



Health Canada Santé Canada


## Primary Health Care Transition Fund

# Summary of Initiatives

Final Edition

March 2007





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Published by authority of the Minister of Health.

Primary Health Care Transition Fund, *Summary of Initiatives – Final Edition*, March 2007 is available on Internet at the following address:

**[www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf)**

Également disponible en français sous le titre : Fonds pour l'adaptation des soins de santé primaires *Résumé des initiatives – Dernière édition*  
Mars 2007

For further information or to obtain additional copies, please contact:

Publications  
Health Canada  
Ottawa, Ontario K1A 0K9  
Tel.: (613) 954-5995  
Fax: (613) 941-5366  
E-Mail: [info@hc-sc.gc.ca](mailto:info@hc-sc.gc.ca)

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HC Pub.: 1254  
Cat.: H21-248/2007E-PDF  
ISBN: 978-0-662-42356-0

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# Primary Health Care Transition Fund

The Government of Canada established the \$800-million Primary Health Care Transition Fund (PHCTF) in September 2000, to support the efforts of provinces and territories and other stakeholders to develop and implement transitional primary health care renewal initiatives. The Fund was also designed to enable recipients to address overarching primary health care issues that are common nationally or across two or more jurisdictions. In fact, the PHCTF has been a unique tool in its ability to support collaborative initiatives undertaken by more than one jurisdiction or stakeholder to provide results beyond what any single recipient could achieve on its own.

The PHCTF was divided into five funding envelopes:

1. **Provincial-Territorial Envelope** – to support provincial and territorial governments in their efforts to broaden and accelerate transitional activities that lead to permanent and sustainable primary health care (allocated primarily on a per capita basis).
2. **Multi-Jurisdictional Envelope** – to support collaborative, transitional initiatives undertaken by two or more provinces and territories to improve primary health care in multiple jurisdictions.
3. **National Envelope** – to support activities that address barriers to primary health care reform and transitional initiatives that are common nationally.

4. **Aboriginal Envelope** – to support transitional initiatives that benefit First Nations, Inuit, and Métis peoples; address the unique needs of Aboriginal communities; and improve accessibility of Aboriginal peoples to primary health care, regardless of where they live in Canada.
5. **Official Languages Minority Communities Envelope** – to support transitional activities that improve access to primary health care services for French- and English-speaking minority communities across Canada.

The importance of primary health care was firmly rooted in First Ministers health care agreements in 2000, 2003 and 2004 and was the focus of several major national and provincial health studies conducted over the years. Although now concluded, the PHCTF has been an important federal mechanism for the acceleration of primary health care renewal across the country, and a key federal lever for a dynamic health care system overall. The objectives of the Fund were:

- To increase the proportion of the population that has access to primary health care organizations, which are accountable for the planned provision of a defined set of comprehensive services to a defined population;
- To increase emphasis on health promotion, disease and injury prevention, and chronic disease management;
- To expand 24/7 access to essential services;
- To establish interdisciplinary primary health care teams of providers, so that most appropriate care is provided by the most appropriate provider; and
- To facilitate co-ordination, and integration with other health services, i.e. in institutions and in communities.

PHCTF initiatives are now complete. This report, *“Summary of Initiatives – Final Edition”*, March 2007, includes summaries and fact sheets for the completed initiatives that highlight key information about each initiative.



In addition to this report, the information arising from the PHCTF initiatives has been synthesized to form a series of four reports based on the themes of Chronic Disease Prevention and Management; Collaborative Care; Evaluation and Evidence; and Information Management. The series will include an overview report 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*. The overview and the synthesis reports will be available in March 2007.

The *Summary of Initiatives – Final Edition*, the overview and synthesis reports, as well as the final reports received from the individual PHCTF initiatives, will also be available on the PHCTF website at **[www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf)**.

Introducing improvements to the health care system is a challenging task that takes time and unwavering effort. The PHCTF is just one example of how the Government of Canada is making substantial investments to ensure that efforts to renew primary health care lead to long-term, sustainable change.

The outcomes of the PHCTF initiatives are the results of hard work and dedication undertaken by governments, organizations and stakeholders all sharing the same objective of accelerating and introducing improvements in Canada's primary health care system.

# Provincial-Territorial Envelope

The Provincial-Territorial Envelope supported the efforts of provinces and territories to broaden and accelerate transitional primary health care renewal initiatives to lead to sustainable changes in primary health care systems within the respective 13 jurisdictions. These initiatives were to be innovative and provide results for Canadians while respecting the objectives of the Primary Health Care Transition Fund.

All federal, provincial, and territorial governments agreed to the following Primary Health Care Transition Fund objectives in October 2000:

- To increase the proportion of the population that has access to primary health care organizations, which are accountable for the planned provision of a defined set of comprehensive services to a defined population;
- To increase emphasis on health promotion, disease and injury prevention, and chronic disease management;
- To expand 24/7 access to essential services;
- To establish interdisciplinary primary health care teams of providers, so that most appropriate care is provided by the most appropriate provider; and
- To facilitate co-ordination, and integration with other health services, i.e. in institutions and in communities.





## Yukon Primary Health Care Transition Fund Initiative

Provincial–Territorial Envelope

### 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

### Background and Goals

The Yukon government faces many challenges in delivering health services from a structural, functional and technological perspective. For example, one-third of its people live in small population pockets of a few hundred people, while two-thirds live in the urban capital of Whitehorse. Despite the territory'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 achieve this, Yukon's initiatives centred on two objectives: 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.

### Activities

This initiative, which ran from January 2003 to September 2006, undertook the following activities, which can be grouped into two categories of priorities that further classified Yukon objectives: refocus organizational structures and processes; and implement

improved technology to support structures and processes.

- *Refocus organizational structures and processes.* Smaller action areas were identified, and activities occurred under each. Under the area of *healthy living*, activities included: a public campaign strategy

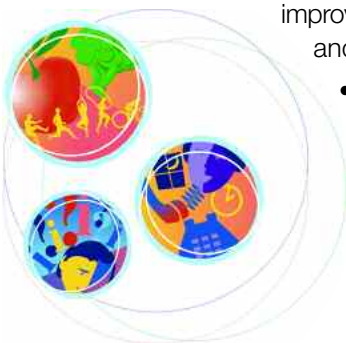
providing parenting information; a walking program to promote active living; and a literature review on healthy eating. For *providing health information*, activities encompassed: producing a *Yukon Health Guide*; enabling web access and creating a nurse information line; developing a program information and disability handbook; and conducting a study on access to professional health literature. To *address key health issues*, activities included: funding a child development centre to train providers in early diagnosis and intervention of fetal alcohol syndrome (FAS); giving funds to the FAS Society of Yukon for prevention and support; funding addictions research; providing diabetes collaborative learning sessions; securing electronic access to a toolkit for chronic disease management (CDM); and implementing a national ambulatory care reporting system.

- *Implement improved technology to support structures and processes.* Pre-established information technology (IT) priorities guided a separate IT steering committee. IT activities included developing a mental health synapse and a community nursing integrated public health information system (iPHIS).

An evaluation plan provided an evaluation framework and an assessment of process, outputs and outcomes. Data are still forthcoming; it is hoped that knowledge gained will be used in future policy, planning and practice.

### Resources

- Report on the primary health care planning forum
- Public campaign strategy to provide parenting information
- Literature review on options and support for promoting healthy eating



- *Yukon Health Guide* and web-accessed information (based on British Columbia's model)
- Program information and disability handbook
- Training program for providers on early diagnosis and intervention of FAS (10 workers trained)
- Alcohol and drug research and survey
- Diabetes collaborative learning sessions and a CDM toolkit
- Ambulatory care reporting system in Whitehorse General Hospital
- Two feasibility studies on continuing care multi-level care facilities
- Literature review and consultation on palliative care in Yukon
- IT synapse application for mental health clinicians and iPHIS application immunization module for community nurses

## Key Learnings

Generally, Yukon has shifted the way it thinks about providing primary care services. The benefits of working together more effectively have been seen, resulting in a different thinking of how Yukon might organize itself at all levels of the health system, from government and non-governmental organizations to practice settings. Evaluation is ongoing for this initiative; however, learnings to date have been grouped according to four action areas: healthy living, health information, key health issues and technology.

- 1) *Healthy Living*: Promoting physical activity through a walking program had very mixed results. Workplace participation increased, but individual and rural community involvement decreased. Providing more parent information led to increased coordination and collaboration among stakeholders who deliver parenting programs.
- 2) *Health Information*: The Diabetes Collaborative, considered to be Yukon's success story, improved coordination and collaboration among health providers. Success was achieved through the use of learning sessions for providers and obtaining access to British Columbia's CDM toolkit. This collaborative provided the opportunity for health professionals to work together to undertake

activities such as group patient visits for diabetes care. The *Yukon Health Guide* was distributed to 13,500 households, and survey results indicate that 65 per cent of Yukoners recall receiving the guide; and, of that number, 82 per cent have used it.

- 3) *Key Health Issues*: The Yukon Alcohol and Drug Survey identified what could be done differently and by whom in order to respond appropriately to individuals who need these services. The Palliative Care Development Project increased coordination among care providers and identified key areas for future programming, including access, coordination, support and education, with specific recommendations for each. Ambulatory care reporting data on mental health/addictions and injury information are now used in the Whitehorse General Hospital, but the same system could not be implemented in Yukon communities.
- 4) *Technology*: The IT initiatives laid the groundwork for implementation of an electronic health record and other IT developments. Infoway is now providing support separately from the PHCTF in preparing a broad information management plan for Yukon.

Sustainability has been a challenge to the Yukon initiative from the beginning. The intent was for all projects within the initiative to be self-sustaining; however, this could not always be achieved. That said, new funding has been provided through the Territorial Health Access Fund (THAF) for some of the activities, including healthy living initiatives, palliative care programming, implementation of a nurse information line, and development of a health human resources strategy.

**Approved Contribution:** \$4,537,282

## Contact Information

Pat Living  
Communications Specialist  
Government of Yukon  
Phone: 867-667-3673  
E-mail: [patricia.living@gov.yk.ca](mailto:patricia.living@gov.yk.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Northwest Territories Primary Health Care Transition Fund Initiative

Provincial–Territorial Envelope

### 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; and Dehcho Health and Social Services Authority

### Background and Goals

The primary goal of this initiative was to support the transition of health care delivery in the Northwest Territories (NWT) to a Primary Community Care (PCC) model. At the time this initiative began, the Department of Health and Social Services (DHSS) had just finalized the design of an Integrated Service Delivery Model (ISDM), envisioning a full integration of health and social services in the territory. The PCC model is the foundation of the ISDM and targets service and system integration, from primary community care to secondary and tertiary levels of service. This model has a strong focus on offering a more comprehensive range of primary health care, wellness and social services. This initiative included 11 individual projects, which supported the NWT’s transition to a PCC approach. Designed to promote a collaborative, client-centred approach for health and social services, the 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.

### Activities

Between December 2002 and September 2006, this initiative undertook many activities, including:

- *Coordination, promotion and implementation of PCC initiatives:* A coordinator was hired and a plan to support the transition to interdisciplinary teams and to the ISDM was designed and implemented.
- *Education on primary health care reform:* Several conferences were held in Yellowknife, including “There Is a Role for Everyone”—which introduced ISDM and promoted interdisciplinary teamwork; “Working Together to Prevent Sexually Transmitted Infections”—which guided a five-year strategy to prevent and control such infections; and “Moving from Theory to Practice”—which provided updates on the reform. Also, another symposium, “Strengthening Connections: Building on Interprofessional Collaboration,” fortified linkages with community stakeholders.
- *Development of integrated PHC teams/services:* Two interdisciplinary health services were established: the Integrated Wellness Centre at the Tlicho Community Services and the Yellowknife Community Health Clinic. The first is based on the “Healing Path,” a strategy consisting of wellness coursework for youth, a networking strategy for professional staff, and a customized community wellness strategy. The other successfully piloted and implemented the first electronic health record in the NWT. In addition, two-day mandatory team-building workshops were held at health centres throughout the Beaufort Delta Health and Social Services region.
- *Public education to strengthen self-care:* A self-care handbook was adapted to assist NWT residents in making decisions to appropriately access the PCC system. Also, two six-week Chronic Conditions Self-Management (CCSM) workshops were delivered each year to educate patients on healthy eating, exercise, dealing with anger and other topics. The Respected and the Prevent Alcohol-Related Trauma in Youth (PARTY) programs were also offered in some communities.
- *Improvement of women’s reproductive health services:* A midwifery program was developed and implemented at the Fort Smith Health and Social Services Authority, a prenatal care clinic was opened at the Stanton Territorial Health Authority, and a toll-free line for providers was established to facilitate travelling arrangements made by nurses when referring patients to Yellowknife.
- *Training for various health care providers:* This was established in collaboration with Aurora College. Also, a regional nursing conference and several educational workshops (e.g., CCSM program leaders, Baby-Friendly initiative) were organized.



- *Community Dental Health project*: This intended to reduce the incidence of dental decay and included an oral health census on preschool-aged children in the Beaufort Delta and Sahtu regions.
- *Evaluation of PCC initiatives*: This included the development of detailed evaluation frameworks, final evaluations for each of the 11 projects, and an overall evaluation.

## Resources

- *A Self-care Handbook* adapted to the NWT (available in English and French)
- Health and social programs tailored to meet the needs of the communities and health providers of northern communities, such as the Healing Path Wellness Program, Midwifery Program and the Northern Women's Health Program
- Training programs, such as the Nurse Practitioner Clinical Training Centre, the Aboriginal Community Health Worker Training and the 18-hour lactation management course

## Key Learnings

This initiative, which supported an increased understanding of the NWT's PCC approach, was relevant, successful and cost-effective. The public education plan provided tools to promote self-care and placed greater emphasis on health promotion, disease and injury prevention, and chronic conditions management. Since the introduction of clinical midwifery services, the number of women seeking midwifery care in the community has increased, as has the number of women choosing to give birth locally. With the new training programs, nurse practitioners and community health workers are better prepared to help Aboriginal and northern clients with illness prevention and health promotion, and to encourage self-care, healthy living and management of chronic conditions. In addition, the new interdisciplinary health centres are providing residents of NWT communities with better access to services.

Despite some challenges (health human resources, change management issues and the high costs of renovation), stakeholders who were interviewed about the initiative agreed that it has helped start the NWT's transition process to a PCC approach, although full system transition has not yet been achieved. Over 90 per cent of the stakeholders surveyed indicated that their projects were either very successful (27.5 per cent) or successful (62.7 per cent) in meeting their specific goals. There were some particular areas of, and reasons for, success:

- Communication about the initiative increased throughout the NWT.
- Interdisciplinary teamwork (and learning about the facilitators of and barriers to effective teamwork) has been boosted. Now, there is much more of a team approach to the delivery of health and social services.
- Having a dedicated coordinator contributed greatly to the success of many projects.
- Significant partnerships were developed at various levels through this initiative.
- The fact that some of the projects were community driven and that the community had input into designing the service delivery models contributed to their success.

Primary health care renewal is a long-term process that preceded the PHCTF and will continue beyond the life of the fund. The majority of individual projects have become operational programs sustained by their individual authorities.

**Approved Contribution:** \$4,771,470

## Contact Information

Vicki Lafferty  
Planning Specialist  
Department of Health and Social Services  
Government of the Northwest Territories  
Phone: 867-873-7060  
E-mail: vicki\_lafferty@gov.nt.ca

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).



## Nunavut Primary Health Care Renewal Initiative

Provincial–Territorial Envelope

### Lead and Partner Organization(s)

**Nunavut Department of Health and Social Services**

### Background and Goals

Several challenges affect the delivery of health services in Nunavut, including geographical isolation, language and cultural differences (there are four official languages), and difficulties recruiting and retaining staff. Furthermore, there is a disproportionate number of non-Inuit health professionals, and they face difficulties delivering health services to the Inuit population because of differences in cultural values and health behaviours. This initiative focused on strengthening Nunavut's ability to face these challenges through four specific goals:

- Establish two new primary health care (PHC) organizations;
- Increase the emphasis on health promotion and PHC outreach to communities;
- Establish demonstration projects and support network-building events that promote the practical use of interdisciplinary PHC teams; and
- Facilitate, coordinate and integrate health services to improve and strengthen communication between PHC providers and all communities.

### Activities

Ending March 31, 2006, this initiative took place over a three-year period. Under its auspices, two interdisciplinary collaborative practices were established in Iqaluit: a Family Practice Clinic and a Regional Rehabilitation Clinic. In order to support health promotion and disease and injury prevention, several activities were pursued, including the development and facilitation of:

- Training programs, like the Mental Health Train-the-Trainer and the Mental Health Diploma;
- Training sessions, including the Nunavut Baby Friendly Initiative Training Project, which allowed participants to obtain Levels 1 and 2 certification in breastfeeding; the Great Kids Program Workshop, a

parenting and family support program; and the RespectEd and the C.A.R.E. Programs, which focus on preventing abuse, harassment, bullying and promoting personal safety; and

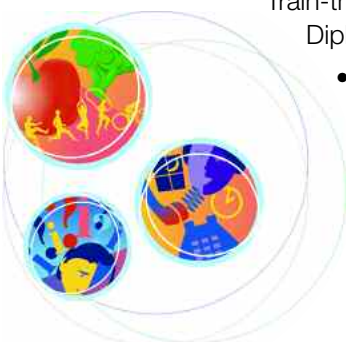
- Resources for caregivers and communities offering information on key health topics, including sexual health and tuberculosis. In addition, the initiative supported the purchase of educational booklets in French and English on sexually transmitted infections and their subsequent translation into Inuktitut and Inuinnaqtun.

Several activities were undertaken to strengthen integration of stakeholders in PHC. These included:

- Establishing a Territorial Community Health Representative Coordinator position;
- Holding two conferences on integration, collaboration and leadership at the community level;
- Supporting the development of the Citizen Engagement Strategy in Nunavut's three regions;
- Holding key workshops, including ones on Determinants of Health and Public Health Planning;
- Supporting participants in the National Indian & Inuit Community Health Representative Organization Conference; and
- Holding a three-day Needs Assessment Workshop to facilitate professional development training of Community Health Representatives and supporting their networking.

### Resources

- Mental Health Train-the-Trainer course adapted from the World Health Organization's Mental Disorders for Primary Care Education program for the Inuit culture
- Mental Health Diploma Program Pilot Project, a two-year diploma course that is now available at Nunavut Arctic College and includes Inuit culture and traditional knowledge
- Mental Health resources (posters and flash cards) focusing on anxiety, depression and post-traumatic



disorders, which have been translated into Nunavut's four official languages

- *Sexual Health Manual*, which contains Nunavut best practice guidelines for contact tracing, follow-up and health teaching. Materials are culturally and age sensitive
- *Engaging Nunavummiut: A Guide to Strengthening Community in Nunavut*, a toolkit to help communities deal with health and wellness issues and identify community health priorities

## Key Learnings

This initiative has created new resources that will enable more effective PHC services in Nunavut. It has also pioneered a new interdisciplinary approach to planning and policy development in this new territory and placed a greater focus on interdisciplinary and intersectoral teams. It facilitated access to services in Iqaluit through the Family Practice Clinic—the first of its kind in that city—permitting residents there to access interdisciplinary PHC services in a non-hospital setting. Furthermore, the initiative supported the development of Nunavut's health human resources. By making possible the design and implementation of

training programs tailored to meet the needs of the Inuit population, the initiative attempted to encourage more Inuit to become health care providers and ensure that the non-Inuit have a deeper understanding of Inuit health practices. Lastly, the initiative established opportunities for community development and participation in health programs and facilitated interdisciplinary networks across the three regions.

The Department of Health and Social Services has assumed responsibility for the long-term sustainability of this initiative and has integrated it within its health regions and branches.

**Approved Contribution:** \$4,508,924

## Contact Information

Nancy Campbell  
Director of Communications  
Department of Health and Social Services  
Government of Nunavut  
Phone: 867-975-5714  
E-mail: [ncampbell1@gov.nu.ca](mailto:ncampbell1@gov.nu.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## British Columbia Primary Health Care Transition Fund Initiative

Provincial–Territorial Envelope

### 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

### Background and Goals

This initiative focused largely on helping general practitioners to improve care for priority populations, based on evidence showing gaps in care. It addressed three areas:

- *Improving Health Outcomes:* Three broad categories of projects were undertaken in this area: chronic disease management, a prevention support project, and patient self-management. The goals were to improve patient care according to best practices, to improve the outcomes of patient care, and to provide care more efficiently.
- *Supporting a Range of Practice Models:* Four broad categories of projects were undertaken in this area: practice models/networks; shared care; physician engagement; and technology. The goals were to promote an interdisciplinary approach; improve access to more integrated patient health record data; establish quality assurance mechanisms; extend hours and 24/7 access; offer education and professional development; and integrate health care with community services.
- *Professional/Organizational Development, Evidence and Evaluation:* There were three broad categories of projects undertaken in this area: patient navigation and process mapping, BC NurseLine, and the Centre for Health Services and Policy Research (CHSPR) PHC (primary health care) Logic Model. The goals were to identify a small number of changes that would create the biggest improvement for patients, improve consumer access to timely and accurate information about medications, and provide mechanisms to guide performance measurement, monitoring and evaluation.

### Activities

The initiative took place between April 2002 and March 2006 and centred on the three areas:

- *Improving Health Outcomes:* British Columbia developed an approach based on the expanded Chronic Care Model. The province formed quality improvement collaboratives, bringing together organizations and individual practitioners in an effort to improve care for people with a specific chronic illness. Activities focused on the development of clinical practice guidelines and the Chronic Disease Management (CDM) toolkit—software that allows teams of care providers to more effectively deliver evidence-based care to individuals with chronic disease. B.C. physicians were encouraged to focus more on prevention, targeting people aged 50 to 70, and given financial incentives, nurse facilitators to support change management, and tools for doing so and also for meeting other care goals. Self-management also loomed large in this initiative. In 2003–04 and 2004–05, 46 leader-training workshops were held; 508 leaders (persons with a chronic condition) were trained; 268 courses were held, with 2,873 participants; and British Columbia hosted the International Patient Self-Management Conference in September 2005.
- *Supporting a Range of Practice Models:* To engage physicians, nine Professional Quality Improvement Days were held in 2004 and 2005. These days provided an opportunity for physicians, health authorities and the Ministry of Health to discuss the challenges of providing total care in the community (Full Service Family Practice) and the opportunities for building health care system capacity, and also to tackle the issue of fair compensation. Health authorities and care providers collaborated to determine appropriate models depending on the needs of the population. These models, which were implemented, had the primary objectives of establishing an interdisciplinary approach and enabling access to more integrated patient health



data, as well as improving care coordination and continuity. Shared care was implemented through information-sharing systems, mapping tools, and clinical practice guidelines and protocols. As British Columbia developed its approach to PHC renewal, it became clear that there was a need to use information management and information technology (IM/IT) to support delivery of health care. This led to four initiatives: implementation of electronic medical records (EMRs), development of an electronic medical summary (e-MS), development of a chronic disease management IM/IT system and development of CDM core data and messaging standards.

- *Professional and Organizational Development, Evidence and Evaluation:* Patient mapping was undertaken to identify the gaps in service. This resulted in service frameworks that optimize the delivery of care of a target population (e.g., patients with diabetes) across the health system. In addition, literature review and multi-stage iterative feedback resulted in a logic model for PHC, which provides a shared conceptual foundation. Through PHCTF funding, pharmacist services were added to BC NurseLine based on assessed need.

## Resources

- The Prevention Support Program developed an electronic prevention flow-sheet and clinical prevention intervention material for 10 areas, including tobacco use, alcohol use, colon screening, influenza, cervical screening, breast screening, hypertension, weight issues, healthy eating and physical activity.
- *Living a Healthy Life with Chronic Conditions* (a tailored book to help patients self-manage)
- A patient-self management training workshop
- Shared care protocols, including service frameworks and patient pathways process maps
- A logic model for PHC
- A website, [www.healthplanning.gov.bc.ca/phc](http://www.healthplanning.gov.bc.ca/phc)

## Key Learnings

The collaborative process appears to have been successful in achieving service integration, multidisciplinary teamwork, information transfer, and adherence to B.C. guidelines for certain chronic diseases at least, in sev-

eral communities. This initiative focused primarily on two major chronic conditions: diabetes and congestive heart failure. Quality of care has increased for patients with these conditions, while corresponding mortality and hospitalizations appear to have decreased.

A total of 92 practice models were implemented or enhanced during the PHCTF time frame, while 26 sites undertook enhancements to the structure or delivery of PHC. There is a move towards team-based care, and electronic medical record technology has been introduced in 85 per cent of sites. Most sites engaged in health promotion and disease prevention activities, but only a few were formally involved in the provincial prevention support program. Although extended PHC access beyond traditional business hours has not occurred at the majority of the PHC sites, same-day access for immediate medical care was generally available. PHC providers indicated that they are highly satisfied overall, although there have been complaints from nurses and pharmacists that the onus for renewal has been on physicians.

British Columbia has committed to accelerating the CDM work enabled through the PHCTF. It has committed tens of millions of dollars to CDM in its 2006 agreement with physicians. The patient journey map projects will lead to service frameworks, which will be used to identify gaps in care on a system-wide basis and to make recommendations on how to close the gaps. The BC NurseLine is fully sustainable and is being expanded. Opening up communication with physicians is creating new opportunities for partnerships and new provisions in physician-government negotiations.

**Approved Contribution:** \$74,022,488

## Contact Information

Darcy Eyres  
Project Director, Primary Health Care  
Medical Services Division  
British Columbia Ministry of Health  
Phone: 250-952-1583  
E-mail: [darcy.eyres@gov.bc.ca](mailto:darcy.eyres@gov.bc.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Alberta Primary Health Care Transition Fund Initiative

### Provincial–Territorial Envelope

### 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; town of Pincher Creek; Canadian Mental Health Association; Alberta Mental Health Board; Alberta Medical Association; NAPI Friendship Centre; Aakom-Kiyii Health Services; Piikani Nation

### Background and Goals

Through this initiative, the Province of Alberta supported the transitional costs of implementing large-scale primary health care (PHC) projects. These were intended to improve access, accountability and integration of services through fundamental and sustainable change to the organization, funding and delivery of PHC services. Two major strategies were initiated:

- 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 (CBF), which has funded nine initiatives, and other provincial coordination activities that supported the implementation of new primary care models and the broader implementation of CBF activities across the province.

Alberta established five objectives for the funded initiatives: 1) develop and integrate innovative health promotion, disease and injury prevention and chronic disease management programs; 2) develop, support and use interdisciplinary health teams, integrated care models and other innovative methods of delivering PHC; 3) develop and implement effective change management strategies at regional and provincial levels, establish models of collaboration (e.g., team building) and encourage a culture of change (system-wide); 4) establish and implement education and training services to support new models of PHC collaboration and service delivery; and 5) identify and develop infrastructure that supports the delivery of PHC.

### Activities

Over the four years of this initiative (2002–06), Alberta undertook many activities to improve the delivery and quality of PHC:

It established Health Link Alberta. Staffed by registered nurses, it provides province-wide, 24/7 symptom-based health advice (triaging), reliable general health information, and assistance in locating providers of needed health services.

Through the CBF, regional health authorities forged partnerships with many other organizations and associations to develop and implement several initiatives:

- *The Interdisciplinary Primary Health Care Team Initiative* developed an interprofessional curriculum for staff and worked with the universities of Alberta and Calgary to develop interprofessional curriculum for students.
- *Health First Strathcona* established an after-hours, multidisciplinary urgent care centre.
- *Chronic Disease Prevention and Management Network (Chinook)* enhanced chronic care prevention and management services.
- *Pincher Creek Rural Health Care Initiative*, which was physician-led, focused on chronic disease management, mental health services, health promotion and screening, and an expanded surgical program.
- *PHC Chronic Disease Management (Calgary)* improved chronic disease management through the use of multidisciplinary teams and greater self-management support.
- *Southern Alberta Child and Youth Health Network (SACHYN)* had two components:
  - *Healthy Minds/Healthy Children* built the capacity of local care providers to offer mental health services to people in their own communities and established coordinated linkages with specialized services.
  - *Healthy Infants* developed a maternal risk screening tool for physicians.
- *Shared Mental Health Network*, a collaborative effort involving family physicians, mental health clinicians and psychiatrists, boosted the capacity of family physicians to assess and manage patients with mental health concerns.
- *Police and Crisis Team*: A mental health professional was teamed up with an Edmonton Police Service constable to respond to calls identified as having a mental health component to ensure appropriate treatment.
- *Primary Care Diabetes Project* consolidated diabetes resources in rural communities to decrease service fragmentation and support a multidisciplinary team approach.



Other provincial coordination activities included these programs:

- *Living Well* is a community-based program that provides exercise, disease-specific education and self-management support for people with chronic conditions.
- *Stanford Self-Management Leadership Training* built the capacity of all health regions to train at least two Leaders through the Stanford Self-Management Leadership Training to help patients manage their chronic conditions.
- *Interdisciplinary Training Program* developed a resource training manual for multidisciplinary teams providing comprehensive PHC services.
- *Primary Care Improvement Project* increased awareness of the concepts of primary care improvement and offered workshops to apply changes.
- *Primary Health Care Renewal Grant* provided support for regional health authorities implementing ongoing PHC renewal activities.

## Resources

CBF initiatives developed:

- Tools to assist in the self-management of chronic diseases
- Resources to promote the development and effective use of multidisciplinary teams
- Clinical protocols to assess and manage chronic diseases in a multidisciplinary setting
- Physician desk references for children's health issues such as depression, anxiety and suicide
- A 110-question *Healthy Mother, Healthy Baby* screening tool, which takes into account lifestyle, access to health services, environmental factors and risk factors

## Key Learnings

Health Link has increased the capacity of callers to practice self-care at home and is encouraging more appropriate use of Alberta's health care resources by providing Albertans with an alternative PHC service and referring callers to services that meet their health needs. The majority (63 per cent) of Albertan households are aware of Health Link Alberta. By 2005–06, an estimated 46 per cent of households used Health Link Alberta at least once. User satisfaction surveys have indicated high levels of satisfaction with almost all aspects of the service.

Through the CBF:

- *Pincher Creek Rural Health Care Initiative's* interdisciplinary Good Health Team has boosted patients' ability to self-manage their chronic diseases (thereby reducing non-emergent office visits), and has improved links to community programs and resources. It has held health screening and information sessions for at-risk women, such as weight management and cervical screening tests.
- *PHC Chronic Disease Management's* community-based exercise program primarily for diabetics and chronic obstructive pulmonary disease (COPD) patients involved 1,200 patients.
- *Healthy Minds/Healthy Children* held 207 clinical consultations.
- *Shared Mental Health Network* provided a total of 911 shared care consultations.

The CBF has produced diverse initiatives and learnings regarding enhanced use of interdisciplinary teams, improved linkages among providers and the development of health promotion and chronic disease management programs. While partnerships have been developed and innovative programs have been established, the challenge is now to expand and adapt these models and programs and disseminate learnings more widely across the province. Several of the projects are expanding beyond the health authority in which they were developed to take on a provincial focus, including the *Living Well* program, which has expanded to four health authorities, and the *Stanford Leadership Training* program, which has been used to train 234 individuals from all nine health regions.

While Health Link Alberta is now funded through global funding allocations to Capital Health and Calgary Health Region, each CBF initiative has achieved sustainability in different ways: by incorporating initiatives into regional programs and services, securing funding from or linking with other programs, and by integrating with primary care networks.

**Approved Contribution:** \$54,876,073

## Contact Information

Betty Jeffers  
Director, Primary Care Unit  
Alberta Health and Wellness  
Phone: 780-415-2843  
E-mail: [betty.jeffers@gov.ab.ca](mailto:betty.jeffers@gov.ab.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Saskatchewan Primary Health Care Transition Fund Initiative

Provincial–Territorial Envelope

### Lead and Partner Organization(s)

**Saskatchewan Health**

### Background and Goals

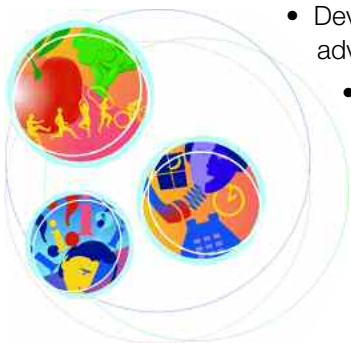
The Saskatchewan Action Plan for Primary Health Care was released in December 2001 with the overall aim of improving the quality of primary health care (PHC) services and access to them. Since the Action Plan's inception, however, Saskatchewan changed its governance structure, reorganizing its 32 health districts into 12 regional health authorities (RHAs). Saskatchewan intended to develop its PHC networks and teams within the new RHAs, and adopted the following Primary Health Care Transition Fund objectives:

- Increase the proportion of the population with access to PHC organizations that are accountable for providing a defined set of comprehensive services to a particular population;
- Increase the emphasis on health promotion, disease and injury prevention, and the management of chronic disease;
- Expand 24/7 access to essential services;
- Establish interdisciplinary PHC teams of providers, so that the most appropriate care is provided by the most appropriate provider; and
- Facilitate coordination and integration with other health services.

### Activities

From 2003 to June 2006, Saskatchewan's initiative focused on seven specific activity areas:

- Building capacity within the Department of Health;
- Building capacity within RHAs;
- Developing PHC programs in RHAs through community development and team facilitation;
- Developing a 24-hour telephone advice line (HealthLine);
- Providing educational opportunities to upgrade the skill levels of PHC team members;



- Developing incentives to encourage physicians to participate in the plan; and
- Increasing the capacity in RHAs to enhance practice behaviours in the PHC setting, through facilitation initiatives.

In addition, new activities were incorporated that were not originally part of the initiative. These included: developing a business case for a provincial way-finding database; introducing HealthLine Online (June 2006), a web-based application of health information and services; and forming a midwifery implementation committee to establish a midwifery PHC team by the autumn of 2006. The initiative also developed evaluation frameworks and measures for accountability and reporting.

### Resources

- Guidelines for the development of an RHA plan for PHC services
- Accountability measures and indicators for PHC
- Evaluating PHC in Saskatchewan: a proposed rationale and indicator framework
- Workshops and guides on team facilitation
- A provincial diabetes plan
- HealthLine: a 24-hour telephone advice service (managing over 200,000 calls since August 2003), and an online health information service (HealthLine Online), including a marketing and communication strategy for both
- A draft Memorandum of Understanding and a model physician contract

### Key Learnings

Team development has been accelerated in Saskatchewan. By providing funding for dedicated resources at the regional level, Saskatchewan has ensured a continued focus on PHC at a time when much attention was being directed towards both reorganization and urgent care issues such as surgical wait times. To date, 37 PHC teams, serving approximately 23 per

cent of the population, have been developed. PHCTF funding supported the creation of 17 of those teams, which give 12 per cent of the provincial population access to PHC services. More than 90 per cent of the teams provide 24/7 access to a physician and/or registered nurse practitioner. Funding Directors of PHC in each RHA facilitated the implementation of PHC teams. In addition, through the team development project, expertise in team facilitation is now present in every RHA to support teams and assess community readiness.

In the initial phase of PHC team development, nurse practitioners, along with family physicians, were placed on the teams. However, the availability of fully licensed nurse practitioners, coupled with the unwillingness of some nurses to relocate outside of urban centres, as well as other related human resources issues, proved to be daunting challenges. The number of nurse practitioners working in an expanded role did increase, however.

No new funding was made available through the initiative to address the physician remuneration requirements for the new PHC teams. The existing fee-for-service budgets were utilized to offset payment arrangements, but as a result, there was no extra incentive for physicians to participate and form PHC teams. The finalizing of a Memorandum of Understanding with the Saskatchewan Medical Association and a corresponding model contract for physician participation in PHC teams was more complicated than originally envisioned, but discussions continue.

Nevertheless, the number of physicians on alternate payment plans who work on a PHC team did increase.

The RHAs have been struggling with the distinction between PHC, population health and community-based services. This has led to inconsistencies from one RHA to another, creating many challenges for Saskatchewan Health in how to relate to each region. The Action Plan for PHC also identified a core set of PHC services that RHAs are expected to deliver, and within each set, Saskatchewan Health planned to more specifically define a core basket of services at the team level. This proved to be a challenge, however, due to the province's geography and resource availability.

Through this initiative, Saskatchewan has gained a deeper understanding of the challenges of team development. It has learned that co-locating health professionals does not necessarily mean that a "team" exists. Overall, Saskatchewan is committed to a renewed PHC system, but change does take time.

**Approved Contribution:** \$18,592,405

### Contact Information

Donna Magnusson  
Executive Director, Primary Health Services Branch  
Saskatchewan Health  
Phone: 306-787-0875  
E-mail: [dmagnusson@health.gov.sk.ca](mailto:dmagnusson@health.gov.sk.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).



## Manitoba Primary Health Care Transition Fund Initiative

Provincial–Territorial Envelope

### 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

### Background and Goals

To guide its primary health care (PHC) renewal, Manitoba developed a Policy Framework and a Master Proposal, based on information garnered through consultations. The framework’s vision states that “Manitobans will have access to community-based, integrated and appropriate PHC services,” while its mission is to work with regional health authorities (RHAs), in partnership with key stakeholders, to develop and support PHC services. Manitoba divided its Provincial–Territorial Envelope per capita allocation into two phases: the first identified five priority foundational initiatives to facilitate the integration and enhancements of PHC services in the province, and the second involved the solicitation of PHC initiative proposals from Manitoba’s RHAs. The initiative’s goals were threefold: 1) to 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) to 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) to 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.

### Activities

Over the course of this initiative, many activities were undertaken, divided into two phases.

Phase 1 activities included:

- The identification of five initiatives undertaken in Phase 1 (proposed and selected by

Manitoba Health) and 17 in Phase 2 (proposed by the RHAs and selected by Manitoba Health);

- The monitoring and evaluation of these initiatives;
- Dissemination activities, such as the development and presentation of a display promoting the objectives of this initiative; the development of a PHC informational booklet; the creation and dissemination of several news releases to provide updates; the creation of a website; and presentations at conferences;
- Expansions to Health Links–Info Santé (enlarging physical space, improving call centre technology, hiring additional staff and training them, and establishing a medical panel to approve protocols);
- Education and training of paramedics through the Emergency Medical Services (EMS) Program to enable them to take on expanded roles, including greater involvement in health promotion, education, screening and care;
- Implementation at one urban community access centre and two rural sites of integrated information technology solutions designed to provide access to disparate sources of information; and
- Development and implementation of a formal training model for collaborative practice, and development of a social marketing strategy to guide promotional activities to raise public awareness and understanding of PHC.

Phase 2 activities included:

- Development of a region-specific PHC framework that focuses on building community capacity processes and coordination and training of health providers;
- Establishment of a community access centre in Brandon, community health centres in Wabowden and Riverton, a PHC centre in Niverville, and a telehealth/videoconferencing room in Churchill;
- Expansion of community resource centres in Lac du Bonnet and Pine Falls and regional health services in Parkland (e.g., Regional Diabetes Program);



- Addition of two new advanced practice nurses to the Interlake RHA; and
- Several integration/redesign activities that included the implementation of a community oncology team, reconfiguration of staff roles and responsibilities, integration of teams and services, and implementation of shared care mental health services.

## Resources

- An outbound program to monitor patients with congestive heart failure (used by Health Links–Info Santé)
- *Assiniboine Primary Health Care Handbook*, which contains tools and practical information about PHC and its relation to the workplace and the community
- Primary Health Care Lens, a method to evaluate programs and services' compliance with the principles of PHC
- One Window Approach, a tool and process that helps to assess current programs and support the creation of a plan for improvement
- Clinical Cancer Guidelines for cancer care and follow-up guidelines for breast and thyroid cancer
- Post-graduate interdisciplinary curriculum on collaborative practice
- Resources for team development and change management

## Key Learnings

The initiative improved access through a number of investments that advanced regional PHC initiatives and provided additional or new access to underserved populations. It also improved access to health services through better communication with clients, providing practical services outside standard health care (e.g., laundry and shower facilities), and, in one project, by having facilitated contact with health providers for reluctant clients. Progress in moving toward integrated service delivery has been clearly demonstrated with collaborative practice projects, system changes throughout entire regions, some success with integrated client files and working in partnership with other service providers in health and other sectors. Several regions have implemented service delivery changes that involve new or expanded

roles. Screening for some types of cancer, diabetes, hypertension and other chronic conditions are being provided by nurses, EMS workers and/or dietitians to free up physicians' time. A social marketing initiative informed and educated staff and the public about what to expect and how to use PHC to their advantage. Partners both in and outside the health care sector were better able to see the connections and advantages of collaboration and common goals. Client satisfaction is high for new and expanded services, and there has been a decrease in the number of "no shows" for appointments.

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. Regions seem ready to embrace the principles of PHC and to more broadly support local initiatives and activities. RHAs were given the flexibility to target funds in a way that would benefit them the most. This flexibility was very important for the achievement of their goals and should not be lost in future funding. Manitoba is committed to shifting the focus of its health care system from acute care to a greater reliance on community-based PHC services. This initiative created community partnerships and mentored committed individuals who will be key to the future sustainability of this initiative. Other key elements for sustainability include active involvement of service providers, the ability to effectively leverage products and lessons learned across the province, continuous effective communication and information strategies, a sound human resource strategy, and continuing financial support.

**Approved Contribution:** \$20,844,059

## Contact Information

Barbara Wasilewski  
Director, Primary Health Care  
Manitoba Health  
Phone: 204-786-7176  
E-mail: [bwasilewsk@gov.mb.ca](mailto:bwasilewsk@gov.mb.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Ontario Primary Health Care Transition Fund Initiative

Provincial–Territorial Envelope

### Lead and Partner Organization(s)

**Ontario Ministry of Health and Long-Term Care**

### Background and Goals

The Government of Ontario declared in 2000 that “improvements to primary health care are crucial to the renewal of health services.” In order to advance primary health care (PHC) in the province, Ontario undertook nine key PHC renewal initiatives; four were to be centrally implemented (enrolment in new PHC models, systems development and information technology, communication, and project management), while the other five were to be implemented through a grant application process. These initiatives sought 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.

Ontario implemented 101 operational grants across five initiatives, all of which had different objectives:

- *Demonstration, research and evaluation projects (interdisciplinary projects)* aimed to develop and test new models of care that support the integration of various health care professionals and other services in PHC settings;
- *Accreditation projects* sought to develop formal accreditation process with a quality measurement accountability system to ensure that new primary care models continue to improve;
- *Leadership and training projects* were to develop learning opportunities to assist providers in the transition to a more collaborative approach to health care delivery;
- *Mental health projects* sought to better integrate mental health providers and specialists in primary care; and
- *Rehabilitation projects* aimed to establish and strengthen linkages between rehabilitation services and PHC, with clear lines of responsibility and accountability.

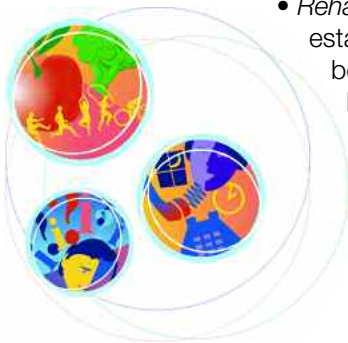
In addition, Ontario awarded 59 capital grants, the majority of which were intended to integrate a range of different disciplines into

practices. Some of the projects’ objectives included integrating pharmacists into family practices; bringing together under one roof family physicians, pharmacists and nurse practitioners; and integrating dietitians and family physicians. Over 44 of the capital grant projects were linked to Family Health Teams (FHTs), a key component of the government’s PHC plan.

### Activities

Over the four years of this initiative (2002–06), many activities were undertaken. A selection includes the following:

- Several pre-operational steps were taken to support physician and patient enrolment in other PHC models, including setting up related telephone advisory services and creating an IT and accountability infrastructure. Many efforts were made to familiarize physicians and other PHC professionals with the various new models. In addition, PHC enrolment kits were prepared and distributed and enrolment/consent forms were sent to all Ontarians.
- The PHC team provided ongoing management, accountability monitoring and reporting of all initiatives, which included several site visits to operational and capital grant projects. The team also 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.
- Design of business and system requirements, proof of concept project, and evaluation of a document and workflow management system were undertaken. Also, an interim Decision Support System was implemented and business requirements of the Contract Management System for all PHC models were identified.
- Patient toolkit/education resources and more than 20 educational materials for providers were created.
- An accreditation process was developed and disseminated. (Some of the tools developed include assessment tools to evaluate quality in pilot practice sites; a Master Assessors Training Workshop; and a website to disseminate program model, tools and findings.)



- A curriculum to build knowledge and skills in the areas of Plan-Do-Study-Act cycles, information management, Work Redesign, Collaboration and Integration, and Performance Measurement were developed. Three learning modules on leadership took place in 2005 with the participation of 12 primary care teams.

## Resources

This initiative supported the development of several hundred resources that will support the work of health care stakeholders, including health care providers, health care administrators, and patients. The tools developed included:

- Toolkits
- Best practices and protocols
- Innovative models of care
- Evaluation instruments
- Training modules, care plans
- Accreditation standards
- Website: [http://www.health.gov.on.ca/english/providers/project/phctf/fund\\_projects.html](http://www.health.gov.on.ca/english/providers/project/phctf/fund_projects.html)

## Key Learnings

The full impact of this initiative is difficult to quantify, yet a few key numbers point to the gains made by Ontario. Enrolment in new PHC models has more than doubled in 2005–06, from 2.6 million in March 2005 to 6.8 million in September 2006. The success of the enrolment process was largely facilitated by the development of an effective enrolment system and corresponding communication strategies.

Over 90 interdisciplinary PHC teams have been established through the grant programs, and more than 33 different kinds of providers are now involved in the teams. Those involved found that the effective integration of allied health professionals (AHPs) into PHC settings took on average 4 to 6 months, and success was influenced by factors such as trust, open communication, mutual understanding of scopes of practice and roles within the setting, time, and commitment to collaborate. The addition of AHPs facilitated earlier access to more comprehensive and effective health care promotion and self-care support. Patients were overwhelmingly satisfied with the care received

through an interdisciplinary team, and clinical outcomes were often improved.

All projects embraced Ontario's chronic disease prevention and management framework and consistently found that patient-centred approaches to chronic disease management (CDM) facilitate patient decision-making, and improve clinical outcomes and cost-effectiveness in care. For those examining the effectiveness of an interdisciplinary CDM model, a key component was the use of a single person (usually a registered nurse) to act as the first point of contact and coordinator of interactions with other providers and services. Several projects found that this model was effective in providing much-needed support to complex chronic disease patients by a range of interdisciplinary team members.

The leadership and training initiatives facilitated the transition from independent practice toward collaborative care. Those involved found that the development of new skills was supported by clear targets, timelines, team work and opportunities to give and receive feedback. Barriers included the lack of time and resources and system complexity. The most common changes to practice were found to be earlier identification, more accurate diagnosis and better management of conditions. Training in change management has been instrumental in the shift toward new models of care.

Capital and operational grant projects have provided needed infrastructure, expertise, human resources and/or services and programs to assist in and expedite the establishment of more than 30 FHTs—directly supporting the provincial government's plan to build a health care system that delivers on the key priorities of keeping Ontarians healthy, reducing wait times and providing better access to doctors and nurses. Further implications are likely to be felt in the years to come.

**Approved Contribution:** \$213,170,044

## Contact Information

Marsha Barnes  
Business Lead, Primary Health Care Team  
Health System Accountability and Performance Division  
Ontario Ministry of Health and Long-Term Care  
Phone: 416-327-7056  
E-mail: [marsha.barnes@moh.gov.on.ca](mailto:marsha.barnes@moh.gov.on.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Quebec Primary Health Care Transition Fund Initiative

Provincial–Territorial Envelope

### Lead and Partner Organization(s)

**Ministère de la Santé et des Services sociaux du Québec [Quebec Department of Health and Social Services]**

### Background and Goals

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. Each FMG signs an agreement with a local community service centre (CLSC) to have the CLSC deliver psychosocial services in particular to the FMG clientele. The groups belong to a more extensive network comprising other FMGs, hospitals and other services. Through the networks, the FMGs provide access to some services 24 hours a day, 7 days a week. 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 those set at the First Ministers Meeting 2000, 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 the 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 declared its intention to register 75 per cent of the populace on FMG lists in the coming years, and expects to establish about 300 FMGs in the province.

The first wave of FMGs appeared in the fall of 2002, and the PHCTF has since contributed to their development.

### Activities

The initiative, conducted between October 2001 and March 2006, included the following activities:

- Continuing the government's FMG implementation process;
- Negotiating contractual agreements, especially for the hiring of nurses (who maintain an employment relationship with the CLSCs); and
- Developing and installing information systems.

### Resources

- 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.



## Key Learnings

In April 2006, a *Université de Montréal* case study of five first-wave FMGs found that:

- There had been notable progress in the level of collaboration among physicians and nurses in most of the FMGs studied.
- The majority of users saw only the benefits of enrolling in an FMG.
- Users saw improvements in the following areas (presented in order of importance): accessibility after regular business hours; accessibility during regular business hours; doctor–nurse coordination; inclusiveness of care; and knowledge of the patient.
- FMG client enrolment went much more smoothly than expected, and consisted mainly of patients already under the care of the doctors involved.
- There were no serious disparities between the services offered by the FMGs under study.

The evaluation also noted challenges, including: a slow and bureaucratic government process; contractual agreement problems between FMGs and nurses, who maintain an employment relationship with CLSCs (the nurses feel the lines of authority are unclear, while some doctors have been frustrated by negotiations with the local union); lack of support for the change process; and delays in installing information systems, which have disappointed the professionals.

Despite these problems, the case study clearly showed that FMGs significantly benefit Quebec's population, and play an important role in supporting the province's primary health care system.

**Approved Contribution:** \$133,681,686

### Contact Information

Quebec Department of Health and Social Services

**[www.formulaire.gouv.qc.ca/cgi/affiche\\_doc.cgi?dossier=7402&table=0](http://www.formulaire.gouv.qc.ca/cgi/affiche_doc.cgi?dossier=7402&table=0)**

## Health Care Renewal in New Brunswick

Provincial–Territorial Envelope

### 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

### Background and Goals

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. Two priorities were identified: the establishment of a network of community health centres (CHCs) and improvement in ambulance services. To this end, NB used its funding to support six initiatives in health care renewal:

- Start-up and establishment of five CHCs, including implementation and orientation support;
- Development of a CHC formative evaluation framework, including progress indicators to further inform development of a CHC network;
- Upgrade of ambulance services, focusing on advanced life support training for emergency medical technicians and the purchase of durable and disposable supplies to support this enhanced scope of practice. As well, upgrade of the existing ambulance service dispatch and information system;
- Development of change management strategies and activities to support implementation of CHCs and other PHC renewal activities;
- Completion of a preliminary analysis of information management system needs for public health and mental health; and
- Support of a telehealth initiative in tele-homecare.

### Activities

Beginning in 2003, the NB government identified five CHCs to be established. As of June 2006, the following activities had been undertaken:

- Hiring of a senior advisor to manage and champion change;
- Announcement of five CHC sites, with regional health authorities (RHAs) establishing the sites;
- Establishment of committees, policies and guidelines to build this new form of service delivery;
- Involvement of communities and creation of advisory committees to complete community health needs assessments that will be used to design services and select staffing;
- Development of a work plan strategy for the selection of an electronic health record (EHR);
- Use of change management strategies to increase awareness among all stakeholders, to address concerns and to generate enthusiasm;
- Training and education of health service providers to support the knowledge, skills and attitudes required. (Training was provided to health care providers through five provincial conferences and the *Building a Better Tomorrow* Initiative [BBTI]. Through BBTI, there have been 127 sessions, with a total attendance of 2,209. A Certificate in PHC Collaboration was awarded to 179 health care providers, who completed the four core training modules. An orientation manual was developed for staff in all CHCs);
- Development of a formative evaluation framework and identification of progress indicators;
- Hiring of a consultant to help evaluate ambulance services and to design the training program for advanced life support skills (ALS) for ambulance attendants (EMTs). (More than 500 EMTs received ALS training);



- Enhancement of the roles of nurses in emergency rooms and support of the role of licensed practical nurses (LPNs) in nursing homes and RHAs. (Enhanced training was offered to more than 500 nurses working in emergency rooms across NB, 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 LPNs received training that better enables them to work to their scope of practice in nursing homes and RHAs);
- Commissioning of reports on remuneration models for physicians and information management support for public health and mental health; and
- Organization of a telehealth pilot project on tele-homecare (EMP care@home).

## Resources

- The NB CHCs Framework
- The NB Community Health Needs Assessment
- NB CHCs Core Basket of Services
- Logic Model for Development of CHCs in NB
- Framework for Progress Indicator Reporting and 2-Year Process Evaluation for CHCs in NB
- CHC Service Provider Survey
- CHC Patient Survey
- NB CHC Benchmarks—Self-Assessment Tool
- Minimum Data Set Chart of Accounts for CHC Registration
- NB CHC Orientation Manual

## Key Learnings

Five CHCs were established and are operational. Clients surveyed as part of the evaluation process indicated that they are satisfied with the services received. Two more CHCs have been opened and planning has begun for a third. Needed infrastructure—in terms of buildings, technology and policies—was developed, and a variety of communication and advertising campaigns were sponsored. Neighbouring communities are now asking for a CHC. Provincial workshops have been organized to share success stories and leverage learning in the ongoing journey to establish community-based services. However, health care teams will require ongoing support and training, and more policy development is required.

The EHR is in place and soon will be in operation at all sites. Ambulances are now appropriately equipped. The ambulance dispatch service was upgraded, along with the associated information technology. The telehealth pilot (EMP care@home) is in progress. Capital investments were made in facilities, technologies and change strategies to achieve NB's priorities. The Department of Health has realigned existing resources for the ongoing support and maintenance of these endeavours.

**Approved Contribution:** \$13,689,805

## Contact Information

Bronwyn Davies  
Senior Advisor/Director of Primary Health Care  
New Brunswick Department of Health  
Phone: 506-453-7926  
E-mail: [bronwyn.davies@gnb.ca](mailto:bronwyn.davies@gnb.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).



## Primary Health Care Renewal in Nova Scotia

Provincial–Territorial Envelope

### Lead and Partner Organization(s)

**Nova Scotia Department of Health**

### Background and Goals

The vision for primary health care (PHC) in Nova Scotia requires a carefully structured strategic approach that fundamentally changes the system over time while simultaneously managing the change process in a manner that respects individuals, health professionals and communities. The Primary Health Care Transition Fund (PHCTF) allocation to Nova Scotia allowed it to focus on initiatives that target system change. The province proposed four strategic approaches: move PHC toward collaborative teams that service a defined population; develop a cultural shift among PHC providers toward population health, collaboration and health promotion; shift PHC providers' remuneration away from a volume-driven focus; and prepare the PHC system for the future implementation of an electronic record. Three transitional initiatives were established to support these strategies, with the following goals:

- Implement enhancements to PHC services and create new ways to develop sustainable primary health networks/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 primary health system transition to an electronic patient record.

### Activities

The Department of Health and the District Health Authorities (DHAs) have worked collectively over the past three years to support these initiatives.

*Provincial activities:*

- The establishment and associated work of a PHC Executive Steering Committee;
- The development of a Primary Health Information Management Program, including steps toward the implementation of a province-wide electronic patient record;
- The Diversity and Social Inclusion initiative, including the development of a culturally inclusive policy and guidelines;
- The Primary Maternity Care Working Group, which was designed to provide a framework for primary maternity care collaborative teams;
- The Health Literacy Awareness initiative, which was designed to raise awareness among PHC providers about literacy issues and how they can help their patients better understand information about their health; and
- PHC evaluation and research efforts to ensure consistent collection of information across DHAs.

*District Health Authorities activities:*

- Implementation of the provincial lead activities;
- Development of leadership infrastructure and planning, which included hiring a PHC manager for each district to provide ongoing transition support, facilitation, coordination and management of all PHC activities;
- PHC service delivery enhancements, which were numerous and included, for example, the development of a chronic disease strategy within South Shore Health, and the Patient Education Information Management initiative in the South West Health District;



- Support for the development of sustainable models for PHC organizations including nurse practitioners, alternative payment plans, team development and renovations to PHC organizations, and chronic disease management and health promotion initiatives.

## Resources

- A PHC website: [www.gov.ns.ca/health/primaryhealthcare/default.htm](http://www.gov.ns.ca/health/primaryhealthcare/default.htm)
- The Diversity and Social Inclusion Initiative and its Cultural Competence Guidelines, which can be applied to all health sectors and other jurisdictions in Canada
- The Health Literacy DVD: *Making the Connection*
- Many others developed, available on the website

## Key Learnings

The Nova Scotia PHC renewal initiative has served as a key contributor to PHC system improvements across the province. PHCTF resources augmented the DHAs' capacity to support community planning and ensured that health professionals could participate in planning and implementing PHC networks/organizations. A PHC renewal team at the Nova Scotia Department of Health provided dedicated resources to support DHA development of transition structures and processes. This team, coupled with strong DHA leadership and commitment to PHC renewal, was instrumental in facilitating enhanced teamwork and collaboration in practice settings. PHC providers interested in working as part of a network or organization were given financial aid to establish or renovate physical space that would facilitate collaboration. The introduction of nurse practitioners (currently 19 positions across the province) working in collaboration with family physicians has been effective in increasing access to PHC and changing the focus of PHC encounters. For example, new ways of delivering PHC services using a population health approach have been developed.

Through the initiative, the groundwork has been laid to ensure that when electronic health records are implemented in the province, the PHC system will be ready. Establishing data governance policies was a challenge that was met through intense engagement of the health provider community. "Champions workshops" that supported physician training in the use of PHC information systems was one of many change management strategies that proved to be effective. Many teams are now using an electronic patient record, and by September 2006, approximately 30 per cent of the province's primary care physicians will be registered in the PHC information management program.

Many of the activities of the initiative have resulted in success stories that will resonate in future PHC planning and renewal efforts. The Diversity and Social Inclusion initiative, for example, produced the first provincial guidelines for the delivery of culturally competent PHC in Canada. This is certain to have an impact on future PHC policy and planning, human resource recruitment and retention, and service delivery in the province. The initiative's activities were intended to be transitional, although certain activities and roles have been found to be necessary to the continued achievement of the strategy. Sustainable provincial funding is critical to the continuation of certain key programs.

**Approved Contribution:** \$17,073,265

## Contact Information

Paula English  
Director, Primary Health Care  
Department of Health, Nova Scotia  
Phone: 902-424-3076  
E-mail: [englishpm@gov.ns.ca](mailto:englishpm@gov.ns.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Prince Edward Island Primary Health Care Redesign

Provincial–Territorial Envelope

### Lead and Partner Organization(s)

**Government of Prince Edward Island**

### Background and Goals

Prince Edward Island (PEI) undertook primary health care (PHC) redesign to address such issues 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. Health care redesign is helping to strengthen PHC in the province by changing the way services are currently funded, organized and delivered. This initiative's goals were to: 1) improve access to comprehensive PHC services; 2) improve continuity of care through coordinated and integrated PHC service delivery; 3) increase emphasis on health promotion and chronic disease prevention and management, including self-management; 4) maintain or improve patient/client satisfaction with PHC; 5) maintain or improve provider satisfaction through collaboration; and 6) improve accountability.

To achieve these goals, five initiatives were planned: the establishment of collaborative Family Health Centres (FHCs); a provincial Healthy Living Strategy; Integrated Palliative Care; Improved Drug Utilization; and Videoconferencing. The first three initiatives form the basis of the redesign and have been implemented using an incremental approach. The last two initiatives were not implemented, given concerns with sustainable funding for ongoing operations.

### Activities

Over the four years of the initiative (2002–06), PEI took an incremental, phased-in approach to advance three of the five initiatives (FHCs, PEI Strategy for Healthy Living, and Integrated Palliative Care) to full implementation.

- In order to implement the FHCs, professional education and training was offered to support health care professionals in collaborative interdisciplinary team environments. Along this line, PEI facilitated a

conference workshop on interdisciplinary collaborative practice and evidence-based chronic disease management for all FHC staff. In addition, PEI, in partnership with the other Atlantic provinces, through the Building a Better Tomorrow initiative, participated in the development of six curriculum training modules, including Understanding Primary Health Care, Collaborative Practice, Team Building and Conflict Resolution. All FHCs underwent an operational review, with recommendations covering four areas for further development of collaborative practice: commitment to collaborative practice, roles and responsibilities, core staffing, and communication and technology. The five FHCs were linked to the provincial health information system, and practice management software was installed at all centres, ensuring a compatible database. Electronic health records were not installed due to high costs but remain on the provincial agenda. FHCs implemented clinical programs and activities that are very valuable to their communities. As an example, use of clinical protocols for hypertension has yielded impressive outcomes for patients of the centres. Furthermore, an Influenza Vaccine Program is being offered to reach patients in the province without a family physician.

- Regarding the Strategy for Healthy Living, the provincial government partners of Health, Social Services and Seniors, Education, and Community and Cultural Affairs have responsibility for a lead role. Non-governmental organization (NGO) partners include three existing alliances: PEI Tobacco Reduction Alliance, Active Living Alliance, and Healthy Eating Alliance, as well as health charities, the Federation of Municipalities, PEI French Language Health Services Network, PEI Recreation and Trails Association, the Attorney General, and school boards. The strategy's focus is the development of regional networks, which are supported by Healthy Living Coordinators to build community capacity in the delivery of community-level health promotion and chronic disease prevention activities. The result has been numerous and varied healthy



living programs, promotions and videos aimed at reducing the risk factors for chronic disease.

- *The Integrated Palliative Care initiative* hired a provincial coordinator to provide leadership and support to the health regions as they undertook their strategic planning and implemented the palliative care service delivery model. Front-line palliative care staff received training on the basics of palliative care, while clinical resource teams—a physician, nurses, social worker, pharmacist, hospice coordinators of volunteers, and spiritual advisors—received enhanced training to support front-line staff and physicians in palliative care delivery to clients and families. The service delivery model has been integrated across the province, and clients are being registered into the palliative care programs from all care sites. Client and family care planning is occurring using a common palliative care assessment tool.

## Resources

- Five family health centres with collaborative practice teams
- Numerous and varied health promotion and chronic disease prevention activities and programs
- A nationally recognized palliative care service delivery model
- Palliative care clinical resource teams

## Key Learnings

The FHCs currently serve approximately 22,800 people (16 per cent of the PEI population). Establishing collaborative practice requires dedicated and relentless time, energy, support and resources—it does not

happen solely by co-locating health practitioners. To date, 25 FHC staff collectively took part in 61 training days, and seven staff received a university certificate in Primary Health Care Collaboration.

Changing behaviours that affect health must begin with increasing the awareness of an individual's role in their own health status. Efforts to make a difference must extend beyond the traditional boundaries of the formal health system. Once established and defined, partnerships with other government sectors, NGOs, municipalities and communities, among others, can compound the benefits and strengths of a multi-risk factor approach to healthy living.

In January 2005, PEI's Integrated Palliative Care Program was one of six initiatives (and the only one in palliative care) highlighted by the Health Council of Canada as a best practice. Components of the model that make this a best practice include collaborative practice among disciplines and care sites, coordinated entry to the programs, a client- and family-focused approach, and the common palliative care assessment tool.

**Approved Contribution:** \$6,526,879

## Contact Information

Donna MacAusland  
Primary Care Analyst  
PEI Department of Health  
Phone: 902-368-6508  
E-mail: [ddmacausland@ihis.org](mailto:ddmacausland@ihis.org)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Newfoundland and Labrador Primary Health Care Initiative

Provincial–Territorial Envelope

### Lead and Partner Organization(s)

**Newfoundland and Labrador Department of Health and Community Services**

### Background and Goals

This initiative is part of Newfoundland and Labrador's (NL's) ongoing efforts to reform its primary health care (PHC) system. It follows on the heels of *Healthier Together: A Strategic Plan for Newfoundland and Labrador* (2002); the establishment of the Office of Primary Health Care and a Provincial PHC Advisory Committee (2002); and the provincial PHC framework, *Moving Forward Together: Mobilizing PHC* (2003). Based on this framework, PHC includes a range and balance of services that promote health, prevent illness and injury, diagnose and treat episodic and chronic illness and injury, and encourage individuals, families and communities to achieve and maintain health. The new direction promoted a team-based interdisciplinary approach to services provision, with the aim of having PHC teams provide PHC services to at least 50 per cent of the province's population by 2010. This province-wide initiative continues that approach, with the specific goals of enhancing accessible, sustainable PHC services; supporting comprehensive, integrated and evidence-based services; promoting self-reliant healthy citizens and communities; and enhancing the accountability and satisfaction of health professionals.

### Activities

During the four years of this initiative (2002–06), it undertook a wide range of activities.

To increase the proportion of the population having access to PHC organizations accountable for the planned provision of a defined set of comprehensive services to a defined population, activities focused on:

- Developing, implementing and evaluating a provincial framework for PHC;
- Integrating all services across the continuum (from primary prevention to acute and episodic illness) at the PHC service delivery level; and

- Supporting PHC teams (serving populations ranging from 6,000 to 25,000 persons) to provide interdisciplinary services, based on the needs of the population served.

To increase emphasis on health promotion, disease and injury prevention, and management of chronic diseases, all PHC team areas worked on, and succeeded in:

- Initiating Community Advisory Committees;
- Enhancing wellness activities; and
- Initiating the Diabetes Collaborative.

To expand 24/7 access to essential services, activities focused on:

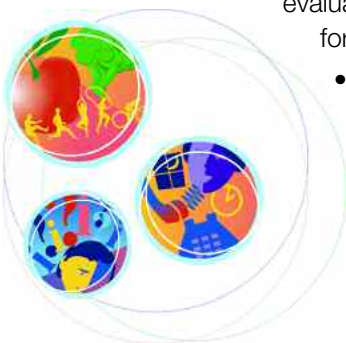
- Enhancing emergency transportation in some areas; and
- Implementing a provincial 24/7 nurse phone line.

To establish interdisciplinary PHC teams of providers, so that the most appropriate care is provided by the most appropriate provider, activities focused on:

- Securing provincial leadership support for implementation of PHC changes;
- Establishing eight PHC teams, with ongoing evaluation, and assisting with their development as teams (in the areas of scopes of practice, chronic disease management collaboratives, Building a Better Tomorrow [BBT] initiative training modules, professional development, as well as partnerships with the inter-professional health education system for inter-professional development at the pre- and post-licensure levels); and
- Opening up discussion on physician funding and contracts.

To facilitate coordination and integration with other health services, activities focused on:

- Supporting providers to work together;
- Establishing formal linkages through chronic disease management (CDM) collaboratives with secondary and tertiary services;



- Electronically sharing health information through institutional, community and medical records, as well as through telehealth and Selfcare/Telecare; and
- Forging partnerships—which have aided the development and approval of a provincial framework with the support of a Provincial Advisory Council; Working Groups; Family Practice and Inter-Professional Collaboration Department at Memorial University—and ongoing linkages and communications with associations, unions, etc.

## Resources

- *Physician Funding Payment Model Discussion* (a document)

## Key Learnings

Despite some rather formidable challenges (majority of physicians being paid on a fee-for-service basis, NL's large geography and small population, maintaining an Aboriginal health system along with the provincial one), NL has managed to advance its PHC reform agenda through this initiative. Eight PHC teams have been initiated, with three more team areas in the early stages of proposal implementation, and three more finalizing proposals. Proposals were based on population needs. Large numbers of professionals participated in team development and worked on scopes of practice processes, and early evaluation results show positive shifts towards increased teamwork. All PHC team areas established Community Advisory Committees, and all PHC teams, in cooperation with the provincial Wellness Strategy and Regional Wellness Coalition, increased support for wellness initiatives. The CDM Collaborative was implemented in the 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 were 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 record [EMR], and the PHC classification system ICPC2).

The provincial framework and the infrastructure that was developed supported PHC renewal activities in the province and will continue to provide support for future PHC team areas. These will also support implementation of all provincial health strategies at the service delivery level. PHC renewal will also be sustained by collaboration with stakeholders, capacity building for providers/leaders, seeking opportunities to integrate the BBT modules and standards of practice processes into professional practice; self-paced learning and web-based adaptations of some of the tools; leadership for PHC at the executive level of the Regional Integrated Health Authorities (RIHAs); exploring opportunities to continue with Memorial University of Newfoundland and the College of North Atlantic for professional education and development; and integrating the provincial leadership for PHC into the current Department of Health and Community Services structure.

The initiative's organizers believe that much of what has been developed—proposals, scopes of practice, BBT modules, CDM Collaborative—will be useful to other departments and divisions within the Department of Health and Community Services, to the RIHAs, as well as to other jurisdictions and organizations.

**Approved Contribution:** \$9,705,620

## Contact Information

Sheila Miller  
Director, Planning and Evaluation  
Department of Health and Community Services  
Government of Newfoundland and Labrador  
Phone: 709-729-7075  
E-mail: millers@gov.nl.ca

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

# Multi-Jurisdictional Envelope

The Multi-Jurisdictional Envelope supported collaborative initiatives between two or more provincial/territorial governments, providing a unique opportunity for governments to work together on primary health care renewal. Through this envelope, governments joined efforts that would:

- Realize economies of scale;
- Encourage the sharing of strengths and experience across jurisdictions;
- Increase efficiency by avoiding duplication of effort; and
- Overcome common barriers to primary health care renewal.

Initiatives funded under the Multi-Jurisdictional Envelope were intended to support and complement the primary health care renewal activities of the provinces and territories under the larger PHCTF Provincial-Territorial Envelope.







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

Multi-Jurisdictional Envelope

### 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

### Background and Goals

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 collaboration in advancing PHC reform, and that the move towards interdisciplinary health care would require providers to develop new skills and demonstrate new behaviours, 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. The goal was to develop an interprofessional education program aimed at giving providers the preparation and the tools they need in order to work successfully with others in teams and to deliver care in new ways.

### Activities

This initiative, which ran from April 2003 to September 2006, undertook the following activities in developing and delivering the training modules:

- *Comprehensive needs analysis:* This was conducted before developing the program content with Dalhousie University's Continuing Medical Education Division.
- *Delivery method design:* This involved pilot testing the various modules with a variety of stakeholders and obtaining feedback.
- *Delivery strategy:* Training was delivered face to face as well as through computer-based learning modules, videoconferencing and distance education on the web from Memorial University's Continuing Medical Education program. The delivery strategy combined expert and "train-the-trainer" resources, as appropriate. As of August 31, 2006, 683 modules had been delivered to a total of 8,891 participants,

including nurses, physicians, social workers, pharmacists, other health promoters and allied health professionals. And 751 participants across the Atlantic provinces had received a certificate offered by Dalhousie and Memorial universities for successfully completing at least five of the seven training modules.

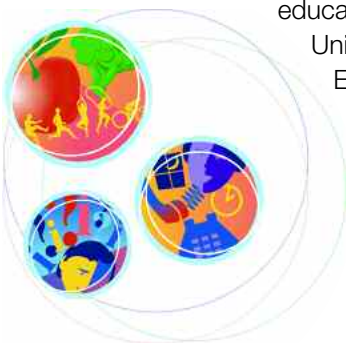
### Resources

The initiative developed seven core BBT modules on topics specifically chosen to emphasize the concepts of determinants of health, population health and health promotion and to help professionals build interdisciplinary teams:

- Understanding Primary Health Care
- Building Community Relationships
- Team Building (two modules)
- Conflict Resolution
- Facilitating Adult Learning (two modules)
- Electronic Patient Record
- Program Planning and Evaluation

### Key Learnings

BBT brought thousands of health care professionals together to learn how to work effectively in teams and to deliver health care in new ways. The initiative built tremendous capacity for change within regions, districts and communities across the Atlantic provinces. Many BBT participants who completed the training modules believe that there are now leaders and champions in all four provinces and that there is a critical mass with a unified vision of where PHC needs to move. In other words, there is real momentum for change. In terms of sustainability, all the Atlantic provinces have incorporated the core BBT modules and programs within ongoing training programs in their respective jurisdictions and regions. Embedding curricula into existing accreditation processes will



ensure that training continues for current and future health care providers. Provinces can also leverage and sustain partnerships and relationships through the provincial education committees, which were established in every Atlantic province to help develop course content and explore opportunities to integrate content into pre- and post-licensure programs. Those who worked on this initiative note that the knowledge and experience gained by working in a collaborative multi-jurisdictional initiative such as BBT bodes well for future opportunities in PHC.

**Approved Contribution:** \$7,011,126

### **Contact Information**

Merv Ungurain  
Senior Consultant, Primary Health Care  
Nova Scotia Department of Health  
Phone: 902-424-5859  
E-mail: [unguramg@gov.ns.ca](mailto:unguramg@gov.ns.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Health Lines

### Multi-Jurisdictional Envelope

### Lead and Partner Organization(s)

**Alberta Health and Wellness;** with the governments of British Columbia, Manitoba, Northwest Territories, Yukon Territory, Nunavut and Saskatchewan

### Background and Goals

Health lines have become an accepted model of accessing and delivering high-quality evidence-based health information and advice services, and they continue to expand and grow. Their focus remains on promoting more appropriate utilization of health care services, including emergency department referrals. The potential exists to use health lines to create linkages with primary health care (PHC) agencies to support clients and the health system in a variety of ways. For these reasons, seven jurisdictions in Canada worked together through this initiative to explore common issues related to the planning, implementation and delivery of health line services. This multi-jurisdictional collaborative viewed health lines as an integral part of the PHC system. The vision of the initiative partners included:

- Supporting the PHC system by improving access to health information and services;
- Using health lines to assist jurisdictions with the management of chronic disease;
- Contributing to the effective utilization of health services;
- Improving staff retention, quality of staff's work life and the efficiency of health line operations;
- Improving sustainability by creating economies of scale and avoiding duplication;
- Sharing skills, knowledge and expertise; and
- Leveraging infrastructure to provide "one-stop shopping" approaches to the delivery of a variety of health services.

### Activities

The initiative began in September 2003 and continued for three years. The work was completed by a variety of consultants in response to requests for proposals issued by the multi-jurisdictional steering committee (MJSC). Activities were clustered under the five areas of collaboration that support the implementation and enhancement of health lines in each jurisdiction:

- *Staff education:* A current state assessment (CSA) of staff education and health lines was conducted, competencies were defined and a staff education program developed.
- *Evaluation:* A CSA of the efficiency of health lines was completed. Tools and frameworks to support the evaluation of health lines were developed and field-tested. A values statement, costing model and a framework for conducting an economic evaluation for health lines were developed. A business planning guide was created and field-tested in three jurisdictions.
- *Promotion and marketing:* The information from a national and international CSA on promotion and marketing of health lines was used to develop common strategies, processes and materials. Partnerships with BC NurseLine and the National Quality Institute were established and "At Work Tool Kits" were developed for each jurisdiction.
- *Chronic disease management:* A CSA was conducted on the use of health lines to support chronic disease management (CDM). Three CDM help line projects were supported: "Enhanced triage support for clients with diabetes" (Alberta), "Integrated delivery of telehealth self-management support in primary health care" (British Columbia), and "Chronic disease management of congestive heart failure via telehealth" (Manitoba).
- *Coordination and collaboration:* An evaluation of the cross-jurisdictional work was conducted and a national health line symposium was held in April



2006 to showcase the work of this collaborative initiative.

## Resources

- The initiative website: [http://www.health.gov.ab.ca/key/Multi\\_Jurisdictional%20Health%20Lines%20Initiative.htm](http://www.health.gov.ab.ca/key/Multi_Jurisdictional%20Health%20Lines%20Initiative.htm)
- An education program for nursing and health line management staff
- The Efficiency Self-Assessment Tool for ongoing assessment of health line efficiency
- A Business Planning Guide to inform health line planning and decision-making
- An evaluation and monitoring framework
- A white paper, *Improving the Sustainability of the Health Care System* (includes a costing model economic evaluation framework for health line services)
- At Work Tool Kits
- A promotion and marketing plan and toolbox with shared strategies and materials
- CDM models and approaches from three projects supported by the MJSC

## Key Learnings

Over the course of the initiative, the MJSC focused on sustainability and looked for opportunities to leverage knowledge and technology across the jurisdictions. Significant economies of scale were generated by developing common programs, frameworks, products, strategies, templates, reports and tools that can be used to develop and expand this service across Canada. The commitment and involvement of each jurisdiction in shaping the collaboration contributed to the initiative's overall success. The national health line

symposium created networking opportunities and opened the door to pan-Canadian planning and discussion on the future direction of health lines.

Through the work of the three projects that used health lines to support interdisciplinary CDM, the MJSC recognized that each jurisdiction approached CDM in a different manner and that there were significant opportunities to share information, insights and experiences. The MJSC believes that the models developed through these projects can be utilized across jurisdictions and/or regional/national centres of excellence could be developed.

In terms of staff education, the initiative determined that using consistent, defined competencies for recruitment and ongoing performance management of new health line employees greatly enhances client safety and quality of service. The staff education program that was developed provides this consistency and could be used in the transition to formal curriculum development and certification.

The extensive array of practical tools developed by the initiative will assist in the evolution and expansion of health lines. As well, the relationships that have been developed will continue to promote collaboration and move health lines and PHC renewal forward.

**Approved Contribution:** \$6,813,600

## Contact Information

Betty Jeffers  
Director, Primary Care Unit  
Alberta Health and Wellness  
Phone: 780-415-2843  
E-mail: [betty.jeffers@gov.ab.ca](mailto:betty.jeffers@gov.ab.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

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

Multi-Jurisdictional Envelope

### 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

### Background and Goals

Individuals often suffer concurrently from mental health and substance abuse problems, yet this is not frequently recognized and therefore individuals are not adequately treated. They run the risk of falling through the cracks of the system because primary care and specialized mental health and addiction services typically work in isolation from one another. This initiative sought to integrate services and establish greater collaboration. Overall, there were three main goals: improve the prevention, identification and treatment of individuals with concurrent disorders; enhance the efficiency, effectiveness and accessibility of primary health care (PHC) services for these individuals; and integrate community and regional resources for mental health and addiction services within a collaborative and multidisciplinary framework.

### Activities

Over the course of the initiative, which took place from 2003 to 2006, key activities to link mental health, addictions and PHC services included:

- A system change process to improve linkages and working relationships among mental health, alcohol and drug, and PHC services, using an eight-step change process based on John P. Kotter's model;
  - Interdisciplinary collaborative care teams, set up in three regions (two in British Columbia's Central Okanagan and North Shore areas, and the entire Yukon Territory), each of which developed an approach to best meet local needs;
  - A National Health Sciences Student Association, established

to integrate health and social disciplines, as one way to foster multidisciplinary collaborative care. National student conferences were convened in January 2005 and again in January 2006. Nineteen schools for health and human services disciplines and 14 local campus chapters of the association were created; and

- An evaluation plan, implemented to measure progress toward goals and objectives; a baseline was established in March 2005 and then measured one year later.

### Resources

- An eight-step system change process
- Tools and resources to support change in organization and practice for collaborative care, which are available at [www.collaborativecare.ca](http://www.collaborativecare.ca) (tools are divided into the resource categories of planning, communication, training, clinical, administrative and evaluation)
- A National Health Sciences Student Association with local chapters and newsletters ([www.nahssa.ca](http://www.nahssa.ca))

### Key Learnings

Preliminary findings suggest that the initiative has had a positive impact on physician practices, and on the organization and delivery of mental health and addiction services. Service providers have seen improved collaboration and changed practices, resulting in better services. Overall access for clients with substance abuse and other mental health conditions has improved. For example, in one region, a mental health clinic that began practicing collaboratively within a primary care team was able to see up to five times as many patients as its counterpart in a traditional mental health clinic.



Best practices were incorporated into the planning and delivery of collaborative primary care services through training and the establishment of protocols, guidelines and tools. Sites report improved identification of concurrent disorders. Clinicians in these collaborative primary care teams see significantly more clients with substance-related and concurrent mental health disorders than their counterparts in formal mental health and addiction services.

All three regions now have defined roles for multidisciplinary team providers, and preliminary results indicated that the attitudes and expectations of service providers have changed. A survey of participating regions showed increased support for collaborative care, better relationships among diverse service providers and improved practices. Providers at all sites believe that these changes have led to improved and more timely patient care, and that they have reduced the stigma experienced by patients.

The National Health Sciences Student Association findings indicated that interprofessional, educational and work experience programs afford students the opportunity to learn about other types of health professionals. Through the association, students have built trust and respect with their future health care

partners, and have learned about and experienced team-based care.

This collaborative care initiative was unique in that it involved system change management, included the integration of addictions services with mental health and primary care services, and created reforms at the clinical service level. In March 2006, a think-tank of key stakeholders from British Columbia and Ontario who were involved in collaborative care was convened. It identified key factors in moving the collaborative care agenda forward. These included: demonstrating benefits and transfer of knowledge; involving the right stakeholders and developing a common vision; ensuring infrastructure support for change management; and securing funding.

**Approved Contribution:** \$1,500,000

### **Contact Information**

Sherry Masters  
Project Manager, CARMHA  
Phone: 604-886-8595  
E-mail: sherrymasters@dccnet.com

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Selfcare/Telecare

Multi-Jurisdictional Envelope

### Lead and Partner Organization(s)

**New Brunswick Department of Health;** with Newfoundland and Labrador Department of Health and Community Services; Nova Scotia Department of Health; Prince Edward Island Department of Health; New Brunswick Department of Justice; Newfoundland and Labrador Department of Justice; New Brunswick Department of Intergovernmental Affairs; Newfoundland and Labrador Intergovernmental Affairs Secretariat

### Background and Goals

The four Atlantic provinces (Newfoundland and Labrador, New Brunswick, Nova Scotia, and Prince Edward Island [PEI]) approached the PHCTF with a proposal to examine the feasibility of establishing teletriage and a health information system in both official languages for all of Atlantic Canada. This initiative aimed to increase opportunities for the public to access helpful, accurate and timely evidence-based health information that could have a positive influence on the use of health care resources and on individuals' behaviour and ability to stay healthy. Specifically, this initiative aimed to design, propose and implement a business plan for the establishment of:

- Toll-free lines for symptom triage, general health information, health resources information, poison control, and rabies and West Nile virus information;
- Automated audiotape library services using the same toll-free lines to provide advice on health topics; and
- Web-based services to provide health information and access to qualified personnel to answer health questions.

Telehealth services were to be delivered from contact centres operating 24/7 and staffed by experienced registered nursing staff, following evidence-based protocols and algorithms. As New Brunswick already had an operational telecare service in place, this initiative intended to build on the expertise and resources available there.

### Activities

This three-year initiative (2003–06) undertook the following key activities:

- Established a steering committee, which had representatives from all four provinces. This committee provided strategic direction and general oversight to the project and acted as a liaison with several provincial bodies. New Brunswick, being the lead province, chaired this committee;
- Conducted a needs assessment in all provinces (except PEI, which had conducted a similar assessment in 2002) and an environmental scan of existing Canadian telecare programs;
- Prepared provincial business plans to cost the various options under consideration and develop an implementation plan and schedule; these documents were presented respectively in all the Atlantic provinces to key personnel;
- Undertook negotiations to define the relationship with the private contact centre operator (Clinidata Corp.); also, a Memorandum of Understanding was created to define the relationship among participating provinces;
- Designed and implemented marketing and promotion campaigns in the participating provinces; and
- Acquired capital equipment, and in September 2006 opened three contact centres in Newfoundland and Labrador, while the existing two centres in New Brunswick were enhanced.

An external consulting firm conducted an evaluation of the initiative between June and September 2006.



## Resources

- Contact centres providing toll-free lines for symptom triage, general health information, and health resources information to the public in both official languages
- Key planning documents, including an Environmental Scan, Business Plan, and Memorandum of Understanding

## Key Learnings

Implementation of this initiative proved to be much more complex than originally anticipated. Reaching consensus among all provinces regarding governance models and the role of the private sector was very challenging. Negotiation between and within the provinces took a long time and required a great deal of commitment. The creation and promotion of a joint vision was fundamental to success, and despite the fact that the provinces came to a hard-won agreement on this point, success could still prove elusive because of ongoing challenges, such as privacy legislation.

Nova Scotia and PEI decided not to participate because of large operating costs. Should they decide to implement selfcare/telecare services in the future, they could build on the experiences of the other Atlantic provinces, thus realizing economies of scale and increasing efficiency by avoiding duplication of effort.

Despite the initiative's challenges and limitations, it achieved important milestones. It:

- Created a governance model to manage multi-jurisdictional, multi-site services;
- Negotiated an agreement between two provinces to support the governance model;
- Opened a multi-site contact centre in rural Newfoundland;

- Acquired and installed the necessary capital equipment in Moncton's contact centre to service the Newfoundland and Labrador sites and to position the infrastructure for future growth; and
- Elevated the profile of selfcare/telecare within PEI and Nova Scotia and advanced the initiative in budgeting and program approval processes in those provinces.

Selfcare/Telecare resulted in a higher degree of cooperation, not only among jurisdictions, but also within health care and government organizations in the provinces. More importantly, it supported better use of existing health care resources. Of 478 telehealth clients surveyed in New Brunswick between January and April 2006, 56 per cent of them reported that they would have gone to the emergency department had this service not been available. Furthermore, the initiative strengthened equity regarding access to health services by ensuring that health advice and information are within equal reach of both rural and urban communities.

Participating provinces are committed to covering the operating costs to ensure these services will continue to be provided. Opportunities will be assessed to expand current services (for example, outbound calling and chronic disease management).

**Approved Contribution:** \$6,940,266

## Contact Information

Ken Ross  
Assistant Deputy Minister, Addictions and Mental Health Services  
New Brunswick Department of Health  
Phone: 506-453-3888  
E-mail: ken.ross@gnb.ca

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).



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

Multi-Jurisdictional Envelope

### Lead and Partner Organization(s)

**Government of Alberta (lead jurisdiction on behalf of WHIC);** with British Columbia Ministry of Health; Saskatchewan Health; Manitoba Health

### Background and Goals

Chronic diseases have significant impacts on the patient and the health system as a whole. The WHIC chronic disease management (CDM) initiative arose from clinicians' need for timely and appropriate clinical information on chronic disease. The overall goal—to support CDM by facilitating clinicians' access to this data—could be reached only by including clinical data in a common, consistent format as part of an accessible, integrated electronic health record. The initiative focused 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 of the partner jurisdictions.

The specific goals were to:

- Identify, define and standardize core data sets and information interchange messages for three chronic diseases: diabetes, hypertension and chronic kidney disease;
- Implement the defined data standards and messages in support of CDM in four jurisdictions; and
- Evaluate the project and position CDM infostructure for uptake and sustainability.

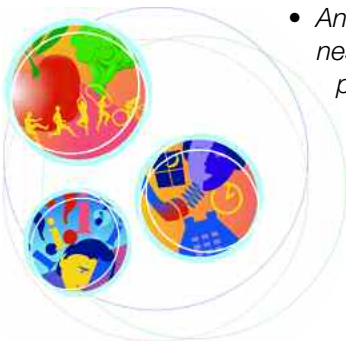
### Activities

The initiative was launched in July 2003 and completed in September 2006. Specific activities included:

- *An assessment of existing CDM infostructure.* Four regional workshops considered provincial, national and international systems, tools and policy;
- *An exploration of the common business requirements of an interdisciplinary primary health care team for each of the diseases.* Clinical best practice guidelines and health surveillance data requirements were reviewed and a blueprint of

common functional and information requirements was developed;

- *The development of an information management framework.* A model of CDM was used to guide the collection of disease specific data requirements, data quality and standards processes;
- *The development of data standards for CDM that allowed for common definitions, values and vocabularies.* This was an intensive activity that required time for consensus-building and collaboration;
- *Definition of standards-based messaging specifications using HL7 version 3.* This allowed interoperability of information systems locally, regionally, provincially and eventually nationally, including the electronic movement of CDM data between locations;
- *Implementation planning and support activities.* This included assembling resources and documentation for an implementation toolkit as well as promoting the standards through conferences and other forums; and
- *Implementation in the four provinces.* This focused on enhancing the existing systems already in use in each province. All jurisdictions selected two or more implementation sites. British Columbia, Saskatchewan and Manitoba worked collaboratively to enhance the CDM Toolkit application, originally developed by British Columbia. The new version of the CDM Toolkit, which supports the WHIC CDM data standards, is being implemented in each of the three provinces, and will also be implemented by the Yukon government (which did not participate directly in the initiative but will benefit from its outcomes). Two large Alberta health regions worked collaboratively to implement the data standards into their regional CDM systems. Across the four provinces, there are approximately 2,000 clinicians with access to electronic chronic disease data as of September 30, 2006.



An evaluation framework, which was developed early on, focused on the initiative's outcomes rather than on the initiative's effect on the health system. The dissemination and communication plan focused on sharing information with internal and external stakeholders to inform, gain consensus and acceptance, and solicit feedback.

## Resources

- The initiative website, [www.whic.org/public/profiles/cdm.html](http://www.whic.org/public/profiles/cdm.html)
- A generic chronic disease model that is a framework for the development of standards
- Common business requirements document
- CDM data standards documentation
- HL7 version 3 messaging standards documentation
- Evaluation materials (framework, strategy and final report documents) and presentation materials

## Key Learnings

The WHIC CDM initiative has facilitated access to electronic CDM data by a greater number of clinicians. A tangible by-product of electronic CDM data is the capability to conduct patient measurement. The initiative helped to accelerate the establishment of interdisciplinary teams in the provincial implementation sites and has enabled the sharing of CDM clinical data. It has received positive feedback, indicating that the standards documentation is thorough, easy to navigate and well organized.

The development of robust, extensible data standards that are clinically credible was possible because of the participation of numerous clinicians via provincial workshops and the WHIC CDM Clinical Advisory Group. This work involved considerable collaboration between clinical and business resources from four provinces and stands as a model for future efforts. The mix of participants at the workshops meant that special attention had to be paid to the presentation of materials and facilitation. The CDM Steering Committee met the challenge of reaching consensus on factors such as the procurement of resources and the approach to workshops. Although costly and time-consuming,

face-to-face meetings were found to be critical to the success of the initiative. The commitment and continuity of key participants were also vital.

The processes that were used to build consensus and to develop the CDM standards gave the standards strong credibility. Developing HL7 version 3 message specifications was an important part of the initiative, and this work required a strong blend of clinical resources, HL7 resources and business analysts. HL7 is the industry standard for health information exchange, but the initiative found that the costs required to develop HL7 message specifications and implement the messages are significant.

All participating provinces are in the process of implementing the standards for the target diseases (diabetes, hypertension and chronic kidney diseases), as well as for numerous other chronic diseases. 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 provinces are actively planning for integration of the CDM standards into broader electronic health record work. The success with data standard development among the four provinces is a strong asset as efforts shift toward pan-Canadian adoption of the standards and implementation of the messaging into vendor products. The initiative has increased national awareness of CDM in primary health care, and the WHIC CDM work has helped to advance the primary health care renewal agenda.

**Approved Contribution:** \$8,000,000

## Contact Information

Linda Miller  
Assistant Deputy Minister  
Information Strategic Services Division  
Alberta Health and Wellness  
Phone: 780-415-1501  
E-mail: [linda.miller@gov.ab.ca](mailto:linda.miller@gov.ab.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

# National Envelope

The National Envelope was intended to address some of the common barriers to or gaps in primary health care renewal and create the necessary conditions at a national level to advance primary health care renewal across the country. This envelope allowed work on a scale that was beyond what any single jurisdiction could achieve on its own. National Envelope initiatives also complemented activities funded through the Provincial–Territorial Envelope.

The objectives of the National Envelope were to:

- Enhance sustainability of the primary health care system by engaging stakeholders and the public in dialogue on primary health care renewal;
- Educate the public on primary health care renewal;
- Maximize synergies and the use of collaborative approaches to renewal by providing fora for information sharing;
- Improve availability and quality of information on primary health care nationally;
- Create common practical tools to address challenges that arise during the renewal process;
- Facilitate collaboration among primary health care professions; and
- Facilitate changes to practice patterns for primary health care providers.

The National Envelope supported initiatives through three funding streams:

- **National Strategies:** Initiatives conducted at the national level, which maximized synergies and cost-effectiveness by developing common or collaborative approaches in key areas of primary health care renewal. Three national strategies were developed as a result of the PHCTF: the National Strategy on Collaborative Care, the National Primary Health Care Awareness Strategy, and the National Evaluation Strategy.
- **Tools for Transition:** Offered providers, planners, and administrators venues to share information and experiences on change management as renewal efforts were implemented. Tools for Transition consisted of a Federal/Provincial/Territorial component and a Responsive component.
- **National Initiatives:** Primary health care renewal activities that were national in scope or relevance, but that occurred largely in local or regional settings.





# National Envelope

## National Strategies

### *National Strategy on Collaborative Care*

One of the central features of primary health care renewal is the implementation of various collaborative care models across Canada. In fact, a determinant of the success of primary health care renewal will be the availability of health professionals equipped to work in a collaborative organization and/or team approach.

Collaborative care ensures coordination and continuity of care across primary health care providers to meet the needs of the patient, usually through a team approach.

The PHCTF played a significant role in supporting the provinces and territories' shift toward a more collaborative approach to care through the Provincial–Territorial and Multi-Jurisdictional Envelopes. The National Strategy on Collaborative Care was created to complement and reinforce this direction by supporting national initiatives aimed at addressing the barriers and facilitating approaches to collaborative care within the primary health care sector.

Initiatives funded through the National Strategy on Collaborative Care:

- provided evidence of what works and what does not work regarding the implementation of collaborative, inter-professional primary health care;
- created resources and tools to assist various health care professionals to work in a more collaborative environment; and
- obtained support and agreement among various professionals about their roles and responsibilities in collaborative settings.

The Strategy consisted of five initiatives:

- Canadian Collaborative Mental Health Initiative (CCMHI);
- Canadian Nurse Practitioner Initiative (CNPI);
- Enhancing Interdisciplinary Collaboration in Primary Health Care: A Change Process to Support Collaborative Practice (EICP);
- e-Therapeutics Drug Therapy Management: Tools and Technology to Enhance Collaboration and Communication to Improve Safety and Outcomes from Drug Therapy; and
- Multidisciplinary Collaborative Primary Maternity Care (MCP<sup>2</sup>).





## Canadian Collaborative Mental Health Initiative

National Envelope

### 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

### Background and Goals

Despite the prevalence of mental illness in Canada, most people with a treatable mental disorder are not getting the treatment that would benefit them. A consortium of 12 national organizations representing consumers, families and caregivers, community and health care providers worked together under the umbrella of the Canadian Collaborative Mental Health Initiative (CCMHI) to improve mental health care for Canadians. They believed that more effective collaboration among primary health care (PHC) providers, specialized mental health care providers, consumers and their families and communities, supported by the appropriate funding mechanisms, would strengthen the health care system's capacity to respond to the mental health needs of Canadians. Specifically, collaborative care models could expand the PHC sector's capacity to identify and treat mental health problems, and enable resources to be used more efficiently and effectively. The goals of the CCMHI were to:

- Conduct an analysis of the current state of collaborative care;
- Develop a Charter that represents a shared vision of collaborative care that is acceptable to all partners of the initiative;
- Develop specific approaches and strategies for implementing collaborative care approaches; and
- Disseminate the findings and materials from the initiative to a broad array of stakeholders.

### Activities

The activities of the initiative were conducted during a two-year period and were designed to support the move toward collaborative mental health care.

Activities included:

- *Analysis of the current state of collaborative care:* Twelve research papers were commissioned that described collaborative mental health care, barriers to its implementation, its benefits and the characteristics of best practices in the field.
- *Development of a collaborative mental health care Charter:* This was accomplished through: consumer consultations; association-specific consultations; an expert advisory forum; an online survey and a leaders' forum. The Charter was endorsed by all 12 partner organizations.
- *Development of strategies for advancing collaborative care:* A series of practical toolkits for clinicians, consumers, caregivers and educators was developed. These toolkits address the needs of specific populations, such as children, ethnocultural groups and individuals with a severe mental illness.
- *Dissemination of findings:* This was accomplished through presentations, the distribution of research publications, a website, e-mail updates to an extensive database, external working group communications, meetings with federal, provincial and regional planners, providers and educators, and broad distribution of promotional materials.

An evaluation plan assessed the effect of the overall process against the initiative's goals.



## Resources

- 12 research reports on numerous topics related to collaborative mental health care
- *The Canadian Collaborative Mental Health Care Charter*
- 12 practical toolkits
- The CCMHI website, [www.ccmhi.ca](http://www.ccmhi.ca)

All resources are available in both English and French.

## Key Learnings

The CCMHI has established an engaged community of interest that stretches across the country and has nurtured a groundswell of support for future endeavours. Members of professional associations have found the initiative's research papers to be a rich resource, and some associations have used them to provide practical support to members who work with PHC teams. The CCMHI has made the unique recommendation that consumers be included in alternative models ranging from the care setting to evaluation, policy and planning. Its Charter, which has been endorsed by all 12 organizations represented on the steering committee, will stand as the initiative's most enduring legacy. The Charter principles speak to the importance of a holistic, population health

approach that includes health promotion along with treatment. The toolkits improve the availability of information on how to develop collaborative practices, and steering committee associations are using them in a variety of ways. They are considered to be a key resource for future collaborative care projects.

It is expected that the community that has been engaged throughout the initiative will extend the knowledge base developed by the CCMHI by using, adapting and refining the toolkits, and creating innovation in collaborative mental health care by applying the Charter's principles. Leads in each of the partner organizations will continue to implement the Charter with the help of their executive and membership.

**Approved Contribution:** \$3,845,000

## Contact Information

Scott Dudgeon  
Executive Director, CCMHI  
Phone: 416-525-5136  
E-mail: [dudgeon@rogers.com](mailto:dudgeon@rogers.com)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).



## Canadian Nurse Practitioner Initiative

National Envelope

### Lead and Partner Organization(s)

**Canadian Nurses Association**

### Background and Goals

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 and regulatory practices for NPs regarding title, scope of practice, licensure requirements and continuing competency requirements. Furthermore, there have been variations in the educational programs of NPs across the country. This initiative, which grew out of the vision of the Nurse Practitioners' Planning Network—a partnership involving nursing regulatory bodies and organizations, provincial and territorial governments and nurse educators—attempted to address some of these inconsistencies and to facilitate the sustained integration of NPs into PHC services across the country. The initiative focused on developing the foundation of a shared understanding of NPs in five areas:

- Educational preparation;
- Practice;
- Government legislation and professional self-regulation;
- Health human resources planning; and
- Change management, social marketing and strategic communication.

Furthermore, the initiative aimed to create mechanisms and processes to support the integration and sustainability of the NP's role across all these areas.

### Activities

The Canadian Nurse Practitioner Initiative (CNPI) was divided into four phases. During Phase 1, a literature review and consultations with several stakeholder groups in all jurisdictions were undertaken. In addition, several communication activities took place, which resulted in a communication framework and a plan. These documents guided the development of comprehensive French and English websites, and a wide variety of promotional materials.

During Phase 2, regional consultations were conducted in eight cities across Canada (Vancouver, Edmonton, Winnipeg, Toronto, Montréal, Québec City, St. John's and Fredericton). All provinces, territories and major stakeholder groups gathered to express their opinions and generate discussion on the challenges and opportunities associated with the initiative's five areas of focus.

Phase 3 saw the development of several frameworks and other tools aiming to support the sustainable implementation of the NP role in PHC. Expert consultations and workshops were also held to verify findings and recommendations and to assess options to successfully overcome persistent challenges.

During Phase 4, the designed frameworks were integrated into a technical report and a condensed version, which was prepared for the broader public audience. Both reports are available on the initiative's website. Several presentations and meetings took place to disseminate the findings, recommendations and implementation plans with several stakeholder groups, including governments, employers, nursing regulatory staff, nursing educators, NPs, Canadian Institute of Health Information, Canadian Healthcare Association and health care professionals.



## Resources

- *Legislative and Regulatory Framework for Nurse Practitioners in Canada*
- *Health Human Resources Planning Simulation Model for NPs in Primary Health Care*™
- *Canadian Nurse Practitioner Core Competency Framework*
- *Competence Assessment Framework for Nurse Practitioners in Canada*
- *Education Framework for Nurse Practitioners in Canada*
- *Canadian NP Exam—Family/All Ages* (plus supporting documentation)
- *Implementation and Evaluation Toolkit for NPs in Canada*
- Initiative's French and English websites: **www.iciip.ca** and **www.cnpi.ca**, respectively

## Key Learnings

NPs are a key component of PHC renewal, as they can help increase access to health services, decrease wait times and improve population health outcomes. CNPI engendered a comprehensive set of recommendations, frameworks and actions to facilitate the sustained integration of the role of NPs in Canada's health system. More importantly, CNPI put forth evidence of the greater public, government and other health professional groups' acceptance and awareness of the NP 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 NPs as an integral component of PHC renewal.

In some health care groups across the country, this has already happened. Moreover, the establishment of NP associations across the country and the NP Council of Canada, along with current legislation and regulation governing the licensure and practice of NPs across provinces and territories, suggests that NPs have a permanent role in our health care system. However, to increase NPs' participation across the country and achieve the vision of a "renewed and strengthened PHC system that optimizes the contributions of the NP to the health of all Canadians," the initiative proposed the appointment of a coordinating committee to oversee the implementation of an action plan focusing on a pan-Canadian approach. CNPI has gone further and crafted this implementation plan—*The Way Forward Plan: Committing to Action*—to support a national and integrated approach.

Throughout the life of CNPI, there was a remarkable degree of consensus among all stakeholder groups involved regarding the initiative's direction, findings and recommendations, and this bodes well for sustaining the work that has been completed.

**Approved Contribution:** \$8,914,526

## Contact Information

Janet Davies  
Director, Public Policy and Communications  
Canadian Nurses Association  
Phone: 1-800-361-8404  
E-mail: [jdavies@cna-aiic.ca](mailto:jdavies@cna-aiic.ca)

The full report is available in the language of the author on the PHCTF website, **[www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf)**.

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

National Envelope

### 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

### Background and Goals

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 main goal of the initiative was to explore, and ultimately reach agreement on, the common elements needed to enhance the quality, effectiveness and efficiency of interdisciplinary collaboration in the delivery of PHC in Canada. Specifically, the initiative was designed to pursue the following objectives: to develop a set of guiding principles and a framework that describe how PHC professionals can work together effectively in every setting; to determine what conditions will need to be in place to make this happen; to have the principles and framework broadly supported by PHC practitioners and ratified by their professional associations; to support the implementation of the principles and framework; and to develop tools for PHC professionals to use to work more effectively together.

### Activities

Over the two years of this initiative (2004–06), it undertook a number of activities to meet its objectives.

- *Steering committee meetings and workshops:* to collaboratively develop the principles and framework, and to create a strategy for effecting change within member associations;
- *Research:* on themes pertinent to understanding and advancing interdisciplinary collaboration;
- *Pan-Canadian consultations:* to build on this research and engage stakeholders in the change process (these included small group discussions, regional workshops, barriers and enablers task force groups and leaders' forums, all with meeting reports that informed the development of the principles and framework);
- *A multi-pronged communication strategy:* including an interactive, bilingual website, an online survey, newsletters, videos and an ambassadors' meeting to share the principles and framework with a broader community of health professions; and
- *The development of a toolkit:* to inform health professionals who are interested in implementing or developing collaborative practices, including a case study of five PHC practice sites across the country.

Both an interim and a final evaluation were conducted.



## Resources

- *The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care* (available in French and English)
- Four research reports: *Enhancing Interdisciplinary Collaboration in Primary Health Care in Canada; Individual Providers and Health Care Organizations in Canada; Canadian Policy Context: Interdisciplinary Collaboration in Primary Health Care* and *Barriers and Facilitators to Enhancing Interdisciplinary Collaboration in Primary Health Care*
- *The Collaboration Toolkit*, which holds more than 200 tools for implementing and developing collaborative practices, and includes a case study report, *Interdisciplinary Primary Health Care: Finding the Answers*
- The EICP website, [www.eicp-acis.ca](http://www.eicp-acis.ca), which highlights the toolkit and the major research and communication documentation

## Key Learnings

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 the prospects and options for more collaborative care. In the process, they also earned broad support for the principles and framework from a multitude of other organizations that ratified the document as well. 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. It developed

and assembled tools to help PHC professionals work more effectively together in their practice settings. Through its pan-Canadian consultations, the initiative raised the profile of interdisciplinary care and initiated change advocacy at the grassroots level. It reinforced the idea that health system reform requires a clear focus on strategic change management. Most importantly, the initiative strengthened the relationships among the participating health professionals and their associations. The success of the EICP partnership demonstrates that effective, equitable interdisciplinary leadership is critically important to PHC renewal. The partnership and its approach—which focused on research, change management, communication and evaluation—can serve as a model for future endeavours. Governments, health professionals and organizations that have embraced the principles and framework will need to advance the momentum established by the initiative to ensure that interdisciplinary collaboration continues to develop in PHC settings throughout the country.

**Approved Contribution:** \$6,551,700

## Contact Information

Dr. John Service  
Executive Director  
Canadian Psychological Association  
Phone: 613-237-2144  
E-mail: [jservice@cpa.ca](mailto:jservice@cpa.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

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

National Envelope

### 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

### Background and Goals

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. Ensuring that this expenditure represents good value for Canadians is a major challenge, as some alarming estimates exist regarding the level of harm caused by the inappropriate use of drugs. To lessen this harm, providers need access to up-to-date, Canadian, evidence-based drug and therapeutic information. The goal of e-Therapeutics is to support best practices and promote optimal drug use for all primary care providers through the use of a comprehensive, online Canadian source of drug therapy information.

### Activities

The initiative began in January 2004 and continued for 30 months, officially closing in June 2006. Work was divided into six streams:

- *Governance and project management:* A framework was created to guide the strategic and operational development of the required tools and technology. The National e-Therapeutics Network was formed; a National Stakeholders' Conference was held; a strategic advisory and implementation team was put in place; and an internal board was set up to review and approve change requests.
- *Content development and maintenance:* Content for the e-Therapeutics portal was taken primarily from the Canadian Pharmacists Association (CPhA) Compendium of Pharmaceuticals and Specialties (CPS), Therapeutic Choices (TC), and Patient Self-Care (PSC). This was augmented with external references and information from Health Canada. A rigorous review process was followed for reference materials. Canadian experts wrote the therapeutic content, and leading authorities in each clinical area reviewed it.
- *Technical development:* IBM Canada was the key technology partner in this initiative. Product development went through numerous phases, including pilot testing in real-life situations.
- *Change management:* Leaders were involved early in the development process. Focus groups were held with family physicians and pharmacists, and a transition advisory group aided in the change management process.



- *Marketing and communication:* Internal and external communications plans were executed; communications products included a business plan, product logo, marketing materials and stakeholder consultations.
- *Evaluation:* The structure, process and outcomes of e-Therapeutics were evaluated. Two major pilot projects were undertaken to assess the usability and functionality of the e-Therapeutics portal. Short-term goals have been evaluated, and longer-term goals continue to be evaluated.

## Resources

- A set of electronic decision support tools provides point-of-care access to current, evidence-based, Canadian drug and therapeutic information through the e-Therapeutics web portal, **www.e-Therapeutics.ca**. Some content is available for Palm or PocketPC devices. Typically, users are paying subscribers.
- A customized and flexible technology platform supports the creation, maintenance and delivery of the tools.
- Standards and protocols allow content to be integrated into other applications (such as the electronic health record) to serve pharmacists and prescribers at the point of care.

## Key Learnings

The e-Therapeutics initiative gave primary health care providers access to point-of-care electronic decision support tools to promote optimal drug therapy. This resource addresses the concerns of both health professional and consumer groups about the safety of

medication, the need for improved prescribing, and access to new information. The initiative is still at an early stage, but indications are that this electronic decision support tool for drug therapy was well accepted by providers and is delivering “just-in-time” content. Pilot testing showed that 92 per cent of users were likely to visit the e-Therapeutics portal again, and 84 per cent were likely to visit the portal regularly to support their drug and therapeutic decision-making. Eighty-seven per cent said they would recommend the portal to others. In the second pilot test, 93 per cent of respondents felt that e-Therapeutics was a credible source of drug and therapeutic information. CPhA will be conducting a longer-term evaluation of the clinical content.

e-Therapeutics was designed to integrate electronic health record applications in the future, and is supportive of several national e-health initiatives that are currently underway. The CPhA is committed to covering the ongoing costs of e-Therapeutics through a more long-term business model; sustainability will depend on the awareness of primary care providers and their willingness to use the tools provided.

**Approved Contribution:** \$8,840,300

## Contact Information

Ajit Ghai  
Senior Director, Information Technology  
Canadian Pharmacists Association  
Phone: 613-523-7877  
E-mail: [aghai@pharmacists.ca](mailto:aghai@pharmacists.ca)

The full report is available in the language of the author on the PHCTF website, **[www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf)**.

## Multidisciplinary Collaborative Primary Maternity Care Project (MCP<sup>2</sup>)

National Envelope

### Lead and Partner Organization(s)

**Society of Obstetricians and Gynaecologists of Canada;** with the Association of Women's Health, Obstetric and Neonatal Nurses; the Canadian Association of Midwives; the Canadian Nurses Association; the College of Family Physicians of Canada; the Society of Rural Physicians of Canada

### Background and Goals

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 the development of such models, including regulatory issues; restrictions in scope of practice; financial and economic issues; medico-legal and liability issues; lack of awareness of the benefits of multidisciplinary collaborative care; and overburdened health care providers with no time or energy to seek alternate models of primary maternity care. This national 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's objectives sought to:

- Develop guidelines for multidisciplinary collaborative care models;
- Determine current national standards for terminology and scopes of practice;
- Harmonize standards and legislation;
- Increase collaboration among professionals;
- Change practice patterns;
- Facilitate information sharing; and
- Promote the benefits of multidisciplinary collaborative maternity care.

### Activities

The Multidisciplinary Collaborative Primary Maternity Care Project (MCP<sup>2</sup>) took place over a 24-month period, ending June 2006. A National Primary Maternity Care Committee (NPMCC) was established at the beginning with representatives from each of the partner associations, provincial government representatives and consumers. Members of this committee participated in working groups (Model Development, Public Policy, Research/Evaluation, Communications, and Harmonization/Legal) and were instrumental to the success of this initiative. Some activities undertaken by the MCP<sup>2</sup> included the following:

- An analysis of the maternity care system and collaborative models of care in the United Kingdom, the Netherlands, Germany, France, Sweden and Australia. The resulting report presents models of collaboration within and between professions and the characteristics of maternity care in each country.
- Development of guidelines for multidisciplinary collaborative maternal and newborn care teams. A literature review and extensive consultations (e.g., focus groups, interviews, an e-Delphi process, meetings with the NPMCC) were undertaken. The resulting report contains seven knowledge transfer modules that aim to facilitate changes in practice patterns. These include: Building Teams, Communicating Effectively, and Evaluating the Cost Implications of the MCP<sup>2</sup> Model.
- A review of provincial and territorial legislation from each jurisdiction regulating family physicians, nurses, nurse practitioners and midwives. The purpose of this review was to, among others, highlight differences in the applicable legislation and present a high-level overview of the scopes of practice.
- Research on legislation and scopes of practice, which resulted in information on current legislation and regulation regarding the provision of maternity care by regulated health professionals. It also



identified institutional, employment, funding and other elements that prevent health care professionals from working to the full extent of their current knowledge, training, experience and skills.

- A baseline survey and focus groups on the current knowledge and acceptance of multidisciplinary collaborative care.
- Development and implementation of external and internal communication plans to ensure that all information was disseminated to members of the NPMCC and key provincial/territorial stakeholders.
- Several evaluation activities at the beginning and end of the initiative, which included web-based surveys, focus groups at national meetings, and interviews with maternity care providers.

## Resources

- *Current Practice in Europe and Australia: A Descriptive Study*
- *Guidelines and Implementation Tools for Multidisciplinary Collaborative Primary Maternity Care Models*
- *Background Research Paper* (a review of provincial and territorial legislation for the regulation of health professionals)
- Initiative website, [www.mcp2.ca](http://www.mcp2.ca)

## Key Learnings

The initiative developed various guidelines and tools to facilitate the implementation of models of multidisciplinary collaborative care that could relieve health human resources shortages. These tools will affect policy and facilitate changes in practice patterns and will be available on the initiative's website for one more year. MCP<sup>2</sup> enjoyed the continuous support of stakeholders throughout its life. The health human resources crisis in maternity care motivated members of NPMCC to actively participate in this initiative. Working together

created opportunities for formal and informal exchanges of information about philosophies of care, scopes of practice and core competencies—topics that many of these maternity care providers had never had an opportunity to discuss with one another prior to this experience.

Despite some challenges, evaluation activities concluded that MCP<sup>2</sup> encouraged participants to reflect on the options for change. Participants were willing to work together to create a better, more sustainable system and were interested in developing local collaborative models. A large number of 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. Over 87 per cent of those surveyed agreed that there is a need for a pan-Canadian maternity care strategy responsible for planning multidisciplinary collaborative care. To this end, MCP<sup>2</sup> proposed the establishment of a pan-Canadian network that would be responsible for: promoting Canadian standards and quality of care, sharing best practices, promoting a coordinated vision, facilitating the implementation of collaborative care models, and promoting protocols and tools to implement change.

**Approved Contribution:** \$2,000,000

## Contact Information

Dr. André Lalonde  
Chair, Executive Committee  
Society of Obstetricians and Gynaecologists of Canada  
Phone: 613-730-4192  
E-mail: [alalonde@sogc.com](mailto:alalonde@sogc.com)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).



# National Envelope

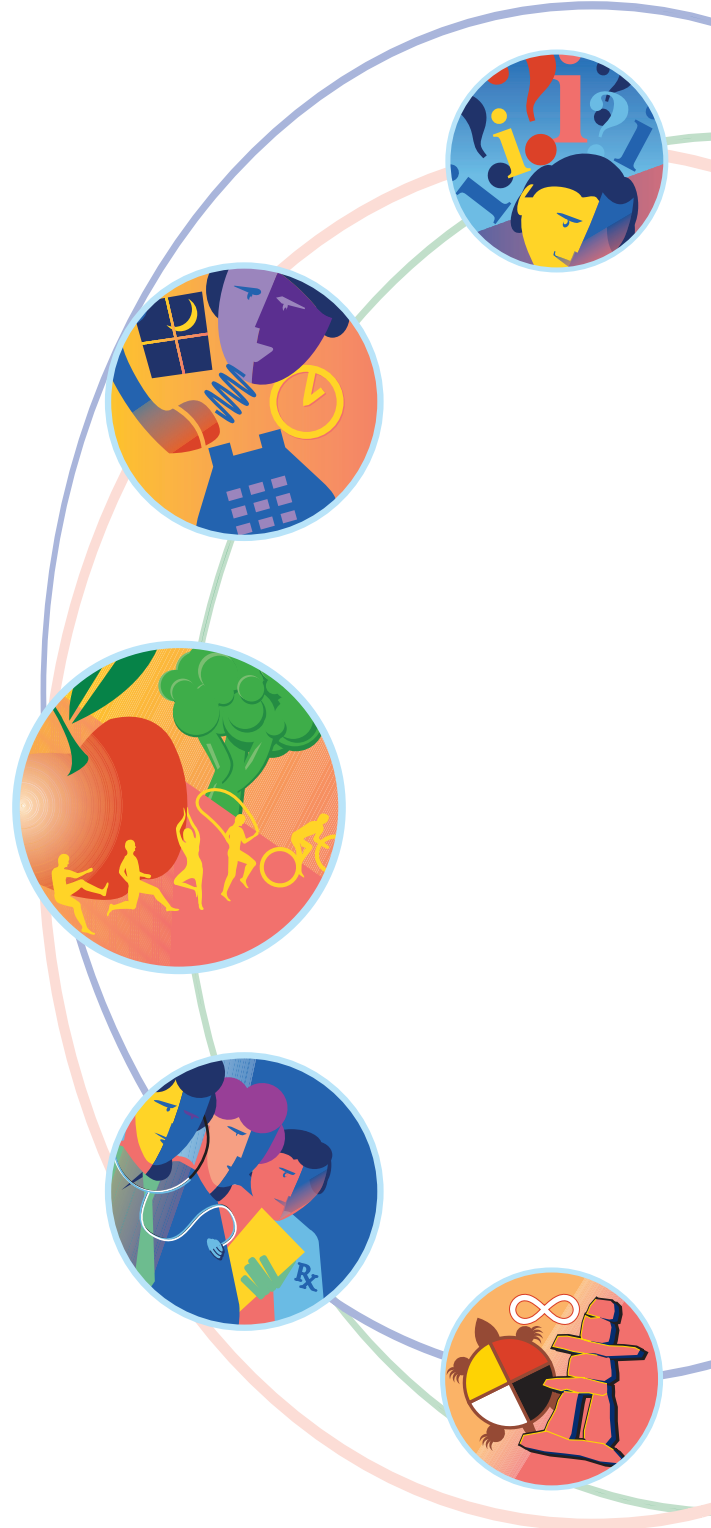
## National Strategies

### *National Primary Health Care Awareness Strategy*

**A**n essential element of primary health care renewal is improved public awareness and understanding about primary health care. Canadians need to be informed about primary health care and its importance to the overall health care system.

The National Primary Health Care Awareness Strategy consisted of two main initiatives, both guided by federal/provincial/territorial steering committees:

- The National Primary Health Care Awareness Strategy; and
- Moving Primary Health Care Forward – Many Successes ... More to Do: A National Primary Health Care Conference.





## National Primary Health Care Awareness Strategy Initiative

National Envelope

### Lead and Partner Organization(s)

**Saskatchewan Health;** with Alberta Health and Wellness; Manitoba Health; New Brunswick Department of Health; Newfoundland and Labrador Department of Health and Community Services; Northwest Territories Department of Health and Social Services; Nova Scotia Department of Health; Nunavut Department of Health and Social Services; Ontario Ministry of Health and Long-Term Care; Prince Edward Island Department of Health and Social Services; Yukon Department of Health and Social Services

### Background and Goals

Recognizing the need to increase public understanding of primary health care (PHC) and its potential to enhance the effectiveness of health care, the National Primary Health Care Awareness Strategy's (NPHCAS) main objective was to raise public awareness about the role of PHC in the health care delivery system, about PHC itself, and about the overall benefits of enhancing PHC.

### Activities

The national public awareness strategy was launched in September 2004 and was undertaken in two phases. The first phase was completed at the end of March 2005 and included: development of the strategic direction; research to inform the direction; identification of an approach (such as media and products) and target audiences; meetings with stakeholders; and development of an implementation plan and objectives to measure effectiveness. The second phase was completed by the end of September 2006. This phase included: the development of products; testing of messages; and implementation that involved media placement and evaluation. Specific activities included:

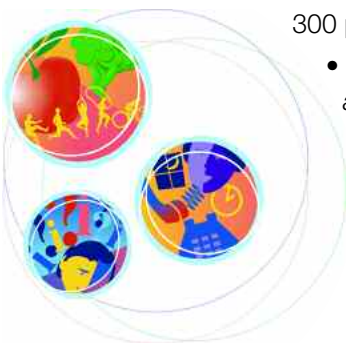
- *National research to benchmark current awareness and understanding:* Through the use of research partners, a survey of 4,800 Canadians was conducted both to inform the strategy and to provide measurable evaluation points upon the completion of the initiative. In addition, 34 focus groups were held across Canada that involved more than 300 participants.
- *Development and launch of an awareness campaign:* Themes and messages were developed based on outcomes of the national research, including the development of the four pillars concept of PHC (teams, information, access

and healthy living), which was used in all communications materials.

- *Development of communications materials:* Public communication materials were developed for the website and media (television, newspapers and magazines), partnerships and public relations. The television (two 30-second ads) and print advertising took place in two waves (September 2005 and February 2006).
- *Dissemination of information to stakeholders:* An electronic newsletter was developed as well as a website, with the latter becoming a destination point for online users seeking information about PHC.
- *Creation of strategies to support the initiative's sustainability once complete:* Provinces and territories received a communications and promotional toolkit (i.e., logo and theme, advertisements, print materials) and a DVD of PHC initiatives in their jurisdictions to assist them with continuing to promote PHC messages.
- *Implementation of an evaluation plan:* Success was measured through the achievement of increasing public awareness and understanding of PHC, and the proficiency of the initiative's organizational and decision-making structure.

### Resources

- Benchmark research
- Newsletters and website  
**[www.primaryhealthcare.ca](http://www.primaryhealthcare.ca)**
- Communication plan and promotional toolkit
- Newspaper and magazine articles about PHC
- Provincial/territorial DVDs of PHC initiatives
- Evaluation of collaborative processes and strategy effectiveness



## Key Learnings

Overall, the collaborative strategy developed by the NPHCAS made it possible for provinces and territories to have a greater impact than they could have had on their own due to the scale and quality of the advertising. Television, the primary media vehicle for the awareness campaign, offered the greatest potential to reach Canadians coast-to-coast, while newspapers, magazines and non-traditional media (such as *Canadian Health and Lifestyle*) were secondary vehicles. The partnerships with high-profile organizations were effective in raising public awareness of PHC.

In March 2006, a national survey was conducted to determine how awareness, knowledge and opinion of the importance of PHC had changed over the life of the NPHCAS. Results show that 70.7 per cent of surveyed Canadians had seen or heard the term “primary health care”—10.2 per cent more than in the benchmark survey undertaken in December 2004. Other findings indicate that:

- 49.8 per cent of Canadians were able to provide an unaided definition of PHC—an increase of 9.9 per cent over the benchmark survey; and
- 79.2 per cent of Canadians rated the importance of PHC as an 8–10 on a 10-point scale—up 6.1 per cent.

The initiative enabled smaller provinces to have the opportunity to conduct an awareness-raising campaign, and the provinces benefited from their collaboration. It is likely research and promotional projects would otherwise not have been carried out by individual jurisdictions.

The initiative also gave each participating jurisdiction the necessary tools to sustain PHC awareness in their own region of the country. The potential long-term impact of the NPHCAS is a shift in public attitude, which could result in a change in how the public interacts with the system and health care providers.

**Approved Contribution:** \$9,592,000

### Contact Information

Donna Magnusson  
Executive Director, Primary Health Services  
Saskatchewan Health  
Phone: 306-787-0889

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Moving Primary Health Care Forward—Many Successes ... More to Do: A National Primary Health Care Conference

National Envelope

### Lead and Partner Organization(s)

**Manitoba Health;** with Saskatchewan Health on behalf of the Federal/Provincial/Territorial PHCTF Advisory Group on the Primary Health Care Transition Fund (PHCTF); and also with the Manitoba Association for Community Health; Manitoba Public Health Association; College of Family Physicians of Manitoba; Winnipeg Regional Health Authority; College of Registered Nurses of Manitoba; Rural/Northern Regional Health Authorities of Manitoba; University of Manitoba, Faculties of Medicine, Nursing and Medical Rehabilitation; Manitoba Medical Association; Manitoba Association of Registered Dietitians; Manitoba Family Services and Housing

### Background and Goals

Described as a “PHC bazaar,” a four-day conference, “Moving Primary Health Care Forward—Many Successes ... More to Do,” took place in Winnipeg in May 2004. Its overall aim was to bring together a broad spectrum of PHC providers, organizations, associations, educators, administrators, policy-makers and the public to advance the PHC renewal process, while its more specific goal was to create an action-oriented, state-of-the-art forum in which to discuss and debate the current reality of PHC and the future projects that could be developed in this field. The conference was intended to be a springboard to accelerate change and improve performance in PHC. In particular, it sought to explore real-world issues under the themes of determinants of health, community perspective/community capacity/citizen participation, information management, accountability and integration.

### Activities

Manitoba Health, Saskatchewan Health and dozens of volunteers from various organizations worked collaboratively to develop and run the conference, which attracted 1,000 participants from across the country. The program included plenary sessions, large and medium-sized group presentations, panel discussions and workshops. The daily conference newspaper summarized many of the sessions and presentations. A synthesis of the key themes and ideas from the conference provided vignettes and highlights from the plenary and concurrent sessions, organized by theme.

### Resources

- A conference program guide
- Conference newspapers
- A conference report: *A Thousand Points of Light? Moving Forward on Primary Health Care*
- A website, **[www.phcconference.ca](http://www.phcconference.ca)**, where abstracts, posters and papers are posted

### Key Learnings

The conference was a review of the PHC journey to date in Canada and a cross-section of experiences and challenges. The synthesis of themes and ideas from the conference was one of the key resources produced by this initiative, and it can be found on the website. Highlights by theme include:

- *Determinants of health, public participation and building communities:* A vision of PHC that embraces these concepts is becoming a reality in several communities. The Youth Health Centres operating in Halifax County schools are an example of this; there, links are being established with



community agencies so that students are referred to both non-health care and health care agencies.

- *Integration:* Whether through regionalization of health care or at a more local level, integration is fast becoming a reality in many Canadian communities. Health professionals being trained in silos presents a barrier to integration and teamwork. Participants discussed Saskatchewan's use of team facilitators in overcoming these silos, and attention also focused on the role of nurse practitioners.
- *Improving primary care:* There has been a quiet revolution in primary care in many parts of Canada, and new services are being incorporated into primary care practices. In Hamilton, Ontario, 38 health service organizations have now incorporated mental health and nutrition services into their practices.
- *Information management and information technology:* If there was consensus on one issue at the conference, it was that the achievement of the PHC vision and quality improvement in all facets of care is highly dependent on good information. British Columbia is a success story; it has implemented an

information system to support chronic disease management and the BC NurseLine.

- *Accountability:* Historically, the health system has been judged implicitly on what it does, but the focus is shifting to what it achieves. Several presentations explored the complexity of demonstrating accountability.

This well-received conference was essentially about reflection and aspiration, and, in looking ahead, participants expressed a desire for further dialogue and concluded that future conferences should focus on action and achievement in PHC renewal efforts.

**Approved Contribution:** \$473,865

### Contact Information

Barbara Wasilewski  
Director, Primary Health Care  
Manitoba Health  
Phone: 204-786-7176  
E-mail: [bwasilewsk@gov.mb.ca](mailto:bwasilewsk@gov.mb.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

# National Envelope

## National Strategies

### *National Evaluation Strategy*

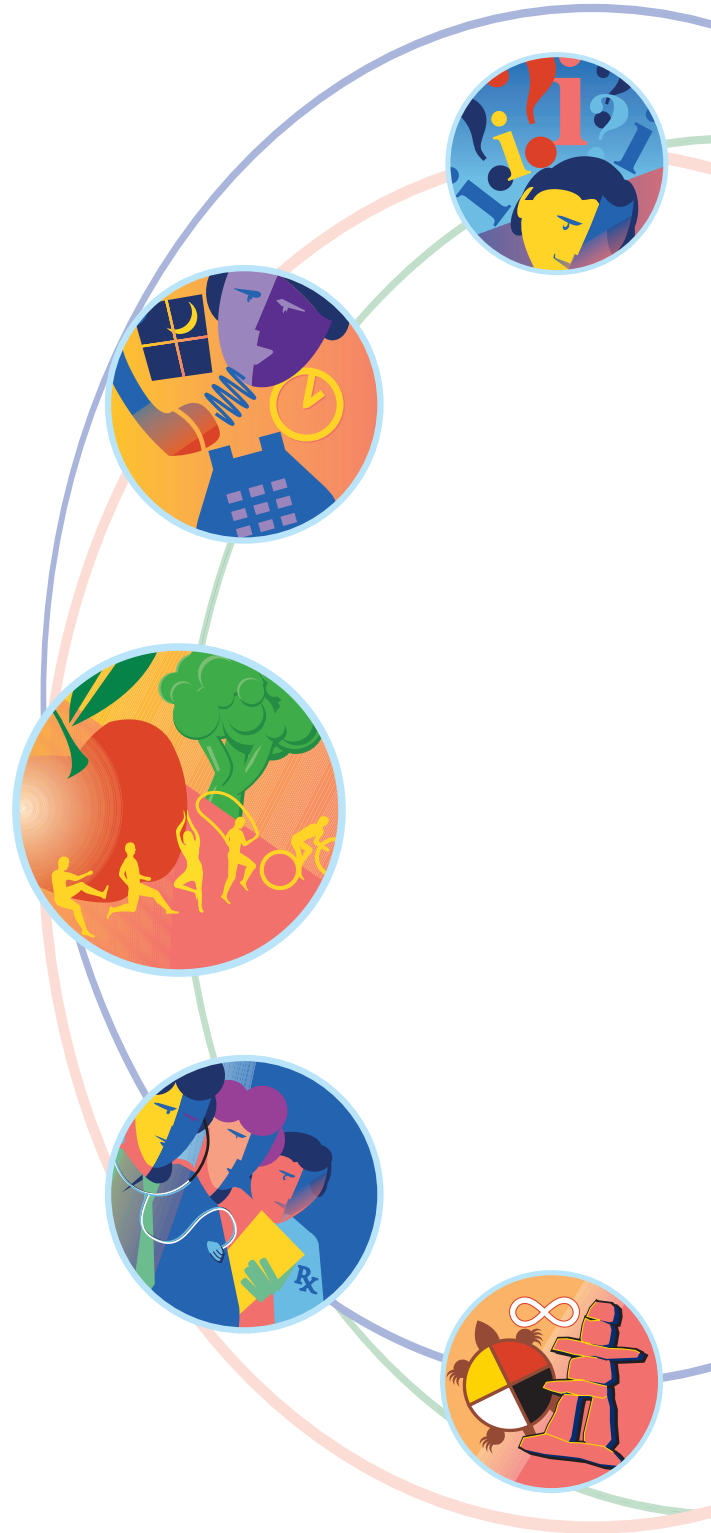
The National Evaluation Strategy (NES) was established to address the need expressed by First Ministers at their 2000, 2003 and 2004 meetings on health system renewal for better information throughout the health system.

The objective of the NES was to generate evidence on primary health care. More specifically, it would:

- Facilitate a process to generate evidence on the various approaches to primary health care, including the Primary Health Care Transition Fund and its impact on primary health care renewal; and
- Increase national capacity to evaluate primary health care, now and in the future.

The Strategy consisted of three initiatives:

- Evaluating Primary Health Care in Canada: The Right Questions to Ask;
- The Pan-Canadian Primary Health Care Indicator Development Project; and
- Toolkit of Primary Health Care Evaluation Instruments.







## Evaluating Primary Health Care in Canada: The Right Questions to Ask

National Envelope

### Lead and Partner Organization(s)

Primary and Continuing Health Care Division, Health Policy Branch, Health Canada

### Background and Goals

To better understand and improve primary health care (PHC) renewal, Health Canada established the Primary Health Care Transition Fund National Evaluation Strategy (NES). The NES had two objectives: to facilitate a process to generate evidence on various approaches to PHC and the impact of PHC renewal; and to increase national capacity to evaluate PHC. The NES comprises three initiatives (evaluation questions, indicator development and a toolkit of evaluation instruments), of which *Evaluating Primary Health Care in Canada: The Right Questions to Ask* is the first. The objective of this initiative was to develop a set of evaluation questions pertinent to the PHC sector; these questions would then serve as the basis for developing a set of indicators and evaluation tools. The five common objectives of the PHCTF were used as the initial organizing framework for classifying these questions.

### Activities

In October 2004, Health Canada began a process to identify a set of evaluation questions. A variety of strategies were used to generate these questions, including:

- *A scan of national and international policy documents:* The international scan was limited to the United Kingdom, Australia and New Zealand. More than 800 explicit and implicit evaluation questions were abstracted and mapped, according to the PHCTF objectives.

- *Further synthesis:* With the input of a small group of PHC experts in Canada, the United Kingdom and Australia, the initial set of questions was further synthesized to 100 questions that addressed all the major inputs, activities, outputs and outcomes of the PHC Results-Based Logic Model developed by Watson et al. in 2004. Wherever possible, questions were formulated in a way that would suggest indicators.
- *A two-day workshop:* The synthesized questions and the insights that emerged from the scan of policy documents were presented to a group of pan-Canadian PHC researchers, evaluators and policy-makers. Participants clarified which PHC objectives should be evaluated, and identified key evaluation questions. At the workshop, small groups were asked to integrate the broader system objectives of equity, cost-effectiveness and sustainability of public funding into the questions.
- *A final review of questions:* Thirty-nine questions were agreed upon by key experts in the field. Nineteen were identified as being important to the PHC objectives and 20 were identified as being necessary supports for the successful delivery of PHC. Modification of the five PHCTF objectives took place, resulting in seven PHC objectives.

### Resources

- A list of 39 evaluation questions for PHC
- A revised list of seven PHCTF objectives

### Key Learnings

The list of evaluation questions developed through this initiative provides an overview of the performance of the PHC system as a whole, not just that of the PHCTF initiatives. This set of questions has helped the two subsequent initiatives of the NES to frame related endeavours. It was noted that the broader system goals of an efficient, effective and equitable system



were implicit in the PHCTF objectives. As well, evaluators who took part in the initiative and policy documents consistently raised the issues of productivity, quality of health care, and responsiveness of providers to patients. These attributes of care represent an intermediate stage of achieving system efficiency, effectiveness and equity. Although they are largely under the direct control of PHC providers, it was felt that they should be included in the PHCTF objectives. In view of these and other insights, experts at the national workshop said that the language in the PHCTF objectives was ambiguous and did not address all the policy concerns

of interest in PHC performance evaluation. As a result, the original five PHC objectives were expanded to seven.

**Approved Contribution:** \$49,838

### **Contact Information**

Primary Health Care Transition Fund  
Phone: 613-954-5163  
E-mail: [phctf-fassp@hc-sc.gc.ca](mailto:phctf-fassp@hc-sc.gc.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## The Pan-Canadian Primary Health Care Indicator Development Initiative

National Envelope

### Lead and Partner Organization(s)

**Canadian Institute for Health Information**

### Background and Goals

To better understand and improve primary health care (PHC) renewal, Health Canada established the Primary Health Care Transition Fund National Evaluation Strategy (NES). The NES had two objectives: to facilitate a process to generate evidence on various approaches to PHC and the impact of PHC renewal; and to increase national capacity to evaluate PHC. The strategy comprises three initiatives (evaluation questions, indicator development and a toolkit of evaluation instruments), of which the Pan-Canadian Primary Health Care Indicator Development initiative is the second. This initiative, led by the Canadian Institute for Health Information (CIHI), had two objectives: to develop a set of agreed-upon PHC indicators, with which to compare and measure PHC at several levels within and across jurisdictions; and to provide advice on the data collection infrastructure that could aid in acquiring the data required to report on these indicators across Canada.

### Activities

In early 2005, CIHI began a process to develop an agreed-upon list of pan-Canadian PHC indicators. The NES evaluation questions (a previous component of the NES, entitled *Evaluating Primary Health Care in Canada: The Right Questions to Ask*) served as a foundation for this process. A variety of strategies were used to generate input and build agreement, including:

- *Environmental scans*: National and international documents on PHC frameworks and indicators were reviewed in order to develop a preliminary list of indicators. Further scan activities related to pan-Canadian, provincial and territorial PHC data collection sources, and innovative international PHC data collection initiatives.
- *Two consensus conferences*: More than 80 policy-makers, providers, researchers and system managers participated in conferences to review potential indicators and develop consensus.
- *Working groups/expert panels*: More than 60 policy-makers, providers, researchers and system managers participated in refining the indicators and developing technical specifications.
- *Pan-Canadian/international consultation*: Throughout the process, CIHI collected additional input through consultations with provincial, territorial and regional stakeholders, professional health associations and international researchers.
- *Delphi process*: Over 70 individuals participated in each of the three rounds to rate the indicators for importance, using a modified Delphi process.

### Resources

- List of 105 PHC pan-Canadian indicators (available at [www.cihi.ca](http://www.cihi.ca))
- *Pan-Canadian PHC Indicators (Vols. 1 and 2)* reports (English and French)
- *Enhancing the PHC Data Collection Infrastructure in Canada* report (English and French)

### Key Learnings

The initiative was able to implement a participatory and evidence-based process for indicator development, using a Delphi approach and extensive consultations. CIHI has now identified existing pan-Canadian PHC data, gaps in data sources, immediate and short-term opportunities for expanding data sources, and options for enhancement of a PHC data collection infrastructure, over time. Consensus-building and regular two-way



communication were critical to the success of this initiative. The final list of 105 agreed-upon PHC pan-Canadian indicators has been identified, and although only a small number have a relevant data source, the indicators have been actively disseminated throughout Canada. More than 500 lists have already been distributed to key stakeholders. CIHI is in discussion with sponsors of the National Physician Survey and the Canadian Community Health Survey (two ongoing national surveys) to determine the potential of modifying certain elements of these surveys in order to incorporate questions related to the pan-Canadian PHC indicators.

**Approved Contribution:** \$1,814,753

### **Contact Information**

Greg Webster  
Director, Research and Indicator Development  
Canadian Institute for Health Information  
Phone: 416-481-2002  
E-mail: [gwebster@cihi.ca](mailto:gwebster@cihi.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Toolkit of Primary Health Care Evaluation Instruments

National Envelope

### Lead and Partner Organization(s)

**Primary and Continuing Health Care Division, Health Policy Branch, Health Canada**

### Background and Goals

To better understand and improve primary health care (PHC) renewal, Health Canada established the Primary Health Care Transition Fund National Evaluation Strategy (NES). The NES had two objectives: to facilitate a process to generate evidence on the various approaches to PHC and the impact of PHC renewal; and to increase national capacity to evaluate PHC. The NES comprises three initiatives (evaluation questions, indicator development and the development of a toolkit of evaluation instruments) of which the Toolkit of Primary Health Care Evaluation Instruments is the third. The toolkit component of the initiative contributed to the overall goals of the NES by building evaluation capacity of PHC and serving as a resource (e.g., to governments, health authorities, local PHC organizations, stakeholders) when evaluating different components of PHC and its renewal in Canada. Its purpose was to identify PHC evaluation instruments, and to develop new PHC evaluation instruments that could be used to facilitate data collection to monitor and measure the impact and renewal of PHC in Canada.

### Activities

In winter 2005, a contract was awarded to Howard Research and Management Consulting Inc. to develop the PHC evaluation toolkit for Health Canada. The company completed the following activities:

- *A literature review:* A comprehensive national and international search on 30 specific evaluation questions was conducted to identify instruments that have been developed to evaluate PHC.
- *An environmental scan:* 35 semi-structured telephone interviews were conducted with senior officials in federal, provincial and territorial governments, recognized experts in PHC and evaluation, representatives of key national organizations and other key respondents to obtain input on the nature and scope of the toolkit and to identify and obtain key resource documents such as evaluation tools, frameworks and logic models.
- *A two-day consultation:* In this meeting, 26 key experts were invited to confirm priority areas where new evaluation tools needed to be developed and which existing evaluation tools should be included in the toolkit's database.
- *Completion of final list and development of new instruments:* Eight new content areas were identified as needing the development of new tools: context, health human resources, multidisciplinary teams, continuity of care, quality of care, reduced health risks attributed to PHC/self-care, information technology and health management policies (HHR and multidisciplinary teams have been grouped together as one instrument because of their inter-relationship).
- *Development of an evaluation toolkit:* The toolkit comprises a searchable database of more than 600 citations (each of which has a reference and abstract) and tools, and the seven new instruments (each of which contains the proposed methodology, sampling process, analysis of limitations and considerations, and recommendations for use). If a person is interested in one of the instruments noted in the set of 600+ citations, the reference and abstract should enable that person to begin the process of finding the information needed to learn more about that instrument.



## Resources

- Searchable online database of more than 600 citations and tools
- Seven new evaluation instruments, based on the following content areas: context, health human resources and multidisciplinary teams, continuity of care, quality of care, reduced health risks attributed to PHC and self-care, information technology and health management policies

## Key Learnings

The toolkit will be available in English and French on the Health Canada website. It contains a searchable database, which includes the abstracts of the citations that are relevant to the toolkit as well as to each of the seven new instruments. Once available, the toolkit will:

- Serve as a resource to provincial/territorial governments, regional health authorities, PHC organizations, and other PHC stakeholders when they evaluate different components of PHC and its renewal in Canada;
- Provide some of the necessary tools by which to undertake evaluation initiatives and assess renewal, both now and in the future;
- Support provincial/territorial governments in obtaining the necessary evidence and information to inform future program and policy development;

- Boost our understanding of barriers to PHC renewal and the actions needed to overcome them; and
- Help us to understand enablers of change and foster an environment to support them.

Although the provinces and territories are at different stages of PHC renewal, and therefore have different priorities and plans, there are numerous barriers and enablers of common concern that can be addressed collaboratively by developing valid evaluation tools/instruments. The toolkit's implications for policy and practice will depend on provincial/territorial governments' priorities. By providing tools to support the collection of evidence and information, the toolkit could help to improve quality of care, patient satisfaction and chronic disease management; promote more informed decision making; validate various approaches to PHC and to renewal; and boost cost effectiveness.

**Approved Contribution: \$489,871**

## Contact Information

Primary Health Care Transition Fund  
Phone: 613-954-5163  
E-mail: [phctf-fassp@hc-sc.gc.ca](mailto:phctf-fassp@hc-sc.gc.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

# National Envelope

## Tools for Transition

*Federal/Provincial/Territorial Component*







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

National Envelope

### 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

### Background and Goals

As care shifts from institutional settings to the community and the home, the roles and responsibilities of family caregivers have assumed increasing significance. Key federal reports have identified the importance of the family caregiving role and called for the integration of this role into the national health care agenda, but this has not happened. The challenge lies in recognizing the distinct needs of caregivers and determining how to integrate them into primary health care (PHC) reform. The Canadian Caregiver Coalition (CCC) and its partners have created a policy framework that supports family caregivers as part of PHC renewal and includes them as partners in care. 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 Coalition's policy framework and introduce tools that change health care providers' knowledge, attitudes and practices. The initiative team hoped that stakeholders would come to view family caregivers as integral members of the caregiving team, and would consider the importance of assessing both the caregiver's needs and those of the care receivers.

### Activities

The single activity of the initiative was a two-day national symposium held in Ottawa November 16–17, 2005. Representatives from more than 30 stakeholder organizations participated in the event, including national health organizations, PHC service provider and caregiver support organizations, and academic researchers. The symposium was designed to create a dialogue between caregiving organizations and national health care provider organizations about strategies to ensure that family caregivers and service providers become true partners in care. The agenda included sessions on caregiver and provider issues, tools to guide practice, strategies to advance a national caregiver agenda and social marketing tools to aid that process. Evaluation included a participant questionnaire and a debriefing session after the event. Feedback from the symposium was used to refine the CCC policy framework.

### Resources

- *Framework for a Canadian Caregiving Strategy* available on the CCC website, **[www.ccc-ccan.ca](http://www.ccc-ccan.ca)**, in French and English
- A caregiver assessment (CARE) tool was introduced at the symposium and feedback solicited for the next iteration

### Key Learnings

The symposium was a positive first step toward increasing the understanding among stakeholders of the challenges facing the caregiving and service provider communities. The initiative facilitated knowledge exchange and the establishment of linkages, and created the potential for future collaboration among the stakeholders. Many participants indicated a desire to continue networking beyond the symposium, and a number said that they



had gained insights and new information that could be incorporated into future proposals and advocacy endeavours. Participants learned how other groups had developed national strategies and gained useful information from federal and provincial governments about planning next steps.

There was agreement that the *Framework for a Canadian Caregiving Strategy* is a tool that is timely and should be supported. Many valued the opportunity to contribute to the development of this framework and the vision of the strategy. The initiative also offered practical and concrete support to those involved in PHC renewal. Participants found a number of tools presented at the event to be extremely useful, including: Dr. Mark Nowaczynski's video *House Calls* about family practice and housebound seniors in Toronto; presentations by the Care Renewal Project; Jane Petricic's presentation on Social Marketing; and the CARE tool. Participants indicated that these tools will

be valuable in translating policy into practice as a national caregiver strategy begins to unfold.

The sustainability of this project is dependent on resources, continued interest and the active collaboration of those who participated at the symposium. The event generated considerable momentum and, with adequate support, the Coalition anticipates that the creation of a Canadian caregiving strategy will proceed.

**Approved Contribution:** \$23,135

### Contact Information

Linda Lysne  
Executive Director, Canadian Caregiver Coalition  
Phone: 613-233-5694  
E-mail: [llysne@sympatico.ca](mailto:llysne@sympatico.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

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

National Envelope

### Lead and Partner Organization(s)

**Canadian Alliance of Community Health Centre Associations (CACHCA);** with Association of Ontario Health Centres (AOHC)

### Background and Goals

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 identified best practices and developed training resources to support the implementation and evaluation of effective PHC teams in Ontario CHCs. This AOHC project produced a resource kit that summarizes relevant research on interdisciplinary work and contains a self-assessment tool, case studies, and an intervention guide with information on how to address barriers for interdisciplinary care.

This national initiative, led by the Canadian Alliance of Community Health Centre Associations (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.

### Activities

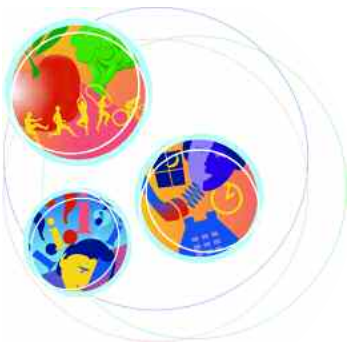
The activities focused on the dissemination of the research work and resource kit and included:

- The distribution of the resource kit to all CHCs in Canada and posting of this information to relevant websites.
- A “train-the-trainer” session with resource people from across Canada to orient them to the resource kit and a workshop methodology. In exchange these individuals committed to delivering at least one workshop in their local area for CHC staff. They also committed to acting as local resources to support CHC staff in future matters related to best practices in interdisciplinary work.
- Several regional workshops across Canada for CHC staff. These two-day workshops included an orientation to the resources developed, assessment of interdisciplinary work, and interventions to strengthen interdisciplinary teams.
- Seventeen presentations at conferences across Canada to highlight the research findings from the AOHC project and the development of the resource kit.

### Resources

The resources disseminated by the initiative are available on AOHC’s website [www.aohc.org](http://www.aohc.org) or CACHCA’s website [www.cachca.ca](http://www.cachca.ca) and include:

- A literature review summarizing interdisciplinary research
- The resource kit for experienced interdisciplinary teams including a self-assessment tool for CHCs, case studies to highlight effective practices and an intervention guide on how to address barriers to interdisciplinary work. The kit is available in French and English.



- A two day workshop that can assist CHCs in strengthening interdisciplinary teams

## Key Learnings

There was strong interest from CHCs to have access to resources that would support them in evaluating and strengthening their interdisciplinary teams. The extensive research that was conducted by AOHC confirmed much about what is already known about teams in general and interdisciplinary teams in particular. A common vision and purpose, good communication, recognition of and respect for the knowledge and skills of everyone on the team, organizational supports, such as time to meet, and mechanisms for resolving conflict were identified as critical to creating effective interdisciplinary teams. The resource kit that was developed and disseminated through this initiative focused on these key competencies and processes.

In disseminating the kit, this national initiative had to overcome several challenges. Feedback from participants at the first pilot workshops was used to redesign the resource kit and subsequent workshops. The redesign included a refocus of content toward those who already have experience working in interdisciplinary teams and a greater emphasis on how CHCs approach the challenges associated with teamwork. Furthermore most of the existing literature reviewed focused on collaboration between physicians and nurses and references to teamwork were found to be based on corporate research with limited application to CHC settings. Finally, the significant reorganization of community care in Quebec meant that the initiative leads had to reconsider the timing and approach for disseminating the resource kit in that province.

Ten trainers and 229 CHC staff from six provinces received training on the resource kit and participated in workshops. The initiative was successful in attracting

qualified, locally-based individuals to co-facilitate regional training workshops across the country. A facilitators' network has been proposed to support sharing of the facilitators' experiences with the kit and workshop across the country.

A core value of CHCs is capacity building. This initiative has developed regional capacity across Canada by continuing to educate health professionals and support them with their interdisciplinary activities. The work of the initiative was aligned with the new emphasis on preparing and training health professionals for interdisciplinary work. The resource kit will be an important tool for the many students who will focus on interdisciplinary teamwork during their community placement at CHCs. CACHCA and AOHC are committed to explore ways in which to ensure the currency of the materials developed and to support their dissemination. They are also very interested in working with other PHC providers to adapt this material to suit their specific needs.

Recent primary health care renewal efforts have focused on forming and supporting interdisciplinary primary health care teams. The kit and workshop produced by this initiative are among the most comprehensive resources developed to support these efforts at an operational level.

**Approved Contribution:** \$299,374

## Contact Information

Ken Hoffman

Co-Project Manager, Canadian Alliance of Community Health Centre Associations

Phone: 613-729-0308

E-mail: [khoffman@web.ca](mailto:khoffman@web.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Enabling Primary Health Care in the North Through Traditional Knowledge

National Envelope

### Lead and Partner Organization(s)

**Government of Nunavut, Department of Health and Social Services;** with Government of Yukon, Department of Health and Social Services; Government of Northwest Territories, Department of Health and Social Services

### Background and Goals

To be effective in restoring and maintaining health, services need to reflect the culture of the people they are intended to assist. This is particularly true in northern and remote communities where there is a strong Aboriginal culture and diverse health needs. Health and social service (HSS) providers need to consult with communities and involve them in identifying the needs and priorities of the population. The goal of this pan-territorial initiative was to give HSS providers a greater knowledge of traditional northern Aboriginal history, culture, health and healing practices so that they are better able to demonstrate cultural competence when providing services to people in Yukon, Northwest Territories (NWT) and Nunavut.

### Activities

The initiative was conducted between 2005 and 2006. The primary activity was the production and dissemination of a DVD for use in the orientation and continuing development of HSS providers. This was accomplished by:

- Establishing an initiative task force group with representation from all three governments and Aboriginal advisors within each territory.
- Holding a face-to-face workshop in July 2005 to discuss the development and production of the DVD. Five broad categories of knowledge were identified as needing to be addressed: appreciating a different way of living; valuing community; being holistic; respecting traditional knowledge and Inuit Qaujimagatjuqangit; and communicating with respect.
- Establishing local advisory groups in each territory to coordinate and oversee local community and individual involvement with the project.

- Producing the DVD. Information on northern Aboriginal history, culture and traditional health and healing practices was gathered from the perspective of the Aboriginal community. This was done through filmed interviews with identified individuals, including Elders from several communities in each territory. The information was used to illustrate each territory's geography, Aboriginal groups and cultural practice, and the environments in which health and social services are delivered.
- Launching the DVD and promoting its use in orientation and continuing development of HSS providers.

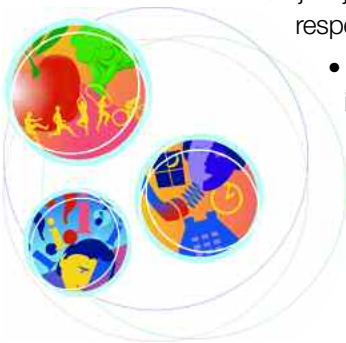
An internal evaluation of the DVD was conducted and involved focus groups in each territory and review by each territorial task force group.

### Resources

- *A Different Way of Living* DVD with an introduction, conclusion and three separate sections, each highlighting the culture and tradition of each respective territory. The DVD covers areas such as how to understand the northern Aboriginal perspective on health; how to approach community leaders and Elders; how to ask questions of an Aboriginal person about traditional healing; and the importance of culture to health and healing practices.

### Key Learnings

The initiative was carried out in a way that demonstrated respect for the traditional knowledge and experiences of Aboriginal people and communities across Yukon, NWT and Nunavut. Feedback received by the initiative suggested that the DVD is considered to be a valuable resource that should be used when orienting new HSS providers. Those consulted deemed the content to be appropriate and liked the use of subtitles, as opposed to voice-overs, because they give new employees a chance to hear an Aboriginal language.



The initiative was able to overcome several process challenges. Working across three territories presented some difficulties; the establishment of one lead jurisdiction was important and prevented the process from becoming stalled at critical decision points. Although every community in the North has its own unique culture and traditions, it was not possible to highlight every community due to geographic and logistical constraints. The face-to-face meeting proved to be invaluable to the shared understanding of each territory's unique perspective. The use of Local Advisory Groups was instrumental in providing support and advice throughout the initiative.

Prior to the onset of this initiative, few tools existed to help prepare HSS providers to work in northern and remote regions. The DVD produced by this initiative is

such a tool. It will enhance the cultural competence of those providing primary health care services to the populations of the three territories and will be particularly useful to new and potential HSS employees.

**Approved Contribution:** \$494,761

### **Contact Information**

Barbara Harvey  
Community Health Nursing Specialist  
Department of Health and Social Services  
Government of Nunavut  
Phone: 867-982-7655  
E-mail: bharvey@gov.nu.ca

The full report is available in the language of the author on the PHCTF website, **[www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf)**.

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

National Envelope

### 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

### Background and Goals

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. Building on previous international experience, several Canadian jurisdictions had integrated facilitators into their PHC renewal strategies and discovered that their expertise and focus on change management was instrumental in building the capacity needed to sustain change over time. In particular, provinces had incorporated facilitators as part of a model to support team and community development and to enhance the integration of prevention activities into physician practice. The initiative was designed to gather and articulate the facilitation experiences of health professionals across the country while building awareness of this approach. The specific objectives of the facilitation initiative were to:

- Create a guide that explores how the facilitation model has been and can be used in PHC renewal processes in the Canadian context;
- Provide information on tools that have been developed across the country that facilitate PHC change;
- Offer support to build facilitation capacity across the country; and
  - Support a collaborative process that would achieve the above objectives.

### Activities

The initiative ran from April 2005 to September 2006 with a focus on building a Canadian facilitation guide through a multi-jurisdictional collaborative process. The activities included:

- A literature review and initial consultation with key players in the partner provinces;
- The development of a first draft of the facilitation guide, presented at a national workshop;
- Incorporation of feedback from this workshop into a revised draft of the guide;
- A visit to key facilitation experts in the United Kingdom to gain further insights;
- Online surveys and orientation sessions to more than 250 participants across Canada to solicit additional feedback for the subsequent revision;
- A collaborative review of the document and production of the final version; and
- An evaluation to determine the effectiveness of the multi-jurisdictional collaboration and the facilitation guide.

### Resources

- *Guiding Facilitation in the Canadian Context: Enhancing Primary Health Care* (available in English and French) is available on provincial and territorial websites.



## Key Learnings

The primary contribution of the initiative is the articulation of a model of change that is rooted in evidence and in practice. The facilitation model was found to be a significant central method for sustaining ongoing change processes in PHC. The initiative's most concrete contribution is the facilitation guide itself, which reflects the learnings, practices and experiences of health care professionals across Canada. The guide is a practical tool, applicable to many settings and useful for those leading PHC change. It will require continuous updating in order to keep it current, however.

During the consultations, participants voiced the need for additional training in facilitation and use of the tools. They also believe that ongoing professional development is vital to building capacity among new and existing facilitators. Facilitators from across the country could continue to connect through networking opportunities and the creation of a virtual community of practice.

The initiative also 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. The project management structure supported good communication, timely sharing of information and effective decision-making processes. The sharing of resources between the provinces and jurisdictions created opportunities that might not otherwise have been possible, given a limited budget and tight timelines. Out of this initiative came the suggestion of a national working group that would cross all jurisdictions and be supported at the provincial/territorial level. This working group could continue to support the network and collaboration of facilitators.

**Approved Contribution:** \$445,600

### Contact Information

Sheila Miller  
Director, Planning and Evaluation  
Department of Health and Community Services  
Government of Newfoundland and Labrador  
Phone: 709-729-7075  
E-mail: millers@gov.nl.ca

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).



## Family Physician Compensation Models and Primary Health Care Renewal

National Envelope

### Lead and Partner Organization(s)

**Nova Scotia Department of Health;** with Nova Scotia District Health Authorities; IWK Health Centre; Doctors Nova Scotia

### Background and Goals

Current challenges to PHC renewal include inadequate attention and lack of infrastructure to support health promotion and disease prevention. PHC renewal is also challenged by current remuneration options for primary care physicians, which are volume-driven. The overall goal for this initiative was to gain a better understanding of family physician remuneration models within the context of PHC renewal from both a provider and a funder's perspective, and to facilitate knowledge transfer across Canada.

### Activities

The initiative took place over a one-year period that ended March 31, 2006, during which time the initiative's promoters:

- Conducted a national and international literature review and critical analysis of research and evaluation on various family physician remuneration options;
- Developed an inventory of current family physician remuneration models used in Canada. (This included an examination of the following factors: their impact on PHC renewal; the acceptability of the model to family physicians; the impact on family physicians; the impact on other primary care providers' practices; the ease of and/or issues encountered in implementation; and the financial impact of the models);

- Organized a conference in Halifax with 100 key stakeholders to present the findings of the literature review and inventory, and to assist stakeholders in developing options for their own interests and jurisdictions; and
- Conducted an evaluation of the project process and its impact on stakeholders involved in this project.

### Resources

- Literature review on family physician remuneration options
- Inventory of current family physician remuneration models used in Canada
- Conference proceedings on family physician remuneration in PHC
- **www.fppay.com**, the initiative's website

### Key Learnings

The literature review and inventory of remuneration models indicate that no single solution exists to the question of how to pay family physicians, but rather that diverse and flexible solutions are required. Little data are available to support the claim that one system—capitation, salary or contract—is more effective and efficient than fee-for-service or that it delivers better value for money or quality of care. Evidence linking payment methods to practice patterns is weak and most of it comes from the United States, which has a very different policy environment than Canada has. The few studies that examine health outcomes have not produced conclusive findings. The review of theoretical and empirical literature suggests that policy-makers may want to consider a blended remuneration scheme as part of a more complete package of conditions. Conference participants felt that although financial incentives are not the major determinant of physician behaviour, they nevertheless represent one of the many enablers of behaviour within the health care system.



Overall, alternative funding schemes appear to have some positive effects on health services delivery. In looking ahead, there needs to be proper investment in new models of delivery, in the remuneration system used and the outcomes it produces. There is an absence of concrete studies on the impact of physician remuneration on PHC renewal. It is hoped that the lessons learned through this initiative will shape new work in this area by all governments, as the initiative's work underscores the need for coherent policy regarding physician remuneration.

**Approved Contribution:** \$506,000

### **Contact Information**

Ian Bower  
Director of Physician Services  
Nova Scotia Department of Health  
Phone: 902-424-2738  
E-mail: bowerib@gov.ns.ca

The full report is available in the language of the author on the PHCTF website, **[www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf)**.

## Increasing Support for Family Physicians in Primary Care

National Envelope

### Lead and Partner Organization(s)

**The College of Family Physicians of Canada**

### Background and Goals

Primary care (PC) reform in Canada has required the development of new primary care 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 the new and evolving demands of their day-to-day practice. This initiative sought to respond to the need to ensure sustainable and healthy work environments in which family physicians feel supported and valued as important contributors to the health of their patients and their communities. FPs must be involved with and understand both the knowledge transfer and change management issues associated with PC reform. The specific objectives of the initiative included:

- Identifying, developing and supporting a cadre of FP PC renewal leaders across Canada;
- Building a network of national, provincial, regional and local FP PC renewal leaders; and
- Providing an opportunity for FP PC renewal leaders from across Canada to meet at a national level 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.

### Activities

The initiative began in early 2005 and continues until March 31, 2007, with support from the Health Human Resource Strategy division of Health Canada. The activities that have taken place or that will occur by the end of the initiative include:

- Developing a national advisory committee for the initiative;
- Creating a practical web-based Primary Care Toolkit for Family Physicians;
- Developing an interactive electronic forum for ongoing knowledge exchange (part of the web-based toolkit);
- Developing a change management leadership group of Canadian FPs who have successfully implemented interdisciplinary collaborative approaches;
- Holding three national forums to share information and generate ideas; and
- Developing and implementing strategies to disseminate, promote the use of and provide training on the toolkit in each province.

### Resources

- The Primary Care Toolkit for Family Physicians, accessible through the College of Family Physicians of Canada (CFPC) website or at **www.toolkit.cfpc.ca**, includes six modules: Introduction to the Toolkit; Remuneration; Governance; Interdisciplinary Collaboration; Continuity and Comprehensiveness of Care; and Information Technology.



## Key Learnings

In January 2007, the web-based PC toolkit was publicly launched. Work will continue with the change management leadership group and will include the eventual establishment of a PC–FP leadership group at the College. Together, the toolkit and leadership group will help FPs to access current and practical transition tools and obtain expert advice from colleagues experienced with PC renewal. It is expected that the toolkit will increase the interest and involvement of FPs in family practice settings and thereby contribute to the sustainability of primary health care renewal. An early benefit of the initiative has been the opportunity to share unique experiences and draw attention to the learnings from provinces, particularly those that are more advanced in their PC reform. CFPC has committed itself to supporting a Primary Care Advisory Committee of family physician leaders and to

maintaining and updating the toolkit beyond the life of the Health Canada–funded project. The CFPC believes that this initiative represents an important first step in increasing support for family physicians in primary care and that it creates the momentum to affect change.

**Approved Contribution:** \$232,900

## Contact Information

Dr. John Maxted  
Associate Executive Director, Health and Public Policy  
The College of Family Physicians of Canada  
Phone: 905-629-0900  
E-mail: [jmaxted@cfpc.ca](mailto:jmaxted@cfpc.ca)

The full report is available in the language of the author on the PHCTF website, **[www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf)**.

## Measuring Cost Effectiveness in Primary Health Care: Developing a Methodological Framework for Future Research

National Envelope

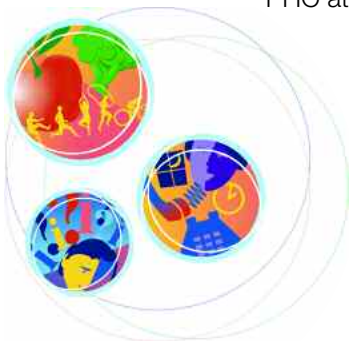
### Lead and Partner Organization(s)

**Canadian Alliance of Community Health Centre Associations (CACHCA);** with Association of Ontario Health Centres (AOHC); University of Toronto

### Background and Goals

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, including 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; a strong focus on individuals, instead of on families and community health; difficulties defining and comparing PHC models; problems arising from assessing the performance of some models and making out-of-context comparisons; and the use of economic research methodologies that are not appropriately refined to deal with research questions related to PHC models and systems.

This national initiative laid the groundwork for a comprehensive agenda for the investigation of the economic effectiveness of PHC. Such an agenda will provide decision-makers with evidence and tools that can support more cost-effective investments in the health care system. The agenda was developed through extensive consultations with over 80 researchers, administrators, funders and policy-makers in PHC at two “think tank” meetings in 2006.



### Activities

The main activities undertaken by this initiative included:

- Establishment of Steering and Technical Advisory Committees representing PHC providers, researchers, health economists and governments.
- Two think tanks were held, bringing together a total of 80 experts in health policy and economics, and representatives from governments and health professional groups. The first think tank identified the key policy questions to be addressed in the economic evaluation of PHC; the second focused on the economic research questions.
- Based on these discussions, a research group representing three universities and Canadian Alliance of Community Health Centre Associations (CACHCA) developed a research proposal that was submitted to the Canadian Health Services Research Foundation (CHSRF) for funding to further advance our knowledge in this area.

### Resources

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* makes the case that the evaluation of PHC must be consistent with the vision and values that Canada espouses for PHC as part of our international agreements (Montevideo Declaration).
- *A Modified Logic Model for PHC* builds on work by Diane Watson et al. to align a results-based logic model to include population health and capacity-building concepts, and integrate the taxonomy of PHC models.
- *Economic evaluation of health promotion* describes the challenges associated with an economic evaluation of health promotion.

- *Economic evaluation of social capital and community capacity building* describes the challenges associated with the measurement and evaluation of community capacity building.
- *Theories of change—PHC as a complex adaptive system*: considers the application of theories of change to the health care system.
- *Next Steps: A research proposal to investigate the performance of PHC systems* advances economic evaluation research by proposing a research agenda to describe and study PHC systems in different Canadian jurisdictions.

## Key Learnings

There are multiple PHC models across Canada and not one stands as the “ideal” model. On the contrary, evidence seems to suggest that the optimum approach is to create a PHC system based on the best mix of PHC models that addresses the needs of communities and families, given their characteristics. This initiative established partnerships across the academic, research and PHC communities across Canada, and leveraging on their collective skills and knowledge, developed a research agenda with a focus on describing PHC systems in different jurisdictions, and measuring their performance. This research agenda was developed based upon the following principles:

- Canada’s international commitment to PHC values and principles (Montevideo Declaration, 1995) as a standard for comparison;

- 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);
- Considering PHC as a system, rather than as isolated, individual providers;
- Considering the influence of context on the development and performance of PHC systems;
- Considering what models of change are most helpful for understanding PHC, i.e., whether the health care system is a complex, adaptive system or a complicated one.

Understanding PHC systems—and the factors that influence the performance of these systems—should enhance the ability of governments and RHAs to make sound decisions when managing and reforming their PHC systems.

**Approved Contribution:** \$351,174

## Contact Information

Ken Hoffman  
Co-Project Manager, Canadian Alliance of Community Health Centre Associations  
Phone: 613-729-0308  
E-mail: [khoffman@web.ca](mailto:khoffman@web.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## National First Nations and Inuit Telehealth Summit: Collaborative Planning for Community Telehealth Services: 2005–2015

National Envelope

### Lead and Partner Organization(s):

**Assembly of First Nations Health and Social Secretariat;** with Aboriginal Nurses Association of Canada (ANAC); Aboriginal Telehealth Knowledge Circle (ATKC); Canada Health Infoway (CHI); First Nations and Inuit Health Branch, Health Canada; Inuit Tapiriit Kanatami (ITK); National Aboriginal Health Organization (NAHO); provincial telehealth directors

### Approved Contribution:

\$500,000

### Summary:

This initiative focused on Aboriginal telehealth. Its aim was to hold a national summit that would bring together federal, provincial, territorial and community telehealth stakeholders to share First Nations and Inuit knowledge of telehealth, with the objective of zeroing in on practices and lessons learned. The summit, which was held in Winnipeg September 23–24, 2005, attracted 197 participants from across the country. Sessions were held on how to:

- Develop a common understanding of the new technologies;
- Plan for integration into provincial, territorial and federal telehealth networks;
- Plan for appropriate cultural inclusion; and
- Explain how various technologies and processes could be used to deliver sustainable community-level primary care services that would reduce pressures on the overall primary health care system.

At the summit, participants also came up with strategies to foster human resource development to encourage youth and community members to learn about and use technologies. The initiative's sponsors hope that the summit will lead to more effective use of community services and to greater opportunities for community involvement and sustainable local employment.

The fact sheet and full report are available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).







## Primary Health Care and Telehealth: Making the Links National Workshop

National Envelope

### Lead and Partner Organization(s)

**Manitoba Health Primary Health Care Unit;** with Manitoba Telehealth; Winnipeg Regional Health Authority

### Background and Goals

Efforts to reform the health care system have focused on both primary health care (PHC) and telehealth. Although telehealth has the potential to enhance and strengthen PHC programs, improve access to and integrate services, and enable improved and expanded contact between practitioners and the public, there has been relatively little exploration of the linkages between PHC and telehealth. 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. The intent was to build and capitalize on the processes and structures already in place in order to move on to next steps. The objectives of the workshop therefore were to: provide a forum for information exchange and creative planning; enable telehealth networks to identify and plan for the management of the operational and technological structures required to support PHC initiatives; enable participants to identify how telehealth could support their objectives; engage key decision-makers in joint planning to identify opportunities to support existing investments in PHC and telehealth at the jurisdictional level by building on existing capacity, infrastructure and expertise; and develop concrete action items for each jurisdiction.

### Activities

Primary Health Care and Telehealth, Making the Links National Workshop was held in Winnipeg, September 22–23, 2005.

The first day focused on what was needed to develop successful links between PHC and telehealth. Participants examined new ways of thinking and putting into practice the solutions and ideas offered by technology to create a sustainable health care system. They presented case studies from Ontario, Manitoba and Newfoundland and Labrador. They also identified the top 10 key points that need to be examined and/or taken into consideration in order to develop effective links between PHC and telehealth. These were:

- 1) Re-engineering the system to use technology for new purposes, such as enabling the provision of appropriate diagnosis and care;
- 2) Emphasizing the importance of clinical buy-in;
- 3) Addressing and working with issues presented by geographic isolation in providing connectivity to rural and isolated communities;
- 4) Developing a sustainable funding model so that telehealth and PHC initiatives are not just project-based, but integrated into service provision;
- 5) Dealing with cost factors in providing links to rural and isolated communities;
- 6) Using technology to improve referral patterns;
- 7) Addressing security and liability concerns;
- 8) Developing opportunities for formal education for health care practitioners so that technology becomes an accepted part of clinical practice;
- 9) Involving and empowering the community at every level when planning new service delivery approaches (including telehealth) and getting social and other service providers on board; and
- 10) Taking changing demographics into consideration when planning services.



The second day focused on next steps. Participants worked in jurisdictional groups to develop specific ideas and concrete action items for links for their province/territory, including:

- Providing a follow-up forum at the jurisdictional level or organizing a workshop in which PHC and telehealth representatives could meet to discuss areas where linkages could be made or expanded;
- Using existing telehealth networks, services and programs to support current PHC initiatives related to provider and public education, and building collaborative multi-function teams;
- Developing innovative pilot projects to support new PHC initiatives through the use of telehealth and, where possible, using existing programs and infrastructure; and
- Working to integrate telehealth into sustained programming.

## Resources

The initiative's website [www.makingthelinks.mbtelehealth.ca](http://www.makingthelinks.mbtelehealth.ca) holds documents related to the workshop, including an environmental scan and a jurisdictional overview.

## Key Learnings

The workshop provided 54 representatives representing PHC and telehealth from jurisdictions across Canada with an opportunity 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. The workshop helped to open participants'

eyes to the full possibilities of telehealth services: it can be used to educate both providers and the public about health promotion, disease and injury prevention initiatives; it can support health professionals working in rural or isolated communities; and it can improve access to specialist services.

The workshop provided an opportunity to create awareness of tools already established, focusing on new uses and applications for telehealth in the PHC context. Participants learned more about how information communications technologies could fundamentally change the practice patterns of health care providers, expanding their ability to support distributed populations and to connect more readily with distant colleagues. The workshop was designed to encourage linkages between and among PHC and telehealth initiatives at a jurisdictional level and to act as a catalyst for the integration of telehealth to support PHC renewal. All in all, the workshop helped participants to realize that there is far more to telehealth than its traditional role of delivering acute care services to remote communities.

**Approved Contribution:** \$249,500

## Contact Information

Liz Loewen  
Director, Manitoba Telehealth  
Winnipeg Regional Health Authority  
Phone: 204-975-7738  
E-mail: [lloewen@mbtelehealth.ca](mailto:lloewen@mbtelehealth.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

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

National Envelope

### Lead and Partner Organization(s)

**Primary and Continuing Health Care Division, Health Policy Branch, Health Canada**

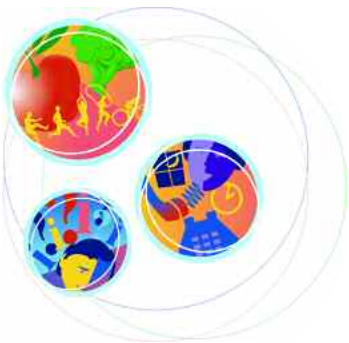
### Background and Goals

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, with the overarching goal of supporting PHC renewal by encouraging the use of information technology in practice settings.

### Activities

The initiative began in January 2005 and will be completed in March 2007. A steering committee composed of key stakeholder representatives was established, and Greymartin Consulting Inc. was contracted to conduct the activities, which included:

- *A literature and document review and consultations with key stakeholders.* This was undertaken in the autumn of 2005 to inform toolkit development and design.
- *The toolkit's development and refinement based on formative evaluation.* The formative evaluation of the toolkit was based on ongoing feedback from a working group and two formal review sessions, held in May and June 2006. The toolkit was released in October 2006, and includes three key elements: a narrative step-by-step "how-to" guide to EMR implementation; tools to support the stages of implementation; and "success stories" that provide examples of successful EMR use.
- *The dissemination of the toolkit.* The intent was to publicize and distribute the toolkit to key target audiences in two stages: first, by raising awareness of the toolkit in general through newsletters, conferences and meetings; and second, by transferring in-depth knowledge of the toolkit through targeted dissemination workshops and by identifying regional champions (regional workshops will be held in February 2007).
- *An evaluation of the initiative.* The summative evaluation will focus on the regional workshops and will evaluate the toolkit itself, as well as the dissemination activities undertaken to distribute it.



## Resources

- The EMR toolkit, available at [www.emrtoolkit.ca](http://www.emrtoolkit.ca)

## Key Learnings

The consultation phase of the initiative strongly confirmed the need for a tool to support the implementation of EMRs. The existing Canadian resources on EMR adoption 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, support and tools for “people” and “processes,” have not been as well documented, or have been underutilized if they exist. Those who have already invested also need help to move to the next level of effective EMR use, when, for example, they will use tools for clinical decision support or quality improvement. Although a variety of EMR resources currently exists, the toolkit consolidates them and makes them available on a national basis.

The toolkit was intended to feature success stories—tangible examples of successful EMR implementation and information technology integration initiatives from across Canada. Early results from the initiative indicated that success stories are somewhat elusive, reflecting

the limited state of EMR implementation across the country.

The toolkit developers were challenged to maintain clarity about the scope of the project. Addressing toolkit characteristics, such as ease of use and appropriate level of information, and addressing multi-disciplinary needs also posed challenges. Content was layered so that stakeholders could choose the appropriate level of detail for their needs, and attention was focused on ensuring user-friendliness and ease of navigation.

It is hoped that the toolkit will prove to be a valuable resource for PHC planners and providers who are interested in implementing an EMR, and will support improved access and quality in PHC.

**Approved Contribution: \$455,000**

## Contact Information

Primary Health Care Transition Fund

Phone: 613-954-5163

E-mail: [phctf-fassp@hc-sc.gc.ca](mailto:phctf-fassp@hc-sc.gc.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

# National Envelope

## Tools for Transition

*Responsive Component*





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

National Envelope

### Lead and Partner Organization(s):

**Labrador East Primary Health Care Project, Labrador-Grenfell Regional Integrated Health Authority;** with 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

### Summary:

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**

National Envelope

**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

**Summary:**

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.



## Sixth National Summit: Cancer Control in Northern and Rural Communities

National Envelope

### 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

### Summary:

Five national sessions to discuss issues related to community or non-institutional cancer control outside of the formal cancer system have been held across Canada in the past few years. This initiative planned, implemented and summarized the 6th National Summit on Community Cancer Control, which focused on cancer control in northern, rural, remote (NRR) and Aboriginal communities. Led by a National Steering Committee, this initiative aimed to develop recommendations and implementation plans through active partnerships at all levels to improve rural and northern community cancer control (including prevention, surveillance, screening/early detection, treatment, supportive care, rehabilitation and palliation). Specifically, this initiative's goals were to: 1) identify and prioritize challenges and barriers associated with cancer control in NRR and Aboriginal communities; 2) identify strategies/mechanisms for improving cancer control in priority areas at all levels, including innovative initiatives; and 3) recommend specific strategies/mechanisms to a broad range of groups and organizations, including community, regional, provincial, territorial and national organizations, as well as cancer advocacy groups and the Canadian Strategy for Cancer Control and its affiliates. This summit—held in Thunder Bay, Ontario—brought together 220 delegates from a diverse range of stakeholder groups to discuss issues related to: health human resources; building healthy communities through community participation; improving access; and electronic health records. These had been identified as priority areas through a literature review, a survey of delegates, and virtual meeting groups. This initiative provided a forum for cancer control representatives from across Canada to identify actions and strategies in all these areas to improve cancer control in NRR and Aboriginal communities. Summit recommendations and action plans have been presented at international conferences and are informing policy- and decision-makers in Canada. They are available on the website [www.communitycancercontrol.ca](http://www.communitycancercontrol.ca).



## **Shaping the Future of Primary Health Care in Nova Scotia**

**and**

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

National Envelope

### **Lead and Partner Organization(s):**

**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

### **Summary:**

The College of Registered Nurses of Nova Scotia sponsored two conferences on primary health care (PHC) reform. The conference Shaping the Future of Primary Health Care in Nova Scotia, held in May 2003, attracted 250 participants from the areas of health, community and government. The topics discussed included: background information on impetus for change; components of a successful primary health care model; strategic directions and targets; system design imperatives (information technology systems, funding models, competencies, collaborative agreements); and cultural, behavioural and attitudinal changes. Momentum 2005, Moving in the Right Direction, held October 26–28, 2005, in Halifax, Nova Scotia, was planned to be a follow-up conference to Shaping the Future in Nova Scotia. Its program centred on four themes—Responsiveness, Inter-professional Collaboration, Tools and Technology, and Integration—with the aim of providing practical strategies and tools for the 142 participants from the health care community to emulate in their own work settings. These conferences together offered participants an opportunity to:

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

## Support Packages for the Uptake of Chronic Disease Management Best Practices

### National Envelope

#### Lead and Partner Organization(s):

**British Columbia Ministry of Health;** with British Columbia Medical Association

#### Approved Contribution:

\$75,000

#### Summary:

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



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

### National Envelope

**Lead and Partner  
Organization(s):**

**University of British Columbia**

**Approved Contribution:**

\$30,000

**Summary:**

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.

# National Envelope

## National Initiatives





## Continuous Enhancement of Quality Measurement in Primary Mental Health Care—Closing the Implementation Loop

National Envelope

### Lead and Partner Organization(s)

**Centre for Applied Research in Mental Health and Addiction, Faculty of Health Sciences, Simon Fraser University (formerly the Mental Health Evaluation and Community Consultation Unit [MHECCU] at the University of British Columbia);** with Canadian Mental Health Association; Mental Health Consultation and Evaluation in Primary-care Psychiatry (MHCEP); l'Institut national de santé publique du Québec (INSPQ); Groupe de recherche sur l'intégration sociale; l'organisation des services et l'évaluation en santé mentale (GRIOSE-SM); University of Calgary; University of Saskatchewan; University of Toronto; University of Western Ontario

### Background and Goals

Most people with mental health problems are seen in primary health care (PHC) settings. A gap exists, however, between what is actually happening at the practice level and what current evidence shows is effective. Without consistent evaluation systems in place to measure the impact of initiatives that seek to improve the quality of PHC (for example, through collaborative care arrangements), it will be difficult to gauge effectiveness. So to help close the gap in care, this initiative set out to:

- Develop a set of quality measures for Canadian primary mental health care services, reflecting multi-stakeholder perspectives, to facilitate quality improvement;
- Exchange information and knowledge with identified stakeholder groups on primary mental health care and quality measurement;
- Identify data quality standards for primary mental health care and quality measures;
- Recommend future directions for implementing these quality measures into existing data systems; and
- Undertake a research sub-project designed to create a practical tool, “The Readiness to Implement Quality Measurement Checklist,” to assess an organization’s readiness to implement quality measurement.



### Activities

There were three stages to the initiative: 1) a domains survey; 2) an expert consultation survey; and 3) a health measures survey.

- *Domains survey:* During the first stage, consensus was reached on the key areas that required focus. This led to the development of a domain framework for the primary mental health system. Additional domains were added to the framework to increase the relevance to primary mental health care. These additional domains were generated through a consensus-based process that involved a wide range of stakeholders. Based on survey responses, 22 priority domains were selected to be the focus of activities. Nine were system-wide domains that could be applied regardless of specific mental health conditions, while 13 were focused on special areas (e.g., youth, psychosis).
- *Expert consultation survey:* During the second stage, a survey was conducted with more than 40 national and international experts to research best practices and existing health measures associated with the domains identified in Stage 1. The 3,000 measures of quality generated will be available in a public, searchable database.
- *Health measures survey:* In the third stage, a final survey on primary mental health care quality measures was sent to 270 stakeholders from every province and territory. The survey’s purpose was to identify an essential and smaller set of consensus measures (20–40).

## Resources

- *Health Quality Measure Specification Template*
- A web-based inventory of 3,000 measures for PHC and mental health services
- A set of 20–40 consensus measures that could be used at various system levels to support quality improvement in primary mental health care
- A checklist tool for assessing an organization's readiness to undertake quality measurement
- A “next steps” document to foster implementation of measures into current and future data systems
- Recommendations for the implementation of primary mental health care measures into current and future health information systems

## Key Learnings

The initiative garnered agreement across Canada from decision-makers, clinicians, mental health advocates/users and academics about domains or areas of focus for quality measurement in primary mental health care. It produced an overview of best practices in primary mental health care, initiated a knowledge transfer and exchange network focused on primary mental health care evaluation, and fostered a joint quality culture in PHC.

The findings present a green light for policy action by decision-makers. It arms them with a small set of very

specific measures that can be used as a focus for primary mental health care reform. The measures will help to bring about practice-based improvement, as they allow people working on the front line of PHC to see how they are doing, where gaps exist and how to bridge them. Identified care gaps that are not under the control of front-line practitioners, consumers or managers can then be targeted for new policy and program initiatives.

The initiative highlights the need for continued capacity building in quality improvement skills/infrastructure, as a gap still exists between identifying measures and implementing them. Out of this initiative came the recommendation that any next steps should involve multiple linked regional pilot projects that would examine the validity of continuous enhancement of quality measures in “real world” settings.

**Approved Contribution:** \$2,000,000

## Contact Information

Reneé Sarojini Saklikar  
National Knowledge Transfer Advisor, Centre for  
Applied Research in Mental Health and Addiction  
Simon Fraser University  
Phone: 604-540-1105  
E-mail: rsaklikar@shaw.ca

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).



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

National Envelope

### 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

### Background and Goals

Arthritis is a serious chronic disease that affects more than 4 million Canadians. It is the most common reason for long-term physical disability and, together with other musculoskeletal diseases, costs the economy an estimated \$17.8 billion annually. Yet, at the primary health care (PHC) level, arthritis care faces significant challenges: difficulty diagnosing rheumatoid arthritis; delay in referring arthritis patients to specialists; long waiting lists for hip and knee replacements (needed mostly by people with 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 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 arthritis;
  - Improve the ability of people with arthritis to self-manage their disease; and
  - Improve outcomes for people with arthritis (i.e., reduced pain, fatigue and disability).



### Activities

This initiative was implemented over 29 months, from November 2003 to March 2006. Activities were organized in four areas: needs assessment; development of educational materials for providers and their patients; facilitation of interprofessional workshops on osteoarthritis and rheumatoid arthritis; and reinforcement activities following the workshops to strengthen the learning. Along these lines, this initiative:

- Surveyed each community or region to identify existing arthritis resources (e.g., community exercise programs, rehabilitation and education programs, arthritis specialists);
- Held patient focus groups in eight communities (Prince Albert, Winnipeg, Courtney, Montréal, Lameque, Halifax, Calgary and Charlottetown) to assess access to care, quality of care, access to information, and barriers and facilitators to using arthritis best practices;
- Surveyed health providers for their knowledge of arthritis best practices and barriers to care;
- Developed educational materials for providers, patients and the general public, adapting them from the original materials produced for the Getting a Grip on Arthritis pilot project;
- Facilitated 30 accredited interprofessional workshops on arthritis best practices for providers in PHC organizations. These workshops (24 in English; six in French) were delivered to 900 health providers in rural and urban communities to help them understand arthritis clinical practice guidelines and find ways to: improve the delivery of arthritis care; review/improve their musculoskeletal physical examination skills; and make a local plan for implementing arthritis best practices. Faculty included health professionals (e.g., rheumatologists, pharmacists, occupational therapists,

physiotherapists, social workers, dietitians), arthritis self-management program leaders, and trained patient educators. These workshops were accredited for nine MAINPRO-C credits by the College of Family Physicians of Canada; and

- Undertook activities following the workshops that reinforced learning on best practices and supported delivery of integrated arthritis care (e.g., through newsletters, videos and resource lists, advanced arthritis education and leadership training).

In addition, the initiative conducted an evaluation including measurements of processes and outcomes. The impact of the program was assessed at the individual, organizational, community, provincial and national levels.

## Resources

- *Getting a Grip on Arthritis: A Resource Kit for People with Arthritis* (also available in audio format)
- *Financial Resources for People with Arthritis*
- Provider toolkit on arthritis clinical practice guidelines
- Public education poster on arthritis

(These resources are available for free download at [www.arthritis.ca/gettingagrip](http://www.arthritis.ca/gettingagrip) or [www.arthrite.ca/prendreenmain](http://www.arthrite.ca/prendreenmain))

## Key Learnings

This initiative brought together health professionals from many disciplines working in the community, surrounding hospitals, home care programs, private clinics and rehabilitation facilities, and linked them with arthritis specialists, thereby strengthening community partnerships and improving arthritis care. It 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 health professionals in interdisciplinary care. In a post-intervention evaluation, patients/clients reported receiving significantly more recommendations for arthritis best practices from their PHC providers (e.g., information on arthritis, community resources, how to deal with pain, treatment choices, exercise). Health professionals gained from the involvement of people with arthritis in the workshops, the opportunity for hands-on skill development and links to local resources. A provider follow-up survey indicated that the initiative had the greatest impact on arthritis collaborative care (85 per cent) and patient self-management (83 per cent). The initiative was also perceived to increase early arthritis detection (75 per cent), access to specialty care (68 per cent) and arthritis prevention (62 per cent).

This model could be successfully adapted to train health professionals in the care of other chronic diseases requiring self-management, interdisciplinary collaboration and community support. The content could be adapted for other audiences (e.g., providers working in Aboriginal communities or with children with arthritis). The advances in primary arthritis care made by this initiative will be sustained through the relationships that were established and the capacity that was built in communities across the country. For example, as a result of this initiative, new arthritis clinics have been established in Quebec, New Brunswick and British Columbia.

**Approved Contribution:** \$3,876,685

## Contact Information

Sydney Lineker  
Director, Getting a Grip on Arthritis, The Arthritis Society  
Phone: 416-979-3353  
E-mail: [slineker@arthritis.ca](mailto:slineker@arthritis.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Health Care Interpreter Services: Strengthening Access to Primary Health Care

National Envelope

### 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

### Background and Goals

This 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. Without them, equitable access to quality health care services is difficult, and the health of those with limited English or French proficiency (LEP/LFP) may be compromised. Ad-hoc language supports and unprofessional interpreters could lead to a greater chance of misdiagnosis and unnecessary or inappropriate treatment and thereby raise health care costs. Ultimately, the goal of the SAPHC initiative was to facilitate equal access to PHC services for patients with LEP/LFP skills by promoting the development of high-quality health care interpreter services. 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 live—and also to create and pilot-test models/tools that could be used across the country to improve the utilization and integration of professional interpreter services in PHC.

### Activities

Between November 2003 and June 2006, the initiative undertook the following activities. It:

- Marshalled the expertise, experience and efforts of a broad range of health care and interpreter services organizations, providers and other stakeholders;
- Undertook research to complete a comprehensive literature review related to four themes: service delivery, training, professional standards and policy development. Concurrently, research was undertaken in Montréal, Toronto and Vancouver to document the current state of interpreter services and gather information to develop recommendations to improve them, both regionally and nationally;
- Held a national symposium, “Primary Health Care for All: Overcoming the Linguistic Barrier,” in May 2005 to bring stakeholders together from across the country to learn from some of the preliminary findings of the research, benefit from each other’s successes and challenges, provide direction and insight into common themes for the final phase of the initiative and create a common ground to advance the agenda of improved access to PHC for individuals with LEP/LFP;
- Developed and implemented various pilot projects and tools in Montréal, Toronto and Vancouver during the final core phase of the project, building on the recommendations from the research and input from local, regional and national stakeholders;
- Collaborated in Montréal with various organizations to develop a French video to help train health care providers to work with interpreters and bridge the communication gap;
- Implemented and evaluated a centralized model for providing health care interpreters when needed in PHC settings. This took place in Toronto, as part of



the Interpreter Service Delivery Pilot Project. Between October 2005 and January 2006, two pilot sites were given a centralized booking number to contact when patients with limited or no English-language skills needed medical care. Services were provided free of charge for the pilot period as long as the service provider, patient and interpreter completed a questionnaire;

- Developed and tested a Primary Health Care Orientation Module in Toronto in order to provide a template for orienting interpreters who will be working in PHC settings. The module was designed to be adaptable for use across settings;
- Developed a risk management matrix and tool to enable users to determine areas in their health organization or program in need of attention and action. This took place in Vancouver through the Assessment for Risk Management pilot project; and
- Held a final Capstone National Forum in June 2006, out of which emerged recommendations for moving forward and the development of a national collaborative and steering committee charged with continuing the initiative's work through four key working groups.

## Resources

- a French-language video
- an Assessment Risk Management matrix and tool
- a module to orient interpreters to work in PHC

## Key Learnings

This initiative put forth evidence of the importance of interpreter services and developed a tool to help health care organizations in making decisions about language access. The questionnaire results of Toronto's Interpreter Service Delivery Pilot Project showed that the services of a professional interpreter improved the quality of the encounter and both the patient and

service provider's satisfaction with it. The Assessment Risk Management tool was piloted at two sites on the B.C. Lower Mainland and was well received.

Not only did the proportion of the population with LEP/LFP experience improved access to PHC organizations in the three core metropolitan areas where the initiative took place, but the SAPHC initiative also helped to coordinate the integrated provision of interpreter services in PHC settings and to foster conditions that will continue to promote reform in this area. Solutions were identified and information shared that enabled discussion and synergy about the delivery of these services, and by enhancing lines of communication and building momentum towards consensus and advocacy, the SAPHC initiative created and furthered a national agenda to improve interpreter services in the PHC sector. Several recommendations emerged to guide future work in the areas of service delivery, training, standards and policy.

Yet despite the initiative's many successes, challenges remain. Government policy, political priorities and funding affect the status of health care interpreter services and thus will have a very clear effect on the sustainability of the initiative's outcomes. The ongoing commitment of several interrelated levels of government will be required to ensure that the recommendations arising from the initiative are addressed and that the issue continues to move forward.

**Approved Contribution:** \$471,900

## Contact Information

Axelle Janczur

Executive Director

Access Alliance Multicultural Community Health Centre

Phone: 416-324-8677 ext. 230

E-mail: [ajanczur@accessalliance.ca](mailto:ajanczur@accessalliance.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Issues of Quality and Continuing Professional Development (CPDiQ): Maintenance of Competence

National Envelope

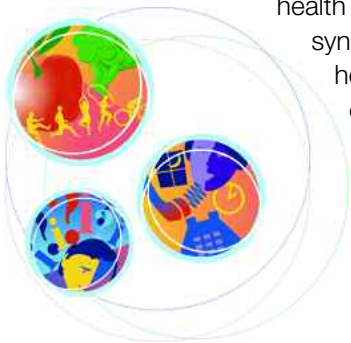
### Lead and Partner Organization(s)

**Association of Faculties of Medicine of Canada (AFMC);** with University of British Columbia's Continuing Professional Development and Knowledge Translation (CPD-KT); University of Alberta; University of Calgary; University of Saskatchewan; University of Manitoba; University of Toronto; McMaster University; Queen's University; University of Western Ontario; Northern Ontario School of Medicine; University of Ottawa; Université Laval; Université de Montréal; Université de Sherbrooke; Dalhousie University; Memorial University; McGill University

### Background and Goals

The World Health Organization is calling on medical schools to be socially accountable in all of their activities, and this has spurred Canadian medical schools to focus more attention on their accountability to the people and patients in the regions they serve. The Association of Faculties of Medicine of Canada and all medical schools in the country therefore undertook to explore and create continuing professional development (CPD) and faculty development initiatives that were: responsive to the health priorities of society; grounded in primary health care renewal; collaborative (through interdisciplinary and team-based learning); and in synchrony with national movements in social accountability. More specifically, this initiative had three objectives:

- To support and facilitate the creation of a national interdisciplinary network of health professionals that will foster, develop and implement social accountability in CPD;
- To construct and evaluate different models of best practices of CPD that provide primary health care professionals with the knowledge, skills and attitudes to respond to the needs of their communities through an interdisciplinary, team-based model; and
- To value, nurture and encourage collaboration among and within professions, and among health professionals, and to maximize the synergy and the output of team-based health practices, taking a patient-centred approach.



### Activities

To achieve this, over a three-year period ending in June 2006, the organizations involved undertook the following activities:

- Created a national network—entitled COACH (Canadian Operative on Accountability in Collaborative Healthcare)—to support the advancement of interdisciplinary and interprofessional collaborations in socially accountable continuing professional development in health. This network met regularly via teleconference, as well as through two face-to-face meetings each year;
- Provided support for a variety of school projects that focused on constructing and evaluating different models and best practices in CPD;
- Supported various school projects that examined inter- and intra-professional collaboration; and
- Developed an evaluation framework to understand collaboration and social accountability. Evaluation was based on the four values of social accountability: relevance, quality, cost-effectiveness and equity. When the evaluation is complete, it will identify best practices across all individual school projects.

### Resources

- COACH Network, a national interdisciplinary network of health professionals focused on CPD in health
- A literature review on CPD and social accountability
- A literature review of best practices in CPD and social accountability
- Lengthier descriptions of the 17 projects and other related materials can be found at [www.afmc.ca](http://www.afmc.ca).

## Key Learnings

Seventeen projects were undertaken as part of this initiative to further understanding of social accountability in health care. In many of the projects, medical schools collaborated with other health sciences departments and, in turn, partnerships were formed with specific communities or populations. The partnership model of CPD, with its problem-based approach to discussion and consultation, was effective in engaging participants, identifying common goals and developing a collaborative approach to solving problems. Projects reported an enhanced understanding of social accountability in health care and, more specifically, of how social accountability can be promoted through the use of team-focused CPD programs. Some medical schools reported that they changed the overall school climate by scheduling regular events that address issues of diversity.

Many of the school projects focused on interprofessional team collaboration and how to develop this culture among providers, thereby fostering a greater understanding of the perceptions of family physicians and health care professionals about the physician's role in interdisciplinary teams. In implementing new ways of better meeting the needs of patients, providers were able to evaluate whether these new ways were more effective. This learning process led to changes in the way education was being delivered and how health care was being practiced.

This initiative was not without its challenges; the most prevalent one was keeping the momentum going among the 17 projects. The use of champions at each school to push the social accountability agenda forward mitigated this challenge. As well, the regular use of e-mail, teleconferences and national meetings assisted in the communication effort and in making the best use of time. An unexpected outcome was the strong networking that occurred as a result of the initiative. This network extends from coast to coast and consists of individuals committed to primary health care renewal with an emphasis on social accountability. Overall, an enhanced understanding of social accountability resulted and new avenues will be sought to weave this concept into the fabric of health care education and practice.

**Approved Contribution:** \$985,000

## Contact Information

Susan Maskill  
Director of Administration  
Association of Faculties of Medicine of Canada  
Phone: 613-730-0687  
E-mail: smaskill@afmc.ca

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## National Home Care and Primary Health Care Partnership Initiative

National Envelope

### 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

### Background and Goals

This initiative stemmed from the Canadian Home Care Association's belief that home care has a key role to play in primary health care renewal. The initiative sought 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 between the two in order to achieve greater proactive patient care with an emphasis on prevention and patient empowerment; more predictable and consistent interventions; as well as the more effective use of appropriate health care personnel. The improved ability to evaluate health outcomes, better use of health care services, and heightened patient/client satisfaction were other objectives. The initiative also encouraged and examined the greater use of information technology (IT) systems to support communications, care and record-keeping.

### Activities

The initiative took place between November 2003 and March 2006, and undertook the following activities:

- Enrolment of 942 patients in a collaborative care model involving the pairing of home care case managers with family physicians in two locations: Calgary, Alberta, and Halton and Peel, Ontario. The focus for collaboration and partnership in this project was the primary care physician and home care case manager; however, improved collaboration with other stakeholders (e.g., contracted service providers, specialists, Diabetic Education Centre staff) was also expected, and achieved.
- Augmentation of the role of home care, particularly as it relates to the case management of individuals with chronic disease.
- Adoption of chronic disease management (CDM) principles. The project sites adopted evidence-based, preferred practice care protocols for adult patients with diabetes and agreed on how to manage the care of patients/clients with this chronic disease.
- Application of information technology to support improved quality with components such as electronic medical records and preventive reminders, and to support increased ability to track issues for follow-up and disease management tools.

### Resources

- Approximately 25 practical tools used and/or developed during the initiative have been posted with instructions on the website **[www.cdnhomecare.ca](http://www.cdnhomecare.ca)**. They include: Physician Request for Services form; Diabetes Assessment Tool; Case Management Intervention Report; a Communications Log; a new diabetes role algorithm, and a flow sheet for diabetes care



- Nationally relevant communication materials, including toolkits for each of the participating jurisdictions

## Key Learnings

The initiative's organizers reported that physicians and case managers established trusting and efficient working relationships, and they felt more positive about their work lives and their professional contributions. They successfully adopted or built on CDM principles (including the use of standardized tools, algorithms and evidence-based guidelines), and implemented IT changes following a challenging development process. Project patients saw improvements in clinical outcomes and levels of satisfaction with their diabetes care. Significantly, patients also became more active contributors to that care and required fewer institutional services.

In particular, the initiative found that:

- Reorganizing home care case managers to align/partner with family physician practices enables the effective leveraging of both physician and case manager skills and competencies to the patients' benefit and providers' satisfaction.
- Development of effective partnerships takes time, but they ultimately contribute to minimizing system barriers.
- The project model has broad application across a wide range of patient populations.
- Home care has a significant role to play within chronic disease management.
- System-level case management is critical to achieving improved patient and system-wide health outcomes.

- IT applications can act as enablers for providers to monitor the progress of client conditions, and provide reminders for follow-up.

An evaluation conducted by IBM Business Consulting found that the self-reported health status of clients was higher than expected for the target population, and clients and providers expressed increasing levels of satisfaction with this model of care over the course of the initiative.

The two sites are moving forward, and there is agreement by all concerned that the partnership and chronic care models experimented with through the initiative were a success. The links on the initiative's website connect the visitor to a series of recommendations targeted to three major stakeholder groups—policy-makers, home care leaders, and physicians—and a series of hands-on, practical tools that were either used or developed during the initiative. The initiative's organizers cited few barriers, although IT proved to be more difficult and time-consuming than initially envisioned. The organizers believe that sustaining this project requires a willingness to change, and that two overarching strategies need to be in place: alignment of home care case managers with family physicians through formalized and structured partnership, and the expansion of the role of home care in CDM.

**Approved Contribution:** \$2,682,100

## Contact Information

Nadine Henningsen  
Executive Director  
Canadian Home Care Association  
Phone: 613-569-1585  
E-mail: [nhenningsen@cdnhomecare.ca](mailto:nhenningsen@cdnhomecare.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).



## Pallium Integrated Care Capacity Building Initiative

National Envelope

### 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)

### Background and Goals

The original Pallium Project was conceived in 2001 with the goal of improving the care of Canadians who are experiencing a life-limiting illness by creating innovative educational resources for rural and remote primary care professionals. From 2004 to 2006, the Pallium Phase II initiative, supported by the Primary Health Care Transition Fund (PHCTF), evolved into a Community of Practice, which worked as a collaborative group of people throughout Canada that shared common practices and interests to advance skills and knowledge in hospice palliative care (HPC). The overarching goals of Pallium Phase II were to improve access to, enhance the quality of and build long-term system capacity for HPC. Through an extensive range of locally championed subprojects, the initiative supported outreach education and continuing professional development (CPD); knowledge management and workplace learning; and service development and innovative modes of collaboration. It emphasized improving supports to regional health authorities and community-based voluntary sector partners.

### Activities

The initiative evolved into 71 subprojects centred on a range of themes. The activities were conducted throughout 2004–06. A sampling includes:

- *Outreach education and continuing professional development:* The activities in this stream brought teaching and learning activities to health care providers in ways linked to the context of their workplace and local/regional health delivery systems. For example, some 957 physicians, nurses, pharmacists and other professionals experienced a multi-professional learning experience within their local health region. Also, 19 audio-conference CPD sessions were undertaken that allowed primary health care (PHC) stakeholders throughout Canada to regularly engage in critical local dialogue about difficult care topics in the community.
- *Knowledge development and workplace learning:* Projects under this stream provided tools to support better bedside decision-making and facilitated learning in the workplace. For example, an 11-module courseware kit—Learning Essential Approaches to Palliative and End-of-Life Care (LEAP)—was developed to advance learning about an end-stage, interprofessional clinical management approach.
- *Service development and system readiness:* A range of initiatives supported the adoption of the Canadian Hospice Palliative Care Association (CHPCA) model as the basic framework for planning and engaging new HPC services and programs. Investments in action learning, applied policy research, and service and program infrastructure development were undertaken to support the uptake of HPC services and programs within the PHC system. For example, 233 front-line coordinators/managers from across Canada participated in an interactive workshop experience that explored barriers and opportunities to service provision and opened up dialogue on local/jurisdiction-level system change and improvement.



- *Network and relationship development*: Networking occurred with several related national initiatives such as the Canadian Strategy on Palliative and End-of-Life Care Coalition of Canada. This was intended to assure alignment and minimize the risk of unnecessary duplication.

Other PHC renewal activities included the alignment of resources and activities to leverage parallel projects, such as the inclusion of the voluntary sector as a PHC partner. Communication and dissemination activities were extensive and included a range of publications and presentations. An external evaluation of the initiative, entitled *A View from the Canopy*, was conducted.

## Resources

- The initiative website: [www.pallium.ca](http://www.pallium.ca)
- *The Pursuit of Possibility: A Report Back to Stakeholders Phase II (2004–06)*, available on DVD
- Phase II resources are available on [www.chpca.net](http://www.chpca.net) and include a national library of more than 400 peer-reviewed journal articles on palliative and end-of-life education.

## Key Learnings

The Pallium Phase II initiative has evolved into one of Canada's most visible and vibrant expressions of an inter-sectoral community of practice, with demonstrated achievements across multiple jurisdictions and key areas of longer-term capacity building in HPC. It was successful in disseminating local innovation rapidly across multiple jurisdictions.

The initiative's outreach education and CPD activities brought timely, relevant and accessible teaching-learning activities, as well as common practical tools, to health care providers. Participants in the initiative have stated that the quality, user-friendliness and application of the products and support materials that were developed have helped immensely with the development of their own educational programs. The

initiative also developed ways to facilitate collaboration and harness the energy, ideas, relationships, expertise and resources of skilled personnel. This collaborative spirit in turn supported the development of the 71 sub-projects and fostered fresh opportunities. For example, the 2002 *CHPCA Model to Guide Hospice Palliative Care Based on National Principles and Norms of Practice*—the world's first national, consensus-based model for hospice palliative care—was broadly adopted and championed to support strategic investments in the systems within which HPC is delivered.

Going forward, the initiative offers several levers that are essential to bringing about sustainable palliative PHC, including: methods to engage PHC professionals in change-management processes related to the delivery of quality care to an aging population; the use of technology and the partnership between providers and organizations; a focus on holistic care that includes the family unit; an understanding of ways to support community-based providers who are challenged to manage complex care problems in an environment of service demands and human resource shortages; and a practical means to facilitate the development of tools and resources among practitioners. It offered insights into strategies the federal government could implement to provide leadership and encourage engagement in targeted areas of service delivery while still respecting the intent of and complying with the local and regional powers among the provinces and territories.

**Approved Contribution:** \$4,317,000

## Contact Information

Michael Aherne  
Director, The Pallium Project—Phase II  
Phone: 780-413-8195  
E-mail: [michael.aherne@pallium.ca](mailto:michael.aherne@pallium.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Physicians and Quality of Care for Canadian Francophone Minority Communities

National Envelope

### Lead and Partner Organization(s)

**Association of Faculties of Medicine in Canada**

### Background and Goals

The health status of French-speaking minority communities is generally poorer than that of their English-speaking fellow citizens, and they have less access to health care and services. In its September 2001 report to the Minister of Health, the Consultative Committee for French-Speaking Minority Communities confirmed these facts and identified training of health professionals, networking, and improvement of reception areas and services as the best ways to improve the situation. Key response elements included: increasing the number of French-speaking professionals; improving training to ensure health professionals better understand the needs of francophone communities and can serve them in French; and improving the quality of services in francophone minority communities.

The initiative was designed to allow students from Canada's 17 faculties of medicine to conduct internships in francophone minority communities, and to promote networking between medical students/residents. To optimize the educational quality of these francophone community training environments, discussion forums were created between them. The initiative's objectives were to:

- Encourage students from francophone minority communities to integrate the communities' health care needs into their training, by offering them French-language internships within these communities;
- Provide academic support to medical learning environments that offer primary health care training to students from these communities;

- Develop and implement discussion and training tools to help clinical environments in francophone minority communities provide services and adopt innovative procedures for offering primary health care; and
- Learn from factors that promote and encourage partnerships to develop and implement activities for improving the health of francophone communities.

### Activities

The initiative, conducted from November 2003 to June 2006, involved the following activities:

- Literature review;
- Identification of francophone training environments prepared to accept interns (more than 100 environments were identified in New Brunswick, Ontario, Manitoba, Saskatchewan, Alberta, British Columbia and Quebec);
- Initiation of 40 internships across Canada (November 2004 to March 2006);
- Organizing of two national discussion and training conferences, in conjunction with two national medical associations: November 2004, Interdisciplinarity and Family Medicine, College of Family Physicians of Canada; and October 2005, Family Medicine at the Heart of Patient Management, *Association des médecins de langue française du Canada*. The conferences provided a forum for more than 100 participants from francophone minority communities in nine provinces to meet and discuss the health care problems facing their communities, and to hone their clinical expertise in fields such as interprofessional collaboration, health promotion and disease prevention, and chronic disease management;
- Ten decentralized training activities in francophone minority communities across Canada (e.g., Moncton, Winnipeg, Yellowknife);
- Evaluation; and
- Dissemination/communication activities (e.g., conferences, posters and displays, oral presentations at national and international meetings).



## Resources

- *Physicians and Quality Care for Canadian Francophone Minority Communities – Literature Review*  
ISBN: 0-9682021-3-6 Published by the Association of Faculties of Medicine in Canada
- Website: [www.afmc.ca/cfm](http://www.afmc.ca/cfm)

## Key Learnings

Despite some problems (e.g., delay in starting the project, difficulty contacting medical students, non-payment of summer interns), the internships were successfully organized. Some 84 per cent of students said they were fairly satisfied with the community where they spent their internship, and 70 per cent said they were fully satisfied with the internship opportunities available to them.

The training activities allowed French-speaking health professionals to get to know each other and determine ways to balance and complement each other's work. The initiative also helped develop a number of partnerships, work aids and assessment tools for achieving various goals. For many in the health care community, this networking of professionals represented the first step toward greater collaboration across disciplines.

In recent years, certain elements have been implemented with regard to the training of doctors for francophone minority communities. Influenced by the current project, these elements include:

- the launch, in Manitoba, of a family medicine residency program for two francophone residents (July 2005);

- the opening, in *L'Université de Sherbrooke's Faculté de médecine et des sciences de la santé*, of three positions for first-year students from francophone minority communities in Western Canada (September 2005);
- the self-identification, in a growing number of medical faculties, of students as francophone or francophile (since 2005); and
- the relocation to Moncton, in September 2006, of the entire medical training program of *L'Université de Sherbrooke's Faculté de Médecine et des sciences de la santé* (the program has admitted 194 first-year students, 24 of whom are now trained in Moncton).

Following this initiative, in 2006 the Association of Faculties of Medicine in Canada (AFMC) created an official resource group for Canada's francophone minority communities. The mandate of the group is to recommend, to the AFMC and Canada's 17 faculties of medicine, courses of action for improving the health status of and medical services offered to francophone minority populations.

**Approved Contribution:** \$888,972

## Contact Information

Dr. Paul Grand'Maison  
National Project Coordinator  
Ms. Dorothée Ouellette  
Professional and Administrative Support  
Telephone: 819-564-5203  
E-mail: [dorothee.ouellette@usherbrooke.ca](mailto:dorothee.ouellette@usherbrooke.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Rainbow Health—Improving Access to Care

National Envelope

### 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 1<sup>st</sup> Nation; Rainbow Health Network/Coalition for Lesbian & 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

### Background and Goals

This initiative was developed to address the historic inequities that face gay, lesbian, bisexual and transgendered (GLBT) Canadians in regard to their health status and access to the primary health care (PHC) system. Research indicates that 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. GLBT people may be reluctant to see a health care provider until their problem becomes acute. This initiative therefore aimed to:

- Develop partnerships with national health care accreditation bodies, professional associations and health delivery associations to address barriers to service and promote GLBT health and wellness;
- Raise the capacity of health care providers to appropriately address the health and well-being of members of the GLBT communities;
- Build the capacity of GLBT communities to appropriately address their PHC needs; and
- Encourage GLBT persons to become active partners in their own health care, increasing emphasis on health promotion, disease and injury prevention, and management of chronic disease.

It also sought to facilitate coordination and integration with other health services.

### Activities

This 29-month initiative undertook two main activities: education and partnership building. Thirteen specific activities were undertaken:

- National environmental scan of GLBT health and wellness resources to determine whether any medical or social work schools had specific curriculum on GLBT health and wellness issues;
- Partnership projects to develop educational resources on GLBT health and wellness;
- Outreach;
- Meetings with professional associations to discuss partnerships;
- National conferences on GLBT health and wellness;
- Web-based clearinghouse on GLBT health and wellness;
- Outlive Homophobia campaign aimed at GLBT community;
- Consultation services, responding to requests for information;
- Support educational institutions in development of curriculum on GLBT health and wellness;
- National Day Against Homophobia, turning this Montréal event into a pan-Canadian one;
- Evaluation plan and activities;
- Dissemination plan and activities; and
- Research initiatives.

### Resources

- a website, **[www.rainbowhealth.ca](http://www.rainbowhealth.ca)**, which contains the largest body of information, educational tools, research studies and other materials related to GLBT health and wellness



## Key Learnings

The initiative focused attention on the special health needs of GLBT persons. Its two national conferences brought together hundreds of health care professionals, health care students and members of the GLBT communities to discuss issues and share information and relevant health care resources. It located these health care resources, added to them, and made them more accessible by collecting them and organizing 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.

The initiative's sponsors believe that this initiative will have long-lasting implications for the health and wellness of GLBT persons. They believe that the over-

whelming difficulty in sustaining this initiative's work is the lack of policy, strategies and funding for GLBT health and wellness. The work will be sustained, however, by those who have an interest and willingness to work on bringing about change.

**Approved Contribution:** \$2,307,000

## Contact Information

Gens Hellquist  
Executive Director, Canadian Rainbow Health Coalition  
Phone: 306-955-5130  
E-mail: [gens@rainbowhealth.ca](mailto:gens@rainbowhealth.ca)

The full report is available in the language of the author on the PHCTF website, **[www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf)**.

# Aboriginal Envelope

The Aboriginal Envelope supported access to integrated primary health care services by Aboriginal populations by promoting large-scale, sustainable changes to the First Nations and Inuit health care system, and the provincial/territorial health care systems that support Aboriginal health.

The objectives of the Aboriginal Envelope were to:

- Promote more productive, cost-effective primary health care service delivery to Aboriginal peoples by integrating existing services and resources;
- Enhance service delivery co-ordination between Health Canada's First Nations and Inuit Health Branch, provincial/territorial governments, First Nations and Inuit communities and health organizations;
- Enhance the ability of provincial/territorial and First Nations and Inuit Health Branch systems to be accountable to each other and their public through collaborative information development;
- Improve the quality of primary health care services delivered to Aboriginal peoples, including the cultural appropriateness of services; and
- Improve linkages between primary health care services and social services delivered to Aboriginal peoples.

The Aboriginal Envelope identified two main streams to support:

- **Health System Renewal:** Large-scale initiatives that renew entire primary health care delivery systems, not just individual centres, professional practices or delivery sites. Large-scale refers to both a broad geographic area that is affected by renewal and to the depth of renewal.
- **Health System Enhancement:** Initiatives improving the delivery of primary health care in a way that specifically benefits Aboriginal peoples.







## Bigstone–Aspen Shared Initiative Care (BASIC)

Aboriginal Envelope

### 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

### Background and Goals

The Bigstone Cree Nation is a First Nation band spanning several communities within the Aspen Regional Health Authority in Alberta. The geography and demographics of this First Nation community makes 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 a 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, which are prevalent in the community. The Bigstone–Aspen Shared Initiative Care (BASIC) 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 an Alternate Relationship Plan (ARP).

### Activities

Between March 2004 and June 2006, the initiative implemented the following activities:

- Creation of a steering committee to oversee research and the implementation process;
- Analysis of services delivered and required;
- Process-mapping of the operational aspects of health service delivery, and an assessment of the impact of sharing information among jurisdictions on privacy;
- Development of a home care model for northern communities and establishment of a multi-purpose facility, including drafting an ARP service delivery model; and
- Creation of health indicators that provided band-specific data.

### Resources

- A shared home-care delivery model, based on implementation experience in northern communities
- A draft ARP model
- A privacy impact assessment
- Indicators on physician, emergency and hospital visits in northern communities

### Key Learnings

Collaboration among jurisdictions can happen, even when significant challenges and barriers are present. A shared home-care delivery model developed for this northern community provides a range of services. An ARP service delivery model presents a new financial reimbursement model for physicians. A multi-purpose facility has been constructed for one remote community that could be reached only by air. It provides local



health, children's and social services, using a multidisciplinary approach. Performance data based on indicators will now allow for comparative reporting and tracking trends in the community.

This initiative found it challenging to build initial trust among the initiative's partners. However, strong leadership from both political and administrative leaders helped facilitate this. Both Bigstone and Aspen have redirected funds to cover the ongoing cost of providing these new services.

**Approved Contribution:** \$1,995,000

### **Contact Information**

Lyle R. McLeod  
Chief Executive Officer  
Bigstone Health Commission  
Phone: 780-891-2000  
E-mail: [lyle.mcleod@bigstonehealth.ca](mailto:lyle.mcleod@bigstonehealth.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

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

Aboriginal Envelope

### 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

### Background and Goals

A full 84 per cent of the population of northern Saskatchewan is primarily Cree, Dene and Metis—a proportion that is rising rapidly (almost half of this population is under the age of 18). Primary health care (PHC) services are delivered through community-based clinics, health centres or nursing stations. Challenges in the North include poorer health status, complex jurisdictional issues, diseconomies of scale, human resource shortages, and issues related to remoteness and isolation. In this area as well, chronic disease rates, dental decay and injury rates are high. The Northern Health Strategy Working Group (NHSWG) was formed in 2001 and formalized in 2002. Its members include representatives from provincial regional health authorities, First Nation Health Authorities and the First Nations and Inuit Health Branch (Health Canada). Together, these partners provide health services to an area that is about half the geographic size of the province.

The goal of this initiative was to leverage the partners' working relationship to strengthen their collective PHC approach. In northern Saskatchewan, PHC is viewed as comprehensive (focused on promotion and prevention, curative, supportive and rehabilitative); accessible (culturally, fiscally, timely); coordinated (to enhance integration, effectiveness and efficiency); accountable (through information collaboration); sustainable; and of good quality.

The initiative's three specific objectives 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.



### Activities

The NHSWG partners identified 10 priorities: mental health and addictions; chronic disease management (with an emphasis on self-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. Work plans were then developed, with consistent steps set out for each of these topic areas. The steps involved the following: identify the current state of the identified priority area; establish standards of practice; analyze the gaps between current state and standards; develop recommendations to narrow the gap; submit them to NHSWG for discussion; edit them based on NHSWG feedback; reach agreement about the recommendations among the partners; submit recommendations to boards of partner organizations; obtain board approval; and implement the approved actions.

The project evaluation was conducted by Saskatchewan Population Health Evaluation Research Unit (SPHERU), a joint institution of the University of Regina and the University of Saskatchewan. The evaluation report captures the experience, challenges and provides recommendations for NHSWG members and will be available on the Shared Paths website.

### Resources

The initiative made several recommendations relating to:

- Collaboration on expanded dentistry services
- Collaboration on expanded mental health services
- The establishment of a chronic care coalition
- Health information/technology access and development
- Training initiatives

- Recruitment and retention strategies
- Program enhancement
- Resource development and distribution
- Collective health promotion strategies
- Cross-jurisdictional decision-making
- Research and advocacy

Website: <http://paths.sasktelwebsite.net/spnh.html>

## Key Learnings

Those involved in the initiative have emphasized that it was successful in promoting collective advocacy and in forging partnerships. For example, one partnership—concerned with the development of health human resources in the North—held a session on career paths, studied compensation, established a northern labour market committee linkage, and promoted health careers. It introduced and promoted technology by gaining access to CNET (a network simulator), establishing a website, and introducing videoconferencing. Partners also 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. They believe that this initiative is a model of best practice in Canada. Communication and coordination have been advanced, and although improvements are still needed, the relationships established and the work completed to date will be sustained through the staff and services of the member organizations. The initiative's organizers have indicated that funding for ongoing coordination will be required, but they are convinced that the mission, objectives and activities will continue beyond the life of the initiative.

**Approved Contribution:** \$3,272,536

## Contact Information

Nap Gardiner  
Northern Health Strategy Coordinator  
Phone: 306-765-1262  
E-mail: [gardn@sasktel.net](mailto:gardn@sasktel.net)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Health Integration Initiative

Aboriginal Envelope

### 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 professionals and evaluators

### Background and Goals

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 reports, including the Kirby and Romanow reports and that of the Royal Commission on Aboriginal People, identified the need for better coordination of health services. To address this need, the Health Integration Initiative (HII) was created, with the aims of:

- Exploring, developing and analyzing models for better integration of federally funded health services in First Nations/Inuit communities with provincial/territorial health services; and
- Identifying mechanisms for collaboration and harmonization between federal, community-based programs and provincial/territorial health systems.

Its objectives were to: improve access and quality of health services; leverage existing capacity; create economies of scale; respond to community priorities; and create “win-win” solutions for all the partners.

### Activities

Over the three years of the initiative (2003–06), the Health Integration Initiative (HII) undertook applied research, policy development and the funding of eight integration projects, which were meant to: provide information concerning the practicalities of integrating federally funded First Nations and Inuit health systems with 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 treatment and rehabilitation services).

The eight projects were:

- *Integrating Health Promotion and Illness Prevention Programs in Nunavut*, which reviewed existing health promotion programs with the goal of harmonizing federal and territorial health care in the areas of maternal health, child health, dental health and addictions treatment;
- *Nova Scotia and New Brunswick Nursing Collaborative Policy Development*, which developed a framework for standards of practice for community health nurses working in First Nations and Inuit communities in these two Atlantic provinces;
- *Integrated Primary Health Care for Elsipogtog First Nation*, which integrated community-based services and improved collaboration with regional health authorities;
- *A Model for the Delivery of Primary and Public Health Care Services to the Communities of Sioux Lookout Zone*, which developed a plan for a holistic primary health care (PHC) system that will integrate all services under a First Nations governance structure;



- *Weeneebayko Area Health Integration Initiative*, which created a local First Nations health authority under provincial legislation;
- *Norway House Health Care Integration Planning Project*, which created an independent health board and plan for an integrated health care delivery structure for the First Nations residents and those of the neighbouring community;
- *Many Jurisdictions, One System: A Diabetes Integration Partnership Project*, which took a cross-sectoral, collaborative approach to diabetes management in northern Alberta; and
- *Vancouver Island Chronic Illness Care Project*, which explored an integrated approach to the management of chronic illness care for First Nations individuals in the areas of depression, arthritis and diabetes.

The initiative also undertook research and analysis to advance knowledge and understanding of health system integration nationally and internationally, and studied provincial/territorial services to First Nations and Inuit people. It encouraged discussions among stakeholders, in particular through three national workshops held in Moncton, Vancouver and Gatineau. The initiative also worked on developing a policy framework to guide integration, and to do this, it conducted regional research projects, environmental scans and integration project evaluations.

## Resources

A number of documents were produced to promote integration at the community level:

- The Weeneebayko Area project developed a draft Tripartite Agreement, a Special Agreement for hospital amalgamation and a Master Service Plan.
- The Atlantic nursing project led to the establishment of 45 policies that will guide nursing practice in First Nations and Inuit communities and the development of a template for future policies.
- The Elsipogtog project developed a Collaborative Practice Manual and training materials based on a population health approach.

- The Nunavut project developed an action plan to treat mental health disorders and addictions, as well as a gap analysis of maternal, child and dental health programs.

## Key Learnings

This initiative has confirmed that integration continues to be an important means of improving health services delivery to First Nations and Inuit people, and that it is vital to achieving federal government policy objectives. The initiative's proponents report that the HII has created a foundation for community health integration, and the project partners appear to be strongly committed to continuing to build on the successes achieved so far. The success of the initiative lay in the fact that it targeted specific health care areas that were community priorities and that would benefit from further integration. The evaluation found that the project partners' flexibility, which allowed the projects to set up structures that worked best for them, contributed to the achievement of project outcomes, as did the initiative's strong emphasis on communication. 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 towards collaborative partnerships, which will be helpful in implementing the Aboriginal Health Transition Fund. Models of health care delivery, tools and resources (such as care maps, guidelines, policies) have been created and will continue to inform the delivery of health services both in the target communities and with other partners that deliver health services to First Nations and Inuit people.

**Approved Contribution: \$10,800,000**

## Contact Information

Catherine Adam  
Executive Director, Health System Development  
Health Canada  
Phone: 613-954-5019  
E-mail: [catherine\\_adam@hc-sc.gc.ca](mailto:catherine_adam@hc-sc.gc.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Northern and Aboriginal Population Health and Wellness Institute

Aboriginal Envelope

### Lead and Partner Organization(s)

**Manitoba Keewatinook Ininew Okimowin;** with Burntwood Regional Health Authority

### Background and Goals

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 northern Manitoba. Jurisdictional issues and barriers had been identified as factors that prevent the implementation of more effective solutions to this problem. To address these concerns, the Manitoba Keewatinook Ininew Okimowin (MKIO) and the Burntwood Regional Health Authority (BRHA) partnered under this initiative to create NAPHWI. The goal was to promote more productive, cost-effective primary health care (PHC) service delivery, and to improve the access, quality and appropriateness of PHC services for Aboriginal people through the integration and enhanced coordination of existing services and resources. It was hoped that the collaborative work of the initiative's partners would increase the capacity of northern and Aboriginal peoples and communities to plan and manage their health issues and services. Additional goals were to:

- Facilitate a broader holistic understanding of health and wellness services and support the integration of traditional healing into conventional health services;
- Develop integrated community-driven, culturally relevant approaches and action plans; and
- Improve access to PHC services among these communities and facilitate the development of inter-jurisdictional approaches to PHC issues.

### Activities

The initiative began in June 2004 and concluded in June 2006. Activities focused on diabetes, youth suicide and traditional healing. They included:

- Consultation with select Aboriginal communities, federal, provincial and municipal officials, and health and social organizations to address the priority areas;
- Environmental scans and literature reviews for each area to ascertain existing governance models, funding sources and partnerships, PHC training priorities, and service delivery demographics and challenges. Best-practice models were also explored;
- Diabetes-related activities, which included focus groups, surveys and a northern diabetes forum, held in March 2005;
- Focus groups, surveys, meetings with key stakeholders and a conference for front-line workers and service providers, which drew attention to the issue of youth suicide; and
- An exploration of traditional healing through surveys and 18 focus groups in four communities. A conference was held in October 2004, which focused on the practice of traditional healing and its impact on individual and community wellness. The NAPHWI team travelled to traditional healing clinics and met with key experts in the field.

### Resources

- The NAPHWI website [www.naphwi.ca](http://www.naphwi.ca)
- The diabetes forum booklet
- A discussion paper from the "Youth Suicide Conference" on strategies for overcoming jurisdictional barriers



## Key Learnings

This initiative has strengthened the involvement of northern First Nations communities in their health and health care decision-making. Notably, the diabetes forum provided a vehicle for community members and service providers to collaborate on a very pressing health problem. Concerns were voiced about the lack of resources applied to preventative and health promotion measures and a lack of Aboriginal role models to promote healthy lifestyles. In response, collaborative action plans have been established, including the development of diabetes materials for the communities, the provision of regular dietitian services and the training of community health staff. The initiative confirmed that youth suicide services in northern Manitoba are confusing and uncoordinated; NAPHWI, in collaboration with its jurisdictional partners, is working to resolve this. It also highlighted the complexity of issues related to traditional healing. During the consultations, questions were raised about compensation and travel as well as the appropriate method for measuring and validating traditional healing. NAPHWI and its partners have developed a framework for continued collaboration on the utilization of traditional healing in PHC, as part of the initiative's work. NAPHWI was also invited to join the Northern Tuberculosis

Working Group, and successfully advocated for meaningful community participation and involvement in efforts to contain an outbreak of this disease. The success of this group has demonstrated how inter-jurisdictional partners can effectively address specific health issues. NAPHWI also became a partner and signatory to the Chronic Disease Prevention Initiative Charter, which has led to a more active role for Aboriginal communities in chronic disease prevention activities in the region.

The partners and the board of NAPHWI are committed to continue working together to leverage the achievements of the initiative in order to bring improved health and wellness to the people of northern and Aboriginal communities.

**Approved Contribution:** \$2,925,150

## Contact Information

Duke Beardy  
Chair, Northern and Aboriginal Population Health and  
Wellness Institute  
Phone: 204-677-0240  
E-mail: [dukebeardy@ktc.mb.ca](mailto:dukebeardy@ktc.mb.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).



## Nursing Strategy Initiative

Aboriginal Envelope

### Lead and Partner Organization(s)

**Office of Nursing Services, First Nations and Inuit Health Branch, Health Canada**

### Background and Goals

The Office of Nursing Services (ONS), First Nations and Inuit Health Branch (FNIHB) of Health Canada provides community health care in communities across seven FNIHB regions in 10 provinces. The nurse is often the only health professional in these communities, typically practicing in an expanded role in remote, isolated settings and relying on consultations with and referrals from provincial tertiary health care services. The ONS provides professional strategic leadership for nurses employed in First Nations and Inuit (FN and I) communities, with a focus on recruitment and retention and quality assurance and standards for nursing practice. Specifically, the ONS seeks to: increase professional and clinical supports for nurses; improve communication between nursing leaders and front-line staff; increase the awareness of nursing and the breadth of health care in FN and I communities; improve and standardize the orientation of nurses working in these communities; improve the clinical skills of nurses in remote areas; and increase the number of people of Aboriginal descent choosing nursing as a profession.

### Activities

The activities undertaken for this initiative included the development of clinical and professional supports and resources, including:

- Standard competencies and statement of qualifications for nurses practicing in an expanded role in the FNIHB communities; nursing practice competencies and education (emergency labour and delivery and emergency trauma competencies);
- A CD-ROM on physical assessment and pharmacotherapeutics;
- Introduction of clinical nurse specialists (CNS) and nursing education consultants in each region to support the professional practice and continuing education of nurses working in Aboriginal communities;
- Strategies and supports to increase the number of Aboriginal people entering health care professions, particularly nursing. Two educational think-tanks were held with national, Aboriginal and nursing education partners, and recruitment materials were developed jointly with the Aboriginal Nurses Association of Canada.

Evaluation activities included: a 2006 EKOS nursing workforce survey to determine characteristics of the FNIHB nursing workforce; a two-phase evaluation of the CNS implementation; and a formative evaluation of the CD-ROM.

### Resources

- The *NurseOne* portal, a national, bilingual web-based information gateway to resources for health care professionals in all domains of practice (direct care, education, administration and research). It supports and enhances their clinical and professional careers and provides access to digital libraries, clinical experts and clinical guidelines.



- A CD-ROM on physical assessment
- A standardized orientation framework and conceptual framework for FNIHB nursing
- A CD-ROM on pharmacotherapeutics
- Standardized competencies for emergency labour and delivery and emergency trauma for FNIHB remote/isolated communities

## Key Learnings

The 2006 EKOS survey of the FNIHB nursing workforce found that 36 per cent of nurses contemplated a job change in the next three years, in part because of a lack of support. Those involved with this initiative believe that providing critical infrastructure for these nurses—like that developed for this project—supports the recruitment and retention of these professionals. The resources and information developed by the initiative were widely disseminated to nursing stations and health centres in the provinces; CD-ROMs were made available to territorial partners on a cost-recovery basis. The development of standardized FNIHB nursing clinical practice guidelines and educational resources based on research and best practice protocols has provided standards for nurses working in similar practice settings. NurseOne is available to all nurses in Canada who are members of the Canadian Nurses Association. The nursing orientation tool will be used by all FNIHB facilities and will be available to other rural and remote health care facilities.

The CNS role is new to FNIHB nursing and involved a change in the roles and responsibilities of clinical support

in these regions. The work of clinical nurse specialists has focused on three key areas: maternal child health, mental health and chronic disease/diabetes. It was determined that there is a limited pool of CNS who are available to fill these community-based positions.

The think-tank meetings provided an opportunity for FNIHB nursing to profile FN and I nursing practice. It also provided networking opportunities for nurses working in education, as well as for those who support rural and remote nurses, to collaborate on policy, education and research on rural and remote nursing. The initiative facilitated the dialogue around the strengths and challenges of delivering health services in rural and remote areas.

Comprehensive PHC and community health programs have historically taken a philosophical and practical approach to service delivery in FN and I communities. The activities undertaken through this initiative have supported FNIHB nursing in advancing this essential system of care.

**Approved Contribution:** \$4,200,000

## Contact Information

Brenda Canitz  
Office of Nursing Services  
First Nations and Inuit Health Branch, Health Canada  
Phone: 613-948-8072  
E-mail: [brenda\\_canitz@hc-sc.gc.ca](mailto:brenda_canitz@hc-sc.gc.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Tui'kn Initiative

Aboriginal Envelope

### 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.

### Background and Goals

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. The initiative's 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.

### Activities

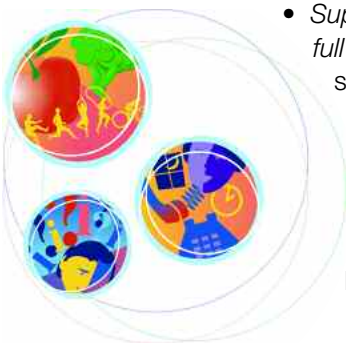
Over the three years of its existence (2003–06), the initiative undertook four strategies and identified four pillars of priority action to translate the renewed model of PHC into action. The four strategies were:

- *Achieving a full complement of family physicians.* This initiative was successful in recruiting three family physicians, who work collaboratively on a non-fee-for-service basis, and the residency training of three family doctors with return-of-service agreements to the local bands;
- *Supporting nurses to practice to their full potential.* The initiative was successful in launching the first nurse practitioner to be introduced in a First Nations community in Nova Scotia and demonstrates improved planning and communication among the community, health district and government;

- *Implementing an electronic patient record (EPR) system in all five Tui'kn sites.* Pilot systems were successfully implemented at all five Tui'kn sites; and
- *Building community capacity to collect, manage and interpret health information.* Health Information and Evaluation Coordinators were trained in each community to collect, manage and interpret health information. In addition, a Health Information System (HIS) was created to link diverse health data sets. The HIS can be used to better understand health needs in the community, identify health priorities and guide health planning and decision-making.

The four pillars of community action were:

- *Diabetes prevention and management.* Key successes included: developing a multi-community collaborative action plan on diabetes prevention and management; establishment of the Unama'ki Diabetes Working Group to implement the various components of the Action Plan; developing a standard screening protocol for type 2 diabetes in children and youth; developing a multi-community proposal to obtain community-based blood-collection services; developing a continuing education series based on results from a survey assessing the diabetes education needs of health workers; hosting a multi-community diabetes education event; and hosting diabetes specialist satellite clinics in the areas of internal medicine and endocrinology and planning for clinics in nephrology and ophthalmology;
- *Non-traditional tobacco use.* The initiative managed to: develop a multi-community action plan for the reduction of non-traditional tobacco use; secure funding to hire a full-time, shared Tobacco Reduction Coordinator; develop and pilot two comprehensive tobacco survey tools (one for youth and one for adults); secure funding to collect and analyze baseline tobacco data and develop customized community reports; plan a community awareness campaign targeted at adults and parents who smoke around children and youth; implement a wide range of



school-based tobacco reduction initiatives; organize workplace cessation programs; educate pregnant women and diabetics on tobacco use; and develop activities focused on chewing tobacco. The Tobacco Reduction Working Group formed a partnership with the already established First Nations/Public Health Services Tobacco Reduction Working Group to mobilize resources to tackle priority issues identified during an action planning forum on the subject;

- *Childhood injury prevention.* Develop a multi-community action plan on Childhood Injury Prevention; Tui'kn entered into a partnership with Eskasoni Mental Health and Social Work to further develop and pilot a unique parenting program that is built around the cultural values of the Mi'kmaq; develop and implement a multi-community survey on childhood injury prevention; and create childhood injury community profiles; and
- *Prescription drug misuse and evidence-based prescribing.* The Tui'kn Initiative hosted a prescription drug misuse forum that laid the foundation for the development of a prescription drug misuse action plan; established a multi-community/multi-agency working group to activate some of the recommendations from the forum; established a working relationship with the College of Physicians and Surgeons of Nova Scotia and is working with them to develop a clear and understandable guide to the College's complaints process; developed and piloted a workshop to assist primary health care professionals in providing culturally competent health care in a First Nations setting—an important step toward preventing first use of potentially addictive prescription drugs; and established a link between the pharmacist and Non-Insured Health Benefits (Atlantic Region) to help gain a better sense of the extent of the prescription drug misuse problem in the five communities.

## Resources

- Two tobacco survey tools (one for youth and one for adults) were developed and piloted.
- A parenting program manual, *Wjit Knijanaq—For Our Children*, based on the experiences from the Eskasoni Model, was published as part of the focus on childhood injury prevention.

- A patient education video that builds on the First Nations oral tradition was created to introduce the community to the new nurse practitioner role.
- A project website ([www.tuikn.ca](http://www.tuikn.ca)), CD-ROM and legacy document were created.

## Key Learnings

Through the Tui'kn Initiative, the five communities learned to collaborate at all points of the health care system (between communities, within practice teams, within patient populations and among levels of government). Second, they also learned about building capacity for the collection, interpretation and manipulation of health information at the community level. Third, the five communities found a solution to one of the greatest challenges in rural primary care service delivery: recruiting and retaining a full complement of family doctors. Finally, the HIS, which was designed as part of the initiative, allows the communities to monitor trends, utilization and outcomes, and to use analysis to support clinical, policy and funding decisions. The initiative's promoters believe that the HIS, which includes data from the electronic patient record and links a range of local, provincial and national sources, provides one of the most robust datasets for health planning and evaluation in the country.

Sustainability lies in the health care positions that have been created and filled, the relationships that have been forged, the evidence of success in introducing new models, the capacity to identify health needs, and finally—as the initiative's promoters point out—policy-makers choosing to make decisions based on evidence of what works.

**Approved Contribution:** \$2,946,380

## Contact Information

Sharon Rudderham  
 Chairperson  
 Tui'kn Initiative Management Team  
 Phone: 902-379-3200  
 E-mail: [srudderham@eskasonihealth.ca](mailto:srudderham@eskasonihealth.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

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

Aboriginal Envelope

### Lead and Partner Organization(s)

Department of Health and Social Services, Government of Nunavut

### Background and Goals

Nunavut faces unparalleled challenges in delivering health care. Its 25 communities vary in size from 148 to 7,000 and are connected only by sea, air and satellite communication. The Ikajuruti Inungnik Ungasiktumi (IIU) Telehealth Network, which means “a tool to help people from far away,” is vital to connecting clients from remote and isolated communities to providers of medical, social and educational services, thus improving access to a broader range of services for the residents of Nunavut. The population, which is 85 per cent Inuit, has disproportionately high rates of infant mortality, suicide, sexual assault, sexually transmitted diseases and tuberculosis, along with a higher than average birth rate and a lower life expectancy—driving home the fact that health and social services are indeed needed. The network has existed since 1999, bringing videoconferencing and store-and-forward technology (the temporary storage of a message for transmission to its destination at a later time, which allows for routing over networks that are not accessible at all times, like those in remote locations) to 15 communities. However, 10 communities—with populations ranging from 150 to 800 people per community—remained isolated and unconnected. This initiative helped to support the expansion of telehealth to seven of these communities, and the Nunavut government leveraged this investment to encourage private donations to connect the remaining three communities. The objectives of the expanded IIU Telehealth Network were to:

- Improve access to health care services, social services, public health, education and administration;
- Support the ongoing investment into telehealth by expanding the infrastructure, services and telehealth programs;
- Support staff providing services in remote locations through continuing education, enhanced problem solving and greater participation in patient care plans and delivery;
- Deliver tools to support the integration of telehealth into the Health and Social Services delivery system, including health information and access to other specialists/professional opinions; and
- Use telehealth as a community development tool, providing communication between communities and regions in support of broader population health determinants.

### Activities

In expanding the telehealth services to the seven communities, the following activities were undertaken over the course of the initiative, from September 2003 to March 2006:

- Program development and enhancement (September 2003 to March 31, 2005), including a comprehensive review of the existing telehealth program and identification of gaps;
- Workstations acquisitions and deployment (October 2003 to March 2005) and training and certification of regional information technology resources to support and maintain the equipment;
- Network and implementation (September 2003 to March 31, 2005) including network engineering and procurement, and site improvements; and
- Evaluation (impact analysis).



## Resources

- The Government of Nunavut has compiled a list of lessons learned so that others may learn from its experience. They are summarized in the End of Project report and would be a valuable tool for any Aboriginal organization interested in implementing telehealth.
- The initiative created an eDoc, an electronic training and reference tool to assist individuals in acquiring an understanding about the IIU Telehealth Network, telehealth programs, the use of videoconferencing equipment, peripherals, and system software for telehealth, session scheduler, IIU Telehealth Network forms; when they are used; and how to get help when using the network.
- In addition, the initiative contributed to the Canada Health Infoway Toolkit.

## Key Learnings

This initiative helped to enable Nunavut to provide comprehensive programming and services to all Nunavummiut (people of Nunavut), as well as make the newest jurisdiction in Canada the first to connect all of its communities with telehealth technologies. It has helped the Department of Health and Social Services to adapt to the challenges of geography, climate and weather so that more clients can receive care closer to home. Although the IIU Telehealth Network's purpose was not to save money but rather

to improve the range of medical, social and educational health services available in the community and to deliver care in a new and practical way, economic benefits conservatively estimated at \$1,631,644 are being generated (largely due to reduced travel costs for medical and educational reasons and for meetings). The impact evaluation reports that Telehealth has had—and continues to have—a positive impact on health at the community level. In terms of sustainability, the Departments of Health and Social Services and Community and Government Services have included telehealth operations and telecommunications in their budgets as regular line items. Each department has dedicated staff that assists in the delivery of telehealth services. Nunavut may not have been able to bridge the gap between services available at the community level in the North compared to the South, but with the aid of the IIU Telehealth Network, it has certainly narrowed it.

**Approved Contribution:** \$2,700,041

## Contact Information

Tina McKinnon  
Telehealth Manager  
Government of Nunavut  
Phone: 867-975-5902  
E-mail: [tmckinnon@gov.nu.ca](mailto:tmckinnon@gov.nu.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Aboriginal Midwifery Education Program

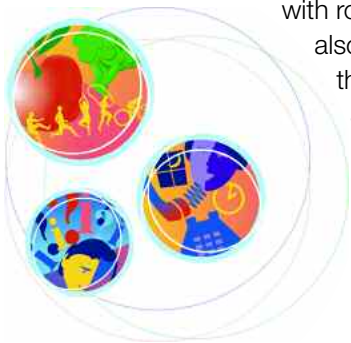
Aboriginal Envelope

### 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

### Background and Goals

Many Aboriginal communities have limited access to maternal/newborn services. The women have poorer outcomes and no opportunity to give birth in the community. Due to the shortage of care providers in northern Manitoba, most pregnant women north of the 53<sup>rd</sup> parallel must leave their communities and families several weeks prior to their due date. Rather than birth being a joyous event for the mother, it is often a sad and lonely experience. Taking women out of their communities is an expensive practice, which adversely affects families, deprives the community of a reason for celebration, and ignores—and thereby hastens the loss of—traditional birthing knowledge. Manitoba Health believes that regulated midwifery is a key strategy to address the shortage of qualified maternity care providers in its province and elsewhere. Midwifery can contribute to better maternal and child health, assist with reclaiming traditional knowledge and self-respect within communities, and ultimately aid in returning the birth experience to the community. Hence, the Aboriginal Midwifery Education Program, whose overall goal 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.” After graduating from a four-year baccalaureate program in midwifery with a specialty in Aboriginal midwifery, these midwives will enable women to give birth closer to home and receive culturally appropriate care, reducing the stress, risks and costs associated with routine evacuation for birth. They will also be trained to identify social issues that may interfere with clients’ health and well-being, as well as work with other service providers to coordinate care.



### Activities

The Aboriginal Midwifery Education Program (AMEP) was a multifaceted initiative that involved many significant partners and stakeholders. Over the two years of this initiative (December 2004 to September 2006), the AMEP team used a two-pronged approach to develop the program.

First and foremost, it engaged in extensive consultations with Aboriginal communities, one of which was a Roundtable on Aboriginal Education, held in Winnipeg in April 2005. The purpose of the consultations was to:

- Seek input into the content and teaching methodologies of the program;
- Learn from Elders about traditions and practices that should be incorporated into the program;
- Obtain community and political support;
- Identify suitable teaching sites; and
- Recruit potential students.

Second, it consulted with experts in Aboriginal education and learning on how best to review and adapt existing models of successful curricula to reflect an Aboriginal focus. AMEP purchased midwifery curricula from the Ontario Midwifery Education Consortium (the McMaster Consortium) and from the Otago Polytechnic University School of Midwifery in Dunedin, New Zealand. In some instances, course material from these two programs was included without significant revision; in the majority of cases, considerable adaptation was required in order to meet the overall goals of the new program. New courses were developed to incorporate the Aboriginal content unique to the program.

## Resources

- The Bachelor of Midwifery Program, “Kanaci Otinowawosowin Baccalaureate Program” (KOPB), which means “sacred midwifery” in Cree, is being delivered as of September 2006 at University College of the North. It consists of 26 courses, a total of 122 credit hours, and more than four years of full-time study. The program allows both direct entry midwifery students and students with significant prior learning—who would be granted advanced standing—to pursue a degree in midwifery with a specialty in Aboriginal midwifery. Upon graduation, students will be eligible to apply for registration with the College of Midwives of Manitoba as a practising midwife. The initial intake will admit nine students, five direct entry students and four students who already possess relevant training and experience and who may not require the full four years to meet baccalaureate requirements. The program will be offered at two northern sites: Norway House Cree Nation and The Pas.
- The AMEP initiative’s website, [www.amep.ca](http://www.amep.ca), has direct links to all stakeholder websites and provides information about AMEP progress, promotional materials, community consultation progress reports, latest events and contact information.

## Key Learnings

This was a challenging initiative in many respects. First, it focused on midwifery, an occupation that is not particularly common—nor unconditionally accepted—in North America. Second, it sought to develop a curriculum that blends traditional knowledge and practices with what is considered to be quality care

by Western standards. To do this, it had to manage the expectations of many communities and adhere to academic standards. Third, it had to market itself to potential students *and* to potential users. For the former, it sought to create a flexible program that offers mentorship and support, allows various entry and exit points and that thoroughly prepares the student for the challenging work she will face as a midwife in isolated northern communities. For the latter, it meant overcoming fears of inferior or inadequate care.

Some key learnings arose from this initiative. First, it is of critical importance to have all the key stakeholders involved right from the beginning of the initiative (Manitoba Health held the initiative back until it had the right players from the communities, academia, professional associations and governments involved). Once they are in place and motivated, change can happen quite quickly. Second, consultations are necessary when trying to effect a profound change that will have ramifications for both individuals and communities, such as where and how women give birth. Third, even significant challenges can be overcome providing that there is the will to do so at many levels. In short, one can learn how to “walk in two worlds.”

**Approved Contribution:** \$1,690,927

## Contact Information

Yvonne Peters  
Project Manager, Aboriginal Midwifery Education Program  
Phone: 204-832-0681  
E-mail: [yvonne.peters@shaw.ca](mailto:yvonne.peters@shaw.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).



## Enhancing Access and Integrating Health Services—Keewaytinook Okimakanak (KO) Telehealth/NORTH Network Partnership Expansion Plan

Aboriginal Envelope

### Lead and Partner Organization(s)

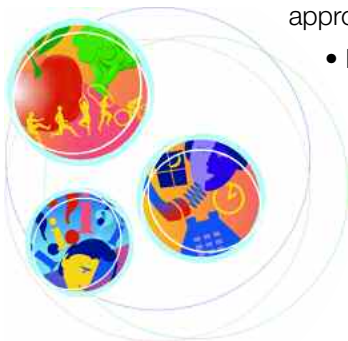
**Keewaytinook Okimakanak (Northern Chiefs Council);** with Northern Ontario Remote Telecommunications Health (NORTH) Network (now part of the Ontario Telemedicine Network)

### Background and Goals

Geographically isolated and culturally distinct communities typically have limited access to health services. After years of pilot projects across the country, telehealth is entering the mainstream as a standard of practice for delivering quality health services to distant communities. Keewaytinook Okimakanak (KO) Telehealth is an Aboriginal telehealth program that serves approximately 23,000 First Nations people living in 25 of the most remote communities in Ontario. KO Telehealth was created through a partnership between Keewaytinook Okimakanak and the NORTH Network in January 2000 and uses telecommunications technology such as digital stethoscopes and patient exam cameras to enhance clinical encounters and support community-based health education and training sessions in remote settings. This service model includes the daily delivery of clinical consults as well as regular educational, training and administrative sessions. Based on the initial success of this model, an expansion plan was proposed to extend the service to 19 communities in the Sioux Lookout Health Zone, and was subsequently funded by the Primary Health Care Transition Fund.

The goals of the KO Telehealth/NORTH Network expansion initiative were to:

- Enhance the coordination of service delivery;
- Promote more productive and cost-effective primary health care services to Aboriginal peoples;
- Improve the quality of health services delivered to Aboriginal peoples, including culturally appropriate services; and
- Improve community-based access to existing medical, health and health education services, thus limiting the travel burden, as well as transportation costs for patients, and reducing isolation for health professionals.



### Activities

The initiative began in October 2003 and funding concluded in March 2006. The activities were designed to expand telehealth service to the additional communities and, in doing so, build capacity by integrating First Nations leadership and management into the planning and delivery of a coordinated health delivery system. The activities included:

- *Establishing administrative and governance processes:* Keewaytinook Okimakanak was responsible for managing the project funding.
- *Recruitment and training:* This included telehealth staff, community telehealth coordinators (CTCs) and their back-ups for all sites.
- *Implementing telehealth systems and network services:* Telemedicine equipment was procured, shipped and installed, and connectivity with the provincial system was established. Telehealth service was extended to all communities in the Sioux Lookout Health Zone and Beausoleil First Nation on Christian Island. Overall, the First Nations communities' use of telehealth services increased to an average of 11 sessions per month per community, mostly for clinical consultations.
- *Designing and implementing an evaluation process:* A community engagement plan and evaluation process was designed and implemented.
- *Initiating a communication and dissemination plan:* National, provincial and regional presentations were made and a website developed.

### Resources

- The KO Telehealth website: **[www.telehealth.knet.ca](http://www.telehealth.knet.ca)**
- *The KO Telehealth Training Manual*
- The KO Telehealth Documentation project: **<http://telehealth.knet.ca/report/pdf.html>**

## Key Learnings

KO Telehealth has created a practical framework that can assist other First Nations, northern and remote communities wanting to introduce this service. The framework provides a methodology for coordinating and integrating provincial and federal program access. Through the work of the initiative, most northern and isolated communities in Ontario have had their access to primary health care services appreciably enhanced. Evaluation results showed very high acceptance of the virtual service, both among patients and providers, and highlighted the importance of the CTC role. Initially, retention of CTCs was a challenge, but this was overcome by restructuring the position. Ultimately, the CTC positions facilitated the increased growth in utilization and community acceptance of the new technology. KO Telehealth helped to make more effective use of increasingly scarce health human resources and has shown some potential in reducing community reliance on medical transportation services. Overall, KO Telehealth has introduced and

managed fundamental changes in the way on-reserve health services are coordinated and supported and has contributed to First Nations understanding, dissemination and implementation of telehealth services and methodologies. The initiative is currently supported by short-term project-based funding. Provincial strategies and regional or national policy would need to be introduced to address the ongoing operational requirements of these services.

**Approved Contribution:** \$3,441,495

## Contact Information

Kevin Houghton  
Program Manager  
Keewaytinook Okimakanak Telehealth  
Phone: 1-800-387-3740, ext. 53  
E-mail: kevinhoughton@knet.ca

The full report is available in the language of the author on the PHCTF website, **[www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf)**.

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

Aboriginal Envelope

### Lead and Partner Organization(s)

**Nunavik Regional Health and Social Services Board;** with 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]

### Background and Goals

The goal of this initiative was to ensure rapid, 24-hour access to radiology services for the population of Nunavik, a remote and mainly Inuit region in Northern Quebec. The region's primary health care services had relied on traditional radiology equipment, which caused delays in reading films and responding to patient needs. The initiative sought to resolve these problems by implementing a digital radiology and tele-radiology system.

### Activities

The initiative began in 2004 and was ready to start clinical activities in May 2006. Its activities involved purchasing equipment and training staff to use it. The purchase of equipment entailed a number of steps, including:

- Issuing a call to tender for digital radiology equipment; among other things, this phase involved identifying potential suppliers, determining technical requirements, conducting site visits, issuing a call for bids, opening proposals and consulting various stakeholders;
- Purchasing equipment (i.e., digital radiology equipment and viewing consoles for two Nunavik health centres: the Ungava Tulattavik Health Centre in Kuujjauq, and the Inuulitsivik Health Centre in Puvirnituq);

- Acquiring picture archiving and communication systems (PACS) for both health centres; a diagnostic console for Nunavik images was also installed at the Montreal General Hospital;
- Installing equipment and conducting preliminary tests;
- Training several health care workers at the sites in question, and offering coaching and guidance from the outset of clinical activities; and
- Evaluating the implementation of digital radiology in Nunavik.

### Resources

- The Ungava Tulattavik Health Centre in Kuujjauq, and the Inuulitsivik Health Centre in Puvirnituq, now have digital radiology equipment, viewing consoles, and PACs.
- The Montreal General Hospital has a diagnostic console for Nunavik images.

### Key Learnings

The initiative provided greater access to the physical resources needed to ensure the efficient operation of Nunavik's health care system and has benefited Nunavik's population in a number of ways. It has improved image quality and increased diagnostic accuracy by, among other things, allowing greater flexibility in the handling of images. Since the start of clinical activities in May 2006, some 500 X-rays have been transmitted per month.

Nunavik residents have greater access to specialists, and local health workers have acquired new skills. Some 28 staff members (14 at each site) have received training, thereby developing human resources.



Films are more accessible, transportation and storage problems have been eliminated, and transactions can now be tracked on the server at all times.

Nunavik now has better integrated health services, a coordination mechanism adapted to the region, and more effective management in identifying and meeting therapeutic needs. Wait times have been shortened from a few weeks to an average of four days, and emergency services have been improved. The initiative's impact is also evident in the higher levels of satisfaction among health professionals. Radiology technicians say they are happy with what has been achieved because handling has been reduced and their work is more stimulating. Lastly, the initiative has improved health services for Nunavik residents, who now have access to the same quality of radiology services as any other Quebec citizen.

However, these advances were not achieved without difficulty. Working with different stakeholders in various locations, who represent a range of interests (such as those persons needed to reach a consensus on equipment purchases), turned out to be a major challenge. Because of the initiative's scale, a consultant was hired to represent Nunavik's interests. There were also technical problems concerning the transfer of images to the McGill University Health Centre (MUHC) and compatibility between the Nunavik and McGill

radiology systems. Additional money from Quebec's health ministry was required to purchase a server. Technical changes delayed the project's deployment and slowed the evaluation process.

Ultimately, the initiative helped create tools that will ensure Nunavik has radiology services for years to come. The benefits are not only short term but long term as well, as the equipment and training have become permanent assets in Nunavik's health care system. New and similar undertakings are expected to supplement the initiative. A new project, presented to Canada Health Infoway, will seek to make the Nunavik and McGill systems more compatible by acquiring a radiology information system for MUHC. Two digital X-ray machines will eventually replace the traditional ones in the towns of Salluit and Inukjuak.

**Approved Contribution: \$801,900**

### **Contact Information**

Gilles Boulet  
Acting Director General  
Nunavik Regional Health and Social Services Board  
Phone: 819-964-2222  
E-mail: [gilles.boulet@ssss.gouv.qc.ca](mailto:gilles.boulet@ssss.gouv.qc.ca)

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

# Official Languages Minority Communities Envelope

**T**he Official Languages Minority Communities (OLMC) Envelope supported transitional activities that improved access to primary health care services to French- and English-speaking minority communities across Canada.

In addition to the five common objectives of the Primary Health Care Transition Fund, the objectives of the OLMC Envelope were to:

- Improve information-sharing, networking, and forging of links among providers, governments, and official languages minority communities;
- Develop training activities and tools for providers to improve accessibility of primary health care services by official languages minority communities; and
- Increase capacity of providers to offer primary health care services to official languages minority communities throughout Canada.

Two umbrella organizations have coordinated these activities by promoting large-scale structural, transitional and sustainable changes that complement the renewal efforts of provinces and territories.

The Community Health and Social Services Network provided support for the development of English-speaking minority communities in Quebec and the Société Santé en français [Francophone Health Society] has supported the development of French-speaking minority communities outside of Quebec, across Canada.





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

Official Languages Minority Communities Envelope

### Lead and Partner Organization(s)

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

### Background and Goals

This initiative was part of a vast reorganization of health services in Quebec. Its goal was to support the reorganization by improving access to English-language primary health care (PHC) services for Quebec's anglophone community. Although demographic realities and access to English-language services are highly variable depending on the region of the province, language barriers can hinder access to services and lead to lower levels of satisfaction among anglophone clients. The initiative's objectives were to improve access to English-language PHC and general medical services, and to promote linkages between the province's anglophone community and its health and social services institutions. To meet these objectives, the initiative committed to fund projects in three separate categories: Info-Santé for the anglophone population; needs-specific services, to provide quality English-language health and social services; and special needs living environments, to provide adequate services to anglophones in residential and long-term care centres (CHSLDs).

### Activities

The initiative was launched on August 1, 2004, and officially ended on March 31, 2006. Its activities centred on 37 selected projects funded in 14 Quebec administrative regions. It was administered by a steering committee, a project officer, three coordinators, and administrative and technical personnel. It embarked on a variety of activities, including:

- Solicitation of project proposals;
- Evaluation of project proposals, and selection of projects;
- Communication of results to sponsors, and drafting of contribution agreements and letters of confirmation;
- Monitoring and follow-up of projects, and visits to sponsors;
- Two conferences (February 24–25, 2005, and November 23, 2005), to give sponsors a chance to know the expectations and develop a network of contacts;
- Participation in the 6<sup>th</sup> Community Health and Social Services Network (CHSSN) Conference (February 22–23, 2006);
- Development and implementation of a communication plan;
- Surveys and studies of the anglophone population, conducted by SOM Surveys, Opinion Polls and Marketing; and
- Drafting of an evaluation report (for the end of September 2006).

### Resources

- Resource development was an important element of the initiative, with projects involving reorganizing and translating a range of documents, community directories, pages of protocol and user guides.



- A number of public communications events were held, in the presence of CHSSN staff and members of the anglophone community, regarding the launch of projects and results achieved. In the special needs living environments, project participants translated orientation guides, policies, codes of ethics, protocols and booklets. They also took part in various media events and organized corporate leadership and motivational meetings.
- The initiative developed several resources as part of its communication plan. On three occasions, it issued a newsletter dealing with all the projects, the Santé Québec survey findings, and project research and evaluations. An Intranet site was developed to facilitate communication with and among the various sponsors. A “News” section on the site provided updates to ensure the project was well managed.
- A “Virtual Library,” available on the Intranet, contained more than 300 English-language virtual documents and reference tools for the sponsors in their respective regions.
- Website: **[www.chssn.org](http://www.chssn.org)**.

## Key Learnings

The initiative’s 37 projects helped meet certain needs among the English-speaking population. They increased, adapted and improved the quality of services to the anglophone community, particularly in special needs living environments. The projects also supported the major reorganization of Info-Santé services to help them better meet the needs of Quebec’s anglophone population. The initiative updated Info-Santé data and conducted surveys in

this regard, and organized information and training activities to help improve services. In general, the 37 projects created a new dynamic within the Health and Social Services Network.

From the start, the initiative highlighted a desire to ensure the sustainability of activities and outputs. There are a number of ways to ensure that any positive changes will last. The reorganization of Info-Santé services will likely take place over a three-year period. It may also develop projects via a clinical planning exercise adapted to the needs of populations in areas served by Health and Social Services Centres. A review of regional programs to improve access to English-language health services is another possible future endeavour. Lastly, the initiative and evaluation will serve to inform a provincial committee in making a recommendation on the English-language delivery of health and social services, which will shortly thereafter be submitted to Quebec’s Minister of Health and Social Services.

**Approved Contribution:** \$10,000,000

## Contact Information

Jennifer Johnson  
Executive Director  
Community Health and Social Services Network  
Phone: 418-684-2289  
E-mail: [johnson@chssn.org](mailto:johnson@chssn.org)

The full report is available in the language of the author on the PHCTF website, **[www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf)**.



## Summary of Initiatives for Francophone Minority Communities

Official Language Minority Communities Envelope

### Lead and Partner Organization(s)

**Société Santé en français (SSF)**; with 17 provincial and territorial affiliated networks

### Background and Goals

Outside Quebec, francophone minority communities do not have the same access to health services and resources in their own language as do the anglophone majority populations. The fact that francophone populations are spread out poses a challenge to the equitable delivery of health services in French. The purpose of this initiative, which generated 70 different projects, was to improve that situation. Under the auspices of the *Société Santé en français*, the projects have promoted various objectives, such as:

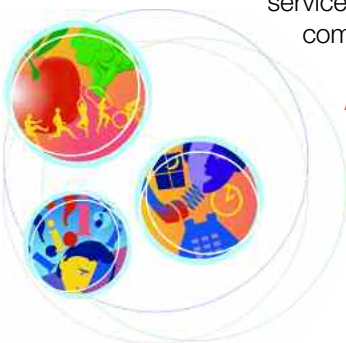
- Creating data banks and websites;
- Developing new service delivery models;
- Building electronic resources;
- Improving the existing infrastructure;
- Collecting and translating documents;
- Designing new primary health care delivery methods and using new technologies to provide care programs to people with heart disease;
- Identifying all French-speaking health professionals in a province or region who could provide their services in French to the francophone minority community, and disclosing that information to francophones;
- Developing health promotion workshops and courses;
- Creating a first point of contact with respect to primary health care in some clinics for francophones within a region; and
- Establishing links between governments, the community and the institutions providing health services.

Despite their various objectives, all projects aimed to improve the general access to primary health services in francophone minority communities.

### Activities

The following is an overview of activities held as part of the initiative conducted across the country throughout the period 2004–06:

- Three projects, New Brunswick's *CyberVillageSanté*, *Répertoire des professionnels de la santé – Nouvelle-Écosse*, and *Promotion de la santé dans les communautés francophones des Territoires du Nord-Ouest*, built websites to promote francophones' awareness;
- In British Columbia, the *En français?* project carried out by the Provincial Health Services Authority coordinated a provincial inventory of francophone health professionals and identified key health documents to be translated;
- The project *Accès aux services de santé pour les nouveaux arrivants francophones de Hamilton/Niagara* delivered awareness and training sessions to help health care providers support victims of war and violence;
- The *Médocentre Saint-Jean* project laid the foundation for establishing an access point for French health services, gave workshops and courses to promote healthy lifestyles, and provided a linguistic certification program for health care employees;
- The *Développement d'une clinique universitaire francophone interdisciplinaire en réadaptation pour la population francophone de la région d'Ottawa-Carleton* project allowed students from the University of Ottawa Health Sciences Faculty to provide their services to an interdisciplinary clinic through a co-op program;
- The *L'amélioration des liens entre les patients, les fournisseurs de soins de santé primaires et les services de cardiologie spécialisés* project in Ontario improved health care services provided to francophones suffering from heart disease and living in rural regions;
- The *BC HealthGuide* project aimed to promote and deliver the *Guide-santé de la Colombie-Britannique* manual to francophones of British Columbia, and promote its use among provincial health professionals; and
- The *Répertoire des professionnels de la santé en soins primaires – Nouvelle-Écosse* and *Répertoire des fournisseurs de services de santé en français de Terre-Neuve-et-Labrador* projects identified all health professionals from both provinces who can deliver their services in French.



The SSF's activities focused on: coordinating calls for proposals and analyzing projects; supporting proponents and partners; ensuring the overall management of the envelope and financial accounting; and making a comprehensive assessment of all funded projects and disseminating project results.

## Resources

Below are some of the resources created by the projects carried out as part of the initiative:

- The Northwest Territories and *En français?* projects developed websites. As part of the *En français?* project, the British Columbia Provincial Health Services Authority's initiative created a comprehensive list of health-related issues with translated resources on health promotion, and displayed the information on a website;
- The *BC HealthGuide* project had four components: the *Guide-Santé* manual and, on the Internet, the BC HealthGuide OnLine, BC NurseLine and BC HealthFiles handout sheets. The project printed 23,800 copies of the *Guide-santé de la Colombie-Britannique* manual and distributed 12,100 of them. Furthermore, 500 copies of the *Guide-santé du Yukon* manual were printed, of which 350 were distributed (the Yukon Territory adapted the *Guide-santé de la Colombie-Britannique* manual in order to distribute it in the Yukon francophone community);
- The *FrancoForme* project in Ontario focused on health promotion by creating a program to reduce cardiovascular risk factors among Eastern Ontario francophones;
- The University of Ottawa Heart Institute initiative, *L'amélioration des liens entre les patients, les fournisseurs de soins de santé primaires et les services de cardiologie spécialisés*, designed a new model focused on links among specialized services, care providers and patients via interactive voice and home telemonitoring technologies;
- The *CyberVillageSanté* project has a multimedia section on its website that deals with healthy lifestyles and health promotion for francophones from New Brunswick and other provinces and territories;
- The *Accès aux services de santé pour les nouveaux arrivants francophones de Hamilton/Niagara* project developed training sessions to help health care providers support victims of war;
- The *Médocentre St-Jean* project delivered workshops on health promotion and healthy lifestyles; it also provided a linguistic certification program for employees of a health care institution; and
- The *Fédération Franco-Ténoise* project in Northwest Territories focused on health promotion, disease and injury prevention, and chronic disease management by offering first aid courses and regular publications on health, and by developing a health-issue resource centre.

## Key Learnings

This initiative has made it easier for francophones across the country to identify health professionals and use their services. The websites, the translation and dissemination of documents as well as the workshops and courses that were developed helped raise francophones' awareness of the existing health services available in French, which ultimately should help them make better health choices. Furthermore, francophones now benefit from improved access to health telephone lines. Efforts to inform the francophone population in British Columbia yielded a slight increase in their use of the BC NurseLine.

Some projects delivered awareness and training sessions to professionals to help them provide services in French and take action in situations such as care delivery for victims of war and violence.

In almost every province and territory, partnerships between the francophone community and provincial/territorial government agencies increased. These relationships will facilitate improvements in and adjustments to components of health programs.

**Approved Contribution:** \$18,050,000

## Contact Information

Hubert Gauthier  
President and Director General  
Société Santé en français  
Phone: 613-244-1889  
E-mail: h.gauthier@forumsante.ca

The full report is available in the language of the author on the PHCTF website, [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

## Résautage Santé en français [Francophone Health Networks]

Official Languages Minority Communities Envelope

### Lead and Partner Organization(s)

**Société Santé en français;** with health institution managers; health professionals; representatives of educational institutions; government officials

### Background and Goals

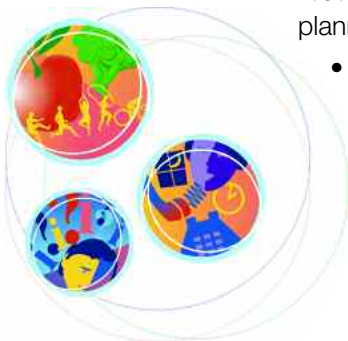
Across the country are a wide range of French-speaking minority communities, and providing French-language health services is a challenge that will require a strategy. For the Consultative Committee for French-Speaking Minority Communities, networking is the cornerstone of the strategies implemented in provinces and territories wishing to improve French-language health services for their francophone populations. However, in 2002 when the federal government announced a \$1.9 million investment for the transition to full network deployment phase, only one network existed: the French Language Health Services Network of Eastern Ontario. The goal of the initiative was to increase this number, and its approach to meet this goal has been to work with groups across the country.

### Activities

The initiative, which lasted for a year (2002–03), had two distinct but complementary levels of network (i.e., provincial/territorial, and national). Groups of promoters 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 build awareness among partners;
- Developing a business plan;
- Defining and implementing the appropriate governance structure;
- Initiating strategic and operational planning; and
- Preparing an evaluation plan.

Each province and territory has chosen a different approach to pursue its objectives.



- In British Columbia, *RésoSanté Colombie-Britannique* is mandated to implement the global development plan for the francophone community in the health sector. RésoSanté consists of 19 individual or community members who represent agencies or institutions.
- In Alberta, those in charge of implementing the network held its inaugural meeting in early fall 2003. Its administrative structure, strategic planning and staff recruitment are more or less complete, and its chosen structure is that of an arm's length provincial agency.
- In Saskatchewan, the *Assemblée communautaire fransaskoise* set out to identify health professionals who can offer their services to the province's francophone population.
- In Manitoba, the *Conseil communauté en santé* (Healthy Communities Council) was tasked with obtaining official recognition by the provincial government, and with drafting proposals for the development of certain services (including, among other things, a call centre for the province's francophone population).
- In Ontario, promoters helped design regional networks in the north and south of the province, in addition to the French Language Health Services Network of Eastern Ontario. Discussions were also held with key health care providers in every region. The three new networks (two in the north) should be fully operational by the fall.
- In New Brunswick, the three *Réseau-action communautaire* organizations helped promote and enhance the health and well-being of francophone and Acadian individuals and communities, by: raising awareness and promoting the concept of healthy communities; and integrating the needs of francophone and Acadian communities into the planning and implementation of local and regional services.

- In Prince Edward Island, a team was established to help plan services within the provincial Ministry of Health and the regional health authorities. The province also decided to create a joint government-community network to put forward practical solutions for the delivery of health and social services.
- In Nova Scotia, networks were developed through public consultation in various regions, and through interviews with community leaders.
- In Newfoundland and Labrador the *Fédération des francophones* held consultations in the three regions where francophone communities are located, an exercise that helped assess the state of health in the communities, along with their health service requirements.
- In the Northwest Territories and Nunavut, leaders of francophone associations in the two territories coordinated their community awareness activities.
- In the Yukon, the group Les EssentiElles has helped set up the *Partenariat communauté en santé* project. Proposed terms of reference for the network have been completed and forwarded to the members for approval, and the network has begun operations (e.g., hiring and deploying staff).

At the national level, the *Société Santé en français* has consolidated its organization, assisted network promotion committees in various regions, begun to define a long-term funding framework for the networks, and helped to support and organize French-language health services.

## Resources

- In Nova Scotia, a discussion paper outlining two models of network was prepared and distributed to participants at a 2003 provincial forum
- Website: **[www.forumsante.ca](http://www.forumsante.ca)**

## Key Learnings

While a number of networks are not yet fully implemented (i.e., some do not yet have formal structures), the initiative has successfully established 17 networks in all provinces and territories. Though these are in various stages of development, 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. The last step in implementing the networks will be the hiring of personnel, and some networks will finalize their governance structure by adopting regulations to guide their activities. While the promoters expect difficulty recruiting and training skilled personnel, the *Société Santé en français* has developed a program to assist networks in this regard. Networking has become a reality and, in the promoters' view, an essential tool in developing French-language health services for the country's francophone minority communities.

**Approved Contribution:** \$1,900,000

## Contact Information

Paul-André Baril  
Networks Manager  
*Société Santé en français*  
Tel.: 613-244-1889  
E-mail: [pa.baril@forumsante.ca](mailto:pa.baril@forumsante.ca)

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