CENTRAL ZONE*
Primary Health Care &
Department of Family Practice

2014-15
Year at a Glance

Our Purpose

The purpose of Primary Health Care and the Department of Family Practice is to support citizens and their communities to start well, live well and finish well.

Our Simple Rules

- Be person, family and community centred
- Build on what exists, or expand where it doesn't
- Be quality driven and evidence informed
- Support primary health care providers in their work
- Be flexible and open to change that is purposeful
- Build meaningful relationships that are respectful and inclusive
- Talk less and do more

Community Master Plan

Our Community Master Health System Plan suggests practical steps for a restructured and evolving primary health care system in the Central Zone (Halifax, Eastern Shore, and West Hants), proposing changes that can be made to strengthen and support the primary health care system over time. As we gain efficiencies in time or money, the savings will be allocated to enhancing access to care, supporting a comprehensive team approach and continuous relationships with primary care providers, and coordinating programs and services across the continuum, all leading to healthier populations and a more sustainable health care system.

Physician and Practice Supports

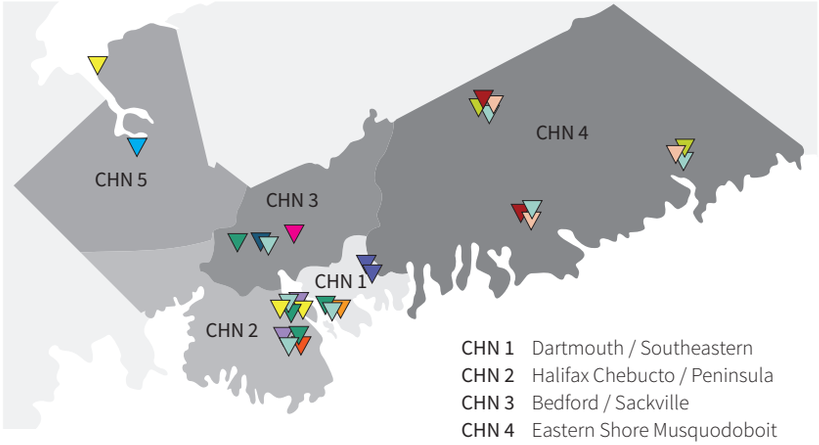
The Department of Family Practice supports family physicians personally and professionally, and provides resources and tools for family practice teams to provide patient care and implement practice improvements.

Overview

Primary Health Care and the Department of Family Practice are working closely together to strengthen and support the primary health care system. Primary health care is an approach to health care that acknowledges the determinants of health and the importance of healthy individuals and communities. It includes the continuum of care from pre-conception to palliative care, emphasizing health promotion, disease and injury prevention, health maintenance, and supporting patients and family in being partners in their health journey.

Adapted from What is Primary Health Care? AVH Vision for Community health Centres

Primary Health Care Programs & Services



CHN 1 Dartmouth / Southeastern
CHN 2 Halifax Chebucto / Peninsula
CHN 3 Bedford / Sackville
CHN 4 Eastern Shore Musquodoboit
CHN 5 West Hants

LEGEND:

- 3 Affiliated Health Centres with interdisciplinary teams
- Cobequid Youth Health Centre: 1,600 client visits
- 2 Collaborative Emergency Centres: 4,500 patient visits
- 4 Community Health Teams: 6,000 participants; engaged over 400 citizens, partners and health providers; 1,600 visits through partner groups
- Community Health & Wellness Centre serving North & East Preston, Cherry Brook & Lake Loon: 1,600 patient visits
- 3 Community Hospitals: Eastern Shore, Musquodoboit Valley, Twin Oaks
- Community Wellness Centre serving Spryfield and surrounding communities
- 2 Dalhousie Family Medicine clinics: 37,000 patient visits
- 4 Diabetes Management Teams (serving 7 locations): 11,000 patient visits
- Hants Health & Wellness Team
- Integrated Chronic Care Service: 10,000 patient visits
- 2 Nursing Homes
- Urgent Care Centre: 6,000 patient visits

* Nine district health authorities amalgamated on April 1, 2015 to form the Nova Scotia Health Authority. The new Central Zone (Halifax, Eastern Shore, and West Hants) represents the former Capital Health district.

www.cdha.nshealth.ca/primary-health-care | www.ddfp.ca

Primary Health Care by the Numbers

Wellness Promotion, Coordination & Risk Factor Management

45 TYPES
OF WELLNESS SESSIONS OFFERED
at *Community Health Teams* during the day, evening and weekend, plus **40** varying programs offered by community partners.

OVER **90%**
Over 90% of *Community Health Team* wellness program participants agreed that they have a better understanding and a plan to improve their health.

PARTICIPATED IN
600 SESSIONS
Community Health Teams participated in **more than 600** sessions focused on engagement, partnership development and community capacity building.

Team Approach in Primary Health Care

430
430 family physicians deliver **7,100** services each day, and manage **400** inpatient and **2,200** long term care beds.

35 family practice nurses and **6** nurse practitioners work collaboratively in primary health care settings.

40
TRAINED AT DALHOUSIE FAMILY MEDICINE
40 family medicine residents trained at Dalhousie Family Medicine clinics.

15 PARTICIPANTS
On average, **15** participants attend each wellness program that is offered by the Community Health & Wellness Centre team.

Chronic Disease & Self Management

153
PARTICIPANTS
153 participants attended *Your Way to Wellness* workshops.

Over 80% of patients with multi-morbidities and complex chronic conditions treated at the *Integrated Chronic Care Service* have achieved improved functional health status.

400
Over 400 health professionals participated in initial competency training hosted by the *Behaviour Change Institute*.

Access & Urgent Care

97%
97% of citizens in the district have a family physician (2005).

OVER **350**
citizens assisted with finding a family practice; 8,000+ monthly visits to **findafamilypractice.ca**

84% of collaborative emergency centre patients agreed that they, or their family member/caregiver, were included in making decisions about their care.

OVER 420
HEALTH PROFESSIONALS
attended *prideHealth* training to increase clinical capacity for GLBTIQ patients.

System Integration & Enablers

3 QUALITY AWARDS
Gold: Integrated Chronic Care Service; **Silver:** Frailty Portal; **Bronze:** Community Health & Wellness Centre

12 FUNDED GRANTS
12 funded grants and **5** publications as part of *Primary Health Care's Research Program.*

5 COMMUNITY HEALTH NETWORKS
Identified across the zone to serve as the foundation for health planning and organizing care for delivery in the future.

15 FAMILY PRACTICES PILOTING THE FRAILTY PORTAL
The Frailty Portal is a web-based tool to support the assessment and care of persons who are frail, and is one of four Frailty Strategy initiatives.

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Highlights

New Community Health Teams

Following citizen and provider engagement sessions in the fall, two new Community Health Teams began operation in early 2015, serving the Halifax Peninsula community and the Bedford / Sackville area (Beaver Bank, Enfield, Elmsdale, Fall River, Hammonds Plains, Lantz, and Waverley).

As well, both of the existing Community Health Teams expanded their catchment areas; the team in Dartmouth now includes Cole Harbour, Lawrencetown and Eastern Passage, while the Chebucto team, serving the Halifax Mainland area of communities (Armdale, Spryfield and Sambro Loop, Clayton Park and Fairview), now encompasses many surrounding communities (Beechville, Lakeside, Timberlea, Tantallon, St. Margaret's Bay and Hubbards, as well as the communities along the Peggy's Cove scenic route).

Hants Health and Wellness Team

New this year, the Hants Health and Wellness Team is an interprofessional team providing programs in wellness and risk factor management, chronic disease management, and complex care programs for citizens and their families in the Hants area (West Hants, Windsor, Hantsport, and Uniacke area). The team builds on the Community Health Team wellness programming and navigation model, and provides chronic disease management as well as complex care for citizens with three or more chronic conditions, in collaboration with their primary health care provider.

Health System Planning & Community Health Networks

Primary Health Care, with other health system partners, has developed a clinical services / health system plan for how community-based programs and services will provide care in the community and work together in the next five to ten years.

Five community health networks were identified across the zone to serve as the foundation for planning and for the future organization of care delivery so that citizens will receive more coordinated and continuous care through a network model of community-based providers. A phase one report outlining the planning process, work to date, and future vision for working together in networks was completed and will serve as a guiding document in the phase two implementation.

Community Profiles

Building on the Population Health Status Report developed by Public Health in 2013, an extensive data collection, geographic information system (GIS) mapping, and interpretation process was conducted to develop community profiles for each community health network to inform the clinical services / health system planning initiative. The community profiles provide a snapshot of the populations and communities within each of the five community health networks that will inform an evidence-based approach to future planning at a local level.

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Highlights (continued)

Quality Awards

Primary Health Care was recognized with gold, silver, and bronze Capital Health quality awards as well as an honourable mention for the following initiatives:

- **Gold** - My care, my voice: Integrated Chronic Care Service initiative to reduce wait times to care for complex patients by providing a 'voice to the patient'
- **Silver** - Strengthening primary health care for frail persons (frailty portal pilot)
- **Bronze** - Community Health and Wellness Centre - A community-driven model
- **Honourable mention** – Building a stronger primary health care system through a better training model: Better experience for learners and better outcomes for citizens (Dalhousie Family Medicine)

Research

Primary Health Care has developed a formal research program to enhance evidence-based practices in the care of individuals. Our research program strives to provide leadership and excellence in primary health care research locally, nationally and internationally through embedded research, scholarly activities and evidence-based care delivery practices. This year, we received funding for 12 grants, plus had five articles published in peer-reviewed journals.

CDPM Corridor©

In 2012, Primary Health Care participated in the Canadian Foundation for Health Care Improvement's Atlantic Collaboration, which led to the creation of a Chronic Disease Prevention and Management (CDPM) Corridor© for the former Capital Health district in 2014. The CDPM Corridor© is a system-level conceptual framework designed to improve care and care experiences for individuals and their families living with, or at risk for, chronic conditions. The overall aim is to promote applicable standards and best practices, and to identify areas of standardization across CDPM programs to ensure all CDPM programs provide efficient and effective evidence-based care.

Nova Scotia Brotherhood Initiative

A new initiative for Primary Health Care, Nova Scotia Brotherhood is a free program for Black men to access health care in the community to improve overall health and wellbeing. Primary Health Care is currently building a team of health care professionals who will provide culturally-appropriate primary medical care plus health and wellness services for men of African descent across Halifax Regional Municipality, focusing on the communities of: North and East Preston, Cherry Brook, and Lake Loon; Dartmouth North and Halifax North End; and Hammonds Plains, Lucasville, Sackville, and Beechville.

New to the Primary Health Care Portfolio

In March, Primary Health Care welcomed the tri-facilities to its portfolio: Eastern Shore Memorial Hospital, Musquodoboit Valley Memorial Hospital, Twin Oaks Memorial Hospital, as well as Braeside Nursing Home and Harbourview Lodge Continuing Care Centre. These facilities, and the many programs and services offered, offering the spectrum of health care, will continue to strengthen the ongoing rural health initiatives and services that are being provided across the Central Zone. Additionally, the Cobequid Youth Health Centre also joined the Primary Health Care portfolio; the Youth Health Centre team provides health services and wellness supports for youth between the ages of 12 – 25.

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