Regina Qu'Appelle
HEALTH REGION

NORTH CENTRAL COMMUNITY CONSULTATION COMMITTEE

A PRIMARY HEALTH CARE PLAN FOR NORTH CENTRAL REGINA

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Executive Summary

A Community Consultation Committee composed of residents, service providers and health care professionals worked together over several months to create a vision and strategies for Primary Health Care in North Central. This report is a plan for a primary health care central site in Regina's North Central neighbourhood.

Regina Qu'Appelle Health Region currently supports a variety of primary health care services that are located in the North Central neighbourhood such as the Child and Youth Services and the Randall Kinship Centre, the Harm Reduction Methadone Clinic, home care services and the Four Directions Community Health Centre that is an official primary health care site. This plan identifies some opportunities to better link and strengthen primary health care for community residents.

The Vision

In North Central Primary Health Care is:

- Accessible Comprehensive Services: 24-hour daily comprehensive health care services that promote positive mental, emotional, physical and spiritual health.

- Culturally respectful: inclusive and respectful to the individual and the cultural diversity of the community, accessible, bridges the gaps and connects members of the community. Community members are engaged, empowered and have a sense of ownership. Individuals take responsibility and ownership for the health of themselves and their community.

- Collaborative approach: part of a collaborative community approach to health. With a team approach, individuals, families and groups are supported and empowered to make healthy lifestyle choices.

- Education and Awareness: creating awareness and understanding through education on primary health care in North Central.

- Determinants of health: Primary Health Care recognizes the determinants of health.

Key Strategies to achieve the vision include:

Improving access to primary health care services in North Central

- Strategy 1: maintain and enhance the North Central Primary Health Care team:
  - Add a second Nurse Practitioner position with clerical support immediately;

- Engage physicians as members of the primary health care team;
- improve access to a full range of mental health and addiction services including prevention;
- enhance the diabetes prevention and management services offered in North Central;
- improve case management and referral services;
- increase access to traditional approaches;
- improve access to childcare support;
- ensure strong leadership to develop and co-ordinate a strong cohesive primary health care team;
- enhance capacity for community outreach;
- improve access to both nutritionist and clinical dietician services.

- Strategy 2: procure appropriate space and technology to accommodate the Primary Health Care team.

- Strategy 3: offer flexible, expanded hours of operations at Four Directions Community Health Centre to provide increased access for the community.

- Strategy 4: work with the RQHR Chronic Disease Steering Committee and the Diabetes Sub committee to develop awareness of chronic conditions, providing better access to the services available to those living with chronic conditions, educating the community about the importance of healthy lifestyles to prevent chronic conditions, assisting the community in making changes to support healthy lifestyles, and work in conjunction with the RQHR Population Health Promotion Strategy to assist the community to make changes to support healthy lifestyles.

- Strategy 5: improve access to lab and x-ray services outside of the acute care facilities.

- Strategy 6: improve transportation services to improve access to care.

- Strategy 7: improve access by integrating home care treatment services as part of the Primary Health Care team in North Central.

- Strategy 8: develop a communications strategy to create awareness of primary health care services and service providers for the community, to increase the ability of people to access services.

- Strategy 9: develop a mechanism for gathering and analyzing data on primary health care programs and services within North Central.

Working Collaboratively

- Strategy 10: work with current initiatives / interagency groups to address a variety of community issues, sharing information and resources, ensuring no duplication of services.

- Strategy 11: establish a forum for consistent co-ordination of all health care services in the North Central community.

Connecting with the community

- Strategy 12: enhance and expand the of Four Directions Community Health Centre Advisors Circle to enhance a culturally inclusive and respectful environment in primary health care services. Ensure First Nations and Metis representation in the Circle.

- Strategy 13: collaborate with others in the community to improve programming that contributes to the determinants of health.

The report from the North Central Primary Health Care Community Consultation Committee is the result of the co-operation, hard work and much discussion of community members, health care providers, and other individuals who deliver services in North Central. We have outlined a plan that will enhance the already excellent services delivered by Four Directions Community Health Centre, moving forward on a path of improved access to primary health care services delivered by an team of health care providers.

This report shows that by working in partnership with community, the RQHR and Saskatchewan Health, we can make a significant improvement to the health care and health related services offered in the North Central community.

I. Background and overview of Primary Health Care site

About the Regina Qu'Appelle Health Region (RQHR)

The Regina Qu'Appelle Health Region provides specialized health services to approximately 465,000 residents of southern Saskatchewan, 245,800 of whom live within the RQHR. Almost 25 percent of our population live in rural communities, 15 percent are seniors, the growing First Nations population makes up eight percent, and there is a large Metis population.

The Regina Qu'Appelle Health Region is the largest health care delivery system in southern Saskatchewan and one of the most integrated health delivery agencies in the country. Regina Qu'Appelle Health Region offers a full range of hospital, rehabilitation, community and public health, long term care and home care services to meet the needs of more than 245,000 residents living in 120 towns, villages and rural municipalities and 17 First Nation communities within the Region. The Region covers a diverse geographic area of approximately 26,663 square kilometres.

The Region employs approximately 9, 000 employees and about 55 physicians. An additional 450 fee-for-service physicians have privileges in the Region. The Region's annual operating budget is roughly $500 million, with more than $1.35 million per day spent on meeting the health care need of residents of the Region and southern Saskatchewan. The Region is governed by the Regina Qu'Appelle Health Authority, and administered by the Senior Management Team.

(See Appendix 1 for map of Region.)

Primary Health Care

In 2002 Saskatchewan Health published *the Saskatchewan Action Plan for Primary Health Care*, of which a key goal was to have an integrated system of health services available on a 24 hour 7 day a week basis via health region managed networks and teams of health care providers. RQHR rose to the challenge and began planning for the creation of Primary Health Care (PHC) sites throughout the region. A strategic plan, 10-year outcomes and five phases for implementation were articulated for the region by the RQHR Primary Health Care Steering Committee.

By the fall of 2004 RQHR was positioned to begin *Phase 3 Local Community Planning and Approval of Plans* with two sites. One site was in the rural area including Broadview, Whitewood, Grenfell, Wolseley, Ochapowace, Kahkewistahaw, Cowesses, and Sakimay communities, and the other in the inner city neighbourhood of North Central in Regina where the Four Directions Community Health Centre is located.

Primary Health Care has been defined as a holistic approach to the provision of services to individuals, families, communities and populations. Primary health care models utilise a proactive approach to preventing health problems before they occur and ensuring better management and follow-up, once a health problem has occurred. Since many of the factors that affect health occur outside of the health care system, primary health care also works with intersectoral partners and community groups to address broader community needs. (Saskatchewan Health 2002)

Primary Health Care:

- Is a philosophy of health care
- Is an approach to providing health services
- Includes a wide range of co-ordinated services including prevention, health promotion, treatment and rehabilitation
- Is provided using a team approach
- Recognises the relationship between physical, mental, social and spiritual well-being
- Is the public and community service providers working together to plan and develop services
- Links with agencies and organizations such as social services, the education system, recreational facilities and groups, police and law enforcement services, municipal governments, and other local community organizations to address factors that influence health (like housing, education, employment, income, social supports)

The principles of primary health care are:

- Accessibility
- Public participation
- Effective health promotion and disease prevention
- Appropriate technology
- Intersectoral co-operation
- Patient / client centred care
- Community development
- Proactive and collaborative approaches to management of chronic disease
- A human resource continuum
- The integration and co-ordination of services

Description of the North Central community

The North Central community, one of the inner city neighbourhoods of Regina, has a population of 10,350 (Statistics Canada 2001 census data – 2001 Neighbourhood Profile). The south boundary is the Canadian Pacific Rail lines, the north the Canadian National Rail lines, the east boundary is Broad Street and

the west boundary is Lewvan Drive. In the neighbourhood there are: five elementary community schools and one high school; a community policing station; a neighbourhood centre housing the community association; a library; a firestation; the historic Territories building, several churches and two small commercial streets (Dewdney and 5th Ave). There are also several RQHR services including the Randall Kinship Centre, Four Directions Community Health Centre, and two methadone clinics (one is a private clinic). It is also home to major community facilities like Regina's Exhibition Park, Taylor Field, the Sportsplex, the Pasqua Hospital, and the Agridome.

There are no long - term care homes in the neighbourhood. With Emergency Services, because call volume is so high, services are provided by a flexible deployment model where all ambulances are likely to be near the inner city at one point or another and may be dispatched to the north central region of the city. In total 62% of calls come out of the inner city (which is primarily North Central Regina). That equates to about 9,500 non-interfacility transport calls per year. These may be non-urgent, urgent, or emergent**.** In total, EMS does about 18,000 + calls a year. Many of these are inter-facility transports.

There are five community pharmacies and four family physicians with offices located within the North Central boundaries.

The community, in its original letter of intent, identified that the neighbourhood is a multi-cultural community with a growing number of First Nations and Metis young people. There are many single parent families living in poverty. It is a very mobile community, in part due to the lack of affordable, quality housing in the area. One outcome of this increased mobility is the higher rate of student turnover observed in local schools each year compared to other schools in the city. There are a number of pawnshops, convenience stores, pharmacies and bars in the community, but no grocery store. There are recreational facilities, but many of them are dirty, unsafe or too far away to be of use to local residents. Lack of transportation is an issue for many people and poses a barrier to accessing other services in the larger community. There are at least 40 human service organizations in North Central, but their efforts may not always be as co-ordinated as they should be.

Despite these challenges, the people are very resilient. There is a strong sense of community and a strong Community Association. Recently, there have been some very positive moves to improve the neighbourhood, making it a safer and more attractive place in which to live. The neighbourhood cleanup and the North Central Community Partnership are just two examples. Four Directions Community Health Centre has done an excellent job of providing health services in the community, but more physical space and staff are needed in order to provide comprehensive services that will effectively meet the health needs of all the community members.

(See Appendix 2 for map of community and for postal codes for the neighbourhood. Saskatchewan Health Covered Population information is not available at the neighbourhood level.)

History of Four Directions Community Health Centre

Four Directions Community Health Centre is an official primary health care site. It opened its doors in December 1996 with a focus of providing services to the community in a culturally sensitive environment. Access to needed services was improved by creating a single facility with consolidated Aboriginal health programs in a community with a significant Aboriginal population. Several existing programs concentrating on the health of prenatal women and families with young children were brought together in one setting. In 1999, a primary health care nurse was added to provide primary care services.

The Centre currently offers the Healthiest Babies Possible Program, which works with women with at risk pregnancies. It also houses the Sunrise Health Program, which offers community health information and education as well as an immunization program to families with young children. Four Directions Community Health Centre had the first Aboriginal Community Development Co-ordinator for the region and an Advisors' Circle drawn from community residents. The Centre has grown to include a part time addictions counsellor, the Good Food Box and Family Basket programs, elder involvement, a newsletter and support groups.

Demographics of the community

Information from the City Neighbourhood Profiles (2001) tells us North Central has a total population of 10,350 with 26% of that population under the age of 14 years. It has the highest proportion of children of all Regina neighbourhoods. Seniors make up just under 9% of the population. Approximately 35% of the people in the neighbourhood are First Nations and Metis compared to the citywide average of 8.7%.

Thirty nine percent of North Central's families are lone parent families, the highest rate of any Regina neighbourhood. Ten percent (10%) of all lone parent families in Regina live in North Central.

North Central Community Consultation Committee

In September 2004 a primary health care community consultation committee was formed. The Community Committee was made up of a variety of individuals who live and/or work in North Central. It was a mix of individuals from the Community Association, human service agencies, both school systems, health care services,

police services, and parent associations, etc. Observer status was given to representatives from the Core Community Association, Al Ritchie Health Action Centre, SIAST Wascana Campus and the Regina Community Clinic. Strong First Nations and Metis representation on this committee was encouraged.

Membership on the committee has fluctuated with new people joining and others dropping away as job or family circumstances change. At each meeting there has been a core of community residents, service providers and health professionals. In addition, an elder has participated in some of the meetings. (See Appendix 3 for a complete list of participants on the Primary Health Care Community Consultation Committee.)

During three meetings in the fall 2004, terms of reference were established for this committee. As part of its role, the committee also reviewed demographic information on the neighbourhood, and other recent research conducted in North Central. To date, several studies have been carried out in North Central, and the concern was noted that this neighbourhood and the community residents feel they have been the subjects of much study without any tangible positive outcomes or changes becoming apparent. The Committee reviewed the most recent studies and highlighted any references to health needs or visions.

The Community Consultation Committee spent considerable time talking about meaningful engagement of the community residents and committee membership. New members were added based on suggestions of participants. By January 2005, the committee agreed that the mix of committee members, along with a process to talk to community residents about the draft vision, would allow for meaningful opportunities for community input into the vision.

Internal RQHR stakeholders were brought together in January 2005 for a presentation on primary health care in RQHR. At this meeting the managers were asked to provide the names of health care professionals that worked in North Central or the Broadview area (the first two sites to be developed) to be part of the Community Consultation Committee.

The Community and Internal Stakeholder groups met separately for the first few meetings, reviewing the same information, each engaging in creating a vision for primary health care in North Central. In March the groups were merged and a common set of vision statements created. The process was completed with the merged groups.

II. Process

The Community Consultation Committee use a facilitated process called the Systems Thinking Approach that works from vision to strategies. This model was developed by the Centre for Strategic Management. In this model there are five key questions to answer:

Where do we want to be? (the vision for the future)
How will we know when we get there? (identifying key measures of success)
Where are we now? (considering current health status and services)
How do we get there? (creating strategies to move toward the vision)
What else is happening around us that will impact our vision and plans? (looking at the environment)

By working through these questions, the Committee created this report for RQHR on the vision, neighbourhood priorities and strategies to enhance primary health care in North Central. Attached in Appendix 4 is an adaptation of the Systems Thinking model for the North Central community process.

A. WHERE DO WE WANT TO BE? Creation of the community vision and outcomes for Primary Health Care in North Central

The Community Consultation Committee created the following vision for primary health care in North Central. To ensure a broad community input into the creation of the vision, each committee member was tasked with talking to at least three community residents about the draft vision. The questions asked of the community members were as follows:

If this is what primary health care looked like in North Central, would that be helpful in keeping you and your family healthy?
What would be most important to you?
What else do you think is important for North Central?

Committee members talked to home care families, moms involved in programs at Four Directions Health Centre, parents and people who work with parents, youth seniors, teachers, young moms in school, community agency staff, women who have been involved in prostitution, and members of the community association. One committee member conducted a survey of all the parents of children in a head start program within her agency. The comments and concerns heard in those discussions have been incorporated into the vision statements.

In North Central Primary Health Care is:
<u>Accessible Comprehensive Services</u>: 24-hour daily comprehensive health care services that promote positive mental, emotional, physical and spiritual health.

- Is centrally located with competent, pleasant staff in a culturally sensitive environment.
- May include:
  - Emergency child care
  - Diagnostic / treatment services
  - Addictions counselling
  - Home care access
  - Transportation
  - Programs for new moms
  - Dentist, nutritionist, home care, mental health, postoperative care.
- Leads both the health system and community members to a preventive health care mind set and health issues are prevented from worsening.
- Ensures positive mental health of community members is maintained and improved.
- Through education and awareness on a variety of health issues, people are motivated to seek out appropriate care.

Culturally respectful: inclusive and respectful to the individual and the cultural diversity of the community, accessible to all, and bridges the gaps connecting members of the community. Community members are engaged, empowered and have a sense of ownership. Individuals take responsibility and ownership for the health of themselves and their community.

It is:

- Culturally respectful and inclusive of all members of the community.
- Acting as a bridge between people of different cultures.
- Well connected to the community and their changing needs.
- Exhibits a "people care" atmosphere.
- Where culturally specific traditional approaches to health are honoured.
- Client directed and respects, recognizes and is responsive to the diverse needs of First Nations and Metis individuals, families and community.
- Sensitive to the cultural beliefs and values and to the diversity of the First Nations and Metis peoples.
- Staff who reflect the cultural makeup of the neighbourhood, and through their actions are role models that encourage others to seek out careers in the health field.
- All working together in an open, respectful, collaborative neighbourhood environment for the good of everyone in the community.

First Nations and Metis people are engaged empowered participants in the development of a holistic model of health care. Education, awareness, and support are needed to encourage First Nations and Metis people to take ownership in changing their future.

<u>Collaborative approach</u>: part of a collaborative community approach to health. With a team approach, individuals, families and groups are supported and empowered to make healthy lifestyle choices.

It is:

- Delivered in a team approach - a team of health and human service providers, sharing information, building on clients' history and treatments for faster, more effective treatment of the whole person.
- Streamlined communication and collaboration through a system of information sharing and partnerships within and between human service and health providers.
- Part of a collaborative community approach to health that encourages individuals to be responsible for their health, empowers youth to model healthy living, and contributes to a health community environment.

<u>Education and Awareness</u>: creating awareness and understanding through education on primary health care in North Central.

It is:

- Advocating on women's issues,
- Expanding the education and resources available to teenagers and pregnant women to decrease teenage pregnancy and have healthy moms and babies.
- Creating awareness, education and understanding on primary health care in North Central. Community residents are knowledgeable and understand what resources are available. It provides information on both treatment and prevention and leads to better self-care and a healthier community.
- Provides education and increased awareness of chronic conditions so that people better understand the resources available to them, to improve self-care and healthy outcomes that result in healthier people with a better quality of life.

<u>Determinants of health</u>: Primary Health Care recognizes the determinants of health.

Primary Health Care, as a holistic model, recognizes the importance of the underlying determinants of health in North Central. Key determinants of health such as education, income, etc affect not only current health status but can also influence disease prevention and health promotion. Comprehensive primary health care can reduce the cost burden (health care costs) through adapting services and participation in initiatives that improve quality of life, with the potential to result in improved health status for all.

B. HOW WILL WE KNOW WHEN WE GET THERE? Identification of key measures of success for Primary Health Care in North Central

The Community Consultation Committee then considered key measures of success for each of the vision statements. The question addressed in the discussion was " **What are the most important areas to track performance in to help ensure progress and success in this initiative?"**

Common indicators emerged and these became the **key measures of success for primary health care in North Central**:

1. increasing number of programs focusing on wellness
2. increasing participation in programs
3. decrease in people requiring services related to illness
- emergency room use
- hospital admissions
4. culturally respectful and inclusive, open to all
- measured by variety of cultural backgrounds of participants and age ranges that access programs and services
- measured by the increased participation rate of First Nations and Metis people.

(Appendix 5 lists all indicators by vision statement.)

C. WHERE ARE WE NOW? Description of current situation – observations, gaps, strengths

The Committee reviewed three sets of information.

(1) Demographics: Demographic information on the community is throughout the report. All demographic data is based on Statistics Canada 2001 census data.

(2) RQHR funded services: The second set of information Committee considered was the range of RQHR supported services in North Central (as of November 2004, not including Pasqua Hospital).

- **The Randall Kinship Center** officially opened in April 2002. The program offered at the centre was developed to meet the needs of families with children and youth that have serious disruptive behaviour problems. The program tries to meet each child's unique needs. Families, as a whole, are provided treatment and support. The services provided at the Randall Kinship Centre are usually long-term and intensive. They are provided in a way that honors First Nations and Metis cultures, values and beliefs.

Randall Kinship Centre programs include:

- Parenting education;
- Care delivered in the home, school and neighbourhood;
- Crisis services;
- Behaviour therapy;
- Problem-solving skills development;
- Community development;
- Partnerships with the community and other agencies;
- Aboriginal Problem Gambling Services; and
- Addictions services for young offenders.

Open weekdays
Note: In early 2005 Child and Youth Services also was relocated to North Central.

- **Harm Reduction Methadone Clinic.** This is a harm reduction program for injection drug users that also includes a recovery option. Program goals include improving the social determinants of health for injection drug users and other at-risk individuals, and to reduce injection drug use, drug-related crime rates and Hep C and HIV infection rates in Regina and area.

Open weekdays and weekends. 6 FTE staff – 2 doctors 5 half days/week, plus nurses. Serves approximately 200 patients, 80 who visit daily for methadone.

- **Home Care Services – Nursing, Home Services**

Several Home Care staff – between 10 – 15 – dependant on number of clients and service required.
One RN assigned to complex, First Nations and Metis client caseload – varies between 30 – 50 clients at any one time.
Services 9am to midnight, 7 days/week.

- **Dental Health Coordination**
  - group education
  - consultation and fluoride varnish treatment for preschool children
  - delivered at Four Directions Community Health Centre
  - Two afternoons / week, service: average 10/week

- **Dental Health Coordination** – Fluoride Mouthrinse Programs in 5 elementary schools in North Central – 1 day in each school per year. Done by volunteers with RQHR staff monitoring program
  - Providing of supplies
  - Training of volunteers
  - Handling problems

Oral Screening in 5 elementary schools – screening and follow-up done by Dental Health Co-ordinator about 15 days / year.

- **Four Directions Primary Health Care Nurse Services** which includes:
  - birth control counseling and dispensing
  - STD diagnosis and some treatment
  - Developmental assessments on infants and preschoolers
  - Pap smears
  - Pregnancy testing and prenatal care

Treatment for common illnesses.
Open 8 – 4:45pm Monday to Friday. One NP with ½ office assistant. Serves 1200 people / year.

- **Sunrise Health Program** – Four Directions Community Health Centre – 4 public health nurses:
  - Child health clinics
  - Parenting programs
  - Home visiting
  - KidsFirst assessments
  - Presentation to community

Open 8 – 4:45pm Monday to Friday and some evening programs.
4FTE's Public Health nurses

- **Healthiest Babies Possible Program** at Four Directions Community Health Centre includes:
  - Outreach for at risk prenatal to 6 months postpartum

- Vitamin and milk supplementation program
- Prenatal classes
- Home visiting
- Breastfeeding support
- Mom's Support circle
- Moss bag classes

Open 8 – 4:45pm Monday to Friday and occasionally after hours for labour and delivery. Includes 3.6 community health workers, 1 public health nurse, .8 nutritionist, serves 150 / year.

- **Aboriginal Community Development Coordinator**:

Develops partnerships to provide programming to meet the community's needs

- **Dental Health Coordination –** delivered from Four Directions Community Health Centre

Programs in Preschools, pre kindergarten and teen drop-in centres

- Screening
- Fluoride Varnish
- Consultations

Serves 150/year – approximately

- **KidsFirst Regina** – is a family support program hosted by RQHR
  Works with approximately 100 vulnerable families in North Central.

(3) Patterns of Care: The third set of information was North Central Patterns of Care from the Four Directions Community Health Centre Needs Assessment done in 2003. Although the geographic boundaries are not exactly the same, it was the best available source of information on access to services by people from this neighbourhood. The catchment population was defined as those living within an 8-block radius of Four Directions Community Health Centre.

- **General Practitioner services**
  - 81% of the catchment population sought GP services in 1999 with no significant change since 1996
  - 32% of all visits were to 4 physician practices in the area, 68% to physicians outside the area.
  - Average of 8 GP services per person
    - For Aboriginal population average of 9 services / person
    - In 1999 / 2000 average was 10 services/person

  - Age breakdown of utilization of GP services:
    - 20 – 39 years 38% of services (males 13%)
    - Under 19 years 26%
    - 65+ years 15%

Therefore: the majority of GP services provided to individuals less than 19 years old and to women 20-39 years old.

- **Use of Pasqua Emergency services**
  - 28% of population used emergency services in 1998
  - average of 2.6 visits/person
  - 32% of Registered Indian population in area accessed services

  (RI women made 82% more visits than males)

  - age range for use of services:
  - individuals 20-39 years old made 39% of visits
    (Females made 50% more visits than males)
    - under 19 years made 26% of all visits
    - seniors 65+ made 14% of visits

Therefore: Registered Indian women 20 – 39 years old had the highest use of emergency services.

- **Themes in emergency service usage:**
  - trauma
  - reproductive health
  - mental health (depressions, anxiety, psychoses, etc)
  - respiratory conditions (upper respiratory infections, asthma)
  - infections
  - diabetes
  - heart health
  - Small number of visits attributed to alcohol addiction or effects.

- **Hospitalizations in 1997/98 of catchment population**
  - 2977 hospitalizations by age category:
  - 28% females between 15 – 39 years (make up only 20% of population)
  - 14% children under 4 years (make up 11% of population)
    (RI children 53% of under 4 admissions but are 47% of under 4 population)
  - 36% of admission are of RI population
  - 17% of admissions from seniors +65years

Therefore: children, women in childbearing years, and seniors account for high percentage of admissions.

- **Visits to Four Directions Health Centre Nurse Practitioner** (2000 – 2002)
  reasons for visits:
  - contraception 22%
  - Regular pre-natal care 10%
  - Well child visits 9.5%
  - High-risk pregnancy visits 7.5%
  - Hypertension of pregnancy 2.6%
  - Diabetes 5.8%
  - Screening of STI's 5.5%
  - Anaemia 4.6%

- Eczema 4.3%
- Asthma 4.3%
- Common cold 2.9%
- Candidiasis 2.3%
- Pediculosis 1.7%

Observations in the discussion "what does the data tell us?" noted that there was limited information at the neighbourhood level on the health status of the residents, and there is limited regional or neighbourhood level information on the health status of First Nations and Metis people.

Gaps that were identified included:

- a lack of / limited access to services because of hours of operation, wait lists and for programs to help manage chronic conditions;
- the limited range of services available in North Central, and especially the lack of community based lab and x-ray services and after hours, non emergency treatment services;
- the need for case management services to help navigate the health system as well as the need for easily accessed information on other available community services;
- a need for a focus on holistic health and culturally respectful services.

Many **strengths** were identified in the community and included the following:

- the history and experience of Four Directions Community Health Centre - strong cultural focus, excellent staff, central location, existing partnerships;
- the variety of RQHR services currently located in North Central;
- a strong community association and variety of other initiatives in community; and
- the desire of the community to improve conditions.

Using this information, as well as drawing on the knowledge and experience of the committee members, the current state information was organized into three themes:

- improving access to primary health care services in North Central
- working collaboratively
- connecting to the community

(1) Improving Access To Primary Health Care Services in North Central

- **access to Nurse Practitioner / Physician services**

- current Nurse Practitioner is often fully booked, drop-in clients sometimes are turned away, cannot wait, or visits are more rushed because others are waiting.

- no coverage for vacation time, attendance at meetings, sick time, etc, so services are interrupted or not offered for periods of time. As senior nurses, Nurse Practitioner's have often accrued considerable vacation time which results in no coverage for extended periods of time.

- as a key part of primary health care, the current Nurse Practitioner is asked to be part of many strategic committees like the RQHR Primary Health Care Steering Committee. While this is a critical contribution it also means that time is taken away from delivery of primary care services, or the Nurse Practitioner cannot participate in the strategic discussions.

- current Nurse Practitioner does some community outreach but this could be expanded to attempt to reach the part of the population that is living in very high risk situations; and, a second Nurse Practitioner would enable clinics at Four Directions to be conducted consistently regardless of other requests for NP time/input.

- anecdotal evidence that some of the most at risk people do not seek regular health care.

- in a recent report from the Regina and Area Drug Strategy "Women at Risk – Documenting the Barriers" the most predominant barrier to women who use injection drugs in seeking prenatal care was the fear of being reported to social services and losing custody of the baby. The ability of the NP to do outreach to reach women in high-risk situations is an important way to link these women with some basic health care services.

- continuity of care is a concern when people receive their primary care mainly through Medi-centres or Emergency Departments

- 28% of general population used emergency services in 1998, with 32% of Registered Indian population accessing services (82% of those were women)

- reasons for emergency service usage included trauma, reproductive health, mental health, respiratory conditions, infections, diabetes, heart health.

- 69% of all visits to physicians were to physicians outside the area
  (from Four Directions Community Health Centre Needs Assessment 2003)

- In the RQHR PHC Annual Update, submitted to Saskatchewan Health in December 2004 four strategies for engaging physicians as regular PHC team members were outlined:
  1. **Follow-up meetings with the Regina Community Clinic (RCC) and Family Medicine Unit (FMU) to determine their capacity to provide services**. Both the RCC and FMU have indicated that without additional resources they do not have the capacity to provide services in North

Central. They have indicated however, that they would be willing to consider some form of a partnership with Family Practitioners working at the site.

2. **Discussions with the five Regina family practices interested in participating in PHC development about opportunities to spend part of their practice time in North Central.** To date follow-up discussions have been held with two of the five practices. Like the RCC and FMU they have indicated that without additional resources they do not have the capacity to provide services in North Central, but would consider some form of a partnership with Family Practitioners working at the site.

3. **Discussions with physicians currently practicing in North Central about their interest in participating on a PHC team.** Meetings with two of the three practices revealed philosophies and approaches to patient care that are not consistent with those of PHC. Requests for a meeting with the third practice were made, to which there was no response.

4. **Addition of services under a system of sessional fees for high risk obstetrical patients.** It is important that the population of high-risk women in North Central who are not currently receiving adequate prenatal care be acknowledged. The benefits of prenatal care in terms of long-term cost savings to the health care system are described extensively in the literature.

   In most cases these women could be successfully served by a family physician. Currently in Regina however, there is a shortage of family physicians providing comprehensive prenatal, postnatal and intrapartum care.

   As indicated in the December 2004 update, it is necessary to augment the time already committed to this service by Dr. Carson (an RQHR salaried Perinatologist) by 13 sessions per year.

- **access to mental health and addictions services**

- the addiction counselor position has recently been increased from 1 day per week to 3 days per week.
- Community member felt there was not enough addictions, detox services

- **access to chronic disease management services i.e. diabetes**

- limited utilization
- barriers to access to education programs such as MEDEC to help manage chronic conditions: waiting lists, ongoing support wait times, no drop-in, full caseloads, no First Nation and Metis staff, no childcare, lack of transportation
- no on-site programs in the North Central neighbourhood

- 2000/01 prevalence rates from *Saskatchewan Diabetes Profile*, Saskatchewan Health show a very significant population with diabetes. Present numbers are greater.
- Using the Saskatchewan rates, an estimate of the number of people with diabetes in North Central is at least 469.

North Central	Population (01Stats Canada)	Prevalence of DM *(per 1000)	Estimated # of People with DM
General Population	6 720	37.3	250
Aboriginal	3 630	60.1	218
Total	10 360		469

- Based on that estimate, a 0.59 FTE (based on 1 educator for 800 clients) Diabetes Educators is needed. The number of educators needed per persons with diabetes is taken from *Diabetes 2000*, (Saskatchewan Health) and does not reflect staff needed for primary prevention, health promotion or screening activities.

- **access to nutritionist and clinical dietician services**
- research indicates that up to 70% of all illness is diet related
- the North Central Regina demographic includes many high-risk groups, including First Nations and Metis people, seniors, children and low-income/poverty.
- in the past decade, high-risk groups, including First Nations and Metis people and children, have shown increased instances of diabetes, obesity and other dietary health issues.

Currently there are no on-site nutrition services at Four Directions Community Health Centre except for Healthiest Babies Possible clients. All others must access clinical dietician by physician referral or other public health nutritionist services. This has been identified as an inequity in services. I.e. Healthiest Babies Possible has supports to which others don't have access.

- **access to childcare**
- lack of childcare is a significant barrier to accessing services for many women. It is not possible to take the time needed with the doctor or NP to fully discuss treatment or prevention actions if your children are demanding your attention. It may also prevent some from seeking care in the first place. On site childcare allows for better access and a more focused and successful visit with the health care professionals or elder.

- 26% of the population in North Central is under 14 years of age, and 10% of the population is under 5 years of age (Statistics Canada 2001)

Strengths regarding access to services included:

- staff working at Four Directions Community Health Centre – dedicated, competent people, good team
- existing programs at Four Directions Community Health Centre
- Currently, 70% of staff at Four Directions are First Nations and Metis
- history and experience of Four Directions Community Health Centre – already have broken new ground, have cultural and gender specific services

- **appropriate space**

Strengths:

- there are many RQHR primary health care services located in North Central. Securing a larger space that could house several services that are appropriate and complementary provides an opportunity to better integrate existing services and provide improved care for residents.
- Discussions are currently underway about RQHR's need for space in North Central through the Integrated Services Centre Committee. Co-located services could potentially include such services as daycare, Randall Kinship Centre, Home Care treatment centre, Methadone Clinic and perhaps EMS.
- location of Four Directions Community Health Centre – close to people who need the services, close to partners in community
- this process is building something that people need – there will be no lack of 'business'

- **hours of service**

Gaps:

- hours of operation for Four Directions – no evening, late night, or weekend services
- accessing services takes a lot of time – not easy and quick, hard to take time off work
- security issues of working beyond 4:45pm

- **access to lab and x-ray services**

Gaps:

- no lab and x-ray services in neighbourhood with extended hours outside of acute care facilities

- **outreach / transportation**

- Transportation to services is a major barrier to access that is identified over and over in the community, especially for parents with young children.

- **communications**

Gaps:

- community doesn't know enough about available services
- people don't know where to go / what help they need / what options there are
- limited central points, welcoming place to learn about services

- **availability of data**

- last needs assessment report on Four Directions Primary Health Care service site done June 2003 using data from 1999 to 2001
- needs assessment based on an eight block radius from Four Directions, not the whole North Central community area.

(2) Working Collaboratively

Strengths:

- Regina Inner City Community Partnership is working in community to make improvements – this partnership was a result of all the studies that had been done on the community.
- Strong North Central Community Association
- Community has strong desire to improve itself – to tackle the issues and make changes

- **Co-ordination of all health care services**

Gaps:

- Community doesn't know enough about available services
- Need better co-operation between all the community institutions
- Not enough overall collaboration of all human services

(3) Connecting to the community

- **Advisors Circle**

- 35% of people in the neighbourhood are Aboriginal (Statistics Canada 2001)

Strengths:

- existing cultural strength and identity of Four Directions Community Health Centre
- community diversity

- **Determinants of health**

- RQHR through Child and Youth Services, funds a significant portion of the Rainbow Youth Centre budget to provide programming for youth 11 to 21 years of age.
- RQHR is the administrative partner for KidsFirst Regina, an in-home family support program that develops strong relationships with the families and helps them to work toward their goals, and link with needed services.

- 27% of the population in North Central is under the age of 14 years old
- North Central has the highest proportion of children of all Regina neighbourhoods.

- Only 38% of youth 15 – 24 are employed compared to the city average of 63%

- Only 38% of North Central youth aged 15 – 24 years attended school in 2000/01 compared to the City average of 60%. This was the lowest percentage for all city neighbourhoods.

- Neighbourhood has the highest incidence of low income in the City at 47% (Statistics Canada 2001)

D. HOW DO WE GET THERE? Creating strategies and setting priorities

The group then moved into the strategies section of the Systems Approach addressing the question "**What are some strategies that will move us from now (current state), using our strengths, to our vision?**

> " *Once you set a vision and take a good look at current reality, the gap causes a problem for you. And once you have a problem, your creative subconscious goes to work to fix it. Now, you can always 'fix' in the direction of your dominant thought or picture. It can go back to current reality causing you to back off your vision or give up altogether; or you go for the vision." Lou Tice*

The group used the previously identified vision statements, key measures of success, observations from the data, gaps, and strengths to create strategies to bridge from now to the vision.

Throughout the strategies discussion a series of questions were used to ensure that the mix of strategies chosen would be the combination most likely to enhance primary health care in the community. The underlying principles were:

- That there be a balance between short-term strategies and long term strategies.
- That there be a balance between strategies that address the needs of small group of high risk individuals, and those that address a large volume of lower risk individuals.
- That the collective impact of the strategies are considered and the best mix of strategies be selected.
- That decisions be evidence based.

(For a complete list of the strategy discussion questions see Appendix 9.)

Key strategies for action

Three key themes emerged in the development of strategies:

THEME 1: IMPROVING ACCESS TO PRIMARY HEALTH CARE SERVICES IN NORTH CENTRAL:

The identification of the primary health care team for North Central was based on the following assumptions and principles:

- The vision for primary health care in North Central includes a balance between treatment and prevention services. However, on a day to day basis, the pressure is for treatment services to take priority. Therefore, to address

this tension, the key is to have sufficient staff to meet the treatment needs, and still have significant capacity available to do preventative work.

- In addition to sufficient staff, element of prevention must be incorporated into every treatment moment.

- Currently in North Central there are individuals living in high-risk situations with complex needs that do not access any primary care services. To have an impact on the health of the community, it is critical to help these individuals to access care. This requires outreach into the community in non-traditional ways, offering a variety of services; and it will result in an increased demand for services.

  Lack of access to health care is one of a number of elements that make up disenfranchisement, or being out of the mainstream. Many people in North Central don't have work although it is available in the city, don't go to school although there are classrooms, don't get proper exercise although there are ways to do so, don't take advantage of cultural and recreational activities although there are options for this. And the reasons behind all of these things are related to what it means to be marginalized. The reality of not being connected to your community makes the outreach function emerge as more important that just about anything. While we want to offer the right kinds of services to people, we must ensure that people who need the service actually find their way to it.

- When enhancing the Primary Health Care team every effort will be made to engage First Nations and Metis professionals, and staff will reflect the cultural makeup of the neighbourhood.

- Support will be given to develop and support the collaborative, team approach and communication skills of the Primary Health Care team.

The following chart summarizes the strategies and the phases in which the strategy would be implemented.

North Central Primary Health Care Implementation Phases

Phase 1 Jan – Dec 2006	Phase 2 Jan – Dec 2007	Phase 3 Jan 2008 Longer term	Current / Ongoing
• **#1 maintain and enhance the NC PHC team** - add a second NP with clerical support - engage consistent physician services - Improve access to a full range of mental health and addiction services - Enhance chronic disease management services (diabetes) - Enhance case management and referral services - Improve access to traditional approaches - Improve access to childcare - Ensure strong leadership to co-ordinate the site - Enhance capacity for community outreach • **#2 procure appropriate space and technology to accommodate the PHC team – short term** • **#3 offer flexible hours of operation** • **#4 improve access to chronic disease monitoring and support**	• **#1 maintain and enhance the NC PHC team** - improve access to nutritionist / dietitian services • **#2 procure appropriate space and technology to accommodate the PHC team – long term** • **#5 improve access to lab and x-ray services** • **#7 improve access to home care treatment services**	• **#6 improve transportation services to improve access to care**	• #8 communications strategy • #9 gather/analyze data • #10 work collaboratively • #11 co-ordinate health care services • #12 enhance Advisor's Circle • #13 work with others to improve programming that contributes to the determinants of health • recruit and retain Aboriginal professional staff • develop team skills

Strategies in Phase 1

Strategy 1: maintain and enhance the North Central Primary Health Care team.

- **Physician / Nurse Practitioner:**

Add a second Nurse Practitioner position with clerical support immediately.

- This position would increase access to primary health care services including pre and post natal care, and work with groups outside of Four Directions Community Health Centre.
- The addition of a second NP's allows for outreach work with those living with addictions, pregnant women who currently do not access any services, and other individuals living in high-risk situations.
- Clerical support allows professional to focus on the activities that only they can do.
- The site could also be a clinical practicum site for NP students

- **Engage physicians as members of the Primary Health Care team.**

In the RQHR December 2004 Annual PHC Update we indicated that two or more of the four strategies for engaging physicians previously outlined needed to be successful to supply appropriate physician services to the North Central Community. Our work to date shows us that this is not going to be achievable.

Further, concern was expressed that even if achieved the result would be a piecemeal approach to providing physician services in this site. In a community like North Central in which many residents are disenfranchised and marginalized, continuity of care is of utmost importance.

For family physician services an additional strategy – the recruitment of new doctors - is the optimal alternative. However, to be able to pursue this, a policy for recruiting new doctors directly to PHC teams is needed. Two options for consideration by Saskatchewan Health are:

1) Recruit a new physician on a Fee-for-service basis initially. Assuming that it will take a period of time for this physician to establish a steady volume of patient visits, a top-up to a maximum amount may be necessary on a short-term basis. After a specified period, once a reliable billing history is established, convert to an alternate payment contract.

2) On a pilot basis, reallocate a portion of all Fee-for-service dollars currently being spent within North Central, equivalent to the cost of one contracted physician.

For obstetrical services one option for funding 13 additional sessions per year would be to recruit an established Fee-for-service obstetrician willing to devote a portion of their time to a pregnancy clinic in North Central. Incrementally, a portion of their current Fee-for-service income could be re-directed to payment of sessional fees at North Central.

Discussions between the RQHR and Saskatchewan Health regarding physician recruitment and remuneration policies related to underserviced populations would be welcome.

- **Mental Health and Addictions services:**

Improve access to a full range of mental health and addictions services including prevention.

- Increase the current addiction counselor services to full time from 3 days/week.
- Create a link to Crisis Response team and other after hours crisis services.
- Create a link to the intake services at Regina Mental Health Clinic, Child and Youth services, and Addiction Services.
- Work with the Regina and Area Drug Strategy and RQHR Addictions Services to co-ordinate and align services with the implementation of the Drug Strategy.

- **Chronic Disease management services (Diabetes):**

Enhance the diabetes prevention and management services offered in North Central.

- Work with the RQHR Diabetes Sub Committee to provide a community based ,culturally respectful diabetes education and prevention program.
- Improve early detection and ongoing care of diabetes for North Central residents by adding a Diabetes Educator to the PHC team, as described on page 23.
- Address barriers to access to current regional diabetes services

- **Case management and referral services**

Add a new position of social worker to Primary Health Care team

- To provide case management service where needed, as well as referrals to other community services (both RQHR and non RQHR services)
- To link to parenting support and education programs for families
- This position would serve as a liaison with SWADD (System Wide Admission & Discharge Department), the single entry point for access to Home Care and Restorative & Continuing Care services, coordination of services and access to Home Care Treatment services. A background and understanding of mental health and addictions issues will be important.

- **Access to Traditional approaches**

Add an on-site elder to the Primary Health Care team.

- Include both female and male representation.
- Include both First Nations and Metis representation.
- Through the Aboriginal Health Initiatives unit ensure there are links to traditional healing and medicine.
- Elder would teach both staff and community regarding First Nations and Metis culture.

- **Improve access to childcare support**

- **Ensure strong leadership to develop and co-ordinate a strong cohesive primary health care team**

Create a new out of scope position of site manager with clerical support

- To co-ordinate activities and services from multiple service areas at the Primary Health Care site.
- Ensure PHC philosophy and approaches are maintained.
- Facilitate ongoing team development

- **Enhance capacity for community outreach**

To engage and connect with people living in vulnerable circumstances it is critical to go to where they are and begin to offer support and services. Once a relationship is established only then is it possible to help them connect to other services that they may need.

Explore various ways to enhance capacity of all primary health care staff to do outreach

Create a Community Outreach worker position to support the Primary Health Care Team

- To assist people in getting to doctor appointments
- To assist with transportation to services
- To work with other community institutions like schools to identify families that may need services and link them with the Primary Health Care team
- To provide for the welcoming face when people first come into Four Directions Community Health Centre. Unique to Four Directions is the need for a person at the front to welcome people, make them feel comfortable, direct people to the right service, set up for classes and outside groups coming in to hold meetings.

Strategy 2: **procure appropriate space and technology to accommodate the Primary Health Care team.**

- Consider co-locating with other complimentary services
- Space to be centrally located in neighbourhood and on/near a bus route

Strategy 3: offer flexible extended hours of operation at Four Directions Community Health Centre to provide increased access for community.

Strategy 4: work with the RQHR Chronic Disease Steering Committee and the Diabetes Sub committee to develop awareness of chronic conditions, providing better access to the services available to those living with chronic conditions, educating the community about the importance of healthy lifestyles to prevent chronic conditions, assisting the community in making changes to support healthy lifestyles, and work in conjunction with the RQHR Population Health Promotion Strategy to assist the community to make changes to support healthy lifestyles.

Strategies in Phase 2:

Strategy 1: maintain and enhance the North Central Primary Health Care team.

- **Nutritionist / clinical dietitian services**

Improve access to both nutritionist and clinical dietician services

- Provide for consistent school / agency visitation and support, nutrition classes and drop-in counseling.
- Tie position into Diabetes strategy to help give access to clinical dietician services.

Strategy 5: improve access to lab and x-ray services outside of the acute care facilities.

Strategy 6: Improve transportation services to improve access to care.

- Improve access to services by securing a van and driver for Four Directions Community Health Centre to be used in helping clients access health services at the Centre and at other locations in the broader community.

Strategy 7: improve access to treatment by integrating home care treatment services as part of the Primary Health Care team in North Central.

Current / Ongoing Strategies to support the Primary Health Care team

Strategy 8: Develop a communications strategy to create awareness of Primary Health Care services and service providers for community, to increase the ability of people to access services.

Strategy 9: develop a mechanism for gathering and analyzing data on primary health care programs and services within North Central.

- These tools to be linked with / compatible with the IT development that is occurring provincially.

THEME 2: WORKING COLLABORATIVELY

Only by working with others in the community can we hope to make a difference in the issues and needs of the community. The North Central Community Consultation Committee strongly supported a collaborative working style for all primary health care services in North Central.

Strategy 10: work with current initiatives / interagency groups, to address a variety of community issues, sharing information and resources, ensuring no duplication of services.

Along with working with other community initiatives, the Committee believed that it was possible to achieve better co-ordination of all RQHR services within the neighbourhood.

Strategy 11: establish a forum for consistent co-ordination of all health care services in the North Central community.

THEME 3: CONNECTING WITH THE COMMUNITY

Working in a neighbourhood with people who have not been part of mainstream community because of poverty, culture or lifestyles, requires opportunities to build trusting relationships before services can be offered. It also requires providing opportunities for people to speak and have input into decisions that will affect their neighbourhood, and it requires a culturally respectful and inclusive attitude. The following strategies speak to a variety of ways the Primary Health Care Team and the community can be integrated.

Strategy 12: enhance and expand the Advisors Circle of Four Directions Community Health Centre to enhance a culturally inclusive and respectful environment in primary health care services. Ensure First Nations and Metis representation in the Circle.

Strategy 13: collaborate with others in the community to improve programming that contributes to the determinants of health.

- collaborate with other community groups to provide programming outside of the main primary health care site.
- work with other community groups to establish a co-op store (with healthy products).

- work with others to develop and deliver programming for youth in arts, culture, and recreation to enhance their healthy development.
- establish a community kitchen that will teach people what to do with different foods and provide utensils to cook meals. Target to do community kitchens with North Central Community Association.
- hold an annual event to honour families – for education and celebration, and to get to know your neighbours.
- Improve access to Early Learning and Care supports

SASKATCHEWAN HEALTH / RQHR INITIATIVES

The Committee recognized two initiatives that are underway that will be of great benefit to primary health care development in North Central. The Committee offers their support and encouragement for the speedy completion and implementation of these projects.

- **Electronic health records** improve communications between health care providers, resulting in better care for the individual. There is a lack of information on the health status of First Nations and Metis people in the RQHR. This would improve regional or urban / rural specific data.

- The development of a **central database or clearinghouse on services** that are available in community would be very helpful in improving access to all human services. In our discussion gaps were identified such as people don't know where to go or what options there are - the community doesn't know enough about available services. The discussions underway to enhance information on community services for the HealthLine would also be very helpful for community.

E. WHAT IS HAPPENING AROUND US THAT WILL IMPACT PRIMARY HEALTH CARE? – Looking at the Environment

There has been and continues to be, considerable focus on the North Central neighbourhood, the needs of the population, and the services that would address those needs. Many levels of government and community have been involved in a variety of initiatives to improve the social conditions for residents.

In a presentation to the Committee by Lisa Workman, the Aboriginal Community Development Co-ordinator at Four Directions Health Centre, a variety of services, activities and interagency initiatives active in North Central were identified. The following list is not inclusive of all programs and services in the neighbourhood, but does give a sample of the variety activity that is underway.

Initiatives:

- North Central Community Association
  - Crime Prevention Through Environmental Design
  - Back Alley House numbering
  - Housing Registry Taskforce
  - Community Clean ups
  - Garbage bin program
  - R mobile Store
  - Negotiating a permanent grocery store
  - Summer students
  - Neighbourhood Watch
  - Block Parent Program

- Regina Inner City Community Partnership – key areas of action:
  Crime and Safety
  - Integrated response team to inspect houses
  - Evaluation of service centers
  - Regina Area Drug Strategy
  - Safer Communities Act
  - Looking at how the streets in North Central are set and up for possible changes

  Housing
  - Working on an focus area
  - Building new homes on empty lots
  - Working with various programs
  - Community Developer hired
  - Extra garbage pickups
  - Graffiti reduction
  - Fire reduction

  Employment
  - Partnerships working group
  - Employers working group

- Development of an employment centre
- Stepping Stones Career Fair
- Childcare creating more placements
- Police Services Cadet program
- Job creation
- Aboriginal Life Guard program

- The Regina Youth Justice Forum Aboriginal Roundtable
- Working Together: Library/Community Connections – A national HRSDC project
- Aboriginal Health Office, RQHR
- First Nations and Métis Diabetes Initiative
- Food Audit – conducted by REACH and DCRE
- In Motion
- Thought About Food – getting the community involved in looking at food security
- A subcommittee of the Regina Area Early Childhood Network is doing a survey on transportation needs. Information is also being collected on waitlists.
- The Regina Friendship Centre will moving to a new building on Cameron St.
- 5th Ave. agencies teaming up for National Aboriginal Day activities
- Albert Scott agencies also teaming up for NAD activities.

Interagency groups:

- 'Together Now' North Central Regina Interagency Network – formed to encourage information sharing and co-operation in the variety of service providers working in North Central. Participation is from a variety of City services and community based agencies.
- Regina Area Early Childhood Network – an informal network of government and community based agencies that work with young children
- The Regina Fetal Alcohol Spectrum Disorders Community Network – a network of health and community agencies that focus on fetal alcohol identification and treatment, and plan for improved community services.
- Albert Library Committee
- Regina Literacy Association
- Four Directions Advisors' Circle
- Regina Intersectoral Committee – an intersectoral committee composed of the regional level of federal and provincial government departments, three school boards, City departments, RQHR, Regina Treaty Status Indian Services, SIAST, University of Regina, and the United Way.
- Regina Inner City Community Partnership

In addition to specific initiatives underway in the community, there are a wide variety of human service agencies, government services and church organizations that deliver a variety of services to the community.

III. Addressing Strategies

- **Strategies to be addressed by community**

The North Central community is involved in many different initiatives aimed at improving the social and physical conditions in the neighbourhood. The strategies in the themes 'Working Collaboratively' and 'Connecting with the Community' are where the community has a strong role in improving the health of people in the neighbourhood by addressing the determinants of health. Participation on the Advisor's Circle and on other community initiatives ensures community voice in the development and delivery of services.

- **Strategies to be addressed by RQHR internal resources**

The strategies within the theme 'Improving Access to primary health care services in North Central' enhance the good work that is underway, and add to the capacity to ensure better co-ordination of delivered services.

Strategy 1: maintain and enhance the North Central Primary Health Care team:

- increase access to a full range of mental health and addiction services including prevention;
- improve case management and referral services;
- increase access to traditional approaches;
- improve access to childcare support;
- ensure strong leadership to develop and co-ordinate a strong cohesive primary health care team;
- enhance capacity for community outreach;
- improve access to both nutritionist and clinical dietician services.

Strategy 2: procure appropriate space and technology to accommodate the Primary Health Care team.

Strategy 3: offer flexible, expanded hours of operations at Four Directions Community Health Centre to provide increased access for community.

Strategy 4: work with the RQHR Chronic Disease Steering Committee and the Diabetes Sub committee to develop awareness of chronic conditions, providing better access to the services available to those living with chronic conditions, educating the community about the importance of healthy lifestyles to prevent chronic conditions, assisting the community in making changes to support healthy lifestyles, and work in conjunction with the RQHR Population Health Promotion Strategy to assist the community to make changes to support healthy lifestyles.

Strategy 5: improve access to lab and x-ray services outside of the acute care facilities.

Strategy 6: improve transportation services to improve access to care.

Strategy 7: improve access by integrating home care treatment services as part of the Primary Health Care team in North Central.

Strategy 8: develop a communications strategy to create awareness of primary health care services and service providers for the community, to increase the ability of people to access services.

Strategy 9: develop a mechanism for gathering and analyzing data on primary health care programs and services within North Central.

- **Strategies for which additional funds are required**

The North Central Community Consultation Committee and RQHR are requesting funding from Saskatchewan Health to address the strategies to improve access to primary health care services in North Central.

Strategy 1: maintain and enhance the North Central Primary Health Care team:

- funding for a second Nurse Practitioner and the office assistant support for the position;
- Funding for consistent physician services;
- Funding for a diabetes educator position to enhance the diabetes prevention and management services offered in the North Central neighbourhood;

IV. Resources for Site

- **Saskatchewan Health Resources**

Position /expense	2005/06 Expense	2006/07 expense	Space needs		Central Team Funding	Requested additional funding
			Long term	**Short term**		
Nurse Practitioner	44,300	88,600	1 office & 2 clinical rooms	Share office with current NP, extend hours of operations	93,900	
Office Assistant	18,500	37,000	1 desk area	Share space	35,000	
Diabetes Educator	39,000	78,000	1 office and access to group rooms	Share space and do communit y outreach		78,000
Family Doctor	90,000	180,000	1 office & 2 clinical rooms	Reallocate internal space usage.		180,000
Obstetrical Services – 13 sessions	7,750	15,500	2 clinic rooms on session days	Work around family doctor space		15,500
Team Development	50,000	50,000			50,000	
Office/Furniture/ Computers	10,000	40,000	Outfit the site for staff	Only buy what can be used in the current space.	50,000	
Renovations		75,000	Utilize for developme nt of permanent space.	Only use the funds needed for temporary space develop	75,000	
	$259,550	**$564,100**				
Additional Funds requested						**$273,500**

- **RQHR Resources**

Position /expense	2005/06 Expense	2006/07 expense	Space needs		RQHR funding identified	Funding to be identified
			Long term	Short term		
Primary Health Care Site Manager	45,000	90,000	1 office	Share office.		90,000
Mental Health & Addictions Services .4 FTE (2 days a week)	13,000	26,000	1 desk area	Share space	26,000	
Social Worker	33,000	66,000	1 office and access to group rooms	Share space and do community outreach		66,000
Child Care	5,000	10,000	Space for 10 kids	Extend hours and have more consistent services in current space.		10,000
Community Outreach	17,500	35,000	1 office and vehicle			35,000
Supports such as telephones, security, etc	15,000	30,000		Allow for security for staff and clients working extended hours.		30,000
Health Records space			Sufficient and appropriate space (HIPA)			
	$128,500	**$257,000**				
Additional Funds requested						**$231,000**

Space Needs

Four Directions Community Health Centre does not have space for additional offices, all additional staff must be accomodated within the current configuration of space if they are to be centrally located.

- An alternative is to set up a virtual office - have a central staff meeting for 15 to 30 minutes daily/weekly at4 Directions and then have staff either booked into space or out in the community.
- Another Alternative is to have some staff at alternative community buildings.

Phase 2

Space

- Looking at alternatives for either a stand alone facility or a collocations with other service sectors.

Lab/Xray services

- Need space first, but then will need to look at cost or service realignment. Discussions with other RQHR departments are needed.

Transportation Services

- Need additional funding or identify an alternative delivery method with the community and the City of Regina.

Home Care Treatment on site

- Reassign services to this site.

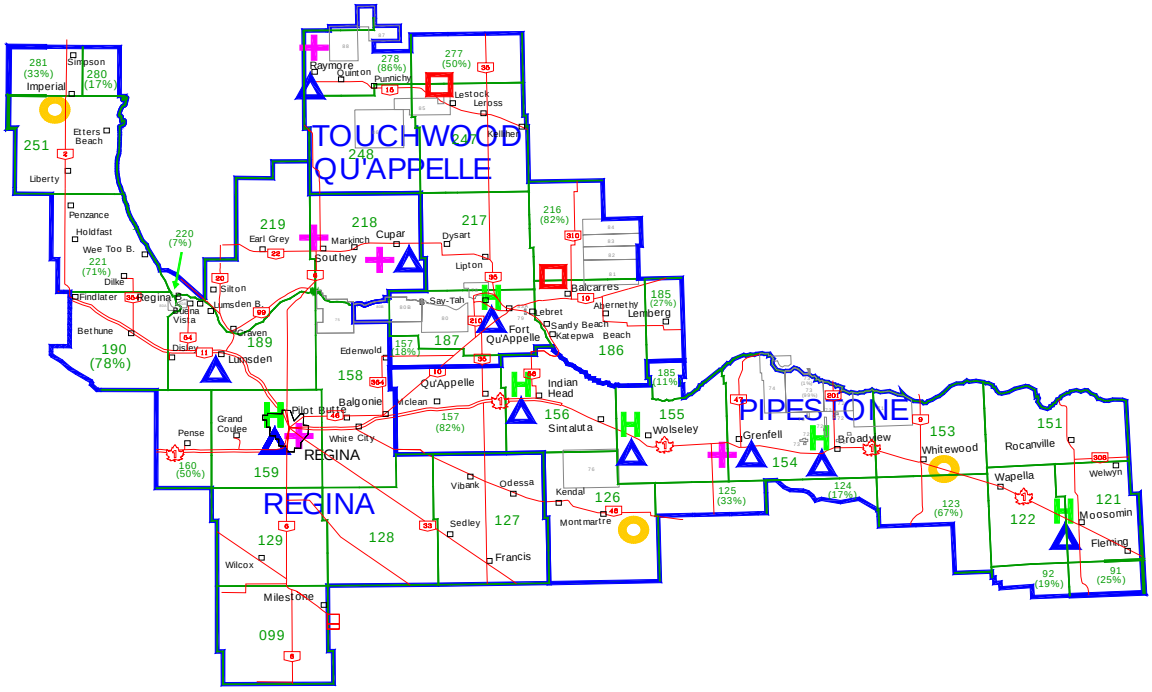
V. Concluding Comments

The report from the North Central Primary Health Care Community Consultation Committee is the result of the co-operation, hard work and much discussion of community members, health care providers, and other individuals who deliver services in North Central. We have outlined a plan that will enhance the already excellent services delivered by Four Directions Community Health Centre, moving forward on a path of improved access to primary health care services delivered by an team of health care providers.

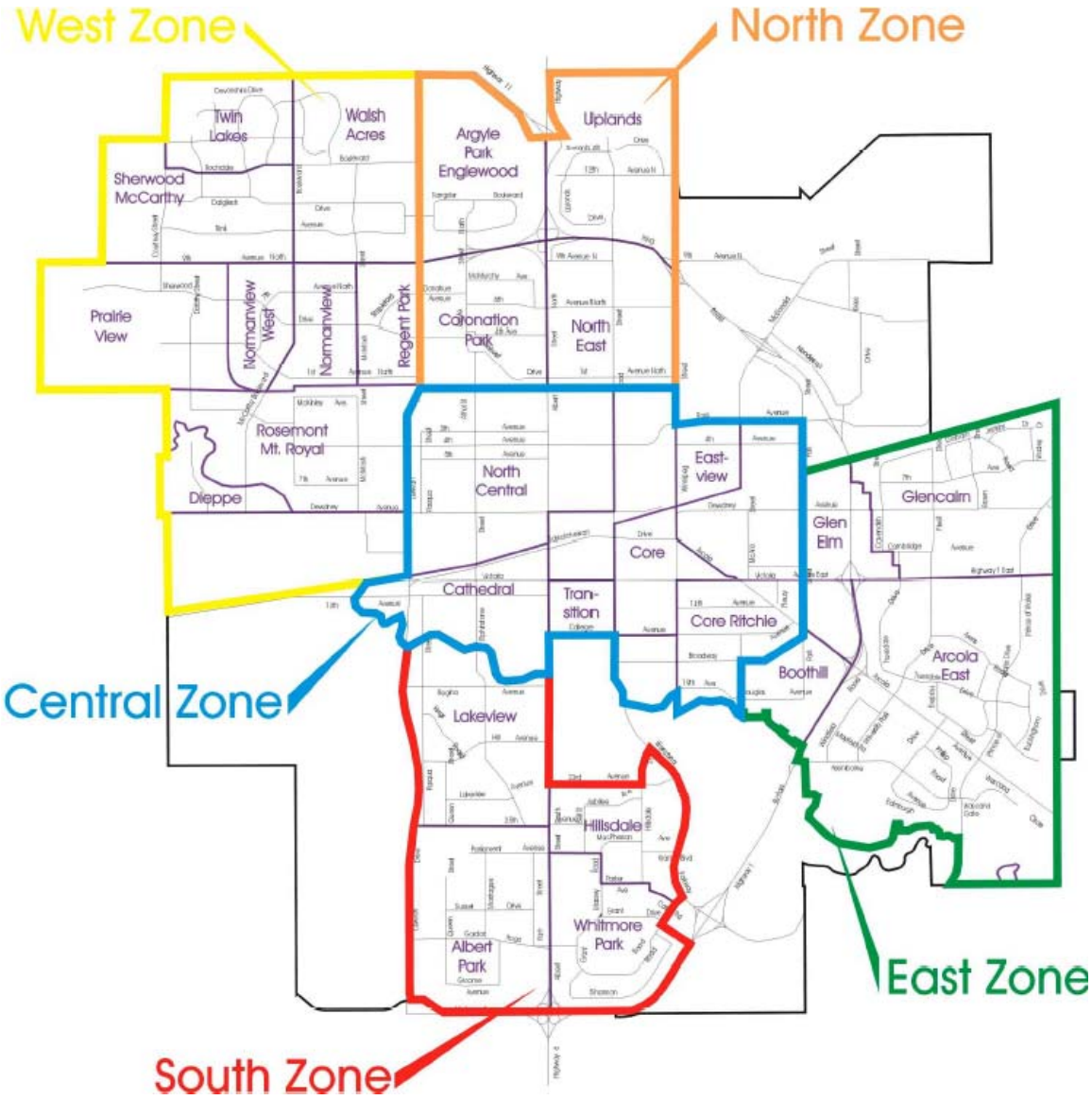
This report shows that by working in partnership with community, the RQHR and Saskatchewan Health, we can make a significant improvement to the health care and health related services offered in the neighbourhood.

Appendix 1

Map of Regina Qu'Appelle Health Region



Appendix 2
Map of North Central Neighbourhood
Postal Codes for North Central



Postal Codes for Regina North Central Neighbourhood

(centre of postal code area with community)

(will include addresses along both sided of Albert Street and Elphinstone)

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S4T0L9	S4T1A1	S4T2G5	S4T2S9	S4T3G7	S4T3R9	S4T4B1	S4T4L6	
	S4T1A2							

Appendix 3
North Central Primary Health Care Community Consultation Committee

Community Members

Joy LaFramboise	Four Directions Health Centre
Sharon Banning *	Four Directions Health Centre
Pam Larsen *	Four Directions Health Centre
Corporal Kollin Erichsen / Kelly Silverman	Regina Police Service – North Central
Mark Sylvestre	City of Regina – community consultant
Chuck Sutberry	North Central Interagency Gathering
Lil Wright	North Central Community Society
Dr Kathy Lawrence	Family Medicine Unit
Delora Parisian	Aboriginal faith community
Jacqui Smith	Community Dev & Outreach, DCRE
Christine Smith	AIDS Programs South Sask.
Dave Hutchinson	Regina Public Schools
Bob Kowalchuk	Regina Catholic Schools
Pat Thomson / Roberta Soo-Oyewaste-Kay*	RQHR Aboriginal Health Initiatives office
Murray Greenwood / Joyce Meyerhoffer	Scott Collegiate
Laureen Musqua	RTSIS
Ivy Kennedy/Gloria Kaiswatum	Women of the Dawn
Tom Wright	North Central Community Society
Shelly Manuel South	Albert School
Marilyn Fasakas	Kitchener School Community Co-ordinator
Reg Sabiston	resident, Kitchener School Parent Assoc.
Madeline Benjoe	Albert / McDermid schools
Janice Cibart	Home Care nurse in North East nursing team
Wendy Plante	resident
Lisa Workman	Four Directions Health Centre

Observers

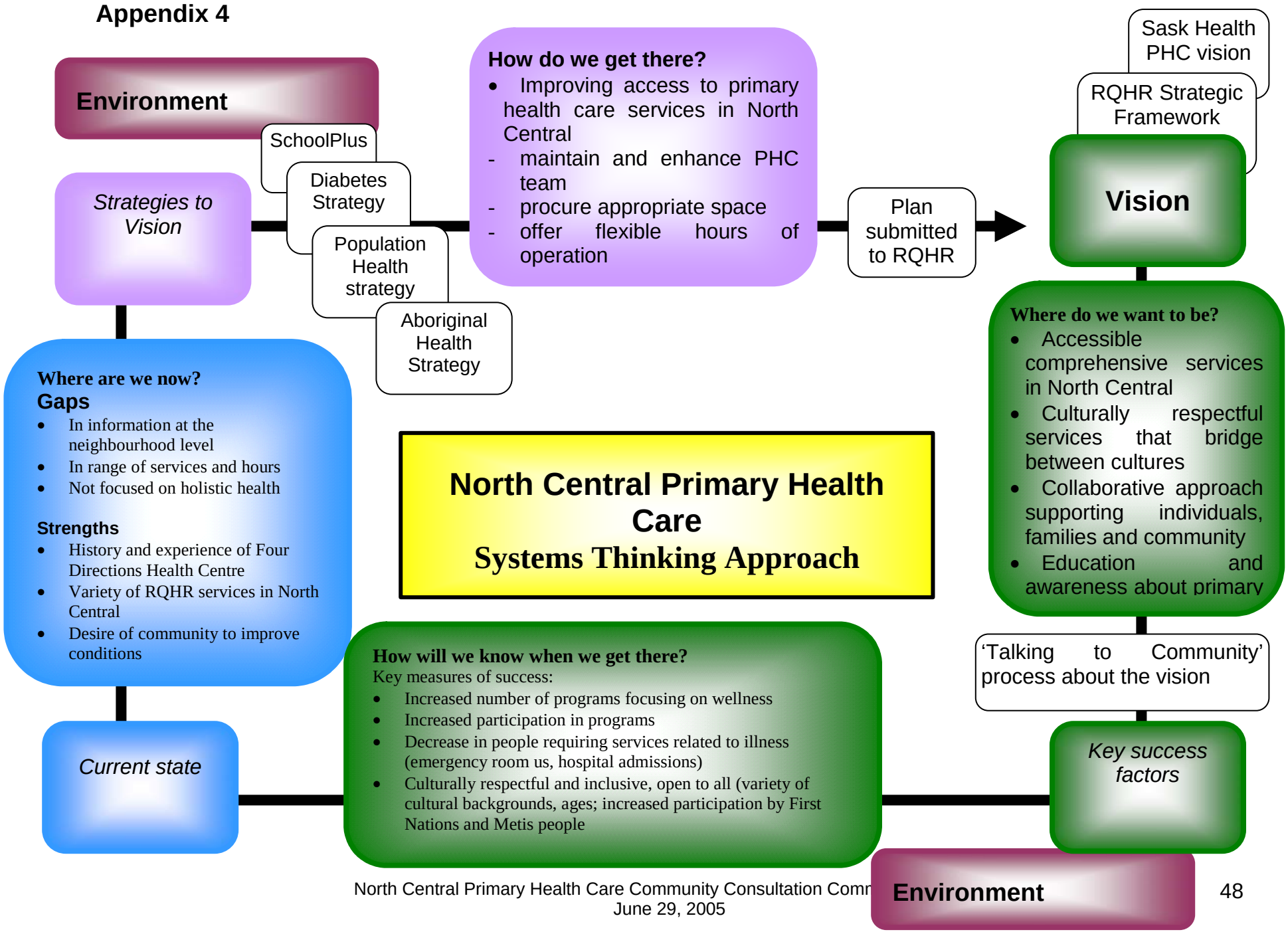
Leila Francis	Core Community Association
Susan Sebo	Al Ritchie Health Action Centre
Diane Lemon	Al Ritchie Health Action Centre
Noel Selinger	SIAST Wascana Campus
Mary Flynn	Executive Director, Regina Community Clinic

RQHR Internal Stakeholders

Sharon Banning* / Pam Larsen*	Population & Public Health (Four Directions)
Stella DeVenney	Nurse Practitioner (Four Directions)
Pat Thomson /Roberta Soo-oya-waste-Kay*,	Aboriginal Health
Kathy Willerth / JoAnne Phillips	Mental Health/Addictions Services
Helen Grimm	PH Emergency
Lois Vandervelden	RGH Emergency
Gary Weisbrodt	Facilities Management
Tracey Kuhtz	Primary Health Care
Gretta Lynn Ell / Shannon Theriault	Restorative and Continuing Care
Julie Maynes	Materials Management
Shelley Hoffman	SWADD
Laureen Larson	Medical Administration
Ali Bell	Research and Performance Support
Anne Marie Greaves	Home Care
Karen Butler	Regional Diabetes Manager

- Individuals who have taken part in both the community and the internal stakeholder meetings.

Appendix 4


Environment
SchoolPlus
Diabetes Strategy
Population Health strategy
Aboriginal Health Strategy
Strategies to Vision
How do we get there?
• Improving access to primary health care services in North Central
- maintain and enhance PHC team
- procure appropriate space
- offer flexible hours of operation
Plan submitted to RQHR
Sask Health PHC vision
RQHR Strategic Framework
Vision
Where do we want to be?
• Accessible comprehensive services in North Central
• Culturally respectful services that bridge between cultures
• Collaborative approach supporting individuals, families and community
• Education and awareness about primary
'Talking to Community' process about the vision
Key success factors
Environment
North Central Primary Health Care
Systems Thinking Approach
Where are we now?
Gaps
• In information at the neighbourhood level
• In range of services and hours
• Not focused on holistic health
Strengths
• History and experience of Four Directions Health Centre
• Variety of RQHR services in North Central
• Desire of community to improve conditions
Current state
How will we know when we get there?
Key measures of success:
• Increased number of programs focusing on wellness
• Increased participation in programs
• Decrease in people requiring services related to illness (emergency room us, hospital admissions)
• Culturally respectful and inclusive, open to all (variety of cultural backgrounds, ages; increased participation by First Nations and Metis people

Appendix 5

NORTH CENTRAL PHC	
VISION	**MEASURES OF SUCCESS**
Accessible comprehensive services: 24 hour daily comprehensive health care services that promote positive mental, emotional, physical and spiritual health	• Increase in program volumes • On-site elder with pay equity • Increase in number of pap smears done • Increase use and participation in harm reduction • Increase prenatal access and care
Respectful and inclusive: inclusive and respectful to the individual and the cultural diversity of the community, accessible, bridges the gaps and connects members of the community. Community members are engaged, empowered and have a sense of ownership. Individuals take responsibility and ownership for the health of themselves and their community.	• Increased awareness • Increased participation of community members • Members of the community have ownership by passing the knowledge/skills to others in community • There will be a paradigm shift
Collaborative: part of a collaborative community approach to health. With a team approach individuals, families and groups are supported and empowered to make healthy lifestyle choices.	• Tracking admissions (to 4D) relating to illness and wellness • Tracking number of programs and number of participants • Develop and implement measurement tools specific to each program • Decrease hospital admissions of NC clients • Increase pop in NC • Monitor diversity of client base
Education and Awareness: creating awareness and understanding through education on primary health care in North Central.	• Education regarding appropriate use of emergency rooms vs. medical clinic visits – outcome will be decreased number of emergency visits • Tracking number of teenage pregnancies • Prevention education re: healthiest babies possible • Prevention education re: healthy lifestyle choices - accessibility to contraception / spacing of children - accessibility to support / education to develop positive self-esteem
Determinants of health: In NC PHC recognizes the determinants of health.	• Reduced poverty, available housing, access to education and health care • Reduced numbers requiring treatment services • Perceptions changed within community • Feeling of security • Grocery store in community • Increased number coming for prevention services • Increased number of programs offered • Decreased dependence on charitable programs • Area is attractive, desirable

Appendix 6

Observations, Gaps and Strengths

What does the data tell us?

- There are gaps in the data for Metis people
- Not enough information on traditional approaches
- There is a fair amount of specialized services in the community
- Data does not take into account population swings within a year (e.g. people moving out to reserve and back)
- Need data to tell us who is accessing programs – neighbourhood people or others from outside neighbourhood
- Data tells us women and children accessing majority of services
  - What are the men doing?
  - How does it compare to city data
  - Based on current programs
- Data does not always reflect intensity of services (e.g. length of time NP spends doing informal counselling while delivering another service)
- There is more details in the data than what we are reviewing
- Seniors accessing services but not PHC nurse as much
- Services are fragmented for individuals
- When are emergency services accessed? And why? (Peak in emergency services after 4 p.m.) What about walk in clinics access?
- How much is Health Line used? – What % of families have phones?
- Is access to GP services higher or lower than average for Regina?
- Most senior services outside neighbourhood (DCRE provides $'s for travel outside area)
- Most GP services through small practices (one or two doc's) – therefore can't provide extended hours.
- Do neighbourhood people access the Avonhurst clinic? Community clinic? Etc
- Data confirms vision – shows we need preventive services, need culturally sensitive services
- Shows many people are getting services – who is not getting services and what services do they need?

Where are the gaps between the current state and our vision?

The gaps are:

- Hours of operation for Four Directions Community Health Centre
- Focus on physical health -> leaves mental, emotional and spiritual health
- GP's not providing holistic services
- Access to GP services – can't get a GP
- No continuity of services – especially through medi services, emergency

- The way we schedule appointments does not cope well with unexpected illness
- Point of access to many services is through the doc's
- $'s and people to offer 24 hour services
- lack of increased hours for support services – lab, x-ray, etc
- few lab and x-ray services outside acute care facilities, with extended hours
- limited access to education programs to help manage chronic conditions: waiting lists, ongoing support wait times, no drop-in, full caseloads, no Indian and Metis staff (MEDIC)
- for gestational diabetics – one clinic one morning /week
- not much participation of men – cultural barriers, gender barriers (men don't seek services)
- accessing services takes a lot of time – not easy and quick, hard to take time off work (part of discussion of men accessing services)
- people don't know where to go / what help they need / what options there are
- limited central points / welcoming place to learn about services
- limited case management / advocate / triage to help navigate system (SWAD – once in system OK, focuses on elderly)
- don't have all health care providers at site (Four Directions Community Health Centre)
- not enough cultural awareness training for service providers – to be aware of cultural patterns, (e.g. families visiting sick member in hospital)
- not enough communication between health care provider and community services
- community doesn't know enough about available services
- not enough services – addictions, detox
- not enough resources (and support services) to expand services
- not enough overall collaboration of all human services
- no central patient database – but want to be careful of confidentiality for individuals
- not enough support for support groups, peer counselling, AA, NA, etc
- better co-operation between all the community institutions

What are the strengths of the current state <u>that fit with PHC</u>?

Strengths include:

- Existing committee with a variety of people from different areas, here and taking part in developing PHC for North Central.
- History and experience of Four Directions – already have broken some new ground, have cultural and gender specific services.
- Have Kinship Centre and Methadone Clinic in community.
- Community residents are survivors; they get through tough situations, maintain a sense of humor through adversity, and have the strength to persevere.

- Annual feast at Four Directions – cultural activity, co-hosted with Police Service this year because it has grown so large.
- Continuum of cultural development – focus on First Nations and Metis culture, inclusive to all.
- Staff working at Four Directions – dedicated, competent people, good team.
- Location of Four Directions – close to people who need the services, close to partners.
- Expectation and goodwill that something positive is/will happen out of this process.
- Existing programs at Four Directions.
- This process is building something that people need – there will be no lack of "business".
- Strong vision for PHC in North Central.
- RICCP working in community to make improvements – came out of all the studies that had been done on the community.
- Strong NC Community Association.
- Strong connections of people to existing services – provides a network of services and opportunities for partnership and communication.
- Community has strong desire to improve itself – to tackle the issues and make changes.
- Community diversity.
- Block party on 5th Ave and other cultural activities put on by a variety of groups in community.
- Existing cultural strength and identity of Four Directions.
- Core funding through RQHR for Four Directions (not operating grant to grant).

Appendix 7

Primary Health Care Site Development
Selection of Strategies for Action
Items for Consideration

May 2005

Underlying Principles:

- That there be a balance between short-term strategies and long term strategies.
- That there be a balance between strategies that address the needs of small group of high risk individuals, and those that address a large volume of lower risk individuals.
- That the collective impact of the strategies are considered and the best mix of strategies selected.
- That decisions be evidence based.

Discussion questions:

Looking at individual strategies:

1. Does the strategy fit with Primary Health care outcomes and principles?

2. Who is the best provider to address the strategy? Is it an RQHR responsibility (community, City, provincial government department)? How can we support others to address it? Are there opportunities to link with, support or enhance other strategies ongoing in the community? (E.g. KidsFirst, Drug Strategy, etc). How will we avoid duplication of services?

3. Is it an appropriate/safe service to deliver at the community level? Is it a service currently being provided in an acute care setting that would be more appropriately provided in the primary health care environment? What are the risks/benefits of changing the service setting - for both PHC and acute care?

4. Is the strategy supported by evidence that the approach works? What evidence? Do we have the ability to measure progress and outcomes?

5. Do we see the **impact** of the strategy over the short term or the long term?

6. How much time and effort will be required to implement the strategy?

Looking at a mix of strategies:
What is the best mix of strategies to get us to the vision?

7. Does this mix of strategies provide a balance between treatment and prevention?

   Are we addressing the health needs of the people living in vulnerable circumstances in the community (site)?

   Over the long term do these strategies have an impact on the health of the population?

8. How will this mix of strategies contribute to individuals / families / communities taking responsibility /being responsible for their own health?

9. What are the costs / benefits (people, $'s, infrastructure, time, effort) of the mix of strategies?

10. What is most important to do in the next year? Over the next 10 years?
    Which do we need to do first?
    What is the sequence?

References

"Focusing on People" August 2004 edition prepared by Doug Elliott QED Information Systems, Inc

City of Regina 2001 Neighbourhood Profiles

Four Directions Primary Health Care Service Site "Needs Assessment for Catchment Population" Population and Public Health Services RQHR June 2003

Final Report of the Four Directions Community Health Centre – Evaluation Committee, Population and Public Health Services RQHR December 2003