

Rooted in Community Gathering Report

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Sheraton Cavalier Hotel
Saskatoon, SK

**Rooted in Community Gathering:
Conversations and Connections for Strengthening Rural Health and Safety**

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Rooted in Community Gathering: Conversations and Connections for Strengthening Rural Health and Safety

INTRODUCTION

It is widely known that, across the board, rural and remote populations are significantly underserved in healthcare. In Saskatchewan, one in three people live rurally, but only 10% of physicians, 9.6% of nurses, and 14% of nurse practitioners practice rurally ^(1,2). Only 2 in 5 rural households have basic services within 15km, facing travel distances for care and services that are significantly longer than for urban people ⁽³⁾. These are only some of the many complex disparities faced by rural communities in terms of health and safety, influenced by a variety of cultural, systematic, occupational, and biological factors.

As such, improving the health of rural and remote populations starts with understanding what the people who live and work rurally themselves see as gaps, successes, and solutions in their access to and quality of health and safety services and practices.

The University of Saskatchewan's - Canadian Center for Rural and Agricultural Health (CCRAH), organized the Rooted in Community Gathering held June 15, 2026. 109 participants took part in the day including members of rural and remote communities, RM Reeves and councillors, farmers, ranchers, healthcare providers, Indigenous Elders and community members, First Nation council members, community organizations, researchers, university staff, grad students and other allied organizations.

The Rooted in Community Gathering: Conversations and Connections for Strengthening Rural Health and Safety was organized to create a safe, inclusive space where participants could:

- Identify successes in rural health and safety
- Explore gaps and barriers
- Highlight priority needs and solutions

Overview of the Day

A moderator supported the activities of the day. To set the stage for the table conversations, short presentations were provided on:

- Access to Care and Supports
- Virtual Care and Remote Presence
- Community Solutions
- Building Connections
- Mental Health
- Health and Safety through the Generations

- Outreach for Health and Safety

Overviews of the presentations can be found in Appendix 1.

Following the presentations, pre-arranged table groups of 8 people/table were formed. The tables groups were pre-arranged to ensure a diverse distribution of individuals were represented at each table. Each table included a table lead and a table recorder. Four table runners supported the movement of the discussion notes between the tables and the content organizers. Two research faculty and a digital recorder were at the back of the room and receiving the ongoing content from the table discussions. As conversations began, note takers wrote down important discussion topics, themes, observations and any other relevant information on sticky notes, which were continuously taken from the table to content organizers at the back of the room. From there, the notes were collated into categories and subcategories based on their content. This collection of notes formed the content provided herein.

An overview of the categories and subcategories, and key takeaways were presented by the content organizers to close out the day. A final digital graphic design of the content was developed from the discussions. Content notes were continuously developed at each table with key takeaways based on the following themes: successes, gaps & barriers, solutions and reflections and brought to the content organizers at the back of the room. The notes were short descriptions of the content under discussion. The content organizers collated the content notes into categories and subcategories based on the content in the sticky note. These formed the content provided herein (<https://cchsa-ccssma.usask.ca/images/rooted-in-community-graphic-recording.jpg>)



KEY TAKE AWAYS

The core problem is a systems-design failure for rural

The conversations repeatedly indicated that services are designed around urban assumptions: fixed appointment times, centralized facilities, digital-first navigation, and physician-centred care. Rural realities — long travel distances, seasonal work, caregiving demands, poor connectivity, and limited transportation options — make even “available” services functionally inaccessible. This matters because adding services without redesigning delivery may not solve the access problem.

Trust is the hidden infrastructure necessity

Many barriers are framed as resource gaps, but the conversations suggest trust is equally foundational: physician turnover, cultural disconnect, racism experienced by Indigenous people, lack of anonymity in small communities, and institutional mistrust all reduce the likelihood that people will seek care or accept health messaging. There was repeated emphasis on “someone I know and trust” signals that relationships are not a soft add-on — they are necessary for service uptake, prevention, and culturally safe care.

Short-term funding and pilot-project culture are a major risk to lasting change

Participants strongly reject temporary approaches: “No more pilot projects! Build on past successes.” The conversations reiterated that short-term grants, temporary research initiatives, and underfunded small-community programs create churn rather than capacity. The implication is that communities may become over-consulted but under-supported, especially if findings are not returned to them or converted into sustained programs.

Create consistent standards without flattening community-specific realities

Participants ask for both stronger provincial systems and more local control: “think provincially act locally.” This tension ran through discussions on healthcare delivery, safety regulation, research, and funding. A single provincial health authority was described as administratively overburdened and disconnected from local needs. The key issue is how to create consistency without flattening community-specific realities.

Effective policy should invest in what is working locally and help communities scale it

The successes section shows where solutions can grow from: mutual aid, youth safety education, mobile clinics, nurse practitioners, pharmacist scope expansion, co-location models, culturally grounded Indigenous practices, and community-led infrastructure. The implication is that effective policy should not simply “deliver help” to rural communities; it should invest in what is already working locally and help communities scale it.

SUCCESSES



CULTURE AND MINDSET

“Slowing down, paying attention”
 -Rooted in Community participant

Rural Culture

Participants cited the positive attributes of rural culture, describing rural people as **loyal, generous, hardy, resilient, and innovative**. Farm life in particular was described as “holistic” in nature, as farmers must know a little (or a lot) of everything to keep their farm running, from horticulture to carpentry to safety, farmers can see the whole of their livelihoods rather than the individual parts.

“Rural communities have the ability to work with what they have”
 -Rooted in Community participant

Participants noted how rural communities are highly willing to reinvest into their communities if/when funding exists to do so.

Youth Prioritizing Health and Safety

As health and safety programs are maturing with the next generation, the ways in which rural people have worked to educate youth to shift towards prioritizing health and safety have been

increasingly effective. Participants note that young people see the importance of protecting themselves, being educated (on health, safety, etc.), and even working to bring communities back together.

Maintaining a Growth Mindset

Participants highlighted a change in mindset as a driving factor of success, including farmers being open to ask for help with both physical and mental health, maintaining an openness to learn new things and try new ideas, building respect for access to care, and an overall willingness to build and grow as a community.

Acceptance of Diverse Cultures and Ways of Being

“All citizens in Saskatchewan need to live together on Mother Earth; in harmony, with respect.”

-Rooted in Community participant

Participants discussed how new cultures were successfully accepted into rural communities by efforts from community members to promote cultural understanding, and how existing cultures have been steadily integrated into healthcare and decision making. This includes connecting modern and traditional Indigenous practices to solve existing issues (e.g. food insecurity through the food bank network, and reaching youth in the community), promoting “strength through ceremony”. Participants noted the benefit of increasing the number of First Nations and Indigenous health care students in helping create better representation in the healthcare system. Additionally, other rural cultures, such as the Hutterites, discussed how their division of labor between men and women ensured children were being watched and kept out of danger by the women on the farm. Another example is the RCMP using translation devices to help understand non-English speakers they encounter. Overall, participants stressed the need to “Honour long standing knowledge in rural communities”, and being open and accepting towards different ways of being.

Collectivism and Collaboration

Participants discussed the benefits of the culture of collectivism in rural communities, and how community members have a strong sense of mutual aid. Especially important was how collectivism influenced their approach to health and safety, including relating how farm accidents affect friends and family to raise awareness about the prevalence and impact of these injuries, but also the way that education is approached, as often family or community farms can't fire workers that are related to them, so instead must find new ways to teach about farm safety.

“Working together to solve problems in rural communities”

-Rooted in Community participant

Collaboration was heavily cited as a major source of success, including between communities, government, and other organizations, leading to less duplication of effort and better circulation of information. Participants discussed how collaborations such as when municipal governments worked together for disaster relief in Oxbow, community discussion days like this event, and grassroots movements in communities, were successes in terms of health and safety.

PROGRAMS AND PROJECTS

“Prevention focused programs”

-Rooted in Community participant

Participants discussed the social, educational, healthcare, and safety programs that were seen as successful:

Social Programs and Projects

Childcare

By mobilizing community members to start initiatives for childcare, and creating wrap-around care supports, participants noted that where childcare was available, it was extremely helpful and worked well for them.

Tailored resources from lived experiences

Participants stressed that customization of resources to specific communities and populations is an effective strategy to promote successful programs. Phrases such as “not one size fits all” were used to describe these types of resources. This also included integrating different cultures, lived experiences, and new perspectives to create successful programs.

Large community events and activities

Participants noted that large events such as curling tournaments, pow wows etc. has led to smaller communities being developed across the country and invites more people to engage with rural communities. Additionally, these types of gatherings create space for conversations about health and safety between community members.

Creating Infrastructure

Participants discussed how building more infrastructure helped improve social determinants of health in their communities, including healing lodges, supermarkets, greenhouses, community fridges etc.

Technological Interventions

Advancements in virtual rural care, 811 health line, UV sun safety bracelets, are all examples of successful technological intervention which participants hope will promote investment into other products and training for rural and remote health.

Healthcare

Retention Programs

High retention promotes long-term relationships, stability, and trust in the community. Participants noted the benefit of this connection for rural health. Participants also noted the effectiveness of monetary incentives to retain rural practitioners

Streamlined Referrals and Self-Testing

Increasing access to specialized services such as specialists, lower age for cancer screenings, free vaccinations, and promoting self-testing all increase access and quality of care.

Increased Number of Nurse Practitioners

Participants discussed the benefits of having more nurse practitioners in the community, practicing locally, including developing trust and building relationships with the community.

Target Health Programs and Collaborations

Participants highlighted the effectiveness of mobile cancer clinics, such as for breast, colorectal, and cervical cancer, as well as first responder programs such as STARS.

Greater scope of practice for non-physician health practitioners

Widening pharmacist roles has helped allow for more access, and less wasted time. Participants supported engaging with paraprofessionals to help build community capacity.

Co-Location Model in Community

Where available, participants noted the benefits of having health services available close to home, whether that is in rural communities or on reserve. This included clinics and homecare. Additionally, participants supported collaborative care in one place; such as a multidisciplinary team of professionals in a co-location model, and especially their role in providing health education and preventative care.

Education

Starting from a young age

Participants discussed how integrating farm safety into school education ingrains health and safety practices into young adults. One suggestion was to get Elders or respected community members involved in educating young people. This also includes initiatives such as AHSN Discovery Days.

Raising awareness

Participants stressed the effectiveness of information dissemination programs, such as the FAST program to raise awareness of stroke, creating agricultural youth work guidelines, university partnerships, or even visiting farm accident victims in hospital to see the real effects of agricultural accidents.

“When it becomes real enough to see yourself as a potential victim [of an incident/accident], you gravitate to proactive prevention”
-Rooted in Community participant

Safety

Participants noted several safety programs as successful, such as the “Call Before You Dig” initiative, the “Farm Health and Safety Group”, SARM partnerships, and conservation spaces. Participants also discussed how using appropriate tools such as mailing out information has helped reach target populations. Safety systems, such as process safety management, network for wildfire management, and conservation spaces have also played an important role in ensuring safety is institutionalized into people’s lives.

[illegible]

LACK OF SERVICES

Version 1.0

*“Stop looking at economics and consider the people and communities”
-Rooted in Community participant*

Long Term Care and Elder support

Participants found that there were not enough LTC services available in community to adequately support the needs of elders; this included a lack of infrastructure (i.e. care homes) but also supports to help elders remain at home when possible, identifying a gap between the supports assessment framework and true needs of seniors, meaning some were not able to access available supports due to scoring too low on assessment.

Disability Services

Participants noted the profound effect of defunding farmer disability services, and overall lack of programs or supports for rural disability needs.

Paraprofessional Services

Broad lack paraprofessional services such as physiotherapy, laboratories, massage therapy etc.

Women’s Health

Participants described pressing issues in women’s health, such as lack of delivery rooms within Indigenous communities and poor access to mental health services for women in agriculture.

LACK OF ACCESS

*“Hands are dirty...reluctant to put on sunscreen”
-Rooted in Community participant*

Where services were available, participants noted extreme accessibility issues, namely transportation, timing, language, culture and technological literacy:

Transportation

Distance to care was described as a “universal barrier” to accessing care; lack of public transportation, especially the cancellation of rural buses, was seen as a major barrier to accessing other health services. Other effects of distance were a lack of home support while caregivers devote time to driving to and waiting for healthcare, geographical barriers (e.g. fly-in communities), and overall expenditure of time and money on transportation to access care.

Rural Timing and Lifestyle

Participants discussed how farming and agriculture timeframes affect time availability for appointments, as farmers may not be able or willing to take time off for healthcare during peak seasons such as harvest, factors which are not currently considered by healthcare services.

Technological Literacy

Often, participants discussed that when resources were available, many target demographics could not access them due to poor delivery or navigation, often due to low technological literacy in older populations and in rural communities overall, with technological advancements such as phone applications for parking and digital information resources creating a digital divide.

LACK OF INFORMATION

*“Information and services aren’t truly inclusive”
-Rooted in Community participant*

Gaps in information and education services were identified as result of poor inclusivity, widespread mis- and dis- information, lack of awareness about health and safety regulations, and top-heavy information pathways, all exacerbated by a lack of fundamental educational infrastructure, such as cell service or connectivity;

Non-inclusive information and services

Information was frequently found to be non-inclusive of immigrants and people of color, and generally inappropriate for diverse populations, including older and younger age groups. This included language barriers, due to both language differences, but also high prevalence of medical jargon which patients found difficult to understand. A lack of alternate methods of communication, other than digital resources, such as print and radio, was identified as a barrier to accessing accurate information due to low technological literacy in target populations. Conversely, the need for youth engagement was identified in regard to farm safety and mental health due to gaps in education, both in young adults (e.g. young people don’t educate themselves on heart and stroke since they don’t think they’ll have them), and children (e.g. kids know to wear life jackets but not sunglasses).

Mis- and Dis- information

Due to gaps and lack of funding for public education, awareness campaigns, and preventative education, participants described seeing a lot of misinformation on what is “safe” and “unsafe” (one example was discussed was the divisive language surrounding GMO and organic products). Additionally, participants described politically divisive language, as well as fear of disease, to lead to “radical choices” for personal healthcare, as well as what are considered “good” vs “bad” products. Participants noted that social media acts as a catalyst for reinforcing unsafe or even dangerous behaviors, especially with the advent of a high usage of AI summaries.

Safety Regulations for Frontline Farmers

A “massive gap” around safety regulations and both individuals (frontline farmers) and international landowners/regulatory bodies was identified by participants. For farmers, this gap appears as a lack of awareness about common farm accidents and fatalities, and available mental health and healthcare services, as well as misunderstanding of safety regulations and compliance standards. On the flip side, a gap was identified between regulations and compliance standards, where regulatory bodies had poor understanding of the nature and realities of family farms and their capacities. Similarly, international landowners were not seen to understand the technological differences present on Saskatchewan farms. Overall, the regulation and governance of Sask farms was seen as top-heavy and impractical for everyday farm realities.

JURISDICTIONAL AND GOVERNMENTAL CONSIDERATIONS

*“Regionalization of healthcare authorities”
-Rooted in Community participant*

There were many jurisdictional and governmental gaps and barriers identified, starting with the understanding that the SHA is currently administratively overburdened, causing delayed service delivery. One health authority was seen as a barrier to providing adequate service to specific local needs, as a top-heavy disconnect exists between decision makers in Saskatoon/Regina and rural communities, compared to local health authorities who could “understand local needs better and... work with communities to make decisions”.

Additionally, gaps between federal and provincial dynamics were identified as a distinct issue, including low investment, prohibitive funding dynamics and approval processes, stipulations to regional transport services, lack of proper engagement with First Nations communities, and jurisdictional issues for communities between Alberta and Saskatchewan, which in particular contributed to creating low access to services, making access to funding confusing or impossible, and forcing individuals to search for loopholes or bypass the system entirely on their own dime.

This type of extreme low access, including both lack of EMT and ambulance services and general practitioner services, frequently put individuals into poor and unsafe situations. Participants described travelling to the USA for a full body check-up and paying out of pocket due to easier, one-time access. On a more dangerous note, some participants described having to lie about their province Saskatchewan/Alberta to access the nearest available emergency services due to jurisdictional issues between the provinces.

These difficulties cause families to drain towards urban centers, decreasing the number of young people in rural communities, and exacerbating existing health and demographic issues. Centralizing medical and health services in large population centers then creates further access issues for the remaining rural communities, which is why many participants suggested regionalization rather than centralization to create supports to exist within communities. Many participants identified the root barrier between jurisdictional and governmental cooperation to be short-term thinking — due to 4-year terms — rather than collaboration on long term goals.

SOCIAL DETERMINANTS OF HEALTH

*“Deserving populations left out”
-Rooted in Community participant*

Social determinants of health played a large role in systemic lack of access and services. This includes poor employment opportunities for indigenous peoples and locally trained professionals/health workers, housing issues, access to water, lifestyle, and food insecurity.

*“Creator doesn’t want us to live a poor quality of life”
-Rooted in Community participant*

Housing

Participants discussed how healthcare professionals don't want to stay in rural areas due to housing shortages leading to higher turnover and poor trust building with community. Where housing is available, participants worry that it creates "houses not homes", further undermining community building.

Water and Food Insecurity

Participants noted the significant effects of food and water scarcity on their communities, the effects of "food deserts" where community members had little or no access to fresh, healthy food, combined with a lack of sustainable and reliable water sources, have created social, financial and geographical barriers to living a full and healthy life. One particularly acute example is a scurvy outbreak in La Ronge with few avenues of support outside the general health center. Indigenous communities have also faced challenges in introducing dietary improvement efforts, due to hesitancy in adopting new or more expensive foods, leading to health issues such as diabetes due to high-carb low vegetable diets in communities.

In agricultural communities, water scarcity can be tied to water management in irrigation in the face of climate change; participants noted that more collaboration and communication is needed to control and manage water resources.

ROLE OF RESEARCH

"Research is hope"
-Rooted in Community participant

Participants were generally in agreement that research is a necessary tool to improve health and safety in their communities, however it was noted that gaps exist between the experts/researchers and those with lived experience, that community or lived knowledge is frequently devalued. In addition, participants noticed that more bridges were needed between programs and potential solutions to community problems, specifically between top-down (regulatory) and grassroots methods, stating "Research has to be co-developed".

BARRIERS WITHIN THE SYSTEM

"People are being failed by the system – prioritizing pills over the root of the problem"
-Rooted in Community participant

While healthcare systems and community organizations were seen as valuable resources for accessing healthcare, common themes of poor cultural integration of physicians and medical professionals, lack of necessary services, and low quality of care appeared. \

Cultural Integration

Participants noted doctors and families struggled to integrate into the community, with most moving out after less than a year of practice. The rotating door of practitioners has eroded trust with the community and simultaneously has made effective practice difficult for physicians who need time to get to know patients and understand their lifestyle. Furthermore, chronic understaffing leaves little time for physicians to interact effectively with their patients, forcing

them to rely on written records and patient histories rather than understand the patient themselves.

Program presence, change, and expansion

Participants discussed how existing programs required expansion of services, namely to First Nations communities, but also generally increasing the number of programs, such as for things like mental health and cancer screenings. Some participants discussed the existence of informal support groups that exist in communities but didn't get noticed or recorded as useful.

Additionally, due to lack of appropriate services, participants described how misuse of emergency departments adds access issues by overloading the system. Overall, the failure or passivity of existing programs — namely the lack of a decrease in fatalities ⁽⁴⁾— was seen as motivation to create more programs and try new approaches for tackling issues.

Poor quality of care

Where programs and services are available, participants noted systematic issues such as lack of follow up post testing, and poor representations of patient lives through electronic medical records (EMR), which were said to not capture enough data to create a full picture of the patient's life.

THE FARM VIEW

“The tyranny of the acute”
-Rooted in Community participant

An important perspective on rural and agricultural health is the farm view, participants discussed how farmers are tired; stressors such as liability issues, difficult working conditions, and “the tyranny of the acute”— immediate problems taking priority over long term solutions — in addition to outdated information and cultural shifts, creates a reactive rather than preventative approach to health and safety. Some costs associated with the rural lifestyle in regards to healthcare include time, money, mental health and caregiving;

Time is money

Access to services can cost days during peak periods where a farmer's livelihood might depend solely on them, or in other rural communities this might also mean having to take time off work. Transport, including gas costs, disability accommodations, childcare, and overnight stays can add up to significant accessibility costs which affect predominantly check-ups and preventative care, leading to lower rates of diagnosis and poorer health outcomes.

Mental Health costs

Burnout in rural providers, liability stress for farmers, the mental health crisis in First Nations communities, compound creating unhealthy work environments for both patients and providers of rural healthcare.

Caregiving

Arranging care for dependent individuals such as children, people with disabilities, or aging individuals is challenging in remote communities. This includes both when caregivers and dependents require care, and inadequate supports exist to provide help.

FUNDING

*“More education learning within communities, more home support, **more funding for small community resources**”*

-Rooted in Community participant

Participants discussed the impacts of loss of funding support, especially noting that smaller areas are less likely to receive continuous funding for initiatives. This combined with only temporary research grants/funding, led participants to discuss how funding is still very necessary, for example financial incentives for rural physicians is ever more pressing, and the need for both money and people who can manage funds to maximize their use. Participants prioritized “Ensuring accountability with funds”.

CULTURAL FACTORS

“Care is not culturally accessible”

-Rooted in Community participant

Cultural factors dominate the ways in which we are comfortable accessing healthcare ^(5,6). For rural and remote communities, this can often involve taking time to build trust with healthcare providers and institutions, working to overcome stigma around sensitive topics, and working to de-normalize farming risks and accidents. This includes;

Lack of Trust

Participants reported a lack of cultural competence from services and institutions, including stereotyping of farmers and rural communities, racism against Indigenous peoples, and a large gap in knowledge and understanding between “experts” and those with lived experience. This was felt particularly acutely in context with Indigenous health, as participants reported the significant and devastating impact that residential schools and the sixties scoop had on their health and wellness of their communities, but also their ability to trust services provided by the same institutions which perpetuated these actions. Some examples discussed was racist incidents in a Rosthern community clinic, and experiences where Indigenous community members had to self-advocate and repeat themselves to access medical care.

For these reasons, and others, participants noted a general mistrust of institutions that provide healthcare, safety, or educational services. If an individual from “outside” comes into the community without taking time to connect with the community, they are unlikely to be trusted to deliver education or medical services. This can also look like resistance to newer methods, approaches, and regulations coming from those same institutions.

“Trust is very important for community driven solutions”

-Rooted in Community participant

Trust and Vaccine Hesitancy

Vaccine hesitancy is more common in rural and remote communities CITE, participants connected this to the same institutional mistrust. Participants discussed how parents in rural and remote communities experience vaccine hesitancy, and even some health providers advocate against vaccines, causing greater risk of disease outbreaks.

Anonymity and Stigma

Rural and remote communities are small by nature, and though this carries positive impacts such as a greater sense of community, participants note that the double-edged sword appears as a lack of anonymity in health services and supports. Participants note a hesitancy to share health information due to worry about a lack of confidentiality; especially for sensitive topics such as accessing sexual health products (e.g. condoms or birth control) or mental health and help-seeking stigma with men and older generation, that may carry stigma or impact their lives in their community.

Feelings of isolation and difficulty speaking up:

Participants described a culture of “I don’t want to burden the system”, feeling difficulty speaking up about issues related to farm work. This has naturally led to feelings of isolation—like an “outsider” within the community — which was discussed as particularly affecting elders, farm wives, and intersecting to elderly farm wives.

Safety Practices

A major difficulty in implementing and retaining safety practices was described as safety “not being considered a priority”, going so far to describe taking safety precautions as being a “wuss”, as well as normalizing farming accidents and risks. However, sometimes reluctance to adopt safety practices stems from poor integration with other existing practices, one example brought up was some farmers being reluctant to wear masks in poultry barns due to reliance on smell and an indicator of a dead chicken, leading to delayed removal of the bird, impacting their work.

SOLUTIONS



“Community building- collective thinking”

-Rooted in Community participant

One word that stands out across this section is “long term”. Building and growing sustainable, long-term programs was a high priority for participants, including mentorship programs, industry and involvement, and investment of time and money by both institutions and individuals. However, participants also noted that “Small issues often compound, needing tough decisions to promote growth”.

BUILDING AND GROWING

“Build for long-term success”

-Rooted in Community participant

Mentorship and Education

Participants suggested creating opportunities to engage relationships with youth in their community through mentorship and guidance, such as rural internships in healthcare, drop-in centers to connect with elders, and co-creating courses around health with classrooms in Indigenous communities. Overall, participants aimed to remove stigma, generate awareness, and create roles for youth to fill in their own communities, saying, “Start with and mobilize your youth!”.

Industry Involvements

Participants described industry-driven policies as having a positive impact on consumers, such as co-branding and leveraging the networks of large companies to increase healthcare awareness.

Individualized community support connected to community needs

Participants suggested working directly with the community you're trying to serve, tailoring programs and opportunities to unique community needs. This can include creating adaptable products, building community goals, and consulting community champions. Shared decision making was highlighted as a necessary improvement to separate actions.

“Partnership was a key theme of our discussion; enables us to do more with less”

-Rooted in Community participant

Engagement from Institutions

Participants suggested more outreach from universities (such as through events and classes), especially through the engineering department, who participants suggested connecting with children on farms.

Engagement from Individuals

Practices such as incentives for healthcare providers to make community connections before moving to virtual care, and integrating healthcare practitioners into communities were suggested to keep people engaged and working within their communities.

Data Management

Participants noted that proper collection and data management would improve knowledge on what public health initiatives are needed, and where they can be the most beneficial. Participants discussed learning how to manage data, but also improve current data collection methods, including adding the ability for users to add two occupations rather than only one, in order to paint a better picture of their lifestyle and social determinants of health.

CREATING ACCESS

“Think provincially act locally – meet needs and adapt to individual communities”

-Rooted in Community participant

A major barrier to equitable healthcare in rural and remote communities is limited access, and participants had many suggestions for potential avenues to help make healthcare more accessible.

Modern Technology and Telehealth

Participants discussed how the implementation of modern technology could improve competency and communication, making tele-health a flexible way to avoid long drives and the barrier of transportation.

Nuance for Each Community; Creating a Flexible Standard of Care

Participants reiterated the benefit of tailoring resources to specific communities and allowing nuances to exist in standardized policies of care. This may include involving different healthcare professionals, and/or reducing strain on physicians by assessing whether each issue needs an in-person consult. One suggestion for a standardized policy is regular yearly checkups for adults over 50 years of age.

Find the Right Person for the Right Job

“Motivate the right people to push the right programs”
-Rooted in Community participant

A solution to the issue of funding, participants discussed how some Indigenous communities hire professional grant writers to address funding shortages and sustain support. This strategy of finding people with specific skill sets to provide for the community would streamline approval processes and alleviate pressure for other processes.

Keep Access Within the Community

Participants stressed the need for specialized and localized services, especially those which could come directly from their own community; a community-based provision of care. This also includes mobile clinics that come into the community (rather than individuals having to leave) as well as increasing healthcare employment opportunities and training for locals. Additionally, participants discussed shifts in perspectives which would create a community centered approach, including building focus on meeting people where they are at, creating a co-operative (multi stakeholder) approach, and giving people alternatives to unsafe behaviors, (centering the power of the positive) i.e “do this, not don’t do this”.

Members highlighted how cultural factors influence the use of products and services, and any projects must be relevant to culture, language, location, customs, values, and adaptability.

Create Resources for System Navigation

Participants suggested using cognitive mapping to identify target communities for programs. Additionally, simplifying system navigation for providers and the public was suggested to make accessing healthcare less stressful.

Champion Recruitment and Retention

Increase the Number of Rural Practitioners

A major focus of participants discussion was simply to increase the number of healthcare practitioners including nurses, nurse practitioners, family physicians, and other healthcare professionals through training, and by removing enrolments caps at medical schools.

Target Rural Youth for the Health Track

Participants suggested focusing efforts of recruiting and training youth from First Nations and rural communities in medical, nursing, and allied fields. This could include collaboration between universities and high schools, encouragement or incentives for rural youth to train and remain in community, creating funding to support students while they pursue education, training students with teachers from rural and remote communities, and especially in First Nations communities.

Create Financial incentives for Rural Practitioners

Participants suggested introducing salary-based positions and compensating nurses for taking on students as financial incentives to retain more health practitioners. Additionally, co-operative clinics were suggested to make doctor's quality of life, and work/life balance better.

IMPROVING INFORMATION AND EDUCATION

“Make resources appealing to the populations they target”
-Rooted in Community participant

Knowledge Sharing

Generally, participants agreed that increasing awareness about health and safety practices was vital for bridging knowledge gaps between “experts” and community members, with a particular emphasis on using appropriate and relevant language to consumers. This can look like active listening, using marketing strategies, diversifying communication strategies (e.g. mail, paper-based, word of mouth, telephone etc.), and even going directly into communities.

Safety Training

Participants suggested increasing the number of early intervention educational initiatives for children to ingrain farm safety practices as their norm. Additionally, participants stressed the importance of further pushing efforts to increase safety awareness for farmers, including PPE use and farm first-aid, ensuring that individuals and their families know of the risks involved to encourage the adoption of safety regulations.

Education

Participants encouraged the use of social media to get accurate messaging for health and safety instead of being a sound bite. This would allow youth to engage their parents regarding safety initiatives. Participants also suggested integrating initiatives directly into the classroom, such as farm safety, or work experience/engagement with elders, involving the Saskatchewan Ministry of Education.

Research

Participants highlighted the need for more research and initiatives on the environmental risks of farming, water safety, and burnout, both for farmers and healthcare providers.

SERVICE IMPROVEMENTS

“Someone I know and trust”
-Rooted in Community participant

A distinct lack of services was noted by participants, and suggestions on service improvements or new programs were made.

Ambulance and Emergency Services

Participants stressed the acute need for EMR services to First Nations communities within a 20km radius, and suggested developing a provincial EMR or EHR service.

Introduce Diet Supports

This included cooking lessons, grocery store advertisements, and nutrition initiatives.

Increase and Expand the Scope of non-physician Health Professionals

Participants recognized that not all health issues require a physician, and suggested health professionals such as pharmacists, midwives, nurses, and even social health advocates are integrated into care pathways to allow more access to services.

Midwives

Many participants touched on a feeling of greater security in delivering a child with the help of a midwife, as midwives tended to be from their community, and held a great deal of trust, making childbirth less stressful and more accessible in the community. That said, some participants felt anxious about relying exclusively on midwives due to distance from a hospital if something were to go wrong.

Pharmacists

Participants suggested increasing pharmacist abilities to perform tests and diagnose issues, creating a valuable in-community resource.

Accredited Social Health Advocates

Participants suggested implementing social health advocates as a bridge between rural communities and public health systems to improve accessibility and ease of navigation.

Create Co-Location Models of Care

To alleviate the time, distance, and stress associated with seeing multiple practitioners, specialists and labs to access care, participants discussed the benefits of introducing more interdisciplinary and primary care clinics, where teams of professionals and paraprofessionals can work together in one building. Iterated was the benefit of the RaDAR clinic, where patients can see all the specialists they require in one day.

Implement More Projects Long-term

“No more pilot projects! Build on past successes”
-Rooted in Community participant

Participants discussed the benefits of implementing pilot projects long term, emphasizing the importance of sharing information collected from pilot projects with the community, and engaging government to keep the projects running in a sustainable way.

Engage Culturally Competent Care

For Indigenous communities, participants noted the importance of engaging Elders and community members in decision making, as they know what is best for their communities. Participants suggested implementing First Nation representatives at all health clinics to help Indigenous patients navigate the system in a culturally competent way and consulting indigenous communities when conducting initiatives.

“Spirituality needs to be a key part of health services”
-Rooted in Community participant

Participants discussed the need for cultural and spiritual sensitivity training for healthcare workers and practitioners, in tandem with community cultural shift to prioritize normalizing mental health help-seeking, and overall increased collaboration between both parties. Overall participants stressed the need for locally trained or culturally integrated primary health practitioners, describing it as having “someone I know and trust”.

Improve Virtual Infrastructure

Participants stressed the use of tele-health as a supportive tool rather than a replacement for in-person visits to help decrease travel burden. Participants suggested improving virtual infrastructure and systems, such as apps, cell coverage, and selective imaging.

Expand long-term care and childcare services

“It has to start with emergency preparedness and not injury prevention”

-Rooted in Community participant

Respite care, wrap around care, and long-term care were highlighted as highly necessary programs. Overall, participants reiterated the need for localized programs, such as Community gardens in La Ronge to mediate the scurvy outbreak, and general changes in practice, such as working to shorten wait times.

Specific Solutions

Co-development of campaigns with communities improves capacity and transparency

-Rooted in Community participant

Participants put forth several concrete solutions to specific problems in their community:

- Making sun-safe clothing in camo print
- Implementing the use of hat extenders for sun safety
- Finding or creating dry fit clothing material for long-sleeve outdoor clothing that is comfortable to wear in the sun
- Work towards developing a community of farm wives to bring like-minded individuals together
- Create a fully integrated de-identified medical record to pinpoint issue hotspots to target care
- Promoting risk assessments, such as rural firefighters going into farms and pointing out potential hazards

GOVERNMENTAL AND POLITICAL ACTION

“Who do you vote for? Is change needed?”

-Rooted in Community participant

Participants highlighted the need for a change of mindset “think provincially but act locally”; they discussed how doing research into their voting decisions can find candidates which better represent their local communities. Causes such as tighter environmental regulations and enforcement, decentralizing systems of health care, and reduction of taxes in favor of community funds, were all discussed as priorities.

FUNDING AND INCENTIVES

*“where there is no vision the people shall perish”
-Rooted in Community participant*

Community investment, and investment in research and initiatives, was stressed as an important pillar of future success. Participants highlighted funding for local training programs, involving registered charities, and prioritizing long term programs over short-term solutions. Additionally, using testimonials from successful programs, utilizing teams of different funding avenues, and most importantly ensuring that programs are well planned out, not just “throwing money at issues with minimal planning”.

*“Rural communities need to draw on their strength as a community rather than pulling away as they would if they were urban”
-Rooted in Community participant*

[illegible]

Participants are concerned about the high prevalence of mental health and addiction issues in their communities, and the fact that little supports exist to help impacted individuals.

*“Addiction is a community issue”
-Rooted in Community participant*

Participants feel a loss of community in the rise of social media and corporate farming.

Farmers worry about the liability they incur for farm safety and other risks, and the difficulty of maintaining a safe environment with the 24/7 life of farming, which often involves working at night, and generally maintaining a poor work/life balance.

Participants worry that community participatory funding relies too heavily on one source, namely departmental funding.

Participants described the need to address AI in the future, integrate the cultural and generational shifts of modern farming into healthcare, and focus on ever-increasing environmental issues, such as ticks and tick-borne illnesses.

Participants note that people in their communities generally don't know what resources are available to them, which is also reflected in the gaps and barriers section.

Child Farm Safety

Participants worry that there exists a sort of catch-22 around farm safety for children, where the more information they have (e.g. how to turn a machine off), they also could misuse it (e.g. turn the machine on).

Representation in Healthcare

Participants were concerned about the lack of rural, Indigenous and spiritual representation in the healthcare system.

Core Access Issues

This includes food (in)security, housing, cell service, energy production, safety, wood burning for homes, and other acute gaps in service and access within rural communities.

INSIGHTS FROM THE GATHERING

The discussions emphasized the importance of community building, collective thinking, and strong partnerships in addressing the challenges facing rural Saskatchewan. Participants highlighted that meaningful progress depends on trust, collaboration, and community-driven solutions that prioritize people and communities over purely economic considerations. There was a shared belief that co-developing research, campaigns, and initiatives with communities increases transparency, capacity, and long-term success. The conversations also recognized the need to understand the unique realities of rural life, including the experiences of farmers and Indigenous peoples, the effects of isolation, addiction, and the ongoing impacts of COVID-19. Encouragingly, service providers were noted to be increasingly willing to adopt harm-reduction approaches and work together to meet community needs.

Participants described how research provides hope and should be community-driven, adequately funded, and built upon existing successes rather than relying on temporary pilot projects. Participants stressed that making a difference takes a long time and requires strong leadership, accountability, and sustained commitment. Education and awareness were identified as essential components of safety and prevention, particularly for underserved populations and rural communities. Improving access to healthcare, increasing funding and resources, recruiting healthcare professionals to rural areas, and promoting the benefits of rural living were also recognized as priorities.

The discussion further highlighted the importance of breaking down organizational silos and fostering collaboration among communities, governments, healthcare providers, educational institutions, industry representatives, community organizations, and political leaders.

Ultimately, participants concluded that creating healthier, safer, and more resilient rural communities will require inclusive partnerships, multi-generational engagement, coordinated advocacy, and a collective commitment to improving quality of life for all Saskatchewan residents.

*“Change takes time”
-Rooted in Community participant*

NEXT STEPS

Create a rural access and navigation model

The strongest cross-cutting issue is that services are hard to reach, understand, or use. Prioritize navigation, community-connected opportunities, and clearer pathways for emergency, primary, mental health, and specialist services.

Increasing collaboration between organizations, and within communities

Participants reiterated the need for inter-organization collaboration, in particular between ambulance partners. They discussed breaking down information silos by funding social prescribing navigators and social health activists, using well-connected community members to distribute information, increasing resources for finding funding, and forming coalitions between different organizations. Additionally, communication within communities was highlighted as vital for creating novel ideas and plans for the benefit of the community.

Invest in local, trusted capacity

Recruitment and retention are not just staffing issues — they affect trust, continuity, prevention, and cultural safety. Focus on rural/Indigenous youth health career pathways, nurse practitioners, pharmacists, midwives, mobile clinics, co-location models, and incentives that help providers stay and integrate into communities.

Move successful pilots into sustained programs

The next phase should identify existing successes — mobile cancer clinics, STARS-style partnerships, youth safety education, community food initiatives, virtual health hubs — and determine which can be funded, governed, and scaled long-term.

Address urgent basic determinants of health

Safe drinking water, food security, housing, childcare, long-term care, transportation, and connectivity are not secondary issues; they determine whether health and safety programs can work at all. These should be treated as enabling infrastructure.

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5. Pavloff, Michelle, et al. “Cultivating Perceptions of Farm Culture: Perspectives from the Canadian Prairies.” *Journal of Rural Mental Health*, vol. 48, no. 2, Apr. 2024, pp. 120–131, <https://doi.org/10.1037/rmh0000243>. Accessed 17 Mar. 2026.
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APPENDIX*Rooted In Community PowerPoint Presentations*1. *Overview, presented by Dr. Shelley Kirychuk*

Thank you to the Planning Committee!

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Thank you!



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and Agricultural Health**
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— USASK SIGNATURE AREAS —
HEALTH AND WELLNESS

BE WHAT THE WORLD NEEDS



INTRODUCING THE MOBILE HEALTH UNIT

Parked in front of
the Sheraton
Hotel!



What are some solutions?

Local Solutions

- **Virtual Health Hub**
- **Agricultural Health and Safety Network**
- **Sask Ag matters**
- **First Nations Health and Culture**
- **Rural and Remote Memory Clinics**

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What are some solutions?

Common Barriers

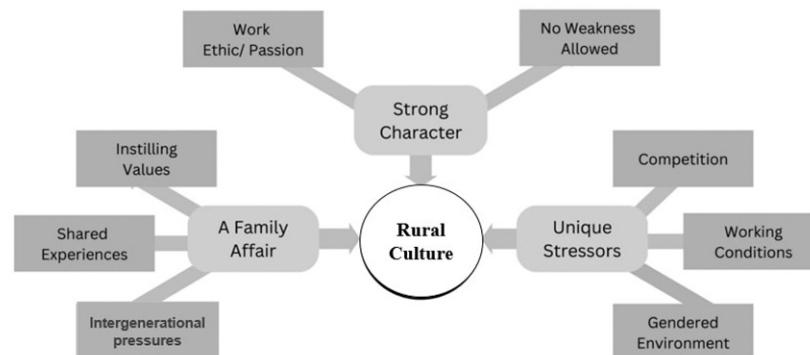
- Recruitment and Retention
- Economic Factors
- Rural Contexts
- Connectivity and Technology

Solutions and Strategies

- Local solutions
- Telehealth expansion
- Rural training tracks
- Regionalized care networks
- Community-based preventive care

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Rural, Indigenous and Agricultural Mental health



Adapted from:
Pavloff, Michelle, et al. "Cultivating Perceptions of Farm Culture: Perspectives from the Canadian Prairies." *Journal of Rural Mental Health*, vol. 48, no. 2, Apr. 2024, pp. 120–131, <https://doi.org/10.1037/rmh0000243>. Accessed 17 Mar. 2026.

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Rural, Indigenous and Agricultural Mental health

In a sample of 646 First Nations people over 18, the prevalence of major depression was 31% (202/646) ♂ 23% in males ♀ 37% in females	Farmer Mental Health in Canada (2021) 76% of farmers said they were currently experiencing moderate or high stress. Suicide ideation was <u>twice as high</u> in farmers compared to the general population.
---	--

Chandima P. Karunaratne, James A. Dorman, Meera J Kachroo, Warren Seesequasis, Carol Naytowhow, Reynaldo Lindain, Nicole Bird, Gerald Bullenstye, Marie Nembu, Jeremy Seesequasis, Malcolm King, Sylvia Abonyi, Mariya Bastz, Shelley Kirychuk, Punam Pahwa "Prevalence of Major Depression and Associated Factors among First Nations Peoples"

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Rural water insecurity and health



Water insecurity including drinking-water advisories alters daily practices such as:

- Influencing hydration/beverage options
- oral hygiene behaviors
- food preparation
- bottled-water reliance (effects household costs)

Rural water insecurity and health



Reserve communities in the north had a drinking water advisory count that was:

- 5.19 times greater than reserves in the south
- 2.63 times greater than towns in the south
- 4.94 times greater than villages in the south
- 2.43 times as many advisories as villages in the north



However, towns situated in the south part of the province had

- 1.98 times as many advisories as reserves in the south
- 1.88 times as many advisories as villages in the south.

McLeod, Lianne, et al. "A Quantitative Analysis of Drinking Water Advisories in Saskatchewan Indigenous and Rural Communities 2012–2016." *Canadian Water Resources Journal / Revue Canadienne Des Ressources Hydriques*, 25 Oct. 2020, pp. 1–13, <https://doi.org/10.1080/07011784.2020.1831404>.

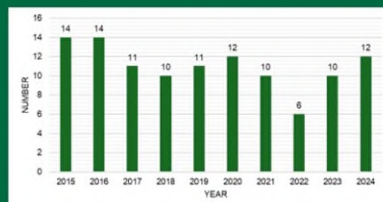
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Agricultural Injuries in Saskatchewan

Between 2015-2024, the number of fatal farm injuries per year have decreased as the farm population has decreased.



Number of Fatal farm Injuries in SK by Calendar Year 2015-2024 (100 deaths)



However, when the absolute numbers are adjusted for the decline in the farm population there has been no change in the rate of fatal injuries.

Karunanayake CP, Koehncke N, Enebeli S, Ulmer K, Rennie DC. Trends in Work-Related Fatal Farm Injuries, Saskatchewan, Canada: 2005-2019. *J Agromedicine*. 2023 Jul;28(3):444-455. doi: 10.1080/1059924X.2022.2134244. Epub 2022 Nov 5. PMID: 36218341.

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Agricultural Injuries in Saskatchewan



There were 110 fatal farm injuries recorded between 2015 and 2024 in Saskatchewan.

Of those, 83.6% were farm work-related.

Karunanayake CP, Koehnke N, Enebeli S, Ulmer K, Rennie DC. Trends in Work-Related Fatal Farm Injuries, Saskatchewan, Canada: 2005-2019. J Agromedicine. 2023 Jul;28(3):444-455. doi: 10.1080/1059924X.2022.2134244. Epub 2022 Nov 5. PMID: 36218341.

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Health of Rural People

Social Determinants

Income levels, local access to food options, housing conditions, water security, local facilities for sports/entertainment, roads,

Mental Health and Substance Abuse

High levels of stress, mental health issues, and substance abuse.

Safety and Environmental Issues

Higher rates of injury, particularly from agricultural or occupational accidents.

Chronic Health Conditions

Higher prevalence of obesity, diabetes, hypertension, and heart disease, and cancer death.

Health Care

Reliance on emergency transfers, generalist providers, and virtual care
Reliance on internationally trained professionals
Patients travel long distances for care

Service Disruptions

Significant staffing shortages
Rural SK experienced 533 health service disruptions between 2019-2023

Karunanayake, Chandima, et al. "Access to Specialist Care in Rural Saskatchewan: The Saskatchewan Rural Health Study." *Healthcare*, vol. 3, no. 1, 16 Feb. 2015, pp. 84-99, [www.mdpi.com/2227-9032/3/1/84.html](https://doi.org/10.3390/healthcare3010084), <https://doi.org/10.3390/healthcare3010084>.
Simes, Jeremy. "'Dying for Doctors': Report Cites Concerns with Health Care in Rural Saskatchewan." *CBC*, 22 Apr. 2024, www.cbc.ca/news/canada/saskatchewan/report-rural-health-care-sask-1.7181115.



2 in 5 rural households
have basic services
within 15km

Travel distances for care
and services
are **significantly
longer** than for urban
people



Canada, "Information Archivée Dans Le Web | Information Archived on the Web." *Publications.gc.ca*, 2025, publications.gc.ca/collections/collection_2025/statcan/11-627-m/11-627-m2025039-eng.pdf.

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What about other health professionals?



There are :
~10% of pharmacists in rural areas



~9.6% of nurses in rural/remote



~14% of nurse practitioners in
rural/remote

Nursing vacancies
in remote regions
are **about twice as
high** than in urban
centers

"Keeping Pace with Changing Population Needs | CIHI." *If/when cihi.ca*, 29 Feb. 2024, www.cihi.ca/en/the-state-of-the-health-workforce-in-canada-2022/keeping-pace-with-changing-population-needs.
"Rural Canada Statistics." *If/when statcan.gc.ca*, www.statcan.gc.ca/en/subjects-start/society_and_community/rural_canada.

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Rural Saskatchewan Physician Services

1 in 3 people live rurally in Saskatchewan



There is 1 physician per ~ 1550 people



Hall, Heather, and Rose Olffert. "Saskatchewan." *State of Rural Canada*, sorc.crrf.ca/saskatchewan/.

Sorokan, Keenan. "Nurses, Doctors Leaving Rural Sask. In High Numbers: Report." *CTVNews*, 28 Feb. 2024, www.ctvnews.ca/saskatoon/article/nurses-doctors-leaving-rural-sask-in-high-numbers-report/.

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and Agricultural Health
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Approximately 18% of Canadians live in rural areas.

That's 6 million people.

"Keeping Pace with Changing Population Needs | CIHL." [Ifw.cihl.ca](#), 29 Feb. 2024, [www.cihl.ca/en/the-state-of-the-health-workforce-in-canada-2022/keeping-pace-with-changing-population-needs](#)
"Rural Canada Statistics." [Ifw.statcan.gc.ca](#), [www.statcan.gc.ca/en/subjects-start/society-and-community/rural-canada](#)
[Ifw.cfp.ca](#), 2024, [www.cfp.ca/content/70/9/597](#)



What does life in rural SK represent to AI?

Life in Rural Saskatchewan

**Wide Open Spaces**
Endless prairie views & stunning sunsets

**Night Skies**
Milky Way & northern lights visible

**Community**
Friendly neighbors & strong connections

**Affordable Living**
Fishing, hiking, snowmobiling & more





**Peace & Quiet**
No traffic, less noise, slower pace

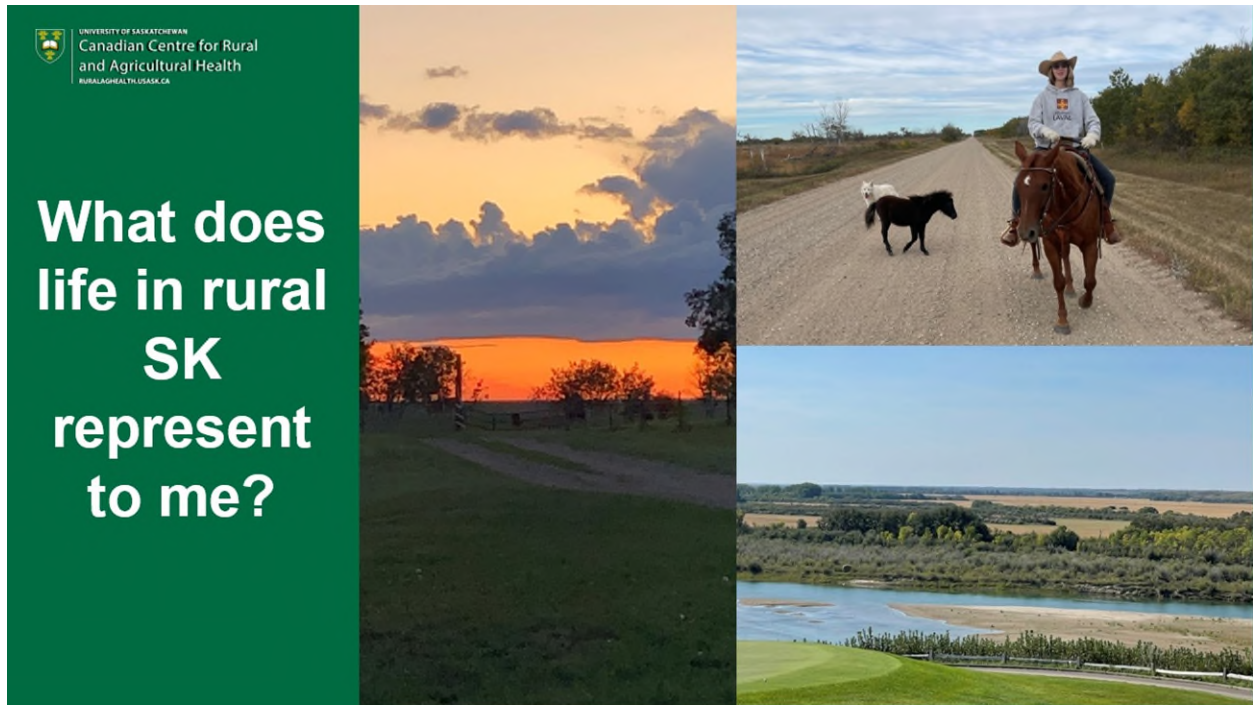
**Self-Sufficiency**
Gardening, farming, independence

**Four Seasons**
True Canadian seasonal experience

**Balanced Life**
Less stress, more time for what matters

**Room to Grow**

Version 1.0



**What does
life in rural
SK
represent
to me?**

Land Acknowledgement

I would like to acknowledge that we are on Treaty 6 Territory and the traditional lands of the Nêhiyawak, Saulteaux, and the Métis Nation.

Treaty 6 represents more than an agreement of the past—it is a living commitment that calls us to build respectful relationships and to honour Indigenous rights, histories, and voices.

As we gather today, we recognize our shared responsibility to advance reconciliation through understanding, respect, and concrete actions.



Wi-fi/Internet Information

Network:
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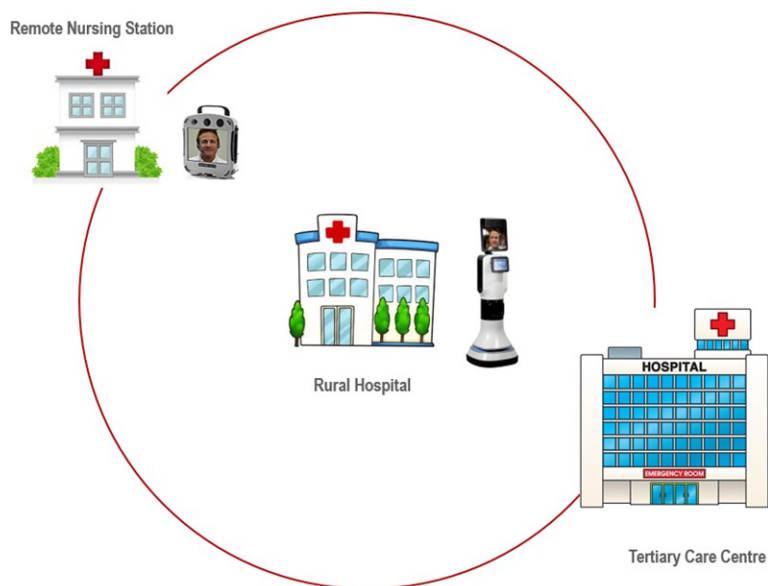
BE WHAT THE WORLD NEEDS



Welcome!
ROOTED IN COMMUNITY:
Conversations and Connections
for Strengthening Rural Health
and Safety

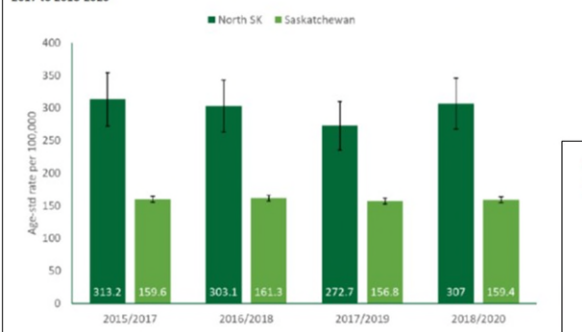


2. *Dr. Ivar Mendez*

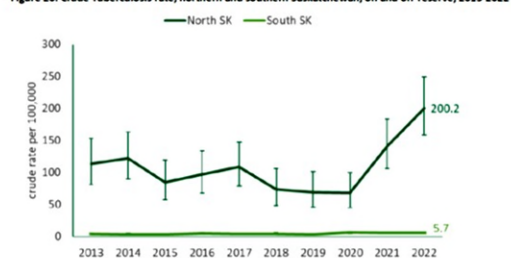


POPULATION HEALTH UNIT
Northern Saskatchewan

Figure 21: Age-std preventable mortality, 3 year average, northern Saskatchewan and Saskatchewan, 2015-2017 to 2018-2020



Tuberculosis
Figure 20: Crude Tuberculosis rate, northern and southern Saskatchewan, on and off-reserve, 2013-2022



Region	2023 to 2024
Atlantic	\$18,294
Quebec	\$28,596
Ontario	\$166,036
Manitoba	\$261,374
Saskatchewan	\$115,915
Alberta	\$69,508
North	\$129,898
Total	\$789,621

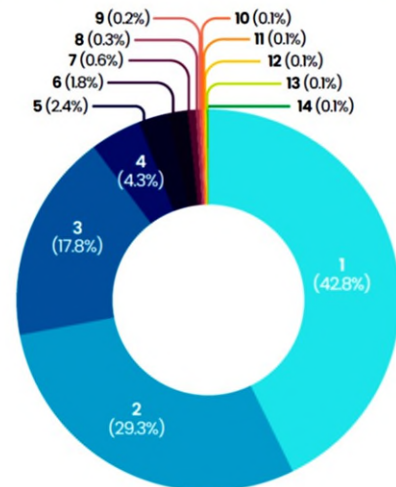


Indigenous Population in Saskatchewan: **187, 885**

Total expenditures (\$ 000's)

WHAT TYPES OF SERVICES ARE BEING DISRUPTED?

- 1 Emergency stabilization services
- 2 Basic radiography and laboratory services
- 3 Not specified
- 4 Obstetrical services
- 5 Medical services
- 6 Fluoroscopy and computerized tomography diagnostic services
- 7 Observation and assessment services
- 8 Surgical services
- 9 Intensive care services
- 10 General surgery
- 11 Internal medicine
- 12 Nursing care
- 13 Obstetrics and gynaecology
- 14 Personal care



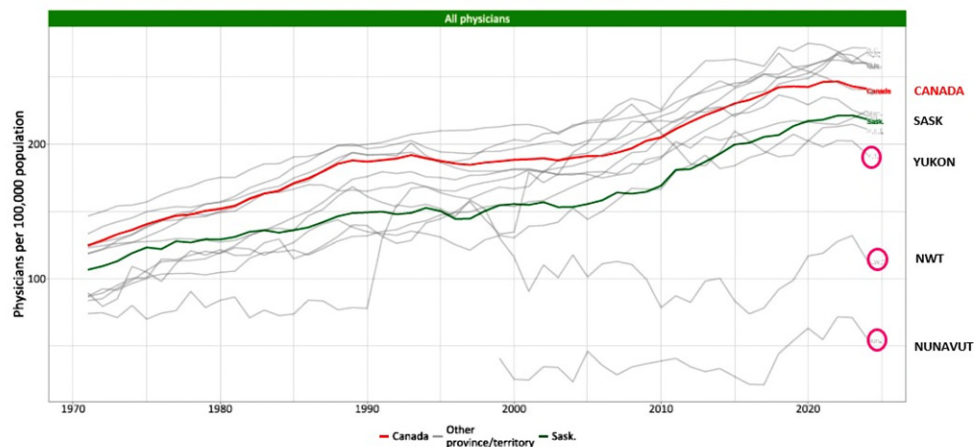
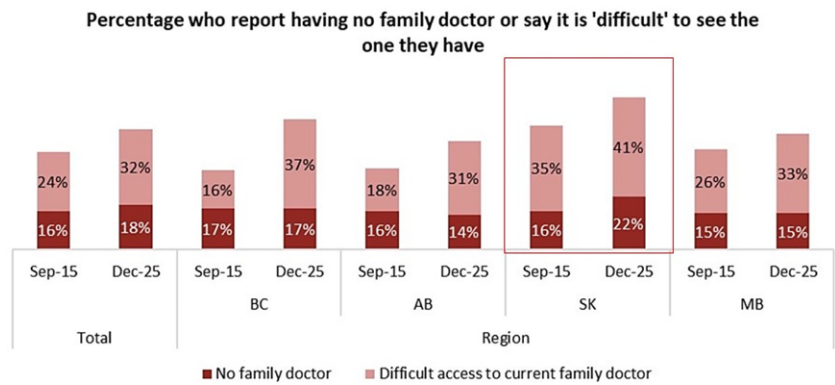
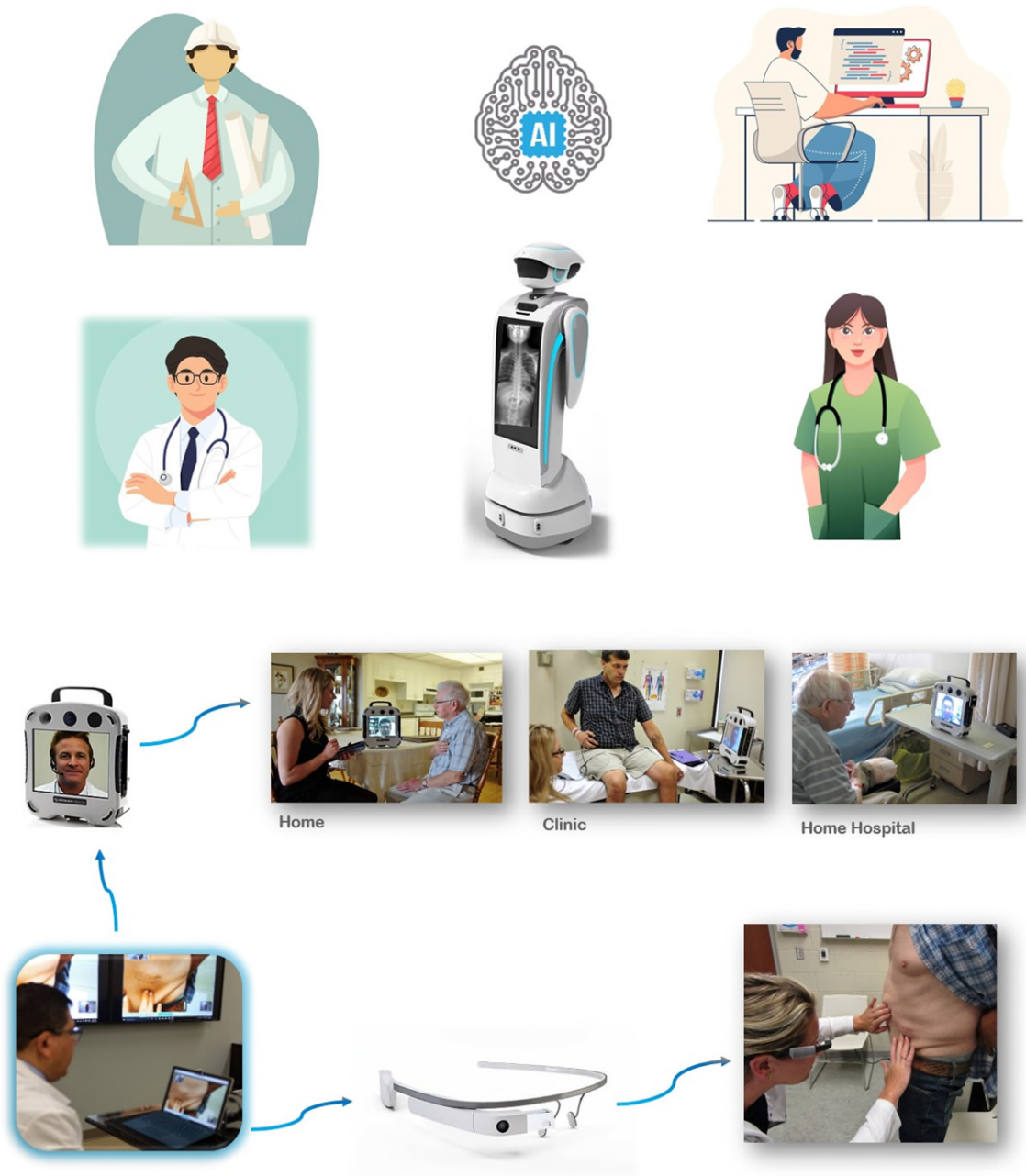


Figure 1: Physician workforce by province/territory, 1971 to 2024.



ACCESS TO HEALTH CARE







VIRTUAL HEALTH CARE WORKFORCE TRAINING



Saskatchewan Indian Institute of Technologies

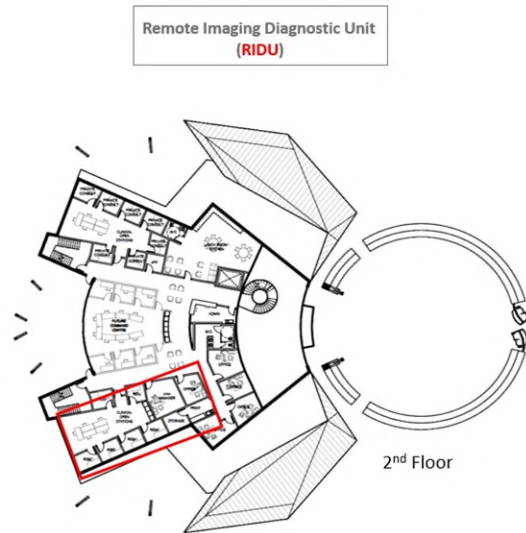
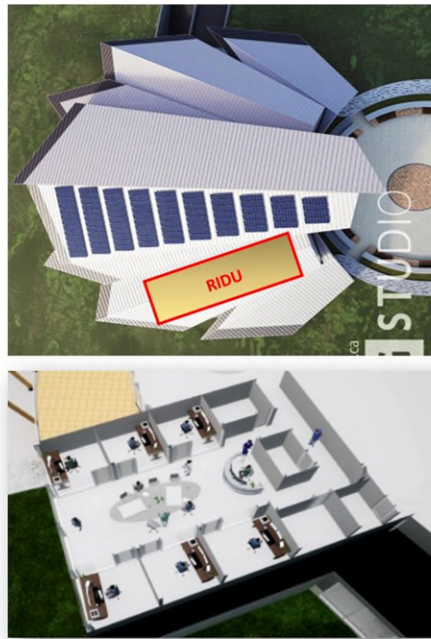


Virtual Health
Care Technologist

□ PERFECTLY POSITIONED FOR VIRTUAL HEALTH TRAINING,
ALREADY OFFERING:

- Register Nurse Program
- Indigenous Practical Nursing
- Health Care Aid Program
- Mental Health & Wellness
- Paramedic Program
- Radiology Technologists
- Laboratory Technologists
- IT Technologist
- Robotic Technologists







Command Center

- Case management
- Resource management
- Statistics and analytics
- Notification system
- Compliance and auditing







La Loche



Stony Rapids



Saskatoon

97 %
Patient Satisfaction

Adams, et al, International Journal of Circumpolar Health, 2021

**Sonographer-site
(Central Site)**



TELEROBOTIC ULTRASOUND



**Patient-site
(Remote Clinic)**



Adams, et al, Canadian Association of Radiologist Journal, 2017

Disparities In Obstetrical Ultrasound Utilization In Saskatchewan



2014-2018 Pregnancies/2nd trimester U/S in Saskatchewan

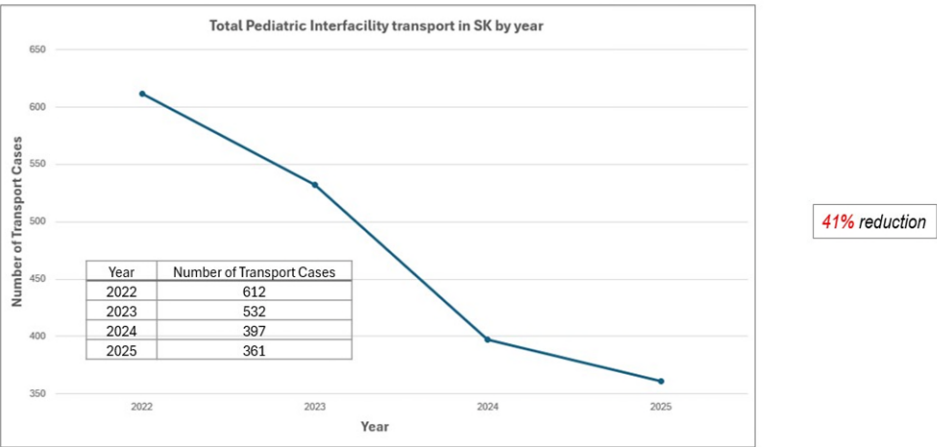
N= 80,536

Patients Less Likely To Have A Second Trimester Obstetrical Ultrasound:

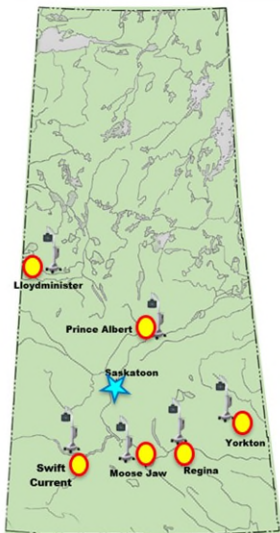
- **Status First Nations individuals**
50% less likely than non-status First Nations
- **Living in a rural area**
30% less likely than those living in an urban area
- **Living in a more remote area (higher index of remoteness)**

Women in the most remote areas were 65% less likely than those living in an urban area

Adams SJ et al. *Acad Radiol*, 2021



ACUTE PEDIATRIC INTERFACILITY TRANSPORT IN SASKATCHEWAN



COST EFFECTIVENESS

Cost

- RP-7i remote presence robot: ~\$70,000 USD
- 1 specialized inter-facility transport: ~\$10,000 USD

Transports Prevented

- 24/38 over 13-month study period

Estimated Savings

- Transport: \$240,000 (24 x \$10,000/transport)
- Hospital bed: \$120,000 (24 x \$1,000/day x 5 days)
- Total: \$360,000

Additional Savings

- Family: travel, accommodations, meals, childcare
- Specialized pediatric transport team availability

REMOTE ACUTE PEDIATRIC CARE

	Robot Intervention	Control	p value
Transported	14/38 (37%)	31/31 (100%)	< 0.05
Mean length of stay non-transported (days)	0	4.9	< 0.001
Regionalized	6/14 (42.8%)	0/31 (0%)	< 0.05
Mean Ped-CTAS score	2.6 (1-4)	2.3 (1-4)	0.89

CTAS= Canadian Triage Assessment Score

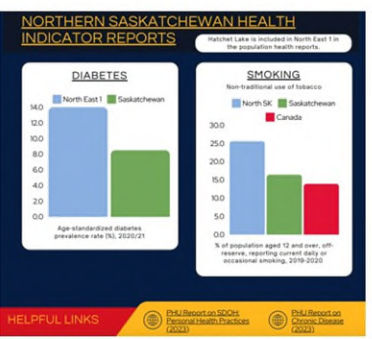
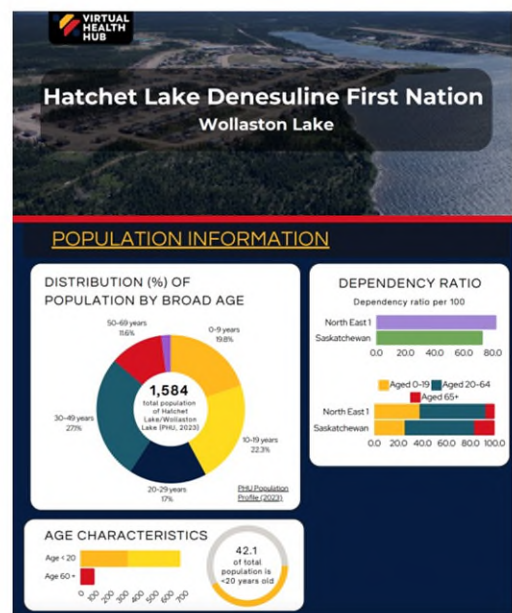
Holt et al., Telemedicine and e Health, 2018

REMOTE ACUTE PEDIATRIC CARE

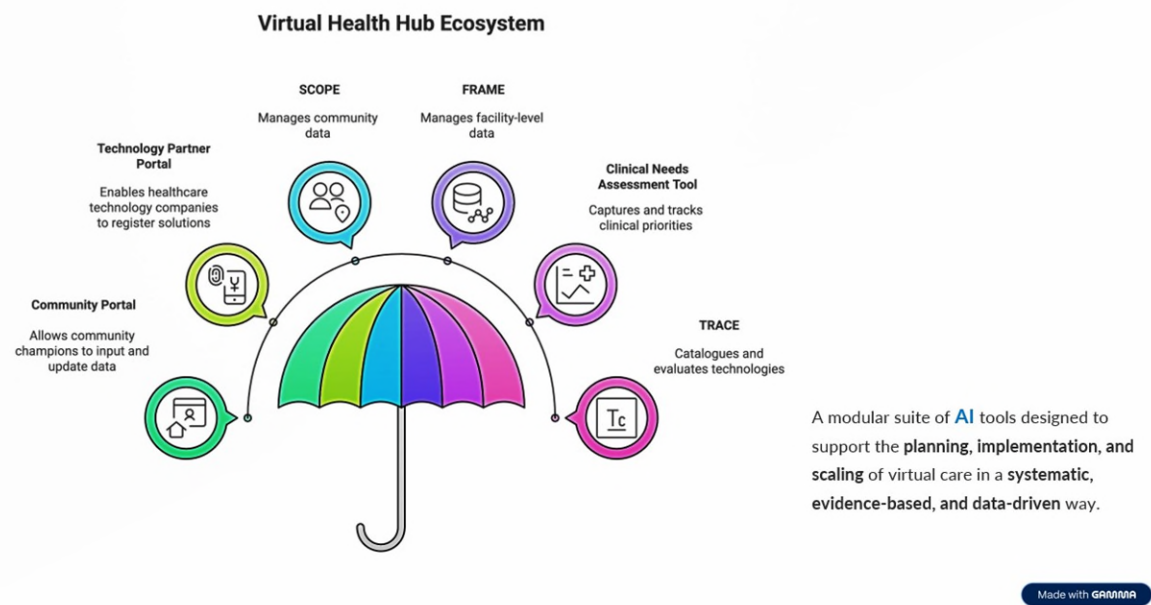


Holt et al., Telemedicine and e Health, 2018

TARGETED DIGITAL SOLUTIONS



Deason et al., Mayo Clinic Proceedings, Digital Health, 2026



Khan et al., Canadian Communicable Disease Report, 2017

3. Kendra Ulmer and Karen Marcinkiw



Thank You!



AGRICULTURAL HEALTH AND SAFETY NETWORK

 aghealthandsafety@usask.ca

 aghealth.usask.ca

 (306) 966 - 6644

Social Media

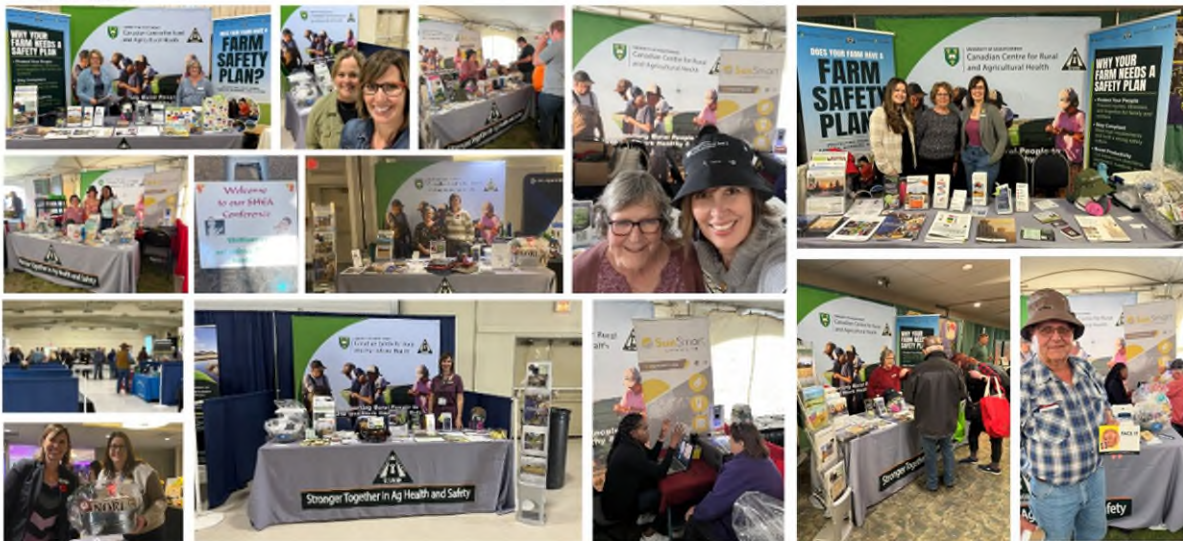
 AgricultureHealthSafetyNetwork

 @SaskAgSafety

STRONGER TOGETHER IN AGRICULTURAL HEALTH AND SAFETY



Trade Show Outreach



Agricultural Health and Safety Network - aghealth.usask.ca



Newsletter & Resources

To the Farm Gate- 25,000+ and Online



Agricultural Health and Safety Network
aghealth.usask.ca



Discovery Days

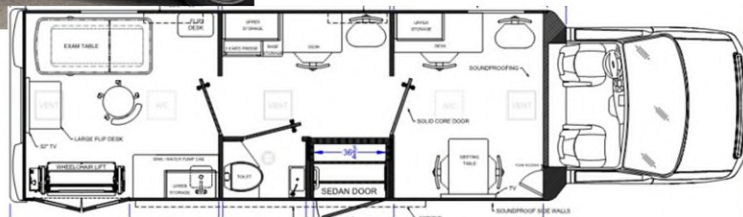
Farm safety education for kids



Mobile Unit



Agricultural Health and Safety Network
aghealth.usask.ca

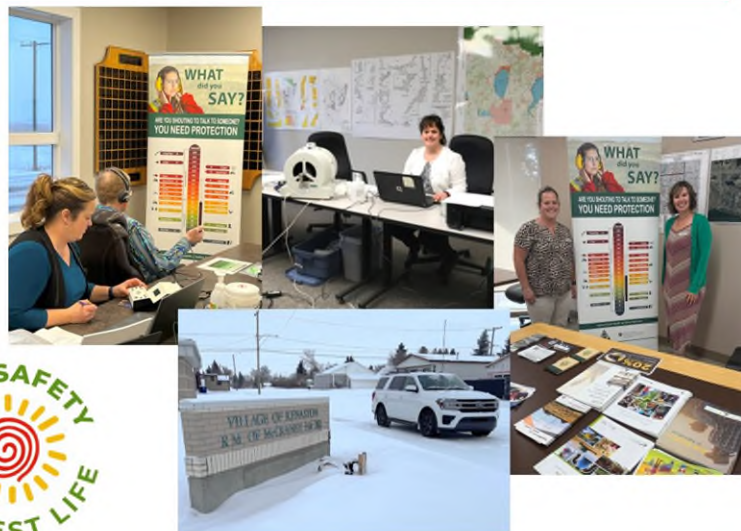


Agricultural Health and Safety Network

STRONGER TOGETHER IN AGRICULTURAL HEALTH AND SAFETY

One2One Clinics

- Individual appointments
- 30-minute individual health promotion & injury prevention assessment
- Performed by a Registered Nurse (Ag Occ Health)
- Test lung health or hearing health
- Health education & Referrals





STRONGER TOGETHER IN AGRICULTURAL HEALTH AND SAFETY



Rural Municipality Membership



SOWING THE SEEDS OF
FARMER & RANCHER
HEALTH AND SAFETY



Mission

To improve the health and safety of the farm through education, service and evaluation research

Goal

To reduce injury and illness related to agriculture production

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Innovation In Rural Health & Safety:

The Agricultural Health and Safety Network (AHSN)

June 15th, 2026 Kendra Ulmer, RN & Karen Marcinkiw, RN



4. *Dr. Michelle Pavloff and Alecia Weinheimer*



1



SaskAgBuddy – Turning care into action.

SaskAgBuddy, simple but powerful well-being option for farmers.

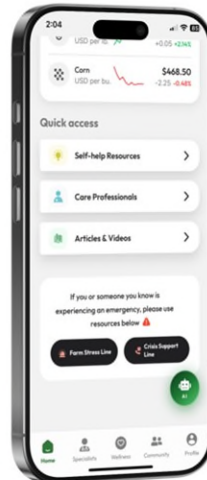
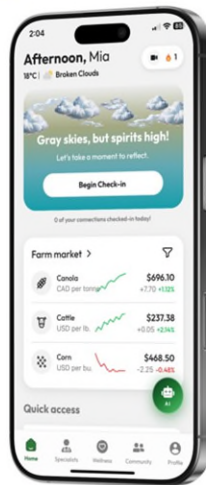
Thank-you.





SASKAGBUDDY

Smart & Supportive Features



Enhancing everyday farm life with other helpful tools:

- **Farm Market Updates** (informational only)
- **Today's Weather Snapshot** for quick planning
- **Emergency Support Access** – Direct call to the Farm Stress Line or a general crisis support line
- **Engaging & Friendly Notifications** to encourage healthy habits

→ These features make the app not only supportive but also practical, relevant, and enjoyable to use daily.



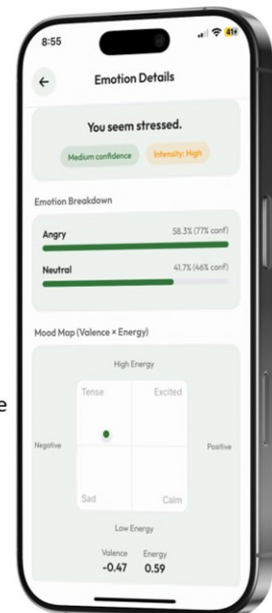
AI Facial Insights

Understand emotions instantly through **AI-powered video analysis**

- Scans facial expressions to **detect emotional state**
- Provides **real-time mental health insights**
- Offers simple, **personalized support recommendations**



→ This feature makes it easier for farmers to access reliable information anytime, helping them make informed decisions in their day-to-day work.



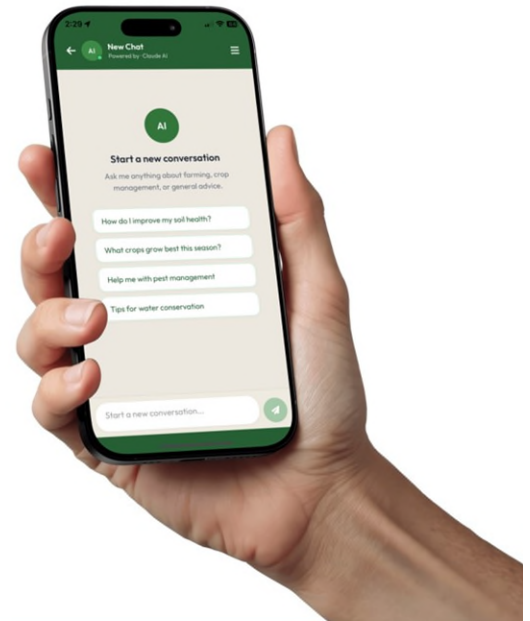


AI Chat Support

Accessible support anytime:

- AI-powered chat trained with **farming-related knowledge and content**
- **Provides guidance** on agriculture topics, daily farm challenges, and operations
- Helps users quickly find **relevant information** and practical advice
- **Available 24/7** for quick and convenient support

→ This feature makes access easy, on your terms, anytime, helping when regular connections may not be available.



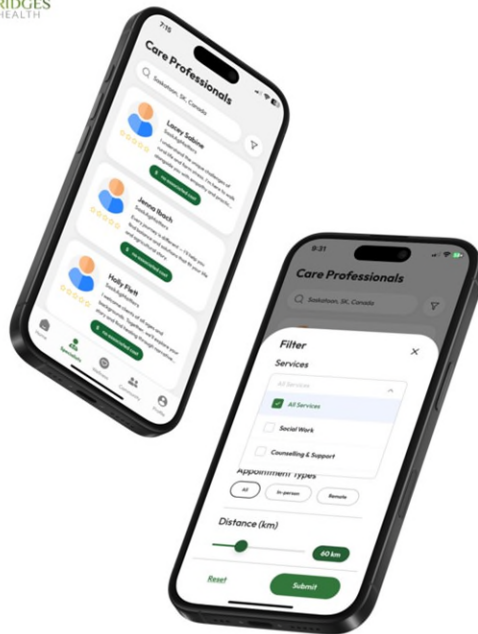
Peer Support

Connections Foster Relatedness

Building a network of connections within a like-minded community:

- **Add friends** and build a support network
- **Chat** and check in with peers
- **Share progress** and encouragement





Specialist Discovery

Users can easily connect with trusted mental health professionals:

- Access to **certified specialists** from **SaskAgMatters**
- Options for **in-person** or **remote** consultations
- Clear profiles to help users find the right fit

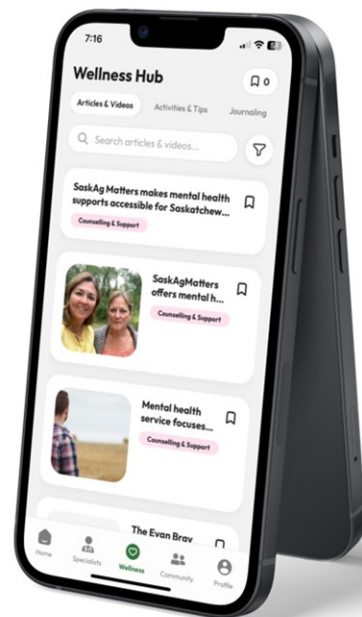
→ This feature removes barriers and makes professional support **more approachable and convenient** for farming communities.

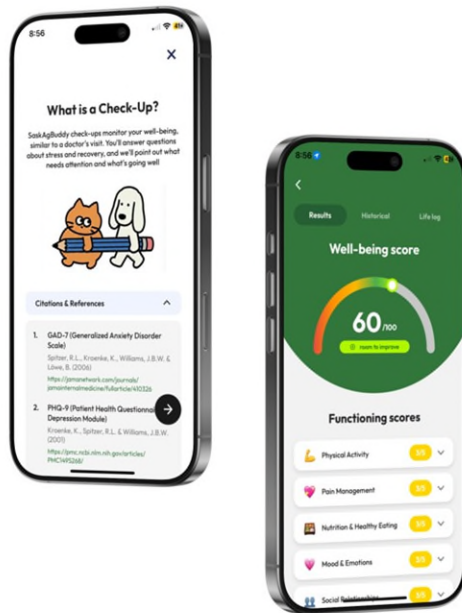


Wellness Resources

SaskAgBuddy provides a rich library of practical well-being content:

- Articles and videos sourced from **SaskAgMatters**
- Farming-specific stress management strategies
- **Guided activities** to improve daily well-being
- **Simple, actionable tips** tailored for busy farming schedules





Check-in Questionnaire

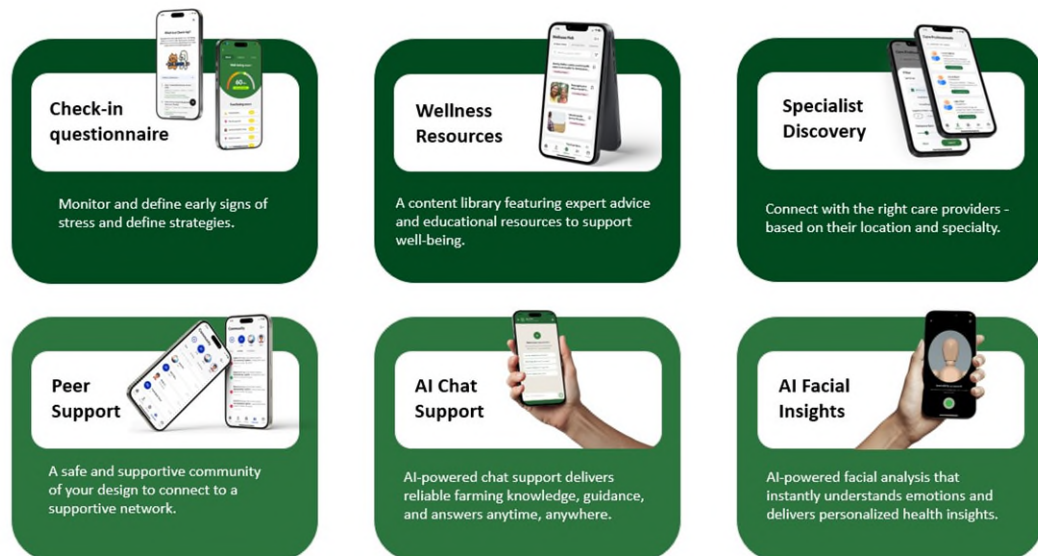
Questions aim to assess and identify risks using clinically validated tools such as the **PHQ-9** to assess symptoms consistent with depression, and **GAD-7** to measure symptoms consistent with anxiety.

By completing the questionnaire and regular check-ins, results provide insights and recommendations.

→ The **patterns identified through the assessments** aim to lead to early action and seeking support when needed.



Key features





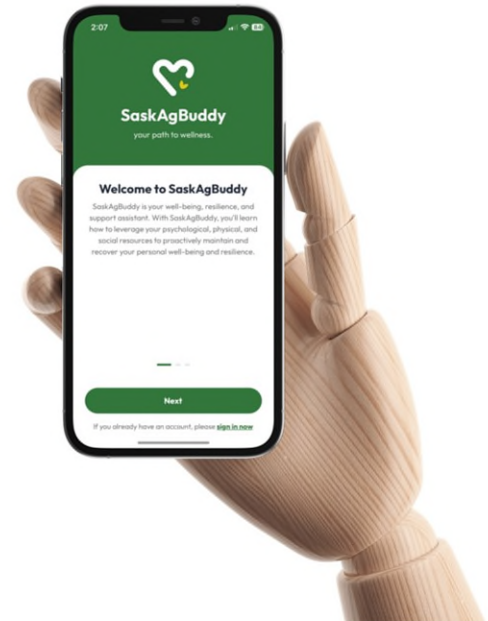
What is SaskAgBuddy?

SaskAgBuddy is a mental health and well-being app built specifically for **farming communities**.

Created in partnership with **SaskAgMatters**, the app gives farmers, agricultural workers, and farm families access to regular well-being check-ins, practical stress-management tools, trusted resources, and pathways to professional support — all from the palm of their hand.

Designed for the realities of agricultural life, SaskAgBuddy helps users build resilience, manage daily stress, and access support earlier, especially during high-pressure seasons.

For farm owners, co-ops, and agricultural organizations, it offers a practical way to promote healthier, more connected, and more productive farming communities.



SaskAgBuddy

Health and Wellness Resources for
the Farming Community.





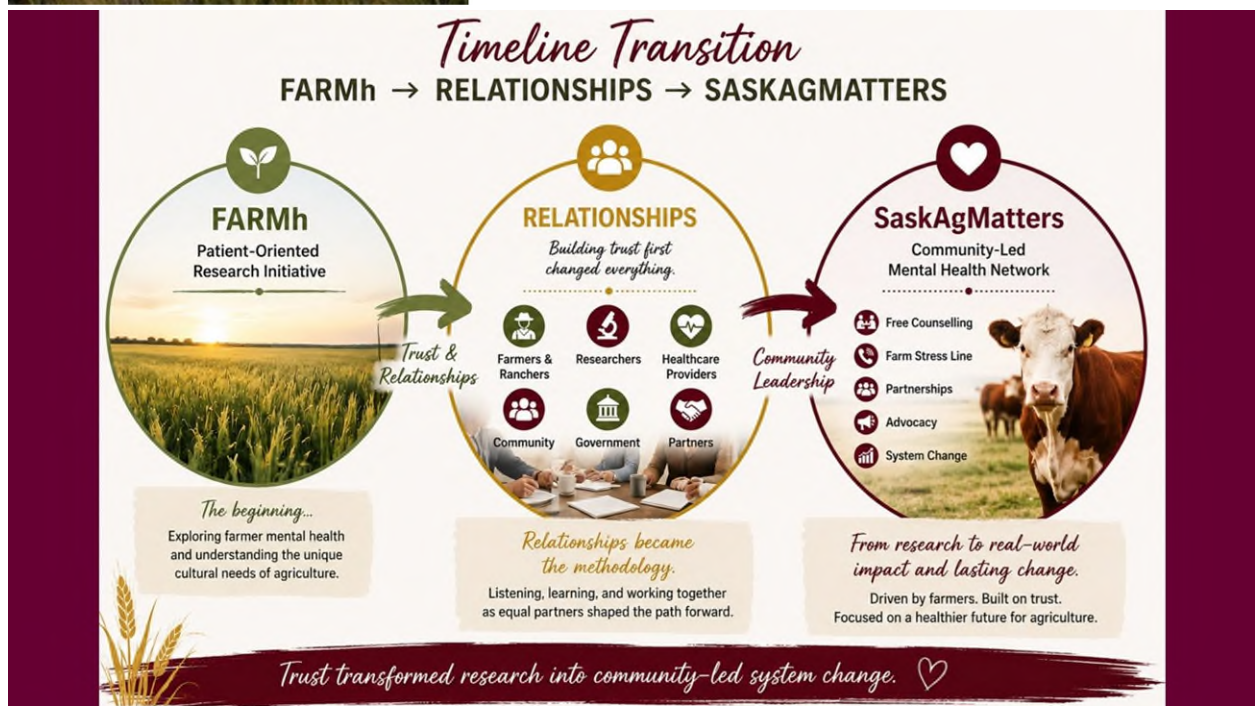
NEXT STEPS...

We are a proud semi-finalist of the Producer Mental Wellbeing Initiative, funded through Agriculture and Agri-Food Canada.



Agriculture and
Agri-Food Canada

Agriculture et
Agroalimentaire Canada



From POR to Government Support

Saskatchewan

EN



New Farm Stress Line Partnership Delivers Enhanced Mental Health Services for the Agriculture Sector

Released on March 31, 2026

As of April 1, SaskAgMatters Mental Health Network Inc. will manage the Farm Stress Line as part of a coordinated mental health support system for Saskatchewan producers, their family members and their employees. The new partnership offers 24/7 confidential access to crisis line counsellors trained in agriculture, as well as follow-up counselling sessions with Saskatchewan-based registered mental health professionals with backgrounds in agriculture.

KNOWLEDGE TRANSLATION BECAME ACTION

Free counselling

Hoodies

Comedy show

Cookbooks

Media
partnerships

Tradeshows

Community events

Advocacy



Patient Family Partners as Leaders



From Research Project to Community Network



The Community Told Us This Work Mattered



- Family cattle operation donated a heifer
- Auction held online during COVID
- Mental health story shared publicly
- Donations continued to arrive afterward

The Saskatchewan Farmer and Rancher Mental Health (FARMh) Initiative

Patient-oriented research
approach

Producers involved from the
beginning

Focus on understanding lived
experiences and barriers

Where SaskAgMatters Mental Health
Network Inc. Began





ACKNOWLEDGMENTS



5. *Dr. Julie Kosteniuk*

How we support RaDAR Primary Care Memory Clinics

- **We work with new PHC teams to adapt clinic model to their practice**
 - **RaDAR research assistant** supports and collects data for research projects
- **Provide resources** (e.g., team laptop, conference phone, MOCA training)
- **Provide decision support** (PC-DATA EMR templates and RaDAR handbook)
- **Provide dementia-related continuing education**
- **Regular workgroup meetings** in first 6-12 months of clinic operation to support and debrief
- **Quarterly check-in meetings** with teams' facilitators and managers
- **Quarterly regional Steering Group meetings** with SHA managers (PHC, LTC, Mental Health)
- **1-1 meetings** with individuals as needed
- **Fund travel** to shadow nearby memory clinics and specialist RRMC
- **Knowledge mobilization** with newsletters, reports, Annual Summit

Interprofessional Teams

Interprofessional Team – composition varies by Team

- Family Physician or Nurse Practitioner
- Home Care Nurse
- Social Worker
- Occupational Therapist
- Physical Therapist
- Dietitian
- Pharmacist
- Alzheimer Society First Link Coordinator
- PHC Facilitator
- Office staff

Care Management

- Clinic day assessments
- Shared EMR flowsheets and decisions
- Team conference with patient and family
- Shared care plan

Education/support for Patient & Family

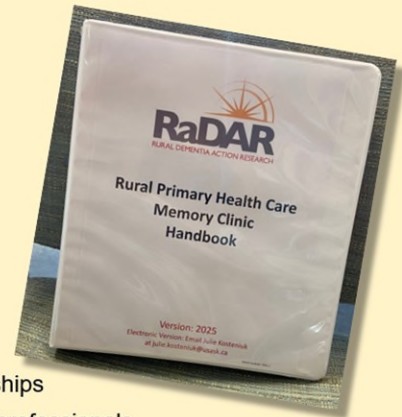
- Alzheimer Society services
- Community services



Kipling Primary Health Care Memory Clinic
 narration by Jean Daku, Nurse Practitioner
 Video by Honey Cut Studios

RaDAR Primary Care Memory Clinics

- Embedded in **rural primary health care teams**
 - 1-day clinic every 1-2 months in each community
 - 2 new patients and care partners
 - Care partners involved
- Purpose
 - Team-based diagnosis and management
 - Offer wrap-around services and supports, establish relationships
 - Ensure patients and families are known to local health care professionals



Lead: Jean Daku, NP
KIPUNG (pop. 1,140)



Lead: Dr. Jared Oberkirsch
WEYBURN (pop. 11,150)



Lead: Toni Giraudier, NP
BENGOUGH (pop. 332)



Lead: Laura Wood, NP
CARLYLE (pop. 1,500)



Lead: Lois Coffey, NP
LAMPMAN (pop. 735)



Lead: Dr. Mandi Nel
ESTERHAZY (pop. 2,500)



Lead: Jean Daku, NP
FILLMORE – HYBRID CLINIC (pop. 300)



Lead: Don Wlock, NP
CANORA (pop. 2,090)



Lead: Raegan Rasmussen, NP
ASSINIBOIA (pop. 2,300)

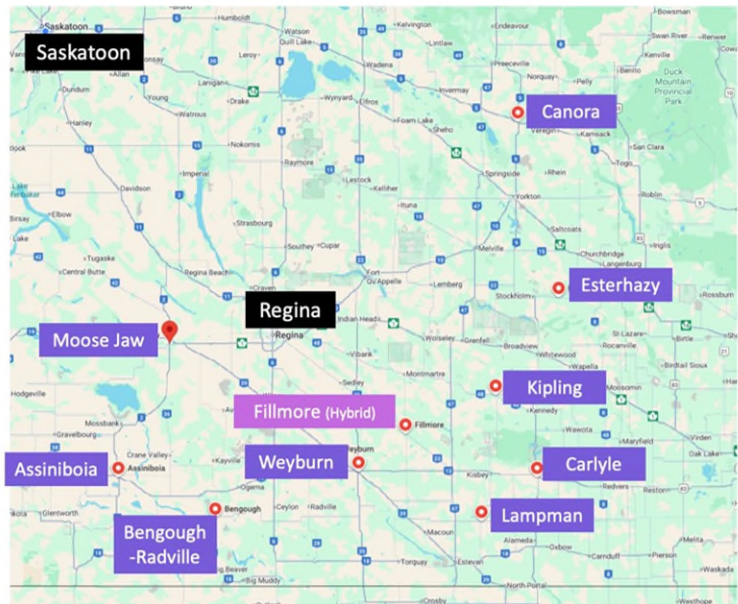


Lead: Kimberley Higgins, CCFP (COE)
MOOSE JAW (pop. 37,400)

Local RaDAR Team members
supporting memory clinics



RaDAR Primary Care Memory Clinics



Specialist Rural & Remote Memory Clinic

MANDATE: Interprofessional specialist assessment, diagnosis, and management of **complex, atypical dementias** for individuals living in rural Saskatchewan

- Established 2004
- Funded by SK government
- Demand is increasing
 - In Fall 2026, clinic will expand from 1 day/wk to 3 days/wk
 - 1 day/wk will be remote, 2 days/wk in-person
- Interprofessional clinical interview with patient, family, and team
 - Neurology
 - Neuropsychology
 - Nursing
 - Physical Therapy
 - Brain Imaging
- End of day team conference after individual assessments
- Follow-up by telehealth videoconferencing and in-person



RaDAR: Rural Dementia Action Research Team

RaDAR aims to improve care for people living with dementia in rural communities

Core USask Faculty

- Megan O'Connell, Psychology
- Allison Cammer, Nutrition
- Andrew Kirk, Neurology
- Julie Kosteniuk, Medicine



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College of Medicine
MEDICINE.USASK.CA

My position is held at the University of Saskatchewan, which is situated on Treaty 6 territory, the traditional territory of Cree Peoples, and on the homeland of the Métis Nation





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Canadian Centre for Rural
and Agricultural Health
CCHSA-CCSRHA.USASK.CA



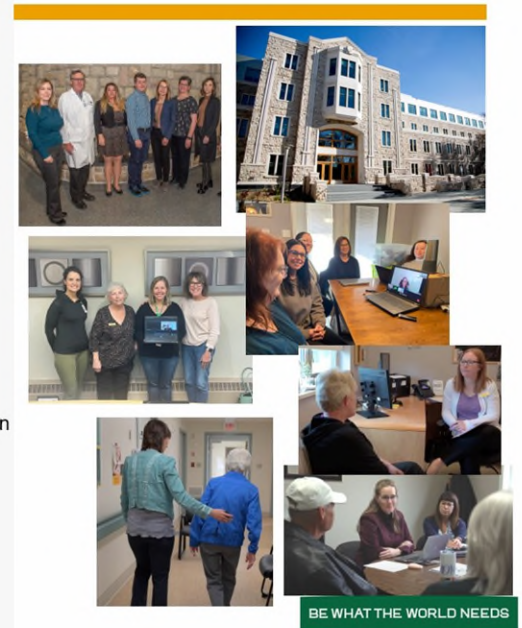
RaDAR Specialist and Primary Care Memory Clinics

Julie Kosteniuk, PhD

Department of Medicine
Canadian Centre for Rural and Agricultural Health, University of Saskatchewan

Rooted in Community Gathering

June 15, 2026



Thank you!



RaDAR website: ruraldementiacare.usask.ca

Email: julie.kosteniuk@usask.ca

Annual Rural Dementia Summit

- ▶ **By invitation, registration is free**
- ▶ Held in person until 2020, now held virtually
- ▶ Started 2008 to guide RaDAR research program
- ▶ Brings together people who want to improve care
- ▶ We would like to involve more people with lived experience

November 19th, 2026
8 am to 1 pm

Bilokreli
Family Fund



Home-based Virtual Rural Memory Clinic Model

Team 1 (Pop. 2,400)

- Team: Nurse practitioner, 2 home care nurses, dietitian, Alzheimer Society First Link Coordinator
- Held 2 test sessions and 1 mock patient appointment
- Appointment process involves home care nurses in the home and other team members participating virtually
- Next steps: Hold series of 6 patient appointments, collect feedback from team, patients, and caregivers



Assiniboia Home-Based Team

Team 2 (Pop. 300)

- Team: Nurse practitioner, home care nurse, primary health care facilitator, Alzheimer Society First Link Coordinator
- Next steps: Hold test sessions and mock patient appointment

Home-based Virtual Memory Clinic Model

Home-Based = Home care nurses and RaDAR research assistant travel to patient's home, other team members join virtually

Phase 1 (6 months): Initial adaptation

Phase 2 (1 year): Iterative adaptation, implementation, and evaluation

Phase 3 (2.5 years): Patient, caregiver, and team experiences and outcomes



Assiniboia Home-Based Team

Funded by CIHR and Alzheimer Society of Canada Research Program

Alzheimer Society
CANADA

CIHR IRSC
Canadian Institutes of Health Research
Instituts de recherche en santé Canada

Hybrid Memory Clinic Model

Iterative Adaptation and Evaluation

- 3 Hybrid memory clinics (October 2025 to April 2026)
- **Hybrid Model**
 - Pre-assessment*
 - Nurse Practitioner reviews patient information and orders tests
 - OT assesses patient in-person
 - Clinic Day*
 - Team meets OT virtually
 - Team assesses patient and consults family in-person
 - Team case conference with patient and family in-person, with OT joining virtually
- **Initial Findings**
 - Good feasibility (e.g., leadership support, practicality)
 - Good team acceptability (costs and gains, perceived effectiveness)
 - Potential sustainability



Fillmore Hybrid Team

Hybrid Memory Clinic Model

Hybrid = Occupational therapist participates virtually on clinic day and completes in-person assessment before clinic day

Phase 1 (6 months): Initial adaptation with one memory clinic team

Phase 2 (6 months): Continual evaluation and adaptation



Fillmore Hybrid Team

Funded by Saskatchewan Health Research Foundation Establishment Grant, 2024-2027



Virtual Models

Care Partner and Patient Experiences



Heather Alford
PhD Student



Amanda Dupperon
PhD Candidate

Methods and Participants

- Qualitative study across memory clinic teams in 7 rural communities (Sept 2024 to Feb 2025)
- 18 semi-structured telephone interviews (2 patients and 16 care partners)
- Participants interviewed twice

