Princeton "Save our Hospital Coalition" Community Consultation Summary

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Background

Rural healthcare delivery is complex. Each community, shaped by a unique history, geographic location and social context, has strengths and needs that collectively make up its capacity for care - capacities that shift in relation to population and resources. When healthcare needs outweigh capacities, communities reach critical points requiring focused attention. Such has been the case in the community of Princeton, British Columbia. As Interior Health and strategic partners seek to solve the complex healthcare issues, various advocacy groups have arisen in the community to better understand and support the necessary change. The Save our Hospital Coalition has been one such advocacy group. As part of the work of this Coalition, members sought to better understand the perceptions of the community regarding healthcare delivery. A community based consultation was organized to solicit the perspectives and experiences of a group of Princeton citizens. This was not a fact finding mission in that no attempt was made to verify participant's claims. Rather the purpose of the consultation was to glean the 'story' from the community's perspective, recognizing that this story is an insight into the collective wisdom that forms an essential part of the solution to such a complex challenge.

Important Limitations

The purpose and scope of the consultation are important to consider when reading this summary. The purpose of the consultation was limited to an exploration of the current healthcare strengths and challenges from the perspectives of citizens in the community. In the context of this discussion, potential innovations were mentioned but these were not explored in any depth. Further, healthcare providers (e.g. physicians) and representatives from Interior Health were not present at the consultation and so important perspectives are missing from this document. Recommendations will not be made, and indeed would be inappropriate, because of the limited nature of the data collected.

Consultation Process

The consultation, held on January 29, 2013 from 6-9 pm, was organized by the Princeton Save our Hospital Coalition. Barbara Pesut, from the University of British Columbia, led and analyzed the focus group findings based upon her expertise in qualitative research methods

and her program of research in rural healthcare delivery. The planning group for this consultation included Susan Brown, Interior Health; Marilyn Harkness, Princeton Town Council; Brad Hope, Area H Regional Director; Nienke Klaver, Secretary SOHC; and Edward Staples, Vice-President SOHC. Sixty-one individuals representing stakeholder groups in the community were invited to attend the consultation (see Appendix 1 for list of invitee organizations). Forty-two individuals indicated their desire to participate and attended the consultation. These individuals were provided with questions beforehand and were asked to solicit feedback from the constituency which they were representing.

The evening began with brief introductions to the Princeton Save our Hospital Coalition by Edward Staples and to the consultation process by Barbara Pesut. Participants were pre-assigned to focus groups based upon shared spheres of influence. A facilitator and recorder led each of the four groups. During the 90 minute discussion, participants were asked to respond as follows: Tell us about what aspects of healthcare are working well in this community. Tell us about aspects of healthcare that are not working so well, and why. Participants were encouraged to tell stories of their experiences, both positive and negative, to gain a deeper understanding of some of the influencing factors. Recorders summarized strengths, weaknesses and potential innovations on flip charts so that participants could ensure that points had been captured accurately. Groups were audio recorded. At the conclusion of the focus groups, participants reconvened in a larger group to hear the summary of each group. Challenges were grouped thematically and participants had the opportunity to prioritize these challenges. Participants were provided with five voting stickers and were instructed to place those stickers on a single challenge or multiple challenges they perceived to be most critical. A summary of this exercise is located in Appendix 2. Data from the consultation was compiled by Barbara Pesut and three research assistants from the University of British Columbia. What follows is a summary of the perceived strengths, areas of challenge and potential innovations brought forward during this evening.

Strengths of current healthcare delivery

Participants reflected on a number of strengths in the community that support healthcare capacity. The dedication of healthcare providers and the climate of cooperation between healthcare professionals and the community were seen to contribute to a sense of cohesiveness. In particular, core groups of champions that worked across multiple levels of the community provided a strong network of communication, innovation and support. Physicians were acknowledged for their willingness to do house calls, to sponsor health promotion initiatives and to maintain regular contact with physicians in Penticton to ensure seamless care. Healthcare providers were seen as hardworking and flexible in their attempts to meet the community's needs, which helped to overcome some of the system challenges. The care of seniors was cited as a particular strength of the community. The overall continuity of care provided in this rural community was viewed by some as an asset.

Participants cited a number of services that enhanced care including walk in clinics; victim services; end of life care and hospice; a nurse practitioner who works at the clinic and provides services to the High School; a responsive EMS service with strong leadership; and the availability of both in-community and visiting services including a cardiologist, pediatrician, physiotherapist, dietician and massage therapists.[1] Diagnostic services were available in a timely manner during a limited number of hours. In addition, participants acknowledged the broad based community services system, likened to a "net thrown over the entire community" that catches those who are most vulnerable. Supportive housing and an affordable Handi-dart transportation system that provided services to Penticton were also seen as significant supporters of healthcare.

Healthcare delivery infrastructure such as Vermillion Court, Ridgewood Lodge, Princeton Hospital, a year-round airport and two pharmacies were viewed as strengths. The recent consolidation of a number of services in a clinic co-located to the hospital was viewed positively for its 'one stop shopping approach.' The physical space available at the hospital and the pastoral surroundings were seen to provide a good basis for the development of future

[1] This list is not exhaustive. These were simply the services cited by participants.

services, although some aesthetic updating of the facility was felt to be necessary to present a better image for the community.

Stories of high quality, timely care were shared. One participant spoke of being injured in a community 4 hours drive away and seeking treatment at the emergency department in that community only to be told there was a 10 hour wait to be seen. The participant returned to Princeton Hospital; treatment was received quickly and the participant was back at home in less time than it would have taken to be seen in the original emergency department. Overall, participants recognized that there was much to build upon in Princeton healthcare. They were further encouraged by the degree of dialogue that had occurred around service challenges which had promoted a heightened degree of awareness and community engagement with the issues. Ultimately this was felt to facilitate the potential for a more sustainable system.

Challenges of current healthcare delivery

The various challenges brought forward during the evening were grouped into five themes: physicians and 24/7 emergency room coverage; escalating downsizing of services; emergency medical services; the impacts of commuting for care; and conflicts in responsibilities and accountabilities for healthcare.

Physicians and 24/7 emergency room coverage

The highest priority identified by participants was emergency room closures and physician shortages. Although participants discussed this in terms of a physician shortage, the issues were more complex. The three physicians in the community, two of whom are close to retirement, still have the capacity to take patients into their practices; there are few “orphaned patients” in the community. Participants stressed that these are highly valued physicians, some of whom have long standing relationships with patients in the community. However, for a variety of reasons, these physicians no longer provide coverage for the emergency room on a 24/7 basis resulting in emergency room closures for periods of time. Despite the official closures, some medical coverage is still provided for ‘life and limb’ emergencies. The challenge then is less about not having physicians to cover the day to day care of patients and more about not having physicians for 24/7 coverage of the emergency department.

Some participants attributed the origin of the problem to the mismatch between the fee for service business model typical of physician payment and the healthcare service needs of rural communities. For example, it is difficult to recruit for emergency room coverage when there are insufficient numbers of patients to support an additional physician practice. Further, physicians may be reluctant to retire if they cannot sell their practice. Alternative strategies to cover the emergency room with locums may have unintended consequences in this community. For example, financial incentives to recruit physicians from outside of the community for short term relief create a two-tiered payment system that potentially devalues the contributions of the physicians residing in the community. Alternative models of funding and contractual arrangements with physicians in rural areas were identified as ways to overcome these challenges.

Participants further suggested that there were a number of challenges related to recruiting physicians, many of which were out of their control. Issues such as the changing nature of medical education (e.g. less emphasis on the skills needed in rural practice), the desire of physicians for a quality work life that included part time options, the increasing acuity of healthcare, and barriers to hiring internationally trained physicians were all cited as difficulties. Further, community based challenges were related to the messaging of a community and hospital in crisis that portrayed Princeton as a less than desirable place to be. One participant mentioned that even the name of the Coalition “Save our Hospital” portrayed a particular message that may detract from recruiting efforts. Participants were encouraged by several recent successful recruiting efforts but desired more long term sustainable solutions.

Stories of the impact of emergency room closures were shared. For example, one participant described having a child with croup who could have been quickly treated in Princeton but having to take the arduous drive to Penticton in the middle of the night for treatment. Another participant with a chronic condition shared the anxiety they experienced when symptoms arose just prior to closure of the emergency at midnight. This participant had to choose to (1) call the ambulance, (2) get in the car and drive to Penticton or (3) wait through the night until the emergency room re-opened. Waiting through the night was often the option

chosen, but this caused anxiety wondering whether this would be the time that the symptoms progressed to something more ominous. This same participant is currently spending most of their time outside of the community so as not to endure this anxiety.

Participants identified the importance of the stabilization process that occurs in the Princeton emergency room prior to transport to referring hospitals. They suggested that many individuals delay calling emergency medical services, and when this delay is compounded by the lack of emergency stabilization in Princeton, then the extended delays have potentially severe adverse consequences. An example provided was of emergency medical protocols that could not be administered in a timely manner in the event of a heart attack or stroke.

Further, participants cited the unique circumstances in Princeton that present a compelling case for 24/7 emergency services: the heavy industries surrounding the town employing hundreds of workers that rely on the emergency department; the location of the town at the intersection of three busy highways; the long commuting distance to the referral hospitals; the high percentage of seniors in the community and the growing tourism industry in the outlying areas. Participants also suggested that there is inappropriate usage of the Princeton emergency room during regular hours and that public education is required.

Escalating downsizing of services

From participants' perspectives emergency room closures were simply the latest in an escalating downsizing of healthcare in the community. Participants spoke of losing their operating rooms, maternity services and a number of acute care beds over the past 15 years. It is important to note that in these conversations healthcare delivery was defined primarily in relation to the hospital and acute care services. This downsizing has led to challenges of morale at the hospital where healthcare providers feel as if they are not providing adequate services to the community, particularly when community members remember "how it used to be." However, many participants were pragmatic about the downsizing, recognizing that it was an inevitable result of the impacts of specialization, and the fact that it was no longer prudent or permissible for general practitioners to perform highly specialized services (e.g., anesthesiology).

The effect of downsizing on the Princeton economy was noted by several participants. The effects include money spent outside of the community when citizens have to travel for care, the economic burden on individuals of commuting for care, and the out-migration of individuals who feel their healthcare needs cannot be adequately met in the community. The perception is that migration into the community has also been affected by the healthcare system challenges, and this has negatively influenced the real estate market. This was particularly distressing for participants who recognized the contributions that the resource industry surrounding Princeton made to the economy of the Province of British Columbia.

Emergency Medical Services (EMS)

Temporary closures of the emergency room were perceived to have had a cascading effect onto EMS services. Princeton has two ambulances. Closures of the emergency department result in more trips to referral hospitals, trips that may be delayed if the referring hospitals are busy. Ambulance attendants must hand over the care of patients to physicians at the referring facility. One participant suggested that a single accident on one of the three highways surrounding Princeton can consume the available EMS resources. Participants gave other examples of situations that were challenging the capacities of EMS to provide timely and responsive services including a helicopter pad that is located away from the hospital and the lack of cellular access for recreational land users. Occasionally, response times are delayed because dispatch personnel are not familiar with the area; this is particularly a challenge in the outlying areas around Princeton.

Experiences of Commuting for Care

The end result of the downsizing cited above is that more patients must commute for care. The closest referring hospital is an hour and thirty minutes away from Princeton and up to three hours away for residents in outlying areas. Winter conditions can add significant travel time and danger to that commute. Participants spoke of the inconvenience and expense of having to commute for basic diagnostic services (e.g. xrays) when the technician is not available. However, more serious challenges arose for those struggling with serious chronic illnesses. Those for whom commuting was most difficult were those who were required to commute most frequently. Commuting to Kelowna was cited as particularly difficult as no

community transportation goes to Kelowna. In general there seems to be insufficient knowledge about the resources located in each community. Commuters knew little about the services available to them in Kelowna (e.g. reasonable accommodation) and healthcare providers in Kelowna knew little about the healthcare services available in Princeton. Participants felt this meant that at times they were kept too long in referral hospitals or asked to have services performed in referring communities that were available in Princeton. A particularly difficult situation arose for participants who were transported to referral hospitals by ambulance. They described being discharged from the referral hospital without clothes or a wallet because during the crisis it had not occurred to them to bring such items in the ambulance. It is assumed in these situations that a family member or neighbour can follow to provide return transportation and support but this is not always the case, particularly with such a large elderly population.

It was interesting to note that the absence of in-community maternity care was not given high priority in the voting despite some of the publicity that has surrounded the lack of maternity care. One participant suggested that a physician who had resided previously in the community had provided strong rationale for why maternity care in the community was no longer a safe option. The challenges mentioned were largely related to high risk pregnancies where diagnostic tests required frequent commuting and the resultant stresses on young families. It may be necessary for these families to relocate close to a referral hospital for varying lengths of time prior to the birth. This may require children to be removed from school for extended periods. For one participant who had long standing family roots in Princeton there was sadness related to the fact that Princeton was no longer written as the place of birth on infant birth certificates.

Conflicts in Responsibilities and Accountabilities for Healthcare

The challenges listed above were exacerbated by a sense that participants had difficulty making their concerns known and were not always aware of the work that was being done to solve the challenges. Administration from outside of the community, and constant personnel changes within Interior Health, left participants feeling as if there were unclear responsibilities and accountabilities. This was apparent in the dialogue that transpired during the focus groups.

For example, participants were not always clear about who had the responsibility to help solve the challenges in the community. They contrasted this to the days when the Hospital Board, made up primarily of individuals residing within the community, had responsibility and accountability for the healthcare decisions affecting the community. Participants suggested that when administrators live outside of the community there may be less awareness of the issues and less commitment to apply for the type of aid and grant funding that provides important supplements for rural healthcare. Participants were articulate about their abilities to envision and innovate for a model of care that would meet the needs of their community stressing the importance of not assuming that urban models and policies would work for rural healthcare.

Innovations

Although innovations were not a specific focus of this consultation, participants had ideas about strategies that could improve health service delivery in the community. The following is a brief summary of those ideas:

- Participants favoured a model of one stop shopping for care that used a multi-disciplinary team paid on a contractual basis. As one participant put it, “It’s not that I don’t have a doctor, I don’t have anyone on my case.” What this participant needed was an integrated model of care that included accessible consultation and education for chronic illness management.
- To promote a more sustainable model of emergency room care participants suggested the use of nurse practitioners and emergency medical services supported by physicians, citing pilot studies done in Nova Scotia. A number of participants spoke of the need for expanding the scopes of practice for nurses, nurse practitioners and emergency medical services so that the community would not be so highly dependent upon the availability of physicians. Further, the training of first responders for outlying communities such as Osprey Lake, is a relatively inexpensive way of ensuring that first line emergency treatment is available.
- Participants further suggested an administrative model that included local citizens similar to the model of the previous Health Boards. Some referred to these as

consultation committees that worked closely with physicians and Interior Health. A major task of these partners would be to define basic essential services in Princeton.

- To provide a sustainable solution to rural healthcare shortages participants supported providing incentive programs for rural students to become healthcare providers and more clinical practicum placements for healthcare students. This would require investing in individuals who could oversee and mentor these students.
- Many saw the potential for distance technology to reduce the necessity for commuting. One participant commented on the irony of being able to admit a patient to the hospital via distance using an admitting clerk from Kamloops but not being able to provide other basic services through that same technology. This distance technology would also prove useful for connecting the many outlying districts to services located in Princeton.
- Finally, participants recommended more active public education around health promotion, appropriate use of healthcare resources, and available resources located within Princeton and referral communities.

Summary and Conclusion

The purpose of this consultation was to gather collective community wisdom and perceptions about the strengths and challenges of healthcare delivery in Princeton. The consultation revealed a number of strengths that support capacity for innovation and change. Five priority challenges were identified: physicians and 24/7 emergency room coverage; escalating downsizing of services; emergency medical services; the impacts of commuting for care; and conflicts in responsibilities and accountabilities for healthcare. Participants shared a number of potential innovations to address these challenges.

Conversations that fostered the sharing of information and the correction of misinformation were an important aspect of this consultation. Participants brought a variety of perspectives, and information was shared that was not known by other participants. Many were not aware of the work that was being done on their behalf by healthcare leaders. This consultation is one contribution to a much larger strategy to solve the identified issues. The willingness of citizens to participate, and the conversations that occurred, revealed the degree

of engagement of the community. Engagement at this level is a powerful resource for change, which bodes well for the future of healthcare delivery in Princeton.

Appendix 1: Invitees

Allison Lake Community Association
Area G Regional Director (RDOS)
Area H Regional Director (RDOS)
BC Health Coalition
BC Lung Association
Canadian Red Cross Services
Cattlemen's Association
Chamber of Commerce
Citizens on Patrol
Coalmont Community Association
CoGen Pellet Plant
Community Services Society
Copper Mountain Mine
Crisis Assistance Society
Eastgate Community Association
Elementary School Principal
Elks Club
Emergency Response Services (ambulance)
Erris Community Association
Fellowhip Baptist Church
Ground Search and Rescue
Hayes Creek Firefighters
High School Principal
High School Students
Hospital Auxiliary
Hospice Society
Legion
Lions Club
Living Waters Four Square Church
Member of the Legislative Assembly
Member of Parliament
Vermillion Trails Society
Weyerhaueser
Missezula Lake Community Association
Old Age Pensioners Organization
Osprey Lake Ratepayers Association
Pentecostal Tabernacle
Princeton Community Arts Council
Princeton Family Services
Princeton Fire Department
Princeton Mayor and Council
Princeton Post and Rail
Princeton Recreation
Princeton Skills Centre
Princeton Social Services
Princeton Teacher's Union
Public Health Office
RCMP, Princeton Detachment
RDOS Board Chair
Ridgewood Lodge
Rotary
Rural Health Services Research Network of BC
Save Our Similkameen (SOS)
School Board (S.D. #58)
Senior Citizens Branch #30
Similkameen Valley Planning Society (SVPS)
South Okanagan Similkameen Medical Foundation
St. Paul's United Church
St. Peter's Catholic Church
Tulameen Community Club
Upper Similkameen Band

Appendix 2: Prioritization of Challenges Identified.

Issue	**Number of Votes**[2]
Physician shortage	29
ER Closures	18
Administration from outside of the community leading to unclear responsibilities and accountabilities	17
Travelling distances for basic health services that should be available in community e.g. xrays, non stress tests, blood glucose monitoring	13
Limitations on NP scope of practice	11
Shortage of healthcare professionals –difficult recruiting	10
Under-utilization of hospital	9
Insufficient health promotion programs	9
Effect of healthcare downsizing on rural economy	5
EMS Staffing	4
Lack of mental health services	3
Lack of knowledge about available services	3
Poor continuity of care	3
No maternity care	3
Lack of resources for community based services	3
Limited walk in clinic hours	3
Lack of patient education (e.g. both health promotion and chronic illness)	2
Limitations on paramedic scope of practice	2
Getting transportation to and from services after an acute event	2
Difficult road conditions in winter	0[3]
Long waits in ER	0
Aging equipment...failures	0
Inappropriate triaging in ER	0
Lack of privacy for healthcare providers	0
Lack of specialist services	0
EMS not always timely	0
Penticton hospital over capacity	0
Demands placed on healthcare from resource industry (e.g. mine, mill)	0
Outsourcing of hospital food and laundry – poor quality services	0
Lack of standardization for EMS protocols or evacuation protocols	0
Inability to find a family physician	0

[2] Total number of votes do not coincide with total number of available votes as some participants declined to vote and others left immediately after the focus group discussions.

[3] Although some challenges were not viewed as “high priority” it should not be assumed that these challenges are unimportant or unworthy of attention.