The Difference of Primary Health Care

A report on the work of primary health care | 2011

Capital Health

Primary Health Care
& District Department of Family Practice

Next

FOREWORD

Primary health care, by its nature, is broad ranging and includes working with others to improve the health of the population, promoting wellness, working with groups at risk of developing disease, treating acute illnesses, and providing ongoing care for chronic conditions, all the while engaging those who are most affected. Under the circumstances, taking the required systems approach while being intentional, focused, and specific is always a challenge. The primary health care system is not simply the sum of its parts but includes the interfaces between the various components and reflects how they interact to support the people for whom it was designed – our Citizens!!

We have put together a report showing some of our work in Primary Health Care and the difference this is making. Changing the health of our communities takes well over a decade and requires collective purposeful work. It is our intention to share stories and to provide measures, where we are able to, showing our progress to date. This past year has been busy as we have been building internal capacity to collect, analyze, and report on data, in keeping with our Quality Framework. As data does not always show the whole picture, we have included stories, as appropriate.

Someone recently questioned why we would produce this report. This is a measure of accountability to all of those who we have worked with, those who have supported the vision of the Community Master Plan, and those who do the work of primary health care. We share this report with community organizations, and with clinical and other program areas within Capital Health. While we are proud of the work we do, we share the accomplishments with others; primary health care reflects the collective work of many teams and citizen groups.

People put their trust in The Promise of Primary Health Care – The Community Master Plan, by identifying primary health care as one of the areas of focus for Capital Health in the organization's first three year business planning cycle. They knew what we know, that one of the key foundational elements of a high performing health system is a strong primary health care system.

To our teams in Primary Health Care, we would like to say how proud we are of the work that you do. We have witnessed tremendous leadership qualities in our management team and many of our front-line clinicians and physicians who come to work each day looking for new and improved ways to meet the needs of their community and/or patients – collectively the Citizens served by Capital Health.

This report is not annual, and we intend to update the content as new information comes available. Only a few copies will be printed; rather, it will be available online. We recognize ongoing challenges within our current fiscal climate. As part of Capital Health, we hold a responsibility to contribute solutions and to share what we have done with others. We welcome the change that is fundamental to our work and we look forward to continuing to work with others in new and innovative ways as we build the community based primary health care system that supports us all.

Lynn Edwards
Health Services Director, Primary Health Care

Rick Gibson
Chief, District Department of Family Practice

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INTRODUCTION

When you think of accessing health care, for many an image of a hospital with doctors and nurses usually comes to mind. In reality, the majority of people experience most of their health care in the community, receiving care from family doctors, nurses, physiotherapists, pharmacists, dentists, and other health care professionals. This network of community-based health care is known as the primary heath care system, and this is where most people seek advice for staying healthy and treatment for their health needs.

Primary Health Care and the District Department of Family Practice work closely together to strengthen and support the primary health care system within the Capital Health district. A strong primary heath care system supports citizens and communities to be healthy, build partnerships and flourish, and enables them to receive the right type of care when and where it is needed most, and over time, reducing demand for hospital-based care. But with an aging population, an increasing prevalence of chronic conditions and reductions to the overall health budget, a transformation of the entire health system is necessary to continue appropriately meeting the health needs of our citizens.

Through our **Community Master Plan,** we are working with others to change the way primary health care is experienced in our communities by beginning to transform the primary health care system to improve citizens' health care experience while contributing to a more sustainable health care system. A fundamental shift in the functioning of the primary health care system is a key component to this sustainability; if demand for health services continues at the same rate as today, we can expect to see a 50% increase in inpatient demand by 2026 in our health care facilities, a mere 15 years from now.[1]

Changes to the current primary health care system can help curtail this trend of increasing demand for health care. Research has shown that an effective primary health care system focuses on access, continuity of care, comprehensiveness of services/programs, and coordination, as well as provides[2]:

- Supports that enable people and communities to build capacity to live well;
- Resources to enable people to build capacity and confidence to better manage chronic conditions;
- Team-based care so that people benefit from the collaboration of different types of primary health care providers;
- Access to urgent care during all hours;
- Effective and efficient information exchange between health care providers;
- Quality improvement programs to continually improve the ways in which care is provided; and
- Support for primary health care providers, including appropriate infrastructure and remuneration.

1 Capital Health Facilities Master Plan
2 Adapted from D. McMurchy (2009)

Capital Health is on a journey to become a world-leading haven for people-centred health, healing, and learning. As part of this journey, we are transforming the way that health care services are provided so that Capital Health, along with our partners, can support citizens and communities to start well, live well, and finish well.

There have been many positive changes to the primary health care system in the Capital Health district in the past few years; there are many more changes that can be made to strengthen and support our health providers working in this system and our citizens living in the communities we serve. Incorporating what we have heard from ongoing citizen and provider engagement, we have begin this transformation with four main themes, as identified in our Community Master Plan: wellness promotion and coordination, an enhanced team approach to primary health care, chronic disease and self management, access and urgent care, and a network of primary health care zones.

Doing things differently by investing resources and change efforts in the primary health care system will not only improve the person-centered health care experience in our district; it will contribute to the sustainable of the overall health care system. Primary Health Care teams are working hard to live Our Promise and support our 2013 Milestones. Much of what we do in Primary Health Care contributes directly or indirectly to these organizational strategic directions. We have indicated the specific areas in this report that are being measured against the milestones.

Simple Rules of Primary Health Care

- Be person, family, and community centered
- Build on what exists, or expand where it doesn't
- Be quality driven and evidence informed
- Be flexible and open to change that is purposeful
- Build meaningful relationships that are respectful and inclusive
- Talk less and do more
- Be true to Our Promise and the Declaration of

2013 Milestones Influenced by Primary Health Care

Citizen Engagement

- Improved self-confidence in managing chronic conditions
- 25% increase in access initiative for underserved/vulnerable groups
- 100% patient involvement in Patient Care Committees
- Policy on engagement is fully implemented at 100% compliance

Innovation & Learning

- Increased primary care capacity has reduced Ambulatory Care visits by 20%
- 25% increase in use of Capital Health web-based technologies

Research

- Contributing to ongoing research as part of the academic health sciences network

Person Centered Health Care

- Wait times measure met/exceed national standards

Sustainability

- 25% of Capital Health's population will have access to a Primary Health Care Team with two or more members
- Increased investment in primary care & care of the elderly
- Improved metabolic targets pre-diabetes & diabetes
- 3% decrease in hospital admissions for identified chronic diseases
- 10% decrease in readmission rates for co-horts with complex chronic disease
- 25% reduction in volume of nursing home patients seen in the emergency department
- 25% reduction in admissions from nursing homes

WELLNESS PROMOTION & COORDINATION

Primary Health Care supports citizens and communities to start well, live well, and finish well. We want to support people to be as healthy as they can be, and to stay healthy throughout their lives. To do this we focus on partnering to build community capacity, wellness and prevention programming, as well as risk factor management.

COMMUNITY HEALTH TEAMS

Community Health Teams (CHTs) focus on the promotion of health and wellness. CHTs support individuals and families to build knowledge, confidence, and skills to help make healthy lifestyle choices and to better prevent and manage risk factors that are common across chronic conditions.

Each CHT collaborates with many partners, including the IWK Health Centre, Public Health, pharma partners, and the QEII Foundation, and is working to strengthen links across the health system, and involves the participation of the community it serves.

The CHT health model recognizes that each community has different needs, and therefore may require different programs, services, and supports to build community capacity. The model takes into account that citizens and health providers need to be involved in tailoring programs and enabling connections to support services in the community that address these needs.

There are two key components that guide the work of each CHT:

1. Wellness Programming

   The CHT provides support and access to a range of wellness programs that complement services and programs already available in the community. Some of the basic programming components include:

   - Personal wellness assessments
   - Goal setting and motivational counselling
   - Group physical activity / exercise programs
   - Group health and wellness learning sessions (e.g., healthy eating, managing stress, setting goals, etc.)
   - Self management peer support programs

2. Wellness Navigation

   The CHT works collaboratively with family physicians, community groups, specialty programs, and other providers and groups to support individuals and families to make linkages with the appropriate services, supports, or programs that are needed to support health and wellness.

There are two CHTs – the Chebucto CHT and the Dartmouth CHT. The Chebucto CHT, located in the Spryfield Shopping Centre within the new Community Wellness Centre, serves communities from Armdale to the Pennants.

The Dartmouth CHT, located on Tacoma Drive and in the East Dartmouth Community Centre, serves all of Dartmouth. The Dartmouth CHT is an anchor point for the implementation of Primary Health Care's initial Community Master Plan initiatives, which are being prototyped primarily in the East Dartmouth community.

The Community Health Team is 'always the right door.'

Participant Volumes

The total number of participants that have attended health and wellness programs (both individual and series sessions) has grown steadily since the opening of the CHTs. Over 900 registrations have occurred from January-March 2011. These volumes include registrations in various community locations within the CHT catchment areas, so as to increase accessibility to the community and to provide programs in other locations that are trusted and familiar to the community. There have been occasions when participant registration is not possible (e.g., drop-in attendance, confidential sessions, etc). In these cases, the CHTs have tracked the number of community members who have participated in CHT-led community based learning programs. From July 2010 – March 2011, this number totals 295.

The CHTs have also been involved in citizen engagement activities. During July – March 2011, the CHTs have engaged over 140 citizens and family physicians to continue to learn about needs, priorities, and what is important to their community.

A significant learning for community driven initiatives, such as the CHTs, has been the long term process required to develop trust and awareness in the community about a wellness based model. A comprehensive communication and marketing strategy has been developed and implemented, which has also been complemented by grass roots supports to promote the CHTs. Awareness of the CHTs has been growing, but it is clear it takes time and is a long term process.

Participant Awareness

Through analysis of feedback from community members, the main sources of how people heard about the CHTs has been:

- Marketing materials and media: 37%
- Word of mouth: 26%
- Health providers or community groups: 25%
- Website: 1%
- CHT team members: 1%

Impacts on Participants

As mentioned previously, there are two key components of the CHT model: wellness programing and wellness navigation. The impacts on participants are measured and reported in this manner.

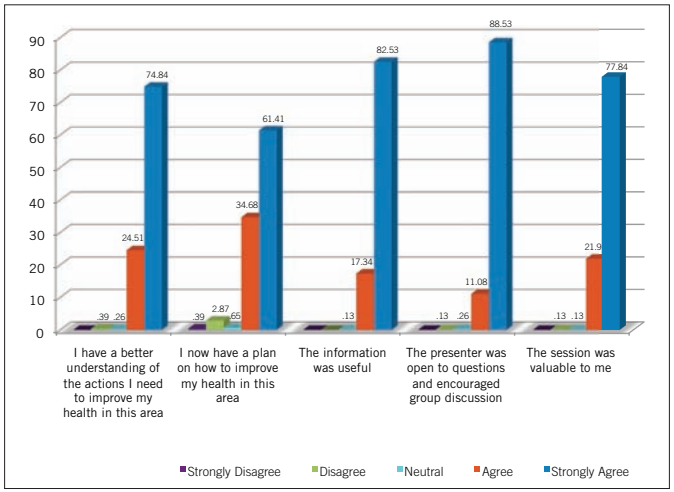
Wellness Programming

Citizens can self refer and register online for their wellness program choice(s). As part of ongoing program development and planning, evaluations have been done to inform program development choices. Staff from the CHTs validate and change programs quarterly, based on the changing needs of the community.

The summarized data in the chart to the right indicates that the majority of participants strongly agree or agree that the wellness programming has been valuable to them, understand what actions they need to improve their health, and have a plan to do so.

The specific elements of the CHT wellness programming, wellness learning programs, Personal Wellness Profile, and the low intensity exercise program are explained in further details on the following pages.

CHT Program Evaluation Results, April 2010 - March 2011



Source: Community Health Teams, April 2010 - March 2011

Wellness Programing: Wellness Learning Sessions

The learning sessions listed in the table on the right are a component of the wellness programming that is offered at various times and locations. The sessions are offered by wellness facilitators and wellness navigators. These programs change and evolve in response to the community needs and are built on behaviour change principles.

Wellness Learning Sessions Offered April 2010 - March 2011

Food, Nutrition and Weight Management	- Beginner's Guide to Weight Management - Craving Change (Four Week Program) - Healthy Weights (Four Week Program) - How Healthy is your Plate? Eating for Health - Making the Most of Your Food Dollar
Physical Activity	- Healthy Lifestyles (10 Week Series) - Leisurely Way to Wellness - Low Intensity Exercise (10 Week Program) - Stretching and Strengthening (4 Week Program) - Walking Groups - What to be Physically Active? Find Out How!
Emotional Wellness	- Beginner's Guide to Stress Management - Beginner's Guide to Self-Esteem - Building Better Healthy Relationships - Building Better Sleep - Caring for a Senior? This session is for you! - Introduction to Mindfulness - Your Way to Wellness Self Management Program - Understand and Get a Handle on Pain
Managing Risk Factors	- Basics of Heart Healthy Living - Building Better Cholesterol - Personal Wellness Profile - Pre-Diabetes - Staying on Track with your Health Goals - Want Better Health? Build Better Goals!
Parenting	- Incredible Years 12 Week Parenting Program (IWK)

Wellness Programing: Personal Wellness Profile

A Personal Wellness Profile (PWP) is an evidence-based, personal health assessment designed to deliver an accurate health profile through evaluating personal and family history of illness, medical conditions, lifestyle habits, and physical measurements (e.g., blood sugar, cholesterol, blood pressures, and anthropometrics). Risk factor analysis helps to highlight areas that may be putting a person at risk for health problems. The PWP provides personalized wellness information for participants to help them make informed decisions about their health. It is designed to facilitate behaviour change through self-management.

The table to the right provides a summary of aggregate results from community members who live, work, or have a family doctor in the the CHT catchment areas and who have completed a PWP between April 2010 and March 2011. Over time, this data will provide a picture of health status data at a community level, which can act as a valuable tool for health planning.

Personal Wellness Profile Risk Factors Identified, April 2010 - March 2011

Risk Type	Risk Factor	Percentage of Participants
Cardiovascular	High total cholesterol (6.24+ or 5.20+ if CHD or Diabetes)	19 %
	High LDL cholesterol (4.16+ or 3.38+ if CHD or Diabetes)	9 %
	Low HDL cholesterol (less than 1.04)	20 %
	High blood pressure (140/90 and above)	25 %
	Excess weight (BMI > 25, high waist girth or % fat)	94 %
	High overall coronary risk	36 %
Cancer	Tobacco use (all forms)	9 %
	Drinking more alcohol than recommended (more than 1-2/day)	5 %
	Fruits and vegetables (less than 5/day)	79 %
Other	Drinks and drives occasionally	4 %
	No regular exercise	33 %
	Personal history of Diabetes	16 %
	High blood sugar (5.60+ fasting, 7.84+ non)	36 %
	“Feel down-hearted and blue”	17 %
	Low in sleep (less than 7 hours per day)	41 %
	Have no good social support system	9 %
	Regularly use drugs that affect mood or ability to relax or sleep	27 %

Source: Participants who attending a PWP session from April 2010 – March 2011 at Dartmouth or Chebucto CHT); Executive Summary Report; Personal Wellness Profile application (by Wellsource Inc.)

Wellness Programing: Personal Wellness Profile (Continued)

Health Age Summary

A person's choice of health practices has a significant effect on health and longevity. In a prospective study of some 7,000 people for 15 years, people who followed a healthy lifestyle lived on average 11.5 years longer than those with poor health practices (e.g., smoking, living a sedentary lifestyle, poor eating habits, being overweight, etc). The health practices of community members in the CHT catchment areas were compared to this study population to determine the effect of their lifestyle on longevity. As indicated in the below table, the average person in this group may add **3.8 years** to his or her life expectancy by maintaining good health practices. For the entire group of 157 people, almost 600 person years may be gained[3]. These findings are representative of community members who completed a PWP between April 2010 - March 2011.

Average Age	Average Health Age	Average Achievable Age	Potential Years of Added Life for Group
58.6	57.8	54.8	598.9

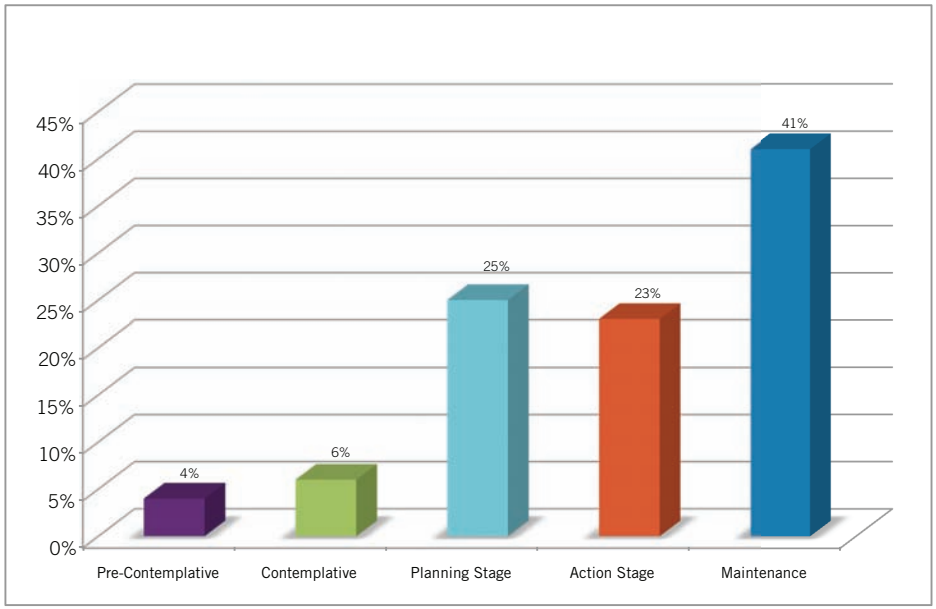
Source: Community Health Teams, April 2010 - March 2011

Summary of Health Needs

Based on the prevalence of health risks identified for this group during April 2010 - March 2011, the following intervention programs are recommended, listed in order of need:

1. Weight management (92% are above their recommended weight range)
2. Cancer risk reduction (76% have higher cancer risk)
3. Coronary risk reduction (62% have a moderate to high coronary risk)
4. Improving fitness (61% showed need for improving fitness levels)
5. Managing cholesterol levels (47% had cholesterol over recommended levels)
6. Better nutrition (42% showed need for making nutritional changes)
7. Managing stress (28% are bothered by excessive stress)
8. Managing high blood pressure (25% had elevated blood pressure levels, 140/90 and above)
9. Quit smoking (9% are smokers)
10. Alcohol management (5% report drinking more than recommended)

Estimated Readiness to Change Distribution, April 2010 - March 2011



Source: Community Health Teams, April 2010 - March 2011

The PWP assesses participants' readiness for change. The graph above indicates the majority of participants are in the planning, action, or maintenance stage for change. This highlights that participants require additional tools, methods, encouragement, and positive support to make lifestyle changes to foster enhance health and wellness.

Wellness Programing: Low Intensity Exercise Program

The low intensity 10 week exercise program is for people who are physically limited by a chronic condition (unable to exercise more than 15 minutes without stopping). It is designed for individuals who have not been able to exercise due to a variety of reasons. Outcomes for a small group of citizens who participated in the low intensity physical activity program (June 2010 – March 2011) identified pre-post changes outlined below:

- An average of 2 kg (5lbs) weight loss (reduction of 0.6 BMI)
- An average reduction of 1 cm waist circumference (the highest waist circumference reduction was 9cm)
- An average pre-post increase of 8% in the distance walked during the 6 minute Walk Test (the highest increase in the pre-post Walk Test was 30%)
- During the pre-session assessment, 16% of participants met guidelines for exercise, compared to 66% who met the exercise guidelines during the post assessment
- On average, participants had a decrease of 1% body fat

Barbara's Story

Barbara spent years dealing with post-polio pain. She'd tried numerous programs to get physically active again and did not feel she was as successful as she could be and was becoming frustrated. When she saw an advertisement in the newspaper for a 10-week low-intensity exercise program offered by the Dartmouth CHT, she decided to give it a try.

Before signing up for the program, Barbara met with the wellness facilitator to talk about her health. He took Barbara's blood pressure, and to her surprise, it was dangerously high. Barbara's doctor prescribed medication to lower her blood pressure, which made it necessary for her to stop taking her pain medication.

"Andrew coached me through pain management," says Barbara. "He explained how pain works, where it's coming from and why. It really helped. I feel really confident in managing my pain."

The low-impact exercise program was a great fit for Barbara, who uses a cane to walk. "I didn't feel out of place. I started by walking for three minutes at a time and resting for seven, and built up to walking for seven minutes at a time and resting for three. I didn't want to leave the program when it was over. It was just right for me."

Although the learning program is over, Barbara continues to walk outside and do her exercises at home. "It's changed my life,"she says. "It's made me a different person."

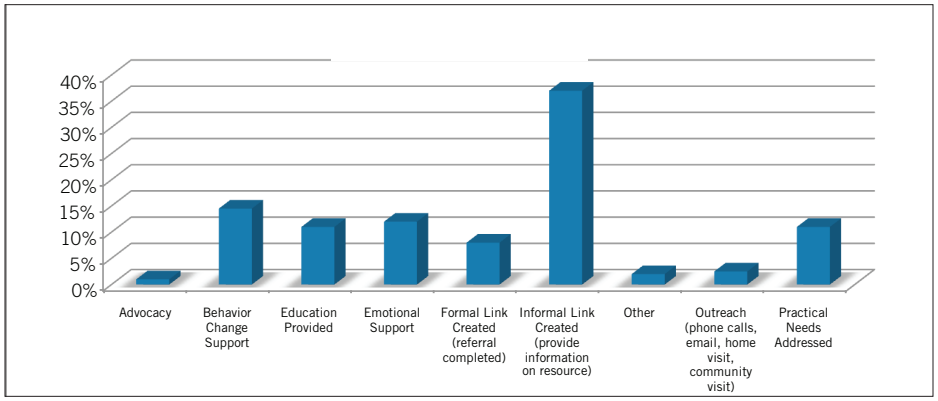
Wellness Navigation

Wellness Navigation is the second key element that guides the work of the CHTs. Wellness navigation teams assist citizens to use their personal resource base to navigate community resources and supports for the purpose of achieving wellness in their own lives. Wellness navigators also link key components of the community resource base together, thereby building capacity, knowledge, and awareness within the community.

Most of the contact for navigation with individuals is face to face, followed by a phone consultation. The most common areas that people seek support from the CHT wellness navigators relates to emotional wellness (18%), behaviour change support (16%), weight management (12%), chronic disease management (12%), and physical activity (11%). Other areas identified are social connections, support for connections to other resources, and nutrition supports.

Wellness navigation is a new support for people in the community. Therefore, it is expected that the nature of this support will change as awareness increases. It is clear from the navigation work completed to date that support is required to help connect citizens with resources that already exist in their community. Behaviour change support is also a key reason that community members seek wellness navigation. The types of navigation supports are depicted in the chart below.

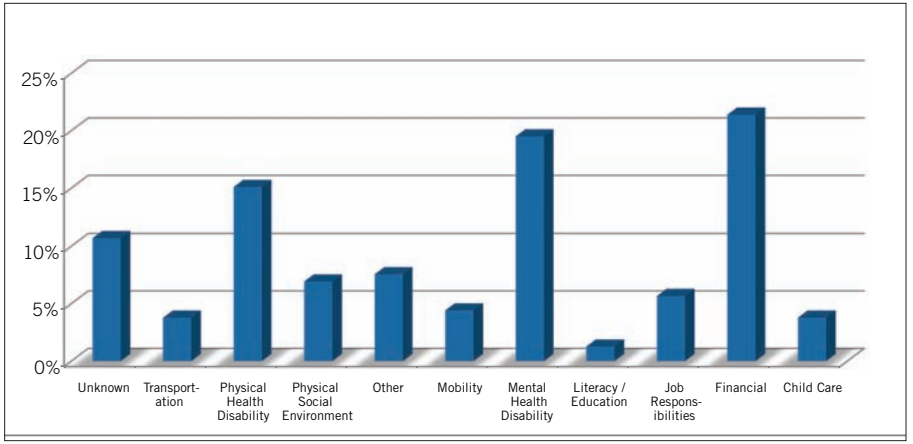
Navigation Support Type, April 2010 - March 2011



Source: Community Health Teams, April 2010 - March 2011

Wellness navigators also address the barriers that often prevent people from optimizing their involvement in supports that could enhance their health. The chart below shows the most common barriers that citizens face.

Barriers to Support, April 2010 - March 2011



Source: Community Health Teams, April 2010 - March 2011

Navigation of Community and Health Resources

Citizens of Dartmouth and the Chebucto area communities said they needed someone to help link them with health and wellness resources. That's what Primary Health Care heard during community conversations leading up to the creation of the two Community Health Teams. Heather now works with community members to do just that.

Heather is a wellness navigator with the CHT. She, along with two other wellness navigators, Karla and Caroline, meet with individuals and groups to identify their health needs and determine the best way to achieve them.

"Sometimes people know what they want and I link them to the resources they need," explains Heather. At other times, Heather provides, "emotional support to help people get through difficult times. People often come to see me when their lives seem complicated and overwhelming. The wellness navigators, and other CHT team members, help people deal with the barriers they face in accessing resources."

Whatever the individual's needs, Heather says, "I'm able to look at each person in their entirety and take a holistic approach."

Heather and other CHT colleagues have also developed tools to connect community members with available resources. For example, they have created helping trees (an easy to read chart) that shows the local programs and resources available. "Community members have accessed resources they didn't even know existed," says Heather.

One of the greatest rewards of Heather's job is hearing from community members that the navigation service has helped them figure out where to start on their journey to better health. "I love it," she says. "I don't think I've ever had so much job satisfaction."

Linking and Collaborating

In addition to delivery of wellness programs, the CHTs have also work closely with health providers and community organizations to build capacity and partnerships, coordinate services, minimize duplication of existing supports, and engage stakeholders to continue to learn community needs and priorities. This work takes time and is a long term process to gain trust within the community.

From October 2010 - March 2011, the CHTs have been involved in over 135 collaborative meetings with a range of stakeholders. The clear majority of these meetings occurred with groups external to Capital Health, with approximately 72% of collaborative efforts occurring with community groups.

The CHTs support collaboration and linkages across different program areas through a broad Expression of Interest (EOI) process for groups within Capital Health and the community to access CHT space to offer free health and wellness programming. From January - March 2011 there have been six groups that have offered nine different programs to approximately 151 people. Some examples of programming offered that would have not previously been available in the community include:

- Anger Control Training - Self Help Connection
- Chronic Pain Self Help Working Group - Metro Pain Pals
- Depression in Seniors - Seniors' Mental Health Outreach
- Heart and Stroke Walkabut Leader Orientation - Heart and Stroke Foundation
- Knowledge is Power - Ovarian Cancer Canada
- MS Peer Support Health Group - MS Society of Canada

Linking and Collaborating (continued)

In addition to the EOI, the CHT has worked with many groups to offer partner programs. Examples of the partnership sessions underway or being developed are detailed in the table on the right.

Dalhousie Legal Aid Service	After hearing of the CHT Expression of Interest process, a lawyer with Dalhousie Legal Aid Service had approached the CHT to explore the possibility of using CHT space to meet with clients who had difficulty accessing the Gottingen Street Legal Aid location. The Dartmouth CHT space has been identified as an intake location to offer a myriad of potential referrals for clients in need of legal aid. Legal aid services are now offered two mornings a month and include the following poverty law services: - Income assistance - Employment Insurance - Residential tenancies - Canada Pension Plan disability
Dartmouth Learning Network	The Dartmouth CHT and Dartmouth Learning Network (formally the Dartmouth Literacy Network) have worked together to enhance learning programs. The Dartmouth Learning Network (DLN) expressed interest in CHT programming and the CHT has been able to provide programming to parents with low literacy at the DLN where trust had already been established. After auditing a CHT wellness session, the DLN assisted the CHT to revise language to more optimally consider Nova Scotia literacy levels.
Dartmouth Community Helping Trees	Following the lead from Community Mental Health, the Dartmouth CHT had collaborated with the Dartmouth Community Health Board, an HRM Community Developer, Self Help Connection, and community members to develop the first ever Dartmouth Helping Tree. This extensive resource for citizens, health providers, and community organizations is now available.
Mindfulness Network	The practice of mindfulness is an area of growing practice. Mindfulness based approaches are offered throughout Capital Health, and is an example of innovation and learning within the district. In order to support the ongoing skill development of practitioners in this emerging field, health providers in the Capital Health district identified the need to have a support system of practicing colleagues. As a result, a Mindfulness Network has been established; the Dartmouth CHT has co-led the development of this network.
Capital Health	The CHTs are working with groups across the Capital Health district to co-develop learning programs that are broad and generic so that the CHTs or other groups can delivery the same sessions. This ensures consistency of messaging across departments and population groups. For example, a pain learning session has been developed with Pain Management Services, a pre-diabetes learning session has been developed with the Diabetes Management Centres, and a leisure session has been developed with Forensic Recreation Therapists. As well, a Public Health team member has worked directly with the Dartmouth CHT over a seven month period to explore collaboration and complementary work.

SICKLE CELL TESTING CLINICS & COMMUNITY HEALTH FAIR

Primary Health Care, in partnership with the IWK Health Centre, the Reproductive Care Program of Nova Scotia, the Health Association of African Canadians, and Lab Services, have offered sickle cell testing clinics for the East and North Preston communities and the Hammonds Plains area.

Sickle Cell disease is an inherited blood disorder that affects people of African ancestry and other ethnic groups, including people who are of Mediterranean, Caribbean, and Middle Eastern descent. In addition to sickle cell testing, the free clinics offered information about the sickle cell trait and sickle cell disease.

One of the sickle cell testing clinics was part of a larger community health fair in the Upper Hammonds Plains area. The community health fair provided a range of health information for men, women, and children. Information was provided on overall health and managing ongoing health conditions, as well as topics such as mental health, addiction prevention, cancer screening, diabetes management, and menopause. There was also testing opportunities for BMI, blood pressure, blood sugar, and a chiropractic gait scan and blood typing. From the evaluation of the people who attended, 92% planned on visiting their health care provider to follow-up on information that they received at the health fair.

Constable Jackson's son has sickle cell anemia, which is an inherited blood disorder that can be passed genetically from parents to their children.

ENHANCED TEAM APPROACH

In some Capital Health communities, citizens have access to a team of primary health care providers through health centers and family practice teams. Collaborative inter-disciplinary primary health care teams working to full scope of practice are better for patients, families, communities, and providers. Our goal is to continue to expand these teams across the district.

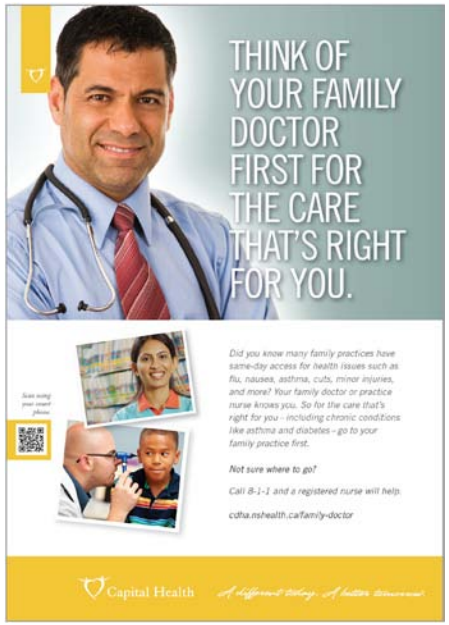
FAMILY PHYSICIANS

Family Physicians play a vital role in the day-to-day primary care needs of more than 400,000 citizens in the Capital Health district. Each of the 450 family physicians in the Capital Health district provide care for up to 1,000 patients, offer first hand knowledge of primary health care, and bring a unique perspective to the leadership of Capital Health.

The District Department of Family Practice (DDFP) represents the family physicians who deliver primary medical care within the Capital Health district. DDFP and Primary Health Care work with family physicians to improve patient care and health system access, and engage in a collaborative approach to primary health care by developing / strengthening relationships within Capital Health to support decision making that affects the primary care system in the district.

DDFP is building a network of family physicians who are developing quality improvement skills and knowledge; by developing networks in the health care community, DDFP is building multidisciplinary teams to explore the delivery of patient care and the role of the family physician.

Family physicians play a critical role in many areas within our district, from being the backbone of primary medical care in our community, to providing care in long term care facilities including the Veterans Memorial Building, managing 450 inpatient beds across the district, teaching undergraduate and postgraduate students, conducting research, and participating in quality initiatives.



FAMILY PHYSICIANS ...

- Deliver 8,000 services collectively each day
- Provide approximately 5,000 house calls to patients each year
- Attend more than 2,300 births at the IWK Health Centre
- Manage 450 inpatient beds and 2,400 long-term care beds

96% of citizens in the Capital Health district have a family physician.

FAMILY PRACTICE NURSES

The Nursing in your Family Practice program is designed to support family physicians to integrate a registered nurse into their practice. Working in a family practice setting as part of a collaborative team, a registered nurse improves patient access, enhances quality of service from both a patient and a provider perspective, provides comprehensive patient care, and improves health outcomes.

There are currently more than 35 Family Practice Nurses (FPNs) working in primary care across the Capital Health district. Originally an initiative of Primary Health Care, the program has now been expanded across the province into other health districts. Evaluation of this program in Capital Health was conducted in 2009/2010, examining the process and outcome measures (Phase 1). A further evaluation of this project was undertaken in 2010 that included a client survey and a chart audit (Phase 2).

Key program outcomes from this evaluation are below:

Phase 1:

- On average, an additional two patients were scheduled each hour resulting in an increase of 40% in capacity, including urgent care patients, which reduced wait times for each practice.

Phase 2:

- FPNs saw 94% of all patients in the practice within a two-year period and were able to enhance quality of care by providing health information on key topics such as smoking cessation and nutrition, recording height and weight, ensuring immunizations were current, and checking blood pressures on a more regular basis (chart audit)
- Physicians reported an improvement in counselling, education, and screening of patients as well as improved chronic disease management and ability to deal with complex cases
- 60% of physicians experienced improved satisfaction regarding how well care is coordinated with other parts of the health care system
- 80% of practices reported improvements in standardized clinical protocols or assessment tools to coordinate patient care since hiring an FPN
- 50% of practices report more accurate and complete patient profiles

Chart Audit Clinical Measures:

- 80% of patients had their blood pressure measured in the past 24 months
- 78% of patients received at least one fasting lipid profile in the past 24 months
- 52% of patients with a BMI over 25 received counseling for nutrition and exercise
- 21% of patients who smoke were offered smoking cessation counseling
- 81% of patients over 65 years of age were offered the influenza vaccine
- 29% of female patients between the ages of 18 and 65 received a pap smear in the past 36 months

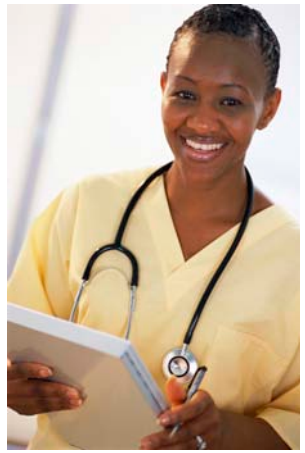
NURSE PRACTITIONERS

Primary Health Care has worked to develop and implement new and enhanced primary health care teams that include interdisciplinary providers, such as **nurse practitioners.** Working collaboratively with family physicians, a nurse practitioner provides primary care for common medical conditions, with a focus on wellness, prevention, and education.

The Hantsport Collaborative Team, established in 2008, serves residents in Hantsport and the surrounding areas, providing a range of comprehensive primary health care programs and services that are offered by a family physician and a nurse practitioner, including assessment, diagnosis, counseling, disease and injury prevention, health promotion, administration, referral, rehabilitation, and palliative care.

The **Musquodoboit Valley Family Practice** undertook initiatives in late 2004 to enhance their collaborative care model. This included the incorporation of a nurse practitioner into the practice, development of new physical infrastructure, team building, and planning and evaluation activities.

Over time, as resources are reallocated to primary health care, it is envisioned that there will be potentially new opportunities to support the role of nurse practitioners in primary care, working with family physicians and others to reach people who do not traditionally access health services, and those with complex chronic conditions.



HEALTH CENTRES

Primary Health Care supports a number of health centres located within the Capital Health district:

Duffus Health Centre is based on a collaborative care model, where patients receive care from a number of health professionals, based on their individual health care needs. Family physicians, along with social workers, nurses, asthma educators, diabetes dieticians, pediatric and adult mental health professionals, and staff of the ANCHOR research project (a heart disease management and prevention initiative) work together to provide comprehensive primary care for patients.

The **Hants Shore Community Health Centre**, owned and operated by the community it serves, is committed to citizen participation in all aspects of health care delivery. The centre delivers comprehensive primary health care by a collaborative health team (family physician, health promotion coordinator and program facilitators, pharmacy clerk, nursery school teacher, and receptionist), along with the establishment of health promotion and preventive medicine structures. The centre is a catalyst for many programs and projects that have a direct impact on the overall wellness of the community; it supports and encourages community involvement, making a continued effort to create supportive environments, strengthen community action, and enables citizens to develop personal skills.

The **North End Community Centre** was founded by local residents in response to a need for health care services in North End Halifax. The centre partners with many local community organizations and service providers to support community health, and also serves as an educational learning environment for students in the health profession. The model of health care delivery at the centre emphasizes inter-sectoral collaboration; it is strongly committed to partnering with community and government agencies to initiate sustainable community-based programs. As well, the centre collaborates with a number of government and community agencies to provide services for women, children, teens, and those struggling with addictions.

The **Community Health and Wellness Centre**, located in the North Preston Community Centre, provides health care services for citizens of African descent who reside in the North Preston community and surrounding areas. Staff at the centre work in partnership with family physicians, nutrition services, the IWK Health Centre, the Diabetes Management Centres, and the Mental Health Program to identify and target the specific health needs of the community.

The **Community Wellness Centre**, located in the Spryfield Shopping Centre, is a joint partnership of Capital Health, Dalhousie Family Medicine, and the Chebucto Communities Development Association. A variety of community-based health services are provided collaboratively at the centre, such as primary medical care, free health and wellness programs, addiction prevention and treatment services, mental health services, and community development resources. The Community Wellness Centre also serves as a hub for resident action and takes a population health approach to improving community well-being.

COLLABORATIVE EMERGENCY CENTRES

As part of the province's Better Care Sooner plan, DDFP and Primary Health Care will be working with citizens and providers to submit proposals for Musquodoboit Valley Memorial Hospital and Twin Oaks Memorial Hospital to become Collaborative Emergency Centres (CECs). CECs bring emergency departments and local family practices together to provide a team-based approach offering continuity of care.

PRACTICE SUPPORTS

Building a Better Tomorrow Together

The Building a Better Tomorrow Together provincial initiative is a series of continuing education modules for health care providers that encourages the development, integration, and support of interdisciplinary teams. These modules are aimed at enhancing interprofessional collaboration and patient-centered practice:

- Conflict resolution
- Decision making and leadership
- Enhancing collaboration
- Generations and learning styles at work
- Interpersonal and communications skills
- Roles and responsibilities
- Team functioning
- Understanding primary health care

Primary Health Care has trained facilitators to deliver the modules of this initiative to collaborative family practice teams within the Capital Health district and will continually work with the Department of Health and Wellness to develop the implementation of this program.

Spring Forum

In the past two years, the DDFP and Primary Health Care have hosted an annual Spring Forum, a multifaceted learning and networking opportunity for the community-based health care system in Capital Health. Focusing on the key pillars of an effective primary health care system, the Spring Forum is structured on the four main initiatives outlined in the Community Master Plan: (1) enhanced team approach, (2) access to health providers, services, and supports, (3) wellness promotion, chronic disease, and self management, and (4) key enablers to a strong health system. Participants interact with the primary health care community in the Capital Health district, attend presentations and discussions, as well as visit the booths that display information about the various programs and services that are available in the primary health care community.

Collaborative Mental Health Conference

DDFP partnered with Capital Health's Mental Health Program and Dalhousie University's Department of Psychiatry to host the 12th Canadian Collaborative Mental Health Care Conference in Halifax in June 2011. Charting a New Course to Better Care: Stronger Links Between Consumers, Families, and Health Care Providers, was an interactive forum to discuss the delivery of collaborative mental health care, showcase several aspects of the triangle of care, and provide new and practical information to use in clinical practices. Evidence-based, innovative, and progressive examples of collaborative mental health care were presented, and the conference showcased the principles and the power of consumer and peer support integration in collaborative mental health care, all combined in an effort to develop a critical and practical understanding of factors that lead to challenges and successes.

CHRONIC DISEASE & SELF MANAGEMENT

Primary Health Care is focused on supporting people who live with a chronic condition to effectively manage their disease. We are working with others to improve coordination between the primary health care system and other parts of the health system, paying particular attention to improving care coordination for those who have more than one chronic condition. Knowing that every individual has the responsibility to manage their own health and understands their own health needs best, we are sharing in this responsibility by making self management easier.

DIABETES MANAGEMENT CENTRES

Capital Health's Diabetes Management Centres (DMCs) work with primary care providers to provide patients with the support they need to manage their diabetes. The DMCs goals are to provide education and self-management support for patients to manage their blood sugars, cholesterol levels, and blood pressure. The DMCs want to help patients maintain their health and prevent the complications of diabetes.

The DMC model advocates and supports an interdisciplinary and integrated approach to diabetes education and management to provide patient centred care. The DMCs adopt a shared leadership approach, promoting integrated patient centered and comprehensive care across the continuum.

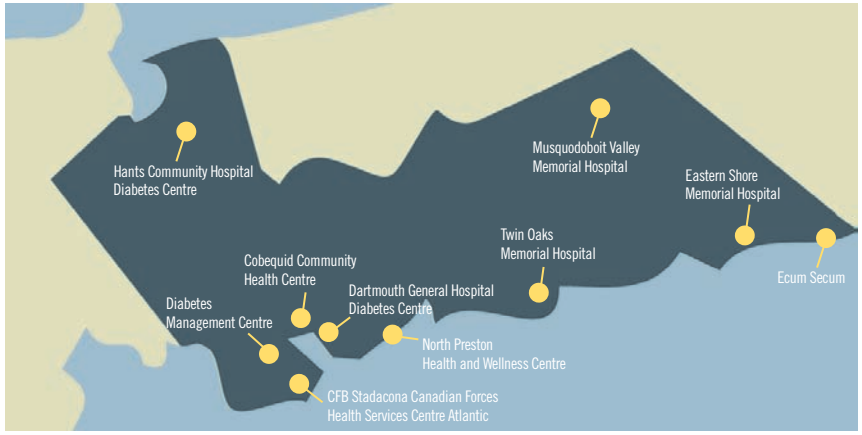
While disciplines such as social work, psychology, podiatry and physiotherapy are available at select sites, the core patient service delivery teams are comprised of a nurse and dietician who are Certified Diabetes Educators. The nurse and dietician team work with patients and other community partners to promote and support the basic tenants of diabetes management: nutrition, physical activity, medication management, self monitoring, and self management.

The DMC model follows a mix of group and individual programing plus a service delivery approach. Programs and services include:

1. Group Behavioral Education Programs for type 2 diabetes and adult type 1 diabetes. This includes sessions on diabetes, heart health, foot care, physical activity, healthy eating, stress management, and other related topics [4]
2. Group Follow Up
3. Individual Consultations (when necessary):
   - Medication management
   - Insulin initiation
   - Insulin adjustment and follow up
   - Insulin pump starts
   - Diabetes nutrition counselling
   - Self-management support
   - Physical activity counselling
   - Links with resources in the community

The DMCs are working to adopt a more integrated approach to chronic disease management that is people-centred and in alignment with Our Promise and the organizational milestones. In the fall of 2011 further changes to programing will occur.

There are five Diabetes Management Centers in the Capital Health district.



[4] While all of our sites vary slightly based on the needs of the population, the majority of sessions run a maximum of one day education program.

Delegated Medical Function: A Patient Centred Approach

Most of the Certified Diabetes Educators (nurses and dieticians) at the DMCs are able to perform an insulin dose adjustment for clients independent of a family physician as a delegated medical function (DMF).

From a patient perspective, this reduces a barrier to accessing timely care; the patient does not need to revisit their physician's office for an adjustment each time an adjustment is needed. Certified DMF Diabetes Educators instruct patients and their caregivers/families how to adjust insulin and provide ongoing education around insulin dose adjustment.

At the foundation of this practice is the constant promotion and support to enable patients to self manage their dosage. This is done with the use of an algorithm tool that enables patients to adjust their dosage with ongoing support from educators. The DMF enables nurses and dieticians to place emphasis on education, counselling, and medical treatment with the patient, who is provided with the knowledge and confidence to develop self management skills to manage their chronic condition.

DMF promotes role optimization of the nursing and dietician functions. Team members are empowered to execute care that in the traditional medical model of care would be defined by a physician. This supports a shift to shared leadership in patient care, promoting seamless comprehensive care at one access point that is more convenient for the patient.

DMF is also efficient and cost effective by eliminating repeat encounters when dose adjustments can be made independently of a family physician.

Accreditation

In 2010, the DMCs engaged in and successfully completed the accreditation process for application of Community Health Services Standards.

Applying the Community Health Services Standards to the DMCs was a new and exciting opportunity enabling the centres to come together as a district team and collectively look at service delivery, showcase successes, and also look to identify opportunities for improvement.

Engaging our Partners

One of the action items identified in the accreditation process was to ask our partners "how are we doing?" While our teams interact with diverse community partners, collectively it was decided to start this evaluation with family practices across the Capital Health district.

In the summer 2010, a survey was administered to family practices in the Capital Health district. The objective of the survey was to solicit general feedback from family practice related to referral rates, awareness of DMC programs and services, accessibility, and quality. Thirty-nine participants completed the survey:

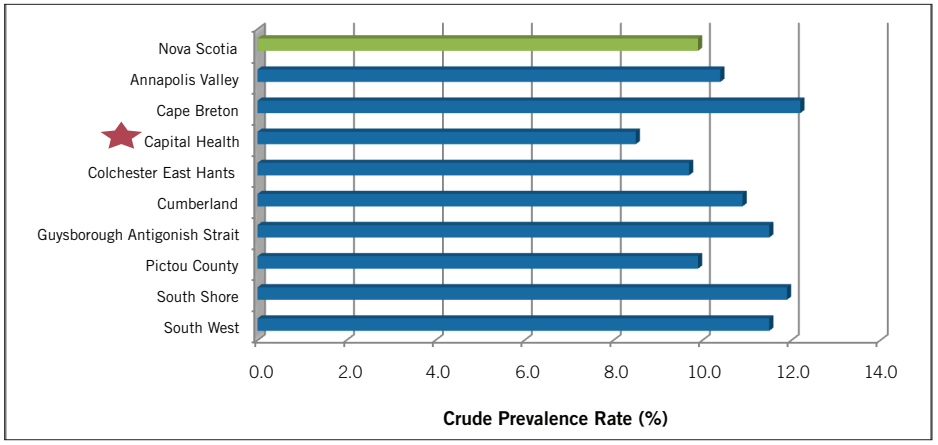
- 64% of respondents refer 75-100% of their patients to the DMCs.
- For respondents who did not refer, identified reasons of non-referral included: patient declines referral (able to manage patients in family practice setting), perceived lengthy wait times, and patient unable to attend.
- 87% found the DMCs to be helpful in managing their patients with diabetes.
- 64% felt that referrals to the DMCs were handled in a timely manner.
- 87% identified the DMC programs and services to be "helpful" in managing their patients with diabetes.
- 48% articulated that "access" to DMC staff via phone consult, fax, and other means of communication was good.

Patient Volumes

For the period of April 2009 - March 2010 the DMCs had a total of 11,635 patient visits. This does not include provider - patient phone consultations. The majority of DMC patient visits are follow-up and re-referrals.

Diabetes Centre	New Diagnosis	Follow ups & Re-referral	Insulin Starts	Total Visits
QEII (Bayers Rd & CCHC)	810	5887	(326)	6697
DGH	311	2299	(79)	2610
Tri Facilities	115	1004	(24)	1119
HCH	56	1153	(44)	1209
Total	1292	10,343	(473)	11,635

The below graphs show the prevalence of diabetes for each district health authority. Capital Health has a crude prevalence rate of 8.5% of the population over 20 years of age with diabetes, slightly lower than the provincial rate.



Source: Nova Scotia Diabetes Statistics Report 2011, Diabetes Care Program Nova Scotia

Below is an overview of the patients that received follow-up care from the DMCs in 2009 as compared to the province.

Characteristics of Adult (≥ 19 yrs) Types 1 & 2 Diabetes Management Follow-Up Cases in Capital Health DMCs - 2009

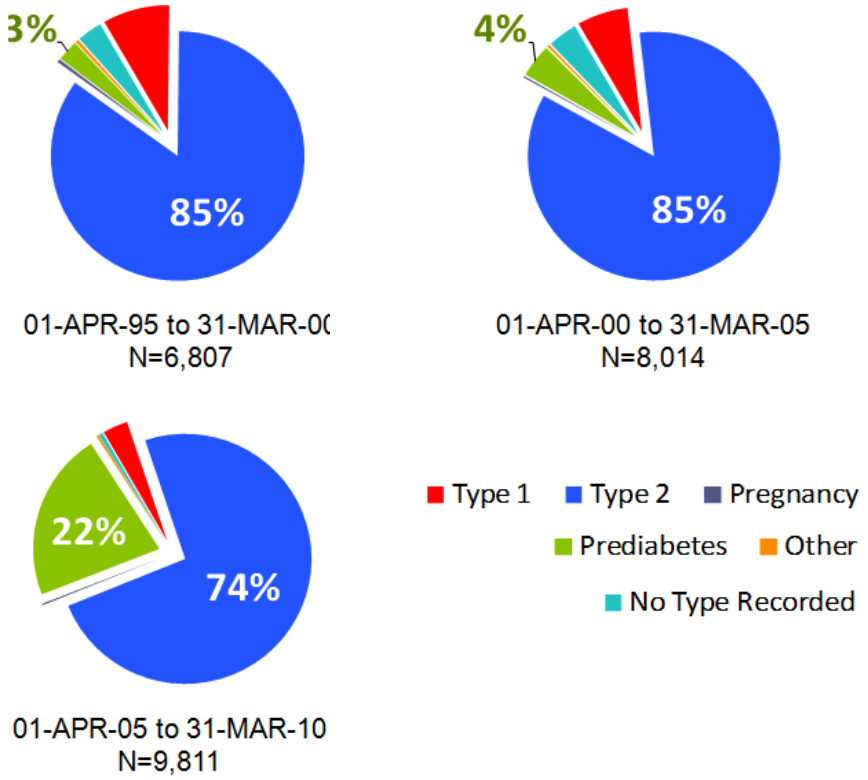
Characteristic	CH	NS
% male / %female	50/50	50/50
Mean age (yrs) as of 31-Dec-09	61.4	65.0
% with body mass index > 30 (i.e., obese)	54.2	55.6
Mean duration of DM in years % of treatment type	9.0	10.7
• Diet/exercise only	21.6	19.5
• Oral agent (OA) only	37.1	45.4
• Insulin only	17.0	17.3
• Insulin/OA combined	24.3	17.8

† Interpret with caution, based on data from only 31% of total Capital Health DMC population

Source: Nova Scotia Diabetes Statistics Report 2011, Diabetes Care Program Nova Scotia

As can be seen below, there has been a seven-fold increase in pre-diabetes management over the last 15 years. The DMCs are working with our community and portfolio partners to improve access to pre-diabetes education and services.

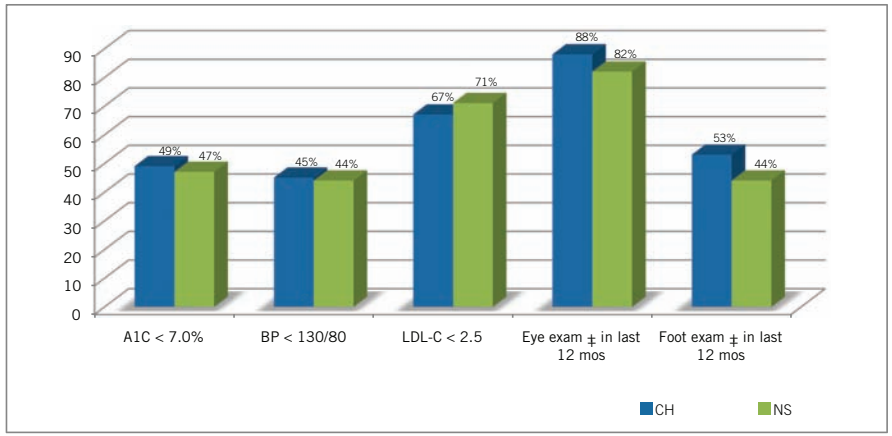
5-Year Trends in Type of Diabetes/PreDiabetes Management for Cases Presenting at Capital Health's DMCs - 1995/96 to 2009/10



Source: Nova Scotia Diabetes Statistics Report 2011, Diabetes Care Program Nova Scotia

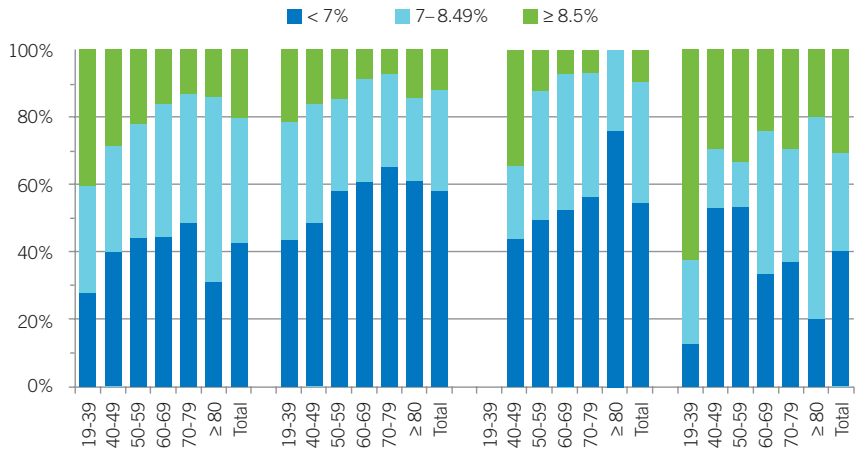
The following graphs show details from patients who visited the Capital Health DMCs in 2009 as recorded in the provincial Diabetes Care Program Nova Scotia (DCPNS).

CH Adult (≥ 19 yrs) Types 1 & 2 Diabetes Management Follow-Up Cases within Management Targets, 2009



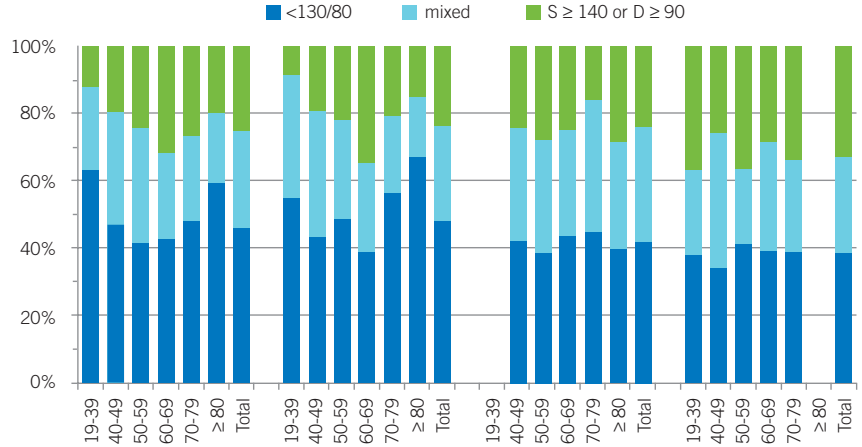
Source: Nova Scotia Diabetes Statistics Report 2011, Diabetes Care Program Nova Scotia

Capital Health - A1C by Age Group and DMC (N = 1,786)



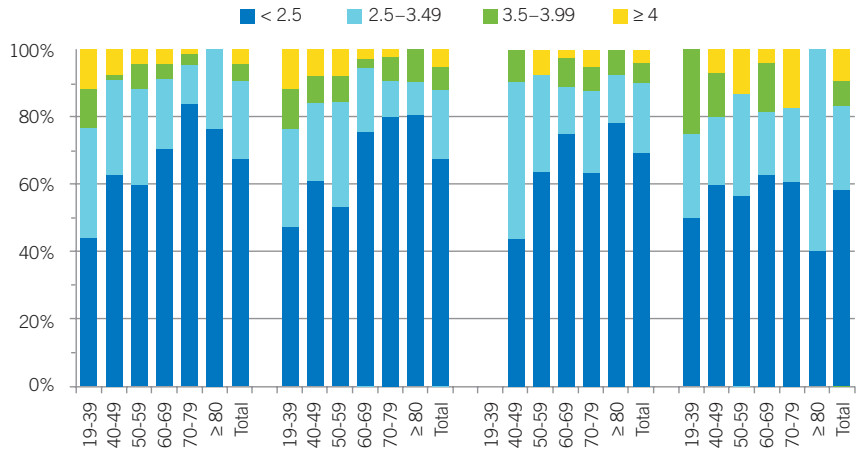
Source: Nova Scotia Diabetes Statistics Report 2011, Diabetes Care Program Nova Scotia

Capital Health – Blood Pressure by Age Group and DMC (N = 1,903)



Source: Nova Scotia Diabetes Statistics Report 2011, Diabetes Care Program Nova Scotia

Capital Health - LDL-C by Age Group and DMC (N = 1,291)



Source: Nova Scotia Diabetes Statistics Report 2011, Diabetes Care Program Nova Scotia

Outcomes*

During 2009/10, approximately 4,700 individuals made almost 12,000 visits to the DMCs. Data from these visits supports that:

- 10% of clients were started on insulin,
- Less than 1% were started on pump therapy, and
- 41% of Capital Health adult follow-up population (2009) were managed with insulin or a combination of insulin and oral agents. This is indicative of more difficult diabetes management.

In 2009/10 there were about 1,300 newly diagnosed patients. 70% of this newly diagnosed patient population had type 2 diabetes, as well as high rates of co-morbidities:

- 62% presented with hypertension,
- 75% presented with dyslipidemia, and
- 50% presented with both hypertension and dyslipidemia.

* Based on the Diabetes Care Program of Nova Scotia Registry Data

The DCPNS registry data demonstrates when comparing select diabetes management targets for the Capital Health adult follow-up population to the corresponding Nova Scotia population in the 2009 calendar year, Capital Health exceeded the provincial average:

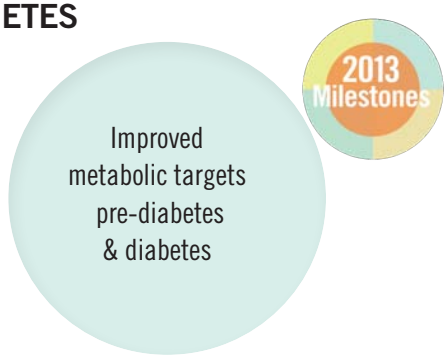
- 49% had A1C < 7.0 %
- 45% had BP < 130/80
- 88% had documented eye exams (target = 80%). In particular, the tri-facilities had the second highest percentage of documented eye exams in Nova Scotia.
- Bayers Road and Cobequid sites had documented foot exams at 95% (target = 80%).
- Capital Health fell below the provincial average in LDL – cholesterol <2.5 at 67%.

A three month pilot analysis of newly diagnosed patients who had follow-up visits eight to 15 months later showed a mean improvement in A1C of 1.1 % . Evidence supports that there is a positive correlation between a 1% A1C decrease and reduced long term risk of complications in Type 2 diabetes (e.g. 43% reduction in lower extremity amputation; 37% reduction in micro vascular disease; 14% reduction in myocardial infarction). Of note, patients in this three month pilot who were managed using medication (insulin and/or oral agents) had a mean 3.7% drop in A1C.

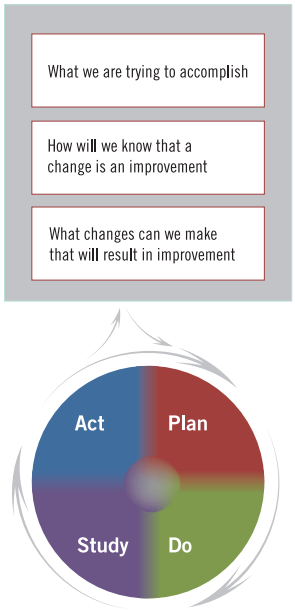
"As a relatively new insulin patient, I can't begin to tell you how much it means to me to have the Diabetic Management Centre caring for me. My team, as how I refer to my RN & Dietician, is absolutely the best! I feel sincerely cared for and cared about while receiving assistance and answers to my questions each and every time. They're always there for me and I cannot imagine going through this new life challenge without them."

– Donna

QUALITY COLLABORATIVE - DIABETES



Quality collaboratives are organized efforts to reinforce evidence-based health care in real life settings. They were pioneered by the Institute of Healthcare Improvement and have been successfully applied in British Columbia, Saskatchewan, Ontario, Australia, and the United Kingdom. Family physicians and members of their teams come together to learn and share ways of cesses and outcomes, apply the learnings in their practices, and track the impact of the practice improvements. Research and experience demonstrates that quality collaboratives are an effective way for primary health care providers to learn and support improvements in health outcomes for patients.



Primary Health Care's first quality collaborative is focused on diabetes, a common health condition that can lead to serious health complications if not effectively managed. Through this quality collaborative, patients of participating family practices, from across the district, will receive improved diabetes care, leading to improved diabetes outcomes (medium to long-term) and patient satisfaction. Intra and interdisciplinary working relationships among the participating family physicians and other primary care providers will improve, and will contribute to building confidence in primary care providers to address quality of care on an ongoing basis.

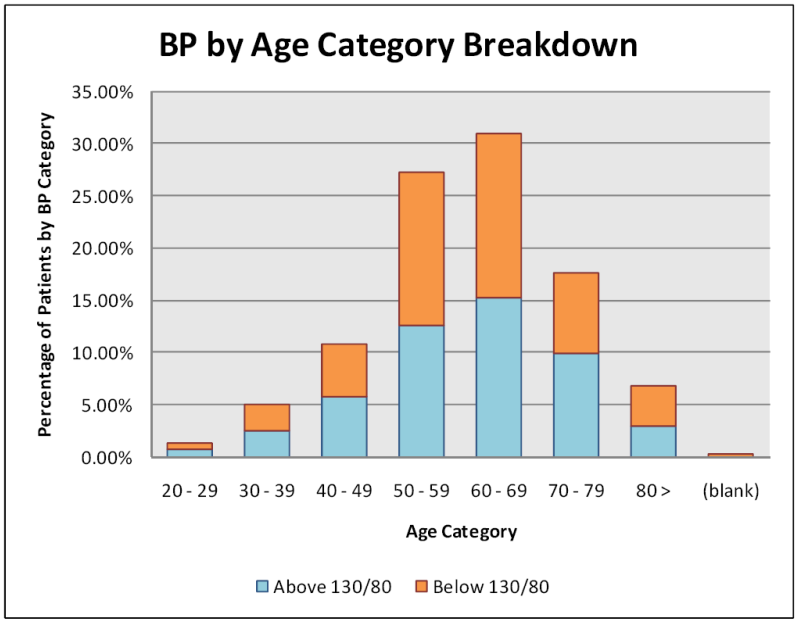
Aims and Measures of the Quality Collaborative for Diabetes:

Improvement Area	Measure
Know patients living with diabetes	Number of diabetes patients who are entered into the diabetes registry
Capture of clinical measures	Number/percentage of patients with diabetes who have their clinical measures documented or reviewed
Use of a care plan	Percentage of patients with diabetes (baseline) with a care plan (with a self management component) created or reviewed
BMI	Percentage of patients with diabetes (baseline) who have BMI documented
Eye	Percentage of patients with diabetes (baseline) with eye exam discussed and/or referred
Lipids	Percentage of patients with diabetes (baseline) with last recorded LDL-C < 2.0
Blood	Pressure Percentage of patients with diabetes (baseline) with last recorded Blood Pressure level ≤ 130/80
hbA1C	Percentage of patients with diabetes (baseline) with last recorded bbA1C of ≤ 7%

[7] Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study."

Quality Collaborative - Diabetes (continued)

The below graph shows a sample of the kind of baseline information that is being collected and analyzed as part of the Quality Collaborative, which is then provided to the site teams / physicians in individualized feedback reports.



Source: Quality Collaborative: Diabetes; Baseline Data Report, August 2011

YOUR WAY TO WELLNESS

Offered across the province, **Your Way to Wellness** is a free self-management program to help those with chronic conditions overcome some of the daily challenges that they face. Developed by Stanford University, the program teaches participants how to set goals and learn problem solving skills to take action and live a healthy lifestyle. Participants learn how to eat healthier, become more active, manage symptoms, improve self-confidence, manage difficult emotions, and learn strategies to improve communications with their doctor and other health care providers. The program is led by trained volunteer leaders, many of whom have chronic conditions themselves.

With sessions that have been completed during 2010, pre and post survey analysis showed that participants' confidence in managing their chronic condition had improved, based on six questions that measure self efficacy in managing their chronic condition. Changes in confidence level are as follows:

Pre survey confidence measure: 6.2
Post survey confident measure: 7.78
(Not at all Confident = 1, Totally Confident = 10)

Now with newly trained lay leaders, a partnership with the Halifax Public Libraries has been developed to deliver the Your Way to Wellness program through their adult programming services; the sessions will be advertised through the seasonal Library Guide. As well, sessions will be offered at the two Community Health Teams on a quarterly basis.

Sessions completed since March 2010: eight

June 2011 lay leader training:

- 12 new people have been trained to deliver the program
- two of these lay leaders speak Arabic

Total trained volunteers (lay leader and master trainer) in program: 19

ACCESS & URGENT CARE

Citizens expect timely access to health care in the most appropriate setting by the most appropriate provider. Primary Health Care is focused on improving people's access to primary medical care by working in partnership with family physicians across the Capital Health district.

MOBILE OUTREACH STREET HEALTH

An initiative of the North End Community Health Centre (NECHC) in partnership with Capital Health, **Mobile Outreach Street Health (MOSH)** provides accessible primary health care services for people who are homeless, insecurely housed, street involved, or underserved in our community. Accessing the health care system can be difficult, or even impossible, for the many people who are living on the margins of our communities.

The MOSH team meets clients "where they are," providing primary care in community locations and on the streets of Halifax and Dartmouth where clients are most comfortable, and also providing care strategies that are adapted to meet the current life situation of each client. The program has three core objectives:

- To increase access to effective and equitable primary health care for community members across the life span who are homeless, street involved, or insecurely housed.
- To improve the health status of marginalized and underserved populations.
- To create a collaborative environment in which information, knowledge, and resources are shared among community service, health care, academic, and government organizations.

Through partnerships with community agencies, the MOSH team provides outreach services at a wide range of shelters and organizations, including: Adsum House, ARK, Barry House, Brunswick Street Mission, Feeding Others of Dartmouth, Hope Cottage, Metro Non-Profit Housing and Support Centre, Metro Turning Point, and the Salvation Army. MOSH nurses also travel in the MOSH outreach van with the Mainline Needle Exchange and Stepping Stone outreach teams to provide primary care services on the streets in the Halifax and Dartmouth area.

Services offered by MOSH

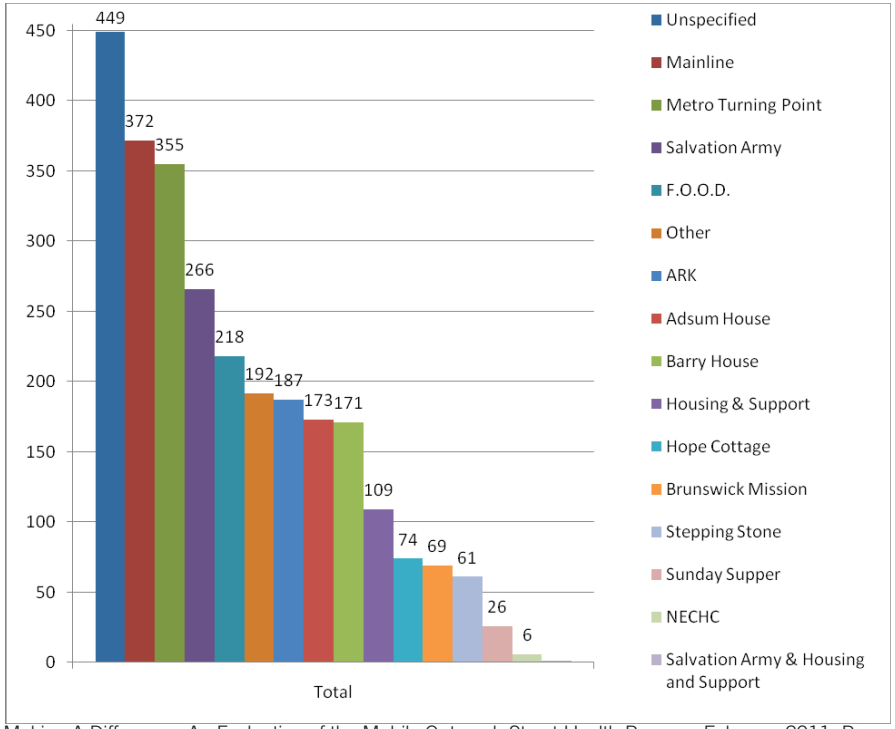
- Addiction-related support
- Birth control and condoms
- Blood work
- Emergency contraception
- HIV and Hepatitis C testing
- Harm reduction supplies
- Health and occupational therapy assessments
- Health promotion programming
- Help getting a health card
- Help managing chronic diseases such as diabetes and heart disease
- Help organizing dental and eye exams
- Help with life skills and daily activity
- Help with medication
- Nursing assessments and triage of health concerns
- PAP tests
- Pregnancy testing
- Referrals to other health professionals
- Sexually Transmitted Infection testing
- Vaccinations
- Vein care
- Wound care

2013 Milestones

25% increase in access initiative for underserved/vulnerable groups

MOSH Program Evaluation

The MOSH program began operation in the fall of 2009. During a 10 month period from November 2009 to August 2010, MOSH nurses had **2,729 client encounters** at various partner locations.



Making A Difference: An Evaluation of the Mobile Outreach Street Health Program February 2011. Pyra Management Consulting Services Inc

There are a wide range of reasons why clients access the MOSH team. The more common reasons include health promotion and education, addressing basic needs (e.g. getting hats, gloves, sleeping bags, food, juice), addressing health determinants (e.g. assistance in accessing housing), providing emotional support, accessing support (e.g. helping to acquire income assistance), and dealing with mental health issues as well as physical health issues (eg. addictions, wound care, and respiratory health).

Beyond Barriers: Photographs from the Frontlines of Health

In January 2011, Capital Health hosted Beyond Barriers: Photographs from the Frontlines of Health, a photography exhibit that celebrated the courage, compassion, and ingenuity of health practitioners who have dedicated themselves to helping Canada's underserved populations. The inspiring stories of frontline health practitioners and patients was documented by a team of award-winning Canadian photojournalists, and featured the work of the MOSH team in Halifax. The Beyond Barriers exhibition is part of the Frontline Health program, a corporate citizenship initiative of AstraZeneca Canada that supports frontline health care workers serving Canada's vulnerable and marginalized populations.

PRIDEHEALTH

Access to safe health care in the existing health system is difficult for many people who are gay, lesbian, bisexual, transgender, intersex, or queer (GLBTIQ). **prideHealth** provides safe and accessible primary health care services for the GLBTIQ community in the Capital Health district by offering health services in community locations and places that are considered safe, improving the health outcomes of the GLBTIQ community.

The prideHealth program raises awareness about the primary health care needs of the GLBTIQ community through sensitivity training, social marketing, health promotion, chronic disease prevention sessions, and training for multidisciplinary health care professionals. As well, the program builds sustainable partnerships with internal and external stakeholders, and reviews policy in order to ensure inclusion of the community as a vulnerable population. prideHealth is a collaborative program supported by Capital Health and the IWK Health Centre.

There is a part time Clinical Nurse Specialist who offer a variety of clinical and health promotion services at four locations on a regular basis (Menz Bar, Stepping Stone, Aids Coalition of Nova Scotia and Youth Project). In fiscal year 2010/11 there were 484 recorded visits, with sexual health, health promotion and transgender health being the top three health issues. The Clinical Nurse Specialist has developed a rapport and trust within the pride community which enables her to be effective in her role.

Continuing Medical Education in Transgender Health Care

prideHealth held two continuing medical education events in the last year that focused on transgender health care in Nova Scotia. Participants learned:

- How to better provide specific health care for the transgender community;
- About the range of clinical protocols and processes related to gender identity disorder; and
- How to provide specific care, readiness assessments, and referrals for those in the transgender community seeking endocrine therapy and surgical treatments.

As a result of the CME training, the number of clinicians now qualified to provide hormone and sex reassignment surgery assessments has greatly increased. A direct result of the training was the creation of a peer led Trans Clinical Supervisory Group that meets once a month. This group not only provides clinical support, but also has access to a variety of people who are specialist in the field from across the country. This group is committed to continuing to increase the opportunities of education for the improvement of trans health in the Capital Health district.

Pride Week

Each year, prideHealth participates in Halifax Pride Week, hosting activities and events for health care providers and the general public: two discussion panels were held, one foucsed on GLBTIQ Sexual Heath: Beyond Disease and the other on GLBTIQ Elders and Inclusive Care; three information displays were setup at Capital Health and IWK locations featuring community resource materials; two interactive health booths with a variety of activities for adults and children were located on the festival grounds; and a float was entered in the annual parade, with over 45 employees and their families / friends participating.

PRIMARY HEALTH CARE CONNECTIONS

Everyone needs a family doctor. Continuity of care with a primary health care team results in better, more coordinated care, and better overall health. Primary Health Care Connections is an initiative that assists people with finding a family physician or collaborate team practice, and is currently being piloted with patients presenting at the three urban emergency departments in the Capital Health district who indicate that they do not have a family physician. Over time, an expected outcome of this initiative is to redirect some people to visit a family physician rather than seek care in the emergency department for health conditions that can be more appropriately treated in a family practice setting.

Since the launch of the program in February 2011, over 50 family physicians in Capital Health have agreed to accept patients into their practice through this service. 162 citizens have been placed with a new family doctor with 60% of people being placed in five days or less.

URGENT CARE CENTRE

Working in partnership with four family practices in the East Dartmouth community, the Urgent Care Centre provides patients of the participating practices with same-day access to medical care on the weekends for urgent, non life-threatening health conditions that require prompt treatment. Between the weekends of January 7 and May 29 2011, a total of 3,335 patients have been seen at the Urgent Care Centre.

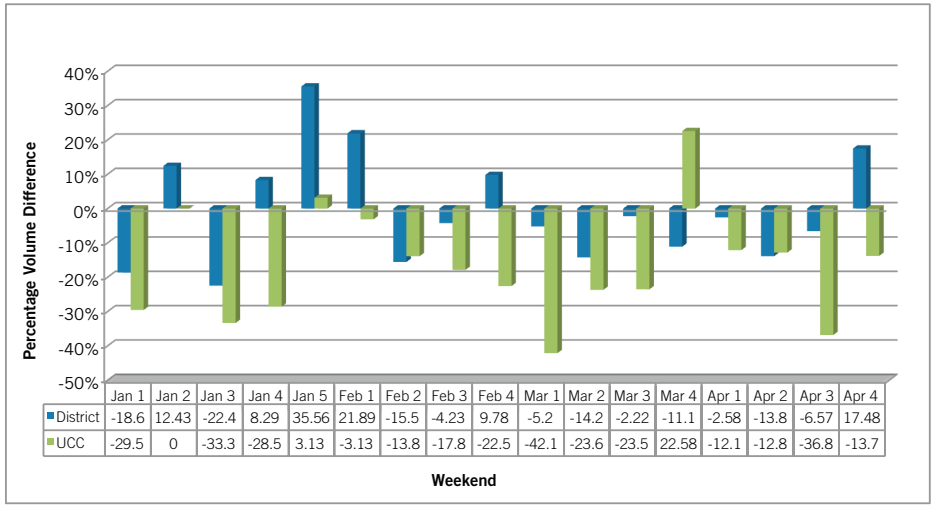
The family physicians on duty at the Urgent Care Centre are able to provide better continuity of care than is typically provided at a walk-in clinic, and give patients a more effective option for urgent health conditions that can be treated by a family physician rather than visiting an emergency department.

One of the primary objectives of the Urgent Care Centre is to reduce the number of patients presenting in the emergency department with health conditions that can be treated by a family physician. The graph on the following page demonstrates a difference in the usage of emergency departments for the patients of the physicians participating in the UCC in 2011 compared to the same time frame in 2010.

Preliminary results show a 17.49% reduction in the number of patients of the participating family physicians in the Urgent Care Centre that visited an emergency department with CTAS levels 4 and 5 complaints, when compared to the previous year. Patients of non-participating family physicians show a reduction in visits of 1.79% for the same comparison (excluding hospitalists and rural family physicians).

With the preliminary data indicating that the Urgent Care Centre in East Dartmouth is reducing low-acuity visits to the emergency department, Primary Health Care will be looking at the possibility of forming more Urgent Care Centres within the Capital Health district.

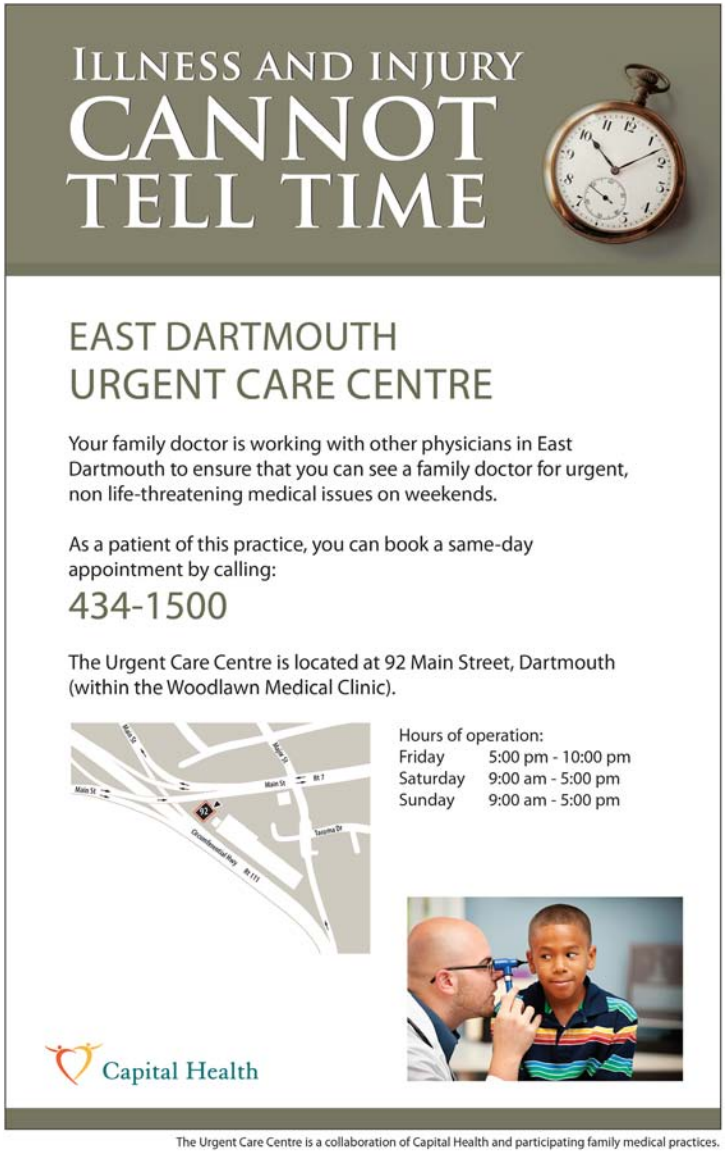
Percentage differences in ED visitors for CTAS 4 & 5 UCC Family Physicians vs rest of the district (comparing weekend to weekend Jan. - Apr. 2010-2011)



	Jan 1	Jan 2	Jan 3	Jan 4	Jan 5	Feb 1	Feb 2	Feb 3	Feb 4	Mar 1	Mar 2	Mar 3	Mar 4	Apr 1	Apr 2	Apr 3	Apr 4
District	-18.6	12.43	-22.4	8.29	35.56	21.89	-15.5	-4.23	9.78	-5.2	-14.2	-2.22	-11.1	-2.58	-13.8	-6.57	17.48
UCC	-29.5	0	-33.3	-28.5	3.13	-3.13	-13.8	-17.8	-22.5	-42.1	-23.6	-23.5	22.58	-12.1	-12.8	-36.8	-13.7

Source: EDIS Reporting; CTAS 4 & 5 weekend visits only included; (Weekend defined as between 5:00pm Friday – 9:00am Monday);

Notes: Weekend 1 April (2010) and Weekend 4 April (2011) included the Easter Holiday Weekend;



PRIMARY HEALTH CARE ZONES

In the future, by dividing the Capital Health district into primary health care zones with an established network, citizens will have a better coordinated and integrated team of primary health care providers and community partners. Currently being partially modeled in Dartmouth, the zone network structure will be more responsive to the health needs of the particular populations in this community, and help primary health care teams to provide better continuity of care.

Primary Health Care plans to work with partners to establish zone networks across the district, where people will have access to their family physician and a team of primary health care providers, who will work together to provide coordinated access to health care services within each zone. The zone structure will facilitate public input into wellness initiatives and care planning and delivery, and will expand opportunities for citizens to access coordinated and integrated primary health care teams closer to home.

DARTMOUTH COMMUNITY NETWORK

To strengthen the health of the Dartmouth community, people who live and work in this community have formed the Dartmouth Community Network. Co-led by the Dartmouth Community Health Board, the Dartmouth Community Network seeks to enhance the coordination and cooperation between community groups. It is responsive to the health needs of the particular populations across Dartmouth, and will use available health information and community engagement results to identify priority areas for its work. Members of the network include citizens and primary health care providers from the Dartmouth area, as well as representatives of Capital Health.

FOUNDATIONAL ELEMENTS & ENABLERS: QUALITY, INFRASTRUCTURE, ACCOUNTABILITY, AND CULTURE

Foundational elements have been developed to guide ongoing and future work of Primary Health Care, including frameworks for quality, compentency , practice facilitation, health and wellness, and wellness navigation. These frameworks will continue to evolve as the work of Primary Health Care evolves.

QUALITY FRAMEWORK

With the number of programs and initiatives being developed within Primary Health Care and the District Department of Family Practice, it was determined that specific indicators were required to evaluate and measure these new projects from their inception. In 2008, a Quality Framework and strategy for the combined District Department of Family Practice and Primary Health Care portfolio in Capital District was undertaken. With leadership from the portfolio, and the support and direction of an advisory group, a review of provincial and regional documents related to quality direction and initiatives was completed, as well as a literature review and external (to Nova Scotia) environmental survey.

Based on the literature, survey, and reviews / interviews from the national (Canadian), provincial (Nova Scotia), regional (Capital Health), and local (primary care and primary health care within Capital Health) perspectives, a comprehensive Primary Health Care Quality Improvement Framework was developed. The associated dimensions of quality for the framework are those as defined by Accreditation Canada.

This framework includes potential indicator sources at the local, regional, provincial, and national levels that primary health care teams can use to monitor successes and improve the quality of services. The sources can assist in identifying indicators, both clinical and non-clinical, that are relevant and meaningful to the teams. To assist with the utilization of these indicators it is recommended that:

1. A few select indicators, both clinical and non-clinical, be identified based on the criteria as approved by the advisory group;
2. The identified indicators be traced through all levels (local, regional, provincial and national) of indicators (i.e. access to services), and be representative of work across many initiatives; and

3. The identified indicators be clearly defined, with identification of collection, monitoring, analysis and reporting methods; various tools identified throughout the report can be utilized to assist with collecting data (i.e. the Nova Scotia Department of Health Primary Health Care Evaluation surveys).

Any organization depends on quality information for effective operations and decision-making. Developing this Quality Framework is the first step in establishing the ability to demonstrate effectiveness of Primary Health Care on our community. An implementation plan is currently being developed and realized.

The framework has informed the Primary Health Care team to ensure that each new or current initiative, program, or service has the ability to report on indicators that are relevant to the success of the initiative, and supports the overall Quality Framework and dashboard (monitoring and implementation of framework).

Quality Framework Dashboard Implementation Updates

The dashboard includes:

- Indicators by quality dimension
- Definitions
- Data gathering plan (tools)
- Link to Capital Health 2013 Milestones/Our Promise
- Timelines

Challenges and considerations:

- Community based
- Ongoing data collection not often available (in a 'system')
- Rely on multiple data sources

The Primary Health Care dashboard indicators have been carefully selected from the longer list of acceptable indicators that resulted from the Quality Framework initiative. From the reduced list of 16 indicators, most have a link to the Capital Health Milestones.

Indicators by Quality Assessment and Domain

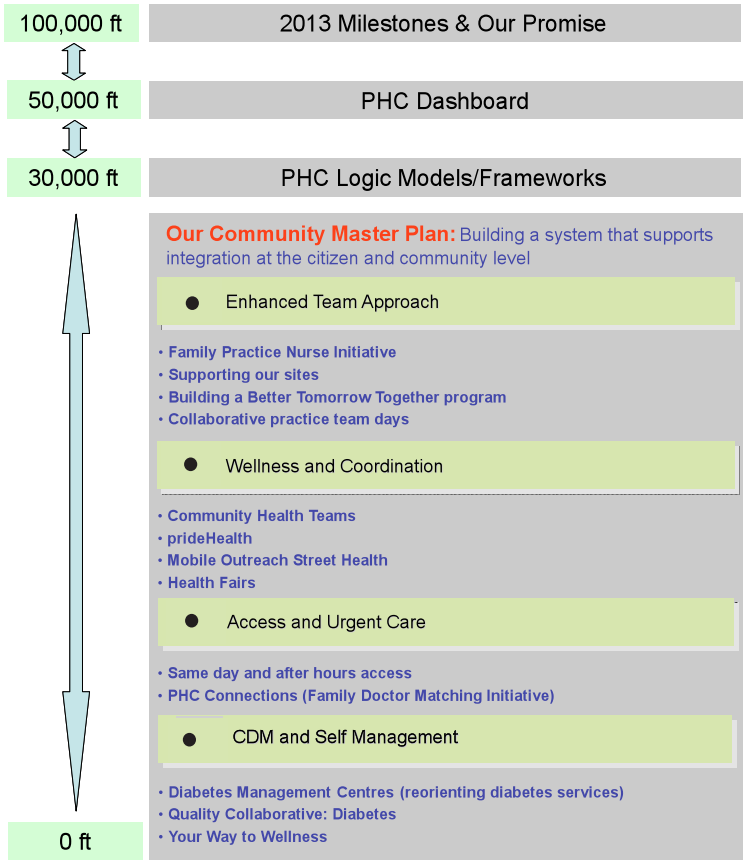
Population Focus
Percentage of targeted processes in place for community input for planning zone services (e.g. advisory committees, focus groups, web-based education and feedback) (CIHI 8 modified)
Percentage of population 18+ years who reported a BMI between 25.0 and 29.9 (CHI)
Percentage of population 18+ years who reported a BMI>30 (CHI)
Accessibility
Average number of days between patient appointment request with their regular primary health care provider and the appointment for non-urgent routine care health problem* (CIHI 32) * Defined as access to a nurse or other health professional (for example, dietician, nutritionist) or both at their medical doctor or regular place of care
Average number of days between patient appointment request with their regular primary health care provider and the appointment for an urgent but minor health problem* (CIHI 32) * Such as a fever, headache, sprained ankle, vomiting or unexplained rash OR Percentage able to see a doctor the same day for an urgent but minor health problem
Percentage of primary health care organizations currently providing after hours coverage* (beyond 9 am to 5 pm Mon to Fri) for their practice population (CIHI 30) * This could include participating in call schedules or office hours beyond MF 9-5
Percentage of population who received primary health care services from an interdisciplinary primary health care organization within the past 12 months* (CIHI 94)

Indicators by Quality Assessment and Domain

Client Centered
Percentage of primary health care patients, 18+ years with a chronic condition(s) who report improved self confidence in managing their chronic conditions.
Percentage of vulnerable/special needs population groups currently provided a specialized focused program* * Vulnerable groups to be defined (e.g. language, recent immigrants)
Effectiveness
Percentage of primary health care patients 18+ where the last HbA1c was < 7.0% (or equivalent) (CIHI 39 modified)
Percentage of primary health care organizations that primarily use electronic systems to complete their professional tasks beyond patient appointment, scheduling and billing to include the entry & retrieval of clinical patient notes. (CIHI 100 modified)
Efficiency
Percentage of population who have made a visit to the emergency department in the past two year for CTAS triage levels 4 and 5
Safety
Percentage of primary health care organizations who currently use an electronic prescribing/drug ordering system that includes patient specific medication alerts (CIHI 68)
Percentage of primary health care organizations with appropriate temperature record keeping of medication/vaccination refrigerators
Work Life
Percentage of primary health care providers who are satisfied with the overall quality of work-life balance by provider type (CIHI 92)
Continuity
Physician continuity: percentage of primary health care patients seen by their usual family physician (instead of a different family physician) Target for QIIP >85%

In addition to the Quality Framework indicators, each program, initiative or service within Primary Health Care has considered quality and evaluation in planning and implementation. This involves developing a logic model and an evaluation matrix that outlines the quality measures that are important to measure if each project is meeting the stated goals and outcomes.

Implementation of Quality / Evaluation in Primary Health Care



PRIMARY HEALTH CARE COMPETENCY FRAMEWORK

An innovative and novel initiative is being developed within Primary Health that focuses on the development of a Primary Health Care Competency Framework. After an extensive literature search, both nationally and internally, a set of competencies for Primary Health Care was not found. The Primary Health Care Competency Framework provides a comprehensive outline of the recommended competencies required for effective primary health care interprofessional and community collaboration and service provision. This Primary Health Care Competency Framework is being mapped to already existing competency frameworks that are complementary and that have been well research and validated. The Primary Health Care competencies can support the "Innovation and Learning" and "Transformational Leadership" strategic streams of Our Promise.

PRACTICE FACILITATOR FRAMEWORK

The practice facilitator is a new role to Primary Health Care and Capital Health. Working directly with family physicians and their practice team, the practice facilitator seeks to assist with quality improvement changes at a practical level. Currently we are working to develop the scope of practice and establish some of the pathways for accessing this service. This will be outlined in a framework document in fall 2011.

The framework discusses the history of practice facilitation and how it has evolved over time, as well as some of the best practice models nationally and internationally including England, Australia, Netherlands, United States, and Canada. The framework highlights some of the more practical elements of conducting practice facilitation such as how the service will be promoted, assessed delivered. We discuss the evaluation of this work and how it feeds back to the Capital Health milestones.

HEALTH AND WELLNESS PROGRAM FRAMEWORK

The Health and Wellness Program Framework is the structure for all of the education initiatives of the Community Health Teams (CHTs). Educational programs and supports focus on health promotion, disease prevention, and chronic disease management, and the CHTs are informed and guided by models that are reflective of this focus (e.g. Expanded Chronic Care Model, Health Promotion Circle of Health Model, and Population Health Promotion Model).

There are three components of the Health and Wellness Program Framework:

1. Wellness Programming: Leading

The CHTs lead health and wellness programming that focuses on general lifestyle and overall wellness content, as well as risk factor management for key risk factors that are common across chronic conditions (i.e., not disease specific education).

2. Wellness Programming: Linking

The CHTs link / collaborate with other provider groups, community agencies, and partners who deliver information on disease specific or knowledge specific topics. These topics focus on risk factor management related to chronic conditions and supports related to the social determinants of health that require content expertise.

3. Wellness Navigation

The CHTs help to navigate the health system, working collaboratively with family physicians, community groups, specialty programs, and other providers and groups to support individuals and families to make connections with the appropriate services, supports, or programs that are needed to support health and wellness.

The program components of the framework provide a supportive environment that allows individuals to access the tools and information they deem necessary to promote positive behaviour change through the provision of health information, community resources, and emotional support. The purpose of these components is to educate community members on their general health and well-being, create supportive environments during group sessions, and encourage the community to take ownership of their personal and collective health.

WELLNESS NAVIGATION FRAMEWORK

Wellness navigation focuses on navigating community members using their personal resource base through community resources and supports for the purpose of achieving wellness in their own lives. Wellness navigation also aims to link key components of the community resource base together, and build capacity of the knowledge base within the CHT communities.

The CHT Wellness Navigation Framework has been guided by A Framework of Support (focus: working with individuals with mental illness in the community) and the Supportive Care Framework (focus: person-centred cancer care in the community). Both of these theoretical frameworks have many elements in common with health promotion and supporting the change experience, which aligns with the overall model of the CHTs. As well, the Wellness Navigation Framework is based on current roles of patient navigators within the Capital Health district, but has been adapted to focus on the health and wellness of a community of people rather than on a diagnosis.

There are three components to the Wellness Navigation Framework:

1) Community Member Wellness Navigation

A flexible and dynamic process based on the community member's needs, focused on the importance of having an open dialogue with the community member to find out where they are in their wellness journey.

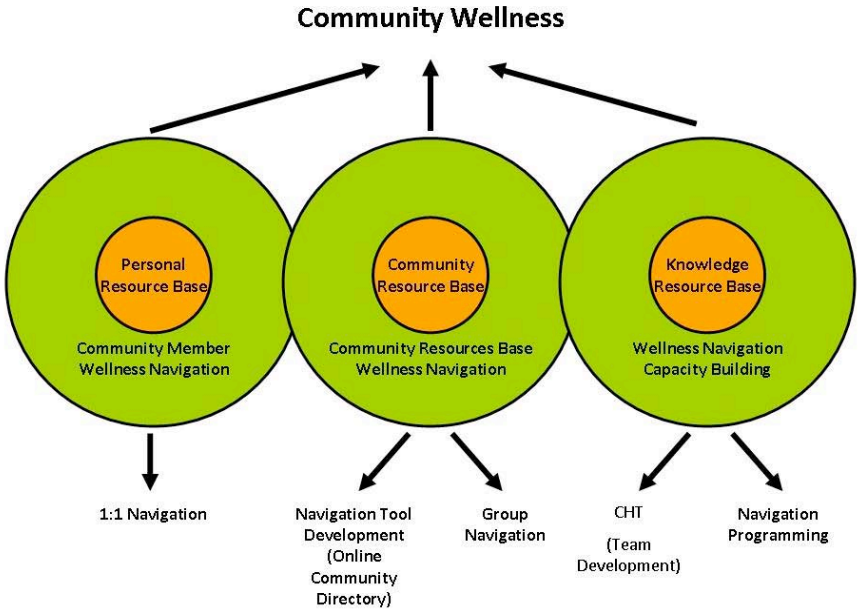
2) Community Resource Base Wellness Navigation

Focused on developing community tools and resources to promote self management. The Wellness Navigator builds relationships and partnerships with community resources and provide group navigation to expand the CHTs relationship with the Community Resource Base.

3) Wellness Navigation Capacity Building (Programming and Team Development)

a) The focus of wellness navigation programming is to promote community capacity building around navigation skills.

b) The purpose of team development around wellness navigation is to increase the capacity of the CHT staff to support community members with navigation needs.



Community Health Team – Wellness Navigation Framework Model

RESEARCH & INNOVATION

Team members working in the Primary Health Care portfolio are often asked to participate in research or innovative initiatives or are leading initiatives; we strive to be innovative in our work and use rapid cycle improvement.

PUBLICATIONS

- The Role of Family Practice Nursing in Capital District Health Authority (in progress)
- Building and Quality Framework for Primary Health Care (in progress)
- Using Qualitative Indicators to Evaluate the Effect of Implementing an Enhanced Collaborative Care Model Among a Community, Primary Healthcare Practice Population

GRANT FUNDING

- 2011 Planning for Access: Integrating accessibility, service delivery and workforce planning for PHC, (Tomblin Murphy, Gail) Lynn Edwards – team member.
  Status: Submitted for CIHR Planning Grant
- 2010 Access to Nova Scotia Family Physicians and their Models of Practice (Emily Marshall) Rick Gibson - investigator.
  Status: Submitted project to NSHRF (funding decision pending).
- Primary Care Practice Survey – Validity and Reliability
  Status: ongoing. Fred Burge, Bev Lawson, Lynn Edwards, principle investigators.
- Transdisciplinary Understanding and Training on Research (TUTOR) – PHC National Program Advisory Committee – Lynn Edwards (advisor).
- Canadian Health Services Research Foundation
  Participation in EXTRA (Executive Training for Research Application program): Lynn Edwards, Rick Gibson, and Shannon Ryan.

AWARDS

Finalist for the 2010 IAP2 Project of the Year, recognizing the citizen and stakeholder engagement work that the Community Health Teams implemented.

ACCREDITATION CANADA

Primary Health Care at Capital Health (via Duffus Health Centre and North End Community Health Centre) participated in a national pilot project with Accreditation Canada to review and help identify standards for Primary Care Services. Capital Health was one of eight organizations from across the country that participated in the pilot project. The Primary Care Services Standards were formally approved by Accreditation Canada's Board of Directors in 2010. These standards offer a unique, new process for assessing and reviewing the primary care services provided by health services organizations, be they large hospitals or small, community-based clinics. The new standards effectively complement other Accreditation Canada standards.

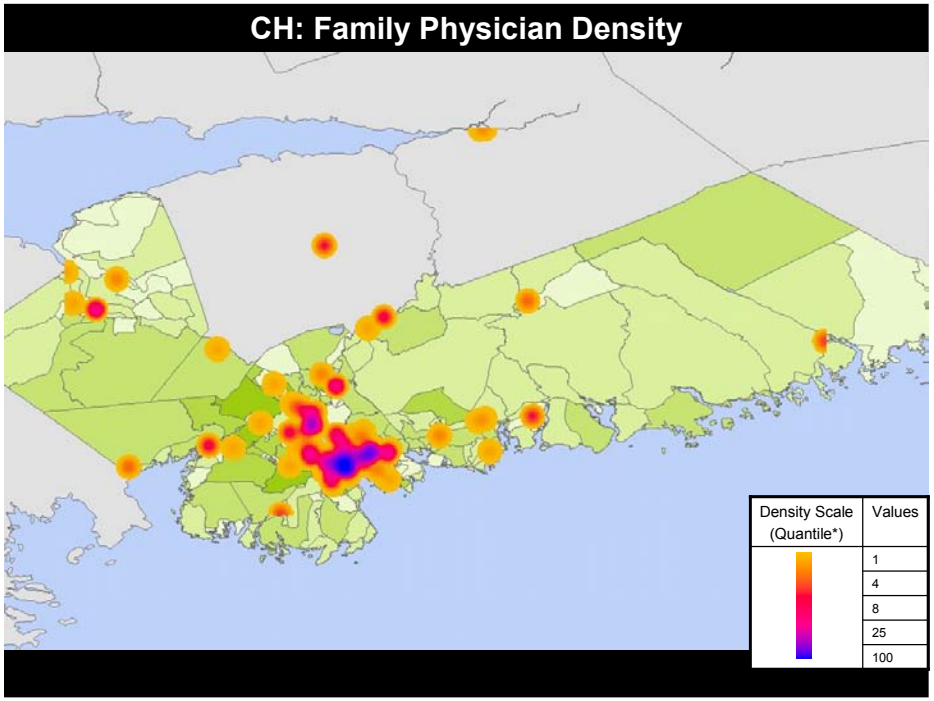
ABSTRACTS PRESENTED / SYMPOSIUMS REPRESENTED

1. Accelerating Primary Care Conference, October 2011 (selected for Poster Presentations):
   - Urgent Care for Urgent Problems: An Urgent Care Centre in Dartmouth, NS
   - Quality Framework Development to Measure Primary Health Care Outcomes: Capital Health District Authority, Nova Scotia
   - Family Practice Care Networks
2. Canadian College of Health Service , 2010 National Health Leadership Conference (selected for presentations):
   - Re-engaging Family Physicians: Creating a District Department'
   - Citizen Engagement - An Innovative Practice to Inform the Development of Community Health Teams
   - 'Asking for a Little Neighbourly Advice', community Conversations on 'Our Health'
3. Evaluating the Impacts of Public Engagement in Health Systems: Knowledge Ex change: (June 17, 2010 Wakefiled, Quebec)

   This knowledge exchange event was part of a multi-year national in scope research study. The purpose of the gathering was to bring together decision-maker partners and the research team to share recent experience and perspectives on punlic engagement and discuss the findings of the study to date.

GEOGRAPHIC INFORMATION SYSTEM

Primary Health Care has collaborated with Dalhousie University (Faculty of Health Information) and Information Technology at Capital Health to explore the use of Geographic Information System (GIS). Initial steps were made to scope and develop GIS data that would help provide single-point access to comprehensive community data and information. Use of GIS will help maximize the management, analysis, and display of geographic data and information to render evidence based decisions. On a go forward basis, this work must link with the work of Understanding Communities Unit in Public Health and continue to forge partnerships with Dalhousie University. These maps have assisted in system planning across the district.



Distribution of family physicians - 2010

CONCLUSION

This was an exciting year in Primary Health Care as we worked to mobilize the components of the Community Master Plan in collaboration with our partners. We hope that our first portfolio report reflects our successes to date, and a continued view on where we are headed in the future .

Over the past year, Primary Health Care has grown both as a team and as an integral part of the broader health care system. In doing so, we have strengthened our relationships with our partners, both internal and external. We have paused to listen, identify synergies in our work, and promoted a dynamic and flexible approach to our work.

Measuring what we do is challenging. We recognize that to continue to build a strong primary health care system, an evidence informed approach to planning and service delivery is critical. We are committed to continue to develop the systems, processes and infrastructure required to build on the quality of our data and support the components of our Quality Framework.

Most importantly, we want to acknowledge, that our successes are not just ours to own, but are the product of a collective vision, strong leadership, and a measure of the combined efforts and commitments of our partners - at the centre of which is Citizens and Community.

Capital Health

Primary Health Care
& District Department of Family Practice

A different today. A better tomorrow.