# Expanding the Community Health Team:

## *The Broader Dartmouth Citizen & Stakeholder Engagement Findings*

Building Healthier Communities Together

Capital Health Primary Health Care in collaboration with IWK Health Centre and community partners

Capital Health

# Expanding the CHT in Dartmouth: The Broader Dartmouth Engagement Findings

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# SECTION 1.
# Expanding the CHT in Dartmouth: The Background

## Capital Health's Community Health Team: District Context

In 2007, **Capital Health** undertook a strategic planning process that led the organization on a journey that asked about what is needed to transform our health care experience. Capital Health believes that each individual has the capacity, right, and responsibility for optimal health and acknowledges and accepts the vital role in this health and wellness journey. Capital Health has embraced a new role as learners committed to creating the conditions necessary to achieve optimal health. In doing so, we will become a world-leading haven for health, healing, and learning. That is our mission and that is what Capital Health is calling *Our Promise*.

Transformation involves a collaboration of roles: citizens, patients, staff, physicians, volunteers, and community members coming together to realize healthy behaviours and healthy living. Capital Health recognizes that to achieve the health, healing, and learning of *Our Promise* we need to create healthy environments, support healthy behaviours to optimize personal health, and provide person-centred health services.

One of the transformative initiatives being undertaken as a result of *Our Promise* is the planning and implementation of Community Health Teams within Capital Health.

## Community Health Team: An Overview

The Community Health Team (CHT) is a community-based health model that supports 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. CHTs are led by Primary Health Care (PHC), Capital Health, in partnership with the IWK Health Centre (IWK) and other organizations and agencies, and collaborates across the care continuum.

There are two key components of the CHT model:

- **Wellness Navigation** – The CHTs work collaboratively with family physicians, community-based services, specialty programs, and other providers to support individuals and families to make linkages with the appropriate services, supports, or programs that are needed to achieve optimal health and wellness. CHTs do not duplicate services that already exist.

- **Wellness Programming** – Based on health data and the health status of the relevant community, CHTs provide support and access to a

range of wellness programs that complement services and programs already available in the community. Some of the basic CHT components include:

- Personal Wellness/Health assessments for individuals and families
- Goal setting and motivational counseling
- Group nutrition and education programs
- Group physical activity/exercise programs
- Peer support/self management program
- Other programs and services aligned with community priorities identified through the engagement process (either link to existing programs/services or CHT led)

## Community Health Team Community Identification Process

The communities for the first CHT was determined through a rigorous process, which involved input from and collaborative decision-making with a variety of stakeholders.

A *Community Identification Advisory Committee* was established, which included representatives from a range of areas such as Primary Health Care, Community Health, Public Health, Acute Care, Rehabilitation Services, Family Practice, IWK Health Centre, Community Agencies, Diversity and Inclusion, Dalhousie School of Health Professions, and Inter-professional Practice. This committee helped to identify key criteria, such as accessible space and community resources, that would support the successful implementation of a CHT. These success criteria aided in the development of a site selection tool, which was used to identify the first communities for a CHT.

The site selection tool was the underpinning of a three phase collaborative process. In Phase I, five communities of interest were identified within the Capital district via the Community Health Boards. In Phase II, the options were narrowed down to two communities that best met the success factor criteria. Phase III involved a more intensive investigation of the suitability of these communities for successful CHT implementation based on the established criteria. Consultations occurred with a range of groups during Phase III, such as relevant family physicians, elected officials, and community providers and champions.

A *Community Identification Committee* was formed to evaluate the data collected and select the community for CHT implementation. This committee was represented by key partners and stakeholders (e.g., Primary Health Care, IWK, Community Health, Community Agencies, Family Practice). Following the evaluation, it was identified that the two communities identified in phase two would both be selected for the first ever CHTs. Those communities were **Spryfield/Herring Cove and East Dartmouth**.

## Community Health Team Engagement Process

The CHT model recognizes that each community has different needs, and therefore may require different programs, services, supports, and interdisciplinary team members. To optimally determine an appropriate CHT model for the community in which the CHT serves, it is critical to involve the citizens of that community, as well as other providers and community groups, as the CHT is developed and implemented.

As each CHT is implemented, it will participate in an initial engagement process that will instrumental in helping to shape the design of the CHT model in the community in which it is part of. This initial engagement will be followed by ongoing engagement events to help ensure that any programs and coordination efforts continue to meet the needs of the community, as well as to help foster effective partnerships with other providers and community organizations.

**Citizen and Stakeholder Engagement Goals:**

1. To obtain citizen feedback/input to help define the CHT scope and design
2. To obtain provider/stakeholder feedback/input to help define the CHT scope and design (based on community needs)
3. To build and/or continue to foster meaningful relationships with citizens and providers/stakeholders within the communities of the CHT

**Citizen and Stakeholder Engagement Objectives**

| | | | | | |
|---|---|---|---|---|---|
| **Engagement Objective:** Provide information about the CHT model and engagement process | **Engagement Objective:** Seek input regarding healthy living education and physical activity programming | **Engagement Objective:** Seek input regarding community wellness navigation (e.g., Individuals/ groups that would most benefit from wellness navigation; mechanisms | **Engagement Objective:** Identify mechanisms for ongoing feedback and communi-cation | **Engagement Objective:** Seek input on how to best coordinate programs and services to reduce duplication & enhance consistency, which fosters a person centered approach | **Engagement Objective:** Identify partners/ Collaborators |

## *Key Findings from the East Dartmouth Engagement Process*

In the summer of 2009, initial engagement events began in East Dartmouth to learn from the community what the priorities were related to the CHT. Key findings of the East Dartmouth citizen and stakeholder engagement process were that the East Dartmouth community wants to connect with one another, learn how to improve the health and wellness for themselves and their community, and to take an active role in the health and wellness of their community.

In addition, it was identified that the CHT could focus on wellness and be flexible and adaptable to community needs. The highest identified priorities for CHT programs and services were:

- Physical activity
- Nutrition (included healthy weights)
- Emotional wellness and stress
- Wellness navigation

Parenting education and supports for young families were also identified as a community priority.

The frail and elderly; children and youth; and those with chronic illness or complex needs came forward as the groups that could most benefit from the CHT.

The key barriers to uptake of CHT programming and services identified were commonly recognized barriers such as lack of transportation and childcare; cost; and lack of knowledge of the support or service.

There were also numerous expressions of interest from representatives of various groups within Capital Health and the IWK Health Centre; academic centres; and community organizations to explore collaboration and partnership opportunities with the CHT.

For specific findings of the East Dartmouth engagement results, please refer to the CHT website at www.communityhealthteams.ca or call 460-4555.

# SECTION 2.
# Broader Dartmouth Citizen Engagement: The Process and Findings

## Introduction and Approach

Following this initial engagement outlined in the previous section, the CHT opened its doors in April 2010 in the East Dartmouth community. After beginning to offer core programming in East Dartmouth, there was a high demand for this CHT to expand to serve the rest of Dartmouth. In order to learn the needs of the broader Dartmouth area, two additional Citizen Engagement events were held to explore needs and priorities. The CHT will reflect on those needs when expanding is programming to all of Dartmouth. Therefore, the remainder of this document will detail the findings from the citizen engagement process, as well as discussions with family physicians in the broader Dartmouth community.

On March 7 and 22, 2011, the Primary Health Care team from Capital Health, with the support of **Chrysalis Strategies Inc.**, held engagement events for citizens from Dartmouth to provide their input into the needs of the CHT for their community. This report has been jointly prepared by the Primary Health Care team and the consultant, **Chrysalis Strategies Inc**.

On March 7, 2011, in the afternoon, an event was held at the Dartmouth North Community Centre and was attended by a total of 53 participants. On March 22, 2011, in the evening, an event was held at the Findlay Centre and was attended by a total of 46 participants.

Each event began with a welcome and a short presentation, video, and story telling to provide a fundamental understanding of what a CHT is and could be. Participants were then engaged in conversation using the World Café approach to identify:

- What excited them most about the CHT
- What the most important needs of the community were that the CHT could address

Each of these questions was given one round of café conversation, and between rounds participants moved between tables to cross-pollinate ideas and surface group themes. At the end of the café, two facilitators moved around the room to have participants identify the themes they had been hearing, and two additional facilitators mapped these onto a large mind-map on the wall.

Participants were then given three sticky dots and were then asked to put those dots on those areas of the mind map that were most important for them and their families.

The main themes from the mind-map were each set up as separate table discussions, and once each participant had placed their dots on the map, they went to the area that was most relevant for them to answer some additional questions with the others at the table. The feedback from these conversations was captured on a sheet from each table. Before leaving, participants also completed a feedback form.

This process allowed four levels of feedback. First, the café conversations identified the greatest needs and concerns of the community in an unaided way. Second, the dots allowed participants to prioritize the needs and concerns according to their needs and the needs of their own families. Third, the theme groups provided additional feedback on each of the aspects of the mind maps, and the priorities within each area. Finally, the feedback forms provided aided feedback about the community by identifying specific programs and asking participants to specify which programs would be of greatest value to their community.

The data from these two cafés have been integrated into this report. For the most part the information from the cafés was consistent. Those areas where there are differences, and the possible reasons why, are identified.

## *Demographics*

Demographic data are based on those who responded to and passed in their feedback forms. 40 were collected in North Dartmouth and 33 at the Findlay Center.

While both groups had 15% of attendees over the age of 65, 38% of the North Dartmouth group was over the age of 55, while 51% of Findlay Center group was aged 55 or more, so the latter group skewed more towards seniors. Both groups had 38-39% between the ages of 35 and 54. The North Dartmouth group had more participants aged 20-34 (13% vs. 6%), and neither event had attendees aged 15-19.

59% of all attendees were female, with a slightly higher proportion of women during the North Dartmouth event.

38% of participants from both groups (33% in North Dartmouth and 45% at the Findlay Center) identified themselves as being part of a distinct group.

The detailed demographic breakdown is below:

| Age Group | North Dartmouth | | Central Dartmouth | | Total | |
|---|---|---|---|---|---|---|
| **15-19** | 0 | 0% | 0 | 0% | 0 | 0% |
| **20-34** | 5 | 13% | 2 | 6% | 7 | 10% |
| **35-54** | 15 | 38% | 13 | 39% | 28 | 38% |

| | | | | | | |
|---|---|---|---|---|---|---|
| **55-64** | 9 | 23% | 12 | 36% | 21 | 29% |
| **65+** | 6 | 15% | 5 | 15% | 11 | 15% |

| Gender | North Dartmouth | | Central Dartmouth | | Total | |
|---|---|---|---|---|---|---|
| **Female** | 25 | 63% | 18 | 55% | 43 | 59% |
| **Male** | 9 | 23% | 11 | 33% | 20 | 27% |

## *Effectiveness of Communication*

Friends and posters seemed to be the most common ways of finding out about the event, although 30% found out from a range of other sources, including soup kitchens and various centers. The detailed analysis on how they heard of the event is below:

| | North Dartmouth | | Central Dartmouth | | Total | |
|---|---|---|---|---|---|---|
| **Newspaper** | 5 | 13% | 6 | 18% | 11 | 15% |
| **Friend** | 9 | 23% | 10 | 30% | 19 | 26% |
| **Poster** | 10 | 25% | 7 | 21% | 17 | 23% |
| **Leaflet** | 6 | 15% | 6 | 18% | 12 | 16% |
| **Other** | 13 | 33% | 9 | 27% | 22 | 30% |

## *Event Evaluation*

The feedback on the Engagement Events was very positive. In rating the overall quality of the event, participants at the events collectively gave a rating of 4.3 on a 5-point scale (1=Poor, 2=Not Very Good, 3=Okay, 4=Good, 5=Excellent).

The remaining questions were on a 4-point scale. The two groups averaged a rating of 3.2 for the completeness and ease of understanding of the background information provided (1=Poor, 2=Inadequate, 3=Adequate, 4=Excellent). Both groups averaged a 3.5 on a 4-point scale when asked if they were satisfied that their opinions had been heard (1=Very Dissatisfied, 2=Dissatisfied, 3=Satisfied, 4=Very Satisfied). Finally, they averaged a 3.1 on a 4-point scale when asked about how confident they were that their opinions would influence the final decision (1=Very doubtful, 2=Doubtful, 3=Confident, 4=Very Confident). The breakdown of the ratings for the two events is below:

| | North Dartmouth | | | Central Dartmouth | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | Avg | St Dev | No | Avg | St Dev | No | Avg | St Dev | No |
| **Overall, how would you rate this event? (1-5)** | 4.3 | 0.7 | 40 | 4.4 | 0.7 | 33 | 4.3 | 0.6 | 73 |
| **How complete and easy to understand was the info? (1-4)** | 3.1 | 0.7 | 39 | 3.4 | 0.5 | 33 | 3.2 | 0.7 | 72 |
| **How satisfied are you your opinions were heard? (1-4)** | 3.3 | 0.5 | 37 | 3.5 | 0.5 | 30 | 3.4 | 0.5 | 67 |
| **How confident are you your opinions will influence final decisions? (1-4)** | 3.0 | 0.8 | 31 | 3.2 | 0.7 | 25 | 3.1 | 0.7 | 56 |

When asked if they felt that they had enough of the right information to take part, 95% of participants said 'Yes' (98% of those in North Dartmouth, and 91% of those at the Findlay Center).

## Community Priorities for Programs and Services

Using the feedback from the café conversations and the feedback forms, several themes emerged as clear priorities for Dartmouth, as identified by the members of that community. There were common threads between the two cafés, as well as needs unique to each one.

### Nutrition

Nutrition emerged as a dominant issue in both cafés, including supports on how to eat healthy, particularly on a fixed/limited income, and maintaining a healthy weight. Priorities in this area included:

- Affordability and accessibility
- Affordable nutritious eating
- Disease prevention
- Food bank
- Nutrition classes, cooking classes
- Recipes
- How to store food

One group suggested the need for community and business involvement in this area, as well as advocacy. It was also suggested that community gardens and more farmer's markets might help. Affordable, healthy nutrition and diets for those with special needs, such as people with diabetes, was also identified as a need.

### Wellness Navigation

There was a strong need expressed at both events for the CHT to help citizens navigate the health care system, as well as potentially to act as an advocate for affordable housing, access to affordable, nutritious food, access to services for chronic pain and other chronic issues, and for a safer neighborhood in North Dartmouth. A need was identified to bring community members, business and helping organizations together to help address

larger issues, such as food insecurity, through collaborative action or advocacy.

**Chronic Conditions**

Both groups identified chronic conditions (e.g., chronic pain), as a significant need. Participants spoke of the need for support programs within their community, of the need for advocacy, and of the need to know what was already available in the community.

**Self-Management Support for Risk Factors**

This was identified as a significant priority on the feedback form. Detailed feedback on priorities was not provided as a themed group did not meet on that topic. However, self-management support was a thread through many of the group discussions with comments put forward such as help needed to identify personal strengths, need for education and prevention support on specific topics (e.g., blood pressure), and need for peer and other support for risk factors such as physical inactivity and unhealthy weights.

**Stress Management**

Participants expressed a strong need for this in the feedback form as well, and during the events identified the need for resources that included acupuncture, exercise, mindfulness and meditation.

**Mental Health Supports**

Both events identified a need for mental health supports, including access to weekly support group, evening programming, easier access to screening and early diagnosis. One group in North Dartmouth identified the need for resources on how to deal with chronic depression, and the North Dartmouth event also identified the need to diagnose and treat bi-polar disorders.

**Exercise/Physical Activity**

Both groups identified the need for exercise/physical activity, particularly with walking clubs and other activities for seniors. There was also an identified need for free access to a gym in their neighborhood, particularly for people with diabetes. In addition to seniors, it was also identified that children needed programs to keep them busy and engaged.

**Other Programs and Services**

The feedback form for the event in North Dartmouth identified a strong need for programs to help individuals manage their finances, but there was no group that met to discuss this. There were other programs and services identified during the cafés and also marked off in the feedback form, but they did not have nearly the number of votes from the participants as those listed above, and consequently do not appear to be immediate priorities for the community as a whole.

**Feedback Form Summary**

Below is a summary of the data from the feedback form, showing how many participants checked the box saying that that support would be of benefit to them and their community. The results are fairly consistent between the two groups, except for the fact that managing risk factors and physical activity were checked by more people in the evening group than the morning group.

| Which would benefit you/community | North Dartmouth | Central Dartmouth | Total |
|---|---|---|---|
| How to eat healthy | 30 | 27 | 57 |
| Maintaining a healthy weight | 28 | 26 | 54 |
| Self-management support for risk factors | 28 | 24 | 52 |
| How do I manage my stress/anxiety | 28 | 23 | 51 |
| Mental health supports | 28 | 23 | 51 |
| Physical activity | 26 | 22 | 48 |
| How to manage my finances | 26 | 16 | 42 |
| Employment supports | 21 | 12 | 33 |
| Addictions supports | 18 | 14 | 32 |
| Helping my children maintain a healthy weight | 14 | 8 | 22 |
| Other | 13 | 9 | 22 |
| Child nutrition for busy families | 12 | 7 | 19 |
| Parenting programs | 11 | 5 | 16 |

## Community Priorities for Target Groups

There was a good turnout at both events with over 95 attending the two sessions. During the events, a number of attendees identified themselves to have a limited or fixed income, and this voice came out strongly as a potential target group for the CHT. Seniors, and to some extent youth, were identified as a priority group to support for the CHT, but not as strongly as in earlier events in East Dartmouth.

### Low Income

The impact of limited or fixed income impacted several potential program and service areas. First and foremost, accessibility is an issue, and there was a strong need expressed for programming within the community that could be accessed by walking or, if required, accessible by bus. Participants also spoke of the need for transportation, because the money they received for bus tickets was often used to purchase basic food. This highlighted a broader need to have free or low-cost programs that they can access within their communities, and also to find out about what is already available to them.

Nutrition and healthy eating emerged as a significant concern as participants expressed how difficult it was to eat, let alone eat healthy on fixed incomes, even with food banks. Participants also spoke of how they wanted to retain their dignity by going to a store for food, rather than food banks.

Finally, those with limited incomes find it difficult to manage chronic conditions and access the programming, special food, or other resources that are required.

### Seniors

Seniors were identified as a key target group for programs and services for the CHT. They need information on what's available now, as well as gentle exercise opportunities, such as walking clubs.

## Barriers

The greatest potential barriers are access and information. Many participants spoke of the challenge of accessing programs within their community, and also of knowing what was offered there. Other barriers included:

- Transportation
- Cost
- Child care
- Language
- Scheduling/Time of day of programming
- Awareness of programming offered
- Weather
- Ongoing health problems limiting the ability to make it to programming

There is a strong need for programming within their communities. Participants in this group said that the CHT could also provide value by identifying all the resources that are available in the community offering this to the

community from a central source – being a 'one-stop-shop' for information and programming.

Some participants spoke of the importance of feeling safe within their community. It was discussed that not all participants consistently feel safe to go out walking, for example, particularly for seniors and children.

Transportation is an issue not just to access programs and services, but also to get to other resources. Individuals on fixed incomes said that they used the money they received for bus tickets to help buy basic food requirements. Many people said that the food provided at the events was the only meal they were getting that day.

## Time of Day

Overall, 25% of participants selected afternoons as the best time for programs and services, 14% chose mornings, and hardly anyone chose weekends as the best time. This was approximately the same at both events. 24% of participants at the Findlay Center selected evenings as the best time, while only 10% of those in North Dartmouth chose the same. This could partly be due to the concerns for safety expressed by those in North Dartmouth. (Note: this does not include people who chose more than one option).

Detailed feedback on preferred times of day for programs and services below (Note: this does not include people who chose more than one option).

| | North Dartmouth | | Central Dartmouth | | Total | |
|---|---|---|---|---|---|---|
| **Mornings** | 6 | 15% | 4 | 12% | 10 | 14% |
| **Afternoons** | 9 | 23% | 9 | 27% | 18 | 25% |
| **Evenings** | 4 | 10% | 8 | 24% | 12 | 16% |
| **Weekends** | 1 | 3% | 0 | 0% | 1 | 1% |

## Broader Dartmouth Citizen Engagement – A Summary of the Key Findings

The findings from the Dartmouth citizen engagement process were collated and analyzed to identify key themes and patterns emerging from the engagement results as a whole. The most prominent themes are outlined below.

### Key Community Priorities for Wellness Programming

There were multiple other diverse findings to help identify priority programs and services facilitated by the CHT. Despite the variety of citizen suggestions for CHT components and programs and services, clear priorities emerged. These included the desire for the CHT to focus on nutrition and chronic illness as the highest priorities for component programming.

Suggestions for nutrition programming included classes on such topics as affordable healthy eating, portion sizes for people with diabetes, healthy recipes and how to store food safely. There was also interest in knowing about community nutrition supports.

Suggestions for programming to support chronic conditions included having information and support programs in the community regarding ways to manage chronic conditions or chronic pain or how to create a wellness plan.

Self-management supports for risk factors, stress/anxiety management, mental health supports and physical activity emerged as secondary priorities.

### Key Target Groups

Individuals with low income were identified as a key target group from the two events that were held. Seniors, and to some extent youth, were identified as a secondary target group.

### Social System Advocacy

A significant number of participants at both events spoke of the challenges of being able to live on a fixed or limited income. These challenges included finding adequate housing to being able to afford and prepare nutritious food (food security). People spoke quite emotionally about the challenges of finding adequate food in food banks or local grocery stores, and about their desire to be able to walk with dignity getting food in a supermarket rather than going to a food bank. Participants also spoke of the need for transportation. They expressed the money they received for bus tickets was often used to purchase food.

Participants at both events expressed the lack of visibility and empathy they feel as a low income citizen. Desire for advocacy for changes to social systems such as housing, income assistance, food security and other supports was discussed at length. Food security and advocacy to increase awareness of and supports for issues related to chronic illness and pain were the two advocacy priorities.

**Wellness Navigation**

There was a strong need expressed at both events for the CHT to help citizens navigate the health care system, social supports, and/or community resources (for example, providing a link to the appropriate supports that address needs around affordable housing).

**Community Connection**

The engagement events identified a strong need to reconnect the community and to improve the health and wellness of the community in order to optimize the health and wellness of the individuals within the community.

## Conclusions from Citizen Engagement Events

Participants at these events expressed very strongly a need to actually grow community and deepen community connection by tapping and building the capacity of the community itself. Attendees recognized there are already many resources and talents within the community, but that there are barriers to accessing them that needed to be overcome. The CHT could act as an enabler, bringing the community together to help the community identify what it really needs, how it can help itself, and what additional resources are needed for programs and services; and for overcoming barriers.

Nutrition/healthy eating and chronic illness were the two most important programs areas, as identified by the attendees. Other, secondary priorities included self-management supports for risk factors, stress/anxiety management, mental health supports and physical activity.

Groups/populations to target were individuals with low income, as well as seniors. Youth & children were also identified as a target group. The supports that wellness navigation can offer around coordination were also identified as important. Finally, attendees identified that advocacy for changes to social systems was important, and discussions ranged from food security, supports for people living with chronic conditions and chronic pain, income assistance, affordable housing and other supports.

Based on the experience of these events, this is a community that is ready to be a partner with the CHT in improving the health and wellness of both the citizens of the community and the community itself.

# SECTION 3.
# Expanding the CHT in Dartmouth: Findings from the Family Physician Engagement

## Introduction and Process

In keeping with the process that was conducted during the initial engagement for the East Dartmouth and Chebucto CHTs, engagement of the family physician population was determined to be of great importance for the expansion into the broader Dartmouth communities. Given the CHT is a primary health care support, the physician engagement process is important for several reasons, which includes:

- Introducing the CHT model to the physicians and gathering feedback
- Providing information and increasing understanding about possible CHT programs and services
- Building relationships with the physicians
- Learning more about how the CHT can best work with family physicians and complement their work

Working with the District Department of Family Practice, the CHT identified family physicians that were practicing in Dartmouth communities. Given previous engagement and communication had occurred with family physicians working in East Dartmouth, it was determined that this engagement effort would solely focus physicians working in group practices that were outside of the East Dartmouth area. The practices that were engaged as part of this process are:

- Albro Lake Medical
- Dartmouth Medical Clinic
- King Medical Clinic
- Penhorn Medical Clinic
- Medicine in Motion

All practices were contacted via telephone to set up appointments for the engagement. Each session began with an overview of CHT model, activities, and staffing. In addition, the purpose and process of the CHT engagement with the public, health professionals, and physicians was reviewed. This was followed by a discussion period with the physicians where questions were asked and potential concerns were highlighted.

Each engagement session was completed over the lunch hour. Lunch was provided for the physicians. Two team members from the CHT conducted each engagement. These sessions began in November 2010 and were concluded in December 2010.

## A Summary of the Key Findings

15 physicians from 5 different practices were engaged through this process. Physicians provided general feedback regarding the CHT and the model. The themes that emerged from the engagement with the physicians included the below.

### *Awareness and Support for CHT*

Approximately half of the family physicians indicated that they had heard about the CHT previously from their patients or colleagues. All physicians were comfortable with the type of programs and services the CHT was offering. Physicians were interested in learning more about the Personal Wellness Profile (PWP) with respect to how it was administered, point of care testing and anthropometrics, and how the team followed up on the results of a PWP. After further discussion with CHT team members, the clear majority of family physicians identified they felt the PWP was an excellent resource for the community. It was identified through the engagement process with a family practice that when delivering the PWP, appropriate support and assistance must be provided to those with low literacy levels.

Many family physicians were also interested to learn more about the team members that were part of the CHT. They wanted to know more about team members' professional backgrounds and experiences and how that would support programming that could be offered by the CHT. The CHT team members discussed this with family physicians and highlighted qualifications and professional experiences that were a fit with the needs and priority. (It is worth noting that team members were not hired until needs and priorities were identified in the initial engagement. At this time, team members were hired that had the most appropriate qualifications and required experiences that aligned with needs and priorities).

### *Physician Perspective of Community Priorities for Wellness Programming*

Chronic conditions were a common theme discussed by family physicians. While physicians often discussed specific concerns for their practice (for example, diabetes, mental health, etc), there was an identified need for support with chronic disease management. During the engagement, the supports that the CHT could offer around risk factors to are common across a range of chronic conditions (e.g., physical activity, nutrition). Physicians identified that this type of programming would be supportive of managing chronic disease and promoting wellness among their patients.

### *Physician Perspective of Barriers to Access*

Finally, there were key barriers to accessing care that were identified for this community. From the perspective of family physicians these barriers included:

- Lack of transportation
- Poverty
- Lack of trust

These barriers are comparable to some of the barriers identified at the community engagement events. Physicians identified that from their perspective, community members who are concerned with the above mentioned issues are less likely to attend community programs if those programs are not addressing their basic needs (e.g., food, shelter, safety).

## Conclusions from Family Physician Engagement

Physicians expressed a strong interest in the CHT and were very supportive of the Personal Wellness Profile/Health Risk Assessment. They identified this service as of strong benefit for the community. Physicians noted that the range of CHT staff backgrounds and skills (e.g., wellness facilitators from disciplines such as dietitics, physiotherapy and social work) can offer broad understanding and support for risk factor management around chronic conditions. Of significance, physicians highlighted challenges to working in the community due to barriers such as poverty, transportation, and trust.

# SECTION 4.
# Expanding the CHT in Dartmouth: How We Will Work and Next Steps

## Community Health Team: Guiding Principles

The CHT will operate under principles that emerged through the analysis of the engagement feedback. These guiding principles will be the benchmark of an acceptable level of performance for this CHT. They may evolve over time in response to ongoing engagement with the community it will serve. At present, the principles that will guide the work of the CHT are:

**Dynamic and Flexible:** The CHT will listen to community members and be flexible in responding to their needs.

**Avoid duplication of existing supports and services:** The CHT will offer programs and supports not currently accessible to the community through other means. This programming may change over time, both in response to community needs and the availability of other accessible programming.

**Learning Together:** Programs under the core CHT components will take place in a group setting to enhance social and peer support for healthy behaviors among other benefits.

**Foster self-management:** The CHT will help people manage their own health through the integration of self management supports and behaviour change techniques into all component programming.

**Seniors, parents and youth age lens:** The CHT will be mindful of the needs and issues of seniors, parents and youth in its activities.

**Person and family centred approach:** The CHT will respect that people best understand their own life experience and are fully capable of fulfilling their own potential for health and wellness. The role of the CHT will be to help facilitate the favorable conditions under which this potential can be achieved.

**Determinants of Health lens:** The CHT will be mindful that many factors and conditions influence the health of individuals and communities.

**Community Connectiveness**: The CHT will support community connectedness, sense of belonging, through the fostering of a community development philosophy among CHT staff and volunteers and with those they connect with.

**Network, partner and collaborate with others:** The CHT will actively network with groups and organizations to explore and undertake informal and formal partnership and collaboration activities that can improve and support

the health and well-being of the East Dartmouth community.

**Ongoing citizen engagement:** The CHT will connect with community members and stakeholders on an ongoing basis.

**Inclusive and Outreach**: The CHT will make it a priority to go to where people are. It will endeavor to be inclusive both in engagement of communities and in delivery of programs and supports.

**Be patient**: It takes time for the community to know the CHT and for the CHT to get to know and understand the needs of the community.

## Performance and Outcome Measurement

Performance and outcome measurements are under development and will be linked to the primary health care quality framework.

## Dartmouth Community Health Team – Next Steps

The CHT planning group is actively working to expand the services of the Dartmouth CHT to cover the entire Dartmouth community (as indicated in the other sections of this report, the CHT initial began in the community of East Dartmouth only). The engagement findings indicated in this report will help shape and determine programming. The immediate efforts being undertaken:

- Provide feedback to community
- Identifying existing community resources and supports
- Community asset mapping
- Explore community rooms or other spaces in Dartmouth communities to offer programming or outreach supports, such as wellness navigation
- Phased program implementation
- Ongoing communication and engagement
- Communicate results to other partners

# Appendix A - CHT Partners, Collaborators and Sponsors

Our thanks to the CHT Partners, Collaborators and Sponsors:

- IWK Health Centre
- Dartmouth Community Health Board
- Chebucto West Community Health Board
- GlaxoSmithKline
- AstraZeneca Canada
- Pfizer
- Nova Scotia Department of Health
- QE II Foundation
- And the many champions and supporters for the CHT within Capital Health.