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Primary Health Care Transition Fund

Collaborative Care

March 2007

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This report has been prepared by Vernon Curran, PhD, Memorial University of Newfoundland.

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Published by the authority of the Minister of Health.

Primary Health Care Transition Fund, *Collaborative Care*, March 2007 is available on the Internet at the following address:

www.healthcanada.gc.ca/phctf

Également disponible en français sous le titre : Fonds pour l'adaptation des soins de santé primaires, *Soins en collaboration*, Mars 2007

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HC Pub.: 1250
Cat.: H21-286/2-2007E-PDF
ISBN: 978-0-662-45025-2

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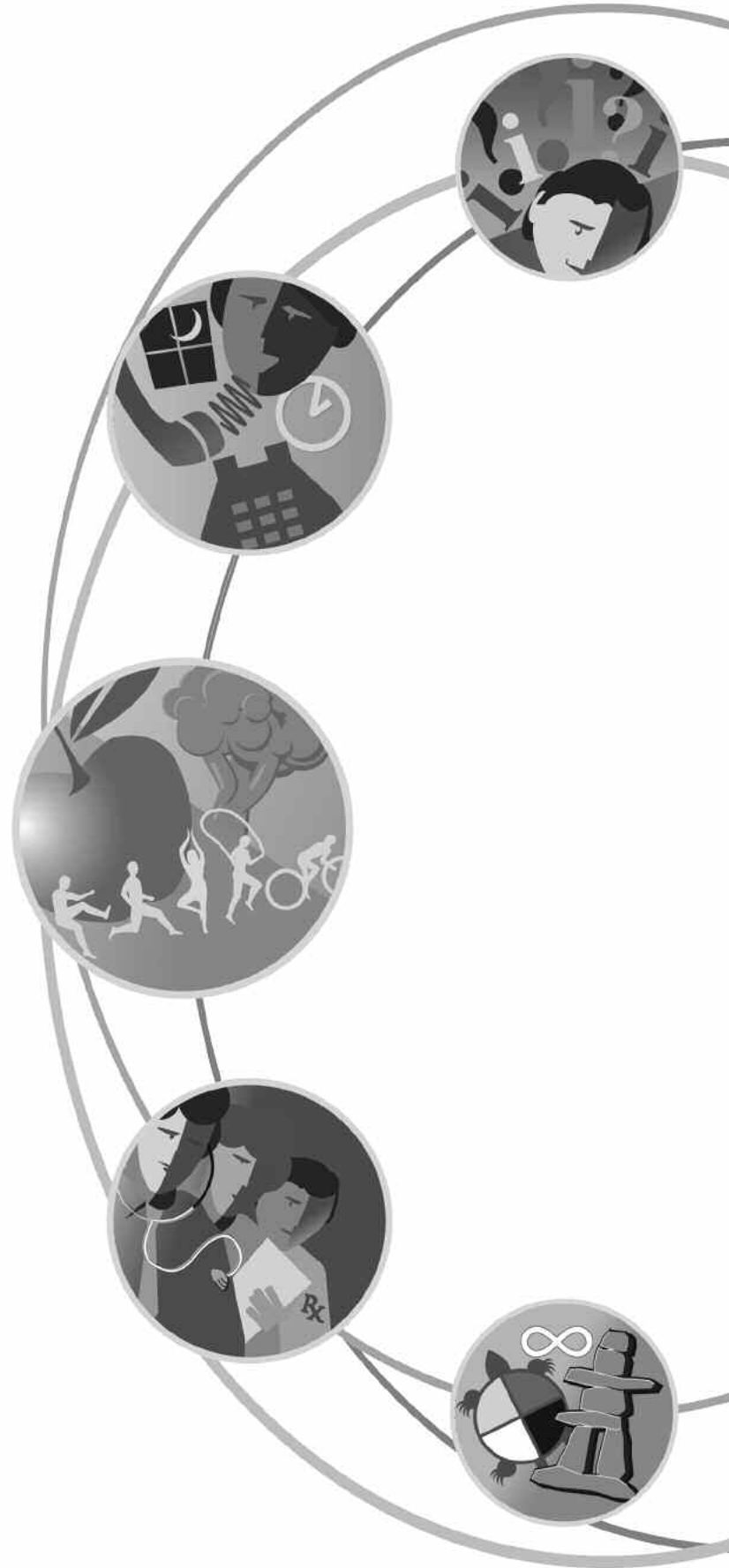
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Vernon Curran, PhD

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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.

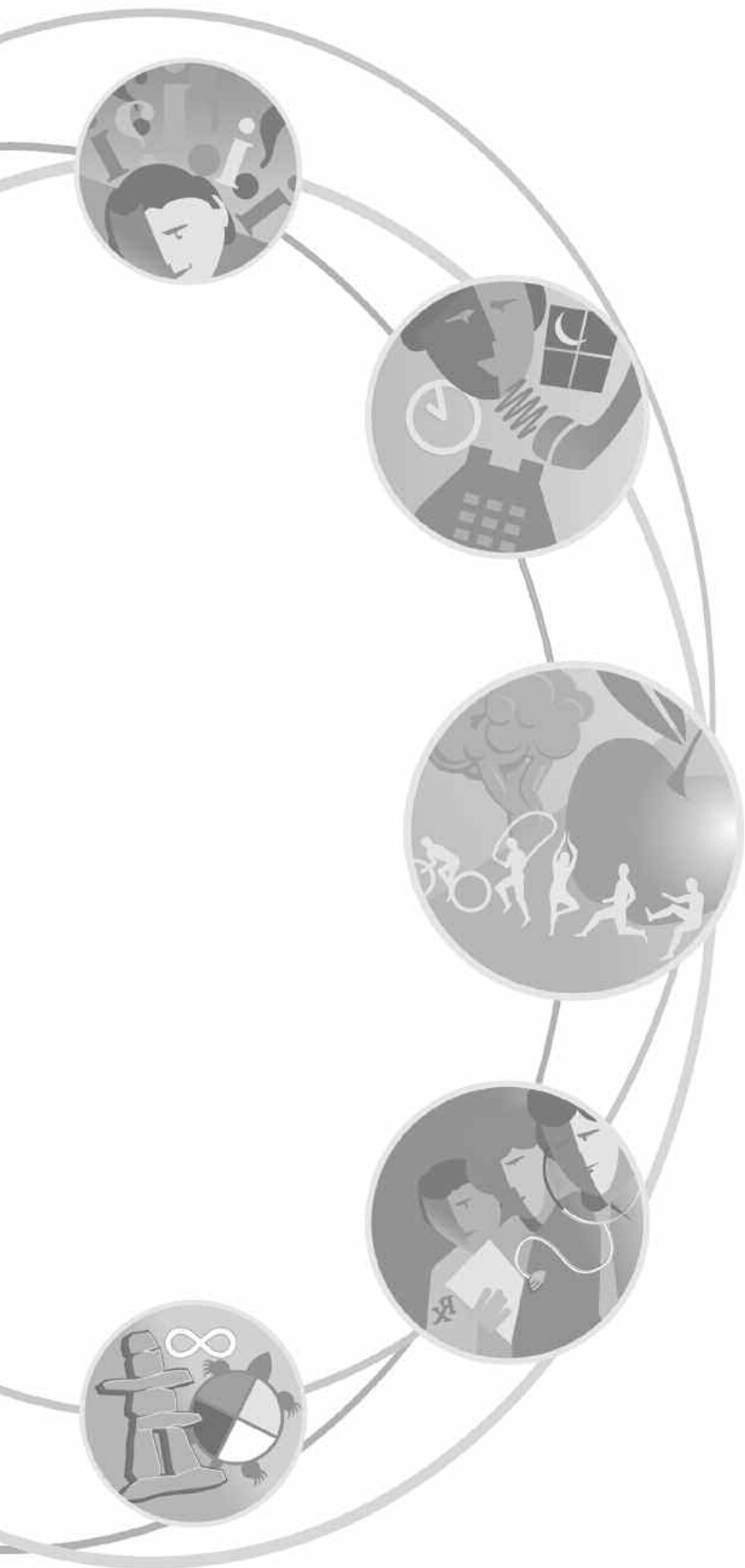
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Acknowledgements

The Primary Health Care Transition Fund *Synthesis Series on Sharing Insights* was commissioned by Health Canada and managed by The Conference Board of Canada.

The author would like to thank Dr. John Service of the Canadian Psychological Association and Gilles Rhéaume of The Conference Board of Canada for their thoughtful comments on the rough draft of this report.

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



Executive Summary

A fundamental principle of primary health care (PHC) renewal in Canada has been the call for greater collaboration among health care providers. Collaborative care is a patient/client-centred process in which two or more professions/disciplines interact to share knowledge, expertise and decision-making in the interest of improved patient/client care. It is believed that teams that collaborate are more able to address the increasing complexity of the Canadian population's health care needs. It is also believed that greater collaboration between health professionals can result in better health, improved access to services, more efficient use of resources, and better satisfaction for both patients and providers. The purpose of this report is to review initiatives funded through the Primary Health Care Transition Fund (PHCTF), which addressed issues related to collaborative care in different PHC settings.

Across all 13 jurisdictions funded through the *Provincial-Territorial Envelope* there was a range of innovative and varying models of collaborative care involving interdisciplinary/interprofessional teams of health and social care providers. Models of collaboration were characterized by the nature of the collaborative (e.g. geographic region vs. patient type), role expansion of team members, regionalization of collaborative care, and delivery of collaborative PHC services based on population health needs. Interprofessional education (IPE) at pre- and post-licensure levels, the enhancement of electronic medical/health record systems, and overall positive outcomes pertaining to patient and provider experiences with enhanced models of collaborative PHC were key trends which emerged across the provincial/territorial initiatives.

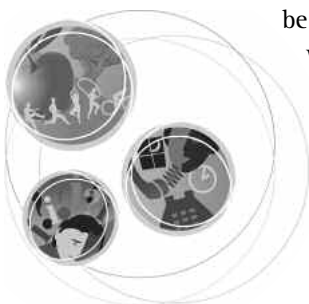
The *Multi-Jurisdictional Envelope* supported regional approaches, which complemented the PHC renewal activities of participating provinces and territories. Regional approaches to post-licensure IPE development and delivery, overall coordination of primary health services and the identification of common standards for electronic health information were found to be successful. *National Envelope* initiatives were funded across three sub-envelopes, including National Strategies, Tools for Transition and National Initiatives. Initiatives funded under the National Strategy on Collaborative

Care sub-envelope were successful in engaging professional associations and developing resources to foster collaborative care models. A common trend across the Tools for Transition initiatives was stakeholder engagement and consultation at provincial and national levels on issues related to collaborative PHC. National Initiatives were funded at local or regional levels and included a focus on enhancing collaboration in chronic disease care, palliative care and care for targeted populations within Canada.

A common theme across *Aboriginal Envelope* initiatives was the promotion of more effective PHC service delivery to Aboriginal people, while enhancing service delivery coordination among all levels of government as well as Aboriginal communities and health organizations. The *Official Languages Minority Communities Envelope* supported activities that improved access to PHC services for English-speaking minority communities in Quebec and French-speaking minority communities outside Quebec, across Canada.

Key outcomes/results and findings emerging from the review were categorized as either representative of interactional, organizational or systemic determinants influencing collaborative PHC. Interactional determinants represented components of interpersonal relationships among team members that affected collaboration. Understanding the roles of team members and how these roles contribute to client outcomes was reported as vital to building trusting relationships and team development. The location (e.g. co-location) of providers was an important factor that supported team development processes in a number of initiatives. Collaborative care was also found to benefit from the availability of standards, policies and interprofessional protocols. Collegial development of collaborative care guidelines or practice manuals was an important interactional factor across some initiatives as well.

Organizational structure, including administrative supports and leadership, was also reported to be an important organizational determinant that fostered collaborative PHC across a number of initiatives. An organization's philosophy and its inherent values were found to have a direct impact on the degree of collaboration. Several key outcomes emerged from the PHCTF



initiatives pertaining to organizational determinants. Key leaders had been successfully engaged in building support and fostering PHC renewal. Some initiatives had advanced knowledge and had adopted best practices to facilitate collaborative PHC. Numerous toolkits, practice manuals, frameworks and other resources related to enhancing and facilitating collaborative PHC resulted from the PHCTF initiatives. Several initiatives also advanced knowledge related to electronic information systems and telehealth to support interprofessional collaboration.

Successful collaborative care was also influenced by systemic determinants. Systemic determinants are elements outside the organization, such as components of social, cultural, educational and professional systems. The professional system has a strong influence on the development of collaborative care approaches, and several PHCTF initiatives were successful in engaging stakeholders from the professional system to advance collaborative PHC. Interprofessional education was a major activity across many PHCTF initiatives, and the outcomes have advanced knowledge of the role and effectiveness of both pre- and post-licensure IPE in fostering and developing collaborative PHC teams. A number of initiatives were also successful in laying the groundwork for advancing collaborative PHC at regulatory and funding/remuneration system levels.

A number of implications for policy and practice form the basis of the following recommendations:

Liability and regulatory enhancements: Further enhancement to liability and regulatory mechanisms at both national and provincial levels needs to be undertaken to support collaborative care in different PHC settings. The recommendations arising from some of the initiatives funded through the National Strategy initiatives would be helpful in guiding pan-Canadian approaches to such changes.

Compensation and funding: Adequate funding and remuneration models are necessary to support the shift to collaborative care models in PHC settings. Traditional fee-for-service methods of remuneration of health care providers discourage collaboration rather than facilitate it.

Interprofessional education: IPE is important in enhancing collaborative competencies that foster team development. IPE at pre- and post-licensure levels, as well as

IPE in practice settings, is critical to fostering patient-centred collaborative care.

Organizational supports: Resources and support at an organizational level are necessary to introduce innovative models of collaborative care, including planning and coordination, information technology (hardware, software, training, ongoing support), common standards, tools and practice guidelines, physical space, and adequate funding and incentives.

Patient-centredness: Patients and caregivers must be included as members of the PHC team. To do this, patients and caregivers need better understanding of the collaborative process and the roles of various providers. Greater efforts to explore the roles of patients and caregivers as members of the team and how to integrate them are critical.

Health human resources plans: The supply, mix and distribution of PHC providers has significant implications for models of collaborative care. Health human resource plans that support collaborative care models are required to sustain PHC renewal.

Integration of traditional providers: Interprofessional teams of both traditional and Western providers are necessary for health care delivery in many Aboriginal communities. Greater effort must be placed on incorporating traditional providers into team-building efforts.

Education of Western providers: Health professional graduates are generally poorly prepared to work with traditional providers in remote areas of the country. Academic institutions need to introduce greater opportunities for students and trainees to learn to be culturally competent.

Greater evidence of collaborative PHC outcomes: There is a clear need for further evidence of the effectiveness of collaborative care models in PHC settings and the characteristics of collaborative efforts that support positive patient and health outcomes, organizational efficiency, and enhanced patient and provider satisfaction.

The PHCTF was successful in fostering and supporting the introduction and further development of a variety of innovative models of collaborative care across Canada. In some initiatives, the PHCTF was effective in establishing collaborative care teams, while in others the PHCTF was helpful in supporting existing strategies

to implement new models of PHC collaboration. The PHCTF initiatives brought together key stakeholder groups at both national and provincial levels to advance PHC renewal. The outcomes/results and findings from the initiatives have advanced knowledge of effective strategies for nurturing and sustaining collaborative care in different PHC settings. Patient and provider

satisfaction has increased in settings in which innovative models of collaborative care have been integrated. The numerous resources resulting from the various PHCTF initiatives will also continue to support collaborative PHC and help to sustain PHC renewal in Canada well into the future.



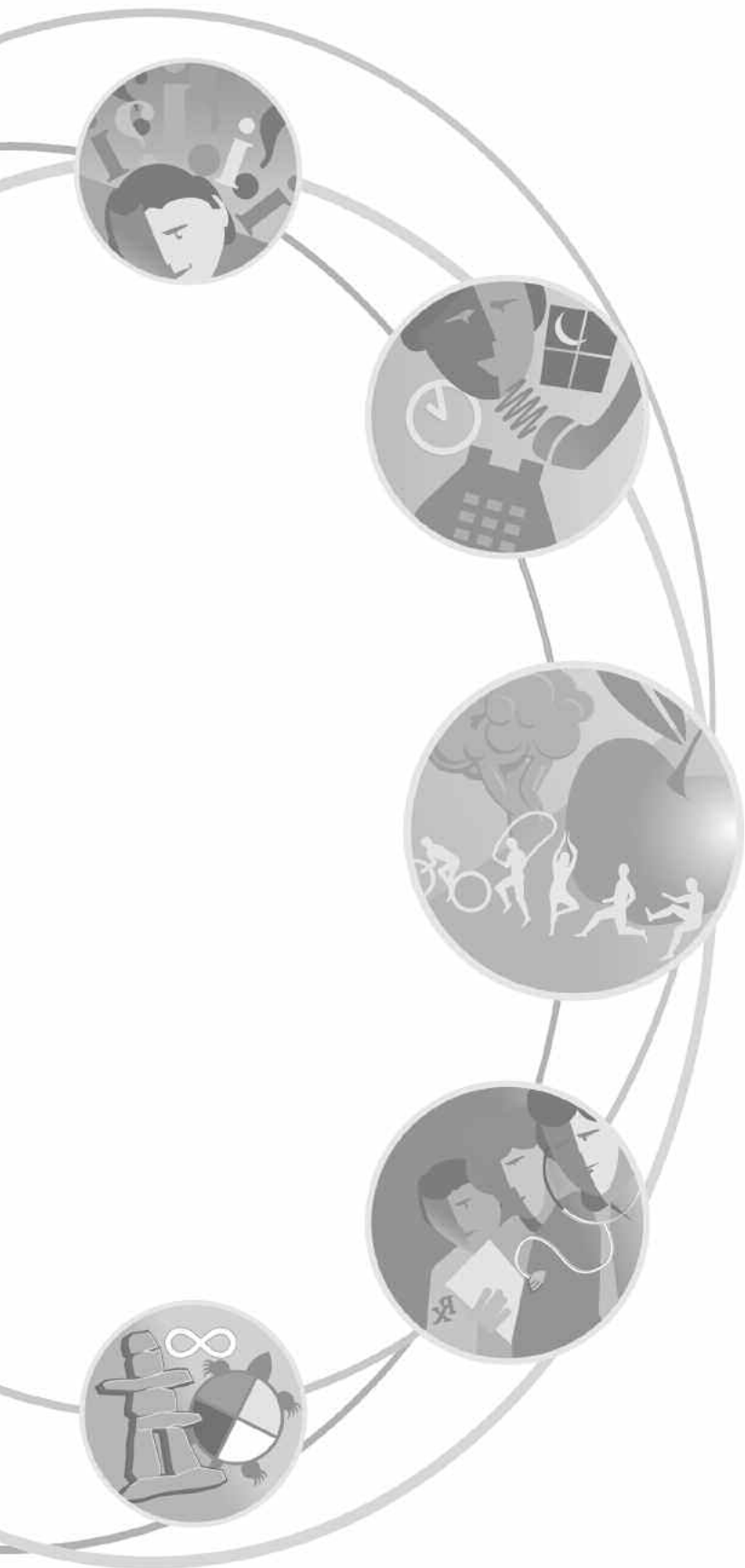
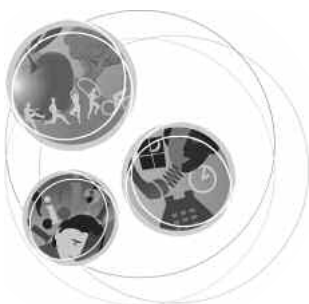
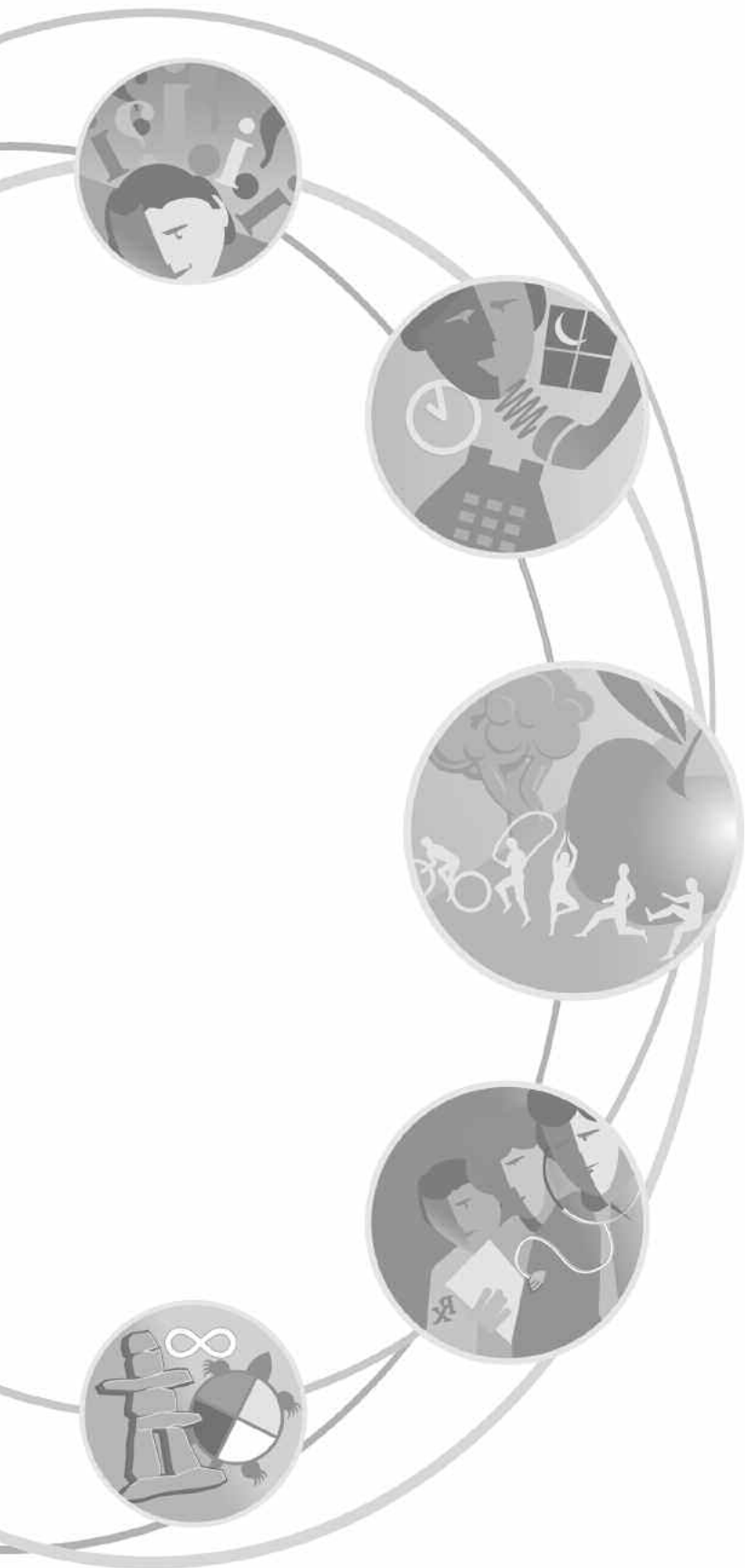


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1 Setting the Context

Primary health care (PHC) renewal has been identified in Canadian policy and by most health reformers as the foundation in a sustainable health care system (Commission on the Future of Health Care in Canada, 2002; Standing Senate Committee on Social Affairs, Science and Technology, 2002; Health Council of Canada, 2005). PHC incorporates primary care—diagnosis, treatment and management of health problems—and also addresses the broader determinants of health. It encompasses the coordination, integration and expansion of systems and services to provide more population health, sickness prevention and health promotion by all disciplines (Mable & Marriott, 2002).

PHC encourages the best use of all health providers, including traditional healers, to maximize the potential of all health resources (Mable & Marriott, 2002). A fundamental principle of PHC renewal in Canada has been the call for a shift toward models of collaborative care in which teams of providers are accountable for offering comprehensive and coordinated health care services to a patient population (Commission on the Future of Health Care in Canada, 2002; Standing Senate Committee on Social Affairs, Science and Technology, 2002; Health Council of Canada, 2005). It has become widely recognized that the needs of many patients are beyond the expertise of any single profession, and genuine patient-centred service requires interprofessional collaborative care (Freeth, 2001).

In the research report *Improving the Effectiveness of Primary Health Care Through Nurse Practitioner / Family Physician Structured Collaborative Practice*, collaborative practice is defined as “an interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided” (Way, Jones, & Baskerville, 2001 Appendix Z, p. 2). The website of the Canadian Association of Occupational Therapists (2005) defines interdisciplinary collaboration as referring to “the posi-

tive interaction of two or more health professionals, who bring their unique skills and knowledge, to assist patients/clients and families with their health decisions.” Oandasan, Baker, Barker, Bosco, D’Amour et al. (2006) describe collaborative practice as patient-centred. It involves the continuous interaction of two or more professionals or disciplines, organized into a common effort to solve or explore common issues, with the best possible participation of the patient. Collaborative practice is designed to promote the active participation of each discipline in patient care. It enhances patient- and family-centred goals and values, provides mechanisms for continuous communication among caregivers, optimizes staff participation in clinical decision-making within and across disciplines, and fosters respect for disciplinary contributions of all professionals (Oandasan et al., 2006).

Collaboration within a team can be described on a continuum of professional autonomy. At one end of the spectrum, professionals may intervene on an autonomous or parallel basis, thus creating a de facto parallel practice as in multidisciplinary practice.¹ At the other end of the spectrum, professionals have a narrower margin of autonomy, but the team as a whole is more independent and its members are better integrated, as in interdisciplinary/interprofessional teams.² Several elements characterize effective interprofessional collaboration. Members need to share a common vision and goals, communicate clearly with other members of their team, understand each other’s roles, trust one another, and make decisions as a group (Poulton & West, 1993; Grant, Finnocchio, & the California Primary Care Consortium Subcommittee on Interdisciplinary Collaboration, 1995; D’Amour et al., 2005). Effective teams also need processes and organizational structures that support their work.

The composition of teams in PHC is also not static; the makeup of the team should be based on the needs of the community or population, the needs of the specific patients/clients being served and the working environ-

1 Multidisciplinary team refers to situations where several different professionals work on the same project but independently or in parallel. In essence, multidisciplinary teamwork characterizes various professionals interacting on a limited and transient basis. Although they do not necessarily meet, the members of a multidisciplinary team manage to work in a coordinated fashion (D’Amour, Ferrada-Videla, Martin-Rodriguez, & Beaulieu, 2005).

2 Interdisciplinary/interprofessional team implies a greater degree of collaboration between team members. It is a structured entity with a common goal, common decision-making process and is based on an integration of the knowledge and expertise of each professional, so that solutions to complex problems can be proposed in a flexible way (D’Amour et al., 2005).

ment. Teams change and evolve to meet the needs of patients/clients and groups of patients/clients; they can include nurses, physicians, dietitians, nurse practitioners, physiotherapists, occupational therapists, social workers, mental health workers, psychologists, pharmacists, speech therapists, family service workers and others required to respond to the needs of the client.

It is believed that teams which collaborate will be better equipped to deal with the increasing complexity of needs and care of the Canadian population (Commission on the Future of Health Care in Canada, 2002; Health Council of Canada, 2005). It is also believed that greater collaboration between health professionals can result in better health, improved access to services, more efficient use of resources, and enhanced satisfaction for both patients and providers (Pritchard & Pritchard, 1992; McNair, Brown, Stone, & Sims, 2001; Roblin, Vogt, & Fireman, 2003; Grumbach & Bodenheimer, 2004). At a fundamental level, working in teams may lead to greater coordination and cooperation among providers and possibly to enhanced care for individuals and communities (Roblin et al., 2003).

A number of factors are considered to be important in fostering and sustaining interprofessional collaboration in PHC. Martin-Rodriguez, Beaulieu, D'Amour and Ferrada-Videla (2005) have proposed that such factors can be categorized at three different levels, which they have referred to as “determinants” of interprofessional collaboration. First, “interactional determinants” represent factors associated with either the individual providers themselves, such as attitudes toward collaboration, or the nature of the interpersonal relationships between different providers on the team. Secondly, “organizational determinants” refer to the various organizational structures, values and philosophies that support and facilitate collaboration within and across organizations. The third category, “systemic determinants,” includes the myriad of factors within the general environment in which the organization functions, including the way in which different providers are compensated (Martin-Rodriguez et al., 2005).

The role of key individuals in encouraging collaborative care approaches is critical, as is induction and team-building for new team members. The ability to exchange

knowledge and information about patients and services, as well as the effective use of information technology (IT) and functioning electronic links between health and social care are factors influencing joint working practices. Vanclay (1996) and Taylor, Blue and Misan (2001) identified a number of factors³ also believed to also be important in sustaining collaborative care, including:

- co-location and amount of time spent at a site;
- understanding of roles and responsibilities;
- trust and respect of each professional;
- ability to share patients/clients;
- sharing information about structures and procedures;
- regular face-to-face contact;
- joint work on local projects or specific topics; and
- support from senior management.

Key barriers to effective interprofessional collaborative care include legislative, liability and regulatory frameworks; lack of adequate financing and appropriate funding; inability to integrate professionals from different disciplines into a team; and a lack of clarity about what an interprofessional team looks like and how it works (Martin-Rodriguez et al., 2005). Financial competition, especially within the fee-for-service environment, is considered a barrier to fostering collaborative relationships between health care professions. The current fee-for-service funding structure in most provinces has been identified as a major barrier to implementing models of collaborative care (Martin-Rodriguez et al., 2005). Fundamental changes to policy and the health system have been recommended in order to find creative reimbursement mechanisms for fee-for-service health care professionals.

Medico-legal and malpractice organizations have also expressed concern about new models for PHC delivery that raise the potential for increased liability for health care professionals working in non-traditional settings

³ These factors may be influenced by the type of interprofessional collaborative practice and its characteristics, including the mix of providers and the funding and remuneration models in place.

(Martin-Rodriguez et al., 2005). There is some uncertainty about the legal liabilities inherent in the working relationship among health care professionals as they relate to scope of practice and responsibilities. A primary concern is that not all health care professionals carry liability insurance and that this has implications for membership on a health care team.

Other factors that can inhibit effective interprofessional collaboration include:

- location and timing of meetings;
- dual (or indeed multiple) reporting structures and requirements and increased practical problems of communication;
- increased workloads;
- lack of common accessible data; and
- conflicting hierarchies (Richards, Carley, Jenkins-Clarke, & Richards, 2000).

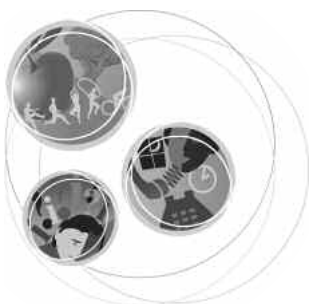
A lack of evidence supporting effective patient and health outcomes resulting from new and innovative models of collaborative care is also believed to be a barrier to fostering interprofessional collaboration in PHC settings (Zwarenstein, Reeves, & Perrier, 2005).

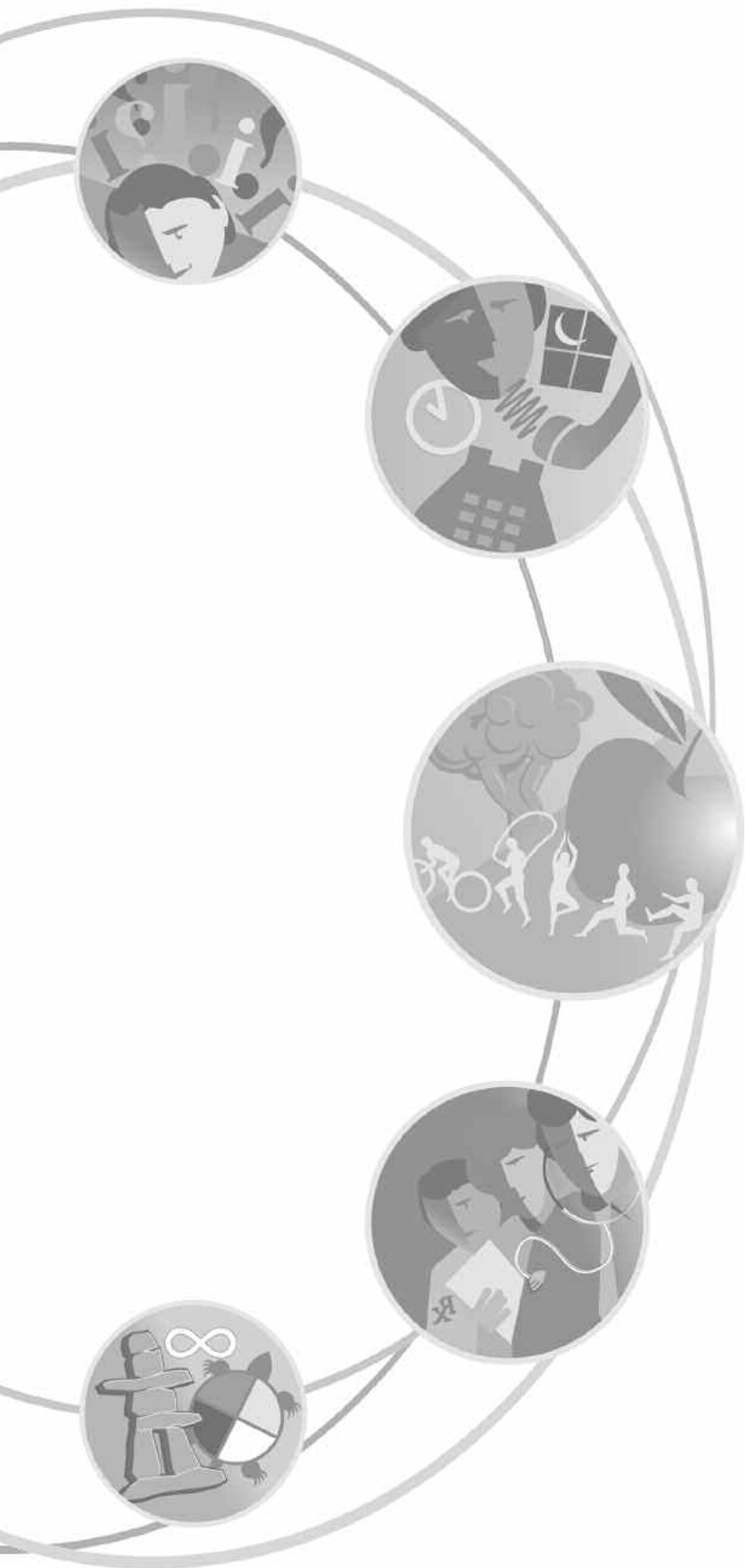
Current PHC reform is a departure for most practitioners, and continuing education and professional development are needed to enable them to work effectively in a collaborative environment. Traditionally, the structures of health professional education have been largely based on “silos” in which health professionals are educated in relative isolation. The curriculum content and structure follows strict disciplinary lines.

When health care professionals are expected to work and function collaboratively as part of interprofessional teams, they should be prepared to engage in these activities through undergraduate education, clinical training and professional development (Drinka & Clarke, 2000; Gilbert, 2005). Recent commissions, committees and policy documents in Canada have identified the importance of reshaping educational preparation and the professional training of health care professionals (Commission on the Future of Health Care in Canada, 2002; Health Accord 2003; Health Council of Canada, 2005).

It has been suggested that interprofessional education (IPE) and training are pivotal to fostering conditions and skills required for sustained collaboration in PHC (Vanclay, 1996). IPE involves members (or students) of two or more professions associated with health or social care engaged in learning with, from and about each other (Barr, Koppel, Reeves, Hammrick, & Freeth, 2005). IPE initiatives are based on the notion that shared learning leads to more comprehensive care and treatment for clients (Barr, 1994; Howkins & Allison, 1997). There is evidence that IPE can help to break down stereotypical views that professionals hold about one another and can result in an increased understanding of the roles, responsibilities, strengths and limitations of other professions (Clark, 1991; Parsell & Bligh, 1999; Parsell, Spalding, & Bligh, 1998).

This section summarized some of the fundamental issues and major trends related to interprofessional collaborative care and PHC renewal in Canada. The next section of the report provides an overview of a number of initiatives funded through the Primary Health Care Transition Fund (PHCTF), which were intended to address issues and barriers pertaining to collaborative PHC.





2 Overview of PHCTF Initiatives

The majority of the PHCTF was allocated to provinces and territories to support their individual renewal initiatives through the Provincial–Territorial Envelope. Funding was also directed toward overarching initiatives that dealt with common issues across jurisdictions through both the Multi-Jurisdictional and National Envelopes. The Official Languages Minority Communities Envelope and the Aboriginal Envelope funded initiatives that addressed the unique PHC challenges of Aboriginal and official languages minority communities across Canada. See the Appendix for summaries of the PHCTF initiatives reviewed for this report.

The final reports of 47 initiatives funded across the PHCTF envelopes were reviewed in preparing this synthesis report on collaborative care. The purpose of this section of the synthesis report is to discuss key themes and trends that emerged across the initiatives which provide insight into issues pertaining to collaborative PHC.

2.1 Provincial–Territorial Envelope

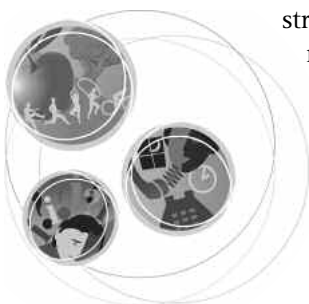
The Provincial–Territorial Envelope supported the efforts of provinces and territories to broaden and accelerate transitional PHC renewal initiatives. Introducing and integrating models of collaborative care into the PHC services of provinces and territories were common themes. In all 13 jurisdictions there was a range of innovative and varying models of collaborative care. Some models of collaborative care were of a “comprehensive” nature and included the provision of a wide range of services to a population in a given geographic region by an interprofessional team of providers. Other models were more “purpose-specific” and involved collaboration between two or more providers in the provision of care to a specific patient population (e.g. diabetic patients, mental health patients).

A common theme across a number of jurisdictions was the importance of interprofessional education (IPE) and continuing professional development in supporting team development processes. Both were reported to be critical components of change management strategies and helped to increase awareness of PHC principles. Interprofessional education at both pre- and post-licensure levels was found to be important in promoting the value of collaboration and enhancing the col-

laborative competencies of practitioners. Understanding the needs of the population served by a collaborative care team was also an emerging trend across initiatives. Assessing the health needs of communities and patient populations enabled organizations to establish teams with the right mix of providers. The involvement of community stakeholders in both the assessment of needs and the planning of collaborative care models was also found to be important. In the *Health Care Renewal in New Brunswick* initiative, five community health centres were established that include interprofessional teams of other health care providers based on the needs of the community.

Purpose-specific models of collaborative care, such as chronic disease collaboratives or palliative care teams, were established across a number of jurisdictions to address the health needs of patients with chronic diseases or other illnesses. In the *Newfoundland and Labrador Primary Health Care Initiative*, eight interprofessional PHC teams were created to service specific geographic regions in the province. A chronic disease prevention and management program was developed, and PHC teams have implemented evidence-based, clinical practice guidelines supporting diabetes services in their regions. The diabetes collaborative, considered the *Yukon PHCTF Initiative’s* success story, improved coordination and collaboration among health providers. Over the 16-month period of the collaborative, the number of patients up-to-date with A1C tests increased from 56 to 70 per cent and LDL testing rose from 67 to 87 per cent. Through the *Prince Edward Island Primary Health Care Redesign* initiative, all health regions in that province established palliative care programs, and weekly interdisciplinary palliative care team rounds facilitate communication among providers and across care sites.

Role expansion is a common principle associated with innovative models of collaborative care. Role expansion enables different providers to practise at a more expanded level within their scope of practice. Expanding the roles of different providers emerged as a common theme across initiatives. In Quebec, Family Medicine Groups have been organized across the province and involve family physicians working in closer collaboration with nurses. The *Manitoba PHCTF Initiative* provided the foundation for implementing service delivery changes that involved new or expanded roles for various



providers. Saskatchewan has established 17 PHC teams through PHCTF funding and within these collaborative care teams the number of nurse practitioners working in an expanded role has increased.

Regionalization of collaborative care models also arose as a distinct trend across some initiatives. In the *North-west Territories PHCTF Initiative*, interprofessional health services were organized around an integrated service delivery model in which primary community care teams are supported by regional support teams. Ontario has pilot tested a variety of interprofessional PHC team approaches by building on approximately 100 PHC models such as Family Health Groups, Family Health Networks and Family Health Teams. More than 900 interdisciplinary providers have participated in some capacity in the many projects of the *Ontario PHCTF Initiative* (e.g. physicians, nurses, nurse practitioners, dietitians, mental health workers, social workers, rehabilitation and other specialists).

Enhanced communications between providers as well as more efficient and secure means for sharing patient health information are key ways to support collaborative care models in the PHC system. The enhancement of electronic medical/health record systems emerged as a key trend across the majority of Provincial–Territorial Envelope initiatives. These new systems were intended to enhance the flow of patient health information and to foster more efficient patient care. In the *British Columbia PHCTF Initiative*, 92 practice models were implemented or enhanced during the PHCTF time frame and electronic medical record technology was introduced in 85 per cent of sites. PHC providers indicated that they were highly satisfied overall with the introduction of such electronic systems.

Overall, a key theme across the initiatives funded under the Provincial–Territorial Envelope was positive outcomes pertaining to patient and provider experiences with enhanced models of collaborative PHC. Across initiatives, patients/clients reported increased access to health services; improved access to appropriate service providers; greater willingness to visit and accept services from different providers; increased satisfaction with services received; and better coordination in health services delivered. Providers also reported an increase in collaboration as well as professional autonomy, and enhanced satisfaction as a result of improved opportunities to participate in team-based collaborative care. As well, initiatives also demonstrated

a commitment to consulting and engaging communities and stakeholders in service planning and delivery.

2.2 Multi–Jurisdictional Envelope

The Multi–Jurisdictional Envelope supported collaborative initiatives between two or more provincial/territorial governments. Initiatives funded under this envelope were intended to support and complement the PHC renewal activities that each participating province and territory was conducting under the larger PHCTF Provincial–Territorial Envelope. In the three initiatives that were reviewed for this report, a geographical regional approach supported by the Multi–Jurisdictional Envelope appeared to be successful in fostering collaboration across jurisdictions and in addressing common issues related to collaborative PHC. Regional approaches were found to be successful in developing and delivering post-licensure IPE, coordinating primary health services and identifying common standards for electronic health information.

In Atlantic Canada, interprofessional education at a post-licensure level was the key focus of the *Building a Better Tomorrow Initiative—Engaging Current Providers in a Renewed Primary Health Care System for Atlantic Canada*. A series of accredited, continuing professional development modules was developed and offered across the Atlantic region to PHC providers and teams. A joint, continuing professional development Certificate in Primary Health Care Collaboration was also established through Memorial and Dalhousie universities and issued to participants completing a core set of the modules. The findings suggest that this post-licensure IPE strategy was effective in enhancing collaborative competencies and fostering interprofessional collaboration. Interprofessional clinical working committees were found to be a useful means of improving the coordination of mental health and addictions services across regions of British Columbia and Yukon Territory, through the *Integrating Primary Care with the Multi-Disciplinary Team: Collaborative Care for Substance Use and Concurrent Disorders Initiative*. The *Western Health Information Collaborative (WHIC) Chronic Disease Management Infostructure Initiative* was also successful in defining and standardizing core data sets and information interchange messages to support chronic disease management across Western Canada. This initiative was successful in initiating a transition toward implementation of health information infrastructure, or “infostructure,” in the partner jurisdictions.

2.3 National Envelope

The National Envelope addressed common barriers or gaps to PHC renewal and fostered necessary conditions on a national level to advance PHC renewal beyond what any single jurisdiction could achieve on its own. National Envelope initiatives also complemented activities funded through the Provincial–Territorial Envelope. The National Envelope supported initiatives through three funding streams: National Strategies; Tools for Transition; and National Initiatives.

National Strategy on Collaborative Care

A common trend across the five National Strategy on Collaborative Care initiatives reviewed for this report was the engagement of professional associations and consumer organizations in identifying and addressing systemic issues to promote conditions for collaborative PHC. National Strategy initiatives were also successful in developing an array of toolkits, conceptual frameworks and other resources to guide the implementation of collaborative care in different PHC settings.

Two initiatives focused on broad-level issues related to fostering and promoting collaborative PHC among stakeholder groups. The *Canadian Collaborative Mental Health Initiative* developed a charter committing partner organizations to work collaboratively and generated specific strategies for the implementation of collaborative care. The *Enhancing Interdisciplinary Collaboration in Primary Health Care: A Change Process to Support Collaborative Practices* initiative engaged PHC providers and other stakeholders in developing and ratifying a set of guiding principles and a framework to enhance interprofessional collaboration. It also supported broad-based awareness of the benefits of collaborative practice and created a body of research about best practices and the state of collaborative care in Canada.

Two initiatives were successful in developing tools to support collaborative care models, one involving nurse practitioners and the other primary maternity care. The *Canadian Nurse Practitioner Initiative* designed various frameworks to support more consistent regulation of nurse practitioners across the country and developed a number of tools to assist stakeholders with the integration of nurse practitioners in PHC settings. The *Multidisciplinary Collaborative Primary Maternity Care*

Project developed guidelines for implementing collaborative models of primary maternity care teams for various patient-centred health care settings.

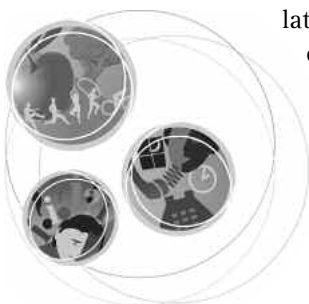
The fifth initiative, *e-Therapeutics Drug Therapy Management: Tools and Technology to Enhance Collaboration and Communication to Improve Safety and Outcomes from Drug Therapy*, resulted in the development of a set of electronic decision support tools for point-of-care access to current, evidence-based, Canadian drug and therapeutic information. e-Therapeutics is designed to be integrated with future electronic health record applications that will enhance communications and information-sharing between members of collaborative care teams.

Tools for Transition

A common trend across the Tools for Transition initiatives was stakeholder engagement and consultation on issues related to fostering and enhancing collaborative PHC in various settings. Thirteen initiatives were reviewed for this synthesis report, seven of which involved conferences and/or symposia to engage PHC stakeholders. These stakeholder consultations took place at both provincial and national levels and included a focus on collaboration in PHC, the role of information and communication technologies in supporting collaborative care and the role of caregivers in collaborative PHC.

At provincial and (or) regional levels, *Shaping the Future of Primary Health Care in Nova Scotia* and *Building Blocks to a Sustainable Primary Health Care System* organized by the College of Registered Nurses of Nova Scotia attracted 250 participants, including PHC providers, policy- and decision-makers, members of District Health Authorities, community health boards and volunteer agencies. The *Sixth National Summit: Cancer Control in Northern and Rural Communities* hosted by Northwestern Ontario Regional Cancer Care enabled stakeholders from community-based health care organizations in northern, rural, remote and Aboriginal communities to identify areas for enhancing collaboration in the field of cancer control.

At a national level, the two-day *Primary Health Care and Telehealth: Making the Links National Workshop* brought together participants from across the country to share information and identify ways in which existing telehealth infrastructure within each jurisdiction could be used to support PHC reform, including collabor-



orative care models. *Becoming Partners: A Consultation to Build Support for a Canadian Caregiving Strategy Among Primary Care Providers* coordinated a two-day national symposium to raise awareness and understanding among PHC providers about caregiver issues, develop approaches to integrate caregivers into PHC, and build links between stakeholders. This initiative in particular brought attention to the important role of the caregiver in collaborative PHC teams.

National Initiatives

Five national initiatives specifically addressed collaborative care, two of which focused on strategies to improve collaborative PHC for chronic disease patients. *Getting a Grip on Arthritis: A National Primary Health Care Community Initiative* used IPE to enhance the confidence of health professionals in identifying and treating arthritis, and increase their understanding of the roles of various health professionals in interprofessional care. This initiative facilitated 30 accredited interprofessional workshops in 10 provinces on arthritis best practices, and over 900 health care providers in rural and urban communities participated. The *National Home Care and Primary Health Care Partnership Initiative* demonstrated that partnering a case manager with a family physician in the care of chronic disease patients benefits the patient, the physician, the home care provider and the health system. *The Pallium Integrated Care Capacity Building Initiative* was a partnership among collaborators in western Canada and the three territories. This initiative implemented a nationally accredited, multidisciplinary course for PHC providers and developed educational resources to support hospice palliative care in Aboriginal communities.

Two initiatives sought to improve collaborative PHC services for targeted populations within Canada. These initiatives raised awareness of the unique needs of these populations in accessing PHC services as well as the way in which collaborative models of PHC could best respond. *Health Care Interpreter Services: Strengthening Access to Primary Health Care* improved access to PHC organizations for individuals with limited English or French proficiency in Vancouver, Toronto and Montréal. This initiative raised awareness of the role of interpreters on the PHC team. *Rainbow Health—*

Improving Access to Care also raised awareness of gay, lesbian, bisexual and transgendered health issues. The initiative hosted two national conferences, which brought together hundreds of health care professionals, health care students and community people to discuss issues and share information and resources.

2.4 Aboriginal Envelope

The seven initiatives of the Aboriginal Envelope that address collaborative care all have a common theme: the promotion of more effective PHC service delivery to Aboriginal people, while enhancing service delivery coordination between federal and provincial/territorial governments, and Aboriginal communities and health organizations. The *Tui'kn Initiative* developed a health human resources plan in consultation with the Nova Scotia Department of Health that maps out physician and nurse practitioner services as part of a collaborative PHC delivery model. The *Health Integration Initiative* identified mechanisms for enhancing collaboration and harmonization among various levels of government to improve access to, and quality of, services and to respond to the needs of specific First Nations and Inuit communities and populations. One initiative focused on blending Aboriginal and Western methods of practice to train a new supply of health providers to work in northern, rural Aboriginal communities. The *Aboriginal Midwifery Education Program* established a Bachelor of Midwifery Program, “Kanaci Otinowawoswin Baccalaureate Program” (KOPD), at the University College of the North in Manitoba. The program is intended to offer culturally appropriate care and to reclaim traditional knowledge and self-respect.

2.5 Official Languages Minority Communities Envelope

Collaborative care was also a feature in at least two Official Languages Minority Communities Envelope initiatives: *Improving Access to Primary Health Care Services for English-Speaking Persons in Quebec* and *Résautage Santé en français*. The latter successfully established 17 networks in a number of provinces and territories to improve French-language health services for their francophone populations.

3 Key Learnings

This section of the synthesis report is intended to summarize the noteworthy results/outcomes and findings that emerged from the review of those PHCTF initiatives which addressed collaborative care. It is not intended to represent a meta-review of evaluative findings resulting from initiative evaluations. The results are summarized under the three broad categories defined by Martin-Rodriguez et al. (2005) as being determinants of successful collaboration in health care: interactional, organizational and systemic determinants.

3.1 Interactional Determinants

Interactional determinants are those components of interpersonal relationships among team members that affect collaboration. They include such things as willingness to collaborate and the existence of mutual trust, respect and communication. Collaboration is, by its very nature, voluntary. To implement a collaborative practice, providers must be willing to commit to a collaborative process. Receptiveness to the idea of collaboration and the providers' commitment to a collaborative care approach are essential in the development of collaboration (D'Amour, Sicotte, & Levy, 1999; Liedtka & Whitten, 1998). Mutual respect implies knowledge and recognition of the interdependence and contributions of the various professionals on a team. Thus, lack of understanding, respect or appreciation of the contribution of other professionals constitutes a very real barrier to collaboration. Communication is another interactional element that plays a critical role in the development of collaborative relationships.

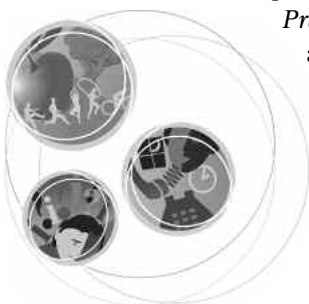
A number of key findings related to interactional determinants emerged from the *Manitoba PHCTF Initiative*. Understanding the roles of team members and how each could contribute to client outcomes was reported as vital to building trusting relationships and team development. Formal team development processes were particularly useful in this initiative to ensure role clarity, provider integration, and to implement reporting structures and processes. Role clarity was also an important finding from the *Canadian Nurse Practitioner Initiative*. Clear guidelines and management frameworks that support effective working relationships were found to be critical to enhancing and supporting the integration of different providers within collabora-

tive care models. Both the *Canadian Nurse Practitioner Initiative* and the *Multidisciplinary Collaborative Primary Maternity Care Project* designed frameworks and (or) developed tools to assist stakeholders in implementing collaborative models of PHC. The tools and resources developed through these initiatives have not only been helpful in advancing collaborative care within the respective domains of these initiatives, but also serve as best practice models for supporting and advancing collaborative PHC renewal in other PHC settings.

The location of providers appeared to be an important factor that supported team development in some initiatives. A key finding of the *Alberta PHCTF Initiative* was that co-location, unstructured opportunities for relationship building, mutual dependency in providing effective patient care and a stable team membership were important elements in developing interprofessional PHC teams. The *Northwest Territories PHCTF Initiative* also found that with co-location, providers were able to access each other and consult on client cases in a more personal and often more timely basis. Co-location also resulted in an increased understanding of, and appreciation and respect for professional scopes of practice, which promoted collaborative practice and enabled greater discussion around common concerns about shared care (e.g. confidentiality and liability issues).

The development of collaborative practice requires appropriate coordination and communication mechanisms. Collaborative care can benefit, in particular, from the availability of standards, policies and inter-professional protocols. Collegial development of collaborative care guidelines or practice manuals emerged across a number of initiatives as an important interactional factor that fostered collaboration. The *Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative* developed a variety of toolkits, accessible through the web, including a Collaboration Toolkit to support practitioners working in a collaborative care setting. As well, the *Ontario PHCTF Initiative* developed a number of provider toolkits/education materials (e.g. How to Establish a Collaborative Primary Care Project) to support collaborative PHC teamwork.

Guidelines were also developed by some initiatives to support collaborative care models. The *Multidisciplinary Collaborative Primary Maternity Care Project* developed



guidelines for multidisciplinary maternal and newborn care teams. These guidelines describe the core members of a collaborative team, identify other professionals who may play a vital role in providing primary maternity care, and emphasize the necessity for well-developed communication systems or strategies to facilitate continuity of care. The variety of guidelines, practice manuals and toolkits developed through the PHCTF initiatives were based on systematic and applied research activities, including literature reviews, environmental scans, stakeholder consultations, as well as extensive interprofessional and intersectoral collaboration. These resources will serve as useful resources to support and advance collaborative PHC now and into the future.

3.2 Organizational Determinants

Individual professionals alone cannot create all the conditions necessary for success. Collaboration exists not only within a team, but in the context of a larger organizational setting that influences it. The structure of an organization can benefit or create barriers to a team's ability to function (Heinemann & Zeiss, 2002). Interprofessional collaboration flourishes within organizational settings that are characterized by structures and supports that encourage new ways of working together (Martin-Rodriguez et al., 2005). The implementation of collaborative care approaches requires administrative support and time to interact and spaces to meet. Strong collaborative relationships demand that enough time is available for providers to share information, develop interpersonal relationships and address team issues (Mariano, 1989). It is therefore essential that the organization give consideration to providing time- and space-sharing opportunities to professionals working in the same team.

The development of collaborative care approaches is also facilitated by having leaders who are able to create an organizational setting that fosters collaboration. Institutional culture must support collaboration; this includes endorsement and leadership from heads of organizations, removal of ideological differences and turf wars among practitioners, and recognition and reward of interprofessional collaboration. An organization's philosophy and its inherent values have a direct impact on the degree of collaboration. A philosophy that values participation, fairness, freedom of expression and interdependence is essential for the development of collaboration within health care teams.

The importance of leadership support was reported in a number of initiatives, and a key finding of the *Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative* was that successful change requires effective leadership. The *Bigstone-Aspen Shared Initiative Care (BASIC)* found that leadership was an important factor for successful promotion and establishment of collaborative care models, particularly strong leadership/show of support from the administrative leaders of partner organizations. A key result from the initiative *Integrating Primary Care with the Multi-Disciplinary Team: Collaborative Care for Substance Use and Concurrent Disorders* was that regional health authorities have an important role to play in moving collaborative care from pilot status to the mainstream by providing leadership, developing appropriate program management structures, supporting ongoing change management (knowledge translation, skill development, training), and providing opportunity to reallocate resources to develop collaborative teams. A salient outcome reported in several PHCTF initiatives was that key leaders had been successfully engaged in building support and fostering PHC renewal.

An important outcome emerging from the PHCTF initiatives was the advancement of knowledge and best practices to facilitate change related to collaborative PHC. A number of initiatives developed toolkits, practice manuals, frameworks and other resources to guide the change process in moving toward innovative models of collaborative PHC. As an example, *Enhancing Primary Health Care: Learning and Applying Facilitation with a System Model* developed a Canadian facilitation guide to be used in PHC renewal processes. The guide provides information on tools that have been developed across the country that facilitate PHC change. The numerous toolkits, practice manuals and framework documents emerging from the national PHCTF initiatives in particular are excellent resources for facilitating the development and implementation of collaborative PHC models.

Change takes time, and a key finding from the initiative *Integrating Primary Care with the Multi-Disciplinary Team: Collaborative Care for Substance Use and Concurrent Disorders* was that "collaboration, regardless of the specific model or approach takes time and support ... to change attitudes that lead to change in practices." A key finding from the *Alberta PHCTF Initiative* was that it takes time to implement new models that contrast with the existing cultural and organizational context

of the health care system. Change management was found to be critical to success in the *Manitoba PHCTF Initiative*. In Manitoba, where change management was planned and effectively implemented, initiative implementation was very successful. The advancement of knowledge around change processes and the variety of change management tools pertaining to collaborative care in PHC settings are important outcomes resulting from the PHCTF initiatives.

Information and communication technologies (ICTs) are a critical component of health care team communication, innovation and collaboration. With electronic connectivity, better integration of the knowledge and skills among members of a collaborative care team can be achieved. Shared electronic access to health records can facilitate collaboration with external providers/organizations and enable easy monitoring of a client's progress. A number of initiatives reported that the implementation of effective ICT systems was essential to supporting and fostering collaborative care. The *British Columbia PHCTF Initiative* developed the Electronic Medical Summary to allow pertinent patient information to be encrypted and transferred electronically among various health care providers. The Chronic Disease Management (CDM) Toolkit was also developed to support electronic decision support at the point of care. The CDM Toolkit is a secure web-based data communication and reporting tool to support data collection, analysis and feedback for providers. It supports four chronic conditions (congestive heart failure, diabetes, depression, kidney disease) and is used by more than 1,300 health professionals. The toolkit has also been adopted by Yukon, Saskatchewan and Manitoba.

Several initiatives also advanced knowledge in the use of telehealth systems to support interprofessional collaboration. One example was the Teleprimary Care: Demonstrating the Role of Telehealth in Enhancing Primary Health Care Project funded through the *Ontario PHCTF Initiative*. This project used telehealth technology, incorporating two-way videoconferencing and electronic medical devices, for the purposes of nurse practitioner-initiated interprofessional consultation. The implementation of telehealth in this project resulted in increased communication between health care providers. Electronic connectivity was also useful in the *National Home Care and Primary Health Care Partnership Initiative*, enabling family physicians and home care case managers to enhance communication and obtain faster access to information. A key finding

emerging from the PHCTF was that ICTs have an important role in supporting enhanced communications among collaborative team members.

3.3 Systemic Determinants

Successful collaborative care is influenced by a number of systemic determinants. Systemic determinants are elements outside the organization, such as components of social, cultural, educational and professional systems. The social system includes those social factors that are often the source of power differences between professionals in a team. Equality between professionals, one of the basic characteristics of collaborative practice, is impeded when there are power differences among the professionals in a team. Specific cultural values may also have an impact on the development of collaboration between professionals. A strong cultural affinity for autonomy fosters individualism and specialization rather than collaborative practice (Mariano, 1989).

The professional system has a strong influence on the development of collaborative care approaches. Professional associations seek autonomy and respect for their members. The professional system is based on separate "silos" of professional practice that often act as a barrier to collaborative practice. The process of professionalization is characterized by autonomy and control, rather than collegiality and trust—dynamics that can lead to a differentiation of professionals and to territorial behaviours among team members (D'Amour, Sicotte, & Levy, 1999). During their professional socialization phase, health professionals are also immersed in the philosophies, values and basic theoretical perspectives inherent to their respective professions (Clark, 1995, 1997). Such differences are often potential sources of conflict and can hinder the development of collaborative practice (Clark, 1995, 1997; Fagin, 1992; Mariano, 1989).

A number of PHCTF initiatives were successful in engaging a variety of stakeholders from the professional system to advance collaborative PHC. The engagement of these stakeholders was critical to promoting awareness and fostering change. The *Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative* promoted and facilitated interprofessional collaboration in Canadian PHC settings by developing and ratifying a set of guiding principles and a framework. Through its pan-Canadian consultations, the initiative

raised the profile of collaborative care and initiated change advocacy at the grassroots level. The initiative also undertook extensive consultations with professional associations' memberships. *Increasing Support for Family Physicians in Primary Care* focused on the needs of family physicians and providing adequate support to family physicians in managing the changes brought about by PHC reform. The initiative created a web-based Primary Care Toolkit for Family Physicians and established a Change Management Leadership Group of family physicians from across Canada. These initiatives were important in initiating and fostering change within the professional system to promote collaborative PHC.

The educational system is also a main determinant of interprofessional collaborative practice because it represents the principal lever for promoting collaborative values among future health care professionals (Martin-Rodriguez et al., 2005). Traditionally, health professionals have been socialized with a strong professional identification to their own respective profession. Such socialization results in very limited knowledge of other professionals in the team. Members of each profession know very little of the practices, expertise, responsibilities, skills, values and theoretical perspectives of professionals in other disciplines (Martin-Rodriguez et al., 2005). This is considered to be one of the main obstacles to collaborative practice in health care teams (Fagin, 1992; Mariano, 1989).

Interprofessional education was a major activity across many PHCTF initiatives, and the outcomes have advanced knowledge of the role and effectiveness of IPE in fostering and developing collaborative PHC teams. Interprofessional education was a significant component of PHC renewal initiatives in Atlantic Canada through the *Building a Better Tomorrow Initiative*. Over 683 continuing professional development modules were delivered across Atlantic Canada to 8,891 participants, including 1,620 nurses, 113 physicians, 398 social workers, 214 senior managers, 138 dietitians, 122 facilitators, 147 occupational/physiotherapists and more than 1,000 other allied health professionals. The *Alberta PHCTF Initiative* implemented education and training services to support new models of PHC collaboration through the Interdisciplinary Primary Health Care Team Project. This project developed an interprofessional curriculum for staff and worked with the Universities of Alberta and Calgary to develop interprofessional curriculum for students. Another project, the Collaborative Practice Education Project, was undertaken

through the *Manitoba PHCTF Initiative* and resulted in a formal curriculum for collaborative practice, including theory, case-based small group learning, and clinical training in an interdisciplinary model to increase the number of appropriately trained PHC providers. The findings from these initiatives support the importance of IPE at both pre- and post-licensure levels in enhancing collaborative competencies and fostering interprofessional collaboration in PHC settings.

Several noted the need for greater systemic change in liability, regulation, funding and remuneration. Cross-country consultations organized by the *Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative* found that current methods of remuneration of health care providers discourage collaboration, and regulatory and liability issues place an increasing strain on providers (Nolte, 2005). A number of initiatives were successful in advancing knowledge around how to effectively address these different systemic issues in order to foster and support collaborative care in PHC settings.

Remuneration issues emerged across a number of initiatives, particularly around the introduction of flexible, alternative compensation plans for different types of health care providers. Several initiatives successfully introduced alternative compensation plans, while others were able to initiate discussions with respective professional groups to explore alternative compensation models. Still others were able to advance knowledge around the interaction of compensation and funding models with the development of different models of collaborative PHC. At a national level, the *Canadian Collaborative Mental Health Initiative* proposed the need for new funding and remuneration/incentive models to facilitate collaborative care approaches in mental health services delivery. As well, the *Canadian Nurse Practitioner Initiative* proposed long-term funding policies for nurse practitioners to enhance their deployment and integration with PHC teams.

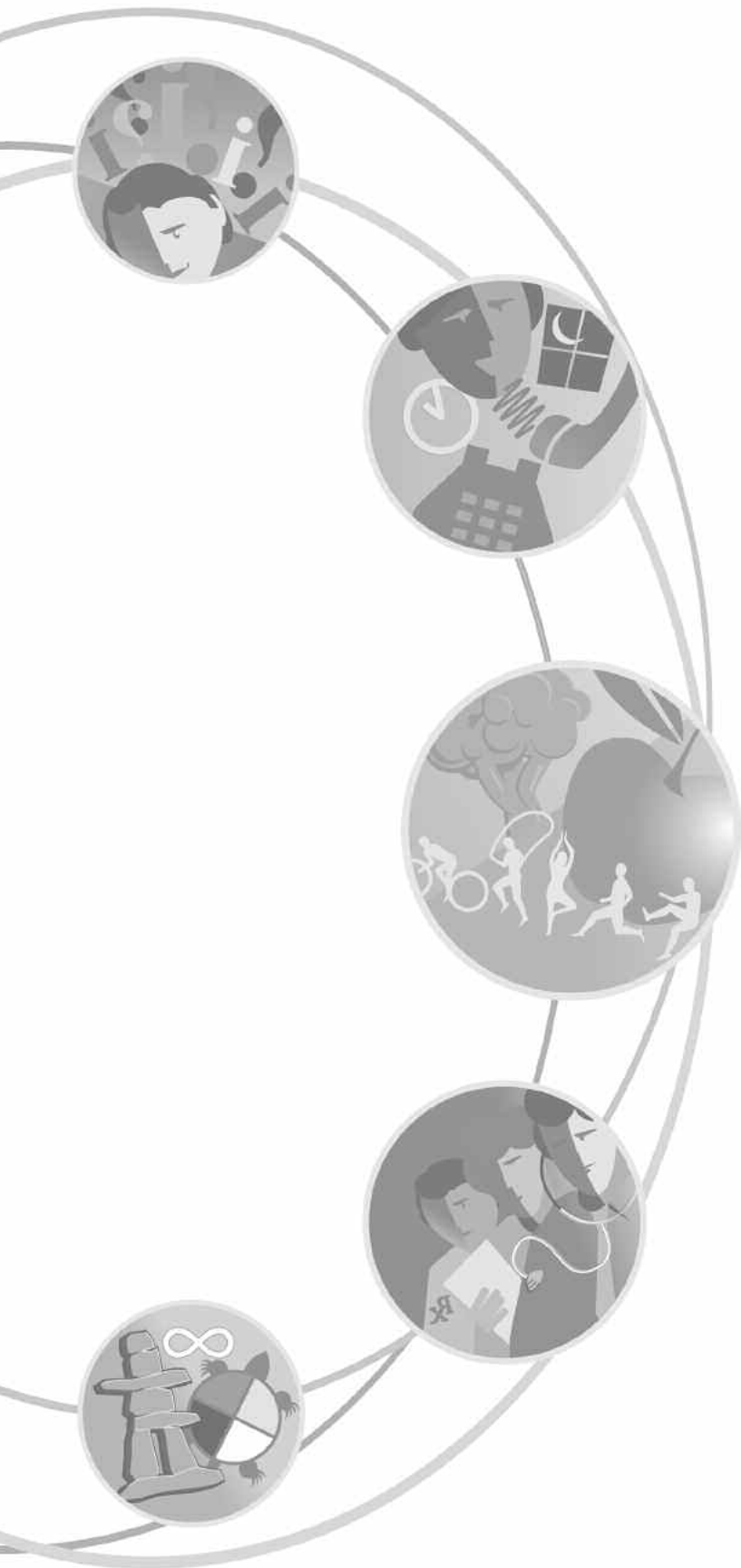
Different models for funding collaborative PHC also emerged as an area of key learning from several of the Provincial-Territorial initiatives that addressed compensation issues. An integral component of the *Saskatchewan PHCTF Initiative* involved voluntary integration of physicians into PHC teams and an alternate payment method of reimbursement rather than the traditional fee-for-service arrangement. The provincial

government and regional health authorities have been working with the Saskatchewan Medical Association on the development of a Memorandum of Understanding, which would see the Saskatchewan Medical Association as the sole bargaining agent for non-fee-for-service general practitioners/ family physicians (GPs/FPs), and a Model Contract that would apply to all GPs/FPs participating in PHC teams. In Ontario, learnings from past PHC reforms and current PHCTF initiatives have given rise to flexibility in compensation models. For example, physicians participating in Family Health Teams were able to choose from one of three compensation models—blended salary, blended capitation or blended complement—while non-physician providers were funded by the ministry largely on a salary basis.

Several initiatives were successful in identifying specific recommendations for enhancing regulatory frameworks to enhance different models of collaborative PHC. The significance of the regulatory work initiated through some PHCTF initiatives was highlighted by the regulatory challenges experienced by others. Different regulatory, scope of practice and referral practices across jurisdictions were identified as a key challenge in implementing the *Getting a Grip on Arthritis: A National Primary Health Care Community Initiative*. Regulatory issues were also raised as a key barrier to PHC renewal by *Integrating Primary Care with the Multi-Disciplinary Team: Collaborative Care for Substance Use and Concurrent Disorders* as well as by the initiative *Increasing Support for Family Physicians in Primary Care*. Although PHC reform is happening nationally, the implementation of PHC happens jurisdictionally. Provincial/territorial legislation and policies sometimes create unique barriers. A key outcome emerging from the PHCTF initiatives was the awareness of the need for enhancing regulatory reform. The groundwork for initiating this reform has been laid as a result of the PHCTF initiatives.

At a national level, a number of initiatives advanced knowledge and best practices around means for facilitating regulatory change to support collaborative care. *Multidisciplinary Collaborative Primary Maternity Care Project* included a review of provincial/territorial legislation from each jurisdiction regulating family physicians, nurses, nurse practitioners and midwives. Regulatory issues as well as limitations and inflexibility in scope of practice were identified as key barriers to the development and implementation of interprofessional collaborative models of primary maternity care. It was recommended that all governments ensure that regulators and legislators work collaboratively with providers to develop regulations and legislation that allow collaborative maternal/newborn care practice to work effectively.

Both the *Enhancing Interdisciplinary Collaboration in Primary Health Care* and the *Canadian Collaborative Mental Health Initiatives* reported recommendations on ways to enhance regulatory frameworks to better support and enhance collaborative PHC. An overall key learning that emerged from the PHCTF initiatives was the need for greater consistency at a pan-Canadian level as it relates to regulatory frameworks for fostering collaborative PHC. As an example, the *Canadian Nurse Practitioner Initiative* reported that the implementation of the nurse practitioner role in Canada has been sporadic and inconsistent. The provinces and territories that have passed legislation and have regulatory approaches for nurse practitioners are not consistent regarding title, scope of practice, licensure requirements or continuing competence requirements. A key recommendation emerging from the *Canadian Nurse Practitioner Initiative* was the need for principles for a pan-Canadian legislative and regulatory framework, including standardized title, scope of practice, autonomy, accountability (responsibility), educational requirements, and national accreditation for education programs.



4 Implications for Policy and Practice

Canada has demonstrated a clear commitment at the policy level to PHC renewal as a foundation of a strong health care system. A fundamental principle of PHC renewal in Canada has been the call for a shift toward greater interprofessional collaboration, in which teams of providers are accountable for offering comprehensive and coordinated health care services to a patient population. A key objective of the PHCTF was to establish interdisciplinary PHC teams of providers, so that the most appropriate care is provided by the most appropriate provider. This review of PHCTF initiatives raises a number of key implications for policy and practice pertaining to collaborative PHC.

Policy change and reform at a systems level (i.e. liability, regulatory, remuneration and funding, education) would appear to have the greatest potential for fostering and supporting interprofessional collaboration in PHC.

4.1 Liability and Regulatory Enhancements

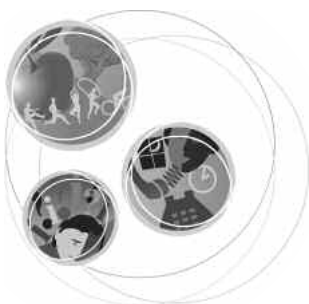
Liability issues continue to be a real concern for some PHC providers. Under the current legal system, negligence and liability is assessed and determined by the courts on an individual level. One of the essential elements of negligence is standard of care and whether or not a provider has lived up to the standard of care under the particular circumstances. At present, it is likely that the courts will continue to respond to malpractice cases involving collaborative practice by applying the conventional legal framework, which assesses negligence on the basis of the individual provider's standard of care and on the amount of responsibility of the provider for that patient's care. The *Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative* proposed the following changes:

- Create a national coalition of provincial/territorial regulatory colleges to effect legislative reform;
- Introduce tort reform, including the establishment of a ceiling, threshold and class actions;
- Develop joint statements from professional liability protection providers; and
- Develop an effective team process in which policies/procedures and best practice are clarified.

Current legislative and regulatory frameworks across Canada need to change to better support collaborative care approaches. The legislation and regulation of health care in Canada is predominantly a provincial/territorial matter; each jurisdiction defines its own scopes of practice, standards of education, core competencies, ethical frameworks and systems of accountability (Martin-Rodriquez et al., 2005). Jurisdictions also differ in the legislative structure of their regulatory systems. If interprofessional collaboration is to become institutionalized and sustainable in the PHC sector, legislative flexibility needs to be enhanced as it relates to the self-regulation of health professions. Champions among government and the health professions must work to enhance the regulatory flexibility needed to foster and support models of collaborative care.

4.2 Compensation and Funding

Adequate funding and remuneration models are necessary to support the shift to interprofessional collaboration in PHC. Cross-country consultations organized by the *Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative* indicated that current methods of remuneration of health care providers discourage collaboration rather than facilitate it. There are several different approaches to funding PHC services delivered by organizations or individual providers: fee-for-service, salary, capitation and blended mechanisms. Different approaches to funding send different signals to providers (Watson & Wong, 2005) and in effect can influence interprofessional collaboration. The current fee-for-service system of reimbursing physicians discourages collaboration among health providers and fails to recognize preventive care efforts (Nolte, 2005). In theory, both fee-for-service and salary remuneration could be used to compensate teams of PHC providers (Watson & Wong, 2005). Many health care committees suggest a move to blended funding mechanisms that combine capitation for enrolled populations with fee-



for-service for specific services (Watson & Wong, 2005). Funding systems must be flexible enough to provide the incentive to collaborate.

4.3 Interprofessional Education

Traditionally, the structures of health professional education have been largely based on silos in which health professionals are educated in relative isolation. When health care professionals are expected to work and function collaboratively as part of interprofessional teams, they should be prepared to engage in these activities through undergraduate education, clinical training and professional development (Drinka & Clarke, 2000; Gilbert, 2004). It is unrealistic to think that simply bringing professionals together in teams will lead to collaboration (D'Amour et al., 2005). Since professionals have to trust each other before collaborative processes can be established, there is a wide range of human dynamics that need to be developed within a team.

It has been suggested that IPE is pivotal to fostering conditions and skills required for sustained collaboration in PHC (Vanclay, 1996). Some recent commissions, committees and policy documents in Canada identify the importance of reshaping educational preparation and the professional training of health care professionals (Commission on the Future of Health Care in Canada, 2002; Health Accord 2003; Health Council of Canada, 2005). The Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) Initiative is part of Health Canada's Pan-Canadian Health Human Resource Strategy. Its objectives are to:

- Promote and demonstrate the benefits of IECPCP;
- Increase the number of educators prepared to teach from an interprofessional, collaborative patient-centred perspective;
- Increase the number of health professionals trained for patient-centred collaborative practice before and after entry to practice;
- Stimulate networking and sharing of best educational approaches for collaborative patient-centred practice; and
- Facilitate interprofessional collaborative care in both the education and practice settings.

Initiatives such as IECPCP are critical for fostering and supporting change in the Canadian health professional education system.

4.4 Organizational Supports

A number of key infrastructure supports facilitate change at both system and practice levels. These supports are critical to success regardless of the collaborative care approach to be implemented, and include planning and coordination, development of resources, project management, information technology (hardware, software, training, ongoing support), structured opportunities to collaborate, common standards, tools and practice guidelines, physical space and adequate funding and incentives.

Effective use of ICTs and functioning electronic links between health and social care are key factors supporting collaborative care models in PHC, for providers must be able to exchange knowledge and information about patients and services in a timely and coordinated manner. A key barrier to the successful implementation of ICT systems in PHC settings is the difference in interfaces between data sources. Issues around privacy and confidentiality, as well as ownership and use of information are also of concern to providers and patients alike. There is a need for greater improvements in technology for standardization and security with the increased introduction and adoption of ICT systems in PHC.

The engagement and involvement of stakeholders emerged as a key component in the process of initiating and fostering PHC renewal. Stakeholders could include recipients of health services and care (e.g. patients, clients, consumers), health authority or regional health board administrators, providers, patient and health advocacy agencies and organizations, and policy-makers.

4.5 Patient-Centredness

A previous review of the literature suggests that a poor conceptualization of the role of the patient/client/family in the collaborative process continues to persist (D'Amour et al., 2005). There is limited detail on how to integrate patients as well as the role that the patient should play on a health care team. It is strongly believed, however, that patients/clients must be involved in their own care and, for some, in monitoring the quality of service (Nolte, 2005). For this, they must be informed

of the process of collaborative care and of the role each person plays on the care team.

Patient-centred care is a widely used concept in health care. It is a holistic approach to health care, seeking an integrated understanding of the patients' world—accounting for their emotional needs, life circumstances and the broader contexts of health and illness. The role of caregivers is also becoming increasingly important as the population in Canada ages and more family members take greater responsibility for caring for their loved ones. Several PHCTF initiatives included a specific focus on the patient/client and caregiver and highlighted their significance in PHC renewal.

4.6 Health Human Resources Planning

A major issue in health care renewal continues to be effective utilization of our health resources. The supply, mix and distribution, and how these various health care providers work singularly and together has important implications for PHC delivery. Having key health providers in a community is fundamental to establishing and developing models of collaborative PHC. For some initiatives, the lack of certain health professionals was a fundamental barrier to introducing collaborative care models.

4.7 Integration of Traditional Providers

It has been suggested that successful collaboration in Aboriginal communities is likely to result from a greater blend of perspectives from traditional health practices as well as conventional western health care (Purden, 2005). For many Aboriginal communities, interprofessional teams consisting of both traditional and western professionals are necessary for health care delivery. Providing care to Aboriginal communities not only

requires addressing interprofessional issues, but also finding ways of incorporating traditional providers into team-building efforts. According to Purden (2005), greater collaboration with traditional providers, as well as with community-based organizations, has the potential for developing more culturally appropriate prevention and public health programs.

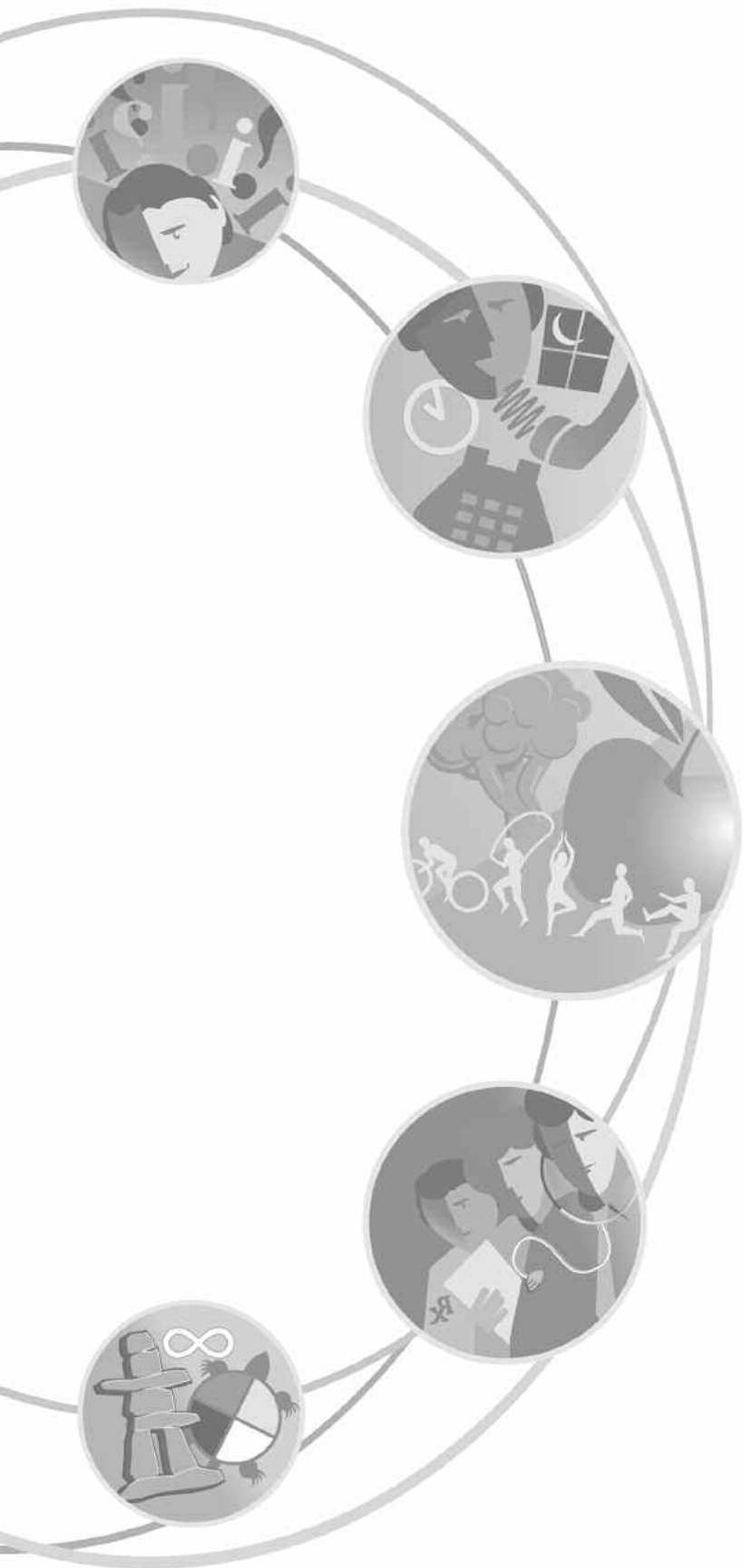
4.8 Education of Western Providers

Graduates of health professional education programs in Canada are generally poorly prepared to work with the increasing number of traditional providers who are being hired to provide direct care in remote areas of the country (Purden, 2005). Purden (2005) suggested that effective cross-cultural caregiving requires inter-professional collaboration to be extended to traditional providers not currently part of the conventional health care team. Academic institutions need to introduce greater opportunities for students and trainees to learn cultural competency, as occurred in the *Aboriginal Midwifery Education Program*. Traditional providers are often excluded from consultations with other health care providers, and a general lack of mechanisms to ensure that information is exchanged with traditional providers suggests insufficient confidence in their knowledge, skills and judgment (Purden, 2005).

4.9 Greater Evidence of Collaborative Primary Health Care Outcomes

There is a clear need for further evidence of the effectiveness of collaborative care models in PHC settings and the characteristics of collaborative efforts that support positive patient and health outcomes, organizational efficiency, and enhanced patient and provider satisfaction.





5 Conclusion

This synthesis report reviewed over 47 PHCTF initiatives that addressed issues pertaining to collaborative PHC. An overview of these initiatives suggests there was a great deal of diversity in the nature and characteristics of initiatives that were funded at the national, regional and provincial/territorial levels. This review also suggests that significant gains have been made and, more importantly, critical groundwork has begun to foster and facilitate collaborative PHC approaches and models across the country. Overall, the PHCTF initiatives reviewed have addressed collaborative PHC issues at a number of different levels, and the results/outcomes and findings of these initiatives reaffirm the significance of interactional, organizational and systemic factors in supporting and fostering collaborative practice in PHC settings.

At an interactional level, PHC providers need to value collaborative practice, respect and understand the roles of other professions, share an understanding of inter-professional collaboration in PHC, and be willing to share decision-making with other members of their team. The professions themselves, including professional associations, have an important role to play in supporting and valuing collaborative care approaches as fundamental to PHC renewal in Canada. Team development activities, including the significance of inter-professional education, were also found to be important strategies for addressing change at an interactional level.

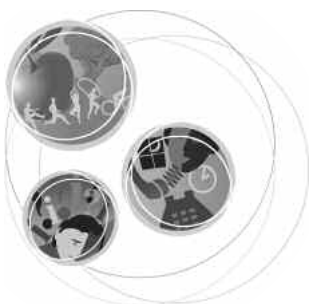
It is important that models of collaborative care, including the mix of health human resources, are established based on the health needs of the community, population and (or) patient/clients being served. As a result, models of collaborative care will vary as they are largely dependent upon and influenced by the unique characteristics of the community, population and culture within which they are situated, as well as prevailing governmental policy. Teams must also be able to change and evolve to meet the needs of patients/clients. These unique

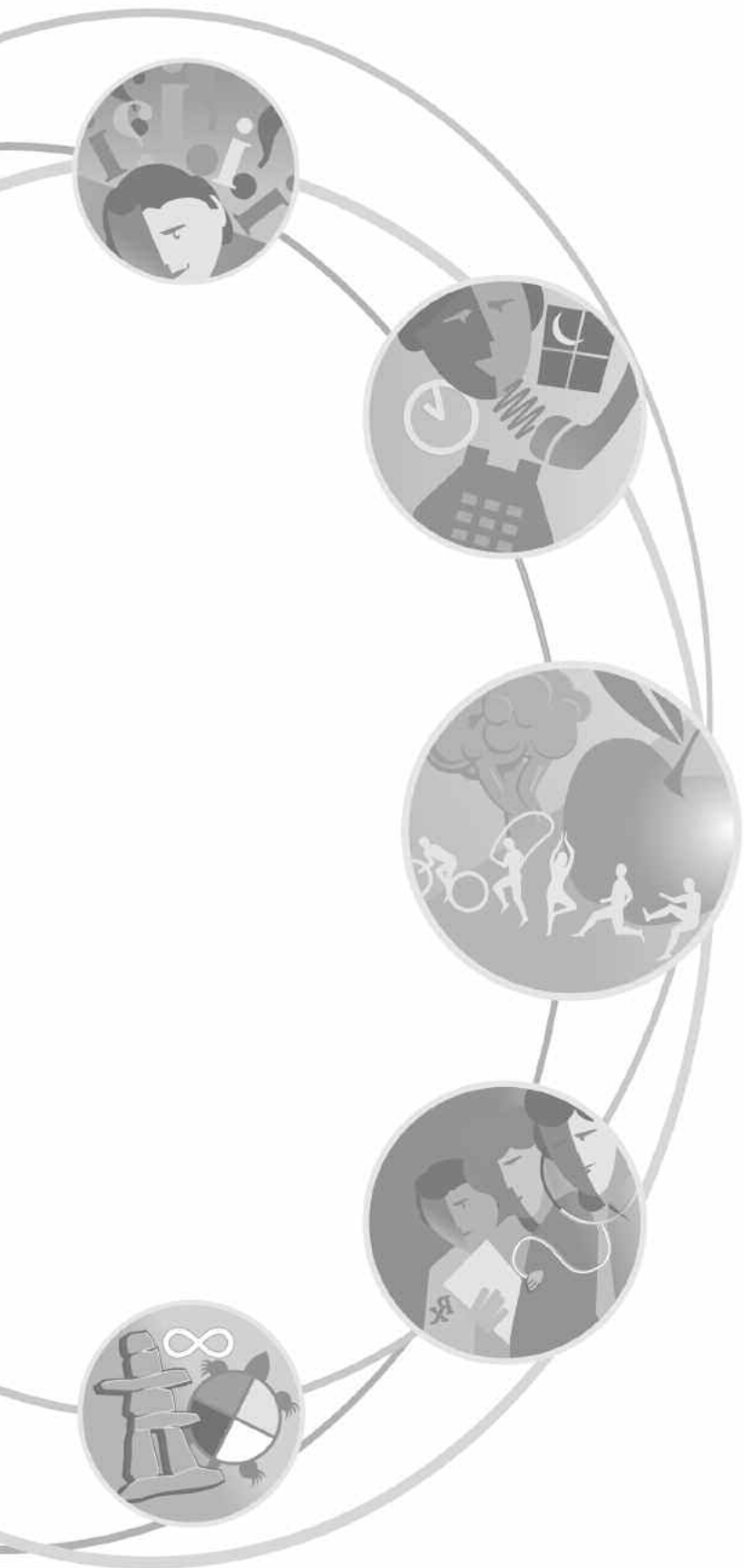
characteristics of collaborative care approaches must be valued, recognized and supported.

At a system level, there is a critical need to address, in a systematic and meaningful manner, the ongoing liability, regulatory, funding and remuneration issues that continue to be perceived as fundamental barriers to fostering and implementing collaborative care approaches in Canada. Much progress was made through initiatives such as the *Canadian Collaborative Mental Health Initiative*, *Enhancing Interdisciplinary Collaboration in Primary Health Care*, *Canadian Nurse Practitioner Initiative* and *Multidisciplinary Collaborative Primary Maternity Care Project*. All of these initiatives identified areas in which specific policy and system change would help to facilitate collaborative PHC. Policy reform at a systems level (i.e. liability, regulatory, remuneration and funding, education) has the greatest potential for fostering and supporting inter-professional collaboration in PHC.

Collaboration is a complex, voluntary and dynamic process. The complexity of the task translates into the presence of varying degrees of collaboration, and the collaborative process is subject to constant change. The PHCTF initiatives underscore the fact that there is still not enough known about collaborative care and how Canadians—and Canadian health care professionals—can benefit from it.

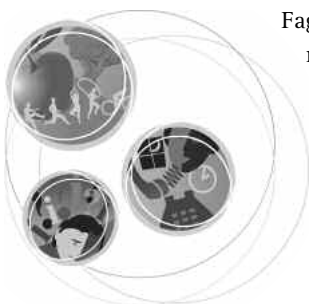
Sustainability is an important concept in discussions of change. Governments at all levels support the fundamental tenets of PHC, and all have adopted PHC principles as the basis of PHC renewal within their jurisdictions. The main challenge for governments at all levels will be to sustain continued commitment to PHC renewal and change. There must be a commitment to see this change through; this will require governmental leadership and political will to sustain PHC renewal initiatives and expand PHC in a more systematic manner.





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Appendix

List of Initiatives Relevant to Report Theme: Collaborative Care

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 Tlicho 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

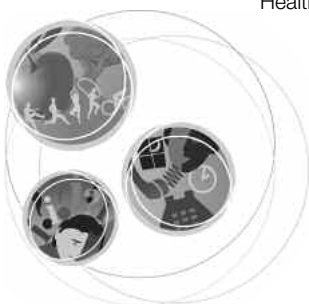
This initiative supported the transition of health care delivery in the Northwest Territories (NWT) to a Primary Community Care (PCC) model. This model, the basis of the Integrated Service Delivery Model (ISDM) being implemented in the territory, targets service and system integration, from primary community 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 Tlicho 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 supported 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

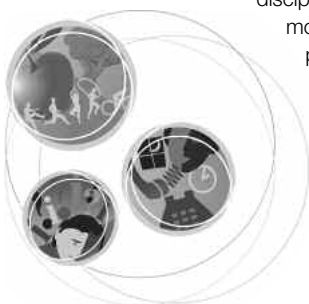
towards PHC reform. As a result of this province-wide initiative, several new PHC centres were developed in the communities of Brandon, Camperville, Waterhen, Niverville and Winnipeg, serving approximately 77,000 people. There was a focus on team development through such initiatives as the Collaborative 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.

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.

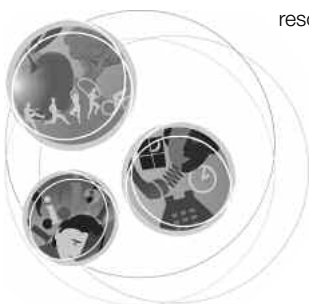
Prince Edward Island Primary Health Care Redesign

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 ICPC2). The anticipated results of the initiative are better health outcomes, improved health status, sustainability and greater cost-effectiveness.

Aboriginal Envelope

Bigstone–Aspen Shared Initiative Care (BASIC)

Lead and Partner Organization(s): Bigstone Health Commission; with Aspen Regional Health Authority; Municipal District of Opportunity; First Nations and Inuit Health Branch; Alberta Health and Wellness; University of Alberta Aboriginal Capacity and Developmental Research Environment (ACADRE) Network

Approved Contribution: \$1,995,000

The Bigstone Cree Nation is a First Nation band spanning several communities within the Aspen Regional Health Authority. The geography and demographics of this First Nation community make it difficult to recruit and retain health professionals, and therefore challenging to provide equitable access to health services for the population. Because of these issues, Bigstone was unable to deliver the full range of health care services. As well, there was a desire to move services towards two areas of special interest: health promotion and prevention, and the management of chronic diseases such as diabetes that are prevalent in the community. The Bigstone–Aspen

Shared Initiative Care identified three goals to address these issues: integration of health services and collaboration; information-sharing among jurisdictions; and development of a financial reimbursement model for physicians through the Alternate Relationship Plan (ARP). A shared home-care delivery model developed for this northern community now provides a full range of services. A new ARP service delivery model presents a new financial reimbursement model for physicians. A multi-purpose facility has been constructed for one remote community that can be reached only by air. It provides local health, children's and social services, using a multidisciplinary approach. Both Bigstone and Aspen have redirected funds to cover the ongoing cost of providing these new services.

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

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

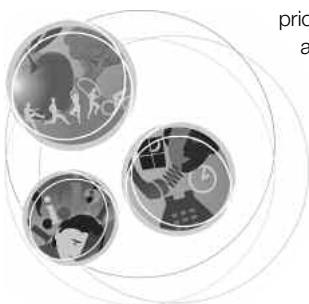
Information and Evaluation Coordinators in each community and through the development of a Health Information System that links diverse data sets. The four pillars of community action were: diabetes prevention and management; non-traditional tobacco use; childhood injury prevention; and prescription 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.

Aboriginal Midwifery Education Program

Lead and Partner Organization(s): Manitoba Health; with Manitoba Advanced Education and Training; University College of the North; Burntwood Regional Health Authority; NOR-MAN Regional Health Authority; Health Canada, First Nations Inuit Health Branch; Norway House Cree Nation; College of Midwives of Manitoba; Kagike Danikobidan

Approved Contribution: \$1,690,927

Due to the shortage of care providers and lack of services in northern Manitoba, most pregnant women north of the 53rd parallel must leave their communities and families several weeks prior to their due date. This costly practice is hard on them, their families, the community and on the health care system. Manitoba Health believes that regulated midwifery is a key strategy to address the shortage of qualified maternity care providers in its province and elsewhere. Hence, the creation of the Aboriginal Midwifery Education Program, the overall goal of which was "to establish a comprehensive and sustainable midwifery program in Manitoba that reflects a blend of traditional Aboriginal and western methods of practice, and the necessary support systems, for persons of Aboriginal ancestry." To develop this program, Manitoba Health engaged in extensive consultations with Aboriginal communities in order to: get input into the program's content and teaching methodologies; learn from Elders about traditions and practices that should be incorporated; obtain community and political support; identify suitable teaching sites; and recruit potential students. It also consulted with experts in Aboriginal education and learning and received advice on reviewing and adapting existing models of successful curricula to reflect an Aboriginal focus. The result is The Bachelor of Midwifery Program, "Kanaci Otinowawosowin Baccalaureate Program," which means "sacred midwifery" in Cree. It is being delivered as of September 2006 at University College of the North. Upon graduation, students will be eligible to apply for registration with the College of Midwives of Manitoba as a practising midwife. Through this program, Manitoba Health and its partners hope to increase health human resources in the North and improve maternal and child health through community-based, consistent and cost-effective quality care. Beyond this, they hope that this program will boost Aboriginals' pride in their traditions, assist with reclaiming traditional knowledge and self-respect within communities, and ultimately aid in returning the birth experience to the community. The website www.amep.ca offers information on this ambitious initiative.



Initiative to Implement a Digital Radiology and Tele-Radiology System in Nunavik

Lead and Partner Organization(s): Nunavik Regional Health and Social Services Board; with the McGill University Health Centre (MUHC); Nunavik Health Centres; *Ministère de la Santé et des Services sociaux* (MSSS) du Québec [Ministry of Health and Social Services]

Approved Contribution: \$801,900

This initiative was designed to ensure rapid, 24-hour access to radiology services for the population of Nunavik, a region where primary health care services had relied on traditional radiology equipment. It purchased digital radiology equipment and viewing consoles for two Nunavik health centres: Kuujjauq and Puvirnituk. It acquired picture archiving and communication systems (PACS) for both health centres, and installed a diagnostic console for Nunavik images at the Montreal General Hospital. To lay the groundwork for clinical activities, it trained staff at the two sites. By improving examination quality and diagnostic accuracy, and giving Nunavik residents greater access to specialists, the initiative helped boost the region's radiology services and improve emergency services. Since the start of clinical activities in May 2006, some 500 X-rays have been transmitted per month. Wait times have also been shortened and emergency services improved for the population of Nunavik.

Multi-Jurisdictional Envelope

Building a Better Tomorrow—Engaging Current Providers in a Renewed Primary Health Care System for Atlantic Canada

Lead and Partner Organization(s): Nova Scotia Department of Health; with Newfoundland and Labrador Department of Health and Community Services; New Brunswick Department of Health; Prince Edward Island Department of Health and Social Services; Dalhousie University; Memorial University of Newfoundland

Approved Contribution: \$7,011,126

Primary health care (PHC) cannot be renewed without making provisions for educating those most affected by the changes—PHC providers. In recognition of the role of interdisciplinary health care in advancing PHC reform, the four Atlantic provinces—Nova Scotia (the lead province), New Brunswick, Prince Edward Island, and Newfoundland and Labrador—undertook the Building a Better Tomorrow (BBT) initiative to help providers to develop new skills and demonstrate new behaviours. It is an interprofessional education program aimed at giving providers the preparation and the tools they need in order to work successfully with others in teams. This program consists of a series of seven core training modules—Understanding Primary Health Care, Building Community Relationships, Team Building, Conflict Resolution, Facilitating Adult Learning, Electronic Patient Record, and Program Planning and Evaluation. These were developed, piloted, evaluated and delivered through this initiative. BBT brought thousands of health care professionals together to learn how to work collaboratively and to deliver care in new ways. All the Atlantic provinces have incorporated the core BBT modules and programs within their respective jurisdictions and regions. Participants report that BBT has built tremendous capacity for change within the regions, districts and communities of the Atlantic provinces and that it has contributed to a unified vision of where PHC needs to go.

Integrating Primary Care with the Multi-Disciplinary Team: Collaborative Care for Substance Use and Concurrent Disorders

Lead and Partner Organization(s): Centre for Applied Research in Mental Health and Addiction (CARMHA); Simon Fraser University (formerly the Mental Health Evaluation and Community Consultation Unit at the University of British Columbia); with Government of Yukon; Government of British Columbia; Mental Health and Addictions, Okanagan Health Services Area, Interior Health Authority; Mental Health and Addiction Services, North Shore/Coast Garibaldi HSDA, Vancouver Coastal Health Authority; Mental Health Services and Alcohol and Drug Services, Health and Social Services, Government of Yukon; Yukon Family Services Association

Approved Contribution: \$1,500,000

Individuals often suffer concurrently from mental health disorders and addictions. The goal of this initiative was to improve access to service through a collaborative approach to care and the use of best practices. Currently, there is a lack of integration between primary care and specialized mental health and addiction services, and individuals may be falling through the cracks. This initiative undertook a system change process to improve linkages and working relationships among the various services. It set up interdisciplinary collaborative care teams in three regions, with each site developing a process and approach that would best meet its needs and situations. The tools and resources available can be found at www.collaborativecare.ca. Preliminary findings suggest that the initiative has had a positive impact on provider practices and on the organization and delivery of mental health and addiction services. This collaborative care initiative was unique in that it involved system change management, included the integration of health services and created reforms at the clinical service level. To integrate the various health and social disciplines and to foster multidisciplinary collaborative care, it also spawned a National Health Sciences Student Association. The three participating regions and the National Health Student Association have developed sustainability strategies to allow them to move forward with their efforts.

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.

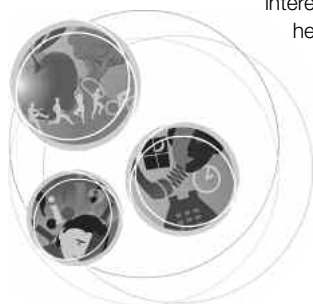
National Envelope

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.



Enhancing Interdisciplinary Collaboration in Primary Health Care: A Change Process to Support Collaborative Practice

Lead and Partner Organization(s): Canadian Psychological Association; with Canadian Association of Occupational Therapists; Canadian Association of Social Workers; Canadian Association of Speech–Language Pathologists and Audiologists; Canadian Medical Association; Canadian Nurses Association; Canadian Pharmacists Association; Canadian Physiotherapy Association; Canadian Coalition on Enhancing Preventative Practices of Health Professionals; Dietitians of Canada; The College of Family Physicians of Canada

Approved Contribution: \$6,551,700

The Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) initiative arose from a shared conviction by those responsible for planning, managing and delivering primary health care (PHC) services in Canada that health professionals need to be used more effectively and efficiently. In particular, they wanted to enhance interdisciplinary collaboration among the broad range of health professionals who deliver PHC across the country. The initiative aspired to develop a set of guiding principles and a framework that describe how PHC professionals can work together effectively in every setting; have the principles and framework broadly supported by PHC practitioners and ratified by their professional associations; and to develop tools for PHC professionals to use to work more effectively together. Through research, pan-Canadian consultations and communication activities, the EICP initiative both promoted and facilitated interdisciplinary collaboration in Canadian PHC settings. The EICP partner organizations successfully developed and ratified a set of guiding principles and a framework to enhance interdisciplinary collaboration in PHC. The initiative created broad-based awareness of the benefits of collaborative practice and created a body of research about best practices and the state of collaborative care in Canada. The research reports, along with a toolkit featuring more than 200 tools to help PHC professionals work together more effectively, are on the EICP website, www.eicp-acis.ca. The initiative not only strengthened the relationships among the participating health professionals and their associations, but also demonstrated that effective, equitable interdisciplinary leadership is critically important to PHC renewal.

Canadian Nurse Practitioner Initiative

Lead and Partner Organization(s): Canadian Nurses Association

Approved Contribution: \$8,914,526

Despite the potential for nurse practitioners (NPs) to make significant contributions to primary health care (PHC) services in Canada, their integration into the health care system has been sporadic and irregular. This seems to be the result of inconsistencies in legislation, regulatory practices, and the education of NPs. This initiative attempted to address these inconsistencies by focusing on developing the foundation of a shared understanding of NPs in five areas: 1) educational preparation; 2) practice; 3) government legislation and professional self-regulation; 4) health human resources planning; and 5) change management, social marketing and strategic communication. Building on several national consultations with

many stakeholder groups, the Canadian Nurse Practitioner Initiative (CNPI) designed various frameworks that will support more consistent regulation of NPs across the country; developed a role description to facilitate the understanding of NP practices and NPs' participation in interdisciplinary teams; and crafted a comprehensive set of recommendations and actions to facilitate NPs' sustained integration into Canada's health system. Some of the resources developed include the *Health Human Resources Planning Simulation Model for NPs in Primary Health Care*TM; *Competence Assessment Framework for Nurse Practitioners in Canada*; and *Implementation and Evaluation Toolkit for NPs in Canada*. CNPI achieved a remarkable degree of consensus among all stakeholder groups involved regarding its direction, findings and recommendations, and this bodes well for sustaining the work that has been completed. More importantly, it put forth evidence of the greater public, government and other health professional groups' acceptance and awareness of the NP's role in the Canadian health care system. This, along with the momentum generated by the initiative and stronger support from other health professional groups, including physicians, will help to consolidate the NP's key and integral role in PHC renewal.

e-Therapeutics Drug Therapy Management: Tools and Technology to Enhance Collaboration and Communication to Improve Safety and Outcomes from Drug Therapy

Lead and Partner Organization(s): Canadian Pharmacists Association; with Alberta Health and Wellness; Best Medicines Coalition; Canada Health Infoway; Canadian Association of Chain Drug Stores; Canadian Agency for Drugs and Technologies in Health; Canadian Institute for Health Information; Canadian Nurses Association; College of Family Physicians of Canada; Health Canada Therapeutics Products Directorate; Health Canada Marketed Health Products Directorate; IBM Canada; National Association of Pharmacy Regulatory Authorities; National Specialty Societies of Canada; Nova Scotia Department of Health; Public Health Agency of Canada; MOXXI Project (Quebec); Royal College of Physicians and Surgeons of Canada

Approved Contribution: \$8,840,300

Drug therapy is a key aspect of primary health care for Canadians. Drug expenditures account for an increasing share of total health costs (17.5 per cent), second only to hospital expenditures, with \$24.8 billion spent on retail drugs in 2005. The goal of e-Therapeutics is to support best practices and promote optimal drug use for all primary care providers through a comprehensive Canadian online source of drug therapy information. The initiative's work was divided into six streams: governance and project management, content development and maintenance, technical development, change management, evaluation, and marketing and communications. A set of electronic decision support tools was developed to facilitate point-of-care access to current, evidence-based, Canadian drug and therapeutic information through the e-Therapeutics web portal, www.e-Therapeutics.ca. The initiative addressed the concerns of both health professionals and consumer groups about the safety of medication, the need for improved prescribing, and access to new information. e-Therapeutics was designed to be integrated with future electronic health record applications. The Canadian Pharmacists Association is committed to covering the ongoing costs of e-Therapeutics through a long-term business model.

Multidisciplinary Collaborative Primary Maternity Care Project (MCP²)

Lead and Partner Organization(s): Society of Obstetricians and Gynaecologists of Canada; with Association of Women's Health, Obstetric and Neonatal Nurses; Canadian Association of Midwives; Canadian Nurses Association; The College of Family Physicians of Canada; Society of Rural Physicians of Canada

Approved Contribution: \$2,000,000

Multidisciplinary collaborative models can substantially increase the capacity of our health care system to successfully face the shortages of maternity care professionals (physicians, midwives and nurses) that have been developing over more than a decade. However, some barriers have limited their development, including regulatory issues and restrictions in scope of practice. This initiative aimed to reduce these barriers and facilitate the implementation of national multidisciplinary collaborative strategies to increase the availability and quality of maternity services for all Canadian women. Specifically, this initiative aimed to: 1) develop guidelines for multidisciplinary collaborative care models; 2) determine current national standards for terminology and scopes of practice; 3) harmonize standards and legislation; 4) increase collaboration among professionals; 5) change practice patterns; 6) facilitate information sharing; and 7) promote the benefits of multidisciplinary collaborative maternity care. Under the guidance of a national committee and through an extensive consultation process, the Multidisciplinary Collaborative Primary Maternity Care Project (MCP²) developed guidelines and tools to support policy-makers and health professionals. Examples include a descriptive analysis of the maternity care system and collaborative models of care in five European countries and Australia; review of provincial and territorial legislation from each jurisdiction regulating family physicians, nurses, nurse practitioners and midwives; and guidelines for multidisciplinary collaborative maternal and newborn care teams, which present a framework for action and include seven knowledge transfer modules to facilitate changes in practice patterns. These resources are available on the initiative's website, www.mcp2.ca. Throughout its life, MCP² encouraged participants' reflection on the options for change. Many professionals strongly agreed with the key elements of collaborative practice identified by the initiative, including mutual respect and trust, shared goals, informed choice, professional competence and collegial relationships among team members. A large majority also agreed that there is a need for a pan-Canadian maternity care strategy responsible for planning multidisciplinary collaborative care. To this end, MCP² proposed the establishment of a pan-Canadian network that would be responsible for promoting a coordinated vision and facilitating the implementation of collaborative care models.

Becoming Partners: A Consultation to Build Support for a Canadian Caregiving Strategy Among Primary Care Providers

Lead and Partner Organization(s): Canadian Caregiver Coalition; with J.W. McConnell Family Foundation; Max Bell Foundation; Victorian Order of Nurses (VON) Canada; Centre for Health and Social Services (CSSS) Cavendish

Approved Contribution: \$23,135

Family caregivers in Canada have assumed increasing significance as part of the care team. Federal reports recognize the importance

of family caregivers; however, family caregiving has not become part of the national primary health care (PHC) agenda. The goals of this initiative were to raise awareness and understanding among PHC providers about caregiver issues, develop approaches to integrate caregivers into PHC, build links between stakeholders, solicit feedback on the Canadian Caregiver Coalition's (CCC) policy framework for a caregiving strategy, and introduce tools that change health care providers' knowledge, attitudes and practices. A two-day national symposium, bringing together caregiving and national health provider organizations was held in November 2005 to accomplish these objectives. The symposium was successful in fostering dialogue between a broad group of stakeholders, facilitating an understanding of the issues and familiarizing participants with key practice and policy tools. Feedback from the symposium was used to refine the policy framework. The *Framework for a Canadian Caregiving Strategy* is available on the CCC website, www.ccc-can.ca. Considerable momentum now exists and, with adequate support, the Coalition anticipates that the creation of a Canadian caregiving strategy will proceed.

Building Capacity in Primary Health Care: Disseminating Best Practices in Interdisciplinary Teamwork from Community Health Centres

Lead and Partner Organization(s): Canadian Alliance of Community Health Centre Associations (CACHCA); with Association of Ontario Health Centres (AOHC)

Approved Contribution: \$299,374

Community health centres (CHCs) across the country have provided interdisciplinary primary health care for more than 30 years. Despite this vast experience, there is little documentation or research on the processes and effectiveness of interdisciplinary teams located at those centres. One exception is the research conducted by the Association of Ontario Health Centres (AOHC) titled *Best Practices in the Evaluation of Interdisciplinary Primary Health Care Teams*, which developed a resource kit with best practice guidelines and training resources to support the implementation and evaluation of effective PHC teams in CHCs in Ontario. The Building Capacity in Primary Health Care Initiative, led by the Canadian Alliance of Community Health Centre Association (CACHCA), aimed to tailor and disseminate these resources produced in Ontario, primarily to CHC staff across Canada and secondarily, to other PHC providers beyond CHCs. Specifically, this initiative aimed to: disseminate on a pan-Canadian level the resource kit that was developed in Ontario; translate these materials to meet the needs of francophone communities across Canada; and develop a strategy to sustain the delivery of the educational resources to CHCs and other PHC providers over the long term. The initiative achieved these objectives by: distributing the resource kit to all CHCs in Canada and making them available on relevant websites; conducting a "train-the-trainer" session with people from across Canada to orient them to the resource kit and a workshop methodology; conducting 2-day regional workshops to introduce the resources developed, methodologies to assess interdisciplinary work, and interventions to strengthen interdisciplinary teams; and by presenting at conferences across Canada to highlight the research findings from the AOHC project and the development of the

resource kit. The resources disseminated by the initiative are available on AOHC's website: www.aohc.org or CACHCA's website: www.cachca.ca and include: a literature review summarizing interdisciplinary research; a resource kit (available in French and English) for interdisciplinary teams, which includes a self-assessment tool for CHCs, case studies to highlight effective practices and an intervention guide on how to address barriers to interdisciplinary work; and a two day workshop that can assist CHCs in strengthening interdisciplinary teams.

Primary Health Care and Telehealth: Making the Links National Workshop

Lead and Partner Organization(s): Manitoba Health Primary Health Care Unit; with Manitoba Telehealth; Winnipeg Regional Health Authority

Approved Contribution: \$249,500

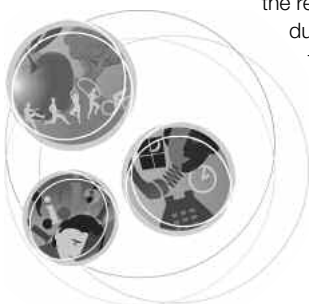
In September 2005, this two-day national workshop brought together 54 participants from across the country, all of whom represent primary health care (PHC) and telehealth. They came to share information and identify the ways in which the existing telehealth infrastructure within each jurisdiction could be used to support PHC reform and sustain the health care system overall. Telehealth services have traditionally been used to deliver acute care services to remote communities, but they can do more. This workshop focused on their ability to support primary care and PHC by: educating both providers and the public about health promotion, disease and injury prevention initiatives; supporting health professionals working in rural or isolated communities; and improving access to specialist services. The goal of the Making the Links workshop was to develop effective, practical and workable linkages between existing PHC and telehealth initiatives at the jurisdictional level. Participants discussed what is needed to develop successful links between PHC and telehealth, and examined new ways of thinking and putting into practice the solutions and ideas offered by technology to create a sustainable health care system. They also identified the top 10 key points that need to be examined and considered in order to develop effective links between PHC and telehealth, and came up with action items. The initiative's website, www.makingthelinks.mbtelehealth.ca, holds documents related to the workshop.

Enhancing Primary Health Care: Learning and Applying Facilitation with a System Model

Lead and Partner Organization(s): Faculty of Medicine, Memorial University and Office of Primary Health Care, Department of Health and Community Services, Government of Newfoundland and Labrador; with Ministry of Health, Government of British Columbia; Primary Health Services, Saskatchewan Health; Ministry of Health, Government of Manitoba; Ministry of Health and Long-Term Care, Government of Ontario; Faculty of Family Medicine, University of Ottawa; Faculty of Medicine, University of Saskatchewan

Approved Contribution: \$445,600

This initiative grew out of a shared recognition across the partner provinces that facilitators are effective in supporting primary health care (PHC) renewal processes. Facilitators engage stakeholders in



change processes and develop the capacity needed to carry change forward. The initiative was designed to gather and articulate the facilitation experiences of health professionals across the country while building awareness of this approach. The objectives were to create a Canadian facilitation guide that could be used in PHC renewal processes, to provide information on tools that have been developed across the country that facilitate PHC change, to offer support to build facilitation capacity across the country and to support a collaborative process that would achieve the above objectives. The facilitation guide, *Guiding Facilitation in the Canadian Context: Enhancing Primary Health Care*, was developed iteratively through a multi-jurisdictional collaborative and a process that included a literature review, pan-Canadian consultations, online surveys and international expertise. The guide reflects the learnings, practices and experiences of health care professionals from across Canada and is both practical and applicable to a variety of PHC settings. The initiative demonstrated the effectiveness of multi-jurisdictional collaboration both in achieving significant goals in short time frames as well as building upon each other's work.

Increasing Support for Family Physicians in Primary Care

Lead and Partner Organization(s): The College of Family Physicians of Canada

Approved Contribution: \$232,900

Primary care (PC) reform in Canada has required the development of new models of care. This has had an impact on how family physicians (FPs) practice and has created some uncertainty about their present and future roles in PC delivery models. As a result, there is a need to find ways to adequately support FPs in managing the changes brought about by PC reform and to provide tools to assist them in meeting the new and evolving demands of their day-to-day practice. This initiative therefore sought to identify, develop and support a cadre of FP PC renewal leaders across Canada at the national, provincial, regional and local levels. These PC leaders had an opportunity to develop and enhance their leadership and advocacy skills; share experiences; develop a PC toolkit for FPs; and explore opportunities for FPs and other health care professionals to better understand and introduce interprofessional team approaches in PC. The toolkit includes six modules: Introduction to the Toolkit; Remuneration; Governance; Interdisciplinary Collaboration; Continuity and Comprehensiveness of Care; and Information Technology. In December 2006, the web-based PC toolkit will be publicly launched and a change management leadership group will be established. The toolkit will be available at www.toolkit.cfpc.ca. Together, the toolkit and leadership group will help FPs to access current and practical transition tools and obtain expert advice from colleagues experienced with newer PC models. The College of Family Physicians of Canada (CFPC) has committed itself to supporting a Primary Care Advisory Committee of FP leaders and maintaining and updating the toolkit. The CFPC believes that this initiative represents an important first step in increasing support for FPs in PC and that it creates the momentum to affect change.

Measuring Cost Effectiveness: A Proposal to Develop a Methodological Framework for Future Research

Lead and Partner Organization(s): Canadian Alliance of Community Health Centre Associations (CACHCA); with Association of Ontario Health Centres (AOHC); University of Toronto

Approved Contribution: \$351,174

In spite of the fact that there are several models for delivering primary health care (PHC) services in Canada, there is a lack of methods to systematically compare their cost-effectiveness and/or their impacts on health outcomes. Previous initiatives to investigate economic effectiveness in PHC have been extremely limited in their scope (often focusing on the cost-effectiveness of a single intervention). As such, their utility to decision-makers is very limited. Investigations to determine the effectiveness, or cost-effectiveness, of specific models of PHC have similarly been fraught with challenges. These include a focus on primary care instead of PHC; difficulties establishing clear pathways linking PHC to inputs, outputs and outcomes; and strong focus on individuals, instead of families and community health. This national initiative laid the groundwork for a comprehensive agenda for the investigation of the economic effectiveness of PHC. Developed through extensive consultations with over 80 researchers, administrators, funders and policy-makers in PHC at two "think tank" meetings in 2006, such an agenda will provide decision-makers with evidence and tools that can support more cost-effective investments in the health care system. This agenda was based upon:

- Canada's international commitment to PHC values and principles (Montevideo Declaration, 1995);
- A population health approach, which addresses the health of the entire community, rather than just the individuals who may seek care at any given time;
- A long-term perspective that includes use of the entire health system by the population over an extended period of time (to capture savings at secondary/tertiary levels from investments in PHC);
- Consideration of PHC as a system, rather than as isolated, individual providers operating individually; considering the influence of context on the development and performance of PHC systems; and
- Examination of models of change to determine which ones are most helpful for understanding PHC (i.e. whether the health care system is a complex, adaptive system or a complicated one).

Some of the resources produced by this initiative include: *Consistent Values: A shared framework: A way forward to adaptive primary health care systems across Canada*, *A Modified Logic Model for PHC.*, *Economic evaluation of health promotion*, and *Economic evaluation of social capital and community capacity building*.

Supporting the Implementation of Electronic Medical Records in Multi-disciplinary Primary Health Care Settings

Lead and Partner Organization(s): Primary and Continuing Health Care Division, Health Policy Branch, Health Canada

Approved Contribution: \$455,000

Renewal initiatives in primary health care (PHC) are highly dependent on the use of information management tools such as electronic medical records (EMRs). This technology has the potential to: support information-sharing among team members; improve quality and continuity of care (especially chronic disease management); support planning and accountability activities; and offer decision-making support. However, uptake in Canada has been relatively slow. Implementation of EMRs requires change management and guidance in practice settings, and these supports have not traditionally been provided. In this initiative, Health Canada sought to address this shortfall by developing and disseminating a toolkit to support the implementation of EMRs. The consultation phase confirmed the need for such a toolkit. It found that existing Canadian resources on EMR implementation tend to focus on providing the knowledge, tools, templates and methodologies to support “first-time” selection and implementation of EMRs. Change management resources, such as training and tools for “people” and “processes,” have not been as well documented, or have been underutilized if they exist. This initiative therefore produced a bilingual toolkit to provide assistance to practitioners implementing EMRs, available at www.emrtoolkit.ca. In addition, it conducted a variety of dissemination activities aimed at putting the toolkit into the hands of health care system providers and planners. It undertook these activities with the overarching goal of furthering PHC renewal by encouraging the use of information technology in practice settings.

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 communi-

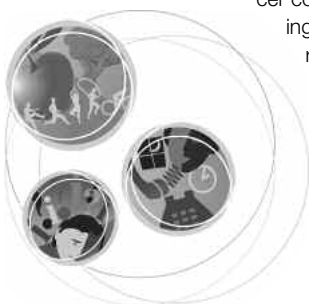
ties; 2) identify strategies/mechanisms for improving cancer control in priority areas at all levels, including innovative initiatives; and 3) recommend specific strategies/mechanisms to a broad range of groups and organizations, including community, regional, provincial, territorial and national organizations, 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.

Fetal Alcohol Spectrum Disorder in Newfoundland and Labrador: A Primary Health Care Approach in Labrador

Lead and Partner Organization(s): Labrador East Primary Health Care Project, Labrador-Grenfell Regional Integrated Health Authority; with the Department of Health and Community Services, Department of Education; Department of Justice; Labrador Inuit Health Commission; Innu Band Councils; Dr. Ted Rosales (pediatrician/geneticist); Regional Fetal Alcohol Spectrum Disorder Working Group; Fetal Alcohol Spectrum Disorder Management Committee

Approved Contribution: \$58,660

This brief initiative (January to June 2005) focused on fetal alcohol spectrum disorder (FASD) in Newfoundland and Labrador. It arose out of a realization by health professionals, community workers, teachers and correctional staff that a large number of their clientele might well be suffering from FASD, and that they needed to learn how to diagnose and help these individuals. The initiative invited pediatrician/geneticist Dr. Ted Rosales to: assess/diagnose a large number of individuals at high risk of FASD; train physicians in correctly diagnosing FASD; train other health professionals and front-line workers to recognize and deal appropriately with FASD; help establish an interdisciplinary FASD diagnostic team; and develop assessment tools and a data collection system, as well as an FASD framework. The initiative also sought to increase public awareness of FASD and of the importance of preventing it. Through this initiative, 125 people were diagnosed with FASD; three local physicians, one resident and a medical student, other health professionals and front-line workers received training in diagnosing it; tools were developed to assess FASD; a data system was established that made sense of multiple sources of information; and interdisciplinary teams at both the regional and community levels were developed. The creation of these teams has strengthened partnerships, which will be vital to continuing this initiative's work, and the tools and skills that have been developed will continue to facilitate the diagnosis of FASD in Newfoundland and Labrador.



National Conference/Workshop on the Implementation of Primary Care Reform

Lead and Partner Organization(s): Ontario Family Health Network; with Queen's University School of Policy Studies; Centre for Health Services and Policy Research; Centre for Studies in Primary Care

Approved Contribution: \$75,000

Ontario has been pursuing primary health care (PHC) reform for a number of years. This initiative formed part of the province's ongoing reform efforts, and was led by the Ontario Family Health Network (OFHN), an arm's-length agency created in 2001 to implement the PHC reform model throughout the province. The OFHN provided family physicians with information, administrative support and technology funding to support the voluntary creation of Family Health Networks and Family Health Groups in their communities. The network, along with its partners, hosted a three-day national conference in November 2003, which attracted 100 participants from across the country and abroad. At the conference, they addressed the complexities of implementing PHC reform, and explored such themes as the establishment of effective interdisciplinary clinical teams; leadership structures; emergence and nature of opposition to reforms; funding approaches; and evaluation strategies and processes. A forum gave provincial, territorial and international representatives an opportunity to share their successes, challenges and effective strategies for addressing barriers to implementation. Participants also took part in panel sessions on broad topics and in a series of single-issue workshops. It is expected that provincial and territorial conference participants will use the knowledge gained to improve the PHC reform agenda in their respective jurisdictions. The Queen's University School of Policy Studies published a book based on the presentations, *Implementing Primary Care Reform—Barriers and Facilitators*, which is available through McGill-Queen's University Press. This stands as a permanent record of the presentations and allows everyone who is interested in PHC reform to benefit from the learnings that emerged.

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 suc-

cessful 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.

Where's the Patient's Voice in Health Professional Education?

Lead and Partner Organization(s): University of British Columbia

Approved Contribution: \$30,000

Patient-centred care has become an important trend in primary health care. Although many developments have increased patient and community involvement in health care planning and delivery, the involvement of patients in the education of health professionals has not kept pace with this trend. A groundbreaking international conference, Where's the Patient's Voice in Health Professional Education? was held in Vancouver in November 2005 to deal with this gap. It brought together patients, scholars, students and policy-makers to share ideas about educational innovation and theory designed to embed the patient's voice in the education of health professionals. The conference fostered a new vision of how the patient could become an integral part of the education process. The University of British Columbia Division of Health Care Communication website <http://www.health-disciplines.ubc.ca/DHCC/> hosts the products developed during the conference, including conference materials, a comprehensive bibliography of relevant publications and a selection of innovative case studies. As a result of the initiative, an international task force was established and continues to work to promote patient involvement in health professional education. A review and call to action report has been published, and future conferences and publications are being planned to develop innovation in this field and to keep the patient's voice on the radar screen of those who influence educational change.

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.

Health Care Interpreter Services: Strengthening Access to Primary Health Care

Lead and Partner Organization(s): **Access Alliance Multicultural Community Health Centre;** with Agence de développement de réseaux locaux de services de santé et de services sociaux de Montréal; Critical Link Canada; Healthcare Interpretation Network; Ontario Ministry of Citizenship and Immigration; Provincial Language Service, Provincial Health Services Authority of British Columbia; Université du Québec en Outaouais

Approved Contribution: \$471,900

The Health Care Interpreter Services: Strengthening Access to Primary Health Care (SAPHC) initiative was founded on the principle that effective communication is crucial to ensuring quality and access to primary health care (PHC), and that appropriate interpreter services in the delivery of health care are needed. The aim was to identify approaches that build on and are best suited to the delivery of PHC services in Montréal, Toronto and Vancouver—where most immigrants choose to live—and also to create and pilot-test models/tools that could be used across the country to improve linguistic access to services. Between November 2003 and June 2006, the SAPHC initiative marshalled the expertise, experience and efforts of a broad range of health care and interpreter services organizations, providers and other stakeholders. It undertook research and held a national symposium. Building on recommendations that arose from these activities, the initiative's organizers developed and implemented various pilot projects and tools at the three core sites. In Montréal, a French video was developed to help train health care providers to work with interpreters and bridge the communication gap. In Toronto, a pilot project set out to implement and evaluate a centralized model for providing health care interpreters for medical appointments. It demonstrated that the services of a professional interpreter improved the quality of the encounter and the satisfaction of both the patient and service provider. Also in Toronto, a Primary Health Care Orientation Module was developed and tested with the aim of creating a template for orienting interpreters who will be working in PHC settings. In Vancouver, a risk management matrix and tool was developed to allow those using it to determine areas in their health organization or program in need of attention and action. It was pilot-tested and well received. The SAPHC initiative offered several recommendations in the areas of service delivery, training, standards and policy to guide future work.

National Home Care and Primary Health Care Partnership Project

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-Temiscamingue; 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

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

This 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 an Internet site 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.

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.



