CONFERENCE REPORT

Primary Community Care Conference 2005
Moving from Theory to Practice

Conference Report

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Note

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The views expressed herein do not necessarily represent the official position of Health Canada.

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1. INTRODUCTION

In September 2000, Federal/Provincial/Territorial First Ministers agreed that "improvements to primary health care are crucial to the renewal of health services. Governments are committed to ensuring that Canadians receive the most appropriate care, by the most appropriate providers, in the most appropriate settings". In response, the Government of Canada announced the Primary Health Care Transition Fund (PHCTF) which is an investment of $800 million dollars over four years to support the transitional costs of implementing large scale, primary health care initiatives. These initiatives are expected to improve access, accountability, and integration of services through fundamental and sustainable change to the organization, funding, and delivery of primary health care services.

The five objectives of the PHCTF include:

1. increase the proportion of the population having access to primary health care organizations accountable for the planned provision of a defined set of comprehensive services to a defined population;

2. increase emphasis on health promotion, disease and injury prevention, and management of chronic diseases;

3. expand 24/7 access to essential services;

4. establish interdisciplinary primary health care teams of providers, so that the most appropriate care is provided by the most appropriate provider; and

5. facilitate coordination and integration with other health services (i.e. in institutions and in communities).

The Northwest Territories (NWT) is participating in the PHCTF and has been approved to complete eleven individual projects. One of these is the hosting of an annual Primary Community Care Conference in the NWT. In January 2005, the fourth such conference was held and this report includes:

- the context in which the conference was undertaken;
- a summary of the conference proceedings;
- the conference evaluation;
- emerging themes; and
- and recommendations.

2. BACKGROUND

Since November 2001, the Department of Health and Social Services (DHSS) has hosted four Primary Community Care (PCC) Conferences. These conferences have been instrumental in bringing together representatives from various administrative categories, professions, and para-professions involved in the delivery of health and social services in the NWT. This includes health and social services practitioners, community service workers, professional associations, and non-government associations involved in delivering care in the NWT. The purpose of the conferences has been to mobilize and motivate these partners to explore ways of working more effectively together within an integrated service delivery model.

The Integrated Service Delivery Model (ISDM) was recently finalized by the Joint Senior Management Committee. The ISDM is intended to define the health and social services system and provide a clear path for the future, based on a primary community care approach. In the ISDM, the term primary community care is used in place of primary health care, which is more commonly used in other jurisdictions. PCC encompasses all of the characteristics and principles of primary health care but reflects a broader, more comprehensive range of primary health, wellness and social services established to meet northern client and family needs.

Integration and collaboration are at the heart of ISDM. A system based on integration and collaboration involves health and social services becoming a single, seamless service where caregivers work together but maintain their distinct, independent practices. PCC Conferences raise awareness of integration and collaboration in the context of the ISDM.

The PCC Conferences have also initiated the process of change management. The conferences provide an opportunity to regularly gather and analyze information about the impact of decisions to date, and how movement to an ISDM approach is proceeding. The conferences also help equip participants to be change agents themselves, helping them to understand the need for new and broader professional skills to do their jobs in new ways. The goal is that all partners will respect and accommodate the interdisciplinary approach.

3. CONFERENCE SUMMARY

3.1 Conference Outline

This fourth annual NWT Primary Community Care Conference entitled "*Moving from Theory to Practice*" took place in Yellowknife in January 2005. Its goals were to aid implementation of primary community care, strengthen multidisciplinary relationships, and share learning experiences from PCC initiatives and projects. These were to be achieved by the following:

- promoting interaction between policy-makers, managers, primary community care providers, professional associations, NGOs and Aboriginal governments involved in the delivery of HSS core services;
- providing a forum for sharing best practices and NWT primary community care projects; and
- enhancing the ability of practitioners to work in a sharing, collaborative manner.

In keeping with the theme of encouraging integration and collaboration among a broad array of service providers, the participants at this year's conference represented a broader spectrum than in previous years. They included:

- PCC providers in the health and social services system, such as social workers, mental health and addictions workers, community health representatives, nurses, physicians, dental therapists, nutritionists, and many others;
- Regional Health and Social Services Authority policy-makers, administrators and coordinators;
- DHSS staff including consultants, policy-makers, administrators, coordinators, planners, and information technology staff ;
- Professional associations including physicians, nurses, midwives, and pharmacists;
- Non-government organizations and agencies involved in delivery of PCC services;
- Students;
- Aboriginal governments; and
- Social Agenda Community Demonstration Projects.

In addition to discussing best practices and experiences with the PHCTF projects, the conference provided participants with the opportunity to discuss themes surrounding the ISDM, in particular the implementation and sustainability of PCC teams. The presentations, workshops, and large group discussions all focussed on identifying the factors that facilitate teamwork, with the client at the centre of the team.

Conference participants, numbering 164, attended from various NWT communities, with guest speakers from Saskatchewan Health. Most participants were front-line workers who represented community, regional, and territorial perspectives and a broad range of disciplines. The agenda (Appendix 1) was designed to provide a mix of best practice information from PCC projects in the NWT and elsewhere, updates on the PHCTF projects across the NWT, and hands-on experience with teamwork through a case study exercise. A large group discussion on the final day provided an opportunity for participants to give their thoughts on PCC, teamwork, and how PCC can be supported throughout the system.

Discussion and relationship-building were encouraged during informal networking and refreshment breaks. As well, flip-charts were situated around the conference room as a tool for participants to document any suggestions, comments, questions or concerns related to PCC.

The 2005 Primary Community Care Conference was the final conference to be funded through Health Canada's Primary Health Care Transition Fund.

3.2 Presentations

A brief summary of the conference presentations is outlined below.

Supporting Primary Community Care

Team Development and Implementation in Saskatchewan's Primary Health Care Sector
Lynn Digney-Davis and Dr. Gill White
Saskatchewan Health

Saskatchewan Health has developed the Saskatchewan Action Plan for Primary Health Care to guide the development of primary community care in that province. Part of this plan includes support for the transition to primary community care teams through a team development project. This project included the development of facilitator position at the regional authority level to support team development on an ongoing basis. The core strategies of team development were education, communication, technology, human resources, legislative reform, and community participation and collaboration. The presenters also noted the importance of leadership, training, and authority support, among other success and challenges.

Moving the Integrated Service Delivery Model Forward: Let's Just Do It!
Marnie Bell, Lead Coordinator ISDM
Department of Health and Social Services

The Integrated Service Delivery Model (ISDM) was recently approved by the Joint Senior Management Committee as the lens through which primary community care and other health and social services are to be viewed. Ms. Bell reviewed the six core services including diagnostic and curative services, rehabilitative services, protection services, continuing care services, promotion and prevention services, and mental health and addictions services. The presentation concluded with a list of 13 elements required for the ISDM to proceed. These are communications, human resource plans, team development, community coordinators, funding formulas, information management, performance agreements, accountability reporting, electronic records, tele-health expansion, infrastructure, legislation regulations and policies, and agreements with partners.

NWT Primary Health Care Transition Fund
Vicki Lafferty, NWT PHCTF Coordinator
Department of Health and Social Services

Ms. Lafferty provided an overview of the NWT Primary Health Care Transition Fund (PHCTF) Initiative, beginning with a description of Health Canada's PHCTF. Each of the 11 NWT projects being funded by the initiative was described briefly, and the balance of the presentation focussed on the three projects housed within the Department of Health and Social Services. These projects are the Coordination of the PHCTF Initiative, the NWT Multidisciplinary Forum, and the Public Education Plan. The PHCTF projects support PCC renewal in five important ways - by offering new services, shifting emphasis toward health promotion and disease prevention, increasing client access, improving services for clients, and facilitating efficiency of services.

The Physician's Role on the Primary Health Care Team
Dr. Gill White
Saskatchewan Health

Dr. White described the physician's role on the primary health care team. While there is some physician resistance to PCC in Saskatchewan, many physicians are enthusiastic to work toward better client care. Most physicians see how teamwork creates a better workload distribution, increases access, and allows them to expand into chronic care and health promotion. To assist with the transition, Saskatchewan used a phased-in approach. It also developed a memorandum of understanding and a model contract to outline the role and concept of PCC, and to describe the physician's role in terms of team participation and medical records ownership, etc.

There have been many successes, although protecting team development funding has been challenging. Another challenge has been change management around the issue of information sharing and the interface with information technology. A particular success has been the recognition that good team leaders are those who are willing and able to lead teams, regardless of their professional background.

The Saskatchewan Team Development Project: A Regional Health Authority Perspective
Chris Mayhew, Primary Health, St. Paul's Hospital
Saskatoon Health Region

Chris Mayhew is a Primary Health Facilitator and is involved in the Saskatchewan team development initiative. Saskatchewan's team development training has evolved around the five-phase ABCDE model that encourages teams to create an ideal future, measure success, convert strategies to operations, implement successfully, and consider the external environment/context. One tool used to formalize the team process is the team charter. It includes items such as ground rules, membership, mission/vision/purpose, measures of success, and an action plan. The role of the Primary Health Facilitator is to facilitate team development and inter-sectoral collaboration. It is crucial to keep the facilitator out of a supervisory role and to be clear about the facilitator's scope of practice. Challenges have included the need to continually define teams and team development, and to recognize the value of community participation. Next steps for this initiative include such things as continuing education and collaboration among facilitators.

Primary Health Care Transition Fund Projects

Tli Cho Healing Path Wellness Centre, Rae Edzo
Patrick Young, Regional Mental Health Specialist and Joe Beaverho, Facility Coordinator
Dogrib Community Services Board

The Tli Cho Healing Path Wellness program is a regional network of caregivers, individuals, families and communities working together to develop and walk a healing path to wellness. The program responds to the issues of additions, sexually transmitted infections, diabetes, tuberculosis, and cancers related to lifestyle choices. The program is based on the principle that, with support, people can take responsibility for developing a personal healing path and walk that path to wellness. The wellness centre helps people recognize these issues and how to access the necessary support. The centre has an integrated approach, bringing together a team of wellness workers, health centre staff, child and family services, schools, and community partners. To date the centre has provided counselling, support to community groups, wellness workshops, and referrals to other agencies. Challenges have been related to human resources, particularly the transience of staff. Successes have centred on the community-based nature of the program. Next steps are expansion, training of new staff, and team development.

Yellowknife Community Clinic
Jill Christensen, Primary Health Care Project Coordinator
Yellowknife Health and Social Services Authority

The Yellowknife Community Clinic is a multidisciplinary community-based clinic and outreach service for vulnerable and underserved client populations based on the principles of PCC. Client groups include youth, aboriginal and immigrant families, homeless persons, the working poor, and families in crisis. The project has included client consultation, establishment of a community advisory committee, development of a communications plan, and selection of a clinic location. Services will likely include medical care, administration, public health, mental health/addictions, social work, voluntary services coordination, nutrition, health promotion, and outreach services. Challenges have been clinic location, managing change, funding, communication and human resources. Successes have been the advisory committee, the community consultation, and the commitment to integrate services. Next steps will include continued PCC promotion, keeping the client as the central focus, finding champions, and continuing to involve the community.

Introduction of Midwifery Services
Leslie Paulette, Registered Midwife
Fort Smith Health and Social Services Authority

The goal of the Introduction of Midwifery Services project is to introduce midwifery service into the current system by integrating midwifes into an interdisciplinary team to support women and families to have healthy pregnancy, birthing and postpartum experiences. The core project activities include establishment of a maternity care committee; development of a delivery model, policies, and procedures; development of an interdisciplinary team; service delivery; and evaluation. To date an interdisciplinary working group has been established, education and relationship-building is occurring, a policy framework is in development, and the site is being developed. The learning curve, team-building, and the definition of roles have been challenges, while the establishment of a regulatory framework, and increased understanding and support have been successes. Next steps include training, renovations, including registered midwives on staff, development of protocols and policies, and service delivery.

Nurse Practitioner Clinical Training Center
Anna Beals, Director, Health and Social Programs
Dogrib Community Services Board

The Nurse Practitioner Clinical Training Centre will increase access to clinical learning placements, and establishing a teaching centre within the Rae Edzo Health Centre that enhances the education of nurse practitioners. While progress to date has been slow, there have been successes in the upgrade of infrastructure and sourcing of materials, the promotion of nurse practitioners, the review of space requirements, and communication with educational institutions. Challenges include human resources, especially the retention of staff. Next steps include promotion of the nurse practitioner role, continued discussions with educational institutions, the creation of nurse practitioner positions, and a cultural orientation for new staff and students.

Northern Women's Health Program
Carla Skauge, Prenatal Care Coordinator
Stanton Territorial Health Authority

The Northern Women's Health Program was established to improve coordination for prenatal care by providing timely access to fetal assessment, increased training opportunities for health care providers, by providing standard assessment criteria, and by enhancing communication. To date a single point of reference has been established for fetal assessments, and a toll free line has been created. An ultrasound machine and fetal monitoring equipment have been purchased, and regular tele-health meetings and the implementation of the prenatal education program have begun. Obtaining the full support of all partners for sharing information and understanding each other's role has been a challenge. Successes include increased communication between health centres, communities, and the hospital, and better coordination of high risk prenatal patients. Next steps involve working for sustainability and building stronger relationships with the communities.

Aboriginal Community Health Worker Training Program
Tambrey Sanregret, Manager, Health Programs
Deh Cho Health and Social Services

The goal of this project is to develop a culturally appropriate education curriculum for Aboriginal Community Health Workers to improve services to underserved communities within the Deh Cho region. Aboriginal Community Health Workers complement the services of Community Health Nurses and others by providing emergency and basic care to four small communities in the region. These workers are currently trained in CPR and First Aid, and other training is received on the job. To date, a partnership has been established with Aurora College to provide additional and consistent training, focusing on health promotion and prevention, so that workers are better prepared to provide first responder care. A coordinator has been hired, the curriculum has been completed, and four sessions have occurred. Challenges include the lack of a full-time coordinator and the issues related to having workers leave their home community for the training, including finding relief workers. Successes include the establishment of partnerships, the development of a good curriculum, and an excellent attendance rate by participants.

Beaufort Delta Wellness Teams
Laura Peddle, Primary Health Care Project Coordinator
Inuvik Regional Health and Social Services Authority

The Beaufort Delta Wellness Teams provide multidisciplinary wellness programs to create a more holistic and client-centred approach to health care. This project has targeted clients living with chronic conditions, young or expectant parents, and adolescents. To date an advisory committee has been established, the three core programs have been created, some staff have been trained, and partnerships have been formed. Staff turnover and limitations in reaching out to the communities have been challenges. Successes include promoting the role of nurse practitioners, a high level of client satisfaction, multidisciplinary teamwork, and enthusiasm for activities. Next steps include the continued promotion of nurse practitioners, and team-building workshops in January 2005.

Community Dental Health Program
Dr. Gerry Uswak, CEO
Inuvik Regional Health and Social Services Authority

The goals of the community dental health program are to reduce the incidence of dental decay in preschoolers and to reduce the number of paediatric dental surgeries. These goals will be met by describing the extent and severity of early childhood caries through a baseline study, increasing earlier access to dental PCC, increasing emphasis on dental health promotion, integrating dentistry back into the PCC team, and improving coordination of services. Activities include an oral health status assessment census of 2-5 year olds, an operational review of dental services, and training for staff and clients. To date the oral health census has been completed, including exams and questionnaires. Challenges have been related to scheduling, consent, communication/promotion, and response rates in the Town of Inuvik. Successes have included good response rates in the communities, excellent raw data, media attention, a draft job description for the manager, and equipment upgrades. Next steps include dental health promotion, regular study, improved administration and performance measurement, and the recruitment and retention of staff.

Practical Examples of Primary Community Care in Action

Women's Wellness Program: A Holistic Approach
Karen Benwell, Jessie Carriere, Keith Marshall, Jennifer Beaulieu, Sherry Jensen-Medernach
Hay River Health and Social Services Authority

The Hay River Women's Wellness Program is an example of teamwork in action. The project was originally planned as a one-stop-shopping service for women's wellness. After community consultation, women expressed an alternative approach with the nurse practitioner as the single point of entry. The nurse practitioner does an initial assessment, then refers or directs the client to the most appropriate provider. This has required a strong team behind the scenes so providers understand each other's roles. Teamwork also occurs on a planning level with a committee that oversees the project. This committee is comprised of Authority members and community members, including students. The committee is currently seeking the membership of an Elder. Challenges have related to promoting the program, ensuring client understanding of the concepts of holistic care, confidentiality, and information sharing. A current challenge is performance measurement.

Working Together: A Community with One Common Goal
Paschalina Thurber, Executive Director
Zhati Koe Friendship Centre

The Social Agenda Community Demonstration Project located in Fort Providence was established to remove structural barriers to working together. The interagency committee in that community has been re-established to increase collaboration, participation, and awareness about wellness issues and traditional customs. Activities include educational workshops, traditional healing and teachings, and the provision of training opportunities. Successes have included an increased use of traditional healing and teachings, better involvement of youth and men, and the creation of on-the-land programs. As well, workshops have been well attended, and there has been interagency group input and participation. Challenges have included providing training in the community, and sustainability. Since this initiative is funded on a project basis, sustaining the momentum will be difficult. It has been a challenge to communicate that short-term funding does not support the long term process of healing. This project has allowed many community organizations to begin the process of working closely together to develop a community wellness plan.

Enhancing Homecare Services
Ruth Robertson, Director, Community Health and
Heather Chetwynd, Manager, Community Health
Yellowknife Health and Social Services Authority

Teamwork has evolved in the Homecare Department at Yellowknife Health and Social Services Authority over the last several years. Since the influx of federal homecare enhancement funding, the homecare team has evolved to include rehabilitation services, a medical social worker, home support workers, nursing services, community mental health services, and a dietician. This has created challenges like how to ensure effective communication, organization, and ongoing education. Through strong commitment the partners have overcome these challenges and now provide an array of coordinated services for Yellowknife area residents. They have also adapted to changing community needs, such as palliative care. Successes have been service growth, and the increased ability for clients to stay at home longer or be discharged from the hospital sooner. As well, the program moved from being provider-focussed to being client-focussed. Challenges remain such as gathering data for decision-making and monitoring, effective communication, and the continual challenge to manage change.

3.3 Case Study Workshops

On the second afternoon of the conference, participants were placed into teams to discuss client-centred case studies. The case studies were developed around the six core service areas of the ISDM and were written by various health and social services partners. The number and type of case studies was determined from the responses provided by conference participants on the registration form. The case study exercise was planned specifically to allow conference participants to benefit from interaction and discussion without the pressure of reporting back to the larger group. Because case study teams were not responsible for taking notes, they were able to focus on the practical experience of working together to address the issues of a particular case.

Led by a team facilitator, each team participated in a short relationship-building exercise by identifying themselves, their role in PCC, and their experience with working in teams. Following this, each group selected a case or two from a package of 4-6 cases representing a mix of core service areas. Using the standard case study questions provided (Appendix 2), the teams began working together to determine the best course of action for the case client/family.

Some teams were able to get to the task at hand quickly and completed two or three cases. Others required more time for relationship-building among members and did not complete all of the questions. Still others were able to begin the task relatively quickly but wrestled with issues of team size, team member perspectives on health, lack of information about the client, and logistical barriers such as time constraints and a less than optimal location for their team meeting.

3.4 Evaluation

Of the 164 conference participants, 72 responded to the evaluation survey - a response rate of 44%. The majority of respondents were nurses, had clinical practice/frontline work as their major work emphasis, had worked in their professions and in the NWT for over 5 years, and were from either the DHSS or the Yellowknife Health and Social Services Authority.

All respondents were either “satisfied” or “very satisfied” with how the goals of the conference were achieved. Participants were most satisfied with how the conference promoted the sharing of learning experiences. They were slightly less satisfied with how the conference strengthened multi-disciplinary working relationships or aided in the implementation of PCC.

Additionally, all respondents were either “satisfied” or “very satisfied” with all ten of the conference elements. They were most satisfied with the Tuesday evening social event, the facilitators, the overall quality of the conference, the facility, the presenters, the networking opportunities, and the question-discussion periods. They were slightly less satisfied with the timing and length of the conference, and the case study workshop component.

Recommendations for future conferences are discussed in section 5.1. Full details of the conference evaluation are available in the *PCC Conference 2005: Evaluation Report.*

4. EMERGING THEMES

On the final day of the conference, the facilitators presented a list of emerging themes for discussion. These themes were a synthesis of the issues and opportunities raised during the presentations, the question and answer periods, participant comments on paper posted throughout the conference room, and the team discussions during the case study exercise. Once presented by the facilitators, the list of themes was confirmed and enhanced by conference participants through a large group discussion. The following themes are the result of this exercise.

1. Manage Change

In order for PCC to move forward, concentrated effort is required to manage the changes that are inevitable. This will include training for partners, team-building, and designating resources to facilitate change. This might include the creation of a Facilitator position in each region, similar to the approach in Saskatchewan. This person would be dedicated to managing change. He/she would possess strong leadership and team-building skills, and would not be selected based on his/her professional designation. Change management is also required at the territorial level so that system barriers are alleviated, good information is available, and assistance is provided. As well, teams need to be guided but left to develop at their own pace. Whatever the approach taken, time and resources dedicated to assisting with the transition to the ISDM and PCC teams is needed.

2. Maintain a Client-Centred Approach

Because PCC and the ISDM are about how services are delivered, there is a tendency to focus on resource requirements, service providers, and protocols. Conference participants stressed the importance of keeping the client and family as the main focus. The client is central to PCC and interdisciplinary teamwork, and therefore is a key partner on the team and the most important source of information. Service providers need to continually remind themselves that the client is the primary decision-maker. Team decisions that do not involve the client are unlikely to succeed. Similarly, clients may be overwhelmed by a large team or the concept of information sharing. PCC requires building trusting relationships with clients and families.

3. Recognize the Importance of Culture

Elders and traditional healers need to be included on PCC teams so that services and approaches are culturally appropriate. This means ensuring a holistic approach, taking the Aboriginal world view into consideration, and making culture and language central to service planning. A focus on culture in PCC teams allows the team to combine the strengths of the western approach and the traditional approach. Cultural orientation for new staff is also very important. Including local and indigenous partners on the team strengthens it, particularly in light of the high turnover rates in the North.

Not only do PCC teams need to plan their services from a culturally appropriate perspective, but advocacy for a more culturally appropriate approach to educating our caregivers is required. Educational institutions should incorporate cultural aspects into the curriculum.

Finally, caregivers need to continually consult the communities and involve them in identifying needs and priorities. This will provide a strong focus on the issues that are most important to the clients.

4. Involve Community Partners

Often PCC is viewed as a health and social services issue, and efforts to integrate services and establish partnerships remain within the Regional Authorities. This restricts the critical involvement of non-government organizations and community agencies. As PCC proceeds, it will be important to identify what NGOs, educational institutions, and independent practitioners exist and how they can become team members to better coordinate care. It is also necessary to involve Elders, traditional healers, and others who bring a cultural perspective to the team environment.

5. Make Communication a Priority

Communication with clients and communities, among team members, and between various levels of government is required if PCC is to move forward. Continual discussion about what is meant by PCC and related terms such as "integration" and "teamwork" is required so a common, practical understanding of how the concepts affect daily operations is created. Sharing of stories and experiences with success will help service providers see how PCC becomes a reality.

Public education about the ISDM and PCC is required so there is general understanding how services are changing. This includes promotion/marketing at all levels so clients and their families are aware of what services are available and how to access them.

Perhaps the most important form of communication is consultation with the community. Remembering that the client is the heart of PCC, it is essential to establish avenues for clients and communities to share their stories, identify their needs, and express their priorities.

6. Provide Ongoing Support

If primary community care and interdisciplinary teamwork are to move forward, ongoing support at all levels is required. This means government commitment to PCC over the long term, including financial support after project funding ends. It also means supporting the ongoing transition to PCC teams through team development and the dedication of funds for this function. Regional and community support for frontline workers is crucial so they do not become overwhelmed with the changes. The frontlines are already understaffed and daily workload is heavy. Shifting service delivery to a PCC approach is an added responsibility that will take support and nurturing.

The PCC and interdisciplinary teamwork transcend the boundaries of project deadlines and funding limitations. PCC needs to be supported. As well, front line providers of PCC need to support those in political or bureaucratic positions who are trying to make PCC a reality.

7. Focus on Health Promotion

Health promotion and disease prevention are key principles of PCC and of the ISDM. Plans for client care, however, are often treatment-oriented and teams may involve only those who work in the health centre. For each team it may not be feasible to have a team member with a health promotion focus (such as a CHR), however all team members need to integrate health promotion and disease prevention thinking into their own areas of expertise. Teams need to help clients and families address the root causes of illness and engage in activities that keep them well. This is especially necessary for vulnerable groups such as marginalized people in society or Elders.

8. Address System Barriers

In order for PCC to move ahead, barriers at a system level must be addressed. Caregivers themselves may be ready and eager to work in a team environment and implement the principles of PCC, yet if system barriers remain, the work cannot occur. Examples of issues that need clarification and/or attention include legislation of health professions, liability of service providers, infrastructure such as space and equipment, and recruitment and retention of team members, with particular attention to reducing high turnover rates. These issues will need the commitment of partners at the territorial and regional levels.

9. Address Confidentiality Concerns

PCC providers want to share information to provide the best service for their clients. They also understand the necessity for confidentiality. Clarity about what is allowable and acceptable in terms of privacy, sharing records, and confidentiality is needed. The client needs to be the central figure in this discussion, especially with the advent of electronic health records.

10. Just Do It

Primary Community Care is a complex concept that has many aspects and involves many people. Because of this, there are still many barriers and issues to be addressed. Conference participants recognized these issues, but understood that PCC and the integration of services could not wait for conditions to be perfect. The recommendation was to simply get started, perhaps in small ways at first, focussing on how to get things done in spite of the barriers that exist. While the barriers and larger system-wide issues need to be identified and solved, teamwork and relationship building can begin now.

5.0 RECOMMENDATIONS

This report's recommendations can be divided into two areas:

- recommendations for future primary community care conferences; and
- recommendations for advancing PCC and the ISDM.

5.1 Recommendations for Future Conferences

Ninety-seven percent (97%) of evaluation survey respondents indicated that PCC conferences should continue in the future. Additionally, 85% of respondents indicated that they would be willing to pay a registration fee to help support future conferences. Suggested fees ranged from a low of $50-$100, to a mid-range of $100-$200, to a high of $300-400. Some respondents suggested that discounts could be given for students, NGOs and for early registration. The majority of respondents want future conferences to be two days in duration and held in January.

Respondents also offered suggestions on topics for future conferences. These included:

- provide updates on the projects presented at this conference;
- offer further discussion on the specifics of PCC team development (change management, facilitators' skill development, how to involve NGOs, developing the cultural sensitivity of PCC teams, etc.);
- include presentations on how PCC teams can address specific topics, including:
    - dealing with aging populations;
    - addressing mental health and addictions issues; and
    - incorporating health promotion into the team environment.
- provide further information on confidentiality - and the *Access to Information and Protection of Privacy Act* - and how those issues relate to the development and implementation of PCC teams;
- offer "on the land" components to learn about traditional medicine and healing, and how to incorporate these into PCC teams;
- ensure further discussion of sustaining PCC teams, especially after the PCHTF expires;
- include presentations on the evaluation of PCC projects;
- provide information relating to health research – specifically what methods and successes there are around Aboriginal populations and health;

- ensure information is included on how PCC is communicated to the client; and
- include sessions which help to bridge the gap between western medical models and traditional Aboriginal concepts of health.

5.2 Recommendations for Advancing PCC and the ISDM

The emerging themes presented in section 4.0 form the basis of this report's recommendations to support change management, effective teamwork, and implementation of the ISDM. The themes represent the key issues that need to be addressed as the PCC momentum increases. It is therefore recommended that each of the themes and issues presented be considered cues for all partners as they share the responsibility for making PCC a reality. The themes again are:

1. Manage Change
2. Maintain a Client-Centred Approach
3. Recognize the Importance of Culture
4. Involve Community Partners
5. Make Communication a Priority
6. Provide Ongoing Support
7. Focus on Health Promotion
8. Address System Barriers
9. Address Confidentiality Concerns
10. Just Do It

The 2005 PCC Conference highlighted the fact that barriers and facilitators of change can be managed through careful planning. Saskatchewan has hired Facilitators in each region to champion PCC, build teams, and manage the various aspects of change. For the NWT, it will be necessary to identify the barriers and facilitators of PCC that exist, and to develop a plan with sustainable, workable strategies to support transition to and maintenance of integrated services, particularly interdisciplinary primary community care teams.

Challenges are opportunities that have not yet been realized.

APPENDIX 1: Conference Agenda

4th Annual Primary Community Care Conference

"Moving from Theory to Practice"

January 11-13, 2005

Explorer Hotel – Katimavik Rooms A, B & C
Yellowknife, NWT

Objectives:

- Provide a forum for sharing on best practices and NWT primary community care projects
- Promote interaction between policy makers, managers, primary community care providers, professional associations, NGOs, and Aboriginal governments involved in the delivery of HSS core services
- Enhance the ability of practitioners to work in a sharing, collaborative manner

Co-Facilitators:

Bernie Hogan - Northern Research + Evaluation
Lynn White - Whiteworks Policy, Planning & Evaluation

Case Study Facilitators:

Rachel Dutton-Gowryluk, Wanda White, Chris Mayhew, Roxanne Stuckless, Lori McMillan, Tony Simmonds, Pertice Moffit, Jo-Anne Hubert, Karen Willy, Carla Skauge

Day 1: Tuesday, January 11, 2005

08:00 – 09:00	Registration and Refreshments
09:00 – 09:30	Opening and Welcome Greetings –Honourable J. Michael Miltenburger, Minister of Health and Social Services Opening Remarks – Dave Murray, Deputy Minister of Health & Social Services
09:30 – 10:30	Opening Plenary, Development of Primary Health Care *"Supporting Team Development from a Ministry Perspective"* Lynn Digney-Davis/Dr. Gill White, Saskatchewan Health
10:30 - 10:45	Stretch and Nutrition Break
10:45 – 11:30	Moving Integrated Service Delivery Model Forward "Let's Just Do It" – Marnie Bell, Lead Coordinator ISDM
11:30 – 12:00	"Supporting, Promoting and Evaluating Primary Community Care" -Vicki Lafferty, NWT PHCTF Coordinator
12:00 – 1:30	Lunch – On Your Own
1:30 - 3:15	*"Improving Client Access through Primary Community Care Teams"*, PHCTF projects: DCSB, Integrated Wellness Centre; YHSSA, Yellowknife Community Clinic; STHA, Northern Women's Health Program; and Introducing Midwifery Services, FSHSSA
3:15 – 3:30	Stretch and Nutrition Break
3:30 – 5:00	"*Investing in a Northern Health and Social Services Workforce*" PHCTF projects: DCSB, Nurse Practitioner Clinical Training Centre; and DCHSSA, Aboriginal Community Health Worker Training Program
7:00 – 9:00	"An Evening of Drumming and Strumming" Entertainment, snacks and beverages provided

Day 2: Wednesday, January 12, 2005

08:00 – 09:00	Refreshments
09:00 – 09:10	Welcome and Recap of First Day - Facilitators
09:10 – 10:15	Opening Plenary " *The Physician's Role on the Primary Health Care Team",* -Dr. Gill White, Sask. Health *"Supporting Team Development from a Regional Health Authority Perspective,* Chris Mayhew, Saskatchewan Health
10:15 – 10:30	Stretch and Nutrition Break (visit the display tables)
10:30 – 12:00	*Practical Examples of Primary Community Care in Action,* "Update on the Multidisciplinary Teams Project, HRHSSA" -Karen Benwell/Jennifer Beaulieu/Keith Mitchell/Sherry Jensen-Medernach/Jessie Carriere; "Fort Providence, Social Agenda Demonstration Project" -Paschalina Thurber, Executive Director; "Enhancing Homecare Services" -Ruth Robertson and Heather Chetwynd, YHSSA
12:00 – 1:30	Lunch (On-Your Own)
1:30 – 2:30	"*Improving Client Access through Primary Community Care Teams"* IRHSSA Beaufort Delta Wellness Teams; IRHSSA, Community Dental Health Program
2:30 – 2:45	Networking Break/Kiosks
2:45 – 4:30	Workshop - *How Teamwork Can Improve Client Care* (participants will discuss case studies developed from NWT Core Service areas)

Day 3: Thursday, January 13, 2005

08:00–09:00	Refreshments
9:00-9:15	Welcome and Recap of Emerging Themes - Facilitators
9:15-10:15	*How Teamwork Can Improve Client Care* Facilitated Large Group Workshop (participants will identify the challenges and opportunities for implementing PCC teams)
10:15 – 10:30	Stretch and Nutrition Break
10:30-11:30	Closing & Next Steps -Vicki Lafferty

APPENDIX 2: Case Study Questions

1. For each case, develop a plan for the client, considering the following:

- What are the issues for this client?
- What service providers should be involved in this client's care
    - at the community level?
    - at the regional level?
    - at the territorial level?
    - in the South?
- What areas of overlap might exist and how these could be streamlined?
- Who should be the case manager?
- What could have been done earlier to prevent some of the issues for this client?

2. Identify the steps to implementing the plan, considering the following:

- What challenges do you expect during implementation?
- What barriers to a team approach could arise?
- How would you resolve conflict?