

Lloydminster Health Service Needs Assessment

FINAL

December 2025

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Executive Summary

Lloydminster occupies a unique position as one of Canada's only cities that straddles two provincial jurisdictions. Its location on the Alberta–Saskatchewan border creates a distinct healthcare environment where planning, funding, and service delivery must be coordinated across two provincial systems. The service area considered in this needs assessment extends 150 kilometers from Lloydminster, encompassing numerous urban, rural, and Indigenous communities.

Key Strategic Directions

The future of Lloydminster's healthcare system is guided by the principle that patients should receive care in the most appropriate setting, supported by coordinated services that allow people to remain close to home whenever possible. The following strategic directions for consideration reflect both immediate priorities and long-term planning needs. Please note that while the report identifies service gaps and opportunities for improvement, it is not intended as a future state roadmap or a comprehensive list of desired enhancements.

Building Local Capacity: The region can focus on strengthening generalist staff by equipping them with additional skills to manage higher-need cases within a safe and appropriate scope. This approach can reduce dependence on tertiary centres in Edmonton and Saskatoon, ensuring more patients can be cared for locally.

Supporting Primary Care: Stronger connections between family providers, community health teams, and acute care may enhance continuity of care. With improved allied health supports, streamlined administration, and rapid referral pathways, primary care can become the backbone of the system, reducing unnecessary Emergency Department use and improving patient access to timely care.

Expanding Specialized and High-Acuity Services: The hospital can enhance its role as a regional hub by expanding surgical capacity, developing a regional Intensive Care Unit (equivalent to Tier-4), and strengthening maternity services. These investments may reduce out-of-region transfers and align local services with projected demand, which may include more than 5,000 surgical procedures annually by 2040.

Prioritizing Prevention and Community-Based Care: Expanded mental health, chronic disease, and elder care supports can enable patients to manage conditions before they escalate to acute care. Rapid access to primary care for low-acuity conditions, combined with new community mental health capacity, will very likely alleviate pressures on the Emergency Department while improving overall wellness.

Improving Patient Flow and Transitions: A Transitional Care Unit would assist in ensuring patients who no longer require acute care can move into appropriate settings, reducing hospital congestion and improving discharge planning. Stronger connections between acute care, home care, and community services may shorten hospital stays and ease Alternate Level of Care (ALC) pressures.

Delaying Long-Term Care Admissions: Expanded respite, caregiver support, and home-based services may enable older adults to remain at home longer, reducing demand for long-term care and supporting independence and quality of life.

Planning for Future Demand: Population growth and aging are expected to increase demand for emergency visits, surgical procedures, inpatient care, and continuing care. Planning efforts must anticipate these pressures, ensuring capacity growth is aligned with efficient service delivery and interprovincial coordination.

Service-Specific Future Directions

Across sectors, targeted improvements are recommended for consideration:

Emergency Department: Integration of physician assistants, dedicated psychiatric nursing, and a Mental Health Short Stay Unit to improve flow and safety.

Surgical Services: Expansion of operating room capacity through extended hours, weekend surgeries, and recruitment of surgical teams.

Critical Care: Consideration for the establishment of a five-bed Regional ICU, supported by trained staff and consultation pathways.

Maternity and Newborn Care: Stable nursing staffing and streamlined interprovincial transfer protocols to reduce avoidable newborn transfers.

Continuing and Home Care: Development of a Transitional Care Unit, stronger discharge planning, and closer alignment of home care with hospital teams.

Mental Health: Creation of a Mental Health and Substance Use Short Stay Unit, expanded community staffing, and a new PACT team to provide care outside of hospital settings.

Diagnostics and Pharmacy: Investment in workforce development, equipment renewal, and bi-provincial data-sharing to improve coordination and reliability.

Given the scale and volume of service changes indicated, prioritization based on clinical and system drivers is required. Across sectors, targeted priority improvements are recommended for consideration:

Establishing a Primary Access Clinic to divert low-acuity patients from Emergency, requiring no infrastructure and moderate staffing resources, with protocols coordinating ED registration and Prairie North Clinic.

Expanding Primary Care Access through team-based and virtual models, leveraging APP/ARP and NP-led care to increase access, improve chronic disease management, and reduce ED pressure.

Dedicated Mental Health Nursing in the ED, a high-impact, low-infrastructure change improving patient safety, de-escalation, and continuity of care, while reducing the burden of 1:1 observation.

Upskilling ED Physicians in Mental Health Assessment and Care, supporting generalist providers to safely manage higher-needs mental health presentations locally.

Prioritizing a Feasibility Study for a Mental Health Short Stay Unit (SSU), a moderate-capital, high-return initiative enabling secure, short-term mental health stabilization, reducing transfers, and improving patient and staff safety.

Developing a Transitional Care Unit, ideally outside the acute hospital, to relieve ALC pressures, support community reintegration, and provide respite and case-managed transitional support.

Strengthening Administrative Supports for Cross-Jurisdictional Information Sharing and Coordination, resourcing staff to carry out essential information-sharing work that currently detracts from clinical care, and laying groundwork for long-term policy and system alignment across provinces.

These priorities are interconnected and collectively support the overarching goal of creating a more accessible, efficient, and patient-centred healthcare system. They focus resources on immediate system needs with relatively low infrastructure requirements, and lay a foundation for improved system integration and efficacy of resources.

GLOSSARY OF TERMS

Acronym / Abbreviation / Term	Full Form Definition
AB	Alberta
ACA	Acute Care Alberta
APPHS	Alberta Ministry of Primary and Preventative Health Services
ALA	Assisted Living Alberta
AHS	Alberta Health Services
AH	Alberta Health
AHWS	Alberta Health Workforce Strategy
ALC	Alternate Level of Care
ALS	Advanced Life Support
APL	Alberta Precision Laboratories
APP	Alternative Payment Plans
ARP	Alternative Relationship Plans
BC	British Columbia
CACS	Comprehensive Ambulatory Classification System
CBC	Complete Blood Count
CCMHBI	Centennial Centre for Mental Health and Brain Injury
CIHI	Canadian Institute for Health Information
CMG	Case Mix Groups
COPD	Chronic Obstructive Pulmonary Disease
ConnectCare	Connect Care is a province-wide clinical information system implemented by Alberta Health Services and partners to provide a single, central access point for patient health information across settings.
ConnectingOntario	The Connecting Ontario Clinical Viewer, a secure provincial electronic health record viewer for Ontario clinicians.
CHSP	Clinical Health Service Plan
CT	Computed Tomography
CTAS	Canadian Triage and Acuity Scale
DAD	Discharge Abstract Data
DTaP-IPV-Hib	Combination vaccine protecting against diphtheria, tetanus, pertussis, polio, and Hib

Acronym / Abbreviation / Term	Full Form Definition
Diagnostic Mammography	Medical imaging procedure to investigate breast abnormalities
DynaLIFE	Canadian private healthcare organization
EMR	Electronic Medical Record
eHR	electronic Health Record
EMS	Emergency Medical Services
ENT	Ear Nose and Throat
ESZ	Emergency Service Zones
FOCI	Future of Cancer Impact
FOIP	Freedom of Information and Protection of Privacy Act
FTZ	Fast Track Zone
FTE	Full Time Employee
GOA	Government of Alberta
HCA	Health Care Aides
HAU	High Acuity Unit
HIA	Health Information Act
HLOC	Higher Level of Care
HPA	Health Professions Act
Hemoglobin A1C	A blood test measuring average blood glucose over past 2-3 months
HSNA	Health Services Needs Assessment
ICD	International Classification of Diseases
IROP	Intensive Rehabilitation Outpatient Program
ICU	Intensive Care Unit
IMIT	Information Management and Information Technology
IR	Interventional Radiology
LIC	Leadership Integration Committee
LGA	Local Geographic Areas
LIS	Lab Information System
LOS	Length Of Stay
MAPS	Modernizing Alberta's Primary Care System
MDSRI	Minimum Data Set Resident Instrument
MCC	Major Clinical Category
MIS	Management Information Systems
MI	Medical Imaging
MHA	Mental Health Act

Acronym / Abbreviation / Term	Full Form Definition
MHSU	Mental Health Substance Use
MHSSU	Mental Health Short Stay Unit
MLA	Medical Laboratory Assistants
MLT	Medical Laboratory Technologists
MIS	Management Information Systems
MOU	Memorandum Of Understanding
MMR	Mumps, Measles, And Rubella
MRI	Magnetic Resonance Imaging
MOH	Ministry Of Health
MySaskHealthRecord	A patient portal in Saskatchewan to an electronic health record
NetCare	Provincial electronic health record system for Alberta
NP	Nurse Practitioner
OCDBP	Outpatient Cancer Drug Benefit Program
OB	Obstetric
OR	Operating Rooms
PA	Physician Assistants
PCA	Primary Care Alberta
PCN	Primary Care Networks
PAC	Primary Access Clinic
PACT	Police And Crisis Team
PMH	Patient Medical Home
PMT	Project Management Team
POCT	Point-Of-Care Testing
PTSD	Post-Traumatic Stress Disorder
PSC	Patient Service Centre
RA	Recovery Alberta
RAI-HC	Resident Assessment Instrument-Home Care
RPHCN	Regional Primary Health Care Networks
RN	Registered Nurses
RT	Respiratory Therapists
RSA	Revised Statutes of Alberta
RCMP	Royal Canadian Mounted Police
SAG	Small Area Geography
SCU	Special Care Unit
Saskatchewan NW4 Health Network	Geographical area within SHA in which Lloydminster is located

Acronym / Abbreviation / Term	Full Form Definition
SHA	Saskatchewan Health Authority
SK MOH	Saskatchewan Ministry of Health
SSU	Short-Stay Unit
STBBI	Sexually Transmitted and Blood-Borne Infections
TCB	Transitional Care Beds
TCU	Transitional Care Unit
Triage	Nursing process assessing and prioritization patients based on acuity
VODP	Virtual Opioid Dependency Programs
VRAAM	Virtual Rapid Access Medicine
WPD	Private ambulance company contracted for service in Lloydminster

1 Introduction

1.1 PROJECT CONTEXT

Lloydminster is uniquely positioned as one of Canada's only cities that straddles two provincial jurisdictions, Alberta and Saskatchewan. The bi-jurisdictional context creates unique healthcare service delivery challenges in Lloydminster and the surrounding areas on both sides of the provincial border. In recognition of the unique complexities of healthcare in Lloydminster, a working group was initially formed in 2013 to complete a needs assessment and oversee healthcare provision in the Lloydminster area. The group includes representatives from the Saskatchewan Ministry of Health (SK MOH), the Saskatchewan Health Authority (SHA), Alberta Health Services (AHS),¹ and the Ministry of Health. Its purpose is to facilitate cross-provincial collaboration and complete a joint health service needs assessment for the Lloydminster and the surrounding area. A bi-provincial Memorandum of Understanding (MOU) was signed in 2014 to formalize a collaborative framework for delivering healthcare in Lloydminster, which was renewed in 2021.

This dual-province structure presents distinct challenges in healthcare service planning, requiring coordination between two provincial systems with differing policies, funding models, and service delivery structures, and while the bi-provincial context creates several challenges, the context can also create opportunities for Lloydminster to leverage the resources of both provinces and allow for residents to access services provided by each respective province that provides a higher standard of care. It is important to note, however, that there is a critical need for collaboration between the Alberta and Saskatchewan governments and healthcare agencies to ensure effective planning and delivery of healthcare services.

The service area of the Lloydminster Health Services Needs Assessment extends up to 150 km from the Lloydminster's city centre, encompassing a mix of urban, rural, and Indigenous communities across the two provinces. This includes over 30,000 people residing in the city and over 200,000 people within the extended service area.² Residents access healthcare services through a combination of Saskatchewan Health Authority (SHA) and Alberta Health.

Accordingly, this report provides an in-depth assessment of current and future healthcare needs in the Lloydminster area, identifying service gaps, forecasting demand, and proposing high-level recommendations to improve healthcare access and efficiency.

¹ Under the *Health Statutes Amendment Act, 2024* and the *Provincial Health Agencies Act (PHAA)*, Alberta has been undergoing a reorganization of healthcare governance and delivery. Alberta Health Services (AHS) has been reorganized under four Provincial Health Agencies, Recovery Alberta, Acute Care Alberta, Primary Care Alberta, and Assisted Living Alberta. The changes were ongoing during this study's duration.

² For the purposes of this study, the extended service area refers to an area encompassing a 150km radius from the centre of Lloydminster. See section 2.2 Community Profile for further details.

1.2 OBJECTIVES

The goal of this project was to develop a high-level Clinical Health Service Plan (CHSP) to guide long-term clinical and service planning for Lloydminster and surrounding areas (15 year-horizon, 2025 to 2040, defined as per the MOU). The primary objectives of this needs assessment were to:

- Evaluate the current state of publicly funded health services Lloydminster and the surrounding region, including acute care, primary care, long-term care, and community health services.
- Identify gaps and barriers in service delivery, particularly those arising from cross-jurisdictional challenges.
- Model and project future healthcare service demands based on demographic trends, population health indicators, and historical service utilization patterns.
- Develop evidence-based insights and recommendations for improving healthcare services delivery, workforce planning, and cross-jurisdictional collaboration.

1.2.1 Scope of Work

This report provides an in-depth assessment of healthcare service needs within the Lloydminster city limits while considering the broader healthcare landscape of the surrounding area. The scope includes an analysis of acute care, primary care, community-based services, and long-term care to support planning efforts across both Alberta and Saskatchewan. Specifically, it identifies existing service gaps, evaluates supply and demand challenges, and projects future healthcare needs within Lloydminster and the surrounding area. The report offers insights and recommendations for consideration and serves as a planning resource that can guide decisions on how to address population needs.

Certain aspects were beyond the scope of this project. This analysis excludes private Assisted Living and Independent Living services. Additionally, support services such as Information Management and Information Technology (IMIT), alongside costing, capital planning, and infrastructure assessments are not included. The study excluded planning for land-based Indigenous communities, as separate planning processes were underway in parallel, led by First Nations. The report does not establish specific timelines for implementation nor capital implications. While the report identifies service gaps and opportunities for improvement, it is not intended as a future state roadmap or a comprehensive list of desired enhancements.

1.3 METHODOLOGY

This study was informed by:

- *Demographic and population health analysis:* Population growth trends, aging patterns, chronic disease prevalence, and healthcare utilization rates were analyzed.
- *Service mapping:* Existing healthcare services, workforce distribution, and patient flows were assessed.
- *Policy and funding review:* Healthcare policies, funding mechanisms, and service provision models between Alberta and Saskatchewan were assessed.
- *Stakeholder workshops:* Healthcare providers, managers, policymakers, and community organizations were engaged to gather insights on service challenges and priorities.
- *Data integration and forecasting:* Statistical modeling was used to predict future service demands and requirements.

1.3.1 Data Sources

AnalysisWorks begins this section with an acknowledgement of, and gratitude to, the Saskatchewan (SK) Ministry of Health (MOH) and Alberta Health (AH) Data teams for their invaluable assistance in gathering and providing the necessary data for this project, and for the quick resolution of issues as they emerged.

In order to comply with relevant provincial Data Sharing Agreements and Privacy Policies, the project team was provided with multiple data extracts covering aggregate data only (i.e. not record-level information) in order to guarantee patient data privacy was maintained. Here are the key data sources that were used throughout this project:

- *Aggregated Discharge Abstract data (DAD)* providing patient profile information on the 5-year age groups, geographical residence area, and case mix groups, as well as hospital utilization data including number of patients and total patient days. The extract provided information on hospital discharges at Lloydminster Hospital, as well as aggregated information on discharges from other facilities in the provinces of Saskatchewan and Alberta. This data enabled the project team to generate comparisons of the Lloydminster hospital usage and that of other hospitals in the surrounding region.
- *Detailed DAD subset* providing information on patient admission and discharge times, as well as the provider service and patient age category information for the Lloydminster Hospital only. This information was used to calculate the daily midnight inpatient bed census across the hospital to determine how beds are currently being

utilized (i.e. number, type, and location) and investigate variations across the different hospital programs.

- Aggregated Perioperative Data consisting of surgical completion information (including surgery date, duration, surgical division, and overtime indicator to indicate if a case started after 4:30PM) and surgical waitlist information (including snapshot of the number of patients waiting for surgery by surgical division, procedure group, and diagnosis target and wait time grouping based on length of wait relative to diagnosis based target).
- Statistical Management Information Systems (MIS) Data for Medical Imaging, Laboratory and Pharmacy, including information on annual service volumes. Additional aggregate data for Medical Imaging information was provided to break down service volumes by fiscal period further and support root cause investigations related to drivers of lower throughput periods.
- Aggregated National Ambulatory Care Emergency Department Data consisting of patient visit information by fiscal year, including patient mix details on 5-year age groups and CTAS triage level.
- Provincial Saskatchewan Population Growth Projection Data (medium growth scenario) and Alberta Population Growth Projection Data, consisting of the size of the population for historical years and projected future year estimations, broken down by 5-year age group, gender, and residence area segments.
- Publicly available Continuing Care Bed Capacity data by facility, including the breakdown of Alberta Type A, Type B, Type B Secured, and Respite bed³ capacity distinctions (where available) for Lloydminster and surrounding regions to support discussions around long-term Continuing Care needs.

Additional internal Alberta and Saskatchewan reporting and analyses on the Lloydminster region was conducted to provide relevant current state data for the different areas of the Lloydminster Hospital. A consolidated overview of data methodologies and analysis is found in Appendix 4.5: Analysis.

³ See sections 2.3.1.2 Continuing Care Facility Standards and Facility Operations and 3.6 Continuing Care for definitions and further details.

1.4 PROCESS

The project was executed in four key phases:

1. *Foundations (Establishing the Project Framework)*: This phase focused on setting the groundwork for the assessment, ensuring clear project scope, structured engagement, and robust data management.
2. *Current State Analysis (Understanding Service Delivery Today)*: The objective was to establish a comprehensive baseline of health services in Lloydminster by analyzing both quantitative and qualitative data.
3. *Future State Modeling (Forecasting Healthcare Needs)*: The goal is to project future healthcare needs over a 15-year horizon, incorporating demographic trends and policy priorities.
4. *Validation and Reporting (Finalizing Insights)*: The final phase ensures consensus on recommendations and delivers a structured report to inform future planning.



The table below outlines the structured approach that was employed for conducting this project, ensuring a data-driven and stakeholder-informed process.

Table 1 - Project Process

1 Foundations Phase

Kickoff and Background Review

A Kickoff Meeting was conducted to align stakeholders on the project scope, schedule, lines of communication and expectations. Background documents were reviewed to understand the current state of services, past planning efforts, and regulatory frameworks.

Project Charter and Governance

A Project Charter was drafted to outline deliverables, methodology, and roles. An Alignment Session with the Project Team and Leadership Integration Committee occurred to validate

the Charter and ensure alignment with Alberta and Saskatchewan policies. Project Management tools such as a risk register and decision log were also established to support project governance. This was further approved by the project's Executive Sponsors from both provinces.

Analytics and Engagement Planning

The Data & Analytics team was engaged to define data requirements and secure access. A Stakeholder Engagement Plan was developed to detail the schedule and attendees for each engagement session. This plan included the type of communication, frequency, key stakeholders, concern, and level of input. Once reviewed and approved by the Project Team, Leadership Team and Executive Sponsors, invitations were sent out for engagement.

2 Current State Analysis

Mapping Existing Service Lines and Data Analysis

A comprehensive map of health services and population data was developed using public sources. Historical utilization and demand data provided was reviewed and analyzed to understand service utilization patterns and trends.

Stakeholder Engagement and Validation

Stakeholder workshops were conducted for validating data and current state information, visioning discussions, and gathering insights into service capacity, demand trends, and operational challenges. Over 20 engagement sessions were conducted with leaders of local municipalities and included organizations such as the Health Foundation, Saskatchewan Health Authority, Saskatchewan Cancer Agency, Alberta Ministry of Primary and Preventative Health Services, Ministries of Health from Alberta and Saskatchewan, and Alberta Ministry of Mental Health and Addiction. Stakeholder engagement was split into three different phases (see section 1.6 Stakeholder Groups).

Consultative Sample

Summarize and Interpret Findings

The outputs from qualitative data, such as data analysis and stakeholder engagement, were synthesized to highlight key insights, gaps, and challenges in current service provision. A

current state analysis was completed based on known information and key metrics that define service lines. Summary of engagement outcomes were also developed.

3 Future State Modeling

Population and Demand Forecasting

Population-based analyses were conducted to model demographic changes by age, sex, and geographic distribution from AB and SK statistics. Trend analyses were performed on service activities such as patient volumes, demographics, and utilization rates. Service volume projections were developed by integrating current state trends with future population growth to identify patterns of change that may impact future demand.

Service Shift and Capacity Planning

The findings from demand forecasting were integrated into a plan that outlines service shifts and capacity requirements. This draft model was developed to summarize the necessary volume changes driven by population growth, as well as their potential impacts on service size, mandate, and location. This document also served as the agenda for the service planning workshops.

During this step, relevant policies were referenced and incorporated to ensure that clinical service planning adhered to applicable regulations, guidelines, practice standards, and broader organizational goals. Information from engagement sessions was reviewed and integrated into this plan. Additionally, service line options and clinical service levels were also provided based on demand projections, clinical best practices, opportunities for enhanced collaboration, and the strategic priorities of Saskatchewan and Alberta governments. Each option or recommended change was supported by a clear rationale.

Workshops for Service Planning

A series of stakeholder workshops were held virtually to review total projected demand by service and discuss strategies to meet this demand, including distributed service models and the introduction of new services.

Future Modeling

The service plan was adjusted based on the input from the stakeholder workshops. Demand projections for each service line encompassing a 15-year period were finalized, including impacts to demands based on other interdependent service shifts.

4 Validation and Reporting

Stakeholder Workshops

Stakeholder workshops with operational and clinical leads, as well as MOH and Alberta⁴ representatives, were conducted to review the future state model and gather feedback. Workforce Planning representatives for both provinces were also consulted for feedback.

Drafting and Review Process

A first draft report was developed which incorporated stakeholder feedback. Draft revisions were facilitated through a structured review process with tracked comments, responses, and clarification meetings.

Final Approvals and Project Closure

The Project Management Team (PMT) supported the sign-off process as directed by the project manager. A close-out report was delivered summarizing findings and recommendations, followed by a final presentation to Alberta and Saskatchewan representatives.

⁴ AH, Alberta Ministry of Primary and Preventative Health Services, and Alberta provincial health agencies' review was conducted offline and written comments were provided.

1.5 GOVERNANCE STRUCTURE

The governance framework for the Lloydminster Integrated Health Services Needs Assessment was established to ensure role clarity, effective decision-making, risk escalation, and strategic oversight across the project. It reflects the bi-provincial collaboration between Saskatchewan and Alberta and is designed to support both clinical service planning and long-term capital planning for the Lloydminster catchment area.

Executive Sponsors

At the senior level, Assistant Deputy Ministers from the Saskatchewan Ministry of Health and Alberta Ministry of Primary and Preventative Health Services served as Executive Sponsors. They provided overarching direction, confirmed alignment with provincial priorities, and endorsed the final assessment.

Leadership Integration Committee (LIC)

The LIC, comprised of Executive Directors from Saskatchewan and Alberta ministries and health agencies, provided strategic oversight and guidance to the project. The committee made consensus-based decisions and advised senior Ministry of Health leadership. As required, representatives from other Alberta ministries and provincial health agencies were invited to participate in discussions relevant to their sectors.

Project Management Team (PMT)

The PMT was responsible for managing the day-to-day activities of the project. Its role included overseeing deliverables, identifying and escalating risks, and ensuring appropriate resources are in place. The PMT reported bi-weekly to the LIC and Executive Sponsors, serving as the primary point of escalation for issues requiring resolution.

Stakeholder and Working Groups

Stakeholder groups provided essential input to support project deliverables, particularly through data analysis, clinical service planning, and targeted engagement activities. A Data Analytics Group was tasked with collecting and providing utilization data, which was then analyzed by the Consultant Team.

Consultant Team

The consultant team was accountable for coordinating the assessment process in collaboration with the PMT and Executive Sponsors. Responsibilities included preparing meeting agendas and materials, maintaining records of decisions, and leading stakeholder

engagement. The consultants provided bi-weekly governance updates, tracked and resolved issues, and submitted monthly progress reports summarizing key activities and schedule status. As part of project close-out, the team delivered the final Clinical Health Service Plan (CHSP) with insights about current and future requirements, and later convened a closing meeting with the Saskatchewan Ministry of Health and Alberta Ministry of Primary and Preventative Health Services.

The Project Charter can be found in Appendix 4.1.

1.6 STAKEHOLDER GROUPS

The stakeholder engagement was conducted in three main phases as outlined in the table below. Throughout the engagement, the aim was to develop a comprehensive, jurisdictionally integrated plan that aligns with both provincial health systems while addressing the unique needs of Lloydminster and surrounding communities. A complete list of engagement sessions and attendees can be found in Appendix 4.2. Note that the original workplan included engagement of Onion Lake First Nation, but as this Nation is currently engaged in a parallel planning process for community health service needs, they declined engagement to avoid duplication of resource efforts. Once both plans are complete, work will need to occur to coordinate service delivery between the Nation and both provinces.

Table 2 – Stakeholder Engagement Phases and Purposes

Engagement Phase		Purpose
Phase 1	Project Foundations	Identify key priorities and considerations from senior stakeholders.
Phase 2 A	Visioning and Alignment	Establish service challenges, future directions, and vision by service area. Provide system-level direction for clinical planning.
Phase 2 B	Current State Data Validation	Validate current state data, contextualize trends. Support and inform the development of clinical service plans at the program level.
Phase 2 C	Current State Challenges and Emerging Directions Validation	Validate summary of gaps and challenges; receive initial input on future state directions.
Phase 2 D	Future Service Directions Workshop	Present future service directions for consideration; refine and validate.
Phase 3	Reporting	Present validated insights for future state service model.

2 Background

2.1 VISION AND GUIDING PRINCIPLES

The vision for the healthcare needs assessment is to create a comprehensive, evidence-based framework for planning healthcare services in Lloydminster that meets the needs of residents across Alberta and Saskatchewan. This vision is guided by four key principles as outlined in the project charter: Prevention and Wellness, Health Equity, Integration and Sustainability, and Appropriateness. These principles guided the design, analysis, and recommendations of the assessment, so that the planning approach is tailored to the region's unique challenges and opportunities.

2.1.1 Prevention and Wellness

A focus on prevention and wellness is critical to decreasing long-term demand on the healthcare system. This means reorienting services toward early, community-based interventions and strengthening public health strategies that promote well-being before medical treatment is required.

In Lloydminster, this principle translates into designing models that reduce fragmentation and support patient-centred integration across the care continuum, from hospitals to primary care, home care, and community-based services. The assessment examines opportunities to improve transitions between levels of care, support aging in place, and reduce unnecessary hospital use by enhancing access to primary, preventive, and rehabilitative care. By shifting demand toward more appropriate and lower-intensity care settings, the system can become more responsive, efficient, and focused on long-term health outcomes.

2.1.2 Health Equity

To serve the population effectively, the healthcare system should strive for equity in both access and outcomes. This includes addressing disparities based on geography, income, and social circumstances, with a particular focus on underserved populations in Alberta and Saskatchewan.

The assessment identifies systemic barriers, such as transportation challenges, financial constraints, and limited availability of specialized services, that affect access, particularly in rural and marginalized communities. Equity also involves ensuring consistency of care regardless of jurisdiction, which is especially important in this bi-provincial context. By examining cross-jurisdictional collaboration, the assessment offers strategies to reduce disparities and improve outcomes across all communities.

2.1.3 Integration and Sustainability

Health services are most effective when they operate as a coordinated, interdependent system. In Lloydminster, this integration is essential as services are delivered under two provincial healthcare structures.

This assessment explores harmonizing care across Alberta and Saskatchewan by strengthening collaboration between provinces as well as across service lines. It identifies opportunities for more seamless service delivery across hospitals, primary care, home and community care, and mental health services, focusing on patient-centred service integration.

Technology may also be considered as a key enabler of integration; facilitating communication, care coordination, and data sharing. Sustainability is addressed through forward-looking strategies for workforce planning, system capacity, and funding models that support population health goals and long-term resiliency.

2.1.4 Appropriateness

Appropriateness means ensuring that care is medically necessary, evidence-based, and beneficial to the patient; avoiding both overservice and underservice across the different care streams.

The assessment applies this principle through a future-ready approach to capacity planning. Using data on population trends, service utilization, and emerging needs, it forecasts health service demand over the next 15 years. The result is identification of service gaps, which may guide investment toward the most effective and scalable solutions across the care system.

By emphasizing appropriateness in both current services and future planning, the assessment aims to ensure Lloydminster's healthcare system delivers high-quality, efficient, and patient-relevant care in the most suitable setting.

2.2 COMMUNITY PROFILE

2.2.1 Geography

The service area defined in the Lloydminster Health Needs Assessment was identified as an area up to 150 km from the centre of Lloydminster, including urban and rural communities. According to the 2021 Census, census dissemination areas within Lloydminster's 150 km radius has approximately 217,000 residents. Key characteristics include:

- **Lloydminster City:** A growing urban centre with a diverse population, serving as a hub for regional healthcare services. Lloydminster Hospital is an SHA-run facility located on the Saskatchewan side of the border and is designated as a Regional Hospital.
- **Other Cities:** Several smaller but important cities are located nearby, including North Battleford, Meadow Lake, Cold Lake, and Bonnyville. Notably, Battlefords Union Hospital (North Battleford, SK) is also designated as a Regional Hospital.
- **Rural Communities:** A number of small towns and farming communities are located nearby with more limited local healthcare infrastructure. Smaller communities with hospitals have a limited scope of services, leading to a dependency on regional facilities.
- **Indigenous Communities:** First Nations and Métis communities with distinct healthcare needs and challenges in accessing culturally appropriate care.

The geographical units used for health systems planning are Local Geographic Areas (LGAs) in Alberta and Small Area Geography (SAGs) in Saskatchewan. LGAs are sub-areas within Alberta Health Zones, largely aligned with municipal district boundaries and including the urban municipalities, hamlets, and localities within its bounds. SAGs are smaller geographic units within Health Networks and are used to organize healthcare at a more localized level.

Note: A regional hospital is typically defined as a hospital that falls between a rural/community hospital and specialized central hospital in terms of levels of service, capacity, and coverage area. As such, a regional hospital serves multiple towns or communities and offers a differentiated range of medical specialty services.⁵

The table below provides a list of jurisdictions that fall within the Lloydminster Health Needs Assessment service area.

⁵ McCord C, Ozgediz D, Beard JH, et al. General Surgical Emergencies. In: Debas HT, Donkor P, Gawande A, et al., editors. *Essential Surgery: Disease Control Priorities, Third Edition (Volume 1)*. Washington (DC): The International Bank for Reconstruction and Development / The World Bank; 2015 Apr 2. Table 4.1, Definitions of Levels of Hospital Care. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK333506/table/ch04.sec1.table1/> doi: 10.1596/978-1-4648-0346-8_ch4

Table 2 - Health Service Areas in Lloydminster Health Needs Assessment Service Area

Alberta		Saskatchewan	
Health Zone	Local Geographic Area (LGA)	SAG No.	Small Area Geography (SAG)
Core Service Area			
Central	Vermilion River County	NW 4.1	Lloydminster
		NW 4.2	Maidstone
		NW 3.1	St. Walburg
Extended Service Area			
Central	Two Hills County	NW 2.2	Meadow Lake
Central	MD of Provost	NW 3.2	Edam
Central	Viking	NW 4.3	Macklin
Central	MD of Wainwright	NW 5.1	Cut Knife
Central	Flagstaff County	NW 5.2	Unity
Central	Vegreville/Minburn County	NW 6.1	The Battlefords
North	Frog Lake County	NW 2.1	Loon Lake
North	Cold Lake		
North	St. Paul		
North	Bonnyville		

While The Lloydminster Health Needs Assessment Service Area has been identified as being up to a 150 km radius from Lloydminster, many localities within these areas access health services in their own communities or other communities closer to their homes.

The jurisdictions of Vermilion River County LGA in Alberta, and the Small Area Geographies of Lloydminster, St. Walburg, and Maidstone in Saskatchewan were identified as the Core Service Area. This largely overlaps with a 1-hour drive time radius from the centre of Lloydminster in normal conditions. Outside of the Core Service Area, the overall use of Lloydminster health services decreases, particularly with increased proximity to tertiary facilities in Edmonton and Saskatoon.

The Core Service Area had a population of approximately 71,000 in 2024. This area identified as the Core Service Area and is highlighted in light green in the map below. However, the Lloydminster Hospital facility catchment as defined by SHA includes an area with a population of approximately 42,000, defined as the number of patients who currently receive/access care at the hospital. This is due to the presence of other hospitals within the core service area which provide general care within those communities.

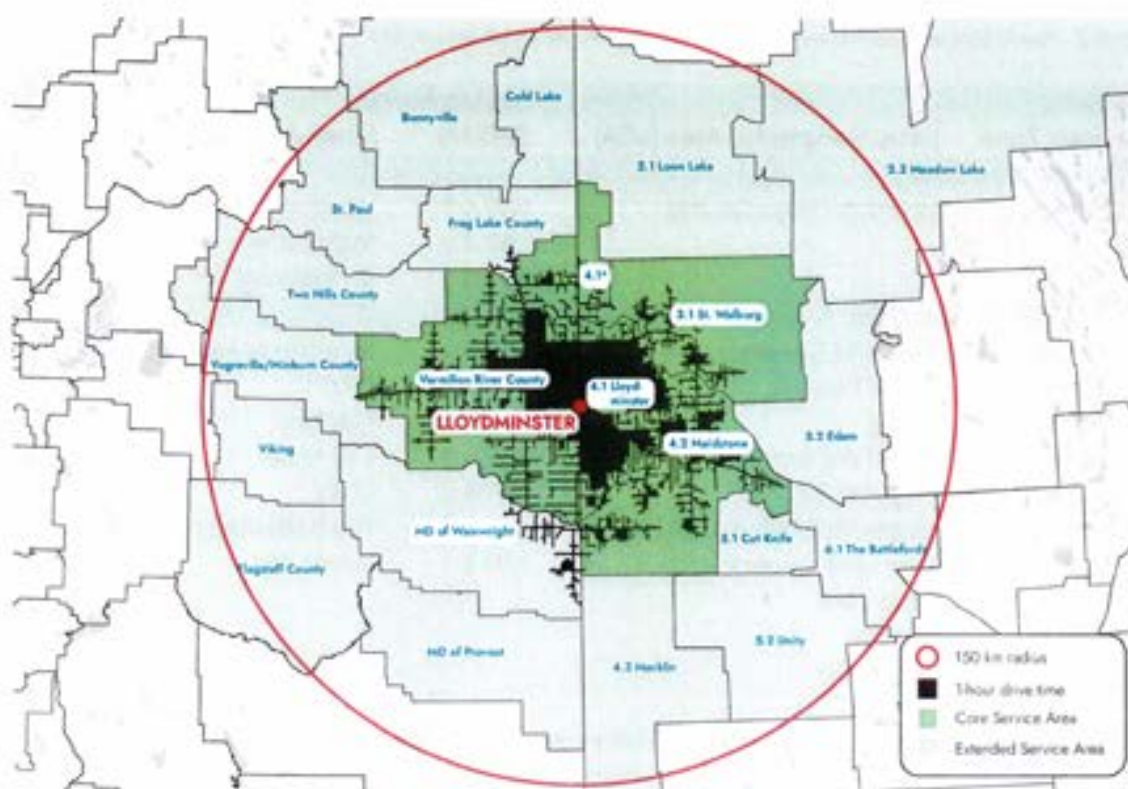


Figure 1 - Breakdown of Lloydminster Health Needs Assessment Service Area: 1-Hour Drive, Core, and Extended

2.2.2 Community Context

Lloydminster is the largest community between Edmonton, Alberta and Saskatoon, Saskatchewan. Lloydminster is located approximately equidistant to these two major population centres, approximately 2.5 hours by vehicle from each. Lloydminster's location on the Alberta-Saskatchewan border presents a number of complications and challenges, such as increased administrative complexity and coordination, fragmentation of systems, and regulatory inconsistencies. However, its cross-border context also provides opportunities, with residents and businesses able to leverage the best of both provincial systems. For example, the Saskatchewan side of Lloydminster is exempt from Saskatchewan's Provincial Sales Tax in order to support business parity on both sides of the border. This also translates to the healthcare context; for example, Lloydminster paramedics operate under Alberta Medical Control Protocols in Lloydminster, which have higher standards than Saskatchewan.

2.2.2.1 Surrounding Cities and Towns

While Lloydminster is the largest city between Edmonton and Saskatoon, there are a number of cities and towns within the service area that are important to consider for the larger regional healthcare context. Within the Core Service Area, the largest communities within Alberta are Vermilion, Kitscoty, and Marwayne, while the largest communities in Saskatchewan within the Core Service Area are Maidstone, Lashburn, and Turtleford. These communities are small and have limited access to healthcare services within the communities.

Within the Extended Service Area, there are a number of communities with a similar (albeit lower) population than Lloydminster with comparable levels of comprehensive health services. These include Cold Lake, North Battleford, Wainwright, Bonnyville, St. Paul, Vegreville, and Vermilion. North Battleford notably contains Battlefords Union Hospital, another hospital designated as a regional hospital by the Government of Saskatchewan, and Meadow Lake Hospital, a district hospital that provides full rural acute services (24/7 ED, inpatient medicine, low-risk obstetrics, day surgery) and supports nearby communities. Other centres include Maidstone Health Complex, Riverside Health Complex (in Turtleford), and Unity and District Health Centre. Many acute care facilities in the extended service area in Alberta contain 24/7 emergency departments and comprehensive acute care, including Cold Lake Healthcare Centre, Bonnyville Health Centre, Vermilion Health Centre, and St. Thérèse – St. Paul Healthcare Centre.

2.2.2.2 Indigenous Communities

There is a large Indigenous population within Lloydminster who make up around 13% of the total City population. Of the 13%, 6% identified as First Nations and 7% identified as Métis. Within the Core Service Area, the proportion of Indigenous people subsequently increases to 17% (10% First Nations, and 7% Métis), in line with the provincial figure in Saskatchewan.

There are a number of First Nations reserves and Métis settlements within the Lloydminster Core and Extended Service Areas. Within the Core Service Area are Makao I.R. No. 120 and Onion Lake Cree Nation No. 344. The estimated population of Onion Lake Cree Nation, at 3,722, is significant within the context of the Core Service Area.

The Extended Service Area further includes Unipouheos No. 121 & 122, Puskiakiwenin No. 122, Blue Quills First Nation, Kehiwin No. 123, Saddle Lake No. 125, Cold Lake No. 149, Fishing Lake Métis Settlement, Elizabeth Métis Settlement, Ministikwan Lake Cree Nation No. 397, Makwa Sahgaiehcan First Nation No. 396, Thunderchild First Nation No. 349, Little Pine No. 340, Poundmaker No. 345, Sweetgrass No. 348, Saulteaux No. 347, Moosomin No. 342,

Flying Dust First Nation No. 395, Waterhen Lake No. 402. Based on available data and assuming homogenous distribution, the percentage of residents identifying as Indigenous in the Extended Service Area is approximately 14% for Alberta, and 21% for Saskatchewan.

2.2.3 Population

2.2.3.1 Historical Population Trends and Projections

Within the City of Lloydminster, the majority of the population resides on the Alberta side of the border at 63% of the total population according to the 2021 Census. However, population growth on the Saskatchewan side has outpaced growth on the Alberta side, with the percentage of the population on the Saskatchewan side increasing from 34% in 2006 to 37% in 2021.

Overall population growth trends in Lloydminster are closely linked with economic conditions and this is particularly tied to the petroleum industry. Lloydminster experienced significant population growth between 1996 and 2016, increasing from 18,953 to 31,410, which represents a 65.7% growth (annual average of 2.6%). Notably, 84% of the residents in Lloydminster city are non-immigrants, 14% are immigrants, and 1% are non-permanent residents. These statistics are relatively close to numbers in Saskatchewan (86% non-immigrants, 12% immigrants, and 1% non-permanent residents), but show a noticeable difference compared to Alberta (75% non-immigrants, 23% immigrants, and 2% non-permanent residents).

However, Lloydminster experienced minimal population growth of 0.5% between 2016 and 2021, following a period of significant expansion from 2011 to 2016 (+13.0%). During the same period, the Core Service Area saw a 3.0% decline in population. This trend has not aligned with the medium-to-high growth projections outlined in the Joint Regional Growth Strategy (2019), which projected an average annual growth rate of 2.1% to 2.2% from 2015 to 2051. The Strategy projected a 2021 population of 36,945 in their medium-high scenario, far higher than the actual 2021 Census figure of 31,582.⁶ This slowdown in population growth is factored into future population and service demand projections. However, given the economy's boom-and-bust cycles and industry-driven population changes, the potential for higher than expected growth compared with the short-term trends must be reassessed in future health service planning updates.

⁶ Joint Regional Growth Study, City of Lloydminster and County of Vermilion River – June 2019

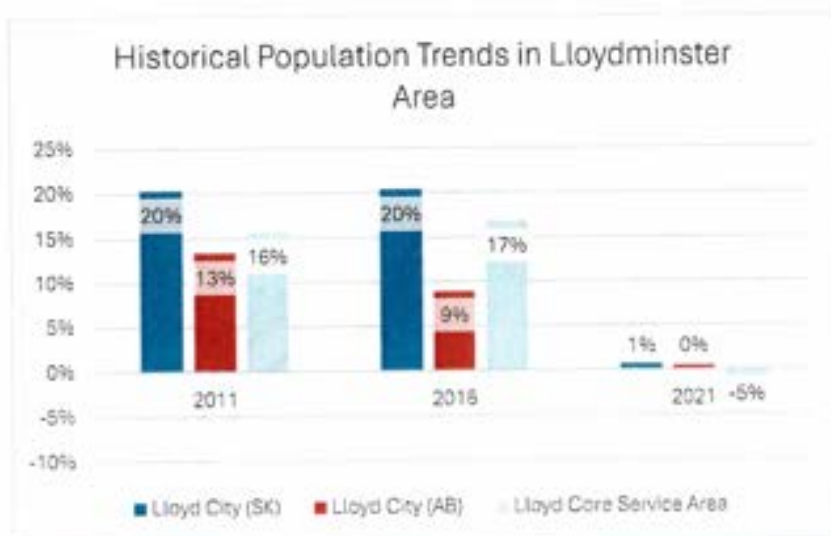


Figure 2 - Historical Population Trends in Lloydminster Area

According to the 2021 Census, the Lloydminster Census Agglomeration has one of the lowest median ages of cities in Canada at 35.6. Lloydminster has a higher proportion of children (0-19) and younger adults (30-54), while the proportion of individuals aged 55+ remains relatively low. There is also a notable difference in age distribution between the Alberta and Saskatchewan sides of the city, with the Alberta side being significantly older than the Saskatchewan side. The Alberta side has a higher proportion of seniors (14% aged 65+) compared to the Saskatchewan side, where only 7% of the population is 65 or older. With the majority of the population of Lloydminster residing on the Alberta side of the border and the Alberta side having a higher concentration of seniors 65+, there is a large skewing in the total senior population toward the Alberta side. Among all Lloydminster residents aged 65+, 77% live on the Alberta side of the border, with only 23% living on the Saskatchewan side.⁷

⁷ One contributing factor to this trend may be attributed to the city's layout, where most residential neighborhoods are located on the Alberta side, while the Saskatchewan side is more commercially oriented.

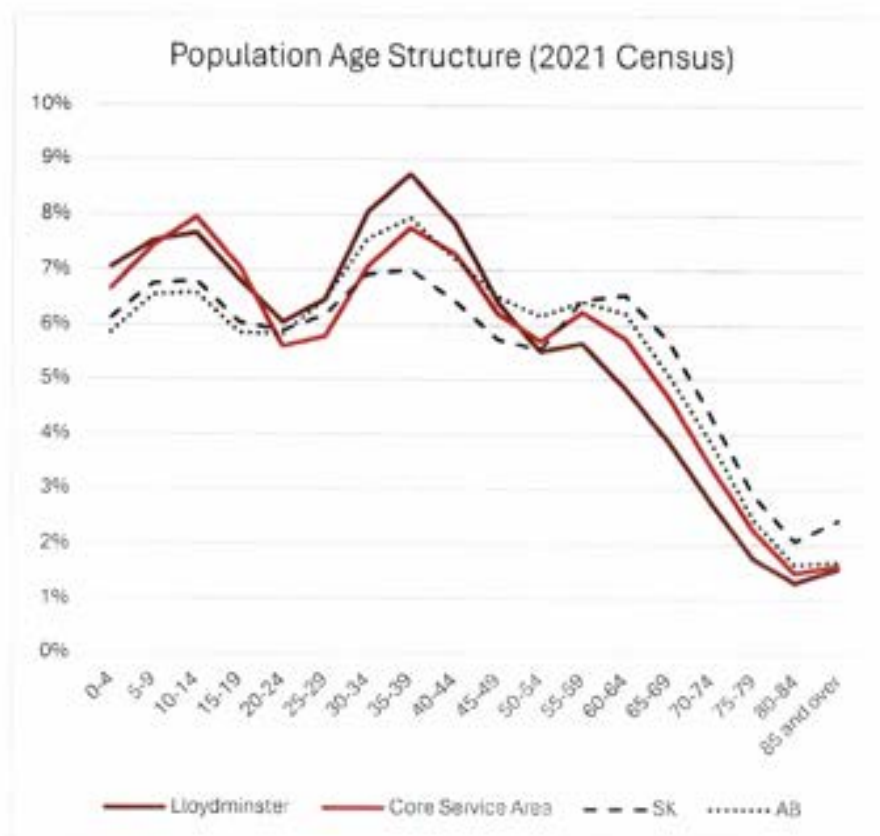


Figure 3 - Population Age Structure (2021 Census)

Population projections to 2040 were provided by each province at the LGA (AB) and SAG (SK) level. The projections utilized assume a medium growth scenario in both provinces. The rate of growth in Lloydminster and the surrounding region from 2025 to 2040 is expected to remain at a low level with a slow decrease over time in line with growth trends in the decade 2011-2021.

Population projections for Lloydminster City were developed using provincial projections at the LGA and SAG level. The historical population of Lloydminster's respective sides was compared against the historical population of census subdivisions that approximate Vermilion River County LGA and Lloydminster SAG. An increasing trend of urbanization was found, with the percentage of the population of Vermilion River County LGA and Lloydminster SAG increasingly concentrated within Lloydminster City. From 2006 to 2021, Lloydminster increased its population share of Vermilion River County LGA from 55% to 59%, while the share of Lloydminster SAG in Lloydminster City increased from 64% to 71% in the same period. At the same time, some nearby towns such as St. Walburg, Vermilion, and Kitscoty experienced population decreases. The increasing urbanization of the region is expected to

continue, and population projections for Lloydminster City were developed with assumptions that historical rates of increasing urbanization will continue into the future.

Table 3 - Population Projections for Lloydminster Area

Area	2025	2030	2035	2040	2025-30	2030-35	2035-40
Lloydminster City	33,519	35,368	37,096	38,587	▲ 6%	▲ 5%	▲ 4%
Core Service Area	72,200	73,801	75,009	75,617	▲ 2%	▲ 2%	▲ 1%
Extended Service Area	234,181	237,660	240,202	241,505	▲ 1%	▲ 1%	▲ 1%

While the population is not projected to increase significantly, the population age structure is anticipated to change, with the average age projected to increase as the community ages. This is in line with provincial and national trends, with all provinces and territories anticipated to see an increase in the population aged 65 and over and rapid increases in the population of 85 and over. This is particularly notable in the years following 2031, when a significant number of 'baby boomers' reach an age that requires increases in healthcare and support services.

Within the Core Service Area, the population 65 and over is anticipated to increase from 10,116 in 2025 to 14,549 in 2040, representing a percentage increase from 14% to 19%. The population aged 75+ is projected to increase from 4,368 to 7,830 in the same period, representing a 79% increase. The aging of the population will have substantial impacts on demand for Continuing Care, Home Care, and may subsequently have knock-on effects on demand for acute care services.

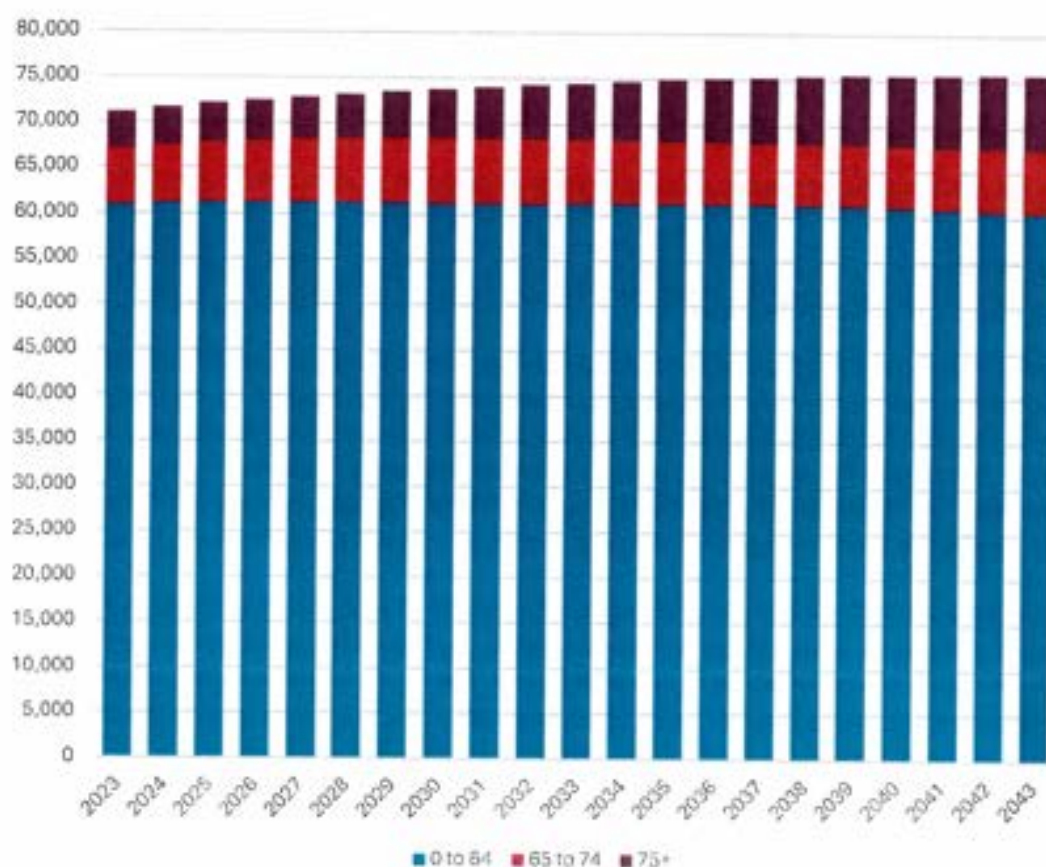


Figure 4.5 - Projected Aging of Core Service Area Population (2023-2043)

2.2.4 Population Health Trends

This section provides an overview of the population health trends for the Extended Service Area. This context informs analysis and recommendations found later in this report. Note that tracking and information management of population health trends in Lloydminster and the surrounding service area differ by province. Within Alberta, population health data is available at the LGA level. However, recent information at a similar geographical scale was unavailable from Saskatchewan. Where possible, Alberta data was assumed to be a proxy for Saskatchewan, and elsewhere, Saskatchewan provincial information was used.

2.2.4.1 Demographics and Population Health Context

The Alberta side of the Extended Service Area had an estimated population of 138,000 residents in 2023. Approximately two-thirds of this population resides in four main LGAs:

Vermilion River County (27%), Cold Lake (15%), Bonnyville (12%), and St. Paul (11%). Population growth in this region has been modest over the past two decades, averaging 10.2% between 2003 and 2023 (well below Alberta's provincial growth rate of 46.6% during the same period). Most of this growth occurred prior to 2016, as recent years have seen slowed growth or slight declines. Trends are uneven across the region; Cold Lake experienced strong growth (+49.2%), while several rural areas declined significantly, including Viking (-11.4%), Flagstaff County (-10.8%), and the MD of Provost (-8.4%). These patterns affect healthcare service distribution, with rural areas facing shrinking populations and potentially reduced access to local health infrastructure. This trend increases reliance on services available in the regional hubs, including Lloydminster, without consistent corresponding resource growth.

Age structure across the Extended Service Area shows key implications for healthcare demand. While the proportion of residents under age 18 and young adults (ages 18–34) averages 44%, aligning with provincial rates, the proportion of seniors is higher than Alberta overall (18% vs. 15%). Some communities are aging much faster; Viking (26.6%), Flagstaff County (24.6%), and the Vegreville/Minburn County area (23.6%) have more than one in four residents aged 65 or older. These LGAs also have the lowest proportion of residents under 34 (35.5–37.5%), suggesting challenges in maintaining informal care networks and local workforce capacity for community-based health services.

The region also has distinct cultural and socio-economic characteristics informing health requirements. Indigenous populations represent 50% of Frog Lake and 24% of St. Paul, compared to <1%–7.5% in other LGAs in the Extended Service Area. It is common for Indigenous communities to experience higher rates of chronic conditions, mental health challenges, and barriers to accessing culturally safe care, requiring culturally appropriate approaches to health service delivery. Additionally, immigration levels across the Extended Service Area are low compared to Alberta overall (7% vs. 20%), although Lloydminster and Cold Lake stand out as newcomer hubs and have higher proportions of visible minorities (9% and 8%, compared to 4% provincially). These factors indicate the need for local strategies to address cultural safety, language accessibility, and social determinants of health.

Economic volatility tied to the petroleum sector introduces uncertainty in population trends and healthcare utilization. Rapid in-migration during economic booms can strain service capacity, while downturns may reduce local demand and workforce availability, which ultimately challenges the sustainability of local health services, particularly in rural areas.

These demographic and socio-economic patterns underscore the need for adaptable, community-specific approaches that account for aging populations in rural LGAs, higher proportions of Indigenous residents in some areas, and the healthcare requirements of increasingly diverse populations in the larger hub communities of Lloydminster and Cold Lake.

2.2.4.2 Socio-Economic Profile

Socio-economic factors are key determinants of public health outcomes. On the Alberta side of the Extended Service Area, these factors show a mix of stability and vulnerability, with marked variation across communities. Household incomes are, on average, below the provincial norm, with a greater share of families in the lowest income quintile (22% compared to 17% provincially). However, several LGAs have a noticeably higher ratio of households with income over \$100K compared to Alberta (27%), including Bonnyville (45%), Cold Lake (44%), and Vermillion River County (38%). Lone-parent households average about 14% of families, comparable to the Alberta average at 15%, with predominantly higher female lone-parent families, also consistent with provincial trends.

Housing pressures are evident and seem to be ubiquitous across the Extended Service Area; approximately 76% of households spend more than 30% of income on shelter as homeowners, marginally above the 71% province-wide rate. However, homes in need of major repair average nearly double the provincial rate. These combined factors suggest a struggling middle class. The percentage of households living in rental dwellings is generally lower than the province (28%) with the exception of Cold Lake (30%), which also has seen the highest population growth, has a higher proportion of residents under 34 years, and is a hub for newcomers.

Homelessness data was only available for Lloydminster City, and shows a sharp increase in recent years. Based on data collected in October 2024^{*}, approximately 246 individuals experienced homelessness in the City of Lloydminster, which is a significant jump from almost 160 in 2013. Over two thirds of participants surveyed in the homelessness count reported having lived in Lloydminster for at least one year, indicating local homelessness may not be primarily driven by in-migration or transience. The majority of respondents indicated financial causes as the primary reason for their homelessness, likely related to the rapid industry changes in the local economy over this same period.

In terms of education and employment, high school completion rates are slightly below the provincial average (75%) in almost all LGAs (69%). Although the ratio of those with university degrees is lower (16%) compared to the province (35%), this is relatively compensated by other post-secondary degree/certificate attainments, which aligns with the regional context that employment is mostly tied to resource-based industries (such as oil and agriculture).

^{*} <https://www.lloydminster.ca/news/posts/city-of-lloydminster-provides-data-from-point-in-time-homeless-count/>

2.2.4.3 Health Status and Life Expectancy

Across the Extended Service Area, chronic disease prevalence is broadly consistent, though there are important local variations. Average rates across LGAs for COPD (5% vs 3% AB), diabetes (10% vs 8% AB), hypertension (24% vs 21%), and ischemic heart disease (5% vs 4%) are close to the provincial rates though generally higher. Notably, Frog Lake and Viking show the highest burdens of hypertension, both at 31%.

Health behaviours and risk factors in the region differ significantly from provincial averages. Overweight and obesity rates are notably higher than in Alberta overall (average of 72% vs. 65% AB), peaking at 86% in Frog Lake and exceeding 70% in Bonnyville, St. Paul, Vegreville/Minburn, Vermilion River, and Viking. Smoking prevalence is also elevated (24% vs. 14% AB), reaching 32% in Two Hills and 31% in Provost. Similarly, heavy drinking⁹ is considerably more common in the region (36% vs. 24% AB), with the highest rates observed in Two Hills (61%) and Frog Lake (51%). By contrast, the proportion of residents meeting physical activity guidelines is roughly in line with the provincial rate (28% vs. 30% AB).

Additionally, the self-reported rates of "In Very Good or Excellent Health" across the LGAs average close to the provincial level, though slightly lower (49% vs. 53%). The largest difference from average is reported by Frog Lake residents at 35%, representing the lowest rate.

Life expectancy across the Extended Service Area shows meaningful variation between communities, reflecting broader differences in health determinants and outcomes. Most LGAs in the Alberta portion of the service area show life expectancy in the range of 78 to 81 years, aligning closely with the provincial average (81.2). The highest life expectancy belongs to Vermilion River County at 86.6 years, while Frog Lake County (75.7) and St. Paul (76.2) have the lowest records. Notably, these two LGA have the highest percentage of Indigenous residents as mentioned above, reflecting national patterns of health disparity for Indigenous communities. Regional data is not available for the Saskatchewan side, however, Canadian Institute for Health Information (CIHI) data indicates a life expectancy at birth of 80.2 years for the province based on 3 years of pooled data, 2015–2017.

The leading causes of death in the Alberta portion of the Extended Service Area mirror provincial trends, with chronic conditions dominating mortality patterns. Across the region, cancers (all types combined) and circulatory diseases are the top contributors to premature and overall mortality. In most LGAs, cancer accounts for roughly 17–33% of deaths, while circulatory diseases (such as ischemic heart disease and stroke) contribute another 11–30%. Other significant contributors include respiratory and neurological diseases.

⁹ At least one episode of 5+ drinks per month.

2.2.4.4 Primary Care Access

Most residents in the Alberta side of the Lloydminster service area visit a GP 3.4 times annually, which is lower than the provincial estimates (4.2). Enrollment in Primary Care Networks (PCNs) across LGAs averages at 86%, slightly below the provincial level (89%). However, while most areas are close to the average, the lowest rates belong to Vermilion River County (69%) and Cold Lake (77%). This could be reflective of the fact that these locations typically accommodate higher numbers of newcomers and a more mobile workforce. This also may suggest that some of these residents predominantly need to rely on walk-in clinics or Emergency Departments and may experience challenges for access to multi-disciplinary services such as chronic disease management, mental health supports, and health promotion, which are typically delivered through PCNs. Nonetheless, clinic-level continuity in the region is considerably above the provincial level (47% vs. 31%). This is a desirable factor and an indication that Alberta's PCN works well in supporting resident in smaller communities and residents are less likely to rely on walk-in clinics or emergency departments for episodic needs. Lower continuity undermines opportunities for preventive care, chronic disease management, and early intervention, and creates pressure downstream in emergency and hospital services, particularly for populations with complex needs.

In Alberta, the Modernizing Alberta's Primary Health Care System (MAPS) initiative¹⁰ provides a strategic framework for the evolution of primary health care over the next five to ten years. The MAPS Strategic Advisory Panel final report (May 2023) sets out 11 recommendations aimed at strengthening primary health care delivery, with particular attention to the needs of rural and remote communities. The report emphasizes improved access given to team-based care, stronger integration between primary and community care, and the establishment of a coordinated and accountable provincial system¹¹. A central component of the MAPS roadmap is the development of a regional model for primary care to build on the strengths of existing PCNs while addressing current gaps in service delivery. Under this model, regional networks would assume responsibility for meeting the primary health care needs of both attached and unattached patients within defined geographic areas and a unified governance. This approach is intended to enhance equity of access and fragmentation of service responsiveness across Alberta.

The CIHI data for the North Central West Zone (SK) during the 2023-24 fiscal year shows that 20.6% of visits to emergency departments were for conditions that could be managed in primary care (SK: 17.5%, Canada: 14.6%). In addition, there were 577 per 100,000 hospitalizations for Ambulatory Care Sensitive Conditions (SK: 405, Canada: 281). Both of

¹⁰ <https://www.alberta.ca/modernizing-albertas-primary-health-care-system-maps>

¹¹ <https://www.alberta.ca/modernizing-albertas-primary-health-care-system-engagement>

these metrics are higher than the provincial and national averages, indicating a poor performance with regard to primary care in this area.

2.2.4.5 Maternal and Child Health

Childhood immunization rates across the Alberta area vary widely and, overall, fall below provincial averages. For children under the age of two, the LGA average coverage for DTaP-IPV-Hib¹² vaccine (71%) lags behind Alberta's 75%, and the MMR¹³ immunization (80%) also trails the provincial rate of 85%. Nonetheless, there are marked disparities between communities. Some, like Viking (82% and 94%) and Cold Lake (83% and 90%), exceed or closely align with provincial benchmarks. Others, such as Two Hills County (27% and 37%) and Vegreville/Minburn (50% and 66%), fall significantly short.

A comparable metric of breakdown by childhood immunization type was not available for Saskatchewan, though all childhood vaccines have been declining in the Core Service Area and the Extended Service Area over the previous 5-year period. The average of the Extended Service Area SAG childhood vaccination doses administered is 6% less in 2024 than in 2019. This could be due to immunization resources being directed towards COVID vaccines during this period, but nonetheless represents a risk for childhood exposure to preventable illness.

This gap may lead to vulnerability in outbreaks with significant short-term and long-term consequences for the public, particularly in rural and remote communities where access to higher levels of care is not immediately available. Targeted public health strategies are required to address localized barriers to immunization uptake.

¹² Diphtheria, tetanus, pertussis, polio, and haemophilus influenzae b

¹³ Mumps, measles, and rubella

2.3 GUIDING POLICY AND PLANNING DOCUMENTS

Lloydminster's unique bi-provincial context presents inherent complexities in the planning, regulation, and delivery of healthcare services. Each province maintains its own legislative framework governing healthcare, including core health services, mental health and addictions, public health, privacy regulations, and provider licensing and regulation. As a result, service providers and patients in Lloydminster must navigate a complex healthcare system with policies that are at times conflicting, leading to challenges to healthcare access and delivery.

Key legislation such as Alberta's *Health Information Act* and Saskatchewan's *Health Information Protection Act* set distinct requirements for the management and disclosure of personal health information, complicating the ability for patients and providers to seamlessly access medical information and records between provinces. Regulations around service standards and licensing also differ between provinces, adding significant complexities to the system. While the challenge of dual legislative and policy frameworks is especially acute in Lloydminster as a cross-border city, these challenges exist in other regions that straddle provincial borders, both between Alberta and Saskatchewan as well as between other provinces.

Please refer to Appendix 4.3 for a comprehensive list of Health Acts and Regulations used to inform planning efforts throughout this project.

2.3.1 Operational Impacts of Dual Jurisdiction

Lloydminster's status as a bi-provincial city presents ongoing operational challenges for health care delivery. While collaboration exists at higher administrative levels, the day-to-day reality for health care providers, support staff, and facility managers is often complicated by the need to navigate two distinct provincial systems. Depending on where care is delivered and the patient's province of residence, teams must work within different legislation, regulatory standards, and service frameworks.

These jurisdictional complexities affect frontline operations across multiple areas, including mental health services, long-term care, professional licensing, and health system navigation. This section highlights key operational impacts stemming from the dual-jurisdictional environment.

To support joint planning, Alberta and Saskatchewan participate in the Bi-Provincial Health Services Committee, which facilitates information sharing and joint planning between AHS and SHA for service delivery in Lloydminster and the surrounding area.

Under a past service agreement, Alberta provided funding through AHS to SHA to deliver acute care, primary care¹⁴, and mental health services to Alberta residents living in Lloydminster or accessing services at Lloydminster Hospital. Although a new agreement was developed in 2020, it was never formally signed. AHS and SHA continued to operate under the terms of the draft agreement, which officially expired on March 31, 2025.

In May 2025, Alberta announced that Acute Care Alberta (ACA) would assume governance and coordination responsibilities for acute care services in the province as of April 1, 2025. Alberta confirmed that there would be no immediate changes to the existing working relationship between the Saskatchewan Ministry of Health and AHS, and that Saskatchewan should continue coordinating directly with AHS until a formal transition to ACA takes place. As of October 2025, ACA is fully operational and no major changes to interprovincial coordination have been identified. Leadership transition is underway following the announced retirement of interim CEO Dr. Chris Eagle, who oversaw ACA's initial establishment and implementation of its governance and accountability frameworks.¹⁵

2.3.1.1 Mental Health Legislation and Service Protocols

Mental health care delivery in Lloydminster is governed by two distinct legal frameworks: the *Alberta Mental Health Act* and the *Saskatchewan Mental Health Services Act*. These acts differ in their provisions for involuntary admission, legal documentation, timelines, review processes, and designated authorities.

In emergency situations, first responders and clinical staff must determine the appropriate legislative framework based on the location where the individual was apprehended and their province of residence. This requirement introduces procedural delays and legal uncertainty, particularly when rapid clinical decisions are required.

Operational Implications:

¹⁴ Future agreements will need to include new agencies and corporations involved in primary care, specifically Primary Care Alberta (PCA) and Regional Primary Health Care Networks (RPHCNs). Inclusion of RPHCNs will depend on their operational status at the time of the agreement.

¹⁵ <https://edmontonjournal.com/news/politics/breakdown-of-alberta-health-agencies>

- Staff must be trained in both Alberta and Saskatchewan mental health legislation, including distinct forms and detention criteria.
- If an individual in Lloydminster experiences a mental health crisis and meets the criteria for involuntary admission under either Alberta's or Saskatchewan's Mental Health Act, they cannot be admitted to Lloydminster Hospital given it is not a designated mental health facility under either province's legislative framework. As a result, individuals requiring involuntary admission must be transferred to a designated facility in their respective province. The closest Alberta-designated facilities are in Ponoka (~300 Km) and Edmonton (~250 Km).
- Procedural errors due to jurisdictional ambiguity may result in legal exposure or compromised continuity of care.

2.3.1.2 Continuing Care Facility Standards and Facility Operations

Continuing Care facilities in Lloydminster operate under either Alberta or Saskatchewan licensure, with each province applying different regulatory standards regarding staffing ratios, facility design, and operational oversight. Alberta generally maintains more prescriptive requirements, while Saskatchewan offers greater operational flexibility under its Personal Care Homes framework.

In Alberta, Continuing Care covers Home Care, Supportive Living, and Long-Term Care. The Alberta Continuing Care Act, effective April 1, 2024, designates spaces in three categories¹⁶:

Type A: Previously known as Long-Term Care, including nursing homes and auxiliary hospitals. Provides 24/7 care for the most complex needs by Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Health Care Aides (HCAs).

Type B: Previously known as Designated Supportive Living. Provides 24/7 health and personal care for more complex needs by LPNs and HCAs.

Type B (Secure): Previously known as Designated Supportive Living, Dementia. Provides 24/7 health and personal care with specialized dementia care in a secure environment.

Type C, hospice: Provides 24/7 on-site health and personal care by specialized healthcare professionals, support staff, and volunteers.

Continuing Care facilities in Saskatchewan do not have comparable prescriptive classifications, though facility types are identified in the Facility Designations Act. Special

¹⁶ See Section 3.6 - Continuing Care for details.

Care Homes are run by the Saskatchewan Health Authority or operated by a provider that has a contract with the Health Authority. Special Care Homes have 24/7 nursing care, physician oversight, and therapy services, and are largely equivalent to Alberta's Type A spaces. There is no equivalent to Type B spaces in Saskatchewan, leading to system challenges, with Alberta providing a service that does not exist in Saskatchewan.

Facilities serving a mixed-resident population frequently face pressure to adopt Alberta-level standards, even when licensed in Saskatchewan, to meet expectations for Alberta-funded clients. However, funding levels do not always align with these standards.

Operational Implications:

- LTC homes may be required to operate at Alberta-standard service levels while receiving Saskatchewan-level funding.
- Family members often report confusion regarding eligibility criteria, fee structures, and care expectations.

Note: Staff are required to adhere to the policies of the jurisdiction in which the facility operates. Those employed in ALA facilities follow ALA policies and Alberta legislation, and similarly those in SHA facilities follow SHA policies and Saskatchewan legislation. Some staff choose to work on both sides of the border, which requires adapting to both sets of policies. In these cases, dual licensure is mandatory.

2.3.1.3 Professional Licensing and Staffing

Regulated health professionals, including nurses, physicians, and allied health staff, must hold licensure in the province where care is provided. Given Lloydminster's integrated delivery environment, many practitioners are required to maintain dual licensure across Alberta and Saskatchewan.

This dual requirement increases administrative burden, delays onboarding, and presents a barrier to recruitment and retention, particularly for new graduates or internationally trained professionals unfamiliar with the complexities of cross-provincial practice. These practitioners may choose to work elsewhere in order to avoid the dual licensure and administrative requirements.

Operational Implications:

- Dual licensure adds cost and time commitments for individual staff and human resources departments.

3 Health Services

3.1 INTRODUCTION

The Health Services sections that follow are each organized as follows:

The *Current State* section describes how the service operates today. It begins with an overview, followed by the service model (such as scope, delivery, and staffing, as applicable), key data points (such as historic utilization trends), and the service's relationships with other components in the system (such as local programs, regional sites, or community). It concludes with the key challenges that currently impact the service. The content in this section was primarily gathered through engagement with stakeholders, resources and data shared by the provincial data teams, and online research.

The *Future State* section outlines how the service is expected to evolve. It includes an overview of the service line's future direction, service-specific assumptions that underpin the planning, and directions for future operations along with requirements that would enable their accomplishment. It also identifies anticipated system impacts, showing how the proposed changes may strengthen service delivery and integration. The content in this section is primarily informed by the consulting team's analysis of engagement and data findings, and is validated through multiple rounds of engagement with clinical, administrative, and operational stakeholders.

3.2 GENERAL PLANNING ASSUMPTIONS

The following assumptions have been included in the development of the demand projections:

- Given the various data sources used throughout the project for each area, the baseline period selected to serve as the current state and baseline for the future state modeling is slightly different among the different areas. The chosen baseline period for each area is documented in each of the program area sections for reference.
- All Programs/Services were given an opportunity to review the baseline data during the engagement meetings. In these meetings, Clinical and Operational leadership from each area were shown program-specific activity and utilization analysis, and were asked to confirm that the baseline data was felt to be appropriate and reflective of their lived reality.
- All modelling recommendations are based on a 15-year planning horizon out to the year 2040.
- The population forecasts are based on the SK Population Projections Medium Growth Scenario provided by the SK MOH, combined with the publicly available Alberta Population Projections taken from the Alberta government website (in March 2025).
- The model assumes that the site will continue to operate at the same level of efficiencies as is currently seen unless stated otherwise in the program section; No efficiency improvements have been factored in in terms of reducing patient visits or Length of Stay (LOS) unless stated otherwise in the program section.
- The projection methodology projects the future state utilization growth based on the population aging and growth rate defined by the Lloydminster Core Service Area, namely Vermillion River County Local Geographic Area (LGA) on the Alberta side and Lloydminster, St. Walburg and Maidstone Small Geographical Areas (SGA) on the Saskatchewan side. Provincial population projections were determined to be sufficient to forecast growth, with no significant regional development plans being expected to impact future growth in the area. If actual growth outpaces projected growth, this could be addressed in any future refreshes of the Health Services Needs Assessment (HSNA).

3.3 SYSTEM SERVICE MODEL

The primary objective of Lloydminster's health service system is to ensure patients receive care in the most appropriate setting for their needs, with better coordination across the continuum of services and across jurisdictions. Achieving this goal is challenged by staff availability, infrastructure limitations, and systemic barriers such as interprovincial information-sharing. Within the scope of this project, these objectives and constraints have informed the following strategy for system change:

Upskilling Generalist Staff

A central feature of the future system recommends building local capacity by equipping generalist staff with higher-need specialty skills within a safe and appropriate scope. This approach would allow Lloydminster to provide a broader range of services locally, reducing dependence on tertiary centres and enabling patients to remain closer to home without requiring local recruitment of specialist staffing. As a significant expansion in speciality service capacities is not anticipated, ongoing educational programming could be in place to ensure continued competence among staff to meet some specialized needs.

Supporting Primary Care Providers

Primary care providers are recommended to be supported to focus on general practice medicine by increased access to allied supports, streamlined administration, and appropriate overhead supports. In the future, stronger connections between family physicians, community health teams, and acute services could reduce unnecessary Emergency Department visits and improve continuity of care. These changes are anticipated to create a system where patients could rely on primary care for most of their needs, with timely referral pathways to specialist services as required. It should be noted that currently, an important barrier to achieving this goal in Saskatchewan, is the lack of a streamlined information sharing system (e.g., visits, medication history, immunization records, etc.) between different service areas including acute care, primary care, and home care.

Local Access to Specialized and High-Acuity Services

Another significant shift to explore would be in expanding access to specialized and higher-acuity services within Lloydminster, where warranted by demand, aligned with provincial policy, and upskilling generalist staff would not be reasonable. Converting the existing Special Care Unit into a Regional ICU would allow the hospital to stabilize and treat more complex patients locally, reducing transfers to Edmonton or Saskatoon. Surgical services could grow to meet rising demand, supported by additional operating room time, extended hours, and targeted recruitment. Maternity care could be enhanced by stronger interprovincial referral pathways. Interprovincial referral pathways should be developed in consultation with the PCA

and the Provincial Pathway Hub/Facilitated Access to Specialist Treatment (FAST) program to ensure coordination and consistency. Collectively, these improvements may enable Lloydminster to function more effectively as a regional service hub.

Strengthening Preventative Care

The future system should place greater emphasis on prevention and wellness to reduce avoidable demand on acute services. Enhanced community resources and case management could support patients before conditions escalate, particularly in areas such as mental health, chronic disease, and elder care. Emergency Department demand could be moderated through rapid access¹⁷ to primary care for lower-acuity patients, expanded community mental health capacity, and appropriate clinical support in community to vulnerable populations. These strategies could help improve health outcomes while easing pressure on acute care.

Timely Transitions from Acute Care

Reducing delays in patient flow should be a priority. Establishing a Transitional Care Unit (TCU)¹⁸ within the Lloydminster community would ensure patients who no longer require acute care have an appropriate setting to stabilize, assess, and plan for appropriate community or continuing care. Improved discharge planning, combined with stronger links to home care and community health services, could shorten hospital stays and free up beds for patients requiring higher levels of care. This would improve both patient experience and hospital efficiency.

Delaying Continuing Care Admissions

Future planning is also recommended to focus on delaying or avoiding premature admissions to continuing care. By supporting family caregivers, expanding respite services, and ensuring elders have access to appropriate community-based resources, the system could help people remain in their homes longer, relieving pressure on long-term care facilities while supporting dignity and independence for older adults.

Proactive Planning for Future Demand

Population growth and aging will significantly shape future service needs. Primarily due to an aging population, Emergency Department visits are projected to continue rising, surgical demand projected to exceed 5,000 procedures annually, and continuing care and inpatient pressures will increase. Planning to meet demand requirements in a more efficient system

¹⁷ Section 3.7.1.2.3 outlines further detail in relation to the introduction of a Primary Access Clinic (PAC) in Lloydminster.

¹⁸ Further detail in relation to the overall functionality of this TCU can be found in section 3.6.1.2.3 of this report.

with greater cross-service coordination would result in improved health outcomes for the community. Importantly, Lloydminster must also be viewed within the larger provincial health services planning frameworks for its strategic and future needs planning.

3.4 ACUTE CARE

Lloydminster Hospital currently provides 66-bed inpatient capacity, including 38 medical beds supported by a hospitalist system, 12 surgical beds, 13 maternity beds, and a three-bed High Acuity Unit (or Special Care Unit) offering step-down care for patients who require closer monitoring or short-term respiratory support. Patients requiring advanced critical care are transferred to tertiary hospitals in Edmonton or Saskatoon. The facility is physically located in Saskatchewan and operated by the Saskatchewan Health Authority (SHA), with Alberta Ministry of Primary and Preventative Health Services funding a portion of the hospital services under the existing MOU. Saskatchewan is responsible for staffing, day-to-day operations, and capital infrastructure.

Acute planning within the scope of the Lloydminster Health Needs Assessment is limited to Lloydminster Hospital to ensure it meets the needs of the surrounding region. The scope of this study does not include recommendations on service shifts or demand projections for other acute facilities within the 150 km radius.

Lloydminster Hospital is the primary acute care facility serving the city and surrounding region. It provides a range of core hospital services including:

- 24/7 emergency care
- Inpatient medical and surgical units
- Maternity and obstetrics services
- Diagnostic imaging and laboratory services
- Surgical procedures including outpatient procedures

Lloydminster Hospital is designated as a Regional Hospital by the Facility Designation Regulations (Saskatchewan Regulations 74/2017)¹⁹. As a part of these regulations, the hospital is required to provide:

- i. Medical services
- ii. Basic radiography and laboratory services
- iii. Fluoroscopy and computerized tomography diagnostic services
- iv. Emergency stabilization services
- v. Observation and assessment services
- vi. Convalescent and palliative care
- vii. Surgical services
- viii. Obstetrical services
- ix. Intensive care services

¹⁹ See Appendix 4.3 Health Acts and Regulations.

- x. Specialty medical services in the areas of internal medicine, general surgery, obstetrics, and gynaecology

Regional hospitals may also provide:

- i. Specialty medical services in areas including, but not limited to, orthopaedics, ophthalmology, urology and otolaryngology
- ii. Rehabilitation Services
- iii. Long-term care
- iv. Health assessment and screening services
- v. Counselling services
- vi. Therapy services
- vii. Referral services
- viii. Health education services
- ix. Health promotion services
- x. Disease and injury prevention services
- xi. Chronic disease management services
- xii. Disability management services

At present, Lloydminster Hospital does not offer Intensive Care Services despite regulatory indications. Battleford's Union Hospital, located 1.5 hours by vehicle from Lloydminster, is the nearest facility that offers intensive care services.

Within the core service area, there are other acute care sites offering limited services in Vermilion, Maidstone, and Turtleford. There are many acute care facilities within the extended service area, the most significant being Battlefords Union Hospital, which is also designated as a Regional Hospital. Battlefords Hospital offers a similar scope of services as Lloydminster Hospital, including emergency, medical, surgical, obstetric, and psychiatric care, as well as an ICU and diagnostic imaging services.

Within the hospital, the Lloydminster Community Cancer Centre delivers cancer treatment services under dual provincial programs, ensuring residents on both sides can access chemotherapy and related cancer care close to home²⁰. The hospital also offers maternal services, supporting low- to moderate-risk pregnancies, with capacity for both scheduled and emergency caesarean sections and epidurals. Its maternal unit includes three birthing rooms and 13 antepartum and postpartum beds. In addition, Lloydminster Hospital provides pediatric surgical procedures and stabilized pediatric care within the adult acute care unit.

²⁰ The hospital has historically provided healthcare services under contract with Alberta Health Services (AHS) to support the Alberta population in the region, although the contract relationship may change in the future following the new restructuring in Alberta and the establishment of Acute Care Alberta.

Originally built in 1986 to serve a population of 15,000, Lloydminster Hospital has not undergone significant expansion despite the city's population doubling since then. The SHA indicated that the inpatient catchment population for Saskatchewan residents was 21,772 in 2023-2024. Between 2021 and 2024, Lloydminster Hospital reported an annual average of 48% of inpatient discharges associated with Alberta Health Card holders. Using that as a proxy for the Alberta catchment population, the hospital serves approximately 42,000 people. The catchment population is not the same as the population within the 150 km service area indicated in this study, as many communities within the area are served by local hospitals, with higher-level services accessed in Edmonton and Saskatoon. Nonetheless, the expansion of services at Lloydminster Hospital may potentially lead to attracting a larger population to the facility from surrounding areas.

3.4.1 Emergency Department

3.4.1.1 Current State

3.4.1.1.1 Overview

The Emergency Department (ED) is a central entry point for acute care, with 14 treatment spaces. These include a dedicated resuscitation bay for trauma or life-threatening emergencies, general treatment bays for urgent and semi-urgent patients, and a designated observation bed for psychiatric care. The ED operates 24/7 and is equipped to manage a full spectrum of medical and surgical emergencies, from acute cardiac and respiratory presentations to injuries requiring stabilization prior to surgical intervention. Staff are trained to provide emergency pediatric care as well, ensuring that both adult and child patients can be assessed and treated on site.

3.4.1.1.2 Service Model

The ED operates as a Tier 3 Emergency Department (Regional Hospital level of service), and is capable of handling resuscitation, laboratory, and medical imaging services. It is open 24/7 to assess and manage urgent and critical cases for anyone who requires these services. Patients arriving at the ED are triaged based on severity using the Canadian Triage and Acuity Scale (CTAS), so that the most urgent and life-threatening cases are treated first, and those with less critical needs are seen in turn. CTAS levels and definitions are outlined in the table below.

Table 4 - Canadian Triage and Acuity Scale

CTAS Levels and Associated Definitions	
Level	Definition
CTAS 1 – Resuscitation	Conditions that are threatening to life or imminent risk. Immediate intervention is required. Examples may include cardiac arrest, severe respiratory distress, major trauma.
CTAS 2 – Emergent	Conditions that could potentially threaten life, limb, or function if not treated quickly. High risk of deterioration. Examples may include chest pain suggestive of myocardial infarction, stroke symptoms, severe asthma attack.
CTAS 3 – Urgent	Conditions that cause significant discomfort or disability or have potential to deteriorate. Not immediately life-threatening. Examples may include moderate abdominal pain, high fever in adults, moderate asthma attack.
CTAS 4 – Less Urgent	Conditions that related to patient age, distress, or risk of complications but are not likely to deteriorate rapidly. Examples may include minor fractures, mild asthma exacerbation, lacerations needing closure.
CTAS 5 – Non-Urgent	Conditions that are stable, non-urgent, and not likely to deteriorate. Often could be managed in primary care. Examples may include mild cold, prescription refill, chronic problem follow-up.

Following renovations in 2012, Lloydminster Hospital introduced a Fast Track Zone in the ED to improve workflow and reduce wait times for less urgent patients; this area is usually not staffed and operational. In practice, low CTAS patients (including CTAS 4 and 5), are triaged and seen with the entire presenting population.

Formal connection with primary care is not available. The Prairie North Health Centre service model intention was to operate after hours care to divert low acuity ED presentations, but due to staffing shortages it is unable to provide extended hours.

The ED is staffed by emergency-trained nurses and physicians, typically with one physician covering all 14 treatment spaces. The physician care is provided under a fee-for-service model. Nursing staffing levels are established based on operational needs, rather than provincially established ratios.

Lloydminster residents have access to Advanced Life Support (ALS) paramedic care through Medavie Blue Cross and WPD Ambulance, which provide pre-hospital interventions such as cardiac care, respiratory support, and medication administration to stabilize patients before they arrive at the ED. The EMS system in Lloydminster is co-ordinated between SHA and ACA.

Service is organized into Emergency Service Zones (ESZs). WPD held the Saskatchewan contract under legacy agreements, and Medavie Blue Cross was contracted on the Alberta side. Although this contract was tied to zones and is currently the subject of a dispute resolution process, the system is intending to shift towards a 'closest available ambulance' model, with a desire to move to a single ambulance provider having previously been indicated. In current practice, WPD is dispatched first for Saskatchewan calls, and Medavie Blue Cross units are available to supplement coverage when needed from Alberta.

Most patients receiving EMS services are transported to Lloydminster ED, with diversions occurring when required based on bypass protocol or operational needs, for example, stroke patients may be taken to Battlefords if CT services in Lloydminster are unavailable. Rare exceptions, such as Code Orange mass-casualty events, may also necessitate alternate destinations.

When patients present at the ED with mental health concerns, they are assessed by ED staff and are held until psychiatric evaluation is possible, if they are considered a danger to themselves or others. On-call psychiatry is available, though limited, so patients requiring assessment wait in ED for sometimes several hours. Lloydminster does not have a dedicated inpatient mental health unit, so certified patients are generally transferred to the mental health inpatient unit at Battlefords Hospital (Saskatchewan residents) or Ponoka Hospital (Alberta residents). Non-certified patients may be discharged with follow-up care to mental health community teams, which include nurses, social workers, and case managers, though care coordination with community is limited. More discussion of the mental health emergency system can be found in Section 3.7.1, Mental Health Emergency and Acute.

3.4.1.1.3 Key Data Points

Relative to 5 years ago, annual Lloydminster Hospital Emergency Department (ED) visits have declined by -6% (or ~1,500 fewer annual ED visits), from approximately 25,300 ED visits in 2019/20 to 23,800 visits in 2024/25. However, despite a reduction in ED visit volumes, the number of hospital admissions from the ED remained consistent at ~1,900 annually, reflecting an increase in the hospital's ED admission rate from 7.8% up to 8.3% in 2024/25. The following information provides a summary related to the current state of the Lloydminster Hospital ED:

- Patients presenting themselves to the Lloydminster ED in 2024/25 were more acute than in previous years. Canadian Triage and Acuity Scale (CTAS) 1 and 2 patients visiting the Lloydminster ED made up 13% of the ED visits in 2024/25 compared to only 11% in 2019/20. In addition to this, CTAS 3 patients made up 33% of total visits in 2024/25 compared to 29% in 2019/20 further indicating a shift towards a more acute visitor profile.

- Patient Length of Stay in the ED has increased, with patients spending an additional 2 hours longer in the Emergency Department (on average) than before, and an average ED LOS increasing from 3.7 hours in 2019/20 up to 5.8 hours in 2024/25 from the time of patient registration to disposition. In comparison to peer community hospitals in Saskatchewan (i.e. facilities with comparable annual ED visits between 10k to 30k, as seen in Lloydminster Hospital), the median ED LOS seen elsewhere is 2.6 hours, which is half of the wait time an average patient is experiencing at the Lloydminster Hospital ED. When comparing Lloydminster Hospital to its peers, it has the highest ED LOS. (Do note that from an acuity perspective, Lloydminster Hospital was found to have a similar median proportion of CTAS 4 and 5 ED visits relative to its peers, indicating that patient acuity is likely not influencing the longer length of stay seen onsite).
- In 2024/25, the top most common visit categories at Lloydminster Emergency (based on Comprehensive Ambulatory Classification System (CACS) codes) were patients that "left without being seen or triaged and not seen" (LWBS), making up 15% of total annual ED visits). During the same period, patients with "Disease or Disorder of the Digestive System with or without Minor Intervention" accounted for 9% of total annual ED visits. This meant that roughly 1 in every 6 patients (or ~3,500 total annual ED visitors) who presented themselves in the Emergency Department at Lloydminster in 2024/25 did not see a physician. In comparison with peer hospitals in Saskatchewan, Lloydminster ranked the second highest in the proportion of LWBS ED visits, with only the neighboring Battlefords Union Hospital showing a higher proportion of LWBS visits (at ~19% of annual ED visits). Overall, peer hospitals showed a median LWBS ratio of 4% (or 7% when excluding patients with a "Z" diagnosis – see below), which is considerably lower than the ratio at Lloydminster Hospital.
- When looking further into the ~3,500 annual LWBS visits in 2024/25, roughly 800 visits looked to have an associated "Z" ICD diagnosis assigned, which is typically used to indicate when a patient is accessing hospital services for reasons other than illness or injury (e.g. for other social and lifestyle factors including homelessness, lack of family support, etc.). Overall, the ED visits with a "Z" diagnosis have increased from ~1,000 annual visits in 2019/20 up to ~1,400 in 2024/25 suggesting a potential increase in social issues or systemic gaps in the community being served.
- Mental Health (MH) related ED visits constituted roughly 4% of the total Lloydminster ED visits in 2024/25 (or ~1,000 annual ED visits), with half of these MH-related ED visits being for CTAS 4 and 5 patients. For patients with a MH diagnosis, Lloydminster showed a higher proportion of lower acuity MH patients visiting the ED when compared to the peer sites in Saskatchewan (where the median percentage of MH ED visits for CTAS 4 and 5 patients was 40%).
- In 2023/24, there were 299 patients who were residents of the core service area who utilized hospitals outside of Lloydminster for MH-related reasons. Of these, few were transferred to Saskatoon or Regina (5% and 3% respectively), largely utilizing facilities in North Battleford, Edmonton Zone (28%), and Central Zone (21%).

3.4.1.1.4 Key Relationships

Key relationships for ED include:

EMS: ED and EMS, including both WPD and Medavie Blue Cross contracted providers, work closely together for coordinated emergency patient care.

Inpatient Units: Patients are admitted to inpatient units when required following ED assessment and management. Coordination for bed availability is required and capacity in both inpatient and emergency spaces is limited. At times, patients are admitted to ED as inpatients when medical beds are unavailable.

Other Sites: Based on protocols, provincial policy, and capacity, patients are transported to other sites when they require Higher Level of Care (HLOC) or when required operationally – for example, due to staffing shortages.

Community Mental Health: Non-certified mental health patient presentations may be discharged to community mental health teams, although in the current state coordination and information transfer is limited.

Primary Care: When patients are discharged with instructions to follow up with their primary provider, information sharing should take place including discharge summaries. Additionally, on occasion patients may be diverted to primary care following ED presentation for low CTAS issues.

3.4.1.1.5 Key Challenges

Emergency Department Pressures

The Emergency Department provides broad-based care, but its role as the first point of contact for many patients underscores several challenges. While the ED is well equipped for resuscitation, psychiatric observation, and pediatric emergencies, it absorbs high volumes of patients whose needs might otherwise be met in community settings. Rising acuity in presentations also increases the complexity of stabilization before transfer to tertiary facilities.

Length of Stay and Patient Flow

One of the most significant challenges for the ED is prolonged LOS, due to systemic inefficiencies in patient flow, including one provider serving all 14 spaces, delays in specialist

consultations, or access to inpatient beds. Though exact volume of these patients was not known due to the aggregation of data, it was identified by stakeholders that inpatient bed shortages can result in admitted patients being held in the ED for a prolonged period, reducing available treatment spaces and slowing throughput for new arrivals. This issue is further exacerbated by challenges associated with outflow, particularly, ALC patients and capacity limitations in Continuing Care.

Patients Leaving Without Being Seen

The ED experiences a high proportion of patients Leaving Without Being Seen (LWBS). Many of these cases are low-acuity patients or individuals with social factors recorded under "Z" diagnoses, such as homelessness or lack of family support. This high LWBS rate reflects long wait times, insufficient fast-track services, and limited alternatives in the community for non-urgent concerns.

Mental Health Care Capacity

Mental health presentations make up approximately 4% of ED visits, and staff face significant challenges in meeting mental health patients' needs. On-call psychiatry is limited, and patients requiring psychiatric evaluation often wait for several hours in the ED, which is not designed to secure holding standards. This poses a safety risk to patients and staff. Once seen by psychiatry, certified patients are routinely transferred to other sites with mental health inpatient care, including for short LOS or stabilization. Non-certified patients are discharged with referrals to community mental health teams, and coordination between the ED and community services is limited, resulting in gaps in care and potentially avoidable presentations.

Alignment Between Service Model and Demand

Although the ED established a fast-track zone to manage high volumes of lower-acuity cases, this area is usually not staffed and therefore not operational. As a result, all patients, regardless of urgency, are managed in the same treatment stream, which causes delayed care for low acuity patients. Efforts to divert low-acuity cases through Prairie North Health Centre have been unsuccessful due to staffing shortages, and limited walk-in capacity is available in the community. As a result, the ED is the only option for unattached or after hours patients requiring non-urgent care. Primary care shortages increase the burden on the ED and contribute to congestion and long waits.

Systemic Pressures and Coordination Challenges

The ED also faces challenges related to broader system coordination. EMS transport protocols occasionally require patients to bypass Lloydminster when services such as CT scanning are unavailable, and inpatient capacity constraints can require patients to be

admitted temporarily in the ED. Additionally, communication with community providers, including primary care and mental health teams, is inconsistent, limiting the continuity of care. These pressures are exacerbated by rising patient acuity, adding challenges for staff balancing urgent care with flow and resource limitations.

3.4.1.2 Future State

3.4.1.2.1 Overview

The Lloydminster Hospital Emergency Department (ED) is the central provider of emergency care for the region, with approximately 23,000 visits annually. Demand has shifted toward higher-acuity presentations, while persistent issues such as long wait times, high rates of patients who were LWBS, ED boarding due to inpatient bed shortages, and increasing volumes of mental health cases continue to create pressure.

Gap: The ED manages ~23,000 visits annually, with increasing acuity and a 12% LWBS rate. Single-physician coverage, lack of urgent care alternatives, and insufficient mental health supports contribute to inefficiencies and patient risk.

Recommendation for Consideration: Introduce additional providers, such as Physician Assistants (PAs)²¹, to support the physician's workload during peak hours, embed a dedicated Mental Health Nurse, and develop a Mental Health Short Stay Unit within the ED footprint. Establish a Primary Access Clinic (RAC) offsite at a primary care clinic to provide next-day appointments for diverted low-acuity presentations. It should be noted that these potential solutions would likely require additional staffing.²²

Potential System Impact: Reduced wait times and decreased LWBS rates, improved ED flow, better quality of care for mental health presentations, and strengthened integration with community-based care.

²¹ PAs practice under the supervision of a licensed physician. Any planning or staffing considerations involving PAs should account for this supervision requirement. The scope of PA practice is defined in Schedule 21 of Alberta's Health Professions Act (HPA). Under the HPA, certain health services are designated as restricted activities due to the level of risk they present to patients and the public; a comprehensive list of these activities is provided in Part 0.1 of the Act. The practice of Physician Assistants includes both restricted and non-restricted activities. In accordance with the Health Professions Restricted Activity Regulation, PAs may perform restricted activities only under the supervision of a physician.

²²

3.4.1.2.2 Service-Specific Assumptions

The 2024/25 baseline period was selected to drive the future state projections for this area. Aside from accounting for population growth and ageing, the ED projection model also considers the following potential future state service shifts and the resulting impact on the projected ED visit demand:

- Adding an ED Physician Assistant (PA) during peak hours would potentially reduce the ED patient Length of Stay and improve throughput, assisting the hospital in meeting the peer median ED LOS of ~2.5 hours from patient registration to disposition. Given that the reduced wait time would only be meeting the median of its peers (and not exceeding some of the community and surrounding hospital ED wait times), this would likely not be expected to draw in additional ED visits to Lloydminster solely due to improved wait times, but would likely improve patient care substantially.
- Improving community support (e.g. through adding temporary housing for unhoused individuals and extending primary care and community walk-in clinic hours of operation, etc.) in the region could help the site reduce the number of ED patient visits for reasons other than acute illness or injury (i.e. with "Z" ICD diagnoses) back to 2019/20 levels. This would also be expected to reduce the overall LWBS ratio from 15% down to 7% (in line with the peer SK facilities) as some LWBS patients will likely be seen elsewhere in the community.
- Having access to two dedicated short-stay inpatient hospital spaces to stabilize Mental Health patients would also improve care significantly for these patients given the number of MH patients currently being seen at and/or transferred out of the Lloydminster Hospital for psychiatric care currently. With additional MH training for the ED staffing, and the additional short-stay MH inpatient capacity, the hospital will likely draw in additional ED patients who are currently receiving care in other Lloydminster service area hospitals. Based on the stakeholder engagement in this project, it was determined that this would likely result in an +30% increase in ED Mental Health visits annually given Lloydminster's location and needs within the community.

3.4.1.2.3 Future Directions

To address the challenges in the current ED system, several service shifts are recommended to be considered. Physician Assistants (PAs) may be introduced during peak hours to support physician workload, enabling them to focus on higher-priority tasks. Nurse Practitioners (NPs) could remain prioritized for primary care expansion, not ED staffing, as these positions are not available in unlimited supply and NP skillsets are well-suited to primary care environments. Mental health services could be strengthened with the addition of a dedicated Mental Health Nurse in the ED and the upskilling of ED physicians in mental health and addictions. A Mental Health Short Stay Unit (MHSSU) is proposed within the ED footprint to maximize staffing efficiency, leverage specialist resources, and provide safe short-term stabilization. The

creation of new Transitional Care capacity and weekend discharge processes will reduce ED boarding. Together, these could work to increase ED throughput and ease the strain on hospital resources. The Home Health (HH) team's discharge function should be located within the acute care setting alongside a discharge coordinator. However, the team should continue to report administratively to Home Health, due to the importance of maintaining operational coordination between acute and community settings. This could help speed up discharges and free up beds, improving patient flow through the Emergency Department.

The development of an offsite Primary Access Clinic (PAC), integrated with primary care in Saskatchewan, could provide a structured pathway for CTAS 4 and 5 patients who do not require emergency care. Because the current nursing scope does not allow nurses to discharge patients, triage and registration processes need to occur together. This combined approach enables patients to be assessed and diverted to a next-day primary care appointment without first being admitted to the ED. It also reflects an emerging best practice across emergency departments, streamlining the patient experience by eliminating an extra step and enhancing overall patient flow. The PAC model has the potential to significantly reduce LWBS rates, improve patient satisfaction, and strengthen linkages between emergency services and community-based care. The Primary Access Clinic is best suited to operate as an SHA-operated facility with after-hours access from 3 p.m. to 7 p.m., as part of an extended hours model that addresses the lack of urgent primary care in the community.

Note: Consideration for establishing an Urgent Care Centre at LH was initially considered; however, stakeholders advised against this approach to avoid drawing additional demand to the hospital. The intended functions of urgent care are effectively addressed through the current recommendations (namely, the expansion of walk-in and rapid-access primary care services, along with improved coordination with diagnostic services) all delivered within a community setting rather than the space-constrained and higher-cost acute care environment.

Projected Requirements

Staffing adjustments are central to improving ED function. PAs may be added to peak shifts to support physician workload.²³

Mental health capacity could be significantly strengthened by introducing a dedicated Mental Health Nurse into the ED, complemented by targeted training for ED physicians in psychiatric assessment and management. The MHSSU, which may be established and placed within the ED unit, could provide 24-to-48-hour stabilization, supported by existing ED infrastructure and staffing efficiencies. Given that the ED is currently the first point of entry for patients with

²³ There are current resource challenges related to the availability of PAs. The University of Calgary is training a 2026 cohort of 20 PAs, which presents a potential future pipeline to support primary care, PAC, and ED services.

mental health and substance use crises, the location of MHSSU within this unit is considered a prudent approach.

The PAC would require additional clinic staffing, likely involving family physicians or general practitioners supported by clinic nurses and scheduling coordinators. Integration with Prairie North Plaza and local primary care networks will be critical to ensuring patient flow between the ED and next-day clinic follow-up. The implementation of this PAC may leverage off the process, protocols and learnings from AB RACs.

Additional allied health staffing, including physiotherapy, occupational therapy, and social work, would be required to enable weekend discharges and reduce ED boarding. Coordination staff would be needed to manage pathways with the PAC and other community providers. All staffing changes would require alignment with union agreements and cross-jurisdictional health professional college licencing requirements. Additionally, the pipeline for Physician Assistants is currently very small, and recruitment may be a challenge due to the small pool of qualified professionals, though stakeholders indicated system improvements are underway in this area.

Lloydminster Hospital will need to **accommodate approximately 25,700 annual ED visits by 2040**. This is equivalent to approximately +1,900 additional annual ED visits by 2040, or an **+8% growth** in annual ED visits beyond what was seen in 2024.

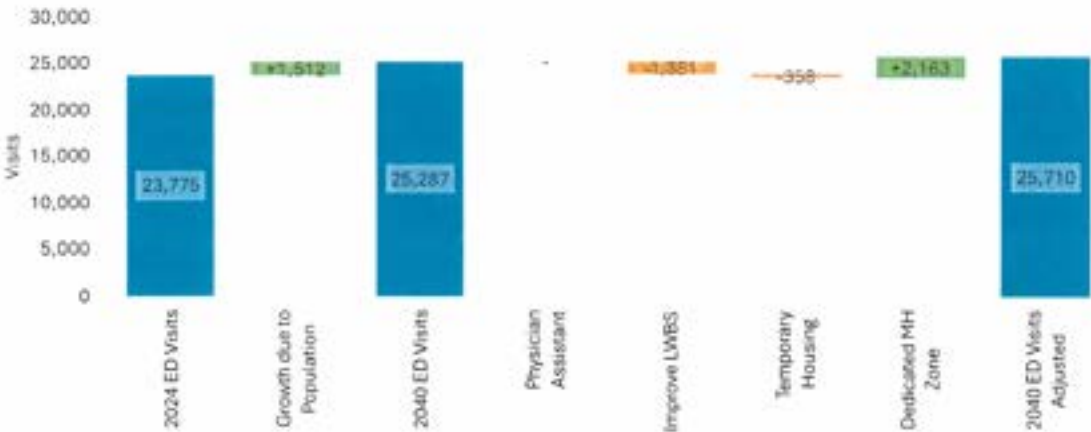


Figure 6 – ED Projected Requirements

The Demand Projection results suggest that Lloydminster’s annual ED visits will grow from ~23.8k to ~25.7k, a growth of +1.9k visits (+8%) from 2024 to 2040

3.4.1.2.4 System Impacts

The ED's primary challenges stem from increased acuity, limited alternatives for non-urgent care, and bottlenecks in admission and discharge. The LWBS rate has risen to 12%, reflecting both patient frustration and capacity constraints. The high LWBS rate is due to a number of factors, including an increase in ED visits linked to mental health and addictions and homelessness, with the ED serving as a community respite space, particularly in the winter. Additionally, admitted patients often remain in the ED due to high ALC rates, which reduces available treatment spaces and limits overall throughput.

Introducing PAs to support physicians during peak hours could expand care capacity without requiring a second physician model. Embedding a Mental Health Nurse and creating an MHSSU in the ED would improve patient and staff safety, enhance quality of care, and reduce long psychiatric boarding times. The introduction of new Transitional Care beds and improved weekend discharges would ease inpatient bottlenecks and support more efficient patient flow. The PAC would also provide an essential outlet for non-urgent cases, reducing reliance on the ED for primary care. By diverting CTAS 4 and 5 patients to next day scheduled visits, the PAC would alleviate pressure on ED staff, shorten wait times, and help ensure that ED resources remain available for true emergencies. It should be noted that some CTAS 4 and 5 presentations, including those who are LWBS, are mental health presentations for patients seeking refuge from cold weather and outdoor living; these patients would not be diverted to the PAC, and should be supported to connect to community resources from the MH nurse on staff.

3.4.2 Surgical Services

3.4.2.1 Current State

3.4.2.1.1 Overview

Lloydminster Hospital provides a broad mix of surgical services, ranging from general surgery, orthopedics, and obstetrics/gynecology to Ear Nose and Throat (ENT), ophthalmology, and endoscopy, serving both Alberta and Saskatchewan populations. Demand has steadily grown over the past few years to currently over 3,500 urgent and elective procedures completed annually across two main Operating Rooms (ORs) and a semi-dedicated Obstetric (OB) surgical suite. The hospital plays a central role in ensuring regional access to moderate-complexity surgery, while more complex specialties such as cardiac, vascular, and urology continue to be referred to other centres.

Although OR utilization is consistently high, surgical waitlists have increased faster than local capacity, with more than 1,100 patients waiting for procedures by the end of 2024/25. Certain specialties including orthopedics and ENT face particularly longer delays. At the same time, limited specialist and allied health availability create additional bottlenecks to timely access and efficient patient throughput.

3.4.2.1.2 Service Model

Lloydminster Hospital provides a wide range of surgical services, including general surgery, obstetrics/gynecology (including C-sections), orthopedics, dental surgery, ENT, ophthalmology, and endoscopy, providing both urgent and elective care including day surgeries. Services are focused on general and moderate-complexity surgeries; cardiac, vascular, and urology are referred to tertiary centres.

The program serves a mixed urban–rural population across Alberta and Saskatchewan. Key service groups include emergency and trauma cases, older adults needing orthopedic procedures (particularly joint replacements), obstetrics patients requiring surgical delivery, and specialty patients (e.g., ENT and ophthalmology) who often travel long distances.

Procedures are carried out in two main operating rooms, complemented by a third procedure space (OB suite) used for minor procedures and obstetric surgeries.

3.4.2.1.3 Key Data Points

Between 2019/20 and 2024/25, the Lloydminster Hospital Main ORs saw a +5% increase in annual surgical OR volumes, with the site going from performing approximately ~3,350

surgeries in 2019/20 up to ~3,500 surgeries in 2024/25 (equivalent to ~150 more surgeries being performed annually). This excludes Endoscopy activity happening in the dedicated Endoscopy suite. This increase in volumes translated into ~2 additional hours of OR capacity being utilized per week in 2024/25 than were used in an average week in 2019/20, an increase of +2% in weekly OR capacity used. In total, there were 91 hours of OR capacity being utilized per week in 2024/25 (compared to 89 hours per week in 2019/20). The following information provides a summary related to the current state of the Lloydminster Hospital Surgery Program:

- The surgical waitlist has grown from ~500 patients waiting for surgery in the beginning of 2023/24 up to over 1,150 patients waiting by the end of 2024/25, more than doubling in size. The overall waitlist growth was mainly driven by an increase in demand for the Orthopedics, General Surgery and Otolaryngology surgeries, with these divisions' individual waitlists each growing by +60-122% within the last year.
- Despite the growing waitlist demand, the number of patients waiting 2 times longer than their clinical diagnosis-based wait time target made up only 4% of the overall number of patients waiting at the end of 2024/25 (with roughly 40 patients having already waited more than two times longer than their target by the end of 2024/25).
- Despite having very few long waiting patients, the percentage of patients waiting longer than their clinical diagnosis-based wait time target at Lloydminster Hospital looks to have remained fairly consistent and decently high over the last two fiscal years, with roughly 20-30 percent of all patients waiting for surgery at any point in time being patients who have already waited longer than they should have (i.e. are out of target).
- Of the 3 main ORs, OR 1 and OR 2 showed an average utilization rate of ~85-88% in 2024/25. OR 3, which is the semi-dedicated Obstetrics OR, was captured to have a surgical activity utilization of ~60%. The lower utilization captured in this OR is partly due to the allocation of this dedicated capacity to perform unscheduled C-section cases as they present to the hospital (i.e. there will be times where no cases present and therefore the room will be unoccupied, but needs to be available) as well as the usage of this room to perform other minor procedures (e.g. Cataracts and "lumps and bumps") which are not recorded in the same surgical data capture. Overall utilization of OR 3 is therefore likely higher in reality than represented above, but could still represent potential opportunities to decant activity from this location that does not require an OR environment/staffing (e.g. those that could be done in a procedure room setting if one was available).
- Outside of Lloydminster Hospital, annually in 2023/24, 500 scheduled Cataract surgeries were performed on Lloydminster Core Service Area residents that travelled to another hospital site to have their surgeries.
- Roughly 200 Urology surgeries (excluding Cystoscopies) were performed on Lloydminster core service area residents that travelled to another site to have their surgeries performed in 2023/24.

3.4.2.1.4 Key Relationships

Key relationships for Surgical Services include:

ED: The OR works closely with the ED for urgent cases requiring surgical intervention, including emergency general surgery, orthopedic trauma, and obstetric emergencies. Rapid coordination is essential to minimize delays, particularly given OR capacity may be limited at peak utilization times.

Inpatient Units: Patients may be initially admitted to inpatients units pre-operatively or following procedures, if further observation or care is required. Bed availability and turnover directly affect surgical scheduling, recovery times, and the ability to manage both elective and emergent cases.

Other Sites: Patients requiring higher-acuity surgical services not offered at Lloydminster (e.g., cardiac, vascular, urology, or complex trauma) are referred to larger regional or tertiary centres, typically in Edmonton or Saskatoon.

Primary Care: Primary care providers play a key role in pre-operative referral and post-operative follow-up. Timely communication and clear discharge information are critical for ensuring continuity, reducing post-operative complication and likelihood of readmissions, and supporting patients in rural areas who may face long travel times.

3.4.2.1.5 Key Challenges

Four key challenges were identified through the engagement process and data analysis.

Capacity Constraints

With only two main ORs and a semi-dedicated obstetric OR handling over 3,500 cases annually, volumes consistently exceed available capacity. This drives persistent waitlists as described above. Previous attempts to expand operating hours beyond the standard schedule for the current ORs were unsuccessful due to lack of uptake by surgeons. Beyond elective waitlists, the absence of weekend surgical services contributes to bottlenecks with regard to urgent cases; for example, orthopedic trauma cases often remain admitted over weekends awaiting surgery occupying beds and delaying new admissions.

Specialist Availability

Although the hospital supports a wide range of surgeries, specific specialties such as cardiac, vascular, and urology are unavailable locally, requiring referrals to tertiary centres. Existing programs like ENT remain limited due to part-time surgeon availability. This factor is partially

interrelated with the capacity constraint challenges, as uncertainty about consistent OR access to maintain their full practice could negatively impact the attraction for new surgeons.

System Inefficiencies

Allied health coverage, particularly physiotherapy, is limited after-hours and on the weekends. This factor unnecessarily prolongs inpatient stays, slowing inpatient throughput and reducing patient quality of care.

Equity and Access Barriers

There are also equity and access concerns. Jurisdictional differences between Alberta and Saskatchewan create referral pathways that may limit some residents from receiving surgery at their preferred site, even when factors such as family or support networks make it the most appropriate option for patients.

3.4.2.2 Future State

3.4.2.2.1 Overview

The Lloydminster Hospital ensures access to moderate-complexity surgeries locally, while higher-complexity cases are referred to tertiary centres. Surgical demand has steadily increased in recent years, placing pressure on existing resources and driving a growing mismatch between capacity and need. The future state focuses on addressing wait times and inefficiencies in inpatient throughput, while also ensuring future readiness through expanded infrastructure and specialist recruitment.

Gap: Despite high levels of utilization, waitlists continue to rise faster than local capacity can accommodate. Patients in certain specialties experience prolonged delays, compounded by part-time surgeon availability and the absence of specialty services within Lloydminster. Inpatient stays are prolonged as a result of inefficiencies caused by limited allied health coverage after-hours and on weekends, further contributing to urgent case backlogs.

Recommendation for Consideration: The Lloydminster Hospital would require an expansion of OR capacity equivalent to an additional 29 hours per week to meet projected demand of approximately 5,400 annual procedures by 2040. Achieving this target would require extending operating hours, including the introduction of weekend surgical services, recruitment and retention of additional surgical specialists, perioperative nurses, and allied health professionals, and potentially, expansion of Medical Device Reprocessing Department, if needed.

Potential System Impact: Reduced wait times, improved equity of access, decreased unnecessary transfers to tertiary hospitals, and enhancement of patient outcomes and overall care experiences within the region.

3.4.2.2 Service-Specific Assumptions

The 2024/25 fiscal year was selected as the baseline period to drive the future-state projections for this area. Aside from accounting for population growth and ageing, the Surgical projection model also considers the following potential service shifts and the resulting impact on the projected Surgical volumes and capacity:

The recent waitlist growth was determined to not be sustainable or representative of likely future growth patterns. Specifically, the dramatic waitlist growth seen over the last couple of years for the Orthopedics service was driven by a central referral system that was put in place regionally that allowed Lloydminster Hospital to support the larger regional demand by taking on patients from other jurisdictions on a short-term basis. This resulted in an unusually high intake of patients to the Lloydminster Hospital over the last year and a large number of non-Lloydminster residents being served, a pattern which is not likely expected to continue as capacity and access improve for other hospitals for these patients to be served within their home health regions. For Otolaryngology, the waitlist growth was driven by the relocation of the primary surgeon from Lloydminster to Edmonton, resulting in the referral of a significant number of out-of-catchment patients to the Lloydminster Hospital for surgery with this physician. As these patterns are unlikely to continue into the future, the model does not assume this rapid waitlist growth rate will continue and will not suggest additional future capacity will be required to sustain it. Despite the waitlist being assumed to stabilize for Orthopedics, the model assumes that the site needs an additional Friday Orthopedics slate to handle the current workload.

There are a significant number of Lloydminster residents currently receiving Cataract surgeries outside of the Lloydminster Hospital, and it therefore could be considered that there is sufficient demand to warrant additional Cataract surgical capacity at Lloydminster Hospital to support patients in receiving care closer to home. The addition of one Cataract slate per week at Lloydminster Hospital would support this goal, with the capacity being suggested to be added on a weekend so as to not impact the already limited OR capacity available to other services during the week. This will likely represent a net gain in terms of annual surgical volumes for the site and would also support increased access for this type of care. It is considered that any potential impact on the requirement for inpatient beds would be considered to be low given that the majority of these surgeries would be day-care cases only.

Given the demand for the Urology surgical service for Lloydminster patients who are currently traveling elsewhere for surgery, it would likely be beneficial to introduce this service on site to

improve access for these patients closer to home. An additional slate of OR time could likely be reasonably accommodated within the existing capacity of OR 1 and OR 2 given the current utilization patterns, and assuming a very short profile of case types will likely be seen for this service as is seen elsewhere (e.g. an average case duration of ~1 hour per case). This will represent a net gain in terms of annual surgical volumes for the site. The model assumes that the site could manage the Surgical Day Care and Inpatient case mix in such a way as to not require additional bed capacity to support this Urology service.

3.4.2.2.3 Future Directions

Increase OR Capacity

Based on the outlined assumptions, Lloydminster Hospital it is estimated that Lloydminster Hospital will need to perform approximately 5,600 annual surgical volumes by 2040. This is equivalent to approximately +2,100 additional surgical cases annually, or a +60% growth in surgical cases beyond what was seen in 2024.

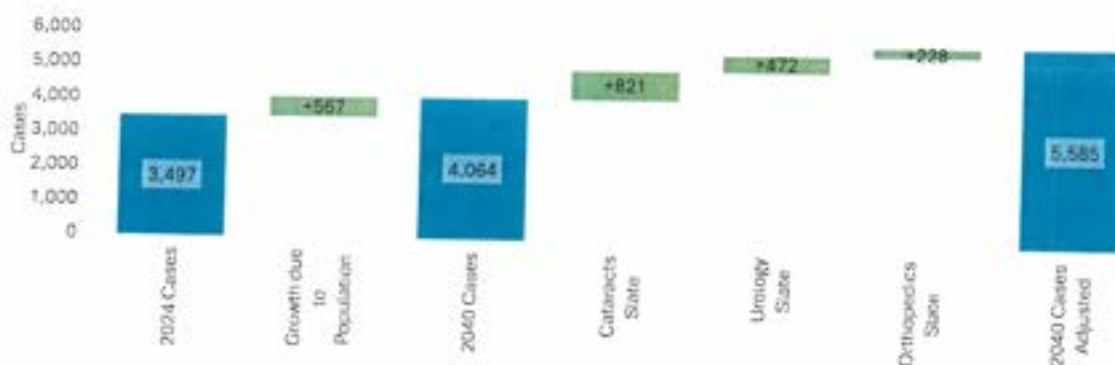


Figure 7 – OR Projected Requirements

The Demand Projection results suggest that Lloydminster's annual surgical cases will grow from ~3.5k to ~5.6k, a growth of +2.1k cases, +60% from 2024 to 2040

To carry out these surgical volumes, the Lloydminster Hospital will likely need to utilize approximately 127 OR hours of capacity per week by 2040. This is equivalent to an additional +36 hours per week of OR capacity, or a +41% growth in surgical capacity above and beyond what was utilized in 2024.

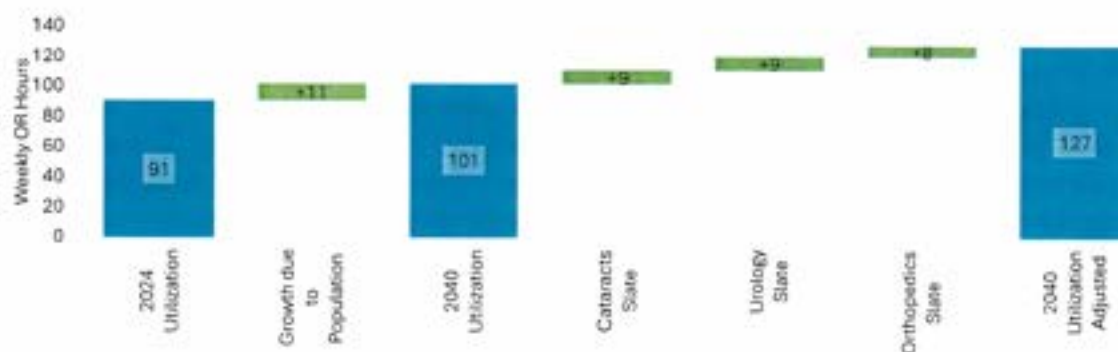


Figure 8 – OR Projected Utilization

The Demand Projection results suggest that **Lloydminster's weekly OR hours will grow from ~91 to ~127, a growth of +36 weekly OR hours, +41% from 2024 to 2040**

By 2040, the 127 weekly OR hours at Lloydminster Hospital are suggested to be allocated based on the following:

- OR 1 and OR 2 would be required to accommodate 86 hours of surgical activity per week (including the additional weekday Urology slate and Orthopedics slate). Each of the two ORs would need to run ~8.5 hours a day, 5 days a week to handle this level of surgical activity. Given the current utilization of the existing capacity within these ORs, it is likely that the two main ORs could continue to perform the same case mix that it is currently being serviced and accommodate the additional Urology (which will likely be of a shorter case profile) and Orthopedics activity through the extension of the scheduled operational hours of the ORs by an hour of additional capacity per day.
- Given the current lower utilization and potential to decant some non-OR-requiring activity to other more appropriate (e.g. procedure room) locations, OR 3 should be able to continue serving its current Obstetrics & Gynecology activity, along with the existing and additional modeled Cataract Activities (including the additional Saturday Cataract slate). This would total ~40 weekly OR hours of activities, which should be manageable for 1 OR running 5 days a week at 8 hours a day (or for a shorter duration over 6 days a week). Again, the site would need additional resources to be able to accommodate a scheduled OR day on the weekend to service the desired Surgical Day Care Cataract slate (given that scheduled surgical activity is currently not seen onsite over the weekends).

Based on these assumptions, Lloydminster Hospital will need to **accommodate approximately 10 Surgical Inpatient beds by 2040**. This is equivalent to approximately +1

additional Surgical Inpatient bed per day, or a +11% growth in the occupancy-adjusted utilization beyond what was seen in 2024.

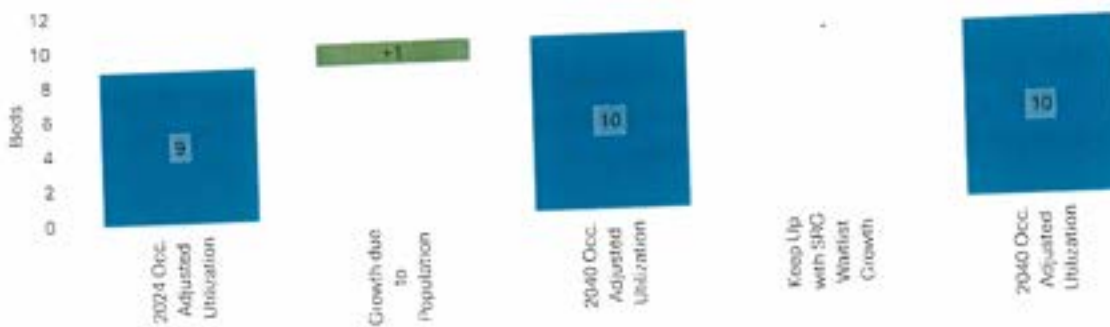


Figure 9 – Projected Inpatient Beds Utilization

The Demand Projection results suggest that Lloydminster's Surgical Occupancy Adj. Utilization will grow from 9 to 10 beds, a growth of +1 bed, +11% from 2024 to 2040

Staffing requirements would need to grow in parallel with expanded OR access:

Specialists: Recruitment is needed in ENT, ophthalmology (with succession planning required due to a pending retirement), and urology, as well as increased anesthesiology support for after-hours and weekend procedures.

Note: This factor could be partly alleviated by expanding OR capacity, which would reassure incoming surgeons that sufficient slates are available to sustain their practice, making recruitment and retention more feasible.

Nursing and perioperative staff: Additional OR nurses, recovery room staff, and surgical support staff would be required, supported by cross-training and float pool development.

Allied health staff: Weekend physiotherapy, occupational therapy, and rehabilitation assistants will be critical to enable early mobilization and discharge.

Note: Approaches such as working to full-scope of practice and utilizing professions (e.g., PT assistants) and locum-based travel teams could help support this initiative. Additionally, collaboration with educational institutions and will likely be needed to strengthen staffing pools.

3.4.2.2.4 System Impacts

The expected impact of outlined directions includes reducing wait times and unnecessary transfers, creating capacity across the region, reducing pressure on tertiary hospitals, and improving patient outcomes and experiences.

Clinical support services in Lloydminster Hospital will be impacted by increased surgical services, requiring expansion at pace with surgical volume growth.

3.4.3 Critical Care

3.4.3.1 Current State

3.4.3.1.1 Overview

Critical care capacity in Lloydminster Hospital is currently provided through a Special Care Unit (SCU), also referred to as a High Acuity Unit (HAU). The unit functions as an intermediate service between general medical wards and intensive care, with capacity for short-term stabilization of patients requiring closer monitoring or limited critical interventions. While this provides some ability to manage acute episodes locally, patients requiring sustained mechanical ventilation or full intensive care support are transferred to tertiary hospitals in Edmonton or Saskatoon.

Because Lloydminster Hospital is designated as a Regional Hospital under Saskatchewan's framework, the absence of a formal ICU creates a gap between the hospital's role in the regional system and the services it is able to provide. The reliance on inter-facility transfers places additional strain on patients, families, and emergency transport resources, while also limiting the hospital's ability to act as a true regional referral centre.

3.4.3.1.2 Service Model

The current SCU provides step-down and short-term high acuity care, with nurse-to-patient ratios higher than general medical wards but below ICU standards. Nursing staff have some additional training, but there is no dedicated ICU nursing workforce. Internal medicine and speciality physicians (including surgeons and pediatricians) oversee care, with support from

respiratory therapists for non-invasive ventilation and stabilization. Intensive care expertise is accessed through remote consultation with tertiary centres when required.

The unit is not designed or staffed to provide ongoing critical care. Patients who require prolonged ventilation, invasive monitoring, or complex interventions are stabilized and transferred to tertiary ICUs. Transfers are common and can be delayed due to weather, air ambulance availability, or transport logistics, creating additional risk for patients. Despite this, the SCU does provide essential short-term support for acute medical conditions such as diabetic ketoacidosis, respiratory failure requiring BiPAP, and other urgent presentations that can often be managed for up to 24 hours locally before transfer.

3.4.3.1.3 Key Data Points

Between Jan 2025 to May 2025, a total of 29 patients were transferred out of Lloydminster Hospital for Critical Care services in an Alberta hospital facility. 7 of the 29 had Cardiac-related diagnoses, 6 of the 29 had Neurological diagnoses (e.g. stroke), 1 had a Urology diagnosis, while the rest (15 of the 29) had Medicine-related diagnoses. Examples of these Medical diagnoses included septic shock, respiratory distress, and head injury trauma, all requiring very urgent and intensive care that could not be serviced at Lloydminster Hospital.

If Lloydminster Hospital had a regional-level (equivalent to Tier-4) ICU to care for patients in the “MED” category, it would require ~1 additional Critical Care bed, suggesting the need for a 4-bed ICU, or 5 at 95% days by 2040.

3.4.3.1.4 Key Relationships

Critical care services in Lloydminster are delivered through Lloydminster Hospital’s Special Care Unit or High Acuity Unit, which operates as a step-down service rather than a full ICU. The unit has strong linkages to the emergency department, with patients stabilized and managed in the ED before being transferred into the SCU when appropriate. Patients who develop complications in hospital medicine and surgery wards also rely on the SCU to provide monitoring and care beyond what is possible on general wards.

Regionally, critical care in Lloydminster depends heavily on tertiary facilities in Edmonton and Saskatoon. Patients who require longer-term ventilation or complex ICU care are transferred to facilities, often via air ambulance. These transfers require coordination and are dependent on weather and visibility, which create challenges for timely and appropriate care. This also places additional demand on external facilities that are already managing significant volumes, and creates delays for patients and families locally.

3.4.3.1.5 Key Challenges

Critical care in Lloydminster faces a number of challenges stemming from the absence of a designated ICU, which is required under Saskatchewan's facility designation legislation. While the hospital once had an ICU, staffing challenges led to the loss of the ICU and downgrading into the SCU. While the SCU provides short-term stabilization, it cannot deliver sustained ventilation or manage complex cases over longer periods. This has led to a reliance on external transfers to tertiary facilities in Edmonton and Saskatoon, creating delays in care and adding stress for patients and families.

Staffing capacity is a challenge that Lloydminster continues to face. While the SCU is staffed by skilled nurses, they are not ICU-trained and do not work at ratios that meet ICU standards. Recruiting and retaining ICU-qualified staff has historically been difficult and will continue to be difficult.

3.4.3.2 Future State

3.4.3.2.1 Overview

Critical care at Lloydminster Hospital is currently delivered through a Special Care Unit (SCU), which is able to manage acute episodes, but requires transfers to tertiary centres in Edmonton or Saskatoon for patients requiring sustained ventilation or full ICU-level support over long periods. The absence of a designated ICU limits the hospital's role as a regional referral centre and places additional strain on patients, families, and emergency transport systems, as well as adds delays in care.

Gap: The lack of a designated ICU represents a significant service shortfall, particularly as Saskatchewan's provincial legislation requires regional hospitals to provide this capacity. The SCU is provided with a workforce of skilled nurses that are not ICU-trained and cannot manage high-acuity cases over extended periods. The recruitment and retention of ICU-qualified staff has historically been a challenge, ultimately contributing to the difficulty Lloydminster has faced in establishing a dedicated ICU.

Recommendation for Consideration: The development of a five-bed regional-level (tier 4) unit and having it function as a regional-level service led by internal medicine physicians, and tertiary consultation support as needed. ED nursing staff could be upskilled into ICU roles, supported by staffing flexibility through collective bargaining arrangements. In this model, allied health services would ideally be available seven days a week. Following this recommendation, the hospital could accommodate approximately five ICU beds by 2040, reflecting a 67% increase in high-acuity inpatient utilization compared to 2024. Once

implemented, patient volumes, transfer activity, and utilization patterns should be monitored to evaluate performance and guide future adjustments.

Potential System Impact: Introducing a designated ICU would reduce dependence on transfers to Edmonton and Saskatoon, improve local response times for high-acuity patients, and relieve pressure on tertiary facilities. This would also enhance integration with other hospital services while bringing Lloydminster into alignment with provincial requirements for regional hospitals. Patients could also stay closer to home, improving family access.

3.4.3.2 Service-Specific Assumptions

Converting the existing Special Care Unit (SCU) to a regional-level (tier 4) ICU would enable Lloydminster Hospital to continue caring for current SCU patients while also reducing some Critical Care transfers to other sites, allowing more patients to remain closer to home. Patients appropriate for ICU care at Lloydminster would be limited to those with Medicine-related diagnoses, without specialized service requirements, and would generally have ICU stays of fewer than 10 days. Patients with specialized-service diagnoses would continue to be transferred to regional ICU hospitals that provide the necessary care.

The hospital currently has three SCU beds, with Internal Medicine patients occupying between one and three beds daily in 2024/25, largely utilizing the existing SCU capacity. For planning purposes, the 2024 calendar year was selected as the baseline for future-state projections due to limitations in more recent Discharge Abstract Data. The ICU bed projection model builds on this baseline, incorporating population growth and aging as well as anticipated shifts in service delivery and their impacts on future inpatient demand.

3.4.3.2.3 Future Directions

Establishment of a Regional-Level (Tier 4) ICU

The establishment of a regional-level (equivalent to Tier 4) ICU at Lloydminster Hospital has been identified as a critical priority to address gaps in critical care. At present, the hospital operates a High Acuity (Special Care) Unit that provides limited short-term support but does not meet ICU standards. This creates a significant gap in the continuum of care, as patients requiring sustained intensive support must be transferred to tertiary centres in Saskatoon or Edmonton. Developing a five-bed regional level ICU would bring services into alignment with provincial requirements for regional hospitals, reduce reliance on long-distance transfers, and ensure more equitable access to critical care for residents of Lloydminster and the surrounding region.

The proposed model would operate under Saskatchewan's tiered framework, similar to the approach in North Battleford. It would not function as a tertiary ICU, but instead could

function as a regional-level service led by internal medicine physicians, with ER staff possibly rotating through as required and remote intensivist consultation available for complex cases, dependent on staff availability²⁴. This proposed unit could provide continuous monitoring and management of ventilated and high-acuity patients, bridging the current gap between step-down care and tertiary critical care.

Staffing is the central requirement for implementation. The Special Care Unit is currently staffed by nurses trained for short-term stabilization, but ICU standards require a lower nurse-to-patient ratio and advanced training. Establishing ICU capacity would therefore require upskilling existing nurses into ICU roles and building flexibility into staffing models through collective bargaining arrangements. It is recommended that the ED nursing pool be cross-trained for ICU roles, increasing the depth of the pool for both services and enabling greater flexibility.

Physician coverage would be provided primarily by internal medicine specialists and ED physicians, as well as being supported by tertiary consultation as needed. Respiratory therapy services, which are already established at Lloydminster, are sufficient to support ICU operations, though national shortages remain a risk. Consideration may also be given to introducing a Respiratory Assistant role, shared between the ICU and ED, to extend coverage and optimize resources. Allied health services, including social work, dietitians, and rehabilitation, should be available seven days a week to support early discharge planning and continuity of care.

The volume of transfers from Lloydminster to tertiary centres highlights the need for a local ICU. Many of these cases involve patients who could be managed locally if ICU capacity were available. The Special Care Unit already manages patients with conditions such as diabetic ketoacidosis or respiratory failure requiring BiPAP, suggesting a steady baseline workload that could sustain ICU operations. Post-implementation, monitoring of patient volumes, transfer reductions, and utilization rates will be required to confirm the effectiveness of the model.

A designated ICU would also create important linkages with other parts of the health system. At the provincial level, it would fulfill Saskatchewan's regulatory requirements for regional hospitals. At the regional level, it would reduce pressure on tertiary centres in Edmonton and Saskatoon by absorbing cases that could be managed locally. Within Lloydminster, the ICU would be closely connected to the ED, hospital medicine, surgical services, and palliative care. This integration would strengthen the hospital's role as a regional referral centre, provide more consistent care for patients with complex and deteriorating conditions, and improve the

²⁴ Historically, there have been significant gaps in availability of remote physicians in general, as such, it is important to ensure services would be supported appropriately.

geographic equity of access to critical care across northwest Saskatchewan and eastern Alberta.

3.4.3.2.4 System Impacts

The introduction of a regional level ICU at Lloydminster Hospital would have broad system impacts across the local, regional, and provincial levels. Locally, it would address the absence of designated ICU services and significantly reduce reliance on inter-facility transfers to Saskatoon and Edmonton. This would shorten response times for critically ill patients, reduce the strain on emergency medical transport systems, and improve family access to care by keeping patients closer to home.

At the regional level, the ICU would enhance Lloydminster Hospital's capacity to function as a true referral centre for northwest Saskatchewan and eastern Alberta. It would relieve pressure on tertiary facilities by managing a greater share of high-acuity cases locally, allowing Saskatoon and Edmonton centres to prioritize patients requiring subspecialty or tertiary-level interventions.

The creation of ICU services would also improve integration across hospital programs. It would strengthen linkages with the emergency department, surgical services, and hospital medicine by creating capacity to stabilize and manage critically ill patients who would otherwise be held in suboptimal settings. In addition, the unit would support more coordinated palliative care and chronic disease management by providing short-term intensive interventions for patients with complex conditions.

System-wide, the establishment of an ICU in Lloydminster would bring the hospital into alignment with Saskatchewan's Regional Hospital designation requirements, improve geographic equity in access to critical care, and ensure that the city's role as a regional hub is supported by an appropriate level of infrastructure and clinical capacity.

Based on the assumptions discussed above, Lloydminster Hospital will need to **accommodate approximately 5 Critical Care Inpatient beds by 2040**. This is equivalent to approximately +2 additional higher acuity Inpatient beds per day, or a **+67% growth** in the occupancy adjusted utilization beyond what was seen in 2024.

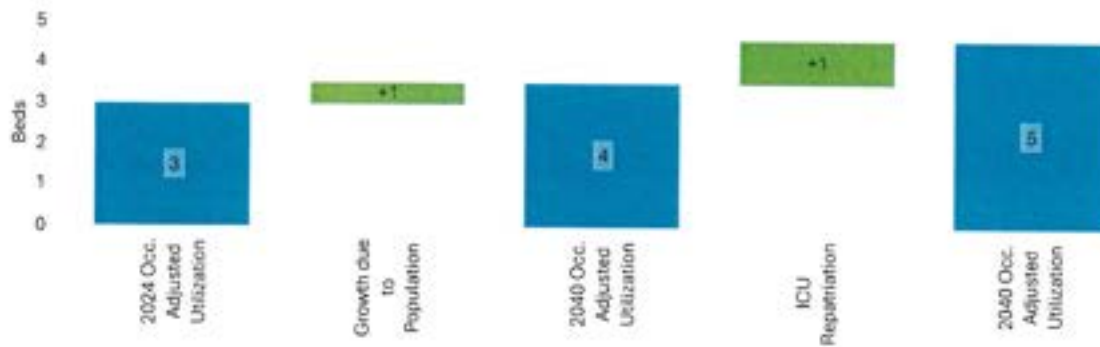


Figure 10 – Projected Critical Care Utilization

The Demand Projection results suggest that **Lloydminster's Critical Care Occupancy Adj. Utilization will grow from 3 beds to 5 beds, a growth of +2 beds, +67% from 2024 to 2040**

3.4.4 Inpatient Care

3.4.4.1 Current State

3.4.4.1.1 Overview

Inpatient Care at Lloydminster Hospital operates as a general adult acute facility, funded for an inpatient bed capacity of 66 beds, including 38 Medicine beds, 12 Surgical beds, 13 Obstetrics beds, and 3 Special Care Unit (SCU) beds. Inpatient beds also support cancer and palliative care admissions, with are supported by the on-site Lloydminster Community Cancer Centre and palliative services. Overall, Lloydminster's inpatient bed to population ratio is in line with national benchmarks as noted by CIHI, and are in line with comparable communities, indicating that bed availability is not significantly higher or lower than other communities.

Inpatient care in Lloydminster is faced with a number of challenges. Lloydminster Hospital does not have a NICU, ICU or Psychiatric beds, and relies on transfers when patients present requiring those services. This presents challenges for continuity of care, particularly when

transfers are delayed by weather, poor visibility, and other factors. Lloydminster also lacks transitional care beds, which contributes to high ALC rates within Lloydminster Hospital.

3.4.4.1.2 Service Model

Lloydminster Hospital delivers a broad spectrum of inpatient acute care services for residents of both Alberta and Saskatchewan, functioning as the regional referral centre for the surrounding communities. The inpatient service model is organized around the following core areas:

General Medicine and Surgery: Medicine and surgical inpatients account for over 90% of daily bed use. Care is supported by 38 Medicine beds and 12 Surgical beds, with the High Acuity Unit providing step-down and short-term stabilization. Patients requiring critical care beyond this scope are transferred to tertiary centres in Edmonton or Saskatoon.

Obstetrics and Maternity: The hospital provides both routine and high-risk obstetric care, supported by 13 dedicated maternity beds and five obstetricians. While nursing staff could deliver advanced respiratory support for newborns, the absence of a Newborn Intensive Care Unit (NICU) requires transfers for infants needing prolonged or specialized care. It is important to note that despite having a NICU, the current offering aligns with Regional Hospital service expectations in this regard.

Cancer and Palliative Care Admissions: Inpatient admissions for oncology patients are generally related to treatment complications, symptom management, or end-of-life care. These beds are supported by integration with the on-site Lloydminster Community Cancer Centre and by hospital medicine and palliative services.

Mental Health and Stabilization: The hospital does not have a dedicated inpatient psychiatric unit. Patients presenting with acute psychiatric needs are initially managed in the Emergency Department and, when admission is required, are transferred to designated facilities, such as Battlefords Union Hospital in North Battleford (SK) or Centennial Centre for Mental Health and Brain Injury in Ponoka (AB).

Transitional and Alternate Level of Care (ALC): Lloydminster lacks transitional care capacity, resulting in patients who no longer require acute care occupying inpatient beds. This contributes to high occupancy rates, limits flexibility to accommodate surges, and creates pressure on both the Emergency Department and inpatient units.

Overall, the inpatient service model positions Lloydminster Hospital as a regional acute care hub. While it provides a comprehensive range of medicine, surgery, obstetrics, and oncology admissions, the hospital relies on referral networks for critical care, newborn intensive care, and mental health services, reflecting both its strengths and systemic gaps.

3.4.4.1.3 Key Data Points

3.4.4.1.3.1 Benchmarking

A benchmarking exercise was completed to compare acute bed availability by population in Lloydminster and the 150 km service area defined in the study. Benchmarking was not used to determine bed requirements or projections and were used to determine indicative levels of service availability by geography. In general, bed-to-population ratios in Lloydminster, the core service area, and extended service area were within the range of national benchmarks. Benchmarking was completed at an LGA and SAG level, with the total number of beds within the LGA/SAG compared to total population of the same geographies.

Lloydminster's Acute Bed to Population ratio varies depending on the denominator of total population used. Within Lloydminster City, the 66 beds to a population of ~33,500 (2025) yields a ratio of 2.0 beds/1000. This is largely in line with national benchmarks, which is estimated by CIHI to be at 1.5-2.0 beds/1000.

The Core Service Area has 110 acute beds in total, distributed at Lloydminster Hospital (66), Riverside Health Complex (Turtleford, 9), Maidstone Health Complex (11), and Vermilion Health Centre (24). With a population of 71,284, the acute bed to population ratio is 1.5 beds/1000, which is on the lower end of CIHI's benchmark range. The lower bed to population ratio within the Core Service area compared to Lloydminster City may illustrate the true effective bed to population ratio due to low bed counts immediately surrounding Lloydminster, areas which highly utilize Lloydminster Hospital. In addition, the scope of these hospitals in the smaller surrounding communities is more limited than Lloydminster Hospital, with Lloydminster Hospital serving has a regional higher level of care centre.

The Extended Service Area has 472 acute beds in total, including the 110 acute beds within the Core Service Area. In Saskatchewan, these beds are located at Northwest Health Facility (32), Battlefords Union Hospital (88), and Unity & District Health Centre (11). Alberta's beds within the Extended Service Area are distributed at St. Joseph's General Hospital (Vegreville, 24), Viking Health Centre (16), Killam Health Centre (5), Provost Health Centre (15), Wainwright Health Centre (21), Cold Lake Healthcare Centre (24), Bonnyville Health Centre (33), Elk Point Healthcare Centre (12), St. Paul (42), and Two Hills Health Centre (15). with a population of 240,617 within the LGAs and SAGs, yielding a ratio of 2.0 beds/1000. This ratio is in line with the national benchmark cited by CIHI, and is higher than the bed to population ratio of the core service area. The higher bed to population ratio of the extended study area shows that as a whole, the extended service area does not have a relative shortage of acute beds that would put additional strain on Lloydminster, which has a lower bed to population ratio.

An analysis was completed to compare acute bed to population ratios by geography in for comparable hospitals in Alberta and Saskatchewan. Yorkton Regional Hospital (Yorkton, SK)

was chosen due to its regional designation and location in a similarly sized community in Saskatchewan, while Medicine Hat Regional Hospital (AB) was selected in Alberta due to its role as a regional hospital and location in a similarly sized community in Alberta. Geographies for these hospitals were determined using a combination of drive time analysis, proximity to other regional and tertiary hospitals, and high-level utilization data to approximate comparable geographies. Compared to similar hospitals in Alberta and Saskatchewan, Lloydminster Hospital has slightly fewer total acute beds per person.

- Yorkton Regional Hospital, Yorkton (SK) - 2.9 beds/1000
- Medicine Hat Regional Hospital, Medicine Hat (AB) - 2.0 beds/1000

Yorkton Regional Hospital's bed to population ratio was slightly higher than Lloydminster Hospital and Medicine Hat Regional Hospital. However, the bed to population ratios at Medicine Hat Regional Hospital and Lloydminster Hospital were equal, and within the national benchmark indicated by CIHI at 1.5-2.0 beds/1000. This shows that in general, Lloydminster Hospital's bed to population availability is similar to peer hospitals and within national benchmarks.

3.4.4.1.3.2 Acute Volumes

Between 2019/20 and 2024/25* (*data only available up to Dec 2024), the number of inpatient beds utilized at Lloydminster Hospital (excluding those used by newborns) remained consistent, with 56 beds utilized on an average day. While an average day saw 56 inpatient beds utilized across the hospital in 2024/25*, on busier days (i.e. the 75th percentile days) the hospital saw 60 beds in use and up to 66 beds on 'peak' days (i.e. the 95th percentile days). The following information provides a summary related to the current state of the Lloydminster Hospital Inpatient Beds:

- The hospital is funded for an inpatient bed capacity of 66 beds (including 38 Medicine beds, 12 Surgical beds, 13 Obstetrics beds, and 3 Special Care Unit beds). This meant that on an average day in 2024/25*, the hospital had an occupancy of 85%.
- In this same year, Medicine and Surgery patients utilized 51 beds on an average day, representing over 90% of the total bed usage on site.
- Despite a lack of dedicated Mental Health and Pediatric services at the facility, the hospital saw ~1 bed being utilized on an average day by patients falling under Psychiatric specialty or being under the age of 17.
- Patients falling under the 'Internal Medicine' specialty utilized between 1 and 3 beds on an average day, with these patients largely occupying the Special Care unit at the site.
- On a typical day, 4 to 7 beds were being used for Obstetrics patients (excluding newborns), making up the remainder of the 51-bed utilization seen for the hospital overall.

- The average length of stay for inpatients staying at Lloydminster Hospital remained consistent between 2019/20 to 2024/25, with an average inpatient staying roughly 5 days.
- In 2023/24 (note: an older data period used due to data limitations), the top two reasons for the inpatient hospital stay (based on Case Mix Groups, or CMGs) for patients were for "Convalescence" and "Other Factors Causing Hospitalization". Combined, these patients utilized ~8 beds on an average day at Lloydminster. Given this, it is possible that some of these patients with low acuity medical needs did not require acute hospital resources (e.g. could be better suited to a rehabilitation/long-term care facility, transition unit, or community-based convalescent care beds). Note that Alternative Level of Care (ALC) bed utilization was investigated but it was determined that ALC data coding was not accurately captured in the data sources provided. Further investigations should be done to quantify the number of sub-acute patients being seen in the acute facility specifically.
- Between Jan 2025 to May 2025, a total of 29 patients were transferred out of Lloydminster Hospital for Critical Care services in an Alberta hospital facility. 7 of the 29 had Cardiac-related diagnoses, 6 of the 29 had Neurological diagnoses (e.g. stroke), 1 had a Urology diagnosis, while the rest (15 of the 29) had Medicine-related diagnoses. Examples of these Medical diagnoses included septic shock, respiratory distress, and head injury trauma, all requiring very urgent and intensive care that could not be serviced at Lloydminster Hospital.
- In that same timeframe, a total of 36 Lloydminster core service area residents visited a nearby hospital and were admitted and discharged within 72 hours. In addition to this, 115 patients with Mental Health diagnoses stayed at Lloydminster Hospital despite no formal inpatient capacity and service being available at the facility. It is likely that some of these short-staying patients could potentially be better cared for in a dedicated Mental Health stabilization unit during the first 48 hours of their stay within the Lloydminster Hospital.

3.4.4.1.3.3 Pediatrics

This section primarily focuses on how Pediatric patients (i.e. those patients aged 14 and under) utilize Lloydminster hospital resources currently and where Lloydminster resident pediatric patients currently receive care in Alberta and Saskatchewan. The activity presented below is a subset of the overall activity within the Emergency and Inpatient program summaries presented previously, segmented to focus primarily on the Pediatric patient population.

- Relative to 5 years ago, annual Lloydminster Hospital Emergency Department (ED) Pediatrics visits have declined by -22% (or ~1,140 fewer annual ED visits), with activity going from approximately 5,250 Pediatric ED visits in 2019/20 to 4,100 visits in 2024/25. However, despite a reduction in Pediatric ED visit volumes, the number of

hospital admissions from the ED remained consistent for this patient group at ~110 admissions annually, reflecting an increase in the hospital's Pediatric ED admission rate from 2.3% up to 2.6% in 2024/25.

- Roughly 1 in 5 ED visits in the Lloydminster Hospital in 2024/25 were for Pediatric patients, with the Pediatric patients presenting to the Lloydminster ED in 2024/25 looking to be more acute than in previous years. This is indicated by the fact that Canadian Triage and Acuity Scale (CTAS) 1 and 2 Pediatric patients visiting the Lloydminster ED made up 9% of the ED visits in 2024/25 compared to only 6% in 2019/20. In addition to this, CTAS 3 patients made up 33% of total visits in 2024/25 compared to 23% in 2019/20, further indicating a shift towards a more acute visitor profile for these younger patients.
- The generally long wait times in the Lloydminster ED looks to have impacted the number of Pediatric patients that left the hospital without being seen, with 14% of all Pediatric ED visits in 2024/25 leaving without being seen that year. This represented a +5% increase from 2019/20, where 9% of all Pediatric ED visits resulted in patients leaving without being seen. The top 10 reasons for the Pediatric ED visits, which accounted for three-quarters of all Pediatric ED visits in 2024/25, are listed in the chart below. Common reasons include respiratory illnesses (such as Influenza), wounds and fractures, as well as other diseases/disorders affecting the digestive system/skin/breast/ENT.
- Although Lloydminster Hospital does not have a dedicated Pediatric Inpatient program, Pediatric patients utilized up to 1 to 2 beds in the hospital daily in 2024/25.
- From a surgical perspective, Oral Cavity/Pharynx Interventions were one of the most common surgical interventions for Pediatric patients visiting the Lloydminster Hospital, with 138 patients having these types of surgical interventions in 2023/24 (Due to DAD entry lag, 2023/24 period is used as opposed to 2024/25)
- In 2023/24, 318 Lloydminster Core Service Area Pediatric patients travelled to get care outside of the Lloydminster Hospital, with these patients being admitted as inpatients or undergoing same-day surgeries at other hospitals. Generally speaking, it appears that some of these patients traveled to receive specialized services that were not being offered at Lloydminster Hospital during this time, including Neurology, Cardiology, Urology, Mental Health, and treatment for other traumatic injuries. The chart below shows the breakdown of these patients by Major Clinical Category.

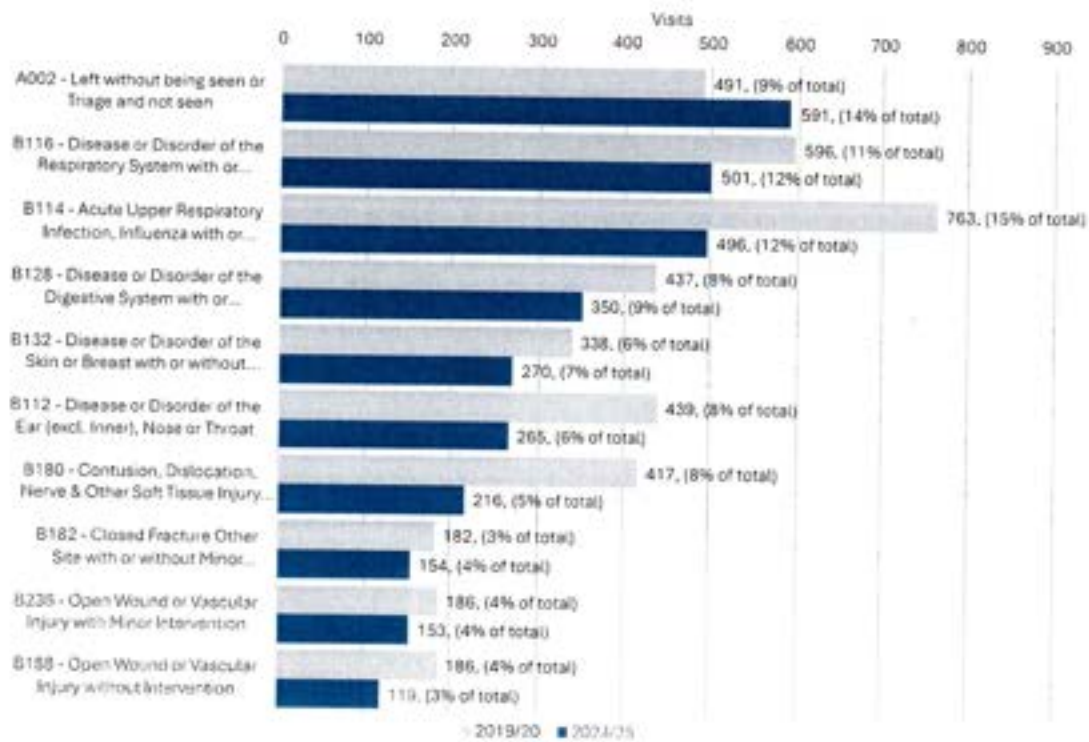


Figure 11- Pediatric Lloydminster Hospital ED Visits by CACS Code

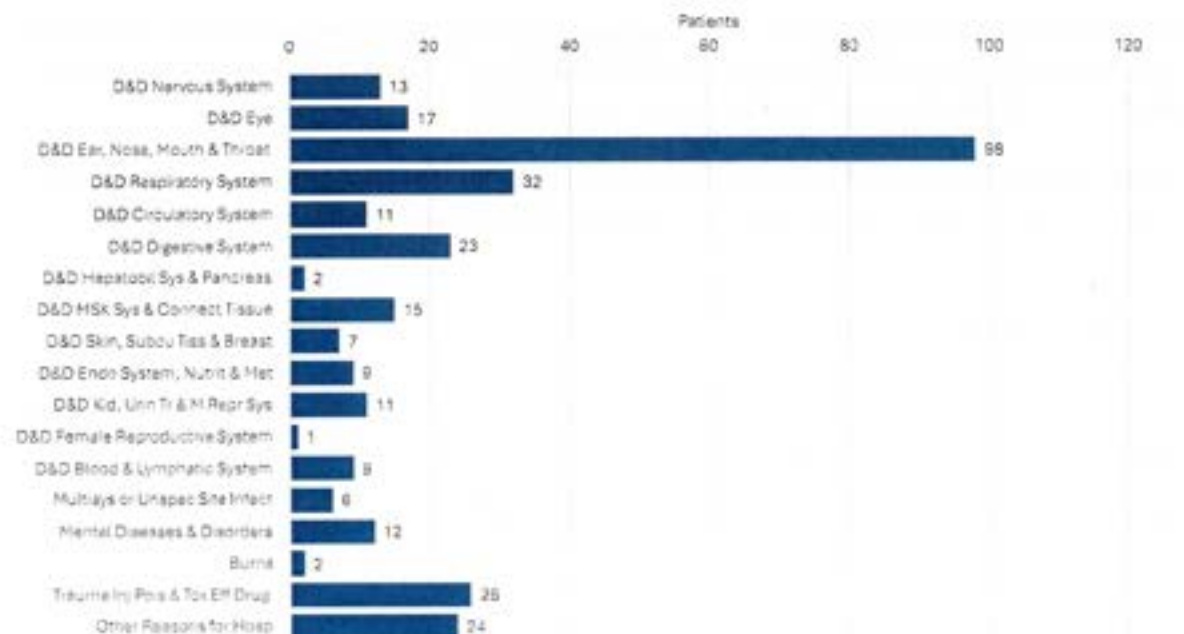


Figure 12 - Lloydminster Core Service Area Resident Pediatric Patients Travelling for Care by MCCs

3.4.4.1.4 Key Relationships

Lloydminster Hospital relies on a network of partnerships and referral pathways to deliver comprehensive inpatient care across multiple service areas. Key relationships include:

Tertiary and Specialty Centres: Patients requiring intensive care, advanced cardiac or neurological interventions, newborn intensive care, or specialized mental health stabilization are transferred to tertiary hospitals in Edmonton, Saskatoon or Ponoka. These referral pathways are critical due to the absence of local ICU and dedicated psychiatric inpatient services.

Core Service Area Hospitals: Smaller hospitals in the region, including hospitals in Turtleford, Maidstone, and Vermilion, rely on Lloydminster Hospital for higher-acuity admissions, surgical interventions, and specialized inpatient services. Lloydminster functions as the regional hub, receiving patients from these facilities when care exceeds local capacity.

Mental Health Transfers: The Emergency Department collaborates closely with regional hospitals for patients requiring short-term stabilization or inpatient mental health admission. High-acuity mental health patients are typically transferred to North Battleford (SK) or Ponoka (AB) for specialized care.

Transitional and Alternate Level of Care Support: Lloydminster lacks a dedicated Transitional Care Unit, depending on continuing care beds and home health services support patient discharge and help manage bed flow within the hospital.

These relationships collectively ensure that Lloydminster Hospital provide a comprehensive range of inpatient services, despite local gaps in critical care, newborn, and psychiatric capacity.

3.4.4.1.5 Key Challenges

While Lloydminster Hospital provides a wide range of acute care services to both Alberta and Saskatchewan residents, several challenges limit its ability to fully meet the needs the population it serves. These challenges cut across emergency, inpatient, surgical, and cancer care, and are further complicated by the hospital's unique position as a shared facility between two provinces.

Absence of Critical Care Capacity

The lack of an Intensive Care Unit remains one of the most significant service gaps. Although the High Acuity Unit provides step-down care and short-term stabilization, patients who deteriorate require transfer to tertiary hospitals hours away. The reliance on air and ground transport introduces delays, particularly in poor weather, and raises concerns about timely access for patients with life-threatening conditions. This gap places added pressure on emergency and inpatient teams, who must stabilize patients beyond what would normally be expected in a facility of this size.

Gaps in Pediatric Care

Lloydminster Hospital has a very robust obstetrics program, managing both routine and high-risk deliveries with five obstetricians and dedicated maternity spaces. However, given that Lloydminster Hospital is classified as a regional hospital and therefore does not have a formal Newborn Intensive Care Unit, there is limited care for newborns who require the highest level of care. While nursing staff could provide advanced respiratory support in the short term, infants requiring prolonged specialized care must be transferred out of the community. This places strain on families, especially given the distance to referral centres. The lack of pediatric beds also increases reliance on transfers and limits the care that could be provided locally to low-acuity pediatric patients.

Limited Acute Mental Health Services

The hospital has no dedicated acute mental health unit, and psychiatric services are limited to an observation bed in the Emergency Department. This lack of inpatient psychiatric capacity means that individuals requiring stabilization or admission must be transferred to

other hospitals, often far from their home communities. As a result, the ED frequently becomes the holding environment for patients in crisis, placing additional strain on emergency staff and reducing capacity for other acute care needs. Patients requiring acute mental health services are predominantly transferred to North Battleford in Saskatchewan or Ponoka in Alberta.

Transitional Care and Alternate Level of Care (ALC) Pressures

High ALC rates contribute to congestion across the hospital, with patients remaining admitted despite no longer requiring acute care. This reduces available beds for new admissions and contributes to ED boarding. Lloydminster lacks Transitional Care Unit (TCU) capacity to manage patients who are medically stable but not yet ready for home or long-term care. Without this intermediate step, patients remain in acute beds longer than necessary. A TCU located outside of the hospital, paired with stronger home health supports, would relieve pressure on inpatient units, improve patient flow, and allow acute resources to be used more appropriately.

3.4.4.2 Future State

3.4.4.2.1 Overview

While the Lloydminster Hospital delivers a broad spectrum of core inpatient programs, it continues to rely on referral networks for critical care, newborn intensive care, and certain specialized mental health supports, as is expected for Regional Hospital sites in an overall provincial system where highly specialized services are centrally located in major urban locations.

Gap: Demand for inpatient beds is growing as the population grows. By 2040, the Lloydminster Hospital could have a projected average daily demand of 61 inpatient beds on an average day, representing an additional five beds beyond 2024 levels and an 8% increase in average daily bed utilization. Gaps in pediatric care are also noted, with no dedicated pediatric beds or NICU. Seasonal surges in pediatric patients creates challenges for care continuity and capacity.

Recommendation for Consideration: Increase funded bed capacity from 66 to 76, consisting of 49 beds for Medicine short-stay patients, 10 beds for Surgery, 2 beds for Mental Health, 5 beds for the regional-level ICU, and 9 beds for Obstetrics and Pediatrics patients. Pediatric flexibility within medicine/surgery units is also recommended to accommodate seasonal surges in pediatric patients to enable care closer to home and strengthen continuity of care.

Potential System Impact: Increased bed counts would lead to appropriate increases to capacity based on projected demand, improving patient flow and ensuring timely and appropriate care. Pediatric flexibility within med/surg units allows for accommodation of pediatric patients during seasonal surges and allows for local admission for low-acuity pediatric conditions. This would improve continuity of care and providing care closer to home, while reducing reliance on transfers to tertiary centres.

3.4.4.2.2 Service-Specific Assumptions

The recommendations for inpatient care at Lloydminster Hospital are based on a set of shared planning assumptions that reflect current service gaps, expected demand, and system priorities.

The calendar year 2024 was selected as the baseline period to drive the future state projections for this area (due to data availability limitations in the provided Discharge Abstract Data for the more recent timeframe). Aside from accounting for population growth and ageing, the Inpatient bed projection model also considers the following potential future state service shifts and the resulting impact on the projected Inpatient bed demand:

TCU for Non-Acute Patients

The introduction of a regional Transitional Care Unit (TCU) could be established to provide care for patients who are currently receiving care in the Lloydminster Hospital despite being suitable for care within a less acute setting. The model assumes that patients falling under the “Convalescence” and “Other Factors Causing Hospitalization” Case Mix Groups would be decanted from the Lloydminster Hospital and cared for in a regional TCU in the future.

Conversion of SCU to Regional-Level (Tier 4) ICU

Conversion of the existing Special Care Unit to a Regional-Level ICU would allow the site to continue to care for the existing Special Care Unit patients and also potentially reduce some of the Critical Care patient transfers to other sites (therefore allowing high-acuity patients to be served closer to home). It is assumed that the patients who could be kept at Lloydminster Hospital for Critical Care ICU services would have Medicine-related diagnoses only (i.e. not those requiring specialized services) and would likely require ICU stays under 10 days in duration only. All other specialized-service diagnoses presenting to Lloydminster Hospital would continue being transferred to other regional hospitals with ICUs which would continue to provide the required specialized services and level of care for these patients.

Short-Stay Mental Health Stabilization Area

Establishing a short-stay Mental Health stabilization area would allow for care to be provided for the current Lloydminster hospital MH patients for the first 48 hours of stay as well as those Lloydminster resident MH patients currently attending nearby facilities for short-term care who could be repatriated and better served at Lloydminster Hospital.

Workforce Strategy

Planning assumes that workforce shortages will persist and must be addressed through role redesign, upskilling, and new staffing models. The availability of Physician Assistants, advanced practice nurses, and allied health staff will be central to supporting throughput in the ED, ICU, and surgical services. Recruitment of certain specialists (e.g., psychiatry, ENT, ophthalmology, urology, anesthesiology) is expected to remain challenging, reinforcing the importance of telehealth, virtual supports, and succession planning. Collective bargaining agreements and cross-jurisdictional credentialing will continue to shape staffing flexibility. The current structure of four inpatient/outpatient nursing managers was assessed against the expanded service demands and the added complexity of operating across dual provincial systems. While efficiencies have been achieved since the previous reduction from five managers, the cumulative management workload and oversight requirements warrant ongoing review to ensure sustainability and adequate leadership coverage. Specifically, alignment with the Alberta Health Workforce Strategy (AHWS), particularly within the "Attract", "Strengthen", and "Innovate and Evolve" strategic focus areas will help support efficiencies in this workforce strategy.

Infrastructure Investment Needs

Infrastructure investment is necessary to expand acute care capacity, but feasibility studies are out of the scope of this project. This includes the creation of a designated ICU, the development of a Mental Health Short Stay Unit within the ED, additional surgical capacity through a third OR and a fully dedicated obstetrics suite, and transitional care capacity that would need to be located outside the hospital. These investments are assumed to be phased in line with available capital planning and provincial priorities.

3.4.4.2.3 Future Directions

The future directions for inpatient care are largely driven by expected bed demand, supplemented with a direction to implement pediatric flexibility within medical/surgical units. Pediatric flexibility within medical/surgical units would enable Lloydminster Hospital to manage a portion of low-acuity and short-stay pediatric patients locally, reducing pediatric transfers and keeping care closer to home.

patients to be treated closer to home while decreasing reliance on tertiary centres. However, it is important to note that nursing expertise varies across disciplines, and differences in pediatric experience should be explicitly acknowledged when evaluating patient care capacity.

Lloydminster Hospital currently has 0 dedicated Pediatric Inpatient beds. However, there were 1 to 2 patients between the age of 1 to 17 utilizing Lloydminster Hospital med/surg beds on an average day in 2024/25.

Based primarily on population aging and growth, Lloydminster Hospital will need to **accommodate approximately 2 Pediatric Inpatient beds by 2040**. This is equivalent to the same number of Pediatric bed usage per day as was seen in 2024, or a 0% growth in occupancy adjusted utilization beyond what was seen in 2024. The implementation of pediatric flexibility within medicine/surgery units will accommodate current and projected demand for pediatric care, accommodating peaks in pediatric bed demand during surges, such as in cases of respiratory illness.

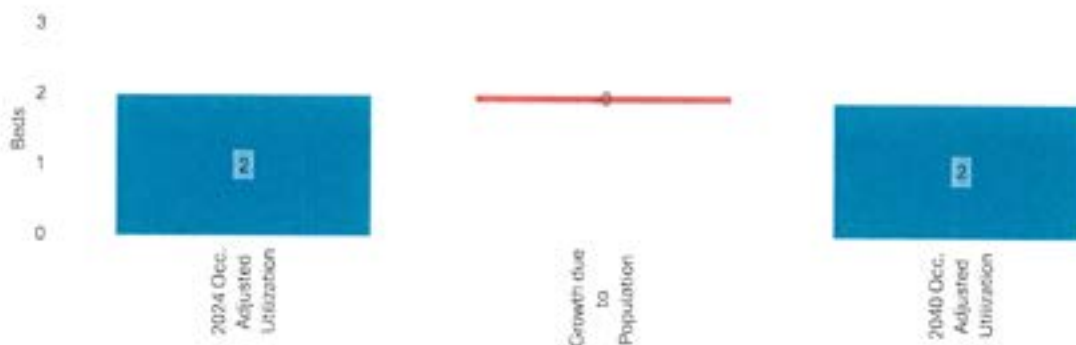


Figure 14 - Projected Pediatrics Occupancy Adj. Utilization

The Demand Projection results suggest that Lloydminster's Pediatrics Occupancy Adj. Utilization will remain at 2 beds, a growth of 0 beds, +0% from 2024 to 2040

Medicine Inpatient Beds

Lloydminster Hospital currently has 38 dedicated Medicine Inpatient beds. Patients falling under the Medicine specialty utilized 48 beds on a busy day in 2024/25 (due to off-service

Home Care, the proposed TCU, and other community supports will be essential to ensure smooth discharge process and decreased ALC rates.

Additionally, clinical support services would need to grow in parallel to inpatient bed growth, reflecting these services' corresponding increased workload.

3.4.5 Maternity and Newborn Care

3.4.5.1 Current State

3.4.5.1.1 Overview

Maternity and obstetric care at Lloydminster Hospital is well-established, with the facility supporting approximately 800 births annually. The unit includes 13 inpatient maternity beds and three delivery rooms and is staffed by five practicing obstetricians. Care services include routine prenatal assessments, labour and delivery support, and surgical deliveries, which are conducted in a semi-dedicated operating room. Nursing staff play a central role in supporting patients throughout labour and delivery and are trained to provide advanced maternal and newborn care during the immediate postpartum period. This combination of physician and nursing expertise enables Lloydminster Hospital to manage both routine and complex obstetric cases within its current service scope.

Newborns requiring more intensive care are often transferred to tertiary centres in Saskatoon or Edmonton, due in part to limited special care capacity for unwell newborns and variable physician coverage. Transfers also occur as a result of constraints related to nursing workload and the scope of general practitioner services, considerations that are expected for a non-NICU site. Despite these limitations, Lloydminster remains a key delivery site for the region.

3.4.5.1.2 Service Model

Lloydminster's maternity care model is delivered through an integrated team of obstetricians, general practitioners, and experienced nursing staff. Obstetricians provide primary leadership over delivery care, with surgical deliveries supported through dedicated access to an operating room. Postpartum care and management of healthy newborns are largely provided by GPs and nursing staff. Newborn care at the site is limited; there is a sole pediatrician with newborn training, however the site does not operate a designated Newborn Intensive Care Unit (NICU) or Special Care Nursery, and newborns requiring specialized or advanced care are transferred to tertiary facilities.

Cross-provincial coordination: Particularly in the context of inter-facility transfers, planning and operations are complicated by cross-jurisdictional governance, which requires alignment between provincial health authorities in Alberta and Saskatchewan.

3.4.5.2 Future State

3.4.5.2.1 Overview

Lloydminster Hospital plays a critical role as a regional maternity care provider, safely supporting approximately 800 births annually. However, its cross-provincial service area presents unique operational challenges, particularly when managing newborns who require care beyond the hospital's approved service scope. In the absence of a NICU, these infants are frequently transferred to tertiary centres in Saskatoon or Edmonton. While appropriate in some clinical cases, these transfers often impose significant stress on families and disrupt continuity of care.

Gap: The current service model lacks the operational supports necessary to consistently manage all clinically appropriate cases locally. Newborn transfers are sometimes driven by staffing constraints rather than patient acuity. Additionally, the absence of clear, coordinated referral and transport protocols between Alberta and Saskatchewan can further complicate care pathways for families in need of escalated care.

Recommendation for Consideration: Prioritize reducing avoidable newborn transfers by ensuring adequate and stable nursing staffing levels to manage peak volumes. Enhance interprovincial coordination between Alberta and Saskatchewan to streamline clinically necessary transfers, with clearly defined referral pathways, transport protocols, and family supports. Strengthen integration with the Emergency Department, given the frequency of high-risk maternity patients presenting through the ED, while collaborating with public health nurses, home care providers, and community physicians to support continuity of care beyond discharge.

Potential System Impacts: Addressing these gaps would reduce clinically unnecessary transfers, improve patient and family experience, and alleviate pressure on tertiary NICUs that may be already operating with constrained capacity. Strengthening nursing resources to support the full, approved scope of maternity care, while also improving coordination between provincial systems, would allow Lloydminster to function more effectively within its regional role. This approach aligns with provincial service delivery planning while ensuring that care remains safe, family-centred, and appropriately distributed across the maternal–newborn continuum.

nurses, home care providers, and community-based physicians will also be vital to support families through discharge and early parenting. Together, these improvements would position Lloydminster to deliver more consistent, family-centred maternity care within its regional role.

Based primarily on population aging and growth, Lloydminster Hospital will need to **accommodate approximately 7 Maternity Inpatient beds by 2040**. This is equivalent to the same number of maternity beds per day as were in use in 2024, or no growth in occupancy-adjusted utilization beyond what was seen in 2024.



Figure 16 - Projected Maternity Occupancy Adj. Utilization

The Demand Projection results suggest that **Lloydminster's Maternity Occupancy Adj. Utilization will remain at 7 beds**, a growth of 0 beds, +0% from 2024 to 2040

3.4.5.2.4 System Impacts

By improving nursing capacity and interprovincial coordination, Lloydminster Hospital could reduce avoidable newborn transfers and strengthen the quality and continuity of maternity care for families in the region. Fewer transfers would ease pressure on tertiary NICUs in Saskatoon and Edmonton, and would also minimize the stress and disruption experienced by families who would otherwise need to leave their communities for care.

This approach does not involve establishing a NICU, which remains outside the hospital's designated role. Rather, it supports enhanced delivery of the existing approved maternity service scope by ensuring the necessary operational and staffing conditions are in place to deliver safe, effective, and consistent care locally.

safely in a community setting, they are connected to the Community Cancer Centre, who coordinates systemic and supportive care. A community cancer transition team at the Community Cancer Centre manage referrals back into community to ensure that there is capacity to safely and appropriately care for the patients.

The Community Cancer Centre is staffed by SHA nurses who provide systemic therapy under the oversight of provincial oncology programs. Pharmacy services are coordinated locally, with treatments prepared and administered on site once consultation and review have been completed. Previously, GPs with additional oncology training supported local services; however, retirements and lack of interest from other GPs in continuing in this area prompted a transition to a remote NP model. This nurse practitioner, registered in both Alberta and Saskatchewan and holding admitting privileges at Lloydminster Hospital, provides continuity of care for Alberta patients receiving systemic treatment. The remote NP model has been effective in supporting patients; however, the service only supports Alberta patients, leading to inequitable access to care.

Staff at the Community Cancer Centre must be trained to use two Electronic Medical Systems and navigate patient pathways in two separate provinces. There is currently a small FTE allocation at Lloydminster for a RN Cancer Patient Navigation role who connects and navigates patients to additional resources they require during cancer treatment. The Community Cancer Centre has an agreement that allows SHA nurses employed at the Cancer Centre to work on two Electronic Medical Records EMRs, which has been working well, but requires additional staff time to facilitate the cross-border coordination work.

3.5.1.1.3 Key Data Points

Despite established benchmarks, wait times for oncology services are being exceeded across all tumour groups. Contributing factors include shortages of oncologists, increased demand, pharmacy clearance processes, and population growth. Alberta's Future of Cancer Impact (FOCI) report projects a 36% increase in new cancer diagnoses by 2040, rising from 23,000 to 37,000 cases annually, driven in part by an annual population increase of approximately 250,000 in Alberta. Comparable data was not available for Saskatchewan, but population increases and aging are also anticipated to increase cancer diagnoses in Saskatchewan.

Data was gathered on Ambulatory services and their activity levels at Lloydminster Hospital. The most recent data made available was from 2019/20. The table below shows the 2019/20 patient registration activities from the different Ambulatory hospital areas within the Lloydminster Hospital for those records having the registration type "Clinic", "Day/Night Care", and "Therapeutics".

The areas with the highest number of patient demand are "Medical Specialty Clinic", "Physiotherapy", "Dialysis", "Obstetrics", "Cancer Outreach", "Preadmission Clinic" and

3.5.1.1.4 Key Relationships

Acute care services: closely linked to ambulatory care, providing care prior to admission and with post-discharge follow-ups. Ambulatory care utilizes shared resources within the hospital and occupy shared spaces.

Primary care providers: refer patients to specialty clinics and provides longitudinal, ongoing care for their patients.

Tertiary care centres: renal and cancer care programs are closely linked with tertiary care centres, who have the expertise to initiate treatment and provide care planning before being transferred back to community if appropriate.

Community health teams: home care teams support patients who require care beyond the hospital visit. Community mental health teams may also support patients experiencing mental health challenges because of health challenges, such as a patient undergoing cancer treatment.

Diagnostic services: Ambulatory care's co-location with hospital lab and imaging services allows for timely results and care.

Pharmacy services: Oncology, dialysis, and chronic disease management rely on coordinated medication management.

3.5.1.1.5 Key Challenges

Workforce capacity

Lloydminster faces workforce capacity challenges, with challenges recruiting qualified health professionals ranging from nurses, allied health, and pharmacists. Workforce capacity challenges limit the care that can be provided, with roles being left unfilled. Dual-licensing requirements in Lloydminster can create barriers to recruitment and retention. Some regulatory colleges have taken steps to ease these challenges, including the Alberta College of Paramedics and alignment of other continuing competency programs. In addition, other regulators are also developing new models to support inter-jurisdictional practice that make it easier and also more affordable to maintain licensure in multiple Canadian jurisdictions.

Specialist availability

Lloydminster has a limited number and range of specialists available in community and relies on visiting and virtual models to deliver care. While this creates challenges for residents, resources in both provinces must be efficiently distributed to ensure that there is equitable

3.5.1.2.3 Future Directions

No specific future directions are recommended for ambulatory care in Lloydminster due to poor data quality and lack of feedback indicating a need for rightsizing of service levels or shifts in service delivery. However, as the population ages and the population grows, demand for services will increase, particularly in cancer and renal care. Due to Lloydminster's Cancer Care being a 'spoke' within provincial hub-and-spoke systems, system capacity is centralized and out of the control of Lloydminster. Cancer care is also shifting to toward chronic disease management with people living longer with cancer. This requires more team-based care to support care delivery and system navigation.

Expansion of services and service levels is limited by infrastructure. Existing infrastructure should be optimized, such as extended hours for clinics. The shortage of oncologists and other medical professionals will likely continue. The utilization of the full scope of services of each profession and shifting responsibilities to areas with higher capacity, such as the utilization of NPs and RN-led clinics would strengthen system capacity.

3.5.1.2.4 System Impacts

With no specific future directions indicated, there are no resulting specific system impacts. The service delivery model for ambulatory care would remain the same, with service levels scaling with demand as the population ages and grows. Provincial-level workforce strategies should be put in place to train, attract, and retain physicians and other health professionals, with strategies to expand and utilize within the existing scope of professions to build capacity and resilience in the system.

Continuing Care capacity, there are a total of 1,327 Type A beds, 478 Type B Beds, and 40 Temporary Stay/Respite Continuing Care beds.

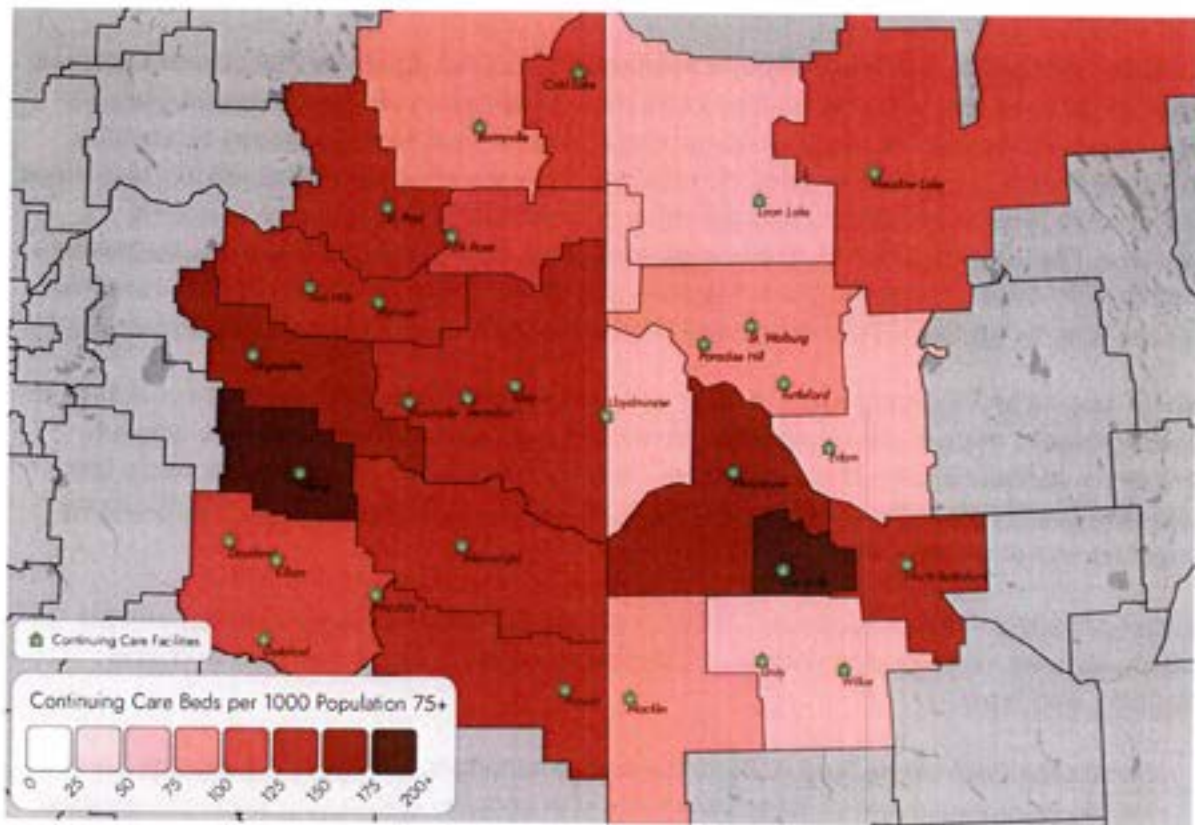


Figure 18 - Continuing Care Beds per 1000 Population 75+ by LGA and SAG

3.6.1.1.2 Service Model

Continuing care in Lloydminster operates within two provincial systems, with each province responsible for managing its own facilities, beds, and funding structures. Saskatchewan Health Authority (SHA) oversees facilities within Saskatchewan (i.e. Jubilee Home), while Continuing Care Alberta manages the facilities within Alberta (either directly managed or contracted).

Eligibility criteria and admission processes differ provincially. In Saskatchewan, temporary health cards can be issued to Alberta residents, allowing immediate admission to facilities such as Jubilee Home when needed. In contrast, access to Alberta continuing care requires individuals to first establish Alberta residency and obtain an Alberta health card. Admission is linked to the province's assessment process, which uses the MDSRI (Minimum Data Set

Within Lloydminster, there are three continuing care facilities operated or contracted by ALA and one operated by the SHA. In total, there are 160 Long-Term Care (Type A/Special Care Home) beds and 104 Designated Supportive Living (Type B) beds. Of all the Long-Term Care beds, 110 are in Alberta and 50 in Saskatchewan, while all Type B beds are in Alberta. In total, about 80% of continuing care beds are in Alberta, with the remainder in Saskatchewan.

Type A/Special Care Home Bed Benchmarking

Long-term care provision in the City of Lloydminster is currently above the national benchmark of 75 beds per 1,000 residents aged 75 and older. Across the city, there are 160 beds, which equates to 109.2 per 1,000 in this age group. This exceeds the Canadian average of about 73 per 1,000. At the core service area level, there are 304 beds (72.1 per 1,000), slightly below the benchmark, while the extended service area has 1,372 beds (86.2 per 1,000), modestly above the benchmark.

The supply of beds is unevenly distributed between Alberta and Saskatchewan. Alberta accounts for 63 percent of Lloydminster's overall population and 79 percent of the 75+ population, reflecting the stronger benefits and services available to seniors. Saskatchewan holds a smaller share of the senior population but has a higher bed ratio compared to its population base.

- Alberta: 110 beds, 76.7 per 1,000 residents aged 75+.
- Saskatchewan: 50 beds, 133.3 per 1,000 residents aged 75+.

Although both sides exceed the benchmark, Alberta faces greater pressure due to its much larger share of the 75+ population.

Lloydminster's Type A/Special Care Home bed to population ratio is within the range of comparator communities:

- Yorkton (104.6 per 1,000)
- Prince Albert (117.3 per 1,000)
- Red Deer (77.9 per 1,000)
- Medicine Hat (67.9 per 1,000)

At the provincial level, the most recent CIHI data (2021) shows Alberta at 54.2 per 1,000 and Saskatchewan at 79.7 per 1,000. Both sides of Lloydminster are above their respective provincial averages.

Some other communities with similar overall populations and bed counts demonstrate significantly lower ratios due to an older age profile. Penticton, for example, has 26.6 beds per 1,000 residents 75 and older, while Powell River has 27.8 per 1,000. These lower ratios

Within the community, links with palliative care, rehabilitation, and mental health teams are essential to supporting residents with complex or changing needs. At the system level, relationships between Alberta and Saskatchewan health authorities are fundamental, as differences in policy, funding, and reporting must be reconciled to ensure equitable access. Effective coordination across these interfaces is critical to maintaining patient flow and ensuring residents receive care in the most appropriate setting.

Specifically, coordination challenges between Lloydminster Hospital and continuing care providers contribute to sustained Alternate Level of Care (ALC) occupancy. Patients who are ready for discharge often wait due to differing eligibility rules, assessment tools, and data systems between Alberta and Saskatchewan. Earlier discharge planning and shared assessment protocols could reduce these delays and improve overall patient flow.

3.6.1.1.5 Key Challenges

The effective provision of continuing care in Lloydminster faces several challenges. The absence of transitional care beds limits options for patients who could otherwise recover function and return home, leading to avoidable long-term care admissions. Respite capacity is limited, placing additional strain on families and caregivers and contributing to crisis-driven hospitalizations and continuing care admissions. Workforce shortages, particularly among HCAs and LPNs, restrict the ability to scale services in line with population growth. Infrastructure disparities between provinces, with older Saskatchewan facilities in particular, limit the quality and flexibility of available spaces. Additionally, bi-provincial inefficiencies in eligibility rules, placement systems, and reporting requirements complicate coordination and prolong hospital stays. These challenges collectively reduce system capacity and contribute to higher acute care utilization.

Ageing Population

Within the core service area, the population aged 65 and over is projected to increase from 10,116 in 2025 to 14,549 in 2040, growing from 14% to 19% of the population. The 75+ cohort will see even sharper growth, nearly doubling from 4,368 in 2025 to 7,830 by 2040 (a 79% increase). This demographic shift will increase demand for continuing care beds, home care, and related community supports. Acute demand will also increase, as older patients represent a larger share of ALC occupancy.

Growing Resident Complexity

The population of residents entering continuing care facilities is increasing in complexity, with an increasing cohort of younger clients entering due to acquired brain injury and substance use. These patients have different medical needs and skillsets required for management than older clients, and existing facilities and staff are poorly equipped to manage these specialized

3.6.1.2 Future State

3.6.1.2.1 Overview

Continuing care services in Lloydminster provide long-term residential care and community supports for older adults and individuals experiencing chronic conditions. These facilities are unevenly distributed, with most located on the Alberta side, and eligibility criteria differ between provinces, complicating access and coordination. With the population of Lloydminster projected to age significantly over the next 15 years, the demand on continuing care beds will increase significantly. The increase required to maintain the same ratio of beds per population 75+ will be significant, both in Lloydminster but also across Alberta and Saskatchewan.

Gap: An aging population and rising resident complexity are driving increased demand for continuing care, home supports, and specialized services. The absence of transitional and respite capacity contributes to high alternate level of care (ALC) rates and delayed discharges. Staffing shortages and home care limitations further slowdown hospital flow, while differences in provincial funding models and eligibility criteria create inefficiencies, duplications, and delays in discharge planning.

Recommendation for Consideration: A Transitional Care Unit (TCU) should be established close to Lloydminster, but not within the hospital, to alleviate ALC pressures and provide a restorative environment for patients transitioning out of acute care. Enhancements to intake and discharge processes such as early discharge planning, embedded coordinators, standardized assessment tools, and seven-day allied health coverage, would also strengthen continuity of care. Realigning home health more closely with teams in acute care would also improve coordination and patient outcomes. Additionally, continuing care capacity should be planned for to reflect future demand, re-assessed following a period of TCU operations to evaluate its impact on continuing care requirements.

Potential System Impact: Introducing a TCU would reduce sustained ALC occupancy, ease demand on long-term care facilities, and allow patients to transition into more appropriate settings. Enhanced discharge coordination would shorten the median time from ALC designation to discharge, lower average ALC census, and free up acute care capacity. Standardized processes and improved interprovincial collaboration would minimize safety risks, reduce administration duplication, and improve continuity of care. Expanding preventative community supports would further reduce reliance on hospitals and long-term care.

3.6.1.2.2 Service-Specific Assumptions

The future state planning for continuing care facilities assumes that the current division of responsibilities for service delivery will continue, with Alberta and Saskatchewan continuing

provinces, issues with data capture and coding practices, operational incentives, blurring of medical with social or non-medical needs, or cultural factors.

There is a significant opportunity also to provide Respite within the TCU, to enable patients who are living at home to be assessed and connected to appropriate community supports, to prevent caregiver burnout or crisis-driven admissions to continuing care or acute care. The system need for transitional care is significant, and an investment in evaluation is recommended to understand the impact of a TCU on acute bed utilization and long-term care demand.

The TCU should be located close to Lloydminster but not within the hospital, due to the hospital's limited space and capacity. The location of the TCU in a less acute environment may also be preferred by patients. The TCU would require staffing models that combine nursing (RNs, LPNs, and care aides) with allied health supports such as physiotherapy, occupational therapy, dietetics, and social work. Recruitment of allied health staff would be challenging, and the exploration of strategies such as telehealth and shared staffing are recommended to meet needs. Physician or ideally, Nurse Practitioner oversight may be provided through dedicated Most Responsible Providers or on-call models. Specialized training would be required in dementia care, addictions, and management of complex behaviors to meet the needs of Lloydminster's increasingly diverse continuing care population.

Successful implementation of a TCU would depend on strong partnerships with acute care teams, home care providers, and long-term care facilities. Effective coordination with discharge planners, primary care providers, and allied health professionals would be central to success. Provincial health authorities in both Alberta and Saskatchewan must align referral processes and care standards to ensure equitable access across the city's bi-provincial context.

Intake and Discharge Enhancements

Improvements to intake and discharge processes has been identified as a key priority for Lloydminster Hospital to reduce unnecessary hospital stays and relieve pressure on acute care capacity. At present, patients often experience delays in discharge due to inconsistent communication across providers, differing eligibility definitions between Alberta and Saskatchewan, and limited weekend or after-hours coverage. These delays contribute to ALC pressures and create avoidable congestion in the hospital system. Enhancing intake and discharge processes is expected to reduce hospital length of stay and create smoother pathways into transitional, long-term care, or community-based services.

The proposed service shift emphasizes early, proactive discharge planning that begins shortly after hospital admission, and led by Home Health staff. Embedding discharge coordinators who are part of community health teams within acute care would enable closer alignment

AB Type B Continuing Care Beds

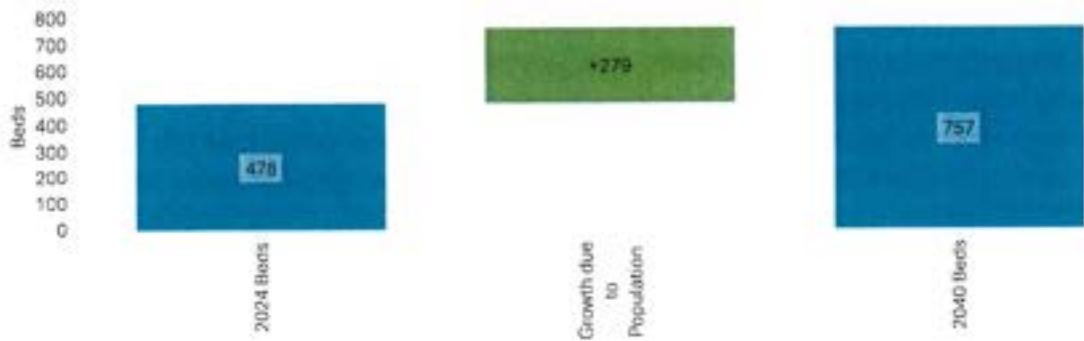


Figure 20 - Projected Type B Continuing Care Beds

The Demand Projection results suggest that Lloydminster's AB Type B Continuing Care beds will grow from 428 to 757 beds, a growth of +279 beds, (+58%) from 2024 to 2040

Respite Continuing Care Beds

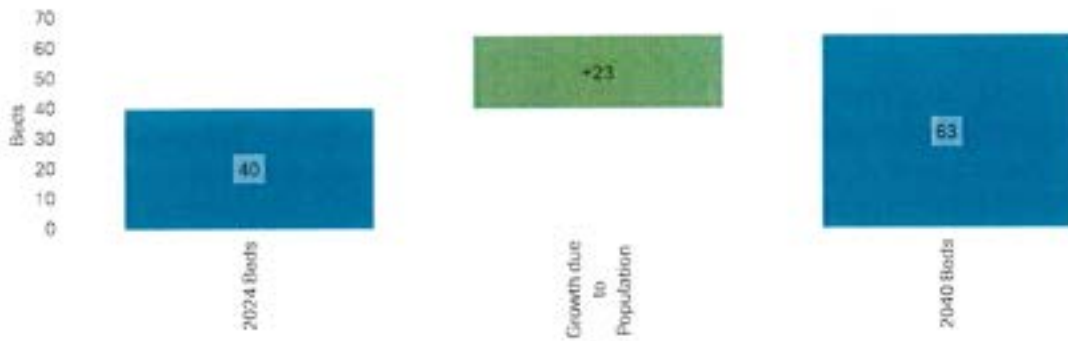


Figure 21- Projected Respite Continuing Care Beds

The Demand Projection results suggest that Lloydminster's Respite Continuing Care beds will grow from 40 to 63 beds, a growth of +23 beds, (+58%) from 2024 to 2040

3.7 PRIMARY CARE

3.7.1.1 Current State

3.7.1.1.1 Overview

Lloydminster's bi-provincial nature straddling two provinces has resulted in the development of two largely independent primary care systems. Primary care is delivered by a mix of longitudinal family physician clinics²⁷, walk-in clinics, and team-based primary care supported by provincially-funded allied staff. The primary care landscape is heavily influenced by fee-for-service models for physicians, who often operate out of multiple private clinics, many of which are licensed on the Alberta side. This has led to weaker connections between these clinics and public-sector services, particularly those managed by the SHA on the Saskatchewan side. The only SHA-run full-service family physician clinic, Prairie North Plaza, fills a critical gap by offering both scheduled primary care and limited walk-in capacity, including after-hours and weekends. However, this clinic cannot meet current demand alone.

Lloydminster is served by Lloydminster Primary Care Network (PCN) on the Alberta side and by Prairie North Health Centre (SHA) on the Saskatchewan side. The Lloydminster PCN covers Lloydminster and the surrounding area and is funded for Alberta patients only, but in practice sees Saskatchewan residents as well. There are 39 Primary Care Networks (PCNs) in Alberta that represent more than 3,800 doctors and 1,000 health care providers and serve close to 3.6 million Albertans. Primary Care Networks are not-for-profit corporations registered under the Alberta Societies Act, and are independent legal entities with a joint governance board with 2 physician members and 2 members of Primary Care Alberta. All Lloydminster PCN employees exist within a single clinic, with a nurse practitioner and allied professionals providing chronic disease management, dietician, mental health therapy, social work, and other primary care services. The primary focus of PCN relates to chronic disease management.²⁸

Within the extended service area, a number of other PCNs provide services, including Kalyna PCN (covering Vermilion, Vegreville, and Viking, Killam, Hardisty, and Tofield), Wainwright PCN, Provost PCN, Cold Lake PCN, Bonnyville PCN, and Lakeland PCN (covering St. Paul and surrounding areas). Many of these PCNs serve communities that straddle the border between Alberta and Saskatchewan and face similar challenges related to the interprovincial context, with challenges related to information sharing, challenges with referral pathways, and unaccounted patient numbers for funding. As part of the healthcare reorganization in Alberta,

²⁷As private physician clinics are independent businesses, their future requirements are not in scope of this study.

3.7.1.1.3 Key Data Points

Alberta has 39 PCNs representing over 3,800 doctors and 1,000 health care providers, serving approximately 3.6 million Albertans.

The patient attachment rate in the Saskatchewan NW4 Health Network, which includes Lloydminster and areas around Lloydminster including Maidstone and Macklin, is very low compared to other nearby Health Networks, at 40%. Due to the location of Lloydminster, residents of each province may receive primary care services in the other province, which will not be reflected in attachment numbers. As a result, attachment rates in Lloydminster and other border jurisdictions are not a reliable metric to determine primary care access for the whole population. The two primary care systems do not coordinate and communicate with each other, creating challenges in understanding the primary care system as a whole in Lloydminster. However, engagement with leadership indicated that in Lloydminster, primary care access is a substantial challenge, mirroring what the attachment rates represent.

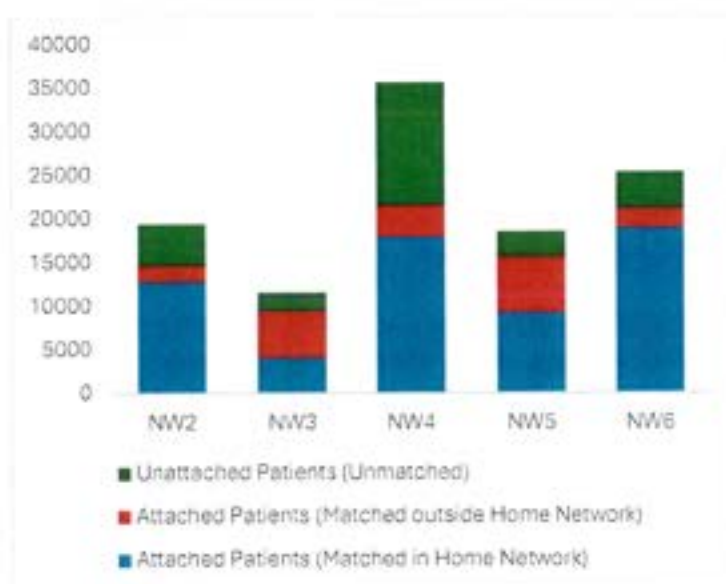


Figure 22 - Patient Attachment Rates

3.7.1.1.4 Key Relationships

Primary Care acts as the first point of contact to the healthcare system for most residents, providing comprehensive longitudinal care and urgent care through walk-in clinics. Primary care is linked to all aspects of the health system, including:

Acute Care: Primary Care providers is linked to acute care through the discharge and provision for longitudinal care for patients being discharged from the hospital and managing

cannot easily access results from across the provincial line, the test is often re-ordered in the patient's home province. Discharge communication is another area of concern. Alberta providers frequently report difficulties obtaining acute care reports from Lloydminster Hospital, a challenge also experienced by primary care providers in private clinics without formal SHA affiliation. These gaps in communication can result in incomplete or absent follow-up, leading to avoidable poor health outcomes.

Funding Structures and Systemic Barriers

A key systemic barrier to streamlining care is the lack of visibility across provincial billing systems. Because each province cannot see the billing practices of the other, duplicate billing is undetected. As a result, most clinics operate on a fee-for-service model, while publicly funded clinics are restricted to serving patients from their own province. This arrangement complicates workload measurement, population health planning, and funding allocation, as patient counts and service utilization are simultaneously under-reported and over-utilized across provincial boundaries. These challenges are not unique to Lloydminster and are shared by many border regions with high rates of out-of-province patients.

Continuity of Care and Physician Recruitment

The recruitment and retention of family physicians is another significant challenge. While this trend is seen nationally, it is especially acute in rural areas like Lloydminster, contributing to gaps in longitudinal care and increased reliance on walk-in clinics. Dual licensure and reporting requirements make recruitment more difficult, as physicians without prior ties to Lloydminster may prefer communities without the added administrative burden. Limited physician capacity constrains patient attachment as well as plans for urgent primary care, pushing more patients toward deferred care or Emergency Department use. This contributes to poor health outcomes, long ED wait times, and inappropriate utilization of acute care services.

3.7.1.2 Future State

3.7.1.2.1 Overview

The future state of primary health in Lloydminster focuses on expanded access to primary care, team-based model, and improved integration with diagnostic and support services. Currently, primary care access is a challenge, resulting in gaps in longitudinal care and increased reliance on walk-in services, including Emergency Department services.

Gap: Access to primary care is currently limited in hours and capacity, particularly with walk-in and urgent care options, leading to increased reliance on emergency room visits. The bi-provincial context also complicates funding, referral pathways, and information sharing, creating gaps for cross-border patients. Providers and regulated professionals face dual-

Recruitment in regulated health professionals is expected to remain difficult, particularly in areas outside of urban centres. Larger structural changes in interprovincial licensure requirements are not expected to change within the planning parameters of the Lloydminster Health Needs Assessment, which will continue to add administrative burden and create challenges for recruitment. Some streamlining of licensure processes may occur, but challenges are likely to persist. However, expansion of APP/ARP and contract models, as well as the growth of NPs as primary care providers, is assumed to ease the strain on primary care providers with Lloydminster and surrounding communities.

Information sharing challenges are assumed to persist, creating challenges for continuity of care and adding to reduplication of tests and services. This will continue to add workload to primary care providers and allied care staff who will continue to be required to devote additional time to acquire patient information from providers in the other province.

3.7.1.2.3 Future Directions

Primary Access Clinic

Establishment of a Primary Access Clinic at an existing primary care site operating in the late afternoon and potentially early morning is recommended to meet the gap in after-hours primary care. Current walk-in clinics absorb non-urgent issues that might otherwise land in the ED, but the availability and capacity within Lloydminster is currently limited. Prairie North Plaza's walk-in clinics typically operate weekdays from 1–5 pm, and Saturday is reserved for scheduled practice patients due to limited capacity. Border City Clinic, a private practice, offers walk-in care six days a week, including Saturday, yet total walk-in volumes (15–16 patients/session) remain inadequate for population needs. In comparison, Maidstone Integrated Facility, in a rural setting, is open 8 am–8 pm daily; after hours, RN triage and virtual physician access cover late arrivals, with low-acuity ER presentations redirected to the clinic when possible. The inadequate coverage of unscheduled and after-hours care is a direct contributor to unnecessary ED visits, with parents of young children often having no alternative for urgent, but non-emergent, health concerns outside of business hours.

It is recommended that the Primary Access Clinic be implemented specifically in Saskatchewan, potentially at the Prairie North Plaza Clinic, for improved feasibility integrating with Emergency Department registration and triage. Low acuity presentations to the ED could be diverted to the Primary Access Clinic for same-day or next-day appointments, which would ease pressure on the ED, shorten wait times, and urgent improve primary care access.

Extended Primary Care Hours

Limited primary care clinic hours is a large contributor to high rates of ED use for conditions that could be managed in the community. Extended primary care hours aim to increase access to timely services and reduce reliance on the ED, particularly for those who cannot

competency requirements) could alleviate these barriers in the short term, rather than waiting for broader inter-provincial licensure reforms, where the timing and feasibility are uncertain.

Streamlining administrative processes for healthcare providers holding dual Alberta-Saskatchewan licenses would reduce barriers to cross-border practice and improve workforce availability. Simplified licensure processes would allow providers to begin delivering care more quickly and reduce delays associated with dual registration. Implementation would require coordination through provincial agencies and policy alignment; MOH representatives indicated some work is already taking place in this area, and these efforts should be resourced and supported to expedite outcomes.

Integrating Virtual Allied Care into Team-Based Models

Current allied health capacity in Lloydminster is limited, with gaps in areas such as dietetics, physiotherapy, social work, and counseling. Integrating virtual allied health services into team-based primary care models would expand access amidst staffing shortages, as allied staff could be shared with larger centres. Virtual platforms would also allow for continuity of care across settings and provinces, ensuring that patients with chronic or complex conditions receive consistent, multi-disciplinary support without having to rely solely on in-person staffing presence. However, it is important to note that regulated health professions must comply with licensing requirements of the jurisdiction in which a patient is located. Funding models will need to be explored in each province, including considerations for the impact on acute care and provider recruitment, to develop a business case for these resources.

3.7.1.2.4 System Impacts

Systemic interventions, including Primary Access Clinics, extended primary care hours, APP and contract physician models, lab collection integration at the Patient Medical Home (PMH; Prairie North Clinic in Saskatchewan) site, streamlined dual licensure processes, and virtual allied care, are interconnected strategies designed to address these structural challenges. Primary Access Clinics aim to absorb non-urgent presentations that would otherwise burden emergency departments. The implementation of Primary Access Clinics would require coordination between acute and community leaders, and ideally involve technology integration for scheduling patient care for service at the PMH from the acute site.

The establishment of extended primary care hours would be specific to provincially-led primary care services. This change would need to be supported by additional family physicians, nurse practitioners, allied health professionals, and administrative staff. Outcomes would be improved access, reduced ED reliance, and alignment with Alberta's goals to provide care outside traditional hours as laid out in the province's Modernizing Alberta's Primary Health Care System (MAPS) plan. Additional staffing, including family physicians and nurse practitioners, would be required to support extended hours. Collaboration with existing clinics and providers would be required to efficiently manage

3.8 COMMUNITY CARE

Community care encompasses a broad range of publicly funded programs and services that enable people to maintain or improve their health, wellbeing, and independence within their homes and communities, thereby reducing reliance on hospital-based care. These services include home health, rehabilitation and specialized therapies, social and community programs, public health initiatives. Community mental health supports are often considered community care; however, this study has separated mental health services into its own section. See Section 3.5 for Mental Health Services.

Within Lloydminster, community care and primary care are closely integrated, with many community care functions, such as home care and therapies, reporting through primary health structures. Outside Lloydminster's municipal boundaries, Alberta Ministry of Primary and Preventative Health Services has historically provided community health services, though these responsibilities have recently been reorganized under new provincial agencies: Assisted Living Alberta, and Alberta Primary and Preventative Care.

Under the terms of the bi-provincial MOU, Saskatchewan is responsible for the delivery of community care within Lloydminster, including home care and public health, with Alberta reimbursing Saskatchewan for the cost of serving Alberta residents living within Lloydminster.

The adequacy of community care resources across the wider service area directly affects hospital operations and demand on continuing care facilities in Lloydminster. Sufficient levels of community-based care capacity contribute to decreased demand for acute care, facilitating timely patient discharge, lower ALC occupancy, and delayed admissions into continuing care facilities.

3.8.1 Home Care

3.8.1.1 Current State

3.8.1.1.1 Overview

Home care in Lloydminster is delivered by the Saskatchewan Health Authority for all residents of the city, including those living on the Alberta side, under the terms of the bi-provincial MOU. In Alberta outside of the boundaries of Lloydminster, Assisted Living Alberta provides home care services include nursing, home support, therapies, and case management, with staff responsible for both community-based care and coordination of hospital discharges.

While the structure ensures that all residents have access to home care regardless of province, it introduces additional administrative complexity compared to single-jurisdiction models. Reporting, intake, and coordination must account for two provincial systems, which can complicate patient flow and discharge planning. Despite these challenges,



Figure 23 - Home Health & Home Support Contact Hours & Unique Clients, Lloydminster SAG

Engagement with leadership and operational staff were not able to indicate a reason for the decline in home care clients and contact hours. However, the decline was not linked to a decline in community need for home care services and are not indicative of future trend demands, particularly with the aging population of Lloydminster.

Benchmarking full-time equivalent (FTE) staffing has been used in this assessment to indicate levels of resourcing in Lloydminster relative to other communities. The benchmarking exercise is not intended to recommend specific positions or determine exact staffing numbers. Instead, it provides a comparative lens to identify where Lloydminster may be under-resourced or over-resourced compared to similar service areas. Input from engagement sessions with local staff and leadership was used to validate these benchmarks, ensuring that the analysis reflects both the quantitative comparisons and the operational realities. This approach highlights areas and positions where gaps exist, supporting evidence-informed planning without prescribing specific staffing models or staffing increases.

Community Health Services in Lloydminster are delivered by SHA for the entire population of the city. As a result, the entire population of Lloydminster has combined with Lloydminster SAG to benchmark community health FTE to population. Benchmarks have been determined through averaging FTE ratios in jurisdictions in the Extended Service area to determine average service levels and comparing the levels to national comparators. Due to the interprovincial nature of community health service work, an additional factor of 10% was applied to account for additional workload with bi-provincial information sharing and coordination.

Overall, Home Care was determined to generally be adequately resourced from benchmarking analysis and engagement. Home Care staffing is slightly below benchmark

levels but is projected to require significant increases to staffing as the population ages. Lloydminster has a lower number of Home Care FTE per 1000 population 75+ than Vermilion River County LGA and the average of the extended service area. However, it was not significantly below the average of the SAGs and LGAs identified as the extended service area. This indicates that in general, Home Care availability in Lloydminster is in line with regional availability.

- Lloydminster City + SAG- 20.53
- Vermilion River County LGA (Excluding Lloydminster) – 27.67
- Extended Service Area Average - 21.99.

In general, Home Care FTE to population ratios are higher in Alberta than in Saskatchewan. Alberta LGAs within the extended service area averaged 30.09 FTE per 1000 75+, while Saskatchewan SAGs within the Extended Service Area averaged 15.8.

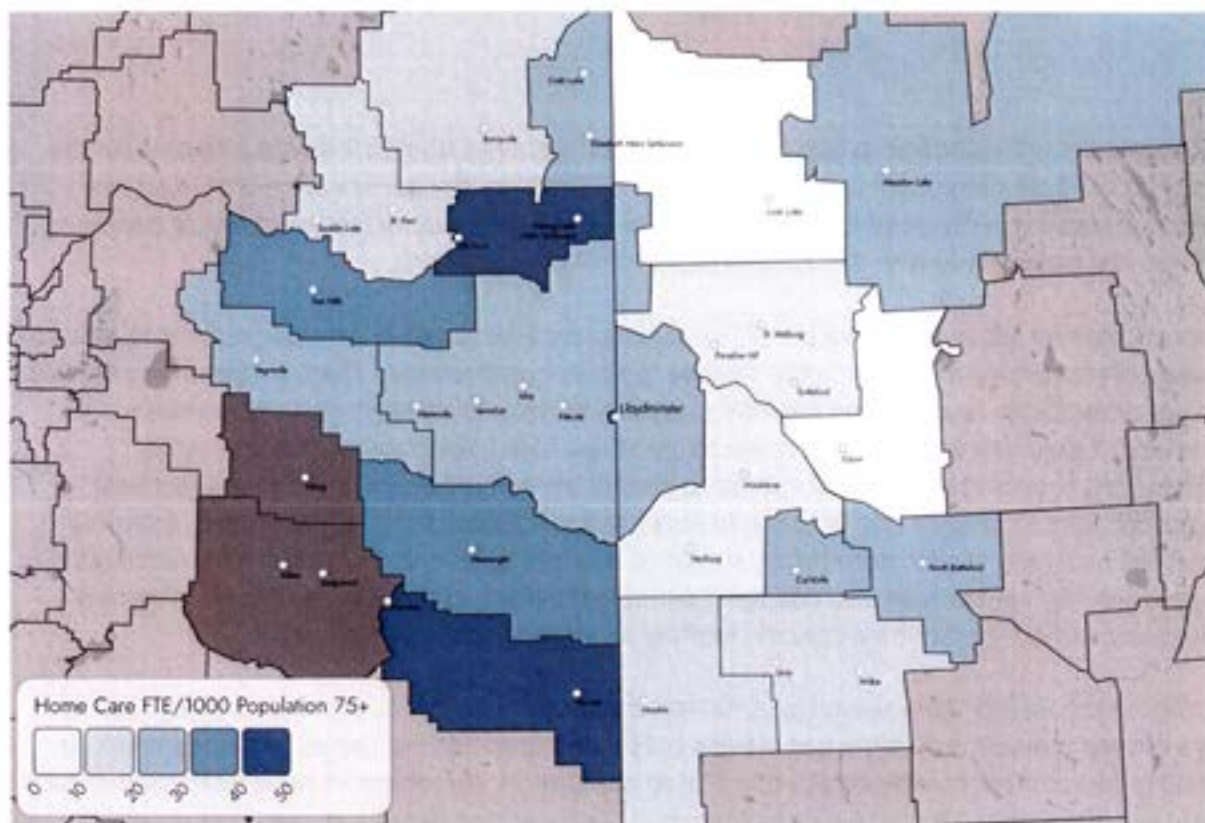


Figure 24 - Home Care FTE/1000 Population 75+

Comparator communities outside Lloydminster had a significant range of FTE per population due to varying service levels and mandates.

- Squamish (2053): 23.69
- Pemberton (2053): 42.74
- Whistler (2053): 12.68
- Powell River (2043): 12.81

There is no national benchmark for Home Care staffing, and Home Care programs vary widely in eligibility, scope, and staffing models. However, a benchmark of 20.0 FTE per 1000 75+ was identified based on levels seen in comparator communities and validated through engagement, where leadership indicated that home care is generally adequately resourced at present.

The benchmarking shows that at, Home Care staffing to population ratios in Lloydminster City are generally in an adequate range, slightly above the identified benchmark of 20.0 FTE/1000 75+. However, to maintain staffing ratios in the future with population aging, an increase in Home Health and Home Support staffing is required. Within the 15-year planning horizon of the LHSNA, the population 75+ is expected to more than double from 2,144 in Lloydminster City + SAG to 4,588.

When factoring in only aging population, the FTE to 1000 population 75+ ratio is projected to decrease significantly in the 15-year future:

- Lloydminster City: -5.99
- Lloydminster City + SAG: -9.59
- Extended Service Area average: -12.46

Significant increases to staffing would be required to reach and maintain a staffing level at benchmark levels.

Table 5 - Lloydminster Community Health Services – FTE Benchmarking

Lloydminster Community Health Services - FTE Benchmarking						
Service Line	Current State FTE	Current State Ratio	Metric	Benchmark	FTE at Benchmark	Future Projected (2040)
Home Care	44.02	20.53	FTE/1000 75+	20.0	42.9	91.8

3.8.1.1.4 Key Relationships

Home Care in Lloydminster is closely tied to the functioning of the broader health system, with direct impacts on both acute and continuing care beds. Its role as the primary support for individuals living with chronic conditions or recovering from hospitalization makes it a central partner across service lines.

Acute Care and Hospital Services: Home Care plays a critical role in enabling safe and timely discharges from Lloydminster Hospital. Home Care provides nursing, rehabilitation, and personal support in the community, relieving pressure on the Emergency Department and reducing ALC. When Home Care capacity is limited, patients remain in hospital longer, contributing to congestion and blocking throughput.

Continuing Care Facilities: Home Care helps delay or prevent entry into long-term care by supporting residents to remain at home safely for longer. When patients require admission continuing care facilities, Home Care provides support in bridging the transition between acute settings and long-term residential placement.

Primary Care: Home Care is closely integrated with primary care providers, who provide physician oversight and primary care for clients. Allied staff work with home care teams to provide care for patients, including therapies. This coordination allows patients to receive holistic, team-based care in the community.

Mental Health and Addictions: Many Home Care clients have co-occurring mental health or addictions challenges. These home care clients are referred to community mental health and addictions teams who provide services to stabilize patients and treat mental illness.

3.8.1.1.5 Key Challenges

Home Care in Lloydminster faces a number of key challenges that constrain its ability to meet current and future demand:

Aging Population

The population aged 75+ in Lloydminster is projected to nearly double over the next 15 years. This demographic shift will significantly increase demand for Home Care. Without proportional growth in capacity, more residents will experience delays in receiving support at home, increasing the risk of acute admissions and ALC pressures.

Staffing Levels and Benchmarks

Staffing levels for home care are slightly above benchmark levels. Lloydminster has a Home Care staff-to-population ratio of 20.53 FTE per 1,000 population aged 75+, compared to an identified benchmark of 20.0, a level determined by comparing staffing levels in comparable jurisdictions. However, Lloydminster's unique bi-jurisdictional creates additional workload for staff, requiring a higher level of staffing to manage the same level of patient care compared to single jurisdiction regions. Additionally, with population aging, the FTE ratio is expected to decline sharply without substantial growth in the workforce.

Recruitment and Workforce Pressures

Like many jurisdictions, Lloydminster faces challenges in recruiting and retaining qualified staff, particularly Health Care Aides and Licensed Practical Nurses. Regulatory changes in Alberta, which will require HCAs to be regulated under the Health Professions Act by 2026, may further strain availability across the bi-provincial region. Without new recruitment pipelines and incentives, staffing shortfalls may limit the system's ability to expand.

Pressures to Decrease Reliance on Acute and Continuing Care Facilities

Home Care is a critical enabler of hospital discharges, but limited staffing and service hours can delay transitions, contributing to ALC occupancy in acute care. These challenges are compounded by the lack of transitional care beds or respite capacity in the community, which forces some residents to remain in hospital when they cannot yet return home safely.

3.8.1.2 Future State

3.8.1.2.1 Overview

Home Care services in Lloydminster, delivered by the Saskatchewan Health Authority, are highly integrated with primary care, with Prairie North Plaza serving as a central hub for community-based supports and collaboration.

Gap: Demand for Home Care is increasing due to an aging population, with the 75+ cohort expected to nearly double in the next 15 years. Staffing shortages and recruitment challenges, compounded by regulatory changes in Alberta requiring HCAs to be regulated under the Health Professions Act by 2026, further constrain capacity. The absence of transitional care beds and limited respite options increases reliance on hospitals, extending lengths of stay and contributing to alternate level of care (ALC) pressures. Administrative workload is higher due to navigating both Alberta and Saskatchewan systems.

Recommendation for Consideration: Adjust staffing and resourcing levels to reflect the administrative demands of a bi-provincial system. Align Home Care teams with acute care services at Lloydminster Hospital to streamline discharge processes and reduce hospital length of stay. Enhance allied health capacity and expand weekend and after-hours coverage to support timely discharge and ensure appropriate community-based care.

Potential System Impacts: These recommendations would reduce the number of ALC patients occupying hospital beds, ease pressure on acute care and emergency departments, and shorten hospital stays. Improved alignment between home care and hospital discharge functions would create more reliable pathways for patients, while expanded allied health capacity would support faster recovery and readmissions. Adjusted staffing to account for bi-

provincial administrative workload would ensure Home Care services are delivered at a level comparable to other jurisdictions in Alberta and Saskatchewan.

3.8.1.2.2 Service-Specific Assumptions

The future state of Home Care in Lloydminster is shaped by several planning assumptions. It is assumed that community care services, including Home Care and Public Health, would continue to be delivered by Saskatchewan for all residents of the city under the current bi-provincial agreement.

Maintaining benchmark staffing ratios of Home Care full-time equivalents to population 75+ is recognized as a challenge. Given existing workforce shortages and funding pressures, it is not expected that staffing levels would keep pace with demographic change in a way that fully meets benchmark ratios. However, the general direction is that Home Care nursing and Home Support staff should be increased as needs grow. Strengthening Home Care capacity across the broader service area is expected to ease ALC pressures, reduce demand on acute care, and delay the need for continuing care admission. Expansion of community care resources outside Lloydminster is acknowledged as important, but it is not within the scope of this assessment.

3.8.1.2.3 Future Directions

Right-Sizing Resourcing Levels to Reflect Administrative Workload

The delivery of home care in Lloydminster is uniquely complex because services are provided under Saskatchewan's mandate for both Alberta and Saskatchewan residents. This creates additional administrative work compared to single-jurisdiction sites. Future workforce planning should adjust staffing levels to reflect this increased workload, recognizing the added effort required to operate in a bi-provincial environment.

Currently, Home Care resourcing is broadly comparable to neighbouring jurisdictions when measured per population aged 75+. For example, Lloydminster City + SAG has an FTE/1,000 75+ ratio of 20.5, compared to 24.13 in The Battlefords SAG. However, Lloydminster's cross-border context adds significant complexity that is not captured in this measure. Future planning must take into account that the same work requires more administrative resources than in other regions, and resourcing should be increased accordingly.

Home Health Team Alignment with Acute Care

Physically locating Home Health within Lloydminster Hospital's acute care services would strengthen collaboration, streamline discharge, and enhance continuity of care. This alignment would enable real-time coordination between hospital and Home Health staff,

improving transitions of care. While the team should remain administratively managed under Home Health and Primary Care to ensure consistency across the system, its physical integration with acute services would enhance day-to-day collaboration.

Pilot programs in other regions have shown that embedding discharge planning functions directly within hospitals could reduce delays and improve system efficiency. In Lloydminster, where patient flow is already constrained by limited continuing and transitional care capacity, stronger alignment between Home Health and acute care would support more timely and coordinated discharges.

Allied Care Enhancements

Allied health services, such as physiotherapy, occupational therapy, dietetics, community paramedicine, and social work, are essential for rehabilitation, recovery, and maintaining independence. In Lloydminster, allied health capacity is limited and often stretched across acute and community settings. These pressures are compounded by the bi-provincial environment, where staff must navigate different eligibility criteria, reporting requirements, and referral processes depending on a patient's province of residence.

Future directions should include strengthening allied health capacity to provide timely supports in both hospital and community settings. Expanding weekend and after-hours services would reduce discharge delays, while increasing therapy services in the community would allow more patients to remain at home, easing demand on acute and continuing care beds. Additional investment in social work and counseling would help patients and families manage the complexity of cross-border care, particularly for those living with chronic illness or dementia. In addition, enhanced community paramedicine support including home visits, care coordination and follow-ups after hospital discharges could be very effective in improving the current allied care provision if implemented.

Recognizing the recruitment challenges for these roles, innovative models should be explored. Virtual care and the use of Rehabilitation Assistants supervised remotely by allied health professionals in larger centres could expand capacity while maintaining quality of care.

3.8.1.2.4 System Impacts

Impact of Right-Sized Resourcing

Adjusting staffing levels to reflect the additional administrative workload would ensure that Lloydminster's Home Care teams are resourced appropriately compared to other jurisdictions. This would help maintain care delivery standards while addressing the unique demands of a bi-provincial system.

Impact of Home Health Alignment with Acute Care

Closer alignment of Home Health with hospital discharge functions would shorten hospital length of stay, reduce the number of Alternate Level of Care (ALC) patients, and free acute beds for higher-acuity cases. This would create more reliable discharge pathways and ease pressure on the Emergency Department by improving patient flow across the system.

Impact of Allied Care Enhancements

Expanding allied health capacity would support faster recovery, reduce readmissions, and improve patients' ability to remain in the community. Enhanced social work and counseling services would also improve navigation of the cross-provincial system, supporting patients and families in accessing timely and appropriate care. Strengthened weekend and after-hours allied health coverage would reduce delays in hospital discharge, while expanded community-based therapy would reduce reliance on hospital and continuing care beds. The impact of this change should be evaluated post-implementation to identify changes to future bed requirements.

3.8.2 Public Health

3.8.2.1 Current State

3.8.2.1.1 Overview

Public Health programming in Lloydminster includes a broad range of prevention and health promotion services delivered by the Saskatchewan Health Authority. Core services include immunization clinics for children, school-based immunization, and travel immunization programs. Families are supported through home visits after birth, prenatal education, and parenting programs, complemented by nutrition services and dental health teaching. Public Health staff also provide harm reduction supports and inspection services to promote community safety. Communicable disease follow-up is also a responsibility of Public Health nurses.

3.8.2.1.2 Service Model

Under the Bi-Provincial MOU, Saskatchewan Health Authority is responsible for the delivery of Public Health services within Lloydminster. In Alberta outside of Lloydminster, Public Health services are delivered by Primary Care Alberta and Preventative Care, with Vermilion and Kitscoty having Public Health Offices. Each of these Public Health offices are staffed with Public Health nurses who deliver immunizations, school health, health promotion, and maternal, child and family health.

Within Lloydminster, Public Health services are primarily delivered out of Prairie North Plaza, with additional delivery in schools, community sites, and through home visits as appropriate. Lloydminster's Public Health nursing covers Lloydminster and some other communities surrounding Lloydminster, including Lone Rock, Hillmon, and Marshall. Lloydminster's Public Health nurses also deliver immunization and STBBI work also serves Alberta clients from Vermilion. Audiology assessments are not available in Lloydminster. The management of Public Health is linked to primary care and therapies and are managed under the same team, facilitating strong collaboration.

3.8.2.1.3 Key Data Points

3.8.2.1.3.1 Volume and Client Data

Volume and unique client data for immunization were provided for the years 2019 to 2024 as available. In 2021, there was a massive spike in adult vaccination doses administered due to the COVID-19 pandemic, which has since returned to levels comparable to 2019 and 2020. While total vaccine doses administered have stayed relatively stable outside of 2021, there has been a decrease in vaccine doses administered to children (from 13,625 in 2019 to 9,236 in 2024) and an increase in doses administered to adults (from 2,950 in 2019 to 4,383 in 2024). This is in line with trends seen nationally with decreasing rates of childhood vaccination and increases in adult vaccination following the COVID-19 pandemic.

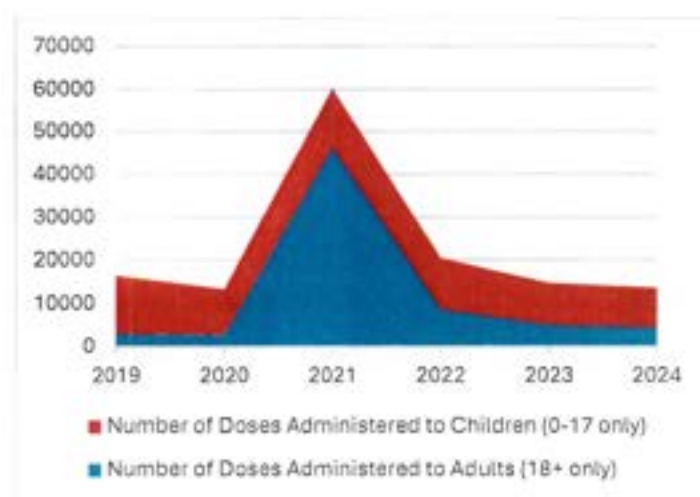


Figure 25 - Number of Vaccine Doses Administered, Lloydminster City + SAG

Unique Maternal Child Health clients (incl. mother and baby) were provided for the years 2022-2024. No strong trends for changes in maternal child health in Lloydminster could be determined from the data, which remained relatively stable between 788 and 807. Outside of large shifts in mandate or public health emergencies, demand for Public Health services are, and will continue to be, driven by population growth and shifts.

3.8.2.1.3.2 Public Health FTE Benchmarking

Within Lloydminster City, Public Health is primarily provided by Saskatchewan for the entirety of the population. Compared to surrounding health planning jurisdictions in the extended service area, Lloydminster SAG and Vermilion River County LGA have a Public Health FTE to population ratio at a combined 0.26, with the regional average being 0.26. Saskatchewan has several Small Area Geographies with no dedicated Public Health FTE, but a higher concentration of Public Health FTE in hubs such as The Battlefords.

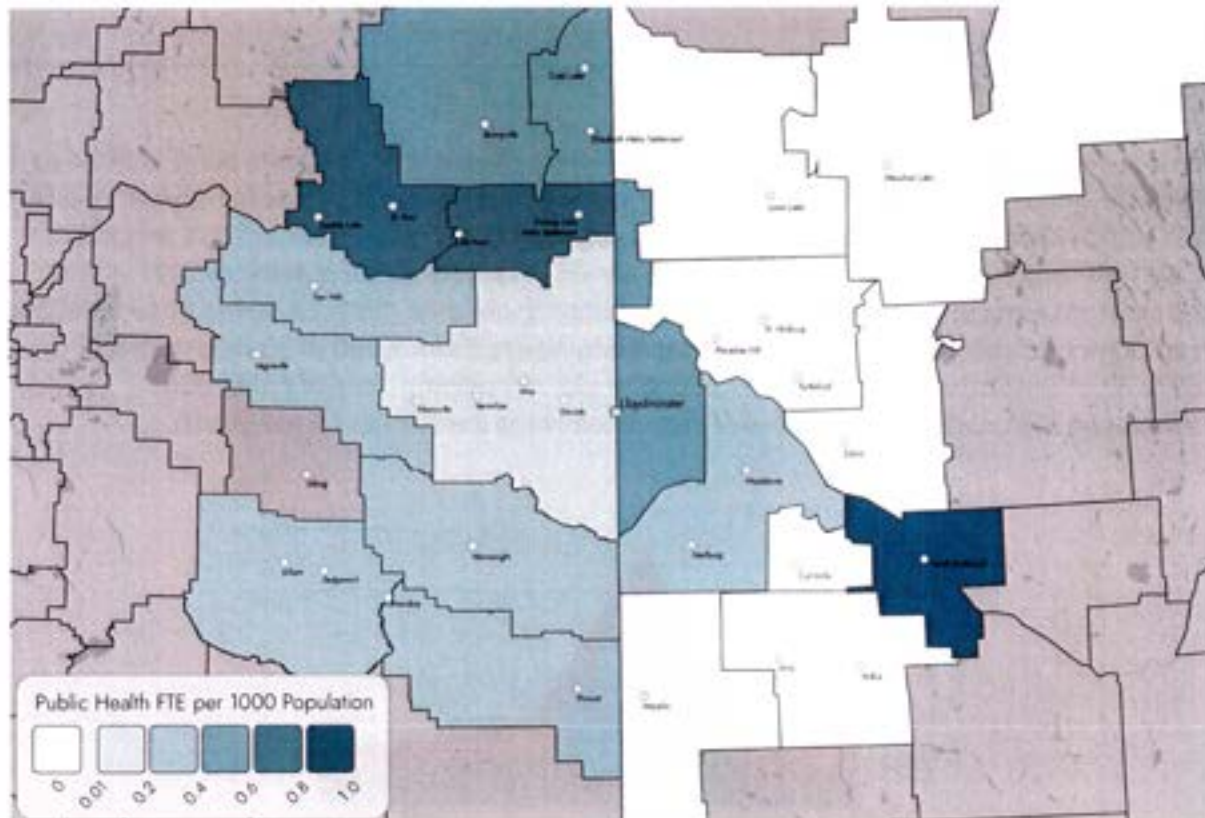


Figure 26 - Lloydminster Public Health FTE per 1000 Population

Table 6- Lloydminster Public Health FTE Information

Jurisdiction	Current State FTE	Current State Ratio	Metric	Benchmark	Benchmark by Future Projected FTE	Benchmark by Future Projected (2040)
Lloydminster (City + SAG)	11.25	0.25	FTE/1000	0.27	13.7	15.2

Public Health has a wide scope of practice that varies in different jurisdictions based on level of service and scope. However, it falls within the below, or in the lower end of staffing ratios in other comparison health service plans:

- Squamish (2053) - 0.24
- Whistler (2053) - 0.40

Though Public Health staffing levels are below benchmark, the scope of services provided by Public Health differ by jurisdiction and staffing level requirements are less indicative, and staffing needs should be dictated by a community's requirements. To match the average FTE to population ratios of the extended service area, Lloydminster will likely need to increase Public Health FTE from 11.25 to 13.7 to right-size service levels, with an increase to 15.2 by 2040.

3.8.2.1.4 Key Relationships

Within the health system, Public Health plays a key role in supporting acute care, primary care, and community care. Immunization programs, communicable disease follow-up, and harm reduction services help prevent hospitalizations and reduce pressure on acute care services. Home visits, parenting and prenatal programs, and nutrition initiatives support maternal and child health, closely linking it to primary care and acute obstetrics services. Public Health inspection services also connect closely with local governments and environmental health, ensuring community safety.

3.8.2.1.5 Key Challenges

A central challenge for public health services in Lloydminster is the bi-provincial delivery structure. Under the bi-provincial MOU, Saskatchewan is responsible for Public Health programs within the city, while Alberta delivers services in surrounding communities. This split complicates workforce planning, recruitment, and retention. Licensing requirements differ between provinces, and pay disparities also contribute to staffing pressures, as compensation is generally higher in Alberta than Saskatchewan.

Program variation is another significant issue. In many smaller Alberta communities, a broader range of Public Health services is available compared to similar centres in Saskatchewan, creating inequities in access across Lloydminster's wider service area. These differences in funding, program scope, and workforce structures increase complexity in planning and service delivery and could limit Lloydminster's ability to operate as a fully integrated regional hub for Public Health.

One specific service gap identified in engagement was well-baby visits during the postpartum period, to ensure newborns are thriving, feeding, hitting developmental milestones, and

parents have the clinical and non-clinical resources they require. This gap was noted to increase risk particularly amidst primary care access challenges in Lloydminster, and in terms of a prevention approach, early intervention in challenges with newborn care is critical as issues can escalate rapidly.

Information-sharing is challenge that shared by the whole health system in Lloydminster. There are gaps in surveillance, immunization tracking, communicable disease follow-up, and continuity of care for individuals who cross between the two provincial systems. This creates additional administrative burden for providers and limits the ability to coordinate regional Public Health responses effectively.

3.8.2.2 Future State

3.8.2.2.1 Overview

Public health services in Lloydminster are delivered with Saskatchewan responsible for programs within the city and Alberta serving surrounding communities.

Gap: The bi-provincial delivery model increases administrative workload and staffing pressures. Variations in program availability between provinces contribute to inequitable access, and gaps in information sharing hinder regional coordination of public health responses. Families that do not have consistent primary care attachment face barriers to preventive services, including well-baby visits and early developmental surveillance.

Recommendation for Consideration: Adjust staffing levels to reflect the additional administrative workload associated with the bi-provincial system. Expand public health's role in well-baby visits to complement primary care, particularly for families without regular access to a physician or nurse practitioner. Integrate these visits with postpartum home visiting, parenting programs, immunization follow-up, and early childhood health promotion to ensure consistent screening and support.

Potential System Impacts: Expanding preventive services would improve access, quality, and coordination of care for infants and families, strengthen early identification and intervention, as well as enhance immunization coverage. This should create a more comprehensive safety net and reduce reliance on acute care.

3.8.2.2.2 Service-Specific Assumptions

Future planning for public health services in Lloydminster assumes minimal shifts in service mandate, with the exception of expanding child and maternal health to include well baby visits. Saskatchewan Health Authority would continue to deliver all public health services

within the city for both Alberta and Saskatchewan residents under the existing MOU, while Alberta Primary and Preventative Care would remain responsible for delivery in Alberta communities outside of Lloydminster.

Lloydminster Public Health staff are assumed to continue delivering some immunizations and STBBI work to Alberta residents in Vermilion. With minimal major shifts in service mandate and responsibilities, the growth in resourcing required is tied to population growth. With population growth projected by both provinces to be minimal in Lloydminster and the surrounding area over the 15-year horizon, increase in demand for public health services is also expected to be minimal.

3.8.2.2.3 Future Directions

Right-size Resourcing Levels to Reflect Administrative Workload

The bi-provincial context of Lloydminster adds additional reporting, coordination, and intake requirements compared to single-jurisdiction communities. Future planning should adjust staffing levels to reflect this increased administrative workload. This would reduce bottlenecks in program delivery and allow frontline staff to dedicate more of their time to direct public health activities.

While the service scope in Lloydminster is consistent with what is offered in each respective province, the cross-border environment introduces unique administrative burdens that are not present in other communities. These additional requirements must be recognized in workforce planning, with resourcing adjusted to account for the extra effort needed to deliver the same programs.

Public Health Well Baby Visits

While primary care providers currently lead routine well-baby visits in Lloydminster, expanding public health's role in this service could help address access gaps for families without attachment to a physician or nurse practitioner. Delivering well-baby visits through public health would build on existing postpartum home visiting and parenting programs, ensuring all infants receive consistent health screening, developmental surveillance, and immunization follow-up in the critical early years.

This expanded role would not replace physician-led care, but provide a complementary service, particularly for families who face barriers to accessing primary care. It would also strengthen integration between immunization programs, parenting supports, and early childhood health promotion. Staffing levels would need to be right sized to support this broader scope, but modest expansion could improve equity of access and ensure that no infants fall through the cracks in the current system.

3.8.2.2.4 System Impacts

Right-sizing public health staffing to reflect the bi-provincial administrative workload would improve access, quality, and coordination of services in Lloydminster. Additional resourcing would allow public health teams dedicate more of their time on public health activities and health promotion.

The addition of public health-delivered well-baby visits would strengthen early identification and prevention for infants and families who may not have reliable primary-care attachment. Structured follow-ups would improve immunization completion rates and improve outcomes for infants. They would also enhance continuity across postpartum, parenting, nutrition, and community mental health programs, creating a more comprehensive safety net for families. This is also expected to reduce reliance on acute care by enhancing preventative care and improving public health more broadly.

3.9 MENTAL HEALTH SERVICES

Mental health and addictions services are limited in both community and inpatient settings. Under the Bi-Provincial MOU, SHA is responsible for mental health and addictions within Lloydminster. Recovery Alberta delivers community mental health services outside Lloydminster's boundaries within Alberta, including the neighbouring communities of Kitscoty and Vermilion. Saskatchewan and Alberta jointly fund Thorpe Recovery Centre, a detox and addiction treatment centre located in the hamlet of Blackfoot, Alberta, 10 kilometres west of Lloydminster. Outpatient services are provided to those who have completed the residential program, including case management, outpatient assessment and treatment, short-term therapy, and addiction counselling.

Lloydminster Hospital does not have psychiatric beds and must refer acute cases to larger centres in Alberta or Saskatchewan, such as Battlefords Union Hospital in North Battleford (SK) or Centennial Centre for Mental Health and Brain Injury in Ponoka (AB). There are limited psychiatry services in Lloydminster due to a lack of psychiatrists, which creates challenges for emergency room psychiatric presentations and extending hospital stays when psychiatrists are not available.

The provincial divide creates challenges related to certification and involuntary admission and treatment under Alberta's Mental Health Act and Saskatchewan's Mental Health Services Act. If someone is apprehended under Alberta's Mental Health Act, they cannot be brought to Lloydminster Hospital because it is not a designated facility under the Act, and is not legally approved to receive, assess, or detain a person involuntarily under those provisions. As a result, those apprehended must be transferred out of the community to a designated facility, the nearest of which are in St. Paul, Edmonton, or Ponoka.

3.9.1 Emergency and Inpatient Mental Health

3.9.1.1 Current State

3.9.1.1.1 Overview

Mental Health and Addictions presentations are a growing share of activity at Lloydminster hospital, with the Emergency Department acting as a point of first contact for people with acute mental illness. The emergency department manages approximately 300 mental health presentations each year, but there are no dedicated psychiatric beds at Lloydminster Hospital. Those requiring admission are transferred out of community, most often to Battlefords Union Hospital in North Battleford (SK) or facilities in Alberta such as Centennial Centre for Mental Health and Brain Injury in Ponoka. The absence of local inpatient capacity

results in the ED acting as a holding environment for patients in crisis, which contributes to congestion and safety risks for patients and staff.

Additionally, the bi-provincial jurisdiction creates challenges due to requirements of each province's respective Mental Health legislation. Under Alberta's Mental Health Act, police may apprehend and transport individuals to an Alberta-designated facility if they believe it is necessary to prevent harm or if the individual is unable to care for themselves. However, Lloydminster Hospital is not a designated facility under Alberta's Mental Health Act. As a result, patients apprehended within Alberta must be transferred to St. Paul. With a round-trip journey exceeding 3 hours excluding time required to process the patient, significant police resources are utilized for apprehensions and transportation of mental health patients.

3.9.1.1.2 Service Model

Within Lloydminster, Mental Health care is delivered by SHA under the bi-provincial MOU. In practice, care is delivered through a combination of local and regional resources due to the lack of local psychiatric beds. Within Lloydminster Hospital, physicians in the Emergency Department provide initial stabilization, supported by an on-call psychiatrist based locally and additional virtual support through North Battleford. There is currently one psychiatrist in the community, which limits capacity within the ED. ED physicians at Lloydminster Hospital are not emergency-certified and often lack the confidence to manage psychiatric presentations, preferring to consult with psychiatry. Patients in crisis sometimes must wait several hours in an unsecured ED space to see the on-call psychiatrist.

Once patients are stabilized, treated, or released at the ED, the psychiatrist would refer the patient to outpatient services or to inpatient psychiatric facilities. The most common referral sites are Battlefords Union Hospital in North Battleford (SK) and Centennial Centre for Mental Health and Brain Injury in Ponoka (AB). While this model ensures appropriate care could be provided at resourced facilities, the reliance on inter-facility transfers and challenges with local psychiatrist availability adds strain on the emergency department's resources. Alberta and Saskatchewan also jointly fund beds at Thorpe Recovery Centre, located in Blackfoot, Alberta, which offers medically supported detox and inpatient addictions treatment.

If patients are released, they are connected to community mental health teams who provide follow-up care after discharge. However, the bi-provincial jurisdiction creates challenges in continuity of care and information sharing. Information from Alberta facilities is not accessible to Saskatchewan's community mental health teams, requiring additional work to coordinate discharge planning and to coordinate care.

3.9.1.1.3 Key Data Points

Lloydminster does not have designated inpatient psychiatric beds and utilizes regional beds to fill this need. Alberta and Saskatchewan both have large centralized psychiatric hospitals, Centennial Centre for Mental Health and Brain Injury (CCMHBI) in Ponoka, Alberta, Alberta Hospital Edmonton, and Saskatchewan Hospital North Battleford, Saskatchewan, each with over 280 psychiatric beds. However, the roles these facilities play in their respective systems differs. CCMHBI is a multimodal facility that offers treatment for acute mental health and addictions, concurrent disorders, and brain injury, while Saskatchewan Hospital North Battleford provides long-term psychiatric rehabilitation and secure forensic mental health services for individuals with complex needs. As a result, transfers to Saskatchewan Hospital North Battleford are limited to more complex cases, while CCMHBI is used as a transfer site for more patients from Lloydminster.

Smaller sites in the region also play a role in the system, including St. Therese St. Paul Healthcare Centre in St. Paul (12 beds), which is geographically the closest hospital designed by Alberta's Mental Health Act. In Saskatchewan, Battlefords Union Hospital (22 beds) is the closest facility with psychiatric beds to Lloydminster and is highly utilized for transfers.

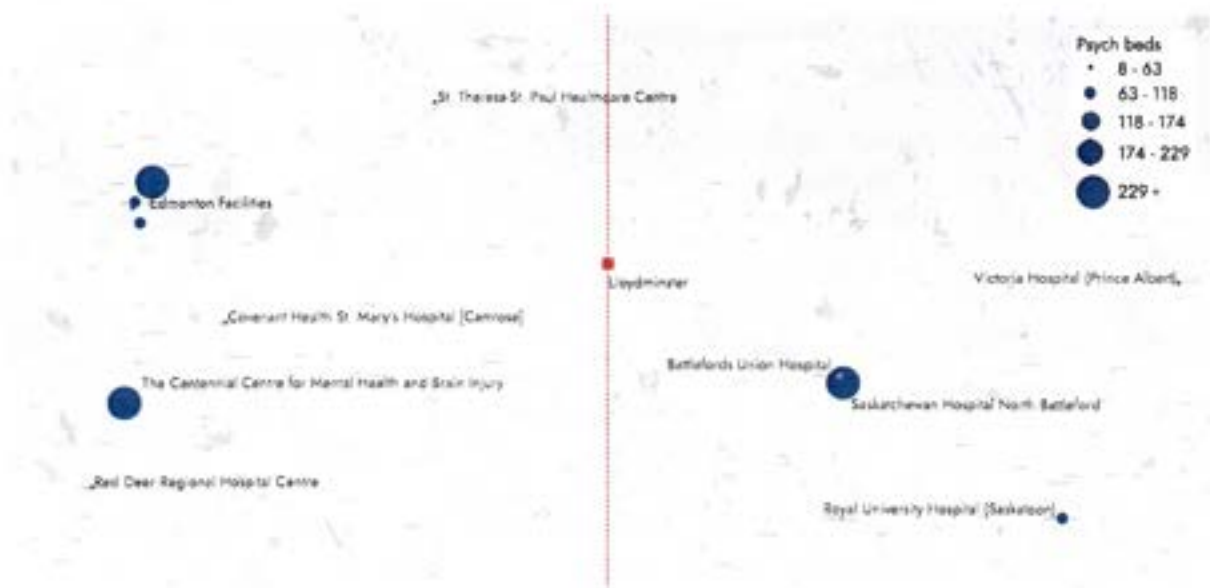


Figure 27 - Psych Beds By Region

Key data points related to MH related hospital visits were gathered from DAD extract data which showed the volume of ED visits, acuity, LOS, and facility use and transfer patterns:

- Mental Health (MH) related ED visits constituted roughly 4% of the total Lloydminster ED visits in 2024/25 (or ~1,000 annual ED visits), with half of these MH-related ED

visits being for CTAS 4 and 5 patients. For patients with a MH diagnosis, Lloydminster showed a higher proportion of lower acuity MH patients visiting the ED when compared to the peer sites in Saskatchewan (where the median percentage of MH ED visits for CTAS 4 and 5 patients was 40%).

- In 2023/24, there were 299 patients who were residents of the core service area who utilized hospitals outside of Lloydminster for MH-related reasons. Of these, few were transferred to Saskatoon or Regina (5% and 3% respectively), largely utilizing facilities in North Battleford, Edmonton Zone (28%), and Central Zone (21%).
- In 2023/24, 115 MH diagnosis patients stayed overnight at Lloydminster Hospital. 49 of these patients were there for substance abuse related reasons.
- In 2023/24, 36 Lloydminster resident patients who visited facilities within the service area were admitted and discharged within 72 hours.

3.9.1.1.4 Key Relationships

Emergency and inpatient mental health care in Lloydminster relies heavily on regional resources due to the absence of psychiatric beds at Lloydminster Hospital and the hospital's lack of designation under Alberta's Mental Health Act. Linkages with police and EMS services are also key, given the reliance on transfers out of Lloydminster and police acting as first responders to mental health crises.

Within Lloydminster Hospital, the Emergency Department works closely with community mental health teams for discharge planning, while community mental health teams have key relationships with the other acute sites in Alberta and Saskatchewan that have psychiatric beds to ensure continuity of care.

3.9.1.1.5 Key Challenges

The provision of emergency and inpatient psychiatric care in Lloydminster is challenged by several factors. Psychiatric capacity is limited, with only one psychiatrist in the community who manages their own private practice and attends the hospital on an on-call basis. This creates gaps in availability, particularly on weekends, leading to long waits and increased strain on the emergency department who must attend to and manage patients who may be out of their scope of practice or comfort levels. This contributes to extended length of stay for patients waiting to be seen by a psychiatrist. Recruitment of additional psychiatrists has been difficult, part of a larger health human resources crisis nationally, particularly in rural areas. Additionally, ED nurses at Lloydminster Hospital often do not have the confidence, training, or resources to manage psychiatric presentations.

The absence of inpatient psychiatric beds is a major gap, leading to a reliance on regional facilities for inpatient care. All psychiatric admissions require transfer out of the community,

which delays access to treatment and disrupts continuity of care. The bi-provincial context adds challenges to discharge processes, with community mental health teams and primary care providers in Saskatchewan unable to easily access information from patients being discharged from inpatient care in Alberta.

Emergency Department staff also face operational challenges in managing mental health presentations within the general ED environment. There is no dedicated psychiatric space other than an observation room, which raises safety risks for patients and staff and contributes to congestion and length of stay. Additionally, there is currently limited diversion and management in community due to the lack of integrated mental health and police responses to crises, leading to ED presentations being the default for mental health crises in community.

Although the Thorpe Treatment Centre does provide medical monitoring, there have been cases where patients have spent 1-3 days in inpatient units before they are stable enough to be transferred to Slim Thorpe or another treatment facility. Staff in inpatient units are not usually trained in medical detox management and the trauma-informed approach³⁰ these patients require, and volumes are not substantial enough for the medical inpatient staff resources to develop a critical mass of these skillsets.

3.9.1.2 Future State

3.9.1.2.1 Overview

Mental Health and Addictions presentations are an increasing proportion of visits to Lloydminster Hospital. The Emergency Department manages approximately 1000 MHA presentations annually, yet there is no dedicated space to provide stabilization for these patients. Current processes rely on ad hoc observation in an existing observation room within the ED, which raises safety concerns, prolongs wait times, and delays appropriate care.

Gap: Psychiatric services are limited with only one community psychiatrist available on an on-call basis, leading to long waits, increased strain on the ED, and avoidable transfers. Recruitment of psychiatrists has been challenging. The ED lacks a dedicated psychiatric space, with care confined to a single observation room raising risks for patients and staff. Additionally, the initial stage of substance use withdrawal is typically managed in inpatient beds, without the required expertise or trauma-informed approach. At the community level,

³⁰ Almost two-thirds of adults are exposed to at least one potentially traumatic event at some point in their lives. A smaller but still significant minority will go on to develop PTSD (~8%) (Source: Survey on Mental Health and Stressful Events, Statistics Canada, 2023)

limited integration between mental health services and police responses means the ED remains the default point of entry for individuals in crisis.

Recommendation for Consideration: Establishing a Mental Health Short Stay Unit (MHSSU) would create a secure, dedicated environment where patients in crisis could be stabilized, observed, and connected to ongoing care. Ensuring adequate 24/7 coverage through the addition of five FTE positions and targeted upskilling of existing staff. Increase training and support for ED physicians to strengthen their ability to manage psychiatric presentations effectively. Access to Virtual Opioid Dependency Programs (VODP) and Virtual Rapid Access Medicine (VRAAM) could also be utilised in this MHSSU, subject to cross-jurisdictional challenges.

Potential System Impact: A MHSSU will bridge the gap between emergency stabilization and longer-term psychiatric care, aligning with provincial priorities to expand community-based and intermediate mental health capacity, while also reducing reliance on transfers to tertiary centres. Projections indicate that Lloydminster would need to accommodate approximately two dedicated psychiatric SSU beds by 2040, representing 100% growth over 2024 levels.

3.9.1.2.2 Service-Specific Assumptions

The Lloydminster Hospital currently has 0 dedicated Mental Health Inpatient beds. However, on a busier day in 2024/25, there was typically 1 psychiatric diagnosis patient utilizing Lloydminster Hospital Inpatient beds.

The calendar year 2024 was selected as the baseline period to drive the future state projections for this area (due to data availability limitations in the provided Discharge Abstract Data for the more recent timeframe). Aside from accounting for population growth and ageing, the Inpatient bed projection model also considers the following potential future state service shifts and the resulting impact on the projected Mental Health Inpatient bed demand:

- Establishing a short-stay Mental Health stabilization area would allow for care to be provided for the current Lloydminster hospital MH and SU patients for the first 48 hours of stay as well as those Lloydminster resident MH patients currently attending nearby facilities – or in the case of SU patients, in inpatient beds - for short-term care who could be repatriated and better served at Lloydminster Hospital in a dedicated area.

The future state of emergency and inpatient mental health in Lloydminster is shaped by several additional planning assumptions. It is assumed that Lloydminster Hospital would continue to operate under Saskatchewan legislation and therefore would not be designated under the Alberta Mental Health Act. As a result, certification and admission pathways for Alberta residents would remain dependent on transfer to facilities in Alberta, while Saskatchewan residents would continue to be admitted under SHA's legislative framework.

The bi-provincial environment is assumed to remain a defining feature of service delivery. Information-sharing challenges, differing legislation, and dual-licensing requirements would continue to complicate care, requiring deliberate planning for cross-jurisdictional coordination.

Staff recruitment is expected to remain an ongoing challenge. Psychiatrist and psychiatric nursing recruitment is assumed to continue to be a significant challenge, particularly in a rural setting, which has been historically difficult. Workforce shortages would likely constrain the ability to expand local services and would continue to necessitate the use of remote psychiatry, telehealth, and consultation arrangements with North Battleford and other centres.

No true inpatient psychiatric beds are recommended for Lloydminster at this time, aside from the SSU beds. Battlefords Union Hospital currently provides inpatient psychiatric care for the region, with available capacity, though it also faces staffing challenges. Adding psychiatric beds in Lloydminster is not considered feasible given the costs, recruitment difficulties, and potential underutilization. Instead, it is envisioned that Lloydminster would continue to rely on inter-facility transfers for patients requiring admission, with North Battleford, Ponoka, and Edmonton serving as primary destinations.

Community-based solutions, such as the development of a PACT and expanded outpatient services, are assumed to be a central part of the future model to reduce avoidable ED presentations and reliance on hospital-based care. These initiatives would require strong coordination between Saskatchewan community mental health services, Recovery Alberta, and the Royal Canadian Mounted Police (RCMP).

3.9.1.2.3 Future Directions

Mental Health Short Stay Unit (MHSSU)

The creation of a designated Mental Health and Substance Use Short Stay Unit (MHSSU) within the Emergency Department would strengthen both patient care and ED operations. By converting the existing observation unit into a secure, specialized space, the MHSSU would provide timely access to psychiatric assessment, safe management for patients in crisis, and short-term stabilization and observation for up to 48 hours. This could enhance patient and staff safety, improve quality of care, and support smoother patient flow by reducing ED congestion.

In addition, having two dedicated short-stay inpatient spaces to stabilize mental health patients could significantly improve care, given the current volume of patients presenting to or transferred from Lloydminster Hospital for psychiatric services. Patients would have the opportunity to be connected to appropriate local community services without the destabilization that occurs with a transfer, when clinically appropriate.

Locating the MHSSU within the ED is recommended for a number of reasons. The ED is already the first point of entry for mental health and substance use crises and would not change in the future. By locating the MHSSU within the ED, physicians and nurses could also gain experience, comfort, and competency to manage psychiatric and withdrawal presentations. With additional support from a psychiatric nurse, there are increased efficiencies concentrating the skillset among this smaller pool of staff.

To operationalize a MHSSU, 24/7 coverage of the ED by a psychiatric nurse is required to ensure that staff have sufficient expertise to provide care for psych presentations. To sufficiently staff a 24/7 role, an additional ~5 FTE would be required to account for vacation, sick leave, and other factors. Recruitment of psychiatric nurses is expected to remain challenging, and true 24/7 coverage may not be feasible. Upskilling of existing staff in psychiatric and withdrawal management care would be required to increase the competency and comfort of all staff in handling psychiatric presentations. Increasing the comfort and competency of ED physicians is particularly important to ensure timely and appropriate care, reducing dependence on on-call psychiatry, which is assumed to continue to be difficult to recruit. The CanREACH program in Alberta could be used as a model in upskilling ED physicians, but modified for adult mental health care.

The additional short-stay MH inpatient capacity, the hospital would likely draw in additional ED patients who are currently receiving care in other Lloydminster service area hospitals. Based on the stakeholder engagement in this project, it was determined that this would likely result in an +30% increase in ED Mental Health visits annually given Lloydminster's location and needs within the community. Other ED visits are assumed to be unaffected by this change.

3.9.1.2.4 System Impacts

At the regional level, the MHSSU could establish a link between emergency stabilization and longer-term inpatient psychiatric care. It could also align with provincial priorities to expand community-based and intermediate mental health and addictions capacity, reducing the need for transfers to tertiary centres and allowing more patients to receive care closer to home.

The success of the Mental Health Short Stay Unit would depend on strong partnerships across the local and regional health system. Within the hospital, the unit would be closely linked to the Emergency Department, providing a dedicated pathway for patients requiring psychiatric and withdrawal stabilization while relieving congestion in acute care spaces. Collaboration with inpatient units and allied health teams, particularly social work, addictions services, and occupational therapy, would be essential to ensure safe transitions of care and continuity beyond the 24-to-48-hour stabilization period.

Integration of the MHSSU with community-based providers on both sides of the provincial boundary are also important. Although Saskatchewan provides community mental health services within the boundaries of Lloydminster, people who present at Lloydminster Hospital may reside in Alberta outside of Lloydminster, which is serviced by Recovery Alberta. Coordination with Recovery Alberta, Saskatchewan Addictions Services, and primary care clinics is essential to ensure timely follow-up after discharge.

Virtual psychiatry and telehealth supports would extend specialist capacity and supplement local services and upskilled generalist staff. Maintenance and strengthening of referral pathways with psychiatric facilities in North Battleford as well as tertiary psychiatric facilities in Saskatoon, Ponoka, and Edmonton would also be required for patients requiring additional inpatient psychiatric care.

Based on stakeholder engagement with hospital leadership, it was determined that access to a MHSSU would likely result in a +30% increase in ED Mental Health visits annually given Lloydminster's location and needs within the community. This contributes to an estimated +2,163 ED visits annually by 2040.

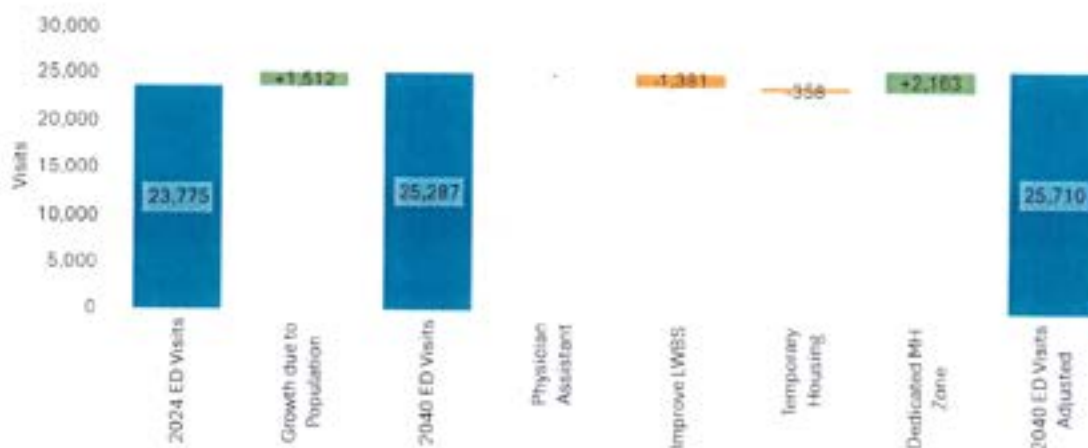


Figure 28 - Projected ED Visits

Based on the assumptions identified above, Lloydminster Hospital will need to **accommodate approximately 2 dedicated Mental Health SSU Inpatient beds by 2040**. This is equivalent to approximately +1 additional Inpatient bed in use per day, or a **+100% growth** in the occupancy adjusted utilization beyond what was seen in 2024.

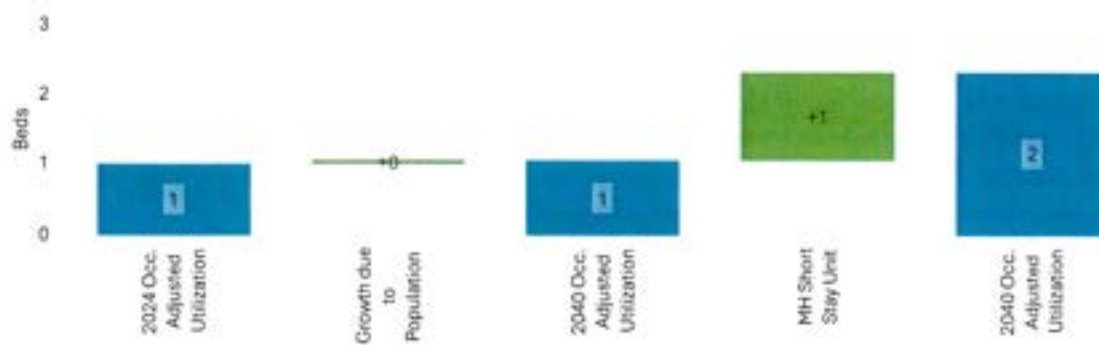


Figure 29 - Projected Mental Health Occupancy Adj. Utilization

The Demand Projection results suggest that Lloydminster's Mental Health Occupancy Adj. Utilization will grow from 1 to 2 beds, a growth of +1 bed, +100% from 2024 to 2040

3.9.2 Community Mental Health

3.9.2.1 Current State

3.9.2.1.1 Overview

Community Mental Health within Lloydminster is delivered by SHA for all Lloydminster residents. Services are provided by Recovery Alberta for Alberta residents outside Lloydminster's city limits. Services are provided through two main sites, Lloydminster Mental Health and Addictions Services located near Lloydminster Hospital, and Prairie North Plaza. A range of teams operate from these sites, including adult services, child and youth programs, community mental health nursing, and a community recovery team. Together, they provide counselling, psychiatric referrals, group programs, and case management for clients with complex or long-term needs.

The absence of inpatient psychiatric beds in Lloydminster means that patients requiring admission are transferred out of community, such as to Battlefords Union Hospital in Saskatchewan or designated Alberta facilities. This reliance on external centres adds to the importance of community-based resources in managing clients locally. While the model ensures access for both Alberta and Saskatchewan residents, staffing levels are well below benchmarks observed in comparable jurisdictions, limiting the ability to consistently meet demand.

3.9.2.1.2 Service Model

Community mental health services in Lloydminster are delivered by the SHA. Services are delivered from two locations: Lloydminster Mental Health and Addictions Services, located at a site near Lloydminster Hospital, and Prairie North Plaza. A number of teams deliver services, including Adult Mental Health & Addictions, Child and Youth Mental Health & Addictions, community mental health nursing, and a community recovery team. Together, these teams provide individual and couples mental health counselling, psychiatrist referrals, child and youth counselling, child and youth anxiety group, and case management for long-term mentally ill clients.

Eligibility and intake processes are coordinated through SHA systems, with Alberta residents accessing services in the same way as Saskatchewan residents within Lloydminster city limits. The bi-provincial context adds complexity for referrals, follow-up, coordination of care, and information sharing, particularly for patients who move between acute, community and primary care. For example, patients requiring inpatient psychiatric care could be referred to facilities in Alberta or Saskatchewan, but information on care provided and discharge planning from an Alberta facility may not easily be accessed by community mental health teams in Lloydminster.

3.9.2.1.3 Key Data Points

Between January 1, 2020, and December 31, 2024, the Lloydminster Royal Canadian Mounted Police (RCMP) handled a total of 2,626 files associated with the Mental Health Act. A file is classified as related to the Mental Health Act if it includes any of the following categories:

Mental Health Act – Offences Only: Incidents involving criminal offences directly related to mental health issues.

Mental Health Act – Other Activities: Files where RCMP involvement pertains to other activities under the Mental Health Act, that are not exclusively offences.

Form 10 Apprehension: Incidents where an individual was apprehended by law enforcement under Form 10 of the Mental Health Act, typically for psychiatric evaluation or treatment at a designated facility under the Mental Health Act.

A breakdown of the scorings related to the Mental Health Act is found in the graph below.

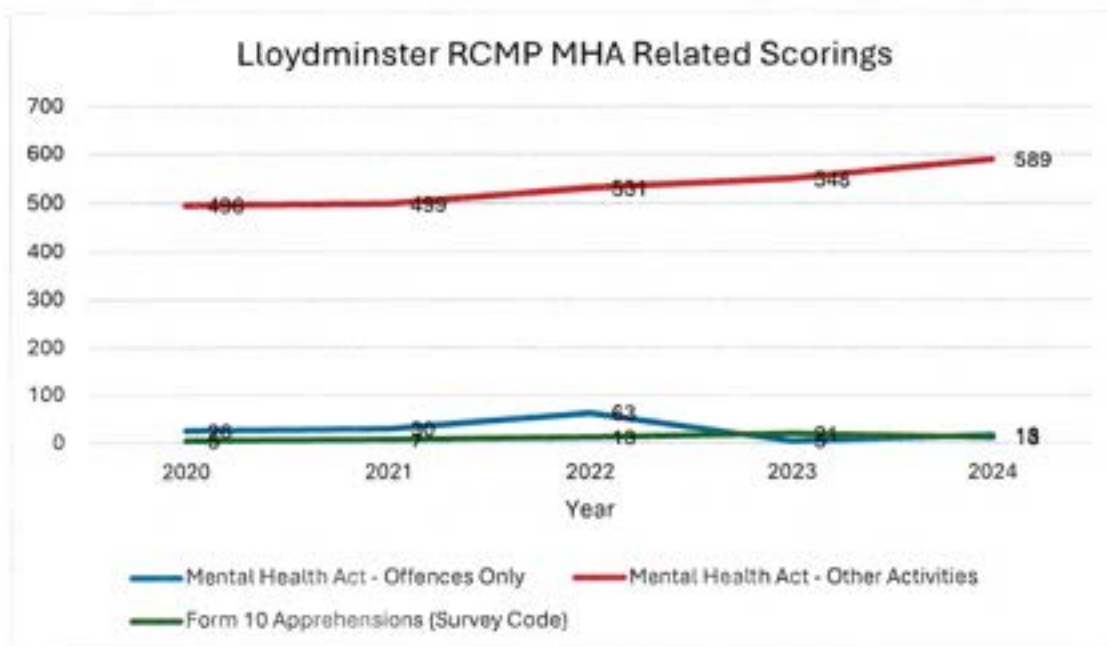


Figure 30 - Lloydminster RCMP MHA Related Scorings

This demonstrates a trend of an increase in Mental Health Act calls that are not exclusively offences. These volumes suggest demand for one PACT team.

The stacked area chart below shows the timeline of when all Mental Health Act related files were generated by the Lloydminster RCMP in 2024, including hours of the day, and days of week.

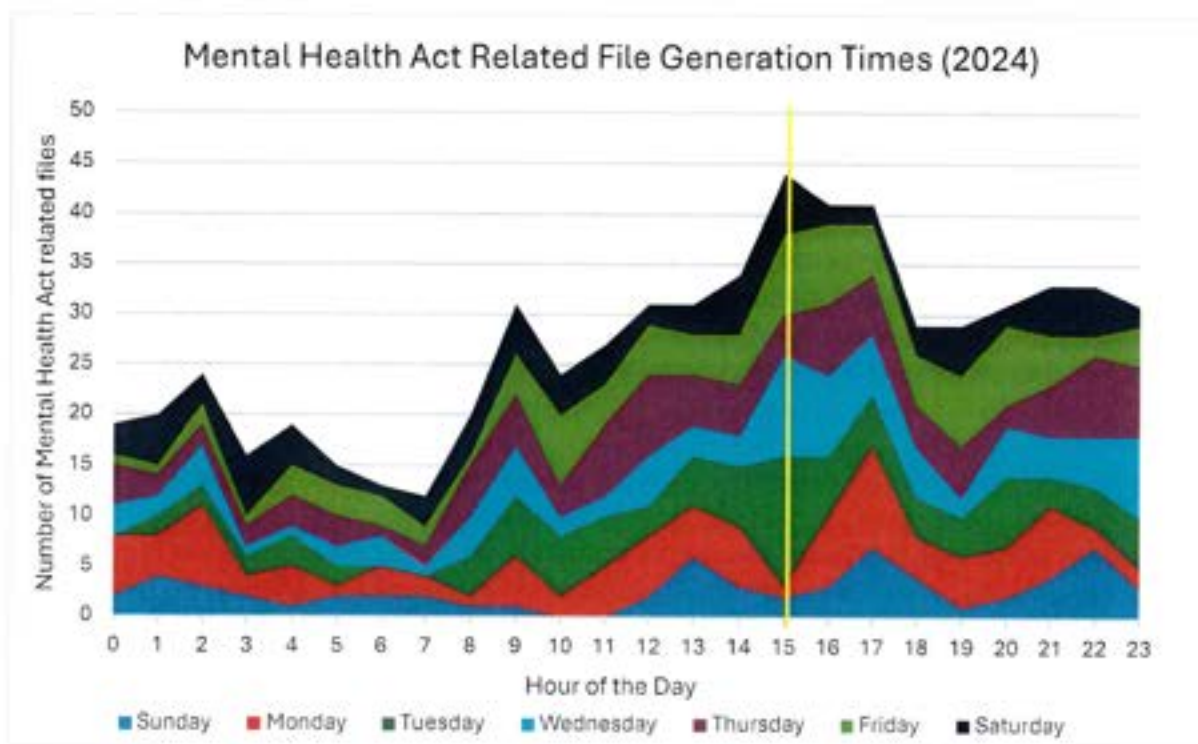


Figure 31 - Mental Health Act Related File Generation Times

Notably, Thursdays had the highest number of files generated, while Sundays recorded the fewest. Most issues occur between 3pm and 11pm.

A benchmarking exercise was completed to show at an indicative level the level of community mental health resourcing relative to other jurisdictions. Lloydminster SAG has 19.5 community mental health FTE that also serve the Alberta residents of Lloydminster City. Within the core service area, St. Walburg and Maidstone SAGs do not have community mental health FTE, while Vermilion River County LGA has their own MHA team that serves that jurisdiction outside Lloydminster.

FTE per 1000 population

- Lloydminster City + SAG: 0.43
- Vermilion River County (excluding Lloydminster): 0.41

Establishing an appropriate benchmark for community MHA staffing for Lloydminster requires consideration of many factors, including complexity and acuity of patient populations, provincial context, and other factors. Community MHA staffing levels in Lloydminster are low compared to current or planned levels in comparator communities, including the Battlefords, Squamish, and Powell River;

- The Battlefords (2024): 1.11
- Squamish (2053): 1.21
- Powell River (2043): 2.46

The benchmark for Community MHA staffing was set at 1.0 FTE per 1000 to bring it closer to levels seen in comparator communities. An additional 10% factor was placed on top of the 1.0 FTE benchmark to account for additional workload associated with Lloydminster's cross-jurisdictional status. Overall, Lloydminster has community MHA staffing levels significantly below benchmark. The Battlefords (SAG) comparatively has a much higher level of community mental health staffing, at 1.11 MHA FTE per 1000. Other jurisdictions have similarly higher MHA FTE to population ratios, both historically and targeted for the future.

Of the national comparators, Squamish (BC) is a community that bears strong demographic and contextual similarities to Lloydminster. They are similar in size, with Squamish's population of 23,819 in 2021 compared to Lloydminster's population of 31,582 in the same period. However, Squamish's population is projected to rapidly grow, matching Lloydminster's population by the late 2030s. Both cities skew younger, with Squamish's median age of 37.6, similar to Lloydminster's median age of 35.6. The health service context is also similar, with Squamish General Hospital serving as a higher level of care centre for the Sea-to-Sky corridor stretching from Lions Bay to N'Quatqua.

Within the Sea-to-Sky Corridor in BC, 1.21 community MHA FTE is the target ratio for Whistler and Squamish in 2053, while Pemberton, a smaller and more remote community with fewer healthcare services, has a target ratio of 1.57 in the same year. The ratios in Whistler and Squamish are slightly higher than in The Battlefords and significantly higher than the ratio in Lloydminster. A ratio of 1.1 Community MHA FTE per 1000 population brings Lloydminster's level of service close to levels in comparable communities.

Table 7 - Community MHA Information

Jurisdiction	Current State FTE	Current State Ratio	Metric	Benchmark	FTE at Benchmark	Future Projected (2040)
Lloydminster (SAG+City)	19.5	0.43	FTE/1000	1.1	50.2	55.9

3.9.2.1.4 Key Relationships

Community mental health services in Lloydminster are closely linked with other parts of the healthcare system, including the emergency department, out-of-community inpatient mental health, and primary care. The emergency department is often the first point of contact for individuals in acute crisis, after which community mental health staff coordinate follow-up and outpatient supports once patients are stabilized. Beyond Lloydminster, linkages to the larger mental health systems are important due to Lloydminster's lack of psychiatric beds and

lack of designation under Alberta's Mental Health Act. This necessitates a close relationship with facilities with designation in Alberta, and inpatient psychiatric beds broadly within both provinces. In practice, transfers to inpatient facilities largely go to St. Paul and Ponoka in Alberta and North Battleford and Saskatoon in Saskatchewan.

Linkages to other allied health professionals provided within the primary care team are central for patients requiring medication management, counselling, or monitoring of chronic mental illness. Referrals flow from family physicians, who rely on community mental health resources for case management. Outside of the healthcare system, there is a close key relationship with police, who act as first responders during mental health crises.

3.9.2.1.5 Key Challenges

Community mental health in Lloydminster is constrained by a shortage of psychiatric capacity. Presently, only one psychiatrist is based in the community. On-call support is sometimes provided from North Battleford, but coverage is inconsistent, and weekend service is limited. As a result, patients face delays in timely care, sometimes waiting several hours before being seen. Emergency physicians carry the responsibility for managing psychiatric cases, creates challenges with sustainability, causing strain on emergency resources. Additionally, emergency physicians are often not equipped to deal with psychiatric presentations. Recruiting additional psychiatrists has been challenging, partly due to general workforce shortages and dual licensure requirements.

There are also no inpatient psychiatric beds in Lloydminster, and individuals who need admission are sent either to North Battleford or to facilities in Alberta, most commonly Ponoka. This reliance on transfer causes delays and adds stress for patients and families. Continuity of care is further complicated by the absence of shared health records between Alberta and Saskatchewan, so community teams are not brought in to care planning following discharge. When patients return from a higher level of care facility – particularly if the facility is in Alberta – community staff are often required to contact previous care providers directly to obtain discharge summaries and care plans. This creates unnecessary administrative work and increases the risk of information gaps.

Staffing levels for community mental health are also low compared with other jurisdictions. Current resourcing equates to 0.43 FTE per 1,000 population, while comparator communities often have more than double this ratio. As a result, Lloydminster has fewer counsellors, case managers, and outreach staff than needed, which contributes to delays in follow-up and increases reliance on hospital-based services. This gap is amplified by rising complexity in the client population, including higher rates of substance use, dementia, and co-occurring conditions.

There is no formal crisis response team in Lloydminster and no after-hours clinical community support, so local police are acting the default first responders for people in acute

mental health crisis and any urgent event outside of business hours, frequently bringing individuals to the emergency department. This places pressure on police resources and results in care that is not clinically appropriate.

3.9.2.2 Future State

3.9.2.2.1 Overview

The future state of community mental health in Lloydminster is envisioned to have strengthened coordination and increased resourcing that would meet the growing demand for mental health and addictions services in an environment reporting increasing demand. Strengthening community mental health services would be essential to providing appropriate and timely mental health care in the community.

Gap: Community Mental Health is currently under-resourced in Lloydminster relative to similar communities, with interprovincial challenges further adding workload to staffing, leading to a strained and under-resourced service. As a result, individuals in crisis are often directed to the hospital and community events are responded to by police; neither of these services are designed for sustained psychiatric management.

Recommendation for Consideration: The creation of a PACT team to reduce reliance on the ED and diverting patients from acute settings by providing care in the community. Increase staffing levels by approximately 132% to align with benchmarks from comparable centres, with an additional 10% adjustment to account for cross-border administrative demands.

Potential System Impacts: The PACT model would allow for earlier intervention and de-escalation in the community. More efficient use of police resources and expanded community mental health capacity would reduce unnecessary transfers, improve safety, and enhance system efficiency overall. By increasing community mental health FTE to meet benchmark ratios (including the population served on the Alberta side of the border) and ensuring that resourcing levels adequately factor in complications related to the bi-provincial context, strain would be reduced on the acute care system while the community's growing mental health needs are met.

3.9.2.2.2 Service-Specific Assumptions

The future state of community mental health services is shaped by a number of assumptions. The current structure of service delivery is largely assumed to continue. Firstly, community mental health would continue to be delivered by SHA for the entire population of Lloydminster under the bi-provincial MOU, with no shift in responsibilities. Psychiatric inpatient capacity would continue to be delivered outside the community in North Battleford, Ponoka, and Edmonton. Inpatient capacity in North Battleford is not consistently full, and the development of new inpatient psychiatric beds is not anticipated or recommended. Transfers out of town

would continue to be relied upon for inpatient mental health care beyond stabilization or short-term observation.

Challenges related to information sharing is assumed to remain, at least in the short term. While information sharing challenges have been a long-standing issue in Lloydminster with solutions sought by leadership on many levels, the problem of non-interoperability of EMRs and challenges with privacy legislation are assumed to continue into the near future. Staff would continue to be required to make workarounds to accessing information, with additional work required for cross-provincial discharge planning and care coordination.

Due to the lack of local inpatient psychiatric care, bolstering community mental health resources is essential in meeting the needs of the community. Without a large increase in resourcing for community mental health, strain on other parts of the system – including ED, police, EMS, and other community resources, would continue to grow. Across all service areas, health human resources challenges would continue in the future, particularly in a small city such as Lloydminster.

3.9.2.2.3 Future Directions

Creation of PACT Team

Lloydminster does not currently have a Police and Crisis Team (PACT), though both Alberta and Saskatchewan have explored this idea and both provinces have recently developed joint business cases with the RCMP. Currently, mental health crises are managed primarily by the RCMP, who act as first responders and bring individuals into the emergency department or designated facility outside Lloydminster in Alberta when necessary. This approach puts a strain on police resources and does not always provide the type of care required.

Establishing a PACT team, staffed jointly by police and mental health clinicians, would create an alternative pathway that keeps many individuals out of the ED and supports resolution of crises in the community. The model has proven effective in other jurisdictions, reducing unnecessary transfers and easing demand on emergency services. The exact mix of staffing differs depending on jurisdiction, but a typical team usually includes a police officer paired with a social worker, psychiatric nurse, or registered nurse.

Because current data shows an increase in Mental Health Act Related File Generations after 3pm, it is recommended that the majority of PACT team shifts should be from 2-10pm. Current volumes suggest demand for one team, which should be piloted and evaluated to determine if expansion is required.

It is recommended that the clinical resources for the team be housed with SHA, to ensure continuity with acute care and community mental health teams. Information sharing protocols and policy alignment would need to be established between the provinces in order

to avoid duplication of resources – a poor outcome would be one PACT team for each province, resulting in further uncoordinated patient care.

Right-Size Service Levels to Reflect Administrative Workloads

Community mental health in Lloydminster operates under two provincial systems, which creates additional reporting, intake, and coordination requirements compared to single-jurisdiction sites. Staff are required to navigate different processes depending on the client's province of residence, resulting in additional workload that reduces available time for direct care. Future planning should ensure that service levels reflect this administrative complexity so that clients have equitable access and staff capacity is not overly stretched by workload arising from cross-border complexities.

The community mental health FTE to population ratio is already significantly higher in The Battlefords than Lloydminster, with more community mental health FTE despite a smaller population. An 132% increase in FTE would be required to bring staffing levels to benchmark levels nearing The Battlefords' staffing ratios, with an additional 10% increase recommended to account for cross-border complexities. The resources recommended for PACT can be included in this FTE count.

3.9.2.2.4 System Impacts

The establishment of a PACT in Lloydminster would significantly change how mental health crises are managed across the city and its surrounding service area. At present, police are the default first responders, and individuals in crisis are typically transported to the emergency department. A dedicated PACT would allow for more timely assessment and de-escalation in the community, reducing reliance on the hospital as the primary point of care. This would alleviate pressure on the emergency department and provide a more clinically appropriate response for individuals experiencing acute mental health episodes.

System impacts would extend beyond the hospital. By diverting calls from the ED, police resources could be used more efficiently by decreasing the amount of time officers spend monitoring individuals in crisis. This change would also strengthen coordination between law enforcement and health professionals, building clearer pathways into outpatient and community mental health services.

Evidence from other communities has shown that PACT models reduce the number of unnecessary ED visits, lower rates of police apprehension, and improve patient engagement with ongoing supports. In Lloydminster, where psychiatric capacity is limited, the addition of a PACT could provide a critical bridge between community-based services and the acute care system. This could improve patient safety, reduce transfers, and enhance the overall efficiency of the health and policing systems serving the region.

3.10 SUPPORTING SERVICES

3.10.1 Medical Imaging

3.10.1.1 Current State

3.10.1.1.1 Overview

The Lloydminster Hospital Medical Imaging Department provides a range of diagnostic services including X-ray, CT, Ultrasound, Mammography, and Fluoroscopy, while MRI is accessed through mobile service on the Alberta side. Collectively, these services support ~18,700 patient visits annually (2024/25), with demand growing steadily over the past decade.

Services support emergency, inpatient, and outpatient referrals, though gaps exist in the data for community-provided imaging (notably Ultrasound and Mammography), much of which occurs in Alberta private clinics under public funding but is not reflected in hospital datasets.

Overall, medical imaging in Lloydminster faces five persistent challenges:

- Growing demand across all modalities, particularly CT and Ultrasound.
- Workforce shortages in technologists.
- Reliance on a single CT scanner, which experiences downtime due to maintenance and repairs.
- Jurisdictional barriers in referrals, reporting, and patient navigation between Alberta and Saskatchewan.
- Data limitations, with incomplete visibility into private and community imaging volumes.

3.10.1.1.2 Service Model

Medical Imaging services are provided within the hospital, with varying operating models across modalities:

X-ray: High-volume, front-line modality, predominantly ED-driven.

CT: Single scanner, extended hours (7 days/week, evenings, overnight on-call).

Ultrasound: Mix of inpatient and outpatient exams, but large volumes provided in Alberta private clinics.

Mammography: Outpatient only at the hospital; many patients access Alberta community providers.

Fluoroscopy: Smaller, stable volumes; mainly outpatient.

MRI: Mobile unit available periodically on the Alberta side.

Across modalities, operating hours, staffing levels, and referral pathways differ. X-ray and Ultrasound often provide same-day ED and inpatient support, whereas elective Mammography and Fluoroscopy rely on scheduled outpatient visits.

3.10.1.1.3 Key Data Points

Relative to 2 years ago, the annual number of patients visiting the Lloydminster Hospital Medical Imaging (MI) Department has increased by +4% (or by ~600 more MI patients annually), with patient counts increasing from approximately 18,000 patients in 2022/23 to 18,700 patients in 2024/25. Almost 60% of the imaging patients seen in 2024/25 came to the MI Department from the Lloydminster Hospital Emergency Department, while 30% of patients were seen as outpatients, and 10% of patients were hospital inpatients. The following information provides a summary related to the current state of the Lloydminster Hospital Medical Imaging Program, including information related to imaging modality:

CT Scan Patient Volume and Trends

Patients requiring a CT scan constituted 34% of all MI patients seen at the hospital in 2024/25. The number of patients requiring CT imaging has increased slightly over the last few years, with annual CT patient counts rising by 2%, from ~6,300 patients in 2022/23 to 6,400 patients in 2024/25. Roughly half of all CT patients were outpatients, while ~40% came for imaging services from the Lloydminster ED, and only ~10% were from the inpatient setting. Each month, this activity equated to ~530 patients requiring CT scans at the hospital, with lower volume months servicing as few as 350 patients (e.g., during months when inadequate staffing support was available).

X-Ray Patient Volume and Trends

X-Ray patients made up 53% of all annually seen MI patients. Patients requiring X-ray services increased by 3% over the last year, growing from ~9,700 patients in 2022/23 to ~10,000 patients in 2024/25. Approximately 75% of these patients requiring X-ray services were from the ED, while the remainder were seen as outpatients or were already inpatients in the hospital. Monthly X-ray patient volumes have been stable over the past few years, with ~830 patients receiving scans each month on-site.

Ultrasound Patient Volume and Trends

Ultrasound patients represented ~9% of the annual patients seen at the Lloydminster MI Department in 2024/25. Patients needing Ultrasound services increased by +30% over the

last year (going from ~1,280 patients in 2022/23 to ~1,650 patients in 2024/25), with this increased demand being driven by patients coming to the MI area from the Emergency setting. Patients presenting for ultrasounds from the Emergency represented 50% of all ultrasound patients, while the remaining 30% were hospital inpatients, and 20% were outpatients.

Fluoroscopy Patient Volume and Trends

Fluoroscopy patients made up only 2% of the total MI patients seen annually at Lloydminster in 2024/25, representing one of the smaller imaging modality patient groups at the hospital. Patients requiring Fluoroscopy imaging have declined by +3% year over year, going from 482 patients in 2022/23 to 468 patients being seen for this modality in 2024/25. Interestingly, this modality saw a steady decline in activity over the last 5 years (During the engagement, the stakeholders did note that there is a general shift to CT instead of using Fluoroscopy). The majority of Fluoroscopy patients were outpatients (~80%), while 15% were hospital inpatients, and only 5% were patients presenting from the hospital Emergency Department. For most months in 2024/25, there was a steady decrease in usage for this modality at Lloydminster Hospital.

Mammography Patient Volume and Trends

Mammography screening patients constituted only 1% of the hospital's overall annual MI patient counts in 2024/25. Notably, the Mammography modality showed the most significant reduction in activity at Lloydminster Hospital over the last year, with a 29% decrease in patient counts observed during this period (from 361 Mammography screening patients in 2022/23 to 257 patients annually in 2024/25). It was noted during the engagement sessions that patients have been traveling to other sites since the start of the COVID-19 pandemic due to insufficient staffing at the site. Currently, all mammography patients are seen as outpatients. Every month, this equated to seeing roughly 10 to 40 Mammogram patients each month. (It was noted that there is a desire to operate back at the pre-COVID-19 level).

3.10.1.1.4 Key Relationships

Emergency Department (ED)

The Lloydminster Hospital Emergency Department is the largest driver of medical imaging demand, accounting for nearly 60% of all imaging volumes. ED clinicians rely on X-ray as a first-line diagnostic tool, with CT increasingly becoming the standard of care for trauma, stroke, and undifferentiated abdominal pain. Ultrasound volumes are also driven by ED referrals, particularly for urgent abdominal and obstetric cases. The ED's dependence on imaging is compounded by the lack of accessible primary and ambulatory care in Lloydminster, which funnels patients with lower-acuity needs into the ED, indirectly increasing imaging demand. Coordination between the ED and Medical Imaging is essential for efficient turnaround of results for critical cases and optimized ED flow.

Inpatient Units

Hospital inpatients account for roughly 10% of all imaging services, though their needs are disproportionately complex compared to ED patient referrals. CT, Ultrasound, and Fluoroscopy are frequently required to support acute inpatient care, surgical decision-making, and cancer staging. Turnaround time is a critical factor, as delays in imaging can prolong increase length of stay. Inpatient imaging is also challenged by limited after-hours access; although CT has extended evening and on-call coverage, other modalities are often delayed until daytime hours. Relationships between inpatient units and Medical Imaging are stressed by workforce shortages, which can limit flexibility in accommodating urgent inpatient scans.

Community Providers

A significant proportion of Lloydminster's medical imaging demand is met outside the hospital through community providers, particularly private Alberta-based clinics. Publicly funded Ultrasound and Mammography services are routinely accessed in these settings, and patients are typically directed to Alberta providers for these services. Results for these services may not be readily visible to Saskatchewan physicians or hospital-based physicians, contributing to delays and duplication of tests. Improved integration and data sharing between the hospital and community providers is a key opportunity.

Alberta and Saskatchewan Health Systems

Lloydminster's unique bi-provincial position means its Medical Imaging Department must operate across two separate health systems, each with its own electronic health records, referral protocols, and privacy regulations. CT and other imaging performed in Lloydminster Hospital are not automatically uploaded into Alberta's NetCare, creating significant challenges for Alberta-based clinicians trying to access results. Additionally, requisitions from Alberta providers using Connect Care must still be manually faxed, leading to administrative inefficiencies and additional workload for staff. These systemic barriers reduce referral volumes from Alberta communities such as Cold Lake, Bonnyville, and Elk Point, even though Lloydminster is geographically their closest imaging hub. Lack of interoperability also places a burden on patients, who are often required to navigate approval rules, billing complexities, and duplicate testing.

Regional Hospitals (North Battleford, Wainwright, Others)

During times of scanner downtime or staffing shortages, patients are diverted from Lloydminster to other regional hospitals such as Wainwright or North Battleford. While these facilities provide important backup capacity, each has its own limitations: Wainwright lacks some specialty services that would be required for urgent scans (such as trauma scope), while North Battleford has staffing resource constraints. These diversion arrangements are

largely informal, without standardized protocols, and often require secondary transfers, which lead to delays in care. Building more structured referral and diversion agreements with these regional partners would be essential in the future state.

3.10.1.1.5 Key Challenges

Rising Demand Across Modalities

Demand for medical imaging services in Lloydminster continues to grow, driven both by population health needs and changes in clinical practice. CT volumes have increased by more than 10% since 2018–19, with the greatest growth seen in emergency referrals for trauma, stroke, and abdominal pain. Ultrasound has also experienced a significant rebound in volumes after the pandemic, although community-provided Alberta services complicate accurate demand tracking as those volumes are not available for analysis. X-ray remains the highest-volume modality, particularly for emergency patients, while Fluoroscopy has steadily declined as CT has replaced many of its indications. Mammography has seen a sharp reduction since COVID-19, with many patients now traveling to Alberta for service. Collectively, this rising and shifting demand places sustained pressure on a department that already struggles with capacity.

Workforce Shortages and Staffing Instability

The availability of skilled technologists is one of the most pressing challenges facing Lloydminster's Medical Imaging Department. Staffing instability has been exacerbated by maternity leaves, retirements, and attrition, with limited replacement capacity due to restricted training program seats in Saskatchewan. Recruitment is further complicated by Lloydminster's bi-provincial context, where technologists may prefer employment under Alberta's system. In some months, staffing shortfalls have reduced CT capacity to as few as 350 patients, compared to a typical monthly average of over 500. The department also lacks a relief pool or casual roster to buffer against unexpected absences. These workforce gaps contribute directly to service delays, longer patient wait times, and higher risks of staff burnout.

Equipment Limitations and Downtime

Lloydminster currently operates with a single CT scanner, which is aging and experiences normal downtime for maintenance and repairs. Service interruptions require emergent diversions to other communities, including Wainwright and North Battleford, neither of which can consistently provide the specialty coverage required for complex cases (typically those being diverted, as non-urgent cases are usually rescheduled). While other modalities such as X-ray and Ultrasound remain functional, their equipment also faces limitations in terms of modern capacity and throughput. Without redundancy or backup systems, any equipment

outage can result in disruptions to patient care, delayed diagnostics, and an increased need for patient transfers out of Lloydminster.

Cross-Provincial Barriers and System Fragmentation

Operating across the Alberta–Saskatchewan border presents significant challenges in coordination, data sharing, and continuity of care. For example, CT and other imaging performed in Lloydminster is not automatically uploaded into Alberta's NetCare system, leaving Alberta providers without direct access to results unless specifically requested. Conversely, Alberta's Connect Care system requires requisitions to be faxed manually to Lloydminster, creating inefficiencies that discourage referrals. This lack of interoperability has led to duplication of testing, increased radiation exposure for patients, and higher overall costs. Patients bear the burden of navigating which services are approved in which province, often facing confusion about where tests will be accepted and which physicians can access results. These issues have contributed to declining referral volumes from Alberta communities such as Cold Lake, Bonnyville, and Elk Point, even though Lloydminster is geographically their closest imaging hub.

Data Gaps and Limited System Visibility

Accurate planning for medical imaging in Lloydminster is hindered by incomplete and inconsistent data. Hospital datasets capture only a portion of overall imaging volumes, as many services, particularly Ultrasound and Mammography, are delivered in Alberta private clinics under public funding but are invisible in Saskatchewan-based reporting. The aggregate nature of available data further reduces accuracy, with some datasets failing to distinguish between inpatient, outpatient, and emergency visits. For example, hospital data for X-ray showed no outpatient volumes, despite outpatient imaging clearly being performed. These data limitations make it difficult to fully understand service utilization, forecast demand, and evaluate the true scale of cross-provincial leakage to community providers.

3.10.1.2 Future State

3.10.1.2.1 Overview

The future vision for Lloydminster's Medical Imaging Department is to establish a sustainable, modernized, and integrated imaging service that meets the needs of patients across both Alberta and Saskatchewan. The operational model would focus on improving access across all imaging modalities, stabilizing workforce capacity, and enhancing integration between the two provincial health systems.

Gap: Demand is increasing across all modalities, especially CT and Ultrasound, while workforce shortages in technologists limit the ability to expand capacity. Reliance on a single CT scanner creates a significant service risk, as downtime from maintenance or repair disrupts continuity of care. Jurisdictional barriers between Alberta and Saskatchewan further complicate referrals, reporting and patient navigation. Data limitations reduce the system's ability to plan effectively.

Recommendation for Consideration: A combination of workforce development, equipment renewal, and improved cross-provincial coordination. A long-term strategy could be developed focusing on maintaining the reliability of CT as the central diagnostic tool, ensuring 24/7 access to X-ray and Fluoroscopy, and exploring sustainable approaches for MRI capacity, either through expanded mobile service or a fixed regional resource. Establishing a dedicated coordination function across Alberta and Saskatchewan could improve referrals, requisition management, and data sharing, along with the training of all technologist staff.

Potential System Impacts: These measures would enhance continuity of diagnostic services, reduce duplication of imaging across all provincial boundaries, and improve system efficiency through stronger coordination and workforce stability. By 2040, Lloydminster Hospital is projected to accommodate approximately 25,800 annual Medical Imaging patients, an increase of 7,100 patients compared with 2024 volumes, representing a 38% growth in demand.

3.10.1.2.2 Service-Specific Assumptions

For future projections, the 2024/25 baseline period was selected to drive the future state projections for this area. Aside from accounting for population growth and ageing, the MI projection model also considers the following potential future state service shifts and the resulting impact on the projected MI patient demand:

Staffing Challenges and CT Capacity Improvement

Given the current Medical Imaging staffing challenges that can be seen to limit the throughput of this department, improving staffing levels for the MI department would better ensure that the site could operate at its full imaging capacity on a month-to-month basis (e.g. especially for the CT modality). The model scales the baseline CT activity up by ~180 patients for October 2024 and November 2024, bringing them closer to an average month of activity, and then projects future demand using this modified current state as the starting point.

Mammography Staffing and Service Expansion

There is a noted desire for the site to improve staffing levels for the Mammography modality to ensure that they can perform both Diagnostic Mammography and Screening Mammography,

as was done onsite in 2019/20. As a starting point, the model assumes that the site can operate at a similar volume to the 2019/20 throughput for Diagnostic Mammography.

Redirecting Lower-Priority CT Patients to Improve Wait Times

One of the recommendations is to allow the lower-priority CT patients who are currently encountering significant long wait times at Lloydminster Hospital to obtain CT MI services more quickly at other hospitals in the region. The model assumes this will not change the total number of patients seen at the MI Department in Lloydminster in the future, but instead assumes that the site would be better able to utilize the hospital resources to see patients within their home catchment areas.

3.10.1.2.3 Future Directions

CT Services: The single CT scanner would continue to serve as the central diagnostic tool, especially for emergency and inpatient care. Efforts would focus on maintaining reliability through service agreements, optimizing uptime, and developing structured diversion protocols for when downtime is unavoidable. Operating hours would remain extended, with urgent access available through on-call coverage.

X-ray: X-ray would remain the highest-volume modality, with a continued focus on supporting emergency demand. Investment in staffing and equipment upkeep would ensure 24/7 access is sustained, making it the most dependable service line within Medical Imaging.

Fluoroscopy: While smaller in volume, Fluoroscopy would continue to support targeted diagnostic and interventional needs. The future direction includes equipment renewal and ensuring consistent availability, even as CT replaces some historical fluoroscopic indications.

MRI: Access would remain reliant on the mobile MRI service located on the Alberta side. Future strategies include advocating for expanded mobile coverage or exploring the feasibility of a fixed MRI resource at the regional level to better serve local demand.

Cross-Provincial Integration: A central priority is ultimately establishing a seamless bi-provincial system. A resourced coordination function should be implemented to manage referrals, confirm requisitions, and ensure results are shared across both provinces. Over time, harmonized electronic referral systems and data-sharing agreements would reduce duplication and improve visibility for providers in both Alberta and Saskatchewan.

Staffing and Workforce Development: The sustainability of these services depends on workforce stability. Saskatchewan Medical Imaging has already moved towards expected training in specialty modalities for all technologist staff. Additionally, a regional “travel team” with specialist competencies, particularly for CT services, should be explored to reduce staffing-related capacity challenges.

Based on these assumptions, Lloydminster Hospital will need to **accommodate approximately 25,800 annual MI patients by 2040**. This is equivalent to approximately +7,100 additional annual MI patients by 2040, or an **+38% growth** in annual MI patients beyond what was seen in 2024.

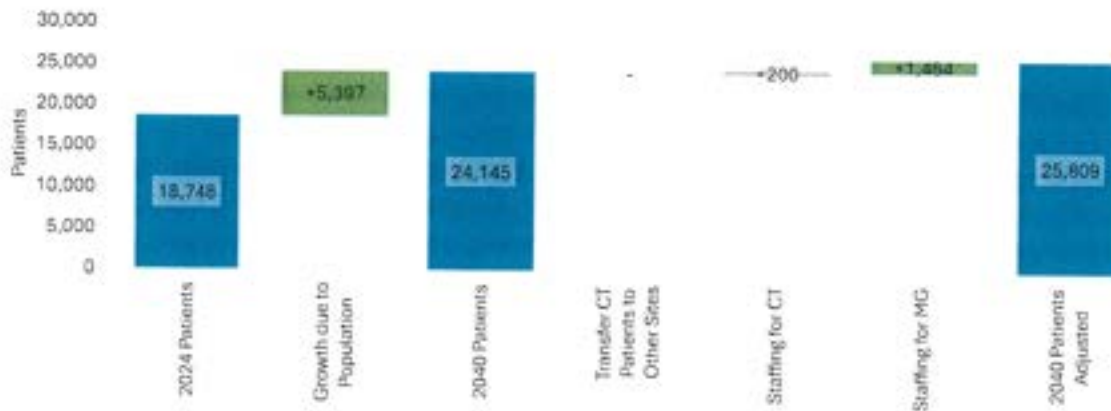


Figure 32 - Projected MI Patients

The Demand Projection results suggest that Lloydminster's annual MI patients will grow from ~18.7k to ~25.8k, a growth of +7.1k patients, (+38%) from 2024 to 2040

For the 2040, patients requiring a CT scan will constitute 31% of all patient counts (or ~8,000 patients annually), X-Ray requiring patients will represent 52% of the patient count (or ~13,400), while the remainder of annual patient counts will be for the Fluoroscopy (3%, ~770 annual patients), Mammography (7%, or ~1,800 patients) and Ultrasound (7%, or ~1,800 patients) modalities.

3.10.1.2.4 System Impacts

The system planning impacts include improved service continuity, reduced emergency department burden, and decreased duplication of imaging across provincial boundaries. Contingency protocols would be established for equipment downtime, and coordination would be enhanced between Alberta and Saskatchewan health systems.

3.10.2 Laboratory Services

3.10.2.1 Current State

3.10.2.1.1 Overview

Laboratory services in Lloydminster operate through a dual structure that supports both inpatient and community needs. The Lloydminster Hospital Laboratory, located on the Saskatchewan side, is focused on acute and urgent testing but also accommodates some outpatient demand. Complementing this, Alberta Precision Laboratories (APL)³¹ provides outpatient diagnostic services at a community collection site on the Alberta side. Together, these facilities serve both Alberta and Saskatchewan residents, but delivery is complicated by bi-provincial governance, fragmented electronic health record systems, and ongoing capacity pressures.

3.10.2.1.2 Service Model

Laboratory services in Lloydminster are delivered through three main channels: the Lloydminster Hospital Laboratory, APL Patient Service Centre (PSC) or community collection site, and limited point-of-care testing.

Lloydminster Hospital Laboratory

Located on the Saskatchewan side and operated by SHA, the hospital laboratory provides a broad acute care test menu including biochemistry, hematology, coagulation, urinalysis, and transfusion medicine. Testing capacity is designed to support inpatient and urgent outpatient needs (such as chemotherapy, dialysis, and pre-surgical testing) rather than community care management. Tests performed on site, including outpatient collections done in-house, usually provide same-day results.

The hospital laboratory operates within an established Saskatchewan referral network, with clear processes for routing specimens. All microbiology, pathology, and specialized testing (e.g., hormones, hemoglobin A1C) are referred to larger Saskatchewan laboratories in North Battleford, Saskatoon, or Regina, depending on the test. For instance, Hemoglobin A1C analysis is only available in a few provincial laboratories, with Lloydminster samples shipped to Regina, adding approximately one day for transport. Despite transportation, reporting for such tests falls within acceptable time limits.

In addition, the Maidstone Health Centre offers extended hours (Monday to Thursday, 8 am - 8 pm and Saturday and Sunday, 8 am - 12 pm) and diagnostic services (laboratory and X-ray), providing an alternative for patients capable of traveling if needed, who may otherwise be

³¹ <https://www.albertaprecisionlabs.ca/>

reliant on Lloydminster Hospital's ED. The Prairie North Plaza Clinic does not currently have laboratory services.

In Saskatchewan, the SHA has been strengthening linkages with primary care clinics to support the repatriation of pathology samples. As of November 2024, pathology specimens such as skin biopsies from Saskatchewan-designated clinics are collected by SHA couriers, delivered to the Lloydminster Hospital for accessioning and preparation by laboratory assistants, and then transported to North Battleford for diagnostic testing.

APL

APL provides all community laboratory services in Alberta, operating under a centralized hub-and-spoke model. Lloydminster's APL site³² functions as a Patient Service Centre³³ for routine outpatient tests, collecting and forwarding specimens to Edmonton (North Hub Lab) for analysis. Results are typically available within 24 hours of collection. While most routine community testing is centralized, urgent specimens may be routed to the nearest testing laboratory.

Surrounding Alberta communities such as Vermilion, Cold Lake, and Bonnyville maintain hospital-based laboratories that collect and test outpatient samples on-site. Test menus in these rural hospital laboratories are typically reduced and aligned to local needs. More complex or microbiology testing from these sites is directed to provincial hubs. This system allows for leveraging economies of scale while ensuring access to specialized diagnostics.

Point-of-Care Testing (POCT)

POCT is increasingly used in smaller Saskatchewan sites to address staffing pressures, with nurses performing basic tests such as CBC and glucose. In Lloydminster, POCT is used less often (mainly for COVID-19 and influenza) given that hospital laboratory staffing has been relatively stable.

Table 8 - Availability of Outpatient Laboratory Services by Community

Community	Laboratory
Loon Lake, SK	1
Meadow Lake, SK	1
St. Walburg, SK	2
Lloydminster	-
Maidstone, SK	-

³² Plaza 44, 4402 52 Ave Suite 108, Lloydminster, AB T9V 0Y9

³³ All community lab work is primarily sent to two hubs: Edmonton and Calgary. Communities with more than 25,000 collections/year (outside Edmonton and Calgary) have Patient Service Centres, which are sample collection sites, and do not perform analysis.

Cut Knife, SK	-
Unity, SK	1
North Battleford, SK	-
Edam, SK	1
Macklin, SK	1
Total (SK)	7
Vermillion River County, AB	1
Two Hills County, AB	1
MD of Provost, AB	1
Viking, AB	1
MD of Wainwright, AB	1
Flagstaff County, AB	-
Vegreville / Minburn County, AB	1
Cold Lake, AB	1
St. Paul, AB	1
Bonnyville	1
Total (AB)	9

3.10.2.1.3 Key Data Points

The Lloydminster Hospital Laboratory focuses on supporting the acute and urgent testing needs for both Alberta and Saskatchewan patients, with the demand for this service continuing to grow over time. The annual Lloydminster Hospital Laboratory order volumes have increased by +13% in 2024/25 (or ~60,500 more orders annually) relative to the number of orders seen in 2019/20. Total annual hospital testing orders increased from approximately 468,000 orders in 2019/20 up to 529,000 orders in 2024/25. During the same time frame, hospital Laboratory orders from the Emergency area grew by +15%, while the demand from hospital inpatients grew by +7%, while outpatient Laboratory testing demand increased by +20%.

In addition to the hospital supported Laboratory testing, outside of the hospital setting, the mobile and Alberta Precision Laboratory (APL) also provide outpatient testing support for patients in this region. Volumes at these external locations have experienced at least a +7% annual growth between 2021/22 and 2024/25, suggesting demand for Laboratory services has expanded significantly both within and outside of the acute hospital setting.

3.10.2.1.4 Key Relationships

Laboratory services in Lloydminster depend on coordination across multiple organizations and referral networks:

The SHA-operated Lloydminster Hospital Laboratory maintains strong links with provincial laboratories in North Battleford, Saskatoon, and Regina for microbiology, pathology, and specialized testing, while also supporting integration with Saskatchewan primary care clinics for the repatriation of pathology specimens.

On the Alberta side, APL's Patient Service Centre in Lloydminster connects to the Edmonton hub laboratory, ensuring timely processing of community-based samples and aligning with Alberta's centralized model. Surrounding rural Alberta hospitals also contribute by collecting and processing outpatient samples locally before forwarding complex tests to provincial hubs.

3.10.2.1.5 Key Challenges

Three key challenges were identified through the engagement process and data analysis.

Bi-Provincial Coordination

A major challenge for laboratory services in Lloydminster is the lack of seamless information sharing across the Alberta–Saskatchewan border. Laboratory results do not flow consistently between Alberta Netcare system³⁴ and Saskatchewan's EMR systems³⁵, creating significant gaps in continuity of care. Although there is a Lab Information System (LIS) in place which connects lab results to EMR systems and MySaskHealthRecord, difficulties still arise in relation to information sharing across both borders. For example, results for Saskatchewan residents who undergo testing at APL cannot be accessed by them and their Saskatchewan-based physicians. This issue often drives these patients to use the Lloydminster Hospital laboratory instead. Similarly, results generated in Saskatchewan are not automatically available in Alberta's systems, meaning providers must often phone other sites or request copies directly. This dynamic contributes to duplication of testing, delays in care, and additional pressure on the hospital laboratory.

Note that the Alberta Netcare system was originally accessible only within Alberta but new processes have been introduced to allow Saskatchewan physicians to apply for access authorization. This system includes critical patient information such as laboratory results and pharmacy prescription histories.

³⁴ <https://www.albertanetcare.ca/>

³⁵ The electronic Health Record (eHR) Viewer is a secure website authorized health care providers can use to access patient information. MySaskHealthRecord is a secure website that enables Saskatchewan citizens to quickly and easily access their personal health information.

Additionally, gaps are also evident in urgent laboratory services, as urgent specimens from the APL collection site in Lloydminster are not routed to the Lloydminster Hospital laboratory but instead sent to Edmonton. This disconnect undermines timely local response capacity.

Outpatient Demand for the Hospital Laboratory Services

The Lloydminster Hospital laboratory was not designed or resourced to function as a community outpatient collection site, yet it has increasingly assumed this role. Outpatient demand, particularly from Saskatchewan residents, has grown significantly, overwhelming both staff capacity and infrastructure. The laboratory lacks the physical space, appropriate layout, and front-end staffing capacity required for outpatient services, which has forced the inpatient and urgent testing areas to absorb community demand. Despite best efforts, staff are struggling to keep pace with the ongoing pressure on service delivery.

Several factors drive patients to the hospital laboratory for outpatient collections. Saskatchewan residents, in particular, use the hospital site because results are more easily accessible through the provincial electronic health records, whereas results from the APL site are not. Patients are also directed to the hospital for urgent testing, as specimens collected at the APL site are transported to Edmonton, delaying the turn-around time. In addition, the hospital is the only site equipped to provide specialized collections, such as blood typing and transfusion preparation for surgery, or tests for patients receiving chemotherapy and dialysis. Recent shifts in Alberta service delivery have also amplified demand. Previously, DynaLIFE³⁶ offered hard-copy results directly at the Lloydminster Patient Service Centre, which was convenient for Saskatchewan residents. Since the transition to APL, patients must use an online process that is slower and requires a fee. At the same time, patients' expectations around accessing their own health information have evolved, with more individuals actively seeking out services that provide direct access to their records. These factors have transformed the Lloydminster Hospital laboratory into a de facto outpatient collection site despite lacking the mandate for this role.

Staffing Recruitment

Both the Lloydminster Hospital laboratory and the APL site face ongoing recruitment and retention difficulties that limit their ability to meet demand and expand services (such as in the Prairie North Plaza Clinic).

At the Lloydminster Hospital laboratory, shortages affect all staff categories, including Medical Laboratory Technologists (MLTs) and Medical Laboratory Assistants (MLAs). Recruitment is particularly difficult for the hospital as it is located in Saskatchewan, where

³⁶ DynaLIFE's operations were returned to Alberta Precision Laboratories (APL), a subsidiary of Alberta Health Services, at the end of 2023 after a short-lived privatization (Dec 2022–2023) marked by long wait times and operational challenges.

wages are lower than in Alberta. This wage differential creates a persistent disadvantage in attracting and retaining qualified staff, especially in a border city where Alberta positions are often seen as more competitive. In addition, the hospital laboratory has limited ability to support training placements. While some placements are offered, it cannot provide comprehensive training for MLTs or MLAs, as required disciplines such as microbiology and pathology are not available on site. Additionally, staffing cannot be easily supplemented by short-term transfers from other Saskatchewan locations. To maintain 24/7 operations in the face of shortages, mitigation strategies have included staff overtime, transferring out non-urgent work, and prioritizing inpatient testing over outpatient collections. Outpatients usually experience extended wait times during critical shortages. Despite these pressures, the hospital laboratory has so far avoided closing outpatient access.

The APL site is primarily staffed by MLAs and has a limited local pool of qualified candidates, making it difficult to fill vacancies unless individuals relocate to Lloydminster. APL currently does not offer training placements in the community, unlike in other parts of Alberta, which limits its ability to build a local recruitment pipeline. APL leadership has identified training placements as a potential strategy to strengthen recruitment, as students who train locally may be more likely to stay if they enjoy the location and community.

3.10.2.2 Future State

3.10.2.2.1 Overview

Laboratory services in Lloydminster are foundational to acute and community care but face persistent challenges related to staffing, outpatient demand, and data sharing. The dual system, i.e., hospital-based acute lab and APL outpatient collection site, creates redundancies when provincial information systems cannot communicate. With demand projected to increase alongside population growth, system sustainability depends on shifting more outpatient diagnostics to community sites, stabilizing staffing pipelines, and addressing cross-jurisdictional interoperability gaps.

Gap: Bi-provincial coordination is hindered by the lack of connection in information sharing between Alberta and Saskatchewan systems, resulting in duplication, delays, and inconsistent continuity of care. The Lloydminster Hospital laboratory is under significant strain from outpatient demand, as it has increasingly functioned as a community collection site despite lacking the infrastructure and staffing for this role. Persistent recruitment and retention challenges constrain the hospital's ability to maintain stable service levels.

Recommendation for Consideration: Outpatient diagnostic demand should be shifted into community-based facilities, including expansion of the Alberta Precision Laboratories (APL) site and the development of an SHA-operated collection service, to relieve pressure on the

hospital laboratory. Sustainable staffing pipelines must be established through the prioritization of recruitment and retention strategies, expanding local training placements, and exploring support for dual licensure. Bi-provincial information-sharing processes should also be strengthened. Given that the role of a Medical Laboratory Assistant is not classified as a regulated profession in Alberta, these individuals may not be subject to licencing requirements typically in place for other allied health care professionals.

Potential System Impact: Patient volume distribution would be more efficient, reducing the unsustainable outpatient burden on the hospital laboratory. Improved patient access and care quality would be achieved through shorter wait times, better continuity of results, and fewer duplicate tests for Saskatchewan patients. Enhanced workforce stability by creating a stronger recruitment and retention framework.

3.10.2.2.2 Service-Specific Assumptions

The following assumptions constitute the basis for laboratory services future planning:

- Neither the hospital laboratory nor the APL site currently has plans to introduce new service types or specializations.
- While no major service changes are anticipated to be required, the focus would be on improving current gaps in information sharing, outpatient flow, and staffing sustainability.
- The 2024/25 baseline period was selected to drive the future state projections for this area. Population growth and ageing were modelled as the main drivers for the future state demand. It should be noted that this projection model only includes Laboratory testing orders from the Lloydminster Hospital Laboratory (i.e. does not include mobile or APL testing activity) and assumes that the rapid growth from the outpatient area over the past few years would stabilize over time as the interprovincial population migration has settled as a result of COVID and the government lowering the immigration targets for people coming to Canada. From that point, it is assumed that demand would continue to present in line with population aging and growth. However, it was noted anecdotally that this rapid increase in Laboratory volume has been happening across Saskatchewan over the past few years. As such, it is suggested that system leaders closely monitor the volume growth over the next few years to see if it does in fact stabilize and becomes more aligned with population growth and aging, or if the growth would instead continue at a more rapid pace in future.

3.10.2.2.3 Future Directions

Based on these assumptions, Lloydminster Hospital would need to process approximately 578,000 in hospital Laboratory Testing orders by 2040. This is equivalent to approximately +50,000 additional orders by 2040, or a +9% growth in orders beyond what was seen in 2024.



Figure 33 - Projected Laboratory Orders

The Demand Projection results suggest that Lloydminster's annual in hospital Laboratory testing orders will grow from ~529k to 578k, a growth of +50k annual orders, (+9%) from 2024 to 2040

As such, the future direction should consider the following:

Shifting Outpatient Diagnostics to Community Sites

The future laboratory services model would continue to operate through a dual stream approach: acute and urgent testing would remain hospital-based, while outpatient collections should increasingly be directed to community-based facilities. This aligns with the strategic direction from the leadership to move non-acute services off the hospital campus and prioritize community-based care.

This could be achieved via expansion of the APL³⁷, as well as the addition of an integrated laboratory within the Prairie North Plaza Clinic (SHA), serving as a collection site for routine samples. This addition would help improve current service fragmentation and improve integration with primary care. It also provides the opportunity for future relocation of more specialized ambulatory needs, including chemotherapy and iron infusions, into community.

The APL site is considered well-positioned for growth, with potential for expanded space, extended hours, and increased staffing to accommodate projected outpatient demand and

³⁷ APL tends not to embed into individual clinics to ensure resources are available to the entire community.

population increases. However, establishing an SHA-operated off-site collection site remains a priority to resolve challenges beyond capacity alone.

Capital investment is required to expand outpatient laboratory collection capacity, as well as appropriate staffing including potentially a phlebotomist. The staffing resources should be scaled to match required volumes, rather than transferring existing laboratory staff from the hospital to the clinic site. Additionally, clear coordination pathways should be established to ensure effective connection between the hospital and primary care.

Ensuring Sustainable Staffing Pipelines

Sustainable staffing is the most pressing resource for the future success of laboratory services. Recruitment and retention of Medical Laboratory Technologists (MLTs) and Medical Laboratory Assistants (MLAs) must be prioritized, with strategies to expand local training placements to support long-term workforce stability. At the same time, implementing financial support for dual licensure should be explored. This is particularly essential for hospital staffing to ensure inpatient services remain protected while reducing reliance on overtime.

Implementing recruitment and retention strategies such as local training placements and financial/administrative support for dual licensure should be explored as a strategic priority.

Improving Information Sharing Practices

In the meantime, improving information-sharing practices and eliminating the bottlenecks in the authorization process for Saskatchewan providers could also help reduce barriers to access with minimal costs. Establishing bi-provincial agreements to facilitate the processes for both residents and providers should be considered, and in the interim, resourcing providers with administrative staff to coordinate information sharing for patient results should be implemented. If information-sharing challenges are addressed, APL could expand community outpatient capacity to compensate for the necessity of a SHA-run collection site.

3.10.2.2.4 System Impacts

The proposed realignment in patient flow provides two key benefits. First, improving efficiency by facilitating information access for providers, reducing duplicate testing, protecting inpatient capacity, and easing the unsustainable burden on the hospital laboratory staff and infrastructure. Second, these changes could result in improving patient care quality by allowing Saskatchewan resident to easily access their results, experience reduced wait times, and also limiting unnecessary exposure of vulnerable populations within the acute care environment.

3.10.3 Pharmacy Services

3.10.3.1 Current State

3.10.3.1.1 Overview

Pharmacy services are an essential supporting service that function within diverse care settings across Alberta and Saskatchewan. The hospital pharmacy provides inpatient dispensing and supports smaller sites such as Maidstone Health Centre, ambulance services, and Onion Lake First Nations Home Care. However, it does not currently service long-term care facilities, which instead rely on community pharmacies or distribution from Edmonton. For oncology care, the Lloydminster pharmacy is unique in operating under two separate provincial programs, supporting chemotherapy for both Alberta and Saskatchewan residents. Community pharmacies, including specialty compounding services, supplement this system and provide contracted services to long-term care.

3.10.3.1.2 Service Model

Pharmacy services in Lloydminster are delivered through several key channels spanning acute, long-term, and community care.

Hospital Pharmacy:

Specialized pharmacy services in the Lloydminster service area are primarily delivered by the Lloydminster Hospital Pharmacy Department, ensuring medication needs are met for inpatients and certain programs across both provinces. The Hospital Pharmacy Department provides three key services:

- Logistical pharmaceutical support for inpatients in Lloydminster Hospital (procuring and dispensing medication) as well as clinical care in interdisciplinary bedside rounds (such as reviewing patients' medications and providing dosing recommendations)
- Distributing medications to smaller sites such as Maidstone Health Centre (daily fills) and other providers including EMS and Onion Lake First Nations Home Care.
- Providing outpatient chemotherapy for both Alberta and Saskatchewan patients. The Outpatient Cancer Drug Benefit Program (OCDBP)³⁸ enables patients to receive treatment closer to home. In Lloydminster, the Hospital Pharmacy team dispenses cancer medications directly on-site, with supply and oversight provided under Alberta Health. The goal is to ensure all required medications are in place within five days to support timely treatment. This unique arrangement requires the pharmacy to operate under two different

³⁸ <https://www.albertahealthservices.ca/findhealth/Service.aspx?id=1025651&serviceAtFacilityID=1096232>

programs (COPS³⁹ in Saskatchewan and Cancer Care Alberta⁴⁰ in Alberta), necessitating staff to be proficient with two sets of protocols and systems. A notable variation in process is that the Saskatchewan program allows for processing by licensed technicians after remote order assessment is completed, while the Alberta program requires assessment by a local pharmacist before preparation.

Community Pharmacies:

Community residents have access to numerous retail pharmacies (e.g. Safeway, Shoppers Drug Mart, Co-op Pharmacy, independent pharmacies) which provide primary pharmacy care. These pharmacies dispense outpatient prescriptions and have expanded clinical roles in recent years. Services available include pharmacist-led medication reviews, vaccinations, and wellness programs such as smoking cessation counseling.

Note that continuing care facilities are served by local community pharmacies or an Edmonton distribution centre, rather than the hospital pharmacy. These pharmacies manage routine fills, dose adjustments, and emergency medication needs for long-term care residents in coordination with facility nurses. The hospital pharmacy itself may offer additional support or advice for complex cases in long-term care, but generally the day-to-day dispensing is handled by the contracted community pharmacies. The Home Care program does not hold medication stock and is responsible for obtaining medications on an ad hoc basis as needed for clients.

3.10.3.1.3 Key Data Points

The annual Lloydminster Hospital Drug Procurement and Distribution staffing earned hours (used a proxy to measure the department's current workload) have increased slightly by +2% in 2023/24 (or ~320 more hours annually) relative to hours in 2020/21. Total annual hours increased from approximately 25,900 hours in 2020/21 up to ~26,200 hours in 2023/24.

3.10.3.1.4 Key Relationships

Pharmacy services in Lloydminster depend on coordination between hospital, community, and provincial systems. The Hospital Pharmacy supports inpatient care, smaller sites, EMS, and outpatient chemotherapy, requiring staff to work under both Alberta and Saskatchewan protocols. Community pharmacies provide most outpatient, long-term care, and home care medications, with added clinical services such as reviews and vaccinations.

³⁹ <https://saskcancer.ca/COPS>

⁴⁰ <https://www.albertahealthservices.ca/cancer/cancer.aspx>

3.10.3.1.5 Key Challenges

Pharmacy service face multiple key challenges:

Bi-Provincial Complexity

Different provincial programs, protocols, and legislation create inefficiencies. For example, Alberta Electronic Health Records (EHR) do not capture fills for Alberta patients that occur on the Saskatchewan side. This means that healthcare providers often cannot rely on EHRs for medication histories.

Staffing and Recruitment

Despite vacancies in nearby communities, the Hospital Pharmacy is currently fairly well staffed largely due to a stable workforce base. However, recruitment challenges are anticipated as retirements increase over the next 15 years. Pharmacy technician and pharmacist roles are typically considered to be challenging to recruit across Saskatchewan.

Funding and Scope Limitations

SHA pharmacy services are primarily funded for acute care. This leaves gaps in areas such as transitional care, long-term care services, immunizations, and opioid agonist therapy, despite the potential value pharmacists could bring.

Space Constraints

Limited space within the hospital makes it difficult to collocate pharmacists within clinical units and closer to the point of care rather than confined to the dispensary.

3.10.3.2 Future State

3.10.3.2.1 Overview

Pharmacy in Lloydminster is a critical but complex service, balancing dual-provincial responsibilities and sometimes limited resources. While currently functioning effectively, challenges in workforce sustainability, care involvement, and data integration pose risks. Future planning should emphasize role optimization, clinical integration, and technological investment to strengthen pharmacy's impact.

Gap: Pharmacy services face inefficiencies from bi-provincial differences in legislation, programs, and EHRS, which limit access to complete medical histories. Staffing is vulnerable

due to future retirements, with recruitment challenges anticipated. Funding is primarily directed to acute care, leaving gaps in transitional care, long-term care, and specialized programs. Limited space within the Lloydminster Hospital also prevents pharmacists from being embedded in clinical units, reducing their ability to contribute directly to patient care.

Recommendation for Consideration: Expand pharmacist involvement in clinical care (rounds, counseling, discharge support), optimize technician roles to increase efficiency, and improve workforce sustainability through targeted recruitment and training placements. Enhance cross-provincial data sharing and re-design space to enable closer integration of pharmacy staff with clinical teams.

Potential System Impact: More efficient allocation of pharmacist expertise, stronger integration into patient care, improved outcomes during transitions, and enhanced workforce sustainability. By 2040, demand is projected to reach approximately 29,100 earned hours in drug procurement and distribution, an increase of 11% compared with 2023.

3.10.3.2.2 Service-Specific Assumptions

The 2023/24 baseline period was selected to drive the future state projections for this area (with later data not available for this area). Population growth and ageing were modelled as the main drivers for the future state demand.

3.10.3.2.3 Future Directions

The future state envisions pharmacists more embedded inpatient care (rounds, counseling, discharge support), expanded technician roles, and stronger infrastructure (EHR integration, space redesign). These incremental enhancements could build capacity and improve continuity without requiring major changes.

Improving Staffing Capacity and Efficiency

This could be achieved via multiple strategies:

- Optimizing technician and pharmacist roles by fully utilizing the scope of licensed pharmacy technicians to free up pharmacists' time for clinical patient-facing activities.
- Involving pharmacists more directly in bedside clinical care by taking on additional responsibilities such as medication history collection, and discharge medication reconciliation, and deprescription.
- Leveraging community paramedics or advanced care paramedics for programs in long-term care and patient assessments to prevent hospital admissions. Engagement identified that similar programs exist elsewhere in Saskatchewan and these integrated care teams can prove to be effective in serving the community.

- Improving integration with pharmacy training programs and seeking collaboration opportunities including expanded work experience placements for students.

To achieve these directions, opportunities should be explored for colocated pharmacist workspace on hospital wards. Additionally, as with other service lines, improving cross-provincial agreements on data sharing would facilitate benefits to pharmacy services across sites and providers, enabling better care continuity and the potential for greater pharmacist integration to care.

Based on the assumptions above, Lloydminster Hospital will need to **budget for approximately 29,100 Hospital Drug Procurement and Distribution staffing earned hours by 2040**. This is equivalent to approximately +2,800 additional staffing earned hours by 2040, or a **+11% growth** in staffing earned hours beyond what was seen in 2023.



Figure 34 - Projected Annual Staffing Earned Hours

The Demand Projection results suggest that Lloydminster's annual staffing earned hours will grow from ~26.3k to 29.1k, a growth of +2.8k hours, (+11%) from 2023 to 2040

3.10.3.2.4 System Impacts

The future model could optimize technician roles to manage dispensing activities and better utilize pharmacists' expertise in more direct clinical care, improving both efficiency and patient outcomes.

3.11 IMPLEMENTATION

3.11.1 Clinical Drivers

Across all sectors, the clinical drivers for change include misalignment between service capacity and community demand, systemic staffing shortages, fragmented care pathways, and aging infrastructure. Inappropriate service utilization in the Emergency Department, reflects broader system access issues. The dual-provincial context further complicates care delivery and coordination, leading to staff and patient burdens. Addressing these drivers requires integrated planning including enhanced workforce strategies, and a renewed focus on community-based and preventive care to ensure the system can meet current and future clinical demands. Below is a description of these clinical drivers in more detail.

Inadequate Acute Care Capacity and Infrastructure

The Lloydminster Hospital is no longer adequate for the population it serves, having been originally built for a much smaller community. It lacks key services, notably an ICU, despite its strategic location between Edmonton and Saskatoon and the local atmospheric challenges with rapid air evacuation. Staffing shortages, particularly among allied health professionals, clinical support services staff, and physicians, limit service availability, resulting in patients traveling for care that are in scope to be provided locally. These issues are compounded by high ED wait times and increasing numbers of patients leaving without being seen or triaged, driven in part by poor access to primary care.

Fragmented and Insufficient Primary Care Access

Primary care services are critically understaffed, with many unattached patients and ongoing difficulties in recruiting physicians. The bi-provincial administrative complexity, fee-for-service payment model, and limited overhead support make recruitment and retention challenging. The lack of after-hours access pushes patients toward the Emergency Department for issues that could be managed in community settings. This burdens acute care and leads to delays in appropriate treatment and care continuity issues. Without a robust and accessible primary care system, the broader healthcare system becomes strained and reactive.

Major Gaps in Mental Health and Substance Use Services

Mental health and substance use services are notably lacking in Lloydminster. Although there is a 24/7 call line in operation through Primary Care Alberta which provides law enforcement partners with priority access to phone-based consultations with Mental Health Clinicians, problems still arise in relation to the availability of such services.

There are no local inpatient mental health beds or after-hours crisis services other than the ED, which is not equipped from a personnel or infrastructure perspective to safely handle mental health presentations. The absence of stabilization and step-down options requires patients to travel to other communities for care, delaying intervention and increasing risk. As a result, the RCMP have become the default responder for mental health crises. This diverts law enforcement resources and highlights the failure of the health system to adequately respond to urgent mental health needs. A shortage of psychiatrist coverage, long wait times in ED, and poor service coordination are illustrative of the Mental Health Substance Use (MHSU) system deficits.

Growing Pressures in Long-Term Care

Limited intermediate options between community care and long term care are resulting in pressures in the continuing care system. There is also an imbalance between Alberta and Saskatchewan in the availability and types of seniors' housing and supports, requiring patients to relocate in order to access care. Increasing acuity and complexity of residents' needs require higher levels of care and staffing, and resources have not kept pace. The lack of respite beds limits support for family caregivers, while insufficient continuing care capacity contributes to acute care bottlenecks, with ALC patients routinely occupying medicine beds.

System Navigation and Cross-Border Care Complexity

Operating within a bi-provincial context introduces unique challenges in navigation, funding, and service coordination. Different policies, protocols, and eligibility criteria between Alberta and Saskatchewan make it difficult for patients to access consistent, coordinated care. There is currently no formal patient navigation system in place to assist with these complexities, leaving patients and providers to manage them independently. This leads to delays in care, inefficiencies, and inequities in service access.

Diagnostic and Specialist Service Limitations

Access to diagnostic and specialist services is limited, particularly for advanced imaging and oncology. Specialist shortages, particularly in rural areas, making timely access to care difficult and compromising early detection and effective treatment planning.

Strain on Community-Based and Preventive Services

Community care services, including publicly funded physiotherapy and community psychiatry, face long wait times and rising demand. This undermines opportunities for early intervention and prevention, leading to deterioration in health and avoidable use of acute care resources. Home care services are overstretched, while public awareness of available community-based services, such as enhanced pharmacy scope, is low. This lack of

knowledge contributes to unnecessary ED visits and duplication of services, illustrating the need for improved system navigation, resourcing, and care coordination.

3.11.2 Priority Service Areas

The Lloydminster health system faces critical challenges related to capacity and infrastructure across several key areas. At the same time, resources are limited and staffing shortages exist across both provinces. Changes need to be prioritized based on clinical drivers and feasibility; this section outlines the areas recommended to be assessed for implementation first.

Establishing a Primary Access Clinic:

Due to the urgent and increasing capacity pressures in Emergency, it is recommended that a Primary Access Clinic function be prioritized for consideration. This change would require no infrastructure and moderate staffing resources. Process and protocols would need to be developed, including clinical screening protocols and coordination of booking between Emergency Registration and Prairie North Clinic. Ideally, this clinic function would be staffed with a Nurse Practitioner and operate between the hours of 3pm-7pm on weekdays, as well as early mornings and daytime weekend shifts as possible.

Expanding Primary Care Access through Team-Based and Virtual Models:

Enhancing primary care by enhancing team-based and virtual platforms aims to increase overall accessibility, by using primary provider time more efficiently and supplementing care with appropriate allied supports. These models support continuous, multi-disciplinary and patient-centred care, reduce unnecessary ED visits, and mitigate current bottlenecks, as well as also being mindful of the fact that primary provider time is critically limited. These solutions are cost-effective as they improve chronic disease management, a primary driver of Ambulatory Care Sensitive Condition acute presentations and strengthen system resilience amid staffing and resource limitations. A key enabler of this change is facilitating APP/ARP and contract models for primary care providers, including Nurse Practitioners, and this system change should be prioritized.

It should be noted that allied staff are in short supply, and as union positions, these positions are unable to be incentivized for recruitment. Virtual allied support in partnership with larger centres should be explored, as well as local training pathways that include flexibility for latent segments of the workforce, such as older community members and parents.

Dedicated Mental Health Nursing in the ED:

Introducing Mental Health nursing support within the ED is a high-impact, low-infrastructure change that would improve patient safety, enhance de-escalation capacity, and support more

consistent assessment and monitoring. MH nurses would also provide real-time consultative support to generalist ED nurses and physicians, improving decision-making and reducing unnecessary transfers. This would help retain more mental health patients locally, reduce flow disruptions associated with 1:1 staffing, and support a more therapeutic patient experience.

Upskilling ED Physicians in Mental Health Assessment and Care:

ED physicians were identified to require additional training in mental health crisis management in order to provide timely and appropriate care and reduce reliance on psychiatry consultative services. Targeted education would increase confidence in managing mental health and substance use presentations; this direction aligns with the system strategy of upskilling generalist providers to safely manage higher-needs cases locally within an appropriate scope of practice.

Mental Health Short Stay Unit (SSU):

The staffing enhancements noted above require relatively low investment with a high system return, and intend to safely treat a greater proportion of mental health patients locally. However, without an appropriate physical environment, the ED will continue to rely on improvised or unsecured locations for observation and short-term treatment, creating safety risks for patients and staff.

A co-located SSU would offer a secure, monitored environment for short-term assessment, stabilization, and transition planning. This represents a moderate capital investment with significant system benefits, including decreased risk, improved care continuity with community teams, decreased avoidable transfers, and improved patient experience. A dedicated study of SSU feasibility should be prioritized in order to determine appropriate scope, infrastructure requirements, and operational alignment with both provincial mental health frameworks.

Developing a Transitional Care Unit:

Establishing a TCU is a targeted strategy to address hospital capacity pressures driven by high ALC occupancy and the lack of specialized transitional care spaces. Ideally this unit would be situated outside the acute hospital setting, and would provide restorative, community-close environments where patients could recover their functional status and transition appropriately. This reduces hospital occupancy, shortens long-term care waitlists, and fosters better patient community reintegration. Additionally, the TCU could provide respite support to patients living in community, and case management support for these patients to enable continued safe community living and prevent caregiver burnout.

This unit may require capital investment, even if an existing facility is identified as able to be re-purposed. A business case should be considered to identify the cost of current ALC patient care and early continuing care admission, and weigh this against the capital and operational costs of establishing a TCU.

Strengthening Administrative Supports for Cross-Jurisdictional Information Sharing and Care Coordination:

Efficient, system-level information sharing and coordination require dedicated administrative efforts. Currently, clinical and administrative staff are fitting this work into their regular duties, taking time away from patient care. Resourcing staff teams to provide time to perform information-sharing and care coordination work in this complex bi-provincial setting is critical to optimizing patient outcomes and system efficiency. Ultimately, Lloydminster should work towards improving data sharing policies, standardizing referral processes, and aligning policies across Alberta and Saskatchewan to reduce the existing administrative burdens, avoid duplicate efforts, and provide equitable, timely access to care. However, it is noted that the larger systemic change would take time, and an urgent measure to resource teams for the workarounds they are already performing would enhance system function in the near term.

These priorities are interconnected and collectively support the overarching goal of creating a more accessible, efficient, and patient-centred healthcare system. They focus resources on immediate system needs, such as urgent care access and hospital capacity, and lay a foundation for sustainable growth through improved system integration and efficient resource use. These targeted investments would maximize system impact and provide better health outcomes within the existing resource constraints.

3.12 SERVICE INNOVATION DIRECTIONS

Strengthening coordination and communication between provincial ministries, healthcare authorities, and foundations, as well as standardizing terminology and definitions, is critical to ensure clear and consistent service delivery across the border. Several opportunities have been identified to improve care delivery in the Lloydminster region, and priorities have been identified in Section 3.11.2.

Prior to the development of these opportunities, several long-range system innovation directions were discussed and developed, ranging from targeting operational improvements to more comprehensive changes. Below is a high-level discussion of each service innovation direction discussed, for consideration of longer-term implementation. Each of these directions would require substantial resources, coordination, and stakeholder engagement, and would likely need to be phased over time. Nonetheless, these directions represent more complete systemic improvements that address the health system challenges in Lloydminster in a more foundational way.

Interoperable EMR

An interoperable electronic medical record (EMR) would allow patient information to be shared between providers in both Alberta and Saskatchewan, addressing one of the most persistent challenges in Lloydminster's bi-provincial health system. Currently, fragmented and siloed EMR systems result in duplicated tests, delayed care, poor care continuity, and a reliance on patients to carry information between providers. By creating a shared digital infrastructure, or, in the short term, establishing a centralized coordination function, care teams would be able to access complete and up-to-date information regardless of which jurisdiction the patient is served under or where they reside.

Improved information flow would enhance continuity of care and patient safety. Clinicians could make better-informed decisions, unnecessary procedures would be avoided, and transitions between hospital, primary care, and community services would be smoother. While implementing a fully interoperable EMR is technically and financially complex, a phased approach could yield early benefits, such as piloting a data-sharing hub to bridge the current gap. In the long term, interoperability would reduce administrative burden, improve efficiency, and provide patients with a more predictable and consistent experience across the care continuum.

Experience in other jurisdictions suggests that this is a viable but long-term undertaking. Alberta's ConnectCare initiative demonstrates the scale of investment and training required to successfully integrate records across service settings, even in a single province, while Ontario's ConnectingOntario system shows how phased regional rollouts can improve clinician access to data and reduce duplication. Interim measures, such as British

Columbia's centralized information-sharing pilots, have delivered early benefits even before full integration was achieved. These examples also highlight that clinician buy-in, clear governance, and incremental implementation are key success factors.

Service Realignment

Service realignment would restructure how health programs in Lloydminster are organized by assigning responsibility for specific service lines, such as primary care, mental health, or long-term care, to one province, regardless of where patients live. This would be paired with pan-provincial licensure, allowing health professionals to practice across the Alberta-Saskatchewan boundary without duplicative regulatory hurdles. By consolidating accountability for each program area within a single jurisdiction, realignment would unify information systems, funding models, and service standards.

This approach offers the most comprehensive solution to the fragmentation that currently characterizes Lloydminster's health system. Patients would experience clearer access pathways, providers would have fewer regulatory and administrative barriers, and overall efficiency would be strengthened. However, the transformation required is substantial. Intergovernmental negotiations, legislative reform, workforce adjustments, and robust public communication would be necessary to implement the model. While ambitious and resource-intensive, service realignment represents the most sustainable pathway to addressing structural challenges and creating a more resilient, integrated system for the long term. It should be noted that information sharing across service lines would still need to be addressed.

Evidence from other cross-border health systems underscores both the opportunities and challenges of this approach. The Ottawa-Gatineau region illustrates the limitations of maintaining separate provincial systems across one urban area, as patients continue to face confusion and inequitable access without formal realignment. In contrast, international examples such as the European Union's Cross-Border Healthcare Directive and Australia's regional cross-state health networks demonstrate that shared responsibility and provider mobility can be achieved where intergovernmental frameworks are in place. These models highlight the potential benefits of clarity and portability but also point to the political complexity of establishing durable agreements on funding, licensure, and workforce rules. For Lloydminster, this suggests that while realignment could provide a holistic solution to systemic fragmentation, it would require sustained political will and transition planning to mitigate risk.

4 Appendices

4.1 PROJECT CHARTER

Ministry of Health

Lloydminster Integrated Health Services Needs
Assessment

Project Charter

Project Lead: Saskatchewan Ministry of Health, Strategy and Innovation

Project Overview

Lloydminster is a city of over 30,000 people with a catchment area of nearly 100,000 people. Because the community is on the Saskatchewan/Alberta border, there is a need for the Alberta and Saskatchewan governments and health care agencies to collaborate, plan and deliver healthcare services in the community.

A working group was initially formed in 2013 to complete a needs assessment and oversees health care provision in the Lloydminster area. It is comprised of membership from the Saskatchewan Ministry of Health (SK MOH), the Saskatchewan Health Authority (SHA), and Alberta Ministry of Primary and Preventative Health Services and its purpose is to ensure Alberta and Saskatchewan are committed to collaboration and completing a joint health services needs assessment for the Lloydminster catchment area. The catchment area includes up to a 150 km radius from the centre of Lloydminster.

Deliverables

The SK MOH, with the support of AH, AHS, and SHA, procured a qualified Proponent/consultant team to provide consulting services and lead an assessment plan as it relates to health service needs for Saskatchewan and Alberta residents in the Lloydminster catchment area. The information from this assessment will be used to inform long term clinical service planning, and potential future capital planning.

The consultant will conduct assessments on the following:

1. Population health needs for services that are publicly funded.
2. Associated clinical services.
3. Modelling and projection of future needs by service line; and
4. Targeted stakeholder engagement.

The consultant will use this information to develop a Clinical Health Service Plan (CHSP). The CHSP is a detailed report which summarizes all health services currently supplied, analyzes projected use of health services, identifies gaps between current service capacity and projected service levels, and provides recommendations for meeting future projected service levels for Lloydminster and the catchment area.

At a minimum the CHSP should include the following key sections:

- Introduction
 - Purpose of the clinical plan;

- Current portfolio overview;
 - Inter-provincial network overview;
 - Strategic initiatives and targets; and
 - Consultation outcomes.
- Current state overview
 - Service description and functions;
 - Current high-level staffing analysis;
 - Current service volumes; and
 - Current state deficits; gaps, and challenges.
- Future state service recommendations
 - Population estimates and projections;
 - Future state high-level staffing analysis;
 - Projection methodology;
 - Projected service levels by service line; and
 - Proposed future services delivery recommendations and options analysis.
- Appendices
 - Detailed data analysis;
 - List of consultation attendees and consultation outline;
 - Project Management documentation;
 - Project structure including team members and resources;
 - Governance structure;
 - Master budget and schedule;
 - Project Management plans; and
 - Risk analysis

The SK MOH and AH representatives will be responsible for the following (detailed roles of each party are described in **Section 6: Project Governance**):

- Approval of project scope and workplan;
- Provide aggregate data and existing information for all locations and surrounding area;
- Provide timely feedback on draft clinical plan reports; and
- Provide any other additional information or documentation as required.

The consultant will be responsible for the following:

- Development and successful delivery of a project plan;
- Collect and analyze all applicable information to inform current and future service line analysis;
- Lead stakeholder engagements;
- Compile findings into a comprehensive and confidential final CHSP report with options; and
- Deliver the final CHSP for endorsement by the Project Management Team.

In addition to the previously mentioned responsibilities, the consultant is required to provide, but not limited to, the following:

- Coordinate and schedule all required meetings in consultation with the project team and executive sponsors, including working groups, and provide agendas, materials, and minutes;
- Bi-weekly regularly scheduled update and governance meetings with project leads;
- Track action items, issues, and decisions, and escalate and resolve issues as needed;
- Provide monthly progress reports, including progress tracking of key tasks and schedule tracking in PDF format; and
- Perform project close out, including a final report with recommendations and scheduling a project close out meeting with Leadership Integration Committee.

Guiding Principles

A number of Guiding Principles have been developed in order to guide this project. A full description of the vision and guiding principles can be found in Section 2.1 of this report for reference, please see below an outline of these principles.

Prevention and Wellness

- A focus on prevention and wellness is required to decrease the demands on the health care system within all health sectors. This will involve a shift in focus from treating illness to promoting wellness.

Health Equity

- Planning and initiatives should account for both urban and rural areas, financial disparities as well as underserved populations, such as First Nations, Métis and Inuit Peoples in Alberta and Saskatchewan. The initiatives need to also continue expanding access to traditional healing practices.

Integration and Sustainability

- System integration in operations should be prioritized to ensure care is delivered in the most appropriate care setting.
- Proactive health system planning should enable the population to be cared for in the most appropriate care setting, and to reduce pressures on acute and institutional care settings.

- Increased use of technology can support health system integration and sustainability by enhancing communication, streamlining processes, and improving data sharing across sectors.
- Sustainable funding models that also support more integrated, value, and population-based funding approaches should be considered.

Appropriateness

- Appropriateness refers to delivery of tests, procedures, and treatments that are medically necessary, evidence-based, and beneficial for the patient. Overuse, underuse, or misuse of services should be avoided.

Early Planning Scope

In Scope	Out of Scope
Report supports planning in SK and AB context	Report is a decision on its own
Enables consistent and transparent approach to planning	Report is the sole source of decision making
Can guide decisions about filling gaps and/or adjusting services to meet the needs of the population	Future state mapping used as a wish list, including Information Management and Information Technology (IMIT) and Infrastructure related items.
Accountability tool (for all parties at stakeholder table)	Costing, Capital related items
Identification of existing service gaps	Infrastructure Assessment
Identification of current supply and demand challenges and areas to enhance services.	Timelines for any actionable deliverable or requirements for short / medium / long term deliverables.
Future projected need and demand for services in the Lloydminster catchment area	

Project Goals

- Determine current state.
- Assess historical utilization and project future demand for acute, long-term care, and community health services within the 150 km catchment area.
- Community health services needs assessment.
- Mapping future state with parameters.
 - Requires parsing need from want.

- Contributes to an ongoing services planning process and relationship.
 - Sets realistic goals and consistently achieves them in pursuit of bettering health outcomes for Lloydminster and area.

Milestone Schedule

		Approvals required		
Milestone	Target Completion			
Engagement Plan Finalized	March 2025	Project Management Team	Leadership Integration Committee	Executive Sponsor
Data Sharing Agreements Executed	March 2025	Privacy and Legal (Sask and AB)	Project Team	
Service Shift Working Paper Adopted (identifies directions based on data analysis and engagement)	July 2025	Project Management Team	Leadership Integration Committee	Executive Sponsor
Final Report Submitted	November 2025	Project Management Team*	Leadership Integration Committee*	Executive Sponsor*

*The findings of the report may be shared with respective Ministers of Health.

Project Governance

	Description	Name(s)
Executive Sponsors	• Provide ongoing direction and senior level support during the project's lifecycle. • Ensures the objectives, scope, and project objectives are met. • Endorse the needs assessment.	David Matear, ADM, MOH SK Christine Sewell, ADM, AH
Leadership Integration Committee (LIC)	• Makes consensus-based decisions to inform and guide the project and provide advice to	Sheldon Brandt, ED, SK MOH

(Executive Directors)	senior Ministry of Health leadership. • Provides strategic direction and oversight to Project Management Team. • Endorses the needs assessment.	Claire Tuttle, ED, AH Tami Denomie, SK MOH AH will invite representatives from the following AB ministries and provincial health agencies as required for their respective health sectors: • Ministry of Mental Health and Addiction • Ministry of Seniors, Community and Social Services • Acute Care Alberta • Primary Care Alberta • Recovery Alberta • Assisted Living Alberta
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Project Management Team (PMT)	- Accountable to the Project Sponsors and Ministries of Health, Saskatchewan, and Alberta. - Responsible for managing core project deliverables. - Provide project oversight, including strategic direction and seeks approval of change orders, as required. - Provide guidance and direction to the Project Management Team and for ensuring adequate resourcing for the PM Team to fulfill its functions. - Assist the Project Lead with the day-to-day management of the project. - Project progress, including emerging issues and risks, is reported to CPT on a bi-weekly basis. - Point of contact for escalation of issues and will review and endorse all decision items prior to submission to CPT.	David Purdy, MOH SK Jodie Zerr, MOH SK Alesha Hill, AH Kate Austin, AH (until September 2025). Bri Tibbatts, Acting Executive Director, Government of Alberta
Stakeholder Groups	- Responsible to provide inputs to complete core project deliverables. - Accountable to PMT and will provide bi-weekly updates (Reporting Template attached).	Alberta Ministry of Primary and Preventative Health Services Alberta Medical Association Alberta Precision Laboratories Cancer Care Alberta City of Lloydminster Government of Alberta

		Lloydminster and District Health Advisory Council Lloydminster Clinic Lloydminster Community Cancer Centre Lloydminster Hospital Lloydminster Primary Care Network Lloydminster Region Health Foundation Primary Care Alberta Recovery Alberta Mental Health and Addiction Services Saskatchewan Health Authority Vermilion Health Centre
Data Analytics & Clinical Service Planning	• Responsible for collecting and analysing utilization data and other data sources (baseline/status quo) • Responsible to review and analyse stakeholder engagement qualitative data (future state/gap analysis)	Sheena McRae, Team Leader, Research, MOH SK Rosalinde Sandoff, RAI Program Support, Corporate Support and Infrastructure, MOH SK Wayne Khun, Senior Researcher, AH Jennifer Bian, Health System Analyst, AH

Organization	Roles and Responsibilities
Ministry of Health Saskatchewan	• MOH is accountable for all procurement decisions as the main contact for procuring a consultant, co-funder of the Project, and is accountable to the citizens of Saskatchewan for the responsible use of public funds to deliver the Project. • MOH will lead and coordinate the functions of the PMT and LIC and approve changes outside the approved Project Scope in consultation with AH. • MOH will be consulted on all aspects of project delivery and maintain final approval in all decisions related to the Project and its management.
Saskatchewan Health Authority	• Responsible for ensuring key stakeholder groups are engaged as appropriate on key steps throughout the life of a project. • Works closely with the MOH on all aspects of the project. • Provides inputs and supports development of clinical service plans; and • Provides support on business case development, planning, design, and delivery of projects to ensure alignment with program and service priorities.
Alberta Ministry of Primary and Preventative Health Services	• Responsible for ensuring key stakeholder groups are engaged as appropriate on key steps throughout the life of a project. • AH is accountable for supporting the Saskatchewan MOH regarding all decisions for procuring a consultant as co-funder of the Project. • AH is accountable to the residents of Alberta for the responsible use of public funds to co-deliver the Project. • AH will support the Saskatchewan MOH with coordinating the functions of the PMT, LIC and Executive Sponsors and jointly approve changes outside the approved Project Scope with Saskatchewan. • AH will be consulted on all aspects of project delivery.
Consultant Team	• Coordinate and schedule all required meetings in consultation with the PMT and executive sponsors, including working groups, and provide agendas, materials, and minutes. • Bi-weekly regularly scheduled update and governance meetings with project leads;

	• Track action items, issues, and decisions, and escalate and resolve issues as needed; • Provide monthly progress reports, including progress tracking of key tasks and schedule tracking in PDF format; and • Perform project close out, including a final report with recommendations and scheduling a project close out meeting with Saskatchewan MOH and AH.
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Initial Risk Register and Mitigation Strategy

Risk Category	Description	Mitigation Strategy
People Risks	We have assigned staff who are available to complete the work as scheduled. If the schedule extends or is shortened significantly, the availability of resources may be impacted.	Manage schedule and update on monthly basis. Establish backup resources and succession plans.
People Risks	Changes in key project management roles, whether due to organizational restructuring or personnel turnover, could disrupt project continuity and affect the quality of deliverables	Establish clear and comprehensive management protocols, including detailed project plans, timelines, and roles and responsibilities. These protocols will be documented and accessible to all team members to ensure continuity.
Project Risks	Ineffective coordination and management of the project's multiple facets, including assessment activities,	Develop a detailed project plan/workplan that outlines all project phases, activities, timelines, and deliverables. This plan will include a Gantt chart to visualize project timelines and interdependencies. Hold regular status meetings to review progress, address issues, and make adjustments. These meetings will include key project

	stakeholder engagement, and data analysis, could lead to delays, cost overruns, and suboptimal outcomes.	stakeholders to ensure alignment and effective communication.
Project Risks	Ambiguities or deficiencies in the governance structure may result in unclear decision-making processes, accountability issues, and conflicts among project stakeholders	As part of Project Charter, establish a clear governance framework that defines roles, responsibilities, decision-making authorities, and escalation processes. Achieve sign-off on Charter prior to proceeding.
Project Risks	Challenges may arise in transferring project responsibilities and obligations to the appropriate parties upon project completion, potentially impacting the implementation of the Clinical Health Service Plan (CHSP).	Write a report that references all material and “stands alone” to be understood by outside parties. Within engagement, include discussion of implementation so that the handover is warm. As part of close out, discuss a handover plan that outlines the process for transferring project responsibilities and obligations to the receiving parties.
Stakeholder Risks	Miscommunication or misalignment among leadership stakeholders (Saskatchewan MOH, AH, SHA, AHS, APPHS) could lead to conflicts and inefficiencies.	Establish regular communication channels, such as biweekly meetings, to ensure consistent and transparent communication among internal stakeholders. Establish project Steering Committee to formalize oversight. Conduct a visioning/alignment meeting at the project initiation phase to ensure that primary stakeholders have a clear understanding of project objectives, roles, and responsibilities, and help build a cohesive team and foster collaboration. Saskatchewan MOH, AH, and other stakeholders must commit to attending engagements as outlined in the Charter.
Stakeholder Risks	Challenges in engaging with external	Develop an engagement plan that outlines strategies for effective communication and collaboration with external stakeholders. This plan will include stakeholder mapping,

	stakeholders, such as local health and community organizations, may result in inadequate stakeholder input or resistance to proposed changes.	meeting schedules, and engagement activities. Saskatchewan MOH and AH must assist with connecting Cornerstone with appropriate contacts at the organizations to be engaged.
Stakeholder Risks	Potential lack of approval from community organizations and care providers could impact the implementation of the CHSP.	Design a sign off procedure with Steering Committee input. Ensure stakeholders are informed and heard to enhance their engagement, seek to understand their concerns and expectations, and clearly communicate how the project will address their needs (such as by sending agenda and presentation in advance, ask for documents, follow ups, etc.)

4.2 STAKEHOLDER ENGAGEMENT

The following list represents the individuals engaged by project phase. Note that some interviewees are listed as associated with AHS; at the time of publication they may be associated with other provincial health agencies.

PHASE 1	
Position	Organization
Mayor	City of Lloydminster
ADM Ministry of Health	Saskatchewan Health Authority
ADM Finance and Capital Planning	Alberta Ministry of Primary and Preventative Health Services
Chair	Lloydminster and District Health Advisory Council
CEO	Lloydminster Region Health Foundation
Interim Executive Director, Community and Foundation Relations	Saskatchewan Health Authority
PHASE 2A	
Position	Organization
Executive Director of Acute Care NW SHA	Saskatchewan Health Authority
Chief Zone Officer; ED Emergency Medical Services	Alberta Ministry of Primary and Preventative Health Services
Director, Quality Planning and Performance	Alberta Ministry of Primary and Preventative Health Services
ED Optimization	Alberta Ministry of Primary and Preventative Health Services
ED of Community Care, SHA	Saskatchewan Health Services
Director of Community Oncology Program	Saskatchewan Health Services
Pharmacy Manager of Community Oncology	Alberta Ministry of Primary and Preventative Health Services
Associate Senior Medical Doctor	Cancer Care Alberta
ED, Supportive Care Services and Patient Experience	Cancer Care Alberta
Director, Cancer Care Teams Community Oncology, Cancer Care Alberta	Cancer Care Alberta
Director, Pharmacy Cancer Care Alberta	Cancer Care Alberta
Executive Director, Mental Health and Addiction Services at Prairie North Region	Saskatchewan Health Authority

Executive Director, Mental Health and Addictions (AMOH) Manager	Alberta Ministry of Primary and Preventative Health Services Recovery Alberta Mental Health and Addiction Services
Director for Addiction and Mental Health in AHS Central Zone – Rural East, AHS Executive Director, Primary Health Care NW Executive Director, Primary Health Care NWS	Alberta Ministry of Primary and Preventative Health Services Saskatchewan Health Authority Saskatchewan Health Authority
Senior Director, Pharmacy Strategy, AHS Director, Dental and Oral Health Executive Director, Foresight and Relationships Director, Program Design and Integration Manager, Program Delivery, Implementation and Accountability	Government of Alberta Government of Alberta Government of Alberta Primary Care Alberta Alberta Health Services
Local Physician Executive Director, Continuing Care NW Interim Senior Operating Officer Executive Director, Seniors Health, Central Zone VP, Provincial Clinical and Support Services Director, Patient Service Centres, North Community Services Associate Sector Medical Director, Community Laboratory Services, North Director, Diagnostic Imaging, Central Zone Medical Director, Imaging	Alberta Medical Association Saskatchewan Health Authority Alberta Health Services Alberta Health Services Saskatchewan Health Authority Alberta Precision Laboratories Alberta Precision Laboratories Alberta Health Services Alberta Health Services

PHASE 2A

Position	Organization
Executive Director of Acute Care NW SHA Chief Zone Officer; ED Emergency Medical Services Director, Quality Planning and Performance	Saskatchewan Health Authority Alberta Ministry of Primary and Preventative Health Services Alberta Ministry of Primary and Preventative Health Services
ED Optimization	Alberta Ministry of Primary and Preventative Health Services
ED of Community Care, SHA Director of Community Oncology Program Pharmacy Manager of Community Oncology	Alberta Ministry of Primary and Preventative Health Services Saskatchewan Health Services Saskatchewan Health Services Alberta Ministry of Primary and Preventative Health Services
Associate Senior Medical Doctor	Cancer Care Alberta

ED, Supportive Care Services and Patient Experience	Cancer Care Alberta
Director, Cancer Care Teams Community Oncology, Cancer Care Alberta	Cancer Care Alberta
Director, Pharmacy Cancer Care Alberta	Cancer Care Alberta
Executive Director, Mental Health and Addiction Services at Prairie North Region	Saskatchewan Health Authority
Executive Director, Mental Health and Addictions (AMOH) Manager	Alberta Ministry of Primary and Preventative Health Services Recovery Alberta Mental Health and Addiction Services
Director for Addiction and Mental Health in AHS Central Zone – Rural East, AHS	Alberta Ministry of Primary and Preventative Health Services
Executive Director, Primary Health Care NW	Saskatchewan Health Authority
Executive Director, Primary Health Care NWS	Saskatchewan Health Authority
Executive Director, Pharmaceutical and Health Benefits	Government of Alberta
Senior Director, Pharmacy Strategy, AHS	Government of Alberta
Director, Dental and Oral Health	Government of Alberta
Executive Director, Foresight and Relationships	Primary Care Alberta
Director, Program Design and Integration	Alberta Health Services
Manager, Program Delivery, Implementation and Accountability	Alberta Health Services
Local Physician	Alberta Medical Association
Executive Director, Continuing Care NW	Saskatchewan Health Authority
Interim Senior Operating Officer	Alberta Health Services
Executive Director, Seniors Health, Central Zone	Alberta Health Services
VP, Provincial Clinical and Support Services	Saskatchewan Health Authority
Director, Patient Service Centres, North Community Services	Alberta Precision Laboratories
Associate Sector Medical Director, Community Laboratory Services, North	Alberta Precision Laboratories
Director, Diagnostic Imaging, Central Zone	Alberta Health Services
Medical Director, Imaging	Alberta Health Services

PHASE 2B

Position	Organization
Director of Acute Care NW at Lloydminster Hospital	Saskatchewan Health Authority
Director – Provincial HealthLine 811 Program and Medical Assistance in Dying	Saskatchewan Health Authority

Provincial Clinical Manager, HealthLine 811	Saskatchewan Health Authority
Clinic Coordinator, SHA	Saskatchewan Health Authority
Local Physician	Alberta Medical Association
Manager, Program Delivery, Implementation and Accountability	Alberta Health Services
Executive Director, Foresight and Relationships	Primary Care Alberta
Executive Director	Lloydminster Primary Care Network
Physician Lead	Lloydminster Clinic
Manager of Mental Health and Addictions Services	Saskatchewan Health Authority
Manager	Recovery Alberta Mental Health and Addiction Services
Manager of Home Care (Jubilee)	Saskatchewan Health Authority
Health Services Manager (Maidstone)	Saskatchewan Health Authority
Health Services Manager (Turtleford)	Saskatchewan Health Authority
Health Services Manager (St. Walburg and Paradise Hill)	Saskatchewan Health Authority
Continuing Care Manager, Dr. Cooke Extended Care Centre	Alberta Health Services
Continuing Care Manager	Alberta Health Services
Continuing Care Placement Office Manager	Alberta Health Services
INH Clinical Integration Manager – Palliative Homecare & Wound Care, SHA	Saskatchewan Health Authority
Home Care Manager at Prairie North Region	Saskatchewan Health Authority
Manager of the Medical Floor and Special Care Unit	Saskatchewan Health Authority
Nurse Manager of Surgical Services, Endoscopy and Ambulatory Care	Saskatchewan Health Authority
Director, Rural Acute Care North East, Central Zone	Alberta Health Services
Site and Acute Care Manager	Vermilion Health Centre
Director/Chief, EMS Central and Medical First Responders	Saskatchewan Health Authority
Executive Director	Lloydminster Community Cancer Centre
Manager of Clinical Services	Lloydminster Hospital
Program Lead – Cancer Patient Navigation	Alberta Health Services
Senior Program Lead, Cancer Care Alberta	Cancer Care Alberta
Executive Director, Medical Imaging, SHA	Saskatchewan Health Authority
Manager of Medical Imaging Lloyd and Area	Saskatchewan Health Authority
Director, Diagnostic Imaging, Central Zone	Alberta Health Services
Medical Director, Imaging, AHS	Alberta Health Services
Executive Director, Laboratory Medicine, SHA	Saskatchewan Health Authority

Laboratory Supervisor, SHA
Director, Patient Service Centres, North
Community Services
Associate Sector Medical Director, Community
Laboratory Services, North
Executive Director, Pharmacy
Pharmacy Services Director-North
Pharmacy Manager
Senior Director, Pharmacy Strategy
ED, Pharmaceutical and Health Benefits

Saskatchewan Health Authority
Alberta Precision Laboratories

Alberta Precision Laboratories

Saskatchewan Health Authority
Saskatchewan Health Authority
Saskatchewan Health Authority
Government of Alberta
Government of Alberta

4.3 HEALTH ACTS AND REGULATIONS

4.3.1 Alberta

Table 9 - Health Acts and Regulations in Alberta

Act/Regulation	Description
Alberta Health Care Insurance Act (A-20) Alberta Health Act (HSAA), 2025 (Not-in-force provisions)	Establishes Alberta's publicly funded health care insurance model. The following not-in-force provisions of the <i>Municipal Government Act</i> that are included in the HSAA, 2025 will be proclaimed on the following timelines: 1. <u>Hospital governance related provisions</u> will be proclaimed on December 1, 2025: • sections 39(3)(a), (4)(a), (5) and (7)) 2. <u>Regional health authority provisions</u> will be proclaimed in spring 2026 (date still to be determined): • sections 39(2), (3)(b), (4)(c), and (6)
Health Statutes Amendment Act (Various Bills) Public Health Act (RSA 2000, c P-37) Mental Health Services Protection Act (M-13.5) Mental Health Act (RSA 2000, c M-13)	Amends and aligns various key healthcare-related statutes. Governs public health interventions, disease control, inspections, and orders. Licenses and regulates addiction and mental health service providers. Sets out the legal framework for involuntary examination, admission, detention and treatment of individuals with mental disorders who pose a risk to themselves or others, and designation of facilities for holding and treating those individuals
Continuing Care Act (C-26.7) Health Information Act (HIA, H-5) Freedom of Information and Protection of Privacy Act (FOIP)	Governs supportive living, long-term care, and home care. Regulates collection, use, and disclosure of health information. Governs access to general records and personal information held by public bodies.

Health Professions Act (H-7)

Provides an umbrella framework for regulation of most health professions.

4.3.2 Saskatchewan

Table 10- Health Acts and Regulations in Saskatchewan

Act/Regulation	Description
Ambulance Act (A-18.1)	Governs the licensing, operation, and regulation of ambulance services in Saskatchewan to ensure safe and reliable emergency medical transportation across the province.
The Facility Designation Regulations (R-8.2)	Sets out the criteria for officially designating facilities under provincial legislation to ensure compliance with safety, operations, and regulatory standards.
The Provincial Health Authority Act (P-30.3)	Establishes the Saskatchewan Health Authority and outlines its responsibilities.
The Saskatchewan Medical Care Insurance Act (S-29)	Governs public funding for physician and hospital services.
The Public Health Act, 1994 (P-37.1)	Primary law governing disease control, environmental health, and public health orders.
The Mental Health Services Act (M-13.1)	Provides the legal framework for mental health services and treatment rights.
The Personal Care Homes Act (P-6.01)	Establishes licensing and operational standards for personal care homes.
The Health Information Protection Act (HIPA)	Regulates collection, use, and disclosure of personal health information.
Freedom of Information and Protection of Privacy Act (FOIP)	Governs access to general records and protection of personal information.
The Health Care Directives and Substitute Health Care Decision Makers Act (H-0.002)	Enables advance directives and designation of substitute health decision-makers.
Various profession-specific statutes (e.g., Medical Professions Act)	Govern regulation, licensure, and discipline of health professionals.

4.4 MAPS AND SERVICE DISTRIBUTION

2.2 Community Profile

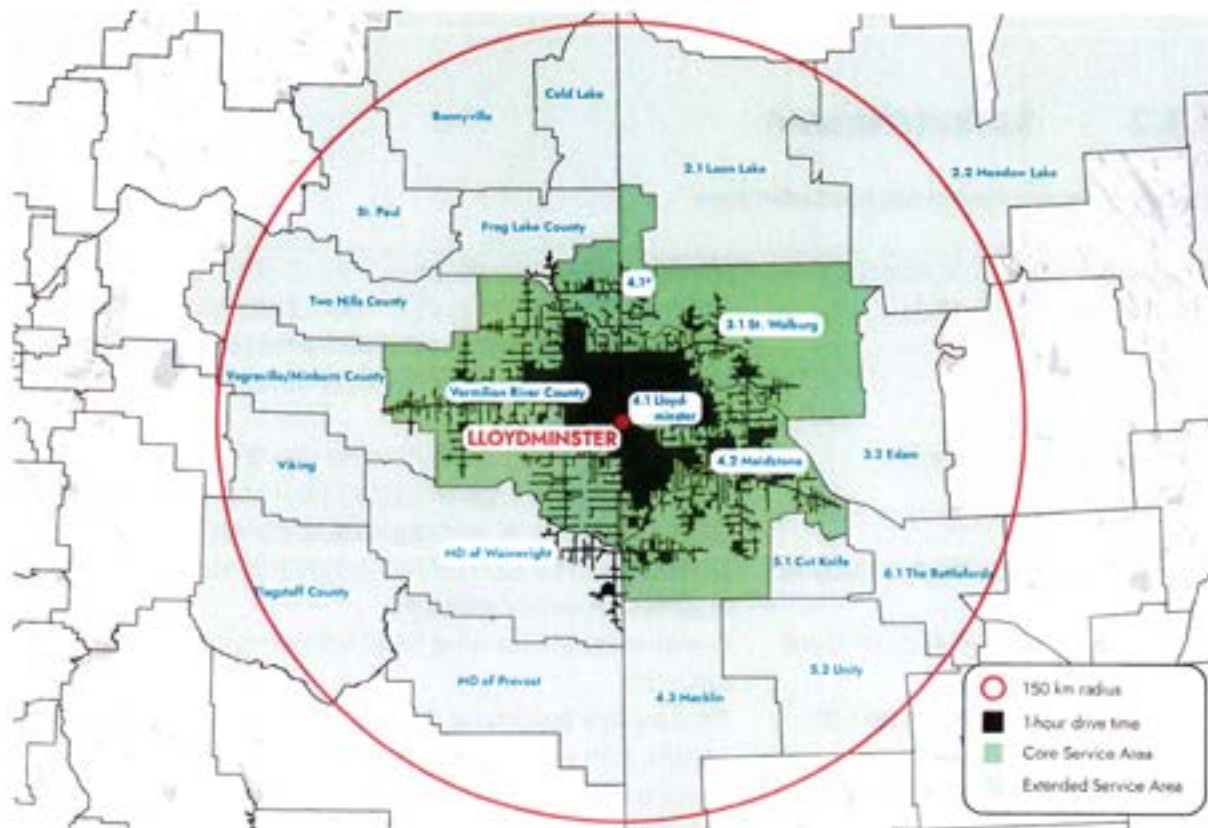


Figure 35 - Breakdown of Lloydminster Health Needs Assessment Service Area: 1-Hour Drive, Core, and Extended

3.6 Continuing Care

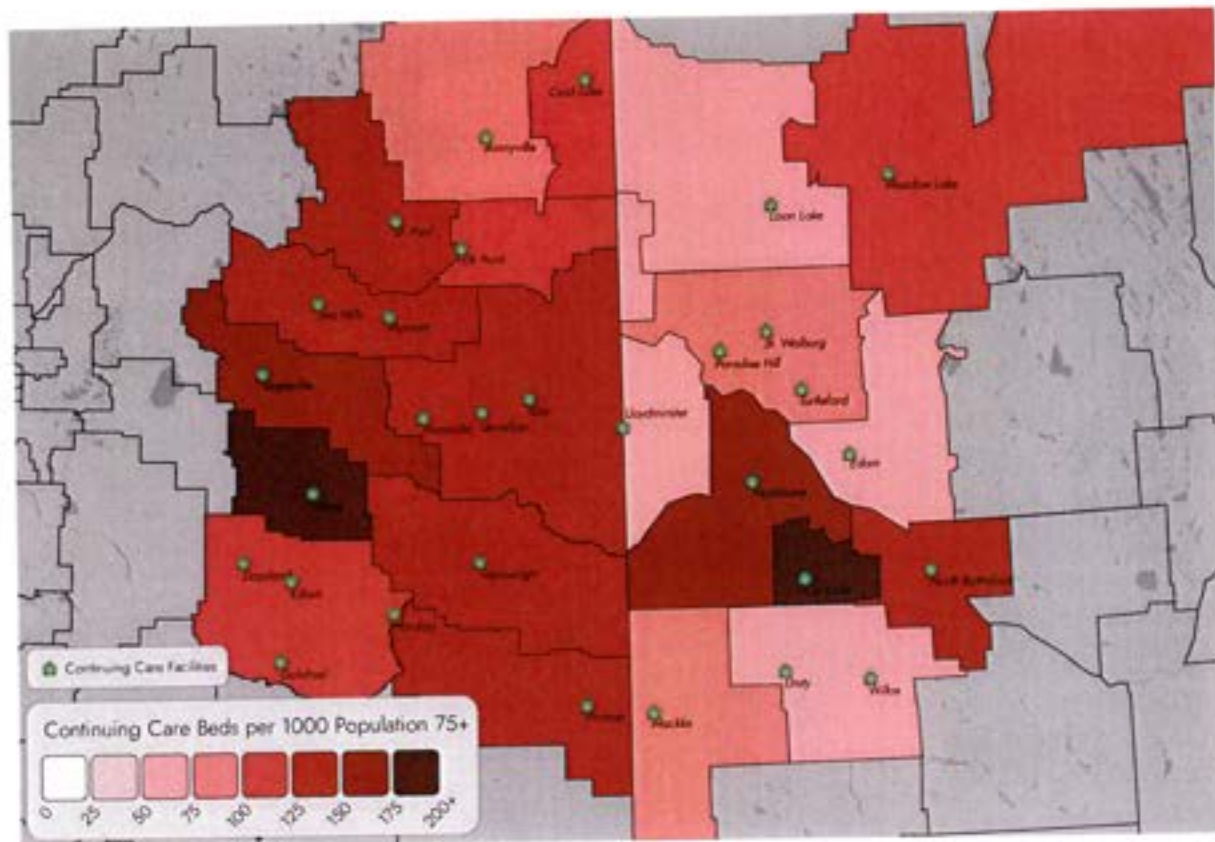


Figure 36 - Continuing Care Beds per 1000 Population 75+ by LGA and SAG

3.8.1 Home Care

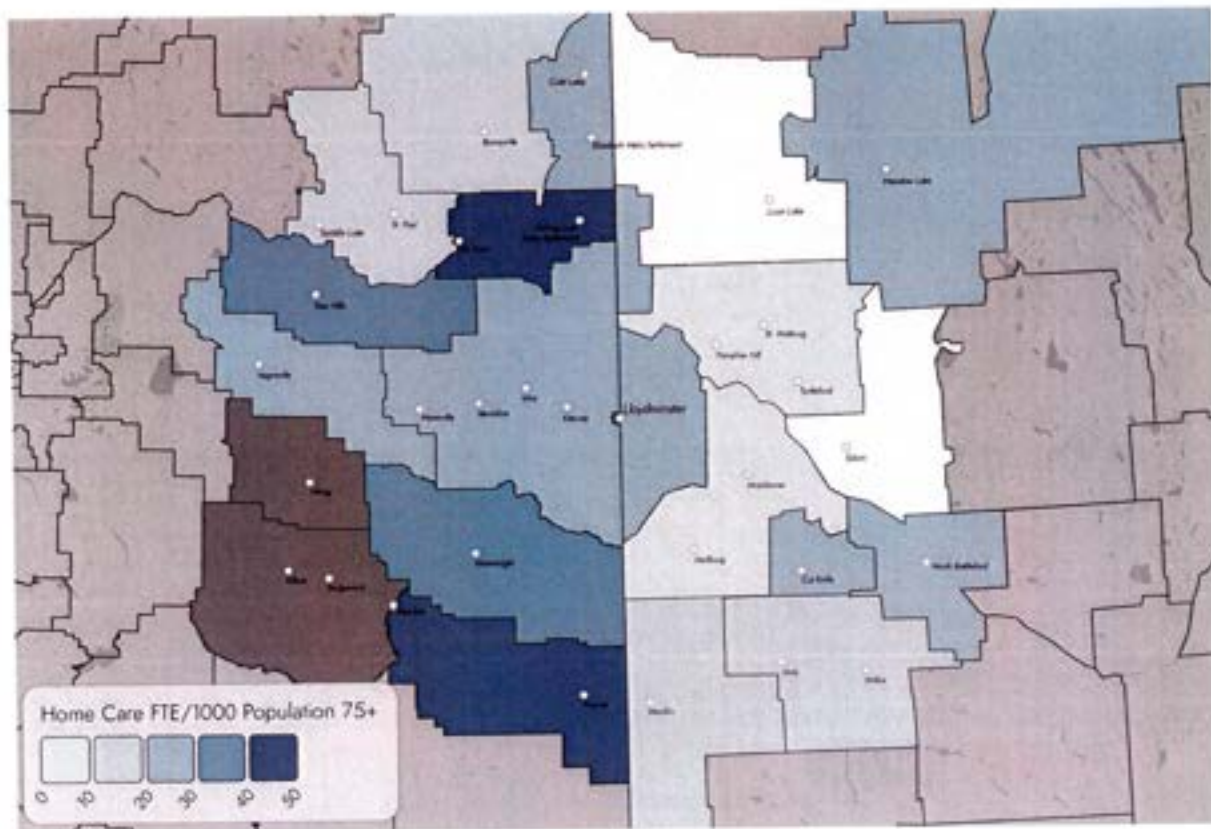


Figure 37 - Home Care FTE/1000 Population 75+

3.8.2 Public Health

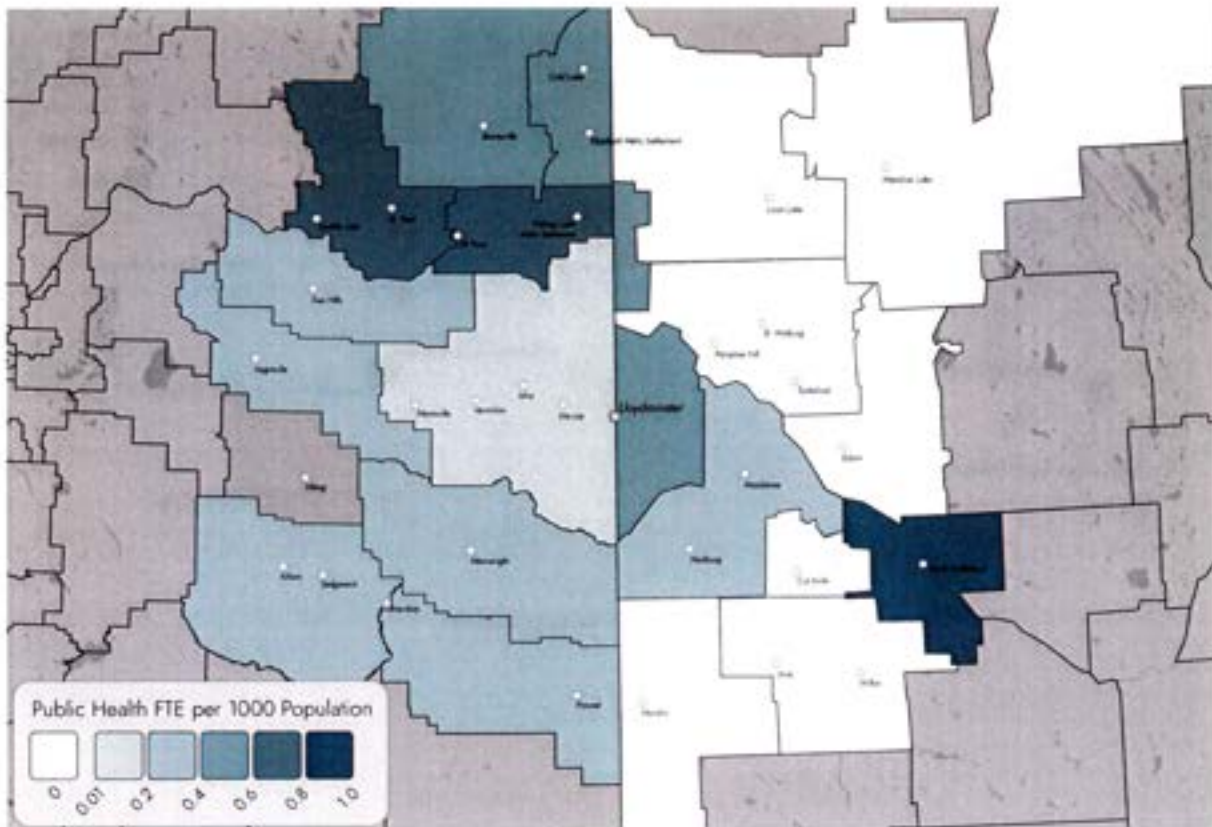


Figure 38 - Lloydminster Public Health FTE per 1000 Population

3.9 Mental Health Services

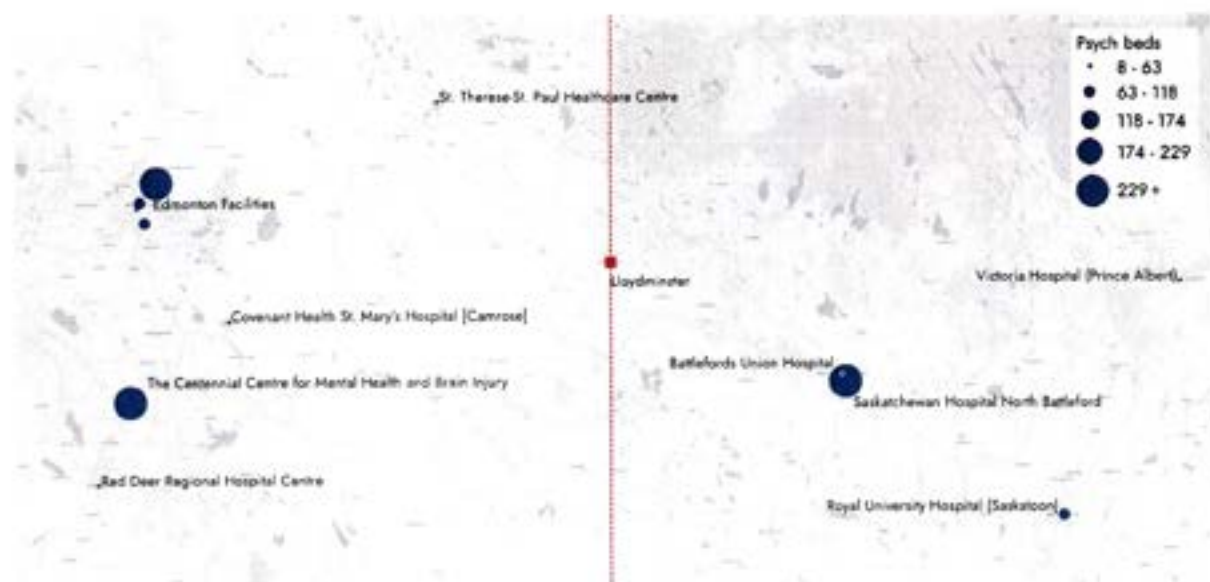


Figure 39 - Psych Beds by Region

4.5 DATA AND ANALYSIS

This appendix is intended to outline the methodology used in preparing for the modelling of Lloydminster's future state demand and the modelling results. It is designed to provide consolidated detail of the methodology and analysis used in this project.

For this project, the AnalysisWorks team focused mainly on the current state analysis and future state modelling for the inpatient, surgery, emergency, supporting services, and long-term care areas. Cornerstone Planning Group led the analysis for community and primary care.

Data Sources

AnalysisWorks begins this section with an acknowledgement of, and gratitude to, the Saskatchewan (SK) and Alberta (AB) Ministry of Health (MoH) Data teams for their invaluable assistance in gathering and providing the necessary data for this project, and for the quick resolution of issues as they emerged.

In order to comply with relevant provincial Data Sharing Agreements and Privacy Policies, the project team was provided with multiple data extracts covering aggregate data only (i.e. not record-level information) in order to guarantee patient data privacy was maintained. Here are the key data sources that were used throughout this project:

- Aggregated Discharge Abstract data (DAD) providing patient profile information on the 5-year age groups, geographical residence area, and case mix groups, as well as hospital utilization data including number of patients and total patient days. The extract provided information on hospital discharges at Lloydminster Hospital, as well as aggregated information on discharges from other facilities in the provinces of Saskatchewan and Alberta. This data enabled the project team to generate comparisons of the Lloydminster hospital usage and that of other hospitals in the surrounding region.
- Detailed DAD subset providing information on patient admission and discharge times, as well as the provider service and patient age category information for the Lloydminster Hospital only. This information was used to calculate the daily midnight inpatient bed census across the hospital to determine how beds are currently being utilized (i.e. number, type, and location) and investigate variations across the different hospital programs.
- Aggregated Perioperative Data consisting of surgical completion information (including surgery date, duration, surgical division, and overtime indicator to indicate if a case started after 4:30PM) and surgical waitlist information (including snapshot of the number of patients waiting for surgery by surgical division, procedure group, and

diagnosis target and wait time grouping based on length of wait relative to diagnosis based target).

- Statistical MIS Data for Medical Imaging, Laboratory and Pharmacy, including information on annual service volumes. Additional aggregate data for Medical Imaging information was provided to break down service volumes by fiscal period further and support root cause investigations related to drivers of lower throughput periods. For Pharmacy, there is data quality issues with the recorded drug volumes in the MIS dataset; hence, the staffing earned hours for the related cost center is used as a proxy to understand the demand for this area.
- Aggregated National Ambulatory Care Emergency Department Data consisting of patient visit information by fiscal year, including patient mix details on 5-year age groups and CTAS level.
- Provincial Saskatchewan Population Growth Projection Data (medium growth scenario) and Alberta Population Growth Projection Data, consisting of the size of the population for historical years and projected future year estimations, broken down by 5-year age group, gender, and residence area segments.
- Continuing Care bed capacity data provided by site leads broken down by facility, including the breakdown of Alberta Type A, Type B, Type B Secured, and Temporary Care bed capacity distinctions (where available) for Lloydminster and surrounding regions to support discussions around long-term Continuing Care needs.
- Additional internal Alberta and Saskatchewan reporting and analyses on the Lloydminster region to provide relevant current state data for the ambulatory areas of the Lloydminster Hospital. The main limitation with these reports is that the data only goes up to 2021/22 and does not cover recent periods.

Assumptions

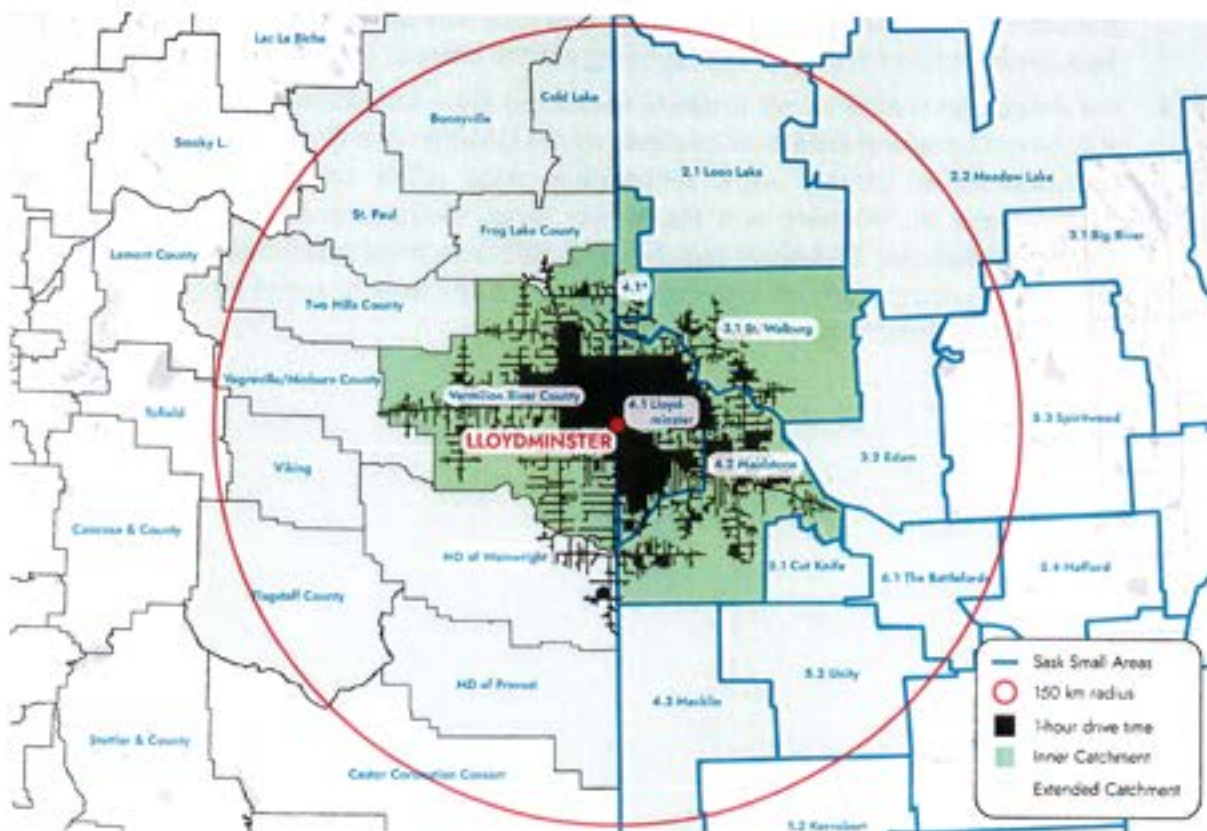
The following assumptions have been included in the development of the demand projections:

- Given the various data sources used throughout the project for each hospital area, the period selected to serve as the current state and 'baseline' for the future state modeling is slightly different among the different areas. The chosen baseline period for each area is documented in each of the program area sections for reference.
- All Programs/Services were given an opportunity to review the baseline data during the engagement meetings. In these meetings, Clinical and Operational leadership from each area were shown program-specific activity and utilization analysis and were asked to confirm that the baseline data was felt to be appropriate and reflective of their lived reality.

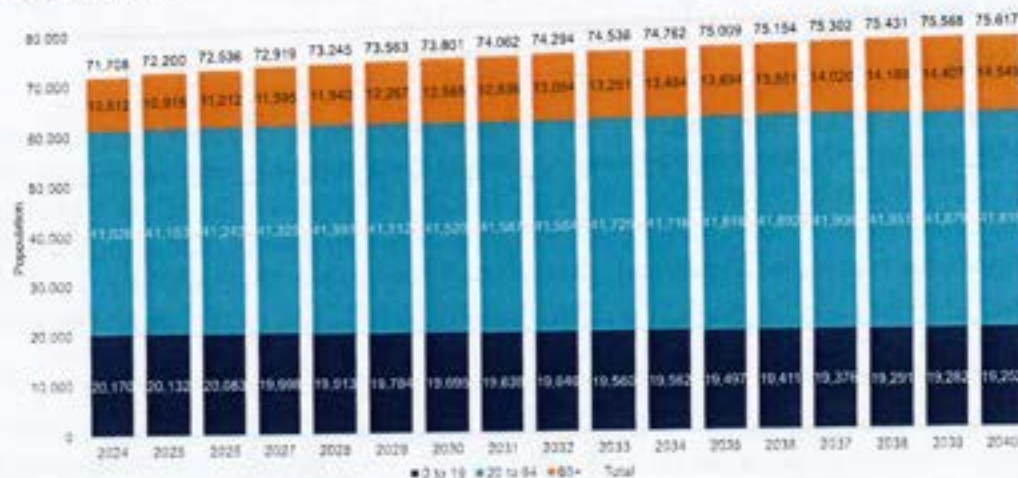
- All modelling recommendations are based on a 15-year planning horizon out to the year 2040.
- The population forecasts are based on the SK Population Projections Medium Growth Scenario provided by the SK MoH, combined with the publicly available Alberta Population Projections taken from the Alberta government website (in March 2025).
- The model assumes that the site will continue to operate at the same level of efficiencies as is currently seen (unless told otherwise); No efficiency improvements have been factored in in terms of reducing patient visits or Length of Stay (LOS).
- The projection methodology projects the future state utilization growth based on the population aging and growth rate defined by the Lloydminster Core Service Area, namely Vermillion River County Local Geographic Area (LGA) on the Alberta side and Lloydminster, St. Walburg and Maidstone Small Geographical Areas (SGA) on the Saskatchewan side. Provincial population projections were determined to be sufficient to forecast growth, with no significant regional development plans being expected to impact future growth in the area.

Population Impact

The population projections forecast that the Lloydminster Core Service Area population (specifically, the Vermillion River County LGA, and Lloydminster, St. Walburg, Maidstone SGAs, as seen in the bright green in the map below) will grow by +5% between 2024 and 2040, going from approximately 71,700 to 75,600 residents (equating to the addition of +3,900 residents by 2040).



Lloydminster Core Service Area Population Growth Projection by Age Category



Despite the overall projected population growth being fairly minimal over the 15-year timeframe, a significant trend noted is the projected growth in the population aged 65 and older. This demographic is known to heavily rely on hospital services (due to higher rates of chronic illness, age-related conditions, and end-of-life care) and will likely represent a significant part of the region's demand in the future. Within the Lloydminster Core Service Area, this age group is expected to grow by +38% between 2024 and 2040, adding ~4,000 age 65+ residents to the region by 2040 (going from approximately 10,500 age 65+ residents to 14,500 by 2040).

Service Area Summaries

The service area summaries below break down the findings and outcomes for each Program/Service. Each section describes the current state volumes, the future state modelling methodology, and the modelling results.

Emergency Department

Current State

Relative to 5 years ago, annual Lloydminster Hospital Emergency Department (ED) visits have declined by -6% (or ~1,500 fewer annual ED visits), from approximately 25,300 ED visits in 2019/20 to 23,800 visits in 2024/25. However, despite a reduction in ED visit volumes, the number of hospital admissions from the ED remained consistent at ~1,900 annually, reflecting an increase in the hospital's ED admission rate from 7.8% up to 8.3% in 2024/25. The following information provides a summary related to the current state of the Lloydminster Hospital ED:

- Patients presenting themselves to the Lloydminster ED in 2024/25 were more acute than in previous years. Canadian Triage and Acuity Scale (CTAS) 1 and 2 patients visiting the Lloydminster ED made up 13% of the ED visits in 2024/25 compared to only 11% in 2019/20. In addition to this, CTAS 3 patients made up 33% of total visits in 2024/25 compared to 29% in 2019/20 further indicating a shift towards a more acute visitor profile.
- Patient Length of Stay in the ED has increased, with patients spending an additional 2 hours longer in the Emergency Department (on average) than before, and an average ED LOS increasing from 3.7 hours in 2019/20 up to 5.8 hours in 2024/25 from the time of patient registration to disposition. In comparison to peer community hospitals in Saskatchewan (i.e. facilities with comparable annual ED visits between 10k to 30k, as seen in Lloydminster Hospital), the median ED LOS seen elsewhere is 2.6 hours, which is half of the wait time an average patient is experiencing at the Lloydminster Hospital ED. When comparing Lloydminster Hospital to its peers, it has the highest ED LOS. (Do note that from an acuity perspective, Lloydminster Hospital was found to have a similar median proportion of CTAS 4 and 5 ED visits relative to its peers, indicating that patient acuity is likely not influencing the longer length of stay seen onsite).
- In 2024/25, the top most commonly seen visit groups (based on Comprehensive Ambulatory Classification System, CACS codes) for patients visiting the Lloydminster Emergency were patients that "left without being seen or triaged and not seen" (LWBS, making up 15% of total annual ED visits) and patients with "Disease or Disorder of the Digestive System with or without Minor Intervention" (making up 9% of total annual ED visits). This meant that roughly 1 in every 6 patients (or ~3,500 total annual ED visitors) who presented themselves in the Emergency Department at Lloydminster in 2024/25 did not see a physician. To put things in perspective, when comparing to peer hospitals in Saskatchewan, Lloydminster ranked the second highest in the proportion of ED visits

that were for patients that “left without being seen” with only the neighboring Battlefords Union Hospital showing a higher proportion of LWBS visits (at ~19% of annual ED visits being LWBS). Overall, the peer hospitals showed a median LWBS ratio of 4% (or 7% when excluding patients with a “Z” diagnosis – see below), much lower than that seen at Lloydminster Hospital.

- When looking further into the ~3,500 annual LWBS visits in 2024/25, roughly 800 visits looked to have an associated “Z” ICD diagnosis assigned, which is typically used to indicate when a patient is accessing hospital services for reasons other than illness or injury (e.g. for other social and lifestyle factors including homelessness, lack of family support, etc.). Overall, the ED visits with a “Z” diagnosis have increased from ~1,000 annual visits in 2019/20 up to ~1,400 in 2024/25 suggesting a potential increase in social issues or systemic gaps in the community being served.
- Mental Health (MH) related ED visits constituted roughly 4% of the total Lloydminster ED visits in 2024/25 (or ~1,000 annual ED visits), with half of these MH-related ED visits being for CTAS 4 and 5 patients. For patients with a MH diagnosis, Lloydminster showed a higher proportion of lower acuity MH patients visiting the ED when compared to the peer sites in Saskatchewan (where the median percentage of MH ED visits for CTAS 4 and 5 patients was 40%).

Future State

The 2024/25 baseline period was selected to drive the future state projections for this area. Aside from accounting for population growth and ageing, the ED projection model also considers the following potential future state service shifts and the resulting impact on the projected ED visit demand:

- Adding an ED Physician Assistant (PA) during peak hours would potentially reduce the ED patient Length of Stay and improve throughput, assisting the hospital in meeting the peer median ED LOS of ~2.5 hours from patient registration to disposition. Given that the reduced wait time would only be meeting the median of its peers (and not exceeding some of the community and surrounding hospital ED wait times), this would likely not be expected to draw in additional ED visits to Lloydminster solely due to improved wait times, but would likely improve patient care substantially.
- Improving community support (e.g. through adding temporary housing for unhoused individuals, and extending primary care and community walk-in clinic hours of operation, etc.) in the region could help the site reduce the number of ED patient visits for reasons other than acute illness or injury (i.e. with “Z” ICD diagnoses) back to 2019/20 levels. This would also be expected to reduce the overall LWBS ratio from 15% down to 7% (in line with the peer SK facilities) as some LWBS patients will likely be seen elsewhere in the community.

- Having access to two dedicated short-stay inpatient hospital spaces to stabilize Mental Health patients would also improve care significantly for these patients given the number of MH patients currently being seen at and/or transferred out of the Lloydminster Hospital for psychiatric care currently. With additional MH training for the ED staffing, and the additional short-stay MH inpatient capacity, the hospital will likely draw in additional ED patients who are currently receiving care in other Lloydminster service area hospitals. Based on the stakeholder engagement in this project, it was determined that this would likely result in an +30% increase in ED Mental Health visits annually given Lloydminster's location and needs within the community.

Based on these assumptions, Lloydminster Hospital will need to **accommodate approximately 25,700 annual ED visits by 2040**. This is equivalent to approximately +1,900 additional annual ED visits by 2040, or an **+8% growth** in annual ED visits beyond what was seen in 2024.



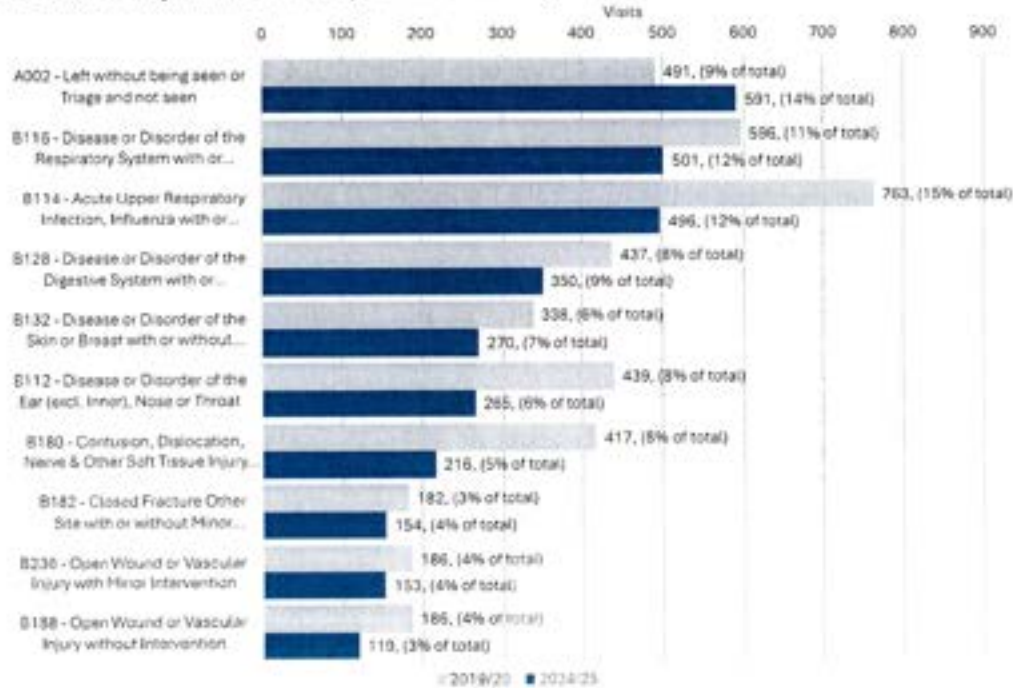
The Demand Projection results suggest that Lloydminster's annual ED visits will grow from ~23.8k to ~25.7k, a growth of +1.9k visits (+8%) from 2024 to 2040

Pediatrics - Emergency

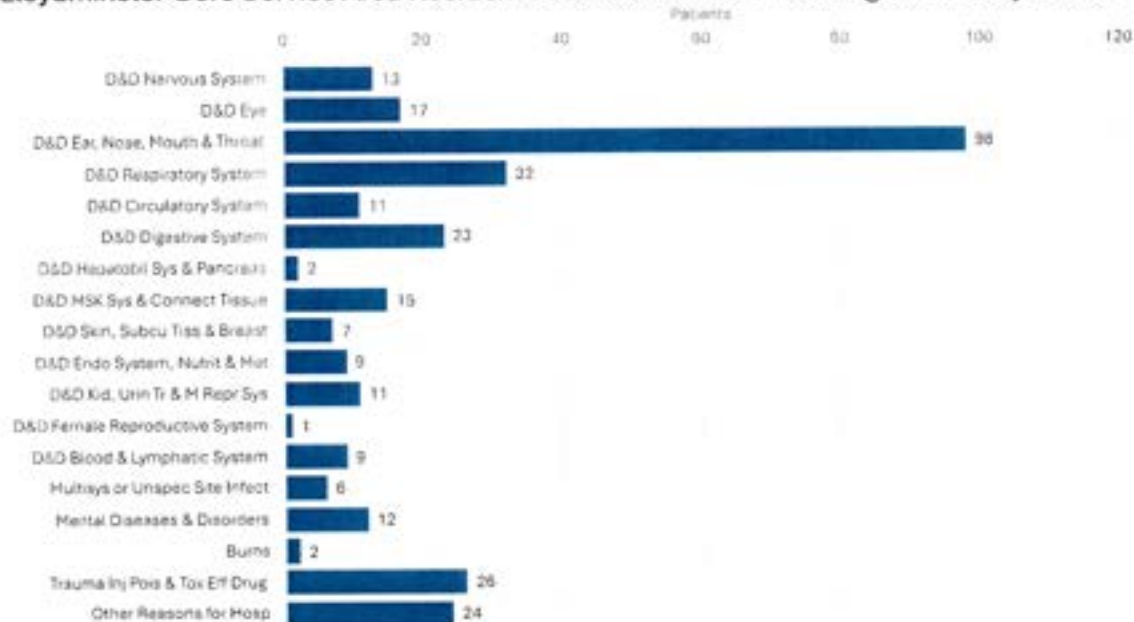
This section primarily focuses on how Pediatric patients (i.e. those patients aged 14 and under) utilize Lloydminster hospital resources currently and where Lloydminster resident pediatric patients currently receive care in Alberta and Saskatchewan. The activity presented below is a subset of the overall activity within the Emergency and Inpatient program summaries presented previously, segmented to focus primarily on the Pediatric patient population.

- Relative to 5 years ago, annual Lloydminster Hospital Emergency Department (ED) Pediatrics visits have declined by -22% (or ~1,140 fewer annual ED visits), with activity going from approximately 5,250 Pediatric ED visits in 2019/20 to 4,100 visits in 2024/25. However, despite a reduction in Pediatric ED visit volumes, the number of hospital admissions from the ED remained consistent for this patient group at ~110 admissions annually, reflecting an increase in the hospital's Pediatric ED admission rate from 2.3% up to 2.6% in 2024/25.
- Roughly 1 in 5 ED visits in the Lloydminster Hospital in 2024/25 were for Pediatric patients, with the Pediatric patients presenting to the Lloydminster ED in 2024/25 looking to be more acute than in previous years. This is indicated by the fact that Canadian Triage and Acuity Scale (CTAS) 1 and 2 Pediatric patients visiting the Lloydminster ED made up 9% of the ED visits in 2024/25 compared to only 6% in 2019/20. In addition to this, CTAS 3 patients made up 33% of total visits in 2024/25 compared to 23% in 2019/20, further indicating a shift towards a more acute visitor profile for these younger patients.
- The generally long wait times in the Lloydminster ED looks to have impacted the number of Pediatric patients that left the hospital without being seen, with 14% of all Pediatric ED visits in 2024/25 leaving without being seen that year. This represented a +5% increase from 2019/20, where 9% of all Pediatric ED visits resulted in patients leaving without being seen. The top 10 reasons for the Pediatric ED visits, which accounted for three-quarters of all Pediatric ED visits in 2024/25, are listed in the chart below. Common reasons include respiratory illnesses (such as Influenza), wounds and fractures, as well as other diseases/disorders affecting the digestive system/skin/breast/ENT.
- Although Lloydminster Hospital does not have a dedicated Pediatric Inpatient program, Pediatric patients utilized up to 1 to 2 beds in the hospital daily in 2024/25.
- From a surgical perspective, Oral Cavity/Pharynx Interventions were one of the most common surgical interventions for Pediatric patients visiting the Lloydminster Hospital, with 138 patients having these types of surgical interventions in 2023/24 (Due to DAD entry lag, 2023/24 period is used as opposed to 2024/25)
- In 2023/24, 318 Lloydminster Core Service Area Pediatric patients travelled to get care outside of the Lloydminster Hospital, with these patients being admitted as inpatients or undergoing same-day surgeries at other hospitals. Generally speaking, it appears that some of these patients traveled to receive specialized services that were not being offered at Lloydminster Hospital during this time, including Neurology, Cardiology, Urology, Mental Health, and treatment for other traumatic injuries. The chart below shows the breakdown of these patients by Major Clinical Category.

Pediatric Lloydminster Hospital ED Visits by CACS Code



Lloydminster Core Service Area Resident Pediatric Patients Travelling for Care by MCCs



Inpatient Beds

Current State

Between 2019/20 and 2024/25* (*data only available up to Dec 2024), the number of inpatient beds utilized at Lloydminster Hospital (excluding those used by newborns) remained consistent, with 56 beds utilized on an average day. While an average day saw 56 inpatient beds utilized across the hospital in 2024/25*, on busier days (i.e. the 75th percentile days) the hospital saw 60 beds in use and up to 66 beds on 'peak' days (i.e. the 95th percentile days). The following information provides a summary related to the current state of the Lloydminster Hospital Inpatient Beds:

- The hospital is funded for an inpatient bed capacity of 66 beds (including 38 Medicine beds, 12 Surgical beds, 13 Obstetrics beds, and 3 Special Care Unit beds). This meant that on an average day in 2024/25*, the hospital had an occupancy of 85%.
- In this same year, Medicine and Surgery patients utilized 51 beds on an average day, representing over 90% of the total bed usage on site.
- Despite a lack of dedicated Mental Health and Pediatric services at the facility, the hospital saw ~1 bed being utilized on an average day by patients falling under the Psychiatric specialty or being under the age of 17.
- Patients falling under the Internal Medicine specialty utilized between 1 and 3 beds on an average day, with these patients largely occupying the Special Care Unit at the site.
- On a typical day, 4 to 7 beds were being used for Obstetrics patients (excluding newborns), making up the remainder of the 51-bed utilization seen for the hospital overall.
- The average length of stay for inpatients staying at Lloydminster Hospital remained consistent between 2019/20 to 2024/25, with an average inpatient staying roughly 5 days.
- In 2023/24 (note: an older data period used due to data limitations), the top two reasons for the inpatient hospital stay (based on Case Mix Groups, or CMGs) for patients were for "Convalescence" and "Other Factors Causing Hospitalization". Combined, these patients utilized ~8 beds on an average day at Lloydminster. While some patients falling under these CMGs may legitimately required hospital-level care, it is possible that some of these patients with low acuity medical needs could have been managed outside of the acute setting if appropriate supports were available (e.g. they could be better suited to a rehabilitation/long-term care facility, transition unit, or community-based convalescent care beds, etc.). Note that Alternative Level of Care (ALC) bed utilization was investigated but it was determined that ALC data coding was not accurately captured in the data sources provided. Further investigations should be done to quantify the number of sub-acute patients being seen in the acute facility specifically.

- Between Jan 2025 to May 2025, a total of 29 patients were transferred out of Lloydminster Hospital for Critical Care services in an Alberta hospital facility. 7 of the 29 had Cardiac-related diagnoses, 6 of the 29 had Neurological diagnoses (e.g. stroke), 1 had a Urology diagnosis, while the rest (15 of the 29) had Medicine-related diagnoses. Examples of these Medical diagnoses included septic shock, respiratory distress, and head injury trauma, all requiring very urgent and intensive care that could not be serviced at Lloydminster Hospital.
- In that same 5-month timeframe, a total of 36 Lloydminster Core Service Area residents visited other nearby hospitals and were admitted and discharged within 72 hours. In addition to this, 115 patients with Mental Health diagnoses stayed at Lloydminster Hospital despite no formal inpatient Mental Health capacity or service being available at the facility. It is likely that some of these short-staying Mental Health patients could potentially have been better cared for in a dedicated Mental Health stabilization unit during the first 48 hours of their stay within the Lloydminster Hospital.

Future State

The calendar year 2024 was selected as the baseline period to drive the future state projections for this area (due to data availability limitations in the provided Discharge Abstract Data for the more recent timeframe). Aside from accounting for population growth and ageing, the Inpatient bed projection model also considers the following potential future state service shifts and the resulting impact on the projected Inpatient bed demand:

- The introduction of a regional Transitional Care Unit (TCU) could be established to provide care for patients who are currently receiving care in the Lloydminster Hospital despite being suitable for care within a less acute setting. The model assumes that patients falling under the "Convalescence" and "Other Factors Causing Hospitalization" Case Mix Groups would be decanted from the Lloydminster Hospital and cared for in a regional TCU in the future.
- Conversion of the existing Special Care Unit to a Level 1 ICU would allow the site to continue to care for the existing Special Care Unit patients and also potentially reduce some of the Critical Care patient transfers to other sites (therefore allowing high-acuity patients to be served closer to home). It is assumed that the patients who could be kept at Lloydminster Hospital for Critical Care ICU services would have Medicine-related diagnoses only (i.e. not those requiring specialized services) and would likely require ICU stays under 10 days in duration only. All other specialized-service diagnoses presenting to Lloydminster Hospital would continue being transferred to other regional hospitals with ICUs which would continue to provide the required specialized services and level of care for these patients.
- Establishing a short-stay Mental Health stabilization area would allow for care to be provided for the current Lloydminster hospital MH patients for the first 48 hours of stay

as well as those Lloydminster resident MH patients currently attending nearby facilities for short-term care who could be repatriated and better served at Lloydminster Hospital.

- While the introduction of an additional Friday Orthopedics slate could serve to increase Surgical throughput and improve patient access to care for this high-demand Surgical service, this would likely have a minimal impact on the required Surgery Program inpatient bed capacity at the hospital should only Surgical Day Care (SDC) cases that do not require an inpatient stay be done, or if any Orthopedic inpatients could be discharged before Mondays (to ensure that beds are available at the start of the scheduled surgery workweek).

Based on these assumptions, Lloydminster Hospital will need to **accommodate approximately 61 beds of capacity on an average day by 2040**. This is equivalent to approximately 5 additional beds per day, or an **+8% growth** in average daily bed utilization beyond what was seen in 2024.



The Demand Projection results suggest that Lloydminster's average bed utilization will grow from 56 beds to 61 beds, a growth of +5 beds, +8% from 2024 to 2040

The modelling above is based on the average beds required per day and does not account for the peaks and troughs likely to be experienced in terms of bed demand at that time. **For capacity planning purposes, the recommended funded Inpatient bed capacity** (i.e. using 75th daily percentile utilization for Medicine, Surgery, Mental Health and 95th percentile for the other areas) **by 2040 is ~75 beds per day**, which would need to consist of 49 beds for Medicine patients, 10 beds for Surgery, 2 beds for short-stay Mental Health patients, 5 beds for the Level 1 ICU, and 9 beds for Obstetrics and Pediatrics patients combined.

Inpatient Recommended Beds - Additional Details

This section provides additional details on Inpatient beds modeling not discussed in the main section of this document, and is intended to serve as supporting materials for the final report. The main Inpatient bed section described the Inpatient bed utilization on an average day as a measure of general utilization. Typically, we suggest that the recommended bed capacity for each program is determined by the bed utilization rates on 'busy' days (i.e. the daily 75th percentile utilization) and 'peak' days (i.e. daily 95th percentile utilization) rather than based on average utilization in order to adjust for occupancy. The 75th percentile utilization has been used for the Medicine, Surgery and Mental Health programs, while the 95th percentile utilization has been used for other programs.

The 95th percentile is used for certain programs because these programs face more urgent and acute demand, with occasional spikes in patient volume or resource needs. Their patients need specialized care and would not be well suited if they were off serviced in other areas of the hospital. By planning at the 95th percentile, the capacity would be sufficient to handle 95 percent of the utilization days. Ideally, all programs should be planned at the 95th percentile; however, considering budget constraints, 75th percentile is used for Medicine, Surgery and Mental Health.

Basing the recommended bed capacity on utilization on the higher occupancy days will ensure that each program is planning for sufficient capacity to handle its peak demand, while balancing off-service placement and potential over-staffing/over-servicing.

Higher Acuity Inpatient Beds

The Lloydminster Hospital currently has 3 Special Care Unit (SCU) beds. Patients falling under the Internal Medicine specialty utilized between 1 and 3 beds on an average day in 2024/25, with these patients largely occupying the Special Care Unit beds on site.

The calendar year 2024 was selected as the baseline period to drive the future state projections for this area (due to data availability limitations in the provided Discharge Abstract Data for the more recent timeframe). Aside from accounting for population growth and ageing, the Higher Acuity Inpatient bed projection model also considers the following potential future state service shifts and the resulting impact on the projected Inpatient bed demand:

- The introduction of a regional Transitional Care Unit (TCU) could be established to provide care for patients who are currently receiving care in the Lloydminster Hospital despite being suitable for care within a less acute setting. The model assumes that patients falling under the "Convalescence" and "Other Factors Causing Hospitalization" Case Mix Groups would be decanted from the Lloydminster Hospital and cared for in a regional TCU in the future.
- Conversion of the existing Special Care Unit to a Level 1 ICU would allow the site to continue to care for the existing Special Care Unit patients and also potentially reduce

some of the Critical Care patient transfers to other sites (therefore allowing high-acuity patients to be served closer to home). It is assumed that the patients who could be kept at Lloydminster Hospital for Critical Care ICU services would have Medicine-related diagnoses only (i.e. not those requiring specialized services) and would likely require ICU stays under 10 days in duration only. All other specialized-service diagnoses presenting to Lloydminster Hospital would continue being transferred to other regional hospitals with ICUs which would continue to provide the required specialized services and level of care for these patients.

Based on these assumptions, Lloydminster Hospital will need to **accommodate approximately 5 Critical Care Inpatient beds by 2040**. This is equivalent to approximately +2 additional higher acuity Inpatient beds per day, or a **+67% growth** in the occupancy adjusted utilization beyond what was seen in 2024.



The Demand Projection results suggest that Lloydminster's Critical Care Occupancy Adj. Utilization will grow from 3 beds to 5 beds, a growth of +2 beds, +67% from 2024 to 2040

Maternity Beds

The Lloydminster Hospital currently has 13 Obstetrics Inpatient beds. Patients falling under the Obstetrics and Gynecology specialty utilized between 3 and 7 beds on an average day in 2024/25.

The calendar year 2024 was selected as the baseline period to drive the future state projections for this area (due to data availability limitations in the provided Discharge Abstract Data for the more recent timeframe). Population growth and ageing were modelled as the main drivers for the future state demand for this area.

Based primarily on population aging and growth, Lloydminster Hospital will need to **accommodate approximately 7 Maternity Inpatient beds by 2040**. This is equivalent to the same number of maternity beds per day as were in use in 2024, or no growth in occupancy-adjusted utilization beyond what was seen in 2024.



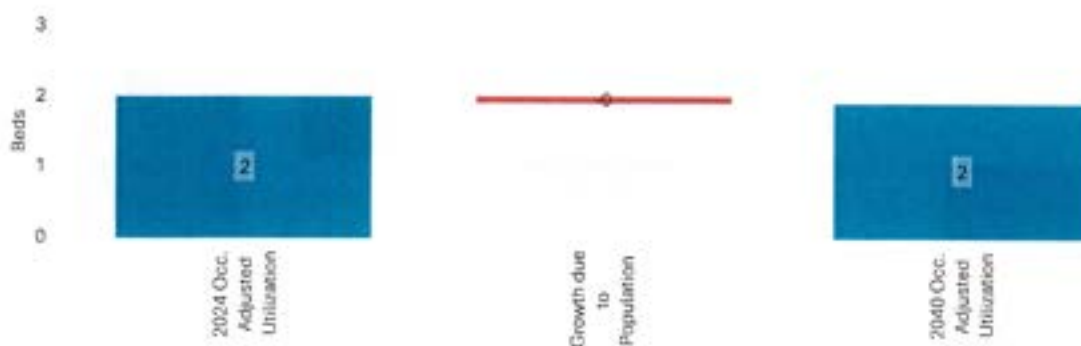
The Demand Projection results suggest that Lloydminster's Maternity Occupancy Adj. Utilization will remain at 7 beds, a growth of 0 beds, +0% from 2024 to 2040

Pediatric Inpatient Beds

Lloydminster Hospital currently has 0 dedicated Pediatric Inpatient beds. However, there were 1 to 2 patients between the age of 1 to 17 utilizing Lloydminster Hospital beds on an average day in 2024/25.

The calendar year 2024 was selected as the baseline period to drive the future state projections for this area (due to data availability limitations in the provided Discharge Abstract Data for the more recent timeframe). Population growth and ageing were modelled as the main drivers for the future state demand for this area.

Based primarily on population aging and growth, Lloydminster Hospital will need to **accommodate approximately 2 Pediatric Inpatient beds by 2040**. This is equivalent to the same number of Pediatric bed usage per day as was seen in 2024, or a 0% growth in occupancy adjusted utilization beyond what was seen in 2024.



The Demand Projection results suggest that Lloydminster's Pediatrics Occupancy Adj. Utilization will remain at 2 beds, a growth of 0 beds, +0% from 2024 to 2040

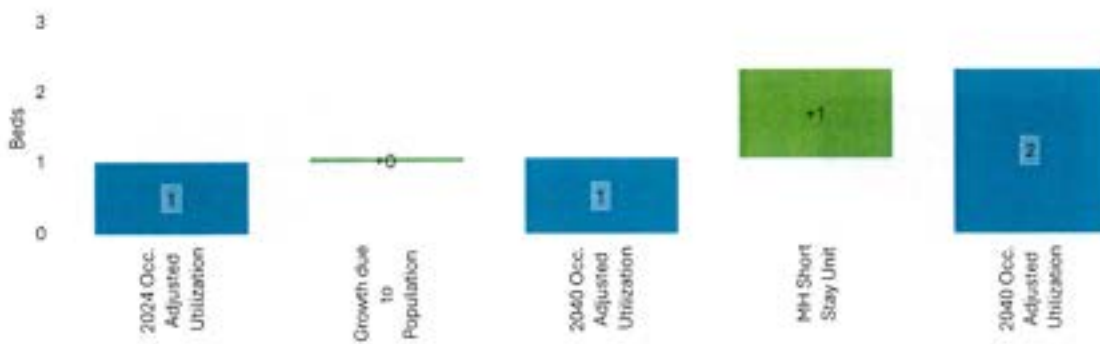
Mental Health Inpatient Beds

The Lloydminster Hospital currently has 0 dedicated Mental Health Inpatient beds. However, on a busier day in 2024/25, there was typically 1 psychiatric diagnosis patient utilizing Lloydminster Hospital Inpatient beds.

The calendar year 2024 was selected as the baseline period to drive the future state projections for this area (due to data availability limitations in the provided Discharge Abstract Data for the more recent timeframe). Aside from accounting for population growth and ageing, the Inpatient bed projection model also considers the following potential future state service shifts and the resulting impact on the projected Mental Health Inpatient bed demand:

- Establishing a short-stay Mental Health stabilization area would allow for care to be provided for the current Lloydminster hospital MH patients for the first 48 hours of stay as well as those Lloydminster resident MH patients currently attending nearby facilities for short-term care who could be repatriated and better served at Lloydminster Hospital.

Based on these assumptions, Lloydminster Hospital will need to **accommodate approximately 2 dedicated Mental Health Inpatient beds by 2040**. This is equivalent to approximately +1 additional Inpatient bed in use per day, or a **+100% growth** in the occupancy adjusted utilization beyond what was seen in 2024.



The Demand Projection results suggest that **Lloydminster's Mental Health Occupancy Adj. Utilization will grow from 1 to 2 beds, a growth of +1 bed, +100% from 2024 to 2040**

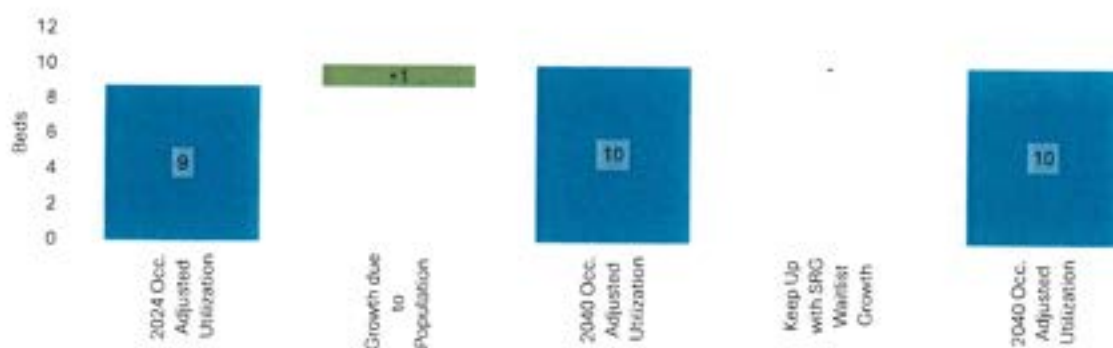
Surgical Inpatient Beds

Lloydminster Hospital currently has 12 dedicated Surgical Inpatient beds. Patients falling under the Surgical specialty utilized 9 beds on a busy day in 2024/25.

The calendar year 2024 was selected as the baseline period to drive the future state projections for this area (due to data availability limitations in the provided Discharge Abstract Data for the more recent timeframe). Aside from accounting for population growth and ageing, the Inpatient bed projection model also considers the following potential future state service shifts and the resulting impact on the projected Inpatient bed demand:

- The additional Cataract and Urology surgical activity was assumed to not have an impact on the hospital's Inpatient bed capacity, as these would be largely Surgical Day Care (for Cataracts) and/or be handled through improved surgical scheduling.

Based on these assumptions, Lloydminster Hospital will need to **accommodate approximately 10 Surgical Inpatient beds by 2040**. This is equivalent to approximately +1 additional Surgical Inpatient bed per day, or a +11% growth in the occupancy-adjusted utilization beyond what was seen in 2024.



The Demand Projection results suggest that Lloydminster's Surgical Occupancy Adj. Utilization will grow from 9 to 10 beds, a growth of +1 bed, +11% from 2024 to 2040

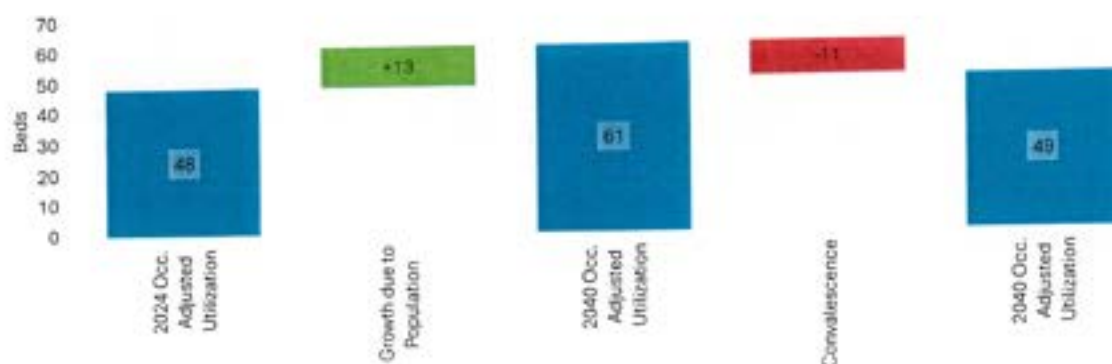
Medicine Inpatient Beds

Lloydminster Hospital currently has 38 dedicated Medicine Inpatient beds. Patients falling under the Medicine specialty utilized 48 beds on a busy day in 2024/25.

The calendar year 2024 was selected as the baseline period to drive the future state projections for this area (due to data availability limitations in the provided Discharge Abstract Data for the more recent timeframe). Aside from accounting for population growth and ageing, the Inpatient bed projection model also considers the following potential future state service shifts and the resulting impact on the projected Medicine Inpatient bed demand:

- The introduction of a regional Transitional Care Unit (TCU) could be established to provide care for patients who are currently receiving care in the Lloydminster Hospital despite being suitable for care within a less acute setting. The model assumes that patients falling under the "Convalescence" and "Other Factors Causing Hospitalization" Case Mix Groups would be decanted from the Lloydminster Hospital and cared for in a regional TCU in the future.

Based on these assumptions, Lloydminster Hospital will need to **accommodate approximately 49 Medicine Inpatient beds by 2040**. This is equivalent to approximately +1 additional Medicine Inpatient bed per day, or a +2% growth in the occupancy-adjusted utilization beyond what was seen in 2024.



The Demand Projection results suggest that Lloydminster's Medicine Occupancy Adj. Utilization will grow from 48 to 49 beds, a growth of +1 bed, +2% from 2024 to 2040

Surgery – Operating Rooms

Current State

Between 2019/20 and 2024/25, the Lloydminster Hospital Main Operating Rooms (ORs) saw a +5% increase in annual surgical OR volumes, with the site going from performing approximately ~3,350 surgeries in 2019/20 up to ~3,500 surgeries in 2024/25 (equivalent to ~150 more surgeries being performed annually). Note: this excludes Endoscopy activity happening in the dedicated Endoscopy suite. This increase in volumes translated into ~2 additional hours of OR capacity being utilized per week in 2024/25 than were used in an average week in 2019/20, an increase of +2% in weekly OR capacity used. In total, there were 91 hours of OR capacity being utilized per week in 2024/25 (compared to 89 hours per week in 2019/20). The following information provides a summary related to the current state of the Lloydminster Hospital Surgery Program:

- The surgical waitlist has grown from ~500 patients waiting for surgery in the beginning of 2023/24 to over 1,150 patients waiting by the end of 2024/25, with the overall number of patients waiting for surgery more than doubling. The overall waitlist growth was mainly driven by an increase in demand for the Orthopedics, General Surgery and Otolaryngology surgeries, with these divisions' individual waitlists each growing by +60-122% each within the last year.
- Despite the growing waitlist demand, the number of patients waiting 2 times longer than their clinical diagnosis-based wait time target made up only 4% of the overall number

of patients waiting at the end of 2024/25 (with roughly only 40 patients having already waited more than two times longer than their target by the end of 2024/25).

- Despite having very few extremely long waiting patients, the percentage of patients waiting longer than their clinical diagnosis-based wait time target at Lloydminster Hospital looks to have remained fairly consistent and decently high over the last two fiscal years, with roughly 20-30 percent of all patients waiting for surgery at any point in time being patients who have already waited longer than they should have (i.e. are out of target).
- Of the 3 main ORs, OR 1 and OR 2 showed an average utilization rate of ~85-88% in 2024/25. OR 3, which is the semi-dedicated Obstetrics OR, was captured to have a surgical activity utilization of ~60%. The lower utilization captured in this OR was partly due to the allocation of this dedicated room to perform unscheduled C-section cases as they present to the hospital (i.e. there will be times where no cases presented and therefore the room will be un-occupied and unavailable to other services to ensure it is available when needed for emergent C-sections). This room is also used to perform other minor procedures (e.g. Cataracts and "lumps and bumps") which are not recorded in the same surgical data capture, resulting in a lower utilization to be captured here than was actually used. While overall utilization of OR 3 is therefore likely higher in reality than represented above, there could still be potential opportunities to decant activity from this location that does not require an OR environment/staffing in future (e.g. those case types that could be done in a procedure room setting if one was available).
- Outside of Lloydminster Hospital, annually in 2023/24, 500 scheduled Cataract surgeries were performed on Lloydminster Core Service Area residents that travelled to another hospital site to have their surgeries.
- Roughly 200 Urology surgeries (excluding Cystoscopies) were performed on Lloydminster Core Service Area residents that travelled to another site to have their surgeries performed in 2023/24.

Future State

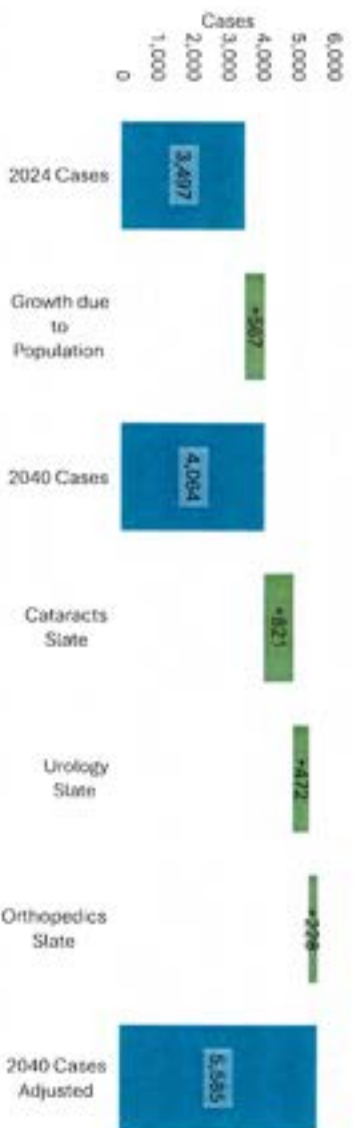
The 2024/25 fiscal year was selected as the baseline period to drive the future-state projections for this area. Aside from accounting for population growth and ageing, the Surgical projection model also considers the following potential service shifts and the resulting impact on the projected Surgical volumes and capacity:

- The recent waitlist growth was determined to not be sustainable or representative of likely future growth patterns. Specifically, the dramatic waitlist growth seen over the last couple of years for the Orthopedics service was driven by a central referral system that was put in place regionally that allowed Lloydminster Hospital to support the larger regional demand by taking on patients from other jurisdictions on a short-term basis. This resulted in an unusually high intake of patients to the Lloydminster Hospital over

the last year and a large number of non-Lloydminster residents being served, a pattern which is not likely expected to continue as capacity and access improve for other hospitals for these patients to be served within their home health regions. For Otolaryngology, the waitlist growth was driven by the relocation of the primary surgeon from Lloydminster to Edmonton, resulting in the referral of a significant number of out-of-catchment patients to the Lloydminster Hospital for surgery with this physician. As these patterns are unlikely to continue into the future, the model does not assume this rapid waitlist growth rate will continue and will not suggest additional future capacity will be required to sustain it.

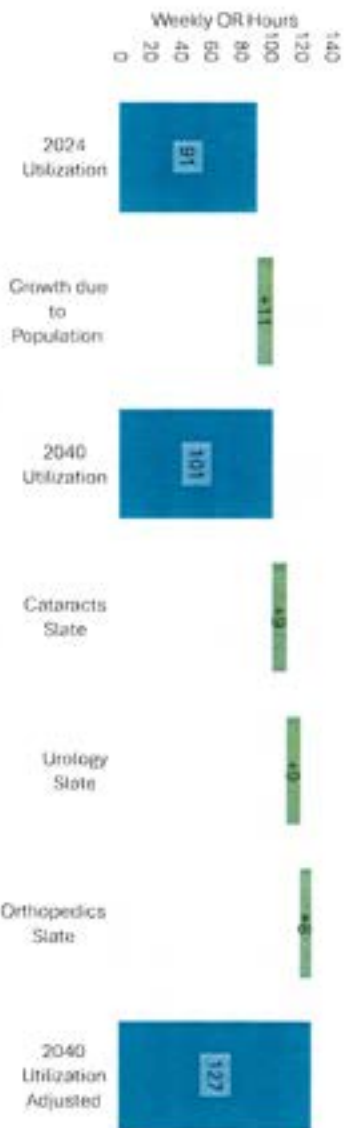
- Despite the waitlist being assumed to stabilize for Orthopedics, the model assumes that the site needs an additional Friday Orthopedics slate to handle the current workload.
- Given that there are a significant number of Lloydminster residents currently receiving Cataract surgeries outside of the Lloydminster Hospital, it appears that there is sufficient demand to warrant additional Cataract surgical capacity at Lloydminster Hospital to support patients in receiving care closer to home. The addition of one Cataract slate per week at Lloydminster Hospital would support this goal, with the capacity being suggested to be added on a weekend so as to not impact the already limited OR capacity available to other services during the week. This will represent a net gain in terms of annual surgical volumes for the site, and support increased access for this type of care, but will not impact the requirement for inpatient beds given that these will be Surgical Day Care cases only. Note, given the high throughput nature of this patient group, the hospital will need to ensure enough physical space (e.g. within the Day Surgery Ward), equipment and staffing are available to support these surgical patients over the weekend.
- Given the demand for the Urology surgical service for Lloydminster patients who are currently traveling elsewhere for surgery, it would likely be beneficial to introduce this service on site to improve access for these patients closer to home. An additional slate of OR time can likely be reasonably accommodated within the existing capacity of OR 1 and OR 2 given the current utilization patterns, and assuming a very short profile of case types will likely be seen for this service as is seen elsewhere (e.g. an average case duration of ~1 hour per case). This will represent a net gain in terms of annual surgical volumes for the site. The model assumes that the site can manage the Surgical Day Care and Inpatient case mix in such a way as to not require additional bed capacity to support this Urology service.

Based on these assumptions, Lloydminster Hospital will need to **perform approximately 5,600 annual surgical volumes by 2040**. This is equivalent to approximately +2,100 additional surgical cases annually, or a **+60% growth** in surgical cases beyond what was seen in 2024.



The Demand Projection results suggest that Lloydminster's annual surgical cases will grow from ~3.5k to ~5.6k, a growth of +2.1k cases, +60% from 2024 to 2040

To carry out these surgical volumes, the Lloydminster Hospital will likely need to utilize approximately 127 OR hours of capacity per week by 2040. This is equivalent to an additional +36 hours per week of OR capacity, or a +41% growth in surgical OR capacity above and beyond what was utilized in 2024.



The Demand Projection results suggest that Lloydminster's weekly OR hours will grow from ~91 to ~127, a growth of +36 weekly OR hours, +41% from 2024 to 2040

By 2040, the 127 weekly OR hours at Lloydminster Hospital are suggested to be allocated based on the following:

- OR 1 and OR 2 would be required to accommodate 86 hours of surgical activity per week (including the additional weekday Urology slate and Orthopedics slate). Each of the two

ORs would need to run ~8.5 hours a day, 5 days a week to handle this level of surgical activity. Given the current utilization of the existing capacity within these ORs, it is likely that the two main ORs can continue to perform the same case mix that it is currently being serviced and accommodate the additional Urology (which will likely be of a shorter case profile) and Orthopedics activity through the extension of the scheduled operational hours of the ORs by an hour of additional capacity per day.

- Given the current lower utilization and potential to decant some non-OR-requiring activity to other more appropriate (e.g. procedure room) locations, OR 3 should be able to continue serving its current Obstetrics & Gynecology activity, along with the existing and additional modeled Cataract Activities (including the additional Saturday Cataract slate). This would total ~40 weekly OR hours of activities, which should be manageable for 1 OR running 5 days a week at 8 hours a day (or for a shorter duration over 6 days a week). Again, the site would need additional resources to be able to accommodate a scheduled OR day on the weekend to service the desired Surgical Day Care Cataract slate (given that scheduled surgical activity is currently not seen onsite over the weekends).

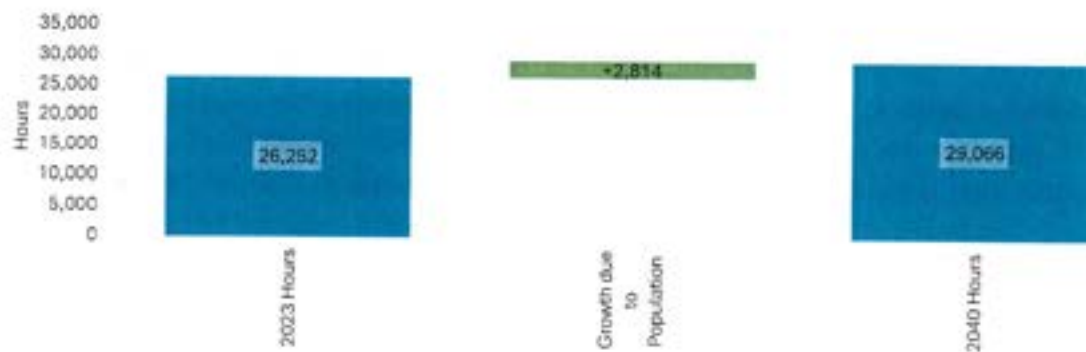
Pharmacy

Current State

The annual Lloydminster Hospital Drug Procurement and Distribution staffing earned hours (used as a proxy to measure the department's current workload due to limited Pharmacy activity data availability) have increased slightly by +2% in 2023/24 (or by ~320 additional annual staffing hours) relative to what was seen in 2020/21. Total annual Drug Procurement and Distribution staffing hours increased from approximately 25,900 hours in 2020/21 up to ~26,200 hours in 2023/24.

Future State

The 2023/24 baseline period was selected to drive the future state projections for this area (with later data not available for this area). Population growth and ageing were modelled as the main drivers for the future state demand. Based on these assumptions, Lloydminster Hospital will need to **budget for approximately 29,100 Hospital Drug Procurement and Distribution staffing earned hours by 2040**. This is equivalent to approximately +2,800 additional staffing earned hours by 2040, or a **+11% growth** in staffing earned hours beyond what was seen in 2023.



The Demand Projection results suggest that Lloydminster's annual staffing earned hours will grow from ~26.3k to 29.1k, a growth of +2.8k hours, (+11%) from 2023 to 2040

Medical Imaging

Current State

Relative to 2 years ago, the annual number of patients visiting the Lloydminster Hospital Medical Imaging (MI) Department has increased by +4% (or by ~600 more MI patients annually), with patient counts increasing from approximately 18,000 patients in 2022/23 to 18,700 patients in 2024/25. Almost 60% of the Imaging patients seen in 2024/25 came to the MI Department from the Lloydminster Hospital Emergency Department, while 30% of patients were seen as outpatients, and 10% of patients were hospital inpatients. The following information provides a summary related to the current state of the Lloydminster Hospital Medical Imaging Program, including information related to each individual imaging modality:

- Patients requiring a CT scan constituted 34% of all MI patients seen at the hospital in 2024/25. The number of patients requiring CT imaging increased slightly over the last few years, with annual CT patient counts rising by +2%, going from ~6,300 patients in 2022/23 up to 6,400 patients in 2024/25. Roughly half of all CT patients were outpatients, while ~40% came for imaging services from the Lloydminster ED, and only ~10% were from the inpatient setting. Each month, this activity equated to ~530 patients requiring CT scans at the hospital, with lower volume months servicing as few as 350 patients (e.g., during months when inadequate MI staffing support was available).
- X-Ray patients made up 53% of all annually seen MI patients, making this the highest volume MI modality seen at Lloydminster in 2024/25. Patients requiring X-ray services increased by +3% over the last year, growing from ~9,700 patients in 2022/23 to ~10,000

patients in 2024/25. Approximately 75% of these patients requiring X-ray services were from the Emergency Department, while the remainder were seen as outpatients or were already inpatients in the hospital. Monthly X-ray patient volumes have been stable over the past few years, with ~830 patients receiving X-ray scans each month on-site.

- Ultrasound patients represented ~9% of the annual patients seen at the Lloydminster MI Department in 2024/25. Patients needing Ultrasound services increased by +30% over the last year (going from ~1,280 patients in 2022/23 to ~1,650 patients in 2024/25), with this increased demand being driven by patients coming to the MI area from the Emergency setting. Patients presenting for Ultrasounds from the Emergency Department represented 50% of all ultrasound patients, while the remaining 30% were hospital inpatients, and 20% were outpatients.
- Fluoroscopy patients made up only 2% of the total MI patients seen annually at Lloydminster in 2024/25, representing one of the smaller imaging modality patient groups at the hospital. Patients requiring Fluoroscopy imaging have declined by -3% year over year, going from 482 patients in 2022/23 to 468 patients being seen for this modality in 2024/25. Interestingly, this modality saw a steady decline in activity over the last 5 years which was noted to be driven by general clinical shift and indication for the usage of the CT modality, rather than Fluoroscopy. The majority of Fluoroscopy patients were outpatients (~80%), while 15% were hospital inpatients, and only 5% were patients presenting from the hospital Emergency Department. For most months in 2024/25, there was a steady decline in usage for this modality at Lloydminster Hospital as clinical indication of this modality lessened overall.
- Mammography screening patients constituted only 1% of the hospital's overall annual MI patient counts in 2024/25. Notably, the Mammography modality showed the most significant reduction in activity at Lloydminster Hospital over the last year, with a -29% decrease in patient counts observed during this period (from 361 Mammography screening patients seen in 2022/23 down to 257 patients annually in 2024/25). This reduction in Mammography screening was noted to be driven by a shift to service these patients outside of the acute hospital to community-based imaging providers (e.g. private Alberta-based clinics) which began during the COVID-19 pandemic due to insufficient staffing at the hospital site. It was noted that there is a desire to return to the pre-pandemic levels of both Screening and Diagnostic Mammography activity in future. Currently, all mammography patients are seen as outpatients at Lloydminster Hospital. Every month, this equated to seeing roughly 10 to 40 Mammogram patients seen at the hospital each month.

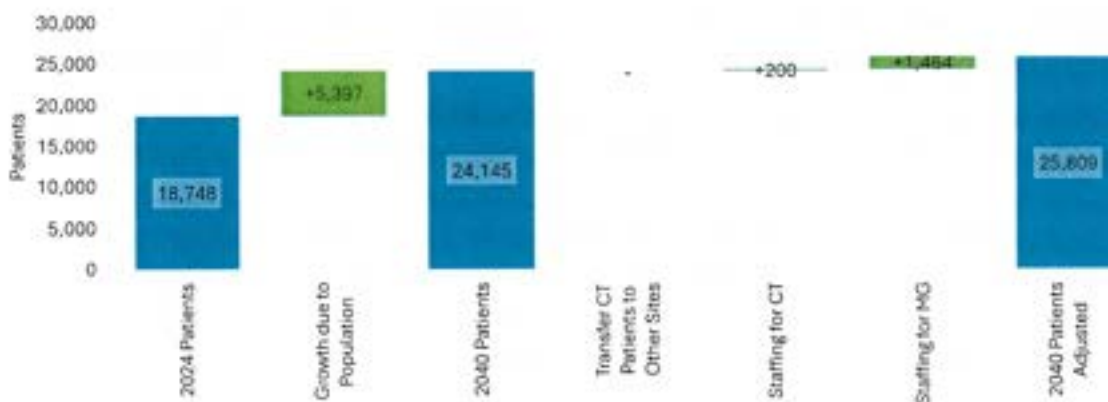
Future State

The 2024/25 baseline period was selected to drive the future state projections for this area. Aside from accounting for population growth and ageing, the MI projection model also

considers the following potential future state service shifts and the resulting impact on the projected MI patient demand:

- Given the current Medical Imaging staffing challenges that can be seen to limit the throughput of this department, improving staffing levels for the MI department could better ensure that the site can operate at its full Imaging capacity on a month-to-month basis (e.g. especially for the CT modality which has seen activity significantly impacted by staffing shortages). The model scales the baseline CT activity up by ~180 patients for the months of October 2024 and November 2024 where the site had previously been most impacted by staffing shortages, bringing the activity closer to an average month on site, with this adjusted annual activity then being projected to determine the future demand for this modality.
- There is a noted desire for the site to improve staffing levels for the Mammography modality to ensure that they can perform both Diagnostic Mammography and Screening Mammography, as was done onsite in 2019/20. As a starting point, the model assumes that the site can operate at a similar volume to the 2019/20 throughput for Diagnostic Mammography, with this adjusted annual activity then being projected to determine the future demand for this modality.
- Given that significantly long wait times are being experienced for CT MI services for lower priority patients at Lloydminster Hospital, it is hoped that these patients would be able to obtain CT MI services more quickly at other hospitals in the region through increased regional cooperation and repatriation. The model assumes this will not change the total number of patients seen at the MI Department in Lloydminster in the future, but help reduces wait times for the local residents who have been waiting to get access to imaging.

Based on these assumptions, Lloydminster Hospital will need to **accommodate approximately 25,800 annual MI patients by 2040**. This is equivalent to approximately +7,100 additional annual MI patients by 2040, or an **+38% growth** in annual MI patients beyond what was seen in 2024.



The Demand Projection results suggest that **Lloydminster's annual MI patient count will grow from ~18.7k to ~25.8k, a growth of +7.1k patients, (+38%) from 2024 to 2040**

For the 2040, patients requiring a CT scan will constitute 31% of all patient counts (or ~8,000 patients annually), X-Ray requiring patients will represent 52% of the patient count (or ~13,400), while the remainder of annual patient counts will be for the Fluoroscopy (3%, ~770 annual patients), Mammography (7%, or ~1,800 patients) and Ultrasound (7%, or ~1,800 patients) modalities.

Laboratory

Current State

The Lloydminster Hospital Laboratory focuses on supporting the acute and urgent testing needs for both Alberta and Saskatchewan patients, with the demand for this service continuing to grow over time. The annual Lloydminster Hospital Laboratory order volumes have increased by +13% in 2024/25 (or ~60,500 more orders annually) relative to the number of orders seen in 2019/20. Total annual hospital testing orders increased from approximately 468,000 orders in 2019/20 up to 529,000 orders in 2024/25. During the same time frame, hospital Laboratory orders from the Emergency area grew by +15%, while the demand from hospital inpatients grew by +7%, while outpatient Laboratory testing demand increased by +20%.

In addition to the hospital supported Laboratory testing, outside of the hospital setting, the mobile and Alberta Precision Laboratory (APL) also provide outpatient testing support for patients in this region. Volumes at these external locations have experienced at least a +7% annual growth between 2021/22 and 2024/25, suggesting demand for Laboratory services has expanded significantly both within and outside of the acute hospital setting.

Future State

The 2024/25 baseline period was selected to drive the future state projections for this area. Population growth and ageing were modelled as the main drivers for the future state demand. It should be noted that this projection model only includes Laboratory testing orders from the Lloydminster Hospital Laboratory (i.e. does not include mobile or APL testing activity) and assumes that the rapid growth from the outpatient area over the past few years will stabilize over time as the interprovincial population migration has settled as a result of COVID and the government lowering the immigration targets for people coming to Canada. From that point, it is assumed that demand will continue to present in line with population aging and growth. However, it was noted anecdotally that this rapid increase in Laboratory volume has been happening across Saskatchewan over the past few years. As such, the project team suggests closely monitoring the volume growth over the next few years to see if it does in fact stabilize and becomes more aligned with population growth and aging, or if the growth will instead continue at a more rapid pace in future.

Based on these assumptions, Lloydminster Hospital will need to **process approximately 578,000 in hospital Laboratory Testing orders by 2040**. This is equivalent to approximately +50,000 additional orders by 2040, or a **+9% growth** in orders beyond what was seen in 2024.



The Demand Projection results suggest that Lloydminster's annual in hospital Laboratory testing orders will grow from ~529k to 578k, a growth of +50k annual orders, (+9%) from 2024 to 2040

Continuing Care

Current State

Continuing Care facilities within the Core Service Area, located on both the Saskatchewan and Alberta sides, are currently used to service the needs of Lloydminster residents. In Alberta,

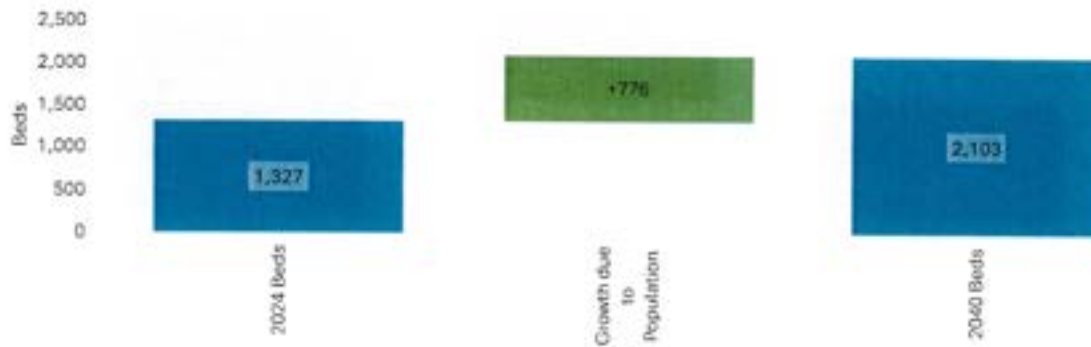
Continuing Care spaces are designated into Type A and Type B (secure and not) categories depending on the method and type of care received at those locations, while Saskatchewan does not classify things in a similar prescriptive way. For the purposes of this review, in order to provide a fair comparison between both provinces, Saskatchewan Continuing Care spaces were deemed to be equivalent to Alberta's Type A spaces. Additionally, Alberta also classifies a proportion of their Type A beds as Respite, and where possible, these have been separated from the overall Type A beds to include additional clarity around patient Respite requirements. Similarly, Saskatchewan temporary care beds are separated from the Continuing Care spaces. Alberta respite beds are treated as the same as Saskatchewan temporary care beds in this analysis.

The Lloydminster Core Service Area is made up of 276 Type A Continuing Care beds, 164 Type B beds, and 10 temporary care beds located throughout the two provinces of Alberta and Saskatchewan. Although most Lloydminster residents are believed to mostly utilise the Continuing Care capacity within the Core Service Area, additional Continuing Care capacity is also available in the outside of this service area (i.e. within the Extended Service Area). The Extended Service Area is made up of 1,051 Type A beds, 314 Type B beds, and 30 temporary care beds. Combining the Core Service Area and the Extended Service Area Continuing Care capacity, there are a total of 1,327 Type A beds, 478 Type B Beds, and 40 temporary care beds.

Future State

The 2024/25 baseline period was selected to drive the future state projections for this area. Population growth and ageing in the region are modelled as the main drivers for the future state demand. Based on these assumptions, the Lloydminster region will need to **accommodate approximately 2,103 Type A beds, 757 Type B beds, and 63 Temporary Care beds by 2040**. This is equivalent to approximately +776 additional Type A beds, +279 Type B beds and +23 temporary care beds by 2040, or a **+58% growth** in Continuing Care beds beyond what was seen in 2024.

AB Type A Beds and SK Continuing Care Beds



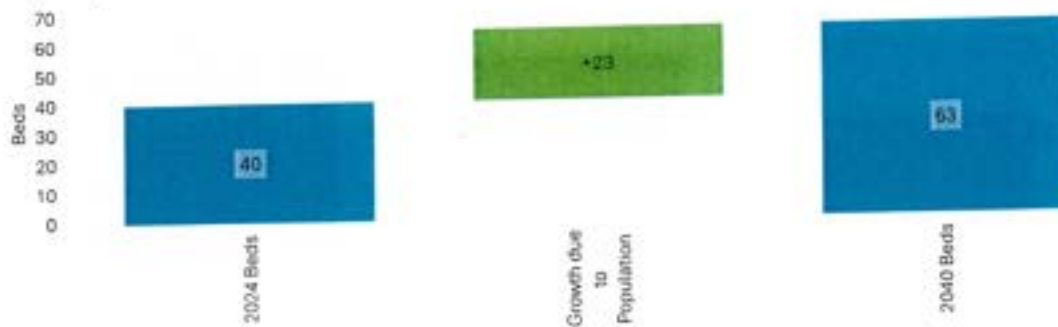
The Demand Projection results suggest that Lloydminster's AB Type A/SK Continuing Care beds will grow from 1,327 to 2,103 beds, a growth of +776 beds, (+58%) from 2024 to 2040

AB Type B Continuing Care Beds



The Demand Projection results suggest that Lloydminster's AB Type B Continuing Care beds will grow from 428 to 757 beds, a growth of +279 beds, (+58%) from 2024 to 2040

Temporary Care Beds

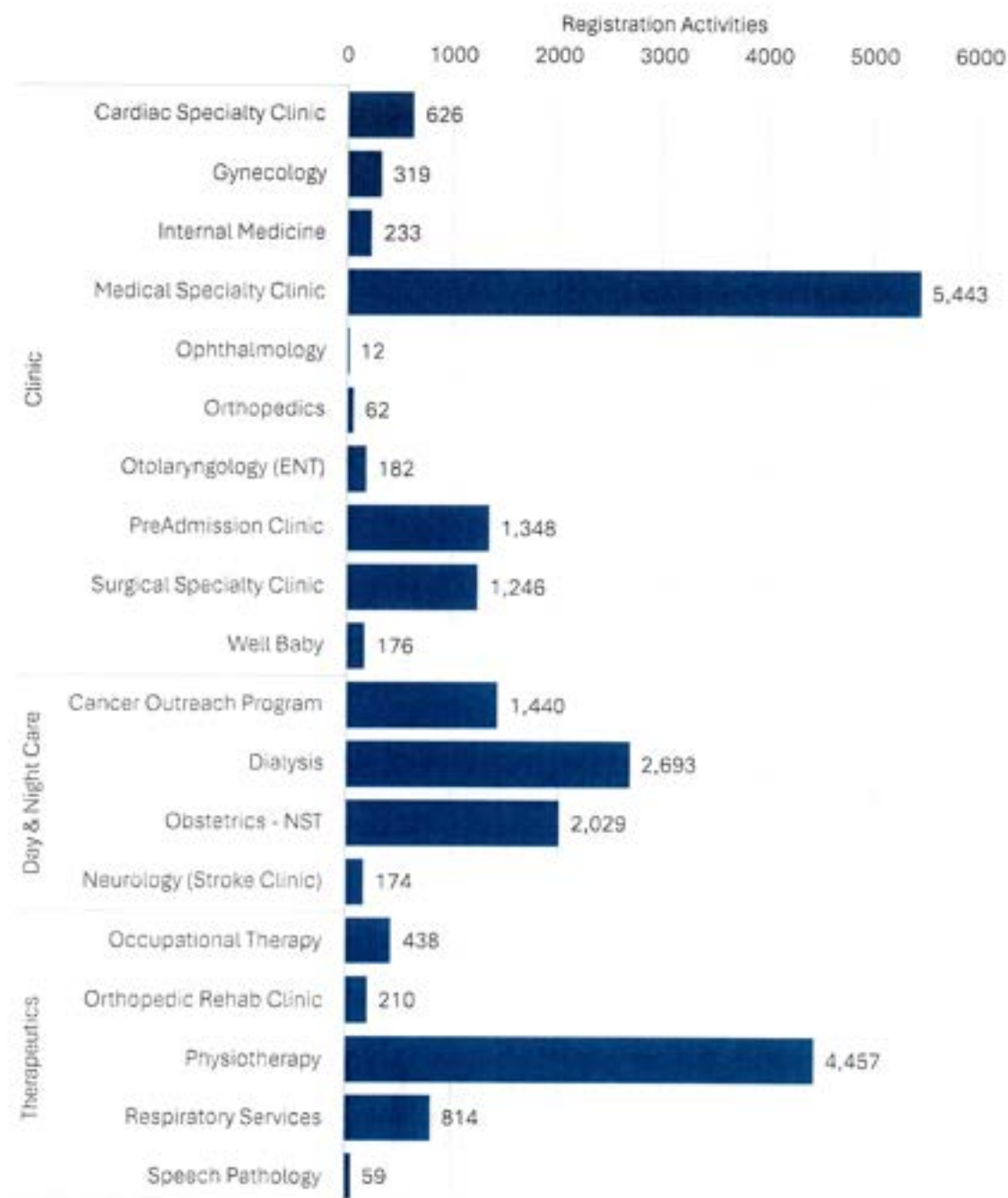


The Demand Projection results suggest that Lloydminster's Temporary Care beds will grow from 40 to 63 beds, a growth of +23 beds, (+58%) from 2024 to 2040

Ambulatory

This section focuses primarily on the Ambulatory services and their activity levels at Lloydminster Hospital. Due to data unavailability for recent data, the future state demand has not been modeled for this area. The table below shows the 2019/20 patient registration activities from the different Ambulatory hospital areas within the Lloydminster Hospital for those records having the registration type "Clinic", "Day/Night Care", and "Therapeutics".

The areas with the highest number of patient demand are "Medical Specialty Clinic", "Physiotherapy", "Dialysis", "Obstetrics", "Cancer Outreach", "Preadmission Clinic" and "Surgical Specialty Clinic". Together, these areas capture ~85% of the overall patient registration records.

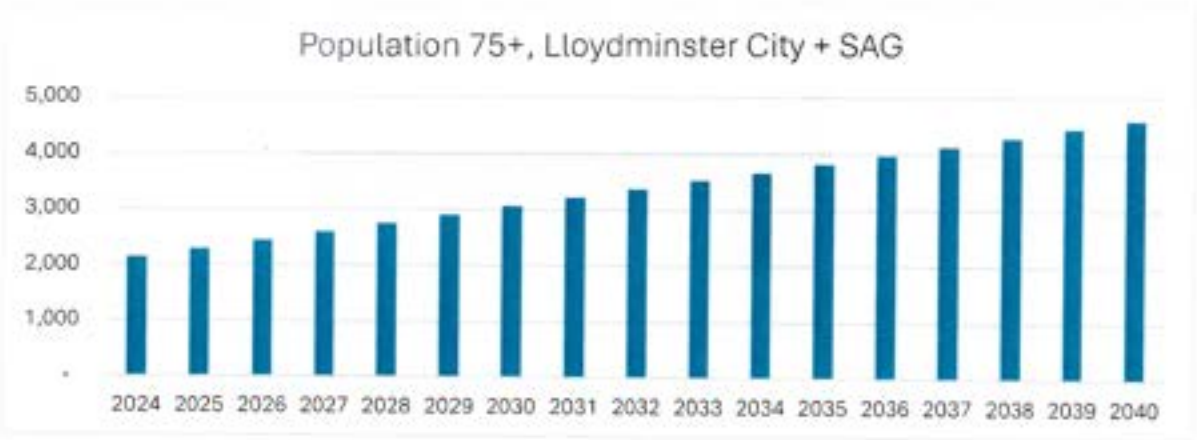


Home Health

The consulting team was provided with Home Care contact hours and unique clients between 2020 and 2024. Within Lloydminster SAG, Home Health unique clients were relatively stable, fluctuating between 1,125 and 1,167, while Home Support clients saw a small decline in unique clients from 260 to 236 in the same period. Contact hours for both Home Health and Home Support saw declines in the same period, suggesting that more patients are receiving fewer care hours than in previous years.



Home Health benchmarking and requirements were driven by the population 75 and over who have the highest utilization of home care services. The population 75+ in Lloydminster City and Small Area Geography is projected to more than double from 2,144 to 4,588 from 2024 to 2040.



A benchmark of 20.0 FTE per 1000 75+ was identified based on levels seen in comparator communities and validated through engagement, where leadership indicated that home care is generally adequately resourced at present. Population and target HC FTE for 2053 were used as benchmarks from Squamish, Whistler, and Pemberton to compare Lloydminster with comparable communities' planned staffing ratios.

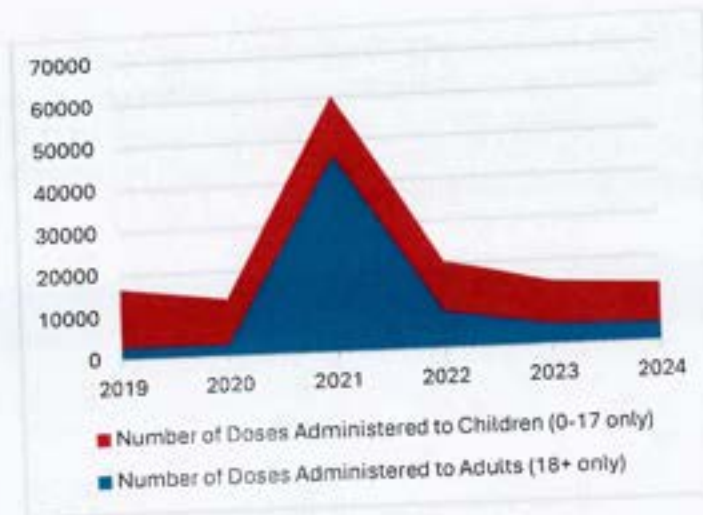
Comparator Home Health Benchmarking					
Community	Ref Year	Population	Population 75+	HC FTE	FTE/1000 75+
Lloydminster (City+SAG)	2024	45,630	2,144	44.02	20.53
Squamish	2053	43,718	2,904	68.79	23.69
Pemberton	2053	12,000	690	29.49	42.74
Whistler	2053	22,277	2,000	25.36	12.68
Powell River	2023	21,785	7,178	90.9	12.66

When factoring in only aging population in Lloydminster, the FTE to 1000 population 75+ ratio is projected to decrease significantly in the 15-year future.

Lloydminster Community Health Services - FTE Benchmarking						
Service Line	Current State FTE	Current State Ratio	Metric	Benchmark	FTE at Benchmark	Future Projected (2040)
Home Care	44.02	20.53	FTE/1000 75+	20.0	42.9	91.8

Public Health

Volume and unique client data for immunization were provided for the years 2019 to 2024 as available. In 2021, there was a massive spike in adult vaccination doses administered due to the COVID-19 pandemic, which has since returned to levels comparable to 2019 and 2020. While total vaccine doses administered have stayed relatively stable outside of 2021, there has been a decrease in vaccine doses administered to children (from 13,625 in 2019 to 9,236 in 2024) and an increase in doses administered to adults (from 2,950 in 2019 to 4,383 in 2024). This is in line with trends seen nationally with decreasing rates of childhood vaccination and increases in adult vaccination following the COVID-19 pandemic.



Public Health has a wide scope of practice that varies in different jurisdictions based on level of service and scope. However, it falls within the below, or in the lower end of staffing ratios in other comparison health service plans.

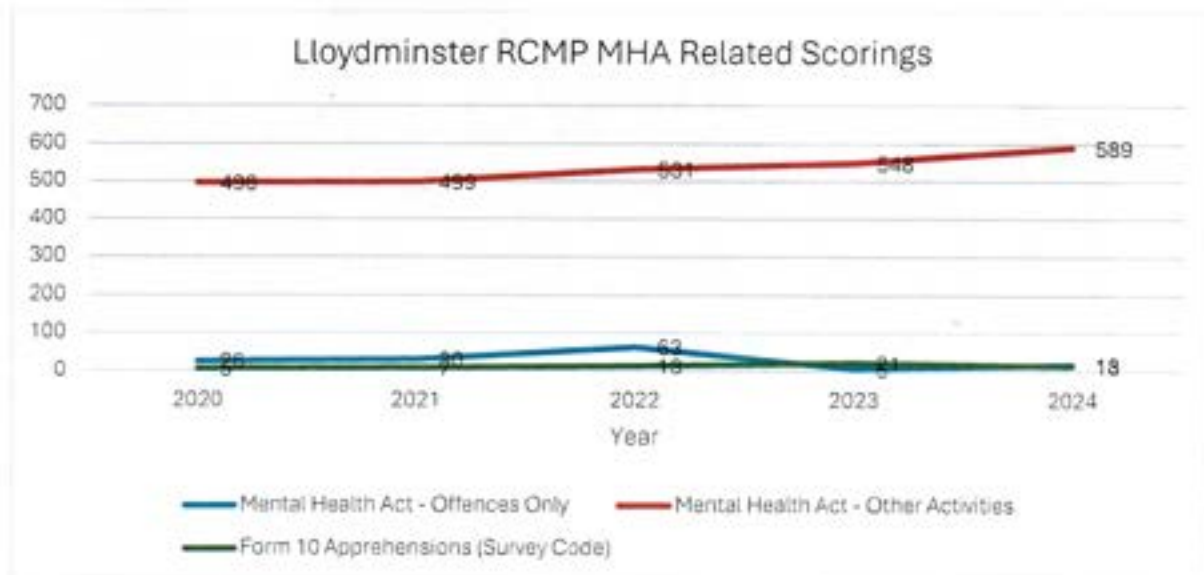
Comparator Public Health Benchmarking				
Jurisdiction	Ref Year	Population	HC FTE	FTE/1000 75+
Lloydminster (City+SAG)	2024	45,630	11.25	0.25
Squamish	2053	43,718	10.6	0.24
Whistler	2053	22,277	8.8	0.40

Though Public Health staffing levels are below benchmark, the scope of services provided by Public Health differ by jurisdiction and staffing level requirements are less indicative, and staffing needs should be dictated by a community's requirements. To match the average FTE to population ratios of the extended service area, Lloydminster will likely need to increase Public Health FTE from 11.25 to 13.7 to right-size service levels, with an increase to 15.2 by 2040.

Jurisdiction	Current State FTE	Current State Ratio	Metric	Benchmark	Benchmark by Future Projected FTE	Benchmark by Future Projected (2040)
Lloydminster (City + SAG)	11.25	0.25	FTE/1000	0.27	13.7	15.2

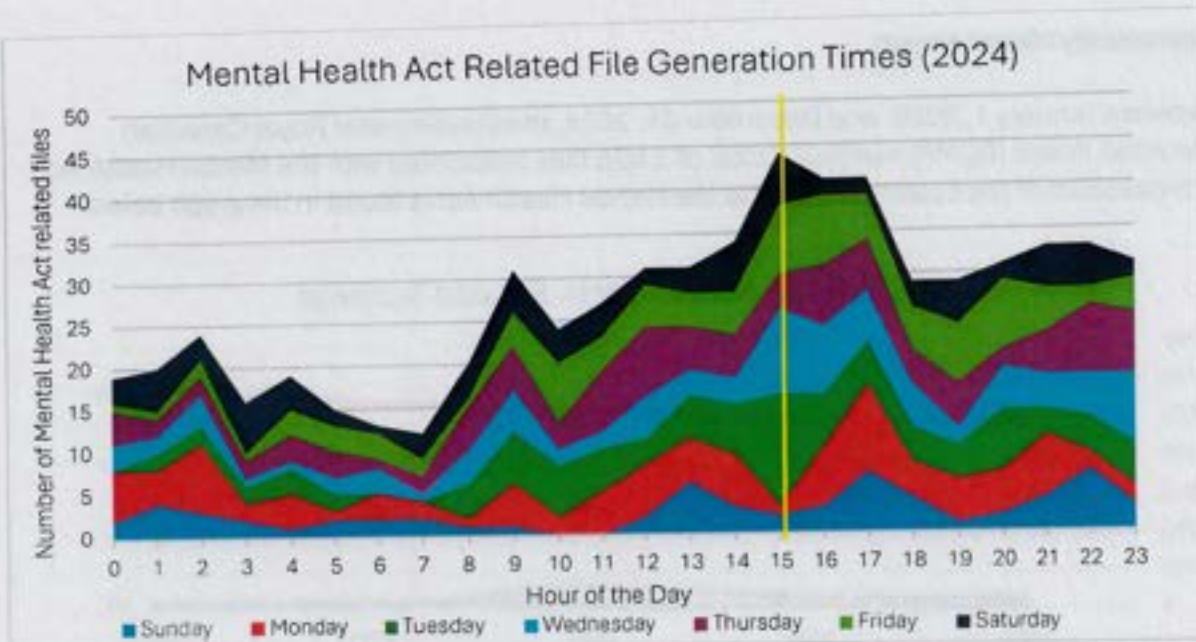
Community Mental Health

Between January 1, 2020, and December 31, 2024, the Lloydminster Royal Canadian Mounted Police (RCMP) handled a total of 2,626 files associated with the Mental Health Act. A breakdown of the scorings related to the Mental Health Act is found in the graph below.



This demonstrates a trend of an increase in Mental Health Act calls that are not exclusively offences. These volumes suggest demand for one PACT team.

The stacked area chart below shows the timeline of when all Mental Health Act related files were generated by the Lloydminster RCMP in 2024, including hours of the day, and days of week.



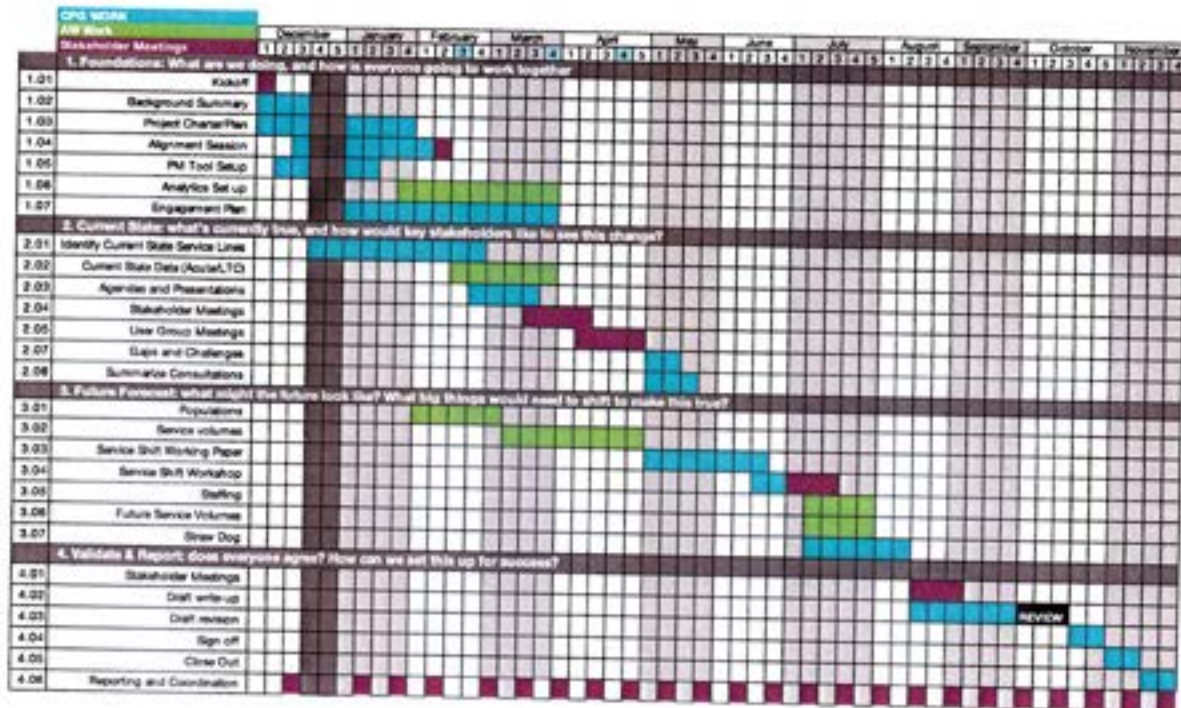
Establishing an appropriate benchmark for community MHA staffing for Lloydminster requires consideration of many factors, including complexity and acuity of patient populations, provincial context, and other factors. Community MHA staffing levels in Lloydminster are low compared to current or planned levels in comparator communities, including the Battlefords, Squamish, and Powell River. The benchmark for Community MHA staffing was set at 1.0 FTE per 1000 to bring it closer to levels seen in comparator communities. An additional 10% factor was placed on top of the 1.0 FTE benchmark to account for additional workload associated with Lloydminster's cross-jurisdictional status. Overall, Lloydminster has community MHA staffing levels significantly below benchmark.

Comparator Community Mental Health Benchmarking				
Jurisdiction	Ref Year	Population	Current FTE	FTE/ 1000
Lloydminster (City + SAG)	2024	45,630	19.5	0.43
The Battlefords (SAG)	2024	24,340	27.0	1.11
Whistler	2053	22,277	26.9	1.21
Squamish	2053	43,718	52.8	1.21
Pemberton	2053	12,000	18.8	1.57
Powell River	2043	21,785	67.4	2.46

Jurisdiction	Current State FTE	Current State Ratio	Metric	Benchmark	FTE at Benchmark	Future Projected (2040)
Lloydminster (SAG+City)	19.5	0.43	FTE/1000	1.1	50.2	55.9

4.6 PROJECT SCHEDULE AND BUDGET

Based on the scope of work identified in the RFP, the following project schedule was established:



The project budget was initially \$249,190 in consultant fees. Additional engagement and data analysis resulted in a scope amendment of \$13,070, for a total contract value of \$262,260 (excluding PST).

4.7 SUMMARY OF FUTURE STATE DIRECTIONS FOR CONSIDERATION

Emergency Department

Introduce Physician Assistants (PAs) to support peak hour throughput, embed a dedicated Mental Health Nurse, and develop a Mental Health Short Stay Unit within the ED footprint.

Primary Care

Establish a Primary Access Clinic (RAC) linked to primary care to provide next-day appointments for diverted low-acuity presentations. Extended primary care hours to increase existing primary care capacity is also recommended to be considered. In addition, streamlined administrative processes for physicians holding dual Alberta-Saskatchewan licenses would reduce barriers to cross-border practice. The implementation of shadow billing as a mechanism to expand publicly-funded primary care access and virtual allied health services are also recommended future state recommendations which would enhance primary care service and accessibility.

Surgical Services

Expand the Lloydminster Hospital's OR capacity equivalent to an additional 29 hours per week to meet projected demand of approximately 5,400 annual procedures by 2040. Achieving this target will require extending operating hours, including the introduction of weekend surgical services, along with the recruitment and retention of additional surgical specialists, perioperative nurses, and allied health professionals.

Critical Care

Develop a five-bed regional-level ICU to function as a regional-level service led by internal medicine physicians, with ER physicians as required, and tertiary consultation support as needed. ED nursing staff should be upskilled into ICU roles. Allied health services should be available seven days a week. Five ICU beds by 2040 reflects a 67% increase in high-acuity inpatient utilization compared to 2024. Once implemented, patient volumes, transfer activity, and utilization patterns should be monitored to evaluate demand and guide future adjustments.

Inpatient Care

Increase funded bed capacity from 66 to 76, consisting of 49 beds for Medicine, 10 beds for Surgery, 2 beds for Mental Health, 5 beds for the regional-level ICU, and 9 beds for Obstetrics and Pediatrics patients combined. Pediatric flexibility within medicine/surgery units is also recommended to accommodate seasonal surges in pediatric patients to enable care closer to home and strengthen continuity of care.

Maternity and Newborn Care

Prioritize reducing avoidable newborn transfers by ensuring adequate and stable nursing staffing levels to manage peak volumes. Enhance interprovincial coordination between Alberta and Saskatchewan to streamline clinically necessary transfers, with clearly defined referral pathways, transport protocols, and family supports. In addition, coordinating with the Saskatchewan Provincial Maternal Program may ensure the provision services at Lloydminster Hospital are aligned with the regional network planning.

Continuing Care

Establish a Transitional Care Unit (TCU) close to Lloydminster, but not within the hospital, to alleviate ALC pressures and provide a restorative environment for patients transitioning out of acute care and respite patients living in community. Enhancements to intake and discharge processes such as early discharge planning, embedded coordinators, standardized assessment tools, and seven-day allied health coverage, will also strengthen continuity of care. Align home health more closely with teams in acute care to improve coordination and patient outcomes.

Home Care

Adjust staffing and resourcing levels to reflect the administrative demands of a bi-provincial system. Align a portion of home care teams with acute care services at Lloydminster Hospital to streamline discharge processes and reduce hospital length of stay. Enhance allied health capacity and expand weekend and after-hours coverage to support timely discharge and ensure appropriate community-based care.

Public Health

Adjust staffing levels to reflect the additional administrative workload associated with the bi-provincial system. Expand public health's role in well-baby visits to complement primary care, particularly for families without regular access to a physician or nurse practitioner. Integrate these visits with postpartum home visiting, parenting programs, immunization follow-up, and early childhood health promotion to ensure consistent screening and support.

Emergency and Inpatient Mental Health

Establish a Mental Health and Substance Use Short Stay Unit (MHSSU) to create a secure, dedicated environment where patients in crisis can be stabilized, observed, and connected to ongoing care. SSU patients are psychiatric patients requiring short term inpatient care as well as medical withdrawal patients out of scope of the local detox facility due to medical requirements in the early withdrawal phase. Ensure adequate 24/7 coverage through the addition of dedicated Psychiatric Nursing presence in ED, and targeted upskilling of existing staff. Increase training and support for ED physicians to strengthen their ability to manage psychiatric presentations effectively.

Community Mental Health

Create a PACT team to reduce reliance on the ED and diverting patients from acute settings by providing care in the community. Increase staffing levels by approximately 132% to align with

benchmarks from comparable centres, with an additional 10% adjustment to account for cross-border administrative demands.

Medical Imaging

A combination of workforce development, equipment renewal, and improved cross-provincial coordination. A long-term strategy should be developed focusing on maintaining the reliability of CT as the central diagnostic tool, ensuring 24/7 access to X-ray and Fluoroscopy, and exploring sustainable approaches for MRI capacity, either through expanded mobile service or a fixed regional resource. Establishing a dedicated coordination function across Alberta and Saskatchewan is recommended to improve referrals, requisition management, and data sharing.

Laboratory Services

Shift outpatient diagnostic demand into community-based facilities to the extent possible, including expansion of the Alberta Precision Laboratories (APL) site and the development of an SHA-operated collection service in primary care, to relieve pressure on the hospital laboratory and improve coordination with community providers. Sustainable staffing pipelines must be established through the prioritization of recruitment and retention strategies, expanding local training placements, and exploring support for dual licensure. Bi-provincial information-sharing processes should also be strengthened.

Pharmacy Services

Expand pharmacist involvement in clinical care (rounds, counseling, discharge support), optimize technician roles to increase efficiency, and improve workforce sustainability through targeted recruitment and training placements. Enhance cross-provincial data sharing and re-design space to enable closer integration of pharmacy staff with clinical teams.

