



CONFERENCE REPORT

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Primary Community Care  
Conference 2003 –  
There's A Role For Everyone:  
Conference Report

Prepared by:

Northern Research & Evaluation

and

Whiteworks Management Consulting

Prepared for:

Department of Health and Social Services

March 31, 2003

## **ACKNOWLEDGEMENT AND DISCLAIMER**

This conference was made possible through a financial contribution from the Primary Health Care Transition Fund, Health Canada.

The views expressed herein do not necessarily represent the official position of Health Canada or the Government of the Northwest Territories, Department of Health and Social Services.

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## 1. INTRODUCTION

In September 2000, Federal/Provincial/Territorial (FPT) 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 to this commitment, 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. It is expected that these initiatives will improve access, accountability, and integrations of services through fundamental and sustainable change to the organization, funding, and delivery of primary health care services.

The five common objectives of the PHCTF that were agreed to by the FPT governments 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).

As part of the NWT submission to the PHCTF, eleven (11) individual projects were approved as part of primary community care renewal in the NWT. One of those projects is the holding of an annual Primary Community Care Conference in the NWT.

This report covers the second such annual conference. The sections covered by the report include:

- the context within which the conference was undertaken;
- a conference summary;
- the issues raised by participants;
- the conference evaluation; and
- a summary of recommendations.

## 2. BACKGROUND

In November 2001, the DHSS hosted the first Primary Community Care (PCC) Conference. This conference, entitled *Co-operating on the Frontlines*, brought together for the first time virtually every administrative category, profession, and paraprofessional involved in the delivery of health and social services in the Northwest Territories – including social workers, addictions workers, nurses, mental health workers, physicians, and community health representatives.

The feedback obtained from this conference clearly stated that such conferences would need to occur on a regular basis in order to: discuss how social work professionals would operate within the proposed primary community care model; bring together individuals involved in delivering primary community care to share experiences and support ongoing projects; and share successes and challenges learned by other jurisdictions implementing primary community care models and establishing primary community care teams.

The second annual conference – entitled *Teamwork in Action: There's a Role For Everyone* – took place in Yellowknife in March of 2003. The purpose of the conference was to:

- increase awareness of primary community care;
- strengthen multi-disciplinary working relationships;
- share learning experiences from primary community care initiatives and projects; and
- highlight the implementation of primary community care projects throughout the NWT.

### 2.1 The NWT Primary Community Care Approach

The NWT philosophy with regards to health and social services is holistic – with programs in wellness promotion, illness/trauma prevention, counselling, rehabilitation, treatment and care developed and operated in a context of healthy public and social policy. Many reviews of the Department of Health and Social Services (DHSS) and strategic documents have called for a shift from an illness model to a wellness model to create a balance between treatment services and wellness promotion.

The NWT approach to health and social services relies on the strength of individuals, families and communities to foster behaviours and environments that promote wellness. People are responsible to live a healthy lifestyle and to care for themselves and each other. When this is no longer possible they need to understand how to access the services they require and be involved in planning for their care. The DHSS has the responsibility to ensure that when NWT residents require health/social services, they receive the right services, from the most appropriate provider, in the best setting, at the correct time and in the most efficient and economical manner. This implies a balance between westernized evidence-based best practices and culturally relevant services that support traditional health and healing practices in the NWT. Shared accountability

is integral in a publicly funded system. An integrated, client-focused and sustainable approach to the delivery of health and social services for the people of the NWT is the intended outcome. This outlook is best summed up as the NWT Primary Community Care approach, which is used interchangeably with Primary Health Care. The NWT Primary Community Care approach contains seven important elements:

*1) The Right Services*

Health and social services should be consistent with the needs of the population and subject to fiscal realities. The revised Core Services 2002 (draft) document describes the range of services to which all residents of the NWT have access. It is important to recognize that not every service can be provided in every community, nor in the NWT for that matter.

The first point of contact with the service delivery system may be different depending on where a person lives. In consultation with the client, primary community care providers have access to a system of referral and transfer for advanced care and treatment services unavailable locally.

*2) The Most Appropriate Provider*

The NWT primary community care approach is to focus on a range of client needs realizing that a sole care provider can rarely meet the complex needs of people in the NWT. Care providers have opportunities to work in multi-disciplinary settings to collaborate for integration of services and continuity of client care. Not only does this facilitate comprehensive coordinated client services but it also ensures human resources are used wisely, healthy working environments are strengthened, and a stable northern workforce is developed.

A team approach helps to avoid overlap and duplication of effort, makes the best use of available resources, adds flexibility to continue core program delivery and can respond more quickly to changing conditions. The number and composition of primary community care teams will vary depending on the target population, community, and available infrastructure.

Adequate orientation, ongoing training and clear mechanisms for referral and consultation enhance quality of care and will do much to improve the retention of providers. Lack of ongoing training can lead to provider stagnation, development of poor working habits and a system that does not foster new practice ideas.

All health and social services professionals are accountable and responsible for their own practice. A profession's scope of practice encompasses the activities for which the professional is educated and authorized to perform, and is influenced by the setting in which they practice, the requirement of the employer and the needs of the clients. When professionals work in an interdisciplinary primary community care environment, they find areas of overlap that exist between their respective scopes of practice.

### *3) The Best Setting*

Services are provided as close as possible to the client in a setting that is culturally sensitive. Each community has providers with assessment skills and access to support and referral networks that allow cases to pass through the system smoothly. Community size and infrastructure has a bearing on the range of available services. Care providers in every community have a support and referral network available to them that allows the client's needs to be fulfilled, although not necessarily in their home community.

### *4) The Correct Time*

Some services such as emergency care are accessible 24 hours a day, 7 days per week. Other services such as health promotion, screening and prevention activities are available on a scheduled basis. A call centre and self-help guide will assist individuals to decide if and when they need to see a local health and social services provider. These services will allow the community's providers to respond to client's need at the right time and at the right place. A more proactive approach places priority on prevention, promotion, early identification, early intervention and harm reduction. Responding sooner rather than later contributes to a better quality of life and saves the health and social system significant dollars that otherwise would be spent on more costly curative services and referrals to secondary and tertiary levels of care.

### *5) The Most Efficient and Economical Manner*

Clients receive comprehensive culturally relevant care based on best practice standards, in a timely fashion, without waste or misuse, by competent providers, in a team environment. The service should not escalate in cost beyond available financial resources. The system is limited by fiscal reality and availability of trained and experienced human resources. However the primary community care approach supports efficient use of finite resources, investment in building a northern workforce and community capacity. Together in partnership with other sectors, non-governmental organizations and community groups, efficiencies can be maximized.

### *6) Public Participation*

The GNWT believes the public should have input into the delivery of health and social services. The public is a key stakeholder in helping shape how the core primary community care services are prioritized.

### *7) Accountability*

In a primary community care system, accountability is a shared responsibility. Each of the partners in the system (outlined earlier) must fulfill certain commitments in order for the overall system to be successful.

### 3. CONFERENCE SUMMARY

#### 3.1 Conference Outline

The second annual primary community care conference, entitled *Teamwork in Action: There's a Role For Everyone*, took place in Yellowknife in March of 2003. The conference aim was to identify and discuss the challenges of advancing primary community care in the Northwest Territories health and social services system. The conference itself is one of eleven projects being funded by the Primary Health Care Transition Fund to increase awareness of primary community care, strengthen multi-disciplinary working relationships, and to share learning experiences.

Conference participants, numbering up to 89 on the first day, attended from various NWT communities, with guests from Calgary and Manitoba. Most participants were front-line workers, and represented community, regional, and territorial perspectives and a broad range of disciplines.

Based on the evaluation results from the previous year's conference, the agenda was developed specifically to allow opportunities for discussion and the exchange of information and ideas. With that end in mind, presentations on a range of primary community care models and programs were given, with ample time provided for questions and group discussion after each. As well, discussion and relationship-building were also encouraged during several informal networking and refreshment breaks.

A brief summary of the conference presentations is outlined below.

#### ***Integrated Service Delivery Model***

**Cathy Praamsma, Assistant Deputy Minister of Health and Social Services**

This presentation focused on a detailed description of the Integrated Service Delivery (ISD) Model which is to be the 'lens' through which primary community care and other health and social services are viewed. The core functions of mental health and addictions services, and continuing care were used as examples.

#### ***Women's Wellness Program: A Holistic Approach***

**Karen Benwell, Jennifer Allen, Hay River, NT**

A team in Hay River is using the principles of primary community care and the ISD model to develop a Women's Wellness Program. The purpose of the program is to provide comprehensive services through a collaborative team approach. Services will be women-centred, wellness-focused, and culturally appropriate and holistic. The program will deal with many issues in women's lives and be a one-stop-shopping approach.



A needs assessment was conducted looking at morbidity rates and other indicators in their target population. The results of the needs assessment will guide program planning. Also presented was a 'program logic model' which framed the project's various components, activities, and objectives. As the program is still in the planning phase, details on implementation have yet to be finalized.

***Community Psychiatric Crisis Services - Mobile Crisis Unit/Crisis Stabilization Unit in Rural Manitoba***

**Pat Olafson, Program Supervisor, Selkirk, MB**

**Allison Done, Program Supervisor, Brandon, MB**

Salvation Army Crisis Services are provided within the continuing care stream of primary community care. Historically, this program developed when Manitoba closed several hospitals and re-routed the funding to community based projects in both urban and rural areas. Planning then began to implement more mental health services at the local level, where easy access and early intervention were key. The resulting community psychiatric crisis services won a national award for best practice. It was client-focussed and extremely collaborative across disciplines and sectors.

The importance of sharing information in a multidisciplinary approach is essential, yet the policy and legislation surrounding confidentiality and information sharing must be well understood and maintained. Manitoba's Personal Health Information Act (PHIA) protects the right to privacy yet acknowledges the need to share pertinent information between providers (with restrictions).

***CUPS (Calgary Urban Project Society): The Social Worker's Perspective***

**Suzanne Stelmack, Shared Care Mental Health Social Worker, Calgary, AB**

This presentation provided an overview of the collaborative shared care model guiding the CUPS Community Health Centre program in Calgary. This program which was developed to provide mental health services to the homeless population living in Calgary's inner city is client-centred and involves an extensive multidisciplinary team. The goal is to provide flexibility for the client to flow through the levels of care best suited to their needs. The Social Worker plays a key role in the model by working in partnership with the team to provide a wide range of clinical services, develop care plans, and linking clients with the most appropriate resources.

***The Role of the Nurse Practitioner in Primary Health Care: A Nurse Practitioner's Perspective***

**Elizabeth Cook, Yellowknife, NT**

The nurse practitioner brings to the primary community care team the skills of advanced health assessment, increased breadth and depth of knowledge and skill; critical thinking skills; and clinical judgment. The nurse practitioner is able to play several roles including educator, collaborator, consultant, coach, leader, and researcher. The Yellowknife Out-Reach Clinic was described as an urban example of the nurse practitioner's role in primary community care. Developing relationships among caregivers and with clients was identified as the key to success.

***Primary Health Care Initiative in the NWT***

**Vicki Lafferty, Primary Health Care Transition Fund Coordinator**

This presentation outlined how the Department of Health and Social Services, in partnership with health and social services authorities developed the NWT submission to the Government of Canada's Primary Health Care Transition Fund (PHCTF). As part of the NWT PHCTF Proposal, eleven (11) individual projects were approved as part of primary community care renewal in the NWT. The aim of the NWT PHCTF initiative is to improve access, accountability, and integration of services. The goal of each of the eleven projects was presented with a status report on each. It was noted that most projects are in the planning or first stages, and that by next year's conference, presentations about the status of each of the projects will be provided by the teams themselves.

***The "How to's of team building ..."How to build a multidisciplinary team that fits into Primary Health Care in the year 2003?***

**Pat Olafson, Selkirk MB**

**Allison Done, Brandon, MB**

This presentation focused on the value of a multidisciplinary team approach to psychiatric crisis services, and how such teams are developed. Emphasis was placed on allowing time for team members to build relationships and a trust for each other, as well as more structured actions such as establishing an implementation committee and policies and procedures to guide the process. As well, many of the challenges of building a multidisciplinary team were identified such as managing the fear that comes with a paradigm shift.

On the final afternoon of the conference, participants were asked to place themselves in one of five discussion groups focused on the themes which had emerged over the 2 days. These included:

- 1) Accountability, Evaluation, and Reporting;
- 2) Sharing of Health Information and Confidentiality;
- 3) Support for Primary Community Care Teams;
- 4) One-Stop Shopping; and
- 5) Human Resources: Recruitment and Retention.

Each led by a facilitator, groups first participated in a short relationship-building exercise by identifying themselves, their role in primary community care, and what they felt were key issues in their own work areas. Following this, each group discussed their particular theme and identified specific recommendations to further enhance and support the transition to the NWT Primary Community Care model. A synthesis of the discussion group results is included in section 3.2 "Issues Raised by the Participants" and the detailed results of each discussion group session are provided in Appendix II.

### **3.2 Issues Raised By The Participants**

During the course of the 2 day conference, participants had several opportunities to discuss primary community care as it relates to the NWT. In so doing, five clear themes emerged as priority areas for further consideration. While each of the themes will be portrayed separately, conference participants recognized that they are interrelated and in some cases overlap.

#### ***1. Accountability, Evaluation, and Reporting***

Primary community care presents a new way of addressing health and social services issues. The holistic, multidisciplinary approach based upon strong collaboration with a client-centred focus will need to be evaluated to determine if a) the approach is working as envisioned, and b) client needs are being met. The dual focus on performance measurement and outcome evaluation are critical to ensure primary community care is achieving what it set out to do. Once evaluated, governing bodies, whether communities, regional authorities, or the GNWT must report the successes and potential growth areas to their respective audiences, thus showing themselves accountable.

There are several key factors which are necessary if solid evaluation and accountability reporting are to take place:

##### Data Collection

Different programs and personnel are collecting data in inconsistent ways. Data collection methods vary from manual entry into a log book to data entry on networked computer systems.

Some front-line workers may be unaware of why data is being collected and therefore unsure of the exact data requirements. The value of data collection at the community level is often not well understood nor particularly relevant to those at the front line. Front-line workers may be wary of the data collection process since resulting information is not communicated back to them.

The lack of a data warehouse is an issue. Information and data is currently spread out in many units and Departments. These data locations are not necessarily 'speaking' to each other. A data warehouse is required.

##### Front-Line Input

Front-line workers need to be involved in designing data collection methods and evaluation as a whole. There is often a breakdown between community data needs and the GNWT reporting requirements. These need to be more congruent and would benefit from more communication between front-line workers and the territorial government.

## Standards for Evaluation & Reporting

The GNWT must meet several different reporting requirements (e.g.; federal government, CIHI, etc). There is a need to collaborate these requirements into a simple and single method of data collection and reporting. As well, there needs to be a standard way of conducting evaluations so that the right things are assessed. Regional authorities should work with the Department to produce annual reports so the reports reflect achievements at the regional level as well as territorially.

## **2. Sharing of Health Information and Confidentiality**

One of the key facets of primary community care is multidisciplinary collaboration, and effective communication is the key to collaborative success. The sharing of information between disciplines and among sectors is part of the communication foundation. That said, client confidentiality and the protection of privacy must be preserved. Finding the balance between the two will create a significant challenge for primary community care teams. Various disciplines have different codes of ethics on this topic. The restrictions and opportunities for information sharing do not exist in a single piece of legislation, yet are described throughout several enactments. Perceptions, lack of trust, misunderstanding of current legislation, and unrealistic expectations create further challenges. Workers at each level need to be shown how they can work together and share information.

The policies and legislation surrounding protection of information must be well understood and maintained. However confidentiality and information sharing clauses exist in several areas and a document which pulls all of this together is necessary. Whether this is to be a new Health Information Act or simply a policy tool that summarizes current legislation must be discussed.

## **3. Human Resources: Recruitment and Retention**

One of the elements of primary community care is to provide the most appropriate provider. Generally, this refers to a multidisciplinary approach to services. However, it also means staffing primary community care teams with well trained and experienced individuals who are able to work within the system on a long term basis. Recruitment and retention of health and social services workers is a challenge in the NWT, and indeed across Canada. Having the right people in place is critical to the success of the primary community care approach.

Suggestions for the recruitment and retention of personnel are listed below:

- Employment could be regional and mobile so that workers are deployed to various communities as either the community needs, or the staff member requests.
- Use more personality profiling as part of the hiring process.
- Give potential employees as much information as possible to make their transition and involvement in the community easier.

- Ensure housing is in place.
- Reinstate vacation travel assistance.
- Ensure good benefits are in place such as removal in/out, professional development, regular training, etc.
- Designate one person to coordinate staff development and education per region. This person could handle the issues of back-fill, funding, identifying appropriate training resources, etc.
- Ensure salaries are competitive.
- Promote the northern/adventure lifestyle, as well as the benefits of expanded work experience.
- Prepare existing staff for the addition of new positions or new employees.
- Develop strategies to deal with burn-out. For example, consider rotating Social Workers between the functions of child protection and other areas to keep them from burn-out. Also consider rotating nurses into different program areas or into various communities.
- Consider having a local family ‘adopt’ a new worker for the first few months so community involvement goes more smoothly.
- Find employment for the partners of primary community care workers.
- Give the presentation on the Integrated Service Delivery Model in various settings to create a common understanding of what we are trying to achieve.

#### **4. One-Stop Shopping**

The term ‘one-stop shopping’ is often used to describe the primary community care approach, since it reflects a single entry point for multidisciplinary care. In most cases it refers to the co-location of services under one roof for client convenience and for promotion of collaboration between care-givers. One-stop shopping can also mean a single entry point where a comprehensive assessment is done and referral to the appropriate service, regardless of location, results.

While there are definitely merits for the client, it cannot be assumed that having practitioners work under the same roof will naturally increase collaboration. Schedules, workloads, and the nature of some work may limit the benefits of location proximity. It is important to allow the workers themselves to decide what promotes interaction. A strong orientation for new staff will be essential as well as recognizing that all workers, including office and administration staff are part of the team.

In a one-stop shopping approach, it is important to be clear about exactly what services are part of the model and how the model works (e.g., which practitioner sees the client first). One-stop shopping can lead to the misperception that all health and social services are located under one roof, which is unrealistic. It is important to identify the parameters of the one-stop shopping service.

Communication overall is important, and communication with the public is critical in particular. A marketing strategy is required to clearly identify what one-stop shopping and primary community care are, and who are the players.

A solid process or system for referral is key to one-stop shopping. If the goal is that clients are assessed and directed to the appropriate services, the referral system supporting this process must be well-understood and seamless, otherwise the client will feel passed around regardless of co-location.

### ***5. Support for Primary Community Care Teams***

As primary community care proceeds in the NWT, several conditions and factors will be required to support the teams involved. Support means more than funding. It means supporting a system that creates healthy environments and leaves a positive legacy for our children.

A strong communication plan to clearly demonstrate how the various disciplines and levels (community, regional, territorial) integrate is required. Likewise, time and patience are required to allow the communities and their team members to build relationships and a trust for each other. Primary community care cannot be forced on people before they are ready.

An accompaniment to the communication plan is the conflict management process. Conflicts and challenges will inevitably arise. A well thought-out process to deal with conflict and change would be useful. Transition management is also needed.

Communication with the public is an important support for primary community care. A public marketing/advertising strategy is an important component of planning.

Building community capacity to take on a new approach is important. Communities need to be staffed with the appropriate people and have the appropriate resources.

Effort should also be taken to identify and celebrate the best practices that are already occurring in the NWT. The tendency is to think of best practice and expertise occurring outside ourselves, but this is not necessarily so.

### 3.3 Conference Evaluation

Out of the 89 conference participants, a total of 42 responded to the evaluation survey. The majority of those respondents were nurses, had clinical practice/frontline work as their major work emphasis, had worked in their professions for over 5 years, had worked in the NWT for over five years, and were from either the DHSS or the Yellowknife Health and Social Services Authority.

Overall, participants seemed satisfied with the conference. They were most satisfied with how the conference increased awareness of primary community care, how it strengthened multi-disciplinary relationships, and how it fostered the sharing of learning from primary community care projects. They were less satisfied with how well the conference highlighted the implementing of primary community care projects in the NWT.

Additionally, participants were most satisfied with the presenters, the facilitators, the question-discussion periods, the break-out sessions, the facility, the conference length, and the overall quality of the conference. They were less satisfied with the timing of the conference.

Next year's conference could be improved by focusing more on the areas where participants were less satisfied, as well as implementing participants' suggestions regarding format, timing, length, and the topics which could be presented (discussed in more detail in section 4.2).

For full details of the evaluation, see the *PCC Conference 2003: Evaluation Report*.

## 4. RECOMMENDATIONS

The recommendations arising from the question/discussion sessions, the specific discussion groups, and the evaluation surveys can be divided into two areas:

- recommendations for enhancing primary community care in the NWT; and
- recommendations for next year's primary community care conference.

### 4.1 Recommendations for Enhancing Primary Community Care in the NWT

- 1 Communicate openly and regularly with workers at the community, regional and territorial levels.
- 2 Commit to clear communication with the public through marketing/communication strategies.
- 3 Ensure capacity (support, human resources, logistics) is in place before starting primary community care programs.

- 4 Be clear about how programs and the system will be evaluated before implementation, including what data is to be collected, by whom, how, and what reports are required.
- 5 Ensure workers understand current policies and legislation surrounding the sharing of health and social services information and confidentiality.
- 6 Celebrate the primary community care successes that already exist in the NWT.
- 7 Recognize that multidisciplinary teamwork has many challenges based on logistical issues and misperceptions.
- 8 Develop clear policies, procedures, and definitions surrounding primary community care and how it works at the front-line.
- 9 Manage Human Resource issues such as recruitment, retention, burnout, turf protection.

#### **4.2 Recommendations for Next Year's Primary Community Care Conference**

- 1 Improve the timing of the conference by avoiding "March Break" and "Year-End".
- 2 Improve the format of the conference by:
  - a. alternating between the main plenary presentations and more interactive small-group work;
  - b. providing more time for networking; and
  - c. providing concurrent sessions tailored to the individual needs of frontline workers.
- 3 Continue with a 2-day conference.
- 4 Involve the HSS Authorities as part of the Conference Planning Team.
- 5 Strive for more balance between the nursing/social worker's perspectives, and those of other health professionals.
- 6 Provide updates on implementing the PHCTF projects in the NWT.



**APPENDIX I: CONFERENCE AGENDA**

<b>Primary Community Care Conference</b> <b>Explorer Hotel, Yellowknife</b> <b>March 20 and 21, 2003</b> <i>Teamwork in Action: There's a Role for Everyone</i>	
<b>March 20, 2003</b>	
<b>Time</b>	<b>Event</b>
8:30am	<i>Welcome and Housekeeping</i>
8:35–8:45	<i>Opening Remarks</i> Honourable Michael Miltenberger Minister of Health & Social Services
8:45-9:45	<i>Integrated Service Delivery Model</i> Cathy Praamsma, Assistant Deputy Minister, Department of Health and Social Services
9:45-10:00	Question Period
10:00-10:15	Break
10:15-11:15	<i>Multidisciplinary Teams in Hay River</i> Jennifer Allen, Hay River Health Authority Karen Benwell, Hay River Health Authority
11:15-11:30	Question Period
11:30-1:00	Lunch
1:00-2:00	<i>Community Psychiatric Crisis Services – Mobile Crisis Unit/Crisis Stabilization Unit in Rural Manitoba</i> Pat Olafson, Program Supervisor, Selkirk, MB Allison Done, Program Supervisor, Brandon, MB
2:00-2:15	Question Period
2:15-2:30	Break
2:30-3:30	<i>CUPS (Calgary Urban Project Society): The Social Worker's Perspective</i> Suzanne Stelmack, Shared Care Mental Health Social Worker - Calgary, AB
3:30-3:45	Question Period
3:45-4:45	<i>The Role of the Nurse Practitioner in Primary Health Care: A Nurse Practitioner's Perspective</i> Elizabeth Cook, Yellowknife, NT
4:45-5:00	Question Period

<b>Primary Community Care Conference</b> <b>Explorer Hotel, Yellowknife</b> <b>March 20 and 21, 2003</b> <i>Teamwork in Action: There's a Role for Everyone</i>	
<b>March 21, 2003</b>	
<b>Time</b>	<b>Event</b>
8:30am	<i>Welcome and Housekeeping</i>
8:35-8:45	<i>Summary of Day 1</i> Facilitators
8:45-9:45	<i>Primary Health Care Initiative in the NWT</i> Vicki Lafferty, Primary Health Care Transition Fund Coordinator
9:45-10:00	Questions & Discussion
10:00-10:15	Break
10:15-11:15	<i>The "How to's of team building": How to build a multidisciplinary team that fits into Primary Health Care in the year 2003?</i> Pat Olafson, Selkirk MB Allison Done, Brandon, MB
11:15-11:30	Question Period
11:30-1:00	Lunch
1:00-3:00	<i>Small Group Discussion</i>
3:00-3:15	Break
3:15-4:30	<i>Group Reports</i>
4:30 - 4:45	<i>Evaluation</i> Facilitators
4:45 - 4:50	<i>Housekeeping</i> Facilitators
4:45- 5:00	<i>Conference Closing</i> Marnie Bell, A/Manager, Integrated Community Services Unit, Department of Health and Social Services

## APPENDIX II: DETAILS OF THE DISCUSSION GROUPS

### Group #1: Accountability, Evaluation, and Reporting

#### Community Issues

There are problems around data collection or the lack of it. Communities may feel they contribute to the data collection and identification of issues yet they get no information back. The value of data collection at the community level is often not well understood or not particularly relevant to those at the front line.

The compatibility or ease with which data is collected and entered into various systems varies. In some cases, manual data is kept. In others, there are elaborate computer systems.

Front-line workers need to be involved in designing data collection methods and evaluation as a whole.

#### Regional Issues & Recommendations

There is often a breakdown between community data needs and the GNWT reporting requirements. These need to be more congruent.

The regions need to take it upon themselves to ensure they understand the reporting requirements and be equipped to produce the reports.

Regional authorities should work with the Department to produce annual reports.

#### Territorial Issues & Recommendations

The GNWT must meet several different reporting requirements (e.g., federal government, CIHI, etc). There is a need to collaborate these requirements into a simple and single method of data collection and reporting.

The lack of a data warehouse is an issue. Information and data is currently spread out in many units and Departments. These data locations are not necessarily 'speaking' to each other. A data warehouse is required.

There is a lack of standards around data collection and evaluation. Standards are required and they must be communicated clearly.

The GNWT should involve more front-line workers in designing the accountability/evaluation framework. Working groups representing various areas would be useful.

The GNWT should provide the tools necessary to collect good data such as computers, time, training, etc.

Annual reports showing successes by regional authority would be useful.

Look at adopting an accreditation-type assessment for the entire system.

## **Group #2: Supporting Primary Community Care Teams**

Supporting primary community care (pcc) and pcc teams means more than funding. It means supporting a system that creates healthy environments and leaves a positive legacy for our children.

### Themes & Recommendations

Building community capacity from the ground up is key.

Identify where best practices are already occurring. We tend to think of best practices and expertise occurring outside the NWT, but this is not necessarily so.

Involve non-government organizations. They do important work.

Create healthy public policy.

Primary community care is a grass roots issue and cannot be forced on people. They must learn from their mistakes and learn at their own pace.

The right resources must be in place.

Education is needed.

Transition management is needed which is more than conceptual and involves more than discussion. Practical transition support is necessary.

There must be commitment to support healthy working environments if primary community care is to succeed.

There needs to be recognition that not everyone will be comfortable with primary community care and a multidisciplinary approach.

### **Group #3: Human Resources: Recruitment and Retention**

A retrieval system is necessary. Employment could be regional and mobile so that workers are deployed to various communities as either the community needs, or the staff member requests. One idea is to ask employees to commit to 12 months employment after which they are free to move anywhere within the region.

Primary community care requires the right person. This means that professional qualifications are not necessarily the highest priority. Employees with the right personality for this type of work are required. This may mean more personality profiling as part of the hiring process.

Potential employees need to be given as much information as possible to make their transition and involvement in the community easier.

Housing must be in place.

Reinstate vacation travel assistance. This encourages retention.

Ensure good benefits are also in place. Examples include removal in/out, professional development, regular training, etc. One person should be tasked with coordinating staff development and education. This person could handle the issues of back-fill, funding, identifying appropriate training resources, etc.

Salaries must be competitive.

The northern/adventure lifestyle must be promoted, as well as the benefits of northern work experience.

Recruitment strategies should not categorize work as 'urban' or 'rural' but also title categories 'expanded practice', northern, etc.

We need better marketing and public relations overall.

Time needs to be taken to prepare existing staff for the addition of new positions or new employees.

Recognize that primary community care may involve team members from outside the common 'health and social services' sector, and recruit in these other areas.

The issues surrounding cross-professional record sharing need to be addressed and clearly understood.

Strategies to deal with burn-out must be developed. For example, consider rotating Social Workers between the functions of child protection and other areas to keep them

from burn-out. Also consider rotating nurses into different program areas or into various communities.

The importance of creating a balance between work and social life is important. Many staff work more than the standard work week, whether by choice or necessity. This is not healthy.

The importance of socializing with the community is important. Consider having a local family 'adopt' a new worker for the first few months so community involvement goes more smoothly.

Finding employment for the partners of primary community care workers is important.

Regular communication with communities, using common terminology, is the key. Face-to-face interaction helps support primary community care. This could mean staff meetings, interagency meetings, or conferences.

Consider giving the presentation on the Integrated Service Delivery Model to others in various settings. This helps create a common understanding of what we are trying to achieve.

Validate and celebrate our current successes in primary community care.

Communicate with the public and stakeholders about primary community care.

Recognize that change takes time.

#### **Group #4: One Stop Shopping (A)**

It is important to recognize the importance of administrative and office staff in the primary community care team.

Make the policies and guidelines for service provision work for you. Do not see them as limitations or constrictions but learn how to meet needs creatively within them.

Collaborative care must often overcome the barriers created by funding being dispersed in a non-collaborative manner. For example funding for one initiative may come from various sources, each with a different expectation and reporting requirement.

Allow the staff themselves to decide what logistical things promote interaction within the one-stop shopping concept. Do not assume that a common coffee room or lunch room instantly creates collaboration.

A good orientation is required for new team members to dispel any misperceptions at the start. Consider having new team members spend time in each unit before officially starting.

Co-location has merits for clients who have transportation, mobility, and child-care issues.

The term 'one-stop shopping' is not the best. Clients are not shopping. Other terms such as comprehensive care, community resource centre, or multi-service provider may be more appropriate.

The number and type of services to be provided through a one-stop shopping model must be clear. One-stop shopping can mean anything from a Walmart approach to a specialty store.

In a one-stop shopping approach a solid process or system for referral is needed.

Evaluation is important for this type of model.

A one-stop shopping approach should start small and expand later.

#### Community Level

Consider hosting more networking meetings to become familiar with team members.

Advocate for needed programs by lobbying, writing proposals, visiting politicians, making presentations, etc.

Collect useful information to demonstrate need.

#### Regional Level

Make communications clear and effective with all stakeholders

Advocate for support such as funding, policy changes, etc

Find locations and sort logistics to make one-stop shopping work (e.g.; union issues)

#### Territorial Level

Dedicate funding to support primary community care in a one-stop shopping model.

Establish or amend policies, standards, and legislation as required.

Conduct high-level analysis or research to identify best practices.

## **Group #5: One Stop Shopping (B)**

One-stop shopping is good in concept but has some practical challenges, such as which practitioner sees the client first, etc. Also, depending on the target population or the program, one-stop shopping could mean any variety of team members and services. The term needs careful definition.

Recruitment and retention under a one-stop shopping model is a challenge. Conceptually this model will foster better collaboration and communication, yet it could be threatening to some. Patience and a strong orientation for new staff will be essential.

One-stop shopping is a positive concept for the client. Currently they feel passed around. Their expectations about what exactly is included in one-stop shopping may actually be too high. Nevertheless, the concept signals convenience for the client and suggests a higher quality of care.

The use of proctors or non-professional people who understand the target group and the community is a good idea.

One-stop shopping suggests stronger relationships between the caregivers and the client, so the client is a partner in their own care. It also suggests an outreach component could exist in one-stop shopping, such as a mobile mental health unit.

### Recommendations

The primary community care model needs to be supported at the territorial level initially with ongoing funding.

Communication at every level is crucial for one-stop shopping to succeed. The planning and implementation processes need to meet community timelines. Workers at all levels need to be regularly informed of what is occurring in primary community care more frequently than at an annual meeting.

Communication with the public is also important. A marketing strategy is required to clearly identify what one-stop shopping and primary community care are, and who are the players.

Communication and education are key within the system to reduce resistance and hesitation to working together. Involve stakeholders early. This will require identifying areas of resistance and developing a plan for them.

Because stereotypes and perceptions will always exist, it is important to get the right mix of people working together. Flexibility in staffing is important.

The clients are the best champions for the one-stop shopping model.