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Primary Health Care
Transition Fund


Chronic Disease Prevention and Management

March 2007

Synthesis Series
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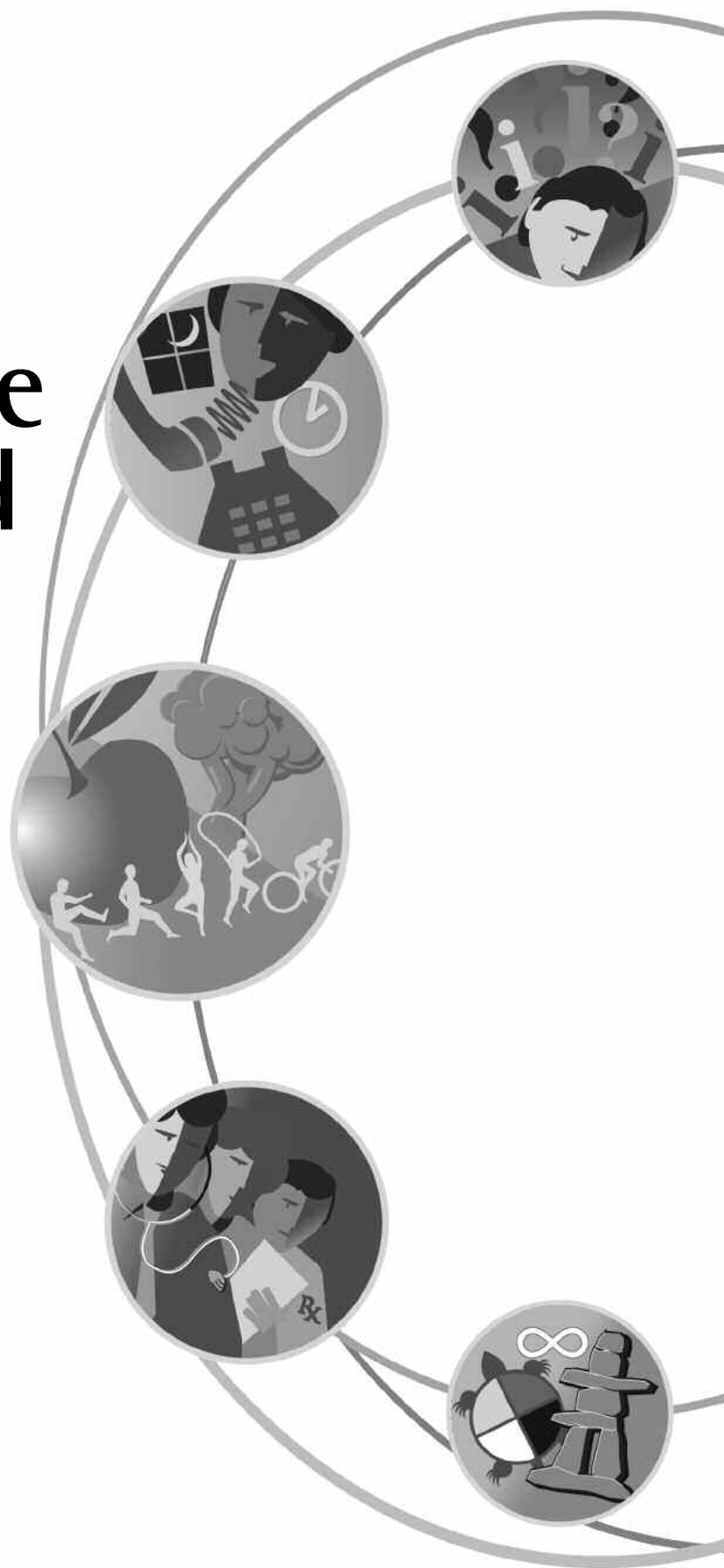
Glass Half Empty, Glass Half Full

March 2007

Peter Sargious, MD, MPH, FRCPC

Synthesis Series
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Canada



This report is one in a series of five syntheses of PHCTF initiative results addressing the following topics: *Chronic Disease Prevention and Management*, *Collaborative Care*, *Evaluation and Evidence* and *Information Management and Technology*. The fifth report is an overall analysis on the role and impact of the PHCTF in primary health care renewal entitled *Laying the Groundwork for Culture Change: The Legacy of the Primary Health Care Transition Fund*. All are available electronically on the PHCTF website (**www.healthcanada.gc.ca/phctf**), which also contains information on individual PHCTF initiatives.



Preface

When Canadians need health care, most often they turn to primary health care (PHC) services.¹ PHC is the first point of contact with the health care system, and traditionally has focused on the role of family physicians. In the past, Canadians visited their family physicians when in need of health care and their physician either provided services directly or, if more specialized care was required, coordinated patients' needs with specialists, hospitalized-based services, or other parts of the health care system.

This episodic, responsive model has served Canadians well, particularly in the context of a relatively young population and prevalence of acute care needs. However, in recent years, several circumstances have given rise to concerns about the ability of this model to meet the changing needs of Canadians. The population is aging, rates of chronic disease are rising, and the health care system needs to respond to these changing circumstances.

For example, prevention and management of chronic disease to avoid or delay costly complications requires a broad skill set, a proactive approach to care delivery, and a patient-centred approach (including active involvement of the patient in his or her own care). Faced with growing numbers of patients with these complex needs and shortages of family physicians in some areas, many family physicians have expressed concerns regarding their working conditions, including long hours and impacts on their own health and family life. These circumstances point to the advantages of a team-based approach to care, with various health care professionals working together to help the patient maintain and improve his or her health. For example, a nurse practitioner might undertake routine monitoring of a diabetic patient, with advice from a dietitian, and involve the physician when more specialized expertise is required.

There is a growing consensus that PHC professionals working as partners in this team approach will result in better health outcomes, improved access to services, improved use of resources, and greater satisfaction for both patients and providers.² Such teams are better positioned to focus on health promotion and improve the management of chronic diseases. A team approach can improve access to after-hours services, reducing the need for emergency room visits. Information technology can support communication among providers, as well as provide support for quality improvement programs (e.g., clinical practice guidelines for chronic disease management). In these ways, all aspects of personal care are brought together in a coordinated way.

Accordingly, in September 2000, Canada's First Ministers agreed that improvements to PHC were crucial to the modernization of the health care system. As part of their 2000 Health Accord, they agreed to work together, and in concert with health professionals, to improve PHC and its linkages with other parts of the health care system.

The Primary Health Care Transition Fund

To support this commitment, the federal government announced the creation of the Primary Health Care Transition Fund (PHCTF). From 2000 to 2006, the PHCTF provided \$800 million to provinces, territories and health care system stakeholders, to accelerate the development and implementation of new models of PHC delivery. Specifically, it provided support for the transitional costs of making the shift to new models of PHC delivery (e.g., new curricula for team-based training, or information systems to support team-based care).³ Although the PHCTF itself was time-limited, the changes it supported were intended to have a lasting impact on the health care system.

¹ Any publication that addresses "primary care" or "primary health care" faces definitional issues. While the two terms are sometimes used interchangeably, some authors draw a distinction between them. However, there is little consensus on this distinction. Generally, the term "primary care" is more limited, and focuses on traditional physician-based medical services, while "primary health care" is broader, including primary care but also extending to other health care providers, and sometimes beyond the health care sector to include other determinants of health such as housing or education. This footnote is intended only to draw attention to the fact of these definitional issues, and not to attempt to resolve them. The issue is addressed within this report to the extent that it was considered relevant by its author.

² As PHC services are responsive to the needs of the communities that they serve, the composition of teams will vary; there is no "one-size-fits-all" model.

³ The PHCTF was preceded by the federal Health Transition Fund (1997–2001), but was distinct from it in several respects. While the Health Transition Fund had four priority areas (including PHC), the PHCTF was exclusively focused on PHC. The Health Transition Fund's mandate was to fund pilot and evaluation projects to generate evidence regarding health care system reform, while the PHCTF was intended to support substantive, sustainable change.

While the PHCTF was a federally funded program, all provincial/territorial governments agreed to its objectives:

- increase the proportion of the population with access to PHC organizations which are accountable for the planned provision of comprehensive services to a defined population;
- increase the emphasis on health promotion, disease and injury prevention, and chronic disease management;
- expand 24/7 access to essential services;
- establish multidisciplinary teams, so that the most appropriate care is provided by the most appropriate provider; and
- facilitate coordination with other health services (such as specialists and hospitals).

All initiatives funded under the PHCTF were required to address at least one of these objectives.

To create opportunities at various levels and to encourage a collaborative approach, PHCTF funding was available through five funding envelopes. First and foremost, the *Provincial-Territorial Envelope* provided funding directly to provincial/territorial governments to support their efforts to broaden and accelerate PHC renewal. This envelope accounted for approximately 75 per cent of PHCTF funding, and was allocated primarily on a per capita basis. Initiatives reflected the priorities and unique circumstances of each jurisdiction, as well as PHCTF objectives.

The remaining 25 per cent of funds was divided among four pan-Canadian envelopes which were intended to encourage collaborative approaches and to address unique population needs.

- The *Multi-Jurisdictional Envelope* (5 initiatives) enabled two or more provincial/territorial governments to collaborate on common initiatives.
- The *National Envelope* (37 initiatives) was open to provinces, territories and health care system stakeholders, and supported collaborative initiatives that addressed common barriers and sought to create the necessary conditions on a national level to advance PHC renewal.
- The *Aboriginal Envelope* (10 initiatives) responded to the needs of Aboriginal communities for high-quality, integrated PHC services.
- The *Official Languages Minority Communities Envelope* (3 initiatives) responded to the unique PHC needs of francophone minority communities outside Quebec and the anglophone minority community within Quebec.

The Role of Knowledge Transfer

PHC renewal requires fundamental changes to the organization and delivery of health care services. It is a long-term undertaking that began before the PHCTF was created and will continue beyond it. Knowledge development is a key component of this process, for although PHC renewal has yielded some impressive results to date, its evidence base remains relatively modest. Therefore, dissemination of the results of PHCTF initiatives was a key element of the PHCTF. To this end, PHCTF dissemination included: the preparation of summaries and fact sheets for individual PHCTF initiatives consolidated in one report, commissioning of synthesis reports, development of a comprehensive website, and holding a national conference in February 2007. In addition to dissemination activities organized by Health Canada, individual initiatives were responsible for disseminating their initiative-specific results.

The production of a series of “synthesis reports” was a key element of this dissemination strategy. To maximize the usefulness of this material for target audiences (including health care system stakeholders, health care providers and researchers), and to identify common trends or key “lessons learned” arising from the initiatives, experts in health system issues were engaged to prepare a series of synthesis reports. The topics of the reports reflect prominent areas of focus within the PHCTF initiatives:

- *Collaborative Care* (Vernon Curran, Director, Academic Research and Development, Memorial University);
- *Chronic Disease Prevention and Management* (Peter Sargious, Medical Leader, Chronic Disease Management, Calgary Health Region);
- *Information Management and Technology* (Denis Protti, Professor, University of Victoria); and

- *Evaluation and Evidence* (June Bergman, Assistant Professor, University of Calgary).

In addition, an “overall” report by Sheila Weatherill, President and Chief Executive Officer, Capital Health (Edmonton), entitled *Laying the Groundwork for Culture Change: The Legacy of the Primary Health Care Transition Fund* examines the legacy of the PHCTF as a whole, and identifies trends across the entire body of PHCTF initiatives.

A Legacy for Change

The PHCTF was never intended to “do it all” and, indeed, the years since its creation have seen a continued emphasis on PHC renewal. Numerous health care system studies at national (Romanow, Kirby) and provincial levels have consistently emphasized the critical role of PHC renewal in health care system reform. Two more First Ministers’ Accords (2003 and 2004) have reiterated this emphasis. The Health Council of Canada, which was created following the 2003 Accord to monitor progress in health care renewal, has repeatedly emphasized the critical role of PHC, stating that “Canada’s future health system is dependent upon the modernization of primary health care ...”⁴

Although individual PHCTF initiatives ended in 2006, individually and collectively they have helped to build the foundation for further improvements to PHC in Canada. This report reflects, and is intended to provide insight into, this context of ongoing change and reform.

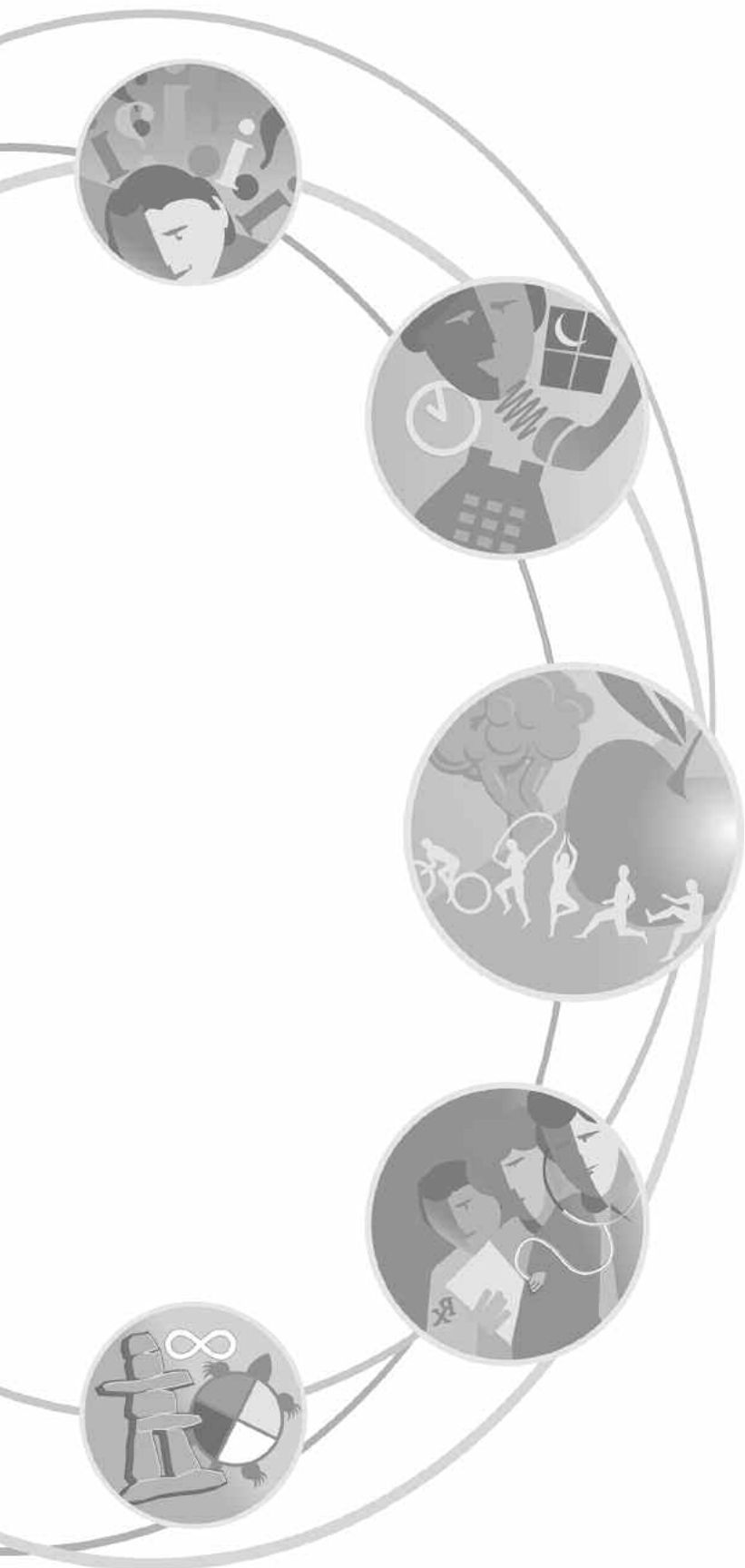
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⁴ Health Council of Canada, *Health Care Renewal in Canada: Accelerating Change*, (January 2005), p. 48.



Executive Summary

Canada, like other developed and developing countries, is facing an epidemic of chronic disease. As a result, concepts of chronic disease prevention (CDP) and chronic disease management (CDM) are emerging as important challenges to individuals, health systems, communities and society as a whole. Yet in spite of their importance, these concepts, and their interrelationship within health system reform and a broader public health agenda, remain poorly understood by Canadians and, arguably, the governments that serve them.

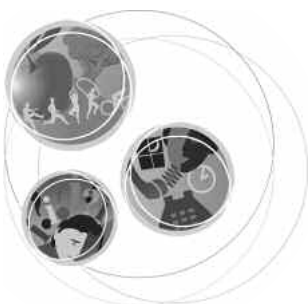
In reviewing the Primary Health Care Transition Fund (PHCTF) initiatives from the perspective of chronic disease prevention and management (CDPM), the following key learnings were identified:

- CDP and CDM are emphasized to different degrees within provincial/territorial health systems—where the emphasis is strong it appears to provide focus for other elements of primary health care, namely collaborative care, information management and technology, and evaluation.
- Efforts at CDP and CDM do not appear to be coordinated.

- Canadian jurisdictions will collaborate to create shared CDPM infrastructure—and benefit from national supports that facilitate and reward this.
- Primary care physician practices were most frequently seen as the focal point around which interdisciplinary CDM should develop.

If one were to regard each of the groups of initiatives (provincial/territorial, national, multi-jurisdictional, official languages minority communities and Aboriginal) as a glass, one could ask, in looking at them, whether in fact the glass is half full or half empty. For each glass, the answer to the question is necessarily both—half empty and half full. All initiatives have contributed in some way to advancing CDPM; all have acknowledged the need to do more.

The experiences related to CDPM in each PHCTF initiative and the findings learned from a collective review have important implications for policy and practice if Canada is to respond strategically to the growing burden of chronic disease. A convergence of thought and strategy between CDM and CDP agendas, and a clearer articulation of their relevance to modern health systems and civil societies, remain ongoing challenges.



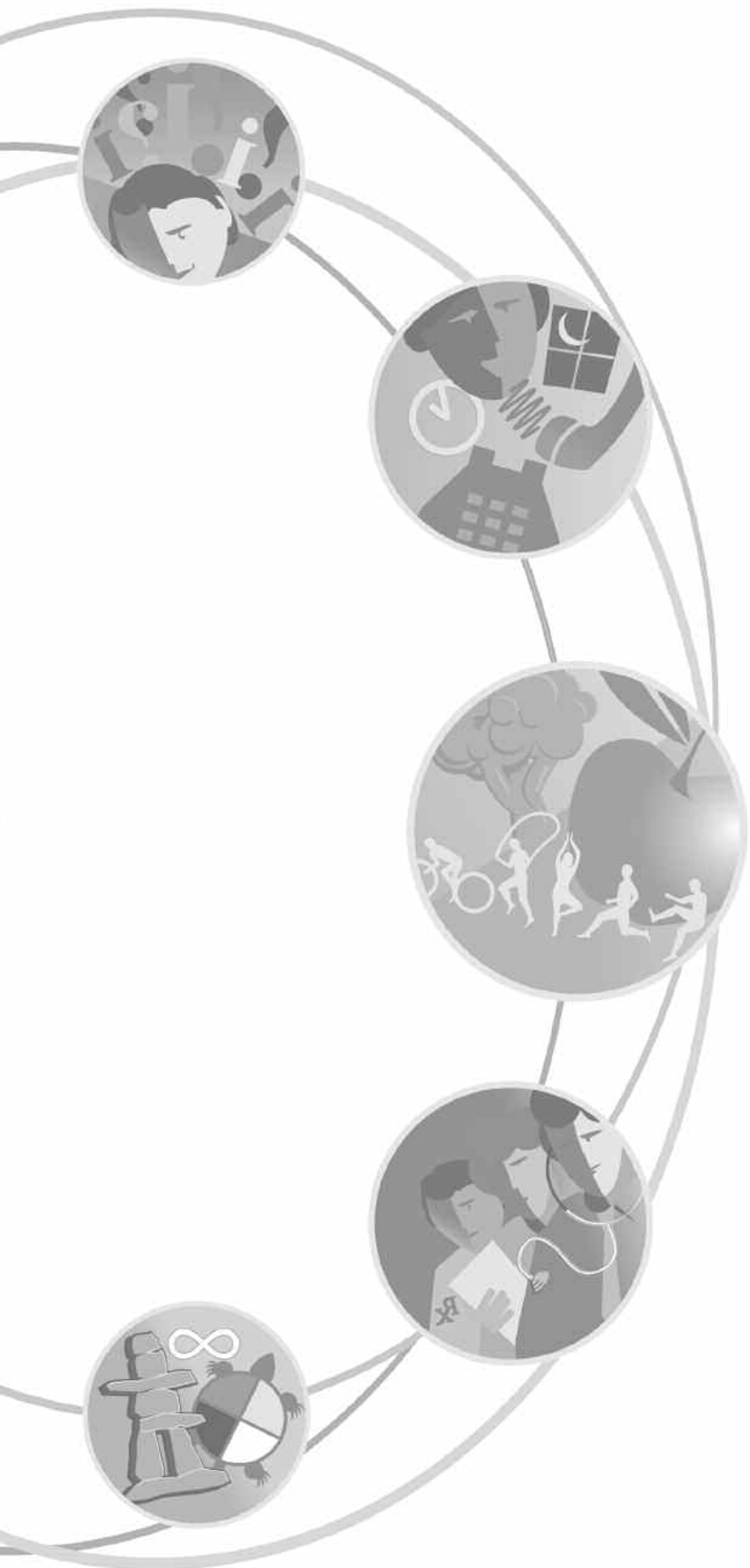
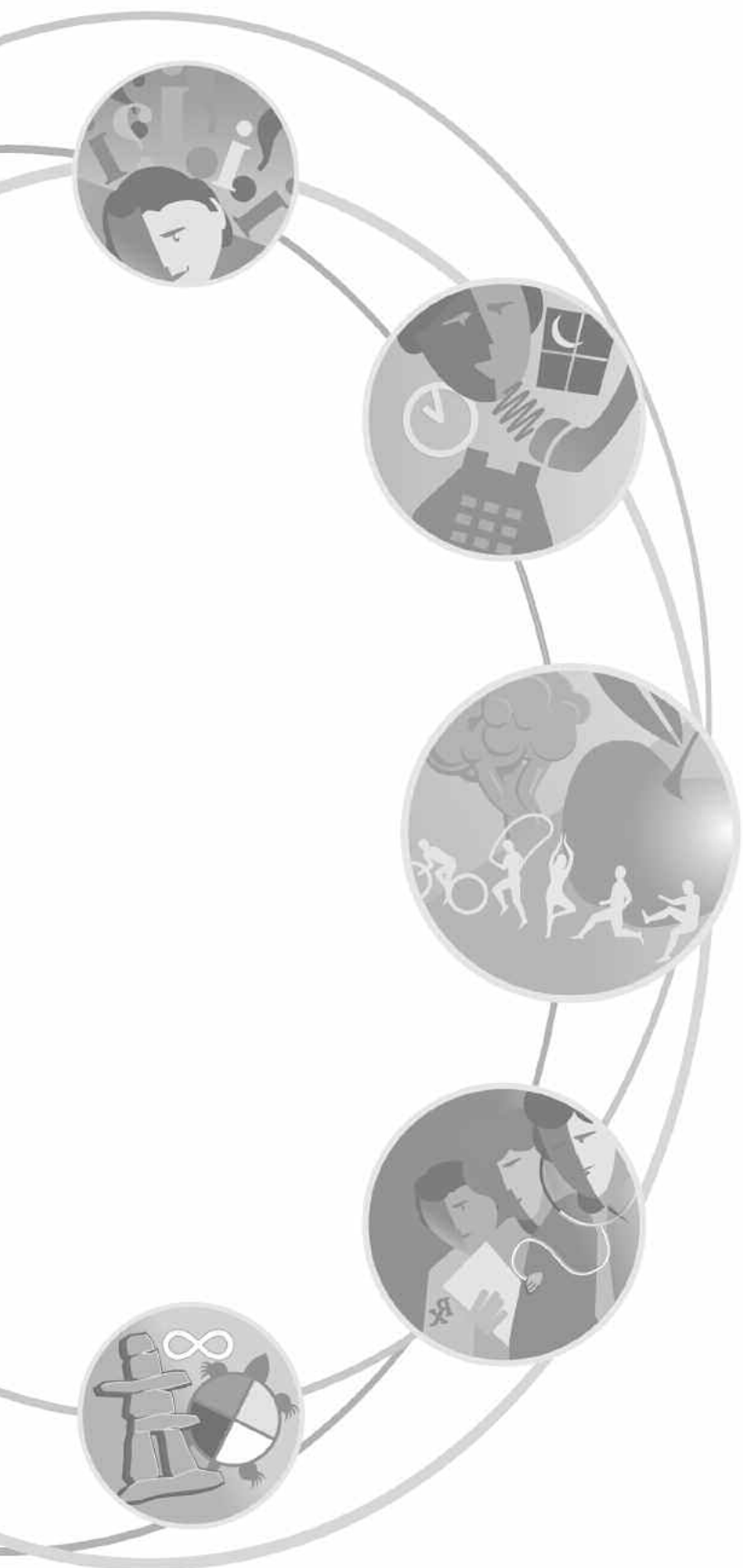


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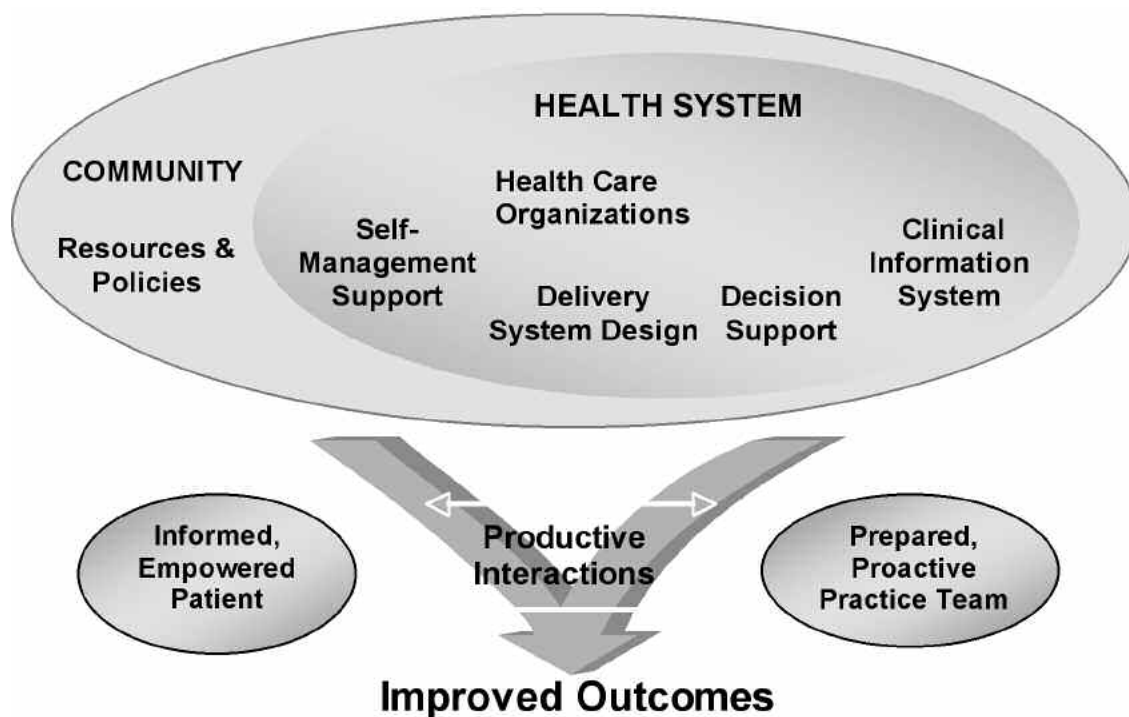
1 Setting the Context

When Kenny Rogers sang, famously, “the best that you can hope for is to die in your sleep,” one presumes that that ideal was to come unexpectedly and without the struggles or suffering associated with one or more chronic health conditions. Regrettably, most Canadians will not be so lucky. The striking reality, according to the World Health Organization (n.d.), is that the number of people worldwide who will die as a result of chronic diseases in 2006 alone will exceed the population of our country; 35 million deaths, more than 60 per cent of the 58 million deaths worldwide, will be attributable to chronic diseases.

At the turn of the millennium, Canada, like other developed and developing countries, is facing an epidemic of chronic disease; concepts of chronic disease prevention (CDP) and chronic disease management (CDM) are emerging as important challenges to individuals, health

systems, communities and society as a whole. Yet in spite of their importance, these concepts, and their interrelationship within health system reform and a broader public health agenda, remain poorly understood by Canadians and, arguably, the governments that serve them. Advances in medicine have modified but not abated the evolution and impact of these diseases; when treatments are shown to be efficacious, practitioners and modern health systems seem unable to dispense them to all, or even most, within appropriate populations. Meanwhile, the discipline of health promotion, viewing prevention as a function of social determinants of health, has struggled to gain currency in modern democracies, the scientific community or “the market” at large. Advocates and politicians alike tend to garner greater public support by enshrining individual conditions—perhaps most appreciably when offering the hope of cure, or, more recently, equitably

Figure 1. Chronic Care Model



Source: Figure 1 from Wagner E.H., Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness? *Effective Clinical Practice* 1998; 1:2-4. Reproduced by permission.

shortened queues to investigation and intervention. And experts, while sharing some early frames of reference, have failed to develop a common language or other vehicles for dialogue and collaboration that might allow greater local and global effectiveness in responding to this worldwide challenge.

In the Canadian context, the struggle to deal with chronic disease has become one part of a rationale for reforming, renewing and re-energizing primary care and primary health care (PHC). Indeed, improved chronic disease management was one objective of the Primary Health Care Transition Fund (PHCTF), which was announced by the Government of Canada in 2000. This five-year \$800 million investment was intended to support the transitional costs of implementing large-scale PHC initiatives. The purpose of this document is to review the PHCTF initiatives from the perspective of chronic disease: prevention and management and, from there, to capture the key learnings and their implications for policy and practice.

In order to discuss commonalities and differences among the initiatives, and to benchmark Canadian efforts in chronic disease prevention and management (CDPM), the Chronic Care Model will be referenced. (See Figure 1.) This model was developed through a systematic, comprehensive literature review, tested in clinical trials, and adopted by health care organizations around the world. First published in 1998, the model focuses on productive interactions between informed, empowered patients and prepared, proactive practice teams as a common pathway to improved outcomes for persons with chronic diseases (Wagner, 1998).

Suggestions that the approach can serve as a template for improving prevention have followed, though this has not been studied as rigorously (Glasgow, Orleans, Wagner, Curry, & Solberg, 2001).



2 Overview of PHCTF Initiatives

This overview is not an evaluative process but, rather, a distillation of the learnings from each initiative as summarized in individual reports. (See the Appendix for the initiatives considered in this report.) In the case of the provinces and territories, these individual reports covered the breadth of PHCTF initiatives, not just those relevant to CDPM. Similarly, each national, multi-jurisdictional, official languages minority communities and Aboriginal initiative had a differing emphasis; some had CDPM as a clear focus, others touched on CDPM indirectly, if at all. For the purposes of this synthesis, the initiatives will be discussed in three groups:

- Provincial/territorial initiatives where established CDPM strategies predated PHCTF initiatives;
- Provincial/territorial initiatives where CDPM strategies emerged primarily as a function of, or in parallel with, PHCTF initiatives; and
- National, multi-jurisdictional, official languages minority communities and Aboriginal initiatives.

If one were to regard each of the groups of initiatives as a glass, one could ask, in looking at them, whether in fact the glass is half full or half empty. I will offer that for each glass, the answer to the question is necessarily both—half empty and half full. All initiatives have contributed in some way to advancing CDPM; all have acknowledged the need to do more. These are their stories.

2.1 Provincial/Territorial Initiatives with Established CDPM Strategies

British Columbia and Alberta had well-developed CDM strategies and frameworks in place before receipt of

PHCTF resources. A key difference was that in British Columbia, the strategy was led by the Ministry of Health with direct negotiation with the British Columbia Medical Association as the primary vehicle for engagement of health professionals; in Alberta, strategies existed within Regional Health

Authorities (RHAs) with local engagement of health care professionals. Collaborations between the authorities were facilitated by Alberta Health and Wellness.

There were two notable distinctions in the PHCTF initiatives of these provinces when compared with those in other provinces or territories:

1. In both cases, all six elements described in the Chronic Care Model were implemented as components of a broad infrastructure—one that was applied to multiple chronic health conditions—before or as part of their PHCTF efforts.
2. Both provinces assumed a leadership role (proactively or responsively) in national and multi-jurisdictional efforts to establish common CDPM infrastructure.

British Columbia developed a CDM approach based on the expanded Chronic Care Model developed by Barr, Robinson and others in 2006. (See Figure 2.)

The model brings greater attention to the role of public policy and community action in population-based efforts to improve disease management. Using this model, the province leveraged the PHCTF to launch quality improvement collaboratives, bringing together organizations and individual practitioners to improve care for people with specific chronic illnesses: diabetes and congestive heart failure. Quality of care has increased for patients with these conditions, while corresponding mortality and hospitalizations appear to have decreased. Information technology (IT) infrastructure was developed—the Chronic Disease Management Toolkit—and helped to deliver evidence-based care to people with chronic disease. Physicians were also encouraged to focus more on prevention, targeting people aged 50 to 70, and were supplied with financial incentives and nurse facilitators to support change management. Self-management capacity saw significant investment, with 46 leader-training workshops held, 508 lay leaders trained, 268 courses offered and 2,873 citizens participating. In September 2005, British Columbia hosted the International Patient Self-Management conference. The value of British Columbia's efforts has been recognized through the adoption of the Chronic Disease Management Toolkit by several other jurisdictions. The province

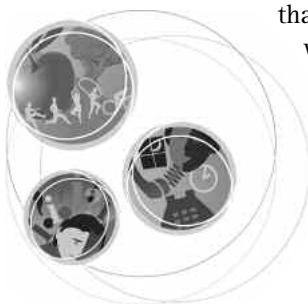
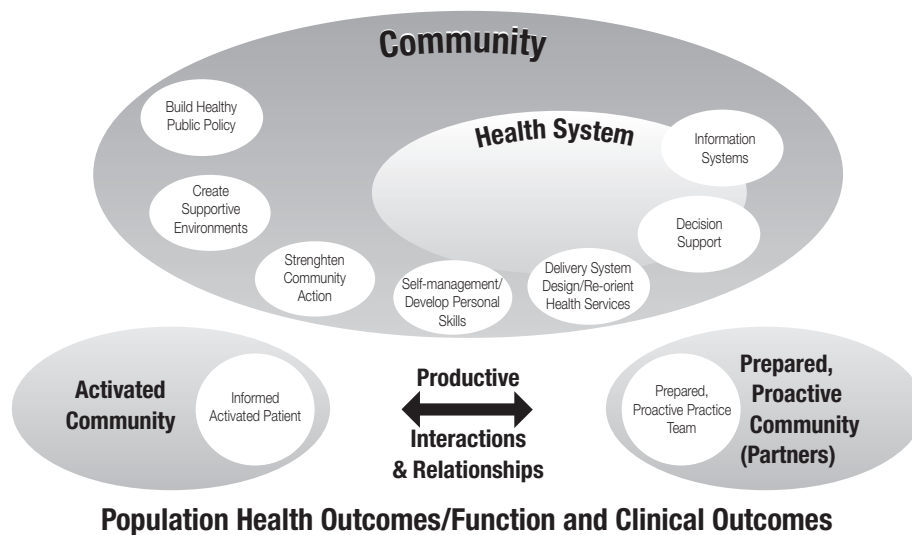


Figure 2. British Columbia's Expanded Chronic Care Model



Source: Government of British Columbia, http://www.health.gov.bc.ca/cdm/cdminbc/chronic_care_model.html.

has committed to accelerating the CDM work enabled through the PHCTF. It has committed tens of millions to CDM in its 2006 agreement with physicians. Primary health care providers indicated that they are highly satisfied overall, though nurses and pharmacists have complained that the renewal efforts are overly focused on physicians.

Alberta's RHAs had adopted the Chronic Care Model before the PHCTF and in some regions had established scalable infrastructures to support strategies for several chronic diseases. The PHCTF allowed for further investment in capacity-building, including interdisciplinary training and exploration of new models of care. Living Well, a community-based program of education, self-management and supervised exercise developed in Calgary, was extended to other regions. The Chinook Chronic Disease Management Network, the Calgary Chronic Disease Management Initiative and the Good Health Team developed programs and services for CDPM patients. Alberta, having experience from the implementation of Health Link Alberta, also played a lead role in multi-jurisdictional initiatives establishing case management, data and messaging standards and health lines infrastructures in support of CDM. Furthermore, CDM is a key priority of its Primary Care Networks, which were launched during the PHCTF. In October 2005, Calgary Health Region and Alberta Health and Wellness hosted the Global Perspectives in Chronic Disease Management conference, with a second conference scheduled for October 2007.

2.2 Provincial/Territorial Initiatives with Emergent CDPM Strategies

The remaining provinces and territories appeared to have CDPM agendas that developed in the context of PHCTF and, often, coupled with the evolution of new primary care teams. These teams were deemed to constitute sound vehicles for future effort and investment targeting chronic disease; specific CDPM policies and strategies emerged secondarily, if at all.

Of note in reviewing these initiatives:

- With reference to the Chronic Care Model, jurisdictions with emergent CDPM strategies made headway on two or sometimes three elements of the model. Delivery system design and community resources were predominant, with early progress in either information technology (IT) or IT development. Self-management support typically represented the third area of activity.
- The provinces and territories with emergent strategies that seemed to make the greatest progress were those that leveraged collaborations with British Columbia and Alberta directly or through national or multi-jurisdictional PHCTF initiatives.
- Reference to sustained infrastructure for chronic disease was infrequent. Initiatives were often disease-specific projects—with diabetes the most

often described—with seemingly little extension to other conditions.

In the territories, Yukon provided an insightful approach that highlights these findings. Interviews conducted in early 2003 identified areas where CDPM and health promotion could be improved. Yukon's endeavours relevant to CDPM included the launch of a diabetes collaborative, adoption of the Expanded Chronic Care Model in 2005 and leveraging of the British Columbia Chronic Disease Management Toolkit for IT infrastructure support in May 2006. Yukon highlighted that “the road to success is not travelled along a straight path” and shared its disappointment that potential synergies, specifically around the development of IT support with Canada Health Infoway, sometimes failed to materialize in a timely fashion. Conversely, its willingness to work with British Columbia accelerated its CDM efforts and may be relevant to the sustainability of CDPM in Yukon and the other territories, where resources for future investment in CDPM are constrained by the demands of acute care. Indeed, an important insight in Nunavut was the need to create training programs, in parallel with service delivery redesign, tailored to meet the specific needs of the Inuit population. This effort is critical to encourage more Inuit to become health care providers while promoting a broader understanding of Inuit health practices relevant to CDPM.

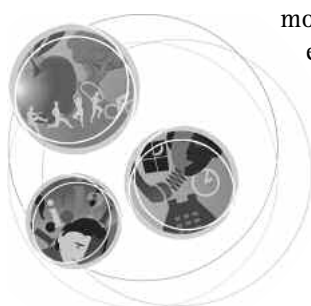
On the Prairies, Saskatchewan and Manitoba were similarly able to accelerate their respective CDM IT efforts through multi-jurisdictional collaborations related to health lines and information exchange standards. Saskatchewan's dedicated PHCTF dollars were directed toward the creation of PHC teams. It learned that a vision of idealized teams, with universal access to nurse practitioners, was difficult to implement due to constraints in training and difficulties relocating qualified personnel. As well, the absence of extra (rather than just offsetting) incentives for physicians to participate in new PHC teams and their related activities, along with the contractual challenges of pursuing such

arrangements, made physician recruitment more complicated than originally expected. It was also recognized that co-locating health professionals does not necessarily mean that a “team” exists. Manitoba made some significant progress in CDPM, including the development of a formalized process for the development

and approval of community action plans focused on modifiable risk factors for chronic disease in the Parkland region; the creation of a community-focused strategy for diabetes and asthma management in Point Douglas; and the rollout of a home-monitoring solution for persons with congestive heart failure fully integrated with the contact centre and the patient care providers. An important learning in Manitoba was that, with RHAs given flexibility to target funds in a way that would benefit them the most, the distinction between PHC, population health and community-based services for CDPM became confusing and unclear. A common taxonomy, even before the definition of core services, might have been of benefit in this and other provinces where health authorities have a degree of autonomy in developing CDPM strategy.

The Government of Ontario declared in 2000 that improvements to PHC are crucial to the renewal of health services. Achievements associated with the PHCTF relate to the enrolment of both patients and providers in new PHC models, as well as the funding of a large number of demonstration, leadership and accreditation projects aimed at developing and testing new models of care, including several with a disease management and disease prevention emphasis. Among the cautions from the Ontario experience was that, in an environment where numerous demonstration and research projects are underway, physician recruitment to CDPM initiatives can be undermined by “participation fatigue,” and that this was an important consideration for future stages of experimentation and infrastructure development. Ontario partnered with Alberta and the Canadian Home Care Association to conduct the *National Home Care and Primary Health Care Partnership Initiative* where the role of home care was augmented to include case and disease management approaches for people with chronic disease—including application of care plans and use of IT and decision-support tools. In April 2006, Ontario hosted a National Chronic Disease Management Conference that brought together more than 110 CDM leaders, stakeholders and jurisdiction representatives to share experiences, lessons learned and next steps in implementing successful CDM initiatives. The conference provided a forum for identifying future directions for strengthening CDM in PHC. Proceedings will be collated and shared in the form of a book entitled “Emerging Approaches to Chronic Disease Management in PHC.”

Quebec has made Family Medicine Groups (FMGs) one of the cornerstones of its primary care reform. An FMG



is a new organization composed of family physicians working as a group in close collaboration with nurses, and providing a wide range of services to clients who enrol voluntarily. The array of services offered by the FMGs include the provision of care suited to the health status of registered patients; disease prevention and health promotion; and medical assessment, diagnosis and treatment of acute and chronic conditions. PHCTF funding supported the government's FMG implementation process, helping to establish contractual agreements, especially for the hiring of nurses, and contributing to the development and installation of information systems. Among the key learnings were that while such arrangements have created progress in the level of collaboration among physicians and nurses, attention needs to be paid to lines of authority between FMGs and local community service centres, with whom the nurses are officially employed. Delays in IT implementation and lack of change management support were also identified as areas for improvement with the ongoing rollout of the FMGs.

In the Maritimes, Nova Scotia directed PHCTF resources to support model development through its RHAs, change management and IT development. Examples relevant to CDPM include the development of a chronic disease strategy within South Shore Health, a Patient Education Information Management initiative in the South West Health District, and support for the development of sustainable population-based models for CDM and health promotion. "Champions workshops," to support physician training in the use of PHC information systems, were thought to be one of many change management strategies that proved effective and perhaps applicable to the dissemination of new approaches to CDPM. Nova Scotia also undertook a Diversity and Social Inclusion initiative that produced the first provincial guidelines for the delivery of culturally competent PHC in Canada. As the prevalence of important chronic conditions varies among cultural groups, the capacity to engage individuals and communities in a culturally appropriate manner constitutes an important foundation for improved CDPM activities in the province and the country as a whole. Highlights of activities in Prince Edward Island related to CDM included the development of family health centres, where the implementation of clinical protocols for chronic conditions like hypertension yielded impressive results. Provincial representatives from the Maritimes noted that, although the PHCTF initiatives were intended to be transitional, certain activities and roles have been

found to be critical to the continued achievement of the provincial strategy and that sustainable provincial funding—including funds for new models of health providers' remuneration—was imperative.

2.3 National, Multi-Jurisdictional, Official Languages Minority Communities and Aboriginal Initiatives

In addition to provincial/territorial initiatives, the PHCTF supported initiatives exploring new family physician–home care partnerships, disease-specific programs, and opportunities to share efforts and resources, as well as those involving the delivery of services over geographic and cultural distance.

Of note in reviewing these initiatives:

- Those initiatives that targeted national or multi-jurisdictional infrastructure development relevant to CDPM highlighted value gained through collaboration. This seemed to hold true whether the infrastructure in question focused on human resource development, information and communication technology, or intergovernmental or intersectoral coordination.
- Initiatives that create awareness of potentially underserved communities should be reviewed carefully when considering provincial/territorial or national strategies for CDPM. The circumstances that isolate these communities may also increase their risk or burden of specific chronic conditions.
- Disease-specific initiatives, though usually conducted across several provinces and territories, did not seem aligned with broad CDPM strategies within each jurisdiction.

The *National Home Care and Primary Health Care Partnership Initiative* saw merit in adding depth to the traditional clinical partnership between the family physician and home care case manager. Almost 1,000 patients were enrolled in two locations: Calgary, Alberta, and Halton and Peel, Ontario. Although the focus for collaboration and partnership in this initiative was the primary care physician and home care case manager, improved collaboration with other stakeholders was also expected—and achieved. The role of home care was

augmented to include case and disease management approaches for people with chronic disease—including application of care plans and use of IT and decision-support tools. In terms of learnings, both patients and providers benefited from the alignment of case managers' and family physicians' skills. Development of effective partnerships and implementation of IT solutions take time, but they ultimately contribute to minimizing system barriers.

The *WHIC* initiative, the *Health Lines* multi-jurisdictional collaboration and the *Health Integration Initiative* each captured opportunities in which coordinated, shared and co-development efforts across organizations can create economies of scale and avoid duplication. The *Western Health Information Collaborative Initiative* resulted in the creation of a robust framework for capturing data elements relevant to any chronic disease, associated messaging standards and implementation in each of the four western provinces. Proving the relevance to other jurisdictions, the work product, through the standard-compliant British Columbia Toolkit, has been implemented by Yukon. At the conclusion of the initiative, discussions with Canada Health Infoway regarding migrating to a pan-Canadian resource for CDM were still in progress.

The *Health Lines* initiative has established a trend toward health lines as sustainable infrastructure within provincial health systems, with significant collaboration and economies of scale. Important to CDM and CDP activities, the use of proactive, outbound calls was deemed a viable service alongside acute response services.

The *Tui'kn* (meaning “passage” in Mi'kmaq) *Initiative* was established to introduce a new way of thinking about health and delivering health care in the five First Nations bands in Cape Breton, Nova Scotia. The effort established a full complement of general practitioners, a new nurse practitioner role and a single electronic health record across the five sites in support of diabetes prevention and management, as well as preventive strategies around non-traditional tobacco use, childhood injury and prescription drug misuse.

Similarly, the *Northern and Aboriginal Population Health and Wellness Institute* engaged four communities in collaboration, driven by dialogue around diabetes, increased awareness of the need for health promotion and

identification of Aboriginal role models for healthy living. Strategies embracing traditional healing represented an important element of the initiative. The Northern Health Strategy Working Group of the *Community and Organizational Transition to Enhance the Health Status of all Northerners* initiative identified CDM (particularly self-management) as one of 10 priority areas establishing a chronic care coalition to encourage sustained collaboration. Finally, in Nunavut, there are 25 communities, with populations from 148 to 7,000, connected only by sea, air and satellite. A telehealth network established in 1999 already supported 15 communities and the initiative *A Tool to Help People from Far Away—The Ikajuruti Inungnik Ungasiktumi (IIU) Telehealth Network* extended services to seven of the remaining 10 communities. This constitutes a communication infrastructure supporting CDM in primary care and collaborations for CDP.

The *Health Integration Initiative* recognized that First Nations and Inuit people receive health care services from both the federal government and provincial/territorial health systems, and aimed to better coordinate these services. Through improved coordination it was hoped that access and quality would be improved, capacity leveraged with new economies of scale, and communities engaged in developing “win-win” solutions. Of the eight sub-projects, two dealt explicitly with CDPM.

In addition to the First Nations communities, two populations were identified where specific attention was required to avoid the potential for isolation and inequities in service: gay, lesbian, bisexual and transgendered Canadians; and patients and families dealing with terminal stages of illness. *Rainbow Health—Improving Access to Care* addressed inequities facing gay, lesbian, bisexual and transgendered Canadians in accessing primary care and highlighted conditions for which CDM and CDP methodologies may be appropriate but are currently underused, including mental health conditions, substance abuse and HIV/AIDS. The *Pallium Integrated Care Capacity Building Initiative* explored methods to engage PHC professionals in new partnerships and change management processes required for the delivery of holistic palliative care that supports the patient and the family unit. This initiative produced the world's first model to guide hospice palliative care based on national principles and norms of practice.

Special attention was paid to Canada's official languages minority communities. For example, *Résautage Santé*



en français supported each province and territory in developing strategies to improve French-language health services in their jurisdictions, while *Improving Access to Primary Health Care Services for English-Speaking Persons in Quebec* did much the same for the anglophone minority in that province.

Three national initiatives focused on prevention and management of specific conditions: mental health conditions, arthritis and cancer. Each closed with the offer to share their resources and best learnings to address other important diseases. Activities of the *Canadian Collaborative Mental Health Initiative* included a comprehensive analysis of the current state of collaborative care, the development of a collaborative mental health care charter and the development of unique models, strategies and toolkits for advancing collaborative care. *Getting a Grip on Arthritis: A National Primary Health Care Community Initiative* surveyed communities and regions to inventory resources and engaged patients and providers in numerous localities to plan and implement self-management and continuing professional education/practice management approaches to improving arthritis care. The *Sixth National Summit: Cancer Control in Northern and Rural Communities* brought together 220 delegates from a diverse range of stakeholder groups.

2.4 International Comparison of CDPM in Primary Care Physician Practices

Individual initiative reports offered no single lens through which the CDPM experiences of Canadian primary care physicians at large could be viewed. Coincident to and independent of the PHCTF, during February through July 2006, when most PHCTF initiatives were nearing completion, primary care physicians from seven countries, including Canada, participated in the ninth of a series of cross-national surveys conducted by the Commonwealth Fund (Schoen et al., 2006). The survey, focusing on IT and clinical record systems, care coordination, use of teams, participation in quality initiatives and financial incentives, also captured the front-line experiences of physicians in Australia, Germany, New Zealand, the Netherlands, the United Kingdom and the United States. The relevant findings of the survey were extracted and are reported below in the hope that they might provide a useful supplement to the synthesis theme.

Among all survey respondents, Canadian physicians described the *greatest* limitation—or poorest results—with the following prerequisites for CDPM:

- receipt of computerized prompts to provide patients with laboratory results;
- listing patients in their practice by diagnosis or health risk;
- listing patients who are due or overdue for tests or preventive health care;
- listing all medications taken by patients (including prescriptions from other doctors); and
- provision of written instructions to patients about how to manage their chronic condition at home.

This difficulty was thought to be related to the uptake of global electronic medical records, where Canadian and U.S. doctors lagged well behind those of other countries. Furthermore, only 55 per cent of Canadian respondents felt that their practices were well prepared to manage patients with multiple chronic conditions, and only 40 per cent felt well prepared to manage mental health problems. The proportion of Canadian physicians who routinely work with other health care professionals for primary or chronic care, at 32 per cent, is significantly lower than that of other countries. In the two years before the survey, the period during which the PHCTF initiatives were being launched, Canadian primary care physicians were *least* likely, at 48 per cent, to have participated in collaborative quality improvement efforts with other practices, hospitals, government agencies or professional associations. Lastly, Canada and the United States were singled out by the authors as lacking national payment initiatives that focus on physicians and primary care.

Without knowing the extent to which surveyed physicians had been a part of PHCTF initiatives, it is impossible to know whether these findings simply relate to the fact that these initiatives have reached only a modest subset—the early adopters—within the primary care physician community in Canada. Regardless, it would seem that PHCTF and its learnings are timely and that continued local and national commitment is required to address ongoing challenges in CDM on the front lines.

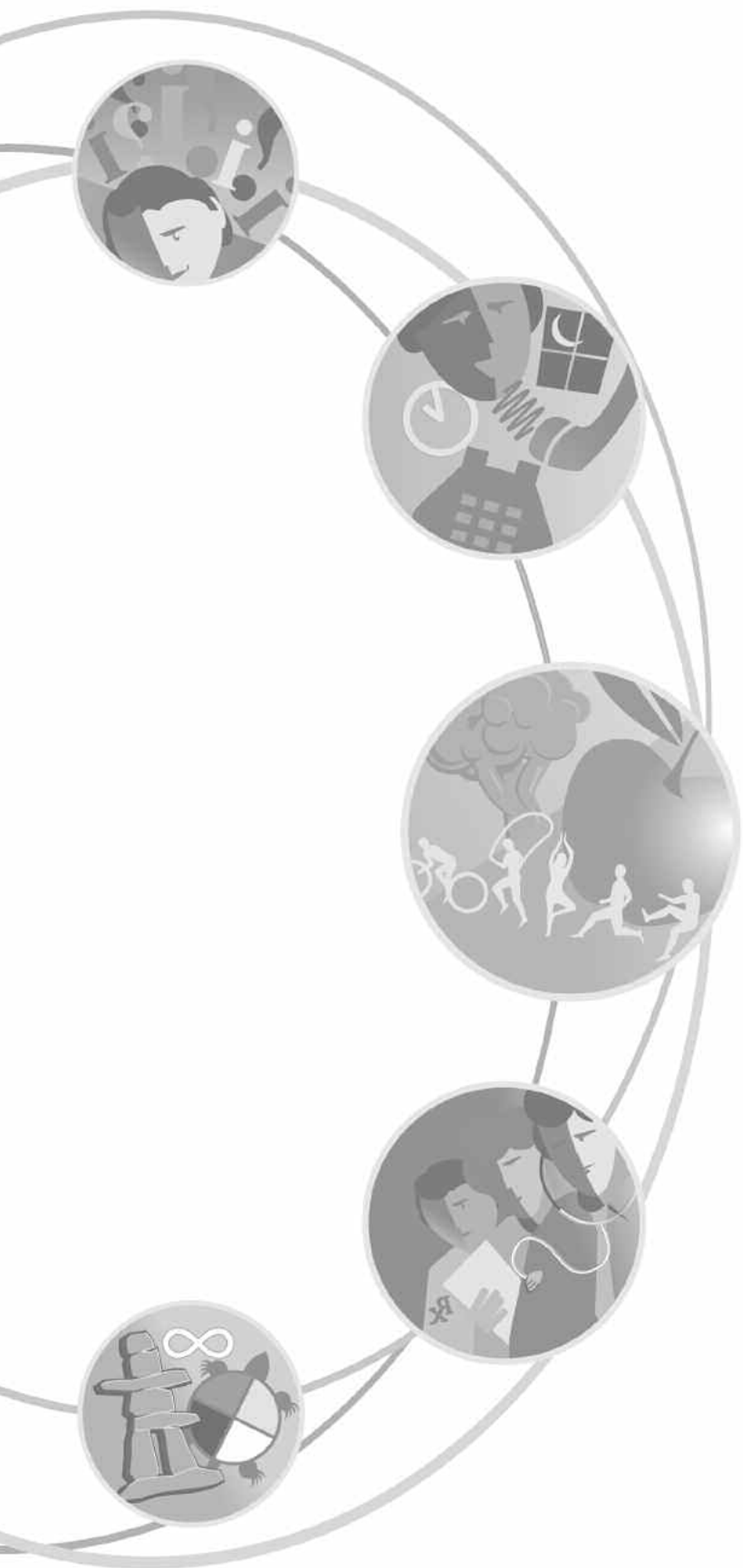
3 Key Learnings

Beyond the individual provincial/territorial-, project- and practice-level experiences, the following overarching learnings emerged from the review of all PHCTF initiatives with reference to CDPM:

1. *CDP and CDM are emphasized to different degrees within provincial/territorial health systems.* When referenced against established models, pre-existing frameworks and strategies were the best predictors of progress in CDPM during the PHCTF. Moreover, CDPM strategies appear to provide focus for other elements of PHC, namely collaborative care, information management and technology, and evaluation.
2. With reference to both established and emergent provincial/territorial strategies, *efforts towards CDP and CDM do not appear to be coordinated.* They seem to operate parallel to one another. While not explicitly explained in the reports, there are several possible and interrelated considerations for this observation:
 - The Chronic Care Model, while purported to be applicable to preventive care, may have limitations in addressing broader CDP issues.
 - The CDP and CDM communities of interest in Canada have evolved in parallel and without sufficient discourse to create integrated approaches at a project level.
 - CDP may indeed have sufficiently different methodologies and societal and cultural undertones as to require a distinct strategic effort, even if under a broad banner of CDPM.
3. Given the appropriate support, *Canadian jurisdictions will collaborate to create shared CDPM infrastructure.* This was evident in the successes of the multi-jurisdictional and Aboriginal initiatives and also in spontaneous exchanges that occurred during the PHCTF. It would appear that these collaborations resulted in considerable leverage and (or) mutual benefit. Infrastructures such as health lines and IT represent specific opportunities for ongoing provincial/territorial collaboration and federal support. There was less indication that investments in disease-specific initiatives created similar motivation for collaboration.
4. Arguably, *primary care physician practices were most frequently seen as the focal point around which interdisciplinary CDM should develop.* Furthermore, the interprofessional relationship most studied and sought was that between physician and nurse. Perhaps for the reasons described in point two above, the focal point for CDP was more varied; sometimes referenced as a function of the relationship between a citizen and his or her care providers, sometimes as a function of the relationship between a citizen and his or her community. Regardless of concerns raised about their perceived comfort, capability and support in CDPM activities, primary care physician engagement, leadership or championship was often described as a foundation for success within the PHCTF initiatives. Once engaged, they are amenable to new mechanisms of care delivery and new ways of relating to patients and other health professionals. Conversely, a lack or slowness of physician engagement was a harbinger of difficulties ahead.

Provincial/territorial initiatives that recognized a need to engage primary care physicians not just as necessary participants but necessary leaders in CDM could be described as having achieved broader and more sustainable success. This recognition was typically reflected in the pursuit of: 1) new collaborative approaches to process and practice redesign; 2) new infrastructure for information management and communication; and 3) new models of compensation (or, at a minimum, new fee-for-service options), to encourage interdisciplinary CDM or CDP activity among community physicians. As suggested by the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians (Schoen et al., 2006), considerable opportunity remains for improvement in these areas.





4 Implications for Policy and Practice

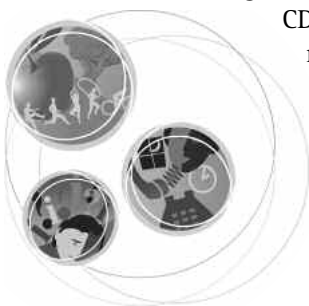
Following directly from the key learnings, the implications for policy and practice will be discussed under four interrelated banners:

- *Emphasizing CDP and CDM as health system priorities;*
- *Coordinating CDP and CDM efforts within a cohesive national CDPM strategy;*
- *Creating shared, sustainable, Canadian CDPM infrastructure; and*
- *Strengthening interdisciplinary CDM care around redesigned primary care practices.*

Emphasizing CDP and CDM as Health System Priorities

In the current era, CDP and CDM are recognized as means to an end (such as reduced acute care utilization) or subsets of broader activities (such as PHC and primary care). Moving forward, CDP and CDM must become ends themselves or risk regressing to the status of a fad—current projections for chronic disease make the lateral scenario, for lack of any kinder characterization, unwise. Affirming the strategic importance of CDPM might include:

- Position statements from federal, provincial/territorial governments and responsible national professional associations recognizing chronic disease as a national epidemic and global crisis;
- The establishment, within provincial/territorial governments and the health care organizations they oversee, of formal integrated responsibility for CDM and CDP strategies and operations; and
- A determination at all levels of government (including municipalities, where CDP methodologies are increasingly relevant) that CDP and CDM are ends in and of themselves, with requisite implications within and outside the health sector.



Coordinating CDP and CDM Efforts within a Cohesive National CDPM Strategy

Regardless of their distinct methodologies and communities of interest, CDP and CDM address a common societal concern—isolated strategies leave each susceptible to marginalization and paradoxically create the potential for frequent competition for scarce political and financial capital. A cohesive national CDPM strategy requires:

- Recognition that, while medical aspects of CDM are logically within the jurisdiction of the health system, CDP and non-medical approaches to CDM require multisectoral engagement, responsibility and accountability;
- Collaboration across communities of interest in CDM and CDP, with both enlightened leadership and integrated theoretical models capturing the points of intersection and divergence between these activities; and
- Integrated theoretical models to capture a common language for discourse and extend to include methodologies outside the reach of current models (including health promotion and complex chronic care) while maintaining the opportunity for international benchmarking achieved with the Chronic Care Model.

Creating Shared, Sustainable, Canadian CDPM Infrastructure

As evidenced through the multi-jurisdictional and Aboriginal initiatives, Canadian jurisdictions have furthered their individual agendas by joining efforts to address the challenge of chronic disease—this includes not only a willingness to “mirror” local infrastructures created elsewhere but to co-develop shared infrastructure in areas such as conceptual/strategic models of CDPM and IT standards. However, collaborative undertakings are effortful, even if cost-effective or mutually beneficial. Strategies to facilitate and reward the creation of shared infrastructure might include:

- Borrowing from our experience with British Columbia's expansion of the Chronic Care Model, investigate, and if appropriate "Canadianize," other existing models for intergovernmental collaboration, such as Australia's National Chronic Disease Strategy and companion Blueprint for Nation-wide Surveillance of Chronic Disease and Associated Determinants (National Public Health Partnership, 2006).
- Second local leaders or administrators to fixed-term appointments to federal agencies during the implementation of strategically important collaborative projects.
- Protect specific funds for infrastructure applications proposed by two or more jurisdictions.
- Make receipt of disease- or condition-specific funding (at the local, provincial/territorial and/or national level) contingent upon implementation within existing infrastructures supporting multiple conditions.

Strengthening Interdisciplinary CDM Care around Redesigned Primary Care Practices

Three common approaches or solutions for the promotion of interdisciplinary CDM emerged from the review of PHCTF initiatives:

- Collaborative approaches to process and practice redesign;
- Development or implementation of IT infrastructure for information management and communication; and
- Study of new models for contracting and compensating health care professionals.

To the extent that these represent ongoing activities built around similar goals and principles in all jurisdictions, the federal government and (or) appropriate federal agencies may be well positioned to support these activities in a variety of ways—including the provision of funding or expertise; development of standards or benchmarking capability; or promotion of common multi-jurisdictional policy frameworks for professional activities, interactions and compensation. Exploration of these options at a national level will help keep interdisciplinary efforts at the front of the health care agenda in all jurisdictions and decrease the risk that they are dropped for economic reasons or vulnerable to political influence in isolated provincial/territorial negotiations.

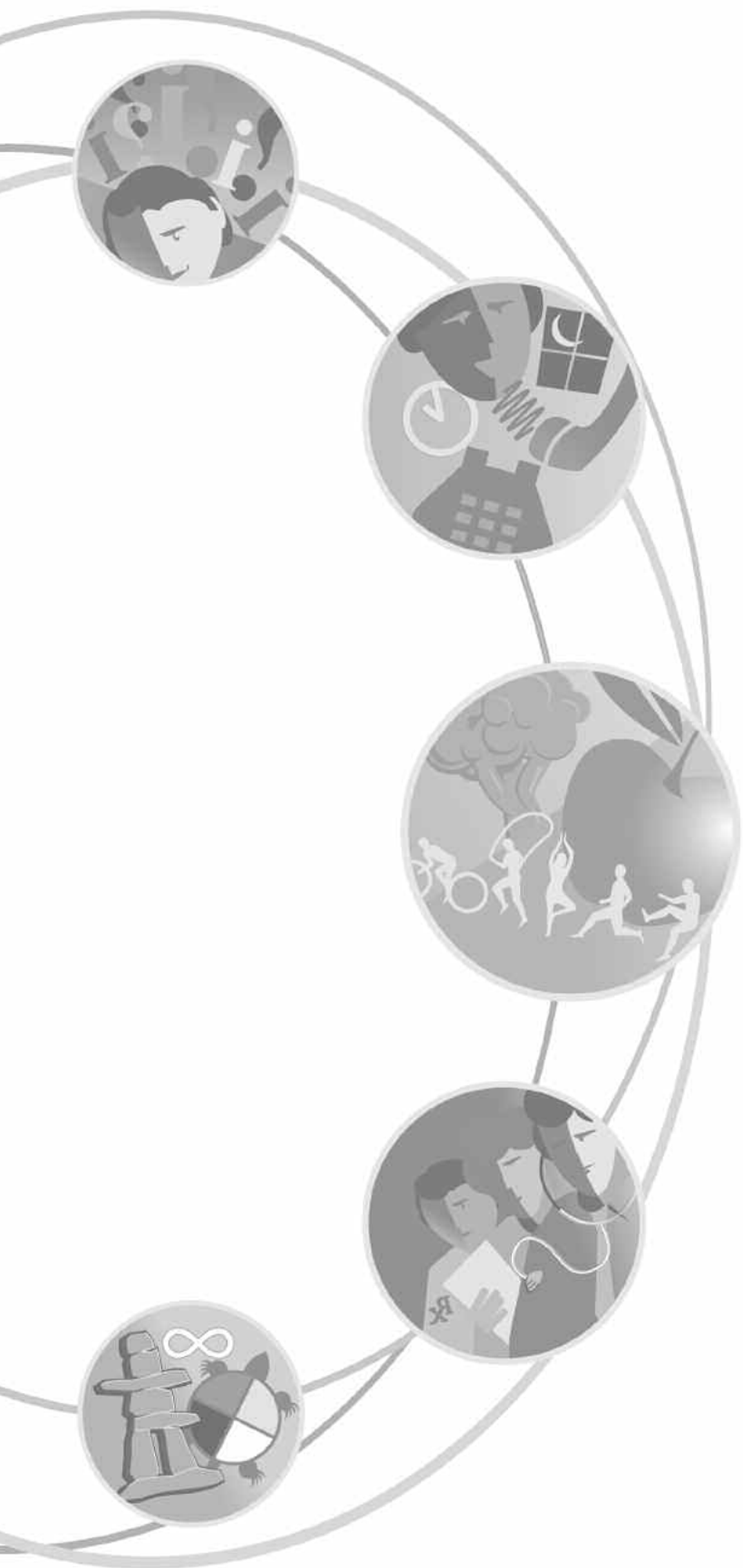
In parallel, institutions of learning, professional associations and colleges must consider mechanisms to train and certify future health care professionals, while accreditation bodies measure organizational competencies, to assure that capabilities and standards of care evolve in concert with the innovations captured from PHCTF activities.

5 Conclusion

The PHCTF investment, through its many and varied initiatives, has strengthened Canada's capacity for CDP and CDM through the advancement of primary care and PHC. But neither primary care nor PHC are ends in themselves (Lewis, 2004). CDP and CDM must evolve to become both means to ends, and ends in and of themselves. This evolution, in spite of its logic in the face of the burgeoning personal and societal impact of chronic disease, must not be taken for granted. It is frequently said that an ounce of prevention—in this case of disease or complications thereof—is worth a pound of cure. Although we have come a significant way in adapting our health care system accordingly, a review of health care headlines from recent years suggests that an ounce of public anxiety or outrage with failings in acute care settings will still tip the scales.

A convergence of thought and strategy between CDP and CDM agendas, and a clearer articulation of their relevance to modern health systems and civil societies, remain ahead. Citizens and public officials will ask, having poured our collective experiences together, how much have we achieved with the PHCTF investment? For CDPM, some will see a glass half empty; others, a glass half full. The balance—and even, if knowable, the truth—probably do not matter all that much. This is where we are and from where we must continue, begin again and begin anew. Going forward, as Jean Monnet offered, “l'important n'est pas d'être optimiste ou pessimiste, c'est d'être déterminé—the important thing is not to be optimistic or pessimistic, it is to be determined.”





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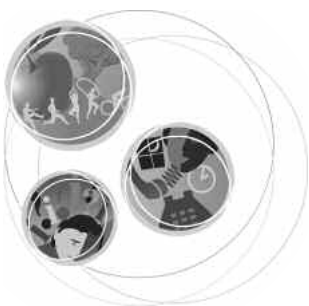
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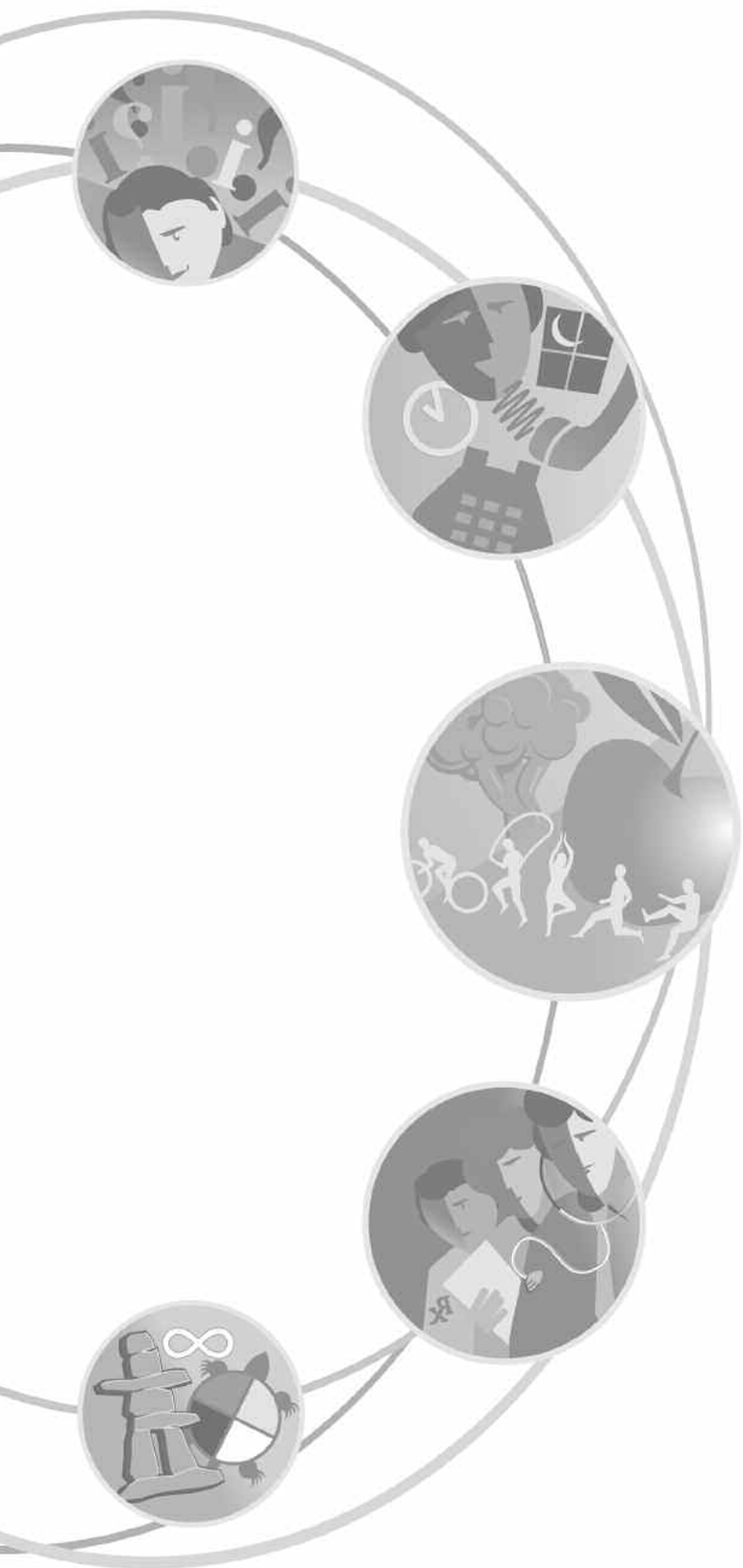
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Appendix

List of Initiatives Relevant to Report Theme: Chronic Disease Prevention and Management

This appendix provides summary information on the PHCTF initiatives which were reviewed in the preparation of this document. For further information, please refer to the PHCTF website www.healthcanada.gc.ca/phctf.

Provincial-Territorial Envelope

Yukon Primary Health Care Transition Fund Initiative

Lead and Partner Organization(s): Department of Health and Social Services, Government of Yukon; with Ministry of Health, Government of British Columbia; Pallium Project, Alberta Cancer Board; Bureau of Statistics, Executive Council Office, Government of Yukon; Information and Communications Technology, Department of Highways and Public Works, Government of Yukon

Approved Contribution: \$4,537,282

The Yukon government faces many challenges in delivering health services from a structural, functional and technological perspective. For example, one-third of the territory's population live in small pockets of a few hundred people, while two-thirds live in the urban capital of Whitehorse. Despite Yukon's small population, its health care system is quite complex, with services delivered or funded by three levels of government (federal, territorial and First Nation). Life expectancies of Yukoners are about 10 per cent lower than the Canadian average, and the territory posts the highest death rates in Canada due to accidents and injuries. The Yukon government recognized that improvements to both the coordination and efficiency of its health care system were needed, new linkages among providers were required, and the roles and responsibilities of the individual, family and community needed to be examined. To begin the change process, Yukon set two objectives for its initiatives: to increase the emphasis on health promotion, disease and injury prevention, and management of chronic diseases; and to facilitate coordination and integration with other health services. The initiative spawned the Yukon Diabetes Collaborative, which emphasized better coordination and collaboration among providers and is widely regarded as Yukon's success story. In addition, this initiative negotiated access to British Columbia's Chronic Disease Management toolkit; produced the *Yukon Health Guide*; and implemented fetal alcohol syndrome assessment and intervention training. The Palliative Care Development Project increased coordination among care providers and identified key areas for future programming. Its many information technology (IT) initiatives laid the groundwork for the implementation of an electronic health record and other IT developments in the territory. Sustainability has been a challenge for the Yukon initiative from the

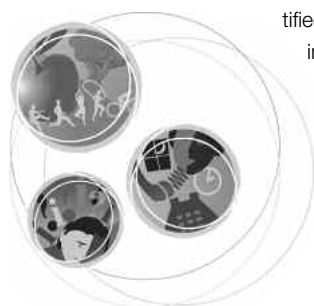
beginning, but new funding has been provided through the Territorial Health Access Fund (THAF) for some activities.

Northwest Territories Primary Health Care Transition Fund Initiative

Lead and Partner Organization(s): Government of the Northwest Territories, Department of Health and Social Services (DHSS); with Tlcho Community Services Agency; Yellowknife Health and Social Services Authority; Beaufort Delta Health and Social Services Authority; Fort Smith Health and Social Services Authority; Dehcho Health and Social Services Authority

Approved Contribution: \$4,771,470

This initiative supported the transition of health care delivery in the Northwest Territories (NWT) to a Primary Community Care (PCC) model. This model, the basis of the Integrated Service Delivery Model (ISDM) being implemented in the territory, targets service and system integration, from primary community care to secondary and tertiary levels of service. It has a strong focus on offering a more comprehensive range of primary health care, wellness and social services. Comprising 11 projects and designed to promote a collaborative, client-centred approach for health and social services, this initiative aimed to: 1) provide public/staff education; 2) coordinate primary care renewal in the NWT; 3) develop integrated primary health care teams/services; 4) support improved women's reproductive health services; and 5) provide training for various health care providers, including nurse practitioners and community health workers. Main activities undertaken included: the facilitation of several workshops to increase capacity for self-care and healthy choices and a symposium to educate health stakeholders on the reform directions; the establishment of two interdisciplinary health services—the Tlcho Integrated Wellness Centre and the Yellowknife Community Health Clinic; the implementation of public education strategies to strengthen self-care; the design and implementation of a midwifery program and a prenatal care clinic to improve women's reproductive health services; the creation of key training programs; and several evaluations and related activities. This initiative supported an increased understanding of the PCC model and furthered the transition to this model of care in the NWT. Several key resources were developed, including: a self-care handbook (adapted to the NWT and available in English and French); health and social programs tailored to meet the needs of the communities and health providers in the North, such as the Healing Path Wellness Program, the Midwifery Program, and the Northern Women's Health Program; and training programs such as the Nurse Practitioner Clinical Training Centre, the Aboriginal Community Health Worker Training, and an 18-hour lactation management course.



Nunavut Primary Health Care Renewal Initiative

Lead and Partner Organization(s): Nunavut Department of Health and Social Services

Approved Contribution: \$4,508,924

This wide-ranging initiative aimed to address some of Nunavut's most pressing challenges: the lack of health human resources and the fact that there are few Inuit working in the health field; the lack of training and networking opportunities for the territory's widely dispersed health care workers; the need to improve access to primary health care (PHC) services; the need to address the health challenges of its far-flung and culturally diverse population, such as mental health, tuberculosis and sexually transmitted infections; and finally, the vital need for health promotion and community development. The initiative sought to enhance PHC services in Nunavut through four specific goals: 1) establishing a PHC and a rehabilitation clinic in Iqaluit; 2) emphasizing health promotion and encouraging PHC outreach to communities; 3) establishing demonstration projects and supporting network-building events that promote the practical use of interdisciplinary PHC teams; and 4) facilitating, coordinating and integrating health services to improve and strengthen communication between PHC providers and their communities. It achieved its objectives by creating culturally sensitive training programs to develop Nunavut's health human resources, and educational resources in the territory's four official languages to address serious public health concerns. Furthermore, the initiative spawned opportunities for community development and participation in health programs and facilitated interdisciplinary networks across Nunavut's three regions. The training program in mental health (Mental Health Diploma), which is offered at the Nunavut Arctic College, and the toolkit *Engaging Nunavummiut: A Guide to Strengthening Community in Nunavut* are just a few examples of the resources produced under this initiative.

British Columbia Primary Health Care Transition Fund Initiative

Lead and Partner Organization(s): British Columbia (B.C.) Ministry of Health; with B.C. Health Authorities and associated agencies; B.C. College of Family Physicians; B.C. Medical Association; non-government organizations such as B.C. Healthy Heart Society; University of Victoria; University of British Columbia; Centre for Health Services and Policy Research (CHSPR); B.C. communities

Approved Contribution: \$74,022,488

The population of British Columbia has grown by 19 per cent over the past decade, and at least 36 per cent of its population has at least one chronic disease. This initiative focused largely on helping general practitioners to improve care for priority populations, which were determined as such based on evidence showing gaps in care. The populations cited are: people with chronic diseases, frail elderly people, people with mental illness or addictions, people at the end of

life, pregnant women and Aboriginal people. The initiative addressed three areas: improving health outcomes, supporting a range of practice models, and professional/organizational development, evidence and evaluation. Over the four years of the initiative, British Columbia focused primarily on two major chronic conditions: diabetes and congestive heart failure. It succeeded in raising the quality of care—according to clinical practice guidelines—for patients with these conditions, while corresponding mortality and hospitalizations appear to have decreased (thereby saving tens of millions of dollars). British Columbia developed more than 14 distinct models of service organization and delivery across the province. They are generally integrated community models, enhanced family practices and provider networks. Over the four-year course of the initiative, a total of 92 practice models were implemented or improved, and 26 sites undertook enhancements to the structure or delivery of primary health care. Electronic medical record technology was introduced in 85 per cent of sites, and most sites engaged in health promotion and disease prevention activities. Overall, this initiative has strengthened British Columbia's ability to address its health care challenges.

Alberta Primary Health Care Transition Fund Initiative

Lead and Partner Organization(s): Alberta Health and Wellness; with Capital Health; Calgary Health Region; Chinook Regional Health Authority; Palliser Health Authority; David Thompson Regional Health Authority; East Central Health; Aspen Regional Health Authority; Peace Country Health; Northern Lights Health Region; Associate Clinic of Pincher Creek, Alberta; Edmonton Police Service; University of Alberta; University of Calgary; University of Lethbridge; Strathcona County Emergency Services; Alberta Alcohol and Drug Abuse Commission; Treaty 7 First Nations; the town of Pincher Creek; Canadian Mental Health Association; Alberta Mental Health Board; Alberta Medical Association; NAPI Friendship Centre; Aakom-Kiyii Health Services; Piikani Nation

Approved Contribution: \$54,876,073

Large-scale primary health care (PHC) initiatives were undertaken to improve access, accountability and integration of services. These initiatives were intended to bring about fundamental and sustainable change to the organization, funding and delivery of PHC services in Alberta. Two major strategies were implemented:

- The development and implementation of a province-wide 24/7 health information and advice service (Health Link Alberta); and
- Support for capacity building, through a Capacity Building Fund, which has funded nine initiatives, and other provincial coordination activities that supported the implementation of new care models and the broader implementation of Capacity Building Fund activities across the province.

Based on the common Primary Health Care Transition Fund objectives, Alberta established five of its own: 1) develop and integrate innovative health promotion, disease and injury prevention and chronic

disease management programs; 2) develop, support and use integrated care models and other innovative service delivery methods; 3) develop and implement effective change management strategies at regional and provincial levels; 4) establish and implement education and training services to support new models of service delivery; and 5) identify and develop infrastructure that supports the delivery of PHC. Health Link Alberta has improved 24/7 access to appropriate PHC services, increased coordination and integration among PHC services and providers, increased emphasis on health promotion, disease prevention and chronic disease management and encouraged more appropriate use of Alberta's health care resources. Through the Capacity Building Fund and other provincial coordination activities, Alberta has developed innovative models in children's mental health, and has emphasized health promotion and disease prevention, chronic disease management and other areas of PHC. It has also established teams of health care providers, implemented new care models and identified change management strategies to develop teams and support a culture change towards multidisciplinary practice.

Saskatchewan Primary Health Care Transition Fund Initiative

Lead and Partner Organization(s): Saskatchewan Health

Approved Contribution: \$18,592,405

The Saskatchewan Action Plan for Primary Health Care was released in December 2001 with the overall aim of improving the quality of primary health care (PHC) services and access to them. Since the Action Plan's inception, however, Saskatchewan changed its governance structure, reorganizing its 32 health districts into 12 regional health authorities (RHAs). Saskatchewan intended to develop its PHC networks and teams within the new RHAs, and identified the following objectives for its PHC initiative: build PHC capacity within Saskatchewan Health and the RHAs; develop PHC programs in RHAs through community development and team facilitation; develop a 24-hour telephone advice line; provide educational opportunities to upgrade the skill level of PHC team members; and develop incentives for physicians to participate in the plan. Saskatchewan was able to accomplish these objectives through the creation of 37 PHC teams, which serve approximately 23 per cent of the population. More than 90 per cent of the teams provide 24/7 access to a physician and/or registered nurse practitioner. HealthLine, the provincial telephone advice line, has managed more than 200,000 calls since August 2003 and now includes an online health information service. A provincial team development project has brought team facilitation expertise to every RHA. The number of both nurse practitioners working in an expanded role and physicians on alternate payment plans who work on a PHC team has increased. Saskatchewan is committed to a renewed PHC system. Activities sup-

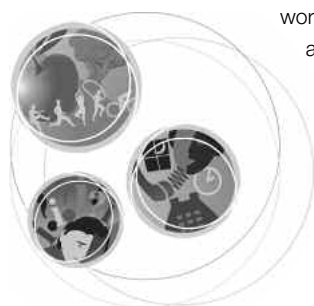
ported through the Primary Health Care Transition Fund will continue, in part, through Health Accord funding provided by the federal government.

Manitoba Primary Health Care Transition Fund Initiative

Lead and Partner Organization(s): Manitoba Health, Regional Support Service, Primary Health Care Branch; with Assiniboine Regional Health Authority; Brandon Regional Health Authority; Regional Health Authority–Central Manitoba Inc.; North Eastman Health Authority; South Eastman Regional Health Authority; Interlake Regional Health Authority; NOR-MAN Regional Health Authority; Parkland Regional Health Authority; Burntwood Regional Health Authority; Churchill Regional Health Authority; Winnipeg Regional Health Authority; CancerCare Manitoba

Approved Contribution: \$20,844,059

To renew its primary health care (PHC) system, Manitoba set three goals: 1) promote the development of PHC organizations delivering service to Manitobans based upon the principles of PHC (with the related objective of needs-based planning and services); 2) enable PHC service providers to deliver services in ways that reflect PHC principles (with the related objectives of planning for interdisciplinary training and alternative remuneration models for both physicians and other PHC providers); and 3) improve the ability of PHC organizations to deliver services (with the related objectives of providing infrastructure and tools, such as guidelines and change management techniques) to support movement towards PHC reform. As a result of this province-wide initiative, several new PHC centres were developed in the communities of Brandon, Camperville, Waterhen, Niverville and Winnipeg, serving approximately 77,000 people. There was a focus on team development through such initiatives as the Collaborative Practice Education Initiative and the Comprehensive Assessment, Referral and Access System. Health services became more integrated through the Urban Primary Care Oncology Network (UPCON) initiative, which linked oncologists with family physicians to provide better coordinated patient care. Information technology projects were also undertaken, such as the Community Service Information System in Winnipeg and the expansion of telehealth in Churchill. Despite some challenges (e.g., significant progress and implementation delays, recruitment and retention difficulties, change management issues), this initiative provided the foundation for PHC renewal in Manitoba by improving access, strengthening system integration and improving quality of service. The resources developed by this initiative included an outbound program to monitor patients with congestive heart failure; a PHC handbook with tools and practical information for patients/clients and their families; resources for team development and change management; and a post-graduate interdisciplinary curriculum on collaborative practice.



Ontario Primary Health Care Transition Fund Initiative

Lead and Partner Organization(s): Ontario Ministry of Health and Long-Term Care

Approved Contribution: \$213,170,044

In order to advance primary health care (PHC) in the province, Ontario undertook nine key PHC renewal initiatives that aimed to: improve access to PHC; improve the quality and continuity of PHC; increase patient and provider satisfaction; and boost the cost-effectiveness of PHC services. In particular, Ontario wanted to ensure that there was flexibility in payment and delivery models for PHC, while meeting the agreed-upon national goals of PHC renewal. Four of the nine initiatives were centrally implemented; these included enrolment in new PHC models, systems development and information technology, communication, and project management. The other five initiatives were implemented through operational grants (101) and included demonstration, research and evaluation (interdisciplinary projects); accreditation; leadership and training; mental health; and rehabilitation projects. In addition, Ontario awarded 59 capital grants, the majority of which served to integrate a range of different disciplines into practices. Over the four years of the initiative, Ontario focused on supporting physician and patient enrolment in other PHC models; developing and implementing information technology systems, including a decision support and a workflow management system; developing several resources for patients and providers; developing a new curriculum to build knowledge and skills in continuous quality improvement and interdisciplinary collaboration; and designing a new accreditation process. In addition, Ontario's PHC Team provided ongoing management, accountability monitoring and reporting of all initiatives, which included several site visits to operational and capital grant projects, and organized key knowledge transfer events, which included conferences and two workshops to update participants on the progress of Ontario's transformation strategy and to share lessons learned. This initiative has advanced Ontario's PHC strategy. Over 90 interdisciplinary PHC teams have been established and enrolment in new PHC models has increased substantially. Furthermore, capital and operational grant projects have provided needed infrastructure, skilled human resources, and new services and programs that are strengthening PHC services. Several resources were produced including toolkits, best practices and protocols, innovative models of care, evaluation instruments, training modules, care plans and accreditation standards.

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Quebec Primary Health Care Transition Fund Initiative

Lead and Partner Organization(s): Ministère de la Santé et des Services sociaux du Québec; [Quebec Department of Health and Social Services]

Approved Contribution: \$133,681,686

Quebec has made Family Medicine Groups (FMGs) one of the cornerstones of its reform. An FMG is a new organization composed of family physicians working as a group in close collaboration with nurses, and providing a wide range of services to clients who enrol voluntarily. The groups belong to a more extensive network comprising other FMGs, hospitals and other services. The array of services offered by the FMGs includes the provision of care suited to the health status of registered patients; disease prevention and health promotion; medical assessments; and diagnosis and treatment of acute and chronic conditions. The goal of the FMGs is to ensure that Quebec's primary health care system remains viable and accessible. Their objectives are consistent with the those set at the First Ministers Meeting 2000 on primary health care renewal, and with the shared objectives of the Primary Health Care Transition Fund (PHCTF), namely, to:

- Ensure people in Quebec have access to a family physician;
- Ensure better access to services, as well as better overall management (continuity of care) and patient follow-up;
- Improve the delivery and quality of medical care, and the administration of front-line services;
- Develop services that supplement those of local community service centres (CLSCs); and
- Recognize and value the role of the family physician.

The *Commission d'étude sur les services de santé et les services sociaux* (Clair Commission) first proposed FMGs in December 2000, and the Quebec government announced their creation in 2001. Quebec has declared its intent to register 75 per cent of the population on FMG lists in the coming years, and expects to establish some 300 FMGs in the province. FMGs began appearing in the fall of 2002, and the PHCTF has since contributed to their development. In February 2006, slightly more than 100 FMGs were active or in various phases of implementation. Some 1,000 family physicians and 200 nurses work in FMGs, and nearly 800,000 Quebecers are enrolled in them. Other FMGs are in the certification stage. A *Université de Montréal* case study of five first-wave FMGs found that there had been notable progress in collaboration between physicians and nurses in most of the FMGs under study, and that the majority of users saw only the benefits of enrolling in an FMG.

Health Care Renewal in New Brunswick

Lead and Partner Organization(s): **New Brunswick Department of Health;** with Atlantic Canada Opportunities Agency; Atlantic Blue Cross Care; Business New Brunswick; National Research Council

Approved Contribution: \$13,689,805

Primary health care (PHC) renewal in New Brunswick (NB) is about improving access to PHC, within a system that will deliver the right health care service, in the right way, at the right time, by the right provider, at a cost taxpayers can afford. NB's vision for a healthy future shifts the focus from acute care to community-based services. It identified two priorities: the establishment of a network of community health centres (CHCs) and improvement in ambulance services. Five CHCs were established and are operational. Training was provided to health care providers through five provincial conferences and the Building a Better Tomorrow training initiative. An orientation manual was developed for staff in all CHCs. An electronic health record is in place and will be in operation soon at all sites. More than 500 ambulance attendants received advanced life support skills. The ambulance dispatch service was upgraded, along with the associated information technology. More than 500 nurses working in emergency rooms across the province received enhanced training, and they are now able to assess, treat and discharge emergency room patients who do not require the services of a physician. Similarly, more than 800 licensed practical nurses in nursing homes and regional health authorities were provided training that better enables them to work to their scope of practice. The telehealth pilot, EMP care@home, is in progress. It is evident that NB is committed to sustaining the work of this initiative. Two more CHCs are being opened and planning has begun for a third. Capital investments in facilities, technologies and change strategies have been made to achieve NB's priorities, and the Department of Health has realigned existing resources for the ongoing support and maintenance of these endeavours. Overall, NB appears to be well positioned to provide PHC to its residents through the use of CHCs.

Primary Health Care Renewal in Nova Scotia

Lead and Partner Organization(s): **Nova Scotia Department of Health**

Approved Contribution: \$17,073,265

Nova Scotia's Vision for Primary Health Care, developed in 2003, set the stage for primary health care (PHC) renewal plans and activities in that province. With support from the Primary Health Care Transition Fund (PHCTF), the Department of Health developed three transitional initiatives to support this vision: implement enhancements to PHC services and create new ways to develop sustainable PHC networks or organizations; support costs associated with change (to encourage collaborative groups of PHC

professionals to work in new or strengthened PHC networks or organizations); and support the PHC system transition to an electronic patient record. The Department of Health and the District Health Authorities (DHAs) collectively planned and conducted a range of activities to support this transition. The initiative strengthened the capacity of DHAs to support community planning for PHC renewal; supported planning and implementing new or strengthened networks/organizations; developed the necessary transition structures, processes and evaluation tools used to assess the initiatives; offered financial support to renovate PHC organizations, including establishing physical space that would facilitate communication and networking as well as participation in PHC planning; supported the development of sustainable models for PHC organizations, including alternative payment plans and teams with nurse practitioners, and chronic disease management and health promotion initiatives. Nova Scotia also laid the groundwork for the electronic health record, in terms of defining standards for clinical software and developing confidentiality and security policies, implementation support, an evaluation strategy, and new/upgraded hardware and software. The Diversity and Social Inclusion program produced the first provincial guidelines for the delivery of culturally sensitive PHC in Canada. The provincial website www.gov.ns.ca/health/primaryhealthcare/default.htm details the PHC renewal initiative.

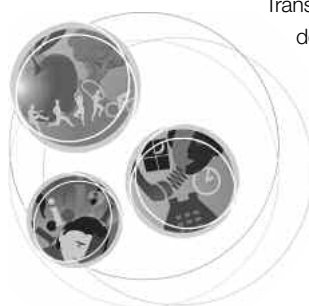
Prince Edward Island Primary Health Care Redesign

Lead and Partner Organization(s): **Government of Prince Edward Island**

Approved Contribution: \$6,526,879

Prince Edward Island (PEI) undertook primary health care (PHC) redesign to address issues such as shortages of health professionals, provider satisfaction, increasing demand for health care services, rising health care costs, high rates of chronic disease and other issues related to accessibility, integration and coordination. This initiative's multiple goals fell into six categories: improve access to comprehensive PHC services; improve continuity of care through coordinated and integrated PHC service delivery; increase emphasis on health promotion and chronic disease prevention and management, including self-management; maintain or improve patient/client satisfaction with PHC; maintain or improve provider satisfaction through collaboration; and improve accountability.

To achieve the goals, five initiatives were planned: establishing five collaborative Family Health Centres (FHCs); implementing a provincial healthy living strategy; integrating palliative care; improving drug utilization; and promoting the use of videoconferencing. Over the four years of the initiative (2002–06), PEI took an incremental, phased-in approach to advance the first three initiatives. As a result, FHCs currently serve approximately 22,800 people (16 per cent of the PEI population) and all FHC staff have been trained in collaborative practice and PHC. The Healthy Living Strategy supported various programs aimed at encouraging healthy lifestyle choices, many of



which were directed at children. Front-line palliative care staff and clinical resource teams across the province have received basic and enhanced training to support and deliver palliative care, and an integrated palliative care program has been established across the province. Some key resources produced by this initiative include five health centres with collaborative practice teams, numerous and varied health promotion and chronic disease prevention activities and programs, and a nationally recognized palliative care service delivery model with palliative care clinical resource teams.

Newfoundland and Labrador Primary Health Care Initiative

Lead and Partner Organization(s): Newfoundland and Labrador Department of Health and Community Services

Approved Contribution: \$9,705,620

With the overarching aim of having at least 50 per cent of the population provided with primary health care (PHC) by PHC teams by 2010, this province-wide initiative had four specific goals: to enhance accessible, sustainable primary health care (PHC) services; to support comprehensive, integrated and evidence-based services; to promote self-reliant healthy citizens and communities; and to enhance the accountability and satisfaction of health professionals. Over the four years of this initiative, a wide range of activities led to the establishment of eight PHC teams, with three more team areas in the early stages of proposal implementation, and three more finalizing proposals. Proposals were developed based on population needs. Large numbers of professionals participated in team development and scopes of practice processes, and early evaluation results show positive shifts towards increased teamwork. Community Advisory Committees were established in all PHC team areas. All PHC teams, in cooperation with the provincial Wellness Strategy and Regional Wellness Coalition, increased support for wellness initiatives. The Chronic Disease Management Collaborative was implemented in seven rural PHC team areas, and is in the early implementation stage in urban settings. The evaluation processes were formalized for all PHC team areas and for special projects (such as enhanced sharing of information). Partnerships have been forged with academic institutions for professional education and development, as well as with the Newfoundland and Labrador Centre for Health Information to move forward with a number of information management initiatives for evaluation and future direction (sharing of electronic health information, telehealth, electronic medical records and the PHC classification system ICP2). The anticipated results of the initiative are better health outcomes, improved health status, sustainability and greater cost-effectiveness.

Aboriginal Envelope

Community and Organizational Transition to Enhance the Health Status of all Northerners

Lead and Partner Organization(s): Mamawetan Churchill River Regional Health Authority; with Athabasca Health Authority; Keewatin Yatthé Regional Health Authority; Northern Inter-Tribal Health Authority; Prince Albert Grand Council; Meadow Lake Tribal Council; Lac La Ronge Indian Band; Peter Ballantyne Cree Nation; Population Health Unit, Northern Health Authorities; Health Canada, First Nations and Inuit Health Branch, Saskatchewan Region; Saskatchewan Health, District Management Services, Northern Region; Northern Medical Services, University of Saskatchewan, College of Medicine

Approved Contribution: \$3,272,536

Most of northern Saskatchewan's population is Cree, Dene and Metis, with 45 per cent of the population under the age of 18. Providing primary health care (PHC) services to this area composed of several remote communities is difficult, and is particularly so because of the poorer health status of the people. To more adequately meet the health care needs of the population, a number of stakeholders from the provincial regional health authorities, First Nation health authorities, First Nations and Inuit Health Branch (Health Canada) and Saskatchewan Health formed the Northern Health Strategy Working Group in 2001. The goal of this initiative was to strengthen member organizations' approach to PHC. In northern Saskatchewan, the goal is to attain comprehensive, accessible, coordinated, accountable, sustainable and good quality PHC. The three specific objectives of this initiative were to: clearly articulate a Northern Health Strategy and communicate it to others; facilitate the development and approval of a work plan that addresses immediate, short-term and long-term actions associated with the implementation of a health strategy; and develop partnerships/agreements among member organizations. The partners identified 10 priorities: mental health and addictions; chronic disease management; perinatal health; oral health; human resources; information technology; health information management; communications; community development; and cross-jurisdictional decision-making. Technical Advisory Committees were formed and work plans developed, with consistent steps set out for each of the 10 priorities. Those involved in the initiative have emphasized that it was successful in promoting collective advocacy and in forging partnerships, particularly to develop health human resources in the North. It introduced and promoted technology; shared training (e.g., on patient self-management, motivational interviewing); promoted communication; advanced health promotion/prevention resources; and developed strategies for making improvements in chronic care, oral health, breastfeeding and sexual health. The organizers believe that this initiative has allowed health stakeholders to reaffirm their commitment to the Saskatchewan Northern Health Strategy and to sustain their collective efforts to transform key aspects of the northern Saskatchewan health care system with the aim of ensuring that the system is as seamless and equitable as possible.

Health Integration Initiative

Lead and Partner Organization(s): **First Nations and Inuit Health Branch, Health Canada;** with First Nations communities and organizations in British Columbia, Alberta, Manitoba, Ontario, Nova Scotia and New Brunswick; an Inuit organization in Nunavut; health ministries from six provinces and one territory and associated regional health authorities; the towns of Norway House (Manitoba), Sioux Lookout and Moosonee (Ontario); professional nursing colleges in Nova Scotia and New Brunswick; health care providers and evaluators

Lead and Partner Organization(s): **First Nations and Inuit Health Branch, Health Canada;** with First Nations communities and organizations in British Columbia, Alberta, Manitoba, Ontario, Nova Scotia and New Brunswick; an Inuit organization in Nunavut; health ministries from six provinces and one territory and associated regional health authorities; the towns of Norway House (Manitoba), Sioux Lookout and Moosonee (Ontario); professional nursing colleges in Nova Scotia and New Brunswick; health care providers and evaluators

Approved Contribution: \$10,800,000

First Nations and Inuit people receive health care services from the federally funded health services in their communities and the provincial territorial health systems. Various government reports have identified the need for better coordination. To address this need, the Health Integration Initiative was created, with the aims of: exploring, developing and analyzing models for better integration of federally funded health systems in First Nations/Inuit communities with provincial/territorial delivery of health services; and identifying mechanisms for collaboration and harmonization between federal, community-based programs and provincial/territorial health systems. Over the three years of the initiative (2003–06), the Health Integration Initiative undertook applied research and policy development and funded eight integration projects, which were meant to: test the practicalities of integrating federal First Nations and Inuit and provincial/territorial health systems; eliminate duplication of effort; identify existing gaps in services; create potential economies of scale; and identify areas for improvements (timeliness, access and quality of services). Some of the initiative's accomplishments include developing legislation for creating a First Nations health authority in northern Ontario; creating an integrated health care delivery structure for the residents of the First Nation and community of Norway House; undertaking a collaborative, multi-jurisdictional approach to diabetes management in northern Alberta; and integrating primary care services from the regional health authority with community health services in the Elsipogtog First Nation. Joint plans for health care delivery, tools and resources (such as care maps, guidelines and policies) have been created and will continue to inform the delivery of health services within the communities. The funded projects have all been successfully implemented, and most of the early outcomes seem to indicate that the projects have contributed to a shift to collaborative partnerships that will be useful for the implementation of the Aboriginal Health Transition Fund from 2006–10.

Northern and Aboriginal Population Health and Wellness Institute

Lead and Partner Organization(s): **Manitoba Keewatinook Ininew Okimowin;** with Burntwood Regional Health Authority

Approved Contribution: \$2,925,150

The Northern and Aboriginal Population Health and Wellness Institute (NAPHWI) was developed in response to a growing concern about the declining health status of Aboriginal people living in the North. Jurisdictional issues and barriers were identified as factors preventing the implementation of a more effective solution to this situation. NAPHWI undertook a community-driven approach to identifying, exploring and recommending resolutions to issues that contribute to the declining health and wellness of northern and Aboriginal peoples, with a particular focus on improving access to primary health care (PHC) services. The goal of this initiative was to promote a more productive, cost-effective PHC service delivery model and to improve the quality and appropriateness of PHC services to Aboriginal peoples. In order to reach this goal, the initiative examined ways to integrate existing services and resources, and enhance their coordination. The initiative targeted three priority themes: diabetes, youth suicide and traditional healing. Activities included research and consultation with a broad range of stakeholders, including a focus on engaging local communities. NAPHWI was successful in establishing connections among many organizations that have mandates for improving health status in northern Manitoba. It also established a precedent for involving northern First Nations communities in the health care decision-making process. The initiative website www.naphwi.ca provides access to some of the major publications that were developed.

Tui'kn Initiative

Lead and Partner Organization(s): **Membertou Band**;** with the five Cape Breton First Nations communities (Membertou, Potlotek [Chapel Island], Eskasoni, Wagmatcook and We'koqma'q) in collaboration with Health Canada; the Nova Scotia Department of Health; Cape Breton District Health Authority; Guysborough Antigonish District Health Authority; Dalhousie University

**This was a collaborative initiative by the five First Nations bands listed above. The technical agreement was hosted by the Membertou Band on behalf of the community partners.

Approved Contribution: \$2,946,380

The five First Nations bands in Cape Breton, Nova Scotia, have some of the highest rates of morbidity and premature death in the country and have near-epidemic rates of diabetes. Out of deep concern over this situation, the Tui'kn (meaning "passage" in Mi'kmaq) Initiative was born to introduce a new way of thinking about health and delivering health care in the five communities. Its four major goals were to: remove the barriers to an integrated, holistic, culturally appropriate, multidisciplinary primary health care (PHC) model; create the mechanism for collaborative planning and partnerships within each community, among the five communities and among the local, district,



provincial and federal levels of government; develop capacity for the collection, management and interpretation of health information at the local level; and translate the renewed model of PHC into action. Over the three years of the initiative, it undertook four strategies and identified four pillars of priority action. The four strategies were: achieving a full complement of family physicians; supporting nurses to practice to their full potential; implementing an electronic patient record system in all five Tui'kn sites; and building community capacity to collect, manage and interpret health information by training Health Information and Evaluation Coordinators in each community and through the development of a Health Information System that links diverse data sets. The four pillars of community action were: diabetes prevention and management; non-traditional tobacco use; childhood injury prevention; and prescription drug misuse. Action plans, partnerships and a publication resulted from working on these pillars. Through this initiative, the five bands gained confidence and learned that they can work together to identify and meet the health care—and other—challenges that they face. They learned about building capacity for the collection, interpretation and manipulation of health information at the community level. They were successful in recruiting health care professionals and established a health information system that allows them to monitor trends, utilization and outcomes, and to use analysis to support clinical, policy and funding decisions.

A Tool to Help People from Far Away— The Ikajuruti Inungnik Ungasiktumi (IIU) Telehealth Network

Lead and Partner Organization(s): Department of Health and Social Services, Government of Nunavut

Approved Contribution: \$2,700,041

Nunavut faces unparalleled challenges in delivering health care and social services to its people. Its 25 communities vary in size from 148 to 7,000 and are connected only by sea, air and satellite communication. The Ikajuruti Inungnik Ungasiktumi (IIU) Telehealth Network, which means “a tool to help people from far away,” is therefore vital to delivering health care services to this territory's small and isolated population. This network has existed since 1999 and has brought videoconferencing and store-and-forward technology (the temporary storage of a message for transmission to its destination at a later time, which allows for routing over networks that are not accessible at all times, like those in remote locations) to 15 communities. However, 10 communities—with populations ranging from 150 to 800 people per community—remained isolated and unconnected. This initiative helped to support the network's expansion to seven of these communities—Clyde River; Hall Beach; Resolute Bay; Coral Harbour; Repulse Bay; Taloyoak; and Kugaaruk—and the Nunavut government leveraged the PHCTF investment to encourage private donations to connect the remaining three. The aims of the expanded IIU Telehealth Network were to:

- Improve access to health care services, social services, public health, education and administration;

- Support the ongoing investment into telehealth;
- Help staff providing services in remote locations;
- Deliver tools to support the integration of telehealth into the Health and Social Services delivery system, including health information and access to other specialists/professional opinions; and
- Use telehealth as a community development tool, providing communication between communities and regions in support of broader population health determinants.

This initiative helped the Department of Health and Social Services to adapt to the challenges of geography, climate and weather so that more patients are able to receive care closer to home. It has helped to enable Nunavut to provide comprehensive programming and services to all Nunavummiut (people of Nunavut), as well as make the newest jurisdiction in Canada the first to connect all of its communities with telehealth technologies. Through this initiative, personnel have been trained and certified to run and maintain the information technology equipment, and the gap between the health services available at the community level in the North and those in the South of Canada has narrowed.

Multi-Jurisdictional Envelope

Health Lines

Lead and Partner Organization(s): Alberta Health and Wellness; with the governments of British Columbia, Manitoba, Northwest Territories, Yukon Territory, Nunavut and Saskatchewan

Approved Contribution: \$6,813,600

Health lines have become an accepted model of accessing and delivering high-quality health services, and they continue to expand and grow. The potential exists to use health lines to create linkages with primary health care to support clients and the health system in a variety of ways. This multi-jurisdictional collaborative involved seven jurisdictions working together to support health line development, as they faced common issues related to the planning, implementation and delivery of health line services. The collaborative's goal was to create economies of scale and avoid duplication by sharing expertise, knowledge and skills in the planning and delivery of health line services. The initiative targeted activities in five areas: staff education, evaluation, promotion and marketing, chronic disease management, and coordination and collaboration. An extensive array of resources was developed through these activities, including an Efficiency Self-Assessment Tool and a Business Planning Guide. The tools, frameworks and templates developed through the initiative can be used both within the partner jurisdictions and across the country, and can be found on the initiative website: http://www.health.gov.ab.ca/key/Multi_Jurisdictional%20Health%20Lines%20Initiative.htm. This initiative established a strong regional network that can help to advance national health line planning and implementation activities.

Western Health Information Collaborative (WHIC) Chronic Disease Management Infostructure Initiative

Lead and Partner Organization(s): **Government of Alberta (lead jurisdiction on behalf of WHIC);** with British Columbia Ministry of Health; Saskatchewan Health; Manitoba Health

Approved Contribution: \$8,000,000

The WHIC chronic disease management (CDM) initiative arose from clinicians' need for better access to clinical information on chronic disease. The initiative focused on facilitating the collection and dissemination of consistent, reliable CDM information, in order to provide clinicians with relevant clinical information to assist in treating persons with chronic diseases. It specifically concentrated on the development of data and message exchange standards to support CDM, including a transition toward implementing this health information infrastructure, or "infostructure," in the computer systems in the partner jurisdictions. Specifically, the initiative identified, defined and standardized core data sets and information interchange messages for three chronic diseases—diabetes, hypertension and chronic kidney disease—and implemented the data standards and messages in the four partner jurisdictions. In developing these standards, the initiative worked extensively with a clinical advisory group and stakeholders who attended multiple provincial workshops. The initiative has increased the capacity of primary health care teams to share the data needed for CDM clinical decision-making. A greater number of health providers from multiple sites now have timely access to clinical information and, as a result, care can be provided in the most suitable setting. The development of CDM standards in a generic framework has ensured that new diseases can be addressed with a minimal amount of change to data content and message definitions. The implementation of HL7 messaging standards, which has begun as a result of this initiative, will facilitate the exchange of common chronic diseases data. This will allow for the interoperability of information systems and, thus, communication of CDM information locally, regionally, provincially and eventually nationally. The initiative website, www.whic.org/public/profiles/cdm.html, hosts documents that may be of interest to other jurisdictions with an interest in implementing the CDM standards.

National Envelope

Canadian Collaborative Mental Health Initiative

Lead and Partner Organization(s): **The College of Family Physicians of Canada;** with Canadian Alliance on Mental Illness and Mental Health; Canadian Association of Occupational Therapists; Canadian Association of Social Workers; Canadian Federation of Mental Health Nurses; Canadian Mental Health Association; Canadian Nurses Association; Canadian Pharmacists Association; Canadian Psychiatric Association; Canadian Psychological Association; Dietitians of Canada; Registered Psychiatric Nurses of Canada

Approved Contribution: \$3,845,000

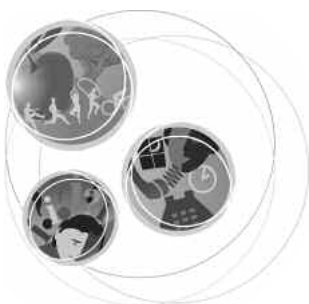
The Canadian Collaborative Mental Health Initiative (CCMHI) represented a consortium of 12 national organizations that worked together to improve mental health care for Canadians. They believed that more effective collaboration among primary health care providers, specialized mental health care providers, consumers and their families and communities, supported by appropriate funding mechanisms, would strengthen the health care system's capacity to respond to the mental health needs of Canadians. Over a two-year period, the CCMHI conducted an analysis of the current state of collaborative care. It was successful in developing a Charter that represents a shared vision of collaborative care among the consortium partners, and it developed a series of practical toolkits on collaboration for clinicians, consumers, caregivers and educators. The CCMHI website, www.ccmhi.ca, provides access to all of the documentation developed over the life of the initiative, including the complete research, toolkits and the Charter. Leads in each of the partner organizations will continue to implement the Charter and toolkits with their executive and membership. The initiative has been successful in establishing a pan-Canadian community of interest that will drive future collaborative mental health care innovation.

Sixth National Summit: Cancer Control in Northern and Rural Communities

Lead and Partner Organization(s): **Regional Cancer Centre—Thunder Bay Regional Health Sciences Centre;** with Canadian Association of Provincial Cancer Agencies; Canadian Strategy for Cancer Control

Approved Contribution: \$75,000

Five national sessions to discuss issues related to community or non-institutional cancer control outside of the formal cancer system have been held across Canada in the past few years. This initiative planned, implemented and summarized the 6th National Summit on Community Cancer Control, which focused on cancer control in northern, rural, remote (NRR) and Aboriginal communities. Led by a National Steering Committee, this initiative aimed to develop recommendations and implementation plans through active partnerships at all levels to improve rural and northern community cancer control



(including prevention, surveillance, screening/early detection, treatment, supportive care, rehabilitation and palliation). Specifically, this initiative's goals were to: 1) identify and prioritize challenges and barriers associated with cancer control in NRR and Aboriginal communities; 2) identify strategies/mechanisms for improving cancer control in priority areas at all levels, including innovative initiatives; and 3) recommend specific strategies/mechanisms to a broad range of groups and organizations, including community, regional, provincial, territorial and national organizations, as well as cancer advocacy groups and the Canadian Strategy for Cancer Control and its affiliates. This summit—held in Thunder Bay, Ontario—brought together 220 delegates from a diverse range of stakeholder groups to discuss issues related to: health human resources; building healthy communities through community participation; improving access; and electronic health records. These had been identified as priority areas through a literature review, a survey of delegates, and virtual meeting groups. This initiative provided a forum for cancer control representatives from across Canada to identify actions and strategies in all these areas to improve cancer control in NRR and Aboriginal communities. Summit recommendations and action plans have been presented at international conferences and are informing policy- and decision-makers in Canada. They are available on the website www.communitycancercontrol.ca.

Shaping the Future of Primary Health Care in Nova Scotia

and

Building Blocks to a Sustainable Primary Health Care System—Momentum 2005: Moving in the Right Direction

Lead and Partner Organization(s): The College of Registered Nurses of Nova Scotia; with Health Canada Atlantic Region; Nova Scotia Department of Health, Primary Care; Canadian College of Health Services Executives (Nova Scotia and Prince Edward Island chapters); Doctors Nova Scotia; Nova Scotia College of Family Physicians

Approved Contribution: \$19,000 for Shaping the Future; \$49,500 for Building Blocks

The College of Registered Nurses of Nova Scotia sponsored two conferences on primary health care (PHC) reform. The conference Shaping the Future of Primary Health Care in Nova Scotia, held in May 2003, attracted 250 participants from the areas of health, community and government. The topics discussed included: background information on impetus for change; components of a successful primary health care model; strategic directions and targets; system design imperatives (information technology systems, funding models, competencies, collaborative agreements); and cultural, behavioural and attitudinal changes. Momentum 2005, Moving in the Right Direction, held October 26–28, 2005, in Halifax, Nova Scotia, was planned to be a follow-up conference to Shaping the

Future in Nova Scotia. Its program centred on four themes—Responsiveness, Inter-professional Collaboration, Tools and Technology, and Integration—with the aim of providing practical strategies and tools for the 142 participants from the health care community to emulate in their own work settings. These conferences together offered participants an opportunity to:

- Profile successes and share experiences and lessons learned;
- Discuss barriers and strategies to facilitate further advancement;
- Participate in workshops to enhance understanding of collaborative practice team development in PHC;
- Identify direct contributions to PHC reform efforts through the Building a Better Tomorrow education modules;
- Learn about national initiatives;
- Be in a better position to adapt these tools and recommendations to local and/or regional settings; and
- Renew their commitment to improving PHC in Nova Scotia and nationwide.

Support Packages for the Uptake of Chronic Disease Management Best Practices

Lead and Partner Organization(s): British Columbia Ministry of Health; with British Columbia Medical Association

Approved Contribution: \$75,000

Approximately one in four British Columbians has been diagnosed with a chronic disease, and statistics indicate that while many practitioners provide optimal care, the health care delivery system as a whole is not structured in a way that best promotes and supports good chronic disease management. Good chronic care typically requires changes in primary care office and clinical processes that include planned visits, patient follow-up and proactive care. In 2004–05, the British Columbia (B.C.) Ministry of Health funded several health profession organizations to design and implement a number of chronic disease management quality improvement initiatives to support family physicians in changing their clinical practice, and in 2005, province-wide consultations were held with B.C. general practitioners. Based on recommendations arising from these initiatives and consultations, the B.C. Ministry of Health, in collaboration with the B.C. Medical Association, undertook this initiative to develop tools known as “support packages”—detailed information/modules that clearly describe: the changes that need to be made at the general practitioner's office practice so that clinical guideline recommendations are effectively embedded in chronic disease management; how to redefine the workflow in the office; and ways to maximize the skills and roles of all practice staff (medical office assistant, nurses, etc.) for optimal patient care. This initiative developed nine support packages: Moving to Group Practice; Improving Practice Efficiency: Advanced Access; Working Within Teams; Sharing Patient Care with Specialists; Managing Chronic

Disease in the Office Setting; Enabling Patient Self-Management; Investing in Prevention and Early Identification; Introducing Group Visits; and Developing a Patient Registry. These are stand-alone tools that will be available on the B.C. Ministry of Health's website, www.healthservices.gov.bc.ca/cdm/.

Getting a Grip on Arthritis: A National Primary Health Care Community Initiative

Lead and Partner Organization(s): **Arthritis Society;** with Arthritis Community Research and Evaluation Unit, Arthritis Health Professions Association; Canadian Alliance of Community Health Centre Associations; Canadian Nurses Association; Canadian Rheumatology Association; Ontario Ministry of Health and Long-Term Care; Patient Partners® in Arthritis; Sunnybrook Health Sciences Centre

Approved Contribution: \$3,876,685

Although there are more than 4 million Canadians living with arthritis, arthritis care at the primary health care (PHC) level faces significant challenges: difficulty diagnosing rheumatoid arthritis and lack of information for patients on exercise, community resources, medication and how to cope with arthritis and deal with pain. Building on the achievements and findings of a project led by the Arthritis Strategic Action Group in Ontario, this national initiative aimed to effectively address these challenges by increasing the capacity of PHC providers and people with arthritis to manage the disease collaboratively. The initiative's goals were to support the delivery of arthritis care and to emphasize prevention, early detection, comprehensive care, more appropriate and timely access to specialty care, and self-management. Specifically, the initiative's objectives were to: define community, patient and provider educational needs regarding arthritis; enhance the capability of communities and PHC providers to manage the burden of this disease; improve the self-management skills of people with arthritis; and improve outcomes for people with arthritis (i.e., reduced pain, fatigue and disability). The initiative achieved these objectives by: conducting needs assessments for communities, patients and providers; developing educational material for providers, patients and the general public; facilitating 30 accredited interprofessional workshops on osteoarthritis and rheumatoid arthritis for providers working in PHC; and conducting activities to strengthen the learning on best practices and to support delivery of integrated arthritis care in the community. This initiative successfully used interdisciplinary learning and care models to boost the confidence of health professionals in identifying and treating arthritis, and deepened their understanding of the roles of various health professionals in interdisciplinary care.

Resources developed by this initiative are available online at www.arthritis.ca/gettingagrip or www.arthrite.ca/prendreenmain and

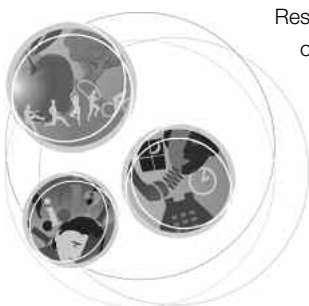
include: *Getting a Grip on Arthritis: A Resource Kit for People with Arthritis*; *Financial Resources for People with Arthritis*; a provider toolkit on arthritis clinical practice guidelines; and an arthritis prevention poster.

National Home Care and Primary Health Care Partnership Initiative

Lead and Partner Organization(s): **Canadian Home Care Association;** with Calgary Health Region; Ontario Community Care Access Centres (Halton and Peel); primary health care providers; Workflow Integrity Network; IBM Business Consulting Services

Approved Contribution: \$2,682,100

This initiative arose from the Canadian Home Care Association's belief that home care has a key role to play in primary health care (PHC) renewal. The initiative's purpose was to demonstrate the effect of an augmented home care case management role in collaboration with the family physician on the care of persons with chronic disease. Individuals with diabetes were targeted. Generally, case managers and physicians work separately. The initiative's goal was to foster greater collaboration and partnership between the two in order to achieve more effective use of appropriate health care personnel and more proactive patient care with an emphasis on prevention and patient empowerment. Other objectives included achieving improved health outcomes, better use of health care services and heightened patient/client satisfaction. In addition, the initiative set out to promote greater use of information technology systems to support communications, care and record-keeping. The evaluation covered the period between October 2004 and September 2005, with 942 patients enrolled in two locations: Calgary, Alberta, and Halton and Peel, Ontario. The initiative demonstrated that partnering a case manager with a family physician in the care of chronic disease patients benefits the patient, the physician and the health system. Benefits realized included: increased client access; improved collaboration between clients and providers and among providers; improved health outcomes; and increased client satisfaction. For providers, there was improved partnership; enhanced collaborative care; greater use of tools and evidence-based guidelines; increased electronic connectivity; more information sharing; better coordination of services; and a higher level of provider satisfaction. From a system perspective, participants saw improved efficiency of service delivery; greater ability to evaluate health outcomes; and more appropriate use of health care services. In communicating its findings, the initiative noted that it had achieved increased public and stakeholder awareness of PHC services. Approximately 25 practical tools used and/or developed during the initiative have been posted with instructions on the website www.cdnhomecare.ca.



Pallium Integrated Care Capacity Building Initiative

Lead and Partner Organization(s): **Alberta Cancer Board, Division of Medical Affairs and Community Oncology;** with national and hospice palliative care organizations and associations and participating jurisdictions (eight Canadian universities, regional health authorities and seven provinces and territories)

Approved Contribution: \$4,317,000

The original Pallium Project sought to improve the care for those in Canada experiencing a life-limiting illness by creating innovative educational resources for rural and remote primary care professionals. From 2004 to 2006, the Pallium Project evolved into a Community of Practice, which worked as a collaborative group of people throughout Canada. This community shared common practices and interests through a shared-care model among primary-, secondary- and tertiary-levels of care and other community partners to advance skill and knowledge in hospice palliative care (HPC). This approach was designed to improve access, enhance quality and build long-term system capacity. Through 71 locally championed sub-projects, the initiative supported outreach education and continuing professional development; knowledge management and workplace learning; service development; and innovative modes of collaboration. It has evolved into one of Canada's most vibrant examples of an inter-sectoral community of practice that has supported, and will continue to support, long-term capacity-building in HPC. It was successful in rapidly disseminating local innovation across multiple jurisdictions. The outreach education and continuing professional development activities brought timely and relevant teaching-learning activities to health care providers. Many of these activities helped to facilitate change in practice patterns among primary health care providers. The initiative's tools and resources can be found at www.pallium.ca or on the Canadian Hospice and Palliative Care Association website, www.chpca.net.

Rainbow Health—Improving Access to Care

Lead and Partner Organization(s): **Canadian Rainbow Health Coalition;** with Gay and Lesbian Health Services of Saskatoon; Nova Scotia Rainbow Action Program; Gris Quebec; La Coalition d'aide aux lesbiennes, gais et bisexuels-les de l'Abitibi-Témiscamingue; 2-Spirit People of the 1st Nation; Rainbow Health Network/Coalition for Lesbian and Gay Rights in Ontario; Gay and Lesbian Health Services of Saskatoon (Avenue Community Centre for Gender and Sexual Diversity); The Centre, Vancouver; Transcend Transgender Support and Education Society/ Transgender Health Program

Approved Contribution: \$2,307,000

Research indicates that gay, lesbian, bisexual and transgender (GLBT) people's health status is substantially poorer than that of the average Canadian, with higher rates of suicide, depression, mental illness, substance abuse and HIV/AIDS. This initiative therefore aimed to:

- Raise awareness of this fact among health care providers and within the GLBT communities across the country;
- Encourage GLBT individuals to become active partners in their own health care; and
- Increase emphasis on health promotion, disease and injury prevention, and management of chronic disease.

This 29-month initiative undertook two main activities: education and partnership building, the latter focusing on schools of medicine, nursing and social work. It held two national conferences, which brought together hundreds of health care professionals, health care students and members of the community to discuss issues and share information and resources. The initiative focused attention on the special health needs of GLBT people. It located numerous relevant health care resources, and made them more accessible by placing them on one website, which now contains the largest body of information, educational tools, research studies and other materials related to GLBT health and wellness.

Official Languages Minority Communities Envelope

Résautage Santé en français [Francophone Health Networks]

Lead and Partner Organization(s): **Société Santé en français;** with health institution managers; health professionals; representatives of educational institutions; government officials

Approved Contribution: \$1,900,000

Across the country are a wide range of French-speaking minority communities, and providing French-language health services is a challenge that will require a strategy. For the Consultative Committee for French-Speaking Minority Communities, networking is the cornerstone of the strategies implemented in provinces and territories wishing to improve French-language health services for their Francophone populations. In 2002, only one network existed. The goal of the initiative was to increase this number, and its approach has been to work with groups across the country to improve access to French-language health services. Groups of promoters have also conducted activities, such as: building a profile of the Francophone community to be served; drawing a profile of health services in the region concerned; starting or continuing to promote awareness among partners; developing a business plan; defining and implementing the appropriate governance structure; initiating strategic and operational planning; and preparing an evaluation plan. The initiative has successfully established 17 networks in all provinces and territories, which are in various stages of development. However, while work remains to be done and some networks do not yet have formal structures, it is clear that each region has begun networking with partners and that the stakeholders can now work together in planning and implementing French-language health services.

Improving Access to Primary Health Care Services for English-Speaking Persons in Quebec

Lead and Partner Organization(s): **Community Health and Social Services Network (CHSSN)**; with Saint-Brigid's Home Inc.

Approved Contribution: \$10,000,000

The initiative sought to improve access to English-language primary health care services for Quebec's anglophone community, and to strengthen ties between the community and the province's health and social services institutions. To meet its objectives, the initiative

funded 37 projects in 14 Quebec administrative regions, in three separate categories: Info-Santé for the anglophone population; needs-specific services; and special needs living environments. These projects helped meet certain needs among anglophones, and increased, adapted and improved services offered to the anglophone community. The initiative also developed various communication resources. A newsletter and a website (www.chssn.org) served as public enquiry points, and an Intranet site for sponsors contained news on initiative-related activities as well as a Virtual Library with more than 300 English-language virtual reference documents and tools.



