability to do more complex home care procedures.
Currently PNRHA responds to Onion Lake patients that present at our clinics. This is currently is a relatively small % of our clients (less than 10%).

Onion Lake clients do make fairly extensive use of the ER for after-hours care.

**Barriers to Access:** Primary care administrators and front line staff identified the following as the most significant barriers to resident access to high quality primary care services:

- Severe shortage of family physicians in the community;
- Shortage of qualified health care staff – mental health, therapies;
- Different policy environments, funding and service delivery models between Alberta and Saskatchewan;
- Long wait times for many primary care services;
- Inequities in what Regional resources are allotted to Lloydminster;
- Physical space challenges;
- Lack of access to shared data to support client care; and
- Funding constraints;

**Alberta and Saskatchewan Primary Care Models:** Very few participants were knowledgeable about the Alberta Primary Care Network Model. Most participants did have a working understanding of the Saskatchewan Primary Care Centre Model and identified the following as advantages and disadvantages of the model.
### Saskatchewan Primary Care Centre Model

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Improved ability to attract family docs in rural areas.</td>
<td>➢ The model relies heavily on Nurse Practitioners who are as hard to recruit as physicians and expensive.</td>
</tr>
<tr>
<td>➢ Improved team work across disciplines.</td>
<td>➢ The model provides for one NP per four physicians.</td>
</tr>
<tr>
<td>➢ More efficient use of resources.</td>
<td>➢ Some physicians fear a loss of practice autonomy.</td>
</tr>
<tr>
<td>➢ Vehicle to coordinate and integrate work.</td>
<td>➢ Access to family physicians may decrease as physicians are now only expected to see 25 patients per day.</td>
</tr>
<tr>
<td>➢ The salaried physicians model better supports better family practice.</td>
<td>➢ Provincial top-up funding for the centers is limited.</td>
</tr>
<tr>
<td>➢ The Battleford’s Family Health Centre was viewed as working quite effectively.</td>
<td>➢ There has been very limited up take on the part of physicians.</td>
</tr>
<tr>
<td></td>
<td>➢ Limited flexibility to hire other resources besides nurse practitioners.</td>
</tr>
</tbody>
</table>

- **Highest Priority Issues to Be Addressed:** Primary care administrators and front line staff identified the following as the most important issues that must be addressed with respect to primary care services:
  
  - Improved access to high quality, patient centered, appropriate primary care;
  - Improved ability to attract and retain family doctors;
  - Engagement of physicians and staff in designing the primary care vision, service model and plan;
  - Reduced service duplication – increased role clarity; and effective utilization of all disciplines to the full scope of practice;
  - Clear priorities supported by adequate resources – adequate staffing complement;
  - Increased focus on achieving measurable outcomes;
• Resolve physical space challenges – facilitate colocation; and

• Improved access and sharing of data required to support quality care

➢ **Potential Strategies**: Participants identified the following as potential strategies to address the major issues and concerns.

• *Vision and Model*: Take a step back and develop the vision and service delivery model of primary health care and build support for the model.

• *Primary Health Care Centres*: Establish a stand-alone primary health care centre(s). Key elements should include:
  - Effective and early engagement of physicians, staff and other partners in the design of the primary care centre;
  - Development of multi-disciplinary teams working to full scope of practice;
  - Use of a case management approach that places the client at the centre of the service;
  - Work process re-design to break down barriers and optimize use of resources;
  - Space development and colocation strategies to improve collaboration and service coordination;
  - Proper change management and staff education to support the plan;
  - Funding and resourcing strategy needs to be place; and
  - Physician recruitment and retention strategy.

• *Physician Payment System*: We need a physician payment system that incorporates the needs of both Alberta and Saskatchewan patients. Services should be seamless for residents regardless in which province they live.

• *Performance Metrics*: Establish clear objectives, strategies and performance measures for the Primary Health Care program in the Region.
- **Education:** Increase local education and training opportunities for health care workers in selected high priority disciplines.

- **Resource Allocation:** Review population, utilization data and staffing ratios across the region with a view to ensuring equitable distribution of resources.

**Community and Municipal Leaders**

Input from more than 35 community and municipal leaders was gathered through focus group sessions with Health Foundation Members, Lloydminster City Council, the Community Health Advisory Board and representatives from surrounding municipalities and the Chamber of Commerce. The key themes emerging from these consultations included the following.

- **Strengths:** Participants identified the following as strengths of the primary health care service.
  - **Dedicated Family Physicians:** Family physicians are very committed; they try hard to provide extended clinic hours and see patients most days of the week. Most clinics provide slots to deal with emergencies. If you have access to a family physician, the care received is very good. Family Physicians are looking at ways to improve the situation.
  - **Quality Care for Those with Access:** Once you are in the system, you are well served by competent and dedicated health care professionals.
  - **Home Care:** The Home Care system/service works very well. It is a major strength of the primary health care service.
  - **Active and Supportive Foundation:** Lloydminster has a very active and supportive Health Foundation that raises substantial funds for the health system and supports physician recruitment efforts. The Foundation has played a key role in attracting two specialists to the community and is increasingly taking on a leadership role to help address identified service gaps/issues.
  - **Community Support:** The people in the community have an innovative, entrepreneurial, “can do” attitude. The community has access to a strong economic resource base; and
there are numerous socially conscious businesses that strongly support the hospital and are willing to get involved and provide financial support for projects.

- **Intermunicipal Cooperation**: Municipalities in the region work well together.

- **Community Partnerships**: The municipality, hospital foundation and board work well together.

- **Public Awareness**: The general public has a heightened awareness of the value of improving life-style choices and mental health.

➤ **Areas Where Effectiveness Needs to Improve**: Participants identified the following as areas where effectiveness should be improved.

- **Access to Family Physicians**: Access to physicians is a major challenge that must be addressed. Wait times to see a physician are too long; and no clinics are taking new patients. We need to recruit more physicians, improve their efficiency and reduce their workload. We need after-hours access to avoid unnecessary use of Emergency Department.

- **Primary Health Care Service Gaps**: In addition to the shortage of family physicians, major service capacity issues exist in the following primary health care areas Mental Health, Addiction, Diabetes Care and Chronic Disease Management. Note: Slim Thorpe Addiction Centre is moving and closing its out-patient addictions services.

- **Emergency Department**: Wait times in the Emergency Department are very long. Emergency room triage system is overwhelmed because of numbers. This is a symptom of the fact there are not enough family physicians and clinics, and people are using the Emergency Department as a walk-in clinic.

- **Long-term Care Beds**: There is a shortage of long-term care beds which blocks access to acute care beds.

- **Supportive Living Options**: There is a lack of Supportive Living Options #1, #2 and DAL.

- **Border Issues**: Having to deal with two governments is a challenge. Decisions take forever, funding systems are different, communications are a challenge, and different
political philosophies exist between the provinces. Salaries and compensation for similar positions is not comparable; e.g. Physiotherapist, Home Care Nurses, etc.

- **Funding Issues:** There is a perception that Lloydminster is underfunded, both from the Alberta and Saskatchewan sides. The net deficit funding from Alberta for 2009-10 is estimated by the Region to be $1.48 million. The ability of the region to plan effectively is also severely compromised by the lack of timely information about funding levels from the Alberta and Saskatchewan governments. For example, the commitment from Alberta for funding is not clear even during the actual operational year, making it very difficult to run an effective operation. We need standardized and transparent reporting of funding from both provinces and PNRHA; we need funding that is equitable in terms of our population served as well as our regional role.

- **Regional Centre:** Lloydminster is a regional Center. 2.5 hours to Edmonton and 2.5 hours to Saskatoon; yet we do not have the scope of hospital and community services that reflect this fact.

- **After-hours Care:** There is very limited access to after-hours care, except through the Emergency Department. There does not appear to be a systematic approach to providing timely emergent care; e.g. Christmas coverage, etc.

- **Service Continuity:** Services are not provided in a client centered, seamless manner; discharge planning and follow-up need to improve; and records management and data collection systems are not integrated.

- **Specialists:** Increased access to specialist within the community should continue to be a focus – internal medicine, emergency medicine, pediatrician, geriatrician, etc.

- **Prevention and Health Promotion:** There is a need to increase the focus on prevention and health promotion, including the alignment and coordination of public health services within the proposed primary care model.

➢ **Highest Priority Primary Health Care Program/Service Gaps:** Participants identified the following as the highest priority primary health care service gaps that need to be addressed.

- Improve the access to basic medical services including family physician services.
- Provide services for unattached patients – those without access to a family doctor.
• Increase service capacity in the areas of Mental Health, Diabetes Education, Heart Health, and Chronic Disease Management, Physiotherapy.

• Increase focus on preventative and health promotion.

• Recognize and fund the Lloydminster hospital as a regional hospital.

• Provide designated personnel to provide casting services. Casting is done by physicians in Lloydminster, whereas North Battleford has specific staff assigned to this.

• Improve access to eye surgery in Lloydminster.

➢ Barriers to Access: Participants identified the following as the most significant barriers to access experienced by residents in the area:

• *Long Wait Times:* There are long wait times for non-emergency services – three to four weeks minimum wait for regular family doctor.

• *Lack of 24/7 Access:* The absence of walk-in clinics; and inability to get care on a 24/7 non-emergent basis is a major challenge. After hours and weekend access are more critical in Lloydminster because of the industry and job make-up of the area.

• *Early Intervention:* There are limited avenues to deal with a primary health issues before it has escalated into a serious problem.

• *Lack of Multidisciplinary Teams:* There is very limited access to non-physician resource/team-based care; e.g. nurses to take out stitches, etc.

• *Border Issues:* Differentiation between funding and eligibility criteria of Alberta and Saskatchewan and other border challenges are severe barriers to planning and delivering effective and integrated primary health care services.

➢ Potential Strategies: Session participants suggested a range of potential strategies to address the major issues and concerns relating to primary health care services. These included:

• *Primary Health Care Vision and Model:* There is a need to better articulate the vision and service delivery model for primary health care for Lloydminster. We need to create a
longer term strategic direction for primary health care that is aligned with community and provincial priorities. We need a strategic approach to articulating vision, identifying priorities, results to be achieved and the strategies to make it happen.

- **Primary Health Care Centres**: Develop primary care centres in Lloydminster. It would make more sense to develop one on each side of the border to overcome some of the challenges associated with alignment of provincial policies. It would be unfortunate if border problem slows down the development of the primary health care centre concept. We need to engage key stakeholders; create local ownership of shared goals; and leverage local funding to secure additional government funding.

- **Formalized Physician Recruitment and Retention Strategy**: Establish the appropriate number of family physicians the Lloydminster area needs based on objective data; clarify who has accountability for recruitment and the respective roles of key stakeholders in the process; develop the recruitment plan, including required incentives and supports; and implement. Develop supporting retention strategies.

- **Innovative Pilot**: Build on strengths of both Alberta and Saskatchewan to develop a demonstration project that could be a model for Western Canada. Position Lloydminster as a test environment for the demonstration project and the application of innovative approaches to the delivery of primary health care services. Develop a “made in Lloydminster,” state of the art solution that capitalizes on the potential of health to be an economic generator for the areas.

- **Professional Qualifications**: Identify and work with appropriate government and professional agencies to remove the provincial barriers relating to the certification and credentialing of family physicians and other health service professionals.

- **Engage Municipalities**: Representatives of the municipalities indicated they recognized good health care services are a requirement for sustained economic growth. Municipalities indicated a willingness to work with the Health Region, the Foundation, and other partners to support new approaches to improve primary health care services.

- **Consistent Data**: There is a need to establish a common understanding of the data that drives demand for primary health services. This should include clear delineation of the Lloydminster catchment area; and a definition of the size of the shadow population.
• **Lloydminster Administrative Zone:** Establish Lloydminster as a unique, stand-alone administrative zone to overcome challenges associated with the Alberta – Saskatchewan border. Develop a solid rationale for Lloydminster’s unique issues and the need for a unique solution; and sell this to provincial decision-makers.

• **Walk-in clinics:** Develop 24/7 walk-in clinics to increase after-hours access, or double shift clinics on a rotational basis to improve access.

• **Increase Capacity:** Improve access to high priority primary health care services such as mental health, diabetes care, heart health, etc. by increasing both human and physician plant capacity.

• **Training Centre:** Develop an educational and training centre co-located with the Lloydminster hospital to attract family physicians and other health care professionals to the community.

• **Political Action:** Develop and implement a strong political advocacy plan to support the achievement of our vision and Plan. This could include the following elements:
  
  – Establish a political action group to lobby government for required policy changes and funding support;

  – Develop and implement a focused communications and marketing plan;

  – Use the political networks of the municipalities, The Foundation, the business community and the Health Region to leverage funding and facilitate solutions to issues; and

  – Work to improve levels of trust within the local community and with the provincial bureaucracy.

**Physician and Primary Health Care Workers Recruitment and Retention:** Session participants were asked to suggest ideas and approaches that would support the recruitment of family physicians and other health care professionals. Suggested strategies included:

• **Certification and Privileging:** Support efforts to streamline certification of more foreign-trained physicians and health care professionals. Clarify roles and requirements of SMA and AMA, and Colleges of Physicians and Surgeons with a view to removing
barriers. Ensure transparent and fair criteria and processes are used for assigning medical privileges. Ensure clarity relating the bi-provincial expectations certification and licensing.

- **City Marketing Strategy:** The City of Lloydminster needs to market itself more aggressively and be more active in selling our community to prospective physicians and health care workers. We need to emphasize our quality of life, economic opportunities and amenities and target those who most likely to favor living in a smaller city.

- **Education and Training:** Provide increased opportunities for family physicians and other health care professionals to do rotations and field placements in Lloydminster. This could include incentives to students including housing, transportation, and subsistence during filed placements, etc. Promote Lloydminster to students at U of S, U of A and Community Colleges engaged in training health care professionals. Develop and use specific package of information targeted to medical professionals.

- **Bursaries:** Establish bursaries and other financial incentives for medical students and other required health care workers with specified return service commitments. This could include identifying local high school students who will consider a career in health care and providing filed placements and financial support for their training.

- **“Grow our Own”**: Develop strategies to promote and grow our own, building on the strengths of Lakeland College; e.g., LPNs, Long-term Aides, Home Care Aides and RNs.

- **Incentives:** Provide a range of incentives to attract and retain family physicians to the community – signing bonuses, subsidized overheads, subsidized housing, access to vehicles, tax credits for physicians, etc.

- **Primary Health Care Centres:** Use primary Health Care Centres as a vehicle to reduce the cost of entry into the profession for new physicians and create a more positive and attractive practice environment.

- **Recruitment and Retention Strategy:** Develop and implement recruitment and retention strategies that include clear recruitment targets and clear accountabilities for leading recruitment efforts. Engage key partners -industry, Chamber of Commerce, municipalities, the health region, the physicians, and the foundations
- **Family Support Focus:** Provide community support for the family. There is a need to create a welcoming and supportive environment for families that helps with the transition to the new community.

- **Municipal Engagement:** Municipal government representatives were asked to comment on their willingness to make investments in infrastructure to enhance access to primary care services; e.g., development of clinic infrastructure to hub a group of physicians and other primary care service providers, support physician recruitment, etc. Comments and suggestions included:
  
  - It was noted that to date the municipalities have not been approached to support infrastructure.
  
  - It was suggested that options could be considered as part of the City’s upcoming strategic planning process.
  
  - Potential municipal incentives to attract physicians included: property tax relief, abatement, incentives; provision of land; deferred tax payments, etc.
  
  - It was suggested that space could be developed within the Servus Recreation Centre for primary health care/family physician clinics.
  
  - The City could support recruitment through supporting the families and making new residents feel welcomed and valued.

- **Other Orders of Government:** Municipal representatives suggested the following actions from other orders of government would be helpful:
  
  - There is a need for both provincial and federal governments to listen more effectively and improve communications at all levels.
  
  - The provinces need to recognize that a unique and special situation exists in the Lloydminster area which creates issues and challenges that must be addressed. The current charter skirts health care.
  
  - It is difficult for current MLAs to have time to focus on specific needs of Lloydminster. Elections are imminent on both sides – this is a long term, policy issue which is difficult raise when in ‘red zone’.
• We need timely data from Alberta regarding health funding and a fair system that reflects the real costs of providing services to Alberta residents.

• Lloydminster needs a model that allows for seamless access to information and services regardless of province of residence.

• The commitment of the federal government in support of Aboriginal population must be a high priority.

➢ Other Comments: Session participants provided the following additional comments and suggestions:

• A clearly defined strategy and action plan is required. We need a roadmap to success.

• Action needs to be taken quickly to avoid a crisis situation.

• Any solution needs to recognize that Lloydminster will continue to grow and needs to define its go-forward models for effective service delivery.

• There is a need to recognize the impact that Onion Lake residents will have on the primary health care service in Lloydminster if they are unsuccessful in retaining a family physician for the community.

• The recruitment strategy needs to focus on other health care professionals as well as physicians.

• The need for other small surrounding communities to have access to physician services and primary health must be factored into any strategy.

• Communication and key messages that local municipal representatives can use to get public support for new directions will be critical – There should be open access to the report coming out of this study for example.

Public Representatives

Input from approximately 20 representatives of the public-at-large was collected through two focus groups and a small number of email submissions. Key themes emerging from this input included the following.
Strengths: Session participants identified the following as strengths of the current primary health care service.

- **Quality of Care:** Once you get into the system the quality of care is very good.

- **Reasonable Access to Specialists:** Family physicians are able to get reasonably prompt access to specialists for their patients. Serious medical issues are dealt with promptly and well, especially if you have a family physician.

- **Long-term Care:** Care at Jubilee and Cooke is excellent. A broad spectrum of service is available – recreation, physiotherapy, etc.

- **Specific Service Strengths:** A number of specific health services were identified as working well including:
  
  - **Cancer Care** - many cancer treatment services are available in Lloydminster;
  
  - **EMS/Ambulance** – high quality service;
  
  - **Handy-van Services** – a valued service;
  
  - **Supportive Living** – PointsWest has been a good addition;
  
  - **Physiotherapy Services** – access to physiotherapy following hip surgery has been made much better since it has been provided as an out-patient service at DCECC;
  
  - **Dialysis** – local access is a positive feature;
  
  - **Palliative Care** – high quality much needed service;
  
  - **Maternity Services** – good service but is running a full capacity; and
  
  - **Victim Services** – effective service.

- **Health Foundation:** The Foundation has been a key resource in successful physician recruitment and raising funds for health care.
Weaknesses: Participants identified the following as areas where effectiveness should be improved:

- **Inappropriate Use of the Emergency Department:** The Emergency Department operates as a walk-in clinic; this is a symptom that the primary care system is not working well. This results in long wait times and inappropriate use of an expensive resource.

- **Unattached patients:** There are many patients without a family physician; newcomers to the community cannot find a family doctor who will take them on as a patient.

- **Pediatric Services:** There is limited access to pediatric services.

- **Maternity Service:** Maternity services are good but they are operating at capacity. More resources are required to meet growing demand.

- **24/7 Access:** There is limited access to after-hours care. No walk-in clinics on holidays, weekends and evenings.

- **Shortage of Physicians:** Lloydminster and surround area has a serious shortage of family doctors; there are problems recruiting new physicians to the region.

- **Patient Data Systems:** Reporting systems (e.g., results of tests) do not work well.

- **Access to Specialized Services:** There is a need to improve local access to specialized medical procedures in Lloydminster rather than Cold Lake/Bonnyville, Edmonton, etc. E.g., orthopedic services, cataract surgery. Access to services and funding should be comparable to similar sized municipalities.

Major Primary Care Service Gaps: Participants identified the following as the highest priority primary health care service gaps.

- Shortage of family physicians;
- Shortage of Mental Health Services, including psychiatric nurses;
- Lack of 24.7 access to services; inappropriate use of the ED; and
- Geriatric services – could use a gerontologist.
Barriers to Access: Participants identified the following as the key barriers to resident access to the primary health services then need:

- **Human Resource Shortages:** The shortage of physicians and other health care workers is the most serious barrier to access.

- **Long Wait Times:** There are long wait times for non-emergency services – minimum three to four weeks for an appointment with a family doctor.

- **Border Issues:** Differences between funding and eligibility criteria of Alberta and Saskatchewan residents is a problem. There are serious challenges with the bi-provincial service delivery and funding models. “We are an orphan in both systems”.

- **Decision-making Authority:** The perception exists that the key health decisions are made in North Battleford, not Lloydminster.

- **Trust Issues:** Lack of trust and communications challenges among Alberta Health Services, PNRHA and physicians limit progress.

- **Regional Hospital Profile:** The hospital does not have a strong profile as a regional hospital - which it should have given the size of the population it serves.

- **Community Funding:** The question was raised as to whether the high level of funding provided by the community through the work of the Foundation, results in less Health Region/provincial resources being allocated to the Lloydminster community.

Potential Strategies: Session participants identified the following as potential strategies to help address primary health care service issues.

- **Certification Requirements:** Address certification requirements and challenges with a view to making it easier to attract new physicians to the province and facilitate physicians working in either Alberta or Saskatchewan.

- **Welcoming Community:** Increase community support and make physicians and their families feel more welcome and appreciated.

- **Exit Interviews:** Conduct exit interviews with physicians leaving the community to determine the issues and causes for their departure.
• **Border Issues:** Rationalize jurisdictional/policy/funding disparities between Alberta and Saskatchewan. Can the experience of education and municipal government be emulated for health care?

• **Primary Care Teams:** Expand the use of nurse practitioners, physician assistants and other health care professionals as part of the primary care team.

• **Recruitment Strategy:** Clarify who has accountability for recruiting physicians – clinics, the Health Region, the Foundation.

• **Expand Capacity:** Lloydminster has capacity issues in many primary health care services areas – physicians, diabetes care, cardiovascular health, mental health, etc. Capacity/resources provided should be based upon accurate population and service utilization (the shadow population in the region) as well as population growth projections.

• **Long-term Care:** Increased capacity at nursing home level is required to reduce pressure on the acute care bed base in the hospitals.

• **Primary Care Centres:** Design new primary care centres and staff them with multidisciplinary teams.

• **Administrative Zone:** Establish Lloydminster as a unique, stand-alone community/administrative zone.

• **Lloydminster Health Region:** Establish Lloydminster and its catchment area as a separate provincial health region.

• **Level Playing Field:** Reduce competition between Alberta and Saskatchewan and other local health centres for scarce human resources. Create a more competitive landscape between provinces – employee compensation and benefits, physician payment systems, etc.

➢ **Physician Recruitment Strategies:** Suggested physician recruitment strategies included:

• **Market the City:** Do a better job marketing of this community’s strengths - what does Lloydminster offer that other communities do not? (E.g., more diverse practice, special patient groups, exposure to two provinces, etc.)
• **Resolve On-boarding Issues:** Identify and resolve on-boarding issues for new physicians and their families. (E.g., what are the issues for a newly recruited resident that need to be managed?)

• **Provide Incentives:** Provide scholarships and incentives to attract medical students and other health care professionals to the area. (Subsidized housing, bursaries, vehicles, government incentives for family physicians to locate in selected areas, etc.)

• **Increase Number of Training Seats:** Remove some of the restrictions on numbers of students training for health services degrees.

• **Field Placement Opportunities:** Provide field placement and educational training opportunities/infrastructure attached to the hospital.

• **Regional Hospital Profile:** Build the profile of the Lloydminster hospital as a regional centre with more specialist supports to make it more attractive for physicians.

### Onion Lake Focus Group Session

Initially the Onion Lake focus group session was to be attended by some Band Council, Health Advisory Board and administrative representatives. The level of community interest in the meeting was such that more than 55 Onion Lake residents attended the session. The meeting format was changed to a “town hall” format to provide the broadest opportunity for input.

Key themes emerging from the session are documented under the appropriate headings:

#### Strengths of the Current Primary Health System

- Onion Lake currently has a well-developed primary health center staffed by multi-disciplinary health care team.

- The community has one very good, well respected and much appreciated physician who provides services within the health center. Residents have fairly good access to family physician and other primary health care during regular hours.

- EMS/ambulance service is very good.
The presence of the physician and primary health care centre at Onion Lake helps to ensure that residents who cannot travel easily, have access to services they need.

The Band has made the provision of health services a priority, which is reflected in the investments made in health care infrastructure and services.

**Areas Where Effectiveness Could Be Improved**

- Onion Lake residents accessing the Emergency Department in Lloydminster feel they are not welcomed or treated with an appropriate level of respect by some hospital staff. Several participants in the meeting indicated that people are often reluctant to go for help for fear of being treated rudely. Concern was also expressed with the lack of cultural sensitivity and awareness on the part of some health care staff in Lloydminster.

- The wait times at the Lloydminster Emergency Department are very long – sometimes as long as seven hours.

- Transportation to and from Onion Lake to the Emergency Department are a significant challenge for many residents that need care in Lloydminster.

- There is limited interaction and communication between PNRHA and Onion Lake. Residents feel “whipsawed” between the Province and the federal government regarding who is accountable for providing services.

- The Onion Lake primary care centre has limited capability to do more complex home care procedures.

- Onion Lake clients have to make fairly extensive use of the Emergency Department in Lloydminster for after-hours care.

- There is very limited access to long-term care services.

- Onion Lake has a registered on-reserve population of approximately 3000 residents. Health status data indicates that this population has a substantially higher burden of disease (diabetes, high blood pressure, low birth weight babies, cardiovascular disease, etc.) The community could easily use two family physicians.

- None of the family clinics in Lloydminster are accepting new patients from Onion Lake.
There is real fear and concern about the planned retirement of the family physician in Onion Lake. If a replacement is not found, there will be huge problems for both Onion Lake and the Lloydminster Hospital Emergency Department.

**Highest Priority Issues**

- Recruit a new family doctor(s) for the community to replace our retiring physician.
- Improve access to Emergency Department services – reduce wait times, address transportation issues.
- Address issues relating to cultural sensitivity and respectful treatment of Onion Lake residents accessing services at the Emergency Department in Lloydminster.

**Suggested Strategies**

- PNRHA should work with the current physician, the Band Council and the community to recruit a new family physician for the community.
- Add capacity to the primary health centre on the reserve, including observation beds and access to 24/7 emergent care and enhanced diagnostic imaging and laboratory services.
- Improve access for residents to long-term care facilities and services.
- Increase the use of Telehealth to support services at the Onion Lake Primary Health Care Centre
- Provide increased opportunities for hospital staff to have more exposure to cultural sensitivity training.

**Other Comments**

- Many speakers at the session expressed grave concerns about the loss of their family physician due to retirement. They indicated they needed help from the health region to support the recruitment of another physician(s).
- Several speakers raised concerns about poor access to specialist physicians.
Some speakers noted the need to build a community hospital with access to urgent care services on the reserve.

Community leaders were very appreciative of the PNRHA’s efforts to hold this meeting and listen to the issues and concerns of residents.
APPENDIX 3:

PHYSICIAN RECRUITMENT FLOW CHART AND ONBOARDING
Physician Recruitment Process

A. Receipt of CVs
- Independent Inquiry or application
- Physician Recruiter
- CV brought forward by Colleagues

B. Confirm Need/Vacancy & Review Skills
- Medical Director/Chief of Staff
- Physician Clinic Leadership

C. Discussion with Candidate
- Scope out intentions
- Permanent move
- Incentives/Recruitment Package
- Employment Opportunities for (Spouse/significant other)

D. DETERMINE ELIGIBILITY
- Refer to CPSA for determination of eligibility;
- All Candidates must apply on line

E. WORK PERMIT
- Initiate Work Permit Documentation (IMG’s)

F. COLLEGE(S) ASSESSMENTS
- Successful completion of assessment

G. JOB OFFER
- Extend Job Offer
- Physician Recruiter prepares offer and Incentives

H. CONTRACT NEGOTIATIONS
- Contract negotiation, review and sign off with COO (currently)
  (should it be Medical Director or Physician Recruiter)

I. Offer Accepted

J. Physician On-Boarding

K. Family On-Boarding

CANDIDATE MEETS EXPECTATIONS OF REGION (GOOD FIT) AND CPSA APPROVAL (CREDENTIALS, INTERVIEW AND ASSESSMENT)

D. Determination of eligibility – Register – What Part? (GP/Specialist)
- Initiate documentation
- Sponsorship
- AH&W (Health Sector Form – released upon successful eligibility)

IMG (International Medical Graduates)
Site visit (see below) would take place at the same time as the assessment. IMG’s have to be assessed within the region or province depending on discipline and resources available.

Work with Chief of Staff – arrange site visit once eligibility is confirmed
- Interview
- Hospital tour
- Dinner with respective Chief and Team
- Community tour
- Arrange accommodation
- Family Needs (Children Entertainment)
- Introduction of Physician Buddy

(POTENTIAL CANDIDATES within Canada)
Work with Chief of Staff – arrange site visit once eligibility is confirmed
- Interview
- Hospital tour
- Dinner with respective Chief and Team
- Community tour
- Arrange accommodation
- Family Needs (Children Entertainment)
- Introduction of Physician Buddy
Candidates proceed to Step G
Sample Physician On-Boarding Work Plan

Site Visit

An appointed physician recruiter should be the point person to coordinate the on-boarding process.

The site visit will be coordinated with the Physician Recruiter and the Chief of Staff in partnership with the recruiting family practice clinic or PHCC.

Develop Itinerary, Plan and Facilitate the Site Visit

Preparatory Work: The Physician Recruiter should have a discussion with the physician candidate concerning special points of interest while visiting the community (scope out needs of the family) and develop the itinerary accordingly. It is important to not only meet the needs of the candidate but the family as well, if applicable.

Recruitment Package: The Candidate should be provided a comprehensive recruitment package (i.e., schools, social involvement, housing, recreation pursuits etc.) This should be prepared by the recruiter and be available to as required support physician recruitment efforts.

Site Visit Logistics: A site visit will usually last over a weekend period of two to three days. Some candidates do appreciate the time alone with their family to scope out the community on their own once they have gained a certain comfort level. The Physician Recruiter will also be available to offer assistance if required. The following should be arranged:

- Travel arrangements;
- Accommodations;
- Interview;
- Meetings with key staff;
- Dinner with respective Senior Administration, Physicians, Directors and staff;
- Introductions/meetings to Mayor or other City representatives;
3. Western Management Consultants

- Children entertainment if required;
- Special points of interest;
- Tour of health facility;
- Tour of community;
- Arrangements for pick up and settling the physician and family into accommodation when they arrive; and
- Arrange transportation details (may require car rental depending on comfort level of the candidate traveling about in the community. Physician Recruiter will be available for assistance).

Site Visit Wrap-Up

When the site visit is complete the physician recruiter should meet with the Physician and with the family to discuss the visit. This provides the opportunity to receive feedback such as:

- Was the visit beneficial? ask for details….
- What could we do better? ask for details….

Note: It is important to provide a personal touch especially for physicians who have families. The site visit is a crucial part of the recruitment process. More importantly it is imperative that the candidate and their families have been provided with relevant and sufficient information to make their decision. A positive one…

Post Visit

- Send thank you letter to candidate and spouse
- Establish next steps, offer accepted? Positive confirmation
- Maintain contact with physician and spouse prior to arrival
- Assist the physician with office space (place of practice)
- Prepare for arrival
Arrival of Physician

The physician recruiter is ultimately responsible for coordination of the physician’s arrival.

- Personally pick up physician and family
- Settle the family into temporary accommodations
- Arrange Real Estate Services (this may happen prior to arrival)
- Proceed with “Family On-Boarding”

Job Specific On-Boarding

Work with the Physician in completing the following documentation, ensuring all paperwork is complete and filed accordingly.

Documents to be Completed

- Initiate Payment (incentives)
- Arrange for Real Estate Agency Services for Physician (if required)
- Obtain copy of License and Insurance
- Obtain copy of work permits and passport
- Confidentiality Forms
- Issue Temporary privileges (Signed off by Medical Director)
- Complete RPAP Forms
- Complete application for Associate Privileges
- Complete application for Medical Staff
- Obtain parking pass and Hospital ID
- Obtain Electronic Dictation with Health Records
- Refresher tour of facility
<table>
<thead>
<tr>
<th>Task</th>
<th>Medical Director</th>
<th>Chief of Staff</th>
<th>Physician Recruiter</th>
<th>Physician Buddy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greeting</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Introduction to key staff including Management</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Communication</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Internal and External, Media Communiqué</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tour of Specific Department</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Office space and supplies (if applicable)</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Orientation EHR</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Laboratory Orientation</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Health Records Orientation</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Health Centre I.D Security Access</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Computer Access – Email Access</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

**Settling In**

- Arrange for welcoming dinner Physician and Spouse with Medical Director, Chief of Staff, Board member, Physician Buddy community members

- Check in with Physician – (See how things are going?) It is important that the Chief of Staff, Physician Recruiter and Physician Buddy periodically – “Check In”.

- Weekly follow up – provide ongoing assistance as required.