

THE COLLEGE OF
FAMILY PHYSICIANS
OF CANADA



LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA



Innovation in Primary Care:

Caring for Unattached
and Marginalized Patients

March 2018





INTRODUCTION:

Innovative care for unattached and marginalized patients

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA (CFPC) is pleased to release the second issue in its *Innovation in Primary Care* series. The series aims to foster collaboration, sharing, and learning among family physicians in different provinces and territories.

It is evident from the case submissions the CFPC received for consideration that “unattached” could refer to many different segments of the patient population—ranging from newborn/early childhood to those with complex or highly specialized needs to those who are vulnerable, socially isolated, impoverished, or homeless. System innovation can help find ways to improve health care delivery to ensure that everyone in Canada has equitable access to high-quality, patient-centred, and coordinated care, including those without a primary care provider.

The substantial role of collaboration and building relationships across disciplines in creating value and producing beneficial outcomes is also apparent. Innovation requires knowing what's available, understanding who to talk to, and being open to looking beyond the usual circles to find others in your community who might have different ideas about how to solve a problem.

In this issue of the *Innovation in Primary Care* series, unique models and practices of care are highlighted across the range of circumstances that leave patients unattached and/or marginalized. The cases from Alberta, British Columbia, Newfoundland and Labrador, Ontario, and Quebec are presented under sub-themes to reflect this range.



Caring for Complex, High-Needs Patients in Alberta

Attachment for patients who are frequent users of health care services

What needed improvement?

Patients with complex needs benefit from coordinated, continuing care provided by an enhanced interdisciplinary team. However, standard funding and resource allocation in the traditional setting are often inadequate for serving these patients. Chronic physical and mental illness, poverty, and social isolation make it difficult to attach them to primary care providers. These patients often become medical nomads, receiving disjointed, episodic care in walk-in clinics, urgent care clinics, and emergency rooms. This reactive and problem-specific care is costly and fails to address underlying determinants of health and well-being, and in the meantime patients continue to decline.

In Alberta, adults who use emergency departments and 911/emergency medical services (EMS) for their primary health care needs had few options for coordinated support and follow-up. They may have seen individual health care providers for specific health and/or mental health issues, but they did not receive coordinated or comprehensive health care services on an ongoing basis.

What was done to help the situation?

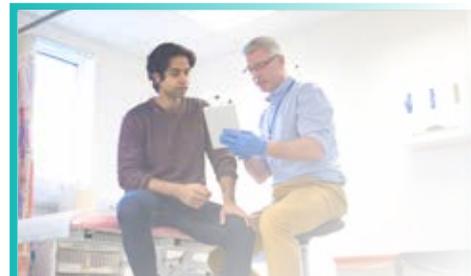
Alberta Health Services and some of its Primary Care Networks (PCNs) developed community partnerships and collaborated with stakeholders to support this population in overcoming barriers to accessing the health care system. Two initiatives that demonstrate this are highlighted below.

- A model for adult frequent users of health care and emergency departments was developed and initiated with partnership support from the [Edmonton Oliver PCN](#), [Homeward Trust](#) (a not-for-profit organization working to end homelessness), and [Alberta Health Services EMS](#). The model was designed with a two-pronged approach:
 - o A patient can receive a direct referral from a Homeward Trust caseworker to the Edmonton Oliver PCN Mental Health Navigator, who assesses the patient's needs and then works to attach the patient to a primary care physician within their neighbourhood to promote a true medical home for the patient.

- o When a patient calls 911 within the downtown core, a paramedic from the [Edmonton Community Paramedic Program's City Center Paramedic Response Unit](#) is attached to the event along with an ambulance. If the patient meets criteria to be seen by a primary care physician and agrees to be seen in a clinic, the community paramedic assumes care of the patient and arranges directly with primary care clinics in the Edmonton Oliver PCN to attach the patient to a primary care physician instead of taking them to the emergency department. This frees up front-line ambulances to respond to other emergencies and decreases emergency department visits.

Although this model has been in place only since August 2017, the hope is that service attachment for frequent users of the health system will provide this population with access to timely, patient-centred, and coordinated medical care. Considerable work remains to be done to increase capacity in all aspects to meet the growing demand for services. Evaluation is ongoing.

- Alberta Health Services established the [East Calgary Family Care Clinic](#) in 2010; while it was initially open to all, it now focuses on serving patients who have multiple medical and psychosocial issues. The clinic's customized approach was featured in [Avenue Calgary magazine](#) in 2013.* The clinic's patients can get many of the services they require at one location, with coordinated care provided by an interdisciplinary team. Case managers are assigned to the patients with the most complex needs to coordinate their care. The clinic works cooperatively with its local PCN ([Mosaic PCN](#)), eventually transitioning some of its patients with less complex needs to the community for care and taking in others from the community and hospital.



WHAT WAS GAINED?

- Patients with complex needs are managed more effectively when they receive coordinated, comprehensive, interdisciplinary care and follow-up in a medical home, rather than disjointed, episodic care through emergency departments and hospitalizations
- Physicians are less burdened with managing aspects of care in which they lack expertise

*Beneteau, G. Big Idea: Family Care Clinics. *Avenue Calgary*. 2013. Available from: www.avenucalgary.com/August-2013/Big-Idea-Family-Care-Clinics/. Accessed 2017 Dec 13.

WHAT WAS LEARNED?

Inappropriate reliance on costly short-term, crisis-driven care by patients with complex needs can be reduced by finding creative ways to improve the allotment of resources through the coordination of health care services and professionals.

TO FIND OUT MORE ABOUT THESE INITIATIVES, CONTACT:

Tanya Kendall, Clinical Manager,
Edmonton Oliver Primary Care Network
Email: tkendall@edmontonoliverpcn.com

Dr. Brian Cornelson, Medical Director,
East Calgary Family Care Clinic
Email: Brian.Cornelson@ahs.ca

CFPC LOCAL CHAPTER CONTACT INFORMATION:

Terri Potter, Executive Director, Alberta College of Family Physicians
Email: terri.potter@acfp.ca

Maternal and Perinatal Health Care in Quebec

La Maison Bleue: An innovative model for perinatal and early childhood care

What needed improvement?

Many children in Montreal, Quebec, are born to and raised in families living in vulnerable situations and with multiple, complex needs. Issues facing these families include poverty, unwanted pregnancy, social isolation, mental health problems, addiction, abuse, neglect, violence, and precarious immigration status. In the health care system it is often difficult for providers to maintain relationships with these families, which can result in the families experiencing gaps in access to the psychosocial and health services they need. A lack of awareness, fear of the system, and/or accessibility issues often mean that these families miss out on the preventive care and continuity of care required to support healthy childhood development.



The opportunity for a new life



Images courtesy of La Maison Bleue

What was done to help the situation?

Dr. Vania Jimenez and her daughter Amélie Sigouin, an early childhood practitioner, founded [La Maison Bleue](#) in 2007 to provide care to families living in vulnerable circumstances, specifically during the perinatal and early childhood stages. The model aims to reduce social inequalities and have a positive impact on the development and life trajectories of children. The “social” perinatal care offered at La Maison Bleue allows staff members to intervene in a family’s life at the time of pregnancy and provide services that go far beyond medical care. The services are offered to pregnant women and to children up to age five, and are shared and supported by a multidisciplinary team composed of family physicians, a midwife, a nurse, a social worker, and specialized educators. This practice aligns with the [Patient’s Medical Home](#) vision of care that is centred on individual patients’ needs, located within their communities, and integrated with other health services. The team offers comprehensive and preventive care adapted to the needs of families while respecting physical, psychological, social, and cultural considerations. Integrated services are offered under one roof, in a warm and supportive environment, and provided entirely by the public health care system thanks to service agreements with an Integrated University Health and Social Services Centre and a family medicine group.

WHAT WAS GAINED?

La Maison Bleue provides preventive perinatal and early childhood services for marginalized patients who likely would not have this access otherwise. The care team has treated approximately 4,000 people (mothers, babies, older children, partners) since 2007 and La Maison Bleue now has three locations in Montreal. This model of care equips vulnerable families with the tools they need to take charge of their own well-being and has had a meaningful impact on its users—a conclusion also reached in the evaluative research study *Évaluation de la mise en œuvre, des effets et de la valeur économique de La Maison Bleue*.[†] Some primary findings from the report that highlight La Maison Bleue's positive outcomes include:



- Achievement of childhood health indicators that are better than the Quebec average:
 - A rate of **3.9 per cent** of babies born underweight, versus **5.7 per cent** (Quebec average)
 - A premature birth rate of **6.3 per cent**, versus **7.1 per cent** (Quebec average)
- Improvements in pregnancy, delivery, and parenting experiences thanks to an adapted approach to physical and psychosocial health
- Development of self-help resources for families: group meetings, special outings, and supports that help them confidently interact with government services and community resources
- Connection with and retention of service users who otherwise would not have access to the health care system
- Optimization of existing resources that increase accessibility and reduce cost

[†]Dubois N, Brousselle A, Hassan G, Laurin I, Lemire M, Tchouaket E. *Évaluation de la mise en œuvre, des effets et de la valeur économique de La Maison Bleue*. Montreal, QC: Agence de la santé et des services sociaux de Montréal; 2014. Available from: www.maisonbleue.info/images/6-Publications/Evaluation-La-Maison-Bleue-2015.pdf. Accessed 2017 Dec 13.

WHAT WAS LEARNED?

La Maison Bleue's interdisciplinary model of care for families living in vulnerable circumstances is effective. It can be replicated thanks to a collaborative approach that is both flexible and stable, promotes empowerment of the family, is rooted in an interdisciplinary practice, and leverages the expertise of engaged health care, social work, and education professionals, while serving as a gateway to additional resources. Early intervention, ongoing screening, continual follow-up, and an understanding of the challenges faced by the users are key to caring for this population.

TO FIND OUT MORE ABOUT THIS CASE, CONTACT:

Pascale Rolland,
Communications Manager,
La Maison Bleue
Email: pascale.rolland@maisonbleue.info

CFPC LOCAL CHAPTER CONTACT INFORMATION:

Nicole Cloutier,
Executive Director,
Quebec College of
Family Physicians
Email: dg@cqmf.qc.ca

Refugee Health Care in Ontario

A sudden surge in refugee health care needs: Innovative practices to support a humanistic approach

What needed improvement?

By the end of 2016 more than 65 million people were living as refugees or displaced persons worldwide[‡]—in 2016 Canada resettled 46,700 government-assisted and privately sponsored refugees.[§] The City of Ottawa typically resettles 800 government- and privately sponsored refugees annually. However, the city received 2,000 Syrian refugees in early 2016 alone and thus required an innovative approach to ensure these people had timely access to high-quality care. Many Syrian refugees experienced trauma during the Syrian civil war, necessitating an approach to care that focused on mental health and included sufficient translation services.



65,000,000

THE TOTAL NUMBER OF
PEOPLE LIVING AS REFUGEES
OR DISPLACED PERSONS
WORLDWIDE IN 2016

What was done to help the situation?

Refugee613, a coalition of housing, education, and health care organizations, was created in fall 2015 in anticipation of this pending refugee intake. The goal was to make use of existing resources and to inform and connect key stakeholders in refugee resettlement. Task forces focused on primary care and mental health needs.

The primary care group used templates based on Canadian [guidelines for screening immigrants and refugees](#)** published in 2011 to ensure that new arrivals received an initial medical assessment. More than 90 per cent of the Syrian newcomers received an initial medical assessment; efforts were then made to link them with community family physicians. The mental health team focused on how best to manage the acute mental health needs of the Syrians and to plan for the increase in needs over the subsequent months. Some approaches applied to improve the existing model included:

- Holding weekly psychiatry clinics at the Ottawa Newcomer Clinic, the central hub for many refugees arriving in the city
- Offering a peer support program through the Ottawa Community Immigrant Services Organization, where Arabic-speaking individuals would be paired up with those in need
- Having family physicians at the Bruyère Academic Family Health Team begin to use narrative exposure therapy, an emerging therapy for patients with post-traumatic stress disorder; family physicians are also training first-year medical students to use this tool as part of their community service learning requirement
- Having cultural navigators work with the medical team and act as liaisons between the newcomers and the health care providers—this was an indispensable resource since many Syrians would not disclose mental health trauma to their doctors but felt secure doing so with the cultural navigators

The Ottawa community was well positioned to respond to this surge of refugees due to existing relationships at the medical school and with settlement agencies. Many international medical graduates with Arabic language interpretation abilities volunteered to fill gaps identified in early stages and ensure medical assessments occurred in a timely manner. Existing networks of practitioners and settlement workers acted collaboratively and iteratively to report statistics and qualitative findings to the government. These reports advocated for additional strategic resources for the mass resettlement of refugees.

[‡]United Nations High Commissioner for Refugees. *Global Trends: Forced Displacement in 2016*. Geneva, Switzerland: United Nations High Commissioner for Refugees; 2017. Available from: www.unhcr.org/5943e8a34.pdf. Accessed 2018 Jan 30.

[§]UNHCR Canada. *Canada's 2016 Record High Level of Resettlement Praised by UNHCR* [news release]. Ottawa, ON: UNHCR Canada; 2017. Available from: www.unhcr.ca/news/canadas-2016-record-high-level-resettlement-praised-unhcr. Accessed 2018 Jan 30.

**Pottie K, Greenaway C, Freightner J, Welch V, Swinkels H, Rashid M, et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ*. 2011;183(12): E824-E830. Available from: www.cmaj.ca/content/cmaj/183/12/E824.full.pdf. Accessed 2017 Dec 13.



WHAT WAS GAINED?

- Considering the unique needs of an incoming cohort in advance of their arrival allowed providers to use existing resources efficiently to meet those needs
- Linking the Local Health Integration Network with Ottawa Language Access (a service supporting providers who care for refugees and other immigrants) means that interpretive services are now available to Community Health Centres and Family Health Teams in the region
- Focusing on mental health services delivery has led to the development of innovative programs that relieved some of the strain on the system and have the potential to do more
- Engaging medical students empowered them to be part of the solution through their experiences with community service learning, ultimately leading to greater social accountability among the future physicians

WHAT WAS LEARNED?

Appropriate planning efficiently addressed inadequacies in a system faced with increased demand. It is important to know the full range of services available in your community to develop creative new approaches for solutions with existing resources—that is, knowing what is available and what relationships can be fostered to make things happen. With the proper training and support from qualified practitioners, mental health services can be delivered by peer support workers, settlement staff, social workers, and other non-medical personnel, increasing their reach. Involving medical learners ensures the sustainability of these services in the future.

TO FIND OUT MORE ABOUT THIS CASE, CONTACT:

Dr. Doug Gruner,
Bruyère Academic
Family Health Team
Email: DGruner@bruyere.org

CFPC LOCAL CHAPTER CONTACT INFORMATION:

Leanne Clarke,
Chief Executive Officer,
Ontario College
of Family Physicians
Email: lclarke@ocfp.on.ca

Community Care for Marginalized and Socially Excluded Orphan Patients in Quebec

The SPOT community health and teaching clinic

What needed improvement?

In the downtown neighbourhoods of Québec, Quebec, better access to more compassionate care was needed for orphan patients—particularly those who are disconnected from services, socially excluded, and living in poverty. This would require improving interprofessional collaboration to break down silos and develop solidarity; providing training for future physicians to help them better understand the social determinants of health by exposing students to the life circumstances of these patients; and addressing prejudices in caring for this patient population.



SPOT Clinic team members.
Photo by Sylviane Robini, courtesy of the Spot Clinic.

What was done to help the situation?

The SPOT Clinic, a non-profit organization, was established in February 2014 to improve the health status of disconnected and marginalized patients and train a new generation of professionals to be aware of the social issues and health needs of this population. The SPOT health education and logic models were created collaboratively with community members, health care educators, representatives of health care centres, researchers, and representatives from private foundations. Resources were mobilized through signed partnership agreements with the local [Integrated University Health and Social Services Centre](#) (Capitale-Nationale) and [Laval University](#), along with community financial support from the [United Way](#), in particular, to deliver these models. Highlights of what worked effectively include:

- Delivering care through five community organizations and a “health bus,” resulting in a warm, friendly environment that allows time for meaningful contact
- Fostering interprofessional collaboration, such as including an extended nursing role with group prescriptions, involving physicians, and integrating a peer caregiver, dentists, and a psychologist into the health care team, coordinated by a community organizer
- Using electronic medical records that are accessible to all members of the health care team
- Developing clerkship opportunities with the program directors involved and integrating university clerkship students (from medical, pharmacy, nursing, psychology, social work, and nutrition programs) into the provision of care and health education activities
- Using a decentralized governance framework that promotes participatory management (i.e., participation of orphan patients, members of the public, students, and community workers on the board and committees)

WHAT WAS GAINED?

- Improved geographic and social access to care for marginalized and socially excluded orphan patients through inter-organizational collaboration and inclusion of an extended nursing role
- Approximately 700 different individuals are provided with health care services annually
- An average of 30 clerkship students work with SPOT each year
- Approximately 1,100 individuals are reached each year through care, clerkships, health education activities, and awareness efforts in the community
- Volunteer/humanitarian efforts involve about 75 individuals each year

WHAT WAS LEARNED?

A well-coordinated, interdisciplinary approach can be a powerful force driving social change—one that takes stock of the needs of the population; considers the individual circumstances of the most vulnerable patients; values and leverages expertise; and integrates students and peer caregivers into a primary care team.

TO FIND OUT MORE ABOUT THIS CASE, CONTACT:

Nathalie Bouchard,
SPOT Clinic Coordinator
Email: coordo@cliniquespot.org

Dr. Céline Leclerc,
SPOT Health Clinic
Email: celine.leclerc@fmed.ulaval.ca

CFPC LOCAL CHAPTER CONTACT INFORMATION:

Nicole Cloutier,
Executive Director,
Quebec College of Family
Physicians
Email: dg@cqmf.qc.ca



HealthConnection Clinic in British Columbia

Improving access to continuous care for patients
with complex medical and/or socio-economic needs

What needed improvement?

High-needs, medically complex, and vulnerable clients in Vancouver's North Shore community in British Columbia were often unattached and difficult to serve, with high rates of hospital admissions, addiction, homelessness, and poor health outcomes.

What was done to help the situation?

The North Shore Division of Family Practice and Vancouver Coastal Health, a regional health authority, partnered to create the [HealthConnection Clinic](#), which opened in July 2013 and has grown steadily since then. The clinic aims to provide team-based primary care to individuals who do not have a regular provider and face complex medical needs (including mental illness and addiction) and/or socioeconomic needs. No scheduled appointment or formal referral is necessary to be seen at the clinic.

WHAT WAS GAINED?

- Providing access, care, and service attachment to about 1,000 vulnerable clients, including at least half of the North Shore's 735 homeless people
- Reducing the number of emergency department visits and admissions, and decreasing the length of stays
- Adding a team-based learning site for all associated disciplines and creating the Complexity Assessment Tool, also known as AMPS (Attachment, Medical, Psychiatric, Social determinants)—an innovative resource that guides primary care clinicians in assessing patients with complex needs and identifying disease-related and other barriers to improved health; care teams can use this tool to develop a care plan tailored to individuals' needs, highlighting any additional medical and/or community services required^{**}
- Establishing partnerships and close collaboration with numerous community agencies, non-profit organizations, and the Royal Canadian Mounted Police (to develop progressive strategies and initiatives to minimize death and injury from high-risk behaviours and to meet the highest standards of public safety in the community)
- Providing infrastructure that enables further integration of primary care resources and services
- Developing stronger relationships and collaboration between family physicians and the health authority
- Fostering a growing sense of community with this disenfranchised patient population—based around home and community care, which includes:
 - o Increasing outreach for homebound/homeless individuals
 - o Advancing the growth of integrated team-based care with community providers
 - o Supporting closer collaboration with mental health/substance use programs
 - o Establishing self-help groups, social events, and a client "council" to give input

^{**}Canadian Foundation for Healthcare Improvement. *HealthConnection Clinic Complexity Assessment Tool (AMPS): An Introduction*. Ottawa, ON: Canadian Foundation for Healthcare Improvement; 2014. Available from: www.cfhi-fcass.ca/sf-docs/default-source/on-call/complexity-assessment-introduction-may31-2017.pdf?sfvrsn=4. Accessed 2017 Jan 4.



WHAT WAS LEARNED?

Partnerships involving a provincial health authority, non-profit organizations, family physicians, and clients can spark innovation in developing clinical resources and be highly successful in providing care for unattached and marginalized patients who have complex medical and social needs.

TO FIND OUT MORE ABOUT THIS CASE, CONTACT:

Dr. Dean Brown,
Medical Director,
HealthConnection Clinic
Email: dvbrown@shaw.ca

CFPC LOCAL CHAPTER CONTACT INFORMATION:

Toby Kirshin,
Executive Director,
British Columbia College
of Family Physicians
Email: toby.kirshin@bccfp.bc.ca

Transgender Care in Newfoundland and Labrador

Addressing a gap in service through self-learning and collaboration

What needed improvement?

Historically, there was no open access to transition-related care for transgender people in Newfoundland and Labrador. Many transgender people have faced substantial health care barriers, including encounters with primary care providers who either did not feel competent in providing services or refused to provide care, and similar experiences with other specialists.

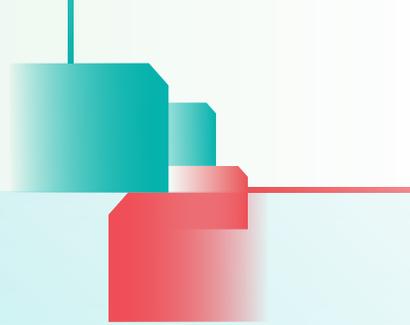


What was done to help the situation?

Dr. Mari-Lynne Sinnott opened [Clinic 215](#) in downtown St. John's, Newfoundland and Labrador, and advertised it as being LGBTQIA2S+ (Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, Asexual, Two-Spirit) friendly, specifically noting that she was ready and willing to provide transition-related care to transgender patients. She created relationships with some local trans-positive counsellors; local adolescent, young adult, and mature adult trans support groups; and parent/family support group peer counsellors. They have built an informal wraparound service providing affirmative care to transgender and gender non-conforming people of all ages. Dr. Sinnott has also connected with several family doctors in rural Newfoundland and Labrador to support the provision of transition-related care, and together they have created an informal provider group for continuing professional development planning, information sharing, and "second-opinion" assessments as needed.

As the few family physicians providing transgender health care in the province, Dr. Sinnott and her colleagues have had to supplement their own learning to make this initiative happen, as transgender care was not part of the curriculum in any of their medical training. They sought out other transgender care providers with whom to do electives during residency training or to shadow as providers to learn about medical transition. They also joined the national and international professional associations for transgender health and attended continuing professional development events to foster their competency in this area, and built a network of mentors in other provinces and countries that they rely on for peer support as needed.





WHAT WAS GAINED?

- St. John's now has affirmative and accessible transition-related care that the transgender community knows about and supports. Technology is used as needed to provide access to transgender people living in rural and remote areas, with aspirations for continued growth in this service.

WHAT WAS LEARNED?

Gaps in medical education and physician training can be addressed locally through self-learning activities and outreach to national/international professional associations for peer support. By identifying an unmet need and working to address it, high-quality care that is inclusive can be provided to a population that is lacking it.

TO FIND OUT MORE ABOUT THIS CASE, CONTACT:

Dr. Mari-Lynne Sinnott,
Clinic 215 and Memorial
University of Newfoundland
Email: m.sinnott@mun.ca

CFPC LOCAL CHAPTER CONTACT INFORMATION:

Debbie Rideout,
Chapter Administrator,
Newfoundland and Labrador
College of Family Physicians
Email: drideout@nlcfc.ca

Conclusion

These cases focusing on the care of unattached and marginalized patients demonstrate that creative and innovative solutions can be found when government agencies, not-for-profit organizations, health care organizations, health care professionals, and educators work together.

Key actions that must be considered locally to help ensure that everyone in Canada has equitable access to high-quality, patient-centred, and coordinated care include:

- Focusing on the unmet need to understand what's driving it and how this obstacle can be overcome
- Involving patients to make sure the solution meets the identified need
- Involving learners to ensure that gaps in medical education and training are addressed, and lessons learned are passed down to future generations
- Connecting with existing community resources and organizations providing care that is not medical—being able to point people in the right direction is crucial

Through these observations, it is evident that collaboration and relationship building are central to delivering innovative solutions to caring for unattached and marginalized patients in our communities. Interdisciplinary teamwork is essential to addressing complex challenges and producing successful outcomes. It creates value for the community and all those involved—educators, social workers, health care professionals, and, most importantly, patients.

If you have an innovative model or practice that you would like to share in our [Innovation in Primary Care](#) series, please email the CFPC's Health Policy and Government Relations team at: healthpolicy@cfpc.ca.

We welcome your case submissions and look forward to sharing them in future publications of this series!



THE COLLEGE OF
FAMILY PHYSICIANS
OF CANADA



LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA