April 2009

Teams in Action: Primary Health Care Teams for Canadians

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Health Council of Canada Conseil canadien de la santé

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FOREWORD

In 2004, governments committed to increase the use of primary health care teams in Canada, with a goal of 50% of Canadians having access to these teams by 2011*. Governments were concerned about the aging population and the increasing number of Canadians with chronic conditions, and using teams of health care professionals was seen as one promising way to help strengthen primary health care in Canada.

Teams allow doctors to focus on medical diagnosis and management, while other health professionals (such as nurses, dietitians, and social workers) provide other services and work with patients to help them improve their health habits and the way they manage their conditions.

Five years later, what do teams look like across the country? And what do primary health care teams mean to you, as both a patient and a taxpayer?

This report answers these questions and more. We looked at research that had been done on team-based care, and interviewed the federal, provincial, and territorial governments to find out about their progress in developing teams. We learned that team-based care in Canada is a creative mosaic of various types of teams, serving a wide range of Canadians with different health needs. Many jurisdictions use teams in rural and remote regions and to provide after-hours access to care; to manage chronic diseases such as diabetes and heart disease, often with innovative approaches tailored to their communities; to provide overall primary health care to specific communities; and to reach out to vulnerable or high-risk populations. In some cases, community-based teams have been structured to play a role beyond medical care and health promotion; they also serve as catalysts for change, working to improve the broader community health and lifestyle factors that put their patients at risk.

What we don't know—yet—is the impact of all this promising activity. Research strongly supports the use of collaborative team-based care for people with chronic diseases, for mental health issues such as depression, and for some special-needs populations—but there isn't enough reliable evidence to date that shows whether teams make a difference to the general population. We also need to know whether Canadian teams have the right mix of professionals for the patients they serve, how much and how well professionals truly collaborate with one another, and how this ultimately benefits their patients. Better evaluation of all these factors is needed. That's how governments will know how to use teams most effectively in the future, not only to improve the health of Canadians, but to ensure that we spend our health care dollars wisely.

JEANNE BESNER, RN, PHD
CHAIR, HEALTH COUNCIL OF CANADA

5 YEARS LATER

What do teams look like across the country?

What do primary health care teams mean to you, as both a patient and a taxpayer?

*For more information, see ***What governments promised*** and ***A history of teams in Canada*** on page 26.

For this draft, Teams in Action stories are enclosed as a Word document.

Team-based care can make a difference

Joe, 60, has diabetes, high blood pressure, and arthritis. He says that shuttling around town to various health care appointments is like a full-time job. "I'm never sure how much these people talk to each other," he adds. "I worry that something's going to get missed somewhere." Health concerns—and sometimes just anxiety about his health—have driven Joe to the emergency department more than a few times. His wife adds that Joe doesn't always follow what he has been told by the different health care professionals about taking care of himself. "I think he's overwhelmed and depressed," she says.

Joe would likely benefit from access to a primary health care team, commonly described as two or more health care professionals working together in a coordinated, integrated effort to provide a patient's basic health care.

If you have chronic conditions such as Joe's, research shows that team-based care offers more comprehensive care and faster access to a range of health care professionals, all working closely with one another and coordinating the services you need. In addition, doctors who are part of a team can focus their time on medical issues, allowing other health care professionals (such as nurses, dietitians, and social workers) to provide patient education on healthy living or how to manage chronic conditions more effectively.

Given this support, it's not surprising that people who receive care from teams report that they are more satisfied, knowledgeable, and better skilled in managing their health conditions. Research also shows that people in team-based care tend to make fewer visits to doctors and hospitals.

There's a growing body of evidence that illustrates how team-based care improves people's health. The research is particularly strong in support of using teams to care for people with chronic health conditions such as diabetes or heart disease, with mental health issues such as depression, and with other special needs. People with these conditions see improvements in both their health and overall quality of life.

Teams are also known to be an effective way to provide primary health care services to rural, remote, and under-serviced areas that don't have enough (or any) family doctors.

Research supports the use of teams to care for people with chronic conditions and to provide primary health care in areas that don't have enough family doctors.

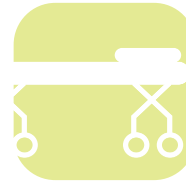
Some positive effects of team-based care

- A review of studies about the use of collaborative care for people with depression showed that, compared to usual primary care, people were twice as likely to stick with their antidepressants. The improvements people experienced were still seen two to five years later.

- Diabetes patients receiving team-based care reported better health results such as lower blood pressure.

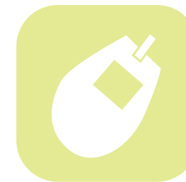
- Children with asthma who were treated by a collaborative team had fewer days per year of symptoms than children in standard care.

- Alzheimer's patients receiving collaborative care were more likely to receive the most appropriate medication, and they had significantly fewer psychological symptoms of dementia at 12 and 18 months.

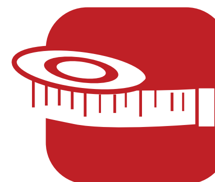


- Terminally ill patients receiving team-managed, home-based primary health care reported significant improvements in factors such as their level of pain and mental health.

- A review of studies of patients with heart disease showed that those who received follow-up by a multidisciplinary team were 23% less likely to be hospitalized than those who did not receive this type of follow-up.



- In British Columbia, team-based diabetes management has contributed to a drop in diabetes complications and therefore fewer emergency visits and hospital stays. As a result, provincial costs for diabetes care dropped from an average of $4,400 per patient in 2001/02 to $3,966 in 2004/05.



- Overweight patients being treated by a multi-disciplinary group were more likely to achieve their weight-loss goals than those in other treatment groups.

It's important to note that the existence of a team alone isn't enough to make a difference.

In order for patients to benefit, teams must have the right mix of skills and health disciplines; team members need to communicate and collaborate well, with clear objectives; and they need to provide top-quality care to patients.

The epidemic of chronic conditions

"When I was diagnosed with type 2 diabetes, I had a fantastic doctor who referred me to a diabetes clinic with a team. I had a nurse and a dietitian taking care of me. I learned so much during the one-on-ones with them, and my progress was great. Then I moved ... and the best in my town is a big group meeting at the hospital. I consider myself lucky to have experienced a team of professionals at the diabetic clinic to walk me through the early stages of learning about it all!"

– feedback from patient consultation with the Health Council of Canada

Chronic conditions are on the rise in Canada. Roughly 5% of Canadians have type 2 diabetes, up from 3% a decade ago. If the trend continues, the number of Canadians diagnosed with diabetes is expected to nearly double by 2016, to 2.4 million, far outpacing population growth. Three-quarters of people with type 2 diabetes have other chronic health conditions, such as heart disease and depression.

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Type 2 diabetes is just one of seven health conditions that are known to have a high impact on people's quality of life and/or a significant economic burden on the health care system. These seven conditions are:

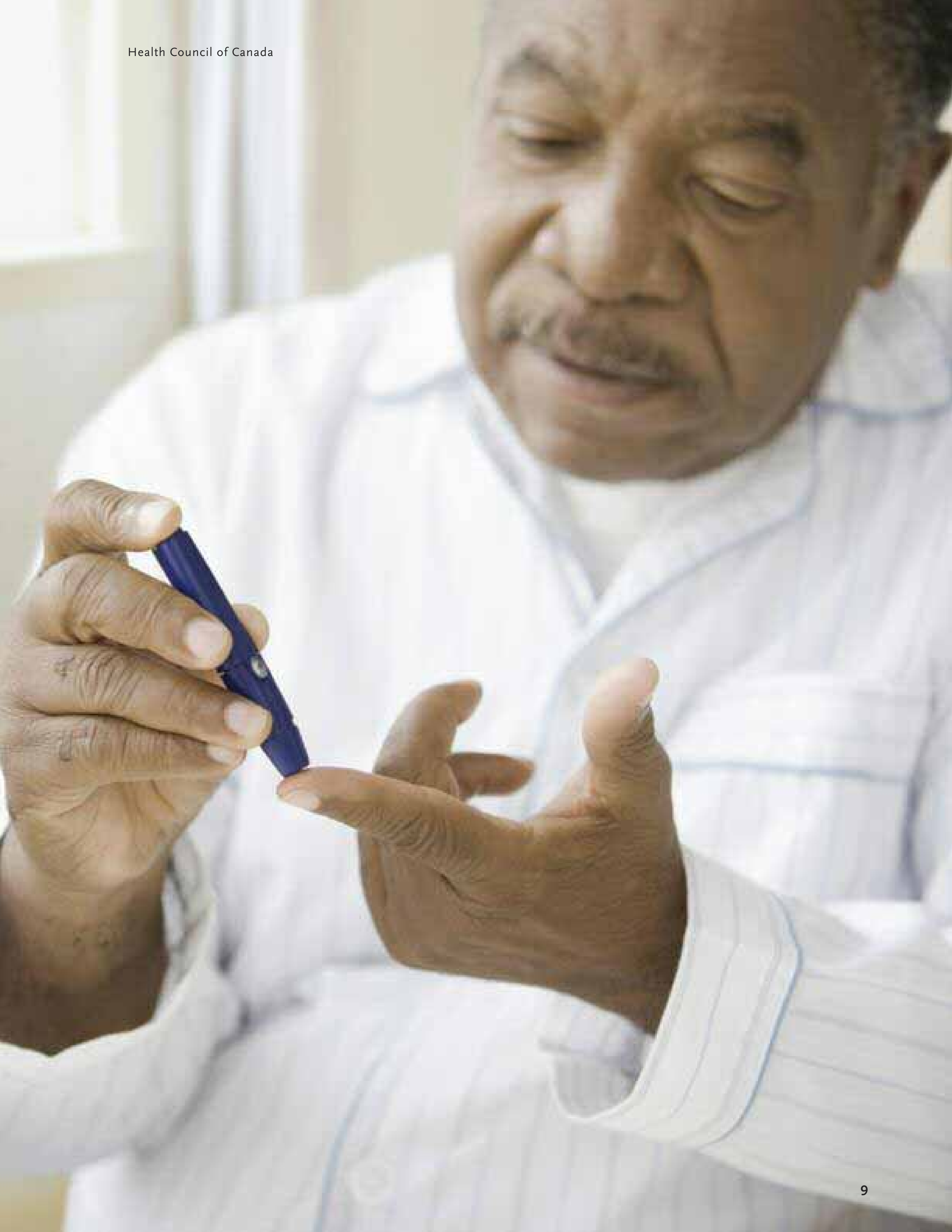
1 ARTHRITIS
2 CANCER
3 CHRONIC OBSTRUCTIVE PULMONARY DISEASE
4 DIABETES
5 HEART DISEASE
6 HIGH BLOOD PRESSURE
7 MOOD DISORDERS (e.g. depression)

7 CHRONIC HEALTH CONDITIONS

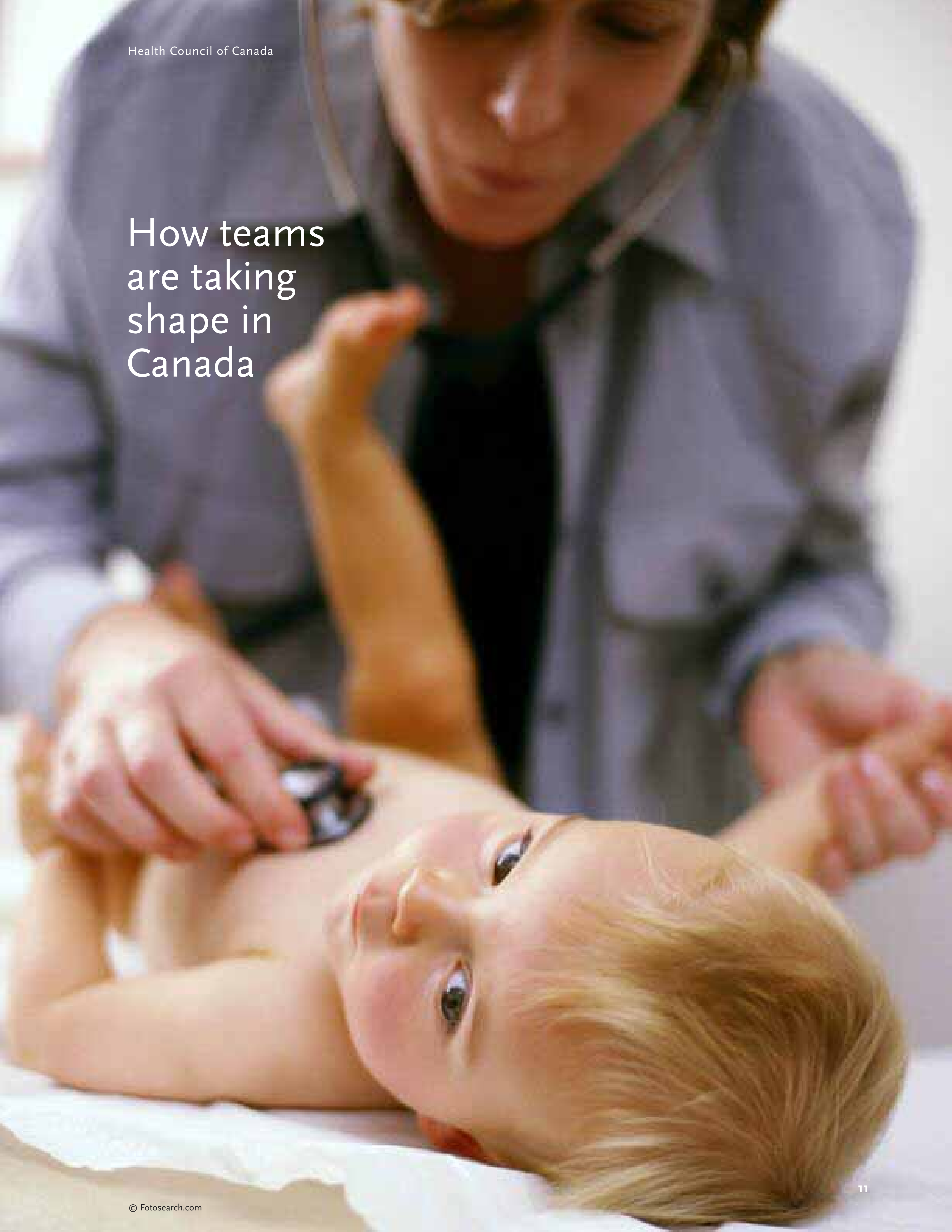
These seven chronic conditions now affect at least one in three Canadian adults – more than nine million people – and the numbers are growing.

People with chronic conditions often struggle with complications, diminished health, and quality of life, and they require many health care services. One-third of Canadians with a high-impact chronic condition uses 51% of all visits to family doctors, 55% of visits to specialists, and 72% of nights spent in hospitals.

That's why teams have such value. Research shows that helping patients manage their chronic conditions more effectively can make a significant difference in their health. Teams of health professionals work together with the patient to develop a plan for his or her chronic disease management and coordinate the services he or she receives. Many teams targeted to chronic disease management have a strong focus on patient education and health promotion, helping patients better manage their existing conditions by improving lifestyle factors such as diet and exercise.



In 2004, governments committed to providing 50% of Canadians with primary health care teams by 2011.
Where are we now?



How teams are taking shape in Canada

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HOW TEAMS ARE TAKING SHAPE IN CANADA

Primary health care teams have really only started to expand across Canada within the last decade, the result of a push to improve primary health care. Millions of dollars have been earmarked to support these changes. (Details can be found in *What governments promised* and *A history of teams in Canada* on page 26.) Governments recognized the growing challenge of managing and preventing chronic conditions, particularly with an aging population. They encouraged the development of teams of health professionals to deliver primary health care with a particular focus on improving the care of chronic conditions, promoting health, and preventing disease.

In 2004, as part of the *10-Year Plan to Strengthen Health Care*, the federal government and all the provinces and territories* committed to ensuring that 50% of Canadians have access to multidisciplinary teams for primary health care by 2011.

To learn how teams are taking shape across Canada, we interviewed government officials in participating provinces and territories as well as the federal government (which provides primary health care services to specific populations).

The *10-Year Plan to Strengthen Health Care* states that jurisdictions will increase their use of teams, but it doesn't define what a team should look like, how it should work, or what it should do.

As a result, each jurisdiction has the flexibility to develop team-based care that meets the specific needs of its population. The results are interesting, varied, and promising. Teams look quite different across the country, and they work differently, too. They are tailored specifically to meet the needs of their region or populations.

In one region, a team may be a dozen health professionals working in different locations but in frequent contact to plan and monitor their patients' care. In another, it could mean a paramedic and nurse working together in a mobile primary health care clinic, located in a converted bus.

As expected, many jurisdictions use teams in rural and remote regions and to provide after-hours access to care. Every jurisdiction has designed teams to manage chronic diseases such as diabetes and heart disease, often with innovative approaches. In addition, there is clearly a significant level of commitment and creativity in using teams to address specific regional needs, particularly reaching out to vulnerable or high-risk populations struggling with problems such as poverty and language or cultural barriers. In some cases, teams have been structured to play a role beyond medical care and health promotion; they also serve as community catalysts for change, working to improve their communities and reducing the factors that put their patients at risk.

***Quebec agreed to the overall objectives but committed to developing its own plan.**

The Health Council of Canada has also produced five in-depth case studies of successful teams: four in Canada and one in Finland, available at **www.healthcouncilcanada.ca**

A cross-Canada view of teams begins on page 24. Read Teams in Action and learn how your province or territory is choosing to use team- based primary health care.

For this draft, Teams in Action stories are enclosed as a Word document.

WHAT MAKES A TEAM?

A collaborative team is more than just two or more health care professionals working together. What matters most is whether the team has the right mix of professionals for the patients they serve, how well team members collaborate, and how this ultimately benefits their patients.

A good team works together to solve or explore common issues, with the best possible participation of the patient. There is shared planning, decision-making, and a willingness to participate. And although team members have well-defined and distinct roles, and may even be employed by different organizations, they share an identity as a working team and a responsibility for achieving common goals.

We don't know how many teams in Canada are meeting this ideal. Several jurisdictions shared examples of teams that have taken to the concept of collaborative practice from the start. But jurisdictions have also said that some health care professionals have more difficulty than others moving from a traditional hierarchy of professional roles and responsibilities to working with other disciplines in a more collaborative style. The success of their teams, said several jurisdictions, has depended on the willing participation and ongoing cooperation of its members, a finding confirmed by studies. Some jurisdictions also spoke of the need to educate the public and help people become comfortable with seeing health professionals other than a doctor.

Research shows that working in a primary health care team has advantages for health care professionals too. A number of studies confirm that professionals who work in a team are more satisfied and have a more positive work experience than those who don't practice in these settings. Team members develop greater knowledge and skills and hold a more positive perception of working collaboratively than those who don't practice in these settings. They also practice differently by offering more timely and appropriate referrals, follow-up, and preventive care.

Are teams good value for money?

Will teams improve the health of Canadians and, in doing so, save money in the health care system? The theory is that although team-based care can be more expensive than a doctor alone, the increased health promotion and chronic disease management that teams provide will improve people's health and therefore reduce their use of other health services, including costly hospitalizations.

There are no answers yet. Although some research shows that team-based care may lead to fewer doctor and emergency department visits, fewer hospitalizations, and fewer medications per patient, there is still not much system-wide information on the cost benefits of team-based care. This is an area that governments need to look at more closely.

FAMILY DOCTORS AND NURSES SUPPORT TEAM CARE

In 2007, the College of Family Physicians of Canada and the Canadian Nurses Association issued a formal statement in support of team-based care.

Both organizations stated that they believe that "when family physicians and registered nurses bring their skills together, there is significant potential to increase access and to reduce waiting times for patients with benefits to the whole system."

They expressed a commitment to looking at how team-based care could be put in place across the country.

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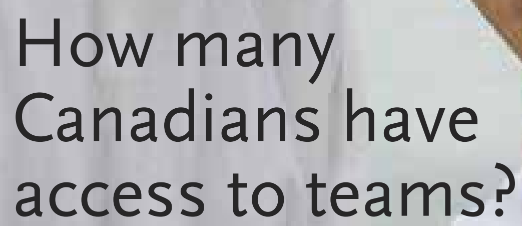
OTHER HEALTH PROFESSIONALS ALSO SUPPORT TEAMS

A partnership between 10 national associations of health disciplines took the lead to investigate the best ways for health care professionals to work together to improve the health results of their patients.

Funded by Health Canada, the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative represented physicians, nurses, social workers, physiotherapists, speech-language pathologists, audiologists, dietitians, psychologists, pharmacists, occupational therapists, and one national coalition on preventive practices. The EICP collected examples of successful primary health care in both urban and rural settings, assessed successful team practices across Canada, and provided information on ways to encourage collaboration.



How many Canadians have access to teams?

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HOW MANY CANADIANS HAVE ACCESS TO TEAMS?

We're unable to report how many Canadians are experiencing team-based care. Not all governments are gathering this information in a consistent way. In addition, jurisdictions define and use teams differently, and this is reflected in the percentage of their population that is covered by team-based care.

However, two national surveys provide some clues about Canadians' access to health care teams: the 2007 National Physician Survey, and the 2008 Canadian Survey of Experiences with Primary Health Care, co-funded by the Health Council of Canada.

In the 2007 National Physician Survey, nearly one-third (31%) of family doctors reported that they had a formal arrangement to collaborate with nurses. Half of these doctors reported that they worked with highly specialized nurse practitioners and/or psychiatric nurses. Family doctors also reported that they worked with dietitians or nutritionists (14%), social workers (13%), physiotherapists (12%), pharmacists (11%), occupational therapists (11%), mental health counsellors (10%), or psychologists (10%). Younger family doctors were more likely than older doctors to work in team settings.

In the 2008 Canadian Survey of Experiences with Primary Health Care, one-third (32%) of Canadian adults reported that they had access to more than one primary health care provider, meaning that they said a nurse worked with their doctor* and was involved in their care (16%), that another health professional worked in the same office as their doctor (10%), or both (6%). (See pie chart, page 19.)

***A small percentage of these respondents did not have a regular medical doctor but said they had a regular place of care, such as a clinic.**

Whether these people are receiving team-based care is unclear (for example, two professionals working in the same office does not necessarily mean they are a collaborative team), but results did show that these respondents had several advantages over those who only saw one primary health care provider.

Canadians who had additional access to either a nurse and/or other health care professionals were:

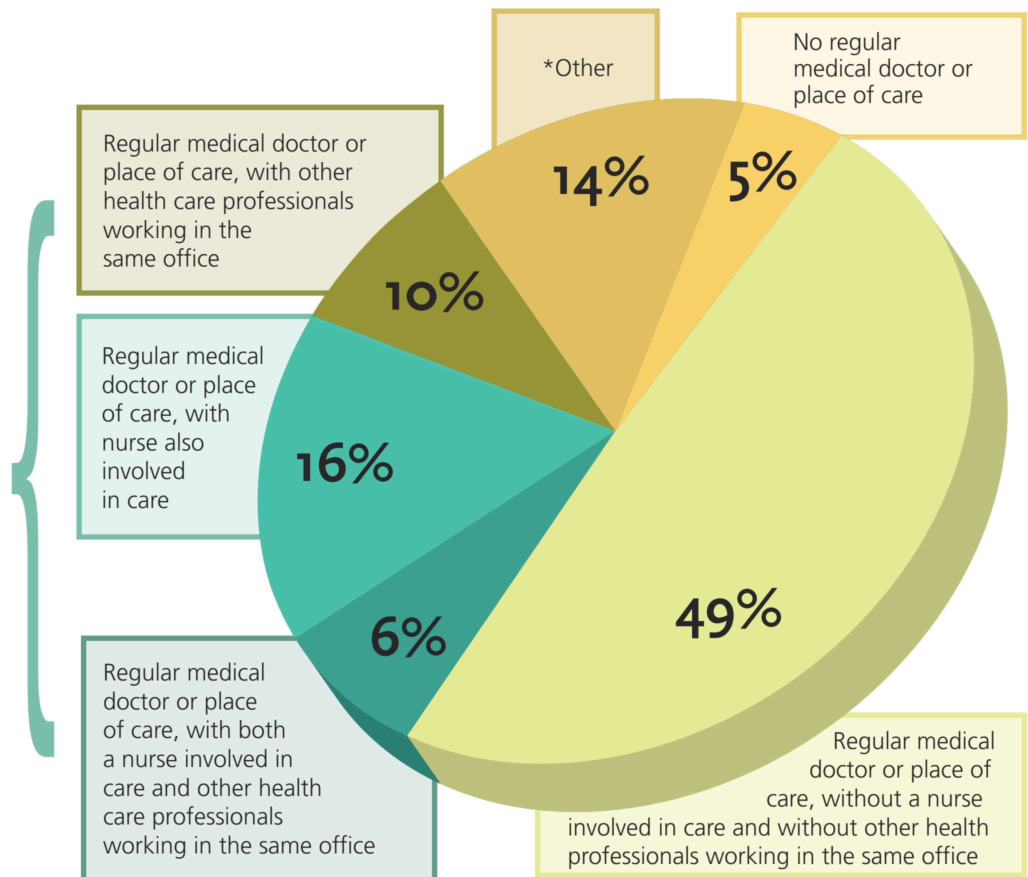
- more than 2.5 times more likely to report that their health care provider(s) provided a range of services that met most of their needs;
- 42% more likely to rate the quality of the health care they received as good, very good, or excellent, compared to those with access to one provider; and
- 46% more likely to report that they had more knowledge about their conditions and 67% more likely to report that they know how to prevent future problems.

Adults with one chronic health condition were 41% more likely to report that they had access to more than one primary health care professional (such as both a doctor and a nurse or dietitian), compared with those with no long-term health problems. Adults with two or more chronic conditions were 52% more likely to say this.

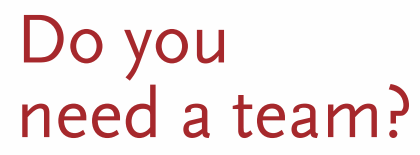
These findings indicate that people with chronic health conditions and more extensive health needs are seeing more health professionals than the general population. Unfortunately, the data can't tell us if they're seeing the most appropriate mix of professionals or whether those professionals work as a collaborative team.

One-third of Canadians have access to more than one primary health care provider

32% of Canadians have access to more than one primary health care provider.



*** Refusals and responses that did not fit into other categories**
Source: 2008 Canadian Survey of Experiences with Primary Health Care

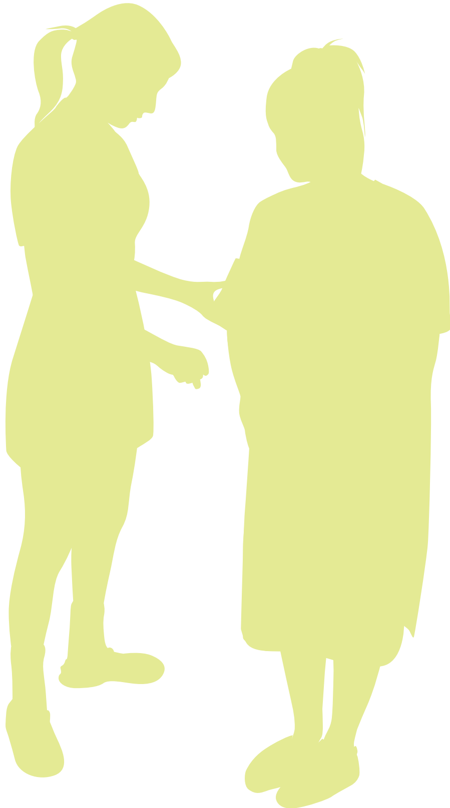


Do you need a team?

> Nearly three-quarters of Canadians like the idea of teams, and would prefer that their family doctor work as part of a team.

Research shows that teams are particularly helpful for preventing and treating chronic diseases, for treating mental health issues like depression, and for providing care to specific populations. More research is needed in this area before any conclusions can be reached about the value of teams for the general population.

If you need only basic primary health care—if your health is good and your needs are uncomplicated—there isn't enough reliable evidence to say whether teams provide any additional health benefit over seeing a single provider (such as a doctor or nurse practitioner).



Nevertheless, Canadians like the idea of teams. Nearly three-quarters (70%) of Canadians strongly support the idea of a team—such as a doctor, nurse, pharmacist, or other health care provider – that collaboratively provides care, and a similar number (74%) would prefer that their family doctor work as part of a team, rather than practice on his or her own. Canadians also like the idea that primary health care teams offer an increased focus on wellness, prevention, and patient education. Canadians see that teams can be a solution to the challenge of finding a family doctor, and that a supportive and collegial team would reduce the burden on doctors, prevent burnout, and encourage health professionals to locate and stay in rural and remote areas.

At the same time, only half (54%) of Canadians said they would be satisfied seeing a nurse rather than their doctor for routine health care services such as ear infections or immunizations, to manage diabetes, to monitor high blood pressure, or to check progress on a surgical wound. This research was done in 2002, and some jurisdictions confirmed that there continues to be some public resistance to seeing health professionals other than a doctor. They said it is important to educate the community about team care in order to gain acceptance.

Summing Up

CONCLUSIONS

There has been a significant push in funding and efforts in the last decade to expand the use of teams in primary health care, but team-based primary health care is still evolving in Canada. Each jurisdiction has made a good start. They are largely tailoring their activities towards special-needs populations and high-needs groups (such as those with chronic conditions and mental health issues like depression), where teams have been shown to make a difference. They are also using teams to provide service to areas that lack enough—or any—family doctors and to reach out to vulnerable populations that can have difficulty accessing the primary health care they need.

What clearly came through in our interviews with all governments is a strong commitment to implementing team-based care, with a wide range of often-innovative approaches. But there were some significant gaps in the information provided:

- We're unable to report how many Canadians have access to collaborative teams. Not all jurisdictions are gathering that information in a consistent way. It is unlikely that in two years governments will be able to claim that they have met the target established in 2004: that 50% of Canadians would have access to multi disciplinary teams by 2011. However, since 2004, more evidence has been gathered that shows the value of teams is most significant for specific populations. It may make more sense for governments to focus on expanding team care for those who need it the most. This may or may not represent 50% of their populations.

- Research shows that teams make a difference for people with chronic conditions and mental health issues. Beyond that, do they make a difference for other populations, or for people with relatively uncomplicated health care needs? We don't know—at least, not yet. There currently isn't enough evidence. We urge governments to thoroughly evaluate and commission appropriate research.

- One challenge in evaluating the cross-Canada efforts is that there is no single, clear definition of what makes a truly collaborative team. There are lots of different models of teams in Canada, but little evaluation to tell us how they work together or which mix of health professionals is best for addressing specific health needs.

Ultimately, team-based care has significant potential to improve the health of many Canadians. But governments must make sure that their current efforts are evaluated to determine what types of teams work best, where they offer the greatest benefit to patients, and where they provide the most value for money to the health care system.

Teams in Action

For this draft, Teams in Action stories are enclosed as a Word document.

Appendix

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A HISTORY OF TEAMS IN CANADA

In order to strengthen health care in Canada, the prime minister and premiers (First Ministers) made significant investments over the past decade to improve access to and quality of primary health care, and committed to increase the proportion of Canadians who have access to teams.

- Between 1997 and 2001, the Health Transition Fund was established to support investments in demonstration projects that were designed to test new models of delivering care in the community. At that time, only four provinces required family physicians to work in groups and interdisciplinary teams as a precondition for funding.

- In 2000, the First Ministers agreed on a vision for renewal—Action Plan for Health System Renewal—that included, among other things, additional investments in primary health care so that "Canadians receive the most appropriate care, by the most appropriate providers, in the most appropriate settings."

WHAT GOVERNMENTS PROMISED

In the 2003 *First Ministers' Accord on Health Care Renewal*, governments agreed to the goal of ensuring that at least 50% of their residents have access to an appropriate health care provider, 24 hours a day, 7 days a week.

In the 2004 10-year plan to strengthen health care, governments agreed to 50% of Canadians having 24/7 access to multidisciplinary teams by 2011.

The purpose of the 24/7 language in both the 2003 and 2004 goals was to ensure that more Canadians receive the primary health care they need after-hours, rather than going without or making unnecessary visits to hospital emergency departments.

Since that time, there have been a number of advancements in 24/7 coverage; for example, nearly all jurisdictions now have established telephone health lines staffed by registered nurses to provide after-hours access to health care advice. Some jurisdictions also use after-hours clinics, which may or may not be staffed by multidisciplinary teams.

To that end, in this report we comment on the 50% target for team-based primary health care, but not on the issue of 24/7 access.

First Ministers agreed "to promote the establishment of interdisciplinary primary health care teams that provide Canadians first contact with the health care system. Such teams would also focus on health promotion, the prevention of illness and injury, and improved management of chronic disease."

They agreed to accelerate primary health care renewal and work towards ensuring timely access to services outside of expensive emergency departments."

- In 2000, the Government of Canada responded by announcing the Primary Health Care Transition Fund (PHCTF), which established a policy framework to guide the investment of $800 million over five years, in support of implementing large-scale, primary health care renewal initiatives.

  Among the objectives of the PHCTF were "to establish multi-disciplinary teams, so that the most appropriate care is provided by the most appropriate provider," "to increase the emphasis on health promotion, disease and injury prevention, and chronic disease management," "to expand 24/7 access to essential services," and "to facilitate coordination with other health services (such as specialists and hospitals)."

- In 2003, the *First Ministers' Accord on Health Care Renewal* reaffirmed a national vision for primary health care renewal and established goals, objectives, and requirements for federal transfer payments for a newly established, five-year reform fund. In the accord, the First Ministers declared, "The core building blocks of an effective primary health care system are improved continuity and coordination of care, early detection and action, better information on needs and outcomes, and new and stronger incentives to ensure that new approaches to care are swiftly adopted and here to stay." They agreed to the goal that, by 2011, "at least 50% of their residents have access to an appropriate health care provider, 24 hours a day, 7 days a week."

- In 2004, the First Ministers' *10-Year Plan to Strengthen Health Care* referred to an "objective of 50% of Canadians having 24/7 access to multidisciplinary teams by 2011."

ABOUT THE 2008 CANADIAN SURVEY OF EXPERIENCES WITH PRIMARY HEALTH CARE

The first survey of Canadian experiences in primary health care, funded by the Health Council of Canada, was conducted by Statistics Canada in 2007, with approximately 2,200 respondents. Statistics Canada has produced a paper summarizing the 2007 survey findings with regard to the effects of team care.

In 2008, the Health Council of Canada and the Canadian Institute for Health Information co-funded the Canadian Survey of Experiences with Primary Health Care to provide new information about access, use, experiences, and outcomes among the general population, as well as adults who have chronic health conditions. These survey data offer pan-Canadian population-based estimates.

This cross-sectional telephone survey was conducted by Statistics Canada from April to June 2008 and administered in either French or English (depending on the preference of the survey participant). A total of 11,582 adults completed the survey. (These respondents came from a sample of nearly 16,000 adults in the Canadian Community Health Survey, Cycle 4.1, who were approached to participate in the 2008 Canadian Survey of Experiences with Primary Health Care.)

LEARN MORE

About chronic conditions

Why Health Care Renewal Matters: Learning from Canadians with Chronic Health Conditions

Why Health Care Renewal Matters: Lessons from Diabetes

In 2007, the Health Council of Canada produced two comprehensive reports on the growing epidemic of chronic disease in Canada, and what can be done about it.

About teams

Getting It Right: Case Studies of Effective Management of Chronic Disease Using Primary Health Care Teams

In 2009, the Health Council of Canada commissioned a research team, led by Dr. Thomas Rathwell of Dalhousie University, to examine four Canadian and one international chronic illness care programs that use collaborative teams to deliver primary health care. This report serves as an experience-oriented tool for primary health care providers, planners, and decision-makers who wish to improve an existing program or implement a team-based approach for chronic disease management.

Canadian Health Services Research Foundation: Interprofessional Collaboration and Quality Primary Healthcare

In 2007, the Canadian Health Services Research Foundation and the Health Council of Canada commissioned a research team, led by Juanita Barrett, to gain a better understanding of the evidence regarding team-based care. The resulting research synthesis looked at both international and Canadian evidence on teams.

All of these reports are available at www.healthcouncilcanada.ca, as well as several videos about team-based care.

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ABOUT THE HEALTH COUNCIL OF CANADA

Canada's First Ministers established the Health Council of Canada in the 2003 Accord on Health Care Renewal and enhanced our role in the 2004 10-Year Plan to Strengthen Health Care. We report on the progress of health care renewal, on the health status of Canadians, and on the health outcomes of our system. Our goal is to provide a system-wide perspective on health care reform for the Canadian public, with particular attention to accountability and transparency.

The participating jurisdictions have named Councillors representing each of their governments and also Councillors with expertise and broad experience in areas such as community care, Aboriginal health, nursing, health education and administration, finance, medicine and pharmacy. Participating jurisdictions include British Columbia, Saskatchewan, Manitoba, Ontario, Prince Edward Island, Nova Scotia, New Brunswick, Newfoundland and Labrador, Yukon, the Northwest Territories, Nunavut and the federal government. Funded by Health Canada, the Health Council operates as an independent non-profit agency, with members of the corporation being the ministers of health of the participating jurisdictions.

The Council's vision
An informed and healthy Canadian public, confident in the effectiveness, sustainability and capacity of the Canadian health care system to promote their health and meet their health care needs.

The Council's mission
The Health Council of Canada fosters accountability and transparency by assessing progress in improving the quality, effectiveness and sustainability of the health care system. Through insightful monitoring, public reporting and facilitating informed discussion, the Council shines a light on what helps or hinders health care renewal and the well-being of Canadians.

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TAKING THE PULSE

Access Centres weave a tighter safety net

Bringing health and social services under one roof – to make it easier for people to get the services they need – is the idea behind Manitoba's urban Access Centres. But this model of care is not just about the convenience of being in the same building. Besides the bricks and mortar, Access Centres are built with the vision of integrated services that weave a tighter safety net for people with complex needs, so that fewer people will slip through.

At ACCESS River East in northeast Winnipeg, the first of three centres to open so far, that integration is taking place, as Dr. Paul Sawchuk, medical director at the centre, describes.

I recently saw a patient who was psychotic and unable to work. But because he had no job, he couldn't pay for the medication that would control his psychosis. And he couldn't manage to apply for the income assistance that would help him pay for his medication.

I could walk him upstairs, talk to someone at Income Assistance, and get him the help he needed, Dr. Sawchuk explains. Where he worked in the past, "I would not have seen that as part of my job.

The scale of things at ACCESS River East says a lot about what it takes to make urban communities healthier. Debra Vanance, director of the River East centre and another in neighbouring Transcona, oversees more than 750 staff between the two locations, serving 126,000 residents, [DV email] a community larger than many Canadian cities. ACCESS River East serves a cluster of neighbourhoods that includes the highest concentration of seniors in Winnipeg. Formally, the centre is part of the Winnipeg Regional Health Authority but it includes programs of Manitoba Family Services and Housing. The new two-storey building houses a dozen types of services – interprofessional primary health care, public health and community mental health programs, home care, income and job supports, resources for seniors, child and family services, and community development programs.

Integrating such a rich array of services has opened doors to some creative and productive partnerships with community agencies outside of the centre walls, such as schools, churches, doctors' clinics, seniors' group, and the local hospital, Vanance says.

"For example, we license child care centres in the area, and because we also have health services staff in our responsibility, we have had speech-language pathologists working with child care providers on literacy for children." **Page 17 of 32 Jurisdictional pieces for Teams # 1 report Page 18 of 32 Compiled for Monitoring Committee review – March 12, 2009**

The primary health care team at ACCESS River East includes family doctors, nurse practitioners (who, at this clinic, have their own patients and do most of the things that family doctors do), public health nurses (who focus on health promotion and preventive screening), midwives, mental health counselors, dietitians, and more. "Our priority opulation is people without family doctors, and people with very complex needs," says Vanance. "We are set up to serve the hard to serve. They often can't navigate the system themselves, whether because of poverty, trauma, health conditions, whatever. These are very high-cost patients for any system." Since ACCESS River East opened in 2004, [CHECK] Manitoba has launched three access centres so far – two in Winnipeg and one in Brandon – and plans are underway for one more in each of those cities.

QUICK FACTS - MANITOBA

Population: 1.2 million

9% of family doctors *in Manitoba have joined a Physician Integrated Network, an initiative to improve access to and the quality of primary health care, particularly for people with chronic health conditions*

Mobile bus takes primary care to lower-income neighbourhoods

When the Saskatoon Health Region was looking into the idea of a mobile health bus to reach out to inner city residents, they asked for advice from community-based organizations in these communities – and what they heard was direct and invaluable.

Don't fool yourself by thinking 'If you build it, they will come,' because that's not the way these communities work, " one advisory committee member told the health region. "They need three things – to feel welcome, to feel safe, and to feel as though they are not being judged.

That philosophy now underpins the work of Saskatoon's new mobile team clinic, called the Health Bus, a converted RV with a fully-equipped examination room. The bus is operated by a team of paramedics and nurse practitioners who provide a range of health services: health checks, blood pressure and blood sugar checks, chronic disease management, wound care, follow-up care, and advice on how to live a healthier lifestyle. The paramedic and nurse practitioner call on local physicians as required, and also link patients to other health and community services as needed. Those who use the bus include First Nations people, Metis, immigrants, and refugees. Many people from these groups are hesitant to access conventional providers or health care centres. To preserve their confidentiality, and to encourage them to come forward to the bus for care, patients don't need to show a health card or otherwise identify themselves. Bus staff work to reach out to their patients, making it easy for people to come to them by operating seven days a week, 2 p.m. to 10 p.m., and parking in convenient locations such as outside a local McDonald's or in the parking lot of Wal Mart.

The flexible hours can be helpful to people who work shifts or low-paying day jobs which allow limited time off for appointments. The bus was started as a pilot project in the August 2008; since then it has seen about 1,000 people, approximately 8 to 9 a day. "The Health Bus has been an overwhelming success," says Saskatoon Health Region president and CEO Maura Davies. "The response shows how important this service is to the Saskatoon community."
In February 2009, Saskatchewan Health approved the bus as an annually funded program. The Health Bus is just one of the new primary health care teams implemented in Saskatchewan in the last few years, each one established after a careful community review to make sure that the team is designed to meet the specific
needs of the population.

For more information about other teams in Saskatchewan, click here.