



Primary Health  
Care Services of  
Peterborough

2009

ANNUAL  
REPORT

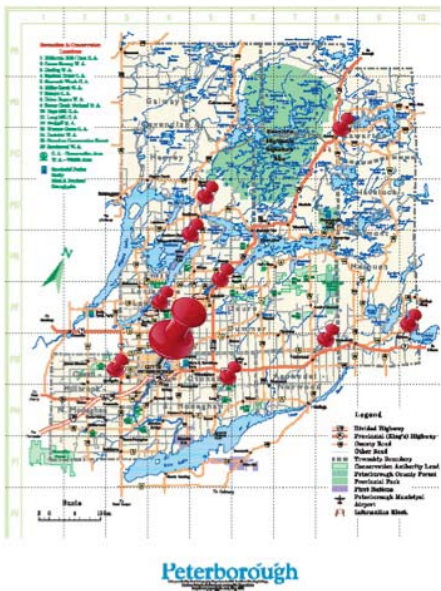
Peterborough Networked Family Health Teams:

# Leading the way in primary health care reform



# Primary Health Care Services of Peterborough

Serving residents of  
Peterborough County



## Mission

Primary Health Care Services of Peterborough (PHCSP) is committed to providing all residents of our community with a high-quality, seamless care experience built upon the foundation of primary care. PHCSP will enhance quality of life for residents and health care professionals by leading the development of an integrated and effective health care system.

## Vision

Primary Health Care Services of Peterborough will:

- Provide leadership in the enhancement of primary care through development and support of the Family Health Teams and our community partners.
- Develop a Peterborough Health Sciences Campus that includes coordinated, accessible, community-based outpatient services in support of primary care.
- Promote an attractive work environment for physicians, other health professionals, and staff through the provision of administrative support and services to the Family Health Teams.
- Coordinate access to all health care services in support of a targeted, integrated approach to chronic disease prevention and management.
- Invest in the development of Family Health Teams through planning, training, education, team building, innovative practice, evaluative research, and advocacy with the funder.
- Connect all Family Health Teams and other care providers to an information technology infrastructure that supports effective care and quality improvement across the continuum of the patient experience.

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## PROVIDING LEADERSHIP IN PRIMARY CARE

The Health Council of Canada recently published a report that explores the team model for delivering primary health care in communities across Canada. The report profiles teams in action and highlights one program from each province. In Ontario, Peterborough was selected as a clear demonstration of a successful transition from doctor-based care to providing primary care through teams of health professionals. In addition, the Ontario Ministry of Health and Long-Term Care will be profiling Peterborough on its website as a successful community in preventing and managing chronic disease.

## Summer 2009



Over the last three years our community has seen tremendous change in our primary health care system. We believe the changes have been very positive for the citizens of our community. In fact, Peterborough has become a model community providing leadership across the province and the country when it comes to primary health care reform.

Change started in 2006 with the creation of the Peterborough Networked Family Health Teams (PNFHTs) to provide appropriate and effective care for our citizens. We are very proud of our accomplishments, which include successfully recruiting 66 additional health care providers and 16 additional family physicians. We have significantly reduced the number of patients without a family physician from 27,000 to less than 4,000. As well, our Family Health Team After-Hours Clinics have contributed to a significant reduction in emergency room utilization which has decreased from almost 89,000 in December 2005 to less than 74,000 by December 2008.

The Peterborough Networked Family Health Teams have developed new medical facilities to accommodate the additional health providers and implemented electronic medical records with a 100 percent adoption by all five Family Health Teams.

Our Family Health Teams are now well positioned to continue to increase access to care, expand the scope and reach of existing programs and to pursue new opportunities for program development, particularly in the area of chronic disease management and prevention.

Our success in primary health care reform has not gone unnoticed. In June 2009, the Honourable David Caplan, Ontario Minister of Health and Long-Term Care selected the Medical Centre in our community to announce funding for an additional 19 Family Health Teams. "I wanted to be here today because it has been so successful," Minister Caplan said. "We're now going to drive (forward), based upon the model you've had here in Peterborough...on to the next wave of the 19 Family Health Teams." In addition to ongoing recognition by the Ontario Ministry of Health and Long-Term Care, The Peterborough Networked Family Health Teams have been recognized nationally by the Health Council of Canada.

We are pleased to provide this annual report which documents the story of the Peterborough health care community from our recent troubled past, to overcoming our challenges, to becoming a leader in primary health care reform. We are very excited about the prospects for the future of this community and look forward to sharing our ongoing success with the citizens of Peterborough, as well as the rest of the province.

**Dr. Stephan Ragaz**  
Board Chair  
Primary Health Care Services  
of Peterborough

**Dr. Don Harterre**  
Physician Lead  
Primary Health Care Services  
of Peterborough

## I. Executive Summary

In three short years, from 2006 to 2009, Peterborough has become a model community providing leadership across the province and the country when it comes to primary health care reform. Transformation was started by a small grassroots group of family physicians committed and driven to finding a solution to the ailing primary health care service in our community. The small group expanded over time with representation from across the region.

Ultimately, it was the community-wide determination, perseverance and vision to create an integrated and collaborative health care approach to treat as many co-morbid conditions in one setting as possible that led to the successful creation of our Networked Family Health Teams (FHTs). Primary Health Care Services of Peterborough (PHCSP) has helped produce a cohesive vision for our Network of Family Health Teams; working together to realize that vision has ensured our success. As Henry Ford said about teamwork, "coming together is a beginning, keeping together is progress and working together is success."

By 2005, the health care situation in Peterborough had reached a critical level. Family physicians were overworked, disgruntled and anxious to retire or leave their family practice to join other levels of care. The lack of family physicians and the large proportion of patients without a primary care provider added significant pressure to all other aspects of our system. Our clinics were filled beyond their capacity with patients waiting too long to see a physician while our emergency rooms were overburdened with non-emergency patients who had nowhere else to go.

This all changed with the creation of the Peterborough Networked Family Health Teams in 2006. Since our network of Family Health Teams has been established, we have successfully recruited 66 additional health care providers, 16 family physicians, significantly reduced the number of patients without a family physician from 27,000 to less than 4,000, and reduced the number of emergency room visits by providing after-hours and weekend clinics.

With our Family Health Teams well established, we are now able to provide even greater health care services to our community through the development of innovative programs such as the Partners in Pregnancy Clinic, the Pharmacist-Managed Diabetes Program, and the Anticoagulation Monitoring Program. Our allied health care professionals are collaborating to bring such integrated preventative health programs as Meet Your Heart, Diabetes Awareness Day, Healthy You, Craving Change and the Lipid Class. In the area of Chronic Disease Prevention and Management, the PNFHT is leading the way across the province with such programs as: Early Identification and Management of Depression, Psychiatry Shared-Care Initiative and the Comprehensive Vascular Disease Prevention and Management Initiative.

These programs are possible with the tremendous support we receive from across the community, including Public Health, the municipalities, business groups, Children's Aid, the local Health Unit, and all our health care professionals.

We have learned that a successful integrated team approach to health care is best achieved in partnership with our many stakeholders. Our integrated model continues to expand for the benefit of our patients, health care providers and overall community. Since our inception, we have had the good fortune to partner with health service providers, agencies, industry and local stakeholders to identify and meet community needs, expand access to care, and develop and support innovative programming.

Primary Health Care Services of Peterborough remains committed to fostering positive and fruitful relationships with our partners. These relationships touch on almost every aspect of our health care system. Some of the most significant partnerships include: the Central East LHIN, community specialists, and industry leaders such as AstraZeneca Canada Inc., Pfizer Canada Inc., Hoffman-LaRoche Ltd., as well as the Greater Peterborough Health Services Foundation.

Our vision for the future is to build on our current success by continuing to invest in our health care providers, further integrating the teams, connecting with community specialists, developing additional infrastructure and adding new innovative programs. We will seek to work with additional partners, and find further sources of revenue to supplement our current funding allocation from the Ministry of Health.

We will strengthen our community by seeking to provide leadership to other regions across the province and the country that recognize the success we have achieved in primary care reform. It is our hope that as we provide guidance and leadership, the integrated primary health care model will become standard practice across the country and those that have embraced this team approach will operate effectively and continually improve the level of care that they are able to provide to their citizens.

**“The strength of the team is each individual member...  
the strength of each member is the team.”**  
- Coach Phil Jackson, Chicago Bulls

## II. Background

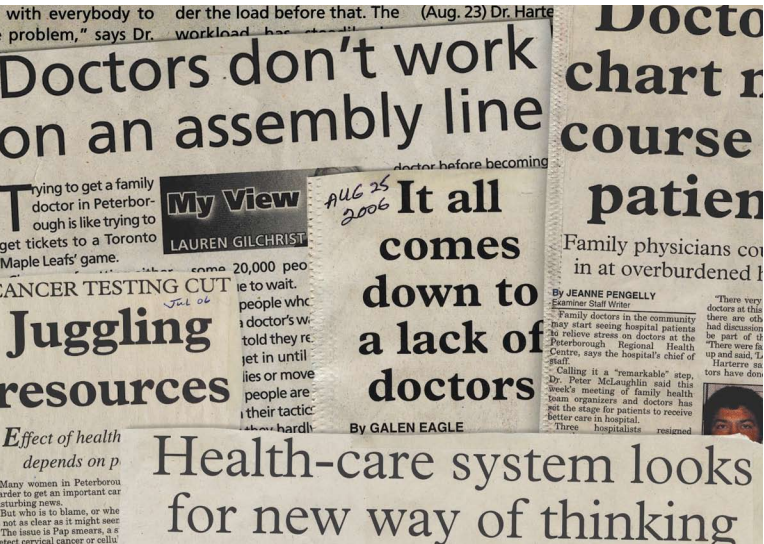
Primary Health Care Services of Peterborough is a non-profit corporation that guides and oversees the Peterborough Networked Family Health Teams. The development of the PNFHTs was the strategic solution to a degrading primary health care situation that had evolved over several years in Peterborough and by 2005 had become critical.

### The Crisis

In 2005, primary health care in Peterborough had degraded to the point where 27,000 people, which represented one in 4.5 residents, did not have access to a primary care physician. At the time, there were few incentives to attract new family physicians to the area. Primary health care had become a crisis in Peterborough, largely because:

- many family physicians in the area were retiring and were not being replaced by younger physicians;
- family physicians in practice were disgruntled and overworked;
- younger physicians were leaving to work in hospitals or walk-in clinics outside of Peterborough, and;
- very few medical students were choosing family practice.

To further intensify the problem, Peterborough has an older-than-average population with the highest proportion of individuals 65 and older in Ontario and second highest in Canada, placing an ever-increasing demand on primary health care as chronic conditions continue to rise.



Source: Peterborough Examiner

### THE CRISIS

Headlines from  
the Peterborough Examiner

**April 1, 2006**  
Situation Critical – Thousands of Peterborough residents don’t have family doctors. There may be hope on the horizon, but for now accessing basic health care can be a challenge. Many have no choice but to use emergency room, or day clinic services.

**July 6, 2006**  
Family doctor leaving city.

**August 23, 2006**  
Doctors meet to discuss the impending “crisis.”

**August 25, 2006**  
It all comes down to a lack of doctors.

In 2005 we had a real crisis on our hands. There were more than 27,000 unattached patients in Peterborough City and County. Three short years later, with the hard work and dedication of Primary Health Care Services of Peterborough, this number has decreased to less than 4,000 – what an achievement! Aside from patient placement, Family Health Teams have greatly improved primary care in Peterborough and have attracted more family physicians and health care providers to our area, which is of benefit to the entire community. As Mayor, I am most appreciative of these collective efforts and commend PHCSP for their many achievements to date.

*D. Paul Ayotte, Mayor  
City of Peterborough*

Peterborough statistics in 2005 prior to the formation of the PNFHTs	
Population*	78,593 City, 43,826 County, 122,419 Total
Percentage of population over 65**	18.2
Ontario Percentage of population over 65**	13.6
Number of unattached patients (without a family physician)	27,000
Family physicians over the age of 60	12
Annual ER visits	89,000 (reduced to less than 74,000 by end of 2008)
Additional family physicians required	12–14
* Greater Peterborough Area Economic Development Corporation, September 2008	
** Statistics Canada, 2006 Census Data	

### The Challenges

A group of eight dedicated family physicians led by Dr. Don Harterre recognized the growing crisis and began working together in 2001 to help develop a plan to address some of the key challenges we were facing at the time, such as:

- how to create access to primary health care for the large number of unattached patients;
- how to ensure appropriate or adequate physician compensation to encourage family doctors to come to Peterborough;
- how to take the burden of having to be all things to all people off the overworked family physicians’ shoulders.

### A Grassroots, Community-wide Approach

In 2003, the grassroots group of eight that had been meeting every month grew into a larger community-wide steering group headed by Bill Casey and Dr. Don Harterre. The group was comprised of health care professionals from across the region all volunteering their time and energy to find a solution to the ailing primary health care service in our region. It was the community-wide determination, perseverance and vision to create an integrated and collaborative health care approach to treat as many co-morbid conditions in one setting as possible that led to their ultimate success.

### LEADERSHIP

#### Dr. Don Harterre

Dr. Don Harterre has been an active, passionate and committed member of the medical community in Peterborough since 1966. He is tirelessly dedicated to providing the very best primary care services to our citizens. That is why in 2002, when he retired as a family physician, he volunteered to lead a local movement to create critically needed improvements to our health care system. His driving force led to the successful development and implementation of the five Networked Family Health Teams.

Dr. Harterre has a long history of dedication to health care in our community and has been recognized for his contribution. During his career he was named Family Physician of the Year for Eastern Ontario and received the coveted Glenn Sawyer Award from the Ontario Medical Association for services to the profession and the community. Recently, he received the Paul Harris award from the Rotary Club of Peterborough for his part in creating local Family Health Teams. He has held a number of administrative posts including President of the Peterborough County Medical Society, President and Vice-President of the Medical Staff of Peterborough Regional Health Centre and Chief of Staff of the Peterborough Regional Health Centre.

Today, Dr. Harterre is the Lead Physician of Primary Health Care Services of Peterborough and represents the Networked Family Health Teams on several committees of the Central East Local Health Integration Network. He remains committed to his vision of a world-class primary health care system in Peterborough.

#### Bill Casey

For the last 12 years Bill Casey has called Peterborough home. Since moving into the area, he has been actively engaged in local, regional and provincial health care reform strategies. Mr. Casey’s collaborative skills and business acumen have paid significant dividends to our community. As Manager of Corporate and Public Affairs at the Peterborough Regional Health Centre, Mr. Casey worked closely with his community, physicians, municipal and provincial politicians and the Ontario Ministry of Health and Long-Term Care in developing the successful business case for our new hospital which opened in 2008.



In 2004, Mr. Casey left Peterborough Regional Health Centre to join Dr. Harterre to lead necessary reform to address the growing crisis in our primary health care system. He was instrumental in obtaining the provincial government’s approval of the five Family Health Teams for our community. Currently he is the Executive Director of the Primary Health Care Services of Peterborough. Under his leadership, recruitment and retention of family physicians and allied health professionals (AHPs) in the community have thrived. In three short years from 2006 to 2009, his vision for improved care transformed a primary health care system in crisis to one that is held up as a model for change throughout the province and the country.

Mr. Casey remains committed to the success of our community having served in the volunteer capacity as Chair of the Greater Peterborough Chamber of Commerce in 2005 and has been involved in the United Way as Co-Chair of the 2007 Health and Social Services Campaign.



### The Solution – Integrated Family Health Teams

In January 2006, after submitting our business case for the Peterborough Networked Family Health Teams, our organization known as Primary Health Care Services of Peterborough, a non-profit corporation with a physician-led Board of Directors, secured sustainable funding from the Ontario Ministry of Health and Long-Term Care.

Subsequently, five physician-led teams were established and linked as a network. Two of our Networked Family Health Teams are multi-specialty clinics with providers operating under the same roof, and three are currently virtual teams linked electronically throughout the region. Each team is comprised of physicians, registered nurses, nurse practitioners, pharmacists, mental health clinicians, dietitians, medical secretaries, receptionists and administrative support personnel. Team members refer patients internally as appropriate. Patients are sent to specialists when they require care beyond the scope of any of the primary care providers. As such, patients transition easily to acute care if needed and then back to primary care for follow-up.

The five Family Health Teams are integrated through the administration and guidance of Primary Health Care Services of Peterborough. In addition to playing a number of important roles in building and sustaining Family Health Teams, PHCSP connects the teams with the community to ensure health care needs are anticipated and met and acts to enhance the health system in Peterborough County.

### Key to Success

The key to our success started with the dedication of a core group of local health care professionals who never lost sight of the over-riding goal to provide a patient-centred, integrated and collaborative health care approach to treat as many co-morbid conditions in one setting as possible.

The determination to attain that one over-riding goal led to many subsequent achievements, including the following:

- significant support from community groups including the Peterborough Regional Health Centre, the Peterborough Community Care Access Centre, the Peterborough County/City Health Unit, the business community, local municipal governments and the public
- a large percentage of unattached patients incorporated into the network and accessing primary care providers
- a substantial reduction in emergency room visits
- a sustained network of family physicians and other health care professionals
- GPs and other health care professionals linked by electronic medical records (EMR)

### The Road Ahead



It is our intention to build on the success we have achieved in primary care reform and expand service to include working with community-based specialists. We will continue to be dedicated to this community and its residents and will provide additional investment in health provider education, program development, capital space and equipment.

In addition, we will use our experience to work toward leading the transformation of the health system throughout the province and increasingly across Canada.

### III. Priorities and Initiatives

#### Strengthening the Family Health Teams

Family Health Teams were introduced as a new way to provide health care. They bring together family physicians and other health care providers to coordinate the best possible care for patients. All team members work together to meet patient needs. Their focus is to keep individuals and their families healthy, not just to treat them when they become ill.

Our community has embraced this concept with the successful establishment of the five Family Health Teams in 2006. The Teams are networked through Primary Health Care Services of Peterborough. The five Family Health Teams combine the expertise and services of a variety of health care providers to meet many different health care needs.

In addition to family physicians, our Family Health Teams include nurse practitioners, dietitians, mental health clinicians, registered nurses, medical secretaries and pharmacists. Our collaborative team approach allows doctors to focus on medical diagnosis and management, while the allied health professionals provide other health care services and work with patients to help them improve their health habits and the way they manage their conditions.

The aim of our Networked Family Health Teams is to:

- provide our residents better access to care, closer to home;
- reduce the number of unattached patients in the community;
- work as a team to keep patients healthy;
- attract and retain family physicians and allied health professionals;
- provide extended hours and after hours physician-led clinics for rostered patients;
- provide extended hours and after hours access to a registered nurse through the Telephone Health Advisory Service;
- help patients navigate their way through our health care system;
- provide primary health care, chronic disease management, self-help tools and innovative programs to improve health, and;
- use state of the art electronic medical records (EMRs) that give providers access to patient information and test results.

In the three years since 2006, the primary health care landscape in Peterborough has transformed to one of collaboration among health care providers. Patients who once waited weeks or even months to see their family physician now have more immediate access to additional collaborative care such as a nurse practitioner, dietitian, mental health clinician, pharmacist and others as required. By providing access to allied health care professionals within the team, the logjam created by the demand for family physician appointments has been broken thus reducing wait times and allowing our physicians to accept new patients.

**The Greater Peterborough Family Health Team** is a geographically diverse team made up of 24 doctors. Physicians and AHPs are located across Peterborough City and County in 13 separate locations including Millbrook, Norwood, Buckhorn, the First Nations community of Curve Lake and Apsley as well as Peterborough. Their AHP complement includes 5.2 nurse practitioners, 4.1 mental health clinicians, one pharmacist, two dietitians and nine RNs. Since 2006 the average practice has increased by five percent, the group practices have a total of 31,675 rostered patients to date.

**The Curve Lake First Nation** lost access to primary care in 2002, when fee-for-service physicians at the nearby Lakefield Clinic closed their practices. Today, in partnership with Primary Health Care Services and the Greater Peterborough Family Health Team, the Curve Lake community is developing a model for sustainable, integrated, community-based health services, based on a shared vision of health promotion and disease prevention.

A Family Health Team nurse practitioner, mental health professional and physician work alongside community health care providers at the Curve Lake Health Centre to provide primary care, social services and chronic disease prevention and management programs in a trusted community-run setting. Through a collaborative process of planning and developments, the Curve Lake First Nation and Peterborough's Family Health Teams have made high-quality, accessible care a reality.

Over the next year the Greater Peterborough FHT hopes to complete the implementation of electronic medical records and work towards improved chronic disease management strategies. They plan to continue to work on team building and providing a seamless patient care experience.

**The Medical Centre Family Health Team** is located at 707 Charlotte Street in Peterborough. In addition to the 18 family physicians, the team also consists of an administrator, two nurse practitioners, two mental health clinicians, one dietitian, 0.5 pharmacist and six RNs. There are approximately 21,000 patients currently rostered with the Medical Centre FHT. This represents an increase of almost 4,000 new patients since 2006.

To date this increase in service delivery has been accomplished through the hard work, commitment and professionalism of the team members. This was achieved despite the space challenges which required their nurse practitioners and physicians to share clinical space and required their allied health professionals to be located off-site at the Primary Health Care Services of Peterborough King Street offices. The Team is very pleased that within weeks they will begin to occupy their newly constructed space, to bring their allied health professionals into the Medical Centre site and to provide the entire team with efficient work space. They are actively working toward recruiting a third nurse practitioner to join them in the near future. Over the last 2.5 years they have been pleased to welcome five new family physicians to the Medical Centre team.

As part of the larger Medical Centre facility, the Medical Centre Family Health Team benefits from close proximity to a variety of physician specialties including allergy and immunology, cardiology, gastroenterology, general surgery, obstetrics and gynecology, ophthalmology, E.N.T., paediatrics, plastic surgery, rheumatology and urology. All Medical Centre patients, including those of the FHT, are supported by a variety of in-house services, including pharmacy, audiology, x-ray, mammography, ultrasound and a specimen collection lab.

The Medical Centre FHT is looking forward to potential future enhancements to the variety and scope of services offered to our patients.

Our Family Health Teams have become an invaluable asset in addressing the problems encountered in our rural municipality in Peterborough County. We have a wonderful doctor who has worked on his own for 30 years. Before the Family Health Teams he was unable to keep up with the growing workload and contemplating retirement. Being part of a team has given him the opportunity to consult with other physicians and collaborate with the nurse practitioner and the other allied health care professionals to help with patient care. Our doctor has been able to reduce his workload and now would like to continue to work as long as he is able. Patient care has also improved. For example, with the addition of technology, the doctor and nurse practitioner can be in direct contact with a specialist thus reducing the need for patients to sometimes endure long and difficult drives. Jim Whelan, Reeve, North Kawartha Township

*Jim Whelan, Reeve  
North Kawartha Township*

**The Chemong Family Health Team** consists of seven family physicians practicing at the Chemong Medical Centre and the Lakefield Clinic, as well as an administrator, two nurse practitioners, two mental health clinicians and a registered dietitian. Effective July 1<sup>st</sup> 2009, a new part time physician joined the Lakefield Clinic. Since 2006, the clinic's patient roster size has increased by 45 percent with the addition of three full-time physicians.

The Chemong Team has grown substantially in the past two years. Five physicians have joined the Chemong FHO since the summer of 2007 consisting of three full-time and two part-time physicians. The community members of Lakefield have been working diligently with the Lakefield Foundation to build a brand new clinic to house their five physicians and nurse practitioner. The clinic is slated to open in September, 2009. The building will also be able to accommodate a lab, physiotherapy, a pharmacy and possibly radiology thus bringing many resources under one roof helping to provide seamless care to patients to what was once a critically under serviced area.

Chronic Disease Management and team development will play a central role in the future of the Chemong Team. This past year an INR Clinic was developed in-house with the expertise of the team pharmacist. They currently have two pharmacists providing INR services on site to patients and another providing counseling to patients who are on multiple medications. This has drastically reduced wait times for patients, staff and physicians. They are hoping to expand this clinic to all physicians and patients on the Chemong Team and begin to roster unattached psychiatric patients who are currently under the care of a psychiatrist at Peterborough Regional Health Care to provide front line care. The Chemong Team will focus on preventative care measures/targets and chronic disease management.

**The Peterborough Community Family Health Team** has become a recognized centre of medical care in our community, with the move of most of its physicians and allied health professionals to the wonderful new Turnbull Medical Building in July 2008. Peterborough now has a state of the art medical facility in its downtown core, with seven family physicians, three nurse practitioners, social worker and mental health worker, as well as registered nurses and support staff. The team pharmacist offers an anticoagulation clinic for their patients in the same location. a service highly praised by its clients and most valued by the clinicians in our team. Recently a laboratory facility opened in their building, and they expect full x-ray and ultrasound services in the very near future. The Turnbull Medical Building also houses the Partners in Pregnancy Clinic, which is connected to their team and has become a well recognized success in Peterborough's health care community. Furthermore, two ENT surgeons opened practice at the same location, as well as an audiology service. Shopper's Drug Mart has served their patients since the Clinic opened.



The Peterborough Community Family Health Team also remains connected to the larger community with two satellite sites, at the Scott Clinic in the South and the Westclox Building in East City, with two physicians and registered nurses or nurse practitioners on each site.

The physicians and other health professionals of Peterborough Community Family Health Team provide primary care to an ever larger group of patients. The Team's roster has increase by about 15 percent since its inception in 2006.

Peterborough Community Family Health Team is intent on optimizing their team work and to gain the best resources for their patients. Preventative care will remain a strong focus, as well as care for their ever-increasing geriatric population. They want to continue to reach out to the community, hopefully with new programs for their palliative patients and for the homeless and poor, who might not have access to traditional office practices. They also want to continue to work with their hospital to provide their patients with the most seamless care possible.

**The Peterborough Clinic Family Health Team** is housed in the Peterborough Clinic. The Clinic was established in 1920 and is the oldest continuously operating medical clinic in Canada. The Clinic relocated to its new state of the art, environmentally friendly 52,000 square foot building in January 2008. The new facility is home to 35 physicians as well as many ancillary and complementary health care services for patients. It is located directly opposite the Peterborough Regional Health Centre.

In addition to 17 family physicians and the FHT allied health professionals, the Clinic has specialists in cardiology, internal medicine, pediatrics, gastroenterology, general surgery, obstetrics and gynecology and ophthalmology. In-house medical services include Day Clinic, Gamma-Dynacare medical laboratory, Pharmacy, Physiotherapy, Audiology, Orthotics, Cancer care products, Heart Testing, Ultrasound and X-ray.

The Clinic has been working with electronic medical records for over 10 years. All family practice patients have an electronic medical record which provides numerous benefits to the patients as well as the family physicians and their staff. The family physicians have been providing an extended-hours facility on a seven day per week basis since the early 1980s.

The Clinic is proud of its past and is very optimistic about the future and the continuing care it offers to the community.



Recruitment and Retention

The establishment of the Networked Family Health Teams in Peterborough has been the impetus to attract and retain quality health care providers. Between 2006 and June of 2009, we have successfully recruited 66 health care providers. Since April 2007, 16 family physicians have joined the FHTs. In contrast, between 2001 and 2006 only three family physicians had been recruited to our community. We continue to focus on recruitment and integration of new health care providers into primary care as an overriding priority to continually improve access to care.

The Networked Family Health Teams have had a positive impact on physician retention as well. A number of our older physicians, once disgruntled, over-worked and anxious to retire, have indicated that the team-based care model will enable them to practice for several years beyond their expected retirement.

The table below lists the five Networked Family Health Teams in Peterborough and the various health care professionals associated with each team.

FHT	FP	NP	MHC	Dietitian	Pharmacist*	RN
Partners in Pregnancy Clinic	5	1	1.6	.5		2
Chemong	7	2	1.2	.5	.2	1
Greater Peterborough	24	5.2	4.1	2.1	1	9
Medical Centre	18	3	2	1.1	.4	6
Peterborough Clinic	16	3	2	1	.4	3
Peterborough Community	11	3	2	1.5	.4	5
Peterborough Networked FHT					.3	
FP Family Physician, NP Nurse Practitioner, MHC Mental Health Clinician, RN Registered Nurse						
*.3 FTE allocated for administration						

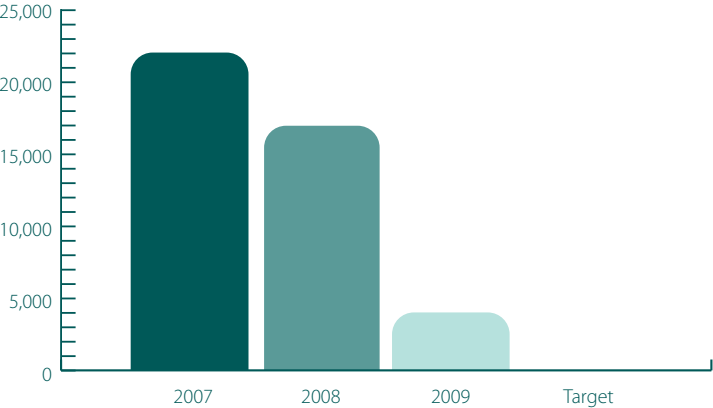
Currently, we are maintaining 95 percent recruitment of our complement of allied health professionals. Our current retention rate is an astonishing 96 percent.

Peterborough has among the best recruitment and retention rate for FHTs in the province. This has been achieved despite a province- and country-wide shortage of health care providers, particularly family physicians. Many of our health care providers have expressed that the opportunity to work in a collaborative, patient-centred, team environment not only results in excellent patient care, but in considerable job satisfaction.

We have had tremendous success in recruitment and retention over the last three years, but certain systemic issues, such as our inability to offer cost-of-living increases, may affect our ability to maintain and attract quality health care providers in the future.

Patient Enrolment

In addition to recruitment and retention of health care providers, assigning unattached patients to a family physician has been one of our top priorities. As the FHT resources and the integrated care model have become established, we have been able to significantly decrease the number of patients in our area who did not have a primary care provider as illustrated in the chart below.



Today, with the addition of 22,000 patients, enrolment stands at an all-time high of 103,107. This exceeds our projected target for June 30, 2009.

Resource Allocation

While we have exceeded our target for 2009 in terms of rostering patients, we remain approximately 50 percent below the health provider resources that formed the basis of those targets. A higher ratio of AHPs to physicians than is currently in place would help facilitate the development of the evidence-based care model outlined in our original business plan and would create an even more positive impact on access to primary care and enhance the quality of care and programs available to our residents.

In the absence of additional AHP resources, our members are demonstrating their commitment to the team model by participating in initiatives related to quality improvement, chronic illness care, and system partnerships. The participation of AHPs in these initiatives creates increased capacity through greater efficiency driving our ability to achieve our target for patient rostering. However, we have clear data to indicate that additional resources are required to fully meet the needs of our target population.

One of the most significant areas of concern is wait times for supportive care. Our average wait time for dietitian services is approximately 29 days, but non-urgent clients may wait three or four months after referral. Similarly, wait times for mental health clients have increased from 15 days to 27 days over the past six months. We are committed to continue to improve our wait times.

The Family Health Team model, as fully implemented here in Peterborough, has singularly been the most distinguishing factor in our recent success in recruiting family doctors to the Greater Peterborough Area. Since the implementation, we have virtually doubled the number of family doctors recruited to this area than was our previous experience. The impact of the implementation has been dramatic both in quality of patient care and accessibility to a primary care physician. Our expectation is that because of the FHT model retention of family doctors in our communities will no longer be an issue.

*John MacDonald, Physician Recruiter  
Greater Peterborough Area*

### Allied Health Professionals

Our allied health professionals include pharmacists, dietitians, nurse practitioners, mental health clinicians and registered nurses. They are a strong team of professionals that work collaboratively to make our health care system function more effectively.



#### Pharmacists

In November 2008, the pharmacy team of the Peterborough Networked Family Health Teams had completed its staffing. The team is funded for a 2.7 FTE but is made up of 13 pharmacists who share just over 85 hours per week in pharmacy support to meet the needs of the patients of the five Family Health Teams. Funds for the development of the pharmacy team were provided by the Ontario Ministry of Health in recognition of the value pharmacists provide to the integrated health care model.

With the pharmacy team in place, the FHTs are now able to provide some progressive pharmacy services and clinics. One is the medication reconciliation program through which team pharmacists provide a prescription drug review for patients who have recently been hospitalized or seen a heart or kidney specialist. This important step helps reduce problems with medication, which are not uncommon after prescriptions have been added or changed by a specialist or during a hospital stay. This program is currently being offered by the Medical Centre and the Peterborough Clinic Family Health Teams.

#### Registered Dietitians

The addition of dietitians to our integrated Family Health Teams has been a significant benefit to patient care in our community. The group of six registered dietitians consults with as many as 50 patients per day, and there is no charge to the patient for the health care service they provide. The dietitians have roughly 7,000 patient encounters per year and service even more patients with the groups and workshops they have created to address specific patient needs within our community.

Family physicians refer patients to the dietitian for a wide variety of reasons including lipid disorders, gastrointestinal disorders, food allergies or intolerances, pancreatitis, kidney disease, liver disease, eating disorders, diabetes, hypoglycemia, obesity, healthy eating, and vegetarian diets. The registered dietitians work with their patients to further educate and empower them. In order to help to manage patient health, they provide comprehensive eating plans, establish goals and provide counselling and support. The doctor is always kept informed of his or her patients' progress through electronic medical records.

Aside from one-on-one counselling, the registered dietitians have also created a number of group programs to better meet the needs of the community, including groups for hypertension, dyslipidemia, Craving Change and a Multidisciplinary Healthy Lifestyle class that integrates diet, fitness and mental health.

#### Nurse Practitioner Network of Peterborough

Nurse practitioners (NPs) work collaboratively with our family physicians to deliver comprehensive care to our patients. In 2008, more than 34,000 patient visits to nurse practitioners took place across Peterborough City and County. Comprehensive primary health care includes: health promotion, disease prevention, curative care, rehabilitative care and supportive care. By providing this level of care, NPs play an important role in helping to improve access to primary care in our Networked Family Health Teams.

Our 17 nurse practitioners have come together to form the Nurse Practitioner Network of Peterborough (NPNP). This is an active group whose members have a wide variety of experience in various specialties including paediatrics, women's health, cardiology, diabetes, emergency, and Public Health.

To continually improve on the care they provide to our patients, the NP group meets monthly to discuss clinical issues, community involvement projects, and other matters related to the primary health care arena. In 2008, with the support of AstraZeneca, 14 members became Certified Asthma Educators. Of this group, several went on to become Certified COPD Educators, and three NPs have written the national exam giving them Certified Respiratory Educator status.

#### Mental Health Clinicians

The mental health clinicians (MHCs) play a significant role in our collaborative care model. They have received training in assessment and stepped care treatment of depression, including Cognitive Behavioral Therapy for depression, supported self-management, and relapse prevention.

MHCs work within the multi-disciplinary team to provide psychosocial assessment, psychosocial health education, crisis intervention and advocacy on behalf of their patients. They also connect patients to other community organizations and facilitate access to other health care providers as necessary. Collectively, they have approximately 9,200 patient encounters per year.

Patients really enjoy coming to their appointments and learning about the impact of their diet on health. We see a wide variety of patients from young and old and it's wonderful to feel that we can provide support and help them to make healthier choices. They are so happy to have this wonderful resource available to them. In an effort to proactively manage our wait times we have been creating group programs to service a larger population of patients.

*Alyson Kubica, Dietitian  
Greater Peterborough  
Family Health Team*

The addition of nurse practitioners, along with our other allied health professionals, has certainly assisted in creating greater access to primary care for our patient population, allowing us to roster more patients as well as provide greater access to primary care providers for acute and chronic care needs.

*Shari Comerford, Nurse Practitioner  
Medical Centre FHT*

Our FHT pharmacists work closely with their patients to make sure they are on the correct medication and the correct dosage. They also make sure their patients understand what they need to know about their medications and are taking them in a way that works well with their lifestyle.

*Lynda Chilibeck, Pharmacist  
Peterborough Networked Family  
Health Teams*



Prior to Family Health Teams there were very few affordable resources in the community to meet the demands of our patient population for counseling and therapy services. Now, every Family Health Team has mental health clinicians, which is not only a huge support for doctors but provides a much needed service to patients that did not previously exist.

*Brenda Whiteman,  
Mental Health Clinician  
The Peterborough Clinic FHT*

As part of the Family Health Teams, registered nurses have the opportunity to be part of preventative health care and patient education, which is not only of benefit to the patients but also professionally rewarding.

*Patti Fitzgerald, RN, Clinic Coordinator  
Partners in Pregnancy Clinic*

Mental health clinicians created an Anxiety Group in collaboration with the Peterborough Clinic and Peterborough Community Family Health Teams. Patients were referred by either their physician or their MHC to the eight-week group program. The group focus was on identifying triggers, learning coping techniques, understanding treatment options and learning relaxation skills. Patient response was very positive with several requests for more groups in the future.

The addition of mental health clinicians to our Networked Family Health Teams has meant that our patients with mental health problems are receiving more time, attention and care from their AHP and thus diverting demand away from the family physician.

**Registered Nurses**

Since the inception of FHTs many family physicians have benefited from having registered nurses (RNs) integrated into their practice. The RN is an integral part of a multi-disciplinary team who works co-operatively with all its members in the promotion of patient health and prevention of disease. The registered nurse practices within his or her full scope of practice as outlined in the Standards of Practice by the College of Nurses of Ontario.

The RNs support the Family Health Teams by providing the following services:

- **Triage incoming patient calls, assess patient health care needs, discuss test results, respond to questions pertaining to health promotion and disease prevention, and redirect calls to booking when necessary.**
- **Prepare for patient appointments, initiate the electronic medical record (EMR) of the patient visit, record patient vitals and prepare patient and room for examination.**
- **Implement physician orders to ensure that patients undertake requisite diagnostic testing. Book appointments for patients and educate them about the purpose of and preparation for such tests.**
- **Maintain EMR Health Maintenance Plans to ensure patient compliance to timelines for health promotion, disease prevention programs such as pap smears, mammograms, FOB testing, bone density and diabetes care.**
- **Administer and record immunizations and allergy injections. Ensure immunizations are current and educate patients about the need for and possible side affects of such injections.**
- **Administer clinical procedures such as suture removal, skin and wound dressings, TB testing, wart treatment and ear syringing.**
- **Perform blood pressure follow-ups, assess response to medications, educate patients and promote health through blood pressure management.**
- **Maintain the INR monitoring and management system.**

- **Complete pre-operative and Ministry of Transportation physical forms.**
- **Maintain accurate, concise and confidential EMR documentation pertaining to patient history and encounter data.**
- **Educate and monitor patients with other chronic diseases such as diabetes.**
- **Call in physician-ordered prescription renewals and maintain prescription records on the EMR.**

In the Partners for Pregnancy Clinic, the RNs have received special training so that they can further support the clinic in performing all the pap testing.

**Providing Ongoing Leadership –  
Primary Health Care Services of Peterborough**

Primary Health Care Services of Peterborough was created in the fall of 2005 to help our family physicians address a serious crisis in our local health care system. We were originally constituted as a non-profit organization committed to providing all residents of our community with a high-quality, seamless health care experience built upon the foundation of primary care. Our mandate was to enhance the quality of life for our residents as well as our health care professionals by leading the development of an integrated and effective health care system. This led to the creation of the Peterborough Networked Family Health Teams in 2006.

In order to build on the success of the FHTs and to continue to provide leadership, Primary Health Services of Peterborough has recently formed an innovative partnership with the Greater Peterborough Health Services Foundation to fund community-based health initiatives. We have changed our corporate registration from non-profit to charitable non-profit thus enabling us to receive funding from the foundation that complements the funding that the FHTs receive from the Ministry of Health and Long-Term Care and from our other partners.

This relationship and change in status bring about tremendous opportunities to invest in new and exciting initiatives to further improve the health care system in our community. Such initiatives will include innovative disease management and prevention programs, health provider education programs, additional capital space and equipment, to name a few.

**FOUNDATION PARTNERSHIP**

The Greater Peterborough Health Services Foundation, formerly known as the St. Joseph's Care Foundation, and Primary Health Care Services of Peterborough have been working together over the last year to finalize an agreement to fund community-based health initiatives that build upon the recent success that we have achieved in primary care reform. On May 27, 2009, in recognition of our shared objective regarding community health care, we announced our formal partnership.

We are very proud to be partners with the Foundation, a philanthropic leader in the community with a 25-year history of improving and maintaining quality health care for the residents of the Peterborough area. We will work together to build on the legacy of the foundation by identifying and funding innovative programs that bring the very best health care services to our citizens.



## Expanding to Meet the Needs of the Community

The need for additional and appropriate clinic space was identified as a requirement to attract and retain new allied health professionals in our original business plan and during the establishment of the Family Health Teams. With the success of the Teams and the addition of AHPs, the physician clinics and other partners have now committed to substantial new investments in medical facilities.

All five of our Family Health Teams have either embarked upon or are planning significant, state-of-the-art capital projects that not only provide space for additional personnel, but promote the opportunity for further collaboration among the AHPs.

- **The Peterborough Clinic** opened a new multidisciplinary clinic facility in February 2008. The new facility, which received some financial support from the Ontario Ministry of Health and Long-Term Care, allows for the full integration of all Family Health Team members including a dietitian, medical receptionists, registered nurses, nurse practitioners and mental health clinicians. With full integration of all members of the FHT, the Peterborough Clinic has established a FHT executive with representation from all members of the team as well as a representative from PHCSP.
- **The Peterborough Community FHT** relocated seven family physicians along with all of their allied health professionals to the brand new Turnbull Medical Building in downtown Peterborough in July 2008. This building is a prime example of modern space conducive to team collaboration. The new Turnbull Medical Building is also home to the Partners in Pregnancy Clinic, which opened in July 2008.
- **The Chemong FHT** welcomed a new physician by opening additional clinic space in downtown Lakefield and renovated its existing facilities at its Bridgenorth location.
- The Lakefield physicians and AHPs will soon move into a new clinic being developed by the township, scheduled to open Fall 2009.
- Two physicians and four AHPs in the **Greater Peterborough FHT** began practicing in the new Buckhorn Regional Health Centre in June 2008, a brand new facility made possible by the Township of Galway-Cavendish-Harvey and through the hard work of many community members.
- The concept of the Family Health Team has prompted an exciting addition to the Burnham Medical Centre. This has accommodated more physicians and allied health professionals for the benefit of both patients and health care providers.
- The Medical Centre in Peterborough is building a new addition to accommodate all the members of its Family Health Team that currently practice off-site as well as provide space for new health professionals joining the team. The expected completion date is Fall 2009.

The addition of medical space designed for team collaboration has led to increased job satisfaction among allied health professionals and increased health care access for patients. Team members are readily able to consult over a patient case to provide more comprehensive patient care.

## Staying Connected



A necessary part of collaboration between the family physicians and allied health professionals is communication and keeping each other up-to-date on patient care. For this reason the adoption of electronic medical records (EMRs) was essential. EMRs were implemented into all practices by 2007/08 with considerable success.

The EMR has proven its value as a communication tool for physicians and AHPs, particularly for those who do not share physical practice space. All health care providers of the Family Health Team can access the patient's health information immediately as required. Access to electronic patient data is also critical to participation in quality improvement initiatives, including Chronic Disease Prevention and Management planning.

Using local expertise, we are able to provide benchmark data on disease prevalence and treatment and generate ongoing reports about improvements in care. Our success in creating an e-health infrastructure in primary care has led to new initiatives across the health sector. We are working with the Central East LHIN to pilot electronic transmission of discharge summaries and other reports from the Peterborough Regional Health Centre's MediTech system to our EMRs. Local specialists are also adopting electronic records to improve communication with GPs.

Peterborough has a 95 percent physician utilization of Electronic Medical Records within primary care. This success is unprecedented in Canada.

Continued investment to build on our EMR infrastructure will be critical to realizing the full potential and subsequent benefits of e-health, as identified by both Canada Health Infoway and the provincial e-Health program.



## IV. Innovative Programs

Our plan for Peterborough's health care system reform was to start with the establishment of the Networked Family Health Teams. Once the FHTs were well entrenched and meeting their objectives, we could develop health care programs to target specific clinical needs. The energy and initiative of our Teams has been supported by partnerships with our health service providers, the Central East LHIN, the Ontario Ministry of Health and Long-Term Care, other agencies, industry, and our community to create exciting innovative programs.

### Partners in Pregnancy



The opening of the Turnbull Medical Building in July 2008 marked the official launch of the Partners in Pregnancy Clinic. The clinic provides care for maternity patients from early pregnancy to six weeks postpartum. It also offers newborn baby care up to six weeks of age for patients that received their pre-natal care at the clinic. Based on the Family Health Team structure and a patient-centred collaborative care model, the Partners in Pregnancy Clinic team includes five family physicians, as well as a breastfeeding support specialist, a nurse practitioner, two registered nurses, a registered dietitian, and two social workers to provide on-site comprehensive maternity care. The clinic was funded by the Ontario Ministry of Health and Long-Term Care through Primary Health Care Services of Peterborough.

The Partners in Pregnancy Clinic provides family-centred care based on respect, collaboration and support, building on the confidence and competence of the mother and her family members at every opportunity. Each patient has a primary physician for her maternity care. In addition, our team approach enables each patient to not only meet all the other physicians, they also have consultations with the entire team to address common pregnancy and newborn issues such as lactation support and education, healthy diet and nutrition, infant attachment and more.

Patients that currently have a family physician in Peterborough may be referred, at their request, to the clinic by their doctor at any time during their pregnancy. Women without a family doctor may self refer by contacting the clinic directly. In addition to the maternity and newborn services, the registered nurses at the Partners in Pregnancy Clinic are certified to perform pap smears and pelvic exams. They work with the physicians to provide this service to all women without a family doctor.

The Kawartha-Haliburton Children's Aid Society has had an extremely positive experience with all members of the Partners in Pregnancy Clinic staff. The staff members of the clinic are well-informed about when a referral to child welfare services is required. In some cases, interventions by staff at the clinic have prevented the need for child welfare services. We are looking forward to a continued positive relationship with the clinic.

*Jennifer Rodman, Supervisor  
High Risk Team, Kawartha-  
Haliburton Children's Aid Society*

Newborn care is also a key focus of the Partners in Pregnancy Clinic. The clinic provides care for up to six weeks for infants whose mothers received prenatal care at the clinic. As part of the Primary Health Care Services of Peterborough objective, all newborn babies without a family physician are placed within a Family Health Team. This facilitates the early follow up of newborns upon hospital discharge as recommended by the Ontario Coroner's Office.

The Partners in Pregnancy Clinic has exceeded expectations in terms of providing excellent maternity care to female patients in our community, extending services to women without a family physician and placing newborns within Family Health Teams. The six weeks of care provided to the infants at the clinic ensures that the newborn is presented to the family doctor with records, allows more time for the babies to be rostered with family physicians and ensures that placement is a smooth, seamless transition for both the patient and the health care provider. In addition, the five physicians share a 24-hour call and are on hand for all deliveries or emergencies for patients. This has helped to reduce the number of emergency room visits.

### Pharmacist-Managed Diabetes Program



A diabetes program is being piloted by the Greater Peterborough Family Health Team with our three specially trained pharmacists who are Certified Diabetes Educators. Patients with diabetes are being referred by physicians to the program.

In addition to providing support and education to the patient, the pharmacist takes primary responsibility for monitoring the glycemic control, lipid status and blood pressure. The pharmacists then assess the appropriateness and efficacy of other medications being taken by the patient and will make treatment recommendations to the physician according to the pharmaceutical care model. The program has an established medical directive to adjust insulin levels and oral hypoglycemics.

The pharmacists are authorized to request the appropriate lab tests required to assess and monitor outcomes. All clinical encounters will be added to the patient's electronic medical record and shared with the patient's physician.

Similar programs to this pilot have been implemented in other communities with positive results. They have demonstrated that diabetes patients respond well to individual treatment counselling and education about diet, exercise, appropriate blood sugar levels, and proper blood pressure. The benefits have included patients better able to self manage their disease resulting in improved glycemic levels, blood pressure control and medication compliance, and minimized long-term complications such as the

The Greater Peterborough, Community and Chemong Family Health Teams have introduced Pharmacist-monitored Anticoagulation Clinics. The pharmacists of these teams have worked in partnership with Roche Diagnostics to provide Point of Care INR results for the patients of these teams. The immediate results provided by this technology allow the pharmacists to adjust the dosing of oral anticoagulants and provide patient education around the management of their medication.

*Lynda Chilibeck, Pharmacist  
Peterborough Networked  
Family Health Teams*

### Anticoagulation Monitoring Program

Another pharmacy program is the anticoagulation (blood thinner) monitoring program. People on high-risk blood thinning medication need to be monitored regularly as the dose they need can be affected by factors such as other medications, diet, and level of activity. Too low a dose leaves the patient at risk for a blood clot and resulting stroke; too high a dose can result in excessive bleeding.

Testing normally involves the patient visiting a busy blood lab, having blood drawn, and then waiting for the doctor to get the results and call with any changes in the medication dose. This process can take several days. This is no longer the case in our community where patients can now visit a convenient one-stop monitoring clinic where a pharmacist uses a finger-prick blood test with immediate results. The pharmacist adjusts the medication dose right then and sends results electronically to the patient's doctor.

The clinic also provides advice on drug interactions, the importance of taking medication appropriately and eating a healthy but consistent diet, and the impact of activity levels. The finger-prick program is used throughout Europe and the US, but Peterborough is one of the first communities in Canada to adopt this method. The results make a significant difference, not only in convenience and reduced discomfort for patients, but in their health.

With the traditional method, approximately 55 percent of patients maintain their medication doses within a safe and effective range. At the specialty anticoagulation clinic in our community, the result is 80 percent.

Anticoagulation clinics are run in three of the Family Health Teams: Peterborough Community, Chemong, and Greater Peterborough. We have experienced the benefit of innovative pharmacy programs and therefore we remain committed to seeking additional funding to expand these programs in our community.

### Integrated Team Programs

Our allied health professionals have come together to provide wellness programs that help to keep our patients healthy and out of their doctor's offices. These programs include Meet Your Heart, Diabetes Awareness Days, Healthy You, Craving Change and Lipid Class.

#### Meet Your Heart

This is a collaborative education program run by dietitians, mental health clinicians, nurse practitioners, and pharmacists. The program objective is to help patients make permanent lifestyle changes. It addresses physical, psychological, pharmaceutical and nutritional health issues to promote healthy management of hyperlipidemia and hypertension. The program runs for six weeks and is open to any of the patients of the Family Health Teams.

#### Diabetes Awareness Days

Patients with diabetes are identified by their physician, pharmacist, nurse practitioner, dietitian, or registered nurse and invited to attend the education and awareness session. Topics include medication options and adherence, diet, nutrition, and exercise. A question and answer period with all AHPs that allows patients to discuss their concerns is also included. Sessions are well attended with excellent response from the patients.

#### Healthy You

This is a seven-week program that provides a healthy lifestyle approach to weight management. Each session incorporates healthy nutrition, physical activity and positive self-esteem. The goal is to help patients shift their attitude toward achieving and maintaining a more natural body weight. It provides an opportunity for education, skill building, community and peer support. The program is provided by two registered dietitians, a personal trainer, and mental health clinicians for patients of the Greater Peterborough and Peterborough Community Teams.

#### Craving Change

This is a seven-session group program that addresses the question of why we eat. It is evidence-based and incorporates cognitive behavioural theory to teach clients techniques to help change their eating habits. The program is provided by two registered dietitians and offered to patients from the Greater Peterborough and Peterborough Community Teams.

#### Lipid Class

This class is led by a registered dietitian to provide education regarding diet and lifestyle strategies to manage dyslipidemia.





# V. Chronic Disease Management and Prevention

## Early Identification and Management of Depression

Our depression management program is designed to provide best practice care for individuals with depression within primary care. This includes early identification, evidence-based treatment, self-management support, and prevention and promotion initiatives.

Our program aims to:

- Support and enhance family physicians’ skills for managing depression.
- Provide primary care patients with mental health treatment within their preferred setting.
- Improve medical outcomes for patients with chronic medical illnesses and co-morbid depression.
- Forge strong linkages with the local Schedule 1 facility.
- Develop stronger relationships with community agencies and other providers around mental health care.

Depression management is the first Chronic Disease Prevention and Management (CDPM) program to be developed within the Peterborough Networked FHTs. It provides a strong foundation for the development of further CDPM programs, as depression is a significant factor in many chronic physical diseases and can influence treatment outcomes.

To support the provision of best practice care for depression in the primary care setting, the program draws on existing resources and evidence-based tools with adaptations to suit our specific plan. For self-management, the project is using several web-based resources that have been developed by provincial organizations and other health care agencies. A significant change in patient care will be pro-active telephone follow-up with patients. As treatment capacity increases within the Family Health Teams, community partnering around prevention and health promotion activities can move forward.

The depression management program is currently in an early stage of implementation and has been introduced into selected practice teams. The program aims to increase the capacity within these teams to provide early identification and evidence-based treatment for depression, and to support patients with mild to severe depression in self-managing their illness.

Anticipated system outcomes include the off-loading of demand on the local Schedule 1 facility so that its services can concentrate on the most serious mental health patients. We also believe that as other CDPM programs evolve within the Teams, overlapping self-management activities will offer efficiencies.

A depression management program is seen as foundational within a primary care setting. It is a reminder that strong mental health care is a must within primary care and requires a clear vision, coordination, and conscious integration into all health care activities.

## Psychiatry Shared-Care Initiative

As part of our plan to address the needs of mental health patients in our community and to be able to provide ongoing and continual care, we have developed a shared-care approach to mental health care. The shared-care model involves a number of family physicians who have volunteered to roster unattached patients from the Peterborough Regional Health Centre (PRHC) mental health services adult outpatient clinic. In exchange, PRHC psychiatrists fast track requests for consultation for these patients should they be required.

Hospital psychiatrists have committed to provide psychiatric consultation on a per session basis with our five Family Health Teams. These sessions provide education, multidisciplinary case conferencing, and other services, and involve family physicians, nurse practitioners, and mental health clinicians. As an added benefit, we have recently been awarded a piece of equipment to enable our participation in the Ontario Telemedicine Network to complement this shared-care initiative with psychiatry. The equipment is located in the Peterborough Clinic for the initial use of family physicians and allied health professionals across the Family Health Teams.

This enhanced collaborative model has demonstrated the benefits of interdisciplinary care. Patients are ensured timely and appropriate services from health care providers in locations more suitable to their needs. Once again, this collaborative approach to managing mental health will provide improved management of all our patients.

## Comprehensive Vascular Disease Prevention and Management Initiative

Vascular disease is the leading cause of death in Ontario. In addition to the impact on a patient’s quality of life, it places a significant cost burden on the health care system. With an aging population, the situation is expected to become increasingly problematic in our community.

In order to address the complex problems associated with vascular disease from both a patient and system-wide perspective, we have created a partnership consortium dedicated to the development of a comprehensive vascular management and prevention disease strategy. Partners include the Networked Family Health Teams, the Vascular Health Network and regional nephrologists, Hospital Chronic Kidney Disease programs, Central East Local Health Integration Network, the Heart and Stroke Foundation of Ontario, AstraZeneca Canada, and the Ontario Ministry of Health and Long-Term Care.

Our vision is to create a single integrated strategy that focuses on screening and management of vascular disease and its associated risk factors such as hypertension, diabetes, dyslipidemia and chronic kidney disease. It is our expectation that integration of services will increase patient access to early detection and prevention programs. As leaders in this area, we plan to share our Comprehensive Vascular Disease Prevention and Management Initiative with other communities across the province and the country.

Vascular disease is the number-one killer of people with chronic kidney disease. We therefore pledge our full support to the Peterborough Vascular Disease Initiative as it will not only help combat early heart disease, stroke and amputations but will also help prevent kidney disease and kidney failure requiring dialysis in our community.

*Dr. Eliot Beaubien and Dr. Srinu Kammila, Nephrologists, Peterborough Regional Nephrology Association*

Peterborough's Family Health Teams have become a model for the rest of the province to emulate. Their benefit to the region led to increased accessibility to health care, innovative and exciting advances in health care delivery and an economic engine for the community. Primary Health Care Services of Peterborough is laying the foundation for the future delivery of health care in Ontario.

*Jeff Leal, MPP*

Without a doubt, the concept of Health Teams has given residents of my municipality new hope and the welcome realization that they can access primary health care. We as a municipality have worked very hard to assist in the establishment of a new Medical Centre that will serve a large area of Peterborough County. Over \$4 million dollars has been raised locally and we now have five family doctors. This would not have happened without the Health Team concept in place. Quite simply, it works.

*J. Murray Jones, Reeve  
Twp. of Douro-Dummer*

## VI. Community Support

A key to our development and subsequent success has been the ongoing communication with the public and subsequent support received from the community for the development of the Networked Family Health Teams. Community support was received from the following:

- **The business community, through the Greater Peterborough Chamber of Commerce and Greater Peterborough Area Economic Development Corporation, fully endorsed the proposal as the shortage of family physicians was affecting the ability of businesses to recruit staff.**
- **Local allied health professionals with the recognition that the proposed network of Family Health Teams represented additional resources to enhance the delivery of health care for patients in the community.**
- **The public who were seeking solutions to a critical health care situation.**
- **The Peterborough municipalities who saw the proposed primary care model as a cost effective solution to a growing community crisis that would maximize existing local medical resources.**
- **Other physicians in Ontario who recognized that the situation in Peterborough was critical and that an urgent solution was necessary.**
- **Local community groups such as the Children's Aid, Health Unit who are now working collaboratively with the FHTs to provide health care services to young mothers.**

## The Patient Perspective

The support from the patients within our community is the ultimate measure of our success, and their ongoing show of appreciation for our health care services will be the key to our ability to continue to grow and succeed. We have heard from hundreds of patients from across our region. Here is a sample of some of the things they had to say:

"As seniors, we are most relieved knowing once again **our lives can be monitored by a health team**, each in their knowledge advising us about our health care. We have found those on the "team" very thorough and attentive to our personal needs. We look forward to our checkups in Peterborough with the most personable and caring members of the team."

"When I decided to lose weight and get healthy, I decided to see one of our dietitians. The dietitian formed a plan that would help me reach my goal, which was to weigh what I did in high school – a loss of 50 pounds. Great news! **I reached my goal** and have decided to continue to see the dietitian. She is such a positive person. She makes you feel you can do it. I have **enjoyed my appointments** with the dietitian, she helps to keep me focused and motivated."

"After living with constant arthritic pain for some years, I was more than happy when our nurse practitioner joined our local health clinic. For me, it made the difference between night and day. I now have a lot less pain and symptoms as the result of the nurse practitioner reducing my medication. **Our nurse practitioner is a godsend to our community**, and words cannot describe how thankful I am for her. I am 76 years old and my symptoms have decreased by 50 percent."

One of Peterborough Regional Health Centre's strategic goals has been to encourage and foster greater collaboration with our community partners. The development of Family Health Teams in Peterborough has been hugely beneficial to the delivery of primary care to the patient population, as well as greatly facilitating communication between primary care providers and the hospital. Family Health Teams have become the voice of primary care and we look forward to closer relationships with Primary Health Care Services of Peterborough in the future.

*Kenneth Powell, Chair, Board of  
Governors, Peterborough Regional  
Health Centre*



"I started seeing the pharmacist in July 2008 to monitor my blood count, which was rarely correct and my blood thinner drug dosage changed monthly for several years. The pharmacist was able to change my dosage to be more consistent. Now, my blood count is right each month when I'm tested by the pharmacist. **I feel much safer** taking this drug. Also, when I had some dental work done, my pharmacist informed my dentist of my blood count. I feel very confident in my pharmacist. Being in my late 70s, it is much appreciated having **someone so caring and competent** to count on."

"When a home pregnancy test came back positive, I was referred to the Partners in Pregnancy clinic. The physician there made me feel welcome and comfortable and certain that I was in very good hands. Over the next four months, I had a chance to see and be seen by all four doctors and enjoyed meeting each one. It was comforting to know at least one of them was bound to be present for labour and delivery, and not an unfamiliar doctor. Each one took time with questions, and the nurse was exceptionally warm and kind. As a result of the **excellent care and focused attention** I received from all the staff members at the Partners in Pregnancy Clinic, I spent a happy pregnancy, found the c-section less frightening, continued breastfeeding with the lactation consultant's help. I was sorry to leave when the six weeks post-partum was up. **Wonderful experience**, thank you!"

"My medical caregiver referred me to a mental health clinician for counselling to help me deal with some personal issues that were having a negative effect on my mental and physical health. When I met with the mental health clinician I found her very easy to talk to. She was able to view my issues objectively and give me some sound advice and ideas on how to deal with them more effectively. After regular meetings with her, I was able to make some major changes that improved my life. I honestly don't know where I'd be today without the mental health clinician's counselling. **She saved my life.**"

"She (therapist) knew what was wrong even though I had never been able to put it into words. I have a dissociative disorder and two cases of post-traumatic stress disorder. Although I have had many hospitalizations and long-term therapy, I have never been able to feel that I could find help from someone who was competent enough to help me. I am so **grateful for this help and for having such a competent therapist** who could help me when no one could after forty years! This means no more suicide attempts, hospitalizations and the loss of half of my life to not being able to function."

## VII. Partnerships

A successful integrated team approach to health care is best achieved in partnership with many stakeholders. In Peterborough, our integrated model continues to expand for the benefit of our patients, health care providers and the overall community. We have had the good fortune to partner with health service providers, agencies, industry and local stakeholders to identify and meet community needs, expand access to care, and develop and support innovative new programming.

Primary Health Care Services of Peterborough remains committed to fostering positive and fruitful relationships with our partners. These relationships touch on almost every aspect of our health care system. Some of the most significant partnerships include:

### Central East LHIN:

- Our FHT members have taken important leadership positions on LHIN committees, including the Chronic Disease Prevention and Management Committee and the Primary Care Working Group.
- We helped to develop and are now a key part of the implementation team for the Timely Discharge Information System (TDIS) project, which aims to implement electronic report transmission from hospitals to physician practices.
- We have been approached by a number of other agencies to partner on future project charters around CDPM that align LHIN, FHT, and community priorities.

### Community Specialists:

- In spring 2009, community psychiatrists began working with our teams on a shared-care initiative in mental health services.
- We continue to work with the Vascular Health Network and the Peterborough Regional Nephrology Associations to develop programs that integrate primary and specialty care around vascular disease, hypertension, diabetes, and chronic kidney disease.
- Our nurse practitioners have received advanced training for asthma and COPD treatment with our local respirologists and industry.
- Local endocrinologists sit on the Diabetes Care Committee of our Board.
- We work closely with our community geriatrician to develop programs in the areas of cognitive disorders, stroke, fracture recovery, rehabilitation, and others, to meet the needs of our aging population.

I have been a respirologist in Peterborough for 12 years and practiced in Toronto for 12 years prior to my move here. One of the shortcomings of asthma management in Peterborough was asthma education for my patients. Through the Family Health Teams we have been able to partner with AstraZeneca to initiate an asthma program in our office. With this program, we have been able to formally train 15 nurse practitioners as asthma educators and some are also COPD educators. This has significantly increased the quality of care provided in this region to people with these diseases. This opportunity would not have been possible had the Family Health Teams not been in place and coordinated through the management office.

*John J. Vlasschaert, MD, FRCP  
Medicine Professional Corporation*

The Healthcare Team Effectiveness training and support from Pfizer has been invaluable in providing tools and exercises to further team integration and address the areas of communication, alignment and methods across our Family Health Teams. We are very grateful to Pfizer for their ongoing support in this evolutionary process.

Laura Kennedy  
Team Development Leader, PHCSP

The Peterborough Regional Vascular Health Network (VHN) is a not-for profit corporation committed to advancing programs for patients and providers throughout the region. The VHN sees up to 9,000 patients per year in various activities. The VHN looks forward to a new and unique collaboration with the CE LHIN, Peterborough Family Health Teams, other specialty services, such as nephrology, and private industry such as AstraZeneca. The aim of this distinctive partnership is to optimize vascular care for 2,500 patients that are not currently being treated for this condition.

William G. Hughes, MD, FRCPC

Local Stakeholders:

- Two FHT physicians and nurse practitioner provide primary care to the First Nations community at Curve Lake as part of their holistic health centre.
- We provide support to the townships in Peterborough County to develop medical facilities and provide service to rural areas across the region.
- The Family Health Teams work closely with Public Health to help prevent health concerns through effective immunization in our community.

Industry:

PHCSP has identified industry partners to provide additional support for chronic disease management programs. Initiatives under development include:

- AstraZeneca Canada Inc. has provided support for our nurse practitioners to receive additional certification for the treatment of asthma and COPD. The company has also been a lead partner in the Comprehensive Vascular Disease Prevention and Management Initiative.
- Pfizer's Healthcare Team Effectiveness workshop has assisted PHCSP to build and facilitate greater integration within our emerging health teams. Pfizer Canada Inc. has further supported our FHTs with workshops on dementia education for physicians, nurse practitioners and registered nurses.
- Hoffman-La Roche Ltd. has supported our Anticoagulation clinic with the donation of INR machines.

VIII. Future Development



Our vision for the future is to build on our current success by continuing to invest in our health care providers, further integrating the teams, connecting with community specialists, developing additional infrastructure and adding new innovative programs.

We have spearheaded research to gain a better understanding of the care gaps that exist in our community. We have identified areas in which programs will be developed and implemented, and where programs already exist they will be strengthened with the addition of further resources.

The areas that have been identified include: anticoagulation, asthma, clinical outreach, childhood mental health, COPD, diabetes, geriatric services, medical reconciliation, pain management, palliative care, vaccination clinic, vascular disease prevention and management.

In order to fund new programming, we will seek to work with additional partners and find further sources of revenue to supplement our current funding allocation from the Ministry of Health and the Central East LHIN.

We will strengthen our community by seeking to provide leadership to other regions across the province and the country that recognize the success we have achieved in primary care reform. It is our hope that as we provide guidance and leadership, the integrated primary health care model will become standard practice across the country and those that have embraced this team approach will operate effectively and continually improve the level of care that they are able to provide to their citizens.

# IX. Financial Report

## Auditors' Report

To the Board of Directors of Primary Health Care Services

We have audited the statement of financial position of Primary Health Care Services as at March 31, 2009 and the statements of operations and changes in fund balance and cash flows for the year then ended. These financial statements have been prepared to comply with the funding agreement with the Ministry of Health and Long-Term Care. These financial statements are the responsibility of the organization's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the organization as at March 31, 2009 and the results of its operations and its cash flows for the year then ended in accordance with the basis of accounting described in Note 2 to the financial statements.

These financial statements which have not been, and were not intended to be, prepared in accordance with Canadian generally accepted accounting principals, are solely for the information and use of the Directors of Primary Health Care Services and the Ministry of Health and Long-Term Care. These financial statements are not intended to be and should not be used by anyone other than the specified users for any other purpose.

Collins Barrow Kawarthas LLP

Chartered Accountants  
Licensed Public Accountants

Peterborough, Ontario  
May 6, 2009

## Statement of Financial Position

As at March 31, 2009

	2009	2008
	\$	\$
<b>ASSETS</b>		
<b>Current Assets</b>		
Cash	450,853	286,116
Accounts receivable	68,203	81,586
Prepaid expenses	198,168	-
Short-term investments (note 3)	2,882,384	3,100,000
	3,599,608	3,467,702
<b>LIABILITIES AND FUND BALANCE</b>		
<b>Current Liabilities</b>		
Accounts payable and accrued liabilities	426,355	231,673
Due to Ministry of Health and Long-Term Care (note 4)	3,165,438	3,228,214
	3,591,793	3,459,887
<b>Fund balance</b>		
Unrestricted	7,815	7,815
	3,599,608	3,467,702



Statement of Operations and Changes in Fund Balance

As at March 31, 2009

	2009 Budget (unaudited) \$	2009 Actual \$	2008 Actual \$
<b>Revenues</b>			
Ministry of Health and Long-Term Care	8,823,580	8,085,624	6,098,664
Interest income	-	86,573	28,227
Other recoveries	-	8,112	-
Miscellaneous income	-	-	8,015
	8,823,580	8,180,309	6,134,906
<b>Expenses</b>			
Human resources	7,453,606	6,806,995	5,043,335
Administration and general overhead	317,205	315,610	199,777
Recruiting	138,270	125,107	81,152
Training and development	89,350	98,165	60,119
Consulting	37,268	71,231	31,590
One time costs	238,839	291,871	160,218
Insurance	34,303	36,069	35,127
Rent	398,110	367,213	236,898
Audit and Legal	20,000	20,575	18,353
Travel	96,629	47,473	32,742
IT/Telecommunications	-	-	180,786
Other	-	-	24,916
Amortization	-	-	22,078
	8,823,580	8,180,309	6,127,091
<b>Excess of revenues over expenses for the year</b>	-	-	7,815
<b>Unrestricted - beginning of year</b>	-	7,815	-
<b>Unrestricted - end of year</b>	-	7,815	7,815

Statement of Cash Flows

For the year ended March 31, 2009

	2009 \$	2008 \$
<b>CASH PROVIDED FROM (USED FOR)</b>		
<b>Operating activities</b>		
Excess of revenues over expenses for the year	-	7,815
Item not affecting cash		
Amortization	-	22,078
	-	29,893
Change in non-cash working capital items		
Decrease (increase) in accounts receivable	13,383	(70,310)
Increase in prepaid expenses	(198,168)	-
Decrease (increase) in short-term investments	217,616	(3,100,000)
Increase in accounts payable and accrued liabilities	194,682	155,998
Increase in due to Ministry of Health and Long-Term Care	(62,776)	2,203,078
<b>Increase (decrease) in cash</b>	164,737	(781,341)
<b>Cash - beginning of year</b>	286,116	1,067,457
<b>Cash - end of year</b>	450,853	286,116
<b>Other information</b>		
Interest received	48,573	28,227

Notes to the Financial Statements for the year ended March 31, 2009

1. Nature of Operations

Primary Health Care Services is a not-for-profit organization incorporated on October 12, 2005 under the provisions of the Corporations Act of Ontario. The organization was formed to assist in the provision of enhanced primary health care services to the residents of the City of Peterborough, Peterborough County and surrounding areas.

2. Significant Accounting Policies

- (a) Basis of accounting  
These financial statements have been prepared in accordance with the significant accounting policies set out below. The basis of accounting used in these financial statements materially differs from Canadian generally accepted accounting principles in that expenditures for capital assets are not capitalized but expensed in the period incurred.
- (b) Revenue recognition  
Primary Health Care Services uses the deferral method of accounting. Restricted contributions are recognized as revenue in the year in which the related expenditures are incurred. Unrestricted contributions are recognized as revenue in the year when received or receivable if the amounts can be reasonably estimated and collection is reasonably assured.
- (c) Capital assets  
Capital assets are reported as an expenditure on the statement of operations and changes in fund balances in the period of acquisition. Capital assets which had previously been recorded at cost and amortized have been fully amortized in the prior year.
- (d) Income taxes  
Primary Health Care Services qualifies as a not-for-profit organization as defined by the Federal and Ontario Income Tax Acts and consequently is not subject to corporate income taxes.
- (e) Management estimates  
The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.
- (f) Financial instruments  
The organization utilizes various financial instruments. All financial instruments are separated into one of the following categories based on the purpose for which the asset was acquired. The organization's accounting policy for each category is as follows:  
  
**Held-for-trading:** This category is comprised of cash and short-term investments which are carried in the statement of financial position at fair value with changes in fair value recognized in the income statement. Transaction costs related to instruments classified as held-for-trading are expensed as incurred.  
  
**Receivables:** These assets are non-derivative financial assets resulting from the delivery of cash or other assets by a lender to a borrower in return for a promise to repay on a specified date or on demand. They arise principally through service delivery or GST rebates which will be collected after returns/reports have been submitted and approved. They are initially recognized at fair value and subsequently carried at amortized cost, using the effective interest rate method, less any provision for impairment. Transaction costs related to receivables are expensed as incurred.

**Other financial liabilities:** This category includes financial liabilities other than those classified as held-for-trading and comprises trade payables and due to Ministry of Health and Long-Term Care. These liabilities are initially recognized at fair value and subsequently carried at amortized cost using the effective interest rate method. Transaction costs related to other financial liabilities are expensed as incurred.

Unless otherwise stated, the fair value of the organization's financial instruments approximate their carrying values.

3. Short-term Investments

Short-term investments consist of guaranteed investment certificates which mature April 7, 2009 and February 26, 2010 at rates of 3.5% and 0.75% respectively.

4. Due to Ministry of Health and Long-Term Care

The amount due to (from) the Ministry of Health and Long-Term Care consists of:

	2009	2008
	\$	\$
Capital and development grant advances	88,504	86,694
Family Health Team Funding 2007	902,058	902,058
Family Health Team Funding 2008	2,239,462	2,239,462
Family Health Team Funding 2009	(64,586)	-
	3,165,438	3,228,214

5. Economic Dependence

Primary Health Care Services receives the majority of its revenues from the Ministry of Health and Long-Term Care. The nature and extent of this revenue is of such significance as to affect the viability of the organization and accordingly, the organization is economically dependent upon the Ministry.

# Acknowledgements

## PHCSP Board of Directors

We express our sincere gratitude to our current and past Board of Directors and our staff for their commitment, dedication and contribution to our success.

We also acknowledge and thank the Ministry of Health and Long-Term Care and the various physicians and institutions that have contributed to the conceptualization of Primary Care Reform.

### Current

- Dr. Stephan Ragaz (Chair)/Lead Physician, Peterborough Community FHT
- Dr. Bob Neville (Vice-Chair) /Lead Physician, The Medical Centre FHT
- Dr. Rick Whatley (Treasurer)/Lead Physician, Peterborough Clinic FHT
- Dr. Tom Bell (Secretary)/Lead Physician, Chemong FHT
- Dr. Nick van der kamp/Lead Physician, Greater Peterborough FHT
- Dr. Laverne Arthur/Associate Lead Physician, Chemong/Lakefield FHT
- Dr. John Beamish/Associate Lead Physician, Peterborough Community FHT
- Dr. Rick Binette/Associate Lead Physician, Peterborough Clinic FHT
- Dr. Tom Richard/Associate Lead Physician, The Medical Centre FHT
- Dr. Don Spink/Associate Lead Physician, Greater Peterborough FHT
- Brenda Whiteman, Mental Health Clinician
- Lynda Chilibeck, Pharmacist
- Shannon Selkirk-Ferrier, Nurse Practitioner
- Alyson Kubica, Registered Dietitian
- Ron Black, Chair, Greater Peterborough Health Services Foundation

### Past

- Dr. Tim Kerr (Treasurer)/Lead Physician, Peterborough Clinic FHT
- Dr. Margaret Dickie/Associate Lead Physician, Peterborough Clinic FHT
- Dr. John Goodge/Associate Lead Physician, Greater Peterborough FHT
- Dr. Mike Moyter/Associate Lead Physician, Chemong FHT
- Greg Clarke, Mental Health Clinician (*ex officio*)



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