

Summary Report

DEER LAKE/WHITE BAY PRIMARY HEALTH CARE STAKEHOLDER ENGAGEMENT SESSION

March 26, 2019

Deer Lake Motel

Prepared by: Tammy Angell

Community Health Manager, Deer Lake/White Bay

Table of Contents

BACKGROUND

Primary Health Care (PHC) is typically a person's first point of contact with the health care system. It encompasses a range of community-based services essential to maintaining and improving health and well-being throughout an individual's entire lifespan. Primary Health Care can include interactions with providers, such as counsellors, family doctors, occupational therapists, pharmacists, social workers and others. It includes services that promote health and wellness, prevent illness, treat health issues or injuries, and diagnose and manage chronic health conditions (Government of Newfoundland and Labrador, n.d.).

The Deer Lake/White Bay area has been identified as a site for improvements to PHC. The Deer Lake/White Bay area includes the following 19 communities: Humber Village, Little Rapids, Pasadena, Pynns Brook, Humber Valley Resort, St.Judes, Deer Lake, Howley, Cormack, Reidville, Bonne Bay Pond/Jackladder, Hampden (including surrounding communities of Beaches, Georges Cove, Fox Point, and Rooms), Pollards Point, Jackson's Arm, and Sop's Arm.

In order to identify priority areas for improvement, a PHC Assessment was completed. This assessment was concluded on February 12, 2019 and is currently available on the Western Health website. A PHC Engagement Session was held on March 26, 2019. The main purpose of this session was to validate the findings of the needs assessment and to discuss future actions for priority issues. Participants included key stakeholders from communities in the Deer Lake/White Bay PHC area, as well as Western Health Staff. This report will summarize the session, providing a description of the event itself and the main points of discussion. It will also provide an analysis of the findings and recommendations for next steps.

OVERVIEW OF ENGAGMENT SESSION

Over 110 people/organizations were invited to the engagment session. Refer to Appendix A and B for the invitation and invite list. A total of 79 individuals attended the session (Appendix C). Fifty individuals were involved fully in discussions, the other 28 individuals were a combination of table facilitators, note takers, session facilitators, and invited guests. Invited guests included senior managers and board members from Western Health, and Executive staff from the Department of Health. These individuals acted as observers during the engagement session. A representative from the Department of Health and Community Services acted as facilitator for the day.

The initial presentation provided a summary of the key findings from the PHC assessment completed for the Deer Lake/White Bay area. Key findings focused on four themes:

demographics, health needs and concerns, health and emergency sssets, and health service utilization. Presentation highlights included:

- Aging population
- Decline in birth rate
- Population decline in White Bay area
- High rates of poor health practices such as smoking, alcohol consumption, and overweight/obesity
- Hypertension, chronic obstructive pulmonary disease (COPD), heart failure, asthma and diabetes were the conditions of highest prevalance

The town of Deer Lake was identified as the hub for many health related services with some outreach services and travelling clinics to smaller communities. Telehealth service was found to be underutilized in the White Bay area. A growing demand for services such as community supports and mental health and addictions was identified. Other issues related to access to services included limitied after hours access to primary care, a high usage of the emergency department at Western Memorial Regional Hospital for non-urgent issues and low utilization of ambulance services in the White Bay Area.

A second presentation introduced the Health Home Model. An overview of PHC was provided with background information from a provincial perspective. The seven attributes of the Health Home model were also introduced with more indepth discussion centered on the first two attributes: continuity and attachment, and inter-professional collaboration. A copy of the powerpoint slides for each presentation is available in Appendix D.

The remainder of the day focused on table discussions with seven to ten participants per table. A facilitator and note taker was assigned to each table. There were six dicussion cycles/topics with polling questions presented at the start of each discussion cycle. For each polling question participants who lived/worked in the Deer Lake/White Bay PHC area were able to vote electronically using key pads. Polling results were tabulated electronically by facilitators through turningpoint software and shared immediately with participants.

Polling questions and table discussions centered around three themes, which had been identified in the needs assessment. The themes included changing communities, access to services, and health related assets. For table discussions, participant reponses were captured electronically by the notetakers, summarized, and main themes presented to the audience throughout the day.

The day concluded with an opportunity for participants to provide additional comments and closing remarks. A participant worksheet was provided and individuals were encouraged to submit any other feedback in writing. A total of 23 participant worksheets were collected at the end of the session. The comments provided on the worksheets as well as comments from table discussions were both considered when results were analysed.

FINDINGS: TABLE DISCUSSION AND POLLING

Topic One: Continuity and Attachment to Primary Care

Figure1: Polling Question One with Results

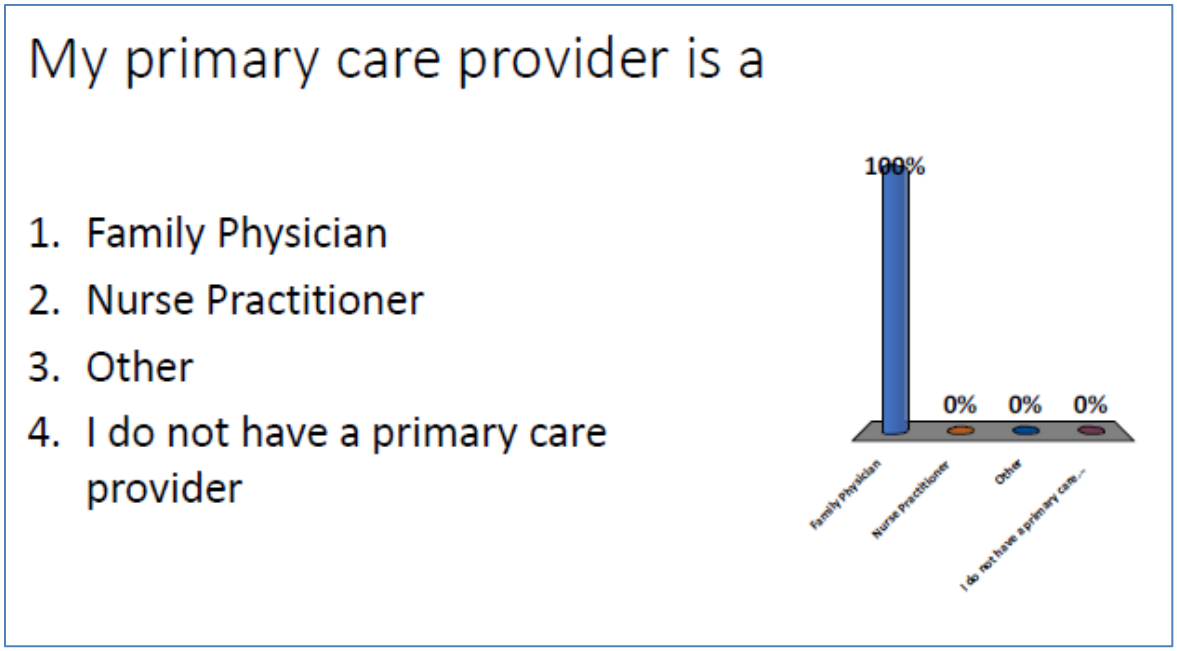
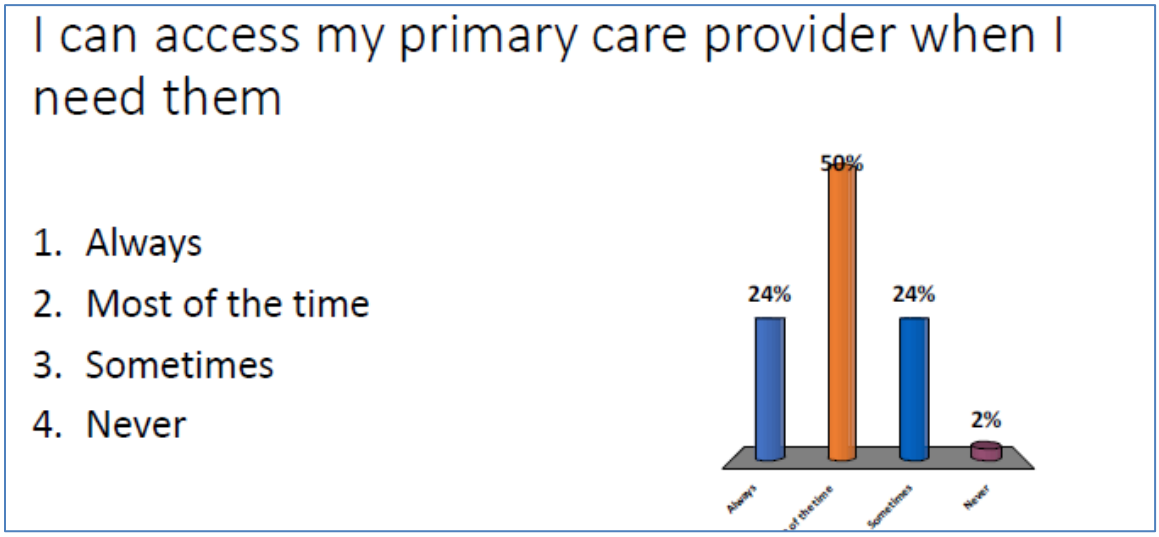


Figure 2: Polling Question Two with Results



Key Themes from Table Discussions

Question: What are some reasons why an individual might not go to their primary care provider?

- Unable to get an appointment when needed, access major problem - limited evening appointments; unable to get after hour appointment options, no walk in clinics available, no same day access, wait times are too long
- Scheduling problems (i.e. high case load, overbooked), physician leaving office
- High rate of no shows – taking appointment times and other people can't get in
- Physician vacancies/vacations; shortage of providers; high turnover of providers, lack of coverage during vacancies, uncertainty around indefinite leave for provider
- Transportation – primary care provider is located in a different community, no bus service
- Working in different community than location of primary care provider, can't take time off to go to doctor, lack of medical leave to travel to appointments. Losing work time is financial strain.
- Dissatisfied with last visit; comfort level when discussing certain issues, fear of losing drivers license, limited support from parents regarding childs mental health, prefer women provider
- Cultural differences, language barriers
- Relationship with provider, embarrassed to share some issues/concerns. Privacy/ confidentiality concerns
- Lack of awareness of other providers, outside physicians

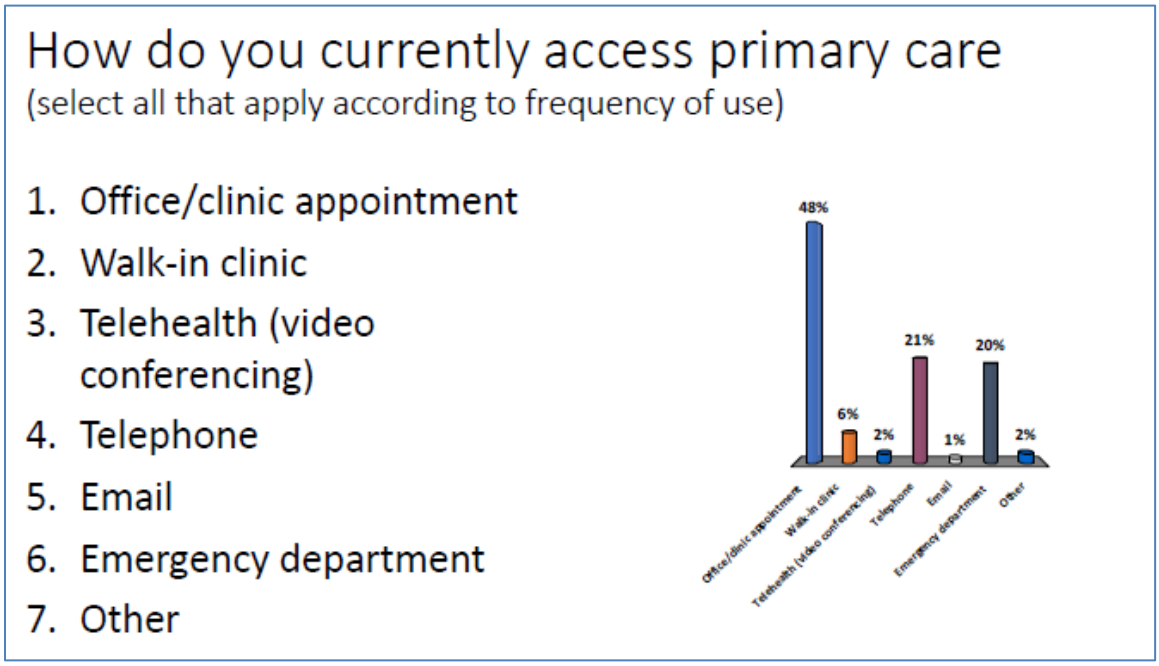
Question: Why are some people going to the emergency department for issues that can be treated by a primary care provider?

- Can't get appointment when you need it, go to emergency department for quick access/ walk-in
- No same day access or walk in clinics
- No other option when doctor is not available or off for period of time, can't use other local providers
- Do not have a primary care provider/ doesn't like current provider
- Childcare issues – don't want to wait, want to be seen right away
- Addiction issues- access to medications
- Advised by providers (i.e. 811) to go to emergency department
- Concerns with Primary Care Provider
- Can access a variety of services – blood collection, x-ray, prescriptions, etc.often quicker than through GP. One stop shop.
- Convenience – can get same day and after hour access; shopping/working in Corner Brook
- Mental health comes to a peak
- Emergency room acts as a second opinion
- Perception that will see specialist quicker if goes to emergency department

- Lack of knowledge regarding when it is appropriate to go to emergency vs. being seen by Primary Care Provider
- Lack of knowledge regarding use of emergency department
- Lack of knowledge if there are other providers who can help instead of doctor/ ER
- Anonymity/confidentiality
- Lack of transportation, ambulance funded and quicker triage. Will go to different ER depending on waiting time.
- Lack of on call physician in Deer Lake like in past

Topic Two: Access to Primary Care Services

Figure 3: Polling Question Three with Results



Key Themes from Table Discussions

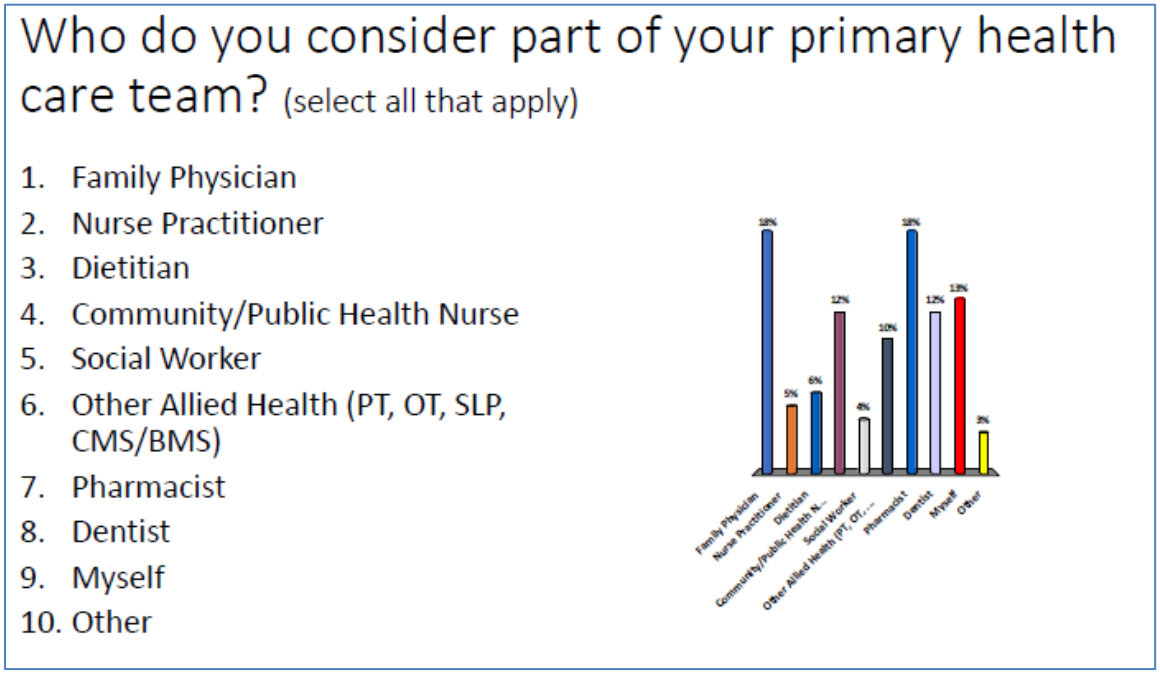
Question: What does good access look like/mean to you in the Deer Lake-White Bay area? What ideas do you have that will help to improve access to primary care?

- Walk in clinics – timely access; reduction of wait times
- Better access to appointments when needed – evening clinics, weekend hours, same day appointments
- Better access for seniors – home visits; mobile clinics
- Able to leave a message at doctors office
- Better policy about triaging appointments
- Time available for urgent appointments
- Better coverage when providers on leave

- More colloboration/partnerships – provider and client and amongst providers, stronger teamwork; better defined roles for providers
- Co-location of service providers, under one roof
- Increased number of providers (i.e. physicians); expanded teams/service providers (i.e. blood collection, dietician)
- Better use of technology (rural areas) – increased telehealth usage (offset transportation costs)
- Better communication – increased awareness of what services are available; amongst providers; email with patient/ texting
- Electronic Medical Record (EMR) access; standardized across providers
- Automated reminders to reduce no shows
- Education re: 811 health line
- Education re: services individuals can self –refer
- White Bay bloodwork services – increased access for Jackson's Arm
- Community paramedicine programs
- Automatic doors for accessibility, improved physical space in clinics
- Sexual health walk in clinic, more services like "doorways"
- Better continuity of care from community to secondary services
- Stop one issue/visit policy
- Direct billing to insurance at more providers (ex. Dentist)

Topic Three: Access to Primary Health Care Services

Figure 4: Polling Question Four with Results



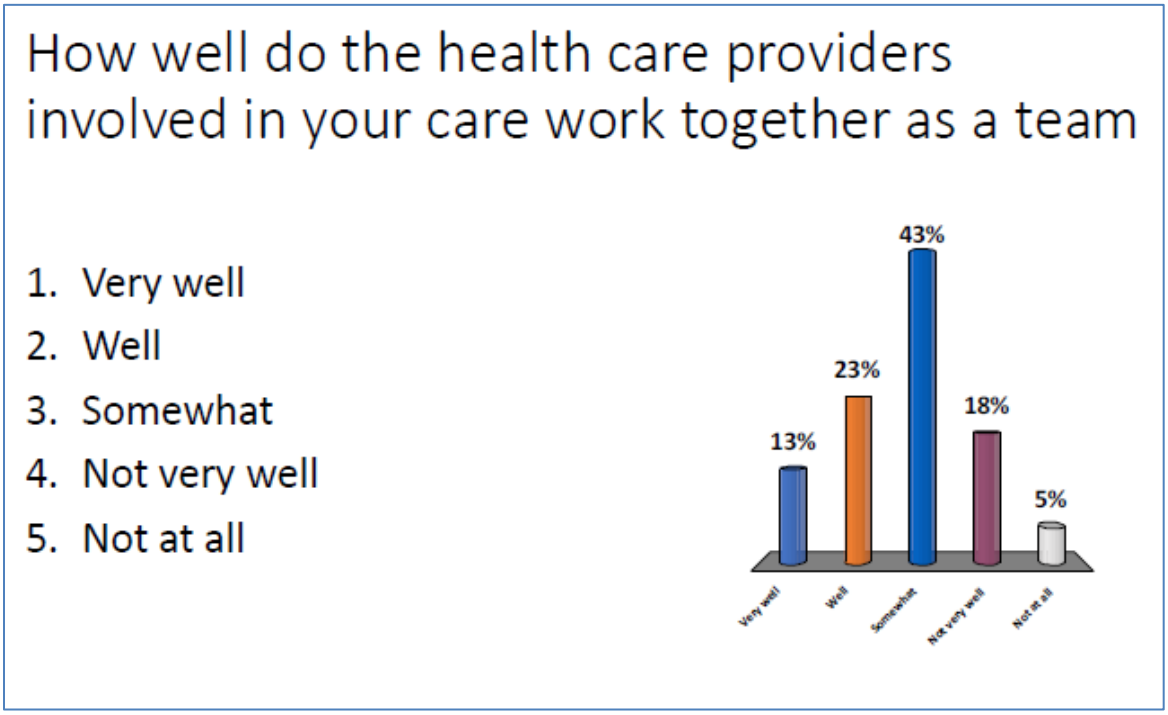
Key Themes from Table Discussions

Question: What are your thoughts and ideas about improving access to primary health care services in Deer Lake-White Bay area?

- Improve access, use group visits, email access
- Walk-in clinics; evening appointments
- Mobile blood collection
- Increase education and awareness such as: what is an emergency and what is not, use of telehealth, help to navigate use community health nurses
- Include health promotion information in school report cards
- Increase awareness of services such as Dial-a-Dietitian, allied health, and Janeway
- More referrals to appropriate providers (including ability to self-refer)
- Use of newsletters, radio, public information sessions
- Collaborate with community partners, schools,churches to get information out
- Offering services by telehealth more, educate people and providers
- Variety of services in an area (co-location and coordination); offering services where people are (mobile, telehealth)
- Utilizing nurse practitioners as well as physicians

Topic Four: Inter-professional Team/PHC Teams

Figure Five: Polling Question Five with Results



Key Themes from Table Discussions

Question: Thinking of the broader primary health care team, what are some possible barriers to the team working together?

- Lack of time for team development; full/overcapacity (workload)
- Lack of staff (physician, leadership for team development)
- Competing priorities
- Resistance to using a team approach
- Geography, transportation, distance, individuals physical location
- Privacy, confidentiality
- Communication – sharing of information, housing/location of information/files, different technologies/systems
- Providers not aware of services that others are providing
- Providers currently working in silos, need more colocation
- Salaried versus fee for service providers
- Not having a shared vision

Question: How can we work together to build upon and improve primary health care in the Deer Lake/White Bay area? How can we ensure ongoing team collaboration to improve primary health care?

- Improve communication (health promotion – TV, email, text, social media, schools) and use of technology; shared documentation, team email network
- Increase awareness of services; knowledge translation among health professionals
- Co-location of services
- Mobile team services
- Committees/teams with representation from community – regular team meetings, rounds, informal team meetings, shared leadership, geographic teams which follow patients through their lifespan.
- Evaluation of services (including team approaches) and client feedback, quality assurance to monitor services
- Patient as active member of the team
- More community services offered such as community kitchens
- Develop a directory of who is available and their contact information and role

Topic Five: Priority Areas in Primary Health Care

Figure Six: Polling Question Six with Results

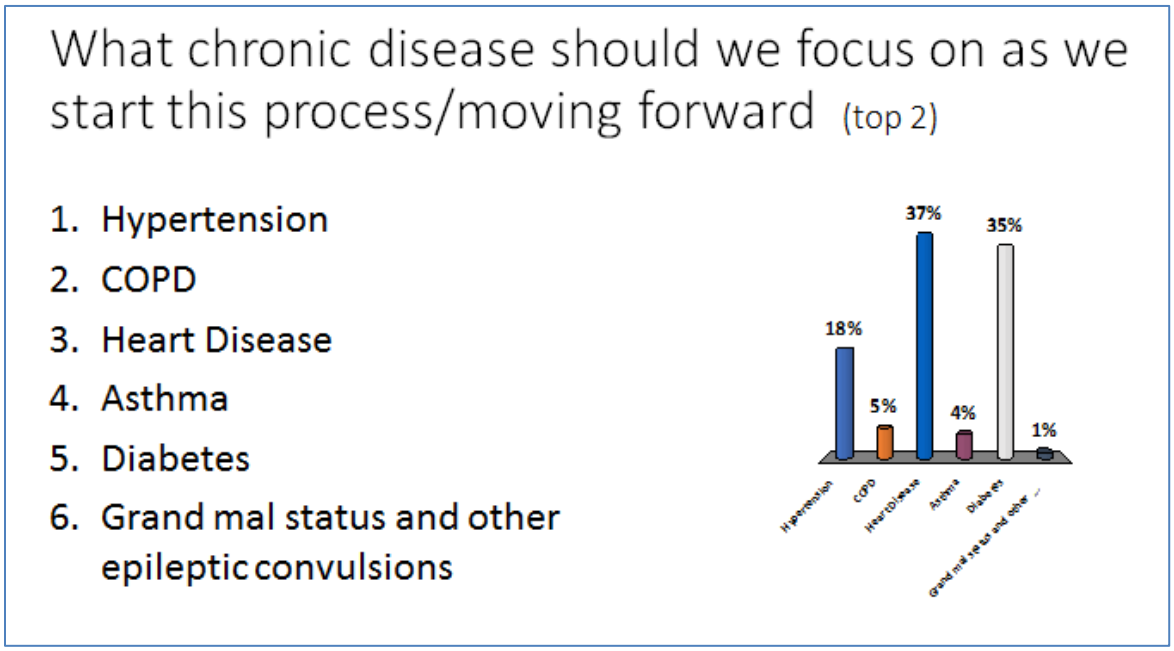
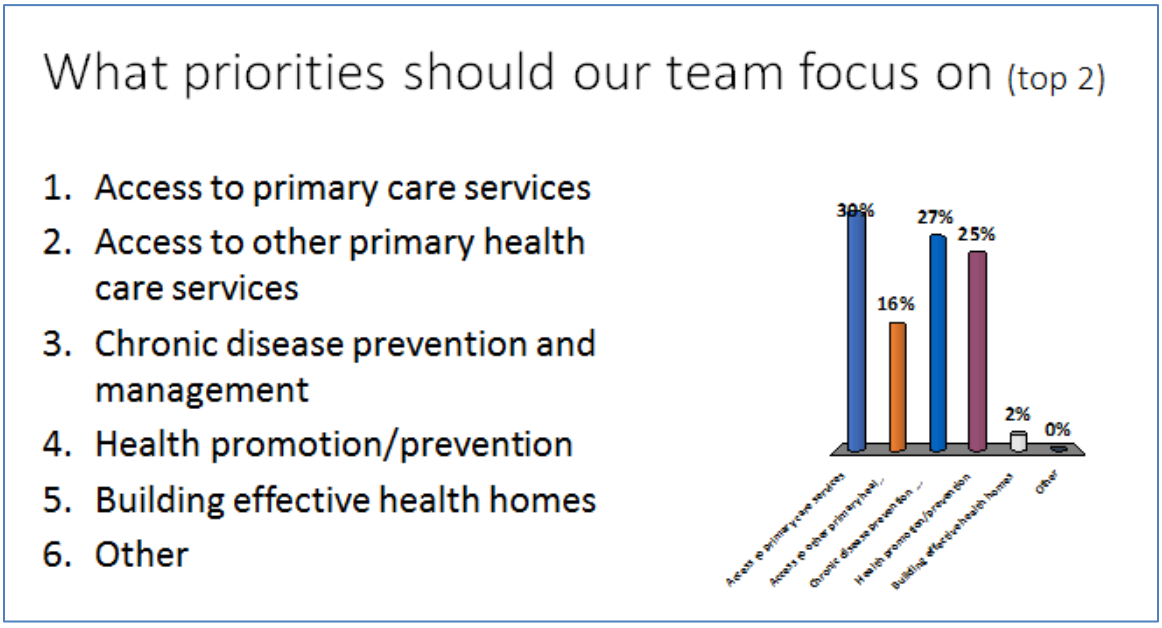


Figure Seven: Polling Question Seven with Results



Key Themes from Table Discussions

Question: Considering your priority area, how can we continue to improve the overall health status of residents of Deer Lake/White Bay area?

Priority 1: Chronic disease prevention and management

- Increased education and awareness regarding self-management and health behaviors
- Make cost of healthy food affordable to people
- Work in collaboration with health system
- Partner with health system to have a navigator promote awareness
- Role of Health Authority
    - Education/promotion of best practices, healthier lifestyles and available services
    - Prevention and self-management (ex. Wellness checks)
- Role of Community
    - Promote/advocate for improved public policy re: health choices/behaviors
    - Work more with health professionals
    - Promote programs and services
    - Make healthier choices at meetings
    - Healthy food policies in community settings/services
- Role of Individual
    - Seek education/information, apply what you learn, be a good model for family/others
    - Advocate for own health

Priority 2: Access to Primary Care Services

- Education and communication on services and different diseases
- Better coordination and access of services (co-location, evening and walk-in clinics)
- Role of Health Authority
    - Education and promotion of services
    - Make programs available in the community and they should be timely
    - More nurse practitioners
    - Use of patient/client navigator
- Role of Community
    - Work in collaboration with the health system
    - Be aware of programs and services that are offered
    - Partner with health system to have a navigator promote awareness
- Role of Individual
    - Take responsibility for own health
    - ducate self/self – management
    - Do not misuse physicians and clinics (ex. cancel appointments versus not showing)

Topic Six: Additional Comments

Question: We welcome this opportunity to hear any additional information that you would like to share about the health care needs of your community and any ideas for improving the health of the community.

- Why is the pharmacy being removed/closed in Pollards Point?
- Increased Community Advisory involvement
- Communicate today's information back to communities and residents
- Coles notes version of final report from todays engagement session
- We need to take ownership ourselves and not always depend on governement
- Aging populations in small rural communities have very limited access to health servies

EVALUATION

Overall, the participants felt they were heard during the engagement session and that their input/feedback would be considered by the organizers of the event. The participants also reported the engagement session was informative, a good use of their time, engaging, and relevant.

Figure 8: Polling Question (1) for Evaluation with Results

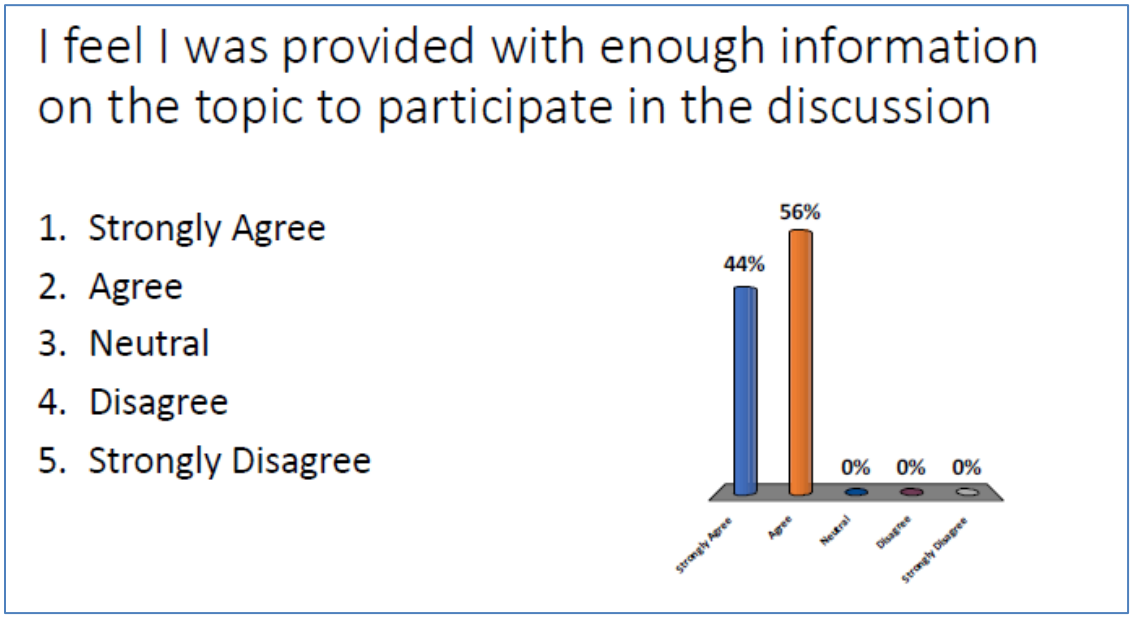


Figure 9: Polling Question (2) for Evaluation with Results

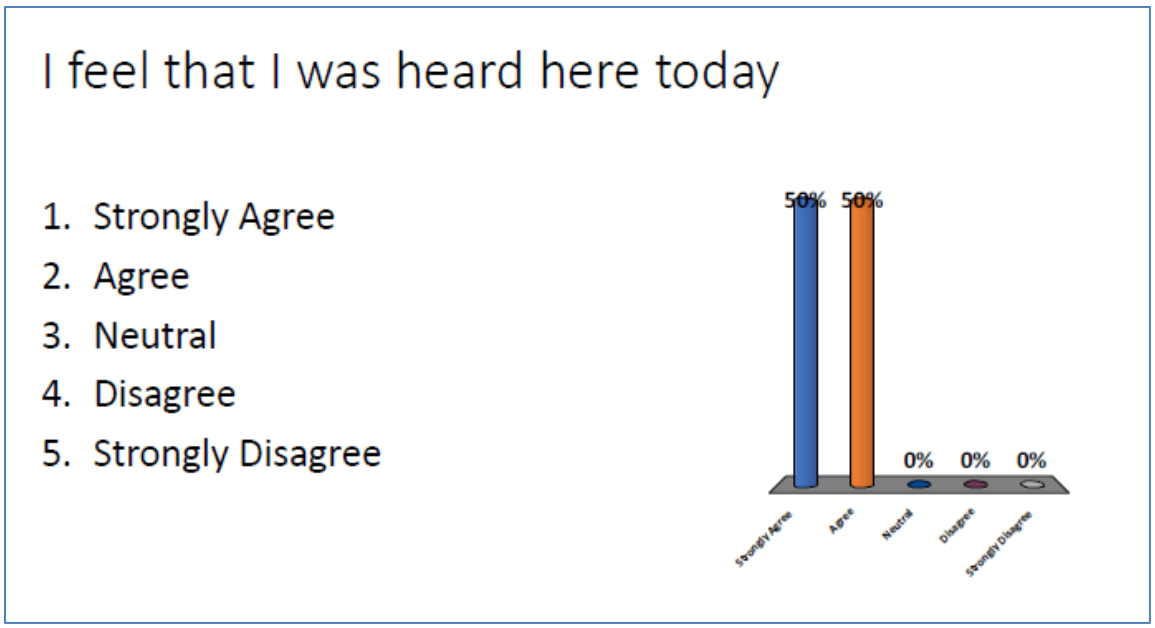


Figure 10: Polling Question (3) for Evaluation with Results

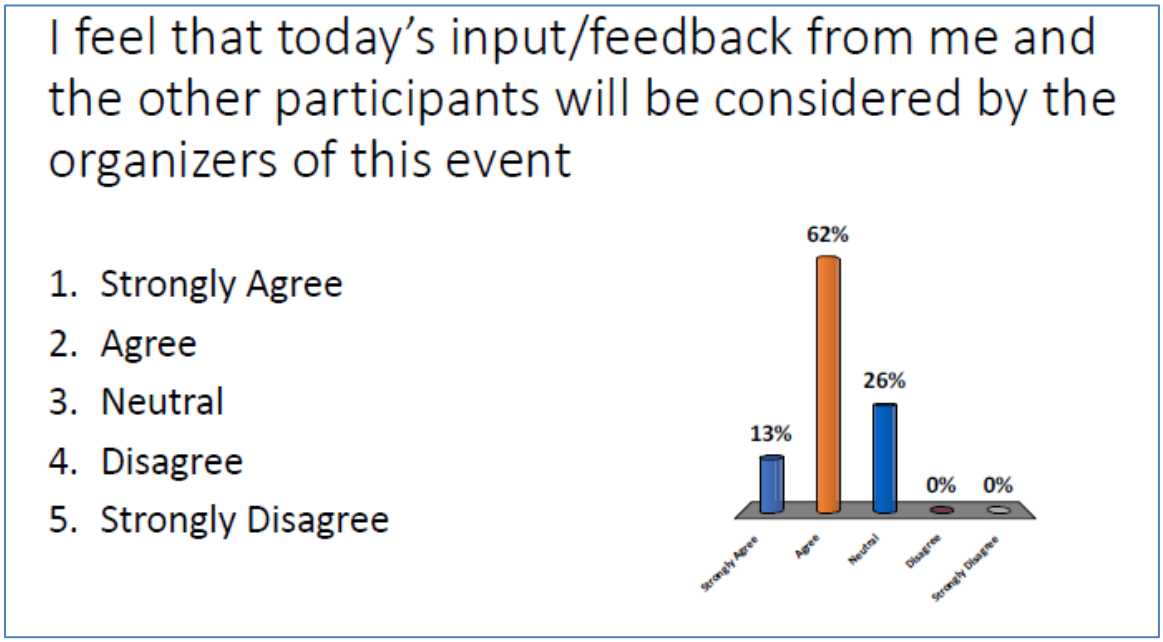
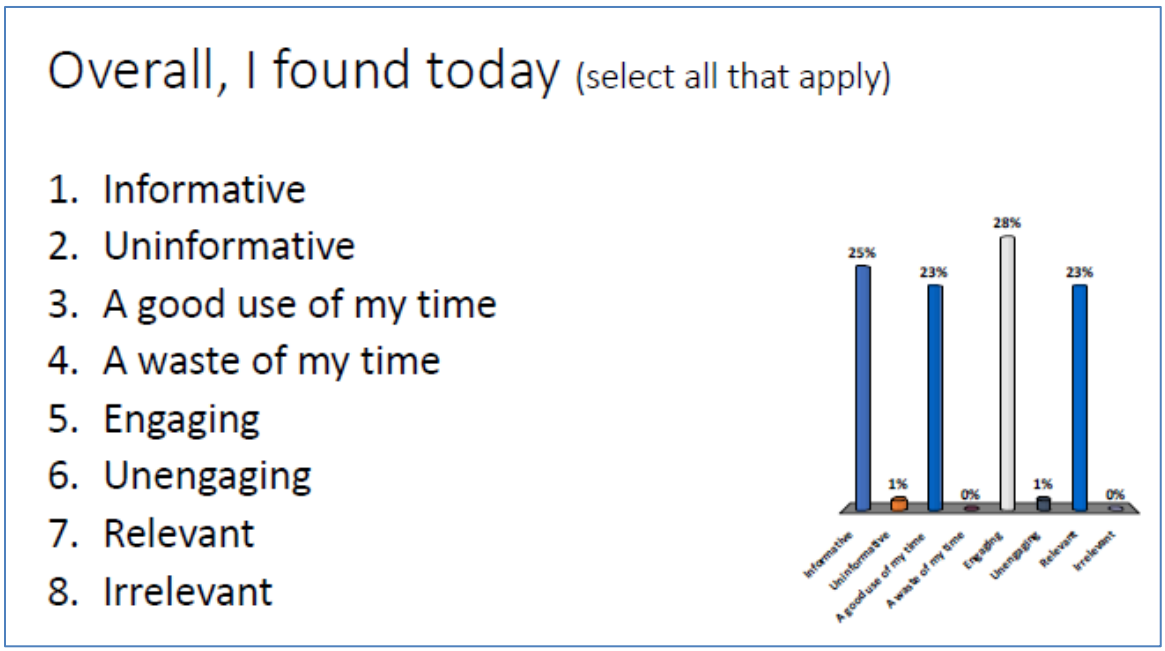


Figure 11: Polling Question (4) for Evaluation with Results



ANALYSIS

Topic 1: Continuity and Attachment to Primary Care

All participants identified that they have a family doctor as a primary care provider, and that they could access their provider (most of the time/always) 75% of the time. Participants identified a number of barriers that prevent them from accessing primary care including transportation, limited after-hour appointments, limited same day appointments, physician shortages, and high rate of no shows. Despite this reported level of access, residents continue to utilize the emergency department on a frequent basis for issues which could be dealt with by their primary care provider. Participants identified that individuals go to the emergency department so they can access to a variety of services, convenience (same day and after hours), and to get a second opinion.

Topic 2: Access to Primary Care Services

The majority of participants identified that they access primary care services through office/clinic appointments (48%). Telephone and emergency department were identified as the other top avenues for accessing primary care services, at 20% and 21% respectively. Participants identified what good access to primary care looked like to them, as well as what would improve access to primary care. Collaboration, co-location of service providers, increased number of service providers, better access for seniors, and standardized record across providers were some suggestions provided by participants.

Topic 3: Access to Primary Health Care Services

When participants were asked who they considered to be part of their primary health care team, family physician, pharmacist, and themselves were the top three responses. Community health nurse, other/allied health, and dentist also had high response. Participants provided suggestions and ideas on how to improve access to primary health care in the Deer Lake/White Bay area. Some suggestions included: using various methods of media to promote and increase awareness of services available, use of telehealth services, walk-in clinics/evening appointments, mobile blood collection, and utilizing nurse practitioners as well as physicians.

Topic 4: Interprofessional Team/PHC Team

Participants felt that their health care providers worked together as a team (very well/well) 36% of the time. Some barriers to working together as a team as suggested by the participants were lack of time, insufficient staff, not having a shared vision, healthcare providers working in silos, geography, and resistance to using a team approach.

Topic 5: Priority Areas in Primary Health Care

Priority areas identified throught the Primary Health Care Assessment were presented to participants to rank in terms of priority for action. Two priority areas identified for action were access to primary health care and chronic disease prevention and management. Hypertension, heart disease, and diabetes were the top three priorites provided by the participants. Some suggestions provided by participants to continue improving the health status of the residents of Deer Lake White Bay in relation to access to primary care services were:

- better coordination and access of services
- the health authority using a patient/client navigator
- offering more programs in the communities
- increased collaboration by communities with the health system
-individuals taking more responsibility for their health and not misusing the clinics

Suggestions related to chronic disease prevention and management were:

-increased education and awaremess for self-management and healthier lifestyles
-making the cost of healthy food affordable
-communities adovcating for improved public policy
-individuals advocating for their own health and being role models to others.

NEXT STEPS AND RECOMMENDATIONS

This report and its key findings will be shared with key stakeholders, as well as the general public in the Deer Lake White Bay area. The report in its entirity will be available on the Western Health Website, and a brief summary forwarded by email to all participants.

The results of this report will be utilized for the development of a comprehensive primary health care quality improvement plan. This plan will consider findings from the Deer Lake White Bay Primary Health Care Needs assessment as well as finding from this engagement session.

Based on results of the PHC Engagement session, the following areas should be considered as quality improvement goals for primary health care in the Deer Lake White Bay Area.

1. Improve access to primary care services

Some actions to support achievement of this goal would be to develop a walk in clinic and/or after hours clinic for primary care services for residents of the Deer Lake/White Bay area. A new model for delivery of services at the Deer Lake Medical Clinic could also be explored.

2. Improve access to primary health care services

Some actions to support achievement of this goal would be to promote and expand use of telehealth, particularly in the White Bay area; partner with communities to increase knowledge of available services (including which services are available via self referral) to residents of the communities; implementation of a client care navigator; and implementation of a community paramedicine program in the White Bay area. Increasing access to the primary health care team through walk-in/after hours service could be explored.

3. Improve interdisciplinary collaboration among primary health care providers in the Deer Lake White Bay area.

Some actions to support achievement of this goal would be to consider co-location of primary care services with other primary health care providers and development of a standardized patient record among primary health care providers. Strategies to improve team work and collaboration, including increasing knowledge of roles and responsibilities, develoment of a shared vision for primary health care, and strategies to improve communication and collaboration across professions (including but not limited to shared patient record). Develoment of a team to work collaboratively on quality improvement in areas of priroity for stakeholders would support this.

4. Improve primary health care outcomes related to chronic disease.

Some suggestions to achieve this goal would be to consider increasing Chronic Disease Prevention Management specifically related to heart disease and diabetes (community priorities). Key primary health care providers should be engaged to develop and implement strategies in these areas. Some considerations may be implementation of the BETTER program, remote

patient monitoring, case management/navigation, and development of team protocols to encourage collaboration.

Appendix A – Invite Letter

Dear Stakeholder,

I am very pleased to invite you to a Primary Health Care Engagement session. We have completed a Primary Health Care assessment for the Deer Lake/White Bay/Pasadena area and would like your input as a key stakeholder in identifying priorities for action.

The session will be held on **March 26 from 10:00 am – 3:30pm** at the Deer Lake Motel. Registration will begin at 9:30am and lunch will be provided.

Pre-registration is required, and seats are limited so we are requesting that you send one representative from your organization. Please RSVP by March 19 by calling 635-7830 or 635-7831.

If you have any questions please call Tammy Angell at 635-7832.

We look forward to hearing from you.

Cynthia Davis
Chief Executive Officer

Appendix B- Invite List

Deer Lake

- Schools
- RCMP
- Churches
- CSSD
- Community Advisory Committee
- Community Drug Action Committee
- Town office (Deer Lake, Reidville, Cormack, Howley)
- Family Resource Center
- Pharmacy
- Family Physicians
- Pediatrician
- Seniors Group (Deer Lake, Howley, Reidville)
- Public Library
- Personal Care Home
- Optometrist
- Physiotherapist
- Ambulance Service
- Massage Therapist
- MHA office

Pasadena

- Schools
- Churches
- Youth Group
- Family Resource Center
- Pharmacy
- Town of Pasadena
- Seniors Group
- Public Library
- Community Garden

White Bay

- Schools
- Churches
- Ambulance Service
- Town office (Hampden & Jacksons Arm)
- District Advisory Council (Pollards Point/Sops Arm)
- Family Resource Center

- Recreation Complex (Hampden)
- Seniors Group
- Public Library
- Personal Care Home

Western Health Staff

- CEO
- VP Population Health and Human Resources
- Director – Community Health
- Community Health Managers
- ER Physician
- Community Support Manager
- Regional PHC Management Team
- Health Promotion Consultants
- Community Health Consultant
- Western Health Board members
- Wellness Facilitator
- Regional Leads (OT, RD, RT)
- Nurse Practitioner
- Cardiac Clinic (NP)
- Manager - Dialysis

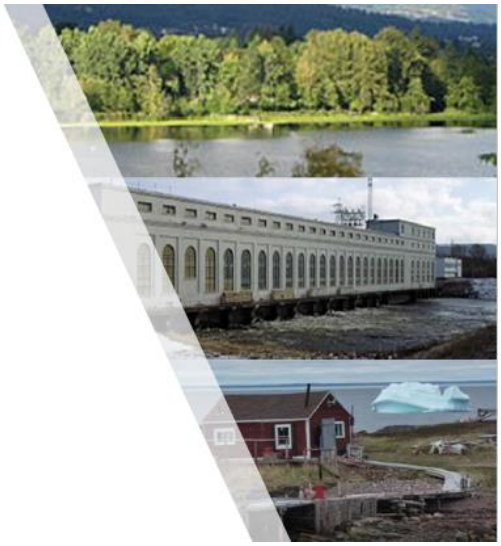
Appendix C – Registration List

	NAME	Organization	Attended (Yes/No)
1	Agnes Brake	50+ Group - Pasadena (634-4088)	Yes
2	Amanda Earle	Western Health	Yes
3	April Dakins	Western Health	Yes
4	Barbara Ball	Lawtons Drugs - Pharmacist	Yes
5	Beth Williams	Western Health	Yes
6	Betty Stead	60+ Seniors Group - Howley	Yes
7	Beverley Pollard	Western Health	Yes
8	Brian Hudson	Town of Pasadena	Yes
9	Brooke Wiseman	Western Health	Yes
10	Bryson Webb	Board of Directors – Western Health	Yes
11	Calvin Wilton	Town of Hampden	Yes
12	Cameron Campbell	Dept. of Health and Community Services	Yes
13	Cara Cullihall	Western Health	Yes
14	Carol Anne Wight	Western Health	Yes
15	Cassie Crisholm	Dept. of Health and Community Services	Yes
16	Cathy Buffet	Western Health	Yes
17	Chris Freake	Western Health	Yes
18	Clifford Reid	Town of Reidville	Yes
19	Colleen Harris	Leo & Lions Club - Pasadena	Yes
20	Cynthia Davis	Western Health	Yes
21	Darla King	Western Health	Yes
22	David Tapp	Western Health	Yes
23	Dean Ball	Town of Deer Lake	Yes
24	Debra House	Paramedic- Town of Jackson's Arm	Yes
25	Dr. Dennis Rashleigh	Western Health	Yes
26	Doreen Noseworthy	Western Health	Yes
27	Dr. John Kielty	Physician – Deer Lake	Yes
28	Dr.Wasef	Physician – Western Health	Yes
29	Eli Bishop	Rural South Development Association	Yes
30	Erica Parsons	Western Health	Yes
31	Gail Osmond	Board of Directors – DLMC	Yes
32	Gary Bishop	Town of Pasadena gbishop@pasadena.ca	Yes
33	George Cole	Deer Lake Manor	Yes
34	Glenda Rice,	Deer Lake Ambulance	Yes
35	Irene Laing Reid	50+ Seniors Group – Reidville	Yes
36	Jackie Barrett	Board of Directors – DLMC	Yes
37	Janis Osmond	Treehouse Family Resource Center	Yes

38	Jason Young	MHA office	Yes
39	Jessica Rex	Aids Committee of NL	Yes
40	Jonathan Andrews	Western Health	Yes
41	Juanita Cooper-Riley	Western Health	Yes
42	Kailey Pauls	Western Health	Yes
43	Kaitlyn Patey	Community Advisory Committee	Yes
44	Kathy Miles	Western Health	Yes
45	Kayla Brake	Western Health	Yes
46	Kerry Gillard	Western Health	Yes
47	Lisa Henley	Western Health	Yes
48	Lloyd Walters	Board of Directors –Western Health	Yes
49	Mariel Parcon	Western Health	Yes
50	Marion Hewitt	50+ Seniors Group - Cormack	Yes
51	Megan Humphrey	Western Health	Yes
52	Michelle Fowler-White	Medicine Shoppe – Deer Lake	Yes
53	Michelle House	Western Health	Yes
54	Myrna Moss	Treehouse Family Resource Center	Yes
55	Nadine Spence	Western Health	Yes
56	Nancy Wiseman	Western Health	Yes
57	Nicki Parsons	CSSD	Yes
58	Nina Mitchelmore	Dept. of Health and Community Services	Yes
59	Peg Ftroud-Mountain	Town of Howley	Yes
60	Roger Barrett	Municipalities NL	Yes
61	Rosemary Ivany	Community Advisory Committee	Yes
62	Sara Randell	Western Health	Yes
63	Sheila Richards	Pasadena Community Garden	Yes
64	Shelly Green Cornick	Pasadena Academy	Yes
65	Stephanie Hynes	Western Health	Yes
66	Susan Madore	Western Health	Yes
67	Tammy Angell	Western Health	Yes
68	Tanya Matthews,	Western Health	Yes
69	Tanya Noble	Dept. of Health and Community Services	Yes
70	Terri Jean Murray	Dept. of Health and Community Services	Yes
71	Tina Edmonds	Western Health	Yes
72	Trevor Wall	Elwood High School	Yes
73	Ulrica Pye	Western Health	Yes
74	Vince Parsons	Town of Jackson’s Arm	Yes
75	Lori Humphrey	Town of Deer Lake	Yes
76	John Ralph	Town of Jackson Arm	Yes
77	Leeann Marsden-Taylor	Western Health	Yes
78	Nicole Wight	Elwood Elementary	Yes
79	Jim Pink	Elwood Elementary	Yes

Appendix D – Powerpoint Presentations

Today's Process & Introductions



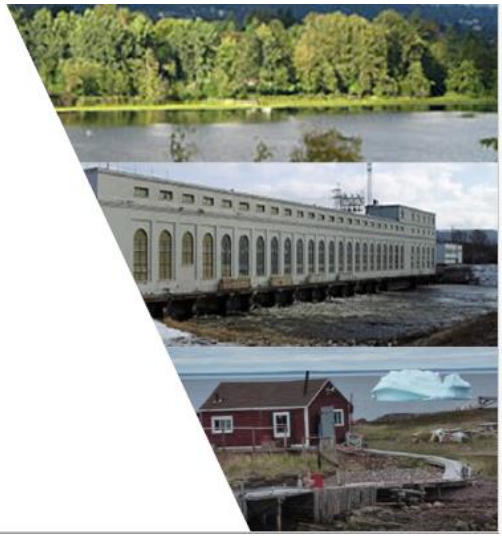
What We Know About Health in the Deer Lake - White Bay Area

Erica Parsons, Community Health Manager, Bonne Bay Health Centre, Western Health

Primary Health Care Assessment: Deer Lake/White Bay Area

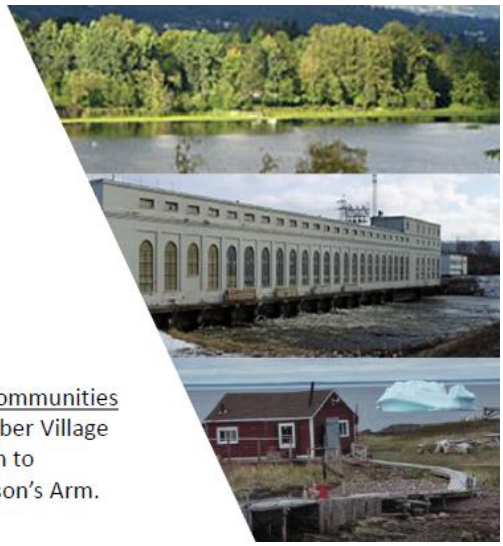
Introduction

- Supporting PHC Renewal
- Integrating team based care
- Improve PHC delivery
- Assessment Completed
  - Demographics
  - Assessment of health needs and concerns
  - Health and Emergency Assets
  - Health service utilization



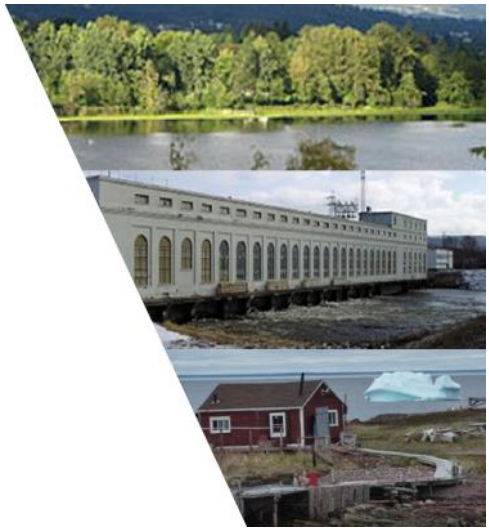
Deer Lake/White Bay Area

<u>19 Communities</u>
Humber Village north to Jackson's Arm.



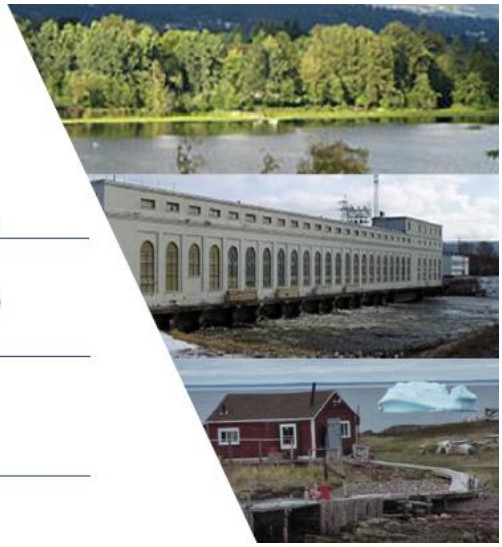
Main Themes

- Changing Communities
- Health Status
- Health Related Assets
- Access to Services



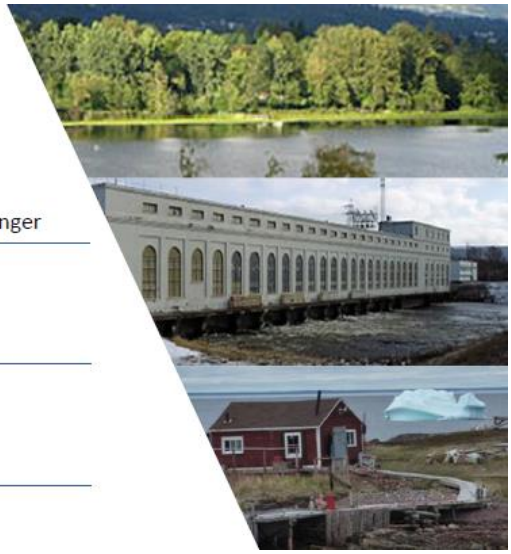
Changing Communities

Population	**2016 Census: 12,040** - DL/Pasadena: growth - White Bay Area: decline
Median Age	**2016 Census** - Deer Lake/Pasadena: 49 - White White Bay Area: 56
Average Birth Rate	- Deer Lake: 56 - Pasadena: 40 - White Bay: 6



Changing Services

Seniors	**Increased demand** - aging population - staying in community longer
Children & Families	**Lower demand** - decline birth rate - low school enrollment
Rural	**Decreased demand** - population decline - aging population



Health Status

Self Assessed Health & Mental Health	**Excellent or Very Good** - Health: 58.9% - Mental Health: 76.4%
Smoking	**Smoking (22.8%)** - Began smoking daily under 19 years of age (61.8%)
Alcohol Consumption	**Consume alcohol (80.8%)** - 34% greater than 5 (4) drinks more than 12 times per year - 9% more than once/week

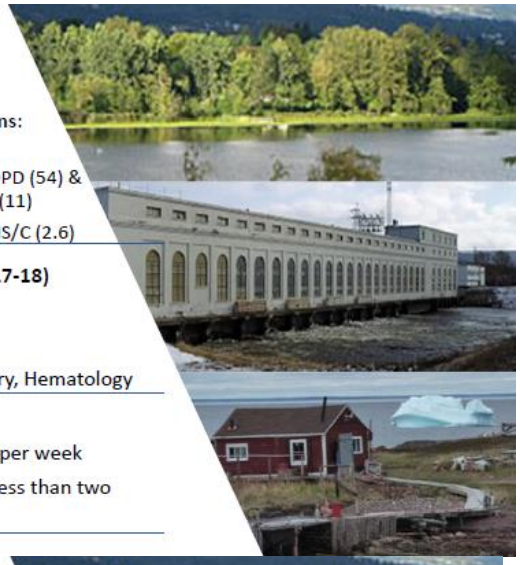
Health Status

Weight	**Overweight or Obese (70.5%)** - 35.5% in obese category - Linked to many chronic diseases
Immunizations	**Childhood immunization Rates are high (95%) in all categories** - HPV (grade 6) 82%
Chronic Disease	**Highest Prevalence Rate (2016/17)** - Hypertension, COPD, Heart Failure, Asthma, Diabetes

Health Related Assets

Deer Lake	- Medical Clinics (primary care), Pop. Health Office, Telehealth (Farm Rd) - Ambulance service, Pharmacy, Dental, physio., chiropractor, optical, pediatric clinic, personal care home
Pasadena	- Medical Clinics (primary care) - Pop. Health Office - Pharmacy, Dental
White Bay Area	- Medical Clinics (primary care), Pop. Health Office, Telehealth (PP Clinic) - Ambulance Service, Pharmacy delivery, personal care home (PP)

Access to Services



Ambulatory Care Sensitive Conditions

Hospital Morbidity/Separations: Heart Disease highest at 10%

Highest # Hospitalizations: COPD (54) & Grand Mal status/convulsions (11)

Avg. LOS (days): COPD (7), GMS/C (2.6)

Telehealth Utilization

Individual Client Appts (2017-18)

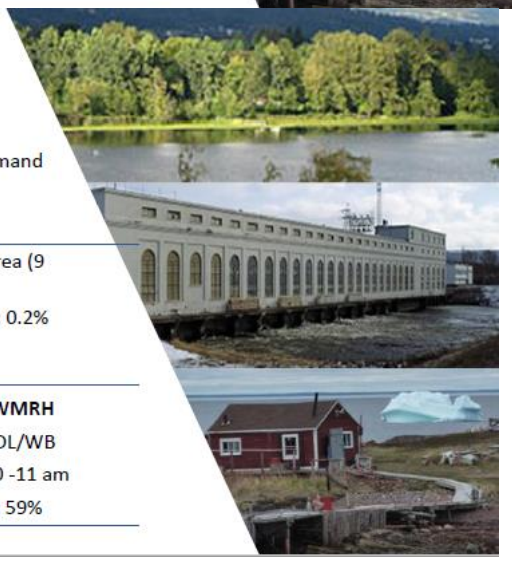
- Deer Lake office: 240
- Pollards Point: 8
- Top 3 : MH and A, Psychiatry, Hematology

Ambulance Services

Emergency call volume

- Deer lake: approx. 21 calls per week
- Hampden/Jackson's Arm: less than two calls per week

Access to Services



Population Health Services

Service Utilization

- Community Supports: ⬆ demand
- MH and A: ⬆demand
- Diabetes services: slight ⬇

Primary Care (Physician and NP)

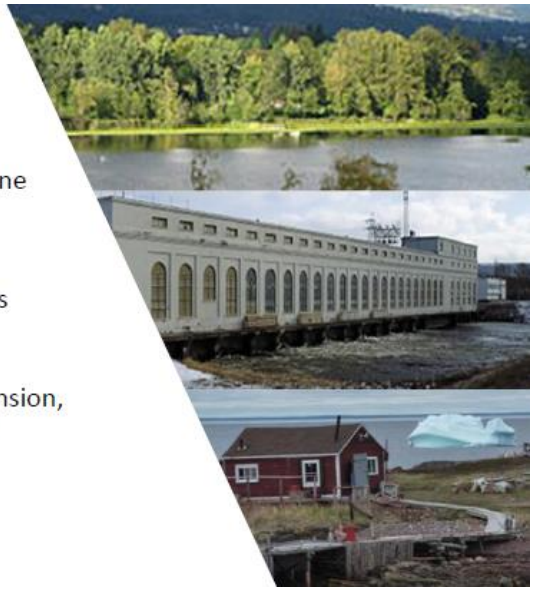
- 10 PC providers in DL/WB area (9 physicians and 1 NP)
- **No Show/Cancellation rate**: 0.2% (4 salaried providers)
- **After hours access**: limited

Emergency Department

Emergency Department at WMRH

- **ED Visits** (2016-17): 6,190 DL/WB
- **Time**: highest # visits b/t 10 -11 am
- **CTAS 4 and 5 (non-urgent)**: 59%

Brief Recap



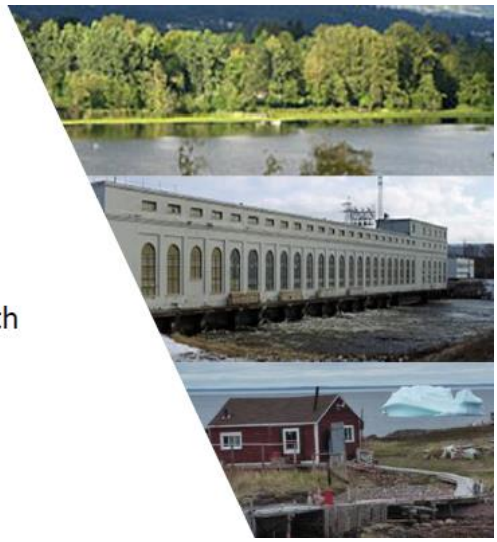
- **Changing communities**
  - Aging population; birth rate decline
  - Population decline WB area
- **Health Status**
  - High rates of poor heath practices (smoking, alcohol consumption, overweight/obesity)
  - Highest prevalence rate: hypertension, COPD, Heart Failure, Asthma and Diabetes

Brief Recap

- **Health Related Assets**
  - DL is the hub for many services
  - Outreach services and traveling clinics to smaller communities
  - Telehealth underutilized in WB area
- **Access to Services**
  - Growing demand for CS and MHA services
  - Limited after hours access to primary care
  - People going to ED during the day for non-urgent issues
  - ACSC: heart disease, COPD, Grand Mal Status/epileptic convulsions
  - Low utilization Ambulance services in WB

Introduction to the Health Home Model

Cassie Chisholm, Primary Health Care Manager, Health and Community Services



Newfoundland Labrador

Primary Health Care in the Health Home

Primary Health Care (PHC)

- First and most frequent point of contact with the health care system
- Range of community based-**services** and **professionals**

Family Practitioners	**Diabetes Educators**
Nurse Practitioners	**Mental Health Counsellors**
Registered Nurses	**Social Workers**
Social Workers	**Occupational Therapists**
Physiotherapists	**Licensed Practical Nurses**
Speech-Language Pathologists	**Dietitians**

- Supports well-being across the life span

Newfoundland Labrador

Background

- Province Wide Consultations
- Guiding Provincial Documents
- *Healthy People, Healthy Families, Healthy Communities: A Primary Health Care Framework for Newfoundland and Labrador 2015-2025*
- *The Way Forward: A Vision for Sustainability and Growth in Newfoundland and Labrador*
- *The Way Forward: Chronic Disease Action Plan*
- *Health Home Model of PHC*

Primary Health Care (PHC)

- Broad health system transformation guided by PHC Framework
- Four goals:
  1. **Engaged** individuals, families, and communities sharing responsibility for health promotion, illness and injury prevention, early intervention, and self-management;
  2. Individuals and families **attached** to a collaborative primary health care team;
  3. Timely **access** to comprehensive, person-focused primary health care services and Supports; and
  4. Connected and **coordinated** services and supports across the health and social sectors.

PHC Focus Areas

- Enhanced community-based services
- Priority areas:
  - Chronic Disease and Ambulatory Care Sensitive Conditions (ACSC)
  - Mental Health and Addictions
  - Complex and Frequent Health System Users
  - Underserviced populations

PHC Sites / Teams

- **Expand Primary Health Care Teams (Action 2.13)**

- Working at over a dozen sites to redesign care
  - Existing resources
  - Meaningful engagement people and providers
  - Purposeful design
- Desire to move to more structured approach
- **Health Home Model**

Origins of the Health Home

- Patient's Medical Home
  - College of Family Physicians **Canada**
- Medical Home Model
  - **US**
- Health Home
  - **Australia**
- Primary Care Home
  - **UK**

Health Home Model of Care

- Collaborative, inter-professional teams form the core
- Teams provide or coordinate a range of services across the lifespan
- 7 key features of the Health Home model
  - ➢ Step-by-step progress

Health Home Attributes

1. Continuity and attachment
2. Inter-professional collaboration
3. Active community engagement
4. Leadership and internal governance
5. Electronic record-keeping
6. Analytics and evaluation
7. Quality improvement capacity

Inter-professional Collaboration

- One provider cannot address all needs, all the time
- Supports complex needs, and care across the lifespan
- PHC team members work to top of scope and skills
- Shift to this style of practice:
  - Training, coaching
  - Supports and resources

Continuity and Attachment

- Continuity, attachment, and **access to care** are connected
- **Continuity**: ongoing relationship between an individual and their primary provider and primary health care team.
- **Attachment**: *documentation* of a continuous relationship
  - People and providers agree to a relationship
  - Primary health care team provides access to quality care
  - People continuously want to access care from the PHC team

Appendix: E

References

Government of Newfoundland and Labrador. (n. d.). Healthy people, healthy families, healthy communities: A primary health care framework for Newfoundland and Labrador 2015-2025. Retrieved from https://www.health.gov.nl.ca/health/publications/PHC_Framework_update_Nov26.pdf