

Healthy People, Healthy Families, Healthy Communities:

A Primary Health Care Framework for Newfoundland and Labrador
2015 - 2025





I am proud to release *Healthy People, Healthy Families, Healthy Communities: a Primary Health Care Framework for Newfoundland and Labrador 2015-2025*. This Framework lays out a vision for a province where individuals, families and communities are supported and empowered to achieve optimal health and well-being within a sustainable health care system.

Primary health care is the essential care that is based in our communities and is often our first point of contact with the health care system. It includes the services and supports that allow us to maintain and improve our physical and mental well-being. Evidence from around the world shows that improved primary health care leads to better health outcomes.

In the fall of 2014, we began a province-wide public consultation process to capture the suggestions of people throughout Newfoundland and Labrador. Through this process we heard many valuable perspectives and insights for delivering the services individuals, families and communities need to lead healthier lives.

Over the last year, the Provincial Government has worked with key partners, including regional health authorities, community groups, primary health care providers and academics from across the province to develop a new plan for primary health care reform. We established a Primary Health Care Advisory Committee that played an invaluable role in helping us translate public feedback and evidence from our research into well-defined goals and objectives that can be achieved as we work to implement the new framework.

As we move forward, the Department of Health and Community Services will continue to work with partners from across government and the health and social sectors to implement the framework for primary health care reform in the province. By working collaboratively, engaging communities, and respecting the knowledge and expertise of health care providers, we can improve the health and well-being of people in Newfoundland and Labrador.

A handwritten signature in blue ink, appearing to read "Steve Kent". The signature is stylized and fluid.

Sincerely,
Steve Kent, M.H.A.
District of Mount Pearl North
Deputy Premier and Minister of Health and Community Services
Government of Newfoundland and Labrador



■■■■ Executive Summary

A Primary Health Care Framework for Newfoundland and Labrador

Newfoundland and Labrador's Primary Health Care Framework lays out a vision where individuals, families, and communities are supported and empowered to achieve optimal health and well-being within a sustainable system. The framework establishes clear goals and objectives to guide the continuation of primary health care reform in Newfoundland and Labrador. These goals and objectives describe the work that needs to be accomplished to fully engage individuals, families and communities, foster increased attachment to primary health care teams, ensure timely access to services, and enhance coordination of health and social services.

As government moves forward with implementing the goals and objectives of the framework, provincial working groups will be tasked with identifying and implementing concrete actions and reforms. Working groups will include representatives from across the Provincial Government, regional health authorities, the health and social sectors, primary health care providers, community members, and individuals with lived experience. These working groups will identify opportunities to implement evidence-based reforms that are meaningful, fiscally responsible, have broad stakeholder support, and have measurable impacts on the health and wellness of the people of the Province.

What is Primary Health Care?

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

Building on Success

Over the last 10 years, the Provincial Government of Newfoundland and Labrador, our regional health authorities, and other partners have engaged in several initiatives that support continued primary health care reform. As Newfoundland and Labrador moves forward in that direction, we will continue to build on the strong foundation we have and continue to engage with the outstanding primary health care providers, community partners, and regional health authorities across the province.

The Case for Primary Health Care Reform

Highly effective primary health care is known to keep individuals, families and communities healthy. Improving population health through changes to the primary health care system can prevent the need for investments in more costly interventions such as surgeries, increased pharmaceutical usage, and hospitalization.

Some of the reasons Newfoundland and Labrador must focus on continuing to reform primary health care include the need to improve health care provider retention, design services for an aging population, reduce growing health care costs, focus on evidence-based promotion and prevention, and ultimately improve population health.

Over the past 20 years, Canadian provinces and countries around the world have continued to reform primary health care. Greater focus has been placed on preventative services available in the community to avoid people becoming so sick that they require acute health care services.

The Social Determinants of Health

The health of individuals, families and communities in Newfoundland and Labrador is shaped less by personal choices than by the social and economic conditions they experience. There is a tremendous body of evidence demonstrating that social factors and experiences are the predominant determinants of health outcomes.

The social determinants of health refer to the social and economic conditions that impact on the health and well-being of individuals, families, and communities. These determinants include education, socioeconomic status, employment, housing, early life experiences, access to social supports, and food security. When people's experience in relation to these determinants is positive, their health and quality of life is improved. Integrating the social determinants of health into new models for primary health care acknowledges the interplay between and impact of these social determinants on our physical and mental health.

Health care provider turnover is expected to increase until 2022. We have the oldest population in Canada. By 2036 31% of the population will be over the age of 65.

We spend \$5,087 per person on health care, \$1,127 more than the Canadian average.

63% of residents have at least one chronic disease.

88% of seniors have one or more chronic diseases.

70% of the population is overweight or obese.

76% of the population does not eat the recommended amount of fruit and vegetables.

What We Heard

The Department of Health and Community Services, with the support of the Office of Public Engagement, consulted with members of the public and stakeholders to determine a clear path forward for primary health care reform. This work included conversations with regional health authorities and health care providers, the establishment of a Primary Health Care Advisory Committee, and an extensive public engagement process. The Primary Health Care Advisory Committee was established in 2014 to provide advice to the Department of Health and Community Services on the development and implementation of a new Primary Health Care framework and related action plans. The Committee consists of representatives from health professions, educational institutions, regional health authorities, regulatory bodies, the general public and government departments.

Ongoing Collaboration

Given the broad nature of primary health care and the scope of the goals and objectives identified within this framework, meaningful and sustained progress can only be achieved through continued collaboration. The Department of Health and Community Services will play a lead role in supporting reform initiatives; however, other stakeholders must be involved. Provincial Government departments and agencies, regional health authorities, members of the Primary Health Care Advisory Committee, health care provider groups, community representatives, educators, and academics will all play a role in defining and developing the actions necessary to continue to reform primary health care in Newfoundland and Labrador.

Goals and Objectives to Guide Action

Based on the strategic directions identified through the engagement process and research from jurisdictions across Canada and around the world, the following goals and objectives have been identified as crucial to improving primary health care in Newfoundland and Labrador.

Goal 1: Engaged individuals, families, and communities sharing responsibility for health promotion and illness and injury prevention, early intervention, and self-management

Objectives:

- 1.1 Engage and support community members in the identification, development and provision of local solutions to local health and wellness issues.
- 1.2 Increase support for health promotion and wellness strategies.
- 1.3 Consider and address the social determinants of health when assessing the ability of an individual, family, or community to meet goals of care or improve health and well-being.
- 1.4 Promote positive mental health and the connection between physical health and mental well-being.
- 1.5 Support individuals, families, and communities to improve health literacy and their ability to take responsibility for proactive management of their health and well-being.

Goal 2: Individuals and families attached to a collaborative primary health care team

Objectives:

- 2.1 Offer a dedicated Health Home where every individual and family can be attached to a health care provider or team that provides access to a comprehensive set of primary health care services and supports.
- 2.2 Expand access to primary health care teams with an appropriate mix of providers working at full scope of practice to meet the needs of the communities they serve.
- 2.3 Develop strong governance, management, and accountability structures for teams.
- 2.4 Expand training so that all primary health care providers have the skills, abilities and knowledge to collaborate as part of a team.
- 2.5 Implement recruitment and retention initiatives to reduce health care provider turnover.

Goal 3: Timely access to comprehensive, person-focused primary health care services and supports

Objectives:

- 3.1 Expand same-day, after-hours and weekend access to health care providers and services.
- 3.2 Include individuals, caregivers and families as partners in decisions surrounding their health and well-being.
- 3.3 Fully utilize appropriate technologies to make services more convenient, reduce barriers to access, and limit the need for travel.

Goal 4: Connected and coordinated services and supports across the health and social sectors

Objectives:

- 4.1 Increase awareness of the health, social, and community services available in local areas.
- 4.2 Develop and implement standard information management systems to facilitate information exchange between elements of the health system.
- 4.3 Support the development and implementation of public policy that improves health and well-being and encompasses the social determinants of health.
- 4.4 Improve communication processes and tools for teams and across the spectrum of care.

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Introduction

Newfoundland and Labrador's Primary Health Care Framework lays out a vision where individuals, families and communities are supported and empowered to achieve optimal health and well-being within a sustainable system. The framework establishes clear goals and objectives to guide the continuation of primary health care reform in Newfoundland and Labrador. These goals and objectives describe the work that needs to be accomplished to fully engage individuals, families and communities, foster increased attachment to primary health care teams, ensure timely access to services, and enhance coordination of health and social services.

The goals and objectives laid out in the framework have been designed to allow for ongoing and incremental changes to the way primary health care services and supports are organized in our province. Continued and meaningful collaboration with a variety of stakeholders will be required in order to design and implement actions that will improve health care provider retention, increase access to community-based services and supports, meet the needs of an aging population, reduce growth in health care costs, focus on evidence-based promotion and prevention, and ultimately improve the health of people across the province.

As the Provincial Government moves forward with implementing the goals and objectives of the framework, provincial working groups will be tasked with identifying and implementing concrete actions and reforms. Working groups will include representatives from the Provincial Government, regional health authorities, the health and social sectors, primary health care providers, community members, and individuals with lived experience. These groups will work with the province and identify opportunities to implement evidence-based reforms that are meaningful, fiscally responsible, have broad stakeholder support, and have measurable impacts on the health and wellness of the people of the province.



|||| What is Primary Health Care?

In Newfoundland and Labrador, primary health care is typically a person's first point of contact with the health care system. It encompasses a range of community-based services essential to maintaining and improving health and well-being throughout an individual's entire lifespan.

Highly effective primary health care should support individuals, families, communities, and the health sector to prevent illness and maintain health. This includes recognizing and working to improve social conditions that have a significant impact on health such as income, housing, education, and environment.

Primary health care is a philosophy for organizing and delivering a range of coordinated and collaborative community-based services that empower individuals, families and communities to take responsibility for their health and well-being. Effective primary health care requires a culture and system designed to be responsive to individual and population health needs.

Primary health care can include interactions with providers such as community volunteers, counsellors, family doctors, occupational therapists, pharmacists, registered nurses, social workers, and others. It includes services that promote health and wellness, prevent illness, treat health issues or injuries, and diagnose and manage chronic health conditions.

Primary health care is essential health care made accessible at a cost which the country and community can afford, with methods that are practical, scientifically sound, and socially acceptable.

Essential primary health care includes health promotion, disease prevention, curative, rehabilitative, and supportive care.

Examples of Primary Health Care Providers Include:

Addictions Counsellors	Health Educators	Psychologists
Chiropractors	Home Support Workers	Registered Nurses
Community Health Nurses	Licensed Practical Nurses	Social Workers
Community Volunteers	Nurse Practitioners	Speech Language Pathologists
Counsellors	Occupational Therapists	
Diabetes Educators	Paramedics	
Dentists	Personal Care Attendants	
Dietitians	Pharmacists	
Family Doctors	Physiotherapists	

Building on Success

As Newfoundland and Labrador moves forward with primary health care reform, we will continue to strive to create real and lasting change for the benefit of all residents of the province. This will require continuing to build on the strong foundation we have and continuing to engage with the outstanding providers, community partners, regional health authorities, and health care professionals working in the province.

Over the last 10 years, the Government of Newfoundland and Labrador, our regional health authorities, and other partners have engaged in several initiatives that support continued primary health care reform. Some of these include:

- Establishment of the Department of Seniors, Wellness and Social Development, with a mandate to bring increased focus to health promotion and wellness;
- Implementation of the Newfoundland and Labrador HealthLine to provide 24/7 access to health advice from a registered nurse;
- Establishment of the *Chronic Disease Self-Management Program*;
- Expansion of pharmacists' scope of practice to allow the administering of influenza immunizations and other medications via injection or inhalation and to permit prescribing for minor ailments;
- Expansion of publicly covered dental services;
- Completion of community health assessments and action plans in various regions of the province;
- Expansion and renovations of our schools of medicine, nursing, and social work; and
- Development of proactive frameworks and strategies, including the *Provincial Healthy Aging Policy Framework*, the *Provincial Wellness Plan*, the *Long-term Care and Community Support Services Strategy*, the *Policy Framework for Chronic Disease Prevention and Management*, the *Population Growth Strategy*, and the *Poverty Reduction Strategy*.

|||| The Case for Primary Health Care Reform

Highly effective primary health care is known to keep individuals, families and communities healthy. Improving population health through reforms to the primary health care system can prevent the need for investments in more costly interventions such as surgeries, increased pharmaceutical usage, and hospitalization.

Some of the reasons Newfoundland and Labrador must focus on continuing to reform primary health care include the need to improve health provider retention, design services for an aging population, reduce growing health care costs, focus on evidence-based promotion and prevention, and ultimately improve population health.

Health Care Provider Retention

Newfoundland and Labrador has high ratios of some primary health care providers, but faces challenges recruiting and retaining others, particularly in rural and remote areas. The province has more registered nurses, licensed practical nurses, social workers, pharmacists, paramedics, dietitians, and family physicians per capita than the Canadian average. By the same measure, the province is below the Canadian average for audiologists, speech language pathologists, occupational therapists, physiotherapists, respiratory therapists, and dentists.

The province has experienced some high turnover rates, particularly among rural family physicians, and registered nurse retirements are projected to continue to increase until the year 2022. High primary health care provider turnover has been shown to negatively affect health outcomes by decreasing continuity of care and diminishing access in affected communities. Improved continuity of care is linked to improved health outcomes and substantial health system savings. Areas of the country that have focused on improving primary health care have demonstrated an ability to increase provider recruitment and retain new graduates.

Aging Population

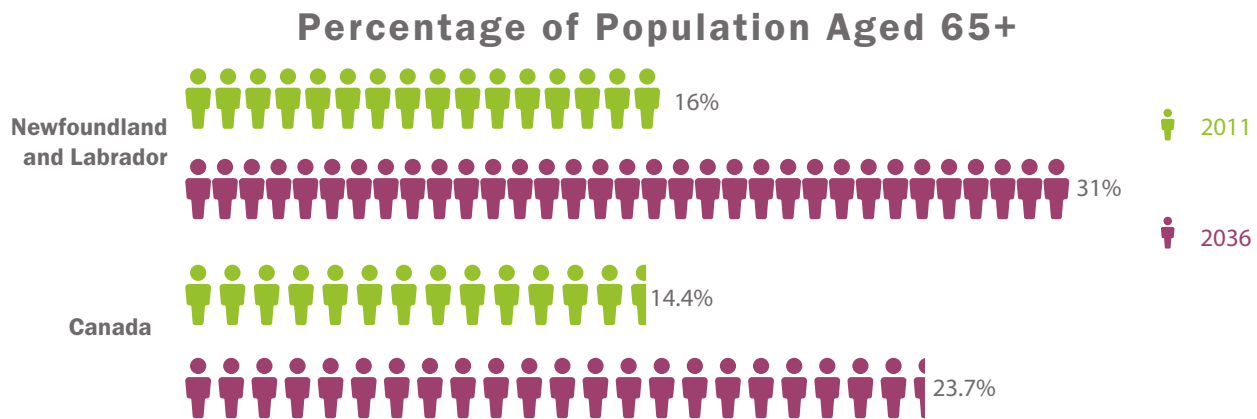
Newfoundland and Labrador's population is aging faster than any other jurisdiction in Canada¹. Out-migration, declining birth rates and longer lifespans have resulted in the oldest median age in Canada and a growing portion of the population is now comprised of individuals over the age of 65. In 2011, 16 per cent of the population was over the age of 65, and that number is projected to jump to 31 per cent by 2036².

Primary health care must adapt to meet the immediate needs of an aging population. Health and well-being are integral to population stability and growth, and include individual needs that go beyond primary health care, such as employment, sense of belonging in a community, and supports to families.

The Population Growth Strategy focuses on four key policy areas that influence people's choices on where to live. These include:

- initiatives to encourage workforce development;
- supports to assist families and individuals of all ages;
- efforts to promote inclusive, safe communities; and
- actions to support immigrant attraction and retention in Newfoundland and Labrador.

As people age, we are more likely to experience health problems, including chronic diseases that require ongoing treatment and management. Thirteen of the 20 most common chronic diseases in Canada are linked to age³. Over 85 per cent of Newfoundland and Labrador seniors, aged 65 or older, have one or more chronic diseases⁴. As the general population continues to age, and people live longer with their health conditions, the rates of chronic disease are expected to rise.



The Department of Seniors, Wellness and Social Development and, in particular, the Divisions of Aging and Seniors, and Healthy Living, have a key role to play in enhancing the well-being of older persons in the Province.

“Healthy aging means that people can make the most of their health and well-being. It is a life-long process that begins at birth. When we all recognize life-long healthy aging, we create a culture of respect for older adults in our Province”. Provincial Healthy Aging Policy Framework

Growing Health Care Costs

The costs of health care services in Newfoundland and Labrador have grown significantly and efforts are needed to ensure the sustainability of our health system for generations to come. Since 2002, provincial health care spending has nearly doubled from \$1.5 billion to almost \$3 billion⁵. The Canadian Institute for Health Information estimated Newfoundland and Labrador health care spending to reach \$6,953 per person in 2014. Of that total, the Canadian Institute for Health Information predicted the Provincial Government health care spending to be \$5,087 per person, which was \$1,127 more than the Canadian average. Much of the difference in costs between health care in Newfoundland and Labrador and the rest of Canada is due to the fact that the province has one of the lowest population densities in the country, one of the highest rates of chronic disease, a rapidly aging population and more overweight and obese individuals than any other province. Although our demographics and geographic distribution will continue to play a role in the province’s health care costs, there are innovative ways to reduce health spending by refocusing on primary health care reform.



Health and Community Services account for 37.5 per cent of the Provincial Government Budget.

A Healthy Dose of Prevention

Continued investment in health promotion and illness and injury prevention initiatives is crucial to improving population health. Health promotion and prevention takes time and often requires intersectoral collaboration, but when done correctly, can radically alter the health of a population and reduce demands on health services.

Recent efforts in Newfoundland and Labrador are already having a significant impact. The proportion of breastfeeding mothers has increased by more than eight per cent in the last 10 years⁶. The number of overweight and obese pre-schoolers is decreasing⁷, and adults are increasingly becoming physically active⁸. Smoking rates have fallen by nearly 10 per cent since 1999⁹ and the number of children exposed to second hand smoke has decreased from 32 per cent in 1999 to just 3.8 per cent in 2010¹⁰. These changes will have a tremendous impact on health and well-being. Continued investment in evidence-based prevention initiatives has the potential to significantly decrease future demand for health services.

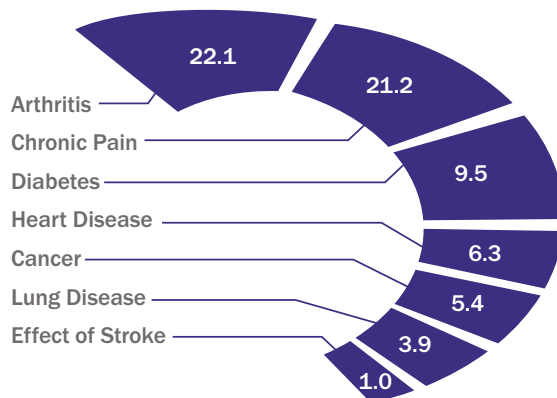
Population Health

Newfoundland and Labrador has some of the lowest rates of physical activity and consumption of fruits and vegetables in Canada¹¹. Over 60 per cent of the adult population has at least one chronic disease such as arthritis, diabetes, heart disease or cancer¹². Almost seventy per cent of people in the province are overweight or obese, 52 per cent are not getting the recommended amount of physical activity, and just 24 per cent are eating the recommended amount of fruits and vegetables¹³. Poor population health indicators are related to high health care costs and contribute to strains on the acute care system.

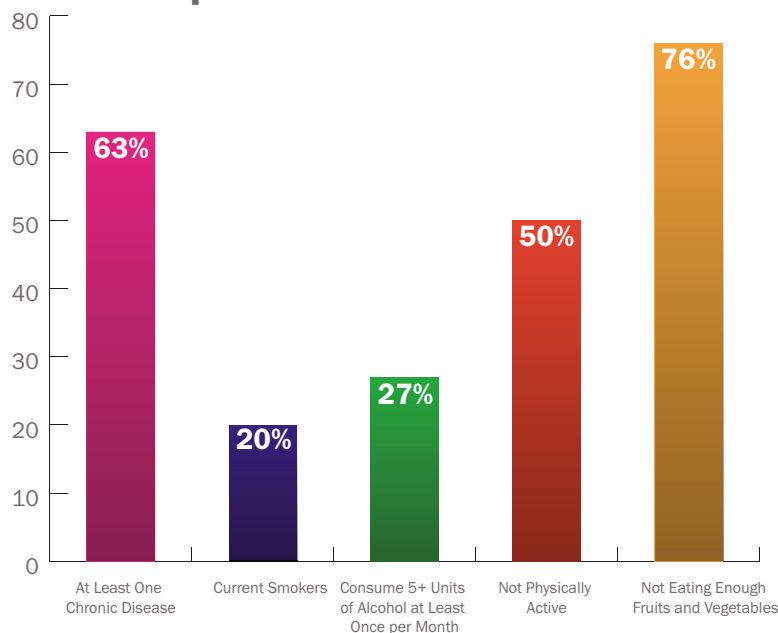
63% of NL residents over the age of 12 have at least one

Chronic Disease

Percent of Adult Population Affected in NL



NL Population Health Indicators



Learning from Best Practices

Over the past 20 years, Canadian provinces and countries around the world have continued to reform primary health care. Greater focus has been placed on preventative services available in the community rather than waiting until people are sick enough that they require acute health care services. Newfoundland and Labrador can learn from the work of other provinces and countries, but there are also excellent examples of primary health care working here in our province.

Engaging individuals, families, and communities to focus on early intervention, prevention and self-management can prevent illness and injury and improve early disease management. By improving recruitment and increasing attachment between individuals and their health care providers we know we can increase continuity of care and improve health outcomes. Connecting and coordinating services and supports across the health and social sectors will allow us to improve care and focus on upstream solutions rather than simply treating symptoms. Improving access to a comprehensive set of services and supports will ensure that every individual, family and community has the supports they need when and where they need them.



Upstream solutions are those that concentrate on fixing or overcoming health challenges before they worsen or ever materialize. This includes exploring preventative approaches designed to keep individuals, families and communities healthy and give them the skills, resources, and supports to achieve optimal health and well-being.

|||| The Social Determinants of Health

The health of individuals, families, and communities in Newfoundland and Labrador is shaped less by personal choices and access to medical treatment than by the social and economic conditions they experience. There is a tremendous body of evidence demonstrating that social factors and experiences are the predominant determinants of health outcomes.

The social determinants of health refer to the social and economic conditions that impact on the health and well-being of individuals, families, and communities. These determinants include education, socioeconomic status, employment, housing, early life experiences, access to social supports, and food security. When people's experience in relation to these determinants is positive, their health and quality of life is improved. Integrating the social determinants of health into new models for primary health care acknowledges the interplay between and impact of these social determinants on our physical and mental health.

As we explore ways to work with individuals, families, communities, and providers to enhance access to primary health care and improve health outcomes, we must fully integrate the social determinants of health into planning and decision making at all levels.

“A health care system—even the best health care system in the world—will be only one of the ingredients that determine whether your life will be long or short, healthy or sick, full of fulfillment, or empty with despair.”

The Honourable Roy Romanow, 2004

The Government of Newfoundland and Labrador's *Poverty Reduction Strategy* takes a social determinants of health approach that compliments the vision of this Primary Health Care Framework.

The three key directions of the *Poverty Reduction Strategy* are to prevent, reduce and alleviate poverty. This work is important to primary health care because poverty and social conditions have been shown to be directly connected to health and well-being.

Social Determinants at a Glance

- | | |
|---|---------------------------------|
| 1. Income and Income Distribution | 8. Social Exclusion |
| 2. Education and Literacy | 9. Social Safety Network |
| 3. Unemployment and Job Security | 10. Health Services |
| 4. Employment and Working Conditions | 11. Aboriginal Status |
| 5. Early Childhood Development | 12. Gender |
| 6. Food Insecurity | 13. Race |
| 7. Housing | 14. Disability |

||||| What We Heard

The Department of Health and Community Services, with the support of the Office of Public Engagement, consulted with members of the public and stakeholders to determine a clear path forward for primary health care reform. This included conversations with regional health authorities and providers, the establishment of a Primary Health Care Advisory Committee, and an extensive public engagement process.

Many issues and solutions identified through these engagement initiatives were not unique to primary health care. Individuals who participated in recent engagement processes to inform the development of a new *Poverty Reduction Strategy Action Plan* and to guide the work of the All-Party Committee on Mental Health and Addictions identified similar issues and solutions. These similarities highlight the fact that poverty and social conditions are directly connected to health and well-being.

Regional Engagement Forums

Between November 2014 and January 2015 members of the public and health sector stakeholders throughout Newfoundland and Labrador were invited to participate in a discussion on the future of primary health care. Facilitated discussion sessions took place in 13 locations across the province. To encourage broad engagement, members of the public were also invited to provide feedback through a number of other methods – by telephone, email, and an online dialogue application. Over 2,400 comments were recorded during the public forums.

Key Findings

The 10 core areas of discussion that emerged from the public engagement process were:

1. **Coordination and Continuity of Care**
2. **Awareness of Services**
3. **Wait Times and Hours of Access**
4. **Prevention and Promotion**
5. **Provider Compensation Models**
6. **Access to Allied Health Professionals**
7. **Proximity to Care**
8. **Community Services and Supports**
9. **Expanded Access/Scope of Practice for Nurse Practitioners and Pharmacists**
10. **Mental Health and Addictions**

Priorities emerging from the Recent Poverty Reduction Strategy Engagement Process included:

- Housing (affordability, appropriateness, and rental regulations)
- Increased supports for vulnerable youth
- Increased supports for vulnerable families with children
- Improved supports for people to work
- Improved access to, awareness and coordination of government services
- Improved access to necessities (transportation, food, adult learning and literacy, prescription medication, and dental services).

Premier's Summit on Health Care

The Premier's Summit on Health Care was held in St. John's on January 14, 2015. The goal of the Summit was to generate ideas and identify tangible actions aimed at improving primary health care in Newfoundland and Labrador. Over 275 content experts, primary health care stakeholders, and members of the public participated.

Key themes from the Summit were clear and included: the importance of utilizing technology, such as Telehealth, to make quality primary health care as efficient and far-reaching as possible; the need for a team approach to primary health care; the importance of education to improving prevention and promotion; and the need for more mental health services and supports. The *Premier's Summit on Health Care: What We Heard* report serves as a starting point for considering the full range of actions and logistical considerations required to enhance primary health care in Newfoundland and Labrador and improve the health of individuals, families and communities across the Province. All suggested actions can be reviewed in the *Premier's Summit: What We Heard* report.

Primary Health Care Advisory Committee

The Primary Health Care Advisory Committee was established in 2014 to provide advice to the Department of Health and Community Services on the development and implementation of a new Primary Health Care framework and related action plans.

Primary Health Care Advisory Committee Membership:

- Association of Allied Health Professionals
- Association of Registered Nurses of Newfoundland and Labrador
- College of Family Physicians of Canada Newfoundland and Labrador Chapter
- College of Physicians and Surgeons of Newfoundland and Labrador
- Newfoundland and Labrador Association of Social Workers
- Newfoundland and Labrador Medical Association
- Newfoundland and Labrador Nurse Practitioner Association
- Paramedic Association of Newfoundland and Labrador
- Pharmacists' Association of Newfoundland and Labrador
- Two Community Representatives
- College of the North Atlantic
- Faculty of Medicine, Memorial University
- School of Pharmacy, Memorial University
- School of Social Work, Memorial University
- Central Health
- Eastern Health
- Labrador-Grenfell Health
- Western Health
- An Evaluation Practitioner
- Newfoundland and Labrador Centre for Health Information
- Department of Health and Community Services
- Department of Seniors, Wellness, and Social Development



■■■■ A Vision for a Healthy Newfoundland and Labrador

Individuals, families and communities are supported and empowered to achieve optimal health and well-being within a sustainable system.

Strong primary health care services and supports are critical to the long-term health of our population and the sustainability of our health care system. Primary health care is a philosophy that must be embraced by our communities, governments and the health and social sectors. This will require a cultural change in how the province will conceive, design, and implement services and supports to maintain and improve health and well-being.

For primary health care reform to be successful, individuals, communities, the Provincial Government, regional health authorities, and health care providers must be willing to implement new approaches while moving away from practices and models that have been shown to be less effective. A willingness to take measured risks, experiment, and discover new and innovative means of improving health and well-being are crucial to fostering a culture of change.

Greater use of evidence-informed and cost-effective approaches to primary health care must be encouraged. Primary health care reform must help to improve population health and the sustainability of our public health care system. Public investments in primary health care must strive to achieve better care, better health, and better value.

Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations.

Public Health Agency of Canada

|||| Principles

As we strive to achieve the goals and objectives described in this document, the following principles will guide the development, implementation, and evaluation of future primary health care initiatives. The principles were developed in consultation with the Primary Health Care Advisory Committee and are based on research and analysis of the core components of highly effective primary health care.

Access

Access refers to the ability of an individual, family or community to receive the right supports, from the right place, at the right time. It includes an approach to organizing services and supports that minimizes unnecessary barriers, aligns with an individual's or family's needs, is available in their local area, is located within a reasonable distance, or available through assistive technologies.

Continuity

Primary health care providers and teams should be encouraged to build long-term relationships with the individuals, families and communities they support. Developing long-term relationships across an individual's lifespan enhances satisfaction with care, avoids unnecessary duplication, enhances quality of care, and improves health outcomes.

Person- Focused

Primary health care services should be provided in the manner that works best for individuals and their families. Service providers must partner with individuals, their families, and the local community to meet a range of health care needs and preferences. This includes ensuring care and supports are inclusive, culturally sensitive and considerate of the beliefs and wishes of each individual.

Collaborative and Team-Based

Each individual and family should have access to a team of primary health care providers working together and at their full scope of practice. This includes health professionals and providers collaborating to increase continuity of care and improving the integration of community-based services.

Processes must be developed to enable inter-professional communication and decision-making that brings together the separate and shared knowledge of various health providers and the individual seeking support to achieve the best possible health outcomes.

Engaged Communities

Community engagement is critical for primary health care planning, implementation, and evaluation. Individuals, families and communities share a responsibility to work with health providers, regional health authorities, and other stakeholders to improve the health of individuals and families. No two communities are exactly the same and improving population health and wellness will require individually tailored solutions.

Coordinated

Highly coordinated primary health care services and supports are key to maximizing the health and wellness of individuals, families and communities. Coordination includes increasing awareness of available supports and ensuring clear communication between individuals, families, providers, community stakeholders, and across the spectrum of primary, secondary, long-term, and tertiary health care. Coordination also includes linkages between the health and social sectors.

Quality Improvement

Ongoing monitoring and evaluation of primary health care services and supports is essential to ensuring quality and supporting the process of continuous quality improvement. Improving the effectiveness of primary health care services and supports, the health outcomes of the population, and the experiences of providers, individuals, families and communities requires ongoing evaluation and continuous improvement.

Comprehensiveness

Comprehensive care encompasses the provision and organization of a full range of services and supports across the spectrum of health and wellness needs. It is a person-focused approach that acknowledges an individual's developmental, physical and mental health; and social needs and does not simply focus on the episodic treatment of specific diseases or illnesses.

Examples of Supports Incorporated into Comprehensive Primary Health Care

Prevention and Promotion

Health promotion and illness and injury prevention must be fully incorporated into all aspects of primary health care. Primary health care must seek to identify causes of illness and injury and target upstream approaches to support health and well-being.

Self-Management

Support for individuals, families and communities to take responsibility for managing and improving their own health is crucial to achieving better population health.

Mental Well-Being

Primary health care can only be successful when the links between physical, developmental and mental well-being are fully acknowledged. Overcoming the stigma connected to mental illness is crucial to reforming primary health care.

|||| Ongoing Collaboration

Given the broad nature of primary health care and the scope of the goals and objectives identified within this framework, meaningful and sustained progress can only be achieved through continued collaboration. The Department of Health and Community Services will play a lead role in supporting reform initiatives; however, other stakeholders must be involved. The Provincial Government departments and agencies, regional health authorities, members of the Primary Health Care Advisory Committee, provider groups, community representatives, educators, and academics will all play a role in defining and developing the actions necessary to continue to reform primary health care in Newfoundland and Labrador.

Interdepartmental

Primary health care and improving population health cannot fall to any one government department or agency on its own. It is the responsibility of all Provincial Government entities to consider the impact their decisions, policies, and programs have on the health and well-being of individuals, families and communities.

As the Department of Health and Community Services moves forward with primary health care reform, it will be essential that other Provincial Government entities including regional health authorities and school boards are active participants. This will require further enhancement of existing working relationships, demonstrating a willingness to work towards common goals, and acknowledging the potential resource and capacity implications of policy changes.

As we strive to implement the goals and objectives described in this framework, it is important to recognize that they complement the goals, actions, objectives, and policy statements contained in other provincial frameworks and strategies. Rather than replicate work that has already been started or completed, this framework is designed to build on and support this progress.

Related Frameworks, Strategies, and Policies

- *Population Growth Strategy*
- *Poverty Reduction Strategy*
- *Provincial Wellness Plan*
- *Recreation and Sport Strategy*
- *Provincial Strategy for the Inclusion of Persons with Disabilities*
- *Strategic Health Workforce Plan*
- *Policy Framework for Chronic Disease Prevention and Management*
- *Provincial Healthy Aging Policy Framework*
- *Working Together for Mental Health*
- *Strategy for Long-Term Care and Community Support Services*
- *Strategy to Reduce Emergency department Wait Times*
- *Caring For Our Future (10-Year Child Care Strategy)*
- *Learning from the Start*

The Department of Seniors, Wellness and Social Development was a key partner in developing the Primary Health Care Framework and played an active role in engaging members of the public, and participating on the Primary Health Care Advisory Committee. The department will play a crucial role in implementing the goals and objective of the framework given its focus on seniors and aging, health promotion, wellness and sport, and its responsibility for the Disability Policy Office and the *Poverty Reduction Strategy*.

Key Government Departments



Frontline Staff and Providers

Without the support and input of frontline staff, regional managers, primary health care providers, and provider groups and associations it will not be possible to move forward with meaningful primary health care reform. The knowledge and expertise of those who provide services and supports on a daily basis must inform future priorities.

Communities

Leveraging the assets, knowledge, and skills at the community level by engaging with community organizations, municipalities, non-profits, and local leaders will be central to continued reform of primary health care. Individuals, families and communities have a responsibility to work with health providers, regional health authorities, and other stakeholders to improve their health and well-being.

Research and Education

Health care educators and researchers have a unique role to play in helping to meet the goals of primary health care reform. Training new primary health care providers, working to improve the skills and knowledge of existing providers and teams, and collaborating to identify new and innovative primary health care approaches are all essential elements of reform. Academics and researchers will also play an important role in helping to monitor and evaluate the implementation of new actions, programs and models.

Public and Private Resources

Although the majority of primary health care providers in Newfoundland and Labrador work in the public sector, many work as independent or private practitioners. Approximately 30 per cent of health care services and supports exist outside of the public sector and the individuals providing these services are a valuable part of the health care system. These providers have a role to play in improving primary health care and should be considered partners in reform.

Structures to Improve Collaboration

There are a number of well-documented ways to improve collaboration and establish formal mechanisms to support intersectoral and interprofessional collaboration. In many cases collaborative structures may already be in place and can be engaged in the work of developing and implementing primary health care reforms.

Examples of providers that often work in the private sector:

Acupuncturists

Dietitians

Physiotherapists

Chiropractors

Paramedics

Psychologists

Dentists

Pharmacists

Inter-Departmental Committees

Inter-Departmental committees are composed of representatives from various Provincial Governmental departments, agencies and sectors. Inter-departmental committees can exist at all levels: at the highest political level (between ministers), at the senior strategic level (between deputy and assistant deputy ministers), or at the technical level (program directors and managers). Committees may consult with the public, service delivery organizations, the community sector, providers, the private sector, and other stakeholders as needed.

Inter-departmental committees may have permanent mandates or be established for a limited time to complete specific tasks. Regardless of the structure of inter-departmental committees, they work best when given a mandate to achieve specific objectives, require active participation from those involved, and have the supports and resources necessary to fulfil their mandates.

Cross-Sector Working Groups

Cross-Sector working groups can achieve significant, sustainable improvements by combining the knowledge and expertise of a diverse group of partners. Working groups may involve stakeholders including Provincial Government departments and agencies, regional health authorities, members of the Primary Health Care Advisory Committee, provider groups, community representatives, educators, and academics. Working groups can aid in understanding the perspectives



of those working in the field and in addressing challenges and barriers to the implementation of policies. Cross-sector working groups should be action oriented, have mandates to provide concrete policy suggestions, and the ability to operationalize and aid in the implementation and evaluation of approved policies and programs.

Community Advisory Committees

A vital component of improving primary health care is community engagement. Community advisory committees can be used as a tool for meaningful public participation and community engagement when they are properly supported and connected to local regional health authorities. Community advisory committees are typically comprised of dedicated community volunteers, primary health care providers and regional health authority representatives. They may also include community leaders, educators, and others from the social sector.

The purpose of community advisory committees is to provide an opportunity for community representatives to work with primary health care providers and regional administrators to assist in planning, implementing and evaluating initiatives to improve the overall health and well-being of the individuals, families, and communities within their geographic area.

In addition to community advisory committees, there are a number of existing structures that can be used to support health and wellness and engage communities. In many areas of Newfoundland and Labrador, Regional Wellness Coalitions have been established. These coalitions can serve as an ideal platform for engaging residents in primary health care reform initiatives.



||||| Goals and Objectives to Guide Action

Based on the strategic directions identified through the Premier's Summit on Health Care, regional engagement sessions, research from jurisdictions across Canada and around the world, and input from a number of stakeholder groups, including the Primary Health Care Advisory Committee, the following goals have been identified:

GOAL 1

Engaged individuals, families, and communities sharing responsibility for health promotion and illness and injury prevention, early intervention, and self-management

GOAL 2

Individuals and families attached to a collaborative primary health care team

GOAL 3

Timely access to comprehensive, person-focused primary health care services and supports

GOAL 4

Connected and coordinated services and supports across the health and social sectors

Each of the four goals is supported by a number of objectives that are designed to be meaningful and measurable. Objectives are placed under the goal to which they have the strongest or most direct link. However, as there are areas of overlap between each of the goals and objectives, they should be viewed as interdependent. For primary health care reform to be successful no one goal or objective can be considered in isolation.

Newfoundland and Labrador's primary health care reform objectives will be achieved through a series of actions. Detailed action plans to support implementation of this framework will be developed collaboratively and implemented incrementally. Working groups will work with the Provincial Government to implement reforms that are meaningful, fiscally responsible, have broad support, and improve the health and wellness of people across the province.

The sample actions described in this framework are designed to provide context and a selection of ideas to be considered when developing future primary health care action plans. Future action plans will not be limited to the examples described in this framework and not all sample actions will necessarily be implemented.

As action plans are developed and implemented, they will be evaluated to determine their effectiveness. Evaluation results will be shared publicly. All actions will be evaluated against their ability to achieve the goals and objectives contained within this framework.



Goal 1: Engaged individuals, families, and communities sharing responsibility for health promotion and illness and injury prevention, early intervention, and self-management

Health promotion and illness and injury prevention approaches are cost effective and the economic benefits are well-documented. We must find ways to shift the focus from the treatment of illness to the promotion of healthy living and proactive self-management. In a province with high rates of chronic disease, obesity, and other poor population health indicators, promotion and prevention will be critical to achieving optimal health and well-being.

Individuals who take an active role in the daily management of their health and well-being generally experience better health and a better quality of life. The people, families and groups living in our communities are an invaluable resource. They have a wealth of skills and knowledge that must be leveraged to improve the health and well-being of those around them.



Objectives:

1.1 Engage and support community members in the identification, development and provision of local solutions to local health and wellness issues.

Community priorities must be recognized and valued as health system priorities. The Provincial Government and regional health authorities must proactively engage communities in primary health care reform. Individuals, families, and communities must be informed and valued participants in improving the way we organize services and supports to achieve optimal health and wellness.

Examples of actions to achieve this objective could include:

- Support the development and ongoing operation of community advisory committees and regional wellness coalitions;
- Engage community advisory committees in developing community profiles that include elements of a needs assessment, health status assessment, and community resource inventory;
- Mobilize and support existing community assets ; and
- Create a “healthy communities” initiative where improvements in community health and well-being are celebrated and rewarded similar to the “Tidy Towns” program.

1.2 Increase support for health promotion and wellness strategies.

Health promotion involves a series of strategies that are required for supporting health and well-being. They include: developing healthy public policies, creating supportive environments, strengthening community action, developing personal skills and reorienting health services. A combination of health promotion strategies provides the most effective approach for enhancing wellness.

Examples of actions to achieve this objective could include:

- Improve public health messaging and ensure people know when they are at risk and how to mitigate and guard against preventable disease, illness and injury;
- Expand and develop evidence-based community programs (fitness, nutrition, wellness, etc.) that fit with the community's health status and demographics;
- Identify and support local health promotion and wellness programs and policies that are already in place and working effectively; and
- Ensure healthy living and wellness is considered and supported in each and every primary health care encounter.

The Government of Newfoundland and Labrador continues to work with and look to the *Provincial Wellness Advisory Council* for its expertise and guidance on the continued implementation and evaluation of the *Provincial Wellness Plan* and to provide strategic advice on wellness issues.

1.3 Consider and address the social determinants of health when assessing the ability of an individual, family or community to meet care goals or improve health and well-being.

As we explore ways to work with individuals, families, communities and health care providers to enhance access to primary health care and improve health outcomes, we must fully integrate the social determinants of health into planning and decision making at all levels. This will require working with Provincial Government departments and agencies. In particular, addressing the social determinants of health will require ongoing engagement with the departments who have a core mandate to reduce poverty.

Examples of actions to achieve this objective could include:

- Support actions and initiatives identified under the Poverty Reduction Strategy;
- Continue to explore options to improve pharmaceutical drug coverage with the goal of universal access;
- Work with all relevant Provincial Government stakeholders to strengthen collaboration and connections with primary health care; and
- Increase services and supports available to at risk and underserved populations.

100,000

people in NL live with a **mental illness**
70% of mental illnesses develop during
childhood and most go undiagnosed

1.4 Promote positive mental health and the connection between physical health and mental well-being.

Primary health care can only be successful when the links between physical, developmental and mental well-being are fully acknowledged. Overcoming the stigma connected to mental illness is crucial to reforming primary health care.

Examples of actions to achieve this objective could include:

- Ensure that mental health is considered and addressed in each and every primary health care encounter;
- Improve early intervention programming for mental illness;
- Ensure a focus on optimal childhood development through early learning environments; and
- Challenge the stigma surrounding mental illness within the health and social sectors and continue to increase public awareness of mental health and addictions.

“Fostering greater connections between health providers and the social sector will improve access for individuals who require additional social supports.” Primary Health Care Advisory Committee Member

1.5 Support individuals, families and communities to improve health literacy and their ability to take responsibility for proactive management of their health and well-being.

Individuals need to be supported and empowered to take control of their own health and well-being.

Examples of actions to achieve this objective could include:

- Develop and distribute accessible and inclusive tools to facilitate self-management and enhance health literacy.
- Explore opportunities to expand the reach of the Provincial Chronic Disease Self-Management Program; and
- Implement principles of advanced health care planning as part of self-management.

Health Literacy has been defined as the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health Literacy means more than being able to read pamphlets and successfully make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment.

World Health Organization, 7th Global Conference on Health Promotion



Chronic Disease Self-Management Program for Newfoundland and Labrador

Improving Health: My Way is a provincially sponsored, free program designed to help people positively manage the daily challenges of living with a chronic condition. Workshops are co-led by trained leaders who themselves have a chronic condition or have cared for someone living with a chronic condition. Workshops consist of six sessions that are offered for 2.5 hours once a week, over a six week period. A support person (friend or family) may accompany a client to the training sessions. Workshops are offered throughout the province, in each of the four regional health authorities.

Goal 2: Individuals and families attached to a collaborative primary health care team

Primary health care reform should work to establish teams of providers that facilitate access to a range of health and social services tailored to meet the needs of the communities they serve. Teams will not follow a standard template or include a predefined group of providers, but will be designed to meet local population health needs. Teams will have the ability to meet changing demands as our population ages and the need for primary health care services increases. They will include a mix of providers that meet the needs of each community and builds on each community's existing strengths, assets and human resource capacity.



Attachment is when a long-term relationship develops between a primary health care provider or primary health care team and an individual. The provider(s) becomes responsible for the majority of the individual's health care needs, improving continuity and coordinating services outside of their scope(s) of practice. Increased attachment has been associated with improved health outcomes and decreased health care costs.

Health care providers, including those working independently or employed by a regional health authority, will be supported and encouraged to practice within primary health care teams. Working in supportive team environments will not only improve care, but will also improve provider recruitment and retention by reducing isolation and creating more dynamic and interactive work places. Effective change will require embracing a set of best practices including an interdisciplinary approach, connecting with available community resources, utilizing electronic record keeping, and participating in training new health care providers.

Objectives:

2.1 Offer a dedicated Health Home where every individual and family can be attached to a provider or team who provides access to a comprehensive set of primary health care services and supports.

A dedicated Health Home is a central hub where individuals and families can access a comprehensive range of services and supports to achieve optimal health and well-being. Health Homes will provide access to primary health care services and connect to other health and social supports required to maintain and improve mental, physical, and social well-being.

A Health Home

- **Fosters continuity of care and attachment to a team of primary health care providers working at full scope of practice**
- **Ensures every individual and family is attached to a family physician who is part of the primary health care team**
- **Provides timely access to a comprehensive set of primary health care services**
- **Coordinates access to a variety of health providers including providers outside of the Health Home**
- **Connects to other aspects of the health and social systems**
- **Responds to the unique needs of each community**
- **Acts as a training site for new providers and health professionals**
- **Utilizes electronic record keeping**
- **Creates a work environment that attracts and retains primary health care providers, thereby enabling the benefits of long-term patient attachment**

Examples of actions to achieve this objective could include:

- Set standards and develop tools to aid teams in adopting the elements of the Health Home concept;
- Inform individuals, families, and communities of what to expect from their Health Home;
- Develop models and best practices that allow Health Homes to colocate at a single site or collaborate across a geographic area; and
- Support independent practitioners in adopting elements of the Health Home concept.



2.2 Expand access to primary health care teams with an appropriate mix of providers working at full scope of practice to meet the needs of the communities they serve.

A variety of providers working together at full scope of practice maximizes efficiency and improves productivity. Enabling all providers to work at their full scope of practice can improve access to meet the needs of communities.

Examples of actions to achieve this objective could include:

- Improve the use of technology to expand virtual access to members of a team (e.g., Telehealth, HealthLine, email consultations);
- Develop, evaluate and refine the core characteristics of teams and the services they will provide to ensure they meet the needs of communities; and
- Compile an inventory of all existing providers and primary health care resources to determine how they can be better organized to meet the needs of the communities they serve.

2.3 Develop strong governance, management, and accountability structures for teams.

In order for providers to work in supportive and cohesive teams, governance and management structures must be well defined and clear to all involved. Issues surrounding shared liability, reporting structures, human resources policies and workplace practices must all be addressed in collaboration with provider representatives and other relevant stakeholders.

Examples of actions to achieve this objective could include:

- Engage with relevant provider associations and unions to ensure compensation models facilitate increased collaboration between primary health care providers;
- Clearly define the reporting and organizational structures of teams;
- Provide clear guidance on the legal and regulatory implications of working within a collaborative team; and
- Put in place resources to facilitate and mentor new collaborative teams.

Various team-based models have been implemented across Canada and around the world. Newfoundland and Labrador can learn from proven models in other jurisdictions as we move to more formally identify team structures in our province.

2.4 Expand training so that all primary health care providers have the skills, abilities and knowledge to collaborate as part of a team.

Understanding how to work in a collaborative interdisciplinary environment is a skill that can be learned. Interdisciplinary training should strive to inform providers of their respective scopes of practice and demonstrate how best to collaborate to meet the needs of the individuals, families and communities they serve. This will require an approach that includes professionals working in other social sectors such as education, income support, economic development and housing as collaborating partners.

Examples of actions to achieve this objective could include:

- Encourage interdisciplinary education so that new graduates understand the scope of practice of other providers;
- Explore options to make training modules available to providers who would like to join a team; and
- Work with the Centre for Collaborative Health Professional Education at Memorial University to enhance provider training opportunities related to team collaboration.

Leveraging Existing Expertise and Knowledge

Building a Better Tomorrow

Building a Better Tomorrow is a series of workshops designed for people working within the health care system. Its purpose is to help develop new skills, gain new insights and increase provider confidence to collaborate in teams with people within and outside of their own professions. Each workshop is 2-3 hours in length. Facilitators work with providers to adjust the timeframes to meet the needs and availability of the specific group or team they are working with.



2.5 Implement recruitment and retention initiatives to reduce health provider turnover.

High primary health care provider turnover has been shown to negatively affect health outcomes by decreasing continuity of care and diminishing access in affected communities. Improved continuity is linked to improved health outcomes and substantial health system savings. Jurisdictions that have focused on improving primary health care have demonstrated an ability to increase provider recruitment and retain local graduates.

Examples of actions to achieve this objective could include:

- Improve recruitment of locally-trained health providers;
- Seek out providers who are interested in the lifestyle and workplace balance often associated with working in rural and remote communities;
- Build contingency plans so that gaps are quickly addressed when there is turnover;
- Ensure that all health provider trainees are exposed to a variety of practice settings and work environments during the course of their training, including rural and remote communities;
- Provide opportunities for rural providers to visit urban centers for training and development of competencies; and
- Provide opportunities for new graduates to work in local interdisciplinary settings.

The **Population Growth Strategy's Workforce Development Action Plan**, and the **Strategic Health Workforce Plan**, both align and support improvements to primary health care by identifying ways to improve health provider recruitment and retention in this province.

Goal 3: Timely access to comprehensive, person-focused primary health care services and supports

Ensuring that every individual, family and community has access to the right supports, from the right place, at the right time will require new models and innovative approaches to organizing services. It will require striking a balance between working with communities to determine population health needs and acknowledging the specific needs and circumstances of individuals and their families.

The organization of specific services may require adjustment as we strive to provide a full range of supports across an individual's or family's spectrum of health and wellness needs throughout their entire lives. New approaches, including the reorganization of services, changes to hours of operation and the use of evolving technologies must all be considered.



Objectives:

3.1 Expand same-day, after-hours and weekend access to health care providers and services.

Primary health care services and supports are often available only during regular business hours and often require a significant wait period. Re-evaluating hours of service may increase access for a great number of individuals and reduce unnecessary barriers associated with visiting a provider. Improving same-day and urgent access may also reduce unnecessary usage of an emergency room and prolonged waits that can negatively impact health and well-being.

Examples of actions to achieve this objective could include:

- Leverage existing community assets, such as pharmacies, to increase access to care after hours;
- Provide after hours on-call services for urgent health needs;
- Increase the range of services available after hours and on weekends to include a mix of providers;
- Support implementation of advanced access models to shorten wait times for access to a provider; and
- Ensure access to health records for providers who provide coverage outside of traditional hours.

Advanced Access offers new ways of scheduling appointments to allow those who need urgent care to get same day access. Advanced Access helps to reduce wait times and enables providers to see more individuals per day.

3.2 Include individuals and families as partners in decisions surrounding their health and well-being.

By including individuals and families in decisions surrounding their health and well-being we are able to better engage them as full partners. This can encourage and inspire people to take charge of their health, provide additional details related to factors that may play a role in their health and well-being, and allow for the development of creative interventions that can lead to sustained improvements in health and well-being.

Examples of actions to achieve this objective could include:

- Broaden the concept of health and well-being when working with individuals and communities to include social determinants and address these as integral to good health;
- Develop tools to help providers engage individuals, their families and caregivers in the creation of care plans that incorporate self-management and a patient oriented approach;
- Develop and implement case management models to be used by primary health care teams; and
- Explore ways to share health information with individuals, their families and caregivers and allow them to easily access or contribute to their own health records.



“I once asked a patient what he thought he needed to get better. He replied that he thought he needed a dog. I was perplexed, but helped him get in touch with the SPCA and adopt a dog.

He started walking his dog and consequently started to lose weight, improve his cardiovascular health and was better able to control his diabetes. His dog did what I couldn’t.”

Physician Stakeholder

3.3 Fully utilize appropriate technologies to make services more convenient, reduce barriers to access, and limit the need for travel.

There are existing technologies such as Telehealth, HealthLine, electronic health records and remote monitoring that can improve the way we access primary health care services and supports. Fully utilizing these and new emerging technologies requires that individuals and providers be trained, supported and authorized to use them.

Examples of actions to achieve this objective could include;

- Increase training on meaningful use of technology;
- Provide support to aid in coordinating the use of technology;
- Ensure payment models allow providers to fully take advantage of available technologies; and
- Use technologies to broaden access to services not traditionally available in small communities.



Goal 4: Connected and coordinated services and supports across the health and social sectors

Improving awareness and leveraging new and existing technologies will be central to better connected and coordinated primary health care. Using technology to increase communication and coordination between providers can improve health outcomes and reduce overlaps in care. These same tools must be implemented to increase communication with other elements of the health care system and social sector.



Supporting the development and implementation of healthy public policy is another way to achieve a coordinated approach to primary health care and focus on prevention and health promotion. Communities, municipalities, employers and other stakeholders all play a role in creating policies and making decisions that ultimately affect health outcomes. A cross-sectoral approach is required to ensure optimal health and well-being.

Objectives:

4.1 Increase awareness of the health, social, and community services available in local areas.

Members of the public and health care providers are sometimes unaware of or unable to find existing health and social services. These services are often in different locations or provided by different groups, departments or agencies. Improving awareness of services will help providers to recommend the best options and reduce barriers to access.

Examples of actions to achieve this objective could include:

- Build and publicize an electronic directory with information on local community services and available primary health care providers;
- Offer individuals who are frequent or high-users of the health care system additional community-based supports to stabilize and improve their health and social well-being;
- Explore innovative ways to expand the use and reach of the Newfoundland and Labrador HealthLine; and
- Increase awareness of provider scopes of practice so that individuals have the knowledge to choose the appropriate provider at the appropriate time.

4.2 Develop and implement standard information management systems to facilitate information exchange between elements of the health system.

Over the last number of years, numerous health information management systems have been introduced in Newfoundland and Labrador. These include the Pharmacy Network, the Client Referral Management System, electronic medical records, and electronic health records. Linking systems and allowing for increased communication between and across providers, while balancing privacy concerns, will allow for increased coordination.

Examples of actions to achieve this objective could include:

- Continue work to implement a single electronic medical record that will be available across the entire province;
- Ensure all providers have access to a form of electronic record keeping that is linked to and shares information with other health information systems;
- Support meaningful use of health information technology; and
- Continue to improve mechanisms for sharing of information across the health, education and social sectors, while considering informed consent and confidentiality.

4.3 Support the development and implementation of public policy that improves health and well-being and encompasses the social determinants of health.

Improving population health through primary health care is a task that will require participation from a wide variety of stakeholders. To achieve success, all stakeholders must be encouraged and empowered to actively support the implementation of health and social sector policies, frameworks, and strategies designed to improve health and well-being.

Examples of actions to achieve this objective could include:

- Coordinate investments in health and social policy across government departments and agencies;
- Explore options to develop a Provincial Government wide Health-In-All Policies Framework;
- Develop formal structures to facilitate ongoing interdepartmental collaboration;
- Work across departments and with community stakeholders to streamline service delivery, reduce redundancy and increase alignment; and
- Encourage the creation of healthy built environments and address population health needs when investing in Provincial Government supported infrastructure.

4.4 Improve communication processes and tools for teams and across the spectrum of care.

Different providers often service the same community or work directly with the same individuals and families. Improving the means for these providers to better communicate with each other is a crucial step towards better integrated primary health care and the establishment of functional teams.

In some cases, there are legitimate privacy and confidentiality restrictions that limit what information providers can share. These restrictions protect our privacy and improved communications between providers and the health and social sector must respect individual wishes, privacy, and personal health information legislation.

Examples of actions to achieve this objective could include:

- Develop tools and processes for coordinating care so that it is convenient for individuals and families;
- Connect primary health care providers to other parts of the health care system and help to facilitate the development of improved processes for individuals transitioning through the continuum of care;
- Support the ongoing development of a shared electronic health record and electronic medical record and explore options to connect health information technology with the social sector; and
- Develop and implement protocols for timely sharing of confidential client information, when needed, to enhance client care.



Taking Action

As the Department of Health and Community Services works to achieve the goals and objectives contained in this framework, we will partner with a range of stakeholders from the Provincial Government and the health, education and social sectors. Together with these partners, we will identify opportunities for reform and develop concrete action plans and tools to support primary health care.

The role of the Department of Health and Community Services will be to support and lead reform initiatives, but without the involvement of a wide variety of stakeholders it will not be possible to improve the health and well-being of people in the Province. Partners including Provincial Government departments and agencies, regional health authorities, members of the Primary Health Care Advisory Committee, provider groups, community representatives, educators, and academics will all play a crucial role in defining and developing the actions necessary to continue to reform primary health care in Newfoundland and Labrador.

The Department of Health and Community Services will establish and support a number of working groups who will be tasked with the development of prioritized actions for implementation. A focus will be placed on the foundational building blocks required to accelerate reform efforts and overcome barriers. Whenever feasible, actions that have broad stakeholder support will be prioritized. The advice of these working groups will be used to create formal action plans, evaluation plans and an accountability framework.

To aid in this process, in addition to ad hoc committees, the following working groups will be established:

- **Recruitment and Retention of Primary Health Care Providers**
- **Coordination of Service**
- **Models of Team-Based Care and Defining the Health Home**
- **Scopes of Practice and Provider Responsibilities**
- **Meaningful Community Engagement**
- **Prevention, Promotion and Self-Management**
- **Evaluation and Accountability**

Measuring Success

Fundamental to implementing the Primary Health Care Framework is the corresponding planning and execution of monitoring and evaluation activities. Ongoing monitoring, evaluation and reporting will support continued improvements and maintain accountability. It will also help to ensure that activities are implemented as planned, outputs are measured, and, ultimately, intended outcomes are realized. Only through evidence-based results can effectiveness of the framework be determined.

Evaluating the success of the framework requires establishing up front what we want to learn from the evaluation and publicly reporting what we learn to inform a process of continuous improvement. As the Primary Health Care Framework sets out the high level goals and objectives of primary health care reform, the following overarching evaluation questions form the foundation of the evaluation:

- 1. Are more residents of Newfoundland and Labrador attached to a regular primary health care provider or team?**
- 2. Has health provider turnover been reduced?**
- 3. Do residents of Newfoundland and Labrador have improved access to comprehensive primary health care?**
- 4. Does Newfoundland and Labrador have a collaborative team-based approach to primary health care?**
- 5. Are primary health care services and supports coordinated across the health and social sectors?**
- 6. Are communities sharing the responsibility for improving health?**
- 7. Are residents of Newfoundland and Labrador experiencing better health outcomes?**
- 8. Is the primary health care system accountable?**
- 9. Does sufficient leadership capacity exist to maintain primary health care reform initiatives?**
- 10. Are changes to primary health care providing a return on investment?**



These high level questions identify the fundamental areas for evaluation. As action plans are developed, companion evaluation plans with more specific evaluation questions will be designed to determine the effectiveness of these actions. The evaluation plans will include indicators for each action, and will encompass activity (i.e., actions) and output (i.e., products) measures as well as those for anticipated short and long-term outcomes (i.e., changes). Evaluation during the first several years of implementation may consist primarily of activity and output indicators, building each year to include more results on short term health system measures and ultimately longer term health outcome measures.

The core evaluation questions provide, in a broader sense, a guide for how the overall framework will be evaluated. Annual Primary Health Care Framework status reports will be made publicly available and provide evaluation results for each action undertaken. As action plans will align with the overall framework, progress towards achieving the high level goals and objectives will also be reported regularly. At the end of the strategy implementation timeframe in 2025, the cumulative results of the status reports will help answer the overarching evaluation questions.

Sample Core Indicators

- Population with a regular primary health care provider
- Primary health care provider supply
- Population with a regular primary health care provider
- Wait time for immediate care of a minor health problem
- Obesity rate
- Physical activity rate
- Fruit and vegetable consumption
- Ambulatory care sensitive conditions hospitalization rate
- Hospitalized heart attacks and strokes
- Avoidable deaths (from preventable and treatable causes)
- Birth outcomes
- Child development outcomes
- Age adjusted public spending per person

Glossary of Terms

Accountability

Accountability is the ownership of conferred responsibilities, combined with an obligation to report to a higher authority on the discharge of these responsibilities and on the results obtained.

Advanced Care Planning

Advanced Care Planning is a process of planning for future medical care in the event that an individual is unable to make their own decisions. During this process, individuals and families explore, discuss, articulate, and document their preferences.

Allied Health Professionals

Allied Health Professionals include a large and diverse group of health care professionals and providers working in the private and public sector. The term is used broadly to include most providers working within the health care system, but typically excludes nurses, nurse practitioners, doctors, and dentists.

Attachment

Attachment is when a long-term relationship develops between a primary health care provider or primary health care team and an individual. The provider(s) become responsible for the majority of the individual's health care needs, improving continuity and coordinating services outside of their scope(s) of practice. Increased attachment has been associated with improved health outcomes and decreased health care costs.

Community

Community is used, in this document, to refer to a broad group of individuals, organizations, and institutions that comprise a community. It should not be interpreted as referring to a specific geographic location, town or city.

Community Development

Community Development is a process involving a partnership among community members or groups to build the community's strengths, self-sufficiency, and well-being, and to solve local problems. This process enables the community to make decisions, and to plan, design, and implement strategies to achieve better health.

Community Health Assessment

A Community Health Assessment is an ongoing process undertaken to identify the strengths and needs of the population, to enable community-wide establishment of health priorities, and to facilitate collaborative action planning directed at improving community health status and quality of life. It provides baseline information about the health status of community residents, encourages collaboration with community members, stakeholders, and a wide variety of partners involved in decision-making processes within the health care system, tracks health outcomes over time, and helps to identify opportunities for disease prevention, health promotion and health protection.¹⁴

Continuity

Continuity is the provision of uninterrupted services that are coordinated within and across programs and organizations, as well as during the transition between levels of services, across the continuum, over time.¹⁵

Continuum of Care

Continuum of Care is a concept involving an integrated system of care that guides and tracks a patient over time through a comprehensive array of health services spanning all levels of intensity of care and the full lifespan of the individual.¹⁶

Continuum of Services

Continuum of Services is an integrated and seamless system of settings, services, service providers, and service levels to meet the needs of clients or defined populations. Elements of the continuum are: self-care, prevention and promotion, short-term care and service, continuing care and services, rehabilitation, and support.¹⁷

Electronic Health Record (EHR)

An Electronic Health Record (EHR) is a secure and private record of a person's health care information, available electronically to their authorized health care professionals. An EHR is designed to facilitate better sharing and interpretation of health information among the health professionals involved in providing care.¹⁸

Electronic Medical Record (EMR)

An Electronic Medical Record (EMR) is a computer-based medical record specific to one provider's (e.g. physician or nurse practitioner) practice or organization. It is the record providers maintain on their own patients, and which details medical and drug history, and diagnostic information such as laboratory results and findings from diagnostic imaging. It is often integrated with other software that manages activities such as billing and scheduling.

Family Physician

Family Physician is used in this document to describe all physicians practicing family medicine. This includes accredited family physicians and general practitioners.

Family Resource Centres

Family Resource Centres provide a variety of community-based activities and resources for children and families that emphasize early childhood development and parenting support. They provide a place for families to gather in a friendly and informal setting.

Food Security

Food Security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life.¹⁹

HealthLine

The HealthLine is a confidential and free telephone line staffed by experienced registered nurses. It is available to all residents of Newfoundland and Labrador and accessible 24 hours a day by calling 811.

Healthy Baby Club

Healthy Baby Club is a prenatal nutrition support program offered by family resource centres for eligible women who may need extra support during and after their pregnancy.

Health Promotion

Health Promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.²⁰

Improving Health: My Way

Improving Health: My Way is a provincially-sponsored, free program designed to help people positively manage the daily challenges of living with a chronic condition. Workshops are co-led by trained leaders who have a chronic condition or have cared for someone living with a chronic condition.

Inclusion

Inclusion means having access and choices on an equal basis with others. This includes access to opportunities or events that happen within any community, such as educational, employment, civic, recreational, cultural and political opportunities.

Interdisciplinary Primary Health Care

Interdisciplinary Primary Health Care is an approach to primary health care delivery which emphasizes coordinated services and supports provided by a team of primary health care providers who work collaboratively and share responsibility for the population they serve.²¹

Intersectoral Collaboration

Intersectoral Collaboration is the establishment of formal linkages between individuals and organizations from different sectors of society. This can include individual stakeholders, government entities, communities, non-profit groups, and others. These linkages are formed to enable partners to take action on issues of mutual interest or concern.

Lived Experience

Lived Experience is knowledge and experiences gained from personal, direct, first-hand involvement. In the health care setting this is typically someone who has lived with an illness or injury or supported a family member who has lived with an illness or injury.

Nurse Practitioner

Nurse Practitioners are registered nurses with additional education and experience who are able to order and interpret diagnostic tests, communicate diagnoses, prescribe pharmaceuticals and perform specific procedures.

Population Health

Population Health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health.²²

Primary Health Care Provider

Primary Health Care Providers are the health care workers, professionals, and volunteers who help individuals, families and communities maintain and improve health and well-being. Primary health care providers include those working in primary care, public health, health promotion and other community based health care roles.

Public Health

Public Health refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases.

Scope of Practice

Scope of practice refers to the range of activities that a qualified practitioner of an occupation may undertake. It establishes the boundaries of an occupation, especially in relation to other occupations where similar activities may be performed. The scope of practice for an occupation may be established through governing legislation or through internal policies adopted by a regulatory body.

Self-Management

Self-Management occurs when individuals are empowered to become the managers of their own health and well-being. This has been shown to slow the progression of disease, often prevents complications and/or disabilities, and may also reduce the number of hospital visits.²³

Self-Management Leaders

Self-Management Leaders are volunteers who act as workshop leaders for the *Improving Health: My Way Chronic Disease Self-Management Program*. These trained leaders are themselves living with a chronic condition or have cared for someone living with a chronic condition.

Social Determinants of Health

The Social Determinants of Health are the social and economic conditions that impact on the health and well-being of individuals, families and communities. These determinants include education, socioeconomic status, employment, housing, early life experiences, access to social supports, and food security

Telehealth

Telehealth is the use of communications and information technology to deliver health care services over large and small distances, including remote and rural areas.

Endnotes

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