KEEPING RURAL HEALTH CARE CLOSE TO HOME

A Report to Grandview Healthcare Solutions

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Prepared for:

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EXECUTIVE SUMMARY

Background

Healthcare service delivery and organization in Manitoba, Canada, has been under review and transition over the past 25 years, due in large part to significant changes in demographics, economy and population. Despite these changes, including a move to regionalized health service delivery, there have been few measured improvements in overall health outcomes. Due to this, a number of studies were undertaken by the Manitoba government to evaluate the state of the provincial health system, including:

- 2013 Provincial EMS Review (Toews Report)
- 2017 Health System Sustainability and Innovation Review (KPMG Report)
- 2017 Clinical and Preventative Services Planning Report (Peachey Report)
- 2017 Wait Times Reduction Report
- 2019 Better Care Closer to Home Report

The findings of these studies resulted in the current healthcare system structure in Manitoba, a single, centralized provincial health organization: Manitoba Shared Health. Results of the Toews Report specifically led to the recommended closure or amalgamation of nearly two dozen EMS stations across the province, 18 of which are rural. The Grandview EMS station, attached to the Grandview Hospital and emergency department (ED), is one of those stations destined to close. Researchers from McMaster University, Hamilton, Ontario were engaged by local community organization, Grandview Healthcare Solutions, to analyze the recommendations of the reports listed above, and work with community members to understand the implications of this future closure on health and wellbeing.

Purpose

The purpose of this report is to critically analyze the provincial reports that led to the considerable changes in healthcare system organization and delivery in Manitoba and understand the best practices and experiences of emergency medical services (EMS) observed by service users and community members within Grandview, Manitoba, and Tootinaowaziibeeng, a nearby First Nations community. This report reviews the current state of healthcare service delivery in Grandview, and Tootinaowaziibeeng, and studies the impacts of proposed changes to healthcare service delivery.

Methods

This report utilized multiple methods, including document review and semi-structured interviews with Grandview community members, members of the neighbouring First Nation and Métis communities, and Grandview EMS service users from the broader rural region. Through an analysis of the documents listed above, this study identifies the findings utilized to support government decision-making on healthcare system transformation and service delivery reform in Manitoba, specifically EMS station closures. Secondly, through a purposive sampling strategy led by the community, semi-structured interviews were held with community members and service users. Through thematic analysis, this study revealed the experiences and viewpoints of Grandview community members, service providers and service users regarding emergency services and the proposed closure of the Grandview EMS station.

Findings

Primary findings from the critical analysis of government documents include:

- Out-of-date and inaccurate data used to determine which EMS stations should be consolidated and closed across Manitoba
- Local contexts and community needs were not taken into consideration
- Concept of community health care was not well described or established

In response to the closure of the Roblin ER, and intended closure of the Grandview EMS station located alongside the Grandview hospital, the community provided a number of viewpoints and concerns:

- Healthcare, through EMS and the hospital, is the centre and foundation of health, wellness and wellbeing within the community
- Healthcare services are relational: patients are people, not just numbers
- Service providers, including physicians and paramedics work together cohesively and effectively in an integrated community hospital setting
- Grandview's healthcare system, including current EMS and hospital services are effectively meeting community needs
- Centralized care, without community-based consultation and support, will lead to the elimination of rural services
- Dehumanized decision-making occurred, excluding community participation
- Government healthcare system planning failed to consider vulnerable people, like isolated seniors, and local Indigenous communities

Recommendations

In order to meet the health needs of rural and Indigenous communities across Manitoba, Government must:

1. Consult, engage and collaborate honestly and authentically with rural and Indigenous communities throughout the planning, development, and implementation of health care system changes

2. Make evidence-based changes to health care services with community support, recognizing the social determinants of rural health and including community-generated evidence

3. Commit to a strengths-based approach to health system changes in rural, remote, northern and Indigenous communities in order to maintain rural community life, health and innovation in Manitoba

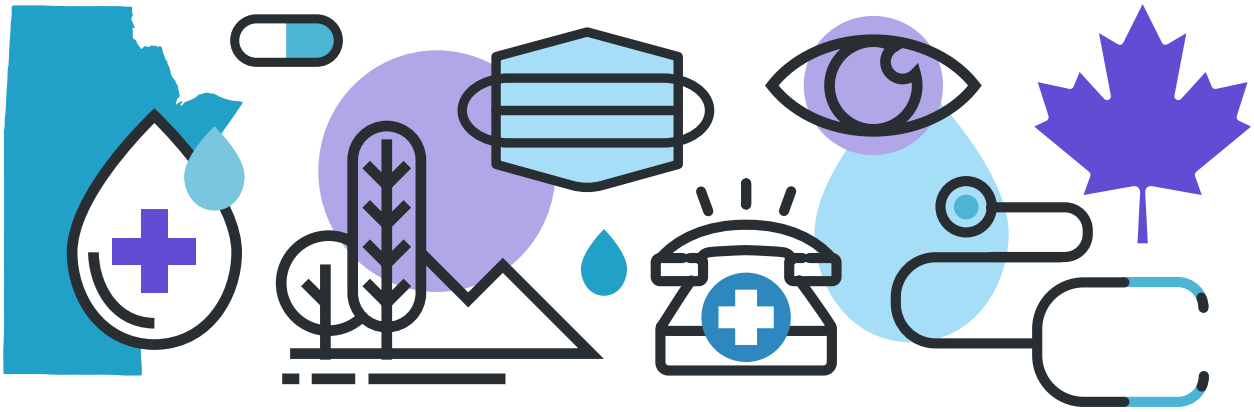
4. Recognize and support effective rural health care service centres. Develop Grandview Health Centre into an Enhanced District Hub as described in the Better Care closer to home Report

BACKGROUND

Canada is made up of diverse peoples and communities, within urban, rural and remote areas of the country. This diversity is considered a core value of Canadians. The image of Canada as an expansive, picturesque wilderness and as an agricultural country is also central to the Canadian imaginary. The rural and remote landscape of the nation makes up over 90% of Canadian landmass, and despite a growing urban Canadian identity, rural, remote and Northern reaches within the country represent home to 19% - 30% of the Canadian population (Williams & Kulig, 2012). As of the 2016 Census, within Manitoba, 27% of the population lives rurally, representing one of the largest rural populations, proportional to total population (Statistics Canada, 2019). In Canada, the rural population is generally in decline, as people age, young people move into urban centres to seek education and employment opportunities, and economic and employment trends change (Williams & Kulig, 2012). As a result, within these communities, the rural experience of health, employment, education, transportation and many other factors is different from those in urban regions across Canada. When planning for the health needs of such a diverse population, it is critical to reflect upon unique experiences and needs or rural peoples.

Access to health care services and the provision of quality health care services are considered central values within Canada. In fact, equitable, timely and effective access to health care is thought of as a right to many Canadians, and the right to good health is found within the social value of equality that Canada represents (Browne, 2016). However, it is clear that despite the presence of a universal health care system, Canadians have inequitable access to primary, emergency and specialty health care services for a number of reasons. Through decades of provincial health care reform, growth of urban populations, and increasing urban and suburban settlement in Canada, health and social services have increased within urban settings, while the provision of rural, remote and Northern services has stagnated or decreased. These changes often accompany large, sweeping healthcare system changes or transformations on a provincial scale, where Canadian provinces are responsible for the delivery of healthcare services under Medicare, Canada's national, publicly-funded healthcare system that ensures all Canadians have timely and reasonable access to medically-necessary hospital and primary care services.

Changes to provincial healthcare systems have been ongoing in the decades following the passing of the Canada Health Act in 1984, requiring the provinces to deliver programs and services for citizens using federal transfer dollars. Recently, major changes have been made in many provinces, with Manitoba undergoing the largest healthcare reform and transformation in the province's history.



Health Care Transformation in Manitoba

The delivery of healthcare services in the province of Manitoba has been under review and change over the past 25 years as the population, demographics, primary economy and provincial needs change. Beginning in 1997, Manitoba moved to regionalize the delivery of healthcare services with the creation of Regional Health Authorities. However, after 20 years operating in that initial structure, the provincial healthcare system was found to be too complex, overlapping, and in many ways, it created barriers for people to access services (MHSAL, 2018b). This regionalized structure allowed for duplication, and healthcare planning that operated in silos with little coordination between regions and provincial health organizations. The province also so saw healthcare funding increase by 97% between 2003 and 2016, however significant positive and improved health outcomes for Manitobans did not accompany this increase, and the province of Manitoba remained one of the lowest-ranking provinces in many health indicator areas (MHSAL, 2018b). These findings are part of the impetus for healthcare transformation in Manitoba.

A series of studies and reports were commissioned by the provincial government between 2012 and 2017 to evaluate the state of the healthcare system, from emergency departments and services, to wait times and sustainability in the healthcare system. Major change in Manitoba's healthcare system rests on the findings of four central reports, including the 2013 Provincial EMS Review (Toews Report), the 2017 Health System Sustainability and Innovation Review (KPMG Report), 2017 Clinical and Preventative Services Planning Report (Peachey Report), the 2017 Wait Times Reduction Report.

Early in 2012, the provincial government, then led by the NDP, recognized that changes were required to address the delivery of emergency medical services (EMS) including ambulance and paramedical care, and patient transfer to emergency departments. Independent consultant Reg Toews, a researcher on healthcare systems, was commissioned by the Government of Manitoba to undertake a review of the state of EMS delivery across the province. The 2013 Provincial EMS Review looked into emergency medical services in Manitoba, evaluating call and wait times, finding that a more integrated, reliable and sustainable emergency response service was needed within the province. One of the major recommendations was an investment

in increased paramedic staffing across Manitoba, including nearly 30 new full-time positions across the province, and 5 new EMS stations (Government of Manitoba, 2017a). While this investment in paramedic staffing and coordination was welcome across the province, the 2013 Review ultimately recommended the closure of nearly two dozen low-volume EMS stations across the province, most of which were rurally or remotely located (Laychuk, 2017a). In an information package to rural municipalities, the province assured residents of government 'commitment to excellent patient care' where only those EMS stations with very low patient call volumes, in poor state of repair or those facing significant staffing shortages would be closed (Government of Manitoba, 2017b). At the time, the province claimed that these closures would result in a more responsive and coordinated emergency medical response service. One of the major limitations to implementing the report recommendations, included the siloed healthcare delivery system used across Manitoba, where numerous independent agencies undertook healthcare delivery, resulting in a lack of coordination, confusion and duplication of services (Toews, 2013). This lack of coordination would have to be addressed by the province in order to improve EMS services across Manitoba.

Following the election of the PC party into provincial leadership in 2016, the government called for a series of studies and recommendations on the healthcare system, which is by far the most expensive provincial expenditure. Fiscal responsibility, reform and sustainability were central to the provision of services going forward. In 2015-2016 a round of studies and reviews were commissioned by the PC government into improved healthcare systems delivery, improved access to quality services and increased provincial healthcare planning.

The result of this recent research produced by government-initiated requests called for the centralization of the health care system in Manitoba. The primary reasoning behind this restructuring and reform was to address fiscal sustainability, according to government reports. With the results of numerous studies and reviews of the fragmented and uncoordinated healthcare system in Manitoba, the province took the step forward towards transforming the system in mid-2017 with the creation of Manitoba Shared Health, a provincial health organization (PHO) that would improve planning and increase integration of healthcare services within Manitoba. One of the major initial changes to healthcare service delivery following the establishment of a single provincial health organization, was the change in emergency medical services, leading to the questionable closure of some EMS stations and emergency rooms (ER) across the province.

OVERVIEW

Grandview, Manitoba is located in the western side of the province, about 375 kilometers northwest of Winnipeg in a rural, agricultural landscape. The nearest city, Dauphin, Manitoba, is about 45 kilometers to the east.

The area surrounding Grandview is primarily rural-agricultural, situated between two sprawling mountain parks. North of Grandview lies Duck Mountain Provincial Park, a popular summer destination for local residents and tourists alike, with many recreational opportunities. Located south of town is Riding Mountain National Park, another major draw of local Manitobans and Canadian tourists to the area. This scenic, picturesque prairie setting represents the idyllic rural town in the Canadian imagination. And for many residents in Grandview, it is.

Transportation in the prairies and across Western Canada has changed, when in July 2018, Greyhound announced that it would cease to operate western routes across Canada, effectively severing public transportation connections between small rural towns and remote hamlets across half of the county (Hutchins, 2018). This change has been seen by many people across Western provinces as a move to cut rural Canada off from the growing, bustling world of urban centres (Hutchins, 2018). More immediate than this however, this loss of service across the prairies means a lifeline to critical health and social services has been cut, preventing people who rely on public transportation from accessing necessary services that can only be accessed out-of-town in larger centres (Hutchins, 2018).

Healthcare Services in Grandview

Since the implementation of the provincial healthcare transformation, healthcare services are now currently overseen and coordinated by Prairie Mountain Health (PMH), the regional health authority (RHA) for Western Manitoba. Prairie Mountain Health provides health care services for the population of Grandview and surrounding area, previously known as the Parkland Regional Health Authority. This RHA is now one of five in Manitoba, a recent change as part of the new health system transformation, initiated in 2017 under the title Shared Health Manitoba in order to reduce the number of regional bodies involved in delivering healthcare services across the province.

The community of Grandview is an outlier when compared to many rural towns across the province. Most impressively, despite its small-town status, Grandview has its own hospital, which operates 24 hours each day, with a rotation of three physicians and two nurse practitioners. The hospital team also includes nurses, lab technicians, dietary and housekeeping staff that have worked within the community over long-term periods, reflecting the stability and continuity of services and providers in Grandview. The Grandview hospital is a modern facility, with 18 beds to accommodate in-patients, chronic and acute patients. Compared with other rural and community hospitals, Grandview's service is consistent, reliable and personal. As an indicator of reliability, one physician stated to local media that the only time the hospital had to close its doors and stop provision of services was during a severe snowstorm about seven years ago (Laychuk, 2017a). Laboratory and x-ray facilities serve the hospital and physicians as auxiliary healthcare services, critical to the operation of the hospital and timeliness of services and test results. The facility itself services people and families outside of Grandview, and is the only hospital located within the 94 kilometer stretch of Highway 5 between Roblin and Dauphin, as seen in Figure 1.

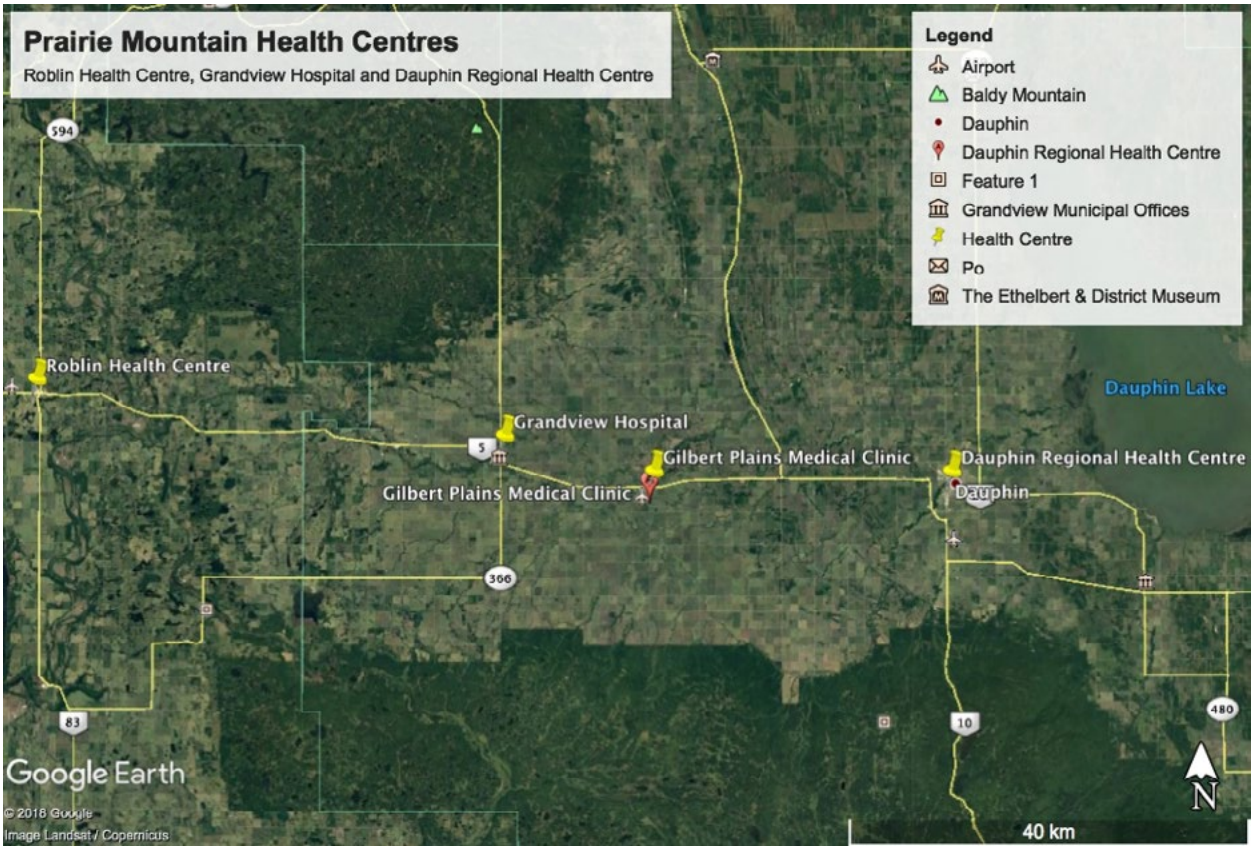


Figure 1: Satellite image of Prairie Mountain Health Centres.

In addition to a 24-hour hospital service complete with emergency department, Grandview has its own EMS station, joined with the hospital, which is staffed 12 hours a day, with on-call services overnight, but equipped to offer 24-hour services to Grandview and the surrounding area (Laychuk, 2017a). The Grandview station employs four full-time Primary Care or Intermediate Care Paramedics. These paramedics perform EMS duties, and in addition also serve as community paramedics by providing community education, volunteering at community events such as sporting events, BBQS and parades. Most importantly the paramedics support other EMS responders and provide assistance to physicians, nurses and staff within the Grandview Hospital. The paramedics are key personnel in the delivery of services within the hospital setting, assisting with triaging of emergency patients, transfer of patients within the hospital and administrative duties.

To quote Dr. Peachey "traditional models of care anchor the professional lives of health professionals to related physician activity" (Peachey, 2017). The physicians' activity in Grandview conforms to this ideal by providing leadership to a team of nurse practitioners, primary care nurses, paramedics, physiotherapist, occupational therapists and diagnostic technicians. The physicians are highly skilled, qualified and experienced. Their collective emergency room experience exceeds 40 years.

The physicians are true rural generalists and also have specialized qualifications in emergency medicine, and anesthesia, bed side ultra sound and addictions medicine. In addition, the physicians have a special interest in Indigenous health and mental health service provision. The physicians take part leadership activities on a local, regional and provincial level.

The Grandview ambulance responds to calls within the town proper, and rural residences outside the town such as those to the west of Gilbert Plains, east of Roblin, and south of the Duck Mountains. When the Grandview ambulance is on a call, a second ambulance would be dispatched to Grandview in the case of a second call from either Roblin, Gilbert Plains, or even Dauphin. While Grandview may be considered a rural EMS station, and often thought of as a low call-volume station, however, from October through December of 2018, Grandview EMS responded to more calls than 46% of the other rural and remote EMS stations under Prairie Mountain Health authority as shown in Table 1 (this excludes stations in Dauphin and Brandon as urban sites). This rate varies quarterly (seasonally), for example, between July and September 2017, Grandview responded to more calls than 66% of the other rural and remote stations within the region. Statistical data gathered from the Ministry of Health, Seniors and Active Living indicates that the Grandview EMS station is more frequently used by the populations that it serves, compared to other rural EMS stations. Utilization of Grandview EMS includes not only emergency medical response, but also inter-facility transfers between Grandview, Roblin, Dauphin and Winnipeg-area hospitals. In 2014, Grandview EMS responded to 218 calls, 185 calls in 2015 and 245 calls in 2016, while over the same period, the Grandview ambulance and EMS staff were responsible 1260 inter-facility transfers within the region. Comparatively, Gilbert Plains EMS responds to 5% fewer calls on a regular basis. Considering this, it is clear that within the Prairie Mountain Health RHA, Grandview is not a low call-volume station, and at least not among the rural and remote stations with the lowest call volumes.

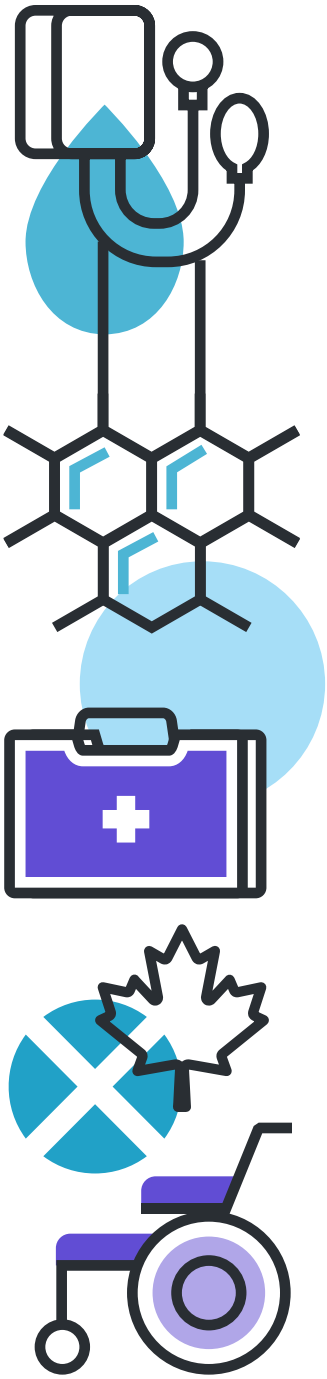


Table 1: Response Compliance by EMS Station Catchment Area, 2018-19 Fiscal Year 3rd Quarter (October 1, 2018 through December 31st, 2018) Report run: January 9th, 2019. Retrieved from: https://www.gov.mb.ca/health/ems/docs/quarterly/octdec2018.pdf

	Maximum Response Time				
	50th Percentile		90th Percentile		
	Priority 1-3	Priority 1-5	Priority 1-3	Priority 1-5	Total Calls
Prairie Mountain Health	**10.77**	**10.70**	**35.45**	**36.05**	**3055**
AS01-Russell	17.97	17.65	31.93	29.93	49
AS02-Birtle	25.40	25.78	47.83	47.92	67
AS03-Rossburn	22.37	22.90	27.58	33.20	80
AS04-Hamiota	19.52	21.75	27.80	30.08	17
AS05-Shoal Lake	27.62	27.90	34.33	37.80	66
AS06-Rivers	11.53	10.67	27.55	24.47	41
AS07-Minnedosa	8.48	9.13	19.05	26.15	48
AS08-Erickson	17.53	17.53	29.35	29.35	63
AS09-Neepawa	8.23	9.67	25.22	23.33	57
AS10-Carberry	10.70	10.70	32.20	29.78	60
AS11-Treherne	18.58	19.30	42.02	42.58	42
AS12-Glenboro	7.45	7.77	34.55	29.70	26
AS13-Baldur	20.42	20.42	22.33	33.03	4
AS14-Cartwright	10.67	10.67	18.05	25.33	4
AS15-Killarney	9.52	9.58	25.68	27.57	33
AS16-Wawanesa	18.42	17.37	33.77	26.42	12
AS17-Boissevain	13.57	12.25	26.87	26.87	26
AS18-Souris	11.73	10.48	29.10	29.10	28
AS19-Deloraine	9.90	10.08	27.02	29.88	24
AS20-Hartney	32.15	32.15	32.15	32.15	1
AS21-Oak Lake	23.83	23.95	32.73	31.95	100
AS22-Virden	11.73	11.73	25.25	26.30	65
AS23-Melita	16.05	16.05	31.37	51.18	29
AS24-Reston	29.63	30.40	43.80	48.50	35
AS25-Elkhorn	22.88	22.88	41.17	41.17	11
Brandon	6.33	6.65	12.30	12.78	1046
Shilo	7.47	5.95	13.27	14.58	32
PK01-Dauphin	10.27	10.27	19.13	18.03	238
PK03-Grandview	12.48	10.25	38.67	38.67	38
PK04-Roblin	9.32	10.03	34.25	28.08	58
PK05-Swan River	9.32	9.35	25.58	25.40	152
PK06-Waterhen	19.80	19.95	46.83	54.52	77
PK07-Winnipegosis	43.53	43.67	64.63	65.62	113
PK08-Ste Rose	28.80	29.13	36.27	38.97	130
PK09-Gilbert Plains	17.25	18.23	27.95	29.63	26
PK10-McCreary	18.18	20.58	28.22	34.67	18
PK11-Mafeking	38.62	40.15	77.42	77.42	139

Importantly, Grandview's ambulance also responds to calls from the nearest First Nation, Tootinaowaziibeeng, located about 23 minutes from town, depicted in Figure 2. Tootinaowaziibeeng is an Anishnabe community, with a population of over 500 residents, with particular healthcare needs, many of which are addressed by physicians and service providers in Grandview.

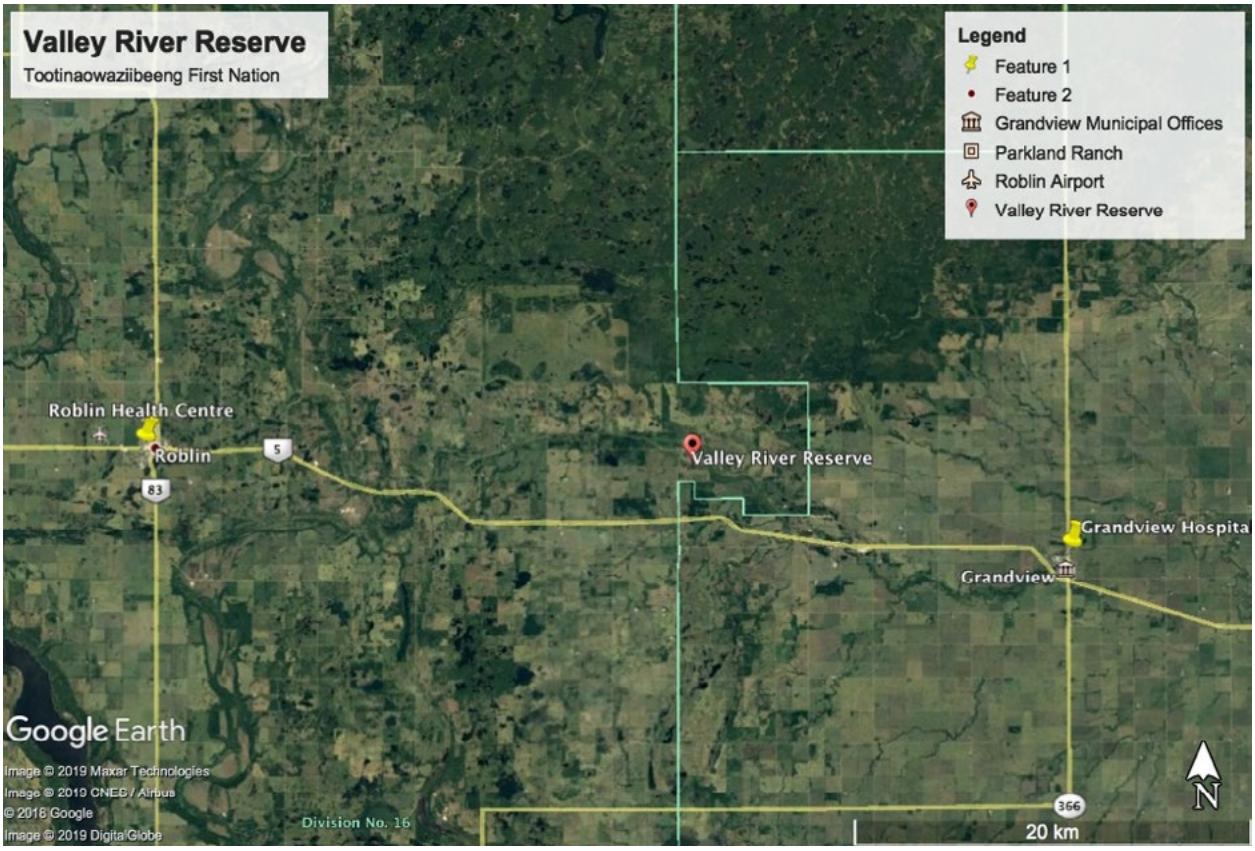


Figure 2: Satellite image of Valley River Reserve, Tootinaowaziibeeng First Nation.

Grandview EMS responds to between 46% and 93% of emergency calls out of Tootinaowaziibeeng, consistently arriving within 30 minutes as demonstrated in Table 2. This is important, as Tootinaowaziibeeng is a remote First Nation, with at least 2 access roads in and out of the community. With Grandview's EMS responding to the majority of calls, paramedics have become familiar with the reserve community and roadways and are able to arrive on the scene of a call in the shortest wait time possible. When compared with the response time from the neighbouring stations and the number of responses to the First Nation, EMS out of Grandview is the fastest and most consistent. Outlier calls and times out of Dauphin for example may reflect instances when those ambulances were dispatched to the scene due to their proximity to the First Nation at the time of the call. Therefore, Grandview's station is the closest to Tootinaowaziibeeng when idle, and arrives in the fastest time.

Table 2: EMS Station Affiliation and Response Times to Tootinaowaziibeeng First Nation from April 1, 2012 – March 31, 2017. Retrieved from MTCC Manitoba.

Fiscal Year	Responding Station	Average Response Time	Median Response Time	Total Responses	Percent of Call Volume
2012-13	PK01-Dauphin	17.30	17.30	1	2.60%
	PK03-Grandview	24.43	23.74	26	68.40%
	PK04-Roblin	36.62	33.67	11	28.90%
2013-14	PK01-Dauphin	22.60	22.60	1	5.00%
	PK03-Grandview	26.54	26.75	13	65.00%
	PK04-Roblin	27.83	25.95	6	30.00%
2014-15	PK03-Grandview	29.48	28.23	29	93.50%
	PK04-Roblin	28.27	28.27	2	6.50%
2015-16	PK03-Grandview	23.88	26.68	11	45.80%
	PK04-Roblin	35.60	36.04	12	50.00%
	PK09-Gilbert Plains	47.67	47.67	1	4.20%
2016-17	PK03-Grandview	28.27	26.72	45	77.60%
	PK04-Roblin	27.73	28.20	12	20.70%
	PK09-Gilbert Plains	35.05	35.05	1	1.70%

Closure of Grandview EMS Station

Despite conflicting utilization and population data, the Government of Manitoba announced its decision to discontinue emergency medical services in the community of Grandview, Manitoba in 2017. While the date of closure has not yet been determined, the knowledge of the impending closure has left residents reeling. The decision to discontinue services came about following the province's decision to act on the 2013 EMS Review, the Peachey Report and the KPMG Report on health sustainability. Under the new provincial health plan, the closure of nearly two dozen EMS stations, 18 of which are rural, and the construction of five new stations would take place over the course of ten years (Laychuk, 2017a). Grandview was identified as one of the stations slated for closure.

Despite the efforts made by the Grandview community and residents of the surrounding area to petition the government's decision to close, the Pallister government confirmed in December 2018, their plan to close Grandview's EMS station, and open a new station out of neighbouring town, Gilbert Plains, located about 13 minutes east of Grandview, between Grandview and Dauphin. Under this plan, Gilbert Plains' station will service the entire Duck Mountain region, a population of about 4,000 people (Laychuk, 2017a). Below, Figure 3 depicts the current daytime catchment area of the EMS stations in Roblin, Grandview, Gilbert Plains and Dauphin, and demonstrates the response time outward from the EMS stations, while Figure 4 shows the proposed catchment area of EMS stations in the region following the implementation of the new EMS strategy.

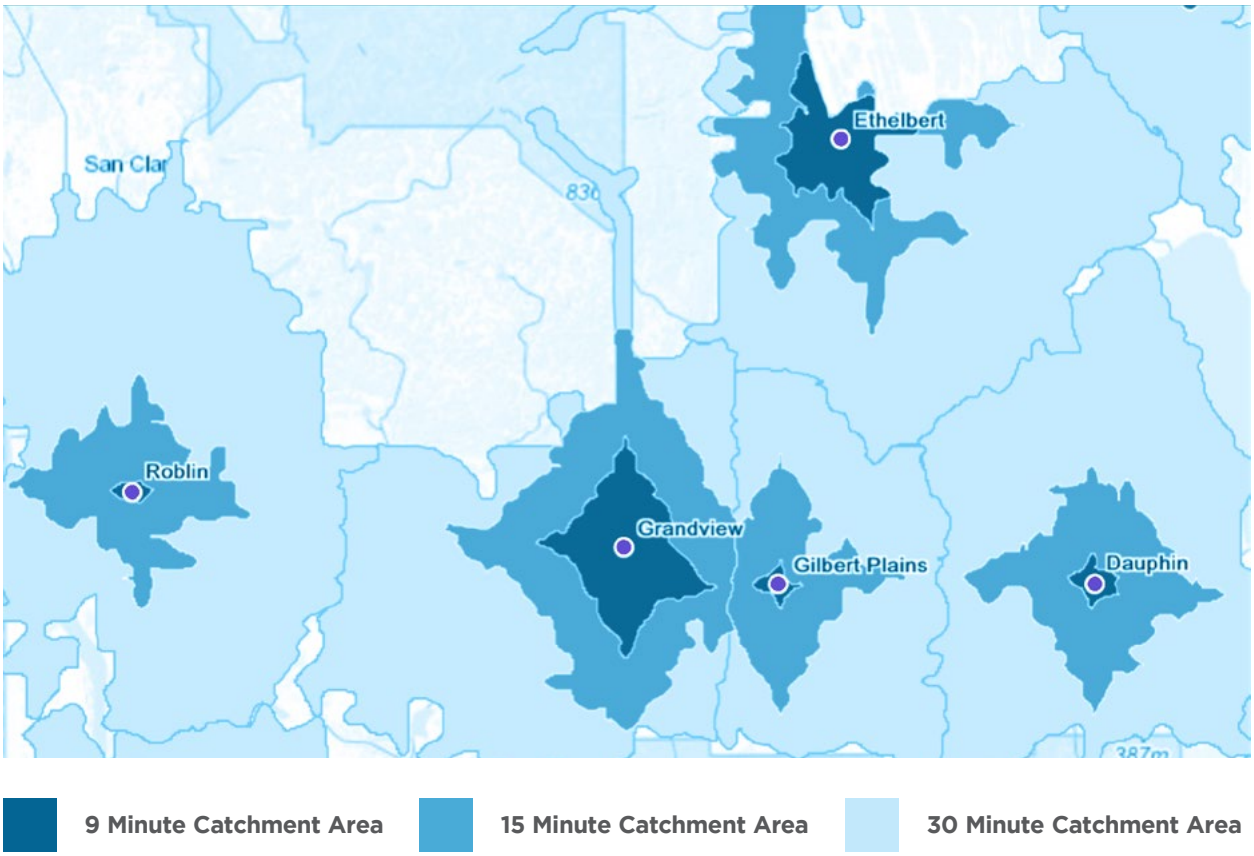


Figure 3: Current EMS daytime catchment areas for Roblin, Grandview, Gilbert Plains and Dauphin, Manitoba. Source: Government of Manitoba, 2019.

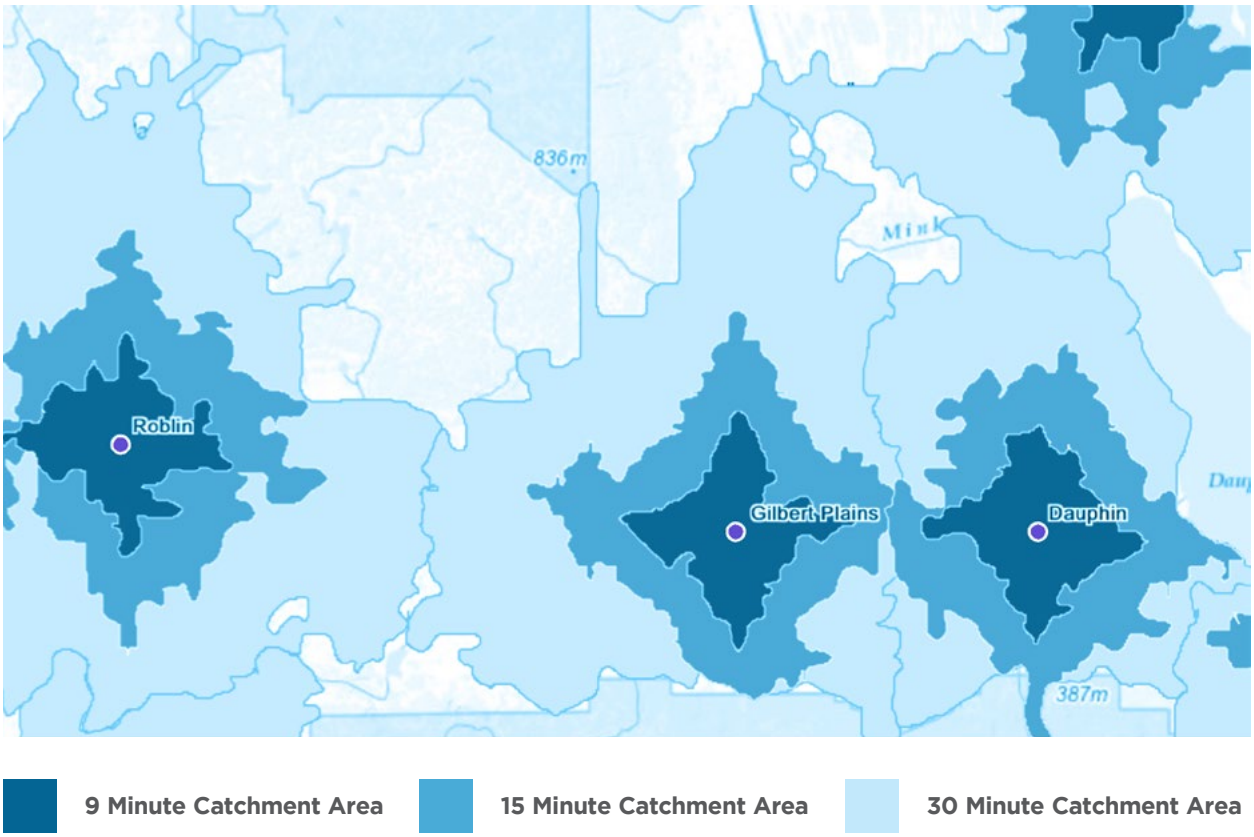


Figure 4: Future EMS catchment areas for Roblin, Grandview, Gilbert Plains and Dauphin, Manitoba. Source: Government of Manitoba, 2019.

Grandview is almost centrally located between Roblin and Dauphin, along Provincial Highway 5, with most recent measurements showing a population of 1,482 people, nearly one third of which (32%) aged 65 or older (Statistics Canada, 2016b). The neighboring town of Gilbert Plains is very similar in terms of census demographics, with a population of 1,470, with adults over the age of 65 representing one quarter (24%) of the town's population (Statistics Canada, 2016a). It is important to note the proportion of older adults within each site, as older people utilize EMS services more often than any other age group (Kulig & Williams, 2012). Besides this significant difference, explained in part by the presence of a seniors' residence in Grandview which likely speaks to the proportional difference of the aging population, the two rural towns are very similar in census-measured areas, such as annual household income, occupations and education. The most glaring difference between the municipalities is the level of healthcare services that are accessible in each. With Grandview offering 24-hour hospital services and primary care through three permanent, full-time physicians, and Gilbert Plains offering three days per week of physician services in the Gilbert Plains Health Centre, and one day each week of nurse practitioner services, there is a clear difference in consistency and continuity of services available to residents. Further to this, EMS services in Grandview operate out of the hospital facility, with the ambulance garage attached to the hospital building. While both services operate 24-hours a day, including

on-call hours overnight, Grandview paramedics are supported with access to a hospital base and responsive emergency department staff, including physicians. Under the new plan, five new EMS stations would be built, including a new station in Gilbert Plains to replace the old one, a community that lacks a hospital, emergency department and urgent care clinic, where more patients are taken into Dauphin to receive hospital services.

When viewing the catchment areas in Figures 3 and 4, it is geographically clear that Grandview is most centrally located between two larger settlements, and has the additional benefit of having its own hospital with 24-hour emergency department. It is also clear that there would be a change in response time for many residents in Grandview and beyond as a result of losing EMS within the town, though the province contends that the impact to response time would be minimal, if at all. In personal communications with community members, the Manitoba department of Health, Seniors and Active Living contends that response times in Grandview will remain within a 12-15-minute window from the Gilbert Plains station and that Roblin and Dauphin ambulances would serve as on-call units for additional calls, should the Gilbert Plains ambulance be in service, with a wait time of 30 minutes out of those locations. Another significant issue with the proposed catchment area, is that residents of Tootinaowaziibeeng would now have an even longer wait for EMS response out of Gilbert Plains located 41 kilometers away, over 20 minutes of emergency-speed travel in ideal road and weather conditions. Realistically, travel from Gilbert Plains to Tootinaowaziibeeng is closer to 27 – 40 minutes, at 90 kilometers per hour and therefore at risk of falling outside the maximum response time goal of 30 minutes or less.

Curiously, in Figure 3 depicting current EMS stations and catchment areas, the remote community of Ethelbert is shown, and indicated to be among the stations slated for closure in the process, as seen in Figure 4. As of August 2017, the EMS station in Ethelbert had been decommissioned and closed for over nine years (Laychuk, 2017c). Concern is raised then, as to where this data is coming from, why it is included (and remains so in 2019), and if other incorrect data has been used in provincial decision-making.

When the announcement to close EMS stations across Manitoba, including Grandview's station, was initially made in 2017, a sense of concern over rural access to healthcare was heightened. Immediate reactions to this proposal were strong across rural Manitoba. In Grandview, the community imagined the elimination of EMS services as a precursor to the eventual closure of the hospital, and from there all of the auxiliary services and businesses that accompany, support and pair with it (Laychuk, 2017a). Confusion spread throughout the community, where people living in Grandview, and even those living on the outskirts of town or beyond, felt that the level of service and the healthcare system as it existed in Grandview was ideal. As one service provider stated, "...we have a current model that works... Once you lose something in a small town, you never get it back," (Hutchins, 2018, p. 1). Following the announcement of their impending EMS station closure, the residents of Grandview prepared to challenge this decision and demonstrate why Grandview's EMS and rural hospital services should remain in place through Manitoba's healthcare transformation.

PURPOSE

This report has been completed in response to the government of Manitoba issuing long-term plans to reduce and centralize emergency medical services in rural and remote areas across the province following a number of government-issued reports and analyses of emergency medical service usage, and evaluations of the provincial healthcare system at large. Specifically, the town of Grandview, Manitoba, where a rural hospital, complete with 24-hour emergency department, physicians and nurse practitioners, and an ambulance station is located, is facing the closure of its EMS station and the impacts that this will have on the health of the community. During the production of this report, in August 2020, the neighbouring town of Roblin was notified by Manitoba Shared Health that newly recruited clinical diagnostic technicians would be redirected to a different hospital. Diagnostic testing capabilities are required of any hospital operating an emergency room, so the relocation of these staff meant that Roblin would be forced to close their ER and transfer current patients to other hospitals, including Grandview. This move took effect on September 4, 2020, when Roblin's ER closed indefinitely, after only a week's notice to the community, staff and patients.

The purpose of this report is to investigate the ways in which emergency medical services are currently being provided within the community of Grandview, Manitoba in the wake of the provincial decision to eliminate emergency medical services (EMS) out of Grandview, and open a new EMS station in the neighboring community of Gilbert Plains, located 16 kilometers, or 13 minutes, east of Grandview. The report aims to provide an understanding of the effectiveness of the Grandview Health Centre as a District Health Hub. Further, this report offers an overview of community access to and satisfaction with healthcare services in Grandview, prior to the closure of the ambulance station in the community and the impacts that this change is perceived to have on the community. The report also provides an overview of the current state of rural health care in the region, following the sudden closure of the Roblin ER, and what this means for other rural hospitals in Manitoba.

Provincial decision-making to ultimately close Roblin's ER, and Grandview and 17 other EMS services in rural communities across the province was done so without direct consultation and communication with those affected community members, and the peoples and populations that would be most significantly impacted by such closures, such as local First Nations and Métis communities, remote residents and isolated seniors. As a result, Grandview Healthcare Solutions, a community-based volunteer and advocacy group sought an inquiry into community attitudes and experiences of emergency medical care and health care services within Grandview, to gather community responses regarding what is working effectively with the forms of health care that are presently offered within the community, and how the community is reacting to the decision to eliminate emergency medical services out of Grandview.

Ultimately, this report answers the central questions that the community of Grandview, Manitoba wishes to address in response to the proposed Health System Transformation:

Why does the Grandview model of healthcare service work best for the community?

How does the Grandview Health Center fit into the provincial system as a District Health Hub?

This report also provides an analysis of the perceived impacts of these decisions on the community, state of rural health and state of healthcare services in Grandview and the neighbouring community of Roblin.

METHODS

In order to meet its objectives, this study utilized multiple methods of data collection to analyze the impacts of government decision-making and policy on the community of Grandview, Manitoba, and to address community satisfaction with the healthcare services currently provided within the community. Multiple methods and sources were important to this report in order to provide a holistic overview and understanding of the ongoing healthcare system transformation, government reasoning behind the decision to eliminate certain EMS stations across the province, and to understand the effects of these on the community and healthcare services within Grandview. The first method utilized was a broad document analysis, including a review of pertinent government reports and documents regarding health system transformation and review of health care services within Manitoba. The second method utilized in this study consisted of semi-structured telephone interviews with community members and service providers living and working in the area of Grandview, Manitoba and the surrounding region. This study reviews and analyses government decisions and the effects of these decisions on rural community members in Grandview and neighbouring First Nation and Métis communities. Manitoba. As such, the methods utilized were relevant and appropriate to this research. A brief overview of each method and sampling strategy is provided in this section.

Document Review

For the document review component of this research, six recent and imperative government documents were selected for review regarding healthcare transformation in Manitoba and the recommendation to close select rural EMS stations across the province. These documents all played central roles in educating government decision-making towards these changes, and are acknowledged as such by the Manitoba government and department of Health, Seniors and Active Living. The documents reviewed in this research include: the 2013 EMS Systems Review by Reg Toews for the Government of Manitoba, the 2017 Provincial Clinical and Preventative Services Planning for Manitoba (Peachey Report) by David Peachey and colleagues, the 2017 Wait Times Reduction Task Force Final Report to the Ministry of Health, Seniors and Active Living, the 2017 Health System Sustainability and Innovation Review (KPMG Report), which was not released to the public until May 2018, the May 2019 Shared Health report, Better Care Closer to Home: Planning for the future of our health care system, and the June 2019 Shared Health report Better Care Closer to Home.

These documents were reviewed and analyzed based on their effect or influence on the government decision to consolidate services across rural Manitoba. The sample size for this component was small, and intentional, as these six documents were commissioned for the purpose of analyzing the effectiveness of the Manitoba healthcare system over the past six years. The central question addressed when reviewing these government documents was ‘how has these reports affected Grandview, Manitoba?’ in order to assist in responding to

the central research questions, 'why does the Grandview model of healthcare service work best for the community?' and 'how does the Grandview Health Centre fit into the provincial system as a District Health Hub?' The review of these core policy documents provides a background to understand government decision-making around the delivery of emergency medical services across the province, but they also represent the basis for all healthcare service delivery in Manitoba in the future.

Semi-Structured Interviews

This study was requested by members of the Grandview community, seeking support in addressing the many ways that the current manner of healthcare service delivery, particularly emergency medical services, benefit the community, while addressing complex health needs and populations within the Grandview area. The population included in this research is made up of Grandview community members, business owners, service providers, parents, older, middle and young adults, and residents of communities nearby Grandview who travel to the town to access healthcare services there, rather than within their local municipality. This population is demographically diverse in order to demonstrate experiences and views from across the lifecourse, various socioeconomic and education levels, and employment backgrounds. While it is not possible to collect the experiences of all residents in Grandview, the population included in this sample is reasonably representative of the diversity of the community.

A purposive, non-random sampling strategy was utilized in order to include community experts, including people who had much experience utilizing healthcare services in Grandview, as well as people who represent various interest groups, such as seniors and residents of other communities seeking care in Grandview. The sampling of community experts was important to this study, where particular knowledge of the healthcare system and services in the community was critical to addressing the research question. Snowball sampling was also utilized, whereby participants were invited to share the study with members of their social networks to encourage participation.

Beginning in fall 2018, members of the Grandview were recruited for participation in this study through an invitation provided through Grandview Healthcare Solutions electronically and in local media. Interested community members were then invited to participate in a 30-minute telephone interview. In total, 25 participants consented and were interviewed over the telephone for the study, between December 2018 and March 2019.

Table 3: Participant sample.

Participant Descriptor	Number of Participants
Grandview Resident / Service User	10
Indigenous Community member	1
Non-Resident / Service User	1
Service Provider	9
Local Government or Business Owner	5
Indigenous community member	2
Total	**26**

An interview guide was used to structure interviews and allow for participants to prepare for their interview in advance. Interview questions included experience-based questions, such as:

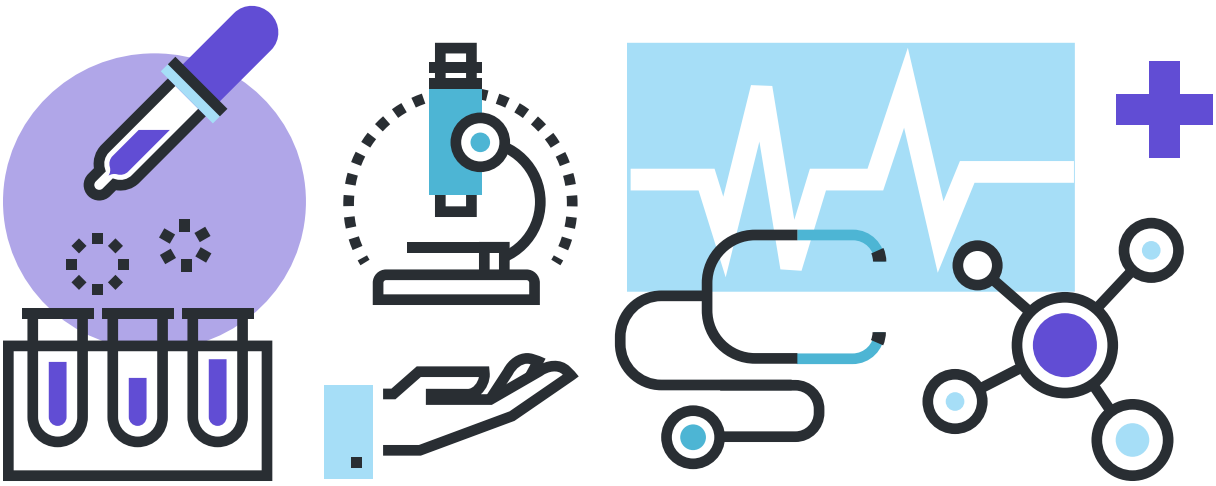
- What are healthcare services like in your community currently?
  - Describe the services provided or available to you.
  - Are there any important experiences that you would like to share?
  - Describe your ability to access care and receive emergency care.
  - Are there important relationships between service providers and sectors that affected the delivery of health services?

The interview guide also included opinion-based questions, to gauge participant feelings towards the EMS changes and how they will affect the community, such as:

- What will happen to healthcare in your community after the proposed change to the delivery of emergency services?
- How will you and the community adapt to this change?
  - Do you feel your needs will continue to be met?
  - Do you feel there will be gaps in services?
  - Are there people that will be more seriously affected by this change than others?

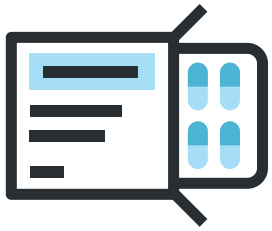
Each interview lasted between 25 minutes and 2 hours, and was audio recorded with consent from the participant and was transcribed.

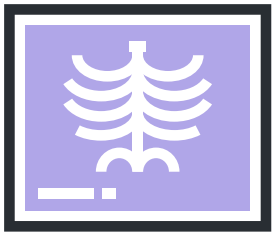
Interview transcripts were thematically analyzed, or reviewed in search of common themes, feelings, beliefs and responses among the participants in response to each interview question. When themes became common among the first five interview transcripts, they created the basis from which the analysis developed. Two thematic areas emerged through analyses. The first reflected community thoughts and experiences of the current Grandview healthcare model and EMS, and the second indicated the participant's views on the impacts that the proposed changes would have on healthcare services and the community now and in the future.



LITERATURE AND DOCUMENT REVIEW

During the completion of this report, a review of academic literature on rural health in Canada and relevant provincial policy literature and reports was undertaken. The following sections provide an overview of the findings from this review and specifically highlight key points from government health reports in Manitoba, rather than summarizing these publicly accessible reports entirely.





Rural Health in Canada

The health of Canadians living rurally and remotely is in many ways profoundly different from those living in suburban and urban settings. This is not surprising, as the demography of rural places in Canada reflects an older population, with lower socioeconomic status, and education levels (Kulig and Williams, 2012). This section provides an overview of the Canadian literature on rural health in Canada, and compares and contrast health and healthcare services between urban and rural places. Perhaps the most apparent difference between rural and urban peoples in Canada is access to healthcare services. There are a number of contributing factors limiting access to healthcare among rural communities, such as geographic barriers, limited availability of healthcare services and service providers, cultural barriers and the detrimental impacts of healthcare reform and transformation (Browne, 2016). These limitations are seen and studied across Canada.

Rural and remote communities are culturally unique and diverse across Canada, resulting in varying healthcare and social service needs. Access to services is often affected by cultural factors, and limited or inequitable access is felt most commonly by peoples who are not members of dominant society (Browne, 2016). Factors such as language barriers, limited experience with the healthcare system, social discrimination and power imbalances between patients and practitioners are often felt by culturally diverse rural peoples (Browne, 2016). In Canada, Indigenous peoples, many of whom live rurally or remotely on reserve, face particularly significant levels of

discrimination when accessing care and require contextual, community-based care in order to address specific health needs. However, Indigenous communities have historically been left out of healthcare decision-making processes, and as a result must utilize services that are not effective towards their needs.

Geographic barriers, such as distance from the community, or rural and remote settlements from the nearest hospital or clinic represent significant limitations to accessing quality healthcare services (Browne, 2016). In some cases, rural people living in the prairies and in the north may travel over 200 kilometers to get to their nearest healthcare centre or regional hospital (Browne, 2016). Most people living in rural areas then rely on road and air transportation to get to and from appointments, or for emergency care access. The travelling distance to access care is compounded and creates an additional barrier for rural communities in severe weather, on hazardous roadways, and for those with limited access to vehicular transportation (Browne, 2016). Further, hazardous and dangerous conditions may leave people waiting for days at a time for an opportunity to travel, or may lead to a cancelled appointment, or even a penalty for missed appointments.

Travel and commuting to seek healthcare services creates additional burdens on individuals, families and communities. In many cases people must leave dependents behind, or find alternative care for them, while they seek care or transport a family member or friend to the nearest clinic or centre (Browne, 2016). Driving significant distances can be costly, financially and in terms of time, and may be compounded in cases require that people take time off from work to travel and thus must spend time and expenses on travel, while missing work and losing wages in order to access care. Geographic barriers and travel take a toll socially and emotionally as well. Separation from family and community during the journey to access care places stress on family relationships and interrupts community life (Browne, 2016). This case is a prime example of inequitable access and makes clear how inequalities in both healthcare access and health itself develop and deepen over time.

Many communities in rural, northern and remote areas of the country face health human resource shortages, where despite even having services and facilities available, or within a reasonable distance, there are simply not enough health care service providers to serve the community. Studies within the Canadian context reveal a greater number of practitioner turnover in rural and remote communities, in which trained professionals enter the community, practice for a number of months or a few years, before leaving the community to practice elsewhere (Browne, 2016). This trend is observed with many different types of service providers including nurses, physicians, dentists and other specialized health practitioners. Rural communities often find it difficult to attract and retain healthcare service providers for a number of reasons, including challenging, and often outdated, working conditions and equipment, long hours, professional and social isolation, a lack of colleagues, few opportunities for continuing education and professional development, and the perception that social and family life would suffer in a remote location (Browne, 2016). For these reasons, many rural and remote communities experience barriers in both seeking and accessing care, as

the development of trusting relationships and rapport between patients and practitioners takes time. For many people with complex health needs, the relationship with their service provider is key in addressing their treatment and adhering to treatment plans. Without a consistent and trusting connection to their local practitioner, many people may simply choose not to seek care or follow up, and may take their treatment into their own hands. These actions may result in avoidance of healthcare services and contribute to inequalities in health experienced in rural and remote regions.

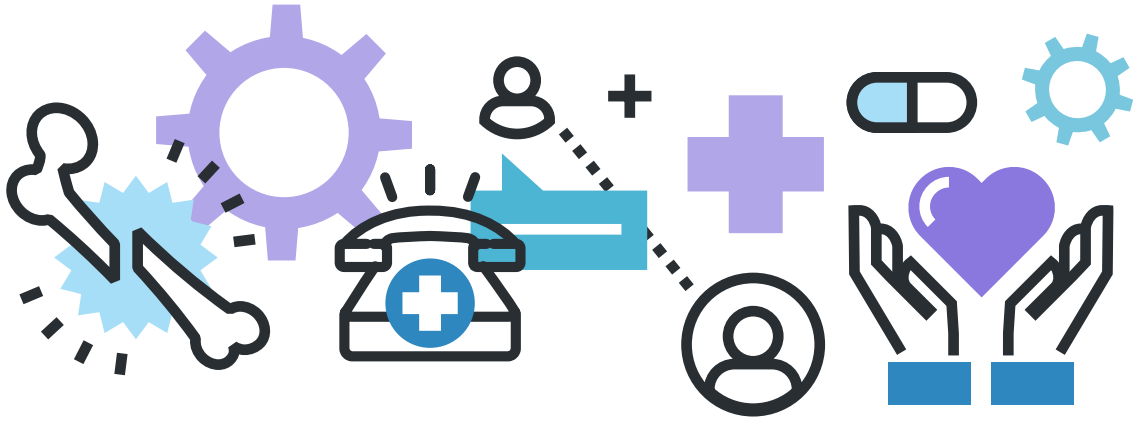
In addition to difficulties attaining and retaining healthcare service providers, as many rural and remote communities continue to age, few long-term care facilities and services exist to support the aging population. In fact, the rural Canadian population is aging on a more rapid pace than in urban settings, as reflected by Census data (Kulig & Williams, 2012). Older adults living rurally would prefer to remain in their home communities, however, without specialist, long-term and appropriate emergency care suited to the aging population, this becomes less feasible in rural communities. Browne (2016) notes that this has recently become a major strain on rural families, having to choose between relocating their elderly family member to an urban setting where appropriate services exist to support their health needs, or attempting to support their loved ones' aging at home without adequate services. As the rural Canadian population ages, it is becoming increasingly more important to establish and maintain adequate healthcare and human resources in such communities to assist older adults and their families to age in place.

Rural and remote communities are culturally unique and diverse across Canada, resulting in varying healthcare and social service needs. Access to services is often affected by cultural factors, and limited or inequitable access is felt most commonly by peoples who are not members of dominant society (Browne, 2016). Factors such as language barriers, limited experience with the healthcare system, social discrimination and power imbalances between patients and practitioners are often felt by culturally diverse rural peoples (Browne, 2016). In Canada, Indigenous peoples, many of whom live rurally or remotely on reserve, face particularly significant levels of discrimination when accessing care and require contextual, community-based care in order to address specific health needs. However, Indigenous communities have historically been left out of healthcare decision-making processes, and as a result must utilize services that are not effective in meeting their specific health needs, though this is not the case in all communities. Where there is collaboration, partnership and reception to local Indigenous community needs, many rural healthcare services are able to effectively address health needs. Critically, this requires a culturally safe approach to service provision and buy-in from Indigenous community members.

Lastly, the impacts of healthcare system reform on rural communities have resulted in issues of access, efficiency and effectiveness of healthcare services within rural places. Healthcare reform includes the structural changes needed and intended to improve the overall healthcare system, and to increase the effectiveness and efficiency of services and systems. Reform often occurs to address primary objectives such as cost-effective service

delivery or sustainability, shift from hospital-based care to community-based care models, and addressing vulnerable, at-risk or illness-specific groups by focusing on social determinants of health (Browne, 2016). Across Canada over the past 30 years, there has been a move in healthcare reform to devolve healthcare planning and services decision-making over to regional health boards or authorities by reducing hospital-based services, and turning them over to the responsibility of local boards. When these moves take place, it is crucial that provincial governments provide community-based supports to accommodate the increased responsibility to provide services (Browne, 2016). When rural hospital-based services are eliminated, healthcare service providers such as community physicians, nurses and social workers struggle to keep up with the needs and demands of their community and their emergency and acute healthcare needs (Browne, 2016).

While this is a move of decentralization of service, there is an accompanying move to centralize and mobilize services out of urban centres, away from small towns and rural authorities in an effort to be cost-effective and responsible. Without the appropriate services in place to serve rural communities, healthcare service professionals in rural and remote regions find themselves performing additional duties. These impacts of reform on rural communities have created places that are not ideal to work, or receive care, due to constant flux and change, and limited support, continuity, and health and human resources.



GOVERNMENT OF MANITOBA HEALTHCARE REPORTS AND REVIEWS

To understand the political context that government decisions have been made within, it is important to review and understand the research that influenced recent changes to Manitoba's healthcare system. The first report, which was commissioned by the previous provincial government, the NDP were in leadership in 2012, has been the basis for the substantial change to the delivery of emergency medical services. The 2013 EMS System Review by Reg Toews is critical to understand in relation to the central research question. However, the following reports, all commissioned by Manitoba's current PC government, are what has led to the ultimate healthcare system transformation in the province, including the elimination of low call-volume EMS stations in rural areas. The following sections highlight these government reports in relation to the policy and health system changes that have affected the residents of Grandview, and many other rural communities across Manitoba.

2013 EMS System Review

In 2012 the provincial government of Manitoba commissioned an external, third-party review of the EMS system across the province in order to address the development of a more "integrated, responsive, reliable and sustainable service," (Toews, 2013, p. 3). The external consultant on the project, Fitch and Associates, had previous experience in the review of emergency systems and regional health authorities in Manitoba, and worked closely with project lead, Reg Toews, the Medical Transportation Coordination Centre (MTCC), which records EMS and patient transport in the province, as well as with the EMS division of Manitoba's department of Health, Seniors and Active Living. The primary objective of the review was to evaluate and make recommendations on the financial, operational and service

standards of EMS in the province, and resulted in the creation of service delivery models that the province was recommended to structure future emergency medical services after (Toews, 2013). The expected outcomes were to specifically include recommendations on service levels matching national response time benchmarks, enhanced integration of EMS provincially, public accountability, and fiscal and operational sustainability (Toews, 2013). The project scope listed a number of areas for review, importantly including current performance standards and benchmarks for rural and urban settings, the location and number of EMS stations across the province and their relation to achieving benchmarks, and integration and collaboration across regional and municipal lines (Toews, 2013). The EMS Review was structured around these objectives and expectations, noting that this review took place at a provincial level, rather than a regional-municipal level, which has had important implications in terms of findings, recommendations and ultimate impacts on regions and municipalities.

The 2013 EMS Review utilized a series of methods, including a review of relevant policy and government documents, and meetings with various organizational and operational stakeholders, including service providers (EMS managers, educators, medical directors and Manitoba Transportation and Coordination Centre), educational institutions (colleges and universities), paramedic associations and unions, and importantly representatives of Indigenous leadership (Assembly of Manitoba Chiefs Secretariat, Manitoba Métis Federation), as well as the Assembly of Manitoba Municipalities. The review also included, but did not name or list, a series of statistical documentation provided by the EMS branch of Health, Seniors and Active Living, the MTCC and "various service providers and others..." (Toews, 2013, p. 7). The Review noted that accessing statistical and population data was difficult, stating,

> ***"The lack of consistent and reliable information available centrally was a challenge. Every effort has been made to make the data as accurate and complete as possible so that it can be considered reliable for the limited purpose of this review. The data should be treated with caution when used for any other purpose. The Annual Operation Plan completed by the RHAs and other service operators was a primary source of information," (Toews, 2013, p. 7).***

This disclaimer indicates that the reviewers believe the data is good enough for the sake of a provincial review, but draws attention to the fact that implementing significant changes based on this data could be problematic. This is a central concern for communities like Grandview, who perceive their community as negatively affected by the results and recommendations of the 2013 EMS System Review.

The report notes several positive aspects of the current EMS system and delivery, such as the fact that, despite an increasing number of calls each year (6% increase rurally), and an aging fleet of vehicles, the land ambulance program was meeting population needs in 2012 at the time of review (Toews, 2013). The optimal EMS system would continue to

do so, with a rural response time benchmark of ambulance arrival within 15 minutes for life-threatening emergencies (Toews, 2013). Toews (2013) also notes that the optimal EMS system is patient-centred, with EMS services playing central roles within community settings, through health education, illness and injury prevention and early risk detection.

Key review findings included that 911 calls were increasing in volume province-wide, that costs and service standards varied widely, gaps existed in data collection, and that services and delivery models were uncoordinated and fragmented across Manitoba (Toews, 2013). These findings resulted in a number of high-level recommendations, those intended to be undertaken at a government, or systems, level. Recommendations included using primary-care paramedics as entry level standard for providers, continuing the practice of two central dispatches centres to assign ambulance units to calls (one for Winnipeg, and one for rural, remote and northern settings), to transform EMS culture from one focused on response to a culture of prevention and risk reduction (Toews, 2013). Most importantly to this study, and rural communities, was the recommendation to "reconfigure land and air ambulance placement to more closely match resources with actual service demand to achieve defined response time standards," (Toews, 2013, p. 2).

In the report, Toews reviews the primary response and EMS deployment practices that were taking place in the province at the time, questioning the reliability and suitability of stations and their fleets, (Toews, 2013). With 92 EMS stations in rural and northern Manitoba, many of which were deploying ambulances over 15 years old, the question arose as to whether this status was sustainable. The report states that for the sake of providing the province with a conceptual service delivery model to align the best number of EMS stations and ambulance units where they are needed most, a computer modelling method was used to design a system where all Manitobans would receive "predictable, responsible and reasonably costed ambulance services" (Toews, 2013, p. 28). The model used is stated to by based on national and international best practices in paramedicine to determine unit demand. The Unit Hour model is highlighted by Toews, and a caution is given in the report that this model is theoretical, to provide the government with an idea of costing for EMS delivery, rather than actually determining the location of EMS stations and units,

"This model is intended for theoretical value only... to give the... Government an order of cost magnitude and it is not intended to reflect actual station locations. A further process will need to be completed to determine the location of the stations. The location names identified in this report were strictly a computerized output to allow for a count of required resources," (Toews, 2013, p. 28).

Essentially, under the unit hour model, and using a demand analysis of EMS needs across the province and applying the cost to staff and deliver to those needs, a recommendation was made to the province. Demand was determined based on geographic area, and call volume for each area. The model focuses on meeting the highest needs first (urban/suburban) and builds outward to rural and remote geographic areas (Toews, 2013). Once this is determined, the number of ambulances and paramedics required to meet demand can be calculated, then the number of hours that are needed to staff those positions for appropriate coverage are given, and ultimately a final cost is ascribed.

Despite the above caution stating that the unit hour model was to be used to provide the appropriate cost to deliver effective services, the 2013 Review then goes on to provide a map and list of recommended EMS resource locations, as depicted in Figure 5. The Review states that the locations were determined by "minimizing risk using generally accepted response time for Urban (8:59), rural (14:59) and remote response (30 minute) times," (Toews, 2013, p. 31). But this method does not clearly describe how the reviewers arrived at these specific locations.

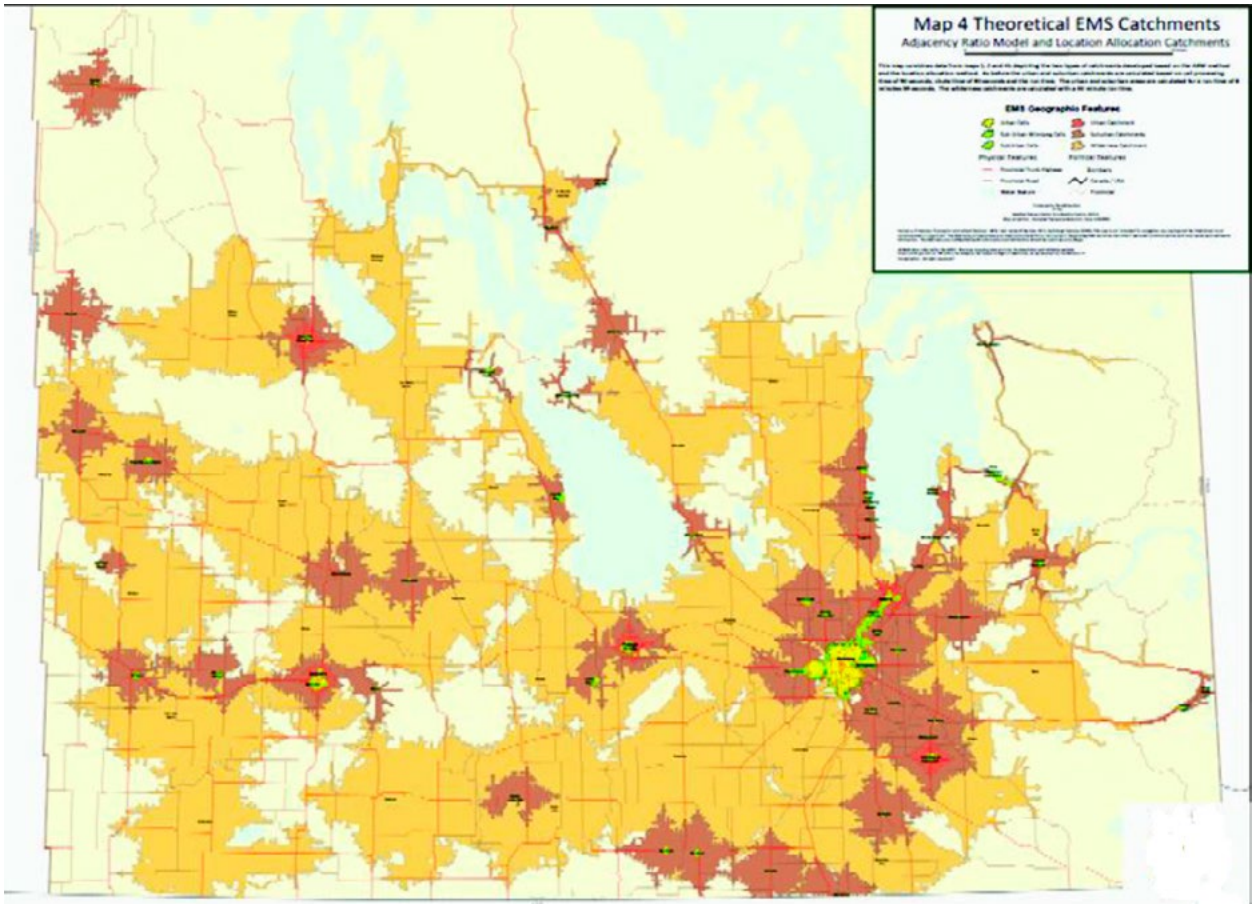


Figure 5: Recommended EMS Resource Locations. Source: 2013 EMS Systems Review (Toews, 2013).

The Review states that according to the unit hour model and demand analysis, the regions south of the 52 parallel will require 89 ambulances, 74 of which are needed outside of the city of Winnipeg to ensure a response time of less than 30 minutes in rural and remote areas 90% of the time for 90% of the population (Toews, 2013). The number of 74 ambulances for rural and remote Manitoba came from supplementary work provided by the MTCC and EMS Branch of Manitoba Health, Seniors and Active Living, utilizing "a combination of computer modelling and judgement from experience," (Toews, 2013, p. 32). Further description is not provided within the report. The 74 required stations is a reduction of 18 stations, from the 92 stations that were then in use across the province's rural and remote areas, 11 of which are situated in the Assiniboine RHA (now referred to as the Prairie Mountain Health RHA). The Assiniboine RHA had previously reviewed and modelled demand versus available units and resources, finding that there were too many EMS stations within the region. Paramedics and reviewers alike stated that many of these were low call-volume stations, particularly in the western section of the region. The reviewers believed that with the recommended reduction in the number of low volume stations in the region, they would still meet the response time requirements (Toews, 2013).

In the report, there were two primary reasons cited for eliminating or consolidating stations in rural Manitoba. The first states that many low volume stations are operated on an on-call basis by emergency medical responders (EMRs), rather than more-skilled paramedics. EMRs are only able to respond to calls with the permission of their employers, as EMRs are not full-time EMS staff, and therefore have jobs and careers outside of emergency response duties (Toews, 2013). This was determined to be unsustainable, and limits the ability to maintain standard minimum response times. Further, EMRs were found to take on EMS duties as a commitment or responsibility to their community, and this sense of commitment or volunteerism is considered a dying trend across the country, and therefore full-time, salaried paramedics will be required to supply EMS services going forward in the long-term (Toews, 2013). Secondly, in order to meet government requirements and goals of provided the best possible emergency care, EMRs and volunteers must be replaced by fully trained and certified paramedics. The fear is that low volume EMS stations cannot attract, retain or sustain the employment of permanent, full-time paramedic professionals (Toews, 2013). Therefore, smaller, low volume, on-call stations will have to be eliminated or consolidated in order to sustain the highest quality paramedic staff on a long-term basis (Toews, 2013).

In the last paragraphs of this section of the report, the reviewers state that "it is becoming less helpful to think in terms of stations," (Toews, 2013, p. 33). When it comes to the elimination of stations, the reviewers are referring to physical EMS garages and on-site staff, rather than ambulances or paramedics. For future-planning and sustainability, the report states that it is more beneficial to think of EMS services as independent of physical locations or home bases, and rather more dependent on having full-time paramedic staff that are effectively geographically positioned (geo-posted) to respond to the greatest number of

calls in the shortest time possible. This way of thinking is problematic however, as it does not take into consideration the local context of current EMS stations and community needs, which could have ultimately changed decisions to close some stations, including the station in Grandview.

The 2013 EMS System Review by Toews represents an important precursor to the eventual transformation of the Manitoba healthcare system, and ultimately to the intended closures of 18 rural EMS stations including Grandview. In the review of this document, a number of issues including lack of clarity, questionable data and use of data, and a lack of community engagement, were found and are expanded on within the Discussion section of this report.

2017 Provincial Clinical and Preventive Services Planning for Manitoba Report (Peachey Report)

Commissioned by the Government of Manitoba in 2015, the Peachey Report sought to determine where inefficiencies and duplications in health care service planning and delivery existed in an effort to improve fiscal sustainability. As a follow-up to an environmental scan of the provincial healthcare system completed in 2016, the Peachey report was intended to explore how healthcare services are being delivered and how they can be improved as a first step to planning a transformational change to the provincial healthcare system. The report notes that while healthcare is a provincial responsibility, most planning and delivery is conducted by the five regional health authorities within the province, along with the Ministry of Health, Seniors and Active Living, CancerCare Manitoba and Diagnostic Services Manitoba (Peachey et al., 2017). This has resulted in "fragmented services, concerns over quality and access, redundancy and inefficiency, and challenges for those responsible for planning health human resources, capital investments, and digital technology," (Peachey et al., 2017, p. 5). This report represents the first time that the province of Manitoba has gone about long-term planning for the provincial healthcare system (Peachey et al., 2017). Overall, Peachey and colleagues focused in provincial clinical governance, and how this should be structured.

The process of the project undertaken by Peachey and colleagues listed a number of principles that would need to be adhered to in effort to ensure the implementation of a new health systems plan over the course of the ten years the researchers budgeted for total system transformation. Such principles include transparent methodologies, patient-centred decision-making where the patient and their family are the focus of healthcare delivery systems, and equitable care across geographic lines within the province (Peachey et al., 2017). These principles are critical in approaching healthcare systems change, but are especially important to community members that would be most affected by such changes, particularly those in geographic areas that have historically had lesser access to quality and specialized care compared to those in major urban centres like Winnipeg. However, following these and

the other listed principles, Peachey (2017) states that a one-time strategic investment in healthcare services planning and delivery can result in wide-spread systemic change that not only improves healthcare services and patient experiences, but also meets government goals to improve quality and reduce costs.

Ten priority areas were highlighted by the researchers as critical to address when planning for Manitoba, and were seen to be in line with the goals and direction of the government of Manitoba. These priorities included: older adults, collaborative care, consolidated services, emergency medical and health services, home care, Indigenous peoples, maternal health, mental health and addictions, palliative care, and public and population health (Peachey et al., 2017, p. 19). While these priorities are critical and must be included, residents of rural, remote and northern areas, known to utilize EMS services more frequently than urban counterparts, and as a source of primary care, and that often face diverse risks and illnesses were not specifically included on this priority list. The most important priority with impact on Grandview's healthcare services, is Peachey's (2017) recommendation to consolidate services wherever possible. Consolidation is beneficial in clinical and preventative services planning as a mechanism to improve quality, centralize resources and decrease cost, and consolidation should always be considered where possible. An important highlight that Peachey makes, however, is that "where safe, care closer to home is an equally compelling goal," (Peachey et al., 2017, p. 54). Peachey (2017) does not state which specific facilities should close or be consolidated, stating that that these decisions are for clinical governance and leadership positions across the province, and cautioning that this will have regional and political impacts.

Peachey does make a list of facts that compel the suggestion to consolidate healthcare services in Manitoba, including two points that have direct relevance to Grandview as a rural hospital site:

> ***"There are 73 hospitals in Manitoba; this is a large number for a population of 1.3 million, even if dispersed; it is not uncommon in a rural setting that patients will call before going to a hospital or emergency department to see if it is open that particular day. Many smaller, rural hospitals are, de facto, providers of long-term and personal care even though funded as hospitals," (Peachey et al., 2017, p. 54).***

Citing various issues as reasons for consolidation or closure avoids the reality that rural practitioners and communities face consistently, a lack of support at regional and provincial levels to ensure consistent and effective delivery of primary and emergency medical services. The Peachey report goes on to list samples of what it considers the most important profiles and descriptors of the Manitoba population, noting socioeconomic indicators, health behaviours, and demographic and age projections, though none of these directly mentioned specific needs of rural peoples.

In the next section of the Peachey report (2017), the authors list key concepts, or themes, that were recurring in their research and planning process. Here "rurality and remoteness" was listed as the second theme, indicating that rural health must be addressed in all areas of a clinical and preventative health plan. Peachey (2017) notes that rural and remote populations statistically experience lower health status than urban counterparts, and that this remains true in Canada, and on Manitoba, where the rural population is comparatively large. Rural and remote areas also struggle to attract and retain healthcare professionals, limiting access to quality, continual care (Peachey et al., 2017). In reviewing healthcare planning literature from across Canada, Peachey and colleagues (2017) cite the work of Kralj (2000, as cited in Peachey et al., 2017), where rural physicians and service providers listed the 10 most important factors that define rurality from a practical standpoint. These characteristics of rural medical and healthcare practice included: "high level of on-call responsibility, long distance to secondary referral centre, lack of specialist services, insufficient numbers of General and Family Physicians, long distance to tertiary referral centre, absence of diagnostic equipment, difficulty in obtaining locum tenens support, no ambulance service, inability to provide obstetrical and surgical services, sparsely populated catchment area," (Peachey et al., 2017, p. 30). Kralj asserted through this Ontario-based study that rurality is important to healthcare planning decisions, and must take into consideration the rural community and lifestyle, the nature of rural healthcare practice as diverse and different from urban practice, and the unavoidable professional isolation and need for support for practitioners and rural places (Peachey et al., 2017). Inclusion of this research for the sake of clinical and preventative services planning indicates consideration towards rural needs, and is mostly reflective of professional, health human resources needs rather than the perceived or actual health needs of communities themselves, otherwise community consultation, patient-led planning and recruitment boards should have been included here.

The second key concept that is relevant to the Grandview study, and was essential to the Peachey report was a focus on patient-centred care, where clinical and preventative services planning should be structured around the needs, contexts and limitations of patients and their families (Peachey et al., 2017). Patient-centred care calls for comprehensive-care, patient-, rather than physician-led decision-making on health, coordination and communication between patient and provider, empowerment of patients and patient autonomy, and lastly timely access to care and information (Peachey et al., 2017). Peachey (2017, p. 35) states that in primary healthcare reform, patient-centred care must be prioritized, quoting from the College of Family Practice of Canada, that each patient must have a "medical home", where they are able to access quality, timely and effective care. Here, a "medical home" is described as a place where:

- "Each patient has a personal family physician
- Patients have access to nurses or nurse practitioners and other health professionals, as needed, either in the practice or through formal links to other settings
- Health professionals work as well-coordinated teams; each offers unique skills to ensure optimal patient benefit
- Systems are in place to ensure timely appointments with the family doctor and other members of the care team
- Arrangements for and coordination of all other medical services are carried out through the medical home
- Electronic medical records are in place to facilitate appropriate information storage and sharing," (Peachey et al., 2017, p. 35).

These factors are considered core elements of a collaborative care model, in which integrated healthcare teams address community, and patient needs and provide quality, continual care for the patient (Peachey et al., 2017). This model of care is highlighted in the report as being crucial to the delivery of quality care.

Of relevance to this report and the community of Grandview, is Peachey's recommendations concerning primary care, and public and population health. The Report makes a series of recommendations in numerous areas, and makes clear statements regarding the continuation of rural hospitals. Another significant recommendation calls for the individual assessment of all rural hospitals in the province, how their beds are utilized, the propriety of their emergency departments, and whether they should remain serving as hospitals in the future (Peachey et al., 2017). Of concern is a lack of criteria provided in the review to determine the suitability of rural emergency departments, acute and chronic beds, and hospital performance in general. Where Peachey and colleagues (2017) recommend the consolidation of services, there is little discussion of what needs to take place in order to ensure the continuity and quality of care for people in rural and remote settings that are facing the closure or consolidation with other services or facilities in their communities. While the Peachey Report refers to the importance of patient-centred care, and the limitations and

needs of clinical and preventative services in rural areas, it does not offer clear instructions to government to determine what services are required in rural communities, or how to work with communities to determine what is required to address their diverse and unique health needs. This issue is revisited below in the Discussion section.

2017 Health System Sustainability and Innovation Review (KPMG Report)

In 2016, the government of Manitoba commissioned private firm KPMG to review the current state of the health care system and consider ways in which the province could improve on fiscal sustainability within the healthcare system in Manitoba. The province was particularly concerned with sustainability and cost-effectiveness at the time, following reports of ever-increasing healthcare expenditures and lack of return in improved health status across the province and during a Fiscal Performance Review across all provincial departments. The research undertaken for the review began in 2016, with a broad review of the system and manner of service delivery, investigating ways in which the province could lead or manage services centrally. KPMG (2017, p. 4) described their review as "high-level," meaning that services and delivery costs were evaluated broadly, and statistically, in order to make general recommendations for cost-effective changes. This review took place over the span of nine weeks, and included over 70 stakeholder interviews, a document review and review of previous health system review that KPMG had previously been involved in (KPMG, 2017). The report was warranted within the province, as Manitoba's healthcare system had not undergone a systemic cost review in many years, and between 2003 and 2016, healthcare expenditures in the province had increased by over 72% (KPMG, 2017). The primary objective of this report, in accompaniment to the 2017 Peachey Report on healthcare governance and planning, was to review and recommend on ways to restructure the provincial healthcare system in a cost-effective manner with the intention of reaching fiscal sustainability.

In the report, titled Health System Sustainability and Innovation Review (HSIR), KPMG noted current practices of budgeting and spending within the health system, stating that at the time health system budgets had been based on historic budgets, rather than population needs, with no incentives to encourage quality and efficiency (KPMG, 2017). Governing bodies, such as the provincial ministry and the regional health authorities had no clearly defined mandates to work within in order to make spending decisions, and healthcare planning was not previously evidence-based resulting in less than optimal services and delivery methods. The system itself was poorly structured with unclear responsibilities across healthcare leadership. For example, with a population of 1.3 million people, Manitoba's healthcare system was at the time far too complex and siloed (KPMG, 2017). Additionally, the Winnipeg Regional Health Authority (WRHA) possessed many provincial clinical and diagnostic resources, including technology, specialists and service areas, and these were

not readily accessible to other regions. The authors referred to healthcare reform in other provinces being based on the consolidation of services, patient-centred care and funding reform, where significant improvements to the health system has resulted. This was the direction proposed for Manitoba.

KPMG made a lengthy number of recommendations for the province to incorporate into a health system transformation with respect to the structure of the health system itself, and making health service delivery more efficient. Over 300 opportunities for cost improvement were identified in the report (KPMG, 2017). Following its review of the provincial health system, KPMG provided an overview of a preferred provincial health system structure which included regional health authorities to deliver healthcare services, the development of a central provincial health organization to regulate the use of province-wide resources and lead in provincial health planning, and lastly the remainder of the Ministry of Health, Seniors and Active Living to undertake planning, policy and funding of the healthcare system in Manitoba (KPMG, 2017). This new provincial structure was stated to allow for a number of improved outcomes, including cost efficiencies through shared rather than siloed services, clear roles and responsibilities of health service organizations and authorities, improved management of provincial programs, and decreased operating costs (KPMG, 2017). The move to a central provincial health organization (PHO) with a clearly defined mandate and responsibilities, as well as clear roles assigned to the regional health authorities was recommended as an immediate change that had to come as a precursor to any additional cost-effective improvements within the Manitoba healthcare system.

One recommendation within the 11 areas of cost-saving opportunity identified was the move to shift healthcare services from acute (hospital) to community-based settings, where diverse rural and urban patients would receive more appropriate and convenient care in community settings, rather than within hospitals, where hospitals act as hubs to connect patients with services in their community (KPMG, 2017). This hub-and-spoke method is considered a best practice in patient-centred care and the provision of integrated healthcare services (KPMG, 2017). In their review of documents and respondent surveys, KPMG found that rural service providers, patients, families and caregivers cited difficulty in accessing services and resources in their communities, which KPMG states could be improved through the use of technology, such as TeleHealth (KPMG, 2017). To support this recommendation, KPMG analyzed emergency department usage across Manitoba's regional health authorities. Significant to Grandview, KPMG found that within Prairie Mountain RHA, patients visited the ED 3% more often than expected when adjusted for age, leading KPMG to state that this

region was particularly suitable for changes to reduce the number of avoidable ED visits residents make. The potential cost improvement, or savings for this area were stated to be in the amount of $0.6 million dollars annually with 4,558 fewer avoidable ED visits per year through health system changes (KPMG, 2017).

A second significant area of opportunity to reduce health system costs was identified as the consolidation of small, proximal emergency departments. However, KPMG's analysis showed that there was little cost savings with a decreased in number of rural ED visits among rural and small hospitals. KPMG (2017, p. 149) states "fixed cost savings from consolidations are likely negligible compared to those associated with the potential to reduce unit costs." In other words, consolidating and eliminating rural EDs and hospitals in general will likely not result in major savings for the Manitoba healthcare system, rather changes should be made to lower the cost per ED visit across the province. KPMG recommends that the first priority in addressing hospitals and emergency departments in Manitoba is to reduce (or improve) ED visit costs, and secondly to reduce the number of emergency department visits in the Southern RHA, where they were found to be the greatest (46% more ED visits than expected). Only once these priorities have been addressed, should the province consider the consolidation of small rural EDs (KPMG, 2017). In the prioritization of this area of opportunity (Core Clinical and Healthcare Services), KPMG recommends that the province undertake these steps on a medium-term basis (3-4 fiscal years) as these are considered to be highly cost-saving, but also expensive and time-consuming to implement as indicated in Figure 6.

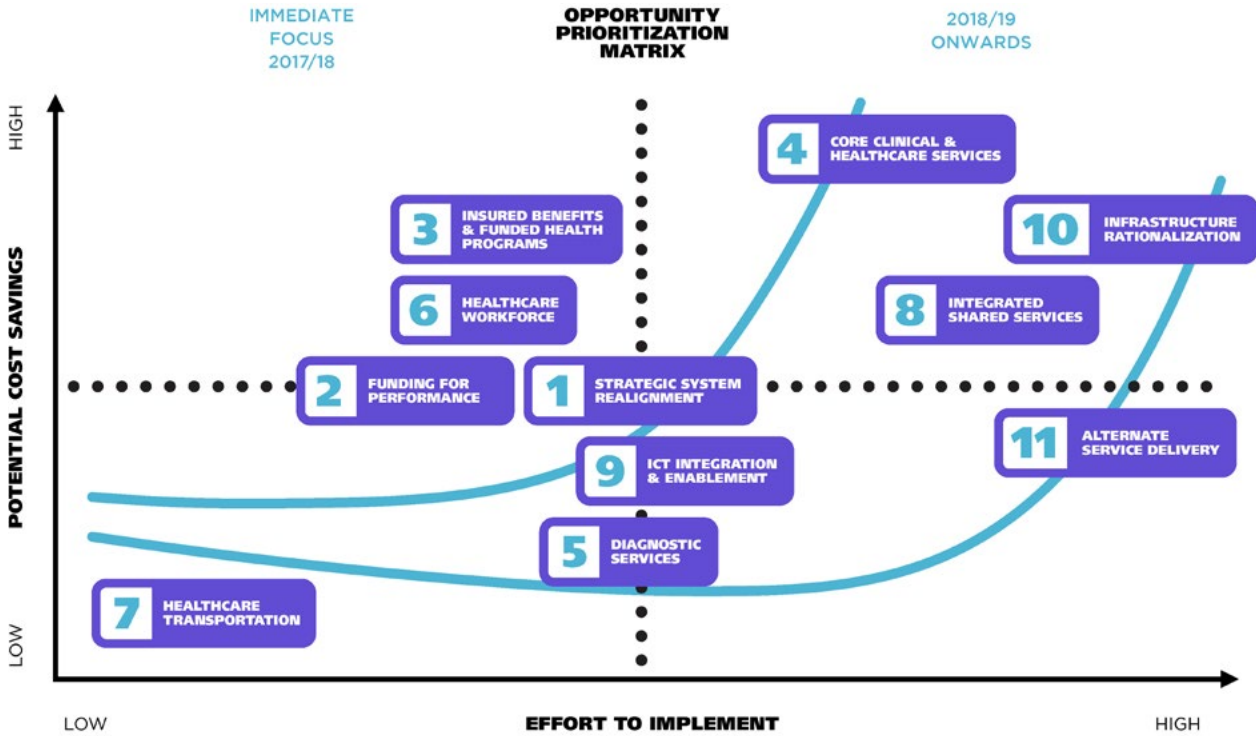
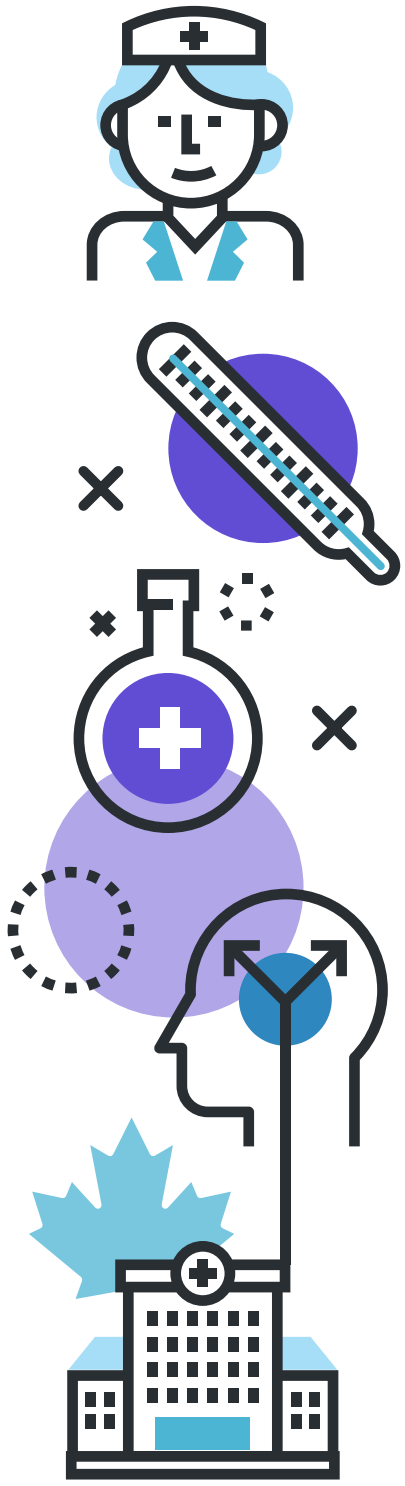


Figure 6: KPMG's Opportunity Prioritization Matrix for 11 area of cost-savings. Source: https://www.gov.mb.ca/health/documents/hsir_phase1b.pdf

For Grandview, and other similar communities with rural hospitals and emergency departments, this provides time to address efficiencies and areas of cost-savings as KPMG results demonstrate that consolidation is not immediately cost effective.

2017 Wait Times Reduction Report

In 2016 the Emergency Department Wait Times Reduction Committee was established under the direction of the Minister of Health, Seniors and Active Living to review and analyze various reports, systematic reviews and data regarding ED use in Manitoba in order to make recommendations to improve access to emergency medical care and reduce wait times in emergency departments. The committee also sought to identify limitations in addressing these improvements, such as health system structures and governance. Not only were government reports utilized to inform this report, but the committee held extensive consultation with many stakeholders, including: front-line healthcare professionals, ED managers, hospital executives, regional health authority leaders, and the public, which would be most affected by recommended changes. Members of the public, as well as practitioners and service providers were surveyed regarding their use, experience and thoughts regarding emergency departments (Manitoba Health, Seniors and Active Living, 2017).



An entire chapter of the report was directed towards rural and remote emergency departments and access to care. Importantly, the authors explored areas such as availability of practitioners and services, distance to specialized services and transportation (MHSAL, 2017). There are 63 rural emergency departments across Manitoba, all with strengths and weakness that result in a great variation in quality, timeliness and effectiveness of services (MHSAL, 2017). The report acknowledges here that many communities rely on services offered outside of their geographic area, and a such transportation and emergency transport is often critical. In reference to access to EDs and primary care, public survey participants voiced much concern over the availability of the emergency department in their local hospital, where in many cases, EDs operated sporadically with patients not knowing whether their local ED was open or closed on a given day or time (MHSAL, 2017). This supports the report's finding that a significant concern that remains in rural Manitoba today is inequitable access to consistent, quality, primary healthcare services due to

limited retention of service providers (MHSAL, 2017). Unfortunately, in most rural settings, the same doctors that are providing primary care through the day to regular patients and through appointments, are the ones that are on-call in the emergency department, often having to cancel or reschedule appointments (MHSAL, 2017). This leads to patients having to use EMS and ED services as a first point of contact with the healthcare system, finding themselves under the care of the same professional that they would have seen during clinic hours. Responsibility across so many domains leads to physician and provider burn out, one reason why the retention of staff in rural EDs is so difficult (MHSAL, 2017). This leads to operational challenges, as so often seen, where clinic hours are cut short, and EDs are only open and available occasionally. This cycle of staffing and operational challenges further reduces the ability of rural EDs to meet the needs of patients, and limits the improvement of rural health. Coincidentally no one from Grandview was interviewed in developing the Wait Times Reduction Report, where the experiences outlined above do not fit the model of service delivery within Grandview, which is consistent, team-based and supportive of service providers.

The Wait Times Reduction Report spends great length discussion EMS services, acknowledging that EMS and the work of paramedics is what connects the emergency care system with patients, requiring strategic governance and planning. EMS is often the point where potentially life-saving treatments begin, prior to patients arriving at the hospital ED, and as such EMS services must be prioritized and supported effectively. Unfortunately, in rural settings, EMS and paramedics face a number of challenges, such as low staffing, and a lack of highly trained and skilled responders (EMRs rather than certified paramedics). Rural EMS services must often provide life-supporting treatment for longer periods of time as a result of travel time and distances between calls and emergency departments, and may face the challenge of being rerouted from an overcrowded ED to an available ED further away (MHSAL, 2017).

Importantly, the Wait Times Report recognizes the skills and position of paramedics in rural settings. A crucial recommendation that the 2017 Wait Times Report makes is that paramedics should not be confined to an ambulance, that paramedics possess unique knowledge, skills, and awareness of their community and community health needs, such that they should be empowered to provide skills in other places, such as in-home care, and supportive care for frequent EMS and ED users (MHSAL, 2017). This sensibility supports the utilization of rural EMS service providers within rural EDs, as support to physicians, nurses and staff, and encouraging integrated, team-based service provision.

The 2017 Wait Times Reduction report also references EMS positioning, stating that EMS stations were previously and traditionally placed in locations located near to a local hospital with an emergency department, however, due to the reality of most rural hospitals and EDs, where they are frequently understaffed, temporarily closed, unable to conduct critical diagnostic processes due to a lack of technology or trained technologists to operate equipment, this positioning model is ineffective (Government

of Manitoba, 2017a). Instead, the current trend and priority response research recommends the use of geo-posting, or geographical positioning, wherein ambulance units are placed in a large area of higher call volume, rather than simply nearby to a hospital (MHSAL, 2017a). The report acknowledges some of the limitations to this new model, for example, using geo-posting, ambulances would be sitting idle, waiting for calls to come in, in order to respond immediately, rather than remaining parked and allowing paramedics to perform other auxiliary duties such as administrative, hospital support and triaging, while they are not responding to an emergency call. Geo-posting supports the concept of dynamic deployment, where ambulances are placed in high call-volume areas and remain idle until a call arrives, such that paramedics perform the sole duty of emergency response where they are needed most. The downside to this recommended practice, is that the additional duties, professional development and emergency department assistance that paramedics provide when posted at or near to a hospital are no longer available.

In its final comments on rural emergency departments, the Wait Times Report states that consolidation of rural EDs is not simply about cost-saving or the closure of low-volume hospitals, but rather about a new vision, set of standards based on population distribution and geography, infrastructure, technology and importantly, health human resources and availability of service providers (MHSAL, 2017). If a rural hospital is going to have an ED, then it must be available to patients when they need it, 24-7, when the right service providers in place to meet emergency needs. Manitoba, and the rest of Canada are facing a shortage of qualified physicians and nurses, set to worsen over the next 20 years, impacting both rural and urban EDs (MHSAL, 2017). As a result, consolidation is taking place across the country to make best use of limited personnel, and provide the best possible care. Consolidation, and the transition of some EDs to urgent care centres, is something that the Wait Times committee feels must happen in Manitoba, but not arbitrarily, rather through a provincial restructuring, so that rural patients are not further limited in accessing quality emergency care. It is important to note here that this restructuring should be inclusive of input from service providers and communities within rural Manitoba, those communities that would be most affected by a provincial restructuring. Communities such as Grandview, were not included in this process.

2019 Better Care Closer to Home Documents

In May 2019, Manitoba Shared Health released the Better Care Closer To Home: Planning for the Future of Health Care System document. This report describes the progress Shared Health has made in implementing the government plans and it states,

"Shared Health is leading the creation of a provincial clinical and preventative service plan that will guide improvements to access, coordination and integration of health services in Manitoba. The plan will cover a five-year timeframe and will be updated annually. It will identify improved, innovative ways of delivering care, clear provider roles and responsibilities and easy to understand pathways for patients to ensure they are able to access appropriate care as close to home as possible, with the certainty that specialized resources are available to them if they are required." (Manitoba Shared Health, 2019, p. 2)

The document proposes a network of health hubs in order to meet health needs of Manitobans on local levels, and providing a continuum of care within the community while patients await specialized services in Winnipeg. The capabilities across hubs will be standardized within a spectrum, yet flexible to align with population needs and resource competency. Below, Figure 7 provides an overview of the proposed health hubs, and their definition at each level.

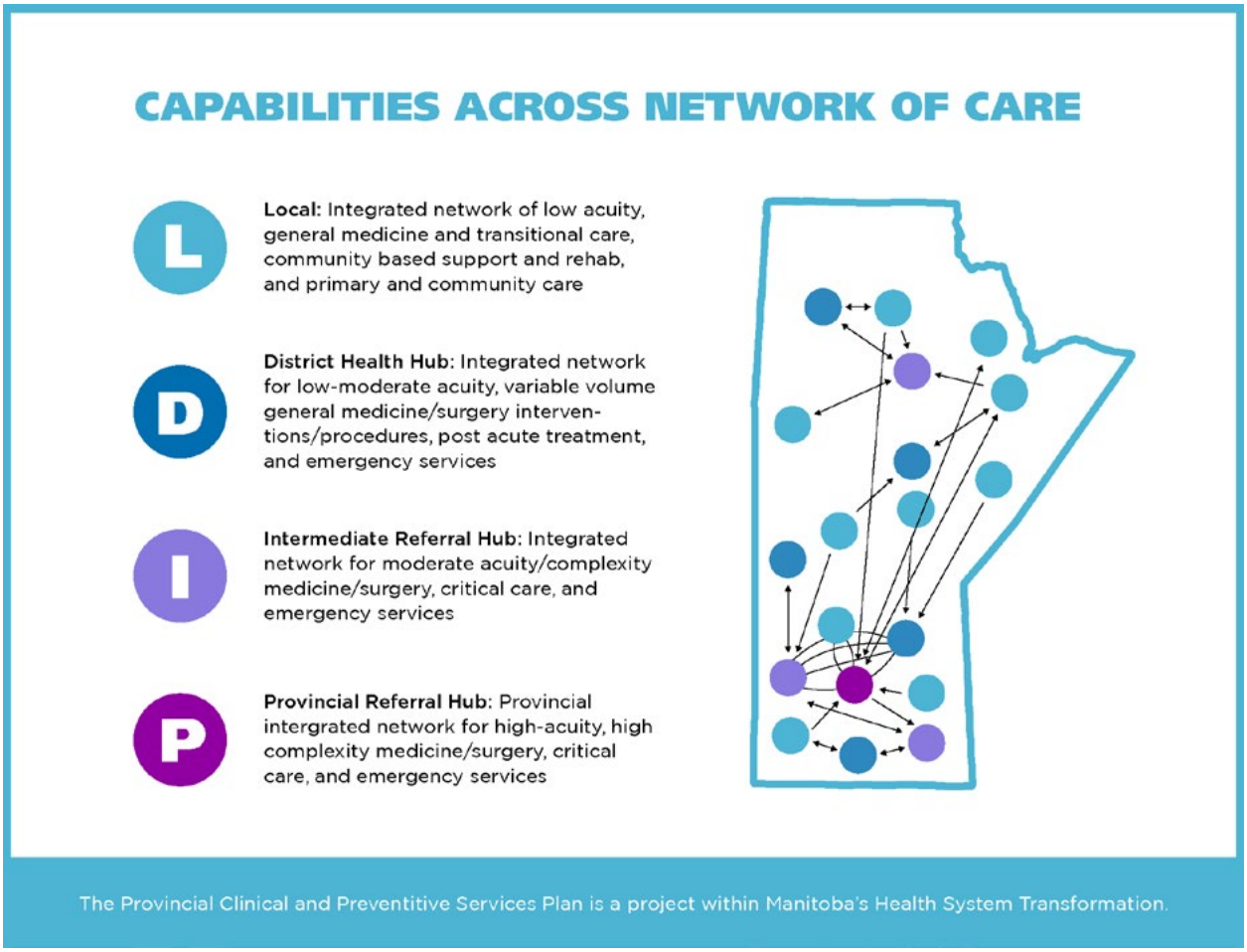


Figure 7: A snapshot of the proposed Health Hubs put forth by Manitoba Shared Health. (Shared Health, 2019).

Better Care Closer to Home highlights the fact that all government-produced documentation through the development process has clearly identified the focus of the health system changes as an effort to place the patient at the bottom of the inverted pyramid with the bureaucracy occupying the top and practitioners in the middle, ultimately making health care and health system decisions on a top-down basis. It further states that Manitoba's indigenous population has poor outcomes in many areas, making equitable access to quality services and the development of strong innovative partnerships a key priority of health system transformation.

The June 2019 Better Care document reviews the most recent district health meetings, and summarizes system changes and proposals up to this time. This document identifies the ways in which Shared Health has used all the other recent government-commissioned health system reports to guide the planning, and system changes underway in Manitoba. Most importantly there is an expanded description of the network of care across the province. One of the elements of this network are District Health Hubs, which are described as an integrated network for low to moderate acuity, variable volume general medicine and surgery, intervention and procedures, as well as post-acute treatment, and emergency services. As indicated in Figure 7, district health hubs are larger, community-based healthcare services centres that bridge local, primary- and community-care, with emergency and low to moderate acuity services to provide continuous care, and act as points of reference for patients requiring critical and complex care from Intermediate health hubs. This definition describes the healthcare system and services in place in Grandview, where primary and emergency care are delivered through a compliment of EMS and ED services from the Grandview Hospital.

The 2019 Better Care Closer to Home documents also provide an overview of the strategic shifts taking place within the provincial health system as a result of the system transformation. Listed in Figure 8, the first strategic category, is the enhancement of local capacity within the system. The strategy states that the province must improve upon existing community services to meet local health needs. This strategy then requires consideration of the efficacy of community-based services across rural Manitoba. The intention to retain and build upon successful community healthcare services and systems supports the retention and enhancement of those EMS and ED services offered in Grandview.

STRATEGIC SHIFTS – WHERE AND HOW CARE IS DELIVERED

CATEGORY		FOCUS
1	ENHANCE LOCAL CAPACITY	Improve use of existing facility-based resources to better serve local communities
2	INCREASE ACCESS TO SPECIALIZED CARE	Reconfigure specialty services among provincial and intermediate providers to work as a system of specialized care
3	BUILD CARE CLOSER TO HOME	Create capacity closer to home for episodic medical and surgical care, both in facility and in community-based care
4	PROVINCIAL PRACTICE IMPROVEMENTS	Target areas where a move to a common provincial standard of care through targeted clinical practice improvements will improve outcomes.
5	EFFECTIVE CHRONIC CONDITION MANAGEMENT	Create capacity to manage chronic conditions and longer term care needs, closer to home in facility and in community-based care

The Provincial Clinical and Preventitive Services Plan is a project within Manitoba's Health System Transformation

Figure 8: An overview of the strategic directions of the provincial health system transformation (Shared Health, 2019).

These strategic shifts represent the directions that health system transformation is working towards within the province, and as a result must take into consideration the viewpoints and experiences of rural communities that have the current capacity to meet community needs. Such an inventory requires the participation and consultation of rural communities.

CONCLUSIONS

In reviewing these recent and central government documents and reviews, it is clear that the province of Manitoba has undertaken extensive research in order to improve the provincial healthcare system on all levels. Particular concern was paid to cost-effectiveness and sustainability. However, consideration of rural, remote, northern, vulnerable and Indigenous peoples was taken, though not through community-based engagement and consultation. Broad and sweeping changes to the healthcare system will affect all Manitobans, but it is clear that changes to services and service delivery, through EMS services, hospital EDs and community service providers will take the greatest effect on Manitobans that already experience inequalities, barriers and limitations in accessing care. Communities like Grandview, that are facing changes to not only the provision of EMS services in town, but also the potential consolidation or feared closure of the local emergency department and hospital, are placed in a precarious position. In such a community where residents enjoy accessible primary and emergency care, timely EMS response, and consistent, patient-centred care, the thought of change and reform for the sake of cost-saving and reform is particularly challenging. Noting the highlights and strategic directions of Manitoba's health system transformation, Grandview operates successfully, utilizing local capacity to deliver the suite of services expected of district health hubs. The following section provides key themes and findings resulting from community interviews in Grandview, Manitoba, where EMS services are intended to be eliminated, and the local hospital and emergency department are at risk of closure or consolidation in the wake of the healthcare system reform reports reviewed above.

FINDINGS

In response to the research questions, ***why does the Grandview model of healthcare service work best for the community,*** and How does the Grandview Health Centre fit into the provincial system as a District Health Hub, several findings arose through community member interviews that became remarkably clear as interviews proceeded. These findings have been arranged into themes and presented in the following section of the report. In addition to the findings that came about in response to the central research question, there were a number of themes resulting from interviews that indicated the community's response to the EMS closure and the perceived impacts that this would have on residents, the economy, and on the community itself. The following sections provide a description of the findings gathered through community interviews.

GRANDVIEW HEALTHCARE SERVICE MODEL

The first area that this report seeks to address reflects the current state of healthcare services in Grandview and community experiences and impressions of the healthcare services that are accessible in Grandview. Overall, the current level of healthcare service within this community is crucial to the way of life and wellness that residents enjoy in Grandview. The following themes came about from interviews with community members.

Theme One: Community Wellness and Wellbeing

Members of the Grandview community attribute both their personal sense of wellbeing and their concept of community to the presence of a strong, supportive and effective local healthcare system. Often, participants spoke of their own personal health achievements as resulting directly from access to the services that they received from local healthcare services, as one participant stated, "...healthcare here is good, very good. I've had the same doctor here for 20 years and [over that time] people start to notice how well I'm doin.' I owe that to the care [here].

Community members frequently reflected on the notion that the hospital, and adjacent EMS station are at the centre of community life in Grandview, in more ways than one. For example, participants often spoke about how their family, friends or neighbours came to be residents of the town, stating that regular and consistent access to healthcare, particularly hospital care, was a central determining factor. People with greater medical needs, that wanted to live a rural way of life outside of larger urban and suburban hubs, chose to settle in Grandview because they knew about the excellent care offered there, and the regular EMS and emergency department services available. As one service provider and Grandview resident stated. "After school I chose to move to Grandview, because access to healthcare was good, and there is a great recreation program and education system." Grandview's healthcare services work well for the community, because they meet community health needs, but also community social needs. Clearly, individuals and families are choosing to live in Grandview because their health and access to healthcare are central priorities. With this case being true for most participants, it is evident that the services delivered through Grandview EMS and hospital are part of the foundation for community wellness. A service provider in the community described Grandview as "generally healthy, people are able to live independently here into old age." For this service provider, access to immediate EMS services is critical to many older adults in Grandview being able to age in place at home, in their community, where many people can life in their homes until they are over 90 years old.

Perhaps the most compelling evidence to address the central research question, are the many stories, experiences and examples shared by participants about their personal interactions with emergency healthcare services in Grandview. Many people attributed their health and life, or those of a family member or friend, to the swift response of Grandview EMS services, or the fast action of community physicians in the hospital. Now, in light of the government decision to eliminate EMS services, community members are concerned that should they require emergency response, they will be taken to a different hospital, where they will experience care of a lesser quality.

Theme Two: Relational Care

In interviews with residents, particularly with patients of the Grandview health system, it is the personal connection and relationship with their service providers, including physicians, nurses and paramedics, that contributes so greatly to their positive experience of healthcare in town. For many, it is this relationship that they have with their providers that gets them through the door to their appointments, or the confidence to seek emergency care; because they know who is waiting to care for them.

A primary statement throughout the interviews was that healthcare services are better in the small community clinic and hospital, because they are more personal and individualized. As one service provider, who lives outside of Grandview stated, "it's a small community, so it has better care. Doctors have a closer bond with the people. In Grandview you are not just a number." This statement was mentioned repeatedly, the feeling that patients are family, rather than a number. This connection and relationship is important to many patients, but especially to those that require additional, or specialized assistance. One health service provider spoke about high-needs clients, who often have difficulty seeking medical assistance due to their conditions, stating that their health is absolutely dependent on their relationship and trust with service providers in Grandview.

Residents have consistently made known their concern that with the closure of the Grandview EMS station, and the reliance on EMS services out of Gilbert Plains, or if that ambulance is on a call, the EMS out of Roblin, that the emergency department in Grandview hospital will be completely bypassed by those ambulances (Laychuk, 2018). Even if Grandview hospital is closer to the emergency call, residents iterated concern that the ambulance would be more likely to return to its station, and that Grandview residents would then be taken to hospitals either in Dauphin, nearer to Gilbert Plains, or in Roblin (Laychuk, 2018). This would then leave Grandview hospital underutilized, although fully equipped and staffed in order to triage and treat most emergency calls. The idea of bypassing Grandview hospital to receive emergency care out of Roblin, or Dauphin was concerning to many participants, as they have come to expect and rely on the high level of quality care delivered by paramedics, physicians and service providers in Grandview. A long-time member of the community stated, "...the docs here know your history... you develop a sort of 'comfort zone' and confidence in the care you receive from doctors and nursing staff." The sense of

confidence and comfort described here indicates that many of the social and interpersonal barriers to accessing healthcare, experienced within rural communities are not present in Grandview. It is clear through interviews with residents and patients that healthcare services are inclusive, comfortable and welcoming.

Theme Three: Supportive Healthcare Service Setting

The final theme that supports the current model of healthcare is the sense that Grandview is a supportive healthcare service setting. Within this theme, participants expressed they ways in which service provision in Grandview, particularly within the hospital, and between EMS and hospital staff was a prime example of integrated, team-based care, where service providers deliver coordinated care.

Grandview's EMS staff and ambulance station is located at the same facility as the Grandview hospital. The result of this station is the provisioning of complementary and auxiliary services provided by EMS staff within the hospital setting. Within the Grandview hospital, the adjacent EMS station and paramedics are considered a complementary medical service, where staffing is low and needs are high among the service population and emergency department patients. While health care professionals including doctors and nurses work effectively as a team at Grandview hospital, efficiency and support is increased with the collaboration and assistance of EMS personnel when they are not responding to a call.

Grandview residents and patients noted these relationships and coordination of service provision within the interviews, where patients receiving emergency medical services within the hospital continued to be cared for by paramedics during their time within the emergency department at Grandview, as nurses and doctors were assisted by EMS staff with responsibilities such as patient transfer between wards, triage, monitoring and data collection. A service provider with experience in the Grandview hospital setting remarked, "The EMS personnel help nurses and doctors, they perform crowd control… They are not just doing their EMS job, or only what's in their job description. They dig in and help." This demonstrates the coordination of service provision between service providers, where EMS personnel remain with their patient, and continue in assisting with care past the point of triage in the emergency department, and perform services within the hospital setting beyond and in addition to their regular duties in emergency response. One service provider noted the many external duties and responsibilities that Grandview EMS personnel attend to, stating,

"Our EMS personnel are very community-minded. They promote [hospital] services, they raise their own money, and are present at all the community events. I would say they are very high profile in the community… people have a sense of wellbeing when [the paramedics] are visible."

Many of these sentiments stem from the fact that service providers in Grandview are community members themselves, with a vested interest in the health and wellbeing of their community. One community member said: “EMS staff are residents, they know where every little farm is, but when people are from out of the area, they don’t know these things.” This sentiment reflects on the knowledge that experienced, well-trained and invested paramedics develop over time, working within the same area and community. This is certainly a strategic advantage of Grandview EMS staff. This belief also contributes to the concern that residents have, that EMS personnel out of any other geo-location will not be as efficient as Grandview staff.

The relationships between service providers and patients is also important to note, and a major contribution to what is working so well within Grandview. It is clear that healthcare and EMS staff take the health and wellbeing of their patients, who are also their neighbours, friends, family and community, to heart and establish long-term relationships with the folks that they serve. One participant noted, “[the doctors] share cell phone numbers with patients and [their] family in crises.” Within the hospital and clinic setting, one participant remarked, “there is a spirit of cooperation amongst the physicians... [they] take pride in the facility and how well patients are being looked after. When there is a good outcome, [they] celebrate. When there is a bad outcome [they] grieve.” This comment supports the concept of patient-centred, relational care that is deemed best practice in health service provision. Grandview healthcare staff maintain meaningful personal and professional connections with their patients and fellow community members, contributing to the sense of wellbeing and good health that Grandview residents experience.

COMMUNITY RESPONSE TO SERVICE CHANGES

The second area of findings revealed the community response and feelings towards the imposed changes to services in Grandview. It is clear through this research that the community does not support the proposed changes, and a number of themes support this idea, including that the current healthcare system in place in Grandview is effective and not in need of change, the sense the centralized services will result in the elimination of services in the town, that community voices were not valued or heard in the decision-making process, and that vulnerable people and Indigenous communities were not consulted or considered in this process. The following sections provide a description of the findings within these themes.

Theme One: Consideration of Vulnerable Groups, First Nations, Métis Communities

Concerns were raised by residents regarding the older adults living within the community, many of whom rely on the Grandview hospital, and the services that it provides, including the emergency department. With one third of the population age 65 and older, Grandview is an aging community, and residents feel that the appropriate services must remain in place in order for people to age in place within their community. One participant remarked that a number of services that were previously offered to community members have been removed, or eliminated, "I am concerned for seniors in the community, you know, there used to be a mobile clinic... with nurse practitioners and such. That was removed recently, but the seniors loved it." Another participant, themselves a member of the aging community stated, "Elderly people here are not at risk [at this time]... people retire here knowing they have access to emergency care and acute care."

Many participants feared for the health and wellbeing of elderly neighbours, family members and friends that are aging at home, many of whom live alone, or a considerable distance from the town. Additional concern was raised for individuals living with high-risk health needs and illnesses. One health service provider, referring to her clients, stated "I worry for my people..." as a result of the loss of EMS services in town.

Indigenous Communities

Tootinaowaziibeeng First Nation is located approximately 25 kilometers west of Grandview, with a travel time of 13.38 minutes at 110 kilometers per hour. In contrast, both Gilbert Plains, located 41 kilometers east of Tootinaowaziibeeng, and Roblin, located 32 kilometers west, have travel times of over 15 minutes, 13.38 minutes and 22.22 minutes respectively. These times fall well outside of the ideal wait time for emergency response

within the province. Furthermore, these times assume consistent speed, visibility, weather and road conditions, which certainly cannot be guaranteed. Homes on the reserve are spread out and remote, presenting difficulty to visitors in negotiating the area. Considering that many residences are difficult to locate, wait time is further increased to allow EMS to locate and arrive to the call location. EMS personnel that are unfamiliar with the reserve, its community, and geography may face difficulty in locating the call location. These concerns were raised by nearly all participants.

Importantly, over the last several decades, strong relationships have been developed between Grandview EMS personnel and members of Tootinaowaziibeeng. The EMS staff and paramedics out of Grandview have become familiar with the community of Tootinaowaziibeeng, as one participant who works as a service provider in the area stated,

"I recently took part in an EMS tour of Tootinaowaziibeeng, from the back of an ambulance. I was comforted by the espertise with which the para-medics negotiated the roads. Most roads [on the reserve] are unmarked. The houses are unnumbered, and yet the crew had no trouble pointing out 'so-and-so's' houses. This comes after years of driving on the reserve."

Further, the relationship between Tootinaowaziibeeng patients and Grandview physicians and service providers is crucial to the delivery of care, both on reserve, and in emergency settings. Grandview physicians provide weekly medical clinics on the reserve, reaching people who otherwise would not have regular access to such service, and providing a consistent continuum of care, as well as having staff working in Grandview's hospital from Tootinaowaziibeeng, allowing for a community care connection. These connections and relationships have helped to establish a critical level of rapport and trust between Grandview providers and patients from Tooinaowaziibeeng. As one service provider stated,

"If Grandview loses its ambulance station, Roblin will be dispatched to Tooti-naowaziibeeng... I believe the Roblin crew will take longer to reach patients... they will take patients to Roblin or Dauphin [hospitals]. I believe they will not bring patients to Grandview... I don't believe there is the same trust between Roblin and Tootinaowaziibeeng residents. Roblin has had numerous physicians in the [past] 20 years... with no physician stability or leadership. The same is apparent in their difficulties in staffing their EMS station."

It is clear through this statement that service providers in Grandview have a strong relationship with the Tootinaowaziibeeng community, and consider the services provided in Grandview as central to the health of many people on reserve. Further, the data from the MTCC provided in the Overview section demonstrates that Grandview's EMS services the majority of emergency calls in Tootinaowaziibeeng, which has allowed Grandview paramedics to establish familiarity with the site, but also rapport and relationship. If EMS services were no longer offered out of Grandview, the question of who would respond, and how fast would the response be to Tootinaowaziibeeng. Another service provider framed the impending situation like this:

> ***"In emergency medicine, the 'golden hour' refers to a time period lasting one hour or less, following traumatic injury sustained [through] a casualty or medical emergency, during which there is the highest likelihood that prompt medical treatment will prevent death. Tootinaowaziibeeng patients will not receive care in the golden hour if Roblin [EMS] is dispatched."***

Of particular concern in the provision of healthcare services in Canada, and in Manitoba where the Indigenous population is the greatest per capita, is addressing the specific needs of the Indigenous population, whether rural, remote, reserve or urban. Indigenous peoples living on reserve receive many healthcare services through the Federal government, however, many additional services and specialty programs are provisioned through the province. When it comes to EMS response and accessing emergency care, Indigenous peoples living on reserve often rely on emergency response from the nearest neighbouring town. In reflecting upon the data and mapping, Grandview is the nearest EMS station to Tootinaowaziibeeng First Nation, and also offers medical care within the hospital, or institutional setting that best meets the needs of many residents, as they are familiar with the staff, physicians and facilities of Grandview. For many Indigenous people living in Canada, fear of discrimination and lack of care or respect from service providers is a reality that prevents people from accessing healthcare services in the first place (Browne, 2016; Williams and Kulig, 2012). To change the way residents of Tootinaowaziibeeng experience and access emergency medical services without consultation and response from the community is problematic, and may serve to create or compound barriers that exist in accessing healthcare when it is needed the most.

Within this vein, many participants brought up the fact that without reasonable access to quality healthcare, residents may elect to take their health into their own hands, by either doing something unsafe to help themselves, or by not doing anything at all. For example, one participant simply stated, "people may come to avoid seeking help, seeking services, if they feel they cannot access them." In other words, as a result of EMS withdrawal

from Grandview, or if the ED in Grandview is consolidated, rural residents may not choose to dial 9-1-1 in an emergency, or even take themselves into the hospital when it is reasonably needed, as they perceive that the level of care and compassion they would receive would not be the same as in Grandview.

Most participants felt that because these facts were not taken into consideration when the government announce the elimination of Grandview's EMS services, that Tootinaowaziibeeng, and perhaps other First Nations and Indigenous communities across the province, were not appropriately considered or consulted as to their needs and the impacts that proposed changes would bring to their community. As one participant stated, "there are over 600 First Nations living [in Tootinaowaziibeeng], and they are put at risk if [the ambulance] is not able to arrive from Roblin within 30 minutes... clearly with the government, Toot[inaowaziibeeng] was overlooked." In many ways, community members expressed this as a significant concern, if government planning did not consult with the communities surrounding Grandview, there are implications for Grandview and area, but also bring residents to question if the same may be true for other communities facing the closure of their EMS stations, or EDs.

Theme Two: It's Not Broken

One of the most imminent themes to arise from community interviews was the level of satisfaction community members within Grandview and outside of the community feel towards the level of service and care that they receive at the Grandview Hospital, and from EMS services within the community. As one participant, a long-time resident of Grandview stated, "...if it ain't broke, don't try to fix it." This feeling was iterated by many participants through the course of the interviews.

The suggestion that EMS services would be eliminated from Grandview, and residents would instead be serviced by EMS out of Gilbert Plains or Roblin was problematic for participants, it could even make a difference between life and death for some. One participant, who lives over an hour outside of Grandview proper stated, "...time out here is crucial, it's everything. If you have a stroke, and it takes longer for the ambulance to arrive, then get 'ya to the hospital, that could make or break it for you."

Grandview is located equidistant between Roblin, where medical services are inconsistently available within the ED and hospital there, and Dauphin, the second largest city in the Prairie Mountain Health Region, after Brandon. Geographically, this indicates that Grandview would be the ideal location to provision emergency medical services for the communities located between these two centres, allowing for optimal service delivery. Coupled with the fact that there is a pre-existing EMS station at the Grandview Hospital, where services are available 12 hours per day, and on-call services are available overnight, the provision of EMS

from Grandview is ideal, and many participants felt that EMS services in Grandview should be expanded to ensure 24-hour coverage, rather than eliminated in favour of a new EMS station in neighbouring Gilbert Plains. As one service provider said, "there is a lot more to be lost than gained in that 10-mile stretch [between Grandview and Gilbert Plains]."

Even when participants lived closer to towns outside of Grandview, such as Roblin, or Dauphin, they stated that they would rather be taken into Grandview by EMS to receive emergency care there. A participant living remotely stated, "...from my residence it's an hour [to Grandview] ... Roblin is actually closer, but... there are a lot of times that the emergency services are closed [in Roblin], so a lot of times, rather than guess, in an emergency situation people tend to go straight to Grandview." Another participant, who considers themselves a member of Roblin's geographic community elaborated, "In Roblin the services are, how do I put it... they're doubtful. You never know if there will be physician, will it ever be open? So, my experience is I bypass and will continue to bypass Roblin and go on to Grandview. I've had the same physician for over 15 years, providing excellent service... I feel like I am very fortunate to have had a family doctor for this many years." This sentiment supports the findings of government reports, like the 2017 Wait Times Report, where in many rural and remote communities, residents have variable access to but primary and emergency care. However, it is clear from these experiences of people that live well outside of Grandview, that services within the town are consist ant, reliable and worth hours of travel to receive. If people are choosing to leave their communities, even those that have their own hospital and ED, to receive care in Grandview, it is clear that the system is effective in meeting patient's needs.

The imminent threat of the loss of services is having a considerable impact on community members, businesses and service organizations as well. When asked to share what healthcare services are like in Grandview, one health service provider elaborated on how excellent the service is in Grandview, but then caught themselves, saying, "...it's stressful now because the future [of healthcare in Grandview] is in question." This sentiment was reiterated repeatedly by participants, indicating the toll that government decisions have had not only on services, but on individuals as well.

Theme Three: Fear that Centralized Services Means Elimination

At the announcement that Grandview's EMS station would be closed, the community immediately sensed that this was only the first step in the demise of healthcare services in Grandview. In 2017, Grandview mayor, Lyle Morran commented on the community's confusion at the closure of an EMS station located within an active, 24-hour hospital capable of handling most emergency calls, especially when located almost directly between two larger city centres, Roblin and Dauphin (Laychuk, 2017a). Stemming from the sense of community that the hospital and EMS services provide, comes the feeling within the community that the move to centralize emergency medical services, and other healthcare services, will result in

the elimination of many health-related services within Grandview. Most often, participants commented on a perceived chain reaction of elimination of services following the closure of the EMS station. As one health service provider expressed, "I feel there will be a snow-ball effect of service shut-down here..."

Building off of that fear of service elimination in Grandview, many participants voiced concern that in the absence of services, or mistrust of services elsewhere, that people would be compelled to take their health into their own hands. For example, if Grandview hospital or emergency department were to close, people may delay seeking care or choose to wait to seek care until it is too late because they do not trust other service provider or settings. In response to the elimination of Grandview's ambulance, participants imagined that instead of calling 9-1-1 to wait for an ambulance coming from Gilbert Plains, Dauphin or Roblin, people may try to drive themselves, their family members, or neighbours to the nearest hospital in an effort to save or make up for lost response time. This perceived change in behaviour is troubling, and could result in adverse health outcomes for people in critical need of emergency medical services. One participant who lives about 30 minutes outside of Grandview shared an experience where an ambulance was needed to respond to a farming accident, "...in that emergency, without an ambulance, my [family member] would die. If it took over 40-50 minutes, like the ambulance out of Gilbert [Plains], my [family member] would die. If we have to wait that long, we definitely need to consider driving ourselves to the hospital. But I shouldn't have to make that decision to drive." Reviewing this statement indicates that community members, especially those living further away from the town proper, are already considering how the change to EMS services is going to affect their family.

The threat of reduced services in Grandview has a significant impact on service providers in the community as well. Many of whom also call Grandview home. Participation in a functional, efficient and supportive hospital and emergency department, located in a small, rural setting is considered ideal to service providers who have built, or are developing their careers in this setting. The combination of primary care delivery in the health clinic, regular medical appointments with patients, and the fast-paced and skill-based setting of the rural ED is a perfect balance for those working in Grandview. The move to centralize healthcare services in Manitoba to larger suburban, and urban centres effectively eliminates the opportunity for physicians, nurses and other health service providers to practice in this environment. Further, there is great fear that if hospital and health services are withdrawn from the community, all of the auxiliary services and businesses will go with them. As one service provider stated,

"We can adjust, but the fear is that if EMS leaves, the ER will disappear, that means that there will be no more doctors in town. Pharmacists and others depend on the doctors being in the community."

Within a small town, so many facets of life are intertwined and interrelated, such that the loss of one service is often to the detriment of others. This is the perceived case in Grandview, where the loss of EMS, leads to elimination of the ED and hospital, then doctors altogether, and ultimately businesses and service providers like pharmacies and home care, will all cease to exist. Effectively contributing to the demise of the small town and its economy. As one service provider elaborated:

"If the EMS leaves, quality of care will diminish for residents, and folks in [Tootinaowaziibeeng]. If there is no ER, will the hospital stay open? Will the doctors stay? Will other health providers stay? This will have a spiral effect within the community, affecting quality of care, auxiliary care, the care home and primary services. Young people will not want to stay here. Quality of life is improved is emergent care is there in the town. If the community's needs are not met, then small towns will just get smaller, and that small town quality of life will cease to exist... responsibility will fall to family members and neighbours..."

Theme Four: Lack of Community Consultation, Dehumanized Decision-Making

Throughout the course of participant interviews, it became abundantly clear that the community of Grandview and residents of the surrounding areas felt ignored, excluded, and in many ways silenced by government regarding the impact the provincial healthcare transformation would have on their community. The resulting theme considers the lack of community consultation that took place in production of government research initiatives.

Participants expressed confusion around the proposed closure of the Grandview EMS station. Without knowing all of the reasons for the decision, one service provider remarked, "It's mind-boggling why they are closing Grandview and building new in Gilbert Plains. It's like someone threw a dart at a map and said 'that's where the ambulance will be."

For the most part, this confusion is exasperated by a lack of total communication. For example, in 2017, during a series of community meetings regarding the newly announced EMS closures, Grandview residents and members of Tootinaowaziibeeng First Nation voiced their concerns over the time it would take for residents to arrive to a hospital in the case of an emergency (Laychuk, 2017b). The proposed new EMS station out of Gilbert Plains, responding to Grandview and the surrounding rural area, may take longer to arrive on scene than an EMS vehicle out of Grandview (Laychuk, 2017b). In community meetings, residents were expressly concerned that prior to the provincial announcement of their EMS closure, there had been no community consultation, or either Grandview residents, or members of Tootinaowaziibeeng First Nation (Laychuk, 2017b). As one community member stated to the CBC, "The Conservative government made a big deal about being consultative before they got into office... They've made some major changes without asking the people who are going to be affected," (Laychuk, 2017b, p. 1). These sentiments, voiced over one year ago in those early community meetings in 2017, were echoed again in interviews with Grandview residents for this report, as one participant stated "The government needs to do the footwork [in the community] before making serious changes." One participant called this type of government change, "dehumanized decision-making" referring to the use of statistics and cost-analyses data to inform critical and life-changing decisions regarding the healthcare system and the people that may lose services. One health service provider elaborated,

"The government was looking at paper and demographics [when they made their decision], not at individual community needs. I mean, we have it all here! ... they need to re-evaluate and look at the communities that are being affected. There are always variables [that get missed when relying on statistics]. They need to see the full picture... they did not make an informed decision."

Ironically, the 2013 EMS System Review states in its summary that community expectations must be taken into consideration, and that the implementation of the report's recommendations requires that the provincial government works with community leaders and stakeholders (Toews, 2013). The people of Grandview, including community leaders and service providers have not been directly consulted through the process of healthcare transformation. And to this date, have not been invited to discuss ways to address the potential impacts that service changes will have in their community, despite many requests place to local regional and provincial government representatives. There has been lack of communication on the part of the government, even after the community has attempts to engage with government representation.

DISCUSSION

Access to effective, efficient and quality healthcare is a particular concern people who live rurally and remotely across Canada. Further, the demographics of rural Canadian communities are typically older, less healthy populations that experience higher rates of chronic illnesses and health issues that require acute care when compared with urban counterparts (Moss et al., 2012). Coupled, these factors lead many rural communities to have less accessible and specialized health services that are necessary to address their complex health needs. The findings of this report indicate that the community of Grandview, Manitoba, a true rural town, is overwhelmingly satisfied with the level and quality of care that is being provided through the Grandview hospital and ambulance service, despite the fact that nearly one third of all Grandview residents are older adults that experience acute health issues such as stroke, heart attack or kidney failure that require immediate emergency response (Laychuk, 2017a). It was clearly identified that the community perceived a direct link between 24-7 emergency care, primary care and ambulance services. The move the of EMS services out of such a community, to a dispatch site further down the highway, may limit such residents from being attended to in a timely manner (Laychuk, 2017a). Further, this change will impact community life and sense of health and wellbeing, where unlike many rural and remote communities, Grandview has strong, positive sense of wellness, supported by access to effective and reliable care, both in the emergency department and within the hospital and clinic.

Access to Healthcare in Grandview

While Grandview, Manitoba is considered a rural and small town within the province, and under national standards, the community of Grandview currently does not experience the same barriers to accessing healthcare services that the majority of rural and remote towns do across Canada. As the Canadian literature reveals, there are considerable inequalities across the country in accessing healthcare services, felt most starkly by those peoples that reside outside of major urban centres. Geographic barriers, like distance to the nearest healthcare centre, burdens associated with travel, limited number of healthcare personnel and reliable services within the community are limitations experienced by rural Canadian communities, yet are not true for the community of Grandview. With a 24-hour hospital including an emergency department, three long-serving physicians who provide emergency room coverage on a rotational basis, 12-hour and on-call EMS service out of the hospital, and reliable, dependable and consistent service, Grandview is an outlier among many rural prairie towns. Community members have understandably come to rely upon these services, and the people providing them, not only in a professional way, but on a personal and relational level as well.

Having access to these services close to home in Grandview eliminates the frequent barrier of travel within most rural settings. Grandview residents and people living in the surrounding area are easily able to access consistent, personable and reliable services at Grandview hospital, and further, have come to rely on immediate emergency response out of the Grandview EMS station, from paramedics and providers that they are familiar with. Grandview residents do have to travel into larger centres such as Dauphin, Brandon, or Winnipeg for specialized services, surgeries, and some long-term treatments and therapies. However, this travel is acceptable to the community, acknowledging that these services are centralized in urban areas because they are specialized. This remarkable level of both service (primary, long-term and emergent), and satisfaction in Grandview currently leaves the community questioning the government's decision to do away with this well-functioning system. In short, why would the Manitoba government decide to eliminate a key form of service from this rural community? The province contends that this decision will not create any new barriers to accessing regular or emergency medical care, and will maintain the same level of response that Grandview residents have experienced previously.

Aging in place in Grandview is supported by the current level of healthcare services being provided within the community, central to which is the Grandview EMS station and the paramedics that serve there. Aging within a rural setting is becoming increasingly difficult across Canada as a result of inequitable access to healthcare services, and poor support systems for family caregivers. Alternatively, within Grandview, the provision of a 40-person personal and long-term care home, with access to the full range of hospital services of the Grandview hospital, makes it possible for those people who need additional or greater levels of support and care to remain in their home community. For those community members who wish to age in place within their own home, or on their family farm or property, having consistent and reliable access to primary care physician and emergency services is crucial. It is clear that the hospital and access to local emergency medical services are central to the aging process within this community.

Government Decision-Making

In both community interviews and in the review of government literature, primarily the 2013 EMS Systems Review by Toews, is becomes clear that government decision-making around EMS station closures lacked both engagement with affected communities, but also utilized questionable data. The most glaring finding is that Grandview's EMS station is not among the low call-volume stations within the Prairie Mountain Health RHA (previously amalgamated and referred to in the EMS Review as the Assiniboine RHA). In fact, among the other rural and remote stations within the region, it is one of the higher call-volume stations. Despite the 2017 reports stating that incremental change to the healthcare system would result in overall improvements in health status, expenditures and access to quality care, the impacts on rural communities that face the greatest forms of change, such as losing an EMS station in town, and seeing a change in the use of their ED and hospital, were not studied.

In the 2013 EMS System Review, Toews and colleagues state that moving forward it is not beneficial to think of EMS service delivery in terms of stations themselves, but rather as independent units, ambulances staffed by permanent, full-time paramedics operating on a 24-hour basis. Many rural stations utilize EMRs rather than full paramedics, and deliver EMS services on an on-call basis, which is neither effective nor sustainable. Instead, eliminating low volume stations, or consolidating a number of neighbouring low volume stations, and positioning ambulance units based on proximity to high-risk geographic locations is a more cost-effective, long-term and sustainable way to provide high quality EMS service delivery (Toews, 2013). While this alternative way of thinking about EMS delivery is in line with national and international best practices, and from a government- or policy-level is reasonable and sustainable, it completely neglects community needs and contexts, such as the roles that EMS stations and personnel, whether they are EMRs or paramedics, play within the communities that they service. For many communities across rural, remote and northern Manitoba, the Toews approach to EMS service delivery may be what is best in ensuring quality and efficient response time. However, in the case of Grandview, where the EMS station and staff is intrinsically linked with the services provided within the rural emergency department and hospital at large, the concept of geo-posting, where the ambulance and staff are separated from site or facility, is not effective. Further to this, the suggestion that Grandview's EMS station should be closed, in order to support the construction and staffing of a new station in neighbouring Gilbert Plains is contrary to the geo-posting approach and intention. If the geo-posting method is taken up, there is little reason to close the fully functional station in Grandview, when it can be utilized as a geo-post location for the area, including Gilbert Plains. The construction of a completely new EMS station building in Gilbert Plains would cost the Manitoba government millions of dollars, when the station in Grandview can be refurbished for far less, while continuing to serve the surrounding community in concert with the 24-7 ED and service providers at the Grandview Hospital.

What is missing then, from government decision-making and utilization of the 2013 EMS System Review, is consultation and consideration of community needs. Community members, leaders, service providers and local government in Grandview all stated that their opinions had never been sought following the release of the report, and the urge of the subsequent government reviews and reports to take up the 2013 EMS System Review recommendations, despite the fact that Toews (2013) states in his final recommendations that community consultation and participation of municipalities would be important to implanting many of the recommendations.

As with the 2013 EMS System Review, issues exist within the 2017 Peachey Report, and the recommendations made to close and consolidate rural hospital services and focus on provisioning rural healthcare through community health centres. While the concept of integrated, clinical and social team-based community health centres (CHCs) are not problematic, the suggestion that these must exist at the expense or through the elimination of the rural hospital is concerning, especially in a settling like Grandview where the rural hospital is a community health centre, and offers the services expected of a 24-hour hospi-

tal complete with an active and modern emergency department, equipped to triage and treat trauma patients, and acute and chronic patients. The Peachey Report argues for the uptake of patient-centred and collaborative care, which is clearly being provisioned within Grandview, a site that has upheld these models of care over the past few decades where the same physicians have served and participated actively as community members, establishing relationships within their home community. Further, Peachey's model of a "medical home" is embodied and realized within Grandview, where each rural patient has a regular family physician and access to nurse practitioners when needed, the doctors, nurses and staff work together as a team to provide quality and continuity of care, and service providers ensure that patients only need to travel to an urban health centre of hospital for very specialized services, treatments or diagnostics, such as for chemotherapy or radiation. Contrary to Peachey's issue with rural hospitals often being closed down due to lack or staff or service usage, and suggestion that rural hospitals operate more like glorified long-term care homes or doctors' offices, Grandview hospital is open 24-hours and equipped to provide emergency care, and is considered as such by the community, which has a long-term care facility in addition to the hospital that oversees those needs, leaving the hospital beds to be utilized as intended.

Without consultation and engagement with both community members and service providers in rural settings, especially those with operating hospitals, government decision-making on Peachey's recommendations can be considered problematic. With the diversity of the rural population as it is, and the local and community-based contexts being unique to each rural town, it is impossible to transform an entire provincial health system based on broad and sweeping findings from environmental scans such as Peachey's. Decisions that impact local communities, must be taken up within those communities, with the input of residents and stakeholders collected and considered. That there are too many rural hospital sites that are unable to provide high quality, consistent emergency and hospital care within Manitoba is not being questioned here. This is almost certainly the case, at no fault of small rural communities with limited capacity to mobilize and demand provincial or even regional support, and with limited ability to attract and retain health service providers to their towns. What is of concern in Peachey's report is the language that indicates that this is true about all rural hospitals. It is abundantly clear through review and community interviews, that this is simply not the case in Grandview.

KPMG's 2017 report supports the narrative of Peachey, and Toews, in that the state of Manitoba's healthcare system was at the time far too complex and therefore ineffective, inefficient and expensive in many ways. KPMG focused primarily on sustainability and cost-savings, which at a government or provincial level is often the focus of healthcare reform. The focus on cost-savings over community impact is considerably problematic, yet a common occurrence in government decision-making. Positively, KPMG found that the consolidation of hospital emergency departments would likely result in negligible cost savings, as currently, the cost per ED visit is too great, and in some regions, patients are

visiting or utilizing EDs more often than statistically expected. KPMG suggests that the province should first focus on reducing the cost per visit to the emergency department on a provincial level, and address why more rural (and southern) Manitobans are seeking more care than expected from local emergency departments.

For Grandview, this means that the loss of the ED within the hospital is not presently at risk. However, considerations regarding underutilization of the Grandview ED due to the relocation of regional EMS stations are warranted. If the proposed elimination of the Grandview EMS station is upheld, will the Grandview ED and hospital experience a reduction of visits? Both overuse of rural EDs and underutilization of rural EDs will be problematic going forward, and in the justification of retaining and funding rural hospitals. This will be a key consideration for Prairie Mountain Health RHA as system evaluations continue in the wake of the Peachey and KPMG reports. The 2017 Wait Time Reduction Report discusses the importance of consolidating ED and EMS services, while still ensuring optimal EMS response times, and reducing ED waits. Much of this research is based on a generalized understanding of small rural communities. And while much of this research was based on survey results from both the public and service providers, it is problematic to over qualify location (or under qualify them), and to omit review of outliers, as Grandview must be considered. While it is not a hub-hospital that provides extensive specialist treatments and procedures, it is an effective, 24-7 hospital, dedicated to the needs of the community.

Lastly, the 2019 Better Care Closer to Home documents clearly identify, through the description of an ideal health hub, that Grandview is ideally suited to be a designated District Health Hub for the surrounding area. The description also emphasizes the need to have a direct connection between EMS, ER, Primary, and Acute care services that create the suggested Home Health Care Teams.

Centralization or Marginalization?

Government stance that the centralization of services has but only positive effects on rural communities across Manitoba is false. Many studies across rural Canada, particularly within rural and remote Manitoba and Saskatchewan have found that the centralization of healthcare services put rural residents at a greater disadvantage than urban counterparts, because it leads to the elimination and inaccessibility of services that were previously available and accessible (Moss et al., 2012). This is absolutely the case in Grandview, where residents are now feeling pressure to fight for the healthcare services that have been working effectively to support their community health needs.

The province has repeatedly stated that changes to the EMS delivery system following the 2013 Report, and the subsequent healthcare systems and wait times reports are intended to centralize services to ensure that Manitobans have appropriate access to healthcare services when they need them, however, the elimination of EMS services out of Grandview does not support this rhetoric and intention. It is clear that geographically, and based on

the current location of emergency health resources, that Grandview is the central location for dispatching and delivering emergency services within the region, and particularly to remote location between Roblin and Gilbert Plains, and importantly, to Tootinaowaziibeeng First Nation.

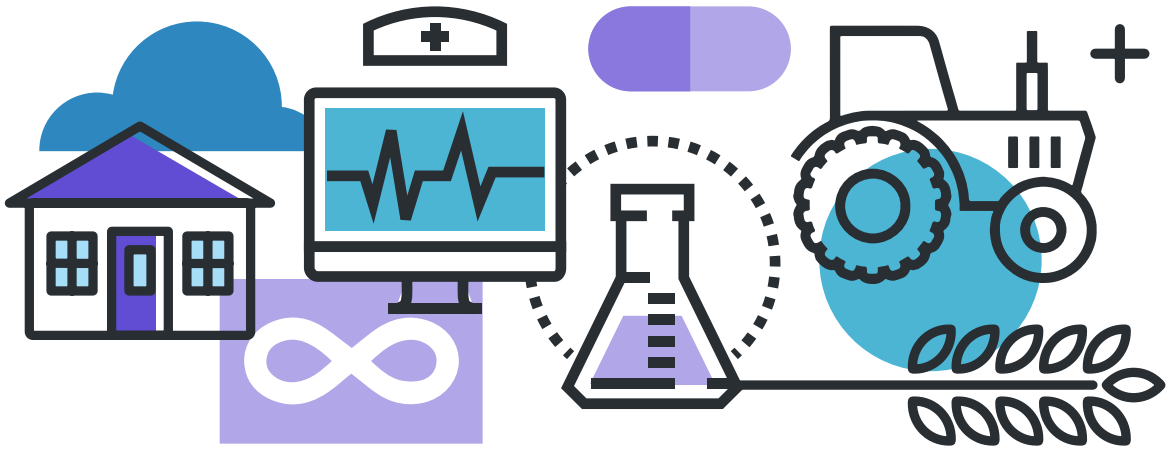
The concepts of geo-posting, and dynamic- or flexible-dispatch are consistently iterated in government documents as being both best practice and best for rural residents in Manitoba, where ambulances are strategically parked, or located in high call-volume areas, waiting idle, rather than being located nearby to under-resourced rural hospitals and emergency departments. While this practice is reasonable and should be recommended in many cases, it does not make sense in the Grandview context, geographically, or in terms of human-resourcing. One central flaw with this move to geo-locate EMS services in Gilbert Plains, rather than in Grandview, is the gap to the west of Grandview, between the town and the next, larger settlement of Roblin, where the EMS station is located to the west of that city, effectively leaving a gap between Roblin and Gilbert Plains of over 65 kilometres, encompassing Grandview, and importantly, the 600-person First Nations community of Tootinaowaziibeeng. This gap in service area results in a wait time of over 30 minutes for residents of Tootinaowaziibeeng for response out of either Roblin or Gilbert Plains. This wait time is in contradiction of the primary recommendations of the 2013 EMS Review, the 2017 Wait Times Reduction Report, and what the province has stated is the standard wait time for all Manitobans. Essentially these closures concentrate EMS services to the east of the region, centred nearest to Dauphin, leaving many open kilometers, and communities at risk of waiting too long for emergency medical services. The findings demonstrate the community belief that incorrect data has been utilized to make the decision to eliminate Grandview's centrally located, emergency department-supported EMS station. If data reflecting the population of Tootinaowaziibeeng had been utilized, it would be clear that there are crucial EMS coverage needs to the west and north of Grandview, and that Gilbert Plains EMS deployment would put that population outside of the 30 minutes wait time window.

The review of emergency department utilization and wait times in rural communities also overgeneralizes the experiences of rural people. While many rural hospitals and EMS stations are short-staff and unable to ensure continuous service, this is not the case across the board. Participants, including community members, service users and service providers alike in Grandview clearly indicated that physician and staff burn-out, lack of skills and training, and patient misuse of emergency care were not problems experienced within the community or in the delivery of services out of the hospital and clinic. It stands to argue then that Grandview's ED, hospital, primary care services and EMS are all functioning within provincial standards for response times and wait times.

Community Cohesion and Collaboration

Following the June 2017 announcement that Grandview's EMS station was slated for closure by the Government of Manitoba, it has been clear that the community of Grandview is vehemently opposed to the closure. For example, a town meeting in August 2017, held by community physicians, saw nearly one third of the community in attendance (Laychuk, 2017b). Actions of the community interest group, Grandview Healthcare Solutions, included questioning government representation on the decision-making and data collection processes, and the creation of a petition to the Government of Manitoba to urge the government to withdraw its proposal to eliminate emergency medical services from Grandview, with over 2,666 signatures gathered from the community and residents of the surrounding area. In the face of adversity and the threat of the loss of essential service, and the change to way of life in Grandview, the community rallied, with community leaders vowing to do everything within their power to preserve the level of quality healthcare available within the community. This community collaboration is a clear indicator of community cohesion and levels of social capital that many small, rural communities do not have access to. The ability for Grandview to gather, mobilize and represent their shared interests, and those of the people living nearby and relying on Grandview's healthcare services is indicative of a strong, healthy and cohesive community.

Community engagement and interviews indicate that the source of this empowerment comes from the very services that Grandview is standing to lose if the government of Manitoba goes forth with the recommendations to eliminate Grandview EMS. In the interview, participants imagined what their beloved community would become following the loss of EMS, and possibly the ED and hospital. The home that they chose to raise families, start businesses, retire and age would be forever changed. The source of health and wellbeing, social activity and community pride would be gone. In a moment where the provincial government is seeking to improve health, wellness and access to care across Manitoba, it is not reasonable to eliminate these very aspects from Grandview.



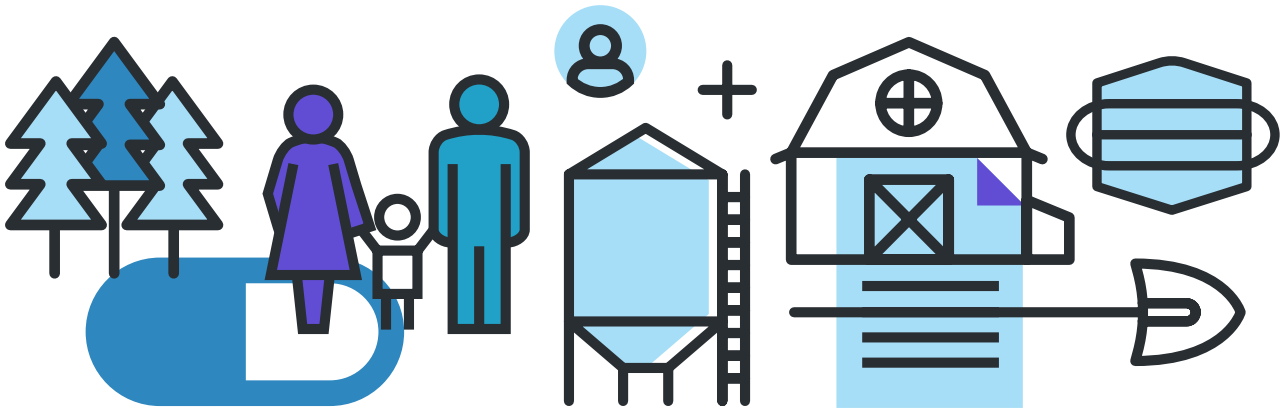
CURRENT STATE OF RURAL HEALTH CARE

There has been a significant shift over the past three years since the Manitoba government took step to radically transform the health care system. Through this time, rural health care services and providers have largely been left in the dark and excluded from health service and delivery decision-making. This lack of clarity has also taken a severe effect on rural communities, left wondering the fate of the services that they rely on and access locally. It has also generated resilience and the social capital required within many communities to advocate for the retention of services.

Most recently, the government announced the closure of the hospital in Roblin, the nearest town to the west of Grandview, located about 30 minutes west along Highway 5 with a population of around 1,600 people. This announcement came on Friday, August 28, 2020, in the midst of the COVID-19 pandemic and as both the province's daily reported cases climb, and cases increase significantly within the Prairie Mountain Health Region. Manitoba Shared Health, the provincial health system agency, and PMH stated that as of 4:00 pm on Friday, September 4, only a week later, the emergency department in the Roblin hospital would be closed (Shared Health, 2020). Shared Health framed this closure in their news release and in media as a 'temporary interruption' of services. The release prefaced news of the ER closure with a report that a shortage in diagnostic services staff due to retirements and a maternity leave in Roblin and the geographical area surrounding has led to this decision (Shared Health, 2020). As a result, PMH has relocated these services including diagnostics and x-ray services to the health centre in the community of Russell, located 35 minutes, or 53 kilometers south of Roblin.

However, in response to the recent retirement and leaves of diagnostic staff in Roblin, the Roblin Clinic Board, a volunteer group of three town councilors and three community members came together to immediately issue the recruitment of diagnostic staff in order to support the continuity of care at the Roblin hospital (Lam, 2020). As board president Sean Keeler stated, "We felt we had to ...try to find more staff so that we can keep our hospital operating ...It's never really looked [at] for communities to have to do this ...it kind of blindsided us, came out of nowhere that this was happening" (Lam, 2020).

These efforts were successful, and in late August, the town notified Prairie Mountain Health that two diagnostic technicians were ready to take the post (Lam, 2020). The decision, then in the hands of the health authority, was to redeploy these two personnel to clinics in neighbouring rural communities of Russell and Shoal Lake. PMH notified the Roblin Clinic Board the same day that the resumes were submitted (Lam, 2020). Shared Health stated that this decision was made to support services for the broader geographical areas in the



rural southwest of Manitoba (Shared Health, 2020). Despite the fact that the community of Roblin had made intense efforts to fill their vacancies, PMH essentially undid their work by relocating the very people that Roblin had sought to staff their own hospital. In Shared Health's memo to the technicians, they were asked to prepare to work out of Russell for approximately six months (Lam, 2020). In response to these directions, Manitoba Association of Health Care Professionals president Bob Moroz said of his members,

> ***"They're very upset that the services they provide are not being provided in the community where they should be... you build a life in Roblin and you're working just a few minutes away and now you're going to be spending an hour a day travelling back and forth to work, that's an impact. Our members who are as professional and as critical as anybody else in the health care system are never really part of the conversation" (Lam, 2020).***

In the August 28 news release, Shared Health indicated that it was continuing to recruit staff for the vacant positions at Roblin, and that the level of health service delivered at the Roblin hospital would be reevaluated as these positions are filled (Shared Health, 2020). In this statement it is clear that there is no indication of when services will resume, or if they will.

Further, Shared Health stated on August 28 that emergency services within the neighbouring communities of Russell and Grandview would remain open through the 'interruption' to Roblin's services. Further stating that service providers within those communities had been made aware of this closure and were prepared with a response plan in providing ER services (Shared Health, 2020). Conversely, ER staff within Grandview and other neighbouring communities were not consulted prior to the announced closure of Roblin's ER, and were made aware at the same time as the public, through media. Appropriate risk mitigation and planning was not conducted before the closure, leaving nearby communities and health service providers confused and ill-prepared. This demonstrates that in addition to a lack of

community consultation in this instance, there has also been no consultation within the health system itself. Administrators and senior decision-makers here are making policy decisions and system changes without working collaboratively with those physicians, nurses and clinical staff responsible for carrying out care. Health providers and ER staff in Grandview, the nearest ER to Roblin, were advised several days after the announcement of a planning meeting with PMH administration, set for September 4, the date of Roblin's closure. Such a meeting comes late in preparing for such a drastic change in service delivery and accessibility.

Community members within Roblin and the surrounding area were left reeling at this decision, and the resulting impacts that it will have on the health and wellbeing of community members, but also on the continued provision of health services within the community. In response and ahead of the government announcement, the community had already feared for the survival of the Roblin ER, which would not be able to function without diagnostic staffing. For example, without an active ER in the hospital, local physicians and health care providers may elect to leave the community to practice elsewhere (CBC News, 2020). In Roblin a concerned community member stated,

"We have four doctors in Roblin, who we've worked very hard as a community to get. We rallied together for years to try to secure doctors in our community, but of course, we are not going to keep them if we don't have an emergency room... this is very devastating." (CBC News, 2020).

Staffing concerns and shortages in Roblin had been of concern for some time, and had been brought forward to Shared Health by town council (Lam, 2020). The head of council, Robert Misko stated that despite these requests for help, Shared Health failed to respond, indicating that rural health human resources simply are not a government priority (Lam, 2020). As Misko stated to the CBC, "It is totally unacceptable," he said. "[They] never consulted with the community, any of the calls that we've had, basically had been announcements" (Lam, 2020). This lack of response has created a fear of losing access to health services among many residents. As another Roblin resident stated, "It's an uneasy feeling for a lot of people around here... I know for a fact if we didn't have the E.R. here, [my family member] wouldn't be with us" (Lam, 2020).

The fear generated among rural communities is shared. One resident stated to CBC News (2020), "I just feel like we've been taken off the map. It's not as though I want Russell not to have a lab. My intent is to save ours." This feeling among Roblin residents that government decisions effectively take them off the map geographically, socially and politically echo the sentiments shared by Grandview participants in this report. In Roblin, community members are asking themselves, "We have hospitals and we have doctors. Why [is PMH] taking those services away from us?" (CBC News, 2020). The question is eerily familiar to those Grandview residents were asking themselves in late 2018 after learning that their EMS station was slated to close, putting their ER in jeopardy. Health care is clearly intrinsic to these rural communities, many of which include a large aging population, and service nearby Indigenous communities. The relocation of diagnostic services to Russell, and a new reliance on ER services in Russell and Grandview is problematic as well for rural and Indigenous residents that rely on Roblin. The Métis community of San Clara, located 26 minutes (38 kilometers) north of Roblin for example, now faces an additional 30-40-minute commute to reach the ER in Russell. This makes travel time over an hour for San Clara residents, far surpassing the reasonable wait time to accessing emergency care. Transportation is often an issue in accessing rural health care services, but becomes compounded when travel time is increased to reach an operating ER, as will be the case for patients in Roblin. Further, there is no public transportation linking the communities together, and none has been offered by Shared Health in response to the Roblin closure (CBC News, 2020). The cancellation of all Greyhound bus services in the Canadian west is a reminder of just how limited rural peoples are in access to transportation. In addition, residents without insurance will be responsible for paying out-of-pocket for ambulance transportation. When travelling distances of over an hour of highway driving, like residents of San Clara, the fee to access emergency care will be exorbitant. Roblin town councillor Robert Misko elaborated to CBC stating that San Clara residents, and people living rurally outside of Roblin may choose not to seek care. Misko stated, "Is that now going to mean that they're going to say, well, I'd better not call because I don't know if I can afford to pay this. There's been no consideration of any of this" (Lam, 2020).

The closure of the ER in Roblin takes additional effect on the surrounding rural hospitals, where ER staff are anticipating additional calls and increased utilization as a result. Further, while the Roblin hospital remains open to serve non-acute patients, all current critical cases requiring daily or regular diagnostic tests will need to be relocated to other hospitals. At the time of the Roblin ER closure, several patients had to be moved, some with just hours' notice, to Grandview. Correspondingly, to make room for Roblin's patients, several patients in Grandview hospital who did not require diagnostic services were transported to Roblin. In these cases, families were given little time to prepare or advocate for their loved ones, and now face additional travel time and long-distance commutes to visit their family member. It is also of note here, that many of these patient transfers required the use of ambulances, that were effectively taken out of emergency service for hours in order to conduct safe moves. This means that urgent care and emergency response will have to come from other EMS stations, and could increase wait times for emergency care. Prairie Mountain Health administration referred to this as "bed management" (personal communication, 2020). However, this is viewed by family as inhumane, uncollaborative and authoritarian. These transfers to new care settings cause a disruption in care and the important relationships formed between patients and service providers, many of which are founded on trust and familiarity. Concerned family members have expressed their disappointment that patients now must recover in settings unknown to them, among strangers (personal communication, 2020). Such sudden moves fail to respect the wishes and health needs of patients and their families.

For the decision to close Roblin's ER to be made at such a time by a government that states that it is actively working to reduce the spread of COVID-19 in communities, and to alleviate the burden of the illness on local and rural health resources is counterintuitive. In this time of COVID-19, especially with confirmed cases increasing within the province, all governments should be working to slow the spread, and support communities and local health care resources in caring for rural residents. This is not the time to close emergency departments, rather Shared Health should be enabling and supporting local health care resources, and distributing health care resources, including health human resources equitably throughout the province. Further, a concerted effort should be made to bolster services within regions where case rates are increasing. Such an effort would reasonably allow for non-emergent primary care to be delivered within community-based settings and within the local system, diverting these away from urban hospitals that are handling and responding to COVID-19-related emergencies. If rural residents can be cared for within their community, the burden of care on other hospitals, both rural and urban, can be reduced. Crowding has been a longstanding issue in hospitals across Manitoba. Clearly, the closure of a rural hospital does not serve to reduce crowding at urban health centres.

The closure of other emergency stations in Manitoba has already taken place over the past year, with several urban stations in and around the city of Winnipeg being closed or amalgamated with nearby stations. This has been among the first actualized move in the province's plan to reduce and centralize services in the Shared Health system transformation,

as part of the recommendations brought forward in the 2013 EMS Services Review. The second step, presumably then, is the impending closure or amalgamation of rural EMS stations across Manitoba. Despite the reliance on now-dated information, Shared Health is proceeding with closures in what appears to be a predetermined agenda to centralize and reduce health expenditures. This includes the withdrawal of services from rural communities, where indeed physician and staff retention has created service delivery challenges, but also where communities are willing and able to take action to solve these problems, as evidenced in the community of Roblin. Communities like Grandview and Roblin have often worked to represent and advocate for themselves, such as in the case of Roblin recruiting new diagnostic staff in order to ensure the continued operation of its ER and hospital, often without the support of the health authority. As one Roblin resident stated, "We always thought we'd lose our ER because we didn't have doctors, not because Prairie Mountain Health would take our lab people away" (CBC News, 2020).

This closure in Roblin serves as another case in which the provincial government has made a critical, community- and health-altering decision at the expense of rural people, without community consultation. Where the community has demonstrated resiliency and capability in handling arising issues in delivering health care services, the government has intervened to diminish and deny the solutions generated by communities. Such an intervention communicates the idea that Shared Health and policy-maker know what is best for rural communities, without actually connecting and engaging with the people and services providers that live and work there. Interestingly, the 2019 Better Care Closer to Home documents highlight the government's intention to develop integrated health networks across the province, linking rural and remote communities through the district health hub model, and ensuring continuity and coverage of services. The closure of the Roblin hospital does not serve this model of care, and leaves the town and surrounding area vulnerable, especially in the case of emergency services. As the president of the Manitoba Association of Health Care Professionals, Bob Moroz stated to the CBC,

"This closure is the direct result of a failure to invest in rural health care. It's the culmination of a failed strategy to ignore and cut... even more services... the Manitoba government has already signaled that we can expect consolidation in rural health care services... with significant impacts to services and accessibility." (CBC News, 2020).

What rural health in Manitoba, and across Canada, needs is revival. Support and investment to allow community-based decisions to support community-based care. If anything, the examples of Grandview and Roblin serve to demonstrate the resiliency of rural communities in times of crisis, and the failure of provincial governments to respond effectively by consulting with communities and rural health care providers, and honour the dedication of these communities to the health and wellbeing of their people.

CONCLUSIONS

The first purpose of this study was to provide a description of the current state of healthcare services and delivery in Grandview, Manitoba, while offering support for why this system has been effectively for the community over the last several years. Secondly, this study provides a summary of community member and service provider perspectives on how they believe the community of Grandview, and healthcare services within the town will be affected following the elimination of services. The findings delivered here contribute to understandings of rural health in Manitoba, and add to an unfortunate and existing collection of narratives from small towns facing similar changes to life and health within their communities.

Through discussions with various members of the Grandview community, including healthcare service users and providers, business owners and members of neighbouring towns, it is clear that the current state of healthcare service delivery in Grandview is meeting, and in many ways exceeding the needs and expectations of the community. However, the review of documentation and communication put forth by the Government of Manitoba indicate that this not a factor in determining whether EMS services can remain in Grandview, or whether the emergency department will be consolidated. This study reveals that what works best for Grandview, Manitoba, is a healthcare system that is built upon community, sense of place and relationality, where service providers, including three dedicated and long-time physicians, nurses, paramedics and other staff deliver quality, personable, patient- and family-centred care. Many of the best practices and recommendations that the 2013 – 2019 government reports refer to as the new standard of care are already being practiced in Grandview.

Residents of the town of Grandview, and members of the community at large, some residing over one hour out of town, have come to depend and rely on the services offered in Grandview, where older adults, service providers, young families, and entrepreneurs alike have selected to settle, retire, practice, raise families and contribute to the community they love. At the heart of this community is the Grandview hospital, complete with primary care clinic and EMS station, where residents trust the best form of care will be offered to them whenever needed. Residents that would choose to receive care in their home community and hospital, rather than be taken into larger cities and towns, where healthcare service is not as meaningful, personal, trusting and inclusive. The findings revealed here indicate that there are few barriers to accessing care in Grandview, unlike in many rural, remote and northern communities across Canada. The healthcare system that works best for Grandview is an enhanced version of what is being delivered effectively now. As many participants in this study, service providers and patients alike, note that an additional physician, two additional full-time paramedics, and additional nurses and support staff would ensure that the community of Grandview, the surrounding region, and residents of Tootinaowaziibeeng First Nation would receive the best possible care, including emergency care, 24-7.

Community consultations, reactions and interviews over the past two years have served to demonstrate that Grandview EMS and the Grandview Hospital are central to life in this rural community. Older adults have chosen to remain in their community, to age in place, knowing that good healthcare was present in the heart of town. Families have returned or settled in Grandview because they knew they had access to emergency medical services, reliable family physicians and personable, family-centred care. Entrepreneurs and business owners have continued to do business within the community, centred around its hospital, and the myriad services provided through it. Younger adults, and recent college and university graduates have returned to their hometown after studying in large cities because of the sense of belonging and promise of healthcare-related jobs in Grandview. In short, the community has continued to thrive, and persevere through the elimination of the 'small, rural, Canadian town,' a phenomenon that is sweeping the country, but is felt acutely in communities like Grandview, where government decisions, framed as beneficial to the wellbeing of communities, and fiscally sustainable, are perceived by rural residents as leading to the demise of rural, community life.

The findings from within this study go beyond the great sense of loss felt by community members at the news that their ambulance services were being withdrawn. This study indicates a real sense of fear among Grandview residents that their way of rural life is being constructively eliminated through government action. The withdrawal of EMS from the town is not the beginning, but perhaps the most threatening and transparent action in this perceived process so far. Despite the decision of Manitoba's government, and the negative impacts that this is currently having on the community of Grandview, and the results it will create in the future, it is critical to remark on the resilience of community, and the level of social capital and capacity to respond and confront issues that threaten the cohesion and sense of wellbeing within the community. Through this study, it is clear that the community of Grandview is collaborative and cohesive, certainly when it comes to issues regarding healthcare and services that the community depends on. It became clear through community interviews that there was a deep sense of pride and concern for the Grandview Hospital, but also the physicians, nurses, paramedics and service providers that operate within that space, and that call Grandview home. Canadian research conducted in Southwestern Manitoba by Ramsey and Beesley (2006, 2007) indicates the importance of rural community resiliency, stating that with resilience, rural communities can persist through change. Perhaps with this social capital, cohesion and resiliency, Grandview and communities across rural Manitoba can affect change or at least provide the necessary input that has been missing from government decision-making into healthcare services within the community and continue as healthy, supportive places to live, work, and age in the future.

Recommendations

Through the analysis of central government documents and interviews with community members and service providers in Grandview, and surrounding rural and Indigenous communities, a number of recommendations are made. In order to meet the health needs of rural and Indigenous communities across Manitoba, Government must:

1 Consult, engage and collaborate honestly and authentically with rural and Indigenous communities throughout the planning, development, and implementation of health care system changes

This study has found that while government commissioned studies have occurred, many of which stating that key stakeholders, and/or the public has been consulted or surveyed, rural communities and Indigenous communities do not feel heard, valued or remotely considered. Wide, systemic change will impact all areas across the healthcare system, but will affect vulnerable peoples and small communities most acutely. In order to create systems change and innovation, governments require community support. This should be gathered through transparent engagement with such communities, in the form that works best for the community. For example, an online survey of healthcare service users is not effective or accessible for older adults living rurally or remotely. In moving forward with the provincial health transformation process, the government of Manitoba needs to reconsider the way it engages with the communities that will experience the greatest change, especially those that believe this change will create barriers to accessing care, or eliminate critical services.

2 Make evidence-based changes to health care services with community support, recognizing the social determinants of rural health and including community-generated evidence

Systems transformations especially at government- and policy-levels require strong evidence to justify and support major systemic changes. This study found that statistical evidence and cost-analyses research was prioritized in commissioned government documents. Much of this research call back to 2011 Census data, or erroneous data on EMS response times and distances. While the importance of statistical data cannot be understated when it comes to systems-wide shifts in service and delivery of care, social and community-based evidence and narratives are also critical to such change. This study acknowledges that not every community can be sampled, nor every resident. However, communities and vulnerable groups, and especially affected Indigenous communities, must be invited to participate in research, and in the process of developing new systems and services that will best meet their needs. This study recommends that future reports and research incorporate community perspectives and community-based solutions in systems reform processes.

3 Commit to a strengths-based approach to health system changes in rural, remote, northern and Indigenous communities in order to maintain rural community life, health and innovation in Manitoba

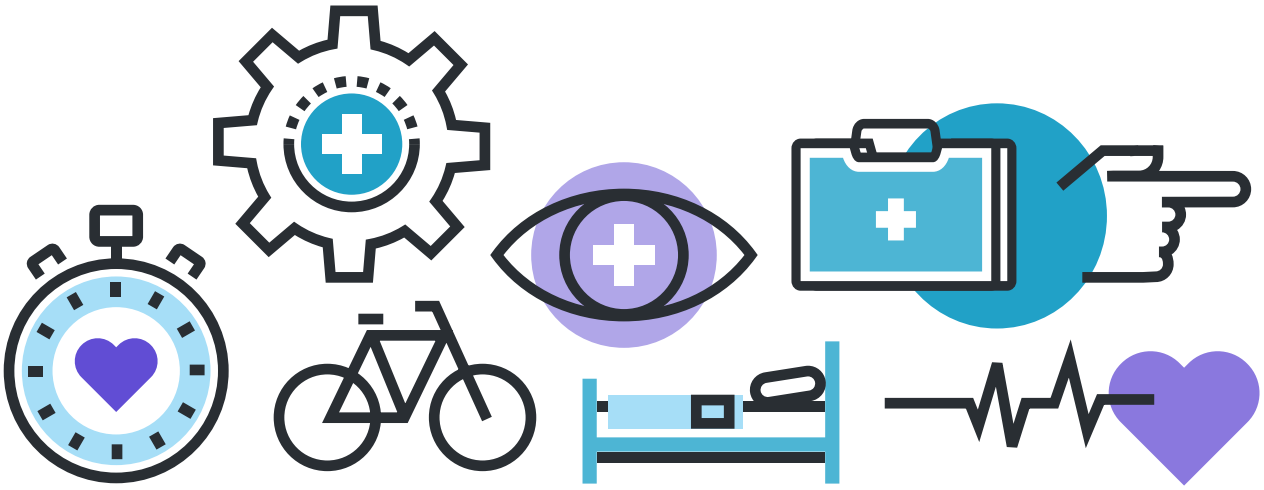
If future planning and reform processes undertake recommendations one and two, then governments will be in better positions to support and sustain the systems that are already in place and successful within communities with specific healthcare needs and ways of life in rural and remote settings. By supporting communities in doing what works best for them, governments are empowering small communities, sustaining rural Canadian life, and affording self-determination and control to communities to identify, address and meet their unique needs. This can be done within a provincial and/or regional system. As Grandview demonstrates, this is already being done in such a way that the community has been self-sustaining its healthcare services, primarily because of dedicated healthcare professionals that have strong relationships and senses of responsibility towards the people that they serve. The systems that currently exist in rural communities can be part of the solution to provincial sustainability issues, rather than problems to be dealt with. As so many participants stated about the healthcare services in Grandview, "...if it isn't broken, don't fix it." Governments can learn from what is working best for successful, resilient communities like Grandview in order to meet the needs of other rural communities in Manitoba and improve the health of peoples across this vast and diverse province.

4 Recognize and support effective rural health care service centres. Develop Grandview Health Centre into an Enhanced District Hub as described in the Better Care closer to home Report.

This recognition must be based on the description provided by Shared Health in the 2019 Better Care Closer to Home documents, which reinforce the importance of integrated primary, emergency and acute care for Manitobans on a community level, on a 24-hour basis. Clearly, the healthcare services that are currently being provisioned within Grandview, to the local community and beyond, to Tootinaowaziibeeng, are meeting community needs. This is the goal of the proposed District Health Hubs, while ensuring a continuum of care for those patients that require specialized care or services in Brandon, or Winnipeg at the Intermediate or Provincial Hub levels. With this system currently in place, operating in such a way that meets community needs, equipped with primary, emergency, and acute care services, as well as health human resources, Grandview Hospital and EMS directly represent the definition of the District Health Hub.

Conclusion

In a country known for its accessible, free and equitable healthcare system, a number of barriers remain for people across Canada to receive the right care and the best care where and when they need it most. In rural, remote and northern settings the Canadian literature demonstrates that communities simply want to be able to access healthcare services more effectively (Ramsay & Beesley, 2007). In these areas, just getting care, or getting to care, is an inequality people experience regularly. It is problematic then, for places like Grandview, Manitoba, where residents are extremely satisfied with the care they access in their community, to be facing the elimination and consolidation of the services they have come to not only expect, but depend on.



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