Introduction:
Resources for Primary Health Care Renewal

The BC Ministry of Health Services/Planning recognizes and seeks to support primary health care renewal as it is being practiced in communities across the province. The goal of this project is to compile a compendium of innovative primary health care activities, programmes and projects currently underway throughout BC. This compendium will be a resource for learning about successes, best practices, challenges, works in progress, and opportunities for partnerships and collaboration.

The compendium is an ongoing project that will expand and change as new material is added and as it responds to comments by users. Our intent is to build a learning network that will facilitate the exchange of knowledge about primary health care. We have asked that each submission provide a contact for those wanting to learn more about specific initiatives.

Megan Loeb, Primary Health Care Division, Ministry of Health Services/Planning (megan.loeb@gems6.gov.bc.ca), (250) 952-2405, is maintaining this compendium and the learning exchange. Please contact her if:

- you have already contributed and would like to update your listing
- you are not listed, but wish to be included
- have any other questions.

Contents

Page

1. **FRASER HEALTH AUTHORITY** **4**
   Agassiz Primary Care Organization 5

2. **INTERIOR HEALTH AUTHORITY** **7**
   Chase and District Health Centre/Primary Health Care Organization 8
   ANKORS Kootenay / Boundary AIDS Network, Outreach and Support Society 10

3. **NORTHERN HEALTH AUTHORITY** **13**
   Injury Prevention 14
   United Church Health Services 16
   Regional Cardiovascular Disease Strategy 17

4. **VANCOUVER COASTAL HEALTH AUTHORITY** **18**
   Mid-Main Community Health Centre 19
   - Mental Health Physician in a CHC @ Mid-Main 21
   - Clinical Pharmacist in a Community Health Centre @ Mid-Main 23
   - Dental Clinic in a CHC @ Mid-Main 25

   REACH Community Health Centre 27
   - Multicultural Family Centre @ REACH 29
   - Healthy Eating Active Living, (HEAL) a Diabetes Prevention Program @ REACH 30
   - Good Food Box @ REACH 31

   Three Bridges Community Health Centre 32
   Research in Three Bridges Community Health Centre: 33
   Accessibility of Health Services for Gay Men in Vancouver 33
   Pender Harbour Health Centre 34
   Noakes Community Maternity Clinic 35
   Richmond Youth Clinic 37
   West Community Health Centre 39
   Vancouver Native Health Society 41
   Vancouver Native Health Society Medical Clinic 43
   ADAPT (Aboriginal Diabetes Awareness and Teaching Program) 45
   Strategic Teaching Initiative re: Inner City Health 47
   Vancouver Native Health Positive Outlook Program 49
   T'uyt Snewiy'alh – Women/Youth Clinic Squamish Nation 51
   United Church Health Services 52

5. VANCOUVER ISLAND HEALTH AUTHORITY 53
Nanoose First Nation Headstart Program........ 54
Community Health Needs Project – Southern Gulf Islands........ 56
Nurse First Call/Salaried Physicians – Galiano and Mayne Islands 57
Integrated Hepatitis Services 58
James Bay Community Project........ 60
Chronic Disease Management in a Community Health Centre........ 62
Comox Valley Nursing Centre........ 64
Family Caregivers Support Circles........ 66
'Namgis Health Centre........ 67

6. PROVINCE-WIDE PROGRAMS AND PROJECTS 69
BC HealthGuide Program........ 70
BC Health Promotion Coalition 72

7. RESEARCH PROJECTS........ 74
Primary Health Care from Rhetoric to Practice: Collaborative Action for Health & Social Change 75
Health Promotion in Primary Care Settings 77
Research and Development of a Peer Resource Network in Communities across BC 78

APPENDIX: SURVEY FORM........ 80

1. Fraser Health Authority

Agassiz Primary Care Organization

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion		Multi-disciplinary Teams	X	A Primary Health Care Organization	X
Prevention		Specialist Shared Care		Information Systems	X
Education		Chronic Care		Telehealth	

Community(ies) served:

Community(ies) served	Site(s)
Agassiz	

Description:

In collaboration with the Fraser Health Authority, full time four – physician group practice in Agassiz is offering wider range of services fitting in a model of primary care. Plans are in progress to develop a primary care nurse role, and initiate client information systems. This will enable an integrated approach to health care. The model will support a primary care nurse providing care to patients at the centre focusing on illness and injury prevention, chronic disease management and self care, and health promotion.

The focus is on a patient centred approach to care. The model will feature coordinated services delivered by the team of physicians, primary care nurse and other health care professions. This will include home care nursing case management, mental health or public health services dependent upon the needs of the population.

Annual operating costs (dollars per year):
$870,000

Anniversary date (year and month when initiative was launched): April 1, 2002

Staffing:

Physicians 4.0 FTE
Manager .5 FTE
Medical Office Assistants (MOA) 4.0 FTE
Primary Care RN 1.0 FTE (recruitment pending)

Others involved
Public Health, Home Care, Mental Health providers to be integrated into primary care organization in the future.

Contact(s):

Name:	Laurie Gould
Title:	Director Planning and System Development – Primary Care Chronic Disease
Phone:	604-581-3989
Fax:	
Email:	Laurie.gould@Fraserhealth.ca

Name:	Elma Pauls
Title:	Manager Agassiz Primary Care Organization
Phone:	604-795-4141
Fax:	
Email:	Elma.pauls@fraserhealth.ca

2. Interior Health Authority

Chase and District Health Centre/Primary Health Care Organization

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	x	Multi-disciplinary Teams	x	Developing a Primary Health Care Organization	x
Prevention	x	Specialist Shared Care	x	Information Systems	x
Education	x	Chronic Care	x	Telehealth	

Community(ies) served:	Site(s)
Chase, Sorrento, Celista, Scotch Creek, Anglemont, Turtle Valley, Chase Creek, Pritchard, Seymour Arm	Chase Health Centre, Chase Clinic, Scotch Creek Clinic

Description:

Catchment Population 12,500; 50% over 50 yrs. ;

Services include: emergency services, ambulatory care, urgent care, primary care nursing services, integrated nurse into clinical office, community respiratory services, home care nursing, long-term care assessment, home support, adult day program, diabetic counseling, nutritional counseling, public health nursing, adult counseling, child and youth counseling, alcohol and drug counseling, integrated nursing service with one Aboriginal band. All services have a teaching / education/ prevention service focus as well as direct care. Diagnostic services include laboratory, radiology, various respiratory diagnostic tests .
Goal: to build a Primary Health Care Organization that utilizes a multidisciplinary team approach to primary care services that is appropriate for a rural community.
Future Plans: Chronic Disease management; affiliation with universities as a teaching site, better integration with Aboriginal communities

Annual operating costs (dollars per year): $2,300,000

Anniversary date (year and month when initiative was launched): September 1999

Staffing:
All staff are included in the initiative
- 3.0 FTE RN, Advanced Practice / Emerg /Primary Care
- 0.3 FTE RN Aboriginal Nursing
- 1.0 FTE Public Health Nursing
- 2.0 FTE HCN/LTC Assessment
- 6.0 FTE Home Support Workers

1.0 FTE Home Support Supervisor
0.2 FTE Diabetic Nurse Educator
0.2 FTE Dietician
0.8 FTE Recreation Therapist
5.0 FTE Physicians
6.0 FTE Medical Office Assistants
0.6 FTE Respiratory Therapist
1.0 FTE Adult Counselor
1.0 FTE Child/ Youth Counselor
0.3 FTE Drug and Alcohol Counselor
1.0 FTE Administrator
1.0 FTE Janitor,
2.3 FTE Admin Support

Others involved: Community Health Advisory Committee

Contact(s

Name:	Dr. Steven Rollheiser
Title:	Physician
Phone:	250-679-8851
Email:	srollheiser@cablelan.net

Name:	Gerri Rintoul
Title:	Administrator
Phone:	250-679-3312
Fax:	250-679-5329
Email:	gerri.rintoul@interiorhealth.ca

ANKORS Kootenay / Boundary AIDS Network, Outreach and Support Society

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	x	Multi-disciplinary Teams		Developing a Primary Health Care Organization	
Prevention	x	Specialist Shared Care		Information Systems	
Education	x	Chronic Care	x	Telehealth	

Site(s): 101 Baker Street, Nelson & #205 14th Avenue, N. Cranbrook

Community(ies) served:

ANKORS provides services throughout the Kootenay and Boundary regions in southeastern BC. There is a division of service availability between the East and West Kootenay/Boundary due to HIV/AIDS funder restrictions. These restrictions prevent equal and equitable programming throughout our geographic area, impacting the East Kootenay programming in particular. ANKORS addresses this gap by providing support and administrative programming to the East Kootenay office ensuring service to those living with, those affected and those most at risk for HIV and AIDS. Several of the larger communities have increasing populations of positive and affected individuals, in part due to the centring of mandated service providers (health, social, financial, etc.) as well as reflecting the mobility of individuals who live with HIV and AIDS ANKORS is funded to provide HIV, AIDS and Hep C prevention, education, harm reduction and support services in the East, West Kootenay and Boundary regions. These regions are over 52,000 square kilometres in area and house over 50+ separate communities.

Description:

ANKORS staff provides outreach, prevention, education and harm reduction services; all services are available to the 50+ communities in our region. Programs and services are structured specifically to address community need. Development takes place in response to emergent needs as well as with input from ongoing needs assessments done by ANKORS Staff, individuals and community partners. There is area specific funding for each sector which defines 'where' programs will be provided as listed below:

HIV/AIDS Services:

- Support Services (Kootenay & Boundary regions)
- Community Development (Kootenay & Boundary regions)

- Board and Volunteer Recruitment, Training and Support (Kootenay & Boundary regions)
- Prevention, Education & Training Services (West Kootenay & Boundary region)
- Community Care Team (East Kootenay Region)
- Harm Reduction and Needle Exchange Programs (West Kootenay & Boundary region)
- Hep C Support and Education (West Kootenay & Boundary region)
- Awareness, Education and Fund Raising Events (Kootenay & Boundary regions)
- Resource Library – video and text (Kootenay & Boundary regions)

Other Services:
- College/University Student Placement Supervision (Kootenay & Boundary regions)
- Job re-entry/entry training (Kootenay & Boundary regions)
- Internet Access/computer availability for consumers (Kootenay & Boundary regions)
- Community Work Service placements for the Ministry of the Attorney-General (Kootenay and Boundary regions)

Levels of local awareness on HIV and AIDS vary throughout our regions. While over the past four years there had been many advances made, the re-structuring in the health and social service sector has impacted much of this progress. Offices – health, social service, mental health, school district, etc. – have been closed and/or moved. Hospitals have been closed; Schools have been closed; services have been removed from many of the small more rural communities, creating centralized health care sites in Cranbrook (EK) and Trail (WK/B). Many individuals who have been close partners and allies no longer are employed, or have been moved to other worksites or given new jobs.
Many organizations continue to undergo changes to funding, service mandates or are being phased out. ANKORS and other AIDS Service Organizations within the Interior Health Authority region are also undergoing a review of services and funding, announcements will be made to each Society in November 2002.

Annual operating costs: While this amount varies ANKORS present budget is $384,270 for this fiscal year 2002-2003.

Anniversary date: ANKORS was first funded in 1994. As of March 31, 2003 all contracts will need to be renewed.

Staffing:
- Education .8
- Harm Reduction/Needle Exchange .8
- Support Services .8
- Hep C .5
- Community Care Team .8
- Administrative Assistants (EK/WK-B Regional Offices) .5
- Executive Director 1

Others involved (e.g. family members care givers, volunteers):

- ANKORS provides work placements for those who are living with a disability or who require job training skills. These individuals contribute approximately 25 hours a week.
- ANKORS has numerous volunteers who contribute to our service delivery – Board of Directors, office and program volunteers, event people. These volunteer hours are approximately 1500 hours a year.
- As well, ANKORS supports families, care partners, hospice and other volunteers when an individual is experiencing a health crisis. These hours are approximately 100 a year.

Contact(s):

Name:	Karen Muirhead
Title:	Executive Director
Phone:	250-505-5506
Fax:	250-505-5507
Email:	karen@ankors.bc.ca

Name:	Garry Falhman
Title:	Board Chair
Phone:	250-505-5506 Message
Fax:	250-505-5507
Email:	info@ankors.bc.ca

3. Northern Health Authority

Injury Prevention

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	√	Multi-disciplinary Teams		Developing a Primary Health Care Organization	
Prevention	√	Specialist Shared Care		Information Systems	
Education	√	Chronic Care		Telehealth	

Other:

Coalition Building

Community(ies) served:	Site(s)
Northern Interior Region	PG, Quesnel, Vanderhoof, Fraser Lake, Burns Lake, McBride, Valemount, MacKenzie, Fort St. James

Description:

- ❖ Injury Prevention goals include increasing awareness of injuries in the region through education, media awareness, and coalition activities with other injury prevention stakeholders in the community.
- ❖ Not only increasing awareness of the injuries but educating around the preventable nature of injuries, cost of injuries (personal and financial), and types of injuries and who is at risk.
- ❖ Currently initiating a surveillance system with our regional hospital to better track injuries for the north.
- ❖ Other future initiatives include a possible pilot project around home safety with parents; other ideas from the coalition include a conference and various health fairs etc.
- ❖ Another initiative is to prevent injuries through education and promotion activities in the communities
- ❖ The program has a grant initiative where the outlying communities can apply for funding an injury prevention initiative in their community; this was introduced last year and funding has continued this year.
- ❖ The list goes on but the target group is birth to death with a strong focus on preventing unintentional injuries in childhood.

Annual operating costs: Not sure but has a modest budget and coverage of a full-time RN.

Anniversary date: June of 2000.

Staffing: Currently there is one full-time employee that will be converted to ¾ time June 2003

Others involved: The coalition includes other injury prevention partners including ICBC, RCMP, City of PG, Playground Inspector, Seniors Fall Prevention Coordinator, Child Care Resource and Referral Agency, PARTY Program, School District 57, Fire Department, Red Cross, YMCA of Prince George, Public Health Nurses, and others.

Contact(s):

Name:	Tara MacKenzie
Title:	Injury Prevention Coordinator
Phone:	250-565-7455
Fax:	250-565-6674
Email:	Tara.Mackenzie@northernhealth.ca

United Church Health Services

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion		Multi-disciplinary Teams	X	Developing a Primary Health Care Organization	X
Prevention		Specialist Shared Care		Information Systems	
Education		Chronic Care		Telehealth	

Community(ies) served:

Community(ies) served	Site(s)
Bella Coola, Bella Bella, Hazelton: note, communities are within the Northern and Vancouver Coastal Health Authorities	Hospitals within each community

Description:

- Provides primary care services to rural remote Aboriginal communities.
- Incorporates the use of Primary Care nurses
- Funded by Alternate Payments Branch
- Physicians salaried – work collegially as a group
- Generous holiday and Continuing Medical Education time/funding
- Administrative support that looks after finding locums, replacements, and deals with the business side of things
- The third party payment arrangement allows flexibility in use of funds – e.g. Diabetes Prevention/Management Project; provision of obstetrical services in community
- 3 physicians in Bella Bella & Bella Coola, 5-7 physicians Hazelton

Annual operating costs: $2,561,000

Anniversary date: Not a new initiative – these services have been provided for 70 years or more.

Staffing: Total physicians – 13 FTE

Contact(s):

Name:	Dr. Ray McIlwain
Title:	Director, United Church Health Services
Phone:	(250) 799-5240
Fax:	(250) 799-5241
Email:	ray.mcilwain@gems7.gov.bc.ca

Regional Cardiovascular Disease Strategy

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion		Multi-disciplinary Teams		Developing a Primary Health Care Organization	
Prevention	X	Specialist Shared Care		Information Systems	
Education	X	Chronic Care	X	Telehealth	

Community(ies) served:	Site(s)
All communities in Northern Health Authority	

Description:

- The Healthy Heart Society supported initiatives in several communities across the north prior to the creation of the NHA. These communities have been making significant progress in establishing community partnerships and planning CVD initiatives. The Healthy Heart Society and the Northern Health Authority brought these communities together for a regional networking forum in April 2002. This event demonstrated that there is a readiness across the region for a regional strategy focused on Cardiovascular Disease and Chronic Disease Management.
- The proposed regional strategy for 2002-2003 will include clinical education for health providers, regional coordination and networking, implementation of community-based action and evaluation.
- See NHA's website for press release on the launch of this initiative: http://northernhealth.ca

Annual operating costs: $400,000 for 2002/03

Anniversary date: Project was launched in October 2002

Others involved: Healthy Heart Society and community organizations in partnership with staff of Northern Health Authority

Contact(s):

Name:	Paddy O'Reilly
Title:	CEO, Healthy Heart Society of BC
Phone:	(604) 742-1772

Name:	Mark Karjaluoto
Title:	Northern Health Authority
Phone:	(250) 565-2694

4. Vancouver Coastal Health Authority

Mid-Main Community Health Centre

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	[ ]	Multi-disciplinary Teams	[ ]	Primary Health Care Organization	[X]
Prevention	[ ]	Specialist Shared Care	[ ]	Information Systems	[ ]
Education	[ ]	Chronic Care	[ ]	Telehealth	[ ]

Other:

See program descriptions on following pages

Community(ies) served:	Site(s)
Mid-Town area of Vancouver	3998 Main Street at E. 24th Ave , Vancouver

Description: Please provide a brief summary of the initiative that describes the goals, population group, key activities, successes identified and future plans (point form would be fine).

Mid-Main provides a range of health programs in one building, located at 24th and Main Street in Vancouver. From the beginning, Mid-Main's purpose has been to provide comprehensive, high-quality, affordable health services based on the needs of our community.
Services are offered through a multidisciplinary team of family physicians, a pediatrician, a clinical pharmacist and a counsellor. Mid-Main also operates a busy dental clinic with dentists, hygienists and certified dental assistants.
Mid-Main is active in partnerships with other community organizations such as Mount Pleasant Community Centre and Little Mountain Neighbourhood House. Various community groups use our meeting space and community health staff of the Vancouver Coastal Health Authority use Mid-Main facilities on a weekly basis for youth clinics, well baby clinics and groups for new parents.

Annual operating costs (dollars per year): $1,750,000

Anniversary date (year and month when initiative was launched): June 1988

Staffing: 30 FTEs which includes four family physicians, one 'nurse practitioner', one half time clinical pharmacist, four dentists and two dental hygienists

Others involved: Mid Main is organized under the Societies Act and is governed by a twelve member volunteer Board of Directors

Contact(s):

Name:	Colleen Ming
Title:	Executive Director
Phone:	604-873-3666
Fax:	604-875-8790
Email:	midmainadmin@telus.net

Mental Health Physician in a CHC @ Mid-Main

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	x	Multi-disciplinary Teams	x	Developing a Primary Health Care Organization	x
Prevention	x	Specialist Shared Care	x	Information Systems	
Education	x	Chronic Care	x	Telehealth	x

Community(ies) served: Site(s)

Community(ies) served	Site(s)
Primarily the Mid-Town area of Vancouver, in addition other Vancouver neighbourhoods	Mid-Main Community Health Centre

Description:

- The Mental Health Physician is a family physician with further education in mental health issues who functions at Mid-Main as an "in-house" specialist for members of the clinical team and patients.
- The Mental Health Physician sees patients referred by Mid-Main health professionals and provides ongoing support to people with mental health issues such as chronic depression, bi-polar illness and schizophrenia. In this capacity, the Mental Health Physician is functioning in a "shared care" role with the existing primary care team at Mid-Main. This individual also provides an initial mental health evaluation for individuals who need a working diagnosis before appropriate referrals can be made.
- As requested, the Mental Health Physician will also review a patient's chart and make recommendations regarding diagnoses and treatment plans of patients for other Mid-Main clinicians.
- Given the prevalence of mental health issues in Mid-Main's patient population, any efforts to increase the number of mental health services to our patients is of great value to patients who are for the most part, unable to access public and private mental health services. Other successes of this initiative include; better management of people living with mental health disorders in the community particularly around decreasing the number and length of hospital stays. This position has provided more support for the family physicians, clinical pharmacist and nurse practitioner in delivering health services to people with mental health problems, increasing education of clinical staff on mental health issues.
- Plans include obtaining direct funding for this position as well as efforts to try to expand the range of mental health services provided at Mid-Main to include drug and alcohol counsellors, mental health workers and the like.

Annual operating costs: 1 x Physician session per week + admin support .20 of an FTE, clinical space

Anniversary date: 2001

Staffing:

- Mental Health Physician: .15 of an FTE. The individual in this role is both a Pharmacist as well as a Family Physician with further education and experience in mental health.
- Administrative support in booking patients, coordinating referrals and data entry of the clinical work of the Mental Health Physician totals .20 of an FTE position of an Medical Office Assistant.

Others involved: The Mental Health Physician works with individual patients and their families and providers. In addition to working with members of the Mental Health Team, Social Workers, Hospital Psychiatric Departmental staff, Community Health Nurses, private Psychiatrists, health professionals located at Detox and Drug and Alcohol programs.

Contact(s):

Name:	Denise Ralph
Title:	Medical Administrator
Phone:	604-873-3666, extension 238
Fax:	604-875-8790
Email:	midmainmedical@telus.net

Clinical Pharmacist in a Community Health Centre @ Mid-Main

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	x	Multi-disciplinary Teams	x	Developing a Primary Health Care Organization	x
Prevention	x	Specialist Shared Care		Information Systems	x
Education	x	Chronic Care	x	Telehealth	x

Other:

Capacity building Efficiency

Community(ies) served:	Site(s)
Primarily the Mid-Town area of Vancouver, in addition to other Vancouver neighbourhoods	Mid-Main Community Health Centre

Description:

- The Clinical Pharmacist (CP) provides pharmaceutical services to people who attend Mid-Main CHC, in addition to supporting physicians in their pharmaceutical practices.
- Patient population mirrors that of Mid-Main; large numbers of young children and families, people of different cultural backgrounds, significant numbers of seniors living alone. The majority of Mid-Main patients live in conditions of poverty with lower socio-economic status than other areas of Vancouver.
- Working in a half-time position, the CP provides services to patients in the clinic (around 45% of all CP services), on the telephone (40%) in patient's home (10%) and nursing home (5%). Referrals to the CP are made by the physicians, nurse practitioner, administrative staff as well as self referral by patients.
- Key activities include educating physicians regarding best pharmaceutical practices and providing drug information and drug therapy monitoring to patients. A considerable percentage of the CP's time is spent providing health promotion activities and education to patients on topics such as nutrition, diabetes, smoking cessation, asthma and depression. The CP also undertakes case reviews of patients' charts, manages all drug supplies, sees drug company representatives, coordinates Pharmanet searches.
- Successes are many; highlights include the development of references and resources for both patients and health professions at Mid-Main, the development of different documentation and assessment tools used by other members of the primary health care team. The CP role has helped to further the development of an integrated team of health professionals working together at Mid-Main. The CP role has helped our efforts to deliver high quality and accessible primary care services to our patients.
- Future plans include trying to find resources to continue to support the position.

Annual operating costs: Salary and Education and Supplies, Admin support, data entry, evaluation, reporting $70,000/year. Physicians chose to be paid less at Mid-Main, in order to fund this as a half time position.

Anniversary date: Pharmacist volunteered for one year prior to starting a half time position in 1999

Staffing: Clinical Pharmacist = 50% of an FTE. Administrative staff = 35% of an FTE position, including data entry.

Others involved: Includes individual patients, their families, care providers. The Clinical Pharmacist also works with other allied health professionals associated with the patient such as community health nurses, community based pharmacists, nursing home employees, mental health workers, physiotherapists/OT's and Specialist Physicians.

Contact(s):

Name:	Denise Ralph
Title:	Medical Administrator
Phone:	604-873-3666, extension 238
Fax:	604-875-8790
Email:	midmainmedical@telus.net

Dental Clinic in a CHC @ Mid-Main

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	X	Multi-disciplinary Teams	X	Developing a Primary Health Care Organization	X
Prevention	X	Specialist Shared Care		Information Systems	
Education	X	Chronic Care		Telehealth	

Other:

Sustainable Dental Clinic using a non profit model

Community(ies) served:	Site(s)
Vancouver and Lower Mainland	Mid-Main Community Health Centre

Description:

GOALS:
Sustainability and low cost. In a small business model in order to provide comprehensive dental treatment to the underserved and beclient focused.
To be able to sustain this model and still meet our mandate we serve a mix of clients in a fee for service model. Those with: dental insurance or those able to pay, the working poor, immigrants and refugees and those covered using a reduced fee guide. i.e. those on MOH coverage plus those covered through First Nations and Inuit Health Branch.
The staff works in a team environment and are all employees of the CHC.
In 1996, we borrowed money from staff and board to establish a hygiene room. Lenders were paid back with a little interest over two years. It has been so successful in accommodating our patients that we are writing up another business plan to establish a second hygiene room to meet the expanding needs of our patients and also provide extra dollars to support our primary care clinic operations.
We constantly advocate to the private dental sector for used equipment and all our staff believes in the philosophy of serving the underserved.

Annual operating costs: We generate $880,000 in an average year. Operating costs are at 90% and any profit goes back into overall clinic services and building maintenance.

Anniversary date: 1988

Staffing:

4 x Dentists	= 2FTE's
6x cert. Dental Assts	= 3FTE's
2x Hygienists	= 1FTE
1 Manager	= 1FTE
3x receptionists	= 2FTE's
1 Executive Director	= .3 of an FTE
Volunteer Board	

Others involved: Family, Staff, Service Providers, Volunteers

Contact(s):

Name:	Colleen Ming
Title:	Executive Director
Phone:	604 873-3662
Fax:	604 875-8790
Email:	midmainadmin@telus.net

REACH Community Health Centre

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	X	Multi-disciplinary Teams	X	A Primary Health Care Organization	X
Prevention	X	Specialist Shared Care		Information Systems	
Education	x	Chronic Care	X	Telehealth	

Community(ies) served:	Site(s)
East Vancouver	Commercial Drive, Van.

Description:

REACH is a Community Health Centre that has been located in the East Side of Vancouver since 1969. REACH strives to meet the medical, dental, and cultural needs of the community with an emphasis on prevention and the development of programs, which reflect the ongoing needs of the ever-changing composition of the community. The key services are medical service, dental services, nutrition, counselling, the Multicultural Family Centre, and a youth clinic once a week. REACH has started many projects in the community and some of them have gone on to become self-sustaining. As well, REACH provides on site training to a number of students every year. REACH generally has a first and/or second year resident physician, pharmacy students, dental students running an emergency clinic one evening a week, nursing students, and various support positions in training. Currently funding is inadequate; however, REACH expects to find a way to keep all of the services going into the future.

Annual operating costs (dollars per year): $2,500,000

Anniversary date (year and month when initiative was launched): REACH opened in 1969.

Staffing: There are approximately 35 FTE staff – 6 physicians, 3 dentists, 2 nurse practitioners, an hygienist, a pharmacist, .8 counsellor, .8 nutritionist, 4 multicultural facilitators, and approximately another 16 FTE support and administration staff.

Others involved: There are volunteers in many aspects of REACH including the dental department, MFC and various nutrition projects. A Board of Directors elected from the community by the membership of the Society governs REACH.

Contact(s):

Name:	Barbara Bell
Title:	Executive Director
Phone:	604-254-5456
Fax:	604-254-8789
Email:	Bbell@reachcentre.bc.ca

Name:	Fran Moore
Title:	Counsellor
Phone:	604-254-1354
Fax:	604-254-8789

Multicultural Family Centre @ REACH

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	x	Multi-disciplinary Teams		Developing a Primary Health Care Organization	
Prevention	x	Specialist Shared Care		Information Systems	
Education	x	Chronic Care		Telehealth	

Community(ies) served: Site(s)

Community(ies) served	Site(s)
Vietnamese, Latin American and African immigrants	East Vancouver, Burnaby

Description:

The Multicultural Family Centre facilitates a variety of health education presentations, delivered in culturally appropriate formats for all three target communities, including information on HIV/AIDS, cardiac health, nutrition, physical fitness, elder abuse prevention, depression, women's health, arthritis, stress management, living with chronic illness, and health benefits.

Annual operating costs: $110,000

Anniversary date: This program started in 1991 with the Vietnamese program and has been building since. It is now in its 11th year in partnership with the REACH Community Health Centre

Staffing: There is a .7FTE Coordinator and three FTE facilitators – one for each community.

Others involved: There are over 25 regular volunteers in these programs plus another 25-35 who come and go.

Contact(s):

Name:	Patricia Dabiri
Title:	Program Coordinator
Phone:	604-254-6468
Fax:	604-254-1079

Name:	Carole Christensen
Title:	Program Director
Phone:	604-254-6468
Fax:	604-254-1079

Healthy Eating Active Living, (HEAL) a Diabetes Prevention Program @ REACH

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	X	Multi-disciplinary Teams		Developing a Primary Health Care Organization	
Prevention	X	Specialist Shared Care		Information Systems	
Education	X	Chronic Care		Telehealth	

Community(ies) served:	Site(s)
Vietnamese, Latin American and African immigrants	East Vancouver

Description:

This program uses a Community Kitchen model to assist members of the Vietnamese, Latin American and African communities to make the necessary lifestyle changes to prevent the onset of diabetes or to prevent complications in those already diagnosed with the disease. These communities have been identified as being at higher risk than the general population for Type II Diabetes. Following the Multicultural Family Centre community development focus, HEAL emphasizes the involvement of members of the three target communities in the design and implementation of the project.

The program has been operating for almost one year and has another 1 and ½ year of funding through Health Canada.

Annual operating costs: $41,000

Anniversary date: Program was launched in late 2001 and will be funded until Mar 31/04

Staffing: There is a .8 FTE coordinator and three (5 hours/week) Kitchen facilitators.

Others involved: There is an advisory committee with various community and agency reps. and there are a number of volunteers who come and provide assistance or professional information during the kitchen time.

Contact(s):

Name:	Jessica Chenery
Title:	Project Coordinator
Phone:	604-254-1374
Fax:	604-254-8789

Good Food Box @ REACH

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	X	Multi-disciplinary Teams		Developing a Primary Health Care Organization	
Prevention	X	Specialist Shared Care		Information Systems	
Education	X	Chronic Care		Telehealth	

Community(ies) served:	Site(s)
East Vancouver, Burnaby and New Westminster	Various depots (36+)

Description:

The Good Food Box is a not-for-profit fresh food access program targeted to those with barriers to getting fresh fruits and vegetables into their homes. In its second year, the program has grown from 25 to 36 depots, and from 250 families to close to 500 families purchasing the box. Once a month fresh fruits and vegetables are delivered to a donated warehouse space and sorted into individual orders by dedicated volunteers. The orders are taken to volunteer-run neighbourhood depots and distributed to customers that paid in advance. In order to start becoming self sufficient, the program started to charge $3 extra per box (moving the price from $12 to $15) to help cover the administrative costs. The project advisory committee is currently working to develop a way this program will be totally self sufficient in the future.

Annual operating costs: $45,000 plus food

Anniversary date: February 2000

Staffing: .6 part time coordinator.

Others involved: Volunteers help pack the boxes, deliver them and run the depots.

Contact(s):

Name:	Carol Ranger
Title:	Nutritionist
Phone:	604-254-1354
Fax:	604-254-8789

Name:	Cheney Cawkwell
Title:	GFB coordinator
Phone:	604-254-1312
Fax:	604-254-8789

Three Bridges Community Health Centre

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	x	Multi-disciplinary Teams		Developing a Primary Health Care Organization	x
Prevention	x	Specialist Shared Care		Information Systems	
Education	x	Chronic Care	x	Telehealth	

Community(ies) served: Site(s)

Community(ies) served	Site(s)
Downtown Vancouver	1292 Hornby Street

Description:

Three Bridges CHC serves residents of the West End, Downtown South, Downtown Business District, Yaletown, False Creek, Fairview Slopes and South Granville neighbourhoods. It offers on-site and outreach health services and support, including primary health care, health information services, and opportunities for community involvement. Community nurses, doctors, community counsellor, rehabilitation therapists, nutritionists, long-term care case managers, addictions counsellors, and other health professionals provide direct health services. Services include newborn home visits and hotline, child health clinics, parent-infant/toddler groups, speech/language services for children, immunization, school-age health programs, rehabilitation therapy, youth health programs, medical care, needle exchange program, methadone maintenance, alcohol and drug treatment services, home care and home support, a home hospice program, and education and support groups. Referral to other regional services such as residential care, adult day centres, treatment centres and meal programs is also offered. The Centre also hosts a number of innovative programs including Pride Health Services for the Lesbian, Gay, Bisexual and Transgender community and Boys”R”Us for male sex trade workers.

Contact(s):

Name:	Val Munroe or Josee Tremblay
Phone:	604-736-9844
Email:	val_munroe@vrhb.bc.ca or josee_tremblay@vrhb.bc.ca

Research in Three Bridges Community Health Centre:
Accessibility of Health Services for Gay Men in Vancouver

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	x	Multi-disciplinary Teams		Developing a Primary Health Care Organization	
Prevention		Specialist Shared Care		Information Systems	
Education		Chronic Care		Telehealth	

Description:

This study involved a masters thesis (G. Moulton) on factors influencing accessibility of health services for Gay Men in Vancouver. It was conducted in partnership with the VCHA and Three Bridges Health Clinic.

Annual operating costs: Unfunded

Anniversary date: January 2002

Staffing: 1 Grad Student (G. Moulton)

Others involved: Health Service Providers

Contact(s):

Name:	Dr. James Frankish
Title:	Assoc Director, Assoc Professor, Senior Scholar -- Michael Smith Fdn
Phone:	(604) 822-9205
Fax:	(604) 822-9210
Email:	frankish@interchg.ubc.ca

Pender Harbour Health Centre

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	X	Multi-disciplinary Teams	X	Developing a Primary Health Care Organization	
Prevention	X	Specialist Shared Care	X	Information Systems	
Education	X	Chronic Care	X	Telehealth	

Community(ies) served: Site(s)

Pender Harbour (Madeira Park, Garden Day & Egmont)	One in Pender Harbour

Description:

- one stop health care
- centrally located centre adjacent to ambulance station
- multi-disciplinary team with room to expand
- governed by a non-profit society that owns the Health Centre building
- actively involved membership
- strong community support (financially & otherwise)
- cost effective service
- blended model of funding: grants for home and community nursing, rental income from fee for service physicians, dentist and chiropractor and local tax levy

Annual operating costs: $275,633.08

Anniversary date: October, 1976

Staffing: 1.5 Nursing, 1 Secretarial Support

Others involved: 9 board members, partnership programs with community school, aquatic centre, public health

Contact(s):

Name:	Linda Curtiss
Title:	Nurse/Administrator
Phone:	(604) 883-2764
Fax:	(604) 883-2780
Email:	phhc@uniserve.com

Noakes Community Maternity Clinic

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	☐	Multi-disciplinary Teams	☐	Developing a Primary Health Care Organization	☐
Prevention	☐	Specialist Shared Care	☐	Information Systems	☐
Education	☐	Chronic Care	☐	Telehealth	☐

Other:

Family Practice Maternity Clinic

Community(ies) served:	Site(s)
mainly Richmond; also Delta; Surrey; Vancouver	Richmond Health Department, Richmond BC

Description:

1.0 Goals:
* To provide perinatal care for clients who plan/desire to give birth at The Richmond Hospital
* To provide perinatal care for clients whose family physician does not deliver babies
* To offer services in an environment that supports optimum perinatal care
* To optimize accessibility to health/resource information
* To optimize accessibility to community resource referrals

2.0 Population group includes pregnant women desiring to give birth at The Richmond Hospital

3.0 Key activities include prenatal/postnatal care to six weeks postpartum offered by family physicians in the clinic, four days per week. Hospital care and on-call support provided by clinic physicians.

4.0 Successes include partnership between Richmond family physicians and Richmond Health Department team; quality perinatal care to clients with identified needs/risk (social determinants of health); and "one stop" health care as Richmond Health Department and The Richmond Hospital are located on the same site

5.0 Future plans include expansion of the clinic hours, as demand for service increases

Annual operating costs: $30,600 plus physician fee for service

Anniversary date: April, 2001

Staffing: Family physicians (eight in the group) work one day every two weeks in the clinic. On-call activities are shared on a roster basis. One program support member working six hours per day, four days per week.

Others involved: Community health nursing support for client referrals; Richmond Health Department support for space, supplies, and equipment

Contact(s):

Name:	Dr. Tamara Leung
Title:	Family Physician; Noakes Community Maternity Clinic physician
Phone:	604-276-1660
Email:	tjleung@shaw.ca

Name:	Diane Bissenden
Title:	Program Leader, Healthy Babies and Families Program
Phone:	604-233-3180
Fax:	604-233-3198
Email:	diane_bissenden@rhss.bc.ca

Richmond Youth Clinic

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	x	Multi-disciplinary Teams	x	Developing a Primary Health Care Organization	
Prevention	x	Specialist Shared Care		Information Systems	
Education	x	Chronic Care		Telehealth	

Community(ies) served:	Site(s)
Youth who "live, work, study or play" in Richmond. (Clients come primarily from Richmond, but also Vancouver, Delta, Langley & Surrey)	Ambulatory Care Richmond Hospital

Description:

Goals: To promote optimal health for youth 13 to 24 years of age by reducing preventable illness & unintentional injury, and preventing STDs & unwanted pregnancies.

Key activities carried out at the clinics include: history taking, assessment, counselling, Pap smears, pregnancy testing, contraception teaching and advice, providing contraception, HIV/STD testing, treatment & follow-up.

Successes: Due to increase in attendance since 1997, the number of clinics per week has increased from one to three and the number of nurses in attendance at each clinic has increased from one to three or four. The attendance has increased from 1059 in 1999 to 2443 in 2001. To date in 2002, 2321 clients have been seen (an increase 0f 116 for the same period last year).

Two drop-in clinics and one appointment clinic per week are held with a physician, clerical support and two or three community health nurses in attendance. On their first visit, youth see a nurse who looks after pregnancy tests and concerns, birth control options and STD prevention concerns; if a pap smear or STD check is required, the youth then sees the physician. A fourth drop-in outreach clinic (Cambie Connections) is held weekly in a portable classroom on the Cambie School site. At this site there is no physician, but youth see nurses as well as other professionals from Richmond Alcohol & Drug Team, Richmond Youth Services and Cambie Community Centre, Chimo Adolescent Crisis Counsellor.

Future Plans: Possibility of adding a second physician to the Friday clinic as there is space to do so on this day of the week.

Annual operating costs: Total cost is approximately $139,280 per year. (See attached annual costs for Youth Clinic).

Anniversary date: The Richmond Youth Clinic has been in existence since the mid 1970s (formerly called Richmond Free Clinic). It has been in existence at the current location since the fall of 1997.

Staffing:

- Sessional physicians (1 session per clinic) are used at each on the clinics held in Ambulatory Care.
- Three community health nurses are assigned to each clinic. Most days all three are required and at times a fourth nurse. This is approximately 1. 33 FTE CHN per week. (This includes nursing time for coordinating duties and Cambie Connections).
- One clerical support person works at each clinic in ambulatory care (no clerical support at Cambie connections).

Contact(s):

Name:	Dr. Anne Vogel
Title:	Clinical Support for Youth Clinic
Phone:	604-244-5538
Email:	anne_vogel@rhss.bc.ca

Name:	Jennifer Hill	or	Cathy Houldson
Title:	Youth Clinic Nurse		Program Leader
Phone:	604-233-3150		604-233-3168
Fax:	604-233-3198		604-233-3198
Email:	jennifer_hill@rhss.bc.ca		cathy_houldson@rhss.bc.ca

Website:	www.richmondhealth.ca (follow the links to youth)

West Community Health Centre

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	[ ]	Multi-disciplinary Teams	[ ]	Developing a Primary Health Care Organization	[X]
Prevention	[ ]	Specialist Shared Care	[ ]	Information Systems	[ ]
Education	[ ]	Chronic Care	[ ]	Telehealth	[ ]

Community(ies) served:	Site(s)
North and West Vancouver	one in West Vancouver

Description:

West Vancouver Family Practice Group - Service Agreement
Operational November 12,2002

Goal:

To co-locate a small group of full service family physicians to the West Community Health Centre (CHC) to help create a more comprehensive, integrated and inter-disciplinary primary health care team.

We (Drs. David Wilson, Joanne Larsen & Holly Workman) are a Lions Gate Hospital credentialed group of family physicians who have a large shared practice in West Vancouver (at 17th and Marine Drive) that offers full service care to our patients. Drs. Wilson and Larsen have shared their practice for 8 years and Dr. Workman has been part of our group for 2 years. We have also had discussions with 3 to 4 other North Shore physicians who are interested in being involved. Some of these physicians are “unattached” which would allow us to increase “capacity” and therefore serve “orphan patients” (a significant problem on the North Shore). Co-locating allows physicians and North Shore Community Health Services staff to collaborate more, especially in areas such as wound care, chronic disease management (e.g. CHF, diabetes), and care of frail seniors. While West Vancouver has a high percentage of seniors, we believe that the practice should embrace all family members including pregnant women, children and youth. We are committed to a gradual, yet formal integration of primary healthcare services.

Objectives:
We will work toward achieving the following objectives over the next 2 – 3 years. We plan to start small, get organized and build capacity by making sure we involve a group of dedicated individuals first.

1 – Include Nurses/Nurse Practitioners on the team who will have direct patient contact and responsibilities, especially in the areas of triage, urgent care, and chronic disease management. Currently, nurse practitioners aren't licensed to work in urban areas; nonetheless utilization of advanced practice nurses is still one of our prime early objectives.

2 – Increase accessibility to care providers by having extended hours (e.g. 0800 to 1900 hours) and some weekend availability. The physicians and nursing personnel will create a schedule to handle booked appointments, same day care, and walk-ins.

#3 – Patients will be "attached" to a physician of their choice but should be comfortable receiving primary care from any of the providers of the West Health Group. This "continuity of care" is important for good care and should minimize use of the ER and walk-in clinics.

#4 – The West Health Group will accept "orphan patients" within a predetermined practice limit, but will not be in the business of seeing patients who have established, full service GP's on the North Shore. The West Health Group will not operate as a general walk-in clinic except for our attached patients and those referred by staff of the community health centre.

#5 – Full service primary care will be provided, including hospital care, care facilities and home visits. Currently, only Dr. Wilson does obstetrics, but we hope to eventually include a midwife and another GP who does primary maternity care.

#6 – A patient registry is one of the cornerstones of care, especially with the emphasis on management of chronic diseases. We also intend to have direct links with diagnostic and pharmacy providers to make sure that care is integrated and efficient.

#7 – A number of other specialist practitioners (e.g. paediatrician, GP gerontologist, acupuncturist, and chronic pain specialist) have expressed interest in joining our group to facilitate the provision of shared care. We will develop a shared care service system.

Annual operating costs: starting with MSP fee for service, planning to apply for population based funding and for PHC transition funds

Anniversary date: November 6, 2002

Contact(s):

Name:	Debbie Ryan
Title:	Director, Community and family Health program (NSCG HSDA, VCHA)
Phone:	604-983-6827
Fax:	604-983-6839
Email:	Debbie.ryan@nshr.hnet.bc.ca

Vancouver Native Health Society

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	X	Multi-disciplinary Teams		A Primary Health Care Organization	X
Prevention		Specialist Shared Care		Information Systems	
Education	X	Chronic Care		Telehealth	

Community(ies) served: Site(s)

Community(ies) served	Site(s)
Aboriginal community in Greater Vancouver	449 East Hastings, Vancouver

Description:

- To improve the health status of Native people by:
  - encouraging and improving the access to all the development of health care services for Native people
  - confronting those issues that directly impact on the health status of native people
  - Improving relations and promoting communications between health care professionals and the Native community
- To assist, support and undertake, if necessary, any program or activity designed to promote health care of Native people.
- To secure or acquire the funds, real property or other assistance necessary to meet the Society's purposes.

Health Care:
Medical Walk-in Clinic – Community Health Clinic
Positive Outlook – HIV/AIDS Outreach Program
Sheway – community outreach for pregnant women
Hep/HIV – education and awareness for those with Hep, HIV or both

Social Services:
Youth Safe House Project
Inner City Foster Parent Program
Co-Ed Life Upgrading Program
Pre-Recovery Empowerment Program (P.R.E.P.)
Residential School Survivors Healing Centre
Aboriginal Head Start

Annual operating costs: $3,710,000

Anniversary date: 1991

Staffing: See program descriptions that follow

Others involved: Organized in a Society Vancouver Native Health is governed by a volunteer board of twelve members.

Contact(s):

Name:	Lou Demerais
Title:	Executive Director
Phone:	(604) 255-9766
Website:	www.vnhs.net

Vancouver Native Health Society Medical Clinic

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	[ ]	Multi-disciplinary Teams	[x]	Developing a Primary Health Care Organization	[ ]
Prevention	[ ]	Specialist Shared Care	[ ]	Information Systems	[ ]
Education	[ ]	Chronic Care	[ ]	Telehealth	[ ]

Community(ies) served:	Site(s)
Vancouver's Downtown Eastside	449 East Hastings St.

Description:

Goals:

- Primary medical and nursing care, methadone maintenance, addictions counselling, phlebotomy, limited medication dispensing

Population Group:

- Under serviced populations such as aboriginals, women, youth, the mentally ill, inner city peoples, the homeless, substance dependent persons

Key Activities:

- Providing primary care, medical trainee teaching program (ST1) diabetes teaching and awareness program (ADAPT), female condom education and awareness program

Annual operating costs: $705,000

Anniversary date: 1991

Staffing:

Physicians	3.8 FTE	Security/Intake	2.0 FTE
Nurse	1.0 FTE	Office Manager	0.5 FTE
MOA	1.2 FTE	Dietician	0.2 FTE
Admin. Asst.	1.0 FTE		

Contact(s):

Name:	Dr. Steve Adilman
Title:	Clinic Coordinator
Phone:	(604) 255-9766
Fax:	(604) 254-5750
Email:	clinic@vnhs.net

Name:	Tina Braun
Title:	Office Manager
Phone:	(604) 255-9766
Fax:	(604) 254-5750
Email:	clinic@vnhs.net

ADAPT (Aboriginal Diabetes Awareness and Teaching Program)

Vancouver Native Health Society

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	x	Multi-disciplinary Teams		Developing a Primary Health Care Organization	
Prevention	x	Specialist Shared Care		Information Systems	
Education	x	Chronic Care		Telehealth	

Other:

Traditional teachings

Community(ies) served:	Site(s)
Vancouver Downtown Eastside area	

Description:

Every Friday there is a drop-in for First Nations families with a different theme. An Elder talks about traditional medicine, people share stories about diabetes self-care and the Dietician Educator provides nutritional counselling. We seek out places to provide workshops with similar themes to members of the community and organizations can also request we offer a workshop in their space.

We offer a series of four classes in the neighbourhood primary schools, some preschools and at an alternative Aboriginal high school. The classes include games, art, storytelling, exercise activities and education about balanced eating.

Twice monthly we hold a free diabetes-specific community kitchen in a local café. Participants plan the menu, cook and eat the food, then take home leftovers. The kitchen events are posted in the community and doctors and nurses in the area refer members of the community to the kitchens.

Annual operating costs: $100,000

Anniversary date: January 2002

Staffing: Dietician educator (100% full-time), Elder (60%)

Others involved: Elders advisory group & student volunteer

Contact(s):

Name:	Pamela Fergusson
Title:	Dietician Educator
Phone:	(604) 254-9949
Fax:	(604) 254-9948

Name:	Corinne Mitchell
Title:	Elder
Phone:	(604) 254-9949
Fax:	(604) 254-9948

Website: www.vnhs.net

Strategic Teaching Initiative re: Inner City Health

Vancouver Native Health Society

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	X	Multi-disciplinary Teams	X	Developing a Primary Health Care Organization	
Prevention	X	Specialist Shared Care		Information Systems	
Education	X	Chronic Care		Telehealth	

Community(ies) served:	Site(s)
Vancouver Downtown Eastside	

Description:

Goals:

1. To develop a model of teaching medical trainees about inner-city medicine using a comprehensive, integrated community-based care approach
2. To develop the capacity to do operational and hypothesis lead research in an inner-city setting
3. To establish a forum through which patients can educate medical trainees about the unique health and SES issues faced by the residents of Vancouver's inner-city.

Population:

- Consists of injection drug users, mentally ill, homeless, single adults, sex trade workers, immigrants, First Nations, street youth

Accomplishments:

- Have introduced ophthalmology care to this area, doing teaching with the students via clients using storytelling, created a 150-page teaching guide on relevant health issues to the area, have done research on MRSA, are currently analyzing research on the prevalence of eye disease in the attendees of the clinic.

Annual operating costs: $50,000+

Anniversary date: October 15, 2001

Staffing:

- 1 project coordinator (0.5 FTE)
- 1 project researcher (variable hours 0.5 FTE min.)
- 3 doctors involved 3 days/week
- staff from Positive Outlook Program (various hours)

Others involved: 5-10 clients

Contact(s):

Name:	Stephen Adilman
Title:	Clinic Coordinator
Phone:	(604) 255-9766

Name:	Bubli Chakraborty
Title:	Project Coordinator
Phone:	(604) 715-7272
Email:	bubli111@hotmail.com

Vancouver Native Health Positive Outlook Program

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	☐	Multi-disciplinary Teams	X	Developing a Primary Health Care Organization	☐
Prevention	☐	Specialist Shared Care	☐	Information Systems	☐
Education	☐	Chronic Care	☐	Telehealth	☐

Other:

HIV/AIDS care, treatment, and support

Community(ies) served:	Site(s)
Greater Vancouver with strong focus on Downtown Eastside of Vancouver. Serving urban Aboriginal populations.	441 East Hastings Street

Description:

HIV/AIDS care, treatment and support
Multi-disciplinary care: physician care, nursing care, drug and alcohol treatment services, outpatient counselling, social work, "Maximally Assisted Medication Therapy" and outreach services. Care and treatment is provided at drop-in office visits, home visits or by accompanying clients to medical appointments. Since advocating for shelter and disability benefits are important components in health care, the staff strives to provide advocacy for community and government resources.
In partnership with BC Housing offer twenty-five housing subsidies that enables clients to live in areas outside of the inner city.
Additional supports: nutritional programs including daily lunches, Loving Spoonful services, weekly food bank and nutritional assessments.
Prevention is the final link in treatment; education programs and support groups are available to both clients and the general public.
Positive Outlook is multicultural and open seven days a week to anyone who is HIV positive.

Annual operating costs: est. $750,000

Anniversary date: 1995

Staffing:

- one Coordinator Registered Nurse
- one Outreach Registered Nurse
- four Outreach Workers
- two Drug and Alcohol Counsellors
- two Security Intake Workers
- one Administrative Staff Person
- three half time Cooks
- four Volunteer Client Kitchen Helpers
- ten Client Peer Support Volunteers

Others Involved: multiple community partners plus BC Centre for Excellence in HIV/AIDS, UBC, Vancouver Coastal Health Authority

Contact(s):

Name:	Doreen Littlejohn
Title:	R.N., Coordinator, Positive Outlook Program
Phone:	(604) 254-9937
Fax:	(604) 254-9948
Email:	popunhs@mdi.ca

T'uyt Snewiy'alh – Women/Youth Clinic Squamish Nation

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion		Multi-disciplinary Teams		Developing a Primary Health Care Organization	x
Prevention	x	Specialist Shared Care		Information Systems	
Education	x	Chronic Care		Telehealth	

Other:

Initially will specialize in women's/young people's health care issues (e.g.: reproductive health, cancer screening)

Community(ies) served: Site(s)

Community(ies) served	Site(s)
Squamish Nation	So-Sah-Latch health & Family Centre, North Vancouver, BC

Description:

- Sessional fees were provided by the Ministry of Health to set up this clinic
- The goal is to improve the health of aboriginal women, to offer reproductive health services to the youth
- A doctor and community health nurse will be available once a week for ~ 3 hrs

Annual operating costs: $35,000

Anniversary date: January 2003

Staffing: Physician: 3 hrs/wk – 48 weeks/yr; CHN: similar hours

Others involved:

- Manager, VCHA, North Shore – assist with planning
- Medical Director, VCHA, North Shore – doc. reports
- Squamish Nation manger, clerical and systems people

Contact(s):

Name:	Sandra Edelman
Title:	Manager, Community Development
Phone:	(604) 983-6715

United Church Health Services

See description in the Northern Health Authority Section

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion		Multi-disciplinary Teams	X	Developing a Primary Health Care Organization	X
Prevention		Specialist Shared Care		Information Systems	
Education		Chronic Care		Telehealth	

Community(ies) served:	Site(s)
Bella Coola, Bella Bella, Hazelton	

Description:

- Provides primary care services to rural remote Aboriginal communities.
- Incorporates the use of Primary Care nurses
- Funded by APB
- Physicians salaried – work collegially as a group
- Generous holiday and CME time/funding
- Administrative support that look after finding locums, replacements, and deals with the business side of things
- The third party payment arrangement allows flexibility in use of funds – e.g. Diabetes Prevention/Management Project; provision of obstetrical services in community
- 3 physicians in Bella Bella & Bella Coola, 5-7 physicians Hazelton

Annual operating costs: $2,561,000

Anniversary date: Not a new initiative – these services have been provided for 70 years or more.

Staffing: Total physicians – 13 FTE

5. Vancouver Island Health Authority

Nanoose First Nation Headstart Program

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	X	Multi-disciplinary Teams	X	Developing a Primary Health Care Organization	
Prevention	X	Specialist Shared Care		Information Systems	
Education	X	Chronic Care		Telehealth	

Community(ies) served:	Site(s)
Nanoose First Nation	one

Description:

The Headstart Program serves families and their children who are 0 to 6 years of age. We follow 6 key components for education, health, nutrition, culture and language, social support, and parent involvement. We offer parenting programs such as Early Learning Canada, Nobody's Perfect Parenting and Partnership Programs. We try to make the program responsive to the needs of community members – for example, the Education Director, Coordinator and Community Health Representative collaborated so that a woman in the Nobody's Perfect parenting program could have home visits to assist with her special needs child. We offer early literacy programs such as Mother Goose and Friends and playgroup. The Mother Goose and Friends program, in collaboration with the Education Director, recently organized a mobile library. The library operates out of a bus; books are available for all ages, children's activities and singsongs are conducted in the back of the bus and in future sessions, a computer will be available for job searching. We also recently offered a Diabetes Initiative Clinic in the local school. Community health nurses checked blood pressure and cholesterol levels with parents while kids learned what balanced eating looks like and participated in a physical activity circuit. The clinic finished with a meal for the children, parents and elders. We are currently offering preschool however we are considering offering family daycare instead.

Annual operating costs: $43,100

Anniversary date: September 1999

Staffing: One Headstart Coordinator and since May 2002 one assistant (from other funding) with experience in child and youth care who assists with activities such as the playgroups and parenting programs. In a two-week period the workers have 63 hours.

Others involved: We tried to involve the community whenever and wherever possible. Community Health Nurses and Community Health Representatives in the diabetes clinics, the Education Director in the mobile library and other staff in the health and education department.

Contact(s):

Name:	Sandra Scott
Title:	Headstart Coordinator
Phone:	(250) 390-0003
Fax:	(250) 390-1537

Community Health Needs Project – Southern Gulf Islands

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	X	Multi-disciplinary Teams	X	Developing a Primary Health Care Organization	
Prevention	X	Specialist Shared Care		Information Systems	
Education		Chronic Care		Telehealth	

Community(ies) served: Site(s)

Community(ies) served	Site(s)
Salt Spring, Galiano, Mayne, Pender & Saturna Islands	

Description:

Goal:

- To provide coordinated supports to residents of the Gulf Islands by building up community resources on each of the islands, so that identified gaps and issues can be addressed.

Key Activities/Successes:

- Initiation of Meals on Wheels programs on smaller islands; increase of Meals on Wheels on Salt Spring
- Initiation of "protective surveillance" service for isolated, frail elderly population
- Extension of medical alert program on all islands
- Extension of Elderly Outreach & seniors' substance abuse counselling to all islands
- Core funding for Wellness Coordinator

Annual operating costs: $193,370

Anniversary date: June 2001

Staffing: 4 Home Care Nurses x 1 day/week, 1 Counsellor (Elderly Outreach, VISTA) x 8 days/month, 1 Wellness Coordinator x 1 day/week

Others involved: Volunteer drivers and paid cooks for Meals on Wheels

Contact(s):

Name:	Karen Davies		
Title:	Manager, Patient/Client Care, Southern Gulf Islands		
Phone:	(250) 538-4848	Fax:	(250) 538-4870
Email:	karen.davies@caphealth.org		

Nurse First Call/Salaried Physicians – Galiano and Mayne Islands

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion		Multi-disciplinary Teams	X	Developing a Primary Health Care Organization	X
Prevention		Specialist Shared Care		Information Systems	
Education		Chronic Care		Telehealth	

Community(ies) served:	Site(s)
Galiano & Mayne Islands	

Description:

Goals:

- To provide continuity of care for patients in isolated communities with only 1 physician and 1 part-time nurse
- To reduce physician turnover due to burnout from being on call every day

Summary of Initiative:

- Registered Nurses provide "on call" coverage for each island's physician 7 or 8 days each month. They are able to assess, diagnose, treat and discharge patients with minor, uncomplicated health problems on their own authority, guided by protocols which have been approved by the health authority. They liaise with physicians in neighbouring island communities as needed, and with the Emergency Room Physicians in the tertiary care hospital if transfer to a higher level of care is required.

Successes:

- Health care coverage for island residents available 7 days/week.
- Improved job satisfaction for RNs.
- Improved lifestyle for GPs with reduced "on call" duty.

Annual operating costs: Nursing First Call x 4 islands = approx. $100,000/year
Salaries for physicians + supplies for Emergency Treatment Rooms through Medical Services Commission.

Anniversary date: June, 1999

Contact(s):

Name:	Karen Davies		
Title:	Manager, Patient/Client Care, Southern Gulf Islands		
Phone:	(250) 538-4848	Fax:	(250) 538-4870
Email:	karen.davies@caphealth.org		

Integrated Hepatitis Services

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	x	Multi-disciplinary Teams	x	Developing a Primary Health Care Organization	
Prevention	x	Specialist Shared Care	x	Information Systems	
Education	x	Chronic Care	x	Telehealth	

Other:

Harm reduction

Community(ies) served:	Site(s)
North Vancouver Island	Campbell River

Description:

The service will consist of a team of two nurses, a social worker, and an addictions counsellor working closely with treating physicians to deliver hepatitis education, counselling, treatment support, and prevention services. While the team will be based in Campbell River, they will be available to travel throughout the North Island.

Access to the service will be through self-referral or service provider referral.

The initial services will be those that are designed to support the treatment of people with hepatitis. The team will work closely with treating physicians to prepare people for treatment, and support them through the treatment process.

Working with other agencies to enhance supports for people with hepatitis will also be an important activity.

In the future the team will be organizing to provide education sessions for health care workers, social workers, addictions workers and others in the North Island to increase their knowledge of hepatitis. Public and school based education will be planned for in the second year of the project.

Part of the project will be enhanced surveillance to better track and understand the epidemiology of hepatitis in the North Island, and help with focussing the prevention.

This project is funded by the BC Centre for Disease Control with a grant from the Ministry of Health, the Vancouver Island Health Authority, and Schering Canada.

Annual operating costs (dollars per year): $100,000

Anniversary date: October 2002

Staffing:

- .8 FTE nursing (two .4 positions)
- .2 FTE Mental health counsellor
- .2 FTE Addictions Counsellor

Others involved: Volunteers will be recruited

Contact(s):

Name:	Pauline Mellanson
Title:	Nurse Coordinator
Phone:	1-877-215-7005
Fax:	1-286-7086

James Bay Community Project

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	X	Multi-disciplinary Teams		Primary Health Care Organization	X
Prevention		Specialist Shared Care		Information Systems	
Education		Chronic Care		Telehealth	

Community(ies) served:	Site(s)
James Bay, Victoria	547 Michigan Street

Description:

The James Bay Community Project (JBCP) began in 1975. It is a non-profit society that provides a means of public participation in the planning and delivery of health and social services to the community of James Bay in Victoria. JBCP is housed in an attractive facility re-built in 1996 through community fundraising. As a locally governed community health centre, the James Bay Community Project serves all ages from young to old with emphasis on the determinants of health through its commitment to health promotion and prevention programming. With a significant primary health care focus, JBCP demonstrates leadership in providing a range of programs, services, and social supports responsive to present and emerging needs. Its staff and board members are committed to improving community, family and individual health, as well as strengthening the capacity of the community. Its programs are organized into three areas: Health Services, Family and Youth Services and Community Services. In 1999, James Bay became a Primary Health Care Organization when it was selected to be one of the sites in the Ministry of Health's Primary Care Demonstration Project.

Annual operating costs: $2,000,000 for this fiscal year

Anniversary date: 1975

Staffing: 20 FTEs

Others involved: About 200 volunteers work in various programs, including the library and community service programs. The JPCP is governed by a volunteer Board of Directors.

Contact(s):

Name:	Judy Burgess
Title:	Executive Director
Phone:	250-388-7844
Fax:	250-388-7856
Email:	jburgess@jbcp.bc.ca
Website:	www.jbcp.bc.ca

Chronic Disease Management in a Community Health Centre

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	X	Multi-disciplinary Teams	X	Developing a Primary Health Care Organization	
Prevention	X	Specialist Shared Care	X	Information Systems	X
Education	X	Chronic Care	X	Telehealth	

Other:

Self Management

Community(ies) served: Site(s)

James Bay	James Bay Community Project Victoria, B.C.

Description:

This initiative was to develop a chronic disease management program for a primarily elderly patient population. We adapted the Chronic Care Model developed by the Group Health Cooperative because the model provides action strategies to drive practice change. Our goal in the first year was to focus on development of chronic disease management program for diabetes. In the second year we hope to focus on other chronic illnesses and incorporate them within our model development.

Our key activities were to implement an electronic medical record that was able to do surveillance for the clinical practice guidelines for diabetes (clinical information system); to work with a local endocrinologist to adapt clinical practice guidelines to an elder population (decision support); to begin to define interdisciplinary practice, particularly the role of nurses in our clinic including chronic disease surveillance and intentional follow up (health system design); and to trial self management groups from feedback from a patient telephone survey and focus group (self management support).

The success of the trial groups for self-management has been a surprise with attendance increasing with each session. The electronic medical record has become a valuable tool to provide data and ease of management of clinical practice guidelines. We have completed a process for medical delegated functions that promotes interdisciplinary practice.

Future plans include further work in defining interdisciplinary practice. We would like to focus on another chronic disease besides diabetes. We will trial provision of clinical

care in groups for patients that are frequent users or have common management issues. We continue to work in partnership with our community and health authority on implementation of an expanded chronic care model that includes the social determinants of health. Our information system has the capacity to collect data on population health.

Annual operating costs: Initiative supported by research projects with Health Canada Rural and Remote Initiatives and the CAHR with the University of Victoria.

Anniversary date: April 2001

Staffing:
- Medical Director
- Nurse coordinator .25 - .5

Others involved: Patients, volunteers and family members involved with self management groups and other programs within the community health centre

Contact(s):

Name:	Judy Burgess
Title:	Executive Director
Phone:	250-388-7844
Email:	jburgess@jbcp.bc.ca

Name:	Anita Dotts
Title:	Program Manager
Phone:	250-388-6811
Fax:	250-380-0244
Email:	adotts@jbcp.bc.ca

Comox Valley Nursing Centre

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	x	Multi-disciplinary Teams		Developing a Primary Health Care Organization	
Prevention	x	Specialist Shared Care		Information Systems	
Education	x	Chronic Care	x	Telehealth	x

Other:

Regional Eating Disorder Programme; Chronic Pain Management Programme

Community(ies) served:

Primarily Comox Valley but do not put restrictions on client access (also see clients from Campbell River, North Island and Parksville/Qualicum areas)

Description:

The Comox Valley Nursing Centre has been an entry point for primary health care since 1994. Initially a two (2) year demonstration project, the CVNC continues to provide care in the following areas:

- Chronic illness management;
- Health promotion;
- Provision of health information including a lending library and internet terminal; and
- Community development.

Nursing care is provided through a daily drop-in clinic, booked appointments with a primary nurse and/or telenursing. The nursing services are complemented by the use of support groups (developed by the Nursing Centre staff with client input) and interagency collaboration.

Clinical specialty areas include chronic illness in general, women's health, chronic pain, and eating disorders. Men's health is an emerging area of need that became evident following a Men's Health Forum in 2000. The majority of clients are female (approximately 75%) and 25 - 60 years of age. The typical client has complex chronic health concerns, multiple diagnoses and is struggling with a number of social and economic factors (i.e. inability to work, poverty, challenging relationships). Comorbidity with depression is common.

Client satisfaction surveys indicate that Nursing Centre staff were highly effective at creating therapeutic relationships (series of 10 questions related to the nurse's "way of being"). As a result of contact with the NC staff, clients described numerous outcomes that positively impacted on their health.

Annual operating costs: $ 346,443.00

Anniversary date:
May 1994 for the Comox Valley Nursing Centre
February 2002 for Regional Eating Disorder Programme (have been involved in Eating Disorder services since 1994 but formalized as a distinct regional programme this year)

Staffing:
- 3 RN's @ .66 FTE
- 1 RN @ .8 FTE
- 1 RN @ .8 FTE for Regional Eating Disorder (ED) Programme
- 1 contract counsellor (16 hours per week) for ED Programme in Campbell River
- 2 casual RN's (approximately 4 –6 shifts per month)
- RN Manager .4 FTE
- Clerical support from VIHA admin but no dedicated clerical position
- 4 support group facilitators hired on contract

Others involved: Volunteers x 15 for varying times, typically 2 –3 hour "shifts" from Monday to Friday

Contact(s):

Name:	Pat Foster
Title:	Nurse Manager
Phone:	250-898-2228
Fax:	250-338-9985
Email:	patricia.foster@cvchc.hnet.bc.ca

Name:	Brenda Bouttell or Diane Lewis
Title:	Staff Nurse
Phone:	250-338-1711
Fax:	250-338-9985
Email:	Brenda.bouttell@cvchc.hnet.bc.ca or diane.lewis@cvchc.hnet.bc.ca

Family Caregivers Support Circles

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	[ ]	Multi-disciplinary Teams	[ ]	Developing a Primary Health Care Organization	[ ]
Prevention	[ ]	Specialist Shared Care	[ ]	Information Systems	[ ]
Education	X	Chronic Care	X	Telehealth	[ ]

Community(ies) served:	Site(s)
Cowichan Valley	

Description:

Cowichan Family Caregivers Support Society operates in Vancouver Island's Cowichan Valley. Activities include information, education, support groups and advocacy.
The support circles program matches a caregiving family with someone in the community who becomes part of the caregiving circle connected with the family. A trained facilitator acts as a catalyst to build the relationship between the caregiving family and the community caregiver. Details about the program's philosophy and activities are found on the Society's website, noted below.

Annual operating costs: $30,000 (funding sources include local fundraising from individuals and organizations and the Vancouver Island Health Authority)

Anniversary date: January 2000. Began as a pilot project with funding from private donors in the community and the Vancouver Foundation.

Staffing: A part-time coordinator and facilitators provide the staff support to this program.

Others involved:
- Family members and community volunteers are active participants in the program
- Local service clubs contribute funds to the program

Contact(s):

Name:	Ranjana Basu		
Title:	Coordinator		
Phone:	(250) 743-7621	Fax:	(250) 743-7628
Email:	ranjana@familycaregiverssupport.org		
Website:	www.familycaregiverssupport.org		

‘Na̲mgis Health Centre

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	x	Multi-disciplinary Teams		A Primary Health Care Organization	x
Prevention		Specialist Shared Care		Information Systems	
Education		Chronic Care	x	Telehealth	

Other:

Training for rural medical practice

Community(ies) served:	Site(s)
‘Na̲mgis Nation, other First Nations in the Area, Village of Alert Bay, Sointula	‘Na̲mgis Nation on Cormorant Island

Description:

The ‘Na̲mgis Health Centre provides a wide range of health and social services. These services include: physician care, community/public health nursing, home and community care for chronic illness, residential treatment for substance abuse, mental health counselling, a Safe House for women and children, child welfare services, a licensed day care, a Head Start pre-school program, and recreation and life skills training for children and youth. Our most recent addition is a dental clinic and dental health program.

The Centre serves the approximately 800 residents of 'Na̲mgis Nation, 200 members of the Whe-la-la-u Area Council as well as about 650 non-First Nations people living in the Village of Alert Bay. The many visitors who come to our community to participate in cultural and sporting events also use our Centre.

We are a primary health care organization. We coordinate services that range from health promotion and illness prevention services, treatment of common illnesses and the management of chronic diseases, through to accessing specialized hospital based services and palliative care. In our approach to primary health care, providers, patients and area residents are part of a community for which all feel responsible. Mutual trust based on continuous open communication is an essential quality that sustains our health organization.

Adjacent to the ‘Na̲mgis Health Centre, on a site made available under a 99-year grant from the ‘Na̲mgis Nation, the Vancouver Island Health Authority operates the Cormorant Island Health Centre/Hospital. This facility provides four short-stay, acute care beds, ten multi-level, long term care beds and a twenty-four hour Emergency department. The Cormorant Island Health Centre operates in very close cooperation with the ‘Na̲mgis Health Centre and is fully a part of our network of health services.

The wide continuum of services and levels of care that are available in our linked centres has created a most desirable teaching site. We host a clinical teaching placement of the Family Practice Residency Program of the Faculty of Medicine at the University of British Columbia. We also look forward to participating in the distributed medical education program that will see the University of Victoria providing medical education in conjunction with the UBC Faculty of Medicine. This educational program can be extended to nursing and other health professionals.

Annual operating costs (dollars per year): $1,300,000

Anniversary date (year and month when initiative was launched): 1980

Staffing:

Overall staffing 50 plus FTEs, includes administration, administrative support, clerical and maintenance staff that support all services and programs

Family physicians on services contract: 2 fulltime
Nursing staff, community health, home and community care: 2.0 full time
Community Health Representatives: 2 full time
Dentist on services contract: 1 full time
Mental Health Social Worker: 1 full time
Treatment Centre counselors: 5 full time
Additional staff are responsible for community development, day care and Head Start, a safe house, children and youth recreation and life skills and environmental health.

Others involved: The Centre is governed by a Board appointed by the ‘Na̱mgi̱s Nation Council

Contact(s):

Name:	Ian Knipe
Title:	Administrator
Phone:	250-974-5522
Fax:	250-974-5952
Email:	IanK@namgis.bc.ca
Website:	www.namgis.org

6. Province-Wide Programs and Projects

BC HealthGuide Program

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	x	Multi-disciplinary Teams		Developing a Primary Health Care Organization	
Prevention		Specialist Shared Care		Information Systems	x
Education	x	Chronic Care	x	Telehealth	x

Community(ies) served: Site(s)

Community(ies) served	Site(s)
Province of British Columbia- all residents are eligible	

Description:

The BC HealthGuide Program is an innovative self-care program that involves three integrated components: the BC HealthGuide Handbook, BC OnLine and the BC NurseLine. The program is based on the Healthwise self-care program that supports citizens to make wise health decisions for themselves and their families.

The program is available 24/7 to citizens whenever they need it, from wherever they live. Handbooks were delivered to every BC residence in March 2001, and anyone may call the BC NurseLine anytime of the day or night to speak with a specially trained registered nurse for health information and advice.

Goals and objectives of the program are to increase consumer health education to help people make wise health decisions; to reduce pressures on emergency resources including physicians, Emergency Rooms and other acute care resources; and to reduce or re-allocate financial costs by promoting improved utilization of health care resources across British Columbia. Early evidence to date indicates that all goals and objectives of the program are being met.

Annual operating costs: N/A

Anniversary date: April, 2001

Staffing:

- Ministry level staff: 1 director, 1 medical consultant, 1 nursing consultant, 1 administrative officer (all full-time), contractors on an ad hoc basis for special projects (media strategy; developing communications and other materials; 1-800 line integration feasibility)

- Call Centre: (all full time unless otherwise noted) 1 director (0.5%) ; 1 senior call centre manager; 1 senior nursing practice leader; 5 @ 0.75% program co-ordinators (nurse supervisors); 42 FTE registered nurse positions; telephony and information technology (1.25%).

Others involved: Many other Ministry of Health staff are involved on an ad-hoc basis to provide support for the BC OnLine and printing of the BC HealthGuide Handbook

The BC HealthGuide also has Endorsers from the BC College of Family Physicians; the BC Medical Association; the Registered Nurses Association of BC; and the College of Pharmacists of BC.

Contact(s):

Name:	Lori Halls, MPA
Title:	Director
Phone:	1-250-952-3207
Fax:	1-250-952-1570
Email:	lori.halls@gems2.gov.bc.ca

Name:	Pauline James, RN, BSN, MN
Title:	Nursing Consultant
Phone:	1-250-952-2473
Fax:	1-250-952-1570
Email:	pauline.james@gems3.gov.bc.ca

BC Health Promotion Coalition

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	*	Multi-disciplinary Teams		Developing a Primary Health Care Organization	
Prevention		Specialist Shared Care		Information Systems	
Education	*	Chronic Care		Telehealth	

Other:

Funding of health promotion

Community(ies) served: Site(s)

Community(ies) served	Site(s)
Province-wide network	NA

Description:

GOAL #1: To share the vision and emphasize the value of community-inspired health promotion work in British Columbia

GOAL #2: To create a social movement for funding of health promotion in British Columbia involving the grassroots.

GOAL #3: To develop an evolving, made-in-BC model for an enduring source of funding that advances "the empowerment of communities, their ownership and control of their own endeavours and destinies" (Ottawa Charter for Health Promotion, 1986).

GOAL #4: To implement the made-in-BC model.

The BC Health Promotion Coalition is open to anyone who wishes to be part of our network and organization. Our mailing list includes 175 individuals, groups, non-profit societies, health authorities, federal and provincial ministry contacts and partners throughout BC and beyond.

Key Activities:

1. Development of an organizational profile
2. Creation of an 8-member core planning group that guides and participates in all Coalition activities.
3. Awareness, public education and networking through email contacts, presentations to numerous local, regional and provincial organizations, production of a newsletter, focus groups associated with project work and distribution of the report, "Walking the Talk in Health Promotion: Research from the Margins."

4. Five province-wide meetings of the Coalition with an average attendance of 18 people. Next meeting is November 20th, 2002.
5. Development of working partnerships with the Canadian Mental Health Association – BC Division, the Institute of Health Promotion Research at UBC, the Social Planning and Research Council of BC, the Public Health Association of BC, Central Island Health Service Delivery Area.
6. Completion of the provincial project, "Funding and Prioritizing Health Promotion in Rural British Columbia."
7. Development of a framework for funding community-inspired health promotion.
8. Finalization of the report, "Grassroots Leadership in Health Promotion Funding: A Framework for Action."

Future Plans:

1. Evaluate our progress thus far.
2. Take steps to develop a health promotion foundation in BC.
3. Write a Position Paper for the BC Health Promotion Coalition.
4. Access funds to research and develop a Peer Resource Network in communities across British Columbia.
5. Continue to develop and expand our network of supporters and partners across BC and beyond.
6. Finalize development of the Coalition website.
7. Hold a provincial conference on health promotion by April 2004.
8. The Coalition has been invited to be part of an international network of health promotion foundations.

Annual operating costs: $3,000 annually to cover operating costs + funds acquired through project work.

Anniversary date: June 2000.

Staffing: No paid staff except for project-funded work.

Others involved: Extensive volunteer network and support.

Contact(s):

Name:	Ronnie Phipps
Title:	Researcher and community developer
Phone:	(250) 746-1797
Fax:	(250) 746-0700
Email:	ronnieph@shaw.ca

7. Research Projects

Primary Health Care from Rhetoric to Practice: Collaborative Action for Health & Social Change

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	✓	Multi-disciplinary Teams	✓	Developing a Primary Health Care Organization	✓
Prevention	✓	Specialist Shared Care		Information Systems	✓
Education	✓	Chronic Care	✓	Telehealth	

Community(ies) served:	Site(s)
Victoria & Prince George	University of Victoria, University of Northern BC, James Bay Community Project, Central Interior Native Health Society

Description:

CAHR-PHC is a 5 year ($ 1.3 million) community-based research project funded by Canadian Institutes for Health Research (CIHR). Dr. Marcia Hills, RN, PhD, University of Victoria, is Principal Investigator. The project is focusing on the development of models of health service delivery (practice) that are consistent with the principles of primary health care and which incorporate health promotion, including self-care and social support. The research objectives include:

- Evidence-based development of an integrated, person-centred, holistic framework for PHC in communities that co-ordinates care, encourages individuals to be actively involved in the responsibility for their own health, and includes community self-reliance and self-determination
- Assessment of the value and contribution of community-based research as a means of enhancing the PHC practices of care providers and encouraging community members to enhance control over factors influencing their health
- Development of community capacity through community action projects, thereby contributing to the health of the community
- Involvement of community and policy stakeholders in research activities, to develop a model and promote the viability and sustainability of community health centres; and
- Education of community members, researchers, policy makers and graduate students about community-based research thereby extending the network of competent community researchers.

Annual operating costs: Approximately $225,000 / year

Anniversary date: April, 2001

Staffing: Co-investigators – approximately 21; Various coordinators, research assistants, students

Others involved: Community members, board members, policy-makers, practitioners, academics.

Contact(s):

Name:	Dr. Marcia Hills, RN, PhD
Title:	Professor School of Nursing, Director – Community Health Promotion Coalition, University of Victoria
Phone:	250-472-4102
Email:	mhills@uvic.ca

Health Promotion in Primary Care Settings

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	[ ]	Multi-disciplinary Teams	[x]	Developing a Primary Health Care Organization	[x]
Prevention	[ ]	Specialist Shared Care	[ ]	Information Systems	[ ]
Education	[ ]	Chronic Care	[ ]	Telehealth	[ ]

Community(ies) served:	Site(s)
NATIONAL UBC-based	

Description:

This is a CIHR-funded project to establish the current characteristics of health promotion in primary care settings in Canada. We are about to launch a web-based survey of some 600 settings. The ultimate intent is to create validated indicators that align with identified characteristics, then to create standards for health promotion in primary care settings.

Annual operating costs: $90,000

Anniversary date: April 2002

Staffing: 1 F-T coordinator, 1 part-time research assistant

Others involved: several faculty from UBC and the Canadian Consortium for Health Promotion Research, Health Transition fund people.

Contact(s):

Name:	Dr. James Frankish
Title:	Assoc Director, Assoc Professor, Senior Scholar -- Michael Smith Fdn
Phone:	(604) 822-9205
Fax:	(604) 822-9210
Email:	frankish@interchg.ubc.ca

Research and Development of a Peer Resource Network in Communities across BC

Select the Primary Health Care Renewal Theme area(s) that apply:

Health Promotion	*	Multi-disciplinary Teams	*	Developing a Primary Health Care Organization	
Prevention		Specialist Shared Care		Information Systems	*
Education	*	Chronic Care		Telehealth	

Other:

Empowerment of communities, their ownership and control of their own destinies.

Community(ies) served: Site(s)

Community(ies) served	Site(s)
Provincial scope and beyond	

Description:

This project is open to anyone who wants to participate. The **purpose** is to enhance learning opportunities for individuals, nonprofits and frontline professionals so they can better serve their communities; to strengthen the role of citizens, associations and communities in initiating and responding to social, economic and environmental change.

GOAL#1: Develop and deliver a series of web-based tools for communities across British Columbia that will enhance learning opportunities and support community agencies in achieving their goals.

GOAL#2: Provide a means for sharing skills, knowledge and resources amongst people across BC who are working to improve the health of their communities.

GOAL#3: Develop a system to provide ongoing mentorship and support for community leaders and frontline personnel across BC.

GOAL#4: Increase the understanding of the role that communities have in addressing the social, economic and environmental determinants of health and through this understanding influence policies and decision making.

Key Activities: This is a 3-year project that is divided into 4 phases, each with numerous key activities and anticipated outcomes: a) Project preparation b) Research component c) Project development and delivery d) Project evaluation *Partners are:* a) The Institute of Health Promotion Research at UBC b) The Public Health Association of BC c) The Social Planning and Research Council of BC d) The BC Health Promotion Coalition e) Determination of interested funding partners is underway

Annual operating costs: Approximately $100,000 annually for the duration of the project (3 years).

Anniversary date: Currently accessing funds.

Staffing: Will involve 2 FT positions, 1 half-time position and 2 time-specific contracted positions.

Others involved: Project Guidance Committee on a voluntary basis.

Contact(s):

Name:	Ronnie Phipps
Title:	Researcher and community developer
Phone:	(250) 746-1797
Fax:	(250) 746-0700
Email:	Ronnieph@shaw.ca

Appendix:
Survey Form

Resources for Primary Health Care Renewal

Name of initiative:

For this initiative, **select the Primary Health Care Renewal Theme area(s) that apply**:

Health Promotion	☐	Multi-disciplinary Teams	☐	Developing a Primary Health Care Organization	☐
Prevention	☐	Specialist Shared Care	☐	Information Systems	☐
Education	☐	Chronic Care	☐	Telehealth	☐

Other:

Community(ies) served: Site(s)

Description: Please provide a brief summary of the initiative that describes the goals, population group, key activities, successes identified and future plans (point form would be fine).

Annual operating costs (dollars per year):

Anniversary date (year and month when initiative was launched):

Staffing: numbers, type, % of their time on this initiative:

Others involved (e.g. family members care givers, volunteers):

Contact(s): We are building a learning network. Please identify one or more individuals who could be contacted by those interested in learning more about your initiative(s).

Name:	
Title:	
Phone:	
Fax:	
Email:	

Name:	
Title:	
Phone:	
Fax:	
Email:	